



Diversion and support of offenders with a mental illness

Guidelines for best practice



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Diversion and support of offenders with a mental illness: Guidelines for best practice

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PRINCIPLES WHICH UNDERPIN BEST-PRACTICE DIVERSION AND SUPPORT

Collaboration, communication and coordination are essential

Complex programs involving multiple stakeholders should seek to deliver a 'single system' experience wherever possible, requiring program goals and activities to be coordinated, process duplication to be minimised, and timely and appropriate information sharing.

Community safety is not compromised

Research indicates that well-designed diversion and support programs do not increase risk to the community. Addressing mental health and related problems that are linked to offending is more likely to reduce recidivism than usual criminal justice sanctions.

Accountability for criminal behaviour is retained

Mental illness may sometimes reduce moral culpability but not legal responsibility. Participation in diversion from mainstream criminal justice processes is commonly linked to alternatives to imprisonment that meet community expectations for accountability. The rights and interests of victims must be acknowledged.

Human and legal rights are protected

Diversion and support programs should seek to enhance and support the exercise of the human rights of people with mental illness. They should also ensure that legal rights are not infringed by the diversion and support process.

Consumer and family or carer participation ensures policy and service development are better targeted, more effective and sustainable

People with mental illness (consumers) and family and friends who care for them (carers) provide vital insights into policy and program design that cannot be provided by other stakeholders.

Mental illness and associated issues are identified, assessed and treated as early as possible

Screening and assessment should seek to identify mental illness and associated problems (especially substance use) as early as possible. Early identification, assessment and treatment increases prospects for recovery and prevention of escalating problem behaviours.

Programs deliver culturally safe, holistic services tailored to individuals

Mental illness is experienced differently by different people, and is often associated with many complex and interacting problems. Programs should be needs-based, and provide or broker well-coordinated, integrated and culturally safe services. This often means working with individuals within the context of their family and community.

Quality and integrity of health interventions are maintained

The quality of services and supports provided to people through diversion programs should be equivalent to services available in the general community. Health interventions should be provided and managed by health services and retain a focus on achieving health and wellbeing related outcomes for individuals and families.

A recovery orientation is essential

Recovery is a personal process of changing one's attitudes, values, feelings, goals, skills and roles. It involves the development of new meaning and purpose and a satisfying, hopeful and contributing life beyond the effects of mental illness. The model is consistent with the "good lives" model of offender rehabilitation.

Programs balance fidelity to the evidence base with environmental constraints and innovation

The evidence for diversion and support programs is growing, but incomplete. Fidelity to the existing evidence base should be balanced by the desirability of local flexibility, innovation and evaluation. Resource limitations, including workforce, infrastructure, funding and other constraints also necessitate innovation.

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1

Introduction

1. INTRODUCTION

Over the past 20 years, the importance of mental health has grown in the public and political consciousness. The pervasive impact of poor mental health on health, socio-economic and cultural life is now well recognised. The need to improve promotion of mental health and responses to people with mental illness across all areas of government has become clear.

Eighteen years after the *National Mental Health Strategy* was endorsed by all Commonwealth, State and Territory governments, Australia is implementing its fourth *National Mental Health Plan*, in the context of a *National Mental Health Policy* revised and updated in 2009. The process of long-term reform has gained new momentum in recent years, with the Council of Australian Governments agreeing in 2006 to a five year *National Action Plan on Mental Health*. A clear and consistent thread in each of these key policy documents is the need for a whole-of-government, whole-of-community response to alleviating mental illness and fostering mental health and wellbeing.

The National Mental Health Policy defines mental illness as “a clinically diagnosable disorder that significantly interferes with an individual’s cognitive, emotional or social abilities”.¹ People with mental illness who ‘slip through the cracks’ in health and social support systems sometimes end up in conflict with the law. Research from Australia and overseas shows that high rates of mental illness are evident at all points in the criminal justice system, including among people who are in contact with police;² are arrested;^{3,4} are held in police cells or on remand;^{5,6} appear in court;^{7,8} are imprisoned;⁹ or have a past history of imprisonment.¹⁰ People who have been in custody are also at increased risk of suicide, both during incarceration and after release.^{11,12}

The impact of comorbid substance use on people with mental illness is particularly significant in the criminal justice context and elsewhere. Among people with serious mental illness, drug and alcohol use is the most commonly occurring health issue,^{13,14} and is strongly associated with worse mental health outcomes and with offending behaviour.¹⁵

Particular mention must also be made of the significant health and socio-economic disadvantage experienced by Aboriginal and Torres Strait Islander people. Indigenous Australians experience higher rates of psychological distress than other Australians and comprise a quarter of Australia’s prison population despite representing 2.4 per cent of Australia’s population overall.^{16,17,18}

In the face of this data, there is a strong rationale for diversion and support initiatives. Well designed diversion and support programs have potential to improve the wellbeing of people with mental illness and that of the communities to which they belong. Diversion and support programs can strengthen human and legal rights; reduce frequency and seriousness of offending behaviour; and improve the cohesion of criminal justice and human service systems. Overall, they reduce the total social cost of under-treated mental illness in the community.^{19,20}

The National Justice CEOs (NJCEOs) Group recognises the potential for mental health diversion and support programs to contribute to national reform efforts in mental health, including Indigenous mental health. Consequently, the NJCEOs Group has developed evidence-based resources to support policy and program development focused on diversion and support of people with mental illness who are in conflict with the law.

While it is clearly preferable that all people with mental illness receive appropriate treatment to achieve an optimal state of mental health, the fact is that a significant portion of people who come into contact with the criminal justice system are receiving little or no care. Diversion and support programs for people with mental illness can act as a gateway to care, redirecting people in need of supports to the services that can provide them. By focusing on the underlying causes of offending behaviour, diversion and support programs also help to make our communities safer.

These guidelines have been developed by the NJCEOs Group, and aim to provide policy makers and program developers with guidance on an evidence-informed approach to establishing diversion and support programs in the community. They have been developed with input from 95 government and non-government stakeholders drawn from all states and territories.

The guidelines are not a consensus policy statement for the Australian jurisdictions and should not be read as such. Many of the issues discussed are complex and far from settled. The guidelines provide a resource for different jurisdictions to devise policy positions and programs that are relevant to the particular issues that concern their jurisdiction. Specific policy decisions will need to be determined in close consultation with affected stakeholders.

This document is structured to provide guidance on the context of diversion, conceptual considerations and practical advice on key issues.

Section 2 provides an introductory overview of mental illness and the criminal justice system including some of the key data on Indigenous people, young people, people from culturally and linguistically diverse backgrounds and women.

Section 3 provides a definition and brief rationale for diversion and support. Section 3 also describes a range of potential diversion and support interventions at different stages of the criminal justice continuum.

Section 4 addresses conceptual issues relating to evidence-based practice, reflecting on suggested underpinning principles, goals and objectives of diversion and support.

Section 5 reflects on the importance of diversion and support initiatives as a collaborative endeavour, while **section 6** addresses five key questions applicable to all diversion and support programs.

Section 7 focuses on essential considerations that should be taken into account when developing programs that will impact on Indigenous people, young people and people from culturally and linguistically diverse backgrounds.

Practical examples of good practice are showcased in **Appendix A**, with references to websites and evaluation material (where available) as well as key commentary.

Throughout the document, summaries or pointers to research outcomes and evidence appear as 'evidence snapshots'. Critical points are also highlighted at the conclusion of most sections and each sub-section in sections 4 and 6.

As the guidelines cover significant territory in terms of the range of different diversion and support programs, most content is relatively general. Suggested further readings to provide additional depth or to contextualise key points are noted in most sections.



2

Mental illness in the criminal justice system

2. MENTAL ILLNESS IN THE CRIMINAL JUSTICE SYSTEM

This section provides an overview of the extent and complexity of mental illness in the criminal justice system.

While at the date of writing, there was no comprehensive national data on Australian prisoner health,²¹ the data that is available points to significantly worse health status than the general population in prisoners and ex-prisoners.^{22,23,24} The Australian Institute of Health and Welfare (AIHW) has observed that:

prisoner populations are marked by severe disadvantage, stigmatisation, social exclusion and poor physical and mental health. Studies of prison inmates also consistently find they are more likely to engage in risky behaviours such as drug and alcohol use, smoking, and unsafe sexual practices. These social and behavioural factors explain their higher rates of bloodborne viruses such as viral hepatitis, of sexually transmitted infections and of drug dependence, mental illness, and other health problems.^[25,26] It follows that both young and adult prisoners have high death rates and there is also growing evidence of excess mortality among offenders after their release.²⁷

There is strong Australian and international evidence that the prevalence of mental health problems among prisoners is significantly greater than in the general population.^{28,29,30,31,32} Twelve-month prevalence scores for any psychotic, anxiety or affective disorder among prisoners have been found to be as high as 46 per cent in Australia, compared with 16 per cent of a similar cohort in the general population.³³ The rates are generally higher among remand prisoners compared to sentenced prisoners.³⁴

Prisoner health data

The first national snapshot of Australian prisoner health will be released in 2010. The Australian Institute of Health and Welfare expects to release *The Health of Australia's Prisoners* in 2010, which includes data across a range of health indicators. The report will present data collected from all states and territories in 2009.

Female prisoners have a greater prevalence of mental illness than their male counterparts, with a 2001 study in New South Wales finding that 42 per cent of men and 62 per cent of women assessed at reception had at least one current mental illness (anxiety, affective or psychotic disorder).³⁵ For prisoners serving a prison term the same study found the 12-month prevalence to be 33 per cent for men and 59 per cent for women.³⁶ This is consistent with a Victorian study conducted around the same time which found prevalence of any mental disorder (excluding substance abuse) to be 66 per cent in female prisoners.³⁷ In Queensland, 68 per cent of female prisoners reported Beck Depression Inventory scores indicating likely depression.³⁸ Most recently, a pilot study in Western Australian prisoners found that 30 per cent of male and 20 per cent of female, non-Indigenous prisoners reported past admission to a psychiatric facility.³⁹

International research in Canada and the US has found that people with serious mental illness have been found to represent a disproportionate percentage of interactions with police.⁴⁰ They are also more likely to be arrested,^{41,42} although it has been argued that the arrest rates are largely explained by high rates of substance use in people with mental illness.⁴³ Unpublished data from a Victorian study suggests that among prisoners detained in police cells, 25 per cent report a psychiatric history; 70 per cent had some form of substance abuse or dependency and 53 per cent were registered on the Victorian public mental health database.⁴⁴

In Australia, there is also evidence that people with mental illness are over-represented in Magistrates' Courts.^{45,46} A 2006 study of 189 Magistrates' Court defendants found that 55 per cent reported experiencing a mental disorder. Of this group, 75 per cent also reported substance abuse.⁴⁷

The *National Survey of Mental Health and Wellbeing 2007* found that among people who have previously been incarcerated, 41 per cent reported a mental illness in the past 12 months, double the rate of people without a history of incarceration.⁴⁸

People who have been in custody are also at heightened risk of suicide,⁴⁹ a risk that increases further in the first few months following release.⁵⁰ A large cohort study in NSW with an average follow-up period of 7.7 years found that among people with a history of imprisonment, males were 4.8 times and females 12.1 times more likely to die by suicide than the general NSW population.⁵¹

Indigenous Australians, young people and people from culturally and linguistically diverse backgrounds are focus groups for these guidelines. Some of the key research on mental illness and justice system involvement in these groups is presented in the evidence snapshots following.

Some additional points are also made about justice-involved women. This is because their mental illness, offending and needs profiles differ from those of men, with implications for diversion and support program design.

Further reading

- Butler, T, Andrews, G, Allnutt, S, Sakashita, C, Smith, NE, and Basson, J (2006), "Mental disorders in Australian prisoners: a comparison with a community sample", *Australian and New Zealand Journal of Psychiatry*, vol. 40, no. 3, pp 272-6.
- Deloitte Consulting (2003), *Victorian Prisoner Health Survey*, available online at www.justice.vic.gov.au (last accessed August 2009).
- Fazel, S and Danesh, J (2002), "Serious mental disorder in 23 000 prisoners: a systematic review of 62 surveys", *The Lancet*, vol. 359, pp 545-50.

Evidence snapshot:

Indigenous Australians and the CJS

The number of years of healthy life lost (incorporating disability and mortality) due to mental disorders is estimated to be 1.6 times greater for Indigenous than non-Indigenous Australians.⁵² Indigenous people in the community are twice as likely to report experiencing psychological distress than non-Indigenous Australians.⁵³ Rates of suicide are also higher – three to four times higher in young Indigenous men, and five times higher in young Indigenous women.⁵⁴

While the proportion of prisoners who are Indigenous varies significantly between jurisdictions, in all jurisdictions it is clear that Indigenous people are over-represented. Indigenous Australians make up 24 per cent of Australia's prison population,⁵⁵ despite accounting for only 2.4 per cent of the population as a whole.⁵⁶

Alcohol and substance use is a significant issue among Aboriginal and Torres Strait Islander people who come into contact with the criminal justice system.⁵⁷ While Aboriginal people are more likely not to drink than non-Indigenous Australians, those who do are more likely to do so at risky levels.⁵⁸ A 2002 survey found that Indigenous people are more likely to have been charged or imprisoned for criminal behaviour where they have alcohol or other drug problems; have lower levels of educational attainment or are unemployed. The study also found that crowded living conditions, financial

stress or being a member of the 'Stolen Generation' was associated with higher rates of imprisonment.⁵⁹

Although data on the mental health of Indigenous people in custody is limited, the most recent research is strongly suggestive of high rates of complex mental health problems.⁶⁰ The double disadvantage flowing from gender and Aboriginality experienced by Indigenous women must be acknowledged.⁶¹ Aboriginal women with mental illness are the most disadvantaged group among all prisoners.⁶²

While there is evidence suggesting that Indigenous male prisoners report levels of psychological distress and rates of mental illness similar to that of non-Indigenous prisoners,^{63,64} they are less likely to have been diagnosed with depression or to have received past support for mental health than non-Indigenous prisoners.⁶⁵ However, Aboriginal women in prison are more likely than non-Indigenous female prisoners to have a diagnosis of psychosis, depression or obsessive compulsive disorder and have higher levels of psychological distress.⁶⁶

The number and frequency of past experiences of trauma, grief and loss is greater in Indigenous prisoners than non-Indigenous, and the nature of those experiences is markedly different to those of other Australians.⁶⁷ Justice-involved Indigenous people also perceive higher levels of racism and discrimination than non-Indigenous:⁶⁸ self-perceived discrimination has been strongly correlated with greater incidence of mental disorder in the United States.⁶⁹

Further reading

- Heffernan, E, Andersen, K and Kinner, S (2009), "The insidious problem inside: mental health problems of Aboriginal and Torres Strait Islander People in custody", *Australasian Psychiatry*, vol.17, no. 1, suppl. pp S41-S46.
- Swan, P and Raphael, B (1995), *Ways Forward. National consultancy report on Aboriginal and Torres Strait Islander mental health*, Canberra: Commonwealth of Australia.

Evidence snapshot:

young people

Young people who are involved with the criminal justice system are more likely to have mental disorders than other young people. Australian and international evidence points to high rates of depression, anxiety, Attention Deficit Hyperactivity Disorder as well as substance use and self-harming behaviour.^{70,71,72,73,74} Psychosis appears in this group at ten times the rate of the general population⁷⁵ and very high incidences of multiple exposure to trauma are consistent with elevated rates of post-traumatic stress disorder.⁷⁶ At least two thirds report childhood trauma or neglect.^{77,78}

Overall prevalence of mental disorder (excluding conduct disorder) has been estimated at between 40-70 per cent in juvenile offenders.⁷⁹ A large US study found that nearly two thirds of males and three quarters of females in juvenile detention met the criteria for at least one psychiatric disorder,⁸⁰ while a NSW report suggests that 88 per cent of juveniles in custody have symptoms consistent with a clinical disorder (inclusive of substance use and conduct disorder).⁸¹

Young females are more likely to have a psychiatric diagnosis than their male counterparts,^{82,83} and the prevalence of depression among incarcerated young women and adolescents is particularly high. An Australian study found 33 per cent of a sample of

juvenile female offenders were currently depressed (a further 22 per cent reported past diagnosis)⁸⁴ which is consistent with international studies.⁸⁵

Comorbidity of multiple psychiatric diagnoses and substance abuse is common among young offenders,^{86,87} and comparison studies have identified a strong correlation between the number of diagnoses and offender status.⁸⁸ Almost two thirds of young people who abuse drugs have been reported as having a diagnosable mental health disorder.⁸⁹

Intellectual disability also appears to feature strongly in juvenile delinquency. Studies suggest approximately 11 per cent of offenders on community orders and 17 per cent in detention have an IQ estimated at 70 or lower.^{90,91} Foetal alcohol syndrome has also been strongly linked to mental health problems and behavioural problems including contact with the criminal justice system.^{92,93}

Young people who end up in contact with the justice system are commonly under serviced by other support sectors.^{94,95,96,97} Services received through the justice system may often represent first contacts with health providers. They may also be unable to access other support services because of exclusion based on behavioural criteria (among other factors). This is a particular issue in a group with high prevalence of behavioural disorders such as conduct disorder (above 50 per cent).⁹⁸

Further reading

- Fazel, S, Doll, H and Långström, N (2008), "Mental Disorders Among Adolescents in Juvenile Detention and Correctional Facilities: A Systematic Review and Metaregression Analysis of 25 Surveys", *Journal of the American Academy of Child and Adolescent Psychiatry*, vol. 47, no. 9, pp 1010-19.
- Human Rights and Equal Opportunity Commission (HREOC) (2005), *Indigenous Young People with Cognitive Disabilities and Australian Juvenile Justice Systems – A report by the Aboriginal and Torres Strait Islander Social Justice Commissioner*, Sydney: HREOC.
- Dixon, A, Howie, P and Starling, J (2004), "Psychopathology in female juvenile offenders", *Journal of Child Psychology and Psychiatry*, vol. 45, no. 6, pp 1050-8.

Evidence snapshot: culturally and linguistically diverse people

Twenty per cent of prisoners were born outside of Australia, including approximately 14 per cent who were born in a country where English is not the main language.⁹⁹ The *National Survey of Mental Health and Wellbeing 2007* found that people born overseas were less likely to have a mental illness in the past 12 months, although this study excluded those who could not speak English well enough to complete the survey.¹⁰⁰

However, in contrast, some smaller studies undertaken with a higher degree of cultural sensitivity have found higher rates of mental disorder in some groups of immigrants compared with Australian-born comparison groups.^{101,102} Prisoners and ex-prisoners from culturally and linguistically diverse (CALD) backgrounds appear to be generally at lower risk of suicide than those who are not.^{103,104}

Many humanitarian migrants also have experiences of social dislocation and significant trauma which, when combined with the difficulties of adjusting to life in Australia, may predispose them to mental illness.^{105,106,107,108} Other groups include established and newly arrived migrants and young migrants. Each of these groups may have different experiences of their migration and subsequent life in Australia and their needs are correspondingly different.

Self-reported experiences of discrimination and racism have also been strongly associated with mental illness in CALD communities.^{109,110} Perceptions of discrimination among ethnically diverse groups can also lead to under-utilisation of mental health services, with implications for recovery and long term wellbeing.^{111,112}

Further reading

- Steel, Z, Chey, T, Silove, D, Marnane, C, Bryant, RA and van Ommeren, M (2009), "Association of torture and other potentially traumatic events with mental health outcomes among populations exposed to mass conflict and displacement: a systematic review and meta-analysis", *Journal of the American Medical Association*, vol. 305, no. 5, pp 537-49.
- Gary, FA (2005), "Stigma: barrier to mental health care among ethnic minorities", *Issues in Mental Health Nursing*, vol. 26, no. 10, pp 979-99.

Evidence snapshot:

women

There is limited Australian research specifically focused on women who offend,^{113,114} but the profile of women involved with the criminal justice system is known to be notably different to that of men.¹¹⁵ Justice-involved women experience greater social disadvantage, but are less likely to be involved in violent offending.¹¹⁶ Overall, women are a higher need, lower risk offender group than men.

Women in Australian prisons generally have higher rates of psychological distress, mental illness and trauma associated with past sexual or physical abuse^{117,118,119} which is consistent with the international research.¹²⁰ Females detained by police are also significantly more likely than men to report use of injectable illicit drugs and drug use preceding offending.¹²¹

Indigenous women are 'doubly disadvantaged' by both race and gender.¹²² A Western Australian study found Aboriginal women to be the most disadvantaged group among all prisoners, with "lower levels of education, less likelihood of having ever been employed and more-common dependence on welfare as a source of income...".¹²³

The Victorian Government's *Better Pathways* strategy includes a useful summary of the key differences between male and female offenders:¹²⁴

- women commit fewer and less serious crimes than men and are more likely to be convicted of crimes involving property or drugs that are motivated by poverty, gambling or substance abuse
- the severity of women's drug use is more closely related to their offending than it is for men – that is, women are more likely to have committed their offence(s) while under the influence of drugs or to support their drug use
- women's offending often develops through relationships with family members, friends and significant others (such as partners, support networks and colleagues) rather than the concept of 'peer associates' that is commonly cited as a risk factor for men
- women respond best to relationship focused and holistic responses that address many of their needs simultaneously
- women offenders are heavily influenced by their responsibilities and concerns for their dependent children
- more women than men experience sexual, physical and psychological abuse and these experiences appear to contribute to women's criminality and shape the pattern of offending
- the complex impact of mental illness, substance abuse and trauma is integral to women's offending and there are higher rates of all three factors for women than men.

Further reading

- Loxley, W and Adams, K (2009), *Women, drug use and crime: findings from the Drug Use Monitoring in Australia program*, Research and public policy series no. 99, Canberra: Australian Institute of Criminology.
- Department of Justice Victoria (DoJV) (2005), *Better pathways: an integrated response to women's offending and re-offending*, Melbourne: DoJV.

Section summary

- People in contact with the criminal justice system are significantly disadvantaged compared to other community members.
- Mental illness, particularly serious mental illness, is significantly more prevalent in the criminal justice system than it is in the community.
- Indigenous Australians experience higher rates of psychological distress and imprisonment.
- People with mental illness who have contact with the criminal justice system are a diverse population; the particular needs of sub-groups require specific consideration.

Notes to Sections 1 and 2

- 1 Australian Health Ministers (2009), *National Mental Health Policy 2008*, Canberra: Commonwealth of Australia.
- 2 Crocker, AG, Hartford, K and Heslop, L (2009), "Gender differences in police encounters among persons with and without serious mental illness", *Psychiatric Services*, col. 60, no. 1, pp 86-93.
- 3 Swartz, JA and Lurigio, AJ (2007), "Serious mental illness and arrest: the generalised mediating effect of substance use", *Crime & Delinquency*, vol. 53, no. 4, pp 581-604.
- 4 Engel, RS and Silver, E (2001), "Policing the mentally disordered suspects: a reexamination of the criminalization hypothesis", *Criminology*, vol. 39, no. 2, pp 225-52.
- 5 Police Response to the Interface with Mental Disorder (PRIMeD) (unpublished), cited in Victorian Government Department of Justice (VGDOJ) (2010), *Justice Mental Health Strategy*, VCDOJ.
- 6 Butler, T, Allnutt, S, Cain, D, Owens, D and Muller, C (2005), "Mental disorder in the New South Wales prisoner population", *Australian & New Zealand Journal of Psychiatry*, vol. 39, pp 407-13.
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- 8 Jones, C and Crawford, S (2007), "The psychosocial needs of NSW court defendants", *Crime and Justice Bulletin* no. 108, NSW Bureau of Crime Statistics and Research.
- 9 Butler, T, Andrews, G, Allnutt, S, Sakashita, C, Smith, NE, and Basson, J (2006), "Mental disorders in Australian prisoners: a comparison with a community sample", *Australian and New Zealand Journal of Psychiatry*, vol. 40, no. 3, pp 272-6.
- 10 Australian Bureau of Statistics (ABS) (2008), *National Survey of Mental Health and Wellbeing 2007: Summary of results*, ABS: Canberra.
- 11 Kariminia, A, Butler, TG, Corben SP, et al (2007), "Extreme cause-specific mortality in a cohort of adult prisoners — 1988 to 2002: a data-linkage study", *International Journal of Epidemiology*, vol. 36, pp 310-316.
- 12 Kariminia, A, Butler, TG, Law, M, Levy, M, Corben, S, Kaldor, J and Grant, L (2007), "Suicide risk among recently released prisoners in New South Wales, Australia", *Medical Journal of Australia*, vol. 187, no. 7, pp 387-390.
- 13 Munro, I and Edward, K (2008), "Mental illness and substance use: an Australian perspective", *International Journal of Mental Health Nursing*, vol. 17, no. 4, pp 255-60.
- 14 Siegfried, N (1998), "A review of comorbidity: major mental illness and problematic substance use", *Australian and New Zealand Journal of Psychiatry*, vol. 32, no. 5, pp 707-17.
- 15 Ferguson, AM, Ogloff, JRP and Thomson, L (2009), "Predicting recidivism by mentally disordered offenders using the LSI-R:SV", *Criminal Justice and Behaviour*, vol. 36, no. 1, pp 5-20.
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3

An overview of mental health diversion and support

3. AN OVERVIEW OF MENTAL HEALTH DIVERSION AND SUPPORT

This section provides a definition of mental health diversion and support. It provides a brief rationale for diversion and support, describes the various intervention settings and program types and provides guidance on key features of successful programs.

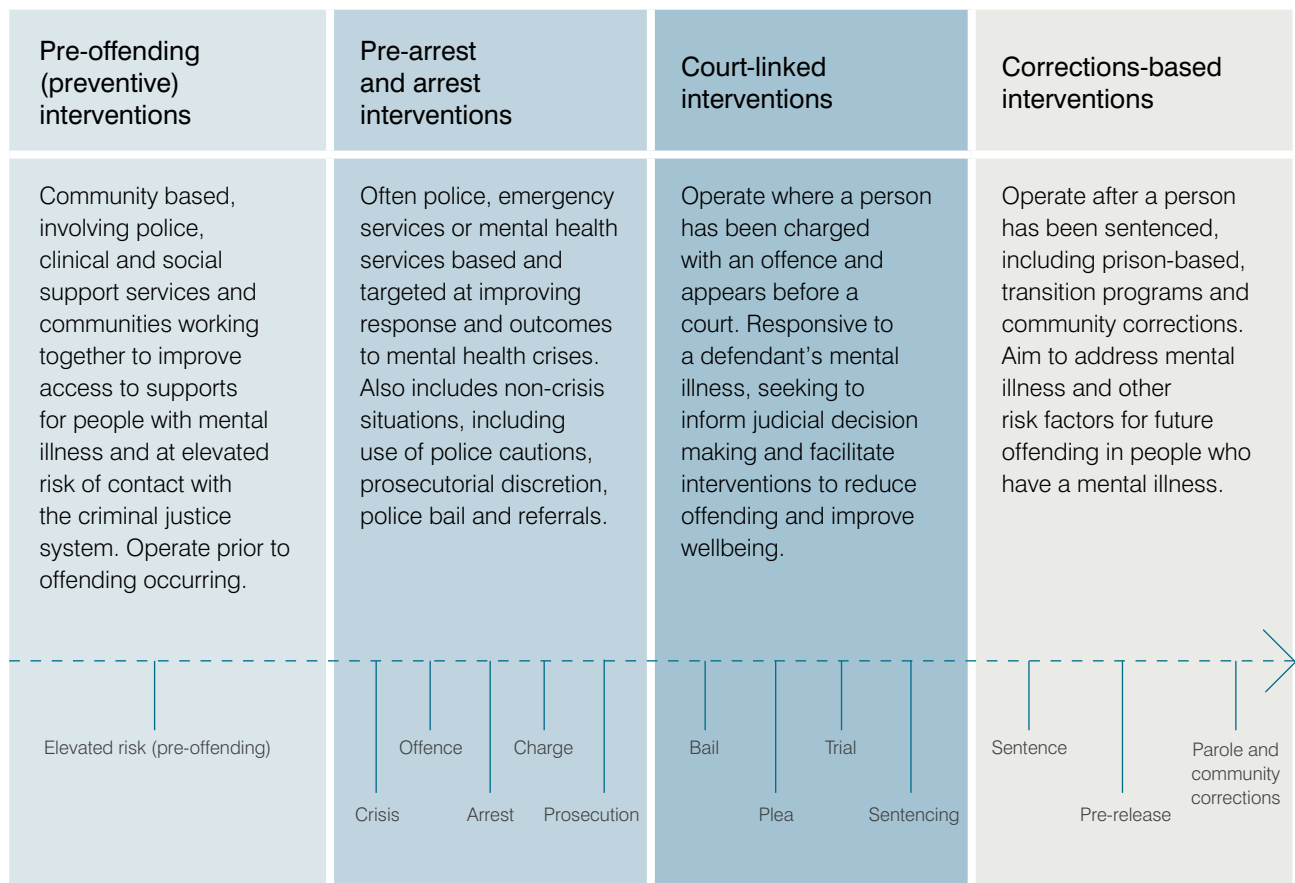
3.1 Definition

The definition of mental health diversion and support used in these guidelines is:

Mental health diversion and support aims to improve wellbeing and reduce recidivism in people whose mental illness significantly contributes to offending behaviour. The aim is to provide interventions and support targeted to their illness and related problems in place of, alongside, or integrated with other criminal justice system processes.

This definition includes programs which operate alongside other criminal justice system processes to improve individual wellbeing and recidivism outcomes in addition to those which divert people 'out of' the criminal justice system. The definition encompasses intervention settings at all stages of the criminal justice continuum (see Figure 3.1).

Figure 3.1 Intervention settings



There is relatively little literature on pre-sentencing diversion programs in Australia. To address this gap, pre-offending (preventive), pre-arrest or arrest and court-linked interventions are the focus of these guidelines. Corrections-based diversion and support programs operate after a person has been sentenced (including prison-based, transition, parole, community corrections) and aim to address the risk factors for future offending in people who have a mental illness. They can be considered diversion and support programs in the sense that they seek to divert a person from a criminal pathway by addressing underlying mental illness and associated problems that are causative of offending behaviour.

3.2 A rationale for diversion and support

There is a growing body of research describing a complex array of socio-economic factors that contribute to offending behaviour. Acknowledging that these factors may require “social or therapeutic responses, rather than legal solutions” underlies an emerging trend to situating justice processes firmly within (rather than above or outside) the broader social context.¹ This is especially so given the low level of empirical support for the effectiveness of punitive sanctions as a specific deterrent to future offending.^{2,3,4}

This approach is coupled with an increased focus on forward-looking justice outcomes that achieve individual and social change to reduce likelihood of future offending.⁵ Cautioning programs for juveniles, drug and problem solving courts and mental health diversion programs are all manifestations of these trends.

There are several explanations for the growing interest in criminal justice diversion programs. The basic rationale for diversion, common to youth diversion programs, is provided by the theory that contact with the criminal justice system has a stigmatising effect that can amplify existing disadvantage and may increase likelihood of further offending.^{6,7} Early diversion can provide opportunities to break the cycle of offending, prevent escalation of offending seriousness and secure better outcomes for offenders and the community.⁸

General diversion programs have also drawn on theories of therapeutic jurisprudence, acknowledging that encounters with the legal system can be stressful and have significant impacts on mental health and wellbeing. Therapeutic jurisprudence seeks to “maximise the therapeutic effects of the law and minimise the anti-therapeutic consequences of the law”.^{9,10,11,12}

The principles of restorative justice have also influenced some diversion programs. Within a restorative justice framework, repairing harm caused in the “human and social context” of the offence is a key objective, rather than a sole focus on the application of the law.¹³

Specific diversion and support programs targeting people with mental illness have been identified as a necessary response to the “criminalisation” hypothesis, which observes that many people receive criminal sanctions in response to behaviours related to their mental illness instead of receiving appropriate treatment.¹⁴

This outcome is sometimes attributed (at least in part) to a lack of capacity within community based services to meet the needs of people who would previously have received care in mental health institutions prior to deinstitutionalisation, although this link is not universally accepted.¹⁵ Other factors include poverty, social disadvantage and marginalisation contributing to drug and alcohol abuse as well as homelessness and consequent over-policing.

Diversion programs operate to reduce the numbers of people with mental illness who receive criminal justice sanctions and reorientate the response to symptomatic behaviours toward provision of human services.

The ‘Sequential Intercept Model’ of diversion, linked to the criminalisation hypothesis, begins with the premise that people with mental illness should not enter the criminal justice system any more frequently than other members of the community.¹⁶ While remaining accountable for crimes unrelated to symptomatic mental illness,

people with mental illness should not be arrested or incarcerated simply because of their mental disorder or lack of access to appropriate treatment – nor should such people be detained in jails or prisons longer than others simply because of their illness.¹⁷

The ‘All-Stages Diversion’ model developed by the Sainsbury Institute of Mental Health in the United Kingdom takes a broad and inclusive view of diversion, including programs that ensure people who enter or are at risk of entering the criminal justice system receive appropriate treatment and support. This model includes within its scope community programs operating before criminal justice system contact, mental health liaison programs as well as transition and reintegration programs following imprisonment.¹⁸

The National GAINS Centre in the United States has suggested that diversion programs are a necessary part of a “holistic systemic approach to mental health service delivery” and can bridge gaps within fragmented service systems and at the boundary of mental health, social support and justice systems.¹⁹

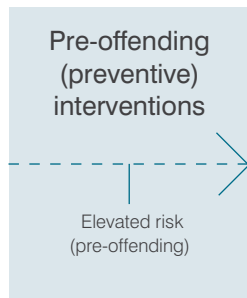
Human rights are also thought to provide a basis for diversionary programs, particularly the United Nations *Convention on the Rights of Persons with Disabilities*.²⁰ Diversion and support programs can facilitate a person’s human rights, including rights to non-discrimination (article 5), equal recognition before the law (article 12), access to justice (article 13), independent living and support (article 19), health care (article 25) and habilitation and rehabilitation (article 26). These rights can be impaired if mental illness goes undetected or is not taken into account by the criminal justice system.

In summary, there are a number of bases for diversion and support programs, each of which has something different to say about the rationale and purpose of establishing diversion programs. Diversion and support programs have potential to:

- provide a health-orientated response to a health-related social problem
- reduce re-offending by addressing underlying causative problems
- mitigate the criminalising or labelling effect of punitive criminal justice sanctions
- reduce the total social cost to the community of under-treatment of mental illness
- improve compliance with human rights obligations.

These guidelines draw on various theoretical perspectives, stakeholder consultation and research, providing guidance for diversion and support programs operating in the Australian context.

3.3 Pre-offending (preventive) interventions



For some people, untreated mental illness and associated problems can lead to offending. This provides a rationale for the justice system to take an interest in facilitating access to treatment as a crime-reduction strategy, and explains why these interventions can fall within the broad definition of 'diversion

and support' programs adopted within these guidelines.

Preventive programs recognise that when mental illness and associated problems are risk factors for offending, intervening early to provide treatment and support can improve individual wellbeing and consequently reduce the risk of offending.²¹

Where chronic mental illness is a causative factor in offending, deterioration in mental health or relapse into illness may lead to further offending behaviour. For some individuals, the realistic justice goal is not to eliminate all offending behaviour, but to put in place preventive strategies that will reduce or contain frequency or seriousness of offending over time.

Preventive programs operate prior to offending having taken place and where police powers of arrest are not engaged, but where there are significant risk factors for future contact with the criminal justice system. Risk factors may include a serious mental illness coupled with drug use, a past history of offending and homelessness.

In general, diversion and support programs, including preventive programs, should avoid inappropriately *increasing* the degree of criminal justice system involvement. For example, through more frequent police contact or so-called 'profiling', where members of minority groups experience more frequent contact solely on the basis of belonging to those communities. Participation must remain voluntary and care must also be taken to ensure that human and legal rights are not infringed. Coercive approaches to service engagement should be avoided.

At the same time, because of their active role in the community and in public spaces, police are commonly in contact with people who may be at higher risk of justice system contact because of their mental illness, including as victims of crime. This presents an opportunity for police to work collaboratively with support services to prevent that risk materialising and reduce long term involvement with the justice system.

Examples of pre-offending (preventive) interventions:

- Programs in which police opportunistically identify and refer at-risk individuals in the community to mental health and other support services.
- Out-reach services which partner with police to assist the former to actively and positively engage with people at higher risk of offending (for example, people with mental illness who are also homeless).
- Mental health system-based programs which modify evidence-based practices to focus on the needs of people with forensic histories, such as the multidisciplinary team approach Forensic Assertive Community Treatment or case-management and service brokerage model of Forensic Intensive Case Management approaches developed in the United States.^{22,23}

Evidence snapshot:

pre-offending (preventive) interventions

The benefits of early intervention are well accepted in the *National Mental Health Policy*, having been linked to improved outcomes for people with mental illness and their families, and reduced total social costs associated with untreated illness.^{24,25} Early intervention in the course of mental illness is also a key direction of the *National Mental Health Policy 2008* and an express priority area within the *National Action Plan on Mental Health 2006-2011*.^{26,27}

There is good evidence that provision of mental health treatments to high-risk young people has also been found to reduce rates of subsequent arrest and detention, pointing to the importance of early intervention both from a clinical and justice perspective.²⁸

A recent review identified that some types of community-based programs can reduce criminal recidivism where:

- they are highly structured, intense and with multiple problem-specific interventions
- clinicians accept a role in preventing offending behaviour in addition to their clinical focus
- clinicians take active responsibility for guiding program participants through their personalised program

- rapid hospitalisation is available where necessary
- court orders are available for some patients to support compliance.²⁹

The adaptation of the Assertive Community Treatment (ACT) approach to forensic populations has been successful in improving indicators including psychiatric hospitalisations, quality of life and symptom severity. However evidence from the United States indicates ACT has generally been less successful in reducing recidivism such as rates of arrest and incarceration. It has been suggested this may be due to a lack of emphasis on criminological risk factors.^{30,31} There is good evidence that certain rehabilitation programs for general populations of offenders reduce recidivism;³² it may be that integration of the two fields could be effective.

Project Link in New York represents a comprehensive diversion program. It provides services to people with mental illness and past convictions, people diverted from current charges or transitioning out of prison. The program is based on the ACT out-reach model, but also incorporates a supervised residential program for people with mental health and substance use problems. A pre and post evaluation (with no control group) suggests the program has achieved reductions in arrests, days in jail, hospitalisations and average hospital days. The program's success is partially attributed to effective service coordination and culturally sensitive service delivery.³³

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3.4 Pre-arrest and arrest interventions



Pre-arrest and arrest diversion and support programs generally operate where a person with a mental illness is alleged or suspected of having committed an offence. They may also operate where no offence has been committed but a person is experiencing an acute mental health crisis or exhibiting

behaviour that is of concern to the community.

People with mental illness are disproportionately represented among all encounters with police and are more likely to be arrested.^{34,35} It is notable that a recent New Zealand study found that two in five people referred to psychiatric facilities for first episode psychosis had contact with the police in the preceding six months.³⁶

Efforts to improve the way police respond to people with mental illness have been driven by the high rate and nature of contacts, but also concerns relating to officer safety and use of force against people with mental illness in crisis situations.^{37,38} The way in which police interact with people with mental illness also impacts significantly on the latter's experience of and behaviour during those encounters.³⁹

A review of the research suggests that best practice pre-arrest and arrest interventions should generally incorporate the following elements:

- strengthening effective partnerships between police, mental health and other service providers and communities through joint program leadership, effective communication, clearly defined roles and responsibilities and a shared understanding of the purpose and goals of diversion^{40,41}
- modifying the traditional law-enforcement role of police to one in which police accept an active role in responding to mental illness as a community safety and public health issue – leadership and advocacy at all levels of the police organisational hierarchy are essential^{42,43}
- training and support for front line police (and dispatchers) to improve their ability to recognise when mental illness may underlie or significantly contribute to a person's problematic behaviour; to better manage crisis situations involving people with mental illness and to reduce potentially stigmatising attitudes and behaviours⁴⁴

Police and mental health

The specific role of police in pre-offending (prevention) and pre-arrest diversion programs should be carefully considered and in general limited to managing risk to safety and facilitating access to appropriate mental health services.

Unnecessary police involvement is stigmatising, may exacerbate situational crises and diverts police resources from other functions.

Diversion programs involving police are not *de facto* mental health services. Mental health services should be provided by trained mental health professionals.

- timely police access to mental health screening and, where screening indicates likely mental illness, the ability to refer for comprehensive assessments by mental health professionals (moderated by appropriate confidentiality and privacy safeguards)
- availability of protocols and guidance for the considered exercise of discretion not to arrest or charge (for police) or prosecute (for prosecutors) where the person has or is suspected to have a mental illness
- referral or re-connection to coordinated community-based services and supports^{45,46}
- systematic follow up to increase likelihood that voluntary referrals are acted upon.⁴⁷

Pre-arrest and arrest programs will not involve a new referral or linkage in all circumstances. For example, police may choose to caution a person they know to be under the care of community mental health services, where it would be detrimental to their recovery and of no benefit to the community to proceed with the criminal process.

Where an arrest is made, interventions may involve facilitating access to assessment or treatment while in police custody; after release from custody while on police bail; or after a decision to release a person without charge. Post arrest interventions may also occur in liaison with prosecutors who are considering whether it is in the public interest for prosecution of the person with mental illness to proceed.

Diversion should occur only with the informed consent of the person involved. This is especially so where there are any conditions attached to diversion. Informed consent is discussed further in section 6.5.2, under 'Pathway negotiation'.

Examples of pre-arrest and arrest interventions include:

- Police exercise discretion where individuals with a mental illness who commit minor offences receive a caution or warning and are referred to supports and interventions, rather than being arrested and charged.
- Police-based models generally comprise specially trained police officers who provide crisis intervention services and liaise directly with mental health service providers. This is commonly referred to as the Crisis Intervention Team model.^{48,49}
- Mobile mental health crisis teams operating in partnership with police, providing a secondary response on call-outs by on-scene police. These teams either consist solely of mental health professionals, or in the co-responder model, mental health professionals paired with specially trained police.⁵⁰
- Systematised mental health screening and assessment of persons in police custody. This is linked to informed decisions about whether to proceed to prosecution and access to appropriate treatment and supports within and outside the justice system.
- Exercise of prosecutorial discretion in which alternatives to prosecuting a person with mental illness are utilised where this is in the public interest and results in provision of supports.

Evidence snapshot: pre-arrest and arrest interventions

The evidence base for police-based interventions is limited and the validity of the research which does exist in the Australian setting is uncertain.⁵¹ However, studies from the United States and Canada suggest that approaches combining in-service education and effective partnerships with local mental health services can decrease arrest rates in crisis situations;⁵² increase the rate of referral to mental health services and linkages to such services;^{53,54} reduce the time spent in jail; reduce some costs incurred by police;⁵⁶ and may reduce the likelihood of use of force by police and injury to police or the person with mental illness.^{57,58}

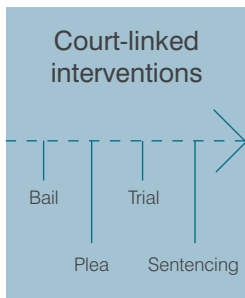
Such programs may also reduce stigmatising attitudes among police towards people with mental illness and improve their perceptions of mental health services.⁵⁹ A respectful approach by police is also likely to improve perceptions of their treatment by people with mental illness.⁶⁰

Formal screening of individuals who are taken into police custody can be effective in identifying people who may have mental health problems,⁶¹ but subsequent assessments and referrals are likely to be more effective where there are active partnerships with mental health services and coordination of follow up.⁶²

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3.5 Court-linked interventions



Court-linked diversion and support programs operate where a person has been charged with an offence and appears before a court. Programs may operate before or after a plea has been entered and may involve suspension of usual proceedings while a diversionary program is undertaken, or

delivery of services alongside usual court processes. Programs integrated with the court process commonly draw on theories of therapeutic jurisprudence.

Mental health courts

Mental health courts are an example of the therapeutic jurisprudence approach and have shown promise for reducing recidivism. In simple terms, therapeutic jurisprudence seeks to “maximise the therapeutic effects of the law and minimise the anti-therapeutic consequences of the law”.⁶³

Although there are various models of mental health courts, key elements include: a specialised list for people with mental illness who are charged with criminal offences; the goal of diverting people away from the criminal justice system and into treatment; mandated treatment as a condition of participation; regular court or judicial supervision; the use of sanctions and rewards to encourage program completion; and voluntary participation.⁶⁴

At the Justice Centre in the United States, mental health courts now number more than 250. The Centre has issued useful guidelines, *Improving Responses to People with Mental Illness: The Essential Elements of a Mental Health Court*. The ten essential elements of best practice mental health courts are adapted below.⁶⁵

1. Planning and administration is guided by a broad based group of stakeholders including representation from criminal justice, mental health, drug and alcohol services and related services and the community.
2. Eligibility criteria address public safety and consider a community’s treatment capacity, as well as the availability of alternatives to remand for defendants with mental illness. 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.
3. Participants are identified, referred, and accepted into mental health courts and then linked to community-based service providers as quickly as possible.
4. Terms of participation are clear, promote public safety, facilitate the defendant’s engagement in treatment, are individualised to correspond to the level of risk that the defendant presents to the community and provide for positive legal outcomes for those individuals who successfully complete the program.
5. Defendants fully understand the program requirements before agreeing to participate in a mental health court. They are provided legal counsel to inform this decision and subsequent decisions about program involvement. Procedures exist in the mental health court to address, in a timely fashion, concerns about a defendant’s competency whenever they arise.
6. 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.
7. Health and legal information should be shared in a way that protects potential participants’ confidentiality rights as mental health consumers and their legal rights as defendants. Information gathered as part of the participants’ court-ordered treatment program or services should be safeguarded in the event that participants are returned to traditional court processing.
8. 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 both treatment and criminal justice goals by regularly reviewing and revising the court process.
9. 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.
10. 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.

Mental health courts have been implemented in South Australia and Tasmania and a specialised mental health court list is expected to commence in Victoria in 2010. Evaluations of those programs indicated that mental health courts can be successfully adapted to the

Australian context.^{66,67} Early evidence points to reductions in arrest rates and charged incidents,⁶⁸ improvements in coordination between justice and mental health agencies and reported efficiencies in handling defendants with mental impairments.⁶⁹

Evidence snapshot: mental health courts

A recent and comprehensive review of mental health courts found the evidence base to be quite limited, although promising.⁷⁰ Mental health courts in the US have been successful in reducing recidivism measured through arrest rates, time in jail and offence severity.^{71,72,73} Some have also been found to be effective at linking people into mental health services and increasing the level of health service utilisation.⁷⁴ Limited evidence suggests that clinical outcomes and psychosocial functioning can be improved,^{75,76} although this is likely to be attributable to clinical and other support services received rather than participation in the court process itself.⁷⁷ Court-linked mental health

interventions have been shown in the US to delay or prevent recidivism in a cohort of young people.⁷⁸

Critics have argued that specialist mental health courts increase the involvement of the criminal justice system in the lives of people with mental illness (net widening); may contribute to stigma and discrimination and may sometimes undermine legal rights.^{79,80} The courts have also been criticised as an inappropriate ‘bandaid’ solution for failings in the public mental health system.⁸¹ Evidence for the cost-effectiveness of mental health courts is limited,⁸² although there is some US research that suggests longer term savings associated with reduced incarceration can offset increased costs of providing additional mental health supports.⁸³

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Integrated court liaison and diversion programs

An alternative to the specialist court approach which has been utilised in Australia and elsewhere is to integrate diversionary programs into mainstream courts. Mainstream courts may be empowered through legislation to deliver a flexible response to people with mental illness, including adjournment of proceedings while a person engages with support services, potentially leading to dismissal of charges or a reduction in sentence.

Where this approach is considered, many of the principles which apply to specialist mental health courts remain applicable, particularly in relation to planning and administration of the diversion program. Evaluation of mental health diversion integrated into local courts in New South Wales highlighted the importance of liaison and

communication between the justice and mental health systems to ensure confidence in the accountability of diversion programs is maintained.⁸⁴

Mental health court liaison services commonly have multiple functions, whether or not they are associated with formal diversion programs. They may undertake mental health assessments and court reports in support of fully informed judicial determinations of fitness to plead and to stand trial, eligibility for court diversion, bail and sentencing considerations. They may also directly support defendants, through provision of clinical services, referral and linkage to other service providers, case management or service brokerage and liaison with community or prison based mental health services.^{85,86,87,88}

Evidence snapshot:

integrated court liaison and diversion

Australian mental health liaison and diversion programs linked with mainstream courts have been shown to be effective at identifying people with mental illness and have been linked to reduced levels of offending post intervention,⁸⁹ as well as decreased symptom severity and improved socio-vocational functioning.⁹⁰

Facilitating linkages to mental health services through bail provisions may provide an alternative to remand^{91,92} and may be a means of reducing the high proportion of remandees with a mental illness.

Winstone and Pakes assessed characteristics of effective and sustainable diversion and liaison programs

and linked seven areas of practice to program effectiveness: screening; assessment; facilitating access to mental health support; liaison; information sharing; multi-agency arrangements; and data collection and analysis.⁹³

Sly et al have also suggested that influences on the clinical outcomes include: “continuity of care, improved follow-up care, and community supervision; better differentiation of professional boundaries; and increased planning and resource availability... Ideal models provide a complete range of services, including: treating psychiatric symptoms and substance abuse; improving functioning; and meeting basic needs...” [references omitted].⁹⁴

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Section summary

- Diversion and support aims to improve wellbeing and reduce recidivism in people whose mental illness significantly contributes to offending behaviour by providing interventions and support targeted to their illness and related problems in place of, alongside, or integrated with other criminal justice system processes.
- There is a growing, albeit small evidence-base supporting the effectiveness of well-designed diversion programs and evidence to suggest they do not increase risk to the community.
- Pre-offending (preventive) interventions operate prior to offending having taken place and where police powers of arrest are not engaged, but where there are significant risk factors for future contact with the criminal justice system.
- Pre-arrest and arrest interventions operate where a person with a mental illness is alleged or suspected of having committed an offence. They may also operate where no offence has been committed but a person is experiencing an acute mental health crisis or exhibiting behaviour that is of concern to the community.
- Court-linked interventions operate where a person has been charged with an offence and appears before a court.

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4

Conceptual considerations for policy and program development

4. CONCEPTUAL CONSIDERATIONS FOR POLICY AND PROGRAM DEVELOPMENT

This section provides guidance on some conceptual issues which require consideration in the early stages of planning diversion and support programs. It first describes a definition of best practice relevant to complex policy and programs, then discusses the development of policy and program objectives and reflects on 10 suggested principles for policy and program development.

4.1 Evidence-based best practice

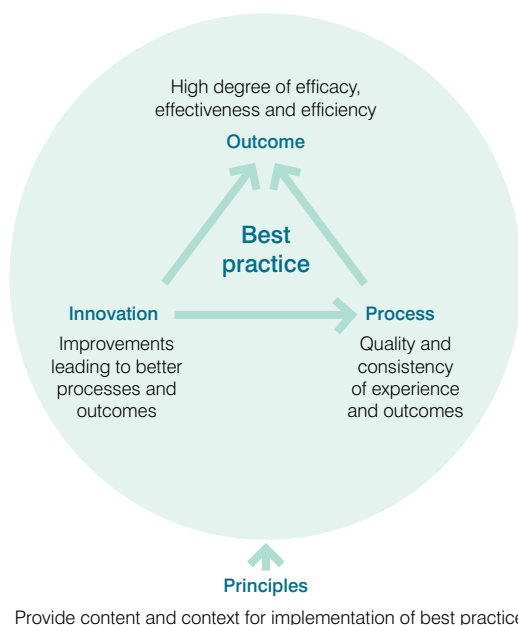
The definition of best practice adopted for these guidelines is:

Best practice approaches adapt the best available evidence to the context of implementation, achieve the best possible outcomes with a high degree of consistency and efficiency and foster a culture of continuous improvement through innovation and evaluation.

This definition focuses on the approach taken to implementing mental health diversion and support programs.

It implicitly acknowledges the limitations of the current evidence base for diversion and support, the necessity of local flexibility in implementation and the need to further develop evidence for what works through innovation and evaluation (see Figure 4.1).

Figure 4.1 Best practice



'Best practice' can mean different things in different settings. An outcomes focused definition of best practice could be consistently doing what is most likely to achieve a specific beneficial outcome. Such a definition pre-supposes an evidence-base that readily identifies the practice 'most likely' to achieve the desired outcome. Examples of this type of approach include clinical practice guidelines or algorithms that attempt to codify best practice.

Where strong evidence is not readily available, or where evidence cannot easily be generalised to different settings, definitions of best practice may be more concerned with processes that are more likely to lead to consistency and quality of experiences and outcomes.

Some models of best practice also give weight to innovative, improvement driven practice that contributes to process improvements or better and more efficient outcomes over time. For example, organisations may review how market or sector leaders implement certain activities and adapt those practices to their own organisations.

The environment in which best practice is defined has a significant impact. External constraints, enablers and modifiers will frequently influence implementation of best practices. Examples include:

- competing and limited funding imposing a requirement of relative efficiency
- geographical setting constraining access to services or resources required for best practice
- rights to self-determination preventing mandating of interventions known to have very high efficacy (for example, childhood immunisation)
- cultural notions of best practice that modify generic models that have been developed from evidence and theory derived from the dominant culture.

The use of evidence

The development of policy and practice based on a validated and reliable evidence base is the ideal in any field. However, there are numerous tensions in facilitating the translation of research evidence into actual policy and practice. At the most basic level, there are inherent challenges in generalising evidence which usually derives from a particular environment and context.

A relevant example is that evidence derived in community mental health services does not in all cases translate well to forensic settings or to the forensic client group.¹ This latter group differs from the people with mental illness in the community across multiple dimensions, including socio-demographic characteristics, rates of drug and alcohol use, rates of exposure to trauma, the impact of criminal charges and the role of legal coercion.²

It can also be difficult to identify the specific factors in complex interventions which may have supported good outcomes. Systematic reviews or meta-analysis can assist with the synthesis of evidence, but may be limited to making highly generalised, non-specific recommendations when dealing with complex subject matter. As Pawson et al have observed:

[e]vidence-based policy is a dominant theme in contemporary public services but the practical realities and challenges involved in using evidence in policy-making are formidable. Part of the problem is one of complexity. In health services and other public services, we are dealing with complex social interventions which act on complex social systems... These are not 'magic bullets' which will always hit their target, but programmes whose effects are crucially dependent on context and implementation.³

Nutley and Homel undertook a review of a highly ambitious and complex crime-reduction policy intervention in the United Kingdom which experienced significant implementation challenges.⁴ They use the example of the UK's Crime Reduction Program to highlight key tensions confronting policy makers attempting to develop and implement complex evidence-based policy and programs. In particular, it was evident that tensions existed relating to "fidelity to the evidence base versus innovation, short-term wins versus long-term learning, and evaluator distance and independence versus a more 'hands-on' and active evaluator role".

The more realistic approach is to focus on developing evidence-informed policy that acknowledges the practical realities of the context in which that policy or program is likely to be implemented.⁵ Local evidence, drawn from the specific setting in which decisions and actions will be taken, should always inform decisions about problems, possible solutions and implementation strategies.⁶

This more flexible approach recognises the practical limitations of the strictly evidence-based process, while retaining a commitment to drawing on the best-available research to increase likelihood of policy success.

Further reading

- Oxman, AD, Lavis, JN, Lewsin, S and Fretheim, A (2009), "SUPPORT Tools for evidence-informed health Policymaking (STP) 1: What is evidence-informed policymaking?", *Health Research Policy and Systems*, vol. 7, suppl. 1, p S1.

Sub-section summary

- Best practice approaches adapt the best available evidence to the context of implementation, achieve the best possible outcomes with a high degree of consistency and efficiency and foster a culture of continuous improvement through innovation and evaluation.
- Evidence for effective policy and programs must always be considered in light of where implementation will take place. This means actively drawing on the knowledge and experience of local communities and services in addition to outcomes from formal research and evaluation.

4.2 Principles for best practice

Mental health diversion and support occurs at the intersection of the criminal justice, mental health and human services systems, and as such, draws on the values of each. Because these values are not always aligned, or are expressed differently, it is essential that programs operating across system boundaries define a set of common principles that underpin their joint activities.

It should be acknowledged from the outset that this is not an easy task. However, the importance of negotiating common ground and acknowledging differences should not be underestimated and will have a significant impact on the likely success of eventual policy and program implementation.

What follows is a description of underpinning principles for diversion and support of people with mental illness. These suggested principles have been developed in consultation with key stakeholders and draw on relevant research. A number of these principles overlap with the *National Statement of Principles for Forensic Mental Health*, which should also be considered in the development of diversion and support.⁷

While these principles are not expressed in order of importance, the first, relating to collaboration, communication and coordination is especially critical. This principle implies that for diversion programs to be most effective, stakeholders from different sectors must arrive at a common understanding and agreement on underlying program principles, objectives, outcomes and key parameters. Key parameters include, for example, client eligibility criteria, access to services, agency roles and accountability, data collection and information exchange.

4.2.1 Collaboration, communication and coordination are essential

Diversion and support programs span a number of complex systems; however program design should aim to provide a 'single system' experience for people with a mental illness moving between mental health, criminal justice and other support sectors. Such an approach seeks to coordinate program goals and activities, minimise process duplication and maximise timely and appropriate information sharing.

At the policy and program level, agreement on program objectives and eligibility criteria is essential. Potential conflicts between involved stakeholders should be pro-actively identified, negotiated and resolved as early as possible.

It is important to build strong working relationships across agency boundaries and develop partnerships with local communities. Developing and documenting service level agreements, operational protocols and program procedures also underpin collaborative program delivery. Regular meetings and liaison between key decision makers and practitioners and the use of "boundary spanning" staff to support coordination can also be effective strategies.^{8,9,10,11} Clear legislation can facilitate program parameters, roles and accountability.^{12,13}

Securing and maintaining commitment from collaborating stakeholders (including local communities) at every level, developing and documenting jointly owned policies and programs, and ensuring program principles, objectives, processes and accountabilities are clear is likely to lead to better outcomes in practice.^{14,15,16,17}

4.2.2 Community safety is not compromised

Community safety is enhanced when causal elements of crime are addressed at the community and individual level.¹⁸ Mental health diversion programs seek to provide an alternative to purely criminal sanctions where the mental illness contributes to offending behaviour. This is, in part, because providing an appropriate range of mental health and other services to address underlying issues is more likely to reduce re-offending than usual criminal justice sanctions.^{19,20}

Punitive sanctions alone do not lead to a safer community – the available research does not support the effectiveness of imprisonment as specific deterrent to re-offending and in fact suggests that it may slightly increase recidivism.^{21,22,23} On the other hand, appropriately targeted diversion and support has the potential to reduce re-offending without increasing risk to public safety.^{24,25,26,27,28}

4.2.3 Accountability for criminal behaviour is retained

When people living with a mental illness engage in criminal behaviour that is unrelated to their illness, they remain accountable for their actions and diversion out of the justice system may not be appropriate. In some circumstances, mental illness may reduce moral culpability but not legal responsibility.^{29,30} Determining the degree of responsibility can be complex where mental health diagnosis is not clear, particularly where other complicating factors are present (for example, substance use issues or complex, non-psychotic post-traumatic stress disorders).

In all cases, where offending behaviour is related to mental illness and diversion considered, the harm caused to victims, as well as their rights and interests must be acknowledged.³¹

It should also be noted that diversion and support programs do not necessarily imply the absence of criminal justice sanctions, but are often linked to alternatives to imprisonment that meet community (and victim) expectations for accountability. These include restorative justice approaches, community service or reparations.

4.2.4 Human and legal rights are protected

It has been acknowledged that detention of people with mental illness in the criminal justice system can raise serious human rights issues.³² More generally, having a mental illness has been associated with legal rights problems.³³ Diversion and support programs should seek to enhance and support the human rights of people with mental illness, particularly those expressed in the *United Nations Convention on the Rights of Persons with a Disability*,^{34,35,36} the *United Nations Declaration on the Rights of Indigenous Peoples*,³⁷ and relevant human rights instruments in each jurisdiction.*

Legal rights must also be upheld, including those embodied in principles of procedural fairness and proportionality in sentencing and independent access to legal advice should not be restrained. Legal competency should be determined prior to any diversion. Diversion programs instituted in place of other criminal justice system processes should be voluntary and require the fully informed consent of participants.

Particular care must be taken where programs link guilty pleas or admissions with access to treatment and support. This can create conflicts of role for defence advocates in non-adversarial settings and potentially lead to “net-widening” through more intensive involvement with the criminal justice system than would otherwise occur (for example under extended bail or supervision conditions).³⁸

4.2.5 Consumer and family or carer participation ensures policy and service development are better targeted, more effective and sustainable

Policy development and service planning are considerably enriched by the contributions of people with personal experience of mental illness (consumers) and the family members, friends and significant others who support them (carers).^{39,40,41} The value of participation by consumers, family and carers in the planning, development and evaluation of services is now well recognised in contemporary Australian mental health policy.^{42,43}

These groups provide a very different perspective to that of clinical experts and other professionals embedded in service systems. They can also contribute culturally specific knowledge.⁴⁴ The need to understand and respond to individuals in their family and community context provides a strong rationale for engaging with family and carers and communities at individual, program and policy levels.

Voluntary and active participation by consumers in planning their own care is desirable and increases likelihood of service engagement.⁴⁵ In many circumstances, family and carers commonly have knowledge that facilitates treatment planning and relapse prevention and play a vital role in supporting recovery.

4.2.6 Mental illness and associated issues are identified, assessed and treated as early as possible

The earlier an emerging mental illness is identified, the better the prospects for recovery and prevention of escalating problem behaviours.^{46,47} Early and accurate screening processes that lead to comprehensive mental health assessment where needed can help to inform better decisions in both the health and justice systems.⁴⁸ Assessment should also include assessment for substance use,^{49,50} acquired brain injury,⁵¹ intellectual disability⁵² and other cognitive disabilities given the significant implications these issues have for both health and recidivism outcomes. Assessments should also be made of both psychosocial and criminogenic needs.

Early and accurate identification and assessment of people with mental illness should lead to reduced total social costs. Poorly targeted criminal justice interventions may exacerbate illness and subsequent recidivism. Improvements in wellbeing should also be evident where individuals receive timely and appropriate services targeted to their mental illness and associated needs.

4.2.7 Programs deliver culturally safe, holistic services tailored to individuals

Each individual’s experience of mental illness is different and is significantly influenced by gender, age, culture, socio-economic status, sexual orientation, beliefs and values, family and community relationships and other factors.^{53,54,55} Service systems should be accommodating of diversity and be able to provide culturally safe services that respond to the way in which each individual understands and prioritises their issues.

* Victoria, through the *Charter of Human Rights and Responsibilities Act 2006 (Vic)* and the Australian Capital Territory through the *Human Rights Act 2004 (ACT)* have enacted human rights legislation.

Mental illness is often associated with a complex range of interacting and compounding problems, most commonly substance use,^{56,57} but also intellectual disability,⁵⁸ acquired brain injury,⁵⁹ poor physical health,^{60,61} unstable accommodation,^{62,63} lower levels of educational attainment and employment,^{64,65} social and self stigma and discrimination.^{66,67,68} Consequently, for complex clients, effective case management is essential.⁶⁹

Supports linked to diversion should be able to provide or broker well-coordinated, integrated services. They should suit the range of problems faced by each individual and build on individual strengths and protective factors. In many cases, this means working with a person in the context of their family and community.

The diversion point itself should also link directly to each individual's needs and offending behaviour. This requires a systematic approach to developing coherent eligibility criteria for programs operating at different stages of the criminal justice continuum to provide a stepped model of intervention and supervision intensity.

Some groups may require specifically targeted policies and programs. Such groups include Aboriginal and Torres Strait Islander people, young people, and people from culturally and linguistically diverse backgrounds. The programs should take into account the essential considerations raised in Section 7 of this document.

4.2.8 Quality and integrity of health interventions are maintained

The quality of services and supports provided to people through diversion programs should be equivalent to services available in the general community for people with a similar level of disadvantage and complexity of need.⁷⁰ Mental health and associated health interventions should be provided and managed by health services, not by justice services.⁷¹ They should retain a focus on achieving health and wellbeing related outcomes for individuals and families.

On the other hand, while justice processes operating alongside diversion and support programs should facilitate health related interventions (and should take advantage of opportunities to do so) they may also focus on compliance and community safety. Justice agencies may also have a role in specific interventions that are focused on criminogenic risk factors, when these programs are appropriate as part of a person's treatment plan.

Diversion programs should be supported by clear and express protocols which accommodate these different roles, and which address issues of privacy and confidentiality, how progress is monitored and breaches reported and what response the program will take to any breaches.

4.2.9 A recovery orientation is essential

Recovery has been defined as a personal process of changing one's attitudes, values, feelings, goals, skills and roles. It involves the development of new meaning and purpose and a satisfying, hopeful and contributing life as the person grows beyond the effects of psychiatric disability. The process of recovery must be supported by individually identified essential services and resources.⁷²

Many mental illnesses are chronic or relapsing conditions and acute phases or relapses may trigger offending behaviour. Relapse is also associated with increased health-care costs.⁷³ Diversion and support strategies should move away from disconnected, episodic interventions and should focus instead on supporting recovery from illness and managing offending behaviour in the longer term.⁷⁴

Australia's *National Mental Health Policy and Fourth National Mental Health Plan* provide strong support for a recovery-orientated response to mental illness.^{75,76} The recovery model also accords with the "good lives" model of offender rehabilitation, which seeks to reduce recidivism by equipping individuals with "the tools to lead more fulfilling lives".⁷⁷

4.2.10 Programs balance fidelity to the evidence base with environmental constraints and innovation

The evidence base for diversion and support is growing, but remains limited.^{78,79,80,81} Local innovation is a practical necessity, as diversion programs are largely reliant on the availability of justice, health and human services. There is substantial variability across and within jurisdictions in infrastructure, workforce and funding associated with these services. For example, it is known that rural, remote and disadvantaged urban areas have less access to health and justice services.^{82,83,84}

A pragmatic approach to implementation of diversion and support initiatives requires an acknowledgement that best practice is context specific, influenced by available resources, environmental factors, and cultural issues.⁸⁵

The limitations of the evidence base, particularly in relation to sub-groups including Indigenous Australians needs to be acknowledged. Policy should encourage innovative local adaptations of the best available evidence, robust evaluation of such programs, and provide mechanisms for information to be shared.

Effective evaluation should be planned during program design to enable systematic, accurate and ethical collection of selected quantitative and qualitative data that provides meaningful insight into the range of outcomes associated with the program.

Sub-section summary

The 10 suggested principles that should underpin development of diversion and support initiatives include:

- Collaboration, communication and coordination are essential
- Community safety is not compromised
- Accountability for criminal behaviour is retained
- Human and legal rights are protected
- Consumer and family or carer participation ensures policy and service development are better targeted, more effective and sustainable
- Mental illness and associated issues are identified, assessed and treated as early as possible
- Programs deliver culturally safe, holistic services tailored to individuals
- Quality and integrity of health interventions are maintained
- A recovery orientation is essential
- Programs balance fidelity to the evidence base with environmental constraints and innovation.

4.3 Goals and objectives

Defining clear goals and objectives is a critical step for any complex initiative. In the case of mental health diversion and support, preferred objectives may be quite different for stakeholders coming from corrections, mental health, human rights, and other perspectives.

It is possible for different objectives to co-exist; however program specific objectives should be developed with the agreement of key stakeholders. The objectives of diversion and support programs should be developed and agreed to by key stakeholders, expressed in clear and unambiguous language and able to be meaningfully evaluated.

It is worth emphasising that consumers also have strong views on which outcomes are most important and may accord them different levels of priority to those from other stakeholder groups. They may also have different views about the meaning and definition of some outcomes. Consumers should be consulted about what outcomes are important to them and meaningfully engage in negotiations around program goals and objectives.

The definition of mental health diversion and support adopted by these guidelines implies two overriding objectives which should have a prominent place in diversion and support programs: improving wellbeing and reducing recidivism. This is consistent with emerging evidence that supports the effectiveness of programs that address both mental health and criminogenic risk factors.^{86,87,88} However, a broader range of objectives are commonly associated with diversion and support. These are framed around individual, systemic and community objectives in a range of outcome areas, including:

- mental health and wellbeing
- recidivism
- identification of mental illness
- access to mental health treatments
- human rights
- community safety
- systemic efficiencies.

The objectives are summarised in Figure 4.2.

Figure 4.2 Individual, systemic and community objectives of diversion and support

| Individual objectives | Systemic objectives | Community objectives |
|--|---|--|
| <p><i>Objectives focused on outcomes for each individual with mental illness in contact with the criminal justice system</i></p> | <p><i>Objectives focused on the appropriateness, efficiency and effectiveness of system responses to mental illness</i></p> | <p><i>Objectives focused on the interests and expectations of the community as a whole</i></p> |
| <ul style="list-style-type: none"> • increasing human rights protections afforded to individuals with mental illness • increasing access to treatment services for individuals with complex mental health and related problems • improving clinical outcomes for individuals with a mental illness in contact with the criminal justice system • improving quality of life for individuals with a mental illness in contact with the criminal justice system • reducing contact with the criminal justice system by addressing each individual’s health and criminogenic needs | <ul style="list-style-type: none"> • improving the early identification and assessment of people with mental illness within the criminal justice system • increasing coordination and efficiency at the interface of criminal justice, health and human services systems • reducing the use of criminal justice sanctions for offending attributable to mental illness and cognitive impairment • reducing the intensity, seriousness and frequency of re-offending by people with a mental illness | <ul style="list-style-type: none"> • improving community compliance with human rights obligations relating to treatment of people with mental illness • increasing community safety by addressing mental illness and related problems that contribute to repeated offending behaviour • reducing the total social cost of processing offenders in the criminal justice system whose repeat offending is attributable to mental illness and related problems • strengthening protective factors that reduce the likelihood of offending |

Sub-section summary

- Securing commitment from key stakeholders to a negotiated set of common principles, program aims and objectives are critical enablers if programs are to operate effectively across system boundaries.

Notes to this section

- 1 Osher, FC and Steadman, HJ (2007), "Adapting Evidence-Based Practices for Persons With Mental Illness Involved With the Criminal Justice System", *Psychiatric Services*, vol. 58, no. 11, pp 1472-8.
- 2 Osher, FC and Steadman, HJ (2007), "Adapting Evidence-Based Practices for Persons With Mental Illness Involved With the Criminal Justice System", *Psychiatric Services*, vol. 58, no. 11, pp 1472-8.
- 3 Pawson, R, Greenhalgh, T, Harvey, G and Walshe, K (2005) "Realist review: a new method of systemic review designed for complex policy interventions", *Journal of Health Services Research and Policy*, vol. 10, no. 3 (suppl 1), pp 21-34.
- 4 Nutley, S and Homel, P (2006), "Delivering evidence-based policy and practice: lessons from implementation of the UK Crime Reduction Programme", *Evidence and Policy*, vol. 2, no. 1, pp 5-26.
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- 6 Oxman, AD, Lavis, JN, Lewsin, S and Fretheim, A (2009), "SUPPORT Tools for evidence-informed health Policymaking (STP) 1: What is evidence-informed policymaking?", *Health Research Policy and Systems*, vol. 7, supplement 1.
- 7 National Mental Health Working Group (2002), *National Statement of Principles for Forensic Mental Health*, Canberra: Australian Health Ministers' Advisory Council.
- 8 Sainsbury Centre for Mental Health (2009), *Diversion – A better way for criminal justice and mental health*, London: Sainsbury Centre for Mental health.
- 9 CMHS National GAINS Center (2007), *Practical Advice on Jail Diversion: 10 Years of Learnings on Jail Diversion From the CMHS National GAINS Center*, Delmar, NY: National GAINS Centre.
- 10 McSherry, B (2009), "Hospital Orders for Offenders with Mental Illnesses: An Appropriate Diversionary Option?", *Journal of Law and Medicine*, vol. 16, no. 4, pp 568-73.
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5

Collaboration and partnerships in practice

5. COLLABORATION AND PARTNERSHIPS IN PRACTICE

Mental health diversion and support programs operate at the intersection of the justice, health and other social support sectors. The success of such programs is largely dependent on the capacity of these sectors to work effectively together. Evaluations of diversion and support programs operating at all stages of the criminal justice system have consistently pointed to the importance of inter-agency and governmental collaboration.^{1,2,3} New models of collaboration between criminal justice and mental health sectors appear to be able to address the needs of people with mental illness in a way which is consistent with the maintenance of public safety.⁴

Effective collaboration within diversion and support programs is supported where there is:

- commitment and leadership from key stakeholders to collaborative practice and meaningful partnerships at all levels
- agreement on principles, goals and objectives, negotiated and documented from the outset
- agreement on delineated roles and responsibilities, preferably documented for consistency and clarity
- collective focus on reducing barriers and strengthening enablers of collaboration, including commitment from all agencies to identify and modify practices and organisational cultures which detract from collaborative practice.

Commitment and leadership

Implementing complex diversion and support programs requires strong leadership and effective collaboration across system boundaries – particularly by the justice and mental health sectors. The common perception that diversion and support programs equate to being ‘soft on crime’ must be countered by rational advocacy of evidence-based policy.

At the government level, cross-portfolio leadership is required to ensure that diversion and support programs are both adequately and securely resourced in the long term. Government leadership is also key to promoting accountability and to ensuring that programs operating at different points in the system are developed within a cohesive and consistent whole-of-government framework.

At the program level, building strong relationships between stakeholders is essential. Cross-agency planning, management and evaluation of diversion and support initiatives is best practice. This includes a commitment to bringing key stakeholder groups together as early as possible to forge agreement on key principles, as well as goals and objectives that are meaningful to each group.

Figure 5.1 Activities in support of collaboration

| | |
|-------------------|--|
| Government | <ul style="list-style-type: none"> • Providing high level community leadership and advocacy at a whole-of-government level • Allocating adequate and stable cross-portfolio resources • Legislating to facilitate diversion and support initiatives • Maintaining strategic oversight to ensure cohesion and consistency of programs, and accountability for outcomes |
| Program | <ul style="list-style-type: none"> • Negotiating agreement on underlying principles and objectives • Strengthening relationships between sectors, agencies, the community and advocacy groups • Establishing mechanisms for cross-agency planning, management, advice and evaluation • Developing networks of local champions in all agencies to lead, model good practice and advocate for programs |
| Team | <ul style="list-style-type: none"> • Employing boundary-spanning staff working across sectors • Conducting regular meetings of key personnel • Implementing reciprocal training initiatives • Devising clear role definitions and practice protocols • Encouraging program staff to develop and nurture effective working relationships with counterparts in other agencies |

Networks of internal 'champions' can act as advocates and leaders for local diversion and support programs, including modelling good collaborative practices. Such practices include timely information sharing and communication, regular meetings of key personnel, reciprocal education and training initiatives, the use of boundary spanning staff operating across sector boundaries and encouraging development of strong working relationships at the individual as well as agency level.

Agreement on principles and objectives

Different values, cultures and ways of working will significantly affect the way in which diversion and support programs are conceptualised, planned, implemented and evaluated. Failure to respectfully acknowledge and attempt to resolve differences can result in the alienation of key stakeholders, and at the practical level, can result in misalignments within the program that hamper effective operation.

Negotiating (and preferably documenting) early agreement on principles and objectives that drive policy and programs facilitates their implementation and encourages stakeholders to see themselves as having an investment in the program's success. The principles outlined within these guidelines have been developed in consultation with a wide range of stakeholders and provide a strong basis for any diversion and support program.

Agreement on delineated roles and responsibilities

In addition to developing a shared understanding of the principles and objectives of diversion and support, the roles each agency will play and the responsibilities they will hold should also be clear. This facilitates the appropriate allocation of resources, helps to identify points of intersection and interface between agencies and helps to ensure that expectations among stakeholders are reasonable and realistic.

A review of the range of existing programs and services should be a part of policy and program development. Such a review should include an assessment of program capabilities, capacities and interfaces with other services and may identify gaps requiring planned responses or the engagement of new partner agencies.

Documentation of specific roles and responsibilities (for example, through service level agreements or operational protocols) provides a sound baseline for collaborative practice. Such documentation should pay particular attention to the interface of different agencies (including areas of overlap), the way in which different services are coordinated and the means by which information is collected, analysed and shared.

Reducing barriers and strengthening enablers of collaboration

Collaborative practice can be hampered or enhanced by factors that are internal and external. Significant internal factors, for example, commonly include organisational policy, practice and culture. External barriers may include legislation dealing with confidentiality of health and other personal information, physical distance between service providers and ineffective communication.

Agencies participating within diversion and support programs can support effective practice by working together to collectively assess external barriers and working together to reduce them. For example, developing joint protocols to facilitate the timely communication of accurate information between agencies in a way that complies with privacy and related legislation.

Individual agencies should also assess internal barriers to collaborative practice and take steps to address them. For example, mental health services may implement in-service training on the justice system's operating environment to improve the ability of their staff to liaise with the justice system and vice versa.

Undertaking barrier analysis at the collective and individual agency level and developing mitigation strategies can support collaborative practice.

Section summary

Effective collaboration within diversion and support programs is supported where there is:

- commitment and leadership from key stakeholders to collaborative practice and meaningful partnerships at all levels
- agreement on principles, goals and objectives, negotiated and documented from the outset
- agreement on delineated roles and responsibilities, preferably documented for consistency and clarity
- collective focus on reducing barriers and strengthening enablers of collaboration, including commitment from all agencies to identify and modify practices and organisational cultures which detract from collaborative practice.

Notes to this section

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- ² CMHS National GAINS Center (2007), *Practical Advice on Jail Diversion: 10 Years of Learnings on Jail Diversion From the CMHS National GAINS Center*, Delmar, NY: National GAINS Centre.
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6

Program development: key questions

6. PROGRAM DEVELOPMENT: KEY QUESTIONS

This section outlines key decision points associated with planning and developing diversion and support programs and provides guidance in support of sound choices.

Who is targeted for intervention? Considers the issues around eligibility criteria, including discussion of which mental impairments and what types of offending may set parameters around programs.

Where and when will interventions occur? Reviews the selection of intervention points for diversion and support programs within a system-wide framework.

What interventions and supports are necessary? Describes the range of supports and interventions that should be considered as part of a holistic diversion and support program.

Which stakeholders should be involved? Describes five key stakeholder groups who should be engaged in diversion and support programs: people with mental illness; families or carers and community; justice; mental health; and human and social service systems.

How will interventions be delivered and evaluated? Reviews the importance of coordinating interventions to people with mental illness and evaluating program outcomes.

Figure 6.1 Individual and demographic characteristics impacting on program design

- Age
- Comorbid health issues
- Concurrent drug and alcohol use
- Cultural background
- Disability, including intellectual disability
- Educational attainment
- Employment
- Family circumstances, including children
- Forensic history
- Gender
- Housing circumstances
- Indigenous status
- Language and literacy
- Socio-economic status

6.1 Who is targeted for intervention?

Developing a profile of the people who will have access to a diversion and support program is essential. A clear profile enables resources to be matched to the target cohort's needs and risk factors.

Coordinating client profiles and associated inclusion and exclusion criteria across programs operating at different points on the criminal justice continuum is important. This can reduce gaps, ensure overlaps are planned and appropriate and support good decision making about the most appropriate pathway for each individual.

For example, drug courts and mental health courts may both deal with offenders who have both a mental illness and a substance use problem, but offer different services. The decision about which court accepts a particular case has significant implications for individual defendants. Coordinated intake criteria based on services and outcomes offered by each court can support more appropriate and streamlined decision making.

It is important to consider the impact of a broad range of individual and demographic characteristics which may significantly affect how programs are designed and delivered (see Figure 6.1). Criminal justice and mental health outcomes are significantly affected by how programs deliver interventions for:

- dynamic criminological risk factors
- co-occurring substance use disorders
- accommodation problems
- multiple forms of mental impairment
- a history of trauma
- more severe psychopathology
- physical health problem (chronic illness or disability).

Ethnicity or cultural background has also been shown to influence outcomes in diversion programs and also has a significant impact on assessment processes.¹ Understanding the cultural background of the client group is an essential first step to devising reliable assessment frameworks and delivering services in a way that is culturally safe.^{2,3}

Evidence snapshot:

who succeeds in diversion?

Although US studies have suggested that being female or having been charged with a non-violent offence increases the likelihood of being recommended for diversion,⁴ the evidence on what characteristics are associated with better outcomes in diversion programs is lacking.

A 2009 study compared re-arrest and days spent in jail pre and post diversion. It looked for significant factors in gender, age, race, charge level, drug use, symptom severity, lifetime sexual abuse, lifetime physical abuse, prior arrests and prior jail days.⁵ None of the clinical factors produced significant differences, but a higher level of prior arrests or time in jail was significantly associated with more arrests and more time in jail in the post-intervention period.

The same study also found that participants who maintained stable housing in the follow-up period were significantly less likely to re-offend. The authors concluded that the lack of significance in the clinical variables means diversion programs should retain a focus on changeable risk factors for criminological behaviour in addition to mental health outcomes.

It is known that a substance use disorder in people with serious mental illness increases the risk of arrest, although the degree of risk varies between disorders. Diversion programs targeting people with co-occurring mental illness and substance use problems may lower arrest rates if they reduce substance use.⁶ Program participants who failed to complete a mental health court diversion program in California were found to have more severe substance use disorders, also indicating the importance of addressing substance use issues.⁷

A higher level of insight into need for mental health treatment was associated with reduced arrest rates in a group of homeless people receiving integrated treatment for substance use and mental illness (primarily mood disorders).⁸

A 2005 US study found that worse symptom severity, psychopathology and greater childhood trauma was associated with poorer outcomes, which the authors suggest points to the need for more intensive and expert interventions to be integrated with diversion programs. Race or ethnicity was found to interact with mental health variables, suggesting that culturally informed practices affect outcomes in diversion programs.⁹

What types of mental health problems are included?

The definition of diversion and support provided on page 17 of these guidelines refers to people with 'mental illness'. Definitions of mental illness vary widely, often depending on the context in which the definition will be applied. For example, definitions differ in legal, social, disability and psychiatric settings.¹⁰

These guidelines are focused on people with mental illness or mental disorder and for the purposes of consistency they adopt the definition of mental illness provided by the *National Mental Health Policy*:

A clinically diagnosable disorder that significantly interferes with an individual's cognitive, emotional or social abilities. The diagnosis of mental illness is generally made according to the classification systems of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the International Classification of Diseases (ICD).¹¹

Many diversion and support initiatives include within their scope people with developmental disorders, intellectual disabilities, acquired brain injuries and other cognitive disabilities which may not generally be considered a 'mental illness'. Mental impairment is a term sometimes used to reflect the range of conditions that affect cognitive functioning.

Programs which will engage with Indigenous people should also consider adopting the social and emotional wellbeing framework as an alternative means of defining eligibility criteria. This is because some problems recognised within a social and emotional wellbeing framework are not captured within a biomedical approach to psychiatric assessment and conversely, some cultural behaviours may be confused with symptoms of mental illness.¹²

The decision as to the inclusiveness of diversion and support programs is an important one. Different types of mental health problems require quite different and often specialised services and supports. Inclusion criteria should clearly relate to the range of services that are accessible through a diversion program.

Figure 6.2 Types of mental impairment

- High prevalence disorders such as anxiety and depression
- Low prevalence disorders such as schizophrenia and bipolar disorder
- Behavioural disorders
- Personality disorders
- Autism spectrum disorders
- Intellectual disability
- Developmental disorders
- Learning disorders
- Acquired brain injury
- Dementia and Alzheimer's
- Neuro-degenerative conditions
- Substance use disorders
- Indigenous-specific issues including loss of identity, acculturation stress and spiritual sickness

It is also important to recognise that many individuals with mental illness may never have been diagnosed when they come into contact with the justice system especially young people. This means that eligibility criteria need to be broad enough to accommodate some interventions which take place before an assessment takes place and a diagnosis is formalised.

In many cases, people may have more than one mental impairment, for example, intellectual disability and schizophrenia. Where a person meets inclusion criteria based on one mental health problem, then unless countermanding exclusionary criteria are in place, that person should also receive integrated supports for related problems as part of a holistic service response tailored to their needs.

What type of offending is eligible?

Diversion and support programs which operate after an alleged offence has been committed should clearly define which offence categories are included. At the program level, which offences should fall 'in scope' for what type of diversion and support programs is largely a matter of balancing three factors:

- community expectations in relation to the offence
- proportionality of the range of program outcomes to the offence
- the likely impact of the program on re-offending and community safety.

Right of appeal

Diversion programs which incorporate exercise of administrative or judicial power will need to carefully consider what rights to review or appeal exist for people who are refused diversion.

If the program model maintains an acceptable degree of accountability for criminal behaviour and does not detract from community safety, there is no empirical rationale for excluding violent offences from diversion and support programs, at least where the offending is relatively minor.

Where the program model does not involve suspension or substitution of criminal justice system processes and sanctions, then it is appropriate to include more serious offences within their scope. For example, mental health liaison services integrated or in partnership with courts may improve coordination of care and access to services, reduce adverse impacts of the court experience and support judicial decision making informed by a full appreciation of the impact of a person's mental health.

Nonetheless, it is important to secure and maintain community and political support for diversion and support programs. Many current programs in Australia exclude offenders charged with violent or sexual offences, particularly when a possible outcome is dismissal of charges or a reduced sentence. This reflects the community's strong condemnation of these particular types of offences.

Evidence snapshot: violent offences and community safety

Diversion programs for people with mental illness can achieve positive outcomes without compromising public safety.^{13,14,15} A 2003 study of jail-diversion programs in the US found that there was no difference in criminal

justice and health service utilisation outcomes for people charged with violent compared with non-violent offences.¹⁶ Involvement in mental health courts has also been associated with lower rates of recidivism and fewer new offences for violent crimes.¹⁷ An increasing number of diversion programs accept offenders with violence-related offences.

Sub-section summary

- A range of individual and demographic characteristics will impact on program design and effectiveness. Developing a profile of the people who will have access to a diversion and support program is essential to support program design and resource allocation.
- Inclusion and exclusion criteria should be coordinated across different diversion and support programs to minimise system gaps and support better pathway selection.
- Clear determination of which forms of mental impairment are the basis of inclusion or exclusion criteria is vital. Different issues may require different, specialised responses.
- Which types of offending behaviour are included also requires careful consideration of community expectations, proportionality of possible program outcomes to the offence and the likely impact of the program on re-offending and community safety.
- There is no research based rationale for excluding violent offences from diversion and support programs, at least where the offending is relatively minor.
- Securing and maintaining community support for diversion and support is important and may require strong leadership and advocacy in support of evidence-informed policy.

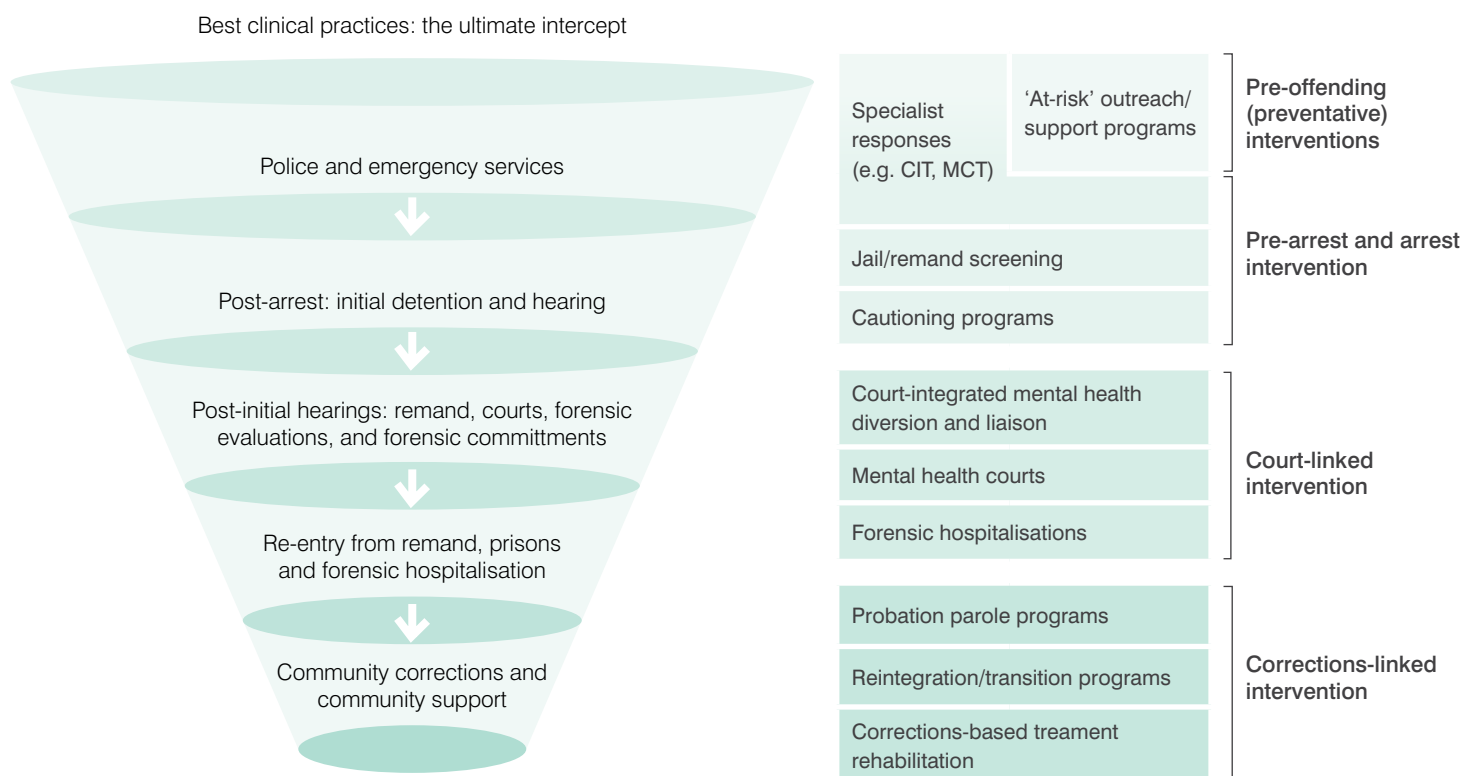
6.2 Where and when will interventions occur?

Mental illness prevention and early intervention is well accepted as good practice in the mental health setting.^{18,19} In the context of diversion and support, it is also accepted that intervention should occur as early as possible in a person’s involvement with the criminal justice system. The well accepted “risk-needs-responsivity” framework

for reducing offending points to minimal intervention in relation to criminological risk factors for low-risk offenders.²⁰ However providing interventions focused on mental health risk factors can be appropriate even for low risk offenders.

A useful model is the Sequential Intercept Model of diversion and support developed by Munetz and Griffen. It describes a series of possible interception points to reduce the chance of people with a mental illness from penetrating deeper into the criminal justice system.²¹

Figure 6.3 The Sequential Intercept Model viewed as a series of filters



Source: Adapted from Munetz, MR and Griffen, PA (2006), "Use of the Sequential Intercept Model as an approach to decriminalisation of people with serious mental illness", *Psychiatric Services*, vol. 57, no. 4, pp 544-9.

Developing a whole-system framework for diversion and support, which articulates coordinated eligibility criteria for programs at different stages in the criminal justice system is best-practice. Figure 6.3 situates a number of examples of diversion and support programs as part of a system of overlapping programs and pathways.

The appropriate point of intervention for each individual within and between the various settings will depend on a range of factors.

- **The availability of support options.** Diversion of an individual is influenced by the availability of programs and support services suited to their needs. Effective diversion requires that linked supports are adequately resourced.
- **The seriousness of the offending involved.** Minor offences are more likely to be appropriately dealt with through pre-arrest and arrest interventions, while it may be better to deal with more serious or more frequent offenders through court-linked interventions.
- **The association between the mental illness and offending.** Diversion earlier in the cycle may be appropriate where there appears to be a strong causal association between mental illness and the offending that may diminish moral culpability (if not legal responsibility). Assessment of mental competency and fitness to stand trial is also a factor in determining whether a person should be in the criminal justice system at all.
- **The degree of supervision necessary to protect the community.** Individuals with higher risk of re-offending may require a correspondingly higher level of supervision by the justice system to ensure community safety is maintained.
- **The effect that supervision is likely to have on the individual.** Some individuals may derive therapeutic benefit from judicial supervision; others may be more vulnerable to the negative effects of the criminal justice process.

The decision as to the appropriate point of diversion for an individual with a mental illness requires careful consideration of the individual circumstances of that person's case.

Further Reading

- Munetz, MR and Griffen, PA (2006), "Use of the Sequential Intercept Model as an approach to decriminalisation of people with serious mental illness", *Psychiatric Services*, vol. 57, no. 4, pp 544-9.

Sub-section summary

- A useful model for the timing of interventions is the Sequential Intercept Model of diversion and support developed by Munetz and Griffen, which describes a series of possible interception points.
- The appropriate point of intervention for each individual within and between the various settings will depend on a range of factors including the availability of supports, the seriousness of offending, the link between offending and mental illness and the appropriate degree and effect of supervision on the individual.
- Early identification and provision of timely interventions for mental illness is associated with better mental health outcomes. Early and accurate assessment of mental illness also enable informed decisions to be made about the timing and nature of diversion and support.

6.3 What interventions and supports are necessary?

While the focus of this document is on people with mental illness, it is essential to recognise that psychiatric issues are often one of a complex range of problems. Key among these are issues relating to stigma and discrimination, health-related comorbidities and social disadvantage in terms of education, employment and housing. In particular, connecting people to effective and coordinated mental health and drug and alcohol services is likely to underpin the success of any diversion and support program.

Other specific issues which need to be identified and addressed may apply to particular groups, including Indigenous Australians, young people and people from culturally and linguistically diverse backgrounds.

Baldry et al have argued that the effect of co occurring problems in people with vulnerabilities such as mental illness is to *multiply* their difficulties: "the effect of one impairment on an already impaired individual is not simply additive but exponential..."²²

It has also been argued that as individuals with psychiatric disability are both more likely to encounter problems in their lives and less able to deal with these problems effectively, they are more exposed to a succession of compounding problems that spiral out of control.²³ Social disadvantage is strongly associated with rates of arrest in the general community, but people with mental illness are more likely to experience such disadvantage.²⁴

Effective diversion and support programs need to be holistic in scope. They should accept and be responsive to the complexity and diversity of contributing and protective factors that impact on both mental illness and offending. Problems which are detrimental to recovery from mental illness and which increase the likelihood of future offending need to be identified, assessed and addressed. Similarly, protective factors that enhance mental health or reduce recidivism should also be identified and utilised – a strengths-based approach.

Diversion and support programs which have focused predominantly on health-related outcomes have been able to achieve positive clinical and quality of life outcomes, although the evidence is not as clear that they reduce offending.²⁵ There are also challenges in adapting evidence based practices for the treatment of mental illness in general settings to the forensic environment.²⁶

It would appear that assessing and addressing dynamic criminogenic risk factors as part of a comprehensive approach adds value to diversion and support programs. Important modifiable risk factors for both mental illness and recidivism include drug and alcohol problems, housing instability and employment.

Further reading

- Osher, FC and Steadman, JH (2007), "Adapting Evidence-Based Practices for Persons with Mental Illness Involved with the Criminal Justice System", *Psychiatric Services*, vol. 58, no. 11, pp 1472-8.
- Baldry, E, Dowse, L, Snoyman, P, Clarence, M and Webster, I (2008), "A critical perspective on Mental Health Disorders and Cognitive Disability in the Criminal Justice System", *Proceedings of the 2nd Australian & New Zealand Critical Criminology Conference*, 19-20 June 2008, Sydney, Australia.

Evidence snapshot:

interventions with potential to improve health and recidivism

A 2007 review examined six evidence-based practices for their potential to improve behavioural health and public safety.²⁷

| Evidence based practice | Potential to achieve* | Data to support* |
|---|-----------------------|------------------|
| • Integrated treatment for co-occurring disorders | ++++ | ++++ |
| • Supportive housing | +++++ | +++ |
| • Supportive employment | +++ | + |
| • Trauma-specific interventions | ++ | + |
| • Illness self-management | ++ | + |
| • Assertive community treatment | +++++ | +++ |

* The possible number of positive icons ranges from 1 to 6, with higher numbers indicating a higher degree of potential impact and available data.

6.3.1 Drug and alcohol services

Problematic substance use is the most commonly co-occurring condition in people with serious mental illness, including complex poly-drug use.^{28,29} Lifetime prevalence rates are very high in those involved in the justice system.^{30,31} Co-occurring substance use has been closely linked to higher rates of contact with the justice system.³²

Integrated mental health and drug and alcohol services are generally considered to be best practice for people with co-occurring disorders in any setting.^{33,34,35} Similarly, availability and provision of integrated services are best practice for any program targeting justice-involved individuals with dual diagnosis.^{36,37,38} Such services should have an emphasis on early intervention, as well as relapse prevention and support. Drug and alcohol services working with people who offend should adopt an approach that assertively promotes engagement and also challenges drug taking and its link with offending behaviour.

Integrated services may be supported through common referral, assessment and screening instruments across drug and alcohol and mental health services. Similarly, memoranda of understanding between local mental health and drug and alcohol services may facilitate collaborative practice.

Further reading

- Swartz, JA and Lurigio, AJ (2007), "Serious mental illness and arrest: the generalised mediating effect of substance use", *Crime & Delinquency*, vol. 53, no. 4, pp 581-604.

6.3.2 Improving housing stability

The Mental Health Council of Australia has observed that:

A home is about having more than just four walls and a roof. It should provide safety and security, and help one develop a strong sense of self. A home also helps to develop community connections. Adequate, appropriate and affordable housing is an essential part of social inclusion and participation. Having a place to call 'home' is integral to everyone's mental health, whether one has a mental illness or not. Stable and secure housing is especially critical for people with mental health problems.⁴⁰

People with mental illness are significantly more likely to experience unstable housing or homelessness.^{41,42} There are clear associations between each of marginal housing and homelessness, mental illness and involvement in the criminal justice system.^{43,44} Evidence from the United States suggests that people with mental illness transitioning out of the criminal justice system view housing as important to community reintegration.⁴⁵

This is consistent with research that suggests stable housing is associated with better criminal justice outcomes (including reductions in the likelihood of future incarceration)^{46,47} and also accords with the priority placed on accommodation by people with mental illness in other contexts.⁴⁸

Housing instability is a clear risk factor for recidivism and a significant barrier to recovery from mental illness. Housing services should be engaged as part of holistic diversion and support programs.

Further reading

- Mental Health Council of Australia (MHCA) (2009), *Home Truths: Mental Health, Housing and Homelessness in Australia*, Canberra: MHCA.
- Roman, CG, McBride, EC and Osborne, JWL (2005), "Discussion paper: principles and practices in housing for persons with mental illness who have had contact with the justice system", presented at the *Evidence Based Practice for Justice-Involved Individuals: Housing Expert Panel Meeting*, 1 June 2005, Bethesda, MD.
- Glover-Thomas, N and Barr, W, (2004) "Housing an individual: property problems with the mentally vulnerable" in Hudson, A (ed), *New Perspectives on Property Law, Human Rights and the Home*, London: Cavendish Publishing.

6.3.3 Supporting opportunities for education and employment

People with mental illness also experience high levels of unemployment and non-participation in the labour force and lower levels of educational attainment,⁴⁹ both of which are criminogenic risk factors. This is particularly so for the more severe disorders; in 1998, three quarters of people with a psychotic disorder were not participating in the labour force compared with 20 per cent of healthy Australians.⁵⁰ This may be at least in part attributed to lower levels of educational attainment which can be linked to the disruptive effect that developing a mental illness has on schooling. Baldry et al have observed that:

it is very likely that young people with emerging mental health issues whose families have little in the way of social and economic capital to support them, are likely to have experienced disrupted schooling. This sets in motion a chain of events and exclusions that intensify their disadvantage.⁵¹

Low levels of workforce participation are in contrast to research indicating that many people with mental illness have both the desire and the capacity to engage in meaningful employment.⁵² There is good evidence that supported employment programs can help people with mental disorders to secure and retain meaningful employment.^{53,54,55,56} King et al have noted that reduced participation in the labour force is indicative of "the social exclusion that deinstitutionalization has failed to overcome".⁵⁷

Diversion and support programs should have access to specialist vocational training and employment services in order to assist people with mental illness to develop meaningful pathways to social inclusion and healthy alternatives to criminogenic behaviours.

Further reading

- Waghorn, G and Lloyd, C (2005), "The employment of people with mental illness", *Australian e-Journal for the Advancement of Mental Health*, vol. 4, no. 2 (Supplement).
- Anthony, WA (2005), "Discussion Paper: Supported employment for people in contact with the criminal justice system", presented at the *Evidence-based Practice for Justice-Involved Individuals: Supported Employment Expert Panel Meeting*, 7 September 2005, Bethesda, MD.

6.3.4 Addressing co-occurring health problems and disability

Physical and psychological comorbidity is commonplace in people in the community with a mental illness. Prevalence of various chronic conditions is higher in this group (for example, chronic heart disease, respiratory disease and diabetes).^{58,59,60} This pattern is also evident in prisons; although prisoners as a whole have poor physical health, those with a mental illness fare worse than others.⁶¹ Perceived unmet physical health care needs have also been linked to higher rates of arrest in a study of homeless people receiving residential treatment for co-occurring substance and mental disorders.⁶²

A study of 200 prison entrants found that 82 per cent reported at least one instance of traumatic brain injury and 65 per cent reported loss of consciousness associated with a blow to the head.⁶³ Prisoners with a traumatic brain injury have higher rates of psychological problems,^{64,65} which is consistent with community studies showing high correlation between acquired brain injury and psychiatric problems.⁶⁶

People with intellectual disability are also overrepresented in the criminal justice system and at higher risk of having a co-occurring mental illness.⁶⁷ A recent study examining comorbidity of intellectual disability and mental illness in people appearing in Magistrates' Courts in NSW suggests a higher prevalence of mental illness in those with an intellectual deficit compared with those with normal cognitive functioning.⁶⁸ Intellectual disability has also been associated with higher rates of recidivism in young people.⁶⁹

High rates of co-occurring health problems and cognitive disabilities in people with mental illness and possible links between these issues and recidivism provide a clear rationale for best practice diversion and support programs to engage with general health and disability supports.

Further reading

- Teesson, M, Slade, T and Mills, K (2009), "Comorbidity in Australia: findings of the 2007 National Survey of Mental Health and Wellbeing", *Australian and New Zealand Journal of Psychiatry*, vol. 43, no. 7, pp 606-14.
- Vanny, K, Levy, M and Hayes, S (2008), "People with Intellectual Disability in the Australian Criminal Justice System", *Psychiatry, Psychology and Law*, vol. 15, no. 2, pp 261-71.

6.3.5 Culturally specific interventions

All interventions should be provided in a culturally safe context and delivered by practitioners who are culturally competent. For some groups, particularly Indigenous Australians and people from culturally and linguistically diverse backgrounds, culturally specific interventions may also support recovery from mental illness.⁷⁰ Planning and providing culturally specific interventions requires meaningful partnership with Indigenous and culturally and linguistically diverse communities.

Interventions aimed at Indigenous people may require cultural translation given that Indigenous groups speak a variety of different languages, use different communication styles and have different understandings of health and identity.⁷¹ Programs addressing diverse, non-Indigenous cultural groups will also benefit from a similar process.

Social and emotional wellbeing

"[The] Aboriginal concept of health is holistic, encompassing mental health and physical, cultural and spiritual health. Land is central to well-being. This holistic concept does not merely refer to the 'whole body' but in fact is steeped in the harmonised interrelations which constitute cultural wellbeing. These inter-relating factors can be categorised largely as spiritual, environmental, ideological, political, social, economic, mental and physical. Crucially, it must be understood that when the harmony of these interrelations is disrupted, Aboriginal ill health will persist"

Source: Swan, P and Raphael, B (1995), *Ways Forward. National consultancy report on Aboriginal and Torres Strait Islander mental health*, Canberra: Commonwealth of Australia.

When working with Indigenous Australians, engaging Aboriginal health workers is generally regarded as best practice to support development of culturally safe services.⁷² Cultural safety requires collective effort at all levels to identify, review and modify practices that conflict with Indigenous culture and values.⁷³ In remote Indigenous settings, inclusion of traditional practitioners in a holistic approach to health may also be appropriate.⁷⁴

Section 7 provides insights into a number of essential considerations for diversion and support programs for Indigenous people and people from culturally and linguistically diverse backgrounds.

Further reading

- Joudo, J (2008), *Responding to substance abuse and offending in Indigenous communities: review of diversion programs*, Research and Public Policy Series No. 88, Canberra: Australian Institute of Criminology.
- Social Health Reference Group (2004), *Social and emotional wellbeing framework*, Canberra: National Aboriginal and Torres Strait Islander Health Council and National Mental Health Working Group.

Sub-section summary

- Mental health issues rarely arise in isolation and are often one of a complex range of problems. Effective diversion and support programs need to be holistic in scope. They should accept and be responsive to the complexity and diversity of contributing and protective factors that impact on both mental illness and offending.
- Mental health diversion programs, particularly those for higher risk offenders should aim to address criminogenic risk factors as well as risk factors for mental illness.
- Integration and coordination of mental health and drug and alcohol services is likely to underpin the success of any diversion and support program for many individuals.
- Achieving housing stability provides a foundation for addressing problems in other areas of life and should be a priority for diversion and support programs.
- Facilitating pathways to social inclusion is important to long term recovery. Such pathways may include opportunities for people to participate in education and employment.
- High rates of co-occurring health problems and cognitive disabilities in people with mental illness and possible links between these issues and recidivism provide a clear rationale for best practice diversion and support programs to engage with general health and disability supports.
- All interventions should be provided in a culturally safe context and delivered by practitioners who are culturally competent. For some groups, particularly Indigenous Australians and people from culturally and linguistically diverse backgrounds, culturally specific interventions may also support recovery from mental illness.

6.4 Which stakeholders should be involved?

The stakeholders who should be engaged within a particular diversion and support program will depend on the intervention setting and the nature of the program. In addition to the people with mental illness who are the subject of diversion and support programs (consumers) there are four groups of stakeholders, outlined in Figure 6.4 and Figure 6.5.

It is unlikely that all potential stakeholders will be involved to the same extent and the large number of interested parties means that some groups will be necessarily more involved than others. It is important to consider which stakeholders have an interest in diversion and support, the nature of that interest and the degree and means by which they should be involved.

Particular attention should be focussed on identifying those core stakeholders with a direct interest in the diversion and support program which is being developed, or who are able to provide essential expertise or services. This will generally require a detailed stakeholder analysis.

People with a mental illness will always be core stakeholders. Other stakeholders may vary depending on the intervention setting.

Figure 6.4 Key stakeholder groups

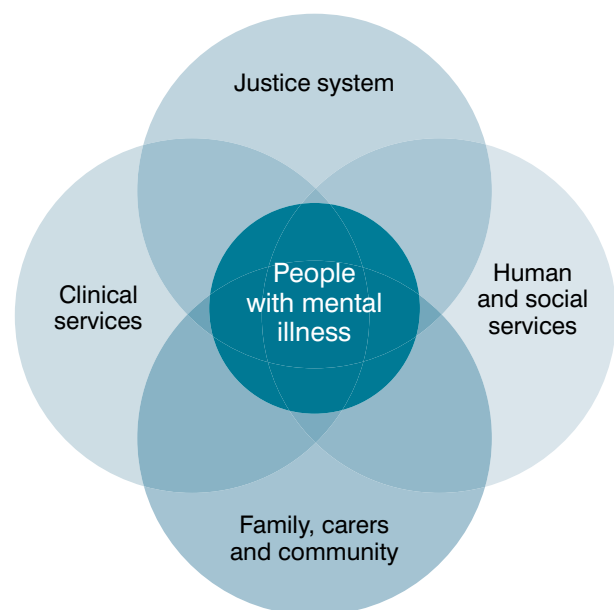


Figure 6.5 Potential stakeholders in diversion and support programs

| | | |
|--|--|--|
| <p>People with a mental illness</p> | <ul style="list-style-type: none"> • People with personal experience of mental illness • Advocacy and support organisations representing people with mental illness | |
| <p>Families or Carers and community</p> | <ul style="list-style-type: none"> • People with personal experience of caring for a significant other with a mental illness • Advocacy and support organisations representing families or carers • Community leaders and representative bodies, including Indigenous and CALD leaders • Local government • Community organisations | |
| <p>Justice system</p> | <ul style="list-style-type: none"> • Government: Justice, Attorney-General portfolios • Police • Sherriff’s officers • Judiciary and court officers • Public prosecutors • Legal aid, criminal defence lawyers • Legal guardianship bodies | <ul style="list-style-type: none"> • Indigenous legal services • Custodial services • Community corrections • Juvenile justice services • Victims support groups • Prisoner advocacy groups • Criminology researchers and experts • Professional associations |
| <p>Clinical services</p> | <ul style="list-style-type: none"> • Government: health, mental health portfolios • Area mental health services • Child and adolescent mental health services • Forensic mental health services • Transcultural mental health services • Drug and alcohol services | <ul style="list-style-type: none"> • General health (primary care) services • Aboriginal community controlled health organisations • Ambulance and patient transport services • Ethno-specific health services • Clinical researchers and experts • Professional associations |
| <p>Human and social services</p> | <ul style="list-style-type: none"> • Government: human and social services portfolios • Psychiatric disability rehabilitation and support sector • Disability support services • Housing and crisis accommodation sector • Education and vocational training sector • Employment sector • Community support organisations | <ul style="list-style-type: none"> • Centrelink • Child protection services • Welfare and social support sector • Youth-focused services • Ethno-specific social support services • Indigenous specific social support services • Social science researchers and experts • Professional associations |

6.4.1 People with mental illness, families or carers and community

People with mental illness

The participation of people with mental illness (consumers)[†] in the planning, development and evaluation of mental health related interventions is supported by the *National Mental Health Policy 2008*.⁷⁵ Many mental health services now engage consumer and family or carer consultants who provide advice on service planning and delivery.^{76,77,78} Consumer and family or carer participation at this level is less well established in the justice system.

The value of securing and continuing meaningful input from people with mental illness in health service planning is generally recognised. It has been observed that “service user involvement, both at a local service level and at a national and international level, considerably enriches any future planning and development of policy agenda...”⁷⁹

Participation by appropriately skilled consumers (especially consumers with forensic history) within the planning of diversionary programs also provides insight into factors that enhance the acceptability of services to consumers and hence their engagement. This applies both in a general sense and in relation to specific culturally diverse consumer groups, including people from Indigenous communities.⁸⁰

In relation to individuals participating in decisions about their own care, there is good evidence that involving consumers in decisions about their care can lead to improved compliance with treatment, better health outcomes and greater satisfaction with services received.⁸¹ While application of this principle in the justice environment can present some challenges, every effort should be made to support individuals’ decision making in relation to treatment and intervention choices.

Families and Carers

People who have personal experience of providing care for a significant other with a mental illness (carers) are also key stakeholders in diversion and support programs. Most commonly ‘carers’ is taken to mean family members, but the term also includes anyone in a close relationship with a consumer and having a non-professional caring role.

Particularly where they are the primary care-giver, carers’ lives are inextricably bound up with the lives of those for whom they care. The shift to community-based care has increased the relative importance of the unpaid carer’s supporting role,⁸² yet families and carers often report that they feel excluded by service providers and that inadequate attention is paid to the contributions they can make, as well as their own needs.^{83,84,85}

Caring for someone with a mental illness often has a detrimental effect on the health and wellbeing of the carer and is associated with high levels of depression and anxiety.⁸⁶ Families and others who care for people with psychosis also report higher levels of verbal and physical aggression (from the consumer) and traumatic experiences.⁸⁷ They may also be in the difficult position of both victim and carer and may feel marginalised by the criminal justice processes.

Families and carers frequently have a different perspective to that of consumers and clinicians.⁸⁸ Actively soliciting and respecting their views is especially important given their key role in supporting a consumer’s participation in and compliance with diversion and support programs. While the important role of family is often emphasised for Indigenous people and young people, engaging with family for other groups of consumers is no less important.

While family or carer involvement is generally to be encouraged, in some circumstances, it should be recognised that a person’s family or community may not be supportive, or that the consumer may attribute their problems to their family. In these circumstances, involvement of family or carers should occur only after careful assessment of the implications of doing so and with the express consent of the consumer involved.

Finally, the right of family and carers to choose not to become involved should also be respected. This is particularly relevant where they may be the victims of the consumer’s offending behaviour.

Further reading

- Mental Health Council of Australia (MHCA) (2009), *Adversity to Advocacy: The Lives and Hopes of Mental Health Carers*, Canberra: MHCA.
- National Mental Health Consumer and Carer Forum (2004), *NMHCCF Consumer and Carer Participation Policy: A framework for the mental health sector*, Canberra: NMHCCF.

[†] The term ‘consumer’ is commonly used within mental health policy to denote a person who has personal experience of a mental illness and may or may not have accessed mental health services.

Community

People with mental illness and their families come from communities in both the geographic and cultural sense. However, many people with mental illness who come into contact with the justice system experience social exclusion from their community, a factor associated with both mental illness and offending.

Communities have a significant stake in diversion and support programs, including in terms of the impact of offending on the community and the role of community in a person's recovery from mental illness. Social inclusion and reconnecting with community are significant protective factors that can enhance a person's prospects of recovery from mental illness.

Communities are also a source of expertise in relation to local networks and resources, as well as potential barriers to program implementation. Ethno-specific community groups are a valuable source of culturally specific information. Community engagement is also important to address misconceptions about diversion as a 'soft option'.

Where diversion and support programs will engage with people from Indigenous backgrounds, meaningful partnership with Indigenous communities is central to their long term success and sustainability. The need for services to come to grips with the diversity and complexity of Indigenous cultures in order to deliver culturally safe services provides an ethical and practical rationale for such partnerships. A second reason is the importance of self-determination and community empowerment for the communities that are home to Indigenous people diverted from the justice system.^{89,90,91}

6.4.2 Justice system

Which components of the criminal justice system need to be involved in individual diversion and support initiatives will be largely determined by the setting in which diversion programs take place. Pre-offending, pre-arrest and arrest based programs will require the involvement of police and others who are involved before a person appears in court, while court-linked programs will also engage the judiciary and others involved in the court process.

Other stakeholders, including victim support groups, prisoner advocacy groups, Indigenous legal services and others may also need to be involved depending on the nature of the program, while expertise in the field of criminology can help strengthen both the evidence-based nature of program design and the rigor of evaluative methodologies.

It is preferable that diversion and support programs operating at different stages of the criminal justice continuum are not developed in isolation from each other. Government departments which hold justice portfolios have a critical role in providing leadership and coordination at the system level and in facilitating the development of programs within a coherent and consistent framework that spans the justice system as a whole.

Further reading

- Glassberg, H & Dodd, E (2008), *A guide to the role of crime victims in mental health courts*, New York: Council of State Governments Justice Center

6.4.3 Clinical services

Connecting people to effective and coordinated mental health and drug and alcohol services is likely to underpin the success of any diversion and support program. Clinical services must be engaged as active partners in developing diversion and support programs and should not be seen as merely an endpoint for referral. In addition to a key role in providing assessments and clinical interventions, clinical services bring vital expertise to the process of screening and identification and outcomes measurement. They can also support efforts to develop greater awareness of mental illness among justice system personnel.

High levels of physical health concerns among people with mental illness mean that diversion and support programs that focus on mental illness should also engage with general health care providers. At the local level, this includes general practitioners, community health centres and Aboriginal community controlled health organisations.

Finally, both forensic and general clinical services are important stakeholders. The quality and continuity of services offered under diversion and support programs can benefit from collaboration between forensic and general health and mental health services.⁹² Such collaborations may also act as a catalyst to reduce barriers to general services for people who are associated with forensic services.⁹³

6.4.4 Human and social services

Human and social services have a crucial role in addressing non-clinical issues which impact on mental health and the risk of offending. The human and social services sector includes community-based, non-government organisations, as well as government stakeholders. Non-government organisations play an essential part in providing many social support services and their expertise should be engaged.

People with mental illness often live in criminogenic environments which are conducive to criminal behaviours.⁹⁴ Stigma and discrimination, unstable housing, unemployment, poverty and social exclusion more generally are also associated with both mental illness and justice-system involvement.

In particular, stable accommodation is often a pre-requisite for effective recovery from illness and is often a priority for people with mental illness and their families.^{95,96} Stable housing has also been associated with reduced arrests in diversion program participants.⁹⁷ Vocational training and supported employment programs may help develop positive life options, promote social inclusion and support recovery from illness.^{98,99}

Child protection, family support and youth-specific services have a vital role to play when dealing with young people with emerging mental illness who are at risk of offending or are engaged with the juvenile justice system. Offending in young people is associated with experiences of trauma and social disruption^{100,101,102,103} and intervening early to provide social and family supports is an essential component of diversion programs targeting this group.¹⁰⁴

Sub-section summary

- A comprehensive stakeholder analysis should be an early priority in policy development and program design.
- People with personal experience of mental illness are always core stakeholders in the development, implementation and evaluation of diversion and support policy and programs.
- Family and carers for justice-involved people with mental illness should be engaged as key stakeholders in development, implementation and evaluation of diversion and support policy and programs.
- Community organisations are sources of local and cultural knowledge that significantly impact on program implementation. Engaging communities is essential to address stigma and misconceptions about diversion programs. Partnership with Indigenous communities is essential where programs will support Indigenous people with a mental illness.
- Both general mental health services and specialised forensic mental health services are important stakeholders in diversion programs.
- The human and social services sector (including both government and non-government organisations) particularly housing, welfare, employment and disability services provide interventions that are vital to a holistic response to mental illness. Consequently, their involvement in planning and implementation of policy and programs is essential.

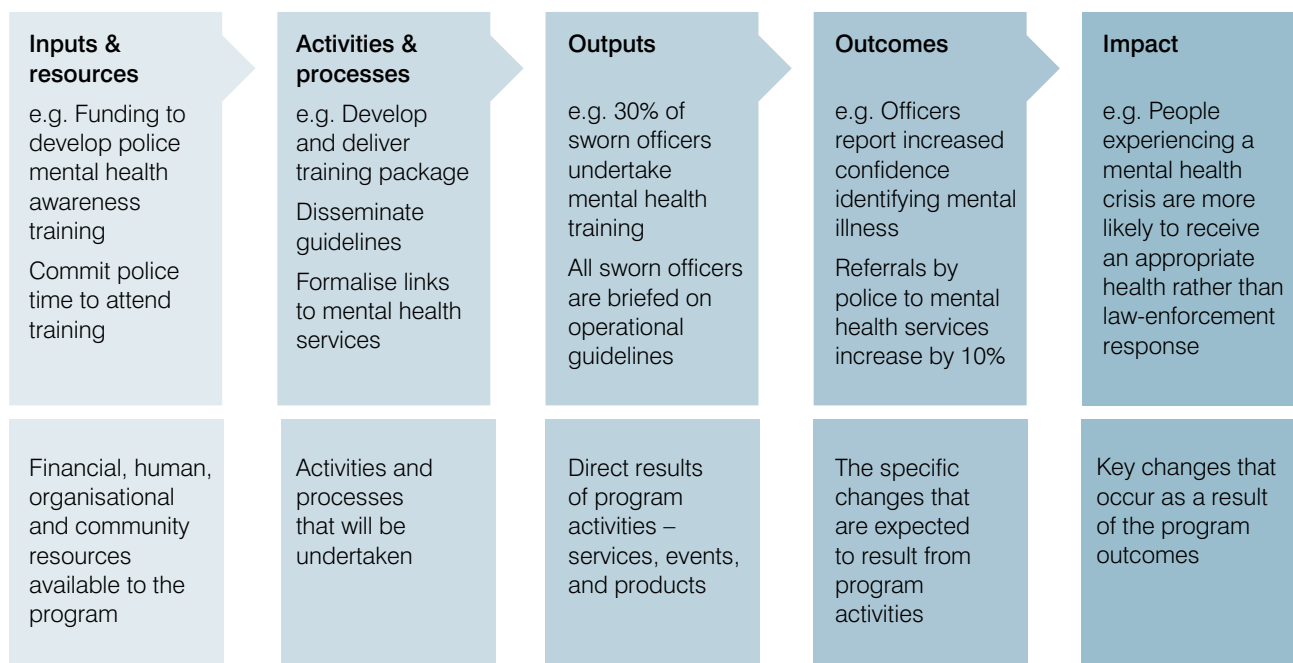
6.5 How will interventions be delivered and evaluated?

Diversion and support programs should be underpinned by sound program logic which describes a theory of how and why the program is expected to work. Good program logic provides the basis for evaluation of effectiveness by helping

to identify key assumptions and links between activities and outcomes which can then be evaluated.

The basic program logic includes five key components: inputs and resources; activities and processes; outputs; outcomes and impact. Figure 6.6 provides a simplified example of program logic behind a training initiative for police.

Figure 6.6 Program logic



6.5.1 Inputs and resources

Program inputs and resources include the financial, human, organisational and community resources which are available to the program. Some resources or expertise that might be indicated as 'best practice' may not be available in all areas (for example, in rural or remote Australia) with flow on effects for the logic model. Innovative approaches may be necessary to maximise program impact in such circumstances.

A key to the development of innovative solutions will be the identification of and involvement of people with specific and relevant local expertise that can be drawn upon as an input to the program. This will include, for example, mental health consumer and families or carers, and local service providers.

6.5.2 Activities and processes

At the most general level, key activities and processes necessary for all diversion and support include participant identification, assessment, pathway negotiation, intervention planning and delivery, and monitoring and review.

Participant identification

Identifying potential program participants is the essential first step in diversion process. This may involve supporting non-clinical justice personnel to recognise signs of mental illness through providing mental health literacy training or provision of simple screening tools or guidelines. Another approach may be systematic screening of potential participants at gateway points such as police cells or court.

Participants may also be identified through external referral processes. For example ex-offenders may be referred to preventive programs by community corrections, or individuals with mental illness may self-identify.

Assessment

Once potential participants are identified, there should be a culturally appropriate assessment of their needs. Assessing their biological, psychological, social and cultural needs provides a comprehensive picture of their circumstances and support needs. It should also identify any protective factors which may exist, for example, strong family or community supports. Similarly, an assessment of their offending risk and criminogenic needs provides important information to assist with decisions about the appropriate diversion and support. It should be noted, however, that criminogenic risk assessment protocols and tools may not have been validated in groups that are the subject of diversion programs.

Demographic and other data including gender, Indigenous status, place of residence and access to transport also facilitate individualised planning.

Assessment processes should aim to collect baseline data, both to allow individual progress to be tracked and for aggregation within planned evaluations of program effectiveness (see Figure 6.7).

The nature of an assessment will vary depending on the context and type of diversion and support program and the purpose for which the assessment is completed.

Pathway negotiation

Information gathered from comprehensive assessments enables informed decision making about the most appropriate pathway for a person to take. Who is involved in negotiation will depend on the context of the diversion program, but should generally include the relevant justice agency, mental health providers and the individual with a mental illness (and their legal representative).

In some cases, particularly pre-arrest diversion programs, pathway negotiation may precede comprehensive assessments.

In many situations, it is appropriate to include the person's family or carer and community representatives in the negotiations. This is particularly the case when dealing with young people, Indigenous people, or people from culturally and linguistically diverse backgrounds.

In a diversion and support context where the individual is legally competent, negotiating informed consent is essential. Informed consent requires that the individual is fully aware of the options open to them, having had these explained to them in plain terms and is able to weigh the advantages and disadvantages of each in reaching a decision. This will require the use of suitably qualified interpreters where language is a barrier.

Figure 6.7 Examples of outcome indicators at baseline assessment and follow up

Criminal justice indicators

- Arrests and police contacts
- Nature and seriousness of offending
- Frequency and duration of incarceration

Mental health indicators

- Status of diagnosis
- Severity of symptoms
- Service utilisation (e.g. hospitalisations)
- Medication compliance

Health and social indicators

- Active substance use
- Current health status
- Housing status
- Employment participation
- Social and emotional wellbeing
- Participation in community and cultural life
- Quality of life

Experiential indicators

- Expectations of the justice system
- Exercise of human rights

Informed consent also means that each individual understands what is expected of them and the consequences if they do not meet those expectations. Those expectations should be clearly articulated, and the nature of any sanctions for non-compliance to expectations carefully considered.

Intervention planning and delivery

The degree and nature of intervention will depend on individual needs and the resources available.

In some cases, the immediate intervention may consist of referral to services. For example, in pre-arrest and arrest diversion programs, police might make a voluntary referral of a person to a community mental health service. Where the initial intervention is limited to a voluntary referral, it is important there are processes in place to ensure that such referrals are taken up.

Programs based around responding to crisis situations generally include crisis de-escalation strategies, safe transportation and referral as key interventions.

Pre-offending and court-linked programs often incorporate more extensive interventions over a period of time. These should be planned and based on a comprehensive assessment of needs and risk factors. They should be undertaken as a consultative process between the agency in the coordinating or case-management role, service providers and the individual. Family members, carers and community representatives may also have a valuable role in many circumstances.

The goals of a coordinated program of interventions should be determined with the person with a mental illness and take into particular consideration the individual's own views on which problems are most important to them. Often these views will not accord with those of service providers and a process of negotiation is necessary. For example, where clinically orientated service providers may consider medication compliance and substance use to be the most pressing issues, the program participant may place greatest emphasis on securing stable housing and reconnecting with family.

High rates of relapse among many people with serious mental illness or substance use issues mean that relapse prevention strategies will often be important. A relapse prevention plan can help individuals to recognise early signs of relapse and to take active steps to reduce the likelihood of relapse.

Confidential information

The clinical and support components of diversion and support programs are likely to capture a significant amount of confidential personal information about participants.

A key issue at the intersection of justice and health system boundaries is when and what information is exchanged. For example, some clinical information that would otherwise be treated as confidential health information may need to be disclosed in court in order to enable appropriately informed judicial decision making both at the outset and as part of ongoing monitoring.

To ensure compliance with information privacy legislation, guidelines should be developed about how confidential information is managed, including processes for seeking express consent from participants when this is appropriate.

In certain circumstances a plan to prevent re-offending may also be relevant. For example, a plan may help individuals to identify situational factors that increase their risk of impulsive offending, and provide strategies to reduce or avoid those factors.

The goals of an intervention plan are often moderated by the availability of services and supports and by the time-limited nature of many diversion and support programs. Where formal programs are of limited duration, a key objective of intervention strategies should be to facilitate ongoing linkages with community services and supports after program exit.

Evidence snapshot:

countering stigma and discrimination

Perceived experiences of stigma and discrimination are associated with decreased quality of life and general life function.¹⁰⁵ They can also inhibit access to health care, which may compound both mental and physical health problems.¹⁰⁶ Similarly, discrimination acts as a barrier to other supports including social and welfare services such as housing.

People with mental illness frequently encounter stigmatising attitudes and experience discrimination,^{107,108} including within the mental health and criminal justice systems.^{109,110} Individuals with lower levels of education and employment (common among those who are involved with the criminal justice system) report higher levels of discrimination.¹¹¹ It is also important to note that people with mental illness themselves often hold stigmatising beliefs about their illness, inhibiting help-seeking behaviours and potentially affecting their recovery.¹¹²

Where a person with a mental illness also has a criminal record, or is involved in the criminal justice system as an accused person or offender, an additional layer of discrimination can apply which limits access to health and other services. Some commentators have suggested that there is at least anecdotal evidence of discrimination by mental health services against people who have a criminal record.¹¹³

Diversion and support initiatives have a key role to play in combating stigma and discrimination relating to people with a mental illness – both in the justice system and the community. Reductions in stigmatising behaviours can be achieved through strategies such as education about mental illness for justice system staff (including police).^{114,115} Programs may also have a role in countering systemic discrimination by providing leverage to secure service access and may avoid the doubly stigmatising effect of a criminal record for people with mental illness.

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Monitoring and review

Monitoring and review activities include regular monitoring by service providers in which progress is assessed and outcome data collected. It also includes formal case reviews by multi-disciplinary teams and program coordinators. Formal reviews provide an opportunity for all stakeholders to reflect on how an individual is progressing, assess how effectively service providers are working with the client and with each other and to make adjustments to the intervention plan if necessary.

In the context of court-linked programs, judicial review provides an opportunity to deliver praise and encouragement from the bench where positive progress has been made and admonition or sanction for non-compliance with the intervention plan. The degree of flexibility afforded to individuals who do not comply with program expectations will depend on individual

circumstances. People with a mental illness who are legally competent should be supported to take responsibility for their own actions.

At the same time, sanctions for minor infractions may be counter productive; the appropriate step to take may be to modify intervention strategies to address the reasons for non-adherence to the conditions of diversion. Both incentives and sanctions have clinical implications and should be applied in individual circumstances with due care and following considered input from the treating mental health professionals.

Recovery from mental illness is often a long term process that is rarely straightforward. It is very likely that there will be relapses of varying degrees, or other circumstantial stressors that may result in 'non-compliance' with program rules. Consequently, any sanctions should always be applied with due consideration of the surrounding circumstances.

Figure 6.8 Examples of some key program activities and processes

| | Pre-offending (preventive) programs | Pre-arrest and arrest programs | Court-linked programs |
|----------------------------|--|---|--|
| Participant identification | <ul style="list-style-type: none"> • Ex-offender release planning • Service agency referral • Self-identification • Engaging potential participants • Referring for comprehensive needs assessment | <p>Crisis response</p> <ul style="list-style-type: none"> • Training police to recognise signs of mental illness • Identifying mental health related emergency calls • Conducting on-scene screening • Developing operational protocols <p>Other gateways</p> <ul style="list-style-type: none"> • Conducting routine screening of police detainees • Self-identification | <ul style="list-style-type: none"> • Routine screening of court defendants • Self-identification • Facilitating other referral pathways (e.g. prosecution, magistrate) • Referring for comprehensive assessment • Training legal professionals and justice staff to recognise signs of mental illness |
| Assessment | <ul style="list-style-type: none"> • Undertaking bio-psycho-social-cultural assessment • Assessing criminogenic risks and needs • Determining program eligibility • Identifying priority needs and protective factors • Collect baseline data | <ul style="list-style-type: none"> • Undertaking bio-psycho-social-cultural assessment • Assessing criminogenic risks and needs • Determining service/program eligibility • Identifying priority needs and protective factors • Collect baseline data | <ul style="list-style-type: none"> • Undertaking bio-psycho-social-cultural assessment • Assessing criminogenic risks and needs • Determining service and program eligibility • Identifying priority needs and protective factors • Preparation of court reports • Collect baseline data |
| Pathway negotiation | <ul style="list-style-type: none"> • Securing informed participant consent (where competent) | <ul style="list-style-type: none"> • Securing informed participant consent (where competent) • Pathway negotiation between police, emergency services, mental health services and the individual • Training mental health agency staff in justice system policies and processes | <ul style="list-style-type: none"> • Securing informed participant consent (where competent) • Pathway negotiation between defendants, mental health services, court officers, judiciary, prosecution • Training mental health agency staff in justice system policies and processes |

Figure 6.8 Examples of some key program activities and processes (continued)

| | Pre-offending (preventive) programs | Pre-arrest and arrest programs | Court-linked programs |
|------------------------------------|---|---|--|
| Intervention planning and delivery | <ul style="list-style-type: none"> • Negotiating priorities and goals with participant • Developing an acceptable intervention and support plan • Coordinating integrated clinical and social supports • Providing, brokering or liaising with services and supports • Supporting compliance (i.e. transport, reminders) • Relapse and re-offending prevention planning • Service continuity planning at exit • Holding regular cross-agency meetings | <p>Crisis response</p> <ul style="list-style-type: none"> • De-escalating crises • Safe transportation <p>Non-crisis intervention</p> <ul style="list-style-type: none"> • Negotiating priorities and goals with participant • Developing an acceptable intervention and support plan • Coordinating integrated clinical and social supports • Providing, brokering or liaising with services and supports • Supporting compliance (i.e. transport, reminders) • Relapse and re-offending prevention planning • Service continuity planning at exit • Holding regular cross-agency meetings | <ul style="list-style-type: none"> • Negotiating priorities and goals with defendant, court and mental health • Developing an acceptable intervention and support plan • Coordinating integrated clinical and social supports • Providing, brokering or liaising with services and supports • Supporting compliance (i.e. transport, reminders) • Relapse and re-offending prevention planning • Service continuity planning at exit • Holding regular cross-agency meetings |
| Monitoring and review | <ul style="list-style-type: none"> • Routine monitoring • Formal case reviews • Collection of outcome data | <ul style="list-style-type: none"> • Routine monitoring • Formal case reviews • Collection of outcome data | <ul style="list-style-type: none"> • Routine monitoring • Formal case reviews • Judicial review • Collection of outcome data |

6.5.3 Outputs

Program outputs are the direct results of program activities, including services, events and products. Outputs are generally expressed in quantifiable terms and may include, for example, training a percentage of police in mental health, delivery of a number of program placements, cross-agency meetings held monthly, or provision of detailed court reports to magistrates within a specified timeframe.

6.5.4 Outcomes and impact

The range of outcomes associated with diversion and support program activities describe the specific changes that result from activities. For example, police training resulting in earlier identification of people with mental illness and increased number of referrals to community mental health services; timely provision of court reports reducing time spent on remand by people with mental illness; and regular cross-agency meetings resulting in improved communication and information sharing.

The impact of a diversion and support program should relate back to the key objectives of the program, as discussed in section 4.3. The impacts will generally be the changes brought about by the diversion and support program at the individual, systemic and community level.

Impacts commonly include 'headline' effects of the program. For example, decreased intensity, seriousness and frequency of offending by people with mental illness; improved service coordination between justice, mental health and other agencies; and improved clinical outcomes for individuals in contact with the criminal justice system.

Evaluation should focus on measurement of both outcomes and impacts, relating these back to policy and program objectives and assessing these against the costs of the program. These indicators may include comparisons of entry, exit and follow up assessments on the domains suggested in Figure 6.7 which measure the impact of the program on individuals, but should also evaluate broader systemic and community outcomes.

The selection of validated and reliable instruments for measuring outcomes is an important step; standardisation of key data elements across programs within and between jurisdictions can facilitate meaningful comparative evaluation about the most effective approaches.

Any assessment of costs should model the complex social impact of a diversion and support program, as a narrow focus on cost to a specific sector may misrepresent the net effect. For example, diversion programs that result in lower costs for incarceration and processing through the criminal justice system may increase short term health service utilisation. Increased short term health costs may in turn be offset by longer term reductions in acute episode hospitalisations as management of a person's illness improves, increased economic participation (employment) and reduced recidivism.

Consequently, a longer term goal of effective diversion and support programs may be to enable reallocation of criminal justice system resources currently consumed by people with mental illness to community supports, rather than generating cost-savings.

Sub-section summary

- Well developed program logic underpins effective program planning and evaluation.
- Key activities and processes which should be documented as part of program design include participant identification, assessment, pathway negotiation, intervention planning and delivery, monitoring and review.
- Assessment processes should aim to collect baseline data, both to allow individual progress to be tracked and for aggregation within planned evaluations of program effectiveness.
- The validity and reliability of assessment tools and processes are significantly influenced by cultural issues. Best practice assessment is culturally appropriate for the intended subject.
- Negotiating informed consent is essential. This requires that the individual is fully aware of the options open to them, having had these explained to them in plain terms and is able to weigh the advantages and disadvantages of each in reaching a decision.
- Exchange of information across system boundaries is a key issue, as clinical and support components of diversion and support programs are likely to capture a significant amount of confidential personal information about participants.
- The goals of an intervention plan are often moderated by the availability of services and supports and by the time-limited nature of many diversion and support programs. Where formal programs are of limited duration, a key objective of intervention strategies should be to facilitate ongoing linkages with community services and supports after program exit.
- Managing situations where program participants do not meet expectations is complex. Identifying the range of possible sanctions and the circumstances under which they will be applied is an important step in policy and program development.
- Recovery from mental illness is often a long term process that is rarely straightforward. It is very likely that there will be relapses of varying degrees, or other circumstantial stressors that may result in 'non-compliance' with program rules.
- Stigma (including self-stigma) and experiences of discrimination have a profound effect on people with mental illness. Diversion and support initiatives have a key role to play in combating stigma and discrimination relating to people with a mental illness – both in the justice system and the community.
- Policy and program evaluation should focus on measurement of both outcomes and impacts, relating these back to policy and program objectives and assessing these against the costs of the program.

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7

Essential considerations: groups with complex needs

7. ESSENTIAL CONSIDERATIONS: GROUPS WITH COMPLEX NEEDS

Considering how policy and programs can address diverse needs is an essential part of developing a comprehensive, holistic approach to diversion and support. In addition to general strategies to respond to diversity, identifying the complex needs of particular groups is an important step in developing best-practice programs.

This section provides insight into key issues that must be taken into account when developing programs that will include as participants Indigenous Australians, young people and people from culturally and linguistically diverse backgrounds. While these groups are the selective focus for these guidelines, other groups also have complex needs, for example women, older people and people with co-occurring intellectual disabilities or cognitive impairment.

7.1 Aboriginal and Torres Strait Islander peoples

The extent of disadvantage faced by Indigenous Australians is well documented, including relatively poorer outcomes in terms of health and wellbeing, housing, education, economic participation and employment.¹ The number of years of healthy life lost (incorporating disability and mortality) due to mental disorders is estimated to be 1.6 times greater for Indigenous than non-Indigenous Australians.² Indigenous people in the community are twice as likely to report experiencing psychological distress than non-Indigenous Australians.³ Rates of suicide are also higher – three to four times higher in young Indigenous men, and five times higher in young Indigenous women.⁴

While the proportion of prisoners who are Indigenous varies significantly between jurisdictions, in all jurisdictions it is clear that Indigenous people are overrepresented. Indigenous Australians make up 24 per cent of Australia's prison population as a whole,⁵ despite accounting for only 2.4 per cent of the population.⁶ The Human Rights and Equal Opportunity Commission has noted that

the over-representation of Indigenous people in custody, in large, is due to historically derived disadvantage and ongoing systemic discrimination. Experiences of separation through the criminal justice system, juvenile justice and care and protection systems, combined with dysfunctional behaviours such as family violence and alcohol and other substance misuse are indicative of the inequality and extreme marginalisation faced by Indigenous Australians.⁷

Although data on the mental health of Indigenous people in custody is limited, the most recent research is strongly suggestive of high rates of complex mental health problems.⁸ The double disadvantage flowing from gender and Aboriginality experienced by Indigenous women must be acknowledged.⁹ Aboriginal women with mental illness are the most disadvantaged group among all prisoners.¹⁰

While the principles outlined earlier apply to programs focussed on Aboriginal and Torres Strait Islander people, the extent of Indigenous disadvantage and the great diversity of disadvantage among Indigenous communities suggest there are a number of additional issues that should be taken into consideration.¹¹ These include:

- adopting the social and emotional wellbeing framework is generally preferable
- experiences of trauma, loss and grief are frequent
- alcohol and substance use has substantial impacts
- culturally safe services are a necessity
- cultural validation improves reliability of assessments
- partnership with community and family underpin Indigenous policy
- racism and discrimination impact on mental health
- mental health and criminal justice contact profiles differ from non-Indigenous.

These issues should be considered in the light of the guiding principles set down in the *Ways Forward* report and endorsed in the *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Well Being (2004–2009)*.¹³

7.1.1 Adopting the social and emotional wellbeing framework is generally preferable

Indigenous assessments, diagnoses and treatments of mental health and illness build on the core concepts of 'social and emotional wellbeing' (SEWB) an established clinical paradigm recognised by the World Health Organisation and in use in many international jurisdictions. Social and emotional wellbeing is founded on a holistic concept of achieving mental health outcomes that build on the core concepts of prevention, early intervention, recovery, social inclusion and healing.¹⁴

Where conventional western models of mental illness identify the problem within an individual, the SEWB framework is holistic in nature and looks to broader social processes to locate dysfunction. Healing is defined as "a spiritual process that includes therapeutic change and cultural renewal"^{15,16} It is not helpful to focus on a single aspect of an Indigenous person's life circumstances in isolation from other areas of life.¹⁷

Concepts of mental ill health for Indigenous people will always need to take into account the entirety of one's experiences, including physical, mental, emotional, spiritual and... cultural states of being.

Relationship to country is another determinant of Indigenous health: 'country' in this context refers to "an interdependent relationship between Indigenous peoples and their ancestral estates". Return to homeland and caring for country have been associated with improved wellbeing.^{19,20}

Some problems recognised within a social and emotional wellbeing framework are not captured through a biomedical approach.²¹ Treatment responses to mental health problems that do not consider the holistic nature of the SEWB framework may also be inappropriate and may in fact exacerbate a person's problems.²²

Best practice responses to mental health in Aboriginal and Torres Strait Islander communities build on Indigenous understandings of social and emotional wellbeing and recognise the impact on assessment, treatment and recovery. Diversion and support programs should respectfully draw on both Indigenous and non-Indigenous expertise in developing holistic responses within a framework of social and emotional wellbeing.

7.1.2 Experiences of trauma, loss and grief are frequent

The number and frequency of past experiences of trauma, loss and grief is greater in Indigenous prisoners than non-Indigenous and the nature of those experiences is markedly different to those of other Australians.²³

High rates of mortality (often in traumatic circumstances) and family break-down lead to repeated exposure to traumatic experiences which, over time impacts on individual and community coping mechanisms.^{24,25}

Experiences of trauma include situational, cumulative and intergenerational trauma.^{26,27} Higher rates of subjective distress not adequately explored in mainstream mental health approaches to assessment and diagnosis relating to Indigenous-specific issues include loss of identity, acculturation stress and spiritual sickness. These issues can be exacerbated in criminal justice settings and require specialist responses and interventions.²⁸

Being a member of the 'Stolen Generation' has also been associated with higher rates of imprisonment,²⁹ while the ongoing impact of colonisation and historical trauma has been characterised as the major cause of Aboriginal loss and grief experiences.³⁰

7.1.3 Alcohol and substance use has substantial impacts

Alcohol and substance use is a significant issue among Aboriginal and Torres Strait Islander people who come into contact with the criminal justice system.³¹ While Aboriginal people are more likely not to drink than non-Indigenous Australians, those who do are more likely to do so at risky levels.³²

Comorbidity of mental health problems and alcohol or substance use significantly increases the complexity of providing service responses and can also hamper access to services. In some circumstances, exclusionary criteria applied by mental health and drug and alcohol services can lead to denial of service to people with comorbid problems.

Holistic diversion and support programs for justice-involved Indigenous people with mental health problems must address high levels of comorbid substance use. Compared to those with one diagnosis or disorder, people with comorbid substance and mental health issues tend to have higher rates of criminal justice system involvement, lower social functioning, more severe psychiatric symptoms and higher levels of substance use. They also have lower treatment compliance, poorer treatment outcomes and higher rates of hospitalisation and relapse.³³

7.1.4 Culturally safe services are a necessity

Culture influences decisions about accessing health services, acceptance and adherence to treatment and follow up, the impact of illness prevention and health promotion and subjective evaluation of quality of care.³⁴ A useful definition of cultural safety is that

a client feels that their cultural, social and human values are respected, and that an organisation providing services to that client re-orient its institutional practices, values, resource and governance arrangements accordingly.³⁵

Employment of Indigenous people contributes significantly to culturally safe services and should be a priority for Indigenous focused programs. However, in utilising the cultural knowledge of their Indigenous staff, services should not abdicate responsibility for cultural safety.³⁶ Cultural brokerage approaches may provide a means for respectfully utilising the cultural knowledge of staff within an organisation.³⁷ Cultural safety requires collective effort at all levels to identify, review and modify practices that conflict with Indigenous culture and values.³⁸

7.1.5 Cultural validation improves reliability of assessments

Best practice assessment of social and emotional wellbeing problems in Aboriginal and Torres Strait Islander people uses culturally validated assessment tools and processes and takes place in a culturally safe context.

Application of Western notions of mental illness to Indigenous people can lead to misdiagnosis, under-diagnosis and over-diagnosis where Indigenous people are assessed outside their cultural context.³⁹ For example, some problems recognised within a social and emotional wellbeing framework are not captured within a biomedical approach to psychiatric assessment and some cultural behaviours may be confused with symptoms of mental illness.^{40,41} Consequently, responses to mental health problems identified via culturally inappropriate assessment may be ineffective or may have a detrimental effect.⁴²

7.1.6 Partnership with community and family underpin Indigenous policy

Meaningful partnership between Indigenous-led organisations and communities and justice, health and human service agencies is the “cornerstone” for effective mental health diversion and support initiatives for Indigenous people.⁴³

The need for services to come to grips with the diversity and complexity of Indigenous culture in order to deliver culturally safe services provides an ethical and practical rationale for such partnerships.^{44,45} A second reason is the importance of self-determination and community empowerment for the communities that are home to Indigenous people diverted from the justice system.^{46,47,48} The seminal *Ways Forward* report observed that:

Self-determination is central to the provision of Aboriginal health services... which must be developed in response to identified needs and provided by Aboriginal organisations whenever possible. Responsibility for programs and services must rest with Aboriginal people. The right and process of self-determination is crucial to ensuring the harmony of these relations.⁴⁹

The many examples of strong and successful Indigenous communities highlight the potential value of ‘whole-of-community’ responses to mental illness and associated social issues.⁵⁰

At the individual level, the importance of kinship and family to Indigenous culture and healing should be recognised when responding to an Aboriginal or Torres Strait Islander person’s problems.⁵¹ Strengthening social supports can reduce contact with the justice system.⁵² Diversion and support programs should work with and support family and their community to in turn support the person at risk.

7.1.7 Racism and discrimination impact on mental health

Racism and discrimination are experienced at systemic and interpersonal levels. While the human rights implications are clear, the individual experience of racism and discrimination can “elicit feelings of anger and hostility, erosion of self worth, and damage to a person’s sense of identity” and it is unsurprising that experiences of racism and discrimination have been found to significantly impact on mental health and wellbeing.^{53,54}

Justice-involved Indigenous people perceive higher levels of racism and discrimination than non-Indigenous.⁵⁵ Systemic racism within the justice system, where it exists, may contribute to higher rates of imprisonment and lower access to diversion,^{56,57} although this is not universally accepted.⁵⁸

There are currently relatively few Indigenous-specific diversion and support programs at police or court level. There is anecdotal evidence that exclusion criteria that disproportionately exclude Indigenous offenders are a key barrier to accessing 'mainstream' programs.⁵⁹

Best practice diversion and support programs should actively take steps to address both the perception and reality of racism and discrimination including empowerment, advocacy and modelling actions against discrimination.

7.1.8 Mental health and criminal justice contact profiles differ from non-Indigenous

Although reliable data on mental illness in Aboriginal and Torres Strait Islander people is not readily available and there are issues with cross cultural assessment and screening,^{60,61} it is clear that experiences of psychological distress are substantially higher in community samples of Indigenous people than non-Indigenous people.⁶²

Incarcerated Indigenous men report levels of psychological distress and rates of mental illness similar to that of non-Indigenous prisoners,^{63,64} but are less likely to have been diagnosed or to have received past support for mental health than non-Indigenous prisoners.⁶⁵ Aboriginal women in prison, on the other hand, are more likely than non-Indigenous female prisoners to have a diagnosis of psychosis, depression or obsessive compulsive disorder and have higher levels of psychological distress.⁶⁶

Indigenous people have a significantly different profile of contact with the criminal justice system. This includes a higher likelihood of receiving a prison sentence on appearance in court, which has been variously attributed to higher rates of conviction for offences involving violence, higher rates of recidivism and systemic racism.^{67,68}

Indigenous people are also more likely to come into contact with the criminal justice system at an earlier age.⁶⁹ The rate of juvenile detention is 28 times higher among Indigenous Australians than non-Indigenous.⁷⁰

Higher rates of justice system contact, a younger Indigenous demographic (half of the Indigenous population is younger than 20)⁷¹ and the difficulties associated with modifying 'trajectories' once set,⁷² together mean that diversion programs for Indigenous people should have a strong emphasis on early diversion and intensive support in the context of a person's community. The demographic profile of Indigenous Australia suggests that prevalence of mental illness and need for services are likely to increase significantly over the coming decades.⁷³

7.2 Young people

This resource does not attempt a comprehensive examination of issues associated with diversion programs undertaken in a juvenile justice context. However, the transition between adolescence and adulthood is often the period when mental illness commonly develops and first contacts with the criminal justice system occur. Mental health diversion and support programs that engage with young people should consider the following key issues:

- offending behaviour often signals an emerging mental illness
- family involvement is often essential
- services should be inclusive, youth friendly and age appropriate
- continuity between adolescent services and adult services is critical.

It is important to note also that a very high proportion of young people in contact with the criminal justice system are Indigenous and that these issues will overlap with those highlighted in 7.1 for Aboriginal and Torres Strait Islander youth.

7.2.1 Offending behaviour often signals an emerging mental illness

Young people who are in contact with the justice system may be experiencing the early signs of mental illness. The age of onset for many mental illnesses is adolescence and young adulthood,⁷⁴ which for many coincides with the age of first contact with the criminal justice system.⁷⁵

Few young people in detention take advantage of available health care in the community prior to admission.⁷⁶ As a result, their mental health and substance misuse problems are frequently undiagnosed. For many young people, the assessment process available to them through the criminal justice system is often the first time they have had a comprehensive medical and mental health assessment.

Detection of emerging mental illness can be complicated by a lack of prior symptoms or treatment history and developmental issues. In some cases symptoms are sub-clinical and do not meet formal diagnostic criteria. Consequently, mental health promotion, illness prevention and early intervention strategies should underpin programs for young people.

Criminal justice systems should be alert to the likelihood that offending behaviour may be a manifestation of mental health problems, especially given the very high rates of mental illness found in justice-involved young people. Overall prevalence of mental disorder (excluding conduct disorder) has been estimated at between 40-70 per cent in juvenile offenders.⁷⁷ Comorbidity of multiple psychiatric diagnoses and substance abuse is common among young offenders^{78,79} and there is a strong correlation between the number of diagnoses and offender status.⁸⁰ The significant majority of juvenile offenders have experienced trauma or neglect in childhood,^{81,82} contributing to elevated rates of post-traumatic stress disorder.⁸³ Intellectual disability also features strongly in juvenile delinquency.^{84,85}

Australian and international research indicates that young people who are involved with the criminal justice system are more likely to have mental disorders than other young people, with high rates of depression, anxiety, attention deficit hyperactivity disorder, psychosis and substance use.^{86,87,88,89,90}

Young females are more likely to have a psychiatric diagnosis than their male counterparts^{91,92} and the prevalence of depression among incarcerated young women and adolescents is particularly high.⁹³

7.2.2 Family involvement is often essential

Families and significant others of a young person with developing mental health problems may have valuable knowledge of a person's general circumstances and can assist with identifying the trajectory of illness. They may have insights into approaches which might be likely to engage a person, particularly in cross-cultural contexts. Family and significant others are often in a position to help a young person maintain engagement with treatment services and support their recovery.

In some circumstances, family issues may have contributed to or exacerbate a person's mental illness and offending behaviour. When appropriate, diversion and support programs should work with a young person and their family to repair and strengthen relationships.

Where it is not possible or inappropriate to involve a young person's family, independent support and advocacy is important to ensure equitable access to programs. Legal guardians, Children's Commissioners or others fulfilling similar functions may have a key role to play.

7.2.3 Services should be inclusive, youth friendly and age appropriate

Young people who end up in contact with the justice system are commonly under serviced by other support sectors^{94,95,96} and may be unable to access other support services because of exclusion based on behavioural criteria (among other factors). This is a particular issue where prevalence of behavioural disorders such as conduct disorder is estimated to be above 50 per cent.⁹⁷

Concerns about confidentiality, shame and embarrassment about mental illness are powerful barriers to accessing services for young people, as are services which are not 'youth friendly'.^{98,99,100}

Mental health, drug and alcohol and other services associated with diversion and support initiatives for young people with mental illness should adopt a flexible, inclusive approach in preference to strict exclusion criteria and should be appropriate to the age of the client group. This includes service settings which are youth friendly: services which employ staff with a strong understanding of developmental issues; take into account practical issues such as lack of access to transport; focus on supporting young people to come to terms with their diagnosis and associated feelings of shame; and develop positive options for recovery.

7.2.4 Continuity between adolescent services and adult services is critical

The transition between child and adolescent services and adult services can increase the risk of young people losing contact with support services. People mature at different rates and strict age eligibility criteria may have the effect of prematurely ceasing specialised adolescent and young adult supports. Services offered by adult services to young people should be appropriately flexible to their developmental needs; abrupt cessation of supports after transition should be avoided.

Diversion and support programs which operate at the boundary of adolescence and adulthood can support continuity between child and adolescent services and adult services in both the mental health and justice sectors. It is preferable that continuous and connected services are provided regardless of where the young person is located in the justice or mental health system.

Strategies may include adopting flexible eligibility criteria based on individual need; developing protocols aimed at seamless service provision; and ensuring that critical information is shared between youth and adult services and between mental health and justice sectors.

7.3 People from culturally and linguistically diverse backgrounds

Twenty per cent of prisoners were born outside of Australia, including approximately 14 per cent who were born in a country where English is not the main language.¹⁰¹ While community surveys have found migrants have lower rates of mental illness than Australian-born people,¹⁰² some smaller culturally sensitive studies have found higher rates of illness, suggesting that "Anglo-centric" screening and assessment may lead to under diagnosis or misdiagnosis.^{103,104}

Some additional considerations in the development of diversion and support programs for people from culturally and linguistically diverse (CALD) backgrounds include:

- cultural safety is essential
- discrimination and stigma affect mental health
- community engagement is vital
- language barriers impact on service access and delivery
- humanitarian migrant experiences can have significant impacts.

7.3.1 Cultural safety is essential

Best-practice diversion and support programs which serve people from CALD backgrounds should provide services in a culturally safe environment. Cultural safety recognises that institutions, systems and individuals carry with them cultural values and assumptions. Culturally secure services aim to provide health and social services that are compatible with the cultural values of each consumer. It focuses on systemic responsiveness rather than individual cultural awareness.

Imposition of cultural beliefs and values on an individual in contact with a service system can lead to disempowerment and alienation for culturally diverse individuals.¹⁰⁵ Similarly, lack of cultural competence can also be disempowering for service professionals, creating a "disabling hesitancy and inertia in their practice".¹⁰⁶ The combined outcome can be disengagement from the treatment process and worse outcomes.

The use of culturally appropriate explanatory models for mental illness is important to ensure that programs and interventions are relevant to the person they are designed to assist. Utilising such models can also assist with differentiating behaviours which are cultural and behaviours which are symptomatic of mental illness.¹⁰⁷

7.3.2 Discrimination and stigma affect mental health

Experiences of discrimination and racism have also been strongly associated with mental illness in CALD communities.^{108,109} Perceptions of discrimination among ethnically diverse groups can also lead to under-utilisation of mental health services,^{110,111} with implications for recovery and long term wellbeing.

In some cultural groups, there may be significant stigma attached to mental illness which acts as a barrier to service engagement, creates feelings of shame and embarrassment and reduces the support available from a person's community.

7.3.3 Community engagement is vital

Culturally safe diversion and support practices services should be planned, developed and delivered in consultation with key community leaders and cultural experts. They should anticipate and work with different community understandings of mental illness and degrees of acceptance of people with mental health problems.

Engaging communities can decrease perceptions of discrimination; build relationships between community and diversion-linked agencies; and increase a community's sense of ownership of programs. Community consultation forms the basis for understanding cultural issues, building culturally appropriate responses and developing community capacity.

Ethno-specific agencies also have a role to play in delivering or supporting delivery of interventions to justice-involved people with mental illness and their families. This role may also take the form of service partnerships between ethno-specific multicultural and mainstream providers.

7.3.4 Language barriers impact on service access and delivery

Using professionally qualified interpreters who have an understanding of mental health and legal contexts is best practice. Employing bi-lingual staff within diversion and support programs who have an appropriate interpreting qualification may not be practical, so sessional interpreters are the next-best option. In this case it is important that justice and health service staff are trained in working with interpreters.

In general, family members or other, non-professional, non accredited people should not be used as interpreters, although their presence alongside a professional interpreter may sometime be helpful.

Diversion and support programs should also have written information readily available in the main languages spoken in their area of operation, prepared by people with an understanding of both linguistic and cultural nuances. Some ethnic groups may prefer to have this information supplemented by information in oral form, such as through community information sessions.

7.3.5 Humanitarian migrant experiences can have significant impacts

Mental health diversion and support programs should consider the impact of the refugee experience, particularly the psychological sequelae of past trauma. The majority of humanitarian migrants have experiences of social dislocation and significant trauma, which, when combined with the substantial difficulties associated with adjusting to life in Australia may predispose them to mental illness.^{112,113,114,115}

A second key consideration for justice-system programs dealing with humanitarian migrants is the possible fear or mistrust of people in positions of authority because of poor experiences in the country of origin or within transit countries. This can lead to negative and stressful interactions with the justice system.¹¹⁶

Notes to this section

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8

Conclusion

8. CONCLUSION

The appropriate diversion and support of people who have a mental illness is of growing interest to governments internationally. In Australia, examples of locally developed programs are also on the rise.

These guidelines are not intended to be prescriptive of policy. Rather, they recognise a groundswell of interest and seek to provide a consistent starting point for mental health diversion and support policy and programs in Australia. They provide a guide to the critical issues and important considerations that should be taken into account when working in this area and provide pointers along the way to key resources that make up the knowledge base in the field.

Diversion and support is a complex area in which to develop effective policy. The complexity of the interactions between service sectors, the often politically charged nature of the law and order debate and the difficulties in securing resources in a competitive policy environment present continual challenges.

To be sustainable in the long term, diversion programs need to prove their value in this difficult operating environment. This will require adherence to the definition of best practice articulated within these guidelines and adapt the best available evidence to the context of implementation; achieving the best possible outcomes with a high degree of consistency and efficiency; and fostering a culture of continuous improvement through innovation and evaluation.

Most importantly, these guidelines confirm the importance of collaboration, communication and coordination. Mental health diversion and support programs, by definition, operate at the overlap of the justice, health and human services system. Such initiatives require meaningful and continued dialogue across system boundaries – these guidelines may provide the basis for beginning that conversation.



9

Glossary of key terms

9. GLOSSARY OF KEY TERMS

Best practice: Best practice approaches adapt the best available evidence to the context of implementation; achieve the best possible outcomes with a high degree of consistency and efficiency; and foster a culture of continuous improvement through innovation and evaluation.

Carer: A person who has a non-professional caring role in relation to a family member or other loved one who has a mental illness.

Consumer: A person with personal experience of a mental illness.

Criminogenic risk factors: Those factors which when present, contribute to increased likelihood of offending behaviour. Dynamic risk factors are those which are changeable, including unemployment, accommodation problems and current substance use. Static risk factors are those which cannot be altered, such as a history of past offending or substance use.

Cultural safety: Cultural safety recognises that institutions, systems and individuals carry with them cultural values and assumptions. Culturally secure services aim to provide health and social services that are compatible with the cultural values of each consumer. Cultural safety focuses on systemic responsiveness rather than individual cultural awareness.

Diversion and support: Mental health diversion and support aims to improve wellbeing and reduce recidivism in people whose mental illness significantly contributes to offending behaviour by providing interventions and support targeted to their illness and related problems in place of, alongside, or integrated with other criminal justice system processes.

Mental illness: Definitions of mental illness vary widely, often depending on the context in which the definition will be applied (for example for legal, social, disability, psychiatric purposes).[‡] These guidelines adopt the broad definition of mental illness provided in the National Mental Health Policy:

A clinically diagnosable disorder that significantly interferes with an individual's cognitive, emotional or social abilities. The diagnosis of mental illness is generally made according to the classification systems of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the International Classification of Diseases (ICD).

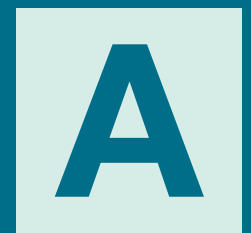
Recovery: a personal process of changing one's attitudes, values, feelings, goals, skills and roles. It involves the development of new meaning and purpose and a satisfying, hopeful and contributing life as the person grows beyond the effects of psychiatric disability. The process of recovery must be supported by individually identified essential services and resources.

Social and emotional wellbeing: Social and emotional wellbeing is a concept that attempts to encompass the Indigenous holistic view of health. It also seeks to recognise Aboriginal and Torres Strait Islander peoples' particular experiences of grief and trauma through colonisation, separation from families and loss of land and culture.

[‡]Karras, M, McCarron, E, Gray, A and Ardansinski, S (2006). *On the edge of justice, the legal needs of people with a mental illness in NSW*, Sydney: Law and Justice Foundation of NSW.



APPENDIX



Examples of good practice

APPENDIX A: EXAMPLES OF GOOD PRACTICE

This collection of case studies aims to provide examples of good practice in the field of diversion and support for people with mental illness who come into contact with the criminal justice system.

Where possible, examples with published evaluations are provided. However, there is a paucity of Australian programs that meet this criterion. Consequently, a number of case studies have been included because although not formally evaluated, they appear to apply aspects of the 10 principles articulated within this document and are considered to exemplify good practice.

While a recent review of Australian diversion initiatives for Indigenous people identified 15 Indigenous-specific programs,[§] none was focused on mental health problems. However the Koori Court in Victoria is included as an example of an Indigenous-specific program with a holistic approach.

The examples highlight diversion and support at key stages of the criminal justice continuum, up to the point of sentencing. The programs profiled include:

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[§] Joudo, J (2008), Responding to substance abuse and offending in Indigenous communities: review of diversion programs, Australian Institute of Criminology Research and Public Policy Series No. 88.

Project Link (New York, United States)

This case study provides an example of a wide spectrum program that includes an early intervention focus for those at risk of justice system involvement.

Project Link in Rochester, New York, is a multi-agency consortium led by the University of Rochester Department of Psychiatry, spanning health care, criminal justice and social services systems. It aims to prevent involvement of individuals with severe mental illness (specifically psychotic disorders) from entering the criminal justice system and focuses on the group which may have been labelled as 'problem patients' or 'treatment resistant' because of the challenges involved in engaging them with traditional community treatment and support.

Project Link acts as a central point of referral and entry to care for individuals who are at-risk for criminal justice involvement. Referrals can originate from the legal system (including police, courts, prosecutions, defence lawyers), community, in-patient mental health services and emergency services, as well as from community agencies including homeless shelters, church agencies and advocacy groups.

The breadth of referral sources means that Project Link supports people with mental illness at all points of the criminal justice continuum, although eligibility criteria include a requirement that the person have at least one previous arrest.

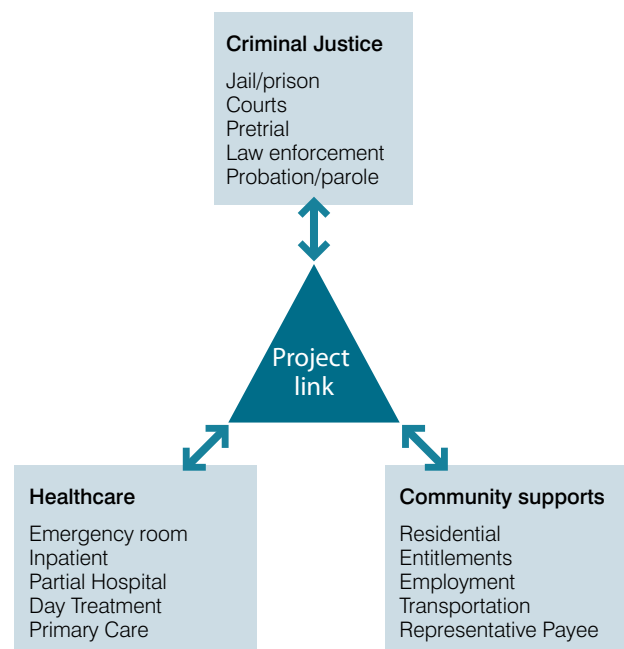
The program incorporates principles of assertive community treatment and intensive case management. Key components of the program include a coordinating and collaborating role with other agencies and referral services, a mobile treatment team including a forensically trained psychiatrist and mental health nurse practitioner, along with an array of supervised residential programs for people with substance use problems.

The program places special emphasis on engaging with people from diverse backgrounds, and the program's success in this area has also been partially attributed to a very high proportion of staff drawn from culturally and linguistically diverse backgrounds.

Outcomes

A retrospective analysis tracked 44 individuals in their first year enrolled in Project Link. It found a reduction in the average number of days in jail (from 104 to 45) and hospital (114 to 8) and the average cost of care per individual fell from US\$74,500 one year prior to enrolment to US\$14,500 one year after enrolment. The evaluation also noted significant improvements in the patients' ability to care for themselves, program satisfaction and reduction in substance use disorders.

Figure A1 Project Link: Multi-point service integration**



Websites

www.urmc.rochester.edu/community-health/programs/highlighted-programs.cfm

www.consensusproject.org/program_examples/project_link

** Source: Weisman, RL, Lamberti, JS, Price, N (2004), "Integrating criminal justice, community health care and support services for adults with severe mental disorders", *Psychiatric Quarterly*, vol. 75, no. 1, pp 71-85.

Evaluation

Weisman, RL, Lamberti, JS, Price, N (2004), "Integrating criminal justice, community health care and support services for adults with severe mental disorders", *Psychiatric Quarterly*, vol. 75, no. 1, pp 71-85.

Lamberti, JS, Weisman, RL, Schwarzkopf, SB, Price, N, Ashton, RM, Trompeter, J (2001), "The mentally ill in jails and prisons: towards an integrated model of prevention", *Psychiatric Quarterly*, vol. 72, no. 1, pp 63-77.

Commentary

Loveland, D and Boyles, M (2007), "Intensive Case Management as a Jail Diversion Program for People with a Serious Mental Illness", *International Journal of Offender Therapy and Comparative Criminology*, vol. 51, no. 2, pp 130-50.

Anonymous (1999), "Prevention of Jail and Hospital Recidivism Among Persons With Severe Mental Illness", *Psychiatric Services*, vol. 50, no. 11, pp 1477-80.

Lamberti, JS, Weisman, R and Faden DI (2004), "Forensic Assertive Community Treatment: Preventing Incarceration of Adults with Severe Mental Illness", *Psychiatric Services*, vol. 55, no. 11, pp 1285-93.

Psychiatric Emergency Response Team (California, United States)

This case study demonstrates a mobile crisis team providing a first-responder service to incidents involving suspected mental illness. It highlights the value of strong governance and a 'partnership' approach.

Psychiatric Emergency Response Teams (PERT) in San Diego County, California are specially trained police officers partnered with mental health professionals who respond to situations involving people with mental illness. The PERT program aims to refer people with mental illness in the community who come into contact with police to the most appropriate service available and in the least restrictive environment possible.

PERT teams are generally dispatched when mental health concerns are identified in 911 calls, including suicide calls, welfare checks, domestic violence calls, and inappropriate or bizarre behaviour.

Police officers selected for PERT undergo 80 hours of training, including training relating to assessment, emergency response, mental illness, community-based organisations and the programs and services available throughout San Diego and other topics related to mental health, substance abuse, homelessness and crisis response.

The PERT program emerged as a partnership of local police and mental health agencies, with an independent not-for-profit organisation established to act as the funding, governance and management vehicle for the program ("PERT Inc"). A number of multi-agency, collaborative committees operate under the auspices of PERT Inc, providing a forum for policy and operational issues to be discussed and problems resolved. An advisory committee includes representation from mental health stakeholders in the community, including family or carers and consumer groups.

Outcomes

In its first two years of operation, PERT responded to 3000 incidents, with only one per cent of these resulting in incarceration. The program has also been attributed with significant cost-savings in responding to mental health crises.

Websites

www.nationalcitypd.com/divisions/patrol/pert
www.comresearch.org/programs/pert/index.asp?id=16

Evaluation

No published evaluation.

Commentary

Hartford, K, Carey, R and Mendonca, J (2006), "Pre-arrest Diversion of People with Mental Illness: Literature Review and International Survey", *Behavioral Sciences and the Law*, vol. 24, no. 6, pp 845-56.

Reuland, M and Cheney, J (2005), *Enhancing success of police-based diversion programs for people with mental illness*, Delmar, NY: GAINS Technical Assistance and Policy Analysis Centre for Jail Diversion.

Emergency Services and SA Health MoU (SA)

This case study provides an example of a high level agreement on protocols and procedures for dealing with mental health crisis situations in the community.

In 2006, the South Australian Department of Health (DH), South Australia Ambulance Service (SAAS), Royal Flying Doctor Service (RFDS) and South Australia Police (SAPOL) signed a Memorandum of Understanding (MOU) which provides the basis for safe and coordinated response to people with mental illness. The MOU is signed and supported at the organisational level, but local and strategic processes are implemented to facilitate, monitor and evaluate the implementation of the MOU.

The objectives of the MOU are to ensure individuals with known or suspected mental illness, or who exhibit behaviours of community concern, are identified, assessed, treated and, if appropriate, transported to a health facility in a timely manner. It also seeks to ensure that service providers work together in a collaborative manner which addresses the safety of the individual, the workers involved and the community.

Specific outcomes are to provide:

- a clear reflection of legislative requirements
- a clear delineation of accountabilities
- operational principles
- agreed standards for the provision of services
- interagency cooperation with respect to service delivery, joint problem solving and information sharing
- improved access to assessment and care
- monitoring of dispute resolution and review processes.

Principles underpinning the MOU include acknowledgement of the right of people to receive culturally appropriate treatment and care in the least restrictive environment and to minimise interference with those rights so far as is consistent with the proper protection and care of the individual and with the protection of the community.

The management of safety is given highest priority. The MOU provides operational protocols for the involvement of different agencies depending on the situation and degree of safety risk assessed. A corollary objective is reducing the inappropriate involvement of police in managing people with mental illness. Primary responsibility for assessment, detention, transport and treatment of people with mental illness lies with health services.

Police involvement is generally a last resort, but may be requested where a safety risk assessment has determined there is a current or imminent serious threat to the safety of an individual, carer, health practitioner or any other person or property.

Where police are first-responders, an operational protocol provides for attendance of mental health services as soon as possible, with a benchmark of 60 minutes. Where there is a requirement for a clinical assessment to issue a detention order (when a person is presented by SAPOL) at an Emergency Department a benchmark of 30 minutes for the process to be completed applies.

The revised *Mental Health Act 2009* (SA) now provides increased powers to ambulance officers, mental health clinicians and RFDS personnel to apprehend and transport people. These powers were previously vested only in police. The Act precludes the use of police to conduct transports between approved treatment centres. If safety issues exist police provide a supporting role. The Act also for the first time recognises the Memorandum of Understanding. Negotiations for a new Memorandum of Understanding have commenced and the MOU will reflect the new Act.

Outcomes

The MOU has led to development of operational protocols and service standards for each of the signatory parties. Although significant improvements have been achieved in the assessment benchmark, the benchmark for field response times are not always achieved. The MOU has led to the creation of ambulance patient transfer officers (PTOs) to assist in the transfer of patients on RFDS aircraft and during other inter hospital transfers. In 2009, it was estimated that approximately 100-130 transfers each month no longer required the use of police.

The MOU also provides a foundation for collaborative improvement efforts across emergency and mental health services, such as the Clinical Practice Improvement (CPI) project. The CPI project is lead by the Western Assessment and Crisis Intervention Service but involves police, ambulance and mental health services. The project utilises the Rapid Plan-Do-Study-Act Cycle methodology to identify and test innovative means of addressing problems that impact on communication between services. Early indications are that this has contributed to improved communication between emergency and mental health services, a reduction in police and ambulance involvement in mental health crisis situations and significant costs savings through improved service efficiencies.

Website

The MOU is located at www.health.sa.gov.au/mentalhealth/Default.aspx?tabid=36

Evaluation

No published evaluation.

Commentary

Sorgini, E, Bailie, M; Central Northern Adelaide Health Service (2009), *Clinical Practice Improvement (CPI) Project – Improving Communication Pathways between MHS, SAAS and SAPOL*, PowerPoint presentation available at www.publications.health.sa.gov.au/mhs/52/

NSW Police Force Mental Health Intervention Team

This case study provides an example of an Australian adaptation of the Crisis Intervention Team model.

The NSW Police Mental Health Intervention Team (MHIT) model commenced as a two year pilot in 2007 and is based on the Crisis Intervention Team (CIT) model which emerged out of Memphis, USA. A successful pilot led to endorsement as a permanent component of NSW Police Force Policy and Programs Command.

The CIT approach was adapted to the NSW operating environment and a partnership was established with key agencies including NSW Health.

The objectives of the MHIT approach are to:

- reduce the risk of injury to police and mental health consumers when dealing with mental health related incidents
- improve awareness amongst front line police of the risks involved in the interaction between police and mental health consumers
- improve collaboration with other government and non-government agencies in the response to, and management of, mental health crisis incidents
- reduce the time taken by police in the handover of mental health consumers into the health care system.

The program involves a four day intensive training program for police. MHIT training aims to ensure course participants work with mentally ill or disordered people in a sensitive, safe and efficient manner. It provides participants with tools such as communication strategies, risk assessment, de-escalation and crisis intervention techniques. It gives participants an understanding of mental health legislation applying in NSW, as well as the Memorandum of Understanding between the NSW Police, Ambulance Service and Department of Health. The training also provides police officers with operational advice in relation to policing and mental health issues.

Local Protocol Committees (LPCs) comprise of local representatives from Health (Mental Health, emergency department, hospital security and Drug and Alcohol), Police and Ambulance. The role of LPCs is to develop and implement local interagency operational protocols and agreements within the bounds of a state-wide Memorandum of Understanding.

Consumer representatives were engaged as part of a consultation group to the program and in the development of training materials and communications activities.

Outcomes

By the end of 2009, 140 operational police had completed MHIT training, in addition to 53 Mental Health Contact Officers located in each Local Area Command in NSW. The expanded rollout is planned to reach 327 officers in 2010 and 1500 in total by 2015.

Website

http://www.police.nsw.gov.au/community_issues/mental_health

Evaluation

The MHIT program has been independently evaluated, with the results available in early 2010. Although not publicly available, interim evaluation results were positive following pilot site implementation, leading to the current state-wide roll out.

Commentary

Laing, R, Halsey, R, Donohue, D, Newman, C and Cashin, A (2009), "Application of a Model for the Development of a Mental Health Service Delivery Collaboration Between Police and the Health Service", *Issues in Mental Health Nursing*, vol. 30, no. 5, pp 337-41.

Mental Health Intervention Project (QLD)

This case study provides an example of a structured approach to inter-agency collaboration to improve emergency services' recognition and management of mental health crisis situations.

The Queensland Mental Health Intervention Project (MHIP) aims to prevent and safely resolve mental health crisis situations through enhanced co-operation, collaboration and understanding between the Queensland Police Service (QPS), Queensland Health (QH), and the Queensland Ambulance Service (QAS).

The project involves a two-tiered response. First Response Officers from the QPS and QAS are trained in recognising and de-escalating crisis situations in which mental illness is a factor. Then teams of MHIP coordinators from QH, QPS, QAS are located in each Health District throughout Queensland to build capacity for inter-agency coordination at initial crisis response and subsequent follow up.

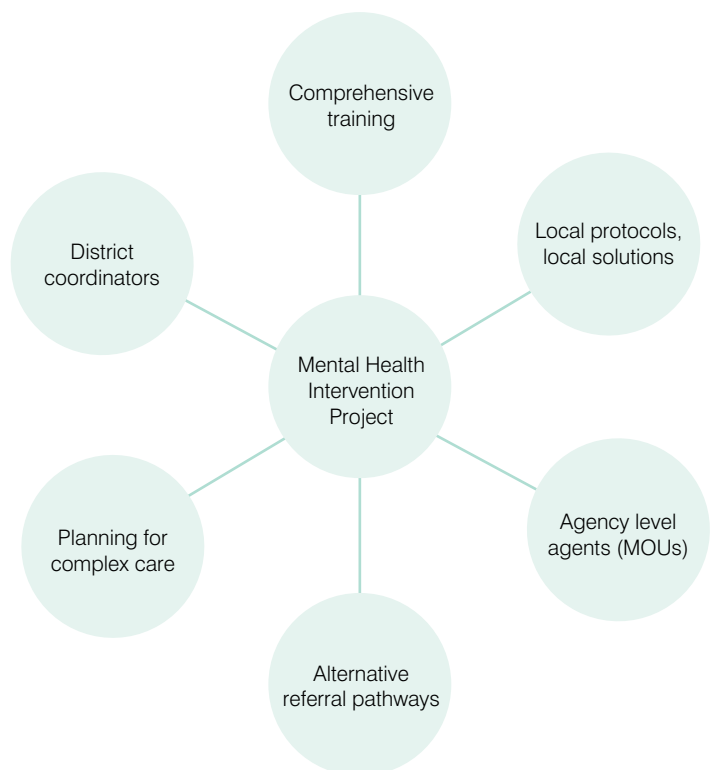
Key activities of the MHIP coordinators include case management; communication; collaborative service and community development; training and evaluation; assessment and support; and crisis intervention. The coordinators use a consultation and liaison model to increase the capacity of District services to prevent and safely resolve mental health crisis situations. These coordinators come together to identify issues, discuss complex cases, develop preventative interventions (such as pre-crisis plans) and identify alternative pathways of referral.

A major achievement of this project has been enhanced information sharing between the QPS and QH which is facilitated through the *Health Services Act 1991* (QLD) and supported by memoranda of understanding. Case management of persons with mental illness who are in crisis is conducted across the state to enhance emergency services response to these situations.

Outcomes

As at November 2009, a total of 6,947 Queensland police had received First Response Officer training focused on developing skills in recognising mental illness in crisis situations and enhancing capacity to deploy appropriate communication skills to de-escalate these situations. The number of officers trained in this program is now more than five times greater than the initial projections. Five hundred and fifty Queensland Health staff and 1400 ambulance officers have also received training. This training program is currently being evaluated by the Queensland Health Service and Evaluation Unit the final evaluation is anticipated in early 2010.

Figure A.2 Queensland Mental Health Intervention Project**



** Source: Queensland Health (2007), "Preventing and Responding to Mental Health Crisis Situations – A Tri-agency Partnership between QPS, QAS and QH", presented at Anex Illegal Drugs and Mental Health Conference 3-4 Sep 2007, Melbourne.

Case study

An incident occurs in the community, involving a person who has a mental illness and is experiencing a mental health crisis. The QPS First Response Officers en route to a mental health crisis may request and receive relevant information about the person in crisis from QH if appropriate. This information is provided to assist in the development of options to safely resolve the crisis.

On arrival, the police officers will attempt to de-escalate the situation using advanced communication skills. If there is no immediate risk to self or others, a voluntary referral is made to local mental health services for assessment by the attending QPS personnel. Alternatively, where risk is perceived, QPS

or QAS personnel can make an involuntary Emergency Examination Order and the person can be taken to an Authorised Mental Health Service for assessment. Training of QPS and QAS staff is based on providing respect and dignity to the person with mental illness and to ensure an appropriate health response is provided.

Mental Health Service staff provide triage, assessment and treatment (as per usual procedures). If the person does not meet the criteria for admission to the Mental Health Service, the person is advised about or referred to an alternate service provider.

The Queensland Health Mental Health Intervention Coordinator or delegate subsequently contacts the person to ensure they have followed up on the advice or referral.

Evaluation

The results of the formal evaluation are expected in 2010.

Commentary

Queensland Health (2007), "Preventing and Responding to Mental Health Crisis Situations – A Tri-agency Partnership between QPS, QAS and QH", presented at Anex Illegal Drugs and Mental Health Conference, 3-4 Sep 2007, Melbourne.

Queensland Police Service (2008), *Annual Report 2007-2008*, available online at www.police.qld.gov.au.

Crisis Intervention Team (Memphis Model – United States)

This case study from the United States demonstrates the most widely known police-based mental health initiative to improve recognition and response to mental health crises in the community.

The Crisis Intervention Team (CIT) model (commonly referred to as the 'Memphis model') was developed in Memphis, Tennessee. Its primary goals are to improve safety of police officers and people with mental illness and to redirect individuals with mental illness from the judicial system to the health system.

The key elements of the CIT model include provision of 40 hours of specialised training to volunteer police officers who are then rostered to provide 24 hour, seven days a week coverage. Training covers general information about mental illness, comorbidities and related issues, as well as site visits and skills based crisis de-escalation training.

Emergency call dispatchers also receive specialised training to enable them to understand the CIT program, identify CIT appropriate incoming calls and ask questions that will assist the responding CIT officer. Calls received by dispatchers involving a person with suspected mental illness are preferentially allocated to CIT officers who take a lead role at the scene and attempt to de-escalate the crisis.

A key feature of the Memphis model is partnership with local mental health services and a 'no-refusal' agreement at the local psychiatric emergency department.

Outcomes

Borum et al (1998) compared CIT officers' perceptions to non-CIT officers and found they felt better prepared to deal with mental health crises; were more likely to consider that the CIT program reduced the time spent dealing with crises and improved community safety; and had more positive perceptions of mental health services.

A study in 2000 (Steadman et al) found that the Memphis model resulted in 95 per cent of dispatch calls for "emotionally disturbed persons" receiving a specialised CIT response and a very low arrest rate of 2 per cent for these incidents. This compared favourably with two other models of police responses (police-embedded mental health professionals and mobile crisis team models) examined in the study.

Cowell et al (2004) explored cost-effectiveness of the Memphis model and found that higher health care costs were associated with diversion, but that mental health outcomes were also improved. Higher health costs were consistent with a finding by Dupont et al (2004) that diversion was associated with increased utilisation of medications, hospitalisation and counselling in persons with mental health and substance use disorders. The latter study also found some association between diversion and improvement in quality of life.

Steadman & Naples (2005) found that CIT programs (including the Memphis program) reduced time spent in jail without increasing the risk to public safety.

Website

www.cit.memphis.edu

Evaluation

Steadman, JH, Deane, MW, Borum, R and Morrissey, JP (2000), "Comparing Outcomes of Major Models of Police Responses to Mental Health Emergencies", *Psychiatric Services*, vol. 51, no. 5, pp 645-9.

Cowell, AJ, Broner, N and Dupont, R (2004), "The Cost-Effectiveness of Criminal Justice Diversion Programs for People With Serious Mental Illness Co-Occurring With Substance Abuse", *Journal of Contemporary Criminal Justice*, vol. 20, no. 3, pp 292-315.

Broner, N, Lattimore, P, Cowell, AJ and Schlenger, WE (2004), "Effects of Diversion on Adults with Co-Occurring Mental Illness and Substance Use: Outcomes from a National Multi-Site Study", *Behavioral Sciences and the Law*, vol. 22, no. 4, pp 519-41.

Borum, R, Deane, MW, Steadman, HJ, and Morrissey, J (1998), "Police Perspectives on Responding to Mentally Ill People in Crisis: Perceptions of Program Effectiveness", *Behavioral Sciences and the Law*, vol. 16, no. 4, pp 393-405.

Steadman, JH and Naples, M (2005), "Assessing the Effectiveness of Jail Diversion Programs for Persons with Serious Mental Illness and Co-Occurring Substance Use Disorders", *Behavioral Sciences and the Law*, vol. 23, no. 2, pp 163-70.

Commentary

Dupont, R, Cochran, S and Pillsbury, S (2007), *Crisis Intervention Team Core Elements*, University of Memphis. Available online at www.cit.memphis.edu

Compton, MT, Bahora, M, Watson, AC and Oliva, JR (2008), "A comprehensive review of extant research on Crisis Intervention Team (CIT) programs", *Journal of the American Academy of Psychiatry and Law*, vol. 36, no. 1, pp 47-55.

Watson, AC, Morabito MS, Draine, J and Ottati, V (2008), "Improving police response to persons with mental illness: a multi-level conceptualization of CIT", *International Journal of Law and Psychiatry*, vol. 31, no. 4, pp 359-68.

Mental Health (Forensic Provisions) Act 1990 (NSW)

This case study provides an example of 'mainstreaming' diversion within magistrates courts.

Section 32 of the *Mental Health (Forensic Provisions) Act 1990 (NSW)* applies to summary offences or indictable offences triable summarily and before a Magistrate. It enables a magistrate to divert defendants from the criminal justice system where the offenders who are, or were at the time of the offence, developmentally disabled, mentally ill or suffering from a mental condition for which treatment is available in a mental health facility. The magistrate must also be satisfied that it is 'more appropriate' to deal with the defendant under the section than otherwise by law.

In addition to powers to adjourn proceedings, grant bail, or make any other appropriate order, magistrates may make orders dismissing charges and discharging a person:

- into the care of a responsible person, unconditionally or subject to conditions
- on the condition that the defendant attend on a person or at a place specified by the magistrate for assessment of the defendant's mental condition or treatment or both
- unconditionally.

An order can be made at any stage of proceedings (generally on application by the defendant) and there is no requirement for a guilty plea. However, a clear and effective treatment plan must be available to the magistrate before a section 32 order can be made. Magistrates have inquisitorial powers for the purposes of determining whether to apply a section 32 order, but cannot require a defendant to incriminate themselves. The usual rules of procedural fairness apply where an application for section 32 is being made.

After an order has been made, if a magistrate suspects that conditions are not being complied with, they may recall people discharged within six months of the order being made. If conditions are being breached, the magistrate can reinstate the charges.

Outcomes

A 2008 report on section 32 orders indicated that amendments in 2004 introducing the recall powers has lead to a significant increase in the number of section 32 orders made. The report noted, however, that the recall provisions had been very rarely used and magistrates surveyed said that follow up reports on compliance and progress were rare. Concerns were raised about the availability of resources to provide services following section 32 diversion.

A 2009 evaluation of the Statewide Community and Court Liaison Service (SCCLS) found that of those individuals who had a finalised court appearance involving dismissal of charges under section 32, those linked with SCCLS had better outcomes compared with those who did not. No significant difference in rates of offending before and after dismissal was observed for individuals who were not linked with the SCCLS, suggesting that the intervention delivered is the important fact rather than the section 32 diversion per se.

Evaluation

Gotsis, T and Donnelly, H (2008), *Diverting mentally disordered offenders in the NSW Local Court*, Sydney: Judicial Commission of New South Wales.

Commentary

Bradford, D and Smith, N (2009), *An evaluation of the NSW Court Liaison Services*, Sydney: NSW Bureau of Crime Statistics and Research.

Perry, T (2008), "Court mandated outpatient treatment for mentally ill offenders in New South Wales", *Current Issues in Criminal Justice*, vol. 19. no. 3, pp 369-75.

Director of Public Prosecutions v El Mawas (2006) 66 NSWLR 93.

Mantell v Molyneux (2006) 68 NSWLR 46.

Statewide Community and Court Liaison Service (NSW)

This case study describes a partnership between justice and mental health systems to better identify, assess and appropriately respond to mental illness among court defendants.

The NSW Statewide Community and Court Liaison Service (SCCLS) operates within local courts across NSW, targeting defendants with mental health difficulties. The service provides mental health assessments and reports to inform decisions by magistrates relating to defendants with mental health problems.

Court liaison officers screen all detainees at court, but also accept referrals from other sources, most commonly court-based personnel. Screening that indicates possible mental illness is followed by a psychiatric assessment and development of a court report including options and recommendations for the court. If diversion is considered appropriate by the court, court liaison officers facilitate linkages into community based services, or prison-based services when a community-based diversion is not appropriate. The program does not have a continuing clinical management role after diversion.

Diversion options open to magistrates following an SCCLS report include issuing a hospital order, make a Section 32 order under the *Mental Health (Forensic Provisions) Act 1990* (see above) and recommending mental health care be provided within a correctional setting.

Outcomes

In the 12 months to June 2008, the SCCLS screened 14,746 individuals appearing at court and identified 1662 cases of severe mental illness.

A 2009 evaluation (Bradford & Smith) compared the number of offences committed prior and subsequent to contact with the SCCLS with a control group of offenders who did not have access to the service. The evaluators also sought qualitative responses from stakeholders.

The evaluation identified a statistically significant drop in the mean number of offences per month in the 18-month study follow-up period compared to the 18 months prior for the intervention group. There was no statistically significant change in rates of offending for the control group. The evaluation concluded that there is evidence the SCCLS “has a positive impact on reducing the frequency with which clients come into contact with the criminal justice system.”

Stakeholder consultation resulted in positive evaluation and found the most significant impacts to be: assistance provided in the timely identification of mental health issues; communication of this information to the courts; and supporting diversion to treatment when appropriate.

Website

www.justicehealth.nsw.gov.au/our-services/mental-health-directorate.html

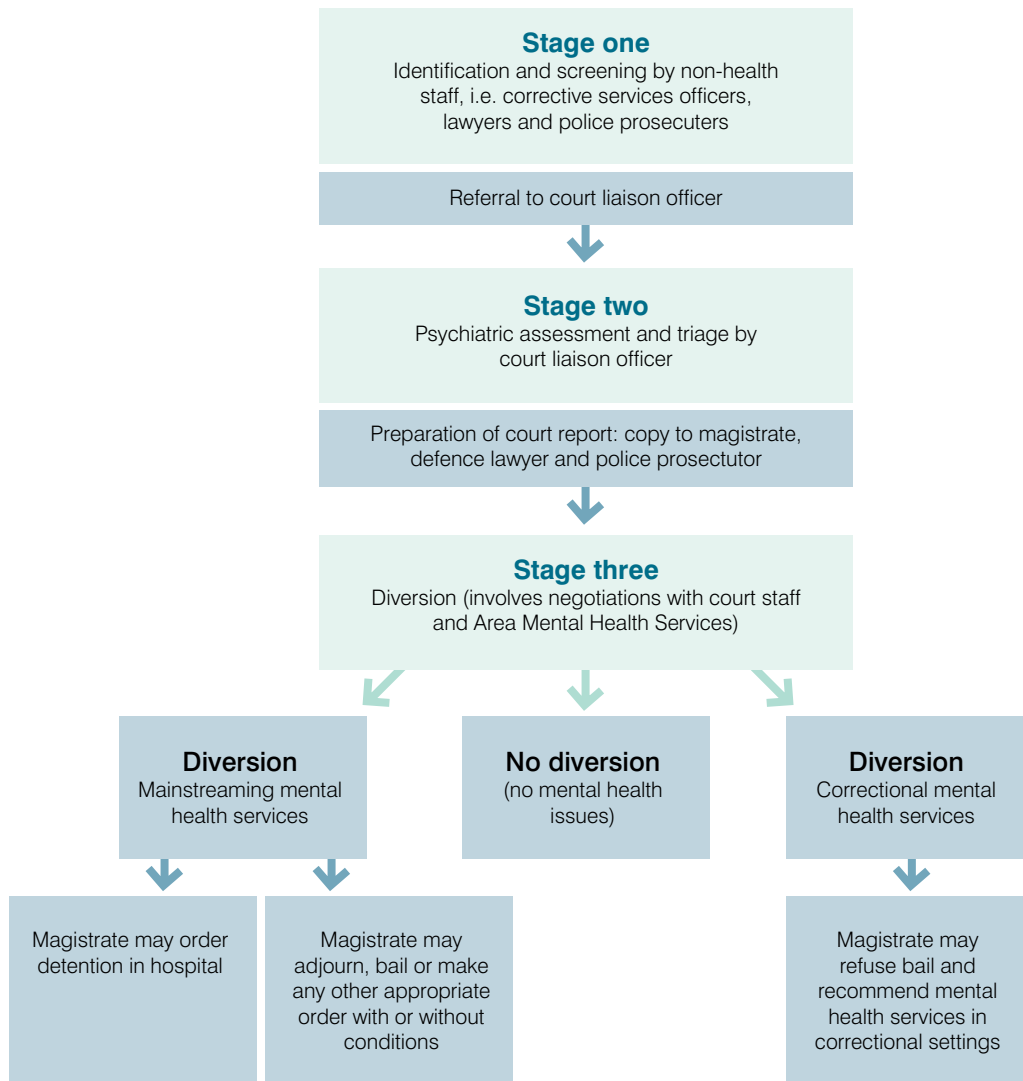
Evaluation

Bradford, D and Smith, N (2009), *An evaluation of the NSW Court Liaison Services*, Sydney: NSW Bureau of Crime Statistics and Research.

Commentary

Greenberg, D and Nielsen, B (2002), “Court diversion in NSW for people with mental health problems and disorders”, *NSW Public Health Bulletin*, vol. 13, no. 7, pp. 158-160.

Figure A.3 SCCLS Diversion process^{††}



^{††} Source: Greenberg, D and Nielsen, B (2002), "Court diversion in NSW for people with mental health problems and disorders", *NSW Public Health Bulletin*, vol. 13, no. 7, pp. 158-160. Adapted from reproduction contained within Bradford, D and Smith, N (2009), *An evaluation of the NSW Court Liaison Services*, Sydney: NSW Bureau of Crime Statistics and Research.

Adolescent Court and Community Team (NSW)

This case study describes an adapted court liaison and diversion service focused on adolescents (12-18) with possible mental health problems.

The Adolescent Court and Community Team operates out of five children's courts in NSW, providing mental health assessments and reports to inform decisions by magistrates relating to young people appearing before the court.

There is no general screening process for people in custody; assessments are undertaken following referral from legal representatives, community workers or other interested parties. Services are generally similar to the adult service in that assessment of mental illness is followed by development of a court report including options and recommendations for the court. A key part of this assessment process is determining what linkages already exist with support services. Commonly there are no current supports in place, particularly where a mental health diagnosis has not previously been made.

A high proportion of young people who come through the service are Indigenous. The pilot program at Cobham Children's Court in Western Sydney was established in consultation with local Indigenous communities, elders and respected persons. Relationships have been established with local Aboriginal Medical Services and legal services. An Aboriginal Mental Health Worker Trainee is employed to build links with the Aboriginal and non-Aboriginal community.

If a magistrate opts for diversion, court liaison officers facilitate referral to appropriate community based services. As with the adult service, court liaison officers do not have a continuing clinical management role after diversion.

Outcomes

Data from the 2007 calendar year indicates that 212 assessments were completed, of which 80 per cent identified mental health issues and 60 per cent were diverted to community based programs.

The value of proactively raising and maintaining service awareness and building collaboration and co-operation between services was noted in Bradford and Smith's 2009 evaluation. The availability of community-based services to accept program referrals was highlighted as critical to the success of the program.

Website

www.justicehealth.nsw.gov.au/our-services/mental-health-directorate.html

Evaluation

Bradford, D and Smith, N (2009), *An evaluation of the NSW Court Liaison Services*, Sydney: NSW Bureau of Crime Statistics and Research.

Commentary

Australian Human Rights Commission (AHRC) (2008), *Preventing Crime and Promoting Rights for Indigenous Young People with Cognitive Disabilities and Mental Health Issues*, Sydney: AHCR.

Mental Health Court Liaison Service (WA)

This case study describes the innovative use of communications technology to provide mental health liaison support to facilitate better informed decision making by courts dealing with mentally unwell offenders.

The Western Australian Mental Health Court Liaison Service provides screening and assessment of mentally disordered offenders across Western Australia. Clinical staff attend metropolitan courts on a weekly basis (daily for the Central Law Courts) and service regional and remote courts via videoconferencing. The service is focused on early identification and assessment for the purpose of ensuring the court is informed about mental health issues. The service is not involved in ongoing treatment.

Clinical staff are senior nurses, authorised to perform assessments and make referrals under WA's *Mental Health Act 1996*. Assessments occur following routine referral of overnight detainees, or from any other source, including defendants (self-referral), police, detention staff, lawyers, family and magistrates. Clinical staff are also proactive in visiting detention centres and seeking referrals.

The court makes hospital orders on nearly all occasions where this is recommended by liaison staff and liaison staff are able to secure admission to forensic beds and a report to the court within seven days. Outside of metropolitan areas, the courts are more reluctant to issue hospital orders and have devised local solutions using bail provisions to facilitate an assessment.

Education sessions are held with police, lawyers and the courts in order to raise the profile of the service and increase likelihood that mental illness will be detected.

Outcomes

Brett (2009) argues that the service is successful at identifying mentally disordered offenders who have been held in custody and provides a useful filter to court ordered assessments.

Brett and Blumberg (2006) have suggested the service has shown that in rural areas, assessment through video conferencing can reduce unnecessary hospital orders a significant benefit in a state the size of Western Australia.

Evaluation

No published evaluation.

Commentary

Brett, A and Blumberg, L (2006), "Video-linked court liaison services: forging new frontiers in psychiatry in Western Australia", *Australasian Psychiatry*, vol. 14, no. 1, pp 53-6.

Brett, A (Unpublished), "Western Australia's mental health court liaison service " manuscript submitted to *Australian and New Zealand Journal of Psychiatry*, February 2009.

Court Integrated Services Program (VIC)

This case study provides an example of court-based, integrated case-management and support services for people with complex needs that operate alongside usual criminal justice processes.

The Court Integrated Services Program (CISP) provides a team-based, integrated assessment and referral to services for defendants with health and social needs at the Magistrate's Court of Victoria. CISP aims to:

- provide short term assistance for defendants with health and social needs before sentencing
- work on causes of offending through individualised case management for up to four months
- provide priority access to treatment and community support services
- reduce the likelihood of re-offending.

Eligible clients are on summons, bail or remand awaiting bail (having been charged with an offence) and have a likelihood of re-offending. They must also have physical or mental disabilities or illnesses, drug and alcohol dependency and misuse issues, or inadequate social, family and economic support that contribute to the frequency or severity of their offending. Participation is voluntary and by consent and there is no requirement for a guilty plea.

Potential clients undergo an assessment which examines the risk of re-offending and the causes of offending. A report is provided to the magistrate outlining issues identified and a targeted treatment or support plan.

CISP provides assessment and development of an individualised case management plan leading to referral for treatment and support services. Formal service level agreements exist with forensic mental health, juvenile justice and corrections agencies.

Case management services are provided to eligible clients for up to four months. Funding is available for drug and alcohol treatment, mental health services, housing and acquired brain injury related needs. The program has staff with a range of skills and backgrounds ranging from drug and alcohol, to disability, mental health, generalist (welfare, community development), acquired brain injury, housing and Aboriginal liaison.

Clients requiring intensive or ongoing support may be referred to outreach services. Progress reports and pre-sentencing advisory reports are provided to the magistrate to ensure that judicial decisions are fully informed by CISP participation.

Outcomes

The CISP program received over 2000 referrals in 2007-08, including 203 involving Indigenous clients. Of the 1792 clients assessed, 1283 were accepted into the program.

A formal evaluation is expected to be completed by early 2010. The CISP program was nominated for an achievement award from the National Association for Court Management in 2009.

Website

www.magistratescourt.vic.gov.au

Evaluation

A formal evaluation is expected early 2010.

Commentary

Magistrates' Court of Victoria (MCV) (2008), 2007-2008 Annual Report, Melbourne: MCV.

Law Reform Commission of Western Australia (LRCWA) 2009. *Court intervention programs: final report*, Perth: LRCWA.

Bartels, L (2009), Challenges in mainstreaming specialty courts, *Trends & Issues in Crime and Justice*, no. 383, October 2009.

Magistrates' Court Diversion Program (SA)

This case study describes a specialised court diversion program that offers offenders with mental impairment the opportunity to be assisted to engage with community-based services under judicial supervision.

The Magistrates Court Diversion Program (originally named the Mental Impairment Court) commenced in 1999. It aims to:

- reduce recidivism by providing early assessment and intervention to address mental health and disability needs of defendants and their offending behaviour
- assist the court in the identification and management of people with a mental impairment in the court system
- provide a diversion option in the Magistrates Court, for people who may otherwise plead a mental impairment defence.

The program has a range of associated outcomes including: improving capacity of the court and court personnel to deal with people with mentally impairment; streamlining and simplifying court processes; improving the health and justice system interface; collection and analysis of key data; and increasing awareness in the community and service providers of the needs of justice-involved people with mental impairment.

Eligible individuals are adults who have been charged with certain minor or summary offences to be heard in the Magistrates Court of South Australia and who have impaired intellectual or mental functioning. The impairment might arise from a mental illness, an intellectual disability, a personality disorder, acquired brain injury, or a neurological disorder including dementia.

The program utilises the general provisions of bail and sentencing legislation.

Participation in the program is voluntary and can occur following self-referral or referral by an interested third party. Eligibility is based on the existence of a mental impairment, causally linked to a charged summary or minor indictable offence. There is no requirement to plead guilty, although the objective facts of an offence must be admitted. An assessment report is undertaken by a court clinical assessor and forms the basis of the magistrate's decision to accept a person into the program.

The program provides for the adjournment of legal proceedings for six months, with bi-monthly judicial review of progress. During this time, program staff work collaboratively with community providers to link the individual into services that seek to address behaviours arising from impaired mental functioning that are linked to offending. Court hearings are informal in nature, including direct interaction between offender and magistrate.

At the conclusion of the six month period the magistrate has discretion to dismiss the matter or convict without penalty. Failure to achieve satisfactory progress under diversion is not relevant to the sentencing process.

Outcomes

A 2004 evaluation (Skrzypiec et al) compared rates of arrest and charge in the 12 months before and after diversion, finding that overall "the results showed a reduction in both the number of participants who were apprehended for offending post-program compared with pre-program, as well as a reduction in the actual number of incidents charged against this group". Although not statistically significant, of a small group of 15 high risk offenders, 12 were either not arrested or arrested on fewer occasions in the 12 months post-program.

A greater likelihood of re-offending was associated with people who offended during the program, who had a lifetime record of five or more convictions, or had charges relating to three or more offending incidents in the two years prior to program entry. Accommodation instability at program entry, current substance abuse or a substance use disorder, chronic physical health problems or disability, or a dual mental impairment diagnosis were also associated with higher rates of re-offending.

Website

www.courts.sa.gov.au/courts/magistrates/

Evaluation

Skrzypiec, G, Wundersitz, J and McRostie, H (2004), *Magistrates Court Diversion Program. An analysis of post-program offending*. Adelaide: Office of Crime Statistics and Research. Available online at www.ocsar.sa.gov.au (search by title).

Hunter, N and McRostie, H (2001), *Magistrates Court Diversion Program. Overview of key data findings*. Information bulletin no. 20, Office of Crime Statistics and Research.

Commentary

Richardson, E (2008), "Mental health courts and diversion programs for offenders with mental illnesses: the Australian context." Paper presented at the 8th Annual International Association of Forensic Mental Health Services Conference, Vienna, Austria. Available online at www.law.monash.edu.au/rmhl/docs/lr-iafmhs-160708.pdf

Burvill, M, Dusmohamed, S, Hunter, N and McRostie, H (2003), "The management of mentally impaired offenders within the South Australian criminal justice system", *International Journal of Law and Psychiatry*, vol. 26, no. 1, pp 13-31.

Magistrates Court Mental Health Diversion List (TAS)

This case study provides an example of an innovative court diversion program which linked existing forensic mental health liaison services with a specialist list.

The Mental Health Diversion List (MHDL) which commenced as a pilot program in the Hobart registry of the Magistrates Court of Tasmania in 2007 has a strong basis in the therapeutic jurisprudence approach. The MHDL seeks to provide defendants who have a mental illness linked to their offending behaviour with an opportunity to address their mental health issues through court mandated treatment programs or interventions. This approach aims to reducing re-offending and improve community safety.

The MHDL is available to adults with a mental illness who are charged with either a summary offence or a minor indictable offence (triable summarily) where the offence is linked to their mental illness. Persons with intellectual disability or acquired brain injury are not eligible unless they also have a mental illness. People who are considered ineligible retain the option of pursuing a legal defence of mental impairment. Participation is voluntary, however there is a requirement to either acknowledge guilt or indicate no contest to the facts on the charges.

Following referral, a Forensic Mental Health Court Liaison Officer (FMHCLO) undertakes an assessment of eligibility. If the person is eligible and consents, the person appears before a specialist magistrate who invokes bail conditions to facilitate further assessment and development of a treatment plan, on advice and recommendations from the FMHCLO. The duration of the plan is tailored to each individual.

Judicial review occurs on a monthly basis, usually preceded by meetings of the diversion list team, consisting of the FMHCLO, defence lawyers and specialist prosecutors. The team meeting reviews defendant progress that is later reported to the court. Judicial review provides opportunity for verbal encouragement or sanction, tailoring of the treatment plan and supervision requirements and finalisation or exclusion from the program.

The program is not associated with specific legislation, and utilises the general provisions of bail and sentencing legislation.

Outcomes

A 2009 evaluation (Newitt & Stojcevski) found a high level of support for the program among health care and service providers. It also highlighted the importance of pre-court meetings, separating health care management from court management, training defence lawyers, and appropriate and sustainable data collection processes.

The evaluation also considered outcomes for a small number of program participants, finding reductions in rates of any offending and incidences of offences in the six months following the program (7.7 per cent re-offended) compared with the six months prior (82.7 per cent had offended).

The evaluation concluded that the MHDL had been largely successful in:

- offering a more therapeutic approach to the criminal justice system for mentally ill defendants
- reducing the re-offending rates of participants
- improving the coordination between the criminal justice agencies and health service providers
- reportedly saving valuable court resources and time with respect to the avoidance of special hearings to determine fitness to plead or stand trial.

Due to the success of the pilot program, the Magistrate's Court has made the MHDL a permanent feature of court operations and has started extending the program into a state-wide concern, encompassing the registries at Launceston, Burnie and Devonport.

Website

www.magistratescourt.tas.gov.au/

Evaluation

Newitt, E and Stojcevski, V (2009), *Mental health diversion list. Evaluation report*. Magistrate's Court of Tasmania. Available online at www.magistratescourt.tas.gov.au/ (search by title)

Graham, H (2007), *A Foot in the (Revolving) Door? A Preliminary Evaluation of Tasmania's Mental Health Diversion List. Report prepared for the Magistrates Court of Tasmania and other Mental Health Diversion List Stakeholders*. Available online at www.eprints.utas.edu.au/7186/

Commentary

Hill, M (2009), "Hobart Magistrates Court's Mental Health Diversion List", *Journal of Judicial Administration*, vol. 18, no. 3, pp 178-85.

Richardson, E (2008), "Mental health courts and diversion programs for offenders with mental illnesses: the Australian context." Paper presented at the 8th Annual International Association of Forensic Mental Health Services Conference, Vienna, Austria. Available online at www.law.monash.edu.au/rmhl/docs/lr-iafmhs-160708.pdf

Mental Health Court (QLD)

This case study provides an overview of a mental health court focused on diversion on legal grounds: where a person is unfit to stand trial or was of unsound mind at the time of offending.

Unlike the other case studies of mental health courts in this section, the Queensland Mental Health Court (MHC) determines issues of fitness to plead or stand trial and whether the alleged offender was of unsound mind at the time of an offence. The MHC also has jurisdiction to hear appeals from the Mental Health Review Tribunal relating to involuntary detention and treatment.

The court was established by the Mental Health Act 2000 (QLD), which provides that cases may be referred to the court when reasonable cause to believe that a person who has committed an indictable offence is mentally ill or was at the time of the offence. If the person has an intellectual disability of a degree that suggests unsoundness of mind, then diminished responsibility or fitness for trial should be considered by the Mental Health Court.

Supreme court justices preside over the court. They are assisted by two psychiatrists who advise on meaning and significance of clinical evidence and issues relating to the treatment and detention needs of people under the Mental Health Act 2000 (QLD).

The court has inquisitorial powers to explore the relationship between the defendant's mental illness and the alleged offences to determine criminal responsibility; to determine their present fitness to stand trial; and whether such unfitness to stand trial is permanent. In reaching its decision, the court may consider evidence that is inadmissible in a criminal trial.

Following a determination that a person is of unsound mind or unfit to stand trial, the court can make a forensic order detaining a person in an authorised mental health service. In deciding whether to make a forensic order the court must consider the seriousness of the offence; the person's treatment needs; and the risk to the community.

The MHC may also make an order for limited community treatment so that the person may access or reside in the community under the supervision of an authorised mental health service. Forensic orders and limited community treatment orders are regularly reviewed by the Mental Health Review Tribunal which has the power to revoke a forensic order. Decisions of the Mental Health Review Tribunal may be appealed to the MHC.

If the MHC finds that the person was not of unsound mind and is fit for trial, the matter is returned to the criminal court. In this situation the MHC may order the person be remanded in custody or bail be granted or enlarged or that the person be detained in an authorised mental health service until they are granted bail or brought before the criminal court.

Whether or not the MHC makes a forensic order, it may make a non-contact order in relation to the victim of the alleged offence.

Outcomes

The Mental Health Court reports to the Minister for Health on an annual basis. The most recent publicly available report (2007-2008) indicates that 397 matters were finalised, including 184 findings that the defendant was of unsound mind. At 30 June 2008, 150 matters were pending, 63 referred by the Director of Mental Health, 72 by defendants or their legal representatives and the remainder by the Director of Public Prosecutions, the Attorney-General or another court.

The Report also noted the 10 per cent of references dealt with by the court related to people with intellectual disability but no mental illness and recommended that consideration be given to devising a form of order "specific to the needs of individuals, suffering from an intellectual disability but not suffering from any psychiatric disorder, who are found to be of unsound mind or unfit for trial."

Website

www.courts.qld.gov.au/4428.htm

Evaluation

No formal evaluation, but the court provides annual reports to the Minister:

Supreme Court of Queensland (2008), *Mental Health Court Report 1 July 2007 to 30 June 2008*. Available online at www.courts.qld.gov.au/4442.htm

Supreme Court of Queensland (2007), *Mental Health Court Report 1 July 2006 to 30 June 2007*. Available online at www.courts.qld.gov.au/4442.htm

Commentary

Richardson, E (2008), "Mental health courts and diversion programs for offenders with mental illnesses: the Australian context." Paper presented at the 8th Annual International Association of Forensic Mental Health Services Conference, Vienna, Austria. Available online at www.law.monash.edu.au/rmhl/docs/lr-iafmhs-160708.pdf

Wilson, M (2003), "Queensland's Mental Health Court", paper presented at the 21st Annual Australian Institute of Judicial Administration Conference, Fremantle, WA. Available online at www.ajja.org.au/ac03/papers/WilsonJ.rtf

Community Resource Court (North Carolina, United States)

This case study from the United States provides an example of a Mental Health Court's approach to accepting people charged with violent offences and the 'graduation' of diverted participants.

The Community Resource Court (CRC) operates in Orange County, North Carolina, and is a co-operative endeavour between the local justice and mental health agencies. It aims to link defendants with mental health problems into support and treatment services. The program's five key goals are to:

- protect public safety
- improve quality of life
- utilise therapeutic jurisprudence to assist recovery and support personal responsibility
- improve outcomes through accountability and collaboration (individuals and services)
- decrease expenditure, by providing more cost-effective treatment.

The CRC has benefited from strong judicial leadership, and is overseen by a coordinating committee including representatives of the district attorney's office, the public defender's office, the local criminal defence bar, community corrections, pre-trial services, the police department's crisis unit, the county sheriff's office, the community mental health centre, the University of North Carolina Schools of Medicine and Social Work and the local chapter of the National Alliance for Mental Illness (a consumer and family organisation).

Acceptance to the CRC requires voluntary participation by the defendant and agreeability to treatment, a diagnosis of mental illness, a dual diagnosis, or a past history of mental illness, with priority accorded to people with severe and persistent mental illness. The availability of appropriate services is also a factor. Unlike many other examples of mental health courts, the CRC does accept defendants charged with violent offences. However, an assistant district attorney must first assess the individual as not posing public safety concerns and the victim must also agree to the case being transferred before the CRC will accept such defendants.

CRC participants are linked with mental health and other support services while charges are either deferred or the person is placed on probation. Each month during the program period, the CRC team meets to discuss all current program participants and possible new referrals. Progress is discussed, as are potential modifications to treatment plans and recommendations made to the judge about what action may be taken in the open court (praise and encouragement, reprimand, or sanctions).

Court reviews are informal, with direct dialogue between the defendant and their supporters and the judge. After a period of successful program engagement, defendants 'graduate' from the program and charges are dismissed or probation ended. Graduation is expressly recognised through congratulations from the court, applause from CRC team members and the award of a certificate.

Outcomes

The 2006 (Moore & Hiday) evaluation of the CRC found that almost two thirds of participants completed the program. This group was significantly less likely to be arrested in the 12 months following entry to the program than both the mainstream court comparison group and CRC program non-completers. When completers did accrue new criminal charges, these were less severe than the comparison group. The evaluators noted the significance of program completion, or receipt of "full dose" interventions.

Website

www.nccourts.org/County/Orange/Programs/CommResource.asp

Evaluation

Moore, ME and Hiday, VA (2006), "Mental health court outcomes: a comparison of re-arrest and re-arrest severity between mental health court and traditional court participants", *Law and Human Behaviour*, vol. 30, no. 6, pp 659-74.

Hiday, VA, Moore, ME, Lamoureaux, M and de Magistris, J (2005), "North Carolina's Mental Health Court", *Popular Government*, vol. 70, no. 3, pp 25-30.

Case study

A 44 year old African-American man employed as an electrician appeared in court on charges of misdemeanour larceny, intoxication and disruptive behaviour. He had been 'self-medicating' with alcohol to ease the symptoms of bipolar disorder. Under court supervision he began individual therapy and was put on psychiatric medication. Soon, however, he had undesirable side effects. He stopped taking the medication and again began to self-medicate with alcohol.

After warnings and reprimands, he explained that the prescribed drugs made him sleepy and affected his work performance. He did not want to apply for a disability pension, as court personnel had suggested, because he did not believe in getting money for free. The judge encouraged him to work with his doctor to get the medication adjusted. Over the next few months, he did so, began to comply with the regimen and visibly changed from a dirty, dishevelled man to a clean, neat person in control of his life. At 'graduation' he was doing well and buying part of the electrical repair business where he worked.

This case study is adapted from Hiday et al (2005).

Commentary

Buckner, J (2005), "Community Resource Court: An inter-agency collaboration", PowerPoint presentation, available online at www.naminc.org/CIT/cit_presentations/Judge%20Buckner.ppt

Koori Court: Magistrates' Court of Victoria (VIC)

This case study describes a sentencing court for Aboriginal people that links offenders to culturally appropriate community-based services through tailored sentencing orders and is strongly engaged with local Indigenous communities.

The Koori Court program was established by the *Magistrates' Court (Koori court) Act 2002* (VIC), and operates in the Magistrates' Court of Victoria. It provides a less formal alternative to mainstream court for Koori defendants who have pled guilty to offences excluding sexual offences and family violence offences. It aims to reduce perceptions of cultural alienation, ensure sentencing orders are culturally appropriate, and assist Koori offenders to address issues related to their offending behaviour. The Koori Court does not have an express focus on mental illness, but does aim to develop a holistic understanding of each defendant's circumstances in tailoring sentencing.

In 2005, a Children's Koori Court was established, focusing on young Indigenous offenders through close collaboration with family, community service providers and criminal justice agencies.

Key features of the Koori Court include a minimum of formality and technicality, with court participants sitting around a table and community involvement through Koori elders, respected persons, the defendant's family, youth worker (in the children's court) and Koori court officer. Defendants and elders sit opposite each other. The Koori court officer has an important role, including community education and liaison, advising the court and community corrections about services and programs available to Koori people and, where appropriate, assisting with the development of case management plans.

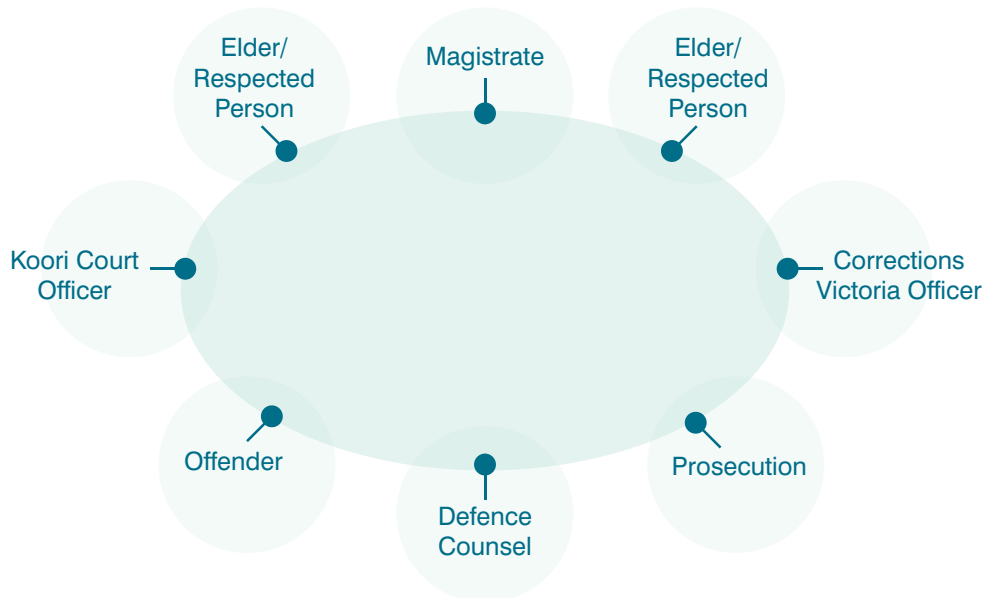
All participants are able to have their say, explain their views and participate in the process. The defendant is also provided with an opportunity to tell their story. While the magistrate retains the full range of sentencing options and sole authority to decide the sentence, determination of the sentence occurs after hearing from all participants and following a discussion with the Koori elders and respected persons.

The Koori Court seeks to:

- improve defendants' understanding of the court process
- encourage defendants to take responsibility for their actions and recognise the consequences of their behaviour
- develop a court system that is culturally appropriate and responsive to the needs and aspirations of Indigenous people
- facilitate greater positive participation by the Aboriginal community in the sentencing process
- explore sentencing alternatives prior to imprisonment.

Koori Courts are located at Shepparton, Broadmeadows, Bairnsdale, Mildura, Warrnambool, LaTrobe and Swan Hill Magistrates' Courts. Children's Koori Courts are located at the Melbourne Children's Court and Mildura Magistrates' Court.

Figure A.4 Koori Court participants^{ss}



Outcomes

A 2004 evaluation (Harris 2006) found that the Koori Courts reduced recidivism, finding rates of re-conviction of 12.5 per cent and 15.5 per cent at the two pilot sites compared with a state-wide comparison rate of 29.4 per cent. The evaluation also noted reductions in breaches of community corrections orders and the number of defendants failing to attend court.

Other outcomes included increasing Koori community participation and ownership over administration of the law and providing a culturally informed forum for sentencing. All defendants who responded to a questionnaire (response rate 66.6 per cent) reported that the Koori Court had been a positive experience and were in favour of its expansion.

The Harris evaluation also found the Koori Courts provided an effective means of integrating service providers who supported tailored community based orders and noted the importance of ensuring that local, culturally appropriate support services were available and adequately funded. McAsey (2005) also considered that engagement of Indigenous community organisations by the Koori Court was essential to success.

McAsey's qualitative evaluation of the Koori Court found it to be successful in building community, particularly through the engagement of elders on the court and the reinforcing effect this had upon their standing in the Koori community and sense of participation in the justice process.

Website

www.justice.vic.gov.au/wps/wcm/connect/DOJ+Internet/Home/Courts/Victorian+Courts/JUSTICE+-+Koori+Court

Evaluation

Harris, M (2006), "A Sentencing Conversation" *Evaluation of the Koori Courts Pilot Program October 2002 – October 2004*, Melbourne: Courts and Programs Development Unit.

McAsey, B (2005), "A critical evaluation of the Koori Court Division of the Victorian Magistrates' Court", *Deakin Law Review*, vol. 10, no. 2, pp 654-85.

^{ss} Source: Department of Justice (2008), *Koori Court – A Defendant's Guide*, available online at www.justice.vic.gov.au (search by document title)

Case study

A defendant appearing before the Koori Court had a long history of contacts with juvenile justice and heroin addiction. Proceedings were adjourned to enable the defendant to attend a range of services under a Court Early Referral Intro Drug Treatment (CREDIT) program, including for mental health assessments. During this period, as a result of the mental health assessments, a diagnosis of previously untreated schizophrenia was made.

Support had been provided by the Koori court officer to attend appointments and the defendant's attendance at meetings and appointments had been good until his emergency accommodation was terminated. While the defendant had established links with an Aboriginal Medical Service's counselling program, his involvement with that program was adversely affected by cessation

of its funding. Some attendance difficulties had also arisen when the defendant had mixed up different agencies and attended the wrong service.

The case is illustrative of the complexity of problems faced by many Indigenous defendants, the important role of the Koori court officer and program staff working collaboratively and the potential impact that a lack of continuity in external programs can have.

On the matter's return to the court, the Koori Court provided a forum in which the circumstances of drug use, the impacts of mental illness and the effect of unstable accommodation were able to be explored in assessing the defendant's situation. The sentence handed down was informed by these issues.

This case study is adapted from Harris (2006).

Commentary

Harris, M (2007), "The Koori Court and the Promise of Therapeutic Jurisprudence", *Murdoch University Electronic Journal of Law, Special Series* (1), pp 129-140, 167-181.

Law Reform Commission of Western Australia (2005), *Aboriginal Customary Laws Discussion Paper*, pp 142-57, available at www.lrc.justice.wa.gov.au/094p.html



Figure 1. Relationship between the number of species (S) and the number of individuals (N) for 10 different species. The fitted curve is shown for comparison.

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