CURBING THE “REVOLVING DOOR” PHENOMENON WITH MENTALLY IMPAIRED OFFENDERS: APPLYING A THERAPEUTIC JURISPRUDENCE LENS

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This paper briefly considers the application of therapeutic jurisprudence principles in the context of the recent innovation of mental health courts which are designed to enhance the “wellbeing” of mentally-impaired offenders. It is argued that mental health courts have the potential to address the criminalisation of mentally-impaired offenders by facilitating positive therapeutic outcomes and diverting mentally-impaired offenders into treatment. In particular, mental health courts can facilitate successful treatment outcomes by minimising the use of coercion and ensuring that mentally-impaired offenders are accorded a “voice” and treated with dignity and respect. Accordingly, the mental health court seeks to advance more integrative and holistic treatment approaches to treatment which ideally should be informed by evidence-based practice. Ultimately, however, the success of any therapeutic intervention is contingent on mental health courts “brokering” relationships with community service providers in order to facilitate accessibility to treatment. The recent introduction of the Victorian Assessment and Referral Court (ARC) List, which aims to consolidate the management of mentally impaired offenders into a single court, is also briefly examined as a timely and promising initiative in curbing the “revolving door” phenomenon.

Mental health courts are a relatively new innovation primarily designed to divert mentally-impaired offenders away from the criminal justice system and into much-needed treatment. Indeed, the mental health court system represents a timely initiative in responding to the overwhelming number of mentally-impaired offenders entering the criminal justice system (Reed, 2001). By embracing a therapeutic jurisprudence perspective, which effectively focuses on the law’s “healing potential”, mental health courts adopt an “ethic of care” in relation to the wellbeing of offenders and attempt to facilitate the implementation of a more innovative treatment-oriented approach which focuses on enhancing treatment outcomes. This paper first briefly examines the problem of criminalisation of mentally impaired offenders and more specifically highlights the problem referred to characteristically as the “revolving door” phenomenon. Secondly, the paper reviews the application of therapeutic
jurisprudence principles of mental health courts in practice. Finally, the paper briefly touches on some relevant concerns for treatment providers which are necessary to ultimately facilitate positive therapeutic outcomes.

The term “mentally impaired” is used to encompass mentally ill, intellectually disabled and dual diagnosed offenders.

The criminalisation of mentally impaired offenders

A “complicated and intractable” problem within the criminal justice system seems to be the persistent failure to adequately respond to the treatment needs of mentally impaired offenders which it has been argued results in the “unfair” and “disproportionate” criminalisation of persons suffering from mental impairment (Slate, 2003, p.12). The evident lack of treatment and support services for mentally impaired offenders as well as the trend in recent years toward “de-institutionalisation,” seems to have largely contributed to a significant over-representation of mentally impaired offenders within the prison system (Zammit, 2004; Slate, 2003). As Denckla & Berman (2002) note, “while the number of people with mental illness in state psychiatric hospitals has decreased precipitously over the last 30 years, the number of mentally ill people in prison … has steadily increased” (p.2). Some critics have labelled this phenomenon as the “transinstitutionalisation” of persons from the mental health system into the criminal justice system. The preponderance of evidence suggests that prisons have been inappropriately utilised as a means of managing offenders with mental impairment (Zammit, 2004). Indeed, as Bernstein & Seltzer (2003) note, “for most, the underlying issue is their need for basic services and supports that the public systems have failed to deliver in meaningful ways” (p.143). A primary issue is therefore addressing the provision of adequate linkage to mental health and disability support services in order to help stabilise these offenders in the community (Herrick, Smart, Ama, Dolezal & King, 2005; Zammit, 2004; Slate, 2003).

Not surprisingly, the number of persons with mental impairment who are “entangled” in the criminal justice system is not only reported to be disproportionately high, but also seems to on the rise (Watson, Hanrahan, Luchins & Lurigio, 2001). According to the Australian Bureau
of Statistics, ABS figures released in December 2009 indicate that the number of adults in
Australian prisons has increased by 6% (equating to 1,700 prisoners) in the twelve month
period ending 30 June 2009. Alarmingly, recent estimates further suggest that there is an
over-representation of mentally ill offenders in the prison system. It has been reported, for
instance, that 28% of Victorian prisoners have a mental illness with approximately half of
those also contending with substance abuse issues (Attorney-General’s Justice Statement 2,
2008). Previous NSW data also suggests that intellectually disabled offenders comprise at
least 13% of the NSW prison population which is four times that of the general population
(NSW Law Reform Commission, 1996). Recent research findings further suggest that mental
illness is a risk factor for multiple periods of incarceration. Baillargeon, Binswanger, Penn,
Williams & Murray (2009), for instance, report that prisoners with major psychiatric disorders
(such as major depressive disorder, bipolar disorders and schizophrenia) are more likely to
have experienced previous incarcerations.

It is disconcerting that an overwhelming number of the prison population are offenders
incarcerated for minor offences who have a mental disorder and a history of frequent contact
with the criminal justice system (Zammit, 2004; McGaha, Boothroyd, Poythress, Petrila &
Ort, 2002). It has been argued that there is a substantial proportion of low-level non-violent
offenders with mental impairment, who pose no serious threat to public safety, who should be
diverted to community-based treatment programs as opposed to being incarcerated (Mariner,
2003). Indeed, incarceration appears to make little sense for this portion of the forensic
population as, first, the prison system is not designed to be a therapeutic environment and is
inadequately resourced to provide the necessary treatment and support services required by
mentally impaired offenders, and secondly, mentally ill and intellectually disabled offenders
are arguably a “vulnerable” population prone to victimisation (Zammit, 2004; Denckla &
Berman, 2002). As Mariner (2003) points out, “prisoners with mental illness frequently
endure violence, exploitation and extortion at the hands of other inmates, and neglect and
mistreatment by prison staff” (p.1). Such conditions may only serve to exacerbate rather than
ameliorate the problems faced by mentally-impaired offenders who are incarcerated for minor
offences in prison settings, where the primary purposes are primarily “detention and security,
not treatment” (McGaha et al, 2002, p.125).
Arguably, the current inadequacy of treatment for mentally impaired offenders in prison, combined with the lack of adequate discharge planning, monitoring and support services to assist their transition back into the community, perpetuates a vicious cycle of re-offending otherwise referred to as the “revolving door” phenomenon (Denckla & Berman, 2002; Haimowitz, 2002). As Denckla & Berman (2002) explain, “the results are painfully clear … many defendants with mental illness churn through the criminal justice system again and again going through a ‘revolving door’ from street to court to cell and back again without ever receiving the support and structure they need” (p.4). Minimising the “criminalisation” of mentally impaired offenders who come into contact with the criminal justice system inevitably poses a pressing policy issue for both criminal justice administrators and providers of mental health and disability services. As Almquist & Dodd (2009) emphasise, the main challenge is “exploring new ways of responding to these individuals to break this costly and damaging cycle” (p.v).

It seems imperative therefore that mentally impaired offenders charged with relatively minor offences who come into contact with the criminal justice system, be properly identified and diverted into structured treatment programs which are conducive to achieving enhanced therapeutic outcomes. Otherwise, as Slate (2003) clearly notes, we will “continue to abdicate our responsibility by forcing individuals into an ill-equipped system and … not consider the consequences of our intervention” (p.14).

**Therapeutic jurisprudence: adopting a remedial perspective**

The adversarial model traditionally adopted by the criminal justice system is arguably counter-therapeutic in the sense that it is not conducive to assessing the treatment needs of mentally impaired offenders (Zammit, 2004; Slate, 2003). Traditional adversarial approaches that apply a “stringent application of rules to the facts of a case without an inquiry regarding an individual’s needs and relationships, may lead to legally relevant but ineffective decisions” (Casey & Rottman, 2000, p.447).

Therapeutic jurisprudence on the other hand offers a remedial perspective which “uses the tools of behavioral sciences to assess the law’s therapeutic impact and … to reshape law and
legal process in ways that can improve the psychological functioning and emotional wellbeing of those affected” (Winick, 2000, p.1). More succinctly, therapeutic jurisprudence has been defined as “the use of social science to study the extent to which a legal rule or practice promotes the psychological and physical wellbeing of the people it affects” (Slobogin, 1996, p.57). As Judge Lerner-Wren (2000) states, “therapeutic jurisprudence is a legal construct which advances the court’s role as an active therapeutic agent in the recovery process” (p.6). By adopting an “ethic of care” perspective, which concentrates on the care and treatment of individual offenders, therapeutic jurisprudence seeks to promote the law’s healing potential (Casey & Rottman, 2000). Indeed, therapeutic jurisprudence seeks to offer new insights and a sense of “renewal” by critically focusing on how legal processes can impact on the well being of offenders. As a primary focus, therapeutic jurisprudence therefore adopts a new “lens” which allows us to examine how the law in its application can affect therapeutic outcomes. As Reed (2001) notes, “therapeutic jurisprudence adds a rich and humane dimension to traditional jurisprudence … and brings the effect of the legal system’s actions on the welfare of the defendant or the litigant squarely into the jurisprudential equation” (p.54).

At the same time, proponents of therapeutic jurisprudence concede that “therapeutic jurisprudence considerations should not trump other considerations and certain values enshrined in our legal system” (Casey & Rottman, 2000, p.5). For instance, while therapeutic jurisprudence primarily seeks to enhance the well-being of offenders and thereby promote the law’s healing potential, it also needs to ensure that the protection of the community is not compromised and that any harm that may arise from legal decisions is minimised (Zammit, 2004; Freiberg, 2003). Accordingly, as Zammit (2004) notes, “the requirement for community protection is balanced with a need to engender constructive change in order to promote future positive behaviour from the defendant” (p.13). Ultimately, the application of therapeutic jurisprudence principles needs to concord with the primary role of the courts in maintaining the rule of law (Bartels, 2009).

Therapeutic jurisprudence promises to “reinvigorate” the criminal justice system by creating “a law of healing” which aims to improve legal procedures in order to formulate and implement enhanced therapeutic outcomes for mentally impaired offenders (Zammit, 2004;
Reed, 2001). It is this focus of therapeutic jurisprudence that captures the appropriate scope of the discussion that follows.

**Promoting the wellbeing of offenders: adopting more integrative and holistic approaches to treatment**

Mentally ill or intellectually disabled offenders often display antisocial maladaptive behaviour which, next to the severity of their mental impairment, seems to play a decisive role in the decision of judicial officers to resort to a sentence of imprisonment (Hayes, 1990). Indeed mentally impaired offenders who come into contact with the criminal justice system usually face an array of psychological and socio-economic disadvantages (NSW Law Reform Commission, 1996). In particular, mentally impaired offenders may be contending with a range of personal, medical and psychosocial problems such as substance abuse, homelessness and unemployment. Furthermore, the propensity of the mentally ill to suffer from co-occurring disorders (such as substance abuse and/or intellectual disability) may render their presentation as even more complex and challenging (Slate, 2003). As Hayes (1990) explains, “offenders who display maladaptive behaviour are seriously limited in their opportunities for integration into educational, residential, employment and recreational facilities both inside and outside prison” (p.265).

Notably, mental impairment within a therapeutic jurisprudence framework is seen as a condition requiring a therapeutic response to a range of spheres that may impact on the quality of an offender’s life. This approach is premised on the understanding that “a lack of wellbeing in one or more areas of life underlies the reason why people come before a court” (King, 2003, p.4). Therefore, premised on therapeutic jurisprudence principles, mental health courts seek to facilitate the integration of treatment and support services for mentally impaired offenders which are optimally conducive in promoting individual wellbeing. As Watson et al (2001) explain, “court staff collaborate with community-based treatment providers and support services to implement a therapeutic intervention that may include medication management, substance abuse treatment, housing, job training and psychosocial rehabilitation” (p.477).
According to the GASR Practice Direction (cited in King, 2003) “the end result of rehabilitation should be a person’s empowerment to lead a productive, harmonious and fulfilling life in the community” (p.6). This understanding of rehabilitation reflects a recent trend in adopting more comprehensive and integrated models of human nature in order to promote the rehabilitation of mentally impaired offenders. As King (2003) poignantly notes, criminal justice practice needs to be based on “an understanding that encompasses the whole person, their social environment and the interaction between them” (p.7).

In accordance with this perspective, Ward & Stewart (2003) argue that “the notion of human wellbeing can provide a coherent conceptual basis for rehabilitation” (p.125). Rehabilitation is accordingly seen in terms of enhancing an offender’s innate capabilities to improve their quality of life, and leading a “good life” which seeks the lawful attainment of “basic human goods” (that is, physical, psychological and social needs necessary to attain a good life). As Ward (2002) argues, underlying the rehabilitation of offenders is the need to instil in them the skills, knowledge and resources that are necessary for them to live “good lives” and resources to achieve psychological wellbeing (p.514). Accordingly, this concept of rehabilitation is premised on a more holistic, constructive and integrative approach, which primarily focuses on enhanced wellbeing in all spheres of an offender’s life (whether that be physical, psychological and social). The construct of “wellbeing” effectively underlies the therapeutic potential of assisting offenders to make informed decisions, develop the requisite skills in leading more fulfilling lives and in turn reduce the risk of recidivism (King, 2003).

**Mental health courts: implementing therapeutic jurisprudence theory into practice**

The emergence of mental health courts have been one of several responses to the escalating number of mentally impaired persons in the criminal justice system (Watson et al, 2001). As Slate (2003) points out, “mental health courts are advocated as a common sense approach to diverting persons with mental illness from the criminal justice system and ensuring linkages to treatment” (p.6). Although there is no single or common mental health model, effectively mental health courts constitute a problem-oriented court with a specialised jurisdiction that is designed to divert mentally impaired offenders charged with non-violent and relatively minor offences from the criminal justice system and into treatment (Slate, 2003; Petrila, 2002). As
Zammit (2004) notes, “ultimately such measures aim to achieve more humane outcomes for offenders with mental impairment” (p.11). As such, the emphasis is on using a treatment oriented approach in an effort to break the cycle of recidivism which tends characterise this offender population (Slate, 2003; Petrila, Poythress, McGaha & Boothroyd, 2001).

Research findings to date seem promising and indicate that mental health courts have the potential to not only reduce the number but also the severity of new arrests among mentally-ill offenders than comparable offenders processed by traditional criminal courts (Moore & Hiday, 2006). Herinckx et al (2005), for instance, found that the most significant factor in determining ‘success’ of mental health court participants, as measured by reduced re-arrest rates, was graduation status from the mental health court with graduates reportedly 3.7 times less likely to re-offend compared with non-graduates.

Notably, mentally-impaired offenders seeking entry into a mental health court must first adhere to the plea structure as endorsed by the particular court in question (Zammit, 2004). Mental health courts typically tend to adopt either a:

(i) *Pre-adjudication model* where charges are held in abeyance pending successful treatment compliance. In accordance with this model, which does not necessarily require a plea to be entered by the offender, charges are usually dismissed or reduced when the court effectively ends its jurisdiction; or

(ii) *Post-adjudication model* where the actual sentencing process may be suspended or deferred pending successful treatment completion. In this instance, the court usually requires offenders to enter a plea of guilty which effectively means waiving the right to subsequently contest the relevant charges (Zammit, 2004; Slate, 2003).

Essential to the operation of mental health courts are the following elements:

(a) *Early identification and intervention.* This is a key feature of mental health courts which focuses on the early identification and expeditious processing of offenders through the use of prompt screening for eligibility and extensive assessment of mental health issues (Zammit, 2004). The emphasis is on assisting mentally-impaired
offenders to promptly gain access to treatment and other support services (Bartels, 2009; Boothroyd, Poythress, McGaha & Petrila, 2003).

(b) *Non-adversarial approach.* The roles of criminal justice personnel are often characterised as being relatively informal and less adversarial compared to the traditional court system. This practice is consistent with the mental health court’s effort to establish a non-adversarial “tone” in court proceedings (Petrila, 2002). The focus is on adopting a problem-oriented and collaborative approach which seeks to promote treatment compliance and foster positive changes in offenders’ behaviour (Zammit, 2004).

(c) *Judicial monitoring and supervision.* The mental health court explicitly facilitates the promotion of a “therapeutic alliance” between offenders and judges (Boothroyd et al, 2003, p.50). A single judge closely monitors offenders’ treatment progress on an ongoing basis. “Status hearings” are typically used to review offenders’ progress and encourage treatment compliance. This continued and intensive judicial supervision means that judges play a primary and active role in the implementation and monitoring of offenders’ treatment program, while engaging in an active “dialogue” with offenders about their perceived treatment needs (Petrila et al, 2001). Offenders are respectfully accorded “a voice” and the opportunity to inform the court of their progress and any problems or issues they may wish to raise (Zammit, 2004).

(d) *Team collaboration.* A “team approach” to treatment intervention is adopted which focuses on the integration of treatment services, and requires a co-operative and collaborative approach to be adopted by a number of parties including the judge, prosecutor, defence counsel, corrections and treatment providers (Berman and Feinblatt, 2001; Petrila et al, 2001). The primary focus in adopting a “team-oriented” approach is to facilitate the treatment compliance by ensuring that offenders receive adequate and comprehensive treatment and support (Zammit, 2004). Judicial officers accordingly “embrace a more collegiate style of working” and tend to make their decisions in consultation with a team of treatment agencies, rather than in isolation (Bartels, 2009, p.5).
(e) Linkage to treatment. Characterised as “treatment courts”, mental health courts primarily seek to link mentally-impaired offenders to specific treatment and other support services as deemed appropriate for their individually assessed needs. Mental health courts may also engage judges to “broker” relationships with various treatment providers (Denckla and Berman, 2002, p.9). In particular, the court may either: (i) identify an existing treatment provider and encourage an individual offender to continue a previously existing treatment plan; or (ii) following a thorough assessment of the offender’s treatment needs make an appropriate referral for community-based treatment; or (iii) in the case of acute presentations where an offender is unable to provide the requisite informed consent to participate in court-endorsed treatment, refer the offender for crisis intervention and formulate a treatment plan, once the person is stabilised (Boothroyd et al, 2003). Ultimately, the treatment services received by mental health participants is contingent on the adequate assessment of individual offenders’ needs and the availability of community resources to service those needs (Almquist & Dodd, 2009).

(f) Non-coercive approach. As treatment courts, the primary aim is to minimise the use of punitive sanctions for non-compliance with treatment. Instead, by adopting positive reinforcement or rewards, the court aims to enhance the self-esteem and motivation of offenders thereby facilitating treatment compliance and ultimately successful treatment outcomes. The mental health court model therefore seeks to provide a meaningful alternative to criminal sanctions by promoting an environment that is conducive to the wellbeing of mentally-impaired offenders rather than focusing on the imposition of punishment (Zammit, 2004; Petrila et al, 2001).

Implications for policy and practice

(a) Minimising coercion and maximising procedural fairness

The danger of coercion is arguably a prominent concern for mental health courts which often has to deal with issues of mental competency (Reno, Marcus, Leary & Gist, 2000). Mental
health courts therefore must ensure that mentally-impaired offenders knowingly and voluntarily consent to participate in legal procedures and any treatment interventions instituted by the court (Zammit, 2004; Petrila et al, 2001). For instance, mental health court participants from the outset should be informed that their participation is voluntary and they have a legal right to opt out of mental health court proceedings in favour of traditional court dispositions (Poythress et al, 2002).

Within a therapeutic jurisprudence framework mental health courts aim to reduce the stigma of mental impairment, enhance autonomous decision-making and impart a sense of “empowerment” to mentally-impaired offenders in order to facilitate therapeutic outcomes (Poythress, Petrila, McGaha & Boothroyd, 2002, p.19). Indeed, mental health courts aspire to be a non-coercive influence in offenders’ lives (Boothroyd et al, 2003). As Poythress et al (2002) explain, “the actions and aspirations of the mental health court imply that reducing a accused person’s sense of coercion, and enhancing the perception of procedural justice are important intermediate goals” (p.519). Undoubtedly, key factors that may promote a subjective perception of procedural fairness on the part of offenders and help facilitate treatment compliance include:

(i) according offenders a “voice” in mental health court proceedings; and
(ii) imparting a sense of “validation” by court personnel treating offenders with dignity and respect (Poythress et al, 2002; Petrila et al, 2001).

Indeed, enhancing a perception of procedural fairness may also help ameliorate offenders’ perceptions of “coercion.” This is especially pertinent in the context of mental health courts which often require a longer period in treatment than what may be ordinarily justified by the severity of the offence. For instance, it is common for mentally impaired offenders to spend a minimum of one year in treatment which mental health court advocates consider necessary in order to successfully engage offenders and facilitate therapeutic outcomes (Denckla & Berman, 2002, p.9; Petrila et al, 2001). Nonetheless, prolonged or extensive treatment needs to be balanced against other considerations such as ensuring procedural fairness of mentally impaired offenders (Reed, 2001). A pertinent consideration in minimising a sense of ‘perceived coercion’ and thereby facilitating treatment compliance is the need to ensure that mental health court participants from the outset are fully informed and understand the terms
of their participation and the respective procedural requirements. As Almquist & Dodd (2009) note, “absence of ‘perceived coercion’ is not a reliable indicator that parties are fully informed about the voluntary nature of the court, the process and their obligations” (p.19). Accordingly, research findings suggest that voluntary participation in the mental health court process, when also accompanied by an understanding of the terms of participation by mental health court participants, is more likely to be associated with successful therapeutic outcomes and treatment compliance (Redlich, 2005).

(b) Encouraging the use of evidence based practice

Although preliminary findings of mental health courts currently in operation suggest a positive impact on the well being of offenders, it has been suggested that currently “there is no accepted definition of a mental health court and no accepted evidence-based models for standards for how mental health courts should function” (National Mental Health Association, 2001, p.2). Indeed, mental health courts are arguably still in their “infancy” and therapeutic outcomes have yet to be properly evaluated. As Zammit (2004) explains, “further evaluation is required to ascertain whether mental health courts are providing long term benefits in improving functioning and well being and hence minimising the potential for re-offending” (p.42).

Notably, therapeutic jurisprudence calls for “thoughtful discourse and experimentation” (Casey & Rottman, 2000, p.454). In accordance with this perspective, future evaluations for instance “will eventually yield information and treatment involvement, community adjustment, criminal recidivism, quality of life and other outcomes” (Poythress et al, 2002, p.518). Moreover, research findings concerning offender treatment and therapeutic outcomes that is drawn from evidence-based practice can then be assimilated into court practices and assist in the promotion of more appropriate and individualised treatment strategies and outcomes (McGuire, 2000). As Almquist & Dodd (2009) succinctly note, in order to “augment” the promising findings to date, there is a continuing need for future research to identify “which aspects of the mental health courts have the greatest positive effects, why and for whom” (p.vi). In terms of assessing the impact of mental health court participation on mental health outcomes, a number of reported key indices for future research include:
(i) improved mental health functioning of participants;
(ii) reduced recidivism rates;
(iii) increased linkages to treatment and engagement of participants with treatment services;
(iv) client and/or program characteristics associated with reduced recidivism and improved therapeutic outcomes; and
(v) long-term cost-effectiveness of such initiatives

(c) Facilitating access to treatment

Another potential problem for mental health courts is the lack of adequate resources of treatment services to meet the extensive needs of mentally impaired offenders (National Mental Health Association, 2001, p.1). Successful treatment intervention is logically contingent on the availability and access to community treatment providers and other support services. Otherwise, mental health courts risk implementing inappropriate interventions with limited prospects of achieving positive therapeutic outcomes (Rottman, 2000). As Zammit (2004) explains, “in order to have a successful mental health court it is essential that adequate resources are available to ensure that the judicial officer can make appropriate linkages to treatment” (p.33). Indeed, the efficacy on mental health courts may be effectively limited and undermined if deficits in mental health service provision are not adequately addressed. Thus although mental health courts have been found to increase access to mental health services, whether this in turn facilitates positive clinical outcomes and reduced recidivism rates for mentally-impaired offenders is ultimately contingent on the type and quality of services that participants actually receive (Boothroyd, Poythress, McGaha, & Petrila, 2003; McGaha et al, 2002).

Recent developments: the Assessment and Referral Court (ARC) List

The implementation of the Assessment and Referral Court List (ARC) of the Magistrates’ Court of Victoria is a timely and innovative initiative. The Magistrates’ Court Amendment
(Assessment and Referral Court List) Act 2010 was assented to on 30 March 2010. It provides for the establishment and operation of the ARC List of the Magistrates’ Court.

The ARC List commenced its operation on 21 April 2010 and is a specialist court list which seeks to address the specific needs of mentally-impaired offenders who have a mental illness and/or a cognitive impairment. It is scheduled to run as a three year pilot program funded by the Victorian State Government, and estimated to hear 300 cases per year.

Pursuant to the Magistrates’ Court Amendment (Assessment and Referral Court List) Act 2010, the main features of the ARC List are as follows.

- The ARC List has jurisdiction in criminal proceedings that are referred to it by the Court (s.4S).
- The ARC List has no jurisdiction to hear charges involving violent offences, serious violent offences or sexual offences as defined by s.6B(1) of the Sentencing Act 1991 (s.4S(2)).
- The Court can only refer a matter to the List if the accused person:
  - meets the stipulated eligibility criteria; and
  - consents to having the matter heard by the List (s.4T). The requirement of consent reinforces the need for facilitative therapeutic approaches that are non-coercive, as stipulated in the Attorney-General’s Justice Statement 2 (2008);
- The accused person must meet a number of eligibility criteria including:
  - diagnostic criteria (namely, that the accused person has a mental illness, intellectual disability, acquired brain injury, autism brain injury, autism spectrum disorder and or a neurological impairment, including dementia);
  - functional criteria (namely, that the accused person has at least one of the impairments listed under the diagnostic criteria which causes a substantially reduced capacity in at least one of the areas of self-care, self-management, social interaction or communication); and
  - needs criteria (namely, that the accused person would derive benefit from receiving coordinated services in accordance with an individual support plan (ISP). (As specified by ss.4T (2), (3) & (4) respectively).
The Court must exercise its jurisdiction with minimal formality and technicality (s.4U (3)).

The Court may, before taking a formal plea from an accused person, seek an adjournment for a clinical assessment of the accused person to:

- identify the accused person’s needs based on the need criteria (s.4T); and
- prepare an Individual Support Plan (ISP) for the accused person (s.4V).

Effectively the focus of the ARC List is to assess the individual and specific needs of participants and link them to appropriate services while encouraging collaborative decision making. The ISP may include case management by the Court Integrated Services Program and/or referral to other community-based services. This is consistent with one of the aims of the ARC List which is to enhance the health and wellbeing of mentally impaired offenders by facilitating access to appropriate treatment and support services.

The Court has power to convene at any time in order to receive reports on an accused person’s progress and compliance with his/her ISP (s.4U(2)(a)) as well as to adjust, amend or vary any individual support plan of the accused person. Effectively, this imports a degree of flexibility in the Court process and allows the judicial officer to periodically review an accused person’s progress compliance with the ISP and to make any necessary variations or amendments.

The Court must fix a return date for the consideration of the proposed ISP and may adjourn proceedings for a period not exceeding twelve months to enable the accused person to be assessed and complete his/her ISP (s.4V(2)).

Participants are not required to enter a plea until they have ended their participation with the ARC List. Accused persons who plead guilty are sentenced within the ARC List. If at any stage an accused person decides to plead not guilty, the matter must be transferred to the mainstream Magistrates’ Court for a contested hearing (s.4X(2)).

The Court is required to take into account the extent to which the accused person has complied with or participated in the Individual Support Plan (ISP) plan, but not to take into account the accused person’s failure to comply with the ISP plan, when sentencing the accused person who who has been found guilty of a charge (s.4Y). This provision potentially reinforces the incentive for participation in an ISP by minimizing concerns that non-compliance will adversely affect an accused person’s sentence.
- The Court has the power to discharge the accused person without any finding of guilt (s.4Y(2)).
- Participation in the ARC List is premised on an accused person’s competency to plead (s.4S(8)).

The Victorian Attorney General, Mr Hulls, has recently heralded the ARC List initiative as one that has the potential to end the ‘revolving door’ experience of accused persons with mental health impairment or disability issues and increase the prospects of reform and re-integration by diverting these accused persons away from the criminal justice system (Attorney General of Victoria, Press Release, 2010). How will we know if the ARC List as a mental health court initiative is effective? This will depend on future evaluations of the operation of the ARC List which in turn may inform best practice and policy development. As McGaha et al (2002) note, “future evaluations of mental health courts would be helpful to both stakeholders and policy makers who presumably would want to know whether, to what degree and how efficiently mental health courts meet their diverse goals” (p.126).

Conclusion

Mental health courts, accordingly, represent a “major shift” in the way our system of justice deals with mentally-impaired offenders. By facilitating the engagement of offenders with treatment services in a more responsive and sustained way, mental health courts have the potential to promote the wellbeing of participants while simultaneously reducing criminal justice involvement (Zammit, 2004; McGaha et al, 2002). The recent introduction of the Victorian ARC List is a promising and timely initiative in addressing the need to provide a more comprehensive, flexible and responsive service delivery for mentally-impaired offenders and improving equitable access and participation in the legal process.
References


Magistrates’ Court Amendment (Assessment and Referral Court List) Act 2010 (Victoria).


