AN EVALUATION OF THE NSW COURT LIAISON SERVICES

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NSW Bureau of Crime Statistics and Research

2009

Published by the NSW Bureau of Crime Statistics and Research

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ISBN 978-1-921626-03-6

This report is available in pdf format on our website and may be provided in alternative formats. Please contact the Bureau on 02 9231 9190 or email us at bcsr@agd.nsw.gov.au

ACKNOWLEDGEMENTS

A number of people contributed to this research evaluation. Thanks are extended to the Justice Health staff from the Statewide Community and Court Liaison Service and the Adolescent Court and Community Team for their assistance and co-operation in conducting this evaluation. In addition, thanks are due to the stakeholders who provided their honest views on the impact and operation of the diversion services. In particular, stakeholder feedback from the Justice Health adult and adolescent diversion staff and program managers, magistrates, court registrars, and representatives from the Aboriginal Legal Service, the Legal Aid Commission, NSW Police Force, Department of Corrective Services, the Department of Juvenile Justice and NSW Health, is much appreciated.

Thanks are extended to Dr Don Weatherburn, Mr Craig Jones, Ms Lily Trimboli and Ms Devon Indig, who provided constructive feedback throughout the duration of this evaluation. Many thanks also to the independent peer reviewers for their helpful feedback.

Thanks are owed to the Bureau's computer programmers, Mr Jiuzhao Hua, Ms Lucy Snowball and Mr Mark Ramsey for extracting relevant data. Thanks are also extended to Mr Steve Moffatt, Ms Clare Ringland and Ms Laura Rodwell for advice on statistical modelling procedures. Additionally, the contribution of Ms Florence Sin in desktop publishing this report is appreciated.

Finally, thanks are due to the Centre for Health Research in Criminal Justice, Justice Health for their on-going support and contributions to this research.

CONTENTS

EXECUTIVE SUMMARY

An evaluation was undertaken of the Justice Health Statewide Community and Court Liaison Service (SCCLS) for adults and the court diversion services provided by the Justice Health Adolescent Court and Community Team in New South Wales. The SCCLS began on a pilot basis in two local courts in 1999 and has since been expanded to 21 local courts across the state. The diversion services provided in the adolescent jurisdiction commenced in 2006 and currently operate in five children's courts across the state. Both services provide assessments and reports to the court on mental health matters and, where appropriate, assist with the diversion of individuals with mental health difficulties into appropriate psychiatric health services.

The NSW Bureau of Crime Statistics and Research (BOCSAR) and the Centre for Health Research in Criminal Justice (Justice Health) were commissioned by the NSW Criminal Justice Chief Executive Officers' Group to undertake this evaluation. The evaluation has two components. The first component comprises quantitative analyses focusing on adult clients of the SCCLS examining whether there is a difference in the mean number of offences recorded per month prior to and subsequent to contact with the SCCLS. The second component of the evaluation comprises stakeholder opinions on the implementation, operation and impact of both the SCCLS and the diversion program for adolescents.

QUANTITATIVE ANALYSES: CRIMINAL JUSTICE OUTCOMES

For the quantitative analyses, two sets of comparisons were conducted assessing criminal justice outcomes over an 18-month follow-up period for both SCCLS clients and control groups of individuals appearing at local courts in New South Wales. The first comparison involved individuals with a finalised local court appearance resulting in a dismissal under the *Mental Health (Forensic Provisions) Act 1990*, in 2004 or 2005. The subset of individuals who had contact with the SCCLS in 2004 or 2005 and a mental health dismissal in a local court serviced by the SCCLS (the treatment group, n=320) was compared with a subset that did not have a record of contact with the service in 2004 or 2005 and had a mental health dismissal in a non-SCCLS local court (the control group, n=842). The second comparison investigated outcomes for the remaining individuals with an identified record of SCCLS contact in 2004 or 2005 (who had a finalised local court appearance, n=1610) with a random sample of individuals given supervised bonds in local courts not serviced by the SCCLS (n=1259). For both comparisons, criminal justice outcomes were measured by examining offences resulting in finalised court appearances.

Preliminary analyses of the descriptive characteristics of each group showed that there were significant differences across both comparisons, with individuals in contact with the SCCLS showing a greater overall degree of contact with the criminal justice system

than control groups. To investigate whether there was any impact of SCCLS contact on the rate of offending (resulting in finalised court appearances), repeated measures analyses were conducted focusing on the change in the mean number of offences per month from the 18-months prior to the index court appearance (pre-period) to the 18-months following this date (post-period). This analysis utilised each group as its own control in determining differences in offending frequency and revealed some positive outcomes for the SCCLS.

For the first comparison of cases receiving dismissals under the *Mental Health (Forensic Provisions) Act 1990* at the index court appearance, analyses controlling for relevant demographic factors showed a significant decreasing trend in the mean number of offences per month in the 18-month follow-up period relative to the 18-month pre-period for the treatment group, but not for the control group. That is, there was a decline in the mean number of offences per month for SCCLS clients across the 18 months following their index mental health dismissal that was not observed for individuals in the control group. With respect to the second comparison, findings revealed a decreasing trend in monthly offences in the follow-up period relative to the pre-period for both SCCLS clients and control cases. However, in the month immediately following the index court appearance there was a large decrease in the mean number of offences per month for the SCCLS client group, while a slight increase was shown for the control group. Specifically, after excluding cases that received custodial penalties at the index court appearance, there was an immediate, significant decline in offending frequency following the index date for SCCLS clients that was not observed for the control group of individuals receiving supervised bonds. Taking the outcomes from both comparisons into consideration, these findings provide some evidence that the Justice Health SCCLS intervention has a positive impact on reducing the frequency with which clients come into contact with the criminal justice system.

KEY STAKEHOLDER VIEWS

Key stakeholder views on the impact and operation of the SCCLS and the diversion services provided by the Adolescent Court and Community Team were ascertained through a combination of face-to-face and phone interviews with stakeholders in criminal justice and health settings. Representatives of the following groups/agencies participated in key stakeholder interviews dealing with the adult diversion service: staff from the Justice Health SCCLS, Local Court Magistrates, court registrars, the Legal Aid Commission, the Aboriginal Legal Service, NSW Health, NSW Police Force and the Department of Corrective Services (DCS). Interviews dealing specifically with the adolescent service were conducted with staff from the Justice Health Adolescent Court and Community Team, Children's Court Magistrates and representatives from the Department of Juvenile Justice (DJJ).

The majority of key stakeholders felt that the impact of both services had been positive and were effective in assisting the court with mental health matters. Stakeholders reported that the most significant benefit of the services has been the overall assistance provided to the court in identifying individuals with mental health issues, communicating this information to the court and, where appropriate, facilitating diversion into treatment services. Other identified strengths of the services included: the availability of the liaison nurses to court personnel to assist with mental health issues, the timely response of service staff in dealing with referrals and conducting mental health assessments, and the capacity of court diversion staff to effectively access the health system.

Some aspects of the services were identified as areas for improvement. Recommendations made in this regard included: increasing service availability and improving coverage for staff leave; increasing the provision of education and training on mental health matters; increasing awareness of the services amongst relevant groups through further advertising of the services; and ensuring that continued efforts are made to establish and maintain collaborative links with all stakeholder agencies, particularly with potential treatment services in health settings.

Further expansion of both services across the state was strongly supported across stakeholder groups. Stakeholder recommendations for future expansion included identifying areas with a "high need" for the services and targeting expansion accordingly. Some stakeholders also suggested that alternative service provision arrangements (other than full-time services) could be considered for lower need areas in order to provide greater service provision across the state.

1. INTRODUCTION

The prevalence of mental illness among persons in the criminal justice system and in custodial settings is markedly higher than in the general population. On an international scale, a review of over 60 surveys examining the prevalence of mental disorders in prisons across 12 countries found that inmates were substantially more likely than the general population to suffer from major mental disorders, including psychotic disorders, major depression and anti-social personality disorder (Fazel & Danesh 2002). These findings are echoed in recent studies in the United States, where estimates of mental health problems among inmate populations exceed 50 per cent (James & Glaze 2006); in New Zealand where considerably elevated prevalence rates of mental disorders (e.g. psychotic disorders, major depression) have been observed in prisoners compared to community samples (Brinded et al. 2001); and in incarcerated juvenile populations in the United States (Teplin et al. 2002).

Similar high rates of mental illness in prisoner populations have been observed in Australia. In the national context, the results of the most recent National Survey of Mental Health and Wellbeing conducted in 2007 found that the 12-month incidence of mental disorders among individuals who have been incarcerated (41%) was more than double that reported for those with no history of incarceration (19%) (Australian Bureau of Statistics 2007). Research examining prisoners in New South Wales revealed that the prevalence of any psychiatric disorder[1] over the preceding 12 months was 74 per cent among inmates compared to 22 per cent in the general community (Butler & Allnut 2003).[2] The 12-month prevalence of mental disorders including psychosis, anxiety disorder or affective disorder was 43 per cent, a markedly elevated rate to that observed in comparison community samples. Notably, this research revealed that the 12-month prevalence of psychosis in the inmate population was 30 times higher than in the general community in Australia (Butler & Allnut 2003). More broadly in the criminal justice system, research examining the self-reported psychosocial needs of a sample of offenders appearing in NSW local courts showed that 55 per cent of individuals sampled suffered from at least one psychiatric disorder (Jones & Crawford 2007). Among adolescents, an analysis conducted in 2003 of young people in custody in NSW found that 88 per cent reported symptoms ranging from mild to severe that were indicative of a clinical disorder (NSW Department of Juvenile Justice 2003). These analyses clearly demonstrate that persons experiencing serious mental health difficulties are over-represented throughout the criminal justice system, particularly in custodial settings.

In response to the findings in the NSW prisoner analysis, Butler and Allnut (2003, p. 16) state that, “the overall burden of mental illness that these findings suggest for both the Corrections Health Service and the Department of Corrective Services is staggering”. Further, the various challenges in delivering mental health services in custodial settings highlighted the need for better methods of providing mental health care to this population (Greenberg & Nielsen 2002).

Mental Health Courts

Different initiatives have been developed in many parts of the world to address the disproportionate rates of mental illness in prison populations, and to deal more appropriately with mentally ill offenders presenting to the criminal justice system. In the United States, specialist courts, commonly referred to as mental health courts, have been established. Mental health courts are a type of problem solving court, similar to drug courts, which function as a dedicated court for processing people with a mental illness (James 2006; Steadman, Davidson & Brown 2001). While court models differ operationally across locations, Steadman et al. (2001) noted that some common features of mental health courts include: the handling of all cases involving mental illness on a single court docket, the use of a courtroom team approach to develop treatment plans and to make necessary treatment linkages, ensuring the availability of appropriate treatment services, and court supervision of program progress with possible sanctions for non-compliance.

Currently in Australia, there are two programs in operation that have adopted the problem solving court model, the Magistrates Court Diversion Program in South Australia and the Mental Health Diversion List in Tasmania (Richardson 2008). The Magistrates Court Diversion Program in South Australia (see Burvill et al. 2003; Hunter & McRostie 2001; Skrzypiec, Wundersitz & McRostie 2004) began on a pilot basis in 1999 and has since been funded to continue and expand its operation (Burvill et al. 2003). The Mental Health Diversion List in Tasmania commenced on a pilot basis in the Hobart Magistrates Court in 2007 and is continuing in operation (Magistrates Court of Tasmania 2009). While there is also the Mental Health Court of Queensland, this court differs to the programs in South Australia and Tasmania, as it mainly deals with issues assessing soundness of mind, fitness for trial and diminished responsibility (Department of Justice and Attorney-General Queensland 2005).

Court Diversion and Liaison Services

Another widely implemented method developed to deal with mentally ill offenders at the court-stage is through court diversion and liaison schemes. Diversion is defined as "a policy of transferring the mentally ill away from the criminal justice system and into psychiatric care" (James 2006, p. 529). Broadly, the objectives of court diversion and liaison programs are to provide court-based mental health assessments, and where appropriate, to divert mentally ill offenders from the criminal justice system and to link them with appropriate psychiatric services in hospitals or in the community (Birmingham 2001; James 1999, 2006; Richardson 2008). In contrast to mental health court models, these services do not engage in follow-up supervision of offenders once diverted from court (Richardson 2008). While there is some variation across schemes in operational structure, many services are staffed by psychiatric nurses who provide a link between the criminal justice system and the health system (Birmingham 2001; Brinded et al. 1996; NACRO 2005). Importantly, "court diversion does not equate with discontinuation of criminal prosecution; it allows for the two systems of diversion and prosecution to work in a collaborative manner. Court diversion to mental health services allows the judiciary to get on with the job of processing individuals through the courts" (Greenberg & Nielsen 2002, p. 159).

Court diversion programs have been operating widely in Magistrates' courts across the United Kingdom since 1989 and in New Zealand since the early 1990s. Research examining the effectiveness of UK programs has revealed some positive findings in successfully identifying mentally disordered offenders, facilitating access to mental health services (James 1999; James & Hamilton 1991), and in reducing court processing time for mental health matters (Exworthy & Parrott 1997). Some evidence of positive outcomes for offending have also been revealed in a recent Home Office funded case-control study comparing individuals admitted to hospital through court diversion with a group of compulsory admissions from the general community (James et al. 2002). Results showed that while court diverted cases had more convictions in the two years following hospital discharge than the community group, the court diverted individuals had significantly reduced conviction rates in the follow-up period compared to the two years prior to hospital admission. Additionally, two-year re-conviction rates were substantially lower amongst the court diverted group compared to the documented Home Office recidivism rates for offenders given custodial or non-medical community orders at court (James et al. 2002).

However, there remains a dearth of comprehensive evaluation research examining the long-term effectiveness of diversion services on client outcomes (Greenberg & Nielsen 2002; Hunter, Boyce & Smith 2008; NACRO 2005). Indeed, authors of a recent review of diversion programs conducted in the UK noted "that there is a serious shortage of reliable quantitative information on the workings of diversion schemes, particularly in relation to their outcomes, effectiveness and cost-effectiveness" (Sainsbury Centre for Mental Health 2009, p. 9). Further, due to procedural variations across service locations (Hunter et al. 2008), more targeted research examining specific program outcomes is needed.

Most jurisdictions in Australia have established court liaison/diversion services for mental health or specialised courts/lists, as reviewed above, for the purpose of assessing and diverting mentally unwell individuals from the criminal justice system into treatment (Richardson 2008; Senate Select Committee on Mental Health 2006). Indeed, as part of the National Statement of Principles for Forensic Mental Health (2002), the provision of court liaison/diversion services is included as a main function of a comprehensive forensic mental health service.

This report focuses on the court diversion services provided in NSW by the Justice Health Statewide Community and Court Liaison Service and the Justice Health Adolescent Court and Community Team.

1.1 DIVERSIONARY LEGISLATION IN NEW SOUTH WALES

In NSW, the process of diversion to mental health services in the Local Courts is supported by specific legislation under sections 32 and 33 of the *Mental Health (Forensic Provisions) Act 1990*.[3] As set out in section 31, diversionary powers under sections 32 and 33 apply to criminal proceedings for summary offences and indictable offences triable summarily before a Magistrate, as well as any related bail proceedings. Committal proceedings are excluded.

Under section 32, magistrates have the authority to dispose of criminal charges for defendants who are developmentally disabled, suffering from mental illness, or suffering from a mental condition for which treatment is available in a mental health facility but who are not mentally ill persons. Using section 32(3) magistrates can make orders dismissing charges and discharging defendants:

a) into the care of a responsible person, unconditionally or subject to conditions, or

b) 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, or

c) unconditionally.

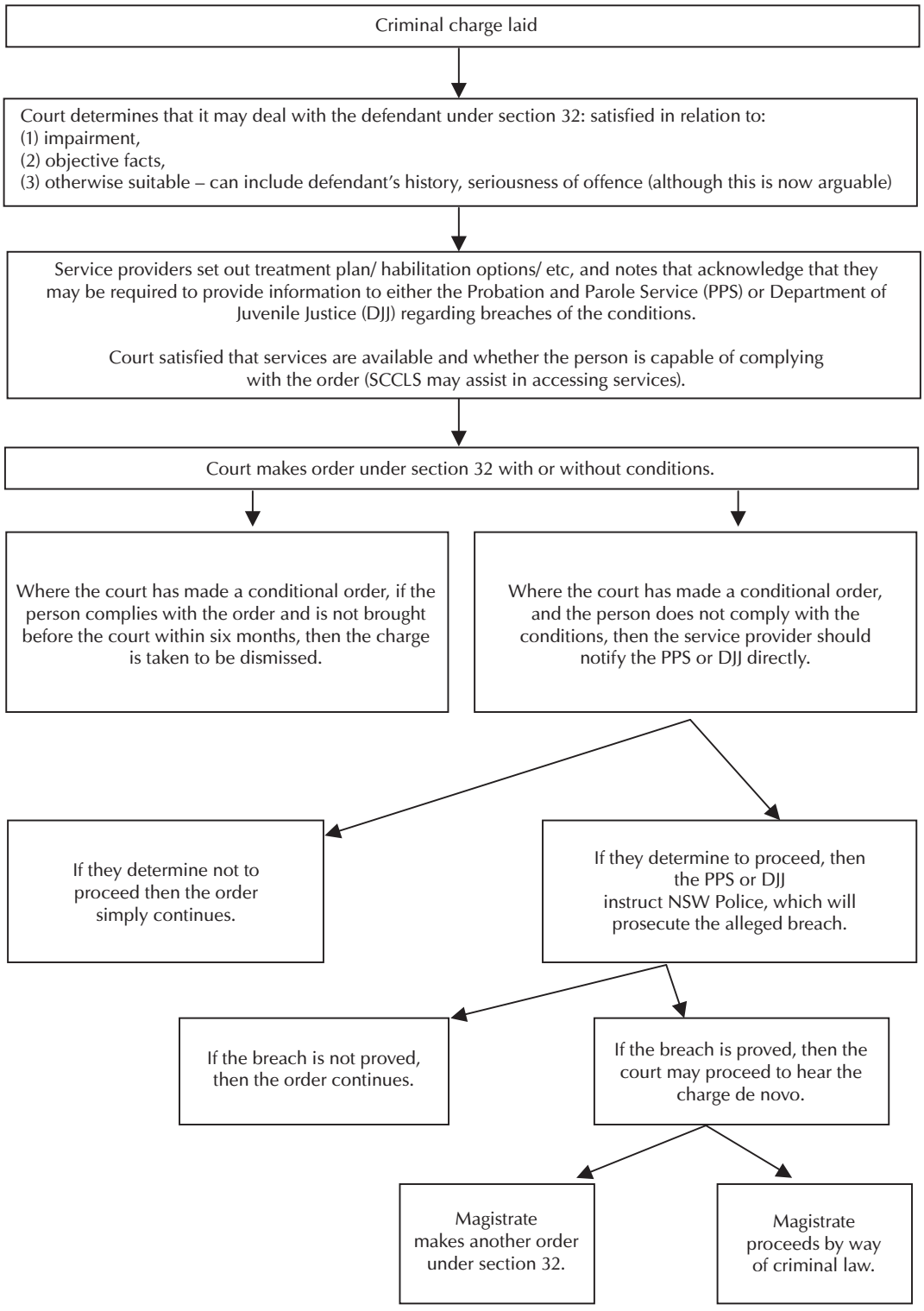
(Source: Mental Health (Forensic Provisions) Act 1990, No 10, Part 3, s. 32)

That is, an order under section 32(3) can result in diversion from the criminal justice system into the health system in lieu of conviction.[4] However, if a magistrate suspects that an individual subject to an order under section 32(3) is not complying with conditions in the six months following the order, the magistrate can call the defendant back to court under section 32(3A), where the charges may be dealt with afresh (de novo). The provision to enforce section 32(3) orders resulted from amendments made by the *Crimes Legislation Amendment Act 2002*, and commenced in 2004 (Spiers 2004).

Importantly, in exercising discretion to grant orders under section 32, the court must be confident that a treatment service is available (DPP v Albon 2000 NSWSC 896). In achieving this, a viable treatment plan should be provided to the court by a service provider before an order is granted (Spiers 2004).

The process of diversion under section 32, adapted from Spiers (2004) is illustrated in Figure 1.

Figure 1: Overview of diversion under section 32, *Mental Health (Forensic Provisions) Act 1990* (Spiers 2004)



Section 33 of the *Mental Health (Forensic Provisions) Act 1990* applies to mentally ill persons. Under this legislation a magistrate:

a) may order that the defendant be taken to, and detained in, a mental health facility for assessment, or;

b) may order that the defendant be taken to, and detained in, a mental health facility for assessment and that, if the defendant is found on assessment at the mental health facility not to be a mentally ill person or mentally disordered person, the person be brought back before a Magistrate or an authorised officer, or;

c) may discharge the defendant, unconditionally or subject to conditions, into the care of a responsible person.

(Source: Mental Health (Forensic Provisions) Act 1990, No 10, Part 3, s. 33)

Also, under Section 33(1A), the magistrate may make a community treatment order in accordance with the *Mental Health Act 2007* to be administered by a health care agency in relation to the individual.

If an individual subject to an order under section 33 is not brought back before the magistrate within six months to be further dealt with in relation to the charges that gave rise to the initial diversionary order, then the charges are taken to be dismissed (Section 33(2)).

1.2 THE NSW STATEWIDE COMMUNITY AND COURT LIAISON SERVICE

Background

The pilot for the Statewide Community and Court Liaison Service (SCCLS) was established in 1999 by NSW Justice Health (formerly NSW Corrections Health Service) primarily in response to two matters (Greenberg & Nielsen 2003):

1. The high rates of mental illness in prisons and the associated difficulties in managing mentally ill individuals in custodial settings for minor offences. This led to an acknowledgment that this population could be better cared for through more immediate referral to appropriate community health settings; and
2. The difficulties experienced by magistrates in utilising the diversionary legislation under the *Mental Health (Forensic Provisions) Act 1990*. Initially, the implementation of the diversionary legislation presented challenges for magistrates, particularly in referring mentally ill offenders to hospitals for treatment under section 33. Greenberg and Nielsen (2003) noted that referrals to hospital for assessment and treatment were frequently rejected and returned to court and that "improved liaison services between the courts and local hospitals were in need of attention" (p. 2).

The pilot for the SCCLS began at Central Local Court and Parramatta Local Court. Feedback about the pilot obtained from stakeholders in mental health services, the criminal justice system and relevant consumer groups was positive and supported the continued existence of current services and further service expansion (Greenberg & Nielsen 2003). The success of the pilot led to the official commencement of the SCCLS in 2002 at seven local courts across the state. Since the official inception of the service, the NSW Government has considered the service statistics on numbers of offenders diverted into treatment and has funded additional service expansion. Indeed,

continued expansion of the mental health court liaison service is included in the NSW Department of Health Strategic Plan Towards 2010 (NSW Department of Health 2007). At the time the current evaluation commenced in January 2008, the service was based at the following 17 local courts in metropolitan and regional settings across the state: Blacktown, Burwood, Campbelltown, Central Sydney, Coffs Harbour, Dubbo, Gosford, Lismore, Liverpool, Manly, Nowra, Parramatta, Penrith, Sutherland, Tamworth, Wagga Wagga, and Wyong. Since this time, the service has been further expanded to Port Macquarie, Kempsey, Milton and Wollongong. [5]

Service Structure

The SCCLS is part of the Statewide Forensic Mental Health Directorate and is entirely under the jurisdiction of Justice Health. The management structure of the service comprises a clinical director, an operations manager, a consulting forensic psychiatrist, an administrative officer, and includes reporting relationships to the Director of Statewide Forensic Mental Health Services. At each court where SCCLS services are available, a court liaison officer (mental health nurses/clinical nurse consultants) provides service to the court under the supervision of consulting psychiatric personnel (Greenberg 2008).

Though there are no formal partnerships, various agencies are working collaboratively with the Justice Health SCCLS. These include: NSW Local Courts, the Attorney General's Department, Magistrates, the Department of Corrective Services, NSW Police, the Director of Public Prosecutions, the NSW Department of Health and Area Health Services, and legal services (Greenberg & Nielsen 2003; The Audit Office of New South Wales 2006).

Program Overview

The SCCLS is a court-based diversion program targeting individuals in the criminal justice system with mental health difficulties. The service is available after the process of prosecution has begun for individuals charged with non-indictable offences appearing in Local Courts. Broadly, the service provides mental health assessments and reports to the court to assist magistrates in making informed decisions about cases involving those with mental health problems (Greenberg & Nielsen 2003).

According to the SCCLS program manual (Source: Greenberg 2008, p. 6), the service aims and objectives are:

1. To assist the courts with the diversion of mentally ill and mentally disordered individuals by linking them to appropriate mental health services in the community, prison and hospital system;
2. To enable the court to make well informed decisions without delay, by providing timely triage psychiatric assessments and evaluations in the courts and holding cells;
3. To ensure those mentally ill individuals have access to and obtain psychiatric and psychological treatment and to minimise unnecessary exposure of people with mental illness to the criminal justice system;
4. To establish and maintain links with a wide range of mental health and community service agencies in order to be able to access the broadest range of advice regarding options and alternatives for the court;
5. To provide a state-wide network of court liaison services in NSW which maintains consistency throughout the courts to provide a system of quality improvement to provide best practice for patient outcome;

6. To provide education and training on mental health matters and its interface with the criminal justice system to a wide range of court personnel, area mental health services, community members, consumers and carers;
7. To undertake research in the area of community and court liaison services to ensure that there is provision of evidence based best practice services.

In meeting these objectives, the SCCLS provides a range of services, including (Source: Greenberg 2008, p. 7):

- The Court Liaison Officer will provide a Triage and Screening service for fresh custodies, remand and out of custody referrals;
- Psychiatric assessment for possible mental illness or mental disorder. This may include individuals with co-morbid drug/alcohol issues, intellectual disabilities and acquired brain injury. On occasions children – this will be on a case-by-case basis - following discussion and support from Consultant Psychiatrist;
- Assessment for the likelihood of the need for psychiatric treatment, management, follow up and care options;
- Providing advice to courts to prioritise mentally ill individuals for psychiatric assessment and treatment in the community, prison and hospital system;
- Assessing the need for more comprehensive psychiatric evaluation and diagnostic psychiatric consultation or Justice Health Judicial court report;
- Assistance in the development of conditions for various community court orders;
- Developing collaborative linkages between the criminal justice system and the mental health system;
- Training of court personnel to identify detainees or arrestees who could benefit from a mental state assessment;
- Education of a broad range of stakeholders working in or in contact with the criminal justice system.

The SCCLS diversion process (Greenberg 2008; Greenberg & Nielsen 2002) broadly comprises three phases:

1. the screening and identification of individuals suspected of having a mental illness or mental disorder;
2. psychiatric assessment and triage by a mental health professional of persons identified in the screening phase; and
3. diversion, if appropriate, in negotiation and consultation with court staff and relevant health services.

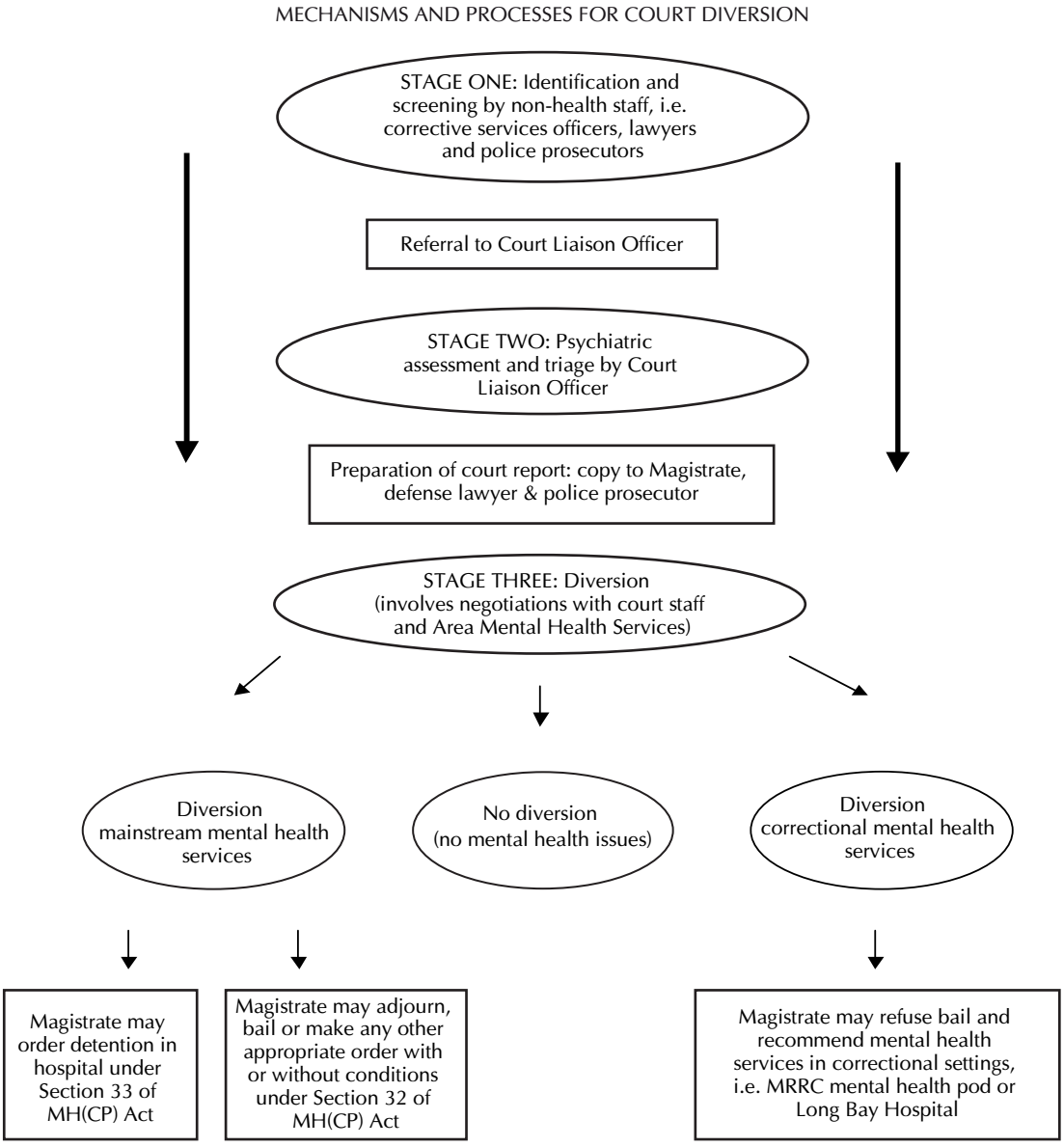
In identifying possible cases for mental health assessment, the court liaison officers screen all detainees at court through daily review of police facts sheets, DCS documents and any other available relevant information (Greenberg 2008). The service also accepts referrals of individuals with suspected mental health problems from a variety of possible sources, though most referrals come from court-based personnel (i.e. legal practitioners and corrective services staff). In the assessment phase, psychiatric interviews are conducted with the informed written consent of all individuals. Following assessments, court liaison officers gather background health information and documentation to support clinical findings and integrate all relevant information into a court report in consultation with supervising psychiatric staff (Greenberg 2008). In reporting to the court, the court liaison officers act as "friends of the court," providing impartial views on mental health matters and making recommendations outlining options for the court in dealing with matters (Greenberg 2008). Finally, if the court deems diversion to mental health facilities in the community appropriate, the court liaison officers communicate with the appropriate services and provide relevant information to assist with the

integration of individuals into treatment. When the court does not consider community diversion appropriate, the court liaison officers can facilitate access to appropriate care in custodial settings (Greenberg 2008; Greenberg & Nielsen 2002). The SCCLS has no ongoing clinical management or supervision role for individuals once diverted from court into the mental health system (Greenberg 2008).

Recent statistics compiled regarding client service provision for the SCCLS show that in the 12-month period from July 2007 until June 2008, 14,746 individuals appearing at courts in NSW were screened for a mental illness and 1,990 were subject to a SCCLS mental health assessment. Of those assessed, 1,662 (84%) were identified as suffering from a severe mental illness or disorder and 1,180 (71%) were diverted to treatment services/facilities in the community (Justice Health 2009).

Figure 2 (extracted from Greenberg & Nielsen 2002, p. 159) summarises the process of diversion provided by the SCCLS.

Figure 2. The SCCLS Diversion Process (Greenberg & Nielsen 2002)



1.3 ADOLESCENT COURT AND COMMUNITY TEAM

The diversion services provided by the Adolescent Court and Community Team began as a pilot project at Cobham Children's Court in 2006.[6] The service has since been expanded and is currently operating on a part-time basis at five children's courts based at: Parramatta, Bidura, Campbelltown, Woy Woy and Wyong. However, at the time the current evaluation commenced, the service was only available at Parramatta, Bidura and Campbelltown. The program is run by the Justice Health Adolescent Health Service and is staffed by a service manager, the clinical director for adolescent mental health, a consulting psychiatrist, and clinical nurse consultants or mental health clinicians based part-time at each of the identified courts.

The service targets young people in the criminal justice system aged 12 to 18 years who have committed non-indictable offences. Similar to the process in the adult jurisdiction, the clinicians based at court accept referrals from other court-based agencies for the purpose of performing clinical assessments for young people showing signs of possible mental illness or emerging mental disorder. However, in contrast to the SCCLS, the adolescent service is currently entirely referral-based and does not include an additional screening component of individuals in custody. Following assessments, court clinicians compile relevant background information and, in consultation with supervising psychiatric personnel, prepare a report for the court outlining mental health issues and possible options for dealing with young people in custodial and community settings. If deemed appropriate by the court, the court clinicians liaise and facilitate diversion to appropriate treatment services in community settings. In the 2007 calendar year, service statistics showed that of 212 assessments completed, 169 (80%) young people were identified with mental health issues and 127 were diverted into community settings/ facilities.

1.4 THE CURRENT STUDY: AN EVALUATION OF THE NSW COURT LIAISON SERVICES

The NSW Bureau of Crime Statistics and Research (BOCSAR) and the Centre for Health Research in Criminal Justice (Justice Health) were commissioned by the NSW Criminal Justice Chief Executive Officers' Group to undertake this evaluation. The primary aim of this evaluation was to assess the effectiveness of the diversion services. This was achieved through quantitative analyses of criminal justice outcomes for adult clients of the SCCLS and qualitative analyses of key stakeholder views towards the adult and adolescent services. While these measures do not encompass all aspects of service effectiveness, they are often employed as important indicators of program success in criminal justice settings. Quantitative analyses were not conducted for the adolescent diversion program due to the relatively recent implementation of the program and insufficient follow-up time to assess offending outcomes.

The aim of the quantitative component of this evaluation was to assess the impact of the court-based mental health intervention provided by the SCCLS on rates of contact with the criminal justice system. To investigate this outcome, two sets of treatment and control groups comprising individuals in contact with local courts in New South Wales were identified and analyses were conducted examining the mean number of offences recorded per month over a 36-month period. In brief, the first comparison focused on individuals with and without contact with the SCCLS whose court matters were dealt with via the diversionary legislation under the *Mental Health (Forensic Provisions) Act 1990*. The second comparison examined individuals with SCCLS contact who had varied court outcomes with a similarly diverse group of offenders receiving supervised bonds.

The second component of this evaluation examined stakeholder opinions on the impact of both the SCCLS and the diversion program for adolescents provided by the Adolescent Court and Community Team. This component broadly addressed stakeholders' perceptions of the impact of the services, the effectiveness of the services in achieving program objectives, and any recommendations for improvement and expansion. The specific issues covered in stakeholder discussions are outlined in detail in the next section.

2. METHOD

This section is presented in two parts. The first part describes the method used for identifying the data sources and selecting samples for the quantitative analyses examining the impact of the SCCLS on contacts with the criminal justice system. The second part describes the method used to obtain feedback from key stakeholders. Ethics approval for this evaluation was obtained in 2007 from the Justice Health Human Research Ethics Committee. With respect to stakeholder discussions, ethical clearance was granted from the required agencies in advance of interview commencement.

2.1 QUANTITATIVE ANALYSES

Data Extraction and Linkage

Data were extracted from two separate databases: the Service Contact Information - Mental Health Outcomes and Assessment Tool (SCI MH-OAT) data collection (containing SCCLS contacts) managed by Justice Health, and the BOCSAR Re-offending Database (ROD). The SCI MH-OAT database is an on-going statewide health initiative for recording client and service data across mental health services (NSW Department of Health 2006). Court liaison officers are required to enter relevant data on client referrals and service provision into this database (Greenberg 2008).

To identify SCCLS clients for linkage to ROD, records from SCI MH-OAT pertaining to SCCLS data were extracted for 2004 and 2005. These years were selected to allow for adequate follow-up time to examine criminal justice outcomes. The SCI MH-OAT variables used for matching were:

- full name;
- date of birth;
- sex;
- Master Index Numbers (MIN) or Criminal Names Index (CNI); and
- date and type of contact with the SCCLS.

A number of individuals in the SCI MH-OAT data set had multiple recorded contacts with the SCCLS in 2004 and 2005. For these individuals, the date of their first SCCLS contact was extracted for linkage to ROD. Using the extracted variables from SCI MH-OAT for all unique cases recorded by the SCCLS in 2004 and 2005, 99 per cent were matched to ROD (n=2479). This group of individuals with a record of SCCLS contact was then broken down into two treatment groups based on local court outcomes in 2004 and 2005, as described in the next section.[7]

Identification of Treatment and Control Groups

In order to examine criminal justice outcomes for patients of the SCCLS, two sets of analyses were carried out comparing individuals receiving SCCLS services to non-equivalent control cases.

For the first comparison, the treatment group (Treatment Group A) consisted of unique individuals who had recorded contact with the SCCLS in 2004 or 2005 and had a finalised local court appearance in a SCCLS court that resulted in a dismissal under the *Mental Health (Forensic Provisions) Act 1990*.[8] The control group (Control Group A) consisted of unique individuals who had a finalised local court appearance in 2004 or 2005 resulting in a dismissal under the *Mental Health (Forensic Provisions) Act 1990* in a local court where the SCCLS was not available. Therefore, this analysis focused on persons who had been deemed appropriate by the court for diversion into community mental health settings, but the key difference between the groups was whether individuals had recorded contact with the SCCLS. For the second comparison, the treatment group (Treatment Group B) consisted of the remainder of unique SCCLS clients identified in SCI MH-OAT and linked to ROD who had a finalised local court appearance in 2004/2005. This treatment group comprised all clients referred to and in contact with the SCCLS in the specified time frame that did not meet the criteria for Treatment Group A; this likely included both individuals with mental health problems as well as those who upon assessment, may have been found not to have mental health difficulties.[9] The control group (Control Group B) consisted of a random sample of individuals who received a penalty of supervised bond in 2004 or 2005 in a local court where the SCCLS was not available. A supervised bond consists of a good behaviour bond where the court has ordered the offender to adhere to certain additional conditions (e.g. participation in treatment programs, performing community service), which are supervised by the Probation and Parole Service. Recent research has shown that a significant proportion of offenders on supervised bonds have mental health treatment needs (Weatherburn & Trimboli 2008). Therefore, this second comparison was an investigation of a more heterogenous group of individuals (both with and without mental health problems) with recorded SCCLS contact versus a similarly diverse group of offenders given supervised bonds.

For each individual within SCCLS contact groups and control groups, it was necessary to identify an index court appearance date from which to examine patterns of past and subsequent contacts with the criminal justice system. For the first comparison, the index date for the SCCLS group was the date of the finalised court appearance in 2004 or 2005 closest to the first recorded SCCLS contact date that resulted in mental health dismissal in one of the twelve local courts where SCCLS services were provided in 2004 and 2005.[10] Because the control group for these analyses did not have contact with the SCCLS, the index date selected was the first finalised court appearance in 2004 or 2005 that resulted in a mental health dismissal in a non-SCCLS local court. For the second set of analyses (Treatment Group B vs. Control Group B), the index court date selected for SCCLS clients (Treatment Group B) was the date of the finalised local court appearance (in any local court) closest to the first SCCLS contact date in 2004 or 2005, resulting in any outcome other than a dismissal under the *Mental Health (Forensic Provisions) Act 1990* in one of the twelve local courts where the SCCLS was available in 2004 and 2005. For Control Group B, the index date selected was the first finalised local court appearance in 2004/2005 resulting in the penalty of supervised bond in a non-SCCLS local court.[11]

For a number of cases with a record of contact with the SCCLS in 2004 or 2005, a suitable index date could not be identified. This was either because the date of the closest local court appearance to the date of SCCLS contact was not within 2004/2005 or because a local court appearance date could not be identified within the specified time frame.[12] This resulted in the exclusion of 428 cases with recorded contact with the SCCLS.

Independent variables

The key independent variable in both sets of analyses was whether or not an individual had contact with the SCCLS. Individuals with SCCLS contact were identified as Treatment Group A and B in the first and second set of analyses, respectively. A number of control variables reflective of demographic indicators known to be associated with offending patterns (e.g. Smith & Jones 2008) were also included in analyses. Control variables extracted from ROD included:

a) Age: Age at reference date broken down into the following categories: 18-24; 25-29; 30-39; 40+;

b) Sex: Gender of the participant (female; male);

c) Indigenous Status: whether the offender identified as being of Aboriginal or Torres Islander descent (yes; no/unknown).

Dependent variables

The outcomes measured to evaluate the impact of the SCCLS on contacts with the criminal justice system were based on records of finalised court appearances extracted from ROD. For each group, the number of finalised court appearances (resulting in any outcome) for offences (allegedly) committed in the 18 months prior and subsequent to the index court appearance date were extracted.

For analyses, an offence was defined as either the principal offence in a case or, if there was no principal offence, the first offence in the case.[13] Only one offence was counted per court appearance and the offence was counted regardless of court outcome. The date of the chosen offence was then used to determine the timing of offences in the 18-month periods preceding and following the index court appearance date. Importantly, the offence corresponding to the index court appearance date was excluded from offence counts.

Final Sample Selection

Following data linking, the sample was examined to ensure that all individuals were at least 18 years of age at their index court appearance date. Additionally, days spent in custody in both the period preceding and subsequent to the index court date were examined to ensure that only offenders with at least 100 free days in both 18-month observation periods were included in analyses. One hundred free days was deemed an appropriately allowable time to examine offending and re-offending patterns across sample groups. [14]

Table 1 describes the offenders included in both the treatment and control groups in the final set of analyses.

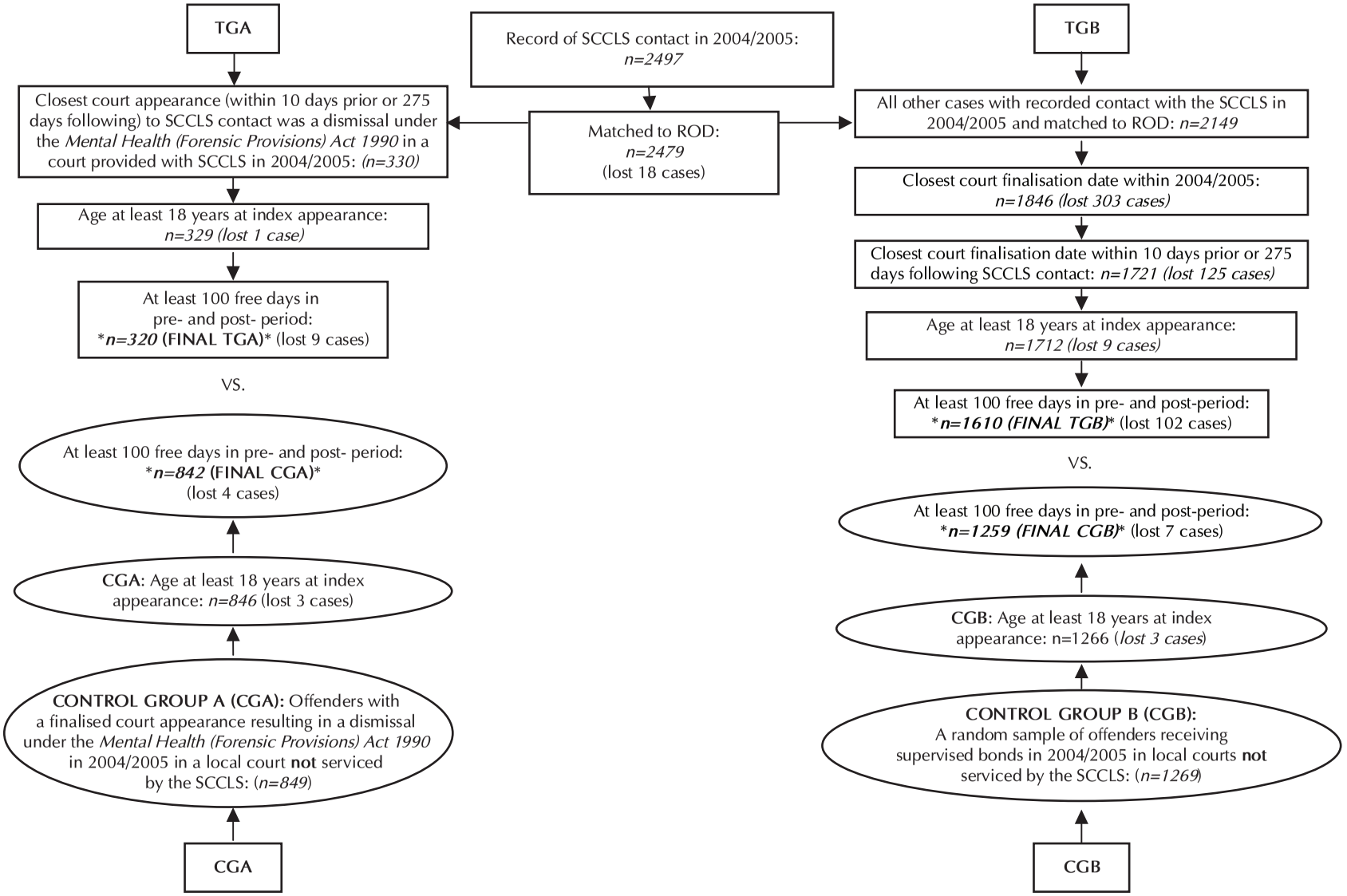
Table 1. Description of the cases included in both the treatment and control groups in the final set of analyses

Group	*Description*	*N* [1]
Treatment Group A (TGA)	Offenders with SCCLS contact whose closest finalised court appearance in 2004/2005 resulted in a dismissal under the *Mental Health (Forensic Provisions) Act 1990* in a SCCLS local court	320
Control Group A (CGA)	Offenders with a finalised court appearance resulting in a dismissal under the *Mental Health (Forensic Provisions) Act 1990* in 2004/2005 in a local court not serviced by the SCCLS	842
Treatment Group B (TGB)	Remaining offenders with a record of SCCLS contact and a finalised local court outcome in 2004 or 2005	1,610
Control Group B (CGB)	A random sample of offenders receiving supervised bonds in local courts in 2004 or 2005 that were not serviced by the SCCLS	1,259

1 This excludes the cases eliminated on the basis of age and the number of free days. Eliminating cases where age at index date was less than 18 or was missing in the dataset excluded 16 cases in total; 1 case from Treatment Group A; 9 cases from Treatment Group B; 3 cases from Control Group A; and 3 cases from Control Group B. Eliminating cases based on having at least 100 free days in pre- and post-periods excluded 122 cases in total: 9 cases from Treatment Group A; 4 cases from Control Group A; 102 cases from Treatment Group B; and 7 cases from Control Group B.

The process of identifying and selecting treatment and control cases is illustrated in-depth in Figure 3.

Figure 3: Identification of study groups



PRELIMINARY DESCRIPTIVE ANALYSES

To examine the characteristics of individuals with and without contact with the SCCLS, preliminary descriptive analyses were conducted for all groups investigating:

- group demographic characteristics (age, gender, indigenous status);
- the characteristics of the offences recorded at the index court appearance; and
- offending and incarceration characteristics prior to and following the index court appearance.

The following analyses were conducted to examine these participant characteristics within each group and to determine whether there were any differences across groups or across the 18-month observation periods prior to (pre-period) and subsequent to (post-period) the index court dates:[15]

- Chi-square tests of association were used to determine if there was an association between group membership and participant characteristics.
- Paired samples t-tests within each group were used to determine whether there were differences in the mean number of offences per month in the 18 month periods before and after the index court appearance.
- Independent samples t-tests were used to determine whether there were differences in the mean number of offences per month between the groups for: the 18-month time period preceding the index appearance, the 18-month time period following the index appearance, and for the change in the mean number of offences per month between the time periods.

Data Modelling[16]

A number of statistical modelling procedures were considered in examining criminal justice outcomes for treatment and control groups. However, in selecting control groups for analyses, a number of important variables were unknown in examining outcomes for individuals with mental health issues (i.e. mental health diagnoses). Additionally, as covered in-depth in the Results section, treatment and control groups across both comparisons displayed significant differences in the known demographic and offending characteristics. These observed differences led to concerns in utilising any between groups modelling procedures of criminal justice outcomes in the 18 months following the index appearance. The main concern was the possibility of additional unknown sources of selection bias contributing to the differences between groups and that statistical adjustment for the known demographic and criminal justice characteristics would not adequately account for the inherent group differences. As a result, the possibility existed that any observed differences shown across groups in between-subjects analyses could be attributable to selection bias, instead of SCCLS treatment.

In light of these concerns, repeated measures analyses examining changes in the mean number of offences recorded per month (resulting in finalised court appearances) across the 18-month time periods before and after the index court appearance were employed to investigate criminal justice outcomes for treatment and control groups. An important benefit of using repeated measures modelling procedures in this context is that each group behaves, to some extent, as its own control, in that any change in the rate of offending in the post-period, is determined by the difference from the pre-period to the post-period for that group. Therefore, this type of modelling procedure is more robust to the influence of potential confounding factors and better accounts for differences in offending outcomes than between-groups procedures. Furthermore, in examining differences in the number of offences committed per month, this type of analytic procedure may be more sensitive to any impact of the SCCLS on offending for individuals that are frequently in contact with the criminal justice system.

Repeated measures model

Repeated measures Poisson regression adjusting for demographic characteristics was used to determine whether there was any difference between treatment and control groups in terms of the size and direction of the change in the mean number of offences per month from the pre-period to the post-period. A generalised estimating equations approach was used to account for the repeated nature of the data. The outcome was the mean number of offences per month from the start of the pre-period (18 months before the index appearance) until the end of the post-period (18 months after the index offence). The number of months was set as a continuous time dependent explanatory variable, ranging from 1 to 18 for the pre-period and from 19 to 36 for the post-period. Month was centred at 18.5 to represent the end of the pre-period and the beginning of the post-period. A flag indicating whether the month was in the pre-period or post-period was set as a categorical time dependent explanatory variable (pre versus post). Time independent categorical explanatory variables were group (treatment versus control), sex, age category and Indigenous status.

In the regression models, all p-values less than 0.05 (or ninety-five per cent confidence intervals not containing zero) indicated a statistically significant difference in the mean number of offences per month for the characteristics of interest.

2.2 KEY STAKEHOLDER INTERVIEWS

The objectives of the key stakeholder interviews were to examine each stakeholder's views on the operation of the SCCLS or the diversion services provided by the Adolescent Court and Community Team. The interviews were semi-structured and consisted of ten questions designed to investigate the broad impact of the services and some of the issues more specific to the different roles of participants. Interview questions addressed: the impact of the service, the strengths and weaknesses of the service, the effectiveness of the service in achieving its aims, the extent to which the service has established collaborative links with the required agencies, any issues related to the use of the diversionary legislation under the *Mental Health (Forensic Provisions) Act 1990*, areas for improvement, and views and recommendations on the possible expansion of the services. Stakeholders were also given the opportunity to make any other comments they deemed relevant to the interview. A copy of the interview schedule is provided in Appendix A.

Representatives of the following groups/agencies participated in key stakeholder interviews dealing with the adult diversion service: staff from the Justice Health Statewide Community and Court Liaison Service (SCCLS), Local Court Magistrates, Attorney General's Department (court registrars), the Legal Aid Commission, the Aboriginal Legal Service, NSW Health, NSW Police Force and the Department of Corrective Services. A total of 69 interviews were conducted with respondents based across a representative sample of the 17 local courts and geographical areas where the adult service was in operation at the time of the evaluation.[17] Interviews dealing specifically with the adolescent service were conducted with staff from the Justice Health Adolescent Court and Community Team, Children's Court Magistrates and representatives from the Department of Juvenile Justice associated with the three children's courts (Parramatta, Bidura and Campbelltown) where the service was in operation at the time of the evaluation. A total of 13 respondents were interviewed regarding the adolescent service. All respondents provided informed consent prior to being interviewed.[18]

All interviews were conducted either face-to-face or over the phone by the first author. They ranged from approximately 10 to 55 minutes in length. Interviews were either scribed or audio recorded by the interviewer and subsequently transcribed. The transcripts were then content analysed to identify the main themes.

3. RESULTS

This section is divided into two parts. The first part deals with the results of the quantitative analyses and the second part deals with the views of the stakeholders who were interviewed.

3.1 QUANTITATIVE ANALYSES

In the following quantitative analyses, criminal justice and offending outcomes are based on finalised court appearances regardless of court outcome. For each finalised court appearance, the principal or first offence (if there was no principal offence) is counted for analysis.

This section explores whether contact with the SCCLS has any impact on the change in the number of offences per month from the period preceding to the period following the index appearance by examining: unadjusted analyses describing differences between groups and adjusted analyses controlling for potential sources of selection bias. These analyses are conducted comparing treatment and control groups A (TGA vs. CGA) followed by treatment and control groups B (TGB vs. CGB). Before presenting the key outcomes for each comparison, results of preliminary analyses are outlined describing the relevant demographic characteristics and criminal justice profiles for each group.

3.1.1 Treatment Group A vs. Control Group A: Dismissals under the *Mental Health (Forensic Provisions) Act 1990*

Demographic Characteristics

Table 2 compares the demographic characteristics of individuals in Treatment Group A (TGA) and Control Group A (CGA). As the table shows, compared to CGA, significantly more individuals in TGA were male (84% for TGA versus 71% for CGA) and Indigenous (23% for TGA versus 13% for CGA). No age differences were observed across groups.

Table 2. Demographic characteristics of Treatment and Control Groups A[19] [20]

	Treatment Group A (n=320)		*Control Group A (n=842)*	
	n	***%***	***n***	***%***
Sex				
Female	52	16.3	242	28.7
Male	268	83.8	600	71.3
	p<0.0001*			
Age at index appearance				
18-24 years	70	21.9	168	20.0
25-29 years	62	19.4	152	18.1
30-39 years	113	35.3	261	31.0
40+ years	75	23.4	261	31.0
	p=0.0872*			
Indigenous status				
Indigenous	73	22.8	107	12.7
Non-indigenous/unknown	247	77.2	735	87.3
	p<0.0001*			

** Chi-square test of association*

Characteristics of Offences at Index Court Appearance

Table 3 compares the principal offences associated with the index court appearance for individuals in TGA and CGA. Compared to CGA, more individuals in TGA had a breach offence as their principal recorded offence (15% for TGA versus 9% for CGA). There were no differences in the penalty or the outcome of the index court appearance.

Table 3. Principal offence characteristics for the index court appearance for Treatment and Control Groups A[21]

	Treatment Group A (n=320)		*Control Group A (n=842)*	
	n	***%***	***n***	***%***
Offence type for the principal offence at the index appearance				
Violence	86	26.9	255	30.3
Property	66	20.6	169	20.1
Breach	49	15.3	73	8.7
Driving	23	7.2	77	9.1
Drugs	10	3.1	26	3.1
Other	86	26.9	242	28.7
	p=0.0345*			
Penalty for the principal offence at the index appearance [22]				
No penalty	304	95.0	807	95.8
Fine	6	1.9	11	1.3
Bond with/without supervision	5	1.5	10	1.2
Imprisonment	2	0.6	2	0.2
Nominal sentence	1	0.3	3	0.4
No conviction recorded	1	0.3	1	0.1
Suspended sentence with/without supervision	1	0.3	2	0.2
Bond without conviction	0	0.0	4	0.5
Community service order	0	0.0	1	0.1
No action taken	0	0.0	1	0.1
Outcome for the principal offence at the index appearance				
Dismissed/withdrawn/no bill	296	92.5	781	92.8
Guilty by verdict/plea	16	5.0	35	4.2
Not Guilty by verdict/direction	8	2.5	26	3.1
	p=0.7221*			

** Chi-square test of association*

Offending and Incarceration Characteristics

Table 4 compares the offending and incarceration characteristics of TGA and CGA in the 18-month pre- and post-periods. Compared to CGA, in the 18 months prior to the index appearance, individuals in TGA were more likely to have been incarcerated (51% for TGA versus 16% for CGA), to have had an offence resulting in a finalised court appearance (56% for TGA versus 32% for CGA), and to have had three or more offences resulting in finalised court appearances (16% for TGA versus 5% for CGA). Similarly, as the table indicates, in the 18-months following the index appearance individuals in TGA were more likely to be incarcerated (26% for TGA versus 8% for CGA), to have had an offence resulting in a finalised court appearance (44% for TGA versus 29% for CGA), and to have had three or more offences resulting in finalised court appearances (13% for TGA versus 5% for CGA) compared to CGA.

Table 4. Offending and incarceration characteristics for Treatment and Control Groups A in the 18 months prior to and subsequent to the index court appearance

	Treatment Group A (n=320)		*Control Group A (n=842)*	
	n	***%***	***n***	***%***
Incarcerated in the 18 months prior to index appearance				
Yes	164	51.3	135	16.0
No	156	48.8	707	84.0
	p<0.0001*			
Number of offences in the 18 months prior to index appearance				
0	141	44.1	574	68.2
1	89	27.8	165	19.6
2	38	11.9	61	7.2
3+	52	16.3	42	5.0
	p<0.0001*			
Incarcerated in the 18 months after the index appearance				
Yes	82	25.6	70	8.3
No	238	74.4	772	91.7
	p<0.0001*			
Number of offences in the 18 months after the index appearance				
0	180	56.3	600	71.3
1	70	21.9	141	16.7
2	30	9.4	63	7.5
3+	40	12.5	38	4.5
	p<0.0001*			

** Chi-square test of association*

Does contact with the SCCLS have any impact on offending from the period preceding, to the period following, the index appearance?

As noted earlier, this section presents both unadjusted analyses describing differences between groups and adjusted analyses controlled for potential sources of selection bias.

Unadjusted

Figure 4 shows the mean number of offences per month for the 36-month study period for TGA and CGA. As the figure shows, the trend in the mean number of offences per month appears fairly stable over time for CGA with some suggestion of a slight increase around the time of the index court appearance (month 18). For TGA, the rate is slowly decreasing until approximately month 11, then shows quite a lot of variability and an apparent increase around the index appearance date (month 18) until month 21, followed by an apparent drop in the mean number of offences per month to the end of the post-period.

Figure 4. Observed mean number of offences per month from the start of the pre-period (18 months prior to the index appearance) until the end of the post-period (18 months after the index appearance) for Treatment and Control Groups A

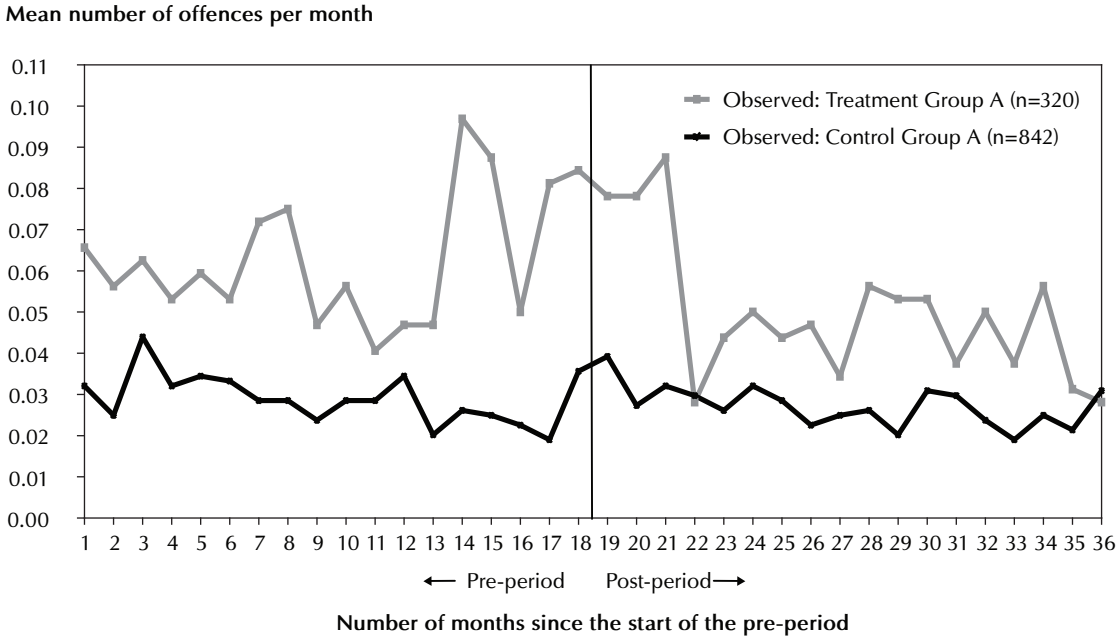


Table 5 compares individuals in TGA and CGA on the mean number of offences per month in the 18-month pre-period and post-period. Findings showed that:

- From the pre-period to the post-period, there was a significant decrease in the mean number of offences per month observed for TGA. In contrast, there were no significant differences observed on this outcome for CGA.
- Compared to CGA, individuals in TGA had significantly higher mean numbers of offences per month in both the pre-period and the post-period.
- The decrease in the mean number of offences per month from the pre-period to the post-period was significantly greater for individuals in TGA compared to CGA.

Table 5. Mean number of offences per month in the 18-month periods prior to and subsequent to the index appearance for Treatment and Control Groups A

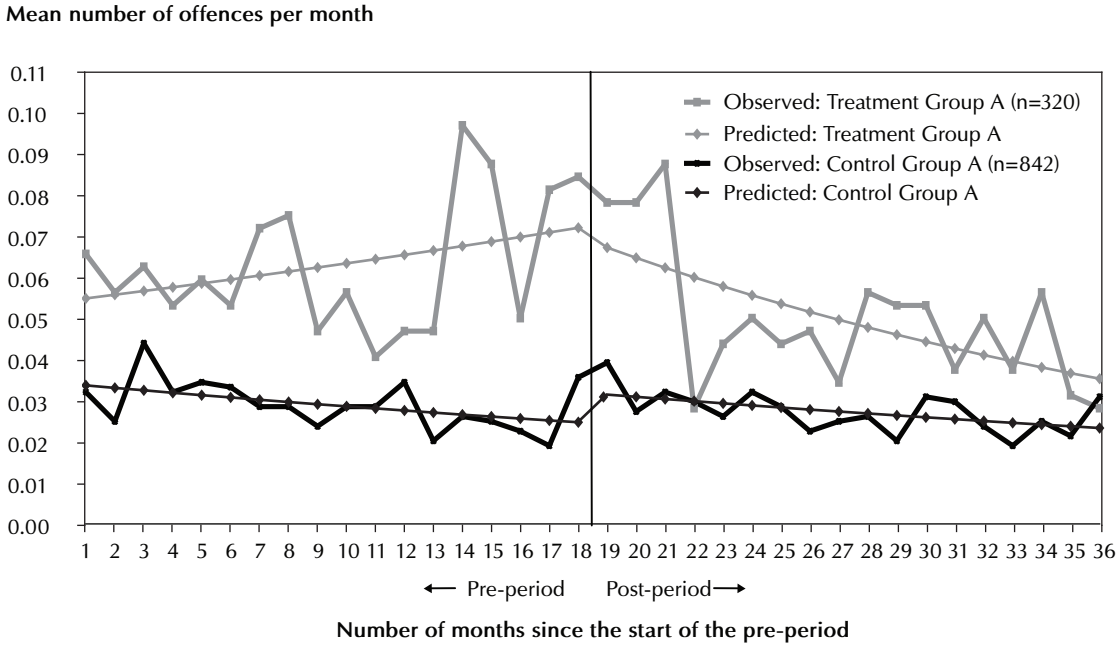
	Treatment Group A (n=320) Mean (95% CI)	*Control Group A (n=842) Mean (95% CI)*	*Difference between group means (95% CI)*	*p-value group differences*
Number of offences per month				
Pre	0.063 (0.054, 0.072)	0.029 (0.025, 0.033)	0.034 (0.026, 0.042)	<0.0001
Post	0.050 (0.041, 0.058)	0.027 (0.024, 0.031)	0.022 (0.015, 0.030)	<0.0001
Change (Post-Pre)	-0.013 (-0.024, -0.003)	-0.002 (-0.006, 0.002)	-0.012 (-0.020, -0.0021)	0.0382
p-value for pre/post differences	0.0099	0.4012		

Adjusted

A repeated measures Poisson regression model, adjusting for demographic characteristics, was used to determine whether there was any difference between TGA and CGA in terms of the size and direction of the change in the mean number of offences per month from the pre-period to the post-period. The model included the following independent variables: age, sex, Indigenous status, month, time period of observation (pre/post), group, two-way interactions between group and time period, month and time period, month and group, and the three-way interaction between group, time period and month.

Figure 5 shows the observed and predicted mean number of offences resulting in finalised court appearances obtained from the regression model. For TGA, Figure 5 suggests a gradual overall increase in the predicted mean number of offences per month across the pre-period and marked decrease across the post-period. For CGA, the figure indicates a slight decline overall in the predicted mean number of offences per month across the pre-period and the post-period.

Figure 5. Observed and predicted mean number of offences per month from the start of the pre-period (18 months prior to the index appearance) until the end of the post-period (18 months after the index appearance) for Treatment and Control Groups A



After adjusting for all characteristics in the model, results for the demographic factors presented in Table 6 show that:

- There was no difference in the mean number of offences per month for males and females.
- Individuals aged less than 40 years had a higher mean number of offences per month compared to individuals aged 40 years or older.
- Indigenous individuals had a higher mean number of offences per month compared to non-Indigenous individuals and individuals whose Indigenous identification was unknown.

Table 6. Regression estimates for demographic characteristics from the model predicting the number of offences per month for Treatment and Control Groups A (*n=1162*)*

	Regression estimate (95% confidence interval)	*p-value*
Sex		
Male	0.000	-
Female	0.047 (-0.138, 0.232)	0.6186
Age category (at index court appearance)		
40+ years	0.000	-
30-39 years	0.233 (0.011, 0.454)	0.0400
25-29 years	0.447 (0.210, 0.684)	0.0002
18-24 years	0.457 (0.223, 0.690)	0.0001
Indigenous status		
Non-indigenous/unknown	0.000	-
Indigenous	0.629 (0.458, 0.801)	<0.0001

** The model fit statistics indicated adequate fit (Pearson Chi Square/DF = 1.1855).*

For the effects related to the size and direction of the rate of change in the mean number of offences per month over time, Table 7 shows:

Overall trends over time:

- For TGA, there was no significant change over time in the mean number of offences per month across the pre-period, however there was a significant decrease over the duration of the post-period.
- For CGA, no significant changes over time were observed in the mean number of offences per month across the pre-period or the post-period.

The difference in the trends over time between time periods (pre versus post):

- For TGA, there was a significant declining trend in the number of offences per month in the post-period relative to the pre-period.
- For CGA, there was no difference in the trends over time in the number of offences per month between the pre-period and the post-period.

The difference in the trends over time between groups:

- TGA showed an increasing trend in the number of offences per month over the course of the pre-period relative to CGA.
- There was no difference between TGA and CGA in the trend in the number of offences per month over the course of the post-period.

The difference in the trends over time between groups and time periods:

- There was a significantly greater decline in the number of offences per month from the pre-period to the post-period for TGA relative to CGA.

Table 7. Regression estimates from the model predicting the trend in the number of offences per month for Treatment and Control Groups A across the study periods (pre/post)

	Treatment Group A (n=320)		*Control Group A (n=842)*		*Difference between groups*	
	Regression estimate (95% CI)	***p-value***	***Regression estimate (95% CI)***	***p-value***	***Regression estimate (95% CI)***	***p-value***
Pre	0.016 (-0.008, 0.040)	0.1865	-0.018 (-0.039, 0.003)	0.0861	0.034 (0.003, 0.066)	0.0336
Post	-0.038 (-0.065, -0.011)	0.0056	-0.018 (-0.038, 0.002)	0.0831	-0.020 (-0.054, 0.013)	0.2345
Difference pre/post	-0.054 (-0.089, -0.019)	0.0025	0.001 (-0.028, 0.030)	0.9663	-0.055 (-0.100, -0.009)	0.0185

For the effects related to the mean number of offences per month at the point of intersection between the pre-period and the post-period (approximately where the index appearance occurred), Table 8 shows:

- There was no difference in the mean number of offences per month from the end of the pre-period to the beginning of the post-period for both TGA and CGA.
- At both the time points corresponding to the end of the pre-period and the beginning of the post-period, the mean number of offences per month was significantly higher for TGA compared to CGA.
- The magnitude of the difference between TGA and CGA was equivalent at the end of the pre-period and the beginning of the post-period.

Table 8. Regression estimates from the model predicting the number of offences per month for Treatment and Control Groups A across the study periods (pre/post) at the index court appearance

	Treatment Group A (n=320)		*Control Group A (n=842)*		*Difference between groups*	
	Regression estimate (95% CI)	***p-value***	***Regression estimate (95% CI)***	***p-value***	***Regression estimate (95% CI)***	***p-value***
Pre	-3.099 (-3.411, -2.787)	<0.0001	-4.095 (-4.380, -3.810)	<0.0001	0.996 (0.657, 1.335)	<0.0001
Post	-3.157 (-3.470, -2.844)	<0.0001	-3.836 (-4.108, -3.563)	<0.0001	0.678 (0.344, 1.013)	<0.0001
Difference pre/post	-0.059 (-0.388, 0.271)	0.7276	0.259 (-0.047, 0.566)	0.0972	-0.318 (-0.768, 0.132)	0.1659

3.1.2 TREATMENT GROUP B vs. CONTROL GROUP B

This second set of analyses focused on the remainder of SCCLS clients (not included in Treatment Group A), who had identified contact with the SCCLS and a finalised local court appearance in 2004 or 2005 resulting in an outcome other than a mental health dismissal in a court provided with the SCCLS in 2004/2005. This group is identified as Treatment Group B (TGB). The control group for the following analyses comprised a random sample of individuals who had received a penalty of supervised bond in 2004 or 2005 in a local court where the SCCLS was not available. This group is identified as Control Group B (CGB).

Demographic Characteristics

Table 9 compares the demographic characteristics of individuals in TGB and CGB. There were no significant differences in terms of gender and Indigenous status across individuals in TGB and CGB. Compared to CGB, significantly fewer individuals in TGB were aged 18 to 24 years (25% for TGB versus 31% for CGB).

Table 9. Demographic characteristics of Treatment and Control Groups B [23] [24]

	Treatment Group B (n=1610)		*Control Group B (n=1259)*	
	n	***%***	***n***	***%***
Sex				
Female	281	17.5	252	20.0
Male	1329	82.6	1007	80.0
	p=0.080*			
Age at index appearance				
18-24 years	409	25.4	388	30.8
25-29 years	293	18.2	214	17.0
30-39 years	559	34.7	396	31.5
40+ years	349	21.7	261	20.7
	p=0.0141*			
Indigenous status				
Indigenous	401	24.9	279	22.2
Non-indigenous/unknown	1209	75.1	980	77.8
	p=0.0860*			

** Chi-square test of association*

Characteristics of Offences at Index Court Appearance

Table 10 compares the types of principal offences associated with the index court appearance for individuals in TGB and CGB. Compared to CGB, fewer individuals in TGB had a driving offence as their principal recorded offence (12% for TGB versus 25% for CGB). However, more individuals in TGB had a property offence as their principal recorded offence (22% for TGB versus 14% for CGB).

As indicated in Table 10, there were considerable differences in the penalties received for the principal offence at the index court appearance across groups. In this study, the criteria for selecting CGB was based on receiving the penalty of supervised bond for at least one offence at the index court appearance. In CGB, 83 per cent of cases received a supervised bond for their principal offence.[25] In contrast, only 11 per cent of individuals in TGB received a supervised bond for their principal offence at their index appearance. The rates of imprisonment for the principal offence at their index appearance also differed substantially (27% for TGB versus 2% for CGB).

Given the selection criteria for CGB, all individuals in this group by definition had a guilty outcome for the principal offence at their index appearance. In contrast, a significant proportion of individuals in TGB had outcomes other than guilty, with 12 per cent found not guilty by verdict or direction and 5 per cent having their principal offence dismissed, withdrawn or resulting in a no bill.

Table 10. Principal offence characteristics for the index court appearance for Treatment and Control Groups B

	Treatment Group B (n=1610)		*Control Group B (n=1259)*	
	n	***%***	***n***	***%***
Offence type for the principal offence at the index appearance				
Violence	437	27.1	405	32.2
Property	360	22.4	181	14.4
Breach	227	14.1	115	9.1
Driving	192	11.9	313	24.9
Drugs	72	4.5	71	5.6
Other	322	20.0	174	13.8
	p<0.0001*			
Penalty for the principal offence at the index appearance [22]				
Imprisonment (adult)	439	27.3	29	2.3
Juvenile control order (juvenile)	3	0.2	0	0.0
Home detention	4	0.3	1	0.1
Periodic detention	28	1.7	18	1.4
Suspended sentence with supervision (adult)	98	6.1	43	3.4
Suspended sentence without supervision (adult)	76	4.7	19	1.5
Suspended control order with supervision (juvenile)	1	0.1	0	0.0
Community service order (adult)	45	2.8	108	8.6
Community service order (juvenile)	1	0.1	0	0.0
Bond with supervision (adult)	172	10.7	1041	82.7
Bond without supervision (adult)	188	11.7	0	0.0
Bond without supervision (juvenile)	2	0.1	0	0.0
Probation with supervision	1	0.1	0	0.0
Probation without supervision	1	0.1	0	0.0
Fine	205	12.7	0	0.0
Nominal sentence	15	0.9	0	0.0
No conviction recorded	19	1.2	0	0.0
Bond without conviction	32	2.0	0	0.0
Dismissed with caution (juvenile)	2	0.1	0	0.0
No penalty	278	17.3	0	0.0
Outcome for the principal offence at the index appearance				
Guilty by verdict/plea	1332	82.7	1259	100
Not Guilty by verdict/direction	194	12.1	0	0.0
Dismissed/withdrawn/no bill	78	4.8	0	0.0
Otherwise disposed of	6	0.4	0	0.0
	p<0.0001*			

** Chi-square test of association*

Offending and Incarceration Characteristics

Table 11 compares the offending and incarceration characteristics of TGB and CGB in the 18-month study periods before and after the index court appearance. In the 18 months prior to the index appearance, individuals in TGB were much more likely to have been incarcerated (68% for TGB versus 16% for CGB), to have had an offence resulting in a finalised court appearance (68% for TGB versus 43% for CGB), and to have had three or more offences resulting in finalised court appearances (19% for TGB versus 6% for CGB) compared to CGB. Similarly, in the 18-month follow up period, individuals in TGB were more likely to have been incarcerated (55% for TGB versus 15% for CGB), to have committed an offence resulting in a finalised court appearance (51% for TGB versus 37% for CGB), and to have committed three or more offences resulting in finalised court appearances (13% for TGB versus 6% for CGB) than individuals in CGB.

Table 11. Offending and incarceration characteristics for Treatment and Control Groups B in the 18 months prior to and subsequent to the index court appearance

	Treatment Group B (n=1610)		*Control Group B (n=1259)*	
	n	***%***	***n***	***%***
Incarcerated in the 18 months prior to index appearance				
Yes	1097	68.1	197	15.7
No	513	31.9	1062	84.4
	p<0.0001*			
Number of offences in the 18 months prior to index appearance				
0	518	32.2	715	56.8
1	471	29.3	341	27.1
2	320	19.9	131	10.4
3+	301	18.7	72	5.7
	p<0.0001*			
Incarcerated in the 18 months after the index appearance				
Yes	885	55.0	184	14.6
No	725	45.0	1075	85.4
	p<0.0001*			
Number of offences in the 18 months after the index appearance				
0	781	48.5	788	62.6
1	390	24.2	273	21.7
2	232	14.4	128	10.2
3+	207	12.9	70	5.6
	p<0.0001*			

** Chi-square test of association*

Does contact with the SCCLS have any impact on offending from the period preceding, to the period following, the index appearance?

As reviewed in the foregoing section, a much higher proportion of TGB was imprisoned for the principal offence at the index court appearance (27% for TGB versus 2% for CGB). Given the magnitude of this difference and concerns about its impact on modeling offending outcomes, the following analyses are conducted with those cases receiving custodial outcomes for the principal offence at the index court appearance removed. [26]

Unadjusted

Figure 6 shows the mean number of offences per month over a 36-month period, from the beginning of the pre-period (18 months prior to the index appearance) until the end of the post-period (18 months after the index appearance) for TGB and CGB. As displayed in the figure, the trend in the mean number of offences per month appears fairly stable for CGB with a slight downward trend from month 21 onward. For TGB, the rate appears to slowly increase in the pre-period, followed by a decrease at the beginning of the post-period that becomes more gradual over the remainder of the follow-up.

Figure 6. Observed mean number of offences per month from the start of the pre-period (18 months prior to the index appearance) until the end of the post-period (18 months after the index appearance) for Treatment and Control Groups B

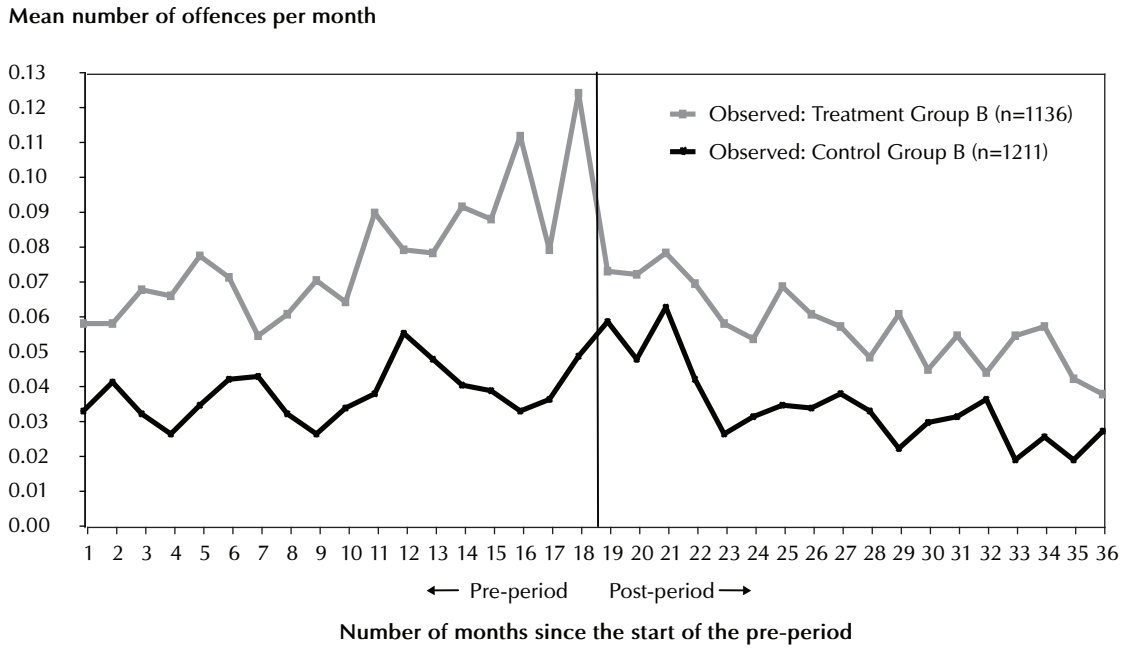


Table 12 compares individuals in TGB and CGB on the mean number of offences per month in the 18 months before and after the index appearance. The key points to note from Table 12 are:

- the mean number of offences per month decreased significantly from the pre-period to the post-period for the treatment group, but not for the control group;
- compared to CGB, individuals in TGB committed a significantly greater mean number of offences per month in both observation periods; and
- the decrease in the mean number of offences per month from the pre-period to the post-period was greater for individuals in TGB than for those in CGB.

Table 12. Mean number of offences per month in the 18 months before and after the index appearance for Treatment and Control Groups B*

	Treatment Group B (n=1136) Mean (95% CI)	*Control Group B (n=1211) Mean (95% CI)*	*Difference between group means (95% CI)*	*p-value for group differences*
Number of offences per month				
Pre	0.077 (0.072, 0.082)	0.038 (0.035, 0.041)	0.039 (0.033, 0.045)	<0.0001
Post	0.058 (0.053, 0.062)	0.034 (0.031, 0.038)	0.023 (0.018, 0.029)	<0.0001
Change (Post-Pre)	-0.020 (-0.026, -0.014)	-0.004 (-0.008, 0.000)	-0.016 (-0.023, -0.009)	<0.0001
p-value for pre/ post differences	<0.0001	0.0793		

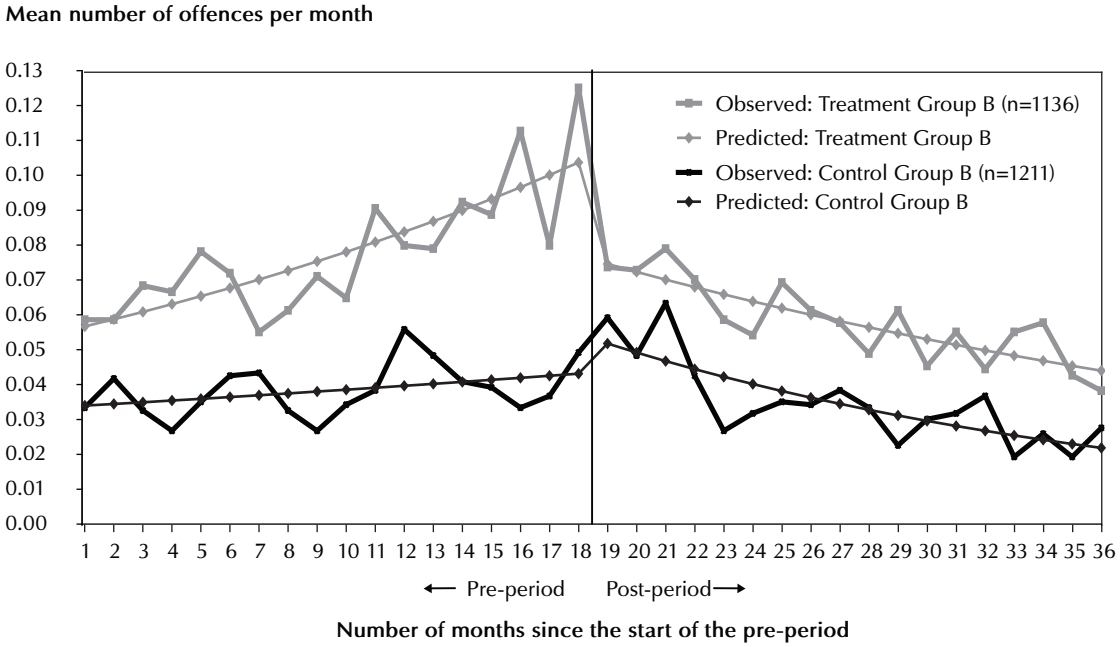
**Cases resulting in custodial outcomes at the index court appearance removed.*

Adjusted

A repeated measures Poisson regression model, adjusting for demographic characteristics was used to determine whether there was any difference between TGB and CGB in terms of the size and direction of the change in the number of offences per month from the pre-period to the post-period. The model included the independent variables: age, sex, Indigenous status, month, time period observation (pre/post), group, two-way interactions between group and time period, month and time period, month and group, and the three-way interaction between group, time period and month.

Figure 7 shows the observed and predicted mean number of offences resulting in finalised court appearances obtained from the regression model. For TGB, Figure 7 suggests an overall increase across the pre-period in the predicted mean number of offences per month that is contrasted by an apparent decrease across the post-period. For CGB, the predicted mean number of offences per month appears to increase slightly over the pre-period, followed by a decrease over the course of the post-period.

Figure 7. Observed and predicted mean number of offences per month from the start of the pre-period (18 months prior to the index appearance) until the end of the post-period (18 months after the index appearance) for Treatment and Control Groups B



After adjusting for all characteristics in the model, results for the demographic factors presented in Table 13 show that:

- There was no difference in the mean number of offences per month for males and females.
- Individuals aged less than 40 years had a higher mean number of offences per month compared to individuals aged 40 years or older.
- Indigenous individuals had a higher mean number of offences per month compared to non-Indigenous individuals and individuals whose Indigenous identification was unknown.

Table 13. Regression estimates for demographic characteristics from the model predicting the number of offences per month for Treatment and Control Groups B (*n=2347*)*

	Regression estimate (95% confidence interval)	*p-value*
Sex		
Male	0.000	-
Female	-0.071 (-0.188, 0.046)	0.2329
Age category (at index court appearance)		
40+ years	0.000	-
30-39 years	0.306 (0.173, 0.440)	<0.0001
25-29 years	0.403 (0.255, 0.551)	<0.0001
18-24 years	0.464 (0.329, 0.598)	<0.0001
Indigenous status		
Non-indigenous/unknown	0.000	-
Indigenous	0.333 (0.239, 0.426)	<0.0001

** The model fit statistics indicated adequate fit (Pearson Chi Square/DF = 1.1954).*

For the effects related to the size and direction of the rate of change in the mean number of offences per month over time, Table 14 shows:

Overall trends over time:

- For TGB, there was a significant increase over time in the mean number of offences per month across the pre-period that was contrasted by a significant decrease over the duration of the post-period.
- For CGB, there was no significant change over time in the mean number of offences per month across the pre-period. However, there was a significant decrease over the course of the post-period.

The difference in the trends over time between time periods (pre versus post):

- For TGB, there was a significant declining trend in the number of offences per month in the post-period relative to the pre-period.
- For CGB, there was a significant declining trend in the number of offences per month in the post-period relative to the pre-period.

The difference in the trends over time between groups:

- In the pre-period, the increasing trend over time in the number of offences per month for TGB was significantly higher than the trend for CGB.
- There was no difference in the magnitude of the decreasing trend in the number of offences per month over the post-period for TGB and CGB.

The difference in the trends over time between groups and time periods:

- There was no difference between TGB and CGB in the change in the trend of number of offences per month from the pre-period to the post-period.

Table 14. Regression estimates from the model predicting the trend in the number of offences per month for Treatment and Control Groups B across the study periods (pre/post)

	Treatment Group B (n=1136)		*Control Group B (n=1211)*		*Difference between groups*	
	Regression estimate (95% CI)	***p-value***	***Regression estimate (95% CI)***	***p-value***	***Regression estimate (95% CI)***	***p-value***
Pre	0.036 (0.025, 0.047)	<0.0001	0.014 (0.000, 0.029)	0.0570	0.022 (0.003, 0.040)	0.0212
Post	-0.031 (-0.044, -0.018)	<0.0001	-0.051 (-0.067, -0.035)	<0.0001	0.020 (-0.001, 0.041)	0.0613
Difference pre/post	-0.067 (-0.084, -0.050)	<0.0001	-0.065 (-0.087, -0.043)	<0.0001	-0.002 (-0.030, 0.026)	0.9081

For the effects related to the mean number of offences per month at the point of intersection between the pre-period and the post-period (approximately where the index appearance occurred), Table 15 shows:

- For TGB, there was a large, significant decrease in the mean number of offences per month from the end of the pre-period to the beginning of the post-period.
- For CGB, there was a small, but significant increase in the mean number of offences per month from the end of the pre-period to the beginning of the post-period.
- At both the time points corresponding to the end of the pre-period and the beginning of the post-period, the mean number of offences per month was significantly higher for TGB compared to CGB.
- For TGB, there was a significantly greater change in the mean number of offences per month from the end of the pre-period to the beginning of the post-period. That is, there was a significant decrease at this time point for TGB that was not observed for CGB.

Table 15. Regression estimates from the model predicting the number of offences per month for Treatment and Control Groups B across the study periods (pre/post) at the index court appearance

	Treatment Group B (n=1136)		*Control Group B (n=1211)*		*Difference between groups*	
	Regression estimate (95% CI)	***p-value***	***Regression estimate (95% CI)***	***p-value***	***Regression estimate (95% CI)***	***p-value***
Pre	-2.630 (-2.778, -2.482)	<0.0001	-3.536 (-3.721, -3.352)	<0.0001	0.906 (0.722, 1.091)	<0.0001
Post	-2.962 (-3.134, -2.791)	<0.0001	-3.335 (-3.523, -3.147)	<0.0001	0.373 (0.170, 0.576)	0.0003
Difference pre/post	-0.332 (-0.499, -0.166)	<0.0001	0.201 (0.001, 0.402)	0.0493	-0.533 (-0.794, -0.273)	<0.0001

3.2 KEY STAKEHOLDER INTERVIEWS

This section outlines the feedback received from key stakeholders. The main issues are presented in ten parts, reflecting the questions addressed in stakeholder discussions. For some sections, stakeholder responses encompassing both the adolescent and adult services overlapped significantly and are presented together, with any issues specific to either service clearly differentiated. In other sections, where appropriate, stakeholder feedback is presented separately for the adult and the adolescent services.

3.2.1 Impact of Diversion Services and Specific Service Strengths

The first two issues discussed with stakeholders examined the impact of the diversion services for adults and adolescents and the specific strengths and weaknesses of the services. Since the responses provided regarding service impact and service strengths overlapped significantly, these responses are presented together. Responses outlining service weaknesses are presented in the next section (3.2.2).

The majority of stakeholders stated that the overall impact of both diversion services had been positive. Comments included:

- Magistrates are made aware of things that they would normally not be made aware of.
- The service is terrific and particularly beneficial in a justice agency.
- In simple terms, I just don't know how we got on without it.
- I think it is a fantastic service.

When asked to identify the specific positive improvements related to the establishment of the services, the most commonly cited strength or benefit was the overall assistance that diversionary staff provide to the court. This includes identifying individuals with potential mental health issues, conducting on-site assessments at court, providing court reports with recommendations and options for dealing with individuals with mental health issues, diverting people in need of assistance and facilitating their access to appropriate treatment. The impact of this assistance was viewed positively across the majority of stakeholder agencies, particularly in identifying persons with mental health issues who, prior to the establishment of the diversion services, may not have been identified, and in allowing the court to make more informed and more appropriate decisions about matters involving mental health issues. Specific comments included:

- Before we had the liaison officer we had the problem of a person appearing in court apparently with mental health issues and never being able to find any answers about what is going on. The fact that the liaison officers have got access to the mental health services and actually can…give us the details of what's going on has just immeasurable benefit in determining whether we should be treating persons as mentally ill or criminally responsible.
- The CLS assists stakeholders in making appropriate and well-informed dispositions for defendants who have a mental illness/disorder.
- The clear thing is the very early picking up of issues and a comprehensive and quite professional way of dealing with that information.

Other service strengths highlighted included:

- The availability of the court liaison officers at court to be accessed by court-based agencies for any assistance or advice on mental health matters. Some representatives from DCS based in local courts noted that the assistance and information provided by court liaison officers was particularly beneficial in facilitating effective management of individuals in custody.
- The ability of the liaison officers to respond in a timely fashion to mental health referrals at court, which some stakeholders believe reduces delays.
- The screening of individuals in custody in the adult jurisdiction and the process of accepting referrals from other court staff for assessment purposes.
- The assistance that the diversion services provide to the court in making decisions about bail and appropriate conditions for persons with mental health issues.
- The positive working relationships between diversion staff and other court staff.
- The professional skills of court liaison staff.
- The ability of court liaison nurses to liaise and communicate more effectively than other court-based personnel with the health system, having more efficient and improved access to health information, and being able to make more appropriate and more successful referrals/admissions to health services, particularly hospitals.
- In the adult jurisdiction, an identified strength was that the liaison nurses can communicate with custodial staff regarding individuals going into custody and can facilitate access to appropriate care services in custody.
- The nurses can have a positive benefit on clients, communicating effectively and calmly with them about mental health issues, explaining the court process and accessing appropriate treatment services for them.
- Having the diversion service based at court allows community mental health workers to communicate with diversionary staff about clients with mental health issues attending court. This was mentioned by community mental health staff interviewed about the adult service.
- A number of staff in the adult jurisdiction explicitly expressed that working for the diversion program has been a positive experience.

A small number of respondents, however, noted that while the diversionary programs have some positive aspects, they also had some mixed or negative aspects.

- Community mental health workers interviewed about the adult service noted that community diversion might not always be the appropriate course of action for persons with mental health issues presenting to the court.
- A minority concern raised in interviews with probation and parole officers about the adult service was that court liaison officers in particular areas might not sufficiently consider clients' background health information during assessments. Developing better working relationships with local health services was suggested as a means to facilitate access to relevant health records and to improve the assessment process.
- For the adolescent service, DJJ staff in one area noted that while the initial impact of the service had been positive, this sentiment had not been maintained. In particular, concerns were raised regarding the current level of service responsiveness and availability. Improvements were suggested in service advertising and in developing better working relationships with DJJ court staff (particularly with reference to the referral process).

3.2.2 Service Weaknesses

When asked to identify weaknesses of the services, stakeholders noted the following:

- Insufficient availability of services at court. This was related to insufficient coverage of staff absences, the restricted availability of current services in some areas, and in the lack of availability of services at more local courts across the state.
- A small number of court users noted that the service assessments are only available for matters that can be dealt with summarily, and not for more serious indictable matters.
- A small number of magistrates highlighted that in some cases the opinion of a psychiatrist is required in determining mental health matters, which the court liaison officers, as nurses, are unable to provide as part of their assessments.
- A small number of respondents noted that the workload for the nurses is variable in some areas, and that during slow periods other tasks could perhaps be incorporated into their role, to better utilise their time. Conversely, other stakeholders noted that at some courts the workload is very heavy and that nurses in these courts could benefit from further support in their role.
- A minority of defence solicitors stated that, at times, in the adult jurisdiction clients have been referred and assessed by court liaison nurses before solicitors have spoken with their clients. These solicitors believed this could potentially have a detrimental effect on a client's case. While this was identified as an infrequent issue, it was noted that it could be improved by having better communication between liaison nurses and defence solicitors about assessments and potential legal issues.
- Some court liaison officers in the adult service reported feeling some isolation in their roles and noted that more contact and support from supervising service staff would be of benefit.
- In certain areas, adult diversion staff felt that the linkages and level of communication with health staff in correctional settings could be improved.
- Some diversion staff identified that there is room for improvement in the working relationships with local health services/facilities in the community.
- A small number of respondents noted that the process of identifying persons with mental health issues could be improved, as some people in need of assistance may be missed. Respondents from the adolescent team noted this is a particular issue with Indigenous young people; their statistics reveal that the service is not currently identifying and assessing a representative proportion of the known numbers of Indigenous young people in custody. However, they are currently investigating methods of addressing this issue.
- A minority of staff associated with the adolescent program noted that, on occasions, there have been misunderstandings among court personnel regarding the boundaries of the role of diversion nurses at court. In these cases, continued education and information has been necessary to clarify their role.
- A minority of adolescent staff stated that, at times, there are difficulties in accessing background information from some external agencies about young people for court reports. However, consulting medical staff for the adolescent program noted that liaison and communication at a management level often resolves these issues.

3.2.3 How have the diversion programs influenced the processing of mentally ill offenders through the criminal justice system?

The focus of this question was largely on whether the court diversion programs have had an impact on the efficiency of the court process for matters involving mental health issues. This question was asked only of stakeholders with direct court experience.

Whilst a small number of respondents found this difficult to answer, the majority of respondents across stakeholder agencies responded that overall, cases involving mental health issues are dealt with in a more efficient manner since the establishment of the diversion programs. Though some stakeholders noted that there has been no quantitative analysis of this impact, most stakeholders perceived that the efficiency of the court process had been increased in the following key ways:

- Individuals with suspected mental health issues can be identified early in proceedings and possible diversion into treatment can be considered at this point and matters can be expedited.
- Mental health assessments and reports can be completed at court and relevant information about mental health can be presented readily to the court. This can reduce the need to adjourn matters to gather additional mental health information and reports from external sources.
- Diversion officers have quick access to relevant information from the health system. This can then be presented to the court in a timely fashion.
- Diversion officers have better access to treatment services, which has increased the efficiency of the referral process to health facilities.

A minority of respondents stated that the assessments conducted by liaison nurses at court on the day were time-consuming and may result in minor delays in court hearings. The assessment process involves conducting interviews, compiling background information, and writing court reports.[27] However, a number of respondents believed that the provision of court liaison reports often resulted in more appropriate outcomes for persons with mental health issues.

In terms of the more general impact of the diversionary programs on the court process, some stakeholders noted that the presence of the services at court has raised awareness of mental health issues in the criminal justice system, has facilitated more appropriate use of the diversionary legislation under the *Mental Health (Forensic Provisions) Act 1990*, and is effective at accessing appropriate mental health services for persons in need of treatment.

3.2.4 Do stakeholders feel adequately informed about the role of the diversionary programs? Is any case follow-up or outcome information provided by the diversionary services?

These questions were asked of all stakeholders and responses are reported separately for the adult and adolescent services. Whilst it is not the specific function of either service to provide treatment and monitor referral outcomes following diversion, the second question sought to address whether any information is provided to stakeholders following the diversion process.

Statewide Community and Court Liaison Service

The majority of program staff identified a number of initiatives designed to provide information about the objectives and the function of the service to relevant stakeholder groups. These include the provision of regular in-service training and educational sessions with health staff as well as regular meetings and liaising with court-based staff. As a result of these efforts, most service staff generally perceived that the relevant stakeholder groups would feel informed. However, a minority of staff noted that court staff and those agencies with regular exposure to the service may feel better informed than agencies external to the court or those agencies with little or no experience of working with the service. Also, a small number of diversionary staff noted that in health settings, staff turnover rates necessitate on-going efforts to provide accurate information about the function of the service.

The majority of stakeholders interviewed from other agencies reported that they had sufficient information about the function of the diversionary program to perform their specific roles. This was particularly the case for magistrates, court registrars, DCS officers based in local courts, mental health workers in the community and most legal practitioners. However, a small number of solicitors, police officers and probation and parole officers believed that the objectives of the diversionary program and the specific function of the court liaison officers are not sufficiently clear. These stakeholders suggested that information be provided about the service, its objectives, the specific role of the liaison nurses at court and how the service can assist and work with particular agencies.

Provision of follow-up information [28]

A significant proportion of court-based respondents and diversion staff noted that court liaison officers provide follow-up information to the court and to court-users about the outcomes of admissions for persons sent to mental health facilities for assessment under section 33 of the *Mental Health (Forensic Provisions) Act 1990*. Generally, court liaison officers notify the court if referral cases have been admitted to hospital for treatment following assessments although, in some courts, officers also inform the court about estimated length of admissions and future discharge dates. Also, some respondents mentioned that in cases where adjournment dates are given so that individuals are brought back to court following hospital discharge in order to address court matters, the liaison nurses would be involved in providing some follow-up to the court.

Since the diversionary program does not provide treatment services, the service objectives do not include follow-up for clients referred under section 32 of the *Mental Health (Forensic Provisions) Act 1990* for community-based treatment. Consistent with this, a number of respondents noted that, for these cases, there is no outcome information available to the court unless an individual returns to court for a breach or a further offence. However, in a small number of courts, diversion staff stated that in some cases they have provided feedback to the court outlining the progress of some referrals under section 32, even though this is not a mandated objective of the program.

Most community mental health staff noted that the system of obtaining feedback from court liaison officers regarding court outcomes for community mental health clients attending court is working satisfactorily. However, it was suggested that it would be preferable if this information was provided in writing rather than verbally or by fax, as often happens in particular areas.

Most of the DCS staff interviewed (based in local court cells) mentioned that court liaison nurses communicate relevant information that specifically relates to their role.

Probation and parole officers responded that no specific follow-up information is communicated by the liaison officers; however, a minority of respondents had mixed views on how this was perceived. For example, one view was that outcomes and follow-up are not part of the process and that it would be beneficial if more follow-up information were available. In contrast, another view was that there is a good working relationship between diversion staff and probation and parole, and that this type of information is not as necessary as it may be at other court locations.

Adolescent Court and Community Team

All adolescent diversion staff noted that they have made significant efforts in liaising, networking and providing information to stakeholder agencies both within the court and in external health settings to ensure that stakeholder groups are informed about the function of the adolescent service. Generally, staff believed that these efforts had been successful in keeping most groups informed. Consistent with this view, all children's court magistrates and most respondents from DJJ stated that they have received sufficient information about the role of the diversionary program. However, a minority of staff interviewed from DJJ felt that diversionary staff must improve their efforts to keep stakeholders informed and aware of the service.

Provision of follow-up information

Some diversionary staff emphasized that, since no treatment is provided as part of the program, after young people have been referred to health services, there is no formal mandated follow-up regarding their progress or outcomes. Indeed, following up on referrals and monitoring treatment progress and adherence is not part of the current program objectives. However, in some cases, diversionary staff may informally obtain follow-up information regarding outcomes for young people in the community; magistrates and court-based staff from DJJ noted, however, that this information is not formally communicated to them.

Additionally, a minority of respondents noted that court reports are provided to DJJ court staff and that there is good communication and follow-up on cases involving DJJ community staff. Further, if a young person returns to court following a referral, liaison nurses could be involved in providing a follow-up report to the court. No other form of regular follow-up was consistently identified. [29]

3.2.5 Is the service effectively diverting individuals with mental health difficulties into appropriate treatment?

Statewide Community and Court Liaison Service

One of the primary objectives of the SCCLS is to assist the court in diverting individuals with mental health difficulties into appropriate mental health services in the community, prison and hospital system (Greenberg 2008). When asked about the success of diversion, most respondents focused on diversion into the community, however a small number of service staff noted that when individuals with mental health concerns are placed in custody, the SCCLS can facilitate access to appropriate care.

Most stakeholders believed that the service is successfully diverting individuals with mental health difficulties into appropriate treatment in the community or is at least making the best efforts to do so. Some respondents highlighted that while the SCCLS is successful at identifying appropriate cases for diversion and making recommendations to the court, the success of the service in diverting into the community is limited by other constraints in the criminal justice and health systems. As noted by one local court magistrate:

- The CLS is generally successful in achieving what can be achieved within the limits of the system.

Of those respondents who identified obstacles to successful diversion into the community, the most frequently cited challenges included:

- Difficulties in accessing the mental health system in hospitals and community settings, for example:
    - Gaps in the availability of appropriate health services and insufficient resources in community health services to accept and support clients referred by the SCCLS. Comments by community health workers included:
        - I think there aren't the resources put into community health to deal with it.
        - To be fair, if you expect the system to respond to the new identified need, you have to put the resources where they should be. Increasing one side doesn't solve the other side.
    - Difficulties in finding treatment options for some groups including individuals with intellectual disability and those with dual diagnosis of mental illness and drug and alcohol problems. Some service staff and magistrates felt that there are significant gaps in available services for these client groups and that diversion to treatment may not be as successful with these populations as it may be for other client groups.
    - In some areas, court-based stakeholders and service staff believed that some community-based health services/facilities are reluctant or in some cases unwilling to accept referrals from the SCCLS, particularly for clients who are violent or have a history of violence.

Some community mental health workers expressed the view that community diversion may not always be the appropriate course of action for individuals with mental health issues presenting to the court and that, in some cases, clients should be dealt with by appropriate health staff in custodial settings.

Another community mental health worker noted that the diversion system creates a loophole, in that the SCCLS might be vulnerable to exploitation by individuals who are trying to avoid criminal punishment. In contrast, one magistrate identified that some area health service staff may believe that defendants are using the mental health system to escape incarceration, but noted this view as an obstacle to successful diversion.

Diversion into the community will not be successful if it is not considered the appropriate course of action by the magistrate. Sometimes this may be due to the nature or seriousness of the offence, prior criminal history of the individual in question, or because of concerns about provision of treatment in the mental health system.

A small number of police officers and probation and parole officers believed that they could not comment on whether the SCCLS is successfully diverting offenders because they were not sufficiently familiar with this aspect of the service.

Adolescent Court and Community Team

Similar to the responses for the adult service, stakeholders in the adolescent service focused their responses on diversion into the community. The majority noted that, within the limits of the criminal justice and health systems, the service is generally successful in achieving diversion. However, some of the difficulties which stakeholders identified in successfully diverting young people included:

- A general lack of appropriate community treatment services for adolescents and challenges in accessing existing mental health services, particularly in hospital settings. One magistrate noted that a major flaw is the absence of a legislative requirement for any of the services receiving referrals to accept the young people for treatment.
- Resource limitations in the availability of community services can delay access to these services.
- Community services having some exclusion criteria related to offending behaviours or certain diagnoses that precludes young people referred from the court diversion program.
- Magistrates' legal decisions not to support diversionary options. For example, one magistrate highlighted that it is not always appropriate to divert young people with mental health issues into the community.
- Since a number of agencies may be involved in dealing with young people in the criminal justice system, at times, a minority of service staff noted that there can be challenges in getting access to a young person in order to conduct an assessment prior to his/her court appearance.
- The use of Audio Visual Link presents challenges to conducting a thorough clinical assessment.
- The operational structure of the adolescent service requires that young people be referred to the diversion staff in order for an assessment to take place. Therefore, this service is limited by the abilities of other court personnel to identify and refer young people who may be appropriate for diversion.

3.2.6 How successfully are the diversion services providing education and training on mental health matters within the criminal justice system?

Statewide Community and Court Liaison Service

Respondents were asked their perception of how successfully the SCCLS has provided education and training on mental health matters within the criminal justice system.[30] The majority of diversion staff perceived that they had successfully educated staff, either through formal educational endeavours or through informal liaison and communication. Some service staff highlighted several formal initiatives that provide education and training to stakeholder groups, such as regular educational sessions with health agencies, participation in external community committees relevant to mental health, meetings and training sessions with court staff, attendance at court user forums and conference presentations. They also noted the daily informal interactions with court staff and the fact that the service is frequently used as a resource to discuss queries or concerns about mental health issues.

Stakeholders from other court-based agencies (e.g. magistrates, solicitors, registrars, DCS officers) had opposing views regarding their exposure to training initiatives, with a minority of respondents in some agencies acknowledging some more formal education from the SCCLS, whilst other stakeholders reported no exposure to any kind of educational training sessions. However, a number of respondents confirmed that the liaison nurses are viewed as an informal resource for queries about mental health matters within the court.

A number of court-based stakeholders noted that it would be beneficial if the SCCLS provided some training sessions or educational materials around mental health issues that could be disseminated to stakeholder groups. Specific suggestions included providing written materials or semi-regular training sessions outlining types of mental illness including information on symptoms and advice on how to identify mental health issues, medications, as well as information about the function of the service and the relevant diversionary legislation under the *Mental Health (Forensic Provisions) Act 1990*.

Most police officers stated that they had not received any specific education or training from the SCCLS.

Adolescent Court and Community Team

Most stakeholders reported that the adolescent diversion service had adequately provided education and training on mental health matters within the courts. Program staff referred to a number of initiatives similar to those for the adult service, including educational sessions to community health agencies, meetings with court-based staff and attendance at court users' forums. Also, service staff believed that nurses in court are a resource on mental health matters and noted that there is regular informal communication about these issues in the court.

However, a small minority of service staff suggested that more could be done in this respect, particularly in the provision of education to community health agencies. Some staff also noted that clinical demands at court limit the amount of time available for nurses to provide education and training.

The majority of children's court magistrates and respondents from DJJ believed that the service provides education on mental health issues within the court. While magistrates highlighted that nurses at court are generally regarded as a good resource to the court on mental health issues, one view raised was that, if education around mental health issues was required, the court would liaise with consulting psychiatrists rather than nurses based at court.

Respondents from DJJ stated that education and training might be more often achieved in an informal manner by responding to queries about mental health issues when at court. However, it was noted that it would be helpful if the service provided more educational information about the diversionary legislation and the behaviours that may signal mental health difficulties for a young person, as this would help to identify appropriate cases to refer to the diversion service for assessment.

3.2.7 How well have the diversion services established collaborative links with stakeholder agencies?

Staff from both the adult and the adolescent services stated that they have made concerted efforts to liaise and establish positive working relationships with the relevant agencies in the health and criminal justice settings. The majority of respondents external to the services, including magistrates, legal representatives, registrars and corrective staff, confirmed that these links have been successfully formed and maintained. While only a small number of respondents from community health services were interviewed about the adult diversionary service, they also stated that links had been well established. However, one community health worker noted that consistent staffing is necessary across agencies to ensure that these links are maintained.

By contrast, some police officers and probation and parole staff believed that collaborative links had not been successfully established with the adult service. A small number of police officers based in one regional area stated that there were good working relationships, whereas officers from other geographical areas noted that this was not the case. Similarly, half of the probation and parole officers interviewed reported that there were collaborative links, whereas the other half of respondents noted that better communication is needed between agencies.

For the adolescent service, the majority of DJJ staff felt that working collaborative links had been successfully developed. However a representative in one geographical area noted that the links initially established at service commencement have not been successfully maintained and that more pro-active efforts are necessary to restore and maintain these links.

A small number of staff from both services stated that while links have been established, there needs to be an ongoing process to strengthen and improve these links, particularly with potential treatment services.

3.2.8 Diversionary Legislation under the *Mental Health (Forensic Provisions) Act 1990*

As reviewed earlier, Magistrates have the legislative authority under sections 32 and 33 of the *Mental Health (Forensic Provisions) Act 1990*, to divert mentally ill persons or individuals who are developmentally disabled or suffering mental illness or condition out of the criminal justice system and into appropriate treatment in mental health facilities/services in the community. The court diversion programs are able to support the court in identifying appropriate cases for diversion, and can assist in accessing treatment services for diversionary court orders.

All stakeholders were asked whether there were any issues related to the use of section 32 and 33 orders, either specifically in relation to the court diversion programs or more generally.[31] Responses relevant to each service are presented separately for section 32 and 33 orders.

Diversions under Section 33 of the *Mental Health (Forensic Provisions) Act 1990*

Statewide Community and Court Liaison Service

A number of stakeholders, mainly comprising court-based personnel and service staff, felt that recommendations and referrals under section 33 are working satisfactorily. In particular, respondents believed that the specific role of the SCCLS is effective in this capacity within the constraints of both the criminal justice and health systems. In addition, most magistrates and solicitors noted that the SCCLS court reports outlining options for dealing with court matters in this context are helpful and informative.

However, more general issues were raised with respect to diverting individuals under section 33. One of the main issues related to accessing hospital-based mental health facilities in certain areas. A minority of respondents mentioned this was particularly problematic when an individual is violent or has a history of violence. Some stakeholders felt that these challenges relate to:

- Resource limitations and bed shortages in hospital settings.
- In some areas, service staff perceived that health staff held negative attitudes about mentally ill offenders, which could be a barrier to successful hospital admissions.
- A minority of court-based respondents, including some service staff believe that, at times, there are misunderstandings amongst health staff regarding the role of the hospital in section 33 referrals. In particular, it was noted that the role of the hospital in these cases is to conduct assessments for mental illness and not to determine whether an individual is fit to be treated in custody.

Some suggestions for addressing these issues included:

- Developing a better understanding of the legislation amongst staff in health settings and a cohesive way of interpreting and implementing procedures across criminal justice and health settings.
- Providing more education and information to health service professionals about the relevant mental health issues for persons appearing in court.
- Ensuring that good links are in place between diversion staff and local area health services.
- Increasing resources to improve current levels of service provision in health settings.

A minority of respondents from community mental health settings noted that there could be improvements in the provision of information from liaison staff regarding section 33 referrals. Instances were identified where health staff had not been adequately informed of a section 33 referral from a court serviced by the SCCLS. It was noted that improving the level of communication and provision of information from the SCCLS in this context would increase the efficiency of the assessment process.

Comments included:

- Sometimes I think just the communication could have been improved and it also facilitates the speed at which they can be seen and managed once they're at the admission office and being assessed.

More broadly, some police officers based in a metropolitan setting noted that the transportation role for police with regard to section 33 orders is not working very well. Officers felt that it is resource intensive for police to transfer individuals from court to

hospitals and to then wait at hospitals for assessments. Further, if individuals referred to hospital are not admitted, keeping individuals in police custody until they can be returned to court poses challenges for police, particularly when court has finished for the day. Some court-based DCS staff also mentioned difficulties in co-ordinating police transfers.

Additional issues raised by a minority of stakeholders included:

- Bail determinations for section 33 referrals to mental health facilities need to be clarified. Whilst in some geographical areas these issues have been resolved through discussions with stakeholders, in other areas, this has not yet occurred.
- A small number of court-based stakeholders noted that in certain areas there can be difficulties in obtaining sufficiently informative hospital reports for individuals who are referred to hospital under section 33, but upon assessment are not admitted and are returned to court.
- Some service staff in regional areas noted that sometimes, psychiatric professionals are not available or accessible to conduct assessments at hospitals, particularly in areas where there are no psychiatric staff permanently available. While officers reported being able to work within these constraints, it was noted that increased resources for psychiatry in these areas would be beneficial.

Adolescent Court and Community Team

As reviewed earlier, in the past, orders under section 33 have not been very frequent in the adolescent jurisdiction. Nevertheless, stakeholders raised a number of issues in relation to section 33.

While most magistrates noted that the recommendations and reports provided by diversion nurses outlining options for orders under section 33 are helpful, a minority view raised was that there are considerable practical difficulties in using this legislation that are beyond the scope of the diversion program.

Similar to the adult jurisdiction, some general difficulties were mentioned in accessing hospitals for mentally ill young people and in obtaining sufficiently informative hospital assessments. Whilst limitations on resources were identified as a contributing factor to this issue, some service staff also perceived that some health staff held negative views about mentally ill young people appearing in court, that, combined with concerns about patient risk management, could result in some reluctance to admit court referrals.

Suggestions for addressing these issues, made by a small number of stakeholders focused on providing more information and training to health staff addressing:

- the issues and risks associated with mentally ill young people appearing in court;
- the intent and breadth of the diversionary legislation; and
- the specific role of the hospital in this process.

Another difficulty raised in referring young people to hospital under section 33 relates to organising transportation. It was noted by a minority of respondents that further clarification is needed in defining the scope and boundaries of this role. Further, staff from DJJ noted that escorting referrals to hospital under section 33 is resource intensive and can be challenging to accommodate, particularly if a young person is under an order to have ongoing DJJ supervision.

Some service staff identified legislative difficulties with reference to the use of section 33 (1)(b). As noted in the introduction, under this section, a magistrate may order an individual to be taken to hospital for assessment, and if found not to be mentally ill, the individual is to be brought back before the magistrate. However, service staff noted that there is currently some ambiguity regarding whether a successfully admitted young person should be brought back to court following discharge from the treating facility. Staff commented that there are some differing views held on this matter across agencies and that clarification is needed regarding the interpretation of this subsection of the legislation.

Finally, a small number of respondents noted that clarification is required regarding the determination of appropriate bail status for young people transferred to hospital under section 33.

Diversions under Section 32 of the *Mental Health (Forensic Provisions) Act 1990*

Statewide Community and Court Liaison Service[32]

Some respondents, mainly comprising court-based personnel and service staff reported no significant issues with diversions into community treatment under section 32. However, a small number of diversion staff and magistrates noted that section 32 orders are most often used for individuals who are already engaged with treatment or known to a treatment provider.

Most magistrates and solicitors noted that the court reports provided by diversion officers outlining relevant background information and court management options are well documented, helpful and informative. However, a minority of magistrates highlighted that, in some cases, SCCLS reports are not sufficient to establish that a person is suffering from a mental illness, mental condition or developmental disability for consideration under section 32. In these situations, a comprehensive psychiatric report is required to satisfy the diagnostic criteria.

Other general matters raised regarding diversions under this section of the legislation included:

- A minority of service staff and magistrates stated that the current six-month enforceability period for complying with conditional orders under section 32(3) is not sufficient. These respondents suggested that extending this period would make these orders more effective.
- A number of court-based respondents reported that breaches for failure to comply with conditions of 32(3) orders are not being reported to the court. Some respondents believed this could be due to a lack of clarity about the breaching process or reluctance amongst service providers to report breaches. A minority of representatives from Probation and Parole and NSW Health, the agencies mandated to be involved in breaches, noted that the breaching process is cumbersome and, generally, not very effective.
- In light of the problems with the breaching process, a minority felt that there might be some reluctance to use this legislation, particularly when other methods of dealing with mental health matters via community diversion (i.e. community treatment orders, bail/bond with mental health conditions), may be viewed as more effective than section 32.

- Some suggestions for improving the enforceability aspect of section 32 orders included:
  - providing ongoing education for service providers with regard to court expectations for s32 referrals; and
  - further discussion and clarification of the role of the relevant agencies in the breaching process.

Additional points made by a minority of respondents:

- There was some disagreement amongst respondents regarding the accessibility of health services for section 32 orders. In some areas, diversion staff reported that the referral process for these orders is working well, whereas in other areas, a minority of diversion staff and solicitors identified some difficulties in accessing appropriate services.
- Of the small number of respondents from community mental health services, most felt that the information provided by diversion staff and the referral process with the SCCLS is working satisfactorily. A minority noted the importance of: liaison nurses providing all necessary information and documentation from court to community services; and of ensuring that community mental health teams have sufficient time to consider the necessary information with respect to compiling appropriate treatment plans.

Adolescent Court and Community Team

Overall, no major issues were consistently raised with respect to the legislation or with the specific role of the diversion program in this process. Indeed, a representative from DJJ in the community noted that the working relationship between DJJ and the diversion program is working well in this capacity.

Most magistrates mentioned that reports provided by the diversion service containing options and management plans for conditional section 32 orders are appropriate and satisfactory. However, as mentioned for the adult jurisdiction, a minority noted that the reports provided by the diversion nurses may, in some cases, fall short of the diagnostic criteria to be considered for section 32.

With reference to the provision of treatment plans for diversions under section 32, some service staff stressed that it is the role of treating community agencies to design appropriate management plans for consideration by the court. Though liaison officers are able to provide some assistance in this process, it is not appropriate for diversion staff to compile treatment plans. Staff noted that, at times, the limitations on the role of the diversion service in this process must be reiterated with some agencies. Whilst no other consistent issues with treatment plans were raised, it was noted by a minority of service staff that continued efforts in providing information to community mental health services about the function of this legislation are necessary to ensure that treating agencies understand the process and the specific requirements of their role.

Further matters raised by a minority of respondents included:

- Insufficient community resources means that appropriate treating agencies in the community are not always available.
- Stakeholders reported having very little or no experience with breaches for failure to comply with section 32(3), though a minority of service staff emphasized that nurses based at court do liaise with community teams about the breaching process.

- In some cases, young people who have been diverted to community mental health treatment under this section of the legislation may also be ordered to have on-going contact with DJJ. A minority of DJJ staff believed that this may not always be appropriate and that DJJ may be used as a safety net for these orders. It was suggested that that this could be alleviated if there were additional resources specifically targeting young people requiring mental health care.

3.2.9 Suggestions for Service Improvement

The majority of stakeholders believed that the diversion programs have had a positive impact, but when asked if the programs could be improved, they made a number of recommendations. Overlapping responses encompassing both services are presented together, with any points specific to either service clearly differentiated.

The most common recommendations for improvement in both services were: improved provisions to cover staff leave; ensuring availability of current services five days per week; and expansion of the programs to new locations.

Some stakeholders, mostly comprising court-based personnel, suggested expanding the breadth of the services in the following ways:

- Additional resources to increase service provision for non-custodial cases appearing at court. As a representative from DJJ commented:
    - There is still a huge gap in how we effectively target and work with kids in the community who are presenting with mental health issues.
    - Service staff in the adult jurisdiction had mixed views regarding increasing service provision in this manner. Some believed this would be beneficial, while others highlighted that individuals out of custody are seen on a referral basis and that the current model is working satisfactorily.
- Making the services available on a consultation/support basis when mental health issues arise in more serious/indictable matters.

Improvements were suggested for both services in communication and contact with court-based stakeholders and external agencies regarding the service and any relevant mental health issues. Specific recommendations included:

- Increased advertising of the service in community settings, particularly with area health staff. Some adult diversion staff stressed that improving links with health services/facilities and ensuring good working relationships are essential. Suggestions for achieving this raised by adult and adolescent diversion staff included:
    - Having more collaborative discussions between health and diversion staff when issues arise.
    - Having dedicated time to disseminate information into the community in order to form and maintain effective collaborative links.
    - Further provision of information, education and support about mentally ill persons in court and issues around accessing treatment in the community.
    - Improving the level of interaction and integration across agencies, possibly through sharing of service placements.
    - Obtaining more regular program feedback from stakeholders, particularly from community mental health services.

- Increasing the amount of education and training provided to court-based personnel.
- Increasing awareness of the service amongst solicitors, for example, through presentations to the Law Society.

More specific areas for service improvements raised by both adolescent and adult diversion staff included:

- Improving computer facilities at court and designing a streamlined database for data recording and extraction that could be used to facilitate future research and evaluation of program outcomes.
- Internal service issues regarding working arrangements that could be addressed through discussions with management, for example, increasing the flexibility of the adolescent service by allowing service staff at nearby courts to assist each other during busy periods.

Specific suggestions for improving the SCCLS

A minority of stakeholders suggested:

- Increased standardization and consistency across courts in the operation of the service.
- In areas where there are not close links with police, improving communication and liaison between police and diversion staff and increasing the education provided to police about the program.
- Ensuring that diversion staff notify community mental health staff about referrals and that any relevant information is exchanged.
- Improving linkages between service staff and staff in correctional facilities.
- Improving the communication and working relationships between probation and parole staff and diversion staff in some areas.
- Expanding the clinical role at court to include administration of medication, when necessary.
- A small minority of adult diversion staff considered conducting short-term follow-up beyond the court setting for some, potentially high-risk, clients referred into the community. It was suggested that this would not involve intensive case-management, but could, for example, focus on whether client referrals to health services are progressing as intended.
- Ensuring on-going education and training for court liaison officers in court matters.
- Regular evaluation of the service to identify areas for possible improvement.
- In the broader context, a small number of stakeholders suggested increasing resources for community mental health services to facilitate better support for court-based initiatives such as the SCCLS. In particular, more appropriate treatment services to support offenders with mental health issues.

Specific suggestions for improving diversion services provided by the Adolescent Court and Community Team

As the current program is entirely referral-based, some respondents suggested expanding the breadth of the adolescent service to include screening of young people to identify those with mental health issues. However, the following concerns were raised:

- Screening may compromise the rights of a young person not to say anything.
- A screening process could lengthen the amount of time young people are in custody.
- Practical limitations on court facilities (e.g. interview rooms) in accommodating a screening process.
- Difficulties in selecting the appropriate instruments for screening and determining the most effective method to implement screening within the court.
- Determining whether or not screening is a cost-effective intervention.[33]

Additional points raised by a minority of stakeholders from DJJ included:

- Establishing more formal agreements between DJJ and Justice Health for accessing information and reports for overlapping cases.
- Exploring methods to expand service provision into Juvenile Justice detention centres to facilitate the identification of young people with mental health issues who may be appropriate for diversion.

3.2.10 Stakeholder Views and Recommendations for Future Expansion

Nearly all stakeholders believed that both the diversion programs for adults and adolescents should be expanded to other locations. Comments included:

- It's an absolutely vital service.
- I think it is a shame that it is not available to everybody in New South Wales who comes before our courts.
- Yes, clearly. Of course it should be expanded.
- I fully support expansion emphatically.

Recommendations made regarding expansion included:

- Identifying new sites with regard to areas most in need of the service (i.e. high volume courts). Some stakeholders in the adult jurisdiction felt that regional/rural areas should be key targets for expansion.
    - A small number of respondents noted that identifying sites where services can be appropriately staffed and sustained in terms of resources and facilities is an important consideration.
- Considering alternative service provision arrangements rather than full-time services at courts with lower volume, for example:
    - Having the service available on-call or on a consultation basis.
    - Having the service available on particular days such that matters with suspected mental health issues could be listed on days when liaison officers are available to the court.

  - Having one liaison officer shared across two closely sited smaller courts.
  - Having hub courts with diversion officers such that nearby courts without services could utilise hub courts for mental health matters. In rural areas, it was suggested that a team of liaison nurses could provide service on a rotating basis to smaller rural courts when needed.
- Prior to beginning new services and to ensure successful collaborative links, providing relevant information, training and education to key agencies and personnel, such as magistrates, solicitors, DCS officers, and especially local area health services.

Additional Comments

Stakeholder responses suggested that the operation and success of services is determined, at least to some extent, by the specific individuals in key roles, local relationship dynamics, and also by the differing constraints of the communities in which services are based.

4. DISCUSSION

The objectives of this evaluation were to:

1. Determine whether there is a difference in the mean number of offences recorded per month prior to and subsequent to contact with the SCCLS; and
2. Determine whether key stakeholders in the adult and adolescent diversion services were satisfied with the operation of the programs and their recommendations, if any, for modifications.

4.1 CRIMINAL JUSTICE OUTCOMES

The first component of this evaluation comprised two sets of quantitative analyses examining court outcomes and re-offending for adult clients of the Justice Health SCCLS versus comparison groups of individuals appearing at local courts in NSW. For the first set of analyses, the treatment group consisted of individuals with SCCLS contact in 2004 or 2005 whose closest finalised local court appearance to SCCLS contact resulted in a dismissal under the *Mental Health (Forensic Provisions) Act 1990* in a local court provided with SCCLS services in 2004/2005. The control group included individuals who had a mental health dismissal in a local court not serviced by the SCCLS in 2004 or 2005. The second set of analyses compared the remainder of unique individuals with recorded contact with the SCCLS in 2004 or 2005 (who had a finalised local court outcome), with a random sample of offenders receiving supervised bonds in 2004 or 2005 in local courts not serviced by the SCCLS.

Preliminary analyses examining a range of demographic and offending indicators were conducted to describe the characteristics of individuals appearing in local courts who did and did not have contact with the SCCLS. However, these analyses were carried out only for descriptive purposes and did not include any statistical adjustments for potential sources of selection bias. While this precludes drawing any conclusions or implications about the findings, the results are discussed briefly to emphasise the observed differences between individuals with a record of SCCLS contact versus those without.

For the first comparison of individuals who received a dismissal under the *Mental Health (Forensic Provisions) Act 1990* at the index court appearance, descriptive analyses revealed significant differences for treatment and control groups in both demographic (i.e. gender and indigenous status) and criminal justice indicators. In particular, individuals in the treatment group were more likely to have been incarcerated, to have committed an offence resulting in a finalised court appearance and to have committed a greater number of offences compared to the control group in both the 18 months prior to and the 18 months following their index mental health dismissal.

Similar differences in the demographic composition and criminal justice characteristics emerged for the second comparison of SCCLS clients versus a random sample of individuals given supervised bonds. With respect to offending indicators, the treatment group showed more severe offending patterns in terms of incarceration episodes and in the commission of offences resulting in finalised court appearances in the 18-month periods of observation both before and after the index court appearance. Furthermore, simple examination of the penalties received for the principal offences at the index court appearance showed important discrepancies in that a significantly higher proportion of

the treatment group received a penalty of imprisonment (27%) compared to the control group (2%).

These preliminary findings show that there were a number of significant differences in the characteristics of treatment and control groups, with individuals in contact with the SCCLS showing a greater degree of overall contact with the criminal justice system than control offender groups. Taking these substantial group differences and concerns about possible selection bias into account, repeated measures analysis focusing on the mean number of offences recorded per month (resulting in finalised court appearances) were conducted across comparison groups to examine criminal justice outcomes in depth. These analyses investigated whether there is any impact of SCCLS contact on offending frequency by examining the change in the number of offences per month from the 18-month period preceding to the 18-month period following the index court appearance. Since this analysis utilised each group as its own control in determining differences in offending frequency, it was more robust to group differences than more traditional between-groups analyses. In addition, given the high rates of contact with the criminal justice system for SCCLS clients, investigation of the change in the number of offences recorded per month may be a more sensitive measure of the impact of the SCCLS intervention on offending outcomes.

DID CONTACT WITH THE SCCLS IMPACT THE FREQUENCY OF OFFENDING AFTER THE INDEX COURT APPEARANCE?

Analysis of the change in the monthly rate of offending was conducted in repeated measures fashion across the entire 36-month period of observation (from the beginning of the pre-period through to the end of the post-period) for both comparisons.

For the first comparison of treatment and control groups receiving dismissals under the *Mental Health (Forensic Provisions) Act 1990* at the index appearance, the unadjusted mean number of monthly offences was significantly higher for the treatment group than the control group in both pre- and post-periods. However, there was a significant decrease in the mean number of offences per month from the pre-period to the post-period observed for the treatment group, but not the control group. This difference between treatment and control groups persisted after adjusting for age, gender and Indigenous status, with findings showing that relative to the pre-period, there was a significant decreasing trend in the mean number of offences per month in the post-period for the treatment group, while the trend in monthly offences for the control group remained stable. That is, there was a decline in the number of offences per month recorded for the treatment group of SCCLS clients in the 18 months following the index court appearance that was not observed for the control group.

In the second comparison of individuals with recorded SCCLS contact with the random sample of individuals given supervised bonds, the unadjusted mean number of monthly offences for the treatment group was significantly higher than the control group in both the pre-period and the post-period. As shown in the first comparison, a significant decrease in the mean number of offences per month from the pre-period to the post-period was observed for the treatment group, but not the control group. When adjusted for age, sex and Indigenous status, the treatment and control groups showed equivalent decreasing trends in the post-period relative to the pre-period. However, analyses investigating the number of offences recorded in the month immediately following the index court appearance revealed a large decrease (relative to the end of the pre-period) in the number of offences recorded for the treatment group that was contrasted by a

small, but significant, increase for the control group. That is, after excluding cases that received custodial outcomes at the index appearance, there was a significant decrease in the number of offences recorded in the month immediately following the index appearance for the treatment group of individuals with recorded SCCLS contact that was not observed for the control group.

4.2 KEY STAKEHOLDER INTERVIEWS

Most stakeholders held positive views regarding the impact of the Justice Health SCCLS and the diversion services provided by the Justice Health Adolescent Court and Community Team. There was strong support amongst stakeholder groups for the further expansion of both services to other areas of need across NSW.

The most frequently cited positive aspect of the services related to the overall assistance that diversion staff provides to the court, including identifying those with mental health problems, advising court staff about mental health issues, liaising with other agencies and services and, where appropriate, facilitating diversion into treatment services. Some of the other perceived strengths of the services included:

- the availability of the court liaison nurses at the court to be accessed by court personnel regarding mental health issues;
- the timely response of the service in accepting referrals and conducting mental health assessments can facilitate early consideration of mental health issues in court proceedings and can increase the efficiency of the court process; and
- the ability of the court liaison nurses to communicate with, and access relevant information from, the health system.

Some aspects of the services identified as areas for improvement included:

- increasing the availability of services at court and providing better coverage for staff absences;
- the need for further advertising and provision of service-specific information to raise awareness of the diversion services amongst stakeholder groups; and
- ensuring that continued efforts are made to develop and maintain effective collaborative links with stakeholder agencies, particularly with potential treatment services in mental health settings.

Most stakeholders felt that the diversion services were either successful in achieving diversion of mentally ill offenders into health systems in the community, or were making strong efforts to do so. The most commonly identified barrier to successful diversion related to gaps in the availability of appropriate mental health services and difficulties in accessing existing health services in the community. A number of respondents noted that there can be significant challenges in this regard. Indeed, "the area mental health services remain the 'gatekeepers' for the provision of local mental health services for detainees" (Greenberg & Nielsen 2002, p. 160). These views are consistent with recent research on court diversion and liaison schemes in the United Kingdom, in which a number of services reported that a lack of beds for clients in need of hospitalisation and difficulties in accessing other community-based mental health services impact on the success of diversion services (NACRO 2005; Sainsbury Centre for Mental Health 2009).

Recommendations by stakeholders with regards to the future expansion of the diversion services included identifying areas with a "high need" for the service and targeting expansion accordingly. Some stakeholders also suggested that service provision

arrangements (other than full-time services) could be considered for areas with lower needs. Finally, in establishing new services there is an important need to ensure that collaborative working links are formed with key agencies and personnel in both the criminal justice and health systems and that there are commensurate services in the community to meet such expansion.

4.3 LIMITATIONS OF THE RESEARCH

It is important to acknowledge the limitations of the current evaluation. One of the most important limitations is the absence of diagnostic mental health information for individuals in the treatment and control groups in the quantitative analyses. The absence of this information in accounting for criminal justice outcomes precluded any investigation on how specific diagnoses relate to offending outcomes and may also have exerted an unknown impact on the outcomes examining the influence of the SCCLS.

In addition to the lack of diagnostic mental health data, this evaluation does not consider health data on any hospital admissions. As a result, any periods of hospitalisation, either during the period prior to or subsequent to the index court date, which exerted an incapacitation effect on individuals' opportunities to commit offences are not controlled for in quantitative analyses of criminal justice outcomes. Further, this evaluation does not examine whether or not individuals referred onto health services are subsequently engaged in treatment or the duration of any such treatment. Therefore, any analyses investigating the relationship between treatment and criminal justice outcomes or the impact of the SCCLS on accessing appropriate treatment services was beyond the scope of the current study.

With respect to the identification of treatment and control cases for quantitative analyses, one of the main limitations relates to the selection of non-equivalent control cases, as results revealed considerable differences in the composition of treatment and control groups. Additionally, while treatment cases were selected from a cohort of individuals with recorded contact with the SCCLS in 2004/2005, we are unable to determine to what degree the treatment groups are representative of the population of clients that are typically assisted by the SCCLS. These limitations may constrain the generalizability of the observed outcomes and conclusions.

Also, in examining rates of offending in the adult jurisdiction, statistical analyses focused on the change in the number of offences per month from the pre-period to the post-period. By comparing broadly across these periods of observation, this statistical procedure may not be sensitive to any deviations within each period. Finally, it is important to acknowledge that the 18-month follow-up period for examining quantitative outcomes may not have been sufficient to detect longer-term changes in frequency of contact with the criminal justice system.

4.4 CONCLUDING REMARKS

This evaluation has revealed some important findings regarding the impact of the Justice Health court liaison services in New South Wales. For the SCCLS in the adult jurisdiction, quantitative analysis of criminal justice outcomes examining offending before and after contact with the SCCLS provides some evidence that SCCLS clients decrease their offending following service contact to a greater degree than comparison groups. In addition, most stakeholders were satisfied with the operation of the SCCLS and the diversion services provided by the adolescent team, and supported further expansion of the services statewide.

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APPENDIX A: KEY STAKEHOLDER INTERVIEW TEMPLATE

1. How the implementation of the CLS has impacted relevant services and agencies (whether positively or negatively);
    i. If there has been a positive impact, what specific improvements have resulted from the establishment of the CLS?
    ii. If there has been a negative impact, what specific consequences have resulted from the establishment of the CLS?
2. What are the strengths and weaknesses of the service? [Other prompts: what aspects of the service are working well and what aspects are not working well?]
3. How the introduction of the CLS has influenced the processing of mentally ill/ disordered individuals in the criminal justice system;
    i. Have court-processing times for mentally ill offenders decreased as a result of the establishment of the service?
4. Whether the service is effective in achieving the aims and objectives for diversion of mentally ill/disordered individuals into appropriate mental health services. If not, what are the obstacles?
5. Do stakeholders feel adequately informed about the role of the CLS in diverting mentally ill offenders into appropriate mental health treatment?
    i. Is any case follow-up or outcome information available to stakeholders?
6. Is the CLS successful in providing education and training on mental health matters within the criminal justice system?
7. Has the CLS successfully established collaborative links with stakeholder agencies to facilitate the process of diversion into appropriate treatment?
8. Whether there are any difficulties involved in Section 32 and 33 orders. If so, how could the process be improved?
9. How could the service be improved in courts with existing services?
10. Any recommendations with respect to initiating the CLS in new locations? [Other prompts: should this happen? If so, any suggestions on how the service should be set up? Any changes from existing services?]
11. Any general comments from relevant agencies on the overall functioning of the CLS.

NOTES

1. Any psychiatric disorder was defined as including psychosis, anxiety disorder, affective disorder, substance use disorder, personality disorder, or neuroasthenia.
2. Community comparisons in this study were drawn from the findings of the National Survey of Mental Health and Wellbeing (ABS 1997).
3. Formerly known as the *Mental Health (Criminal Procedure) Act 1990*.
4. Magistrates may also make interlocutory orders under section 32(2) to adjourn the proceedings, grant bail or make any other order that the magistrate considers appropriate (Gotsis & Donnelly 2008).
5. Additionally in NSW, a court liaison service run by the local community mental health service currently operates in Newcastle. This service is not part of the SCCLS.
6. Due to the relocation of Cobham Children's Court matters to the Parramatta Children's Court Complex, the diversion service was relocated from Cobham to Parramatta Children's Court in 2006.
7. It is important to note that the accuracy of the data on SCCLS clients extracted from the SCI MH-OAT database is dependent upon how reliably diversion staff enter SCCLS patient contacts into this database.
8. This refers to dismissals under sections 32 and 33 of the *Mental Health (Forensic Provisions) Act 1990*.
9. Mental health diagnostic information was not available for the cohort of SCCLS clients.
10. These local courts were located at: Burwood, Campbelltown, Central Sydney, Dubbo, Gosford, Lismore, Liverpool, Parramatta, Penrith, Sutherland, Tamworth and Wyong.
11. In selecting both control groups, no cases were drawn from local courts that were serviced by the SCCLS or that were operating mental health court diversion services independent of the SCCLS at the time this evaluation commenced (January 2008). The court locations excluded on this basis were the 17 SCCLS local courts listed in the introduction and the independent services in operation at this time at Port Macquarie/ Kempsey, Newcastle and Wollongong.
12. For both treatment groups, index court dates were only selected if the court date fell within 10 days prior or up to nine months following the date of SCCLS contact. If an appropriate date could not be identified within this time frame, cases were excluded.
13. The principal offence recorded at a court appearance is the offence associated with the most serious penalty. However, if there is no guilty finding, there will be no principal offence recorded. In these cases, the first listed offence was extracted.

14. Chi-square analyses comparing those cases with recorded contact with the SCCLS who were excluded from final treatment groups (n=549) with the combined analysed treatment group (n=1930) showed no differences in terms of sample composition for age or Indigenous status. However, there were significantly more females in the analysed treatment group (17%) compared to the excluded group (10%) ($p<.0001$). This may be due to females spending less time in custody, making them less likely to be excluded based on the criteria for having at least 100 free days in the pre-and post-period.
15. For all analyses, p-values less than 0.05 indicated statistically significant findings. Additionally, for t-tests, 95 per cent confidence intervals around mean differences that did not contain zero were indicative of significant outcomes.
16. Non-significant explanatory variables were retained in models to ensure consistency across analyses, provided that the inclusion of the non-significant explanatory variable in the model did not affect the size and direction of the relationship between the offending outcome and group (the primary explanatory variable of interest).
17. Only three health staff were interviewed for this component of the evaluation. Whilst attempts were made to recruit additional participants from this agency, ethical limitations on recruiting resulted in low response rates.
18. The views of the service clients and associated carers were not sought as they were beyond the scope of the current evaluation.
19. For TGA, mean age = 33 years (median age = 32 years). For CGA, mean age = 35 years (median age = 33 years).
20. The percentage of cases for which Indigenous status was unknown was approximately 1% in TGA and 9% in CGA.
21. As indicated in the table, a small proportion of both groups received penalties other than 'no penalty' for their principal offence. In these cases, the dismissal under the *Mental Health (Forensic Provisions) Act 1990* was associated with an offence other than the principal offence at the index court appearance.
22. Due to low expected cell frequencies, it was inappropriate to conduct chi-square analysis for this outcome.
23. For TGB, mean age = 32 years (median age = 31 years). For CGB, mean age = 32 years (median age = 30 years).
24. The percentage of cases for which Indigenous status was unknown was approximately 1% in TGB and 4% in CGB.
25. The remainder of cases in CGB received a supervised bond for an offence other than the principal offence at the index court appearance.
26. For TGB, 474 cases were excluded from based on receiving custodial outcomes at index court appearance, leaving n=1136. For CGB, 48 cases were removed based on this criteria, leaving n=1211.

27. A small number of adolescent service staff emphasised that assessments with young people showing signs of emerging mental health issues can be time-intensive, as these assessments often include interviews with families/carers and the gathering of clinically relevant background information from a range of possible sources (i.e. schools, Department of Community Services).
28. Responses exclude representatives from NSW Police Force, as this issue is not specific to the role of the police or their relationship with the diversion service.
29. In contrast to the adult service, referrals to hospital under section 33 of the *Mental Health (Forensic Provisions) Act 1990* have been less frequent in the adolescent jurisdiction.
30. Respondents from NSW Health were excluded, as this question was targeted at stakeholders with regular exposure to court.
31. It is important to acknowledge that diversion into community-based mental health treatment can be achieved by other court orders not falling under section 32 and 33 of the *Mental Health (Forensic Provisions Act) 1990*. However, for the purpose of this evaluation, only the use of the specific diversionary legislation under this act was queried.
32. No comments were provided by court registrars or representatives from NSW Police.
33. Some service staff noted that they are currently in the process of investigating the impact of screening in a research project examining the inclusion of screening at a court that does not currently have the diversion program in place. It is hoped that the outcome of this research will help to better evaluate the utility of this intervention.