

NSW Law Reform Commission Consultation Paper:
*Young people with cognitive and mental health impairments
in the criminal justice system*

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ADCA and the AOD sector – Who we are and what we do

ADCA is the acknowledged national peak body for the AOD sector, providing an independent voice for the people working to reduce the harm caused by alcohol and other drugs.

ADCA is a non-government, not-for-profit organisation which receives its core funding and major ongoing project funding through the Australian Government Department of Health and Ageing under its Community Sector Support Scheme (CSSS) and the National Drug Strategy Program respectively. ADCA is a company limited by guarantee, a public benevolent institution with income tax and sales tax exemption, and a deductible gift recipient.

As the national peak body, ADCA occupies a key role in advocating for adequate infrastructure support and funding for the delivery of evidence-based AOD initiatives. In this regard, ADCA represents the interests of a broad group of AOD service providers and individuals concerned with prevention, early intervention, treatment, harm minimisation, supply reduction and research.

Under ADCA's governance arrangements, the ADCA Board is elected by the ADCA membership and consists of a total of nine Board Directors. The ADCA Federal Council comprising one representative per State/ Territory AOD peak organisation, plus the ADCA Board, is a key mechanism for coordination and cooperation with State/ Territory AOD peak organisations. The ADCA Policy Forum comprises the ADCA Board, the State/ Territory AOD peaks, and the Chairs of the ADCA Working Groups, and is an advisory forum on key policy issues for the AOD sector. Both the ADCA Federal Council and the ADCA Policy Forum come together for face-to-face meetings, and telephone link-ups.

As at 7 February 2011, ADCA's membership totalled 384 comprising 163 organisational members, 51 associate organisational members, 159 individual members, and 11 Life Members. These include AOD services, agencies and individual professionals and practitioners engaged in AOD services throughout Australia, as well as major university research centres, tertiary institutions offering courses in addiction studies and other programs for AOD workers, law enforcement and criminal justice systems, policy analysts, and administration.

Consideration of the issues

This submission seeks to address two central issues that are addressed in the New South Wales Law Reform Commission Consultation Paper, 11, December 2010 – *Young people with cognitive and mental health impairments in the criminal justice system*.

The issues include: the role of Health Diversion Lists/Programs in the criminal justice system (this issue has relevance for questions raised in Chapters 1, 2, 4, 5 and 6) and the role of police and their role in relation to young offenders with cognitive and mental health impairments¹ in the criminal justice system (this issue addresses questions raised in Chapters 1, 2 and 4). It is not clear whether mental illness and cognitive impairment are considered as separate ailments in the Consultation Paper or as combined factors. Section 0.1, for example, uses the terminology “people with cognitive and mental health impairments”, while section 0.2 uses the terminology “people with a cognitive or mental health impairment”. It is therefore unclear whether the Commission considers:

- young people suffering a mental illness OR a cognitive impairment;
- young people suffering a mental illness AND a cognitive impairment; or
- aims to cater for both conditions

We have therefore written our response taking this into account.

Before starting our detailed response to the Commission, we would like to express concerns about the multiple clustering of an already complex criminal justice system aiming at catering for the needs of vulnerable populations. There are currently a total of 11 categories of vulnerable populations, either listed within the Law (such as young people, Aboriginals and Torres Strait Islanders, non-English speaking background individuals, the mentally ill and disabled) or as per social recognition of special needs (like the elderly, sexual and religious minorities, victims of crime, etc)². While such categories may stand out as strong, specific groupings of people needing special consideration by professionals in the criminal justice system, any exercise in further classification needs to be approached with caution. Looking at the needs of young people suffering a mental illness or a cognitive impairment is one such exercise.

The problem lies with attempting to create special processes and sub-categories for people who are a cross section of two or more of the above mentioned categories (Bartkowiak-Théron & Corbo Crehan, 2010). At some point, this further sub-classification and consideration of related sub-processes will need to stop. At a point in time where society

¹ It should be noted that in our view, cognitive impairment and mental illness are two separate conditions which necessitate different forms of treatment and support systems and should have different entry points to the criminal justice system. For example, it needs to be taken into account that a child with cognitive impairment might never understand the consequences of his or her actions, depending on the severity of his or her ailment and regardless of educative efforts. However, it is likely that a young person suffering mild forms of bi-polar disorder or schizophrenia may understand the consequences of an act and may benefit from processing through the justice system, by way of diversion, therapeutic jurisprudence or other alternative justice process. However, for the purpose of this consultation paper, we have addressed both, as per the questions asked.

² See, for New South Wales, the *Law Enforcement (Powers and Responsibilities) Act 2002* n°103 and Regulation 2005, or the *Anti-Discrimination Act 1977* n°48.

and social commentators become more and more aware of the mental health needs of populations such as Aboriginals and Torres Strait Islanders or Refugees, it is important to not create redundant or specific protocols that might not be used in the future, as was the case for some sets of provisions introduced in 1990 in the WA Criminal Code. These provisions were so specific that they have only been used once (see Tasmania Law Reform Institute, 2010, section 3.3.1). While the case of young people suffering a mental illness or a cognitive impairment may appear as a straightforward category, such specificity creates a precedent that might lead to further compartmentalisation, led by the multiple specifics of one individual. As an example of this, an Australian young aboriginal suffering a mild form of Down-Syndrome, suffering depression because of a known history of past abuse, and who is starting to show mild signs of violence by shouting aggressive insults to bystanders and behaving violently on the street. This particular person would be at a cross section of several categories of vulnerabilities, at a much more complex level than the one explored in this consultation document. Such complexity highlights the number of possible sub categories such a clustering exercise may lead to, and it is unlikely that in the current state of complexity of our global society, that any 'special needs categories list' will cover all possible clusters of all possible combinations of vulnerabilities known at any point in time.

The role of Mental Health Diversion Lists/Programs in the criminal justice system

The following discussion relates to courts in Australia that utilise mental health diversion lists or programs to address the particular issues associated with the involvement of people with cognitive and mental health impairments in the Australian criminal justice system. It is not an exhaustive discussion and further information is available from individual jurisdictions and internet sources. The South Australian and Tasmanian Lists discussed here currently operate for adults over the age of 18 years. However, Tasmania is currently reviewing their Mental Health List Program with a view to considering the participation of young offenders to its Mental Health Diversion List (see below). It is the intention of this submission to recommend therapeutic jurisprudence approaches for young offenders with cognitive and mental health impairments and to consider the potential of Mental Health Diversion Lists/Programs as discussed below.

In 2006, the Senate Select Committee on Mental Health held an inquiry into the provision of mental health services in Australia. The terms of reference included investigating the overrepresentation of people with mental illnesses in the justice system. As one of its recommendations, the Committee suggested a significant expansion of mental health courts and diversion programs.

The importance of the development of best practice guidelines in the area of diversion and support of mental health clients in the criminal justice system has been acknowledged by the National Justice Mental Health Initiative 2003-2008 (see http://www.aic.gov.au/crime_community/communitycrime/~media/aic/njceo/justice_mental_health_audit.pdf). In recent years many jurisdictions have sought to incorporate therapeutic jurisprudence concepts when dealing with offenders with mental illnesses.

Therapeutic jurisprudence is ‘the extent to which substantive rules, legal procedures, and the roles of lawyers and judges produce therapeutic or anti-therapeutic consequences’ (Wexler 1991: 981). Such an approach recognises that the way ‘the law is implemented and operates can either have a negative, positive or neutral effect on the psychological wellbeing of participants’ and that anti-therapeutic consequences should be avoided (Newitt & Stojcevski 2009). A therapeutic jurisprudence approach involves a collaborative, largely non-adversarial, approach and seeks to be ‘forward-looking’ and ‘wherever possible, ... promotes the idea that by assisting offenders to address the mental, behavioural or situational issues and problems which underlie the offending behaviour, a more comprehensive resolution can be reached’ (King 2006: 130).

In Australia there has been some attempt to introduce concepts of therapeutical jurisprudence approaches into State jurisdictions. In this context, the following states have sought to provide what Frieberg (2001) has called ‘problem-orientated courts’:

South Australia

South Australia was the first jurisdiction to introduce a Magistrates Court Diversion Program (MCDP) in 1999 (Hunter 2001) and following a three year pilot was permanently established in 2004. The MCDP is a collaborative program. It is not based on specific legislation but rather relies on the State’s bail and sentencing powers to ensure that eligible offenders gain access to treatment and support services while their case is adjourned.

The MCDP was formally evaluated in 2004. Findings included:

- an overall reduction in the number of participants who offended post-program;
- a reduction in the actual number of incidents charged against the entire group (from 348 to 116); and,
- 66.2% of participants did not offend at all during the post-program period (compared to only 7% pre-program) (Newitt & Stojcevski 2009: 35)

Queensland

A separate Mental Health Court (MHC) has been established in Queensland to consider a defendant’s capacity/fitness to plead or to be held criminally responsible for their alleged offending behaviour. The central focus of the MHC is to examine the relationship between the offender’s mental illness and their alleged criminal behaviour. The court can then make a determination about:

- the offender’s mental fitness;
- whether a forensic order should be made and the offender detained for treatment/care;
- whether a ‘no contact’ order should be made; or
- whether the case should be returned to a criminal court and tried in the usual way.

The Brisbane list implements the principles of therapeutic jurisprudence by aiming to deal with the ‘...impaired capacity of disadvantaged people to comply with public order legislation by initially disposing of their case in a more appropriate and constructive manner’ (cited in Newitt & Stojcevski 2009: 20). Unlike South Australia and Tasmania, Queensland has not had a formal evaluation of the MHC.

Victoria

The Magistrates Court of Victoria assesses mentally ill offenders through the Mental Health Court Liaison Services who provide advice to the court about their specific case and where appropriate, refer them for treatment. There is no continuing supervision over these cases.

As in Queensland, persons in Victoria defined as having ‘special circumstances’ (including a physical or intellectual disability, unpaid infringement notice, mental illness, drug or alcohol dependency or homelessness) may be released absolutely or given an order that requires them to be of good behaviour for a set period of time. The ‘Special Circumstances List’ aims to avoid imprisoning socially or economically disadvantaged offenders for failure to pay their fines.

As in Queensland these initiatives have not been formally assessed for their effectiveness. However, Victoria is currently piloting a three-year program funded by the State Government to try and break the cycle of criminal behaviour. A new court opened in Melbourne in April 2010 to cater specifically for those with a mental illness (see <http://www.abc.net.au/news/stories/2010/04/20/2877951.htm>) The project has been allocated \$13.8 million by the Victorian Government.

Tasmania

The Mental Health Diversion List (MHDL) was piloted in Hobart, Tasmania in 2007 and was significantly modelled on South Australia’s MCDP. The Hobart List was established as a response to the prevailing concerns at the local and national level about those with mental health problems in the criminal justice system. It seeks to incorporate ‘a more therapeutic approach to criminal justice in a Magistrates Court setting and aims to address *the reasons for* the offending behaviour, rather than simply addressing and sanctioning the said behaviour’ (Newitt & Stojcevski (2009: 10-11). As Newitt & Stojcevski (2009: 10-11) state, the Tasmanian Mental Health Diversion List (MHDL), like South Australia’s MCDP and unlike New South Wales, ‘does not operate as a separate or distinct court and is not subject to any special or unique legislation or practice directions ... it [is] a court diversion program which operates as a specialist list in the Magistrates Court and uses the existing extensive provisions under the *Bail Act 1994* (Tas) and the *Sentencing Act 1997* (Tas) to formulate and impose treatment plans or conditions on participants. Despite not being a distinct Mental Health Court, the MHDL shares ‘a number of similarities with such courts, including in its general operation and objectives’. Currently, the MHDL is only targets adults aged 18 years and over whose offending behaviour is linked to their mental illness. The operation and management of the MHDL is detailed in the 2009 evaluation of the List

([http://www.supremecourt.tas.gov.au/data/assets/pdf_file/0003/127029/Mental Health Diversion List - Evaluation Report - May 2009.pdf](http://www.supremecourt.tas.gov.au/data/assets/pdf_file/0003/127029/Mental_Health_Diversion_List_-_Evaluation_Report_-_May_2009.pdf) at pages 10-17).

Eligibility for participation in the MHDL is currently limited to adult defendants with impaired intellectual or mental functioning as a result of a mental illness (as defined in the *Mental Health Act 1996*). The concept overall is currently being considered as to whether it may be suitable for young offenders (see [http://www.magistratescourt.tas.gov.au/divisions/criminal_and_general/mental_health_diversion/Mental Health Diversion List](http://www.magistratescourt.tas.gov.au/divisions/criminal_and_general/mental_health_diversion/Mental_Health_Diversion_List)).

Defendants with existing mental health issues that would ground an insanity defence under s.16 of the *Criminal Code*, or an argument about fitness to plead under the *Criminal Justice (Mental Impairment) Act 1999*, are ineligible for referral to the Mental Health Diversion List. Such issues are dealt with in the normal court lists.

The 2009 evaluation of the MHDL concluded:

Overall the MHDL appears to be meeting its intended objectives of offering a more therapeutic approach to the criminal justice system for mentally ill defendants and reducing the re-offending rates of such defendants. The analysis of the available quantitative data indicates that offending rates of participants are considerably lower than their offending rates before participation. The data also indicates that a lower percentage of participants who successfully complete the MHDL re-offend in the six months after their matter is finalised than those who are removed from the List [thus confirming that] the MHDL is helping to reduce the recidivism rate of participants (Newitt & Stojcevski (2009: 83).

Since the evaluation the MHDL has been extended to Launceston (March 2010) and one is being developed for Burnie in the north of the state. In April 2011, the Tasmanian Institute of Law Enforcement Studies at the University of Tasmania is conducting an all-day MHDL workshop to consider the 2009 evaluation and other relevant issues. Participants include relevant stakeholders from Victoria and South Australia, the Tasmanian Law Reform Commission, Mental Health Forensic Teams, Magistrates and Police (for more information about this event please contact Jenny Fleming at jenny.fleming@utas.edu.au

There are a number of challenges and considerations that jurisdictions may have to consider before embracing the Mental Health Court option. The impetus around therapeutic jurisprudence and mental health courts generally appears to be building momentum. Different jurisdictions are developing their own ways of assisting the mentally ill (or in Western Australia the intellectually disabled) offender. Tasmania at least is actively pursuing the extension of its MHDL to young offenders. But not everyone sees the Mental Health Court as a viable option. As Richardson (2008) has pointed out there are critics of this approach. The stigma associated with mental illness is often cited due to the potential stigma that attaches to the offender by being dealt with by such 'specialised courts'. As well, jurisdictions larger than South Australia and Tasmania may need extensive resources to

deal with the inevitably larger numbers of offenders that would come through such courts. In Deputy Chief Magistrate Syme's view (NSW), a better solution is to 'ensure all courts ... became equipped to deal with offenders who suffer from a mental health or intellectual disability and that the courts, police, and government departments communicate more effectively so that all are working together to achieve the best possible outcome for the offender and the community' (cited in Richardson 2008: 10). While such an idea has merit, Australian courts have yet to demonstrate that the principle of generic courts able to cater for all specific needs of vulnerable populations is a viable option. Additionally, lobby groups for various groups would invariably reject such a proposal on the grounds that vulnerable/minority populations are unlikely (in their view) to get the best outcome under this arrangement.

As this submission suggests, there are a number of ways to address the issue of the involvement of people with cognitive and mental health impairments in the Australian criminal justice system. To date, these options have not been extended to the young offender. As Richardson observes:

As these programs are shown to be successful, or as problem solving and therapeutic jurisprudence gain strength, it is inevitable that more such programs will be developed in Australia and will potentially expand to the higher courts ... whether more specialised courts are created or a problem-solving orientation is integrated into the mainstream criminal justice system it is an area of continuing change as courts grapple with the issues posed by the mentally ill offender and attempts to halt the revolving door (2008: 20).

The New South Wales Law Reform Commission has the opportunity to take the Mental Health Diversion List or its equivalent and extend it to the young offender with cognitive and mental health impairments. Evaluations to date suggest that this option is at least worth exploring.

The role of police and their role in relation to young offenders with cognitive and mental health impairments in the criminal justice system

11.13 (2) – Is any amendment required, having regard to the applicability of the Act to young people with cognitive and mental health impairment

We would like to state that current terminology used in the legislation is currently too generic to specifically look at the needs of young offenders suffering mental illness or a cognitive impairment. It is important that the support person as discussed under sections 28 and 29 of the *Young Offenders Act 1997*, has extensive training and specialisation in such areas for the situation of the child to be fully grasped. The current terminology ('an appropriate skilled person' or 'a social worker or other health professional') is not conducive to highly trained and specialised health professionals being mandated to come and support a child in need in the process under review here (a forensic psychiatrist with training in

special needs education, for example, as opposed to a social worker). Social work qualifications may be very broad, and not necessarily encompass the special knowledge needed to properly gauge cognitive behaviour and the depth of a mental illness, and their impact on the commission of an offence. Furthermore, it is advised that the specialised health support person should be, as a matter of priority, a person who has been previously aware of the circumstances and condition of the child, to assess the ability of the child to go through the justice process. In this area, there is a need to gauge the socialisation/sociability of the cognitively impaired person, to see if any judicial decision or process is of benefit for the development of the child as well. It is unlikely that a severely ill or impaired child will relate to the social context within which he/she can understand the consequences of an act. The opposite consideration is also valid: specialised assessment is needed for highly functioning mentally ill or cognitively impaired young persons, in order to assess whether they are in a position to understand, relate to, and likely to benefit from their specific bail conditions.

11.14 (2) – Are police able to screen effectively for cognitive and mental health impairments in young people? If not, can this be improved?

It has been argued by many commentators that police officers are arguably the gatekeepers of the criminal justice system. However, in the particular context that concerns us here, it is important to highlight that police officers are not, and should not be, trained to assess the symptoms relating to a mental illness or a form of cognitive impairment. Rather, they should be able to recognise some *signs* (as opposed to *symptoms*), that will help them refer a person of interest to the relevant health professional.

One of the authors is fully familiar with the training received by police recruits and then at the professional development level in NSW, in her former capacity as a Senior Lecturer and Researcher at Charles Sturt University. Prior to the curriculum changing to problem-based learning at the NSW Police College, recruits received, in their first three months at the College, a brief introduction to vulnerable populations (which involves an introduction to mental health and intellectual disability matters), with a specific focus on related powers and legislation. This is then followed by a Distance Education module undertaken in their capacity of Probationary Constables, once they are posted to their Local Area Command (LAC). Both modules cover all categories of vulnerable populations known in NSW, and are not full modules on mental illness or disability (both categories are just part of the program). While a good introduction and awareness exercise about vulnerabilities and some of the specifics relating to mental illness, this training, at recruit level, is currently insufficient to fully demonstrate the complexity of issues surrounding mental illness and disability. Furthermore, issues of co-morbidity are briefly mentioned but not fully explored (Bartkowiak-Théron, 2009).

Most of the more developed information sessions happen at professional development levels, in the delivery of two specialised training for police officers, namely: the Custody Officer training and the Mental Health Intervention Team Officer (MHIT) training. Both are fairly similar in content, with complex issues such as mental illness or cognitive impairment

caused by brain injuries developed in the programs, although the MHIT training is by far the most developed education program.

In January 2008 the NSW Police Force commenced a pilot program to provide enhanced mental health training for a number of front line officers (principally constables, senior constables and sergeants) in three LACs. Training was developed and delivered by a central MHIT unit and aimed to provide officers with enhanced skills in dealing with individuals suffering from mental health related symptoms, particularly those in crises. In doing so the MHIT program aimed to improve police capacity to respond efficiently and safely to such incidents. Specifically, the program aims to:

- Reduce the risk of injury to police and mental health consumers during mental health crisis events;
- Improve awareness by front line police of risks involved in dealing with mental health consumers and strategies to reduce injuries to police and consumers;
- Improve collaboration with other government and non-government agencies in the response to and management of mental health crisis events and
- Reduce the time taken by police in the handover of mental health consumers into the health care system. (Herrington & Bartkowiak-Théron, 2008b, 8).

The MHIT is extensive in its comprising of three stages: an online pre-course training module, a four-day classroom training module, and a post-course practical exercise (Herrington & Bartkowiak-Théron, 2008b, 32). The extensive nature of this training has proven beneficial and a positive impact on police officers awareness of the complexity of mental illnesses has been demonstrated in subsequent impact evaluation (*ibid.*). However, the efforts needed to develop and deliver the training state wide will put a strain on resources, despite efforts by NSWPF to roll on the initiative to a number of locations. Worldwide, training relating to mental health in the criminal justice system tends to portray whole of government approaches, with a number of agencies becoming more aware of collaboration protocols and partnership initiatives designed to address the social, legal and criminological consequences of mental illness and cognitive impairment (Deane et al, 1999; Hails & Borum, 2003; Martinez et al, 2005; Burgess, 2006; Stephenson, 2008).

11.15 (1) – Are youth conduct orders an appropriate way of dealing with young people with cognitive and mental health impairments?

Youth Conduct orders for young people suffering a cognitive impairment are a delicate matter to approach with caution. As per the intricacies linked to fitness of interviewing (Gudjonsson et al, 2000), the fitness of the young person to understand the content and justification for a Youth Conduct Order needs to be addressed when examining issues on a case by case basis. This goes back to the necessity of having the young person properly assessed by a highly trained specialist. Further to the capacity of the young person to

undergo the severity of an order, the issue of monitoring also warrants attention. Who will be in charge of monitoring a Youth Conduct Order when applied to a mentally ill or cognitively impaired young person? Specific allocation of carer, health and specialised education resources will need to be considered before the Commission pronounces anything on the appropriateness of a Youth Conduct Order for mentally ill and/or cognitively impaired youth. The same concerns were expressed in 2009, when 'generic' Youth Conduct Orders were added to provisions of the Children (Criminal Proceedings) Acts 1987. There were fears that an additional workload would fall on the shoulders of already busy police officers, youth specialised officers or case social workers.

11.32 – Should the *Children (Criminal Proceedings) Act 1987 (NSW)* be amended to provide for psychological, psychiatric or other assessments of young offenders prior to sentencing?

Mandatory assessment of a particular condition for one individual when there are no apparent grounds to do so might create a precedent of assessing every person of interest for any condition possible. This would lead to a potentially large strain on resources and renders real time processing difficult. Therapeutic jurisprudence, while insisting on all precaution to be taken to protect an individual, advises for cases to be promptly assessed and sent to the proper specialised agencies (criminal, health, etc.). Adding to the strain of assessment is not only likely to create a backlog in the criminal justice process, but might also needlessly impact on and aggravate the already existing vulnerable status of the young person. However, assessments are advised when there are visible grounds to do so. Such assessment should not only comprise the exact nature and depth of the young person's ailment, but also mention the personal and social living circumstances of the child (such as caring support, willingness of guardians/carers/parents to go on with proceedings), medical history, etc. The assessment needs to be the most thorough possible, to avoid the need for further assessments in the long term. Such an assessment should not be located within the realm of responsibilities of police, but rather the responsibility of Health and Special Education Departments. The responsibilities of police should always remain within the areas of risk management, protection of the public (and persons in custody), law enforcement and peace keeping.

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