

A Behind-the-Scenes Examination of the Kitchener Mental Health Court: The Diversion of
Persons with Mental Disorders

by

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Declaration

I hereby declare that I am the sole author of this thesis. This is a true copy of my thesis, including any required final revisions, as accepted by my examiners.

I understand that my thesis may be made electronically available to the public.

Abstract

In this thesis I investigate how the Canadian criminal justice system handles persons with mental disorders who come into conflict with the law. Through an in-depth examination of the Kitchener Mental Health Court this research explores the legal concept of diversion. Diversion is a voluntary option for individuals accused of minor offences. Its main objective is to function as a positive intervention. Offenders who participate in diversionary programs avoid a criminal record but are still held accountable for their criminal behavior. Diversion programs lessen the burden on the criminal justice system by decreasing the volume of caseloads in the courts via diverting individuals away from incarceration through alternative measures.

The goal of this study is to uncover the processes involved in diverting offenders away from incarceration and into appropriate mental health treatment. Two theoretical frameworks applicable to mental health courts include the medical model and therapeutic jurisprudence. The thesis explores the philosophies of mental health courts, the principles of sentencing, and the role of community support agencies in the location and provision of mental health treatment.

This research includes a six-month observational study of the Kitchener Mental Health Court setting and five in-depth interviews with the Crown prosecutor, defense attorney, Canadian Mental Health Association Court Coordinator, Salvation Army representative, and a mother of one of the accused.

The findings from this research suggest that mental health courts strongly adhere to the treatment ideology contained in the medical model and therapeutic jurisprudence. The Kitchener Mental Health Court demonstrates this through its empathetic, treatment-oriented approach towards offenders, language, and commitment to locate appropriate health care. This research also reveals the crucial role community support agencies play in directing individuals towards the necessary health care. But most especially, the evidence points to the role community support agencies play as key facilitators in the legal processes of mental health courts.

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Dedication

This thesis is dedicated to my parents, John and Gabriella Leroux. This would not have been possible without their continuous encouragement and support.

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CHAPTER 1: Mental Health Courts

An Introduction

1.1 Introduction

The proportion of mentally disordered accused involved in the already burdened justice system is increasing by 10% annually (Schneider, Bloom and Heerema 2007). It can be argued that the criminal justice system partially acts as a surrogate mental health care provider yet is unable to cope at the rate at which persons with mental disorders are entering the system. In an attempt to resolve this issue, the restorative justice movement has advocated a community based treatment model. The goal is to repair the harm and disruption to relations caused by criminal behavior while involving all stakeholders in the criminal justice system (i.e., victims, community and society). Partly as a result of their initiatives, mental health courts have been created in an attempt to alleviate some of this burden to the current system by developing innovative methods to address persons with mental disorders who are in conflict with the law.

People who commit crimes are subject to the punishments handed down by the criminal justice system in order to deter others from committing similar crimes and to protect society. In cases of persons who suffer from mental disorders and who come into conflict with the law, the traditional approach is arguably unsuitable to address the criminal behavior or the underlying causes of criminality (i.e., mental health issues). The question remains as to how the criminal justice system can handle persons with mental disorders in a way as to not further stigmatize or exacerbate an already delicate socio-legal problem. The justice system needs to recognize the special needs of persons suffering from mental disorders and provide a system that is empathetic while ensuring public safety. Essentially, this requires the system to strike a balance between making these individuals accountable and upholding the integrity of the law while at the same time affording people with mental disorder a degree of empathy and flexibility regular offenders

would not likely receive. Striking this balance is not easy. The mental health court cannot provide offenders a “get out of jail free card” or special treatment above the law. It must develop and employ methods for dealing with mentally disordered offenders that are respectful of the justice system and appropriate given the nature of their mental health condition.

1.2 Purpose of Research

The purpose of this research is to examine the way in which the Canadian criminal justice system manages offenders with mental health issues. This research investigates the establishment of the Kitchener Mental Health Court, including the laws under which it functions, the court’s philosophy, principles of sentencing, the involvement of community health support services, the protection of society, the use of diversionary programs, and the role of various stakeholders.

The goal of this study is to analyze the problems mental health courts face, including issues related to due process, the relevant laws and socio-legal issues with respect to how mentally disordered offenders are identified, how legal rights and treatment needs are addressed, and the use of community treatment orders. In addition, this study aims to uncover the role of community agencies in the social control and treatment of offenders with mental health problems.

The study employs a qualitative approach and is based on semi-structured interviews and unobtrusive observations of the Kitchener Mental Health Court. The study intends to answer four fundamental research questions: What are the general problems and challenges facing mental health courts to-date? Are the principles of therapeutic jurisprudence evident in the practices of Kitchener’s Mental Health Court? What are the roles of community support services and how does the judicial system balance the rights of the accused while protecting the public’s safety?

In particular, this research explores what occurs behind-the-scenes of the mental health court. Specifically, the study investigates the processes that occur prior to the accused going to trial, including the role of the judiciary team, mental health team, community support team, and the offender.

1.3 History of the Mental Health Court

Mental health courts developed in the United States during the 1990s in response to an overburdened criminal justice system. The creation of mental health courts was inspired by the success of drug courts—a type of court dedicated to offenders with substance addictions. Drug courts offer offenders the option to participate in drug treatment in order to avoid serving a sentence for drug-related offences. The goal of drug courts is to break the cycle associated with addiction, focusing on the addiction rather than criminal behavior. By adopting principles of therapeutic jurisprudence (this will be discussed further in Chapter 3), drug courts assist participants in avoiding harsh sentences commonly handed down by traditional criminal courts. It has been argued that the treatment model used in drug courts is likely to be more effective in reducing recidivism, and addressing the special needs of offenders. Given widespread acceptance of drug courts, mental health courts began to spring up (Schneider et al. 2007).

Mental health courts in the U.S. offer treatment over punishment for persons with mental disorders who come into conflict with the law. The goal is to remove individuals from the traditional legal system by linking them to community-based support services. In the case of minor offences, the mental health court views criminal behavior as a result of an individual's inability to control and or manage their symptoms rather than deliberate criminality.

The emergence of mental health courts is the result of the traditional criminal justice system being ill-suited to handle persons with mental disorders effectively, resulting in increased support and appeal for specialty courts. Over the past decade, more than 100 mental health courts have been created across North America. One of the first programs in Canada was implemented in the mid 1990s. The “Diversion of Mentally Disordered Accused,” part of the Crown Policy Manual from 1994, was a diversion program that recognized the presence of the mentally disordered accused in the criminal justice system. The first-ever mental health court was created in Toronto, Ontario in 1998 to handle a broad range of issues related to mental disorder.

Diversion is just one of the alternatives available to the Toronto Mental Health Court, along with other therapeutic intervention approaches at post-arrest junctures.

1.4 Characteristics of Mental Health Courts

The mental health court specializes in cases involving persons with mental disorders who commit criminal offences with the goal of diverting those individuals away from the traditional criminal justice system. Mental health courts have five basic characteristics. First, mental health courts have separate dockets (i.e., list of cases to be heard) and involve a court team that works exclusively with persons with mental disorders. Secondly, this court employs community-mandated treatment; requiring persons with mental disorders to adhere to specific conditions while incentives are provided to the client to encourage their continued involvement in the diversionary program. Incentives come in the form of dropped charges and avoidance of jail time. The third characteristic is that the mental health court ensures compliance by promoting and organizing continued supervision through review hearings and direct community supervision. Judicial status hearings, for example, provide an opportunity for the judge and Crown to review cases and offender progress. Supervision is carried out through community treatment support service providers and probation and court personnel reporting back to the court regarding the offender's progress. Fourth, the mental health court operates under the principles of therapeutic jurisprudence, which takes a gentler, less adversarial approach to persons suffering with mental disorders who come into conflict with the law. Fifth, participation in the mental health court is voluntary. It is the responsibility of the courts to ensure that the offender understands fully the nature of the diversionary program and his or her rights and obligations.

Diversion is employed when persons with mental disorder commit, or are alleged to have committed, low risk offences and whose mental health needs can be effectively addressed by community-based services. The Canadian Mental Health Association defines diversion more specifically as:

Diversion is a process where alternatives to criminal sanctions are made available to people with mental illness who have come into contact with the law for minor offenses. The objective is to secure appropriate mental health services without invoking the usual criminal justice control of trial and/or incarceration. Treating the mental disorder, it is hoped, reduces the likelihood of further offending and the focus is on helping individuals to access community support and treatment (The Canadian Mental Health Association 2007: para. 1).

The Canadian Mental Health Association works alongside mental health courts providing diversion and non-diversion support to clients for a period of up to 12 months. Non-diversion support is for individuals who suffer from mental health problems and are in conflict with the law but do not report to the Crown. It is offered as a short-term only program and requires referrals from other community agencies. A probation disposition is handed down in non-diversion cases and the offender must report to a probation officer within the community. Under non-diversion, a CMHA case manager may be assigned (if a case manager is available) but there is no reporting function back to the courts. Diversion and non-diversion programs are entirely voluntary.

Three groups are meant to benefit from diversion programs: the accused, the judiciary system, and society. On an individual level the accused obtains the help that he or she needs through direct contact with appropriate community services. The mental health court recognizes that people with mental disorders often engage in criminal activity as a result of the disorder and not necessarily criminal intent. The crime results from their inability to execute rational judgment or the disorder places them under social, legal, or economic pressures that result in criminal conduct. Secondly, offenders do not suffer the harsh penalties commonly handed down by the traditional criminal justice system. The mental health court is aware that an adversarial approach is not flexible enough to help individuals who suffer from mental disorder. The third benefit is that the needs of the accused are addressed without jail time. The confinement of jails and prisons may exacerbate the mental health problems of the accused and do not provide the specialized care required to handle issues of this nature. Overall, diversion provides the opportunity for the accused to obtain the treatment they need and hopefully decreases the chances of that person re-offending in the future.

The judiciary system benefits from diversion in that it decreases the amount of people incarcerated for crimes of a less serious nature who would perhaps benefit more from mental health treatment. Secondly, diversion affords the opportunity for the judiciary system to work in cooperation with the community and to help mental health organizations. Establishing this connection allows for a greater flow of resources between the legal system and community organizations, increasing the chances for the accused to receive proper and timely care.

On a societal level, if the needs of persons with mental disorders are addressed, the likelihood of recidivism decreases and the safety of the public is protected. Diversion also saves taxpayers money. By reducing the case load of the regular criminal justice system and using the supports of community agencies, which are funded separately, the mental health court can operate efficiently—moving less serious offenders through the system quicker and into appropriate treatment programs. This would also reduce prison and jail costs by reducing the inmate population overall. In essence, “diversion programs are thought to be among the most effective ways to integrate an array of mental health, substance abuse, and other support services to break the cycle of repeated entry into the criminal justice and mental health and substance abuse treatment systems by persons with mental disorders” (Steadman, Deane, Morrissey, Westcott, Salasin and Shapiro 1999: 1623).

1.5 Background of the Kitchener Mental Health Court’s First Year of Operation

The Kitchener Mental Health Court began on September 20, 2005 and was initiated by Justice Gary Hearn and Deputy Crown Attorney, Sharon Nicklas. Three major factors have contributed to the creation of the Kitchener Mental Health Court. First, a growing number of mentally disordered people are admitted to Ontario correctional facilities every year. As previously stated, the proportion of mentally disordered involved in the criminal justice system is increasing by 10% annually (Schneider et al. 2007). In November 2004, Justice Desmarais ruled that it was unconstitutional to hold mentally disordered persons in jail while awaiting psychiatric

assessment (see R. v. Hussein & Dworkin S.C.). One year later, the Ontario Government invested \$27.5 million dollars towards helping non-violent people with mental disorders stay out of the criminal justice system. A percentage of the funding was allocated towards additional court support services.

According to Kitchener Mental Health Court records, in the first six months of operation in 2005, 93 people attended this specialized court. Of the 93, 73 were identified as eligible for the mental health court diversion program. By 2006, 181 cases had been heard by the court, 140 of which were completed and 41 were still pending. The majority of cases were resolved with either a stay (i.e., a suspension of proceedings), withdrawal of charges (i.e., ending proceedings by dropping the charge), peace bond (i.e., a written promise to the court to keep the peace) or absolute discharge (i.e., accused is discharged but proof of charge or plea of guilt entered) and probation (i.e., a disposition made by the court to subject the accused to conditions upon release back into the community). See Table 1.1 for additional disposition statistics.

Table 1.1 Number of Cases by Type of Disposition in 2006

Type of Disposition	Number of Cases (N=181)
Stay, withdrawal, peace bond, absolute discharge	51
Probation	39
Jail and probation	38
Committed new offence	12
Found “not criminally responsible”	9
Conditional sentence	3
Total cases completed	140
Total cases pending	41

Source: The Kitchener Mental Health Court 2006

1.6 The Kitchener Mental Health Court: Procedures and Processes

1.6.1 Physical Layout of Courtroom 101

The observed mental health court is located at the Ontario Court of Justice, a provincial criminal division, at 200 Frederick Street Kitchener, Ontario, Canada. This location services the

entire Waterloo Region, including cases involving mental health issues, which are transferred from Cambridge, Ontario's satellite court. The Waterloo region comprises three cities: Kitchener, Waterloo, and Cambridge. The Kitchener Mental Health Court operates once a week on Tuesdays in courtroom 101. It is one of six smaller Ontario courts; the largest and only full-time court is located in room 102 in Toronto Ontario's Old City Hall. The other courts are located in Ottawa (three days per week), Brampton (two days per week), London (one day per week), Sudbury (fitness assessments only two days per week), and Newmarket (one day per week). For a physical layout of the Kitchener Mental Health Court, refer to Figure 1.1 provided below.

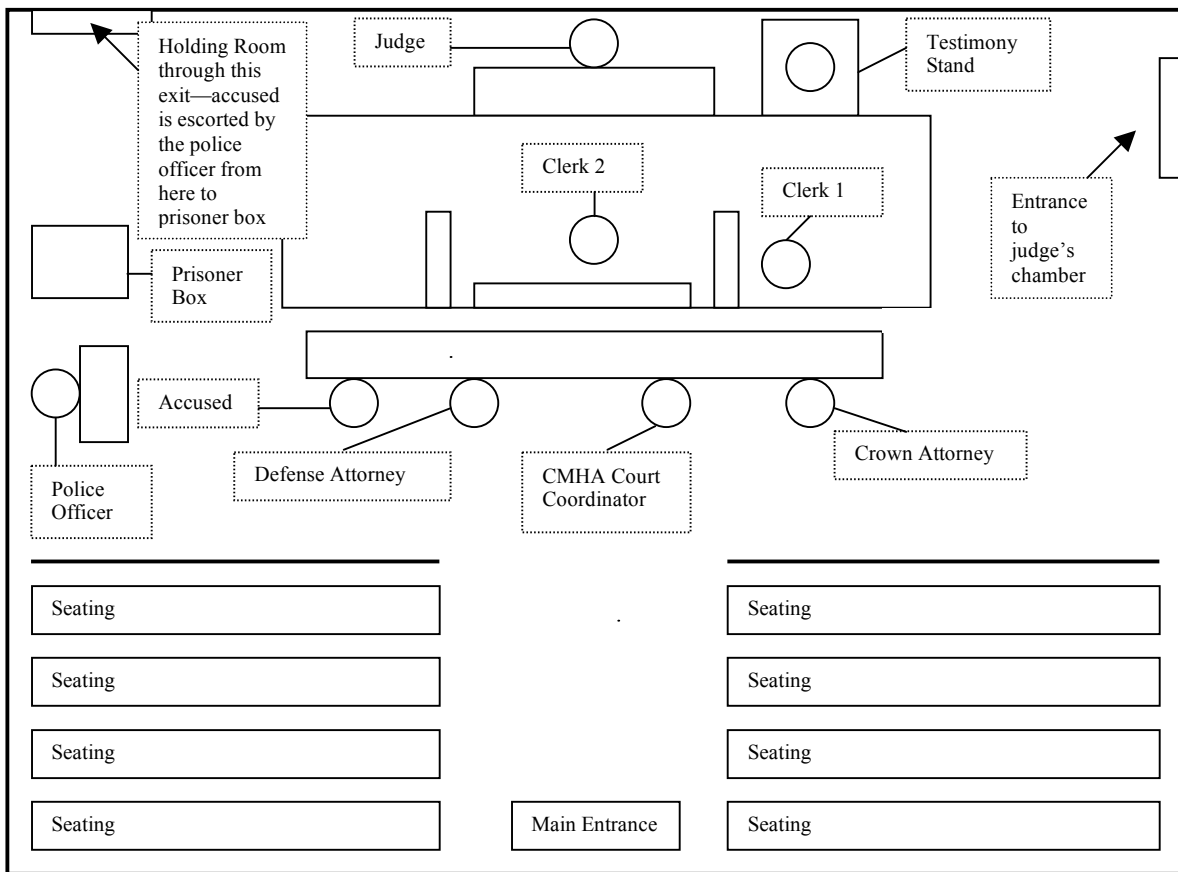
1.6.2 Mental Health Court Team and Procedures

The objectives of the Kitchener Mental Health Court are to deal effectively with persons with mental disorders or disabilities in accordance with the Ontario *Mental Health Act* and *Criminal Code* of Canada. This includes insuring that the accused is held accountable for their actions while at the same time providing appropriate treatment, providing proper attention to accused persons, to ensure public safety, and to protect the rights of the accused while maintaining the integrity of the criminal justice system (The Kitchener Mental Health Court 2006).

The Mental Health Court has four permanent judicial officers who work on a rotating basis. The Crown attorney's team has one appointed team lead and two support Crown prosecutors, in addition to a court support person. The duties of the team lead are to consult on matters at the bail and pre-trial stage and during the screening process. The role of the court support person is to locate available beds at forensic hospitals for individuals who are awaiting assessment. The defense team is comprised of a representative duty counsel who is appointed by the Kitchener Mental Health Court, and three support duty counsels. Duty counsel is funded by the Legal Aid Society of Ontario and headed by a criminal duty counsel supervisor who's duties include training and organizing lawyers within the community who wish to work with the court

and scheduling their court dates. Additional court support includes one dedicated clerk who is assigned to the mental health court, a Constable for court security, and one mental health court coordinator from the Canadian Mental Health Association (CMHA).

Figure 1.1 Kitchener Mental Health Courtroom 101: Physical Layout



Other partners who attend the courtroom setting include representatives of government and community agencies (e.g., The Salvation Army Correctional Division), and special interest groups. The Canadian Mental Health Association Court Support Services (The GrandRiver Branch) is a major participant and assists the process by:

- Consulting with the accused, Crown attorney, and defense counsel;
- Attending bail and mental health court hearings;
- Developing service plans (i.e., housing, counseling, community support);
- Providing pre-fitness screening;
- Securing individual treatment plans and support information;
- Developing mental health court diversion plans.

CMHA court support services also help to facilitate access to community activities for accused persons, develop crises plans, and help to liaise with family and community members. They are also actively involved in the referral process by gathering background information on the client's history of treatment and mental disorder (The Canadian Mental Health Association 2007: para. 1).

1.6.3 Identifying Target Populations for Eligibility

According to the Ontario Ministry of Health and Long-Term Care's (2006) "A Program Framework for Mental Health Diversion and Court Support Services" document, definitions for identifying target populations eligible for mental health court programs are broad and specific depending on the agency and other influencing factors. Definitions vary across the province and are dependant upon government policy and funding initiatives, local need, resource availability, and program capacity.

Four different definitions are provided. The 1997 Human Services and Justice and Coordination Committee Project defines the target population as, "common clients of mental health and/or developmental services and criminal justice sectors who have a current legal involvement or who are considered a high risk for repeat offences" (Ontario Ministry of Health and Long-Term Care's 2006: 6). In January 2005, the Ontario Ministry of Health and Long-Term Care specified the target population as:

Persons with mental illness who have come into conflict with the law, and are at risk of being charged by the police or have been charged by the police or have been sentenced or found unfit to stand trial or not criminally responsible and whose offence is considered low risk and whose mental illness can be appropriately managed through services based in the community (Ministry of Health and Long-Term Care's 2006: 6).

It is evident from the above definitions that differences exist depending on the source. However, the 2006 MOHLTC report provides clearer definitions which are based upon the time of entry into the mental health court program (see Table 1.2 for definitions of target population by key juncture points).

Lastly, the Mental Health Court Support Service Policies and Program Manual, as part of

the Mental Health Court Consortium states:

the primary target population of the MHCS&S Program is any individual aged 16 or older who has a serious mental impairment, including dual diagnoses and concurrent disorders, and has been charged with a criminal offence. However, other individuals who could potentially benefit from MHCS&S (such as individuals with acquired brain injuries) who have been charged with a criminal offence may also be considered (2005: 6).

In the Kitchener Mental Health Court, cases are identified as eligible if the accused has an identified mental disorder or symptoms of mental disorder, and/or are developmentally disabled, and charged with a criminal offence in Waterloo Region. Cases involving brain injuries and domestic violence are accepted but youth cases and addiction-only cases are not eligible.

The Ministry of the Attorney General's Crown Policy Practice Memorandum (2005), outlines the eligibility of offences for Mental Health Court. Offences are divided in the Canadian *Criminal Code* as Class I, Class II, and Class III. Class I offences are "presumptively eligible" for consideration and are dependant upon the circumstances of the offence and the accused, especially in cases of first-time offenders.

Class II cases are eligible but it is the Crown's discretion as to whether or not the case is accepted. Class II offences are more likely to be accepted if they do not resemble an ineligible offence. Class III offences are not eligible for Mental Health Court treatment plans or other types of supervisory programs, irrespective, of the circumstances surrounding the offence and the accused (see Appendix E for a list of Class I, II, and III offences).

1.7 Relevant Legislation and Definition of 'Mental Disorder'

The *Criminal Code* of Canada and the Ontario *Mental Health Act* work together to provide a legislative framework for dealing with persons who are charged with criminal offences and are suffering from mental disorders. The mental health order provisions are in Part XX.1 Sections 672.1-672.95 of the Canadian *Criminal Code* and provide the following: assessment orders to determine the mental condition of the accused; treatment orders; the determination of fitness to stand trial; findings of not criminally responsible on account of mental disorder (NCR); and the

composition and function of the Ontario Review Board to make or review dispositions concerning any accused who is found not criminally responsible or unfit to stand trial.

Table 1.2 Definition of Target Population by Key Juncture Point

Key Juncture	Target Population
Pre-Charge Diversion	Adults (18 and over) who appear to have mental health needs, who are in contact with the police and/or are in conflict with the criminal justice system, and who would benefit from community or hospital-based mental health services as an alternative to incarceration.
Court Support	Court Support Adults (18 and over) with mental health needs, who have been charged with a criminal offence, and who would benefit from community or hospital-based mental health services as an alternative to incarceration. The priority population for community mental health services/supports and brief service provision is for people with serious mental illness. Mental health service/support providers will refer other people with mental health needs to appropriate services/supports.
Post-Conviction	Adults (18 and over) with mental health needs who have been convicted of a criminal offence, and who would benefit from community or hospital-based mental health services as an alternative to incarceration. The priority population for community mental health services/supports and brief service provision is people with serious mental illness. Mental health service/support providers will refer other people with mental health needs to appropriate services/supports.

Source: Ontario Ministry of Health and Long-Term Care (2006).

The Canadian *Criminal Code* defines ‘mental disorder’ under Part XX.1, Section 672 (1) “a disease of the mind” (Department of Justice Canada 2008). The Ontario *Mental Health Act* (2004) Section 1 (1) defines ‘mental disorder’ as “any disease or disability of the mind.” The Kitchener Mental Health Court abides by both definitions. The court recognizes that it needs to be flexible in its adherence to the definitions because some conditions are not commonly accepted or considered valid mental disorders. For example, if a defendant suffered from depression once in their lifetime and subsequently committed a criminal act during that depressive episode, the

mental health court accepts that this condition did indeed lead to the commission of a crime and therefore depression, within this context, would be valid.

The Alternative Measures Program is one of the most important pieces of Canadian legislation regulating diversionary programs. This legislation is outlined in Section 717 subsection (1 a-e) in the Canadian *Criminal Code*. An alternative measure, also referred to as diversion, recognizes that “Not every individual alleged to have committed an offence need be prosecuted” (Department of Justice Canada 2008).

According to the Alternative Measures Program which is outlined in Part IV LITIGATION FRAMEWORK Chapter 14 of the “The Federal Prosecution Service Deskbook,” the fundamental principle behind alternative measures legislation is:

[That] in appropriate cases, alternative measures may provide greater benefit to the offender, the victim, and society than can the formal criminal process. Indeed, the fundamental principle underlying alternative measures is that criminal proceedings should be used with restraint and only when other less intrusive measures have failed or would be inappropriate. This allows the courts to devote their resources to addressing more serious crime (Department of Justice Canada 2008).

There are six preconditions to diversion that the Crown must consider when making the decision to divert an individual. These preconditions are contained within Section 717 (1 a-e) of the Canadian *Criminal Code*. The *Criminal Code* stipulates:

717. (1) Alternative measures may be used to deal with a person alleged to have committed an offence only if it is not inconsistent with the protection of society and the following conditions are met:

(a) the measures are part of a program of alternative measures authorized by the Attorney General or the Attorney General's delegate or authorized by a person, or a person within a class of persons, designated by the lieutenant governor in council of a province;

(b) the person who is considering whether to use the measures is satisfied that they would be appropriate, having regard to the needs of the person alleged to have committed the offence and the interests of society and of the victim;

(c) the person, having been informed of the alternative measures, fully and freely consents to participate therein;

(d) the person has, before consenting to participate in the alternative measures, been advised of the right to be represented by counsel;

(e) the person accepts responsibility for the act or omission that forms the basis of the offence that the person is alleged to have committed;

(f) there is, in the opinion of the Attorney General or the Attorney General's agent, sufficient evidence to proceed with the prosecution of the offence; and

(g) the prosecution of the offence is not in any way barred at law.

The remaining sections of the Alternative Measures legislation include Section 717 subsections two, three, and four (see Appendix E for the complete version of the Alternative Measures Program legislation).

The guidelines for diversion eligibility are broken down into three parts which include: 1) the circumstances of the offender; 2) the nature of the offence; and 3) the circumstances of the offence.

The Crown must use his or her discretion and assess the circumstances of the offender. This includes an investigation of past convictions, to determine whether or not the offender expresses remorse for criminal acts, and the potential risks to the community.

The Crown must also assess the nature of the offence. The Alternative Measures Program is intended for individuals who commit minor offences. The Crown must determine whether or not the offence was summary or indictable; is there a prescribed minimum punishment for the offence; is the sentence generally three or more months; and is there harm to victims or society.

In addition, the Crown must determine the circumstances of the offence. A variety of factors must be examined such as whether or not there was violence or a threat of violence; was a weapon involved; did the offence affect the sexual integrity of the victim; and was there serious impact on the victim. A cluster of additional considerations include whether or not the offence was drug-related (i.e., the offence involved the trafficking or possession of controlled substances).

The Alternative Measures Program recognizes that:

Diversion is not intended to be available for every offender and every offence. Rather, it is an acknowledgement that in some cases, because of the nature and circumstances of the offence and the offender, the public interest would be better served by a resolution outside of the traditional criminal process. Generally, it will be most suitable for younger

adult offenders and those with no criminal record, who have committed minor offences (Department of Justice Canada 2008).

The DSM-IV (Diagnostic and Statistical Manual of Mental Disorder) provides diagnostic criteria for mental disorders and has been developed by the American Psychiatric Association. It provides the most commonly accepted definition of mental disorder. The DSM-IV defines 'mental disorder' as:

A clinically significant behavioral or psychological syndrome or pattern that occurs in a person and that is associated with present distress (a painful symptom) or disability (impairment in one or more areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom. In addition, this syndrome or pattern must not be merely an expectable response to a particular event, e.g., the death of a loved one (Wakefield 1997: 634).

Mental disorder is a term which subsumes a variety of discrete diagnostic categories and which have a set of defined clinical symptoms and or clusters of symptoms. The diagnosis of mental disorder requires a comparison of the patient's behaviour and symptoms to a clinically recognized syndrome. There are four basic functions of the DSM-IV which include the following: a) to distinguish between different types of disorders; b) to distinguish true mental disorder from non-disorders (also known as 'problems in living'); c) to provide the reliable application of criteria, and; d) to provide theory neutral criteria which is accepted by researchers and practitioners irrespective of their theoretical stance (Wakefield 1997: 634).

For the purpose of maintaining consistency with the organization under study, the Kitchener Mental Health Court, this research employs the term 'mental disorder' to describe individuals who suffer from mental health issues who are in conflict with the law.

1.8 Mental Health Court Proceedings

The Kitchener Mental Court proceedings involve four stages which include the referral process, eligibility screening, psychiatric assessment, and acceptance/rejection of referral.

The first stage in the mental health court proceedings is the referral stage. Referrals are made at the initial court appearance in the criminal justice system and or early in the prosecution

process after arrest. According to the “Mental Health Court Support Service Policies and Procedures” manual created by the Mental Health Court Support Consortium (2005) in Section 2.3 Subsections 2.3.1., 2.3.2, and 2.3.3, referral sources to the program include:

Anyone may make a referral to the Court Support Program – the individual who has been charged, family or friends of the accused person, Crown, defense and duty counsel, judges, other court staff, police, mental health professionals and community agencies.

In addition, it is the discretion of the mental health court service and support staff to accept or reject individual cases. Subsection 2.3.2. states:

Referrals are accepted or rejected at the discretion of MHCS&S staff. Some examples of reasons for rejecting a referral include but are not limited to: referral does not fit criteria for program; staff member has a full case load; individual is uncooperative and not interested in receiving services; staff member feels threatened or fears for their personal safety.

The referral procedure involves two possible alternative steps. Referrals can be made from the bail court, through family, friends and agencies, or through self-referral to the CMHA (The Canadian Mental Health Association) Court Coordinator. Alternatively, referrals can be made by Duty and Legal Counsel, Show Cause Court (i.e., a legal proceeding to show why an order should not be put into effect), transfer by the Crown from Regular Court, and or a Pre-trial with the Crown (i.e., a proceeding to clarify and or settle outstanding issues regarding a case or to obtain admissions).

The second stage involves screening individuals for eligibility for entry into the mental health court diversion program. Once the individual is referred, the Crown and CMHA Court Coordinator review the offender’s file to determine whether or not the accused is suitable for mental health court diversion (i.e., determine whether or not the case fits eligibility criteria). The Crown has the final say on all referrals upon the advice of the CMHA Court Coordinator.

Once the screening process is over and eligibility is determined, the accused is sent to a first appearance where the court decides upon a suitable course of action. The court may choose to withdraw the charges, with or without non-diversion support or send the accused back to regular court. In cases of non-diversion support, the CMHA Court Coordinator is responsible for

connecting the individual with community services and creating a personalized crisis plan in order to stabilize the person. An informal contract must be signed by the accused and remains active for six months. If the Crown refers the accused for diversion, the diversion referral is processed and the candidate is connected with a support coordinator, if the referral is deemed appropriate. At this point, there is an adjournment phase that provides a four to six week assessment period.

The Crown must work within a set of parameters when determining whether or not diversion is appropriate. The Crown must be satisfied that there is a reasonable prospect of conviction, that it is in the public's best interest to proceed, the accused has voluntarily agreed to take part in the program, and that diversion can begin in a timely fashion. An admission of criminal responsibility is not required. If the accused is not stable (i.e., physically and or mentally incapacitated) at the time of diversion, the charge can be stayed until the accused is stabilized.

Following screening, psychiatric assessments are conducted. The assessment stage involves four possible courses of action. First, the Mental Health Court uses the Ontario *Mental Health Act* to direct individuals eligible for the court and to determine if diversion is suitable.

If the accused has committed minor offences and suffers from acute symptoms, a Form 2 is completed. A Form 2 is an Order for Examination and is required for the apprehension and transportation of person to a physician for assessment (see Appendix D for a copy of Form 2). A bail order is required for the transportation of the accused to a medical facility. Bail support is provided by the mental health court and is arranged by the CMHA Court Coordinator. Once the individual is admitted, audio remands (i.e., electronic methodologies for conducting proceedings between the court and medical facilities in cases when persons with mental disorders are detained for stabilization and are unable to physically appear in court) are conducted between the court and hospital to track the individual's progress. Once the individual has been stabilized, the Crown decides the next course of action. Duty counsel must contact the Court Coordinator to provide their client's consent to be interviewed (see Appendix D for a copy of the CMHA Consent Form).

Once consent has been granted, the Court Coordinator collects background information and relays the information to the Crown in order to develop a bail release plan. Bail release plans involve locating available housing and treatment and community support.

The mental health court can also use a Risk Assessment Order that can be invoked at any point during the proceedings. If the court believes that the person poses a risk to him/herself or to the public, it is in their power to conduct an assessment and have the individual hospitalized until he or she is stable. Under Section 21 of the Ontario *Mental Health Act*, if the individual is not in custody, the Crown can arrange for a psychiatric assessment. Under Section 22 (1), if the individual is in custody, the Crown must ensure that a forensic hospital bed is available before the order is made. This assessment has a maximum duration of 60 days and the judge must complete a Form 8. A Form 8 is an Order of Admission into a forensic facility (see Appendix D for a copy of Form 8). The judge must be convinced that the person in question does suffer from a mental disorder.

The mental health court must satisfy that the person suffering from a mental disorder is fit to stand trial and understands the nature of the proceedings, the participants involved, and are able to communicate meaningfully with duty counsel. If there is any doubt over fitness, an assessment can be conducted at any time. These assessments are conducted in jail clinics through the use of telepsychiatry, electronic methodologies for conducting assessments irrespective of physical location. The duration of these assessments are a maximum of 30 days but generally five days is sufficient.

If there is an issue regarding whether or not the individual is criminally responsible for the crime, a 30-day assessment is conducted. Under Section 16 (1) of the *Criminal Code*, “No person is criminally responsible for an act committed or an omission made while suffering from a mental disorder that rendered the person incapable of appreciating the nature and quality of the act or omission or of knowing that it was wrong” (Department of Justice Canada 2008). Moreover, under Section 16 (2), the onus is on the defense to prove that the individual suffers from a mental

disorder; otherwise, the individual is presumed not to have a mental disorder and therefore is criminally responsible.

The Crown has the discretionary power to ask for an NCR assessment at any stage, according to Section 672.12 (3) of the *Criminal Code*. If the accused puts his or her mental capacity into question, the Crown can request an assessment. Generally, NCRs are only requested in cases of serious offences (e.g., crimes involving violence or threats of violence) due to a shortage in the number of available forensic beds. Therefore, the Crown must establish factual guilt before a request for an NCR is made.

After the assessment has been conducted, the referral is either rejected or accepted by the Crown. If the referral is rejected, the accused is sent back to regular court for processing. If the referral is accepted, charges are stayed up to 11 months and a commitment is required of the offender to participate in the diversion program. The CMHA develops a plan for the mental health court client which is reviewed by the Crown. Once the Crown approves the plan, the CMHA recommends that charges be stayed and the client must sign a consent form.

If the offender complies with the terms of the diversion program (e.g., to attend regular doctor's appointments, seek counseling et cetera) the offender is discharged from CMHA support coordination and the program has been completed. The option to continue with long-term support is available if necessary and requested. If the offender does not comply, the charges are no longer stayed and the offender will be brought back to court.

1.9 Conclusion

This introductory chapter outlines the purpose of the research and the nature of the research problem with respect to the mental health court, specifically Waterloo Region's. A historical background is provided, comparing the use of drug courts and how they have subsequently influenced the creation of mental health courts. The main purpose of this chapter is to provide a brief historical overview of mental health courts and to familiarize the reader with

the physical and procedural layout of the Kitchener Mental Health Court. Also discussed is the relevant legislation under the *Criminal Code* and Ontario *Mental Health Act*, and the criteria used to judge persons eligible for mental health court diversion.

CHAPTER 2: Literature Review

Current Research on Mental Health Courts

2.1 Introduction

To date, much of the literature on mental health courts describes the roles, procedures, and processes involved in diverting mentally disordered persons away from traditional forms of sanctions (i.e., jail) within a North American context. The purpose of this chapter is to outline the various research studies, which examine the issues surrounding this type of court diversion program, and how those studies address the research problem at hand. The first portion will investigate the problems surrounding the identification of eligible candidates for entry into the mental health program, while the second portion will discuss the issue of coercion and its impact on due process with respect to community mandated treatment orders. A discussion on the strain mental health court programs place on probationary agencies follows. The fourth portion investigates law enforcement strategies used by police departments in the handling of mentally disordered persons who come into conflict with the law. The second last portion of this chapter investigates the outcomes of court ordered treatment with respect to recidivism rates between diverted and non-diverted offenders. Lastly, two issues face mental health court research. The first issue is that there is a lack of empirical evidence measuring mental health court outcomes. This is in part due to conflict between researchers over appropriate research methodologies. The second issue is that there is a lack of a conceptual framework for researchers to develop standard definitions, concepts, and theories to study mental health courts.

2.2 Characteristics of Offenders

According to a case study of the Seattle Mental Health Court conducted by Trupin and Richards (2003), 75% of mental health court referrals were male. Comparably, Steadman and Redlich's (2006) assessment of seven U.S. mental health courts revealed that 45% to 72% of all referrals were male and approximately 20% female. Of the 116 mental health court referrals in Broward County Florida, North America's first-ever specialized court, 68.1% (N=116) were male and 31.9% (N=116) female (Boothroyd, Poythress, McGaha and Petrilá 2003). With respect to likelihood of diversion to mental health courts, 51.4% of males and 38% females are referred (Steadman, Coccozza and Veysey 1999) while 65.5% of males diverted were charged with violent offences (N= 113) (Naples and Steadman 2003). Unfortunately, there are no statistics to-date of Canadian mental health courts with respect to the gender variable.

The average age for mental health court referrals in one study is 38.4 years, ranging from 18 to 63 years of age (Boothroyd et al. 2003). Three other studies found similar ages respectively; 35.6 (Steadman et al. 1999), 37.6-38.57 (Trupin and Richards 2003), and 37 (Naples and Steadman 2003). Again, there are no available statistics on Canadian mental health courts with respect to the age variable.

In terms of race and ethnicity, the majority of mental health court participants are Caucasian. This, of course, depends on the geographical location of the court. For example, in the Brooklyn Mental Health Court, more than half of participants are non-white which is comparable to the general jail and prison population where 63% of inmates are visible minorities (Steadman and Redlich 2006). In Broward County Mental Health Court, however, 61.3% of participants are white, 23.5% black, 9.2% Hispanic, and 5.9% other (N=116) (Boothroyd et al. 2003). Similar statistics are found for Seattle's Mental Health Court in which 60% of participants identified themselves as white (Trupin and Richards 2003). Of the diverted Caucasian population, 57.3%

were for violent offences (N=113) while 44.9% were non-violent offences (N=537) (Naples and Steadman 2003).

As for education and employment, one Canadian study identified that 79.2% of federal prisoners with mental disorder (classified under DSM-IV) had greater than grade 11 education (Brink, Doherty and Boer 2001). A U.S. study revealed that only 2.9% of diverted offenders had less than highschool education, however at time of arrest, only 17.1% were employed (Steadman et al. 1999). Together, this reveals that persons with mental disorder are educated, but perhaps due to their condition, are unable to sustain employment and resort to “survival crimes” such as trespassing and shoplifting (Hiday 2006).

Only, Steadman’s et al. 1999 study provides marital statistics: of the 80 participants diverted to mental health court, the majority were single (48.6%) and 31.4% divorced. The non-diverted participants (N=45) had half the divorce rate and were more likely to be single (60%).

The three most common diagnoses amongst mental health court participants are schizophrenia/schizoaffective disorder (18%), bipolar disorder (13%), and depressive/mood disorders (10%) (Steadman and Redlich 2006; Boothroyd et al. 2003). Those most at risk for criminal behavior are individuals who suffer from combined mental disorder and substance abuse (including drugs and alcohol) which make up approximately 29% of mental health court participants (Boothroyd et al. 2003).

Again, most of the statistics are U.S. based and may not reflect the current condition of Canadian mental health courts. Nonetheless, the statistical information provides a general picture of the mental health court landscape even though it is difficult to draw any conclusions with respect to why these particular characteristics are common to persons with mental disorders as oppose to regular criminal offenders. Not one single study has explored family background or religion, nor has any study explained in-depth why there exists a discrepancy between diverted and non-diverted individuals—in terms of eligibility and the connection between different variables. For example, why are individuals more prone to be diverted at the age of 35 as oppose

to 18? Do mental disorder symptoms manifest themselves later in adult life, displaying overt behaviors more easily detected by law enforcement? Why are diverted participants more likely to be divorced—does their condition impede on maintaining healthy, normal relationships, making it more difficult to cope with partners? Many of these questions remain unanswered by the research but are worth investigating further in order to develop a more precise picture of the characteristics of mental health court participants.

2.3 Identifying Target Populations for Eligibility

One of the major issues identified by the literature is the identification of target populations and program eligibility. In Griffen, Steadman and Petrila's (2002) comparative study of mental health courts in the U.S., they found that one in eight courts accepted misdemeanor cases while seven accepted felony charges. Three of the eight courts included defendants with developmental disabilities, while all courts accepted mental disorder cases that involved substance abuse problems. Six of the eight courts employed court teams that were designated to screen for eligibility with the aid of clinicians, while the other two courts relied on the discretionary powers of prosecutors. Eligibility was determined within 24 to 48 hours of arrest.

With respect to why certain criminal charges are accepted over others, Redlich, Steadman, Monahan, Robbins and Petrila (2006) find that over half of mental health courts accept both misdemeanor and felony charges despite criticism that the mental health court should be reserved for persons with mental disorders who commit more serious crimes. In some instances, U.S. mental health courts have included domestic violence and battery cases. In Steadman and Redlich's study (2006), 80% of courts accepted violent charges including two mentally disordered women charged with murdering their children. It is argued that other types of diversionary programs (i.e., pre-booking programs) are better suited to handle misdemeanors. Although their study does not elaborate on why there is a discrepancy between the two types of criminal charges, it can be postulated that misdemeanors are less serious and do not require the

same amount of legal resources. This places fewer burdens on the mental health court system while effectively treating persons with mental disorder.

Hiday (2006) identifies three broad categories of mentally disordered offenders who are accepted into mental health court programs. The first category of offenders include those individuals who are characterized as homeless, have co-occurring mental disorders, and have substance abuse problems. These offenders commit, what Hiday (2006) terms, “survival crimes” for the purpose of meeting basic needs such as food, clothing, and shelter. This group receives the most attention from government policy-makers because their plight is most directly linked to the failure of the mental health system. The second category of offenders comprises individuals who commit crimes mostly as a result of anti-social tendencies that are not directly related to mental disorder. The third category involves offenders who commit crimes as a direct result of psychiatric symptoms. Although Hiday (2006) provides a starting point for determining the types of offender and their motivations for crime, critics argue that defining the mentally disordered population requires further delineation from the rest of the population. Fisher, Silver and Wolff remark:

Indeed, the work of advocates for diversion and other mental health services intervention builds heavily on a social construction of the “mentally-ill” offender that emphasizes the low-level misdemeanor whose offending or involvement with the criminal justice system can be attributed to[...] the inadequate treatment of severe mental illness and or inaccessible or inadequate mental health services (2006: 549).

Fisher et al. (2006) contend that this broad social construction falls short of representing the full population of mentally disordered offenders. Researchers must examine other sub-populations of mentally disordered offenders to ensure that generalizations, which are formulated upon common stereotypes do not become taken-for-granted as the ‘face’ of mental disorder. Once research provides a detailed picture of offenders including their characteristics and traits, eligibility criteria can be further tailored in order to enhance the quality and range of specialized mental health court treatment.

Although eligibility criteria vary according to each individual mental health court, there are a set of guiding principles. Ideally, identifying target populations suitable for mental health court must take place as expeditiously as possible in order to divert the mentally disordered from the adjudication process. According to the Bureau of Justice Assistance Report:

To be effective, mental health courts share the critical need to identify mentally-ill or disabled candidates at the earliest possible stages of processing to avoid the damaging experience of arrest and confinement, to intervene medically to stabilize offenders and then to situate them in an appropriate placement process (2000: 71).

As such, the mental health court employs informal and formal methods to screen eligible candidates. Informal methods include referrals to mental health services at the time of arrest, arraignment, and jail. Formal methods include in-depth clinical interviews conducted by psychiatrists. Irrespective of the screening method, the process must ensure fair, appropriate, and effective screening procedures, which are premised upon timeliness, accuracy, and confidentiality. These principles originate from the traditional criminal justice system and are adopted by the mental health court. Unfortunately, researchers argue that timeliness, accuracy and confidentiality are difficult to achieve due to conflicting goals (Lamberti and Weisman 2004) . For instance, assessments cannot be rushed for fear of compromising accuracy. The courts require timely and accurate information about the defendant's background but it is sometimes difficult to communicate with mentally disordered persons because of their condition. Obtaining information from mentally disordered persons during the processing phase can thus pose a challenge to police and mental health court staff because they must balance processing the individual expeditiously while at the same time making sure the information is valid and that the mentally disordered are kept safely in custody. As stated in Lamberti and Weisman's (2004) descriptive analysis of mental health courts across North America, "[a]n immediate challenge for those who will manage mentally-ill persons following arrest is to obtain information about the circumstances of the arrest, including mental health history." Unfortunately, however:

Information obtained by an arresting officer may be incomplete as noted previously, and the officer may have a very limited amount of time to convey this information. These

factors can result in the booking officers, attorneys and jail staff knowing very little about a seriously mentally-ill detainee during processing (2004: 156).

2.4 Mental Health Court Sentencing Dispositions

The mental health court administers a variety of sanctions ranging from mandated treatment orders to reprimands. Over the last decade, however, there has been an increase in jail time for non-compliers. According to Steadman and Redlich (2006) and Griffen et al. (2002) 64% of mental health court participants have been jailed for non-compliance. The recent increase in jail sanctions is speculated to be the result of U.S. mental health courts including a greater amount of felony charges.

2.5 Due Process

Mental health courts are sometimes criticized as vehicles for coerced treatment. The advantage of coerced treatment, some argue, is that the court ensures that participants are kept in treatment, increasing their chances for successful outcomes. The disadvantage is that coerced treatment impedes on due process and is ineffective if participants are not committed to their own recovery (Bureau of Justice Assistance Report 2000).

According to Stefan and Winick (2005), one of the major issues facing the mental health court system is voluntariness and competence. Because it is postulated that jail is not an appropriate solution for mentally disordered offenders, it is the role of the mental health court to divert the mentally disordered from the criminal justice system to mental health treatment. The mental health court acts as an agent of social control whereby treatment decisions are made for the benefit of those who cannot make treatment decisions for themselves. On one hand, proponents of mental health courts argue that the voluntary nature of the mental health court (an individual's choice to enter the mental health court) increases positive treatment outcome. It is also argued that there is a coercive element to this system (i.e., legal coercion), which permits the court to threaten the offender with jail if he or she does not agree to or adhere to the court-mandated

treatment plan. In order to prevent this type of coercion, Stefan and Winick (2005) broadly emphasize key principles. These principles include having legal professionals work therapeutically as oppose to paternalistically, provide choice of diversion to the individual, and ensure that the courts are satisfied that the offender's decision is based on voluntariness and competency. They also note that it is the role and responsibility of the defense counsel to outline for their client the advantages and disadvantages of each course of action. There is limited research on coercion and mandated treatment plans which make it difficult to make any substantiated claims regarding outcomes, according to Stefan and Winick (2005).

With respect to coercion, Redlich (2005) recognizes the importance of providing persons with mental disorders praise and encouragement in order to achieve positive treatment outcomes and decreasing perceived levels of coercion within the courtroom setting. Redlich (2005) argues that even though an individual's participation in mental health court must be voluntary, it is not known whether or not the defendant understands and appreciates the decision being made before them by the courts. He recommends that "judges should seek to ensure that the defendant's decision is a voluntary and competent one [and that] defense lawyers should adequately counsel their clients about the advantages and disadvantages of accepting diversion" (Redlich 2005: 523).

Redlich (2005) argues that there is potential for violations of due process. Similarly, Watson, Hanrahan, Luchins and Lurigo (2001) recognize the potential for violations of due process and suggest that the mental health court match appropriate treatment to the disorder and have counsel make explicit to the offender the consequences of particular courses of action.

Additional factors influence the degree to which an individual comprehends a decision handed down by the mental health court. Stress, non-medication, and the threat of jail impede on the ability to fully understand the situation rationally. Redlich asserts:

On its face, a defendant's selection of a therapeutic court over one structured around determining guilt and meting out punishment would appear an obvious choice [...] but further complicating the voluntary election of mental health court involvement is the fact that such decisions are made when the defendant is likely to be under considerable stress,

having been arrested and taken into custody, and perhaps having spent some time in a jail cell, often without treatment (2005: 608).

All of these factors impede the defendant's understanding of mental health court options and increase susceptibility to legalized coercion.

Redlich's (2005) position is heavily criticized by Seltzer (2005) for being too soft on the issue of coercion (p. 585). Seltzer (2005) attacks the mental health court charging that it is inherently coercive despite being characterized as voluntary. She contends that the mental health court is a result of the failure of the mental health and criminal justice system to deal effectively with persons with mental disorder. Specifically, Seltzer asserts that defendants are not fully briefed by counsel despite the fact that explicit information is required for a rational and voluntary choice to be made. Boothroyd et al. (2003) study concludes that only 15% of court transcripts analyzed provided evidence that explicit information was provided to the client regarding voluntary participation.

Several articles address the importance of making it clear to the individual that their choice to withdraw from the mental health court will not affect their case when heard by a regular court. For instance, Seltzer criticizes the mental health court for not giving credit to individuals for time already served. She argues that the goal of the mental health court is to decriminalize persons with mental disorders. Seltzer writes:

To ensure that mental health courts and the services they may initiate are truly voluntary, it is important for defendants to be allowed to withdraw and have their cases heard in a criminal court without prejudice (2005: 575).

Moreover, the courts that do permit the option to withdraw most often impose some form of restriction. Seltzer (2005) finds that "about half imposed some restriction—for example, making withdrawal without prejudice available only in a 30 day time limit" (p. 575). In her observations, she found a lack of evidence to support that withdrawals are unconditional and non-discriminatory.

Seltzer also criticizes the use of guilty pleas as a pre-requisite for an individual's participation in mental health court (2005: 575). Pleas are controversial legal strategies. In the case of persons with mental disorders whom plea guilty or no contest, the literature argues, due process is violated. In Erickson, Campbell and Lamberti's (2006) study they found that nearly half of the mental health courts recorded using guilty pleas to answer to criminal charges. Pleas are problematic to mentally disordered defendants for three reasons. First, guilty pleas are added to criminal records making it difficult for mentally disordered persons to secure housing, employment, and other vital services. Secondly, pleas are discriminatory because they require persons with mental disorders to plead guilty in order to obtain the treatment they need while non-mentally disordered persons would typically have their charges dismissed. The third criticism is that they exacerbate an already clear disparity between the arrest rates and jail times of persons with mental disorder compared to regular defendants (Seltzer 2005). Seltzer argues, "mental health courts are intended as a therapeutic alternative to a traditional trial and should be less punitive. Because of the consequences of a guilty plea it should never be a prerequisite to participation in a mental health court" (2005: 577).

The three most common dispositions to criminal charges in mental health courts are: pre-adjudication, post plea, and probation. Pre-adjudication occurs when charges are stayed until treatment is available for the accused. The disposition is deferred and the conviction is not recorded. Post-pleas involve the deferral of a guilty plea; conviction with a suspended sentence and the accused is released on his or her own recognizance. Probation requires a guilty plea and involves a conviction, and participation in a court-ordered treatment program.

Griffen et al. (2002) suggest that courts are not dropping the charges until individuals agree to mandated treatment, resulting in a form of legalized coercion. According to Petrila, Ridgley and Borum (2003), court mandated treatment is an attempt to leverage adherence. To ensure that coercion is minimized, a balance must be struck between ensuring legal safeguards against state intervention and inappropriate commitment of individuals to hospitals. They argue

that the goal of the mental health court is to help those who cannot make their own treatment decisions while simultaneously ensuring social control and public safety (Petrila et al. 2003).

Monahan, Bonnie, Applebaum, Hyde, Steadman and Swartz (2001) argue that mental health courts use questionable strategies to achieve adherence. These strategies include the court stipulating that individuals must adhere to treatment in order to maintain residency and monthly allowances from social welfare, otherwise they face hospitalization or jail time. Monahan et al. (2001) posits that these strategies violate human rights and due process.

McGaha, Boothroyd, Poythress, Petrila and Ort (2002) examination of the Broward Mental Health Court revealed a positive correlation between mandated court-ordered treatment and perceived coercion. Poythress, Petrila, McGaha and Boothroyd (2002) find that the degree to which information provided by the court (including advice from legal counsel and judge) is made implicit or explicit affects the rate of perceived coercion (i.e., did the defendant feel they were treated fairly by the court throughout the court process). Their study concludes that higher levels of, what they term, 'voice' (i.e., given the right to be heard by the courts) and respect were positively linked to lower perceived coercion on the part of the offender. As a result, Poythress et al. (2002) posit that an empathetic and communicative-style of procedural justice decreases feelings of perceived coercion, leading to greater therapeutic outcome for persons with mental disorders.

2.6 The Role of Law Enforcement

Skeem, Emke-Francis and Louden's (2006) first national survey on probationary responses to supervising mentally disordered offenders found that mental health courts place immense strain on probation officers and agencies. Although Deane, Steadman, Borum, Veysey and Morrissey (1999) do not account for urban-rural differences between departments, this study concludes that the majority of police departments (55%) sampled have not implemented specialized strategies. However, from the police officers interviewed, 82% responded that the

most effective strategy is mental health based response teams which are employed in 30% of police departments. These are teams which are part of the local community of mental health services, working together with police from the time of offence through the processing phase.

Hails and Borum (2003) find that police departments (30%) perceive the mental health based response strategies as the most effective method for handling persons with mental disorders. A lack of funding for community mental health agencies and services limits the availability of these programs, however. Crisis intervention teams are rated the second most viable option. Crisis intervention teams are less expensive, easy to maintain, and require minimal re-structuring of resources and staff. The literature does not clarify what differentiates crisis intervention teams versus mental health based response strategies, short of, perhaps being more tightly linked to community health services.

2.7 Recidivism and Court-Ordered Treatment Plans

Moore and Hiday (2006) provide one of the most extensive research studies on recidivism as it relates to mental health court participants. Their study examined arrests one year before and one year after entry into the mental health court treatment program. They compared data of persons with mental disorder and non-mentally disordered persons over a 12-month period. Their study employed non-equivalent comparison groups with a sample of 82 eligible mental health court participants from 2001 to 2002 and examined age, race, and gender variables. The results indicate that mental health courts do reduce recidivism rates. Less than one-quarter of participants re-offended or were arrested after the twelve-month period. This study finds that the arrest rate for mentally disordered offenders after program completion is half than the traditional criminal court. Full or partial completion of the program did not affect recidivism rates according to termination date records. Moore and Hiday conclude:

To the extent that graduates continue to receive helpful supports (treatment and services), and continue with their behavioral changes, one can expect continual reduced recidivism. Given the chronicity of severe mental illness and the multiple disadvantages of many of

their lives, each support will be working well into the future if the reduced recidivism is to continue (2006: 671).

Naples and Steadman (2003) also find that mental health court clients achieve higher levels of independent living skills and greater reduction in drug addiction than non-diverted clients which in the long-term decreases levels of recidivism. They consistently find that the mental health court is positively correlated with low re-arrest rates year after year which suggests that there is minimal risk to public safety.

Fisler (2005) examines public safety with respect to recidivism and mental health courts and argues that community treatment orders lead to less chance for re-arrest. Treatment takes time, the stakes are higher for the defendant and adherence to treatment is taken more seriously. Fisler (2005) recommends that public safety is achieved through intensive risk management plans. Risk management plans should include a joint effort between all stakeholders (i.e., mental health courts, mental health system, community agencies), involve psychological and sociological assessments of risks of violence and treatment needs, individual treatment plans, family involvement, and strict judicial monitoring. Judicial monitoring is recommended using the principles of therapeutic jurisprudence in order to create trust and enhance communication and information sharing amongst all stakeholders. Fisler remarks:

In many problem-solving courts, judges use an array of graduated rewards and sanctions to motivate and re-enforce progress in treatment: Praise, certificates, admonitions, increased or decreased frequency of court appearances and impositions or lifting of restrictions on activities are examples of mechanisms that judges use to change offender behavior. However, often more subtle aspects of judges relationships with a defendant, established over repeated court appearances, are more important (2005: 597).

2.8 Issues Facing Mental Health Court Research

Finding research on mental health courts that is empirically tested, valid, and reliable is challenging. In general, one of the most commonly cited problems involved in the investigation of mental health courts are weak empirical adequacy (i.e., validity and reliability measures) and over-use of descriptive-style research (Cosden, Ellens, Schnell, Yamini-Diouf and Wolfe 2003;

Draine and Soloman 1999; Erickson et al. 2006; McGaha et al. 2002; Monahan et al. 2003; Petrila 2003; Rice and Harris 1997; Seltzer 2005; Steadman, Davidson and Brown 2001; Stefan and Winick 2005; Trupin and Richards 2003; Watson et al. 2001; and Wolff and Pogorzelski 2005). The majority of studies describe mental health court roles and procedures but fail to provide sufficient empirical evidence to substantiate claims of their effectiveness. Researchers must bridge the gap between theory and practice using empirically tested evidence, otherwise, the research literature will remain vague and inconclusive.

The second most prevalent criticism of the mental health court research is the lack of a conceptual framework and or model from which to work (Erickson et al. 2006; Slate 2003; Steadman et al. 2001; Trupin and Richards, 2003; and Watson et al. 2001). Wolff and Pogorzelski (2005) argue that it is difficult to research the effectiveness of mental health courts for several reasons. First, mental health courts involve multidimensional and process-based interventions which are constantly in a state of adoption and evolution. In addition, each court is unique in so far as it has its own level of formality, personalized interaction network, including different players and philosophies. What is needed are standardized reporting protocols, controlled comparison groups, and a systematic evidence-based approach in order to make solid comparative and evaluative studies of mental health courts. Future research requires multi-site comparison, longitudinal studies and larger sample sizes (Boothroyd, Mercado, Poythress, Christy and Petrila 2005; Petrila et al. 2003; and Poythress et al. 2002). Mental health courts vary across North America in terms of judicial and mental health roles, treatment services, procedures, dispositions, and sentencing outcomes. Furthermore, research must account for time-variance and the changing nature of the mental health court program as it evolves. Wolff and Pogorzelski remark:

These time-varying changes violate the condition of stability, making it difficult to even establish the nature of the intervention that is being assessed. Yet, the nature of all socially complex innovations, such as mental health courts, implies considerable learning and adaptation [...] consequently these types of innovations are inherently unstable, constantly adapting as they are implemented at a local level. This makes it challenging to

assess their performance and even more challenging to extrapolate future consequences (2005: 542).

As such, it is critical to conduct longitudinal studies in order to compare progress on an individual level (i.e., participant recovery, recidivism) and on an organizational level (i.e., procedural efficiency and effectiveness and service provisions) over time.

Overall, researchers agree that areas requiring further investigation are outcomes of recidivism with respect to types of offences and court-ordered supervision, public perception of mental health courts, pro-social outcomes of institutions involved with the mental health court program, including community service agencies and mandated treatment options (Fisler 2005; Monahan et al. 2003; Wolff and Pogorzelski 2005). A detailed examination of different variables (e.g., age, gender, race, education) (Rice and Harris 1997), and other possible alternatives to mental health court programs such as assertive community treatments models and crises intervention teams are also critical to future research (Wolff and Pogorzelski 2005). By examining the effectiveness of different models, including their benefits and shortcomings, a “best practices approach” to managing mentally disordered offenders is possible. It should not be taken-for-granted that the mental health court is the only viable solution but this does not mean that it cannot adopt or work alongside other treatment and intervention models.

2.9 Conclusion

This literature review examined issues surrounding the effectiveness of mental health courts and problems related to certain aspects of identification and eligibility for entry, coercion and due process, probation agencies and police department strategies, and recidivism. An analysis of the literature reveals that there are a variety of fundamental issues and challenges facing the mental health court. At present, the majority of the literature is descriptive, theoretical, and or recommendation-based. In order for the mental health court program to achieve success and proliferate, researchers must provide policy-makers solid, empirically tested evidence in order to

secure funding and persuade proponents of the traditional criminal justice system that the mental health court is an effective solution to handling persons with mental disorders.

CHAPTER 3: Theory

The Medical Model and Therapeutic Jurisprudence

3.1 Introduction

This chapter outlines and discusses the medical model and therapeutic jurisprudence as they relate to the concept of mental disorder and the law. The medical model portion critically examines the concept of mental disorder and its scientific and social utility. The second portion of this chapter critically examines the theoretical framework of therapeutic jurisprudence as it relates to the way in which the legal system employs rehabilitative and treatment orientated methods for dealing with people with mental disorder. The latter part of this chapter will discuss how these two frameworks compliment one another.

3.2 The Medical Model

The medical model is also known as the psychiatric, biological, or clinical model of mental 'illness'. Its prominence is partly the result of the rise of biological psychiatry which posits that that mental 'illness' is the result of neuro-chemical and genetic causes. Because mental disorder is viewed as a 'disease' or 'illness', social interventions require the treatment of the 'illness' by a variety of helping professionals. The medical model is designed to produce change. Its purpose is to conceptualize, organize, and deliver treatment to individuals suffering from mental health issues.

Psychiatrists have the legal status and the medical knowledge to diagnose and treat these issues. The diagnoses of mental disorders are conducted according to the DSM-IV (Diagnostic and Statistical Manual of Mental Disorders) which was developed by the American Psychological Association. The DSM-IV provides the most commonly accepted definition of mental disorder

and is employed by psychiatrists, psychologists and other health professionals throughout the world. As previously defined, mental disorder is:

A clinically significant behavioral or psychological syndrome or pattern that occurs in a person and that is associated with present distress (a painful symptom) or disability (impairment in one or more areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom. In addition, this syndrome or pattern must not be merely an expectable response to a particular event, e.g., the death of a loved one (Wakefield 1997: 634).

Patients receive treatment often in hospitals and or psychiatric wards where doctors and nurses diagnose and treat the individual using various types of therapies. The aim of medical intervention is to offer treatment and rehabilitation to the patient in order that he or she can resume normal functioning (Szasz 1997).

The medical model is compassionate to persons with disability because it seeks to understand the nature of the disorder and manage its symptoms. The medical model is inclusionary. It places emphasis on accommodating persons with disabilities by recognizing that the individual's full participation in society is not always possible because they suffer from a physical or mental illness. This model also supports increased medicalization through investment in health care and health related services. This investment signifies the medical model's view that a just society will place its resources in areas that are most important to improving the lives of people and show a degree of tolerance and leniency to those who are disabled by their condition.

3.2.1 Primary Benefits of the Medical Model

According to Cockerham (1981), the medical model views mental disorder as a disease and or a disease-like entity which can be treated using medical means. This model posits that mental abnormalities are attributed to physiological, biochemical, and or genetic causes. These abnormalities are treated through the use of psychopharmacology (i.e., drug therapy), electroshock therapy (EST), or psychosurgery (i.e., brain surgery).

Drugs are primarily administered to alleviate painful symptoms and distress. Treatments can lessen or alleviate emotional, cognitive, and behavioral symptoms which create disability and impede on normal functioning. Once the distress and/or disability is brought under control by effective drug treatments, individuals can resume normal functioning. Thus, the availability of appropriate drug treatment is the primary benefit of the medical model for patients suffering from mental disorder.

Cockerham (1981) supports this argument by emphasizing the role psychopharmacology has within the medical model. He argues that if it weren't for the encouragement and availability of drug treatments for persons suffering from mental disorder, the mental health movement (including mental health courts) would cease to function (Cockerham 1981).

3.2.2 Secondary Social Benefits of the Medical Model

The medical model can be criticized for having minimal scientific utility. It's usefulness however, lies in its social utility and the significant social benefits that it provides to the psychiatric profession, patients, and society.

3.2.3 Social Benefits for Psychiatry

The medical model clearly benefits the profession and practice of psychiatry since psychiatrists as doctors are given a clear and legal mandate to deal with mental 'illness'. The medical model also attributes to psychiatrists altruistic and humanitarian motives. Szasz (1997) contends that psychiatrists act as agents of social control, having the authority and expertise of medical knowledge, and the power to diagnose. In addition, psychiatrists act as moral agents on behalf of the patient, assuming a paternalistic role. Essentially, doctors and psychiatrists convert patients to accept medical perspectives. The medical profession, under this model, promotes the definition of mental disorder and uses it to convince patients to accept a definition of their

problems as mental illness and to accept medical treatment. As a result, psychiatrists gain cooperation of patients and they enter treatment voluntarily.

The benefits of the medical model, which are bestowed upon the psychiatric profession, serve to disarm opponents and increase the authority, power and prestige of psychiatry.

3.2.4 Social Benefits for Patients

The benefit of the medical model is that it makes people more willing to accept the “sick role.” According to Talcott Parsons (1951), being sick is defined both medically and socially and one assumes the “sick role” when he or she becomes ill. The “sick role” is similar to any other role and, subsequently, has certain expectations, obligations, and rights.

When one assumes the sick role, it is assumed that the patient is balancing his or her personal motivations in order to place recovery as first priority. The privileges and exemptions associated with the sick role are what Parsons terms as “objects of secondary gain” in which the patient is unconsciously motivated to secure and retain the status of ‘sick’ (1951: 438). Once the individual has assumed the sick role, it is understood that he or she is not responsible for the condition and is, in fact, helpless. Secondary benefits include the patient’s right to exemption from normal social role responsibilities—relative to the nature and severity of the illness. The exemption from responsibilities requires support and validation from legitimating agents such as doctors and psychiatrists. According to Parsons’ view of the sick role, the mentally disordered person not only has the right to treatment but also the right to expect special consideration and tolerance from others. The sick person is exempt from responsibility because he or she requires outside, professional help; the mentally disordered person is obligated to accept help and make a commitment to an expeditious recovery in order to lessen the cost associated with not fulfilling his or her social role within the system; and the patient is expected to seek technically competent help and to co-operate with the physician during the process of recovery.

The sick role affords the mentally disordered person a degree of forgiveness for past deviant acts and an opportunity for reconciliation. From the medical model perspective, deviant behavior is resulting from mental illness. The mentally disordered person is not responsible for the condition and is not at fault. The medical model prescribes therapeutic interventions as opposed to a punitive response. Conrad and Schneider (1980) point out that deviant behaviors can be redefined as medical conditions or diseases through social and political processes. They argue that the medical model of deviance “locates the source of deviant behavior within the individual, postulating a physiological, constitutional, organic, or, occasionally, psychogenic agent or condition that is assumed to cause the behavioral deviance” (Conrad and Schneider 1980: 35). As a result, medical professionals who employ medical means to treat the ‘illness’ mandate the intervention.

3.2.5 Social Benefits for Society

The medical model encourages the financial support of resources dedicated to helping persons with mental disorders. Blume (1987) remarks:

The model encourages research on epidemiology, etiology, phenomenology, treatment and prevention. It also provides a framework for enlightened public policy in the regulation of [...] and for rational approaches to social and legal problems related to the disease (1987: 244).

The medical profession has joined forces with powerful groups such as clinical psychologists, social workers, psychiatric nurses, insurance companies, and government agencies to encourage the use of this particular model. As such, the current mental health movement aims to educate the public about mental disorder by presenting the view that mental disorder is similar to other diseases, can affect anyone at anytime, symptoms are treatable and can be alleviated through proper intervention. These arguments attempt to normalize the condition and mitigate shame and embarrassment, reducing the stigmatization associated with mental disorder.

The medical model, in addition, shapes public policy. It takes a humanitarian approach, focusing on putting greater resources into treatment of major social problems such as drug

addiction, delinquency, and crime. The mental health court's philosophy, for example, supports the medical model perspective because it defines mental disorder as an illness and or disorder and recognizes that it involves a great degree of human suffering. Therefore, persons who suffer from mental disorder and who come into conflict with the law receive appropriate treatment for their disorder and more lenient sentences. The medical model, essentially, encourages the use of treatment modalities and a rehabilitation philosophy rather than punitive measures to handle this unique group of offenders. In essence, the empathetic and tolerant nature of the medical model leads to the development of non-coercive programs such as mental health court diversion.

The medical model is inclusionary and from this perspective it is not socially appropriate to take a punitive, hostile, and exclusionary response towards a person who suffers from mental disorder who commits criminal acts. This model posits that the sick person is a victim of their disorder and needs sympathy, support, and treatment. The sick person is victim to a medical condition similar to other physical diseases (e.g., heart disease). As such, this model is attractive to those who have been apprehended by the law for committing deviant acts because it affords them forgiveness, justification for their deviant behavior, and the avoidance of punishment. Understandably, the medical model is likely to be embraced by people who are deviant and disruptive.

The medical model also helps patient families. It supports the use of drug treatments which alleviates symptoms for the patient which, in turn, decreases family strain. This model also helps to diminish feelings of shame the family might feel toward the patient because he or she is suffering from mental illness. The medical model provides an empathetic outlook on mental disorder and, as such, the family is more willing to support the patient.

For all the reasons above, the medical model offers an explanation as to why a person would voluntarily enter psychiatric treatment. The medical model diminishes the stigma of mental disorder by defining it as illness and offers a therapeutic, inclusionary, enlightened, and humanitarian response. The social benefits help to explain why the medical model, despite its

questionable scientific validity, is the dominant model with reference to mental disorders, patients, families, and various treatments. Professionals embrace the medical model because of the social benefits it provides to all concerned.

3.3 A Critique of the Medical Model

A criticism of the medical model's use of drug therapy is that researchers are unable to support the view that mental disorders have physiological or somatic causes. Cockerham states that "although psychotropic drugs may provide an effective short-term solution to many mental problems, they do not cure the source of those problems, nor do they change the social situations that precipitate insanity" (1981: 82).

The medical model's support of drug treatment and intervention does not properly address underlying social problems. Psychiatry suffers from a degree of biological reductionism because it posits that mental health problems are solely caused by chemical imbalances in the brain. Under the medical model the complex interpersonal and communication problems are ignored in favor of drug treatments. However, this perspective is beginning to change with the on-set of the community psychiatric movement which recognizes the role of social stress and is actively engaged in examining the effects of social intervention such as family, counseling, and the establishment of social networks.

According to recent scientific studies, mental disorders are linked to social problems, or what Szasz (1997) refers to as "problems in living." The "problems in living" concept recognizes the role social problems have in shaping or predisposing individuals to mental disorder, and has only recently been included as a consideration under the medical model (Caplan, McCartney and Sisti 2004: 47). Problems of living include social interaction, family, poverty and blocked goals, racism and discrimination and school and work related stress. Theorists propose using a causal model that explains the prevalence of mental disorder as social, in so far as, social stress leads to psychological and emotional distress, resulting in changes in the body's brain chemistry. Thus,

the impact of this distress can have long-term effects on the physiological functioning (e.g., brain chemistry), leading to the development of a mental disorder (e.g., depression, anxiety, and panic attacks). Some symptoms of mental disorder are treatable using drug therapy but this does not mean that the causes of mental disorder are entirely physiologically based.

Recent formulations of the medical model recognize that both physiological and social factors can contribute to mental disorder. The medical model supports the possibility that genetics are not only responsible for the transmission of mental disorders if combined with certain social triggers present in one's environment, but can predispose or make the individual more vulnerable to certain mental disorders (Cockerham 1981). Cockerham remarks:

A highly plausible theory of schizophrenia is that given a genetic predisposition, stressful life events or circumstances elicit the disorder. In sum, it is generally believed that for some people genetics play a significant role in the onset of mental disorder—although we do not know what it is, how it works, or what proportion of mentally-ill people become that way because of the interaction between heredity and environment” (1981: 83-84).

The medical model tells us very little about what social factors or variables contribute to the development of mental disorders. Instead, the medical model locates the problem within the individual rather than a person's social milieu.

Although the medical model supports the notion that psychiatry functions similar to that of medicine, psychiatric practices differ in so far as psychiatrists analyze, advise, counsel, and persuade, rehabilitate criminals, work with police, Crown and defense lawyers, testify in court, amongst a variety of other activities. The medical model fails to point out the major differences between psychiatry and the different branches of medicine. For one, psychiatry recognizes that physiological functioning influences the mind and human behavior, which works opposite to the medical profession. Secondly, psychiatry intervenes on the individual's cognitive processes and social functioning whereas medical doctors intervene on the structure and functioning of the human body as a physiological entity. The third difference lies in theoretical and practical concerns of psychiatrists. Psychiatrists are concerned with the human condition as it relates to the

conscious and unconscious, sexuality, and life passages and emotional reactions. They also examine and consider other social constructions such as religion, art, language, crime, fashion and how they influence human behavior.

Szasz (1997) argues that psychiatry, unlike medicine, is not value-free. Psychiatrists make moral judgments which are disguised as objective and diagnoses are social rather than medical in nature. The medical analogy conceals the social, legal and moral relevancy of psychiatric intervention.

Szasz (1997) encourages us to ask the question: whose agent is the psychiatrist's? Psychiatrists act as agents of social control and their decisions may not be in the best interest of the patient. It can be assumed that under the medical model patients expect their doctors to be primarily concerned for their welfare. As a medical profession, psychiatry lays claim to status and specialized knowledge that places the patient at a disadvantage. This makes mentally disordered patients more susceptible to coercive tactics.

The medical model is also criticized on the grounds that it absolves deviant criminals from taking responsibility for their actions under the law. To this point, the medical model sends a mixed message because on one hand it grants a degree of avoidance of legal responsibility while at the same time resources, both human and financial, are supporting the doctor (medical professional) who is attempting to help the patient. The criminal justice system, if influenced by the medical model, is more likely to sentence individuals according to principles of rehabilitation and employ probationary periods and/or pre-sentence diversionary schemes as opposed to punitive sanctions (e.g., imprisonment).

The DSM-IV (Diagnostic and Statistical Manual for Mental Disorders) definition of mental disorder is also heavily criticized. The DSM-IV definition of mental disorder fails to mention mental disorder as being an 'illness' or having any physiological causes which is incongruent with the medical model's view of mental disorder.

Secondly, it refers to individuals suffering from distress and disability, however, suffering does not preclude social stresses such as poverty, persecution, anomie, guilt and or shame. It does not describe in any fashion the cause of the suffering or one's physical state. The term disability is problematic because it, once again fails to specifically describe the nature of that disability. Disability can be caused by a variety of factors such as poverty, laziness, and fear which are not the result of physiology. In addition, the terms distress and disability are not strictly medical terms, nor are they limited to physiological problems.

An additional criticism is that social stresses as a contributing cause of mental disorder is ignored because medical and psychiatric patients, by definition, suffer from distress and disability, thus, classified within the domain of medicine. Gallagher supports this criticism of the DSM's definition of mental disorder and remarks, "it is exceedingly difficult to define mental illness objectively. Semantic problems are partly responsible for the problem: alternative use of words such as insane, mental disorder, psychopathology, and particularly, mental illness can often result in substantially different interpretations by different people" (1987: 41).

3.4 Therapeutic Jurisprudence

Therapeutic jurisprudence is a theoretical framework implemented in specialized courts such as family courts, drug courts, and mental health courts. Therapeutic jurisprudence takes a non-adversarial approach and emphasizes the importance of therapeutic outcomes for individuals involved in the legal process. It seeks to reform current laws and promote mental health. It is interdisciplinary and collaborative. This theory promotes collaboration between a variety of professionals within the legal and mental health system. The goal is to develop legal reforms which are beneficial to the offender and to create a "best practices" approach within specialty courts. Therapeutic jurisprudence achieves this by amalgamating the traditional principles of the criminal justice system with treatment and rehabilitation philosophies in the goal of

therapeutically improving the lives of offenders in an attempt to reduce future recidivism (Hora, Schma and Rosenthal 1999; McGuire 2000; Slobogin and Fondacaro 2000; and Winick 2002).

3.5 Principles of Therapeutic Jurisprudence

Therapeutic jurisprudence involves five fundamental principles upon which it is premised. The first principle involves the scope of inquiry. Therapeutic jurisprudence views the law as actively involved in a process of inquiry; recognizing a broad spectrum of interdependent, interrelated issues. As such, it rejects the law's narrow conceptualization as a system bound by legal rule and canon. Secondly, it works to achieve legal reform of existing substantive laws in a manner that fosters therapeutic results. The third principle of implementation involves "procedural innovation" (McGuire 2000: 421). Therapeutic jurisprudence concerns itself with how the accused is processed through the legal system and emphasizes the importance of personal levels of satisfaction experienced by the accused, how sensitive the process is to the needs of the accused, and whether or not the law exercised fairness and respect. In addition, it is the responsibility of the legal system to provide the necessary services (i.e., assessment evaluations) within an appropriate amount of time to ensure fewer days in custody. The fourth principle involves the role of legal professionals. Judicial professionals are not expected to assume new roles, but rather to recognize how their role may impact the welfare of the defendant and contain within it therapeutic elements. Under this theoretical framework, legal professionals shift from "dispassionate, disinterested magistrates to sensitive, empathetic counselor" (Rottman 2000: 25). The fifth principle rests on the assertion that the law acts as a multidisciplinary endeavor (Schneider et al. 2007). It is not only a goal but also the responsibility of academia to work collaboratively with the justice system to guide the selection of legal practices through extensive research on the effectiveness of specialized courts.

3.5.1 Benefits of Therapeutic Jurisprudence

Therapeutic jurisprudence is a theoretical framework which attempts to bridge together the application of law (i.e., jurisprudence) with social well-being (i.e., therapeutic). It is a theory, which does not trump the traditional goals of the criminal justice system or consensual societal values, rather it attempts to work alongside these goals to ensure and produce results that are beneficial to the well-being of the accused.

Although the implementation of therapeutic jurisprudence presents a challenge in real courtroom settings, it is characterized as a constructive, sympathetic, and inclusive approach to the traditional criminal legal system. Winick (2002) posits that one of the fundamental principles is that the law has therapeutic and rehabilitative potential and the decisions made by the legal system will impact the offender in either a therapeutic or anti-therapeutic way (Casey and Rottman 2000). Therapeutic jurisprudence recognizes that some offenders suffer from substance abuse problems and mental health issues and are further disadvantaged when they come into conflict with the traditional legal system. The goal is to acknowledge that mentally disordered offenders have special needs and require therapeutic consideration. Schneider et al. (2007) contend that by ignoring the therapeutic potential of the law by “failing to contemplate the long-term consequences of a system that operates in ignorance of the impact it has [on the] accused leaves the accused worse off, and society still worse off” (p. 45).

In Birgden’s (2002) study on cognitive-behavioral models and the effects rehabilitation have on offender well-being, she argues that the legal system has the ability to maximize therapeutic effects while contributing to the psychological functioning or dysfunction of individuals and that psychological well-being is dependant upon how the law is implemented. According to Birgden (2002), treatment-based models have typically been viewed as weak. She argues, however, that by accepting that the criminal law (which rests upon notions of punishment and responsibility) and mental health law (which rests upon notions of containment and treatment) are *not* mutually exclusive will increase therapeutic jurisprudence’s ability to perform successfully for both the court and society. Birgden (2002) contends that a balance between

ethical values (i.e., the best interest of the community) and prudential values (i.e., the best interest of the offenders) is possible. If a balance is obtained between these two set of values, the result is improved mental health and what Birgden defines as a “good lives concept” (2002: 180).

Birgden’s (2002) assertion that this model will help reduce rates of psychological and social maladjustment for the offender suggests that therapeutic jurisprudence is an appropriate rehabilitative approach, bearing in mind that its first assumption stresses how the law has direct impact on the individual’s well-being.

Therapeutic jurisprudence is interested in the roots of criminal behavior and there is less tendency to punish and more emphasis on correction and rehabilitation. The theory assumes that a variety of persons and social problems in combination with other socioeconomic variables contribute to criminal behavior. As a result, criminal behavior is not always a matter of free choice but rather a manifestation of other issues faced by the individual (e.g., psychological illness, poverty, substance abuse) (Schneider et al. 2007).

The criminal law has traditionally operated upon an adversarial, fault-based system and does not examine the underlying factors leading to conflicts with the law. As Rottman points out, the goal of therapeutic jurisprudence within specialized courts is to “qualitatively *improve* outcomes for litigants and society in cases involving individuals with underlying social and emotional problems” (2000: 1).

3.6 A Critique of Therapeutic Jurisprudence

Critics of therapeutic jurisprudence argue that, although it provides the goals and rationale for legal reform, effective implementation remains questionable. Thus far, impact, efficiency, and therapeutic assessments have been minimal. A majority of the literature critiques therapeutic jurisprudence as it evolves from theory into practice. The literature touches upon issues such as the securitization of community support services through government funding, the integration of the mental health court system and mental health system, and the role and functions

of court workers in terms of how effectively therapeutic jurisprudence can be put into practice (i.e., procedural justice). For instance, Winick (2002) raises the point as to whether or not an adjustment in the legal proceedings will facilitate direct rehabilitation; questioning whether or not the legal system can alter its process to accommodate offenders using a therapeutic approach.

A major theoretical criticism of therapeutic jurisprudence is that it goes against the traditional legal system and the “time-honored principles” of retribution, societal protection, and deterrence (Schneider et al. 2007: 61). Critics posit that the conceptual goals of ‘justice’ and ‘therapy’ are irreconcilable because they are formulated upon entirely separate theoretical frameworks and work to achieve different ends (i.e., punitive versus rehabilitative). The traditional justice system does not focus on bringing about goodwill, well-being, and social welfare but rather emphasizes an adversarial system based upon zealous representation of litigants by attorneys, impartial, rational judges, and legal decisions based on facts.

3.7 How These Two Frameworks Work Together

Mental health courts utilize the medical model and therapeutic jurisprudence as a theoretical basis for handling persons with mental disorders who enter into the criminal justice system. The medical model and therapeutic jurisprudence are analytical, as oppose to causal, theoretical frameworks. Both contain treatment and rehabilitative ideologies.

The medical model and therapeutic jurisprudence are both inclusionary. The medical model accommodates the patient by exempting them from certain social responsibilities. The patient, however, is obligated to seek out medical help and to recover as quickly as possible in order to resume normal functioning and contribute to society.

Similarly, proponents of therapeutic jurisprudence urge the criminal justice system to show appropriate consideration to mentally disordered offenders. The integrity of the law, however, must be upheld thus offenders are accountable for their criminal acts and are

reprimanded accordingly. They apprise individuals of their rights while at the same time expect a degree of accountability and responsibility on part of the patient/offender.

In addition, deviant behavior is viewed as a manifestation of other problems that stem from conditions beyond an individual's control. As a result, mental health courts adopt the perspectives of two frameworks which place emphasis on tolerance, flexibility, and a non-adversarial approach while at the same time they seek to understand the root cause of criminal behavior.

In addition, the medical model and therapeutic jurisprudence encourage public education and policy reform in order to reduce the level of stigmatization attached to mental disorder. Education and legal reform are made possible by the medical model's and therapeutic jurisprudence's emphasis on cooperation amongst a variety of stakeholders. Stakeholders include mental health professionals, legal professionals, patients, families, and society.

In the end, the medical model and therapeutic jurisprudence provide compatible frameworks for the criminal justice system to handle persons with mental disorders in a manner that is both benevolent and fair.

3.8 Conclusion

This chapter outlined and discussed the theoretical frameworks of the medical model and therapeutic jurisprudence as they relate to the concept of mental disorder and the law. The medical model portion critically examined the concept of mental disorder and its scientific and social utility. The second portion of this chapter critically examined the theoretical model of therapeutic jurisprudence as it relates to the way in which the legal system employs rehabilitative and treatment orientated methods for dealing with people with mental disorder. The latter part of this chapter discussed how these two frameworks compliment one another.

CHAPTER 4: Methods

Unobtrusive Observations and Semi-Structured Interviews

4.1 Introduction

The following chapter explains the methodology selected for the collection of data and analysis. The methodology uses open-ended semi-structured interviews and unobtrusive observations of the Kitchener Mental Health Court setting to research three main issues: 1) issues related to due process including the relevant laws and significant socio-legal issues dealing with offenders with mental disorders; 2) how legal rights and treatment needs are addressed by the mental health court and the use of community treatment orders; and 3) the role of community support agencies in the social control and treatment of offenders with mental disorders.

4.2 The Kitchener Mental Health Court Setting

As stated previously, the observed mental health court is located at the Ontario Court of Justice, a provincial criminal division, at 200 Frederick Street Kitchener, Ontario, Canada. This location services the entire Waterloo Region including Cambridge. All mental health cases are heard in Courtroom 101 which is located on the first level of the provincial courthouse. Mental health court is held every Tuesday of each week from 10 am to approximately 3 pm. The mental health court docket is located at the front of the courthouse lobby. Court dockets contain information regarding the defendant's name, the name of the defense counsel, and date and time of the court hearing. Access to the Kitchener Mental Health Court setting did not require special permission because criminal courts are open to the public for viewing cases.

4.2.1 The Court System in Canada: A Brief Overview

Each province in Canada has established two levels of trial courts and a provincial court of appeal. The judges at the lowest level are appointed by the provincial government. The federal

government appoints judges for the superior court, the provincial court of appeal, and the Supreme Court of Canada (which was itself established by the federal government).

There are three levels of courts in each province: inferior or provincial courts, superior courts, and the provincial court of appeal.

The provincial or territorial court systems are similar to one another and are based on the English system of inferior and superior courts. Provincial inferior courts are called provincial courts and superior courts are called just that—superior courts. Provincial court judges are appointed and paid by the provinces.

Provincial courts typically have several divisions including a criminal division, a civil division, a family division, a youth division, and a traffic and provincial and municipal offence division. Small claims courts are examples of lower level civil courts and in most provinces, these civil courts will deal with civil claims of \$10,000 or less while superior courts will deal with cases that involve higher amounts.

Within the criminal division, provincial courts deal with less serious summary conviction offences. They will also hold preliminary hearings for more serious criminal offences but the trial itself will be held in a superior court.

Family courts at this level will deal with disputes over child custody and maintenance (support) but are not authorized to grant divorces or settle real property (e.g., real estate) matters.

The highest trial level courts in the provinces are superior courts and they have different names in different provinces and are called the Court of Queen's Bench, the Supreme Court, the Superior Court, or Divisional Court.

There are two levels of provincial superior courts—the trial and appeal court. Most provincial trial courts deal with different branches of law so the surrogate division of a provincial court will deal exclusively with wills and estates; family divisions will hear divorce, custody, matrimonial property, and support cases; and criminal divisions will hear only criminal cases and some appeals from the lower provincial courts.

The proceedings in superior courts are more formal than lower level provincial courts and parties are more likely to be represented by counsel. Judges in superior courts are appointed and paid by the federal government. Jury trials are only heard in the superior courts.

Each province also has a provincial Court of Appeal. The highest court in the land is the federal Supreme Court of Canada. If a court decision is appealed, the appellant must satisfy the court that the trial-level judge did not follow the rules or procedures or that the judge made an error in the application of the law, whether in the choice of the precedent or in interpreting the principle established the precedent case or statutory provision.

Courts of appeal typically assume that the facts of the case are correct and they do not typically rehear witnesses, testimonies, or accept new evidence. They focus on how the law was applied and are mostly concerned with due process and whether there were any errors in law. If a trial was conducted according to the rules, a court of appeal will not overturn a lower court decision. If serious rules were broken, the appeal court can overturn a verdict and/or order a new trial.

The Supreme Court of Canada hears appeals from the courts of appeal of all provinces. There are only limited situations in which one has the right of appeal to the Supreme Court. In the vast majority of cases, the Supreme Court decides whether or not to hear an appeal and grants appeals in cases of national importance or when the issues have great significance to the law in Canada. The Supreme Court does not explain why it decides to hear or refuse to hear a case.

One important feature of the Canadian court system which is meant to ensure that the proceedings are fair, impartial and legitimate is their openness. With few exceptions, the courts in Canada are open to the public and media. Openness ensures that the public can attend and see for themselves how trials are held and whether or not justice is served.

On occasion, witness may be excluded from parts of a hearing so that their testimony will not be tainted by listening to the testimony of other witnesses. In addition, it is common for judges to place a media ban on the publishing of names of sexual assault victims and children,

evidence presented in a preliminary hearing, and the names of young persons involved in the proceedings. The *Criminal Justice Act* allows a judge to exclude any person from a hearing to protect child witnesses and in the interest of public morals.

4.2.2 The Mental Health Court System

In recent years, there has been a trend towards the development of specialized courts such as Drug Treatment Courts and Mental Health Courts in Toronto and Kitchener.

The Kitchener Mental Health Court is a division of the Ontario Court of Justice. The Ontario Court of Justice is a statutory court and is given jurisdiction by provincial and federal laws. This court has jurisdiction over provincial offence trials, criminal and youth justice bails, trials and preliminary hearings. In addition, this court hears family law matters, including child welfare cases, and appeals in provincial offence matters. Ninety-five percent of all criminal matters under the *Criminal Code*, *Controlled Drugs and Substances Act*, the *Youth Criminal Justice Act*, and other federal statutes are rendered with final judgments by this court (Ontario Court of Justice Annual Report 2005: 4).

The Ontario Court of Justice has developed various specialized courts which have a therapeutic orientation (e.g., Drug Treatment Courts, Domestic Violence Courts, Mental Health Courts). The Ontario Court of Justice Annual Report states “these courts are intended to offer a broad range of programs and therapeutic supports to assist offenders and/or victims in the criminal process” and that mental health courts are intended to:

Accommodate the special needs of mentally-ill persons who come before the courts, often repeatedly, and are frequently charged with minor criminal offences. They aim to deal expeditiously with issues of fitness to stand trial and, wherever possible, to slow down “the revolving door” of repeated returns to court by making full use of resources, including diversion programs (2005: 5).

4.3 Kitchener Mental Health Court Stakeholders

Based upon observations of the Kitchener Mental Health Court setting, there are a variety of mental health and legal professionals which include a Crown prosecutor, duty counsel, judge, and Mental Health Court Coordinator from the Canadian Mental Health Association. A police officer is present during the hearings along with a representative from the Salvation Army Correctional Services Division. Probation officers and CMHA case managers are also present within the courtroom setting.

The role of the judge is one of the most important components of the court team. Although they work with persons with mental disorders, they are not required to have any special training. Typically, they are chosen or elect themselves to work in the mental health court system because they have expressed interest in this particular area. Mental health court judges appear to play a less formal role within the courtroom setting. Under the Canadian mental health court program the decision whether or not to divert a person with mental disorder is left up to the discretion of the Crown. The judge does participate in in-court screening processes to determine fitness to stand trial, criminal responsibility, making of dispositions and treatment application hearings, however.

Crown prosecutors are assigned permanently to the mental health court and are appointed by the Attorney General's Office. As part of their responsibilities, they must complete specialty courses required by the Office of the Attorney General of Canada. They are highly experienced in the area of mental health law and Canadian *Criminal Code* provisions pertaining to mental disorder, and are expected to re-integrate the accused back into society expeditiously while maintaining public safety. The Crown is responsible for deciding who is eligible for diversion into the mental health court program, processing applications for mandated treatment orders, attending disposition, criminal responsibility, bail and plea hearings. They assume an "extra-

judicial' role. That is to say, the Crown has complete discretionary power in deciding eligibility and program completion (Schneider et al. 2007: 89).

The Ontario Legal Aid Society provides funding for duty counsel. Duty counsel must have expertise in mental health law and relevant criminal code provisions. The role of duty counsel is to represent persons with mental disorder who do not have legal representation or who cannot appear before the court. The permanency of duty counsel ensures that there is continuity of representation and a degree of familiarity. Their duties include assisting in the preliminary stages of the prosecution process including screening for fitness to stand trial, trials to assess fitness to stand trial, responding to applications for treatment orders by the Crown, disposition hearings, criminal responsibility trials, bail hearings and guilty pleas. They are responsible for recommending private counsel to the accused who wish for a regular criminal trial. The defense works in the best interests of his or her client by apprising them of their rights and ensuring that consent to partake in the mental health court diversion program is voluntary.

Two court clerks are present in the Kitchener Mental Health Court. One clerk is assigned the role of managing the informations (i.e., written allegations, charge documents, oaths etc.). The clerk is also responsible for arraigning the accused and swearing-in procedures. The second clerk is in-charge of connecting the court with outside partners such as mental health support services and communicating directly with hospitals where offenders receive assessments and stabilize. To improve efficiency, all bail orders are processed and completed by the second clerk on-site.

One police officer is present in the mental health court at all times. The police officer is in charge of transporting offenders between the courthouse and medical facilities. Probation officers are present as well. They testify in court as to the offender's progress.

Psychiatrists are not present in the courtroom. All assessments are conducted in medical facilities such as hospitals and forensic units. They perform assessments of referrals, filter through cases in which persons may be of concern to personal and public safety and determine fitness to stand trial.

The CMHA Court Coordinator is a designated mental health professional. He is present at every court hearing and sits adjacent to the Crown. The CMHA Court Coordinator has knowledge and expertise in areas of psychological disorders. Secondly, he links the client with community resources and is familiar with the unique needs of the accused; the impact criminal history had on the accused and the compounding challenges of living in the community. Third, he has knowledge about the psycho-legal issues (e.g., eligibility and candidacy assessments). He assists and plans the return of persons with mental disorder back into the community whether or not they are on bail or probation. He oversees the offender's progress and assists the Crown in determining eligibility, the suitability of the sentence, and degree of supervision. His role functions as a neutral third party; a broker for the court and community who re-integrates the offender back into the community and assists with housing, registering identification documents, social assistance, clothing and medication. It is his duty to provide immediate access to psychiatric and general medical care. In addition, he conducts situational assessments to monitor whether or not the appropriate linkages are maintained between the client and community support services.

The CMHA Court Coordinator is in charge of developing individual treatment plans which include short and long-term goals based upon the individual needs of the offender and the specific supports required for effective recovery. He also meets with family members to discuss the diversionary process and with family to facilitate the execution of treatment plans. He requires approval from the Crown before this plan can be implemented. Thus, his role serves as a tool for offering access and the use of prescribed resources. The CMHA Court Coordinator does not testify in court, however, he is involved in the collection of data to be presented in court.

The Salvation Army representative, also known as a 'Chaplin' or 'Major', is also present in the courtroom setting. She provides basic necessities such as food, clothing, and shelter to offenders. Her role is to accommodate the needs of the offender by using the resources that are available to her through the Salvation Army. The representative works alongside the CMHA

Court Coordinator and legal team to provide the necessary resources for the treatment of offenders.

4.4 Ethics

Ethics approval from the Office of Research Ethics at the University of Waterloo, Ontario was required before this research could begin. Once ethics clearance was granted, the research project commenced. A project description and list of potential interview questions were submitted along with a completed application form detailing the particulars of the study (refer to Appendix A for a copy of the research proposal). Invitations to participate in the research project and consent forms were provided to all participants prior to the interview process. For courtroom observations, consent was not required. As previously stated, access to the Kitchener Mental Health Court does not require special permission because criminal courts are open to the public for viewing cases. For a copy of the invitation to participate and consent form refer to Appendix A.

The element of privacy in unobtrusive research is sometimes a double-edged sword. While it is part of the measurement procedure to evade the awareness of the person, individual privacy can be jeopardized (Webb, Campbell, Schwartz, Sechrest and Grove 1981).

Webb et al. argue that participants in research should be informed of, understand, and consent to their involvement throughout all stages of the research project. “Informed” is specified as “subjects must be told and must comprehend the nature of the research, its purposes, procedures, the risks that may be entailed, the benefits they might expect to receive, if any, that they are free to withdraw at anytime, and the responsible scientist to contact for information about results or for resolution of resultant problems or harms” (1981: 153). With respect to voluntariness, Webb et al. define it as “the research subjects must be in a position to assume willingly the procedures, risks, and benefits of the research” (1981: 153), otherwise this can be taken as a form of coercion.

Consent was required and obtained by all participants interviewed. Special permission from the Attorney General was required for the Crown prosecutor's interview due to confidentiality issues surrounding the possible publication and release of information. With respect to observing the accused, consent to record their individual cases is not required but does raise some ethical concerns due to the highly sensitive nature of information being disclosed during the proceedings. Information included full name (first and last), age, employment, current and or former address, mental health and criminal background, and details pertaining to the case. Not only was information pertaining to the accused disclosed to the courtroom but information relating to their family, friends, and victims. The researcher ensured that this information was kept confidential by omitting names and addresses from the transcripts and keeping direct quotes anonymous. This reduced the chance of exposing or providing identifying information and mitigates further embarrassment and shame associated with the stigmatization of mental disorder.

Overall, there were no known or anticipated risks to the participants in this study. Many of the court workers encouraged the researcher to observe the courtroom proceedings and conduct interviews with several of those involved, although there was no access to accused persons for interviews. The interviews did not pose any ethical challenges and the unobtrusive observations had minimal threats, seeing as the courts are open to anyone for viewing. In no way did the research jeopardize the confidentiality of those observed. As a researcher it is important to remember, "while scientists have an obligation to protect the participants in their research, they also have an obligation to contribute to knowledge" (Webb et al. 1981: 201). The potential benefits of this research far outweigh the ethical costs involved, hence, the methodology proved to be the most effective way to balance ethical concerns with research objectives.

4.5 Unobtrusive Observations and Semi-Structured Interviews

4.5.1 Unobtrusive Observations of the Courtroom Setting

Observations were conducted every Tuesday of each week in Courtroom 101 over a six-month period (May 2007-October 2007). Observations of the mental health court occurred from 10 am until the court was adjourned for the day. The goal of the first observation was to become familiar with the setting and to get a general feel for the processes and actors. After the first observation, a set of more defined goals were developed in order to guide the observation and collection of data. The goals of direct observations were to observe the physical setting of the courtroom, the interactions and characteristics of actors (i.e., the Crown prosecutor, the defense attorney, the judge, the accused, mental health court workers, police officers, and court clerks), and the characteristics and nature of mental health court proceedings (i.e., charges and types of dispositions). These goals served to draw inferences, patterns, and themes for data analyses, compliment information gathered from interviews, and familiarize the researcher with the setting and inner-workings of the mental health court.

4.5.2 Recording, Storage, and Analysis of Observation Data

Once the goals were outlined, formal observations were conducted in the courtroom using a laptop and a notepad for additional jottings. The field notes were recorded using point form and then transcribed into coherent sentences after the observation session. Transcribing immediately afterwards ensured that the information was recorded accurately, according to the recollections from the day. Jottings (i.e., extra side notes) of the observations were later combined with the field notes. All field notes and jottings were stored securely in electronic files. Only the researcher and the research supervisor had access to the data.

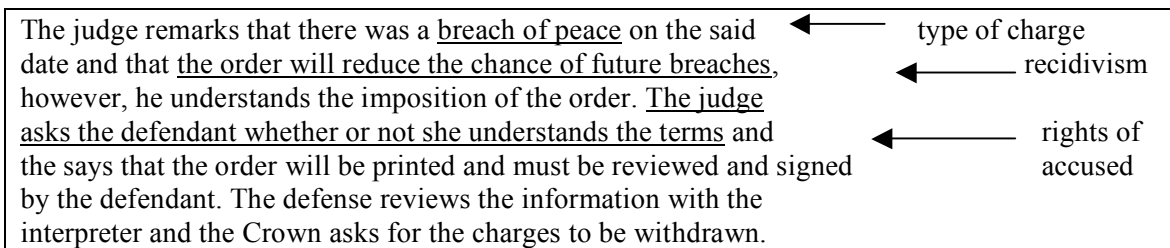
The data analyses involved four stages: 1) preliminary viewing of transcripts; 2) organizing data conceptually into categories; 3) coding; and 4) the final analysis. The preliminary viewing of transcripts was the first step and involved reading through the observation field notes prior to organizing the data conceptually. This step was intended to familiarize the researcher

with the data in order to conceptually organize it into categories and to clear up any ambiguities such as unanswered questions (e.g., What is a Form 2 and Fitness Assessment?).

The organization of data into conceptual categories was the next step in the analysis process. The development of conceptual categories was based upon the four research questions which guided this research project. For example, the research asks how does the judicial system balance the rights of the accused while protecting the public’s safety? Data was assorted according to its relevance to the rights of the accused and protection of public safety.

Once the field notes were organized conceptually, they were coded. If for example the field note was categorized under the topic of the rights of the accused and protecting public safety, the researcher would analyze the excerpt carefully for relevant information pertaining to the topic. Here is an excerpt from one of the observations and an illustration of how the data was coded.

Figure 4.4 An Example of Coding Procedures for Observation Field Notes



Referring to Figure 4.4, the code ‘recidivism’ for example was developed after the researcher recognized that repeat offences and future offences were a re-occurring theme throughout the observations. The ‘rights of the accused’ code was developed as a result of issues of due process repeatedly surfacing, keeping in mind the initial research question (i.e., How does the judicial system balance the rights of the accused while protecting the public’s safety?).

Once all field notes were coded, the researcher conducted an analysis of the codes in order to derive the research findings.

The mental health court observations revealed the different types of proceedings such as trials, pre-trials, judicial monitoring reviews, recesses, adjournments, and audio remands. For instance, the field notes record an audio remand hearing. The field notes read:

The court is conducting an audio remand with a forensic facility. The phone is ringing but no one is answering. Both the Crown and defense are standing waiting for a response. The clerk dials out again to the hospital. The clerk reaches someone and says, "I am calling from Kitchener Mental Health Court." At the same time the judge requests to see information beforehand. The nurse answering the phone says, "We are just going to transfer you." The Crown introduces herself and asks if Mr. _____ is available. Mr. _____ (the defendant) is on the phone and nurse is present as well. The Crown introduces the court to the nurse. Mr. _____ is on a Form 2 for 72 hours but was on a Form 1. The Crown is asking that case be heard at 105 at 10am. The Crown will call on Thursday to see whether the Form 2 will continue. We will check in on your (defendant) status to determine whether there is going to be a discharge. The case will be adjourned until Thursday at 10 am to check status by audio remand. The Crown says, "Thank you very much and talk to you then." The nurse responds by asking is if they are all done and the Crown responds "Yes."

In addition, the observations recorded communicatory interaction between different courtroom actors. For example, the researcher recorded observations of interaction between the residing judge and accused. The field note reads:

The Judge is now addressing Mr. _____. He asks, "How do you support yourself day to day?" Mr. _____ responds, "By soup kitchen." The Judge also addresses the issue of hygiene which he wants to take care of through community services. Mr. _____ further explains that 4 or 5 years ago he used to stay at the House of Friendship in Kitchener and last month he stayed on the streets the whole time. The Judge asks the Crown and defense about whether or not there is support from the community and specifically asks Mr. _____ what kind of support he thinks he needs (e.g., a doctor or employment).

Observations of interaction between stakeholders while court was not in session were also recorded. This is an example of conflict between a community support agent and mother of the accused. The field note reads:

The Salvation Army Major enters the courtroom and leans down and whispers to the lady sitting on right hand side of the courtroom two rows up from where I am sitting. The lady becomes upset and puts her hand in the Salvation Army Major's face...the Major walks away.

Observations recorded the different types of charges and the sentencing dispositions handed down by the judge. The field note reads, with respect to criminal charges:

Mr. _____ is representing Mr. _____ for failure to appear in court, theft under \$5000 (from The Bay), and a breach of recognizance on April 18th 2007 (Section 810 of the *Criminal Code*).

As for sentencing dispositions, the field notes explain:

The judge intercepts and withdraws the charges, orders a conditional discharge whereby no conviction will be registered unless there is a failure to comply, and 15 months probation. The judge also orders all counseling and anger management terms.

Observations outside of the mental health courtroom were also recorded. For example, the researcher notes:

As she walks away and I thank her for her information she tends to a young lady sitting on a bench next to me. She asks if the lady requires help with anything such as duty counsel but then they discuss that perhaps this is not necessary because the matter involves a peace bond.

Other important observations were recorded which included characteristics of offenders such as manner of dress, approximate age, communication-style, and reactions to the courtroom settings (e.g., the defendant is drinking excessive amounts of water). Additionally, the researcher observed and recorded interaction amongst family and friends of the accused and victims who were sitting in the courtroom.

4.5.3 The Advantages of Direct Unobtrusive Observations

Observations are defined as the “selection, provocation, recording, and encoding of that set of behaviors and settings concerning organizations ‘in situ’ which is consistent with empirical aims” (Selltiz, Wrightsman and Cook 1976: 253). Observations of courtroom settings are unique. They involve a variety of processes and groups of individuals. For instance, Blanck (1987) argues that there is immense value in studying courtroom trials and advocates for the articulation of philosophies, strategies, and methods by social scientists who are investigating the courtroom setting.

Mileski (1971) compliments Blanck’s argument by adding that most attention is paid to the activities happening outside of the courtroom setting (e.g., plea negotiations) while little attention is given to the processes and interactions inside. Mileski states:

The courtroom encounter can be approached in its own right. Although some stages may be set and some denouements may be neatly written in prosecutors' offices, the ways in which these sketchy plots are acted out in the courtroom remain largely unexplained (1971: 474).

Mileski (1971) goes further to say that most data and research on courtroom behavior is taken from official court statistics and records thus, weakening the potential for the researcher to examine the character and life-circumstances of the defendant (e.g., the social class status of the defendant).

A qualitative approach is also useful in investigating mental health courts. Appleton contends that qualitative research and multi-method approaches are increasing in popularity and are "particularly useful for studying phenomenon or events about which little is known" (1995: 1). The advantage of qualitative research is that the researcher has the opportunity to see the social world under investigation from the point of view of the actors, leading to a deeper contextual understanding of events and meaning systems humans engage in. Essentially, the actors position serves as the "empirical point of departure" (Bryman 1984: 78). In addition, qualitative research is fluid and flexible in that it allows and affords the chance for discovering the unanticipated. Research plans can be altered if unforeseen events occur during the investigation because it is an approach not hinged upon strict hypothesis generation and "ad hoc procedures" commonly associated with quantitative research (Silverman 1998: 5). Similarly, Silverman (1998) argues that qualitative research has the ability to focus on actual practices in-situ, revealing how things are enacted and happening at that moment.

These arguments demonstrate the importance of developing a methodology that is best suited for effectively observing courtrooms considering their unique nature and respective research challenges.

4.6 Semi-Structured Open-Ended Interviews

4.6.1 Initiating Contact

For this research interviews were conducted with the Crown prosecutor, defense counsel, CMHA Court Coordinator, a Salvation Army representative, and one family member of an accused person with mental disorder. Having completed six months of observations, the researcher developed a rapport with several of the actors within the courtroom setting. The Crown prosecutor, Salvation Army representative, and mother of one of the accused approached the researcher during several observation sessions to enquire about the researcher's presence. All three individuals were eager to engage in dialogue. The Crown prosecutor introduced herself and willingly suggested some reading materials relating to mental health court research. The Salvation Army representative repeatedly asked if the researcher had any questions about the proceedings and volunteered information about her role and the role of the Salvation Army in the Kitchener Mental Health Court. In addition, the Salvation Army representative provided a detailed list of individuals who are willing to be interviewed. These included judges, the Crown, and defense attorneys. On several occasions a mother of one of the accused approached the researcher to discuss her feelings about the mental health court system and her experiences, as a mother trying to navigate the legal system.

4.6.2 Developing Research Questions

Once a rapport developed between the researcher and courtroom actors, a set of questions were developed. The goals of the semi-structured open-ended interviews were to discuss the roles, responsibilities, opinions, and experiences of the actors within the Kitchener Mental Health Court. This served to solidify observation data; that is to say, determine whether or not the information provided from the interviews substantiated what was being observed in the courtroom. The interviews also provided data from which inferences, patterns, and themes could emerge and familiarized the researcher with the actors and processes involved. Overall, the goals of the interviews were to provide additional detailed information which could not be obtained through observational methods.

Once the goals of the interviews were outlined, research questions were developed based upon the four main research questions posed at the beginning of Chapter One. Five categories of research questions were created which included: 1) General Questions; 2) The Accused; 3) Outside Community Support Services; 4) Family and Caretakers; and 5) Challenges and Future Directions.

The General Questions portion of the interview was intended to obtain information regarding the court's basic functions and purpose. For instance, participants were asked "What do you see as the purpose of the mental health court?" and "What are the roles of the judge, Crown prosecutor, defense, and community service agencies and how are the roles different from the traditional criminal court?"

The Accused portion addressed the participant's relationship to the accused and their perception of the role of the accused within the context of the mental health court diversion program. Questions included, for example, "Are there any special challenges you face working with persons with mental disorder that differ from regular criminal offenders?" and "At what point do you come into contact with the accused?"

Questions were asked with respect to the role of community support services and the relationship of the participants to outside agencies. "In what capacity do you work alongside community support services? What are these services?" This category of questions attempted to locate the major community support agencies which are crucial to the Kitchener Mental Health Court and to determine the nature of the relationship between the participants. For example, "How do you perceive the community support services willingness to co-operate with the mental health court?"

The Family and Caretakers category of questions sought to elicit information regarding the role of family members and caretakers in the mental health court process. Questions were tailored to investigate and measure the nature of the relationship between the courts and family. One question asked, "If ever, do you come into contact with family/caretakers of the accused? If

yes, what is your role, duties and responsibilities to them? If no, are there any mental health court workers/teams who are responsible for handling this area?"

The last category of questions were intended to derive information regarding the potential challenges facing the Kitchener Mental Health Court and what is needed to ensure it continues to operate. The question was posed to the participant, "Where do you see the mental health court in 5 to 10 years?"

The questions were written in a straightforward manner so the participants could easily interpret them. In addition, the questions were formatted into thematic categories and followed a certain progression from general to specific. General questions addressed procedural and functionary elements of the mental health court system (e.g., the role of the Crown Prosecutor and defense). For example, the researcher asked the Crown prosecutor, "What is the process you engage in once the accused has been referred to the mental health court? Specifically, what are your duties and responsibilities to the accused?" The Crown prosecutor responds:

I get the file and I look through it with the CMHA Court Coordinator to see if this case is suitable for mental health court and the criteria of the case. If it is not apparent to me, I will often wait until the first court appearance and find out information, screen it for possible conviction, determine whether or not it is in the public's interest to process, the penalty we are looking at, and the hospital. It is the same process as a regular case.

More specific questions intended to address perceptions, interactions, and opinions of individuals and mental health court system (e.g., the accused's resistance to the 'mental disorder' label from the perspective of legal professionals). For example, the researcher asked the defense, "In general, what are some of the challenges the mental health court faces to-date?" The defense counsel responds:

The mental health court is a very effective court and it is working very well. I am certain that a number of people will also agree.

These two responses differ in that one demonstrates the procedural aspect of the mental health court while the other response demonstrates the perceptual, emotional aspects of the court system (see Appendix C for a copy of the interview questions).

4.6.3 The Interview Process

Once the research questions were developed, the researcher began to seek out interview opportunities. Each interview took approximately 30 minutes to two hours in length and invitations to participate and consent letters were provided to all participants prior to the interview process. A copy of the research questions was also provided to each participant prior to the interview. This ensured that the participants understood the nature of the questions and provided an opportunity to clear up any questions or concerns regarding the content (see Appendix A for the invitation to participate and consent letter).

The first interview was conducted with the Crown prosecutor. The researcher contacted the Crown prosecutor at the Ontario Attorney General's Office located at 200 Frederick Street, Kitchener, Ontario. This interview was conducted at a local coffee shop and took approximately one hour in length. The second interview was conducted with the CMHA Court Coordinator. He was also contacted by phone. This interview was approximately one hour in length and was conducted at his office. The second interview was conducted with the defense counsel, who's office is located along Frederick Street. He was contacted by phone and an interview was conducted at his office. This interview took approximately 45 minutes to one hour. These three interviews were conducted after the observation stage of the research was complete. This ensured that the researcher was relatively familiar with the court's processes, actors, and language. For example, the observations revealed that a variety of legal forms are required to order assessments, transportation between facilities, and referrals to community support services. When the interviews were conducted, participants would discuss these forms as part of the legal process. Because the observation stage was complete, the researcher eliminated additional time spent on

clarifying these basic mental health court components and could focus on more important aspects of the interviews.

The interviews with the Salvation Army representative and family member were conducted on-site at the courthouse during court recesses. These two interviews were conducted on a near-by bench in the courthouse lobby. These interviews took place during the observation stage of the research project. Both these interviews took between 30 minutes and one hour.

4.6.4 Recording, Storage, and Analysis of Interviews

All interviews were recorded and transcribed using a laptop. A notepad was used for additional information such as quick memos, reminders, and side comments. All transcripts were stored electronically in computer files and securely managed by the researcher and the research supervisor only. All paper notes were discarded soon thereafter. At the end of each interview, the researcher edited the transcriptions and included additional notes made during the interview process. This ensured that all information was complete and accurate.

The interviews were analyzed using the same method as employed in the observational analysis. The interview questions were based upon the four research questions developed at the on-set of the project and data were conceptually categorized accordingly. Once the responses were recorded and transcribed, the researcher conducted a preliminary review of the transcripts prior to the coding. Similar to the methods employed in the analysis of field notes, the researcher took an inductive approach. By taking this approach, the findings emerged on their own. The interview responses substantiated the observation data and provided answers to the research questions.

4.6.5 The Advantages of Semi-Structured Interviews

While observations are effective for describing the behavior of individuals and environment in which they interact, interviews are a more effective method for getting at the

feelings, beliefs, and motivations of individuals, according to Selltiz et al. (1976). Further, verbal reports in which the information is not necessarily taken at face value can provide insight into other types of knowledge. The advantages of interviews are outlined by Selltiz et al. (1976) in that they can get at complex and emotionally laden subjects, including the underlying feelings and opinions of individuals.

For instance, it would be difficult to ascertain how family members of offenders with mental disorders feel about the mental health court system by just observing them in the courtroom. Furthermore, funding issues would not be detectable through courtroom observation but only through interviewing the right individuals who have specific knowledge of community support resource availability (e.g., The CMHA Court Coordinator). In addition, observations would not elicit personal opinions about the roles of others. For example, sometimes there is disagreement about what is best for the offender. The defense would like to see his client placed in a group home while the CMHA Court Coordinator wants the client to receive appropriate treatment. Because the CMHA Court Coordinator works behind the scenes, only through an interview would the researcher be able to learn that there are conflicts between court workers and what each group or individual would like to see happen to the offender. For instance, the researcher wanted to know whether or not community agencies always support the court. The researcher asks the defense attorney, “Have you experienced any resistance from community support services?” The defense attorney replies:

Never...I have experienced their frustration because they want to help somebody who is not amenable to their help but I have never seen them say they won't help.

Questions like these elicit responses that would not be apparent through observations.

Specifically, open-ended interviews, which do not involve fixed responses, stated alternatives, and/or structured responses, are easy to administer and provide ample opportunity for clarification of questions and responses between the participant and interviewer. Less structured interviews elicit affective and value-laden aspects of responses, illuminating the

personal significance of individual attitudes and provide a social context from which these beliefs and values stem. Once again, the mother interviewed had an entirely different perspective on the effectiveness of the mental health court system. Her experience is shaped within the context of motherhood and a person with no legal background.

Because the research questions were semi-structured, it allowed the researcher a degree of flexibility in the types of questions to ask and at which point in the interview process. For example, the researcher made sure to focus on questions pertaining to the role of community support agencies when interviewing the Salvation Army representative and placed less importance on asking about the future of mental health courts within the next five to 10 years. In the case of the mother of one of the accused, the section of questions pertaining to family and caretakers had more relevance to the discussion than, for example, the portion on the role of the Crown prosecutor.

Open-ended semi-structured interviews, according to Selltitz et al. (1976), allow for spontaneity and are an opportunity for the participant and interviewer to experience moments of self-revelation. Lofland posits that semi-structured interviews provide “information in the respondent’s own words, to gain a description of situation to elicit detail” (1971: 76), address potential ambiguities in real time, and achieve higher response rates than any other social science methods (Appleton 1995). For these reasons, semi-structured interviews were an effective and complimentary method for retrieving rich data.

4.7 Conclusion

The purpose of this chapter was to explain the methods used for the collection and analysis of data from the Kitchener Mental Health Court research. This research employed a qualitative and multi-method approach through the use of unobtrusive observations and semi-structured interviews. This chapter discussed how the researcher initiated contact with the courtroom setting and research participants, addressed the ethical issues, developed conceptual categories for

coding, and the advantages of these two method selections.

CHAPTER 5: Findings

Behind-the-Scenes of the Kitchener Mental Health Court: The Pivotal Role of Community Support Agencies

5.1 Introduction

The research literature often ignores the role that community support agencies (CSAs) play in the operation and success of mental health courts. The current study suggests that CSAs are absolutely essential to the operation of the mental health court. Mental health courts offer a venue for cases of mental disorder to be heard and they provide a legislative framework to resolve legal issues for persons with mental disorders who come into conflict with the law. The legal system, itself, is not equipped to solve the problem at hand but relies instead on CSAs to implement the necessary health care. For instance, clinical psychologists referred by the CSAs perform the initial assessment of subjects with mental disorders as a first and pivotal step towards determining eligibility for diversion. It is clear that the mental health court cannot function properly without the assistance and support of outside community agencies. A discussion of the research findings includes: a) a description of the characteristics of mental health court clients; b) the types of proceedings, charges, and dispositions; c) the factors influencing the criminal behavior of mental health court clients; and d) mental health courtroom behavior. The latter portion of this chapter will discuss and focus on three major themes which have emerged around the role of CSAs. These include the following: a) the role of the Crown and defense attorneys; b) the role of CSAs within the mental health court including the provision of resources; and c) knowledge sharing. Following this discussion, a critique of the Kitchener Mental Health Court system is provided. Two case examples are included in this chapter to illustrate the mental health court processes under examination.

For the purpose of this research community support agencies include any group organization or individual that works in collaboration with the Kitchener Mental Health Court and assists in locating and providing a variety of services to mental health court clients.

5.2 General Descriptive Information Derived from Observations

5.2.1 Characteristics of Kitchener Mental Health Court Clients

The majority of the accused in the Kitchener Mental Health Court were white males, between the ages of 20-40 years old. Because court records were not available to the researcher, some ages were estimated according to physical features and manner of dress. Of the 28 cases brought before the court, 19 individuals were observed directly, while the remaining individuals were observed through audio remand with their attorneys representing them in the courtroom. Sixteen of the 19 subjects were male and two were female. The racial composition of the mental health court participants included 13 Caucasians, four Hispanics and two East Indians.

The most common diagnoses observed were schizophrenia and bi-polar and depressive mood disorders. In several cases, the accused had not been assessed and there was no formal diagnosis or the Crown and defense simply made mention that the individual had mental health issues, a history of mental illness, or psychological problems. In one case, diabetes was contested as a mental disorder on the basis that symptoms linked to low insulin levels mimic those commonly associated with anxiety disorder. The judge ruled against the evidence presented by the defense counsel, however, and the accused was returned to the regular criminal court for trial.

5.2.2 Types of Charges, Dispositions, and Range of Proceedings

Of the 19 cases heard in which the accused was present in court, the most common charge was breach of probation and aggravated assault (see Table 5.1 for a list of charges).

Table 5.1 Types of Charges per Number of Cases

Type of Charge	Number of Cases
Breach of Probation	6
Aggravated Assault (with weapon)	3
Mischief	2
Failure to Appear in Court	2
Breach of Recognizance	2
Dangerous Operation of Vehicle	1
Fraud under \$5000	1
Drug Possession	1
Damage to Property under \$5000	1
Theft under \$5000	1
Total Charges	20

Note: One of the accused was charged with two counts which accounts for the ‘Total Charges’ discrepancy.

In terms of dispositions, the majority of cases were resolved by the judge handing down probation periods ranging from six to 24 months. Three of the probation dispositions were accompanied by additional conditions including fines, reporting terms, and no association and communication clauses (see Table 5.2 for a list of dispositions).

Conditions affixed to the probationary period generally include a set of common restrictions such as notifying the court of address changes, abstaining from the purchase, possession, or selling of drugs and weapons, and a requirement that they attend counseling.

The Kitchener Mental Health Court handles a variety of proceedings daily. Of the total observations, including cases heard by audio remand, the majority of proceedings involved adjournments and trials. Adjournments occurred when scheduling conflicts for trial dates arose, cases were pending because the defense counsel was not ready to proceed, and/or the court was awaiting community treatment orders/assessments. Bail hearings, pre-trial resolution hearings, and progress reviews compiled the remaining proceedings (see Table 5.3 for a list of proceedings).

Table 5.2 Types of Dispositions per Number of Cases

Type of Disposition	Number of Cases
Probation	9
Suspended Sentence	3
Peace Bond	2
Remand until Assessment	2
Conditional Discharge	2
Withdrawal of Charges	2
Stay	1
Restitution (Fine)	1
Incarceration with Treatment Condition	1
Total Dispositions	23

Note: The ‘Total Dispositions’ discrepancy is due to sentences that were combined.

Table 5.3 Types of Proceedings per Number of Cases

Type of Proceeding	Number of Cases
Trials	10
Adjournments	9
Bail Hearings	4
Pre-Trial Resolution	4
Progress Review (also known as ‘Judicial Monitoring’)	1
Total Proceedings	28

Note: The ‘Total Proceedings’ discrepancy is due to proceedings that were combined.

5.2.3 Factors Influencing Criminal Behavior of Mental Health Court Clients

One of the major findings from the research points to the factors influencing the propensity of persons with mental disorders to engage in criminal activity. It was found that (a) homelessness, (b) treatment and compliance issues, (c) lack of family support, and (d) substance abuse were four common elements in all mental health court cases observed. All four factors appeared to be associated with the degree of compliance to court orders, the likelihood for criminal activity and subsequent re-arrest. These courtroom observations were substantiated by interviews conducted with the CMHA Court Coordinator.

The client will typically have difficulties in three to five life domains and have several difficult issues of an ongoing nature. For instance, there may be chronic housing issues, repeated treatment issues because he or she is on and off his meds; he or she may also have no friends and family and is isolated in the community.

(A) Homelessness and Housing Issues

Homelessness or problems linked to sustaining basic housing and shelter were evident in nine of the 19 cases heard in the Kitchener Mental Health Court. A common cluster of problems included homelessness, low education levels, sporadic employment, and family conflict or lack of family support. This observation is also supported by the interview data. Five interview participants commented on the issue of homelessness and problems clients had in finding shelter. When asked about some of the major issues facing the mental health court, one defense attorney comments:

Probably housing. A lot of people are street people and quite often they have no place to go right away. Maybe in jail they are housed, or the House of Friendship if it is not an acute case. For short-term housing there is the respite home when beds are available.

(B) Treatment and Compliance Issues

The most common issue of the 19 cases heard involved 16 mental health court clients who failed to adhere to their prescribed medications. Failure to take prescribed medication was viewed by all parties as a contributing factor to the commission of criminal offences in all cases. Although the judge did emphasize the importance of complying with conditions of the diversionary program and urged defendants to resume treatment, there were no instances in which accused persons were sentenced for non-compliance with respect to medications.

(C) The Role of Family Members

Evidence presented in the court indicates that thirteen of the 19 cases involved long-standing family conflict including domestic violence, child endangerment, and parental abuse. In the majority of instances, the victims and the offender were related through marriage or kinship. While some families were absent from the proceedings, other defendants were supported by family. In general, three distinct patterns emerge with respect to families of the accused within the context of the mental health court setting. These include the following: 1) families who provide

emotional support; 2) families who provide legal support; and 3) families who provide no support. The emotional support role is characterized by family members who demonstrate compassion and support the offender throughout the court process, irrespective of whether or not they were victimized by the accused. The legal support role is characterized by family members who provide surety (i.e., a guarantee to assume liability on behalf of the accused) for the accused or any other form of legal help.

The non-supportive role is characterized by family conflict, abandonment, alienation, and a complete lack of emotional or financial support for the accused. In these cases, family members are not present in the courtroom nor do they maintain any form of contact with the accused. In one case an accused was charged with breach of probation and required treatment for his mental disorder. The defense explained that his client's lack of family and community support is a contributing factor to his instability, lack of compliance to medication, and criminal outbreaks.

The defense argues that all the facts of the case have been substantiated except with respect to the gun. The defense describes Mr. _____ past; he is from Brazil, has a troubled relationship with his mother who will not communicate with her son or provide help, has been diagnosed with bi-polar and anxiety disorder and has a serious diabetic illness. The defense asks the court to be empathetic to the accused because he has no one here in Canada to support him. The defense would like to see his client placed in a group home.

The majority of court cases observed involved non-supportive families. The CMHA Court Coordinator works with family members to develop life plans and explains:

Family members often struggle with mental disorder. Many feel shame particularly if they are from a particular ethnic group. There is often a history of family conflict and many have burned their bridges with family members. They have been written off and are now without any family support.

(D) Substance Abuse

In eight of the 19 cases, mental health court clients were described as having substance abuse problems in addition to a mental disorder. The observations reveal two scenarios facing offenders: 1) non-adherence to medication and use of illegal narcotics and/or alcohol, and 2) combining prescribed medication with illegal narcotics and/or alcohol. The most common

substances were alcohol and marijuana. In all eight cases, substance abuse resulted in their arrest, drug charges, and charges related to breach of probation. In addition, a number of offenders committed other crimes while intoxicated or under the influence of illegal drugs. Most of these summary offences were mischief, public intoxication, and damage to property under \$5000. Judges stipulated drug and alcohol terms in all probationary and conditional discharges. (i.e., complete abstinence from alcohol and illegal drugs and prohibitions against the purchase, possession, and selling of narcotics). In one case, a repeat offender was brought back to the court to stand trial. The Salvation Army representative commented during the interview that:

This client has been in the system for a while. I think the judge will throw the book at him because this is his third time here. It is a shame. He was doing really well. He reconciled with his wife and children for a while and then he started drinking again and was brought to court. It only takes one thing to set these people off and they are back to drinking. It only takes one drink and they are back in trouble.

5.3 Courtroom Behavior

5.3.1 Cooperation and Communication Between Courtroom Participants

Aside from the formal courtroom procedures which are present in any regular criminal court, the mental health court demonstrates its uniqueness through its communicative, collaborative, and holistic approach. The court generally demonstrates empathy towards the accused; all courtroom workers enquire about the well-being of the individual and judges routinely communicate directly with the accused on a person-to-person level.

The importance of CSAs in the Kitchener Mental Health Court is demonstrated through the behavior of the court workers. Judges determine whether or not community support services are available to help the individual and if there are any supports currently in place. Judges place tremendous emphasis on connecting individuals to treatment and support services. In all instances, judges will ask the Crown, defense, and CMHA Court Coordinator to ensure that the individual is provided with necessary assistance.

The CMHA Court Coordinator is present at all courtroom hearings to help clarify any information and or to provide immediate support for the individual following the court proceedings. In addition, a Salvation Army representative is present in the courtroom to address the immediate needs of the individual and to provide basic necessities such as clothing, food, shelter and small financial assistance for items such as transportation. According to the Salvation Army representative, her role is to:

Help people with information and direction and try to comfort them during the process. She ensures that clients have duty counsel and basic resources.

Communication is continuous and encouraged between the community support agencies (e.g., CMHA and Salvation Army) and court workers. Communication between all stakeholders is essential to solving the immediate issues facing persons with mental disorders (housing, clothing, and food), and connecting accused persons to support services for treatment. The level of communication and cooperation is indicative of the Kitchener Mental Health Court's reliance on community support agencies to facilitate the treatment process and assist the accused to stay out of trouble.

5.3.2 Language and Tone of Court Workers

Courtroom observations and interviews with mental health care personnel reveal that court workers demonstrate their commitment to the medical model by advocating treatment and displaying empathy for persons with mental disorders. The language used in the courtroom, the tone of that language, and the respect they show the accused clearly illustrates a commitment to the medical model and therapeutic jurisprudence. Judges and court workers were extremely respectful and considerate of clients. The Crown, defense, and judge refrained from communicating harshly with offenders. Many times, judges offered encouragement and praise to the offender. The Crown and defense were extremely respectful towards the client and always attempted to work together to accommodate the client during the proceedings. Similarly, mental

health court clients were receptive to the court workers with the exception of clients who had communication problems (e.g., speech impediments and lack of comprehension). Most clients were polite and respectful of the court and apologized for their behavior and thanked the courts for being considerate and lenient.

Correspondingly, the interviews revealed re-occurring patterns with respect to: 1) language employed when describing the Kitchener Mental Health Court; 2) language employed when describing responsibilities towards the client; and 3) language used to describe colleagues—specifically community support agencies. In all cases, the Crown, Defense, CMHA Court Coordinator, and Salvation Army representative employed similar language to describe the various aspects of the mental health court system (see Table 5.4).

Table 5.4 Language Employed by Interview Participants to Describe Aspects of Mental Health Court

Topic of Interview	Common Descriptors Employed During Interviews
Court	“kinder, gentler,” “refreshing,” “accommodating,” “holistic,” “flexible,” “committed,” “alternatives,” “enjoyable”
Client	“appropriate consideration,” “understanding,” “empathy,” “best interest”
Colleagues/Community Support Agencies	“caring,” “non-judgmental,” “help,” “partnerships,” “cooperation,” “proactive,” “crucial,” “important,” “vital”

The language used by interview participants and court workers within the courtroom setting connote benevolence, empathy, willingness, and general enthusiasm for the mental health court system and towards accused persons.

The concept of ‘Jurisprudence’ suggest a strong commitment to due process within a formal court setting; that is to say, certain legal terms display respect for the accused and their legal rights (see Table 5.5).

Through an examination of the legal language, clearly, there is an emphasis on due process. Terms such as “full consent”, “voluntary”, and “non-coercive” suggest that the Kitchener

Mental Health Court judge, Crown, and defense are making sure the accused person’s decision to enter into diversion is completely voluntary; eliminating any possibility of legal coercion by the court system.

Table 5.5 Legal Terms Employed by Judge, Crown, and Defense to Describe the Rights of the Accused

Participant	Legal and Other Terms
Judge	“full disclosure”, “understanding terms”, “full consent”
Crown Prosecutor	“voluntary”, “non-adversarial”, “privacy”, “confidentiality”, “fair”, “just”
Defense	“fair legal resolution”, “decriminalize”, “divert”, “fit to stand trial”, “not criminally responsible”, “advise”, “non-coercive”, “voluntary”

Judges, Crown, and the defense attorney demonstrate their commitment to the rights of the accused through language. The observations and interviews, similarly, reveal that Community support agencies also display their respect and genuine concern for the well-being of the accused through language (see Table 5.6).

Table 5.6 Attitudes of Community Support Agency Stakeholders Towards Mental Health Court Clients

CSA Stakeholder	Language Employed to Describe Attitude/Behavior Towards the Accused
CMHA Court Coordinator	“least intrusive manner,” “inclusionary,” “non-invasive,” “helping the accused,” “treatment,” “least restrictive plan,” “consideration for his/her needs,” “gain their cooperation”
CMHA Case Managers	“monitor,” “get treatment,” “concerned”
Salvation Army Representative	“help,” “need,” “direction,” “comfort”
Probation Officers	“concern,” “not well enough”

These findings demonstrate support for the principles of therapeutic jurisprudence and the medical model in the Kitchener Mental Health Court. They also demonstrate the court’s

confidence in community support agencies and the vitalness of CSAs in upholding the court's fundamental ideologies.

5.4 The Role of the Crown and Defense Attorneys

Interviews conducted with the Crown and defense attorney reveal that one of the major issues concerning mental health court diversion is maintaining the integrity of the law. The Crown remarked that one of her concerns was finding a balance between meeting the needs of offenders and upholding the law. Providing an illustration of a common case, the Crown explains that:

Sometimes legal issues arise with respect to the criminal and civil law. There are only certain things we can do with regards to this. The *Criminal Code* and legal system was not developed for persons with mental disorders. For example, families want to send their loved ones to the hospital on a civil order but the accused has a violent record. In this case, the criminal justice system takes priority. So, there is conflict between the civil and criminal law [...] and it is sometimes difficult to find ways to accommodate the various cases [and] maintaining the integrity of the law.

Interview participants emphasized the importance of fulfilling their professional obligation to the courts and the accused. The Crown stressed her obligation to ensure accountability for criminal activity and public safety, while the defense pointed out his responsibility to do what is in the best interest of his client. Both the Crown and defense recognize that in cases of mental disorder, the law requires a degree of flexibility; that is to say, they are empathetic to persons suffering from mental disorders and realize that the root cause of criminal behavior (in these cases) stems from mental disorder and not deliberate criminality. Although the Crown and defense are working together to obtain appropriate treatment for the offender, they are limited by their professional obligations. The Crown remarks that:

Our roles are the same as in the regular criminal justice system. We cannot forget that we must follow the law and *Criminal Code* but what we can do is make the court less adversarial.

Similarly, the defense explains with respect to his role and the role of the Crown:

The Crown's role is handled in accordance to policies and to divert those out of the criminal system so people don't end up with criminal records. It is also her responsibility to make sure that when people are charged that they are fit to stand trial. Her role requires that the needs of the justice system and community are met but most importantly for the individual to be held accountable. The defense role is to make sure the best interest of the accused are handled. My role is to address the individual's problems, the cause for why they are there and to try to come to a final resolution for my client.

He stresses the court's obligation to ensure that a judicial decision include protecting the interests of the community while holding individuals accountable for criminal behavior. As a result, they rely heavily upon and place tremendous confidence in the support of community agencies. The CMHA Court Coordinator acts as a neutral third party who works with the courts and client, and in turn, helps to solve these professional limitations of the Crown and defense. For instance, when families of the accused want to enquire about the nature of the legal proceedings they typically approach the Crown for information. Because privacy laws bind the Crown, the court relies on the CMHA Court Coordinator to provide information to families in order to not jeopardize the criminal case.

[Families] want to know everything going into a weird system. All they want to do is know everything so we do what we can to make it easier on them but the limitations of privacy laws must be understood. I have a lot of contact with family but because of privacy issues I am restricted. I can listen. I usually tell them to speak to duty counsel first because I don't want them to regret telling anything to the Crown. [The CMHA Court Coordinator] plays a large role. He is considered neutral and they might feel more comfortable speaking to him than the Crown.

5.5 The Role of Community Support Agencies within the Mental Health Court

The mental health court relies heavily upon community support agencies for the appropriate resources to treat mentally disordered offenders. Judges appear to have great confidence in the abilities of the community support agencies to help advise court workers in determining eligibility, providing assessments, and tailoring and monitoring treatment plans. CSA workers meet with family to provide information and direction, explain the legal process, and provide counseling support services. They are also responsible for accessing resources and accommodating the needs of the accused. The law serves to bring treatment to people (e.g., bail

conditions allow person to be treated at facility in community) and CSAs work to obtain the cooperation of legal system (specifically the Crown) to develop treatment plans and divert individuals away from incarceration. One defense attorney states:

The most important role though is the role that the community plays. Community workers have initial contact with the individual and they have the means to access resources that are available to them. They make determinations, advise the Crown as to guilty pleas, and provide the basic essentials such as residences. Community workers clearly direct offenders to health care matters.

CSAs make recommendations based on their expertise in mental health and the court recognizes and places confidence in the advice of CSAs when imposing dispositions. For instance, mental health case management functions as a means to treatment and the legal system provides this option if the accused wishes to participate. The mental health court, upon the advice of the CMHA, will withdraw charges in order to provide the offender with case management. In addition, the CMHA is instrumental in encouraging the Crown to stay charges as early as possible to provide quicker access to treatment for the accused. Essentially, CSAs facilitate the entire treatment process by using the legal system as a means to gain the legal mandate to help provide the necessary care to mentally disordered offenders.

5.5.1 The Provision of Resources by Community Support Agencies

Community support agencies are responsible for providing a variety of resources to accused persons with mental disorders. The CMHA is an instrumental partner in the Kitchener Mental Health Court. They offer short-term diversionary and non-diversionary case management support and long-term (indefinite) support. The amount of available case management is limited, however, and in these cases the CMHA will refer individuals to other agencies and counseling services if case management is not an option.

CMHA case managers play a pivotal role in the Kitchener Mental Health Court. Observations of the courtroom reveal that case managers are very much a part of the court process. Their role involves: 1) testifying in court; 2) communicating regularly at judicial

monitoring reviews and providing the court with information regarding the offender's progress; 3) monitoring adherence to medication and rehabilitative treatment programs; and 4) communicating with physicians of the accused.

The CMHA Court Coordinator works alongside other partner agencies to refer mental health court clients for case management. Case management is provided by external community agencies such as the Waterloo Region Assertive Community Treatment Team and Waterloo Region Homes for Mental Health. These agencies provide housing and treatment support for in-community patients.

Community respites are also available. Respites provide beds for individuals in crises who are in transition from psychiatric hospitals. Respites are available temporarily for brief stays of nine to 14 days. Family respites are another resource available within the community. Patients are placed in temporary residences to assist families in coping; providing additional care to patients and a short-term reprieve for the family.

Outreach treatment teams are another viable option provided by CSAs. These include the Grand River Hospital, K-W Habilitation, David Fisher, and Homes for Special Care. These organizations provide housing within a group home setting and ensure that patients take their medications and provide meals, and laundry services. Other community agencies such as the House of Friendship and ROOF provide temporary accommodation for individuals with non-acute cases (e.g., less serious mental health issues).

Substance abuse counseling is also made available to accused persons with mental disorders through CSAs. The Harbor Light Detox program which is run by the Salvation Army Correctional Services Division is located in Toronto, ON. The provision of substance abuse counseling by CSAs is a critical component to the treatment of accused persons with mental disorders. The Kitchener Mental Health Court recognizes drug and alcohol addiction as an aggravating factor of criminal behavior and has developed a joint project with the Kitchener Drug Court to address these additional issues faced by accused persons with mental disorders, and to

direct them to appropriate substance abuse treatment programs.

CSAs also include a variety of other stakeholders who are crucial in providing treatment to mental health court clients. These include probation agencies and forensic facilities. The observations reveal that the Kitchener Mental Health Court works tightly alongside forensic facilities that provide temporary beds, psychiatric assessments, physician treatment, and to monitor the progress of offenders. Psychiatrists conduct mental health assessments which determine eligibility for mental health court diversion and develop progress reports for the courts. Forensic facilities must also communicate regularly with the mental health courts through audio remands for the purpose of notifying the courts of the offender's progress and conducting trials. The mental health court depends on the cooperation of mental health staff to facilitate the audio remand process including hospital administrators, physicians, psychiatrists, and nurses.

Community probation agencies monitor attendance to treatment programs and ensure that offenders are adhering to probationary terms and conditions. They routinely testify in court regarding the offender's progress and communicate regularly with case managers and other mental health professionals in regards to compliance issues and the securitization of resources that are required by the accused (e.g., obtaining housing, employment and physician care).

Family and Children Services also work in collaboration with the Kitchener Mental Health Court. The observations reveal that children are victimized by accused persons with mental disorders. In two cases, FCSs were called by the police after the individuals were arrested. In one case, a woman was charged with Dangerous Operation of a Motor Vehicle while attempting to crash her car with her four-year old daughter in the back seat. She was diagnosed with schizophrenia.

The defense would like his client to be released under her own undertaking and Family and Children Services has been notified for the protection of the children.

In a second case, the accused person was charged with assault on the mother of his child. The judge feared that the child would be traumatized by witnessing these violent outbursts. The

accused was also diagnosed with schizophrenia.

According to the most recent information provided by the mother of the defendant's child, the defendant's daughter is four months old. The mother of the child does not want contact with the defendant. Family and Children Services have stepped in to arrange for supervised visits for the defendant to see his child. The judge informs the defendant that communication with his daughter can be withdrawn at any time if he does not comply with the conditions of his probation. He will need prior written consent to see his daughter which will be arranged through Family and Children Services and through the court.

Family and Children Services' main goal is the protection of children. In order to achieve this goal they must communicate and cooperate with the Kitchener Mental Health Court and probation agencies to ensure that accused persons are complying with probation and court ordered treatment. Compliance on the part of the accused, in some cases, affords the accused a better opportunity for obtaining consent for visitation with their children by the court or to remain as the primary caretaker. Mental health court clients express concern for their children's well-being according to observation data. Therefore, agencies such as Family and Children Services indirectly help accused persons with mental disorders by ensuring the safety of their children when they are incapable of doing so themselves.

5.6 Knowledge Sharing

The CSAs willingness to communicate and share their knowledge with the courts in order for the system to operate effectively is demonstrated by their commitment to cooperate with the court. Community support agencies provide pertinent information regarding the nature of mental disorders, explaining and clarifying mental health concepts and procedures that are unfamiliar to legal professionals. For example, the Crown reviews client files with the CMHA Court Coordinator who answers questions and makes recommendations based on his knowledge of mental disorder and available services.

Furthermore, CSAs work to educate and enlighten the public about mental disorder. The CMHA, specifically, takes a greater role in education.

The CMHA has more involvement and awareness of the Mental Health Court. We have a

representative in court and we get many calls for information and requests for assistance from family and lawyers. We often educate families and patients about the process and how the mental health system works.

The CMHA also partners with other community support agencies to host public talks which are attended by court workers and other mental health professionals. Community support agencies, including charitable organizations such as the United Way, draw together resources to create seminars aimed at educating stakeholders. For instance, a variety of community support agencies hosted a book release party entitled, *“Journey of Recovery: A Mental Health Guidebook for Families in Waterloo Region”* at the local library. Events such as these are brought to the attention of judges, Crown prosecutors, and defense attorneys because they work closely with the Canadian Mental Health Association. For instance, one of the interview participants provided the researcher with an electronic copy of the invite, signifying once again an appreciation for the role community support agencies play.

Many prominent community members including The Hon. John Milloy, Minister of Training, Colleges and Universities attended this event. He commented:

I was pleased to attend the official launch of “Journey to Recovery: A Mental Health Guidebook for Families in Waterloo Region. The book provides a much-needed resource for families that need to navigate through mental health resources in our community. This is a great step forward in recognizing the importance of families in the recovery process.

This quote demonstrates the level of support and encouragement of community support agency initiatives and the importance of educating the public about mental disorder, while addressing the important role family plays within the mental health system.

5.7 Two Kitchener Mental Health Court Case Examples

Case Example One
The Kitchener Mental Health Court
October 9, 2007
Courtroom 101

This case involves a young man between the age of 20-25 years old. He has been brought to court for breaching the terms of his probation. This is a Crown onus bail hearing in which the Crown must provide sufficient evidence to the judge to obtain permission from the courts to allow the defendant out on bail for a psychiatric assessment. The Crown is requesting an Order of Examination (Form 2) under Section 16 of the Ontario Mental Health Act. If the Crown is successful, the courts will consent to have the defendant transported to a forensic facility for examination by a psychiatrist.

The Crown describes the defendant's criminal history. The accused did not have an extensive history of priors. The original event that led to his arrest involved a stand-off with police. The accused had two knives in his possession while he was attempting to steal a bottle of alcohol from the LCBO. When one of the officers went to arrest him for shoplifting, the accused stabbed the officer in leg. The accused refused to drop the knife. A police officer and by-law officer tried to apprehend him by pepper spraying him but this had no effect. He continued to lunge at the officer, eventually stabbing him in the arm. The accused claimed at first that he wanted to kill the officer but then backed down. Both officers had to hog-tie him with a cord and handcuffs in order to secure him. The stabbings required stitches. Once the accused was apprehended he was cooperative with police. They took a blood sample to test for communicable diseases. The results were negative.

The defendant was charged with one count of aggravated assault on a police officer. He was sentenced to 138 days pre-sentence custody and a 15-month jail term. The courts recommended that he be detained in a correction treatment centre which required that he be transported from Maplehurst Correctional Facility to the St. Lawrence Valley Correctional and Treatment Centre.

At the St. Lawrence Valley Correctional and Treatment Centre he was non-compliant with his medication treatment. The medical professionals there considered him untreatable and unstable and likely to re-offend.

Once he completed his sentence, he was released on probation. The defendant did report to his assigned probation officer and, according to the probation officer, understood and signed the order. While out on probation the defendant was residing at the Kitchener House of Friendship but would not sleep there during the nights and failed to notify his probation officer and mental health caseworker of his whereabouts. As a result, he breached the terms of the probation order and was subsequently arrested by police on October 3, 2006 at 11:23pm.

The Crown calls Miss _____ to the stand and she is sworn in by the court clerk. The Crown is examining the witness. She is an intensive probation officer for high-risk offenders and the accused was assigned to her once he was released from the St. Lawrence Valley Correctional and Treatment Centre. The probation officer received a discharge and clinical summary from the medical professionals at the St. Lawrence Valley Correctional and Treatment Centre. The medical professional there did not provide a good report of the defendant. The probation officer testifies that the accused refused to eat and he was considered to be a risk to himself and to others. His mother was given legal authority to dictate her son's treatment but the defendant challenged her status as the legal decision-maker. Even though the courts overturned the decision, he eventually refused all medication and treatment.

The probation officer relays her concerns to the court about his refusal to look after himself. She states that it is difficult to elicit "yes" or "no" responses from him. He is generally un-kept and does not give eye contact when speaking to others. The House of Friendship attempted to provide him with support but he refused.

The Crown states that if the defendant is left untreated he could cause physical harm to himself and others. If he remains homeless the courts and community support agencies have no way of monitoring if he is taking care of himself properly. The Crown argues that the defendant is unstable when not monitored.

The Crown provides evidence to support this claim. From 2003-2004, the accused was housed at the Grand River Hospital under the care of Dr. _____. His records indicate that he

was far more stable at this time. In addition, the St. Lawrence Valley Correctional and Treatment Centre diagnosed the accused with schizophrenia and remarked that the accused has general difficulties with communication and a substance abuse problem. He is addicted to alcohol.

The probation officer testifies that, at this time, he is not well enough to look after himself. She is in constant contact with the family and they are concerned about his present state and they feel he is not well enough to look after himself as well.

The St. Lawrence Valley Treatment and Correctional Centre is advising that the accused receive psychiatric care and the Crown asks the defense if he has a psychiatrist in the community. The defense attorney responds that the House of Friendship requires financial information from the accused to determine whether or not he is covered for psychiatric services. He would like to see his client placed back into the care of the Kitchener House of Friendship.

The probation officer steps down and the court clerk swears-in the defendant. The judge attempts to speak to the defendant and tells him he would appreciate “yes” or “no” answers and not “hmmms.”

The defense attorney proceeds to question his client. He asks the defendant if he would entertain the thought of returning back to the House of Friendship. The defendant responds that he would rather go back to the House of Friendship because “anything is better than jail.”

The Crown asks the defendant, “Why don’t you want to go to the hospital?” The defendant responds that he doesn’t feel he needs medication. He tells the court that he did not agree to take medication or treatment. The case rests.

The Crown outlines her position. She would like to submit a Form 2 under the Ontario Mental Health Act Section 16 in conjunction with Section 515 subsection 10 of Canadian Criminal Code on the secondary grounds of the protection and safety of the public. The Crown has shown cause to meet the secondary grounds by demonstrating that the defendant shows a lack of care for himself. The Crown reads out the terms of the order. The terms include:

- 1. For the accused to reside at the Grand River Hospital or any another psychiatric facility;*

2. *No possession of alcohol or drug otherwise prescribed by a physician; and*
3. *A no firearms term.*

The other alternative provided by the Crown is to stabilize the defendant before a detention order is required. The defense agrees that his client reside at the hospital or remain in custody. The judge points out that this is a Crown onus bail hearing and reads out the evidence again. He provides a synopsis of the case. He remarks that the accused has had prior mental health difficulties, shows a lack of compliance for court orders, and is at high risk for re-offending. The judge agrees that the accused is unable to engage in the process of taking care of himself and that the accused is a “non-communicative sort of individual.”

The judge asserts that the Crown has “amply demonstrated” enough evidence to invoke Section 16 and is of the view that the accused be ordered to reside at the Grand River Hospital because he is not assured that the safety of the public will be maintained if the defendant is released and resides at the Kitchener House of Friendship.

The judge outlines the conditions. The defendant is 1) prohibited from the possession, consumption, ingestion of alcohol or illegal drugs, 2) he must reside at the Grand River Hospital and to remain on the grounds at all times, 3) he is prohibited to posses firearms, and 4) the defendant must keep the peace and demonstrate good behavior.

The judge asks the accused if he accepts those terms and the defendant nods his head which is interpreted by the judge as “yes” (for the record). The judge thanks everyone and signs the Form 2. He wishes the defendant good luck and the police officer transports the defendant out of the jail box and behind closed doors. The case is closed and The Kitchener Mental Health Court is adjourned for the day.

Case Example Two
The Kitchener Mental Health Court
May 27, 2007
Courtroom 101

This case involves a 39 year-old homeless man. He has been charged with one count of physical assault. He stands in the prisoner's box, hand-cuffed. His clothes are tattered and he appears despondent.

The Crown begins by outlining the details of the case. The defendant was approached by two young women while driving in their vehicle at the intersection of Highland Road West and Belmont Road near a local coffee shop. Once they stopped their vehicle to park at the coffee shop, one of the women got out of her vehicle and approached the defendant to ask him if he would like a cigarette. When she approached the defendant he proceeded to kick her in the thigh while shouting "get the fuck away from me." After the assault, the victim called the police who arrested the defendant. He has been in custody since last Friday and has a prior conviction from 2004 for assault.

The Crown explains to the judge that the defendant's current health is poor and his articles of clothing have adhered themselves to his body, requiring them to be removed by scissors. The defense intercepts and argues that, according to the defendant's previous legal aid lawyer, the defendant is doing much better. He has stated that he wants to be compliant, and there has been a three-year gap since his last conviction.

The judge asks the defense attorney if there is any support from the community at this time and if the defendant has any sources of income. The defense replies that the defendant did receive, at one time, a pension administered by his father and a \$50 dollar per month allowance which was deposited into the defendant's bank account. The defendant did have a steady family doctor and a psychiatrist approximately four or five years ago but is no longer seeing either of them.

The judge is now addressing the defendant. He asks, "How do you support yourself day to day?" The defendant responds, "By soup kitchen". The judge also addresses the issue of hygiene which he wants taken care of by community services. The defense further explains to the judge that the defendant, for four or five years, resided at the Kitchener House of Friendship but

last month he went back to the streets. The judge asks the Crown and defense about whether or not there is support from the community and, specifically, asks the defendant what kind of support he thinks he needs (for example a doctor or employment). The defendant is unresponsive.

The judge asks the defense attorney whether or not the defendant has contact with family or friends. The defense responds that no one supports the defendant at this time. The CMHA Court Coordinator stands and addresses the judge. He would like to offer help to the defendant if he is willing. The Crown suggests that perhaps the Salvation Army Major could also help to provide clothing and basic hygiene services (e.g., a shower).

In this case, the Crown is asking for a suspended sentence with a reporting term to see a psychiatrist and probation for one year. She is also requesting a DNA sample be taken because of the defendant's history with assault. An order for a DNA sample is under Section 510 of the Canadian Criminal Code and is kept on record for five years.

The judge turns to the defendant and asks him to agree to meet with the CMHA Court Coordinator and the Salvation Army Major. The Judge seems very concerned with what he calls the defendant's "independent lifestyle" and lack of support network. He is also concerned about the defendant spending five days in the Maplehurst Correctional facility and its potential effects on his psychological state, in addition, how he will cope living in the community.

After the judge raises his concerns to the court he sentences the defendant. The sentence includes several conditions which the defendant must comply to. These conditions include: a) 12 months probation, b) to notify the court of any address changes, c) to sign the probation order, d) a prohibition against weapons, illegal drugs (unless prescribed), or alcohol, e) to attend a counseling program as prescribed by the probation officer, and f) to submit a DNA sample.

The judge wishes the defendant good luck and the defendant is removed from the prisoner box to behind closed doors by the court officer. The case is closed and the Kitchener Mental Health Court is adjourned for the day.

5.8 A Critique of the Kitchener Mental Health Court

Observations of the Kitchener Mental Health Court and interviews with its respective stakeholders reveal a general enthusiasm and support for the system. The Kitchener Mental Health Court appears to be effectively diverting accused persons with mental disorders away from incarceration and into mental health treatment programs. As stated by the CMHA Court Coordinator:

We did not spend a lot of time studying how to set [the mental health court] up or in creating the perfect system. Basically we learned as we went along.

The Crown, similarly, remarks:

The mental health court is a great step and tool but only that. It is not the solution but a way towards the goal.

The Kitchener Mental Health Court is not without its shortcomings, however. The research data reveals that this court faces its own set of challenges which include: 1) funding issues; 2) conflict between stakeholders; and 3) problems facing family members of mental health court clients. The difficulty appears to stem from two major social systems attempting to work together but also attempting to adhere to their own goals and mandates.

(A) Funding Issues

The Kitchener Mental Health Court is funded by two main agencies: The Attorney General's Office and The Ontario Ministry of Health and Long-Term Care. The Ontario Legal Aid Society provides funding for Duty Counsel.

Respondents identified two major areas that require additional funding: psychiatric services and forensic beds. The Kitchener Mental Health Court is seeking a designated psychiatrist who will work for the court permanently to conduct assessments on-site at local hospitals. Presently, the court does not have any psychiatrists on staff but funding is anticipated through the local hospital. Designated psychiatrists would allow the Kitchener Mental Health

Court to accept more serious criminal cases. Furthermore, psychological assessments could be made immediately once the individual is brought to the attention of the mental health court. Immediate assessments would diminish court backlog and quicken the court process for the accused and allow for speedier access to treatment. For instance, the observations reveal that the court process is marked by time lags in court proceedings (i.e., the amount of time between cases) which create noticeable frustration for the judge, Crown, defense and community support workers. Although telepsychiatry is helpful, the geographical distance between facilities slows the proceedings and mental health assessments overall. The Salvation Army representative remarks:

This process is very wearing and there are a lot of days when there are long gaps between cases because people have failed to show up to court or there is some delay.

In addition, the observation data reveal that defendants who fail to appear in court hamper the Kitchener Mental Health Court process. In many instances, the defense has to defend his client's whereabouts, attempt to locate his client, or ask the court clerk to page clients who have not yet appeared. Unfortunately, judges become frustrated by the inability to locate the defendant and will issue a warrant for the individual's arrest thereby adding additional charges to the accused. In one case, the accused did not have the financial means to be transported back to the Waterloo Region. Under these types of circumstances, one of the community support agencies will provide financial assistance to ensure the individual is brought back to court and does not face additional charges. This demonstrates how community support agencies provide resources to facilitate the court process and assist clients.

The second major need for funding, according to respondents are long-term beds. Four interview participants remarked that the Kitchener-Waterloo region does not have an adequate number of forensic beds available to the mental health court. As a result, mental health clients must be transported to other facilities out of town. Again, this impedes the assessment process and slows the overall mental health court system. According to the Crown, funding is anticipated for a local hospital to receive upwards of 50 long-term beds.

At this point, there are no long-term beds in our region. People must go to London. This would help families a lot by cutting down on travel time. This will help us perhaps to send people for immediate assessment or medication.

Additional funding of mental health resources within the community would ensure that the appropriate treatment is immediately available and easily accessible to offenders, their families, and mental health court system.

(B) Conflict Between Stakeholders

In order for the Kitchener Mental Health Court to operate effectively, court workers and community support agencies must work together collaboratively in order to accommodate and treat offenders within the community. Each stakeholder recognizes his or her role in the process, within the courtroom setting, and behind-the-scenes. It is a multidisciplinary approach that involves a variety of individuals with different occupational roles and mandates.

Understanding each others role in the mental health court process requires respect, patience and confidence in one another's abilities and decisions. Although the interdisciplinary nature of this setting is beneficial to the overall effectiveness of this court, each of the participants identified concerns regarding the roles and procedures of other stakeholders. For example, mental health workers are not always familiar with the *Criminal Code* and criminal justice system. The Crown comments:

One of the disadvantages or limitations of working with community support agencies is that they don't always understand that we are bound by the law. For example, I am bound by confidentiality and privacy laws or I make a decision and the community agency will ask me, "Why are you asking for probation or eligibility for diversion?" and I have to explain the nature of the defense.

At times, decisions are questioned by different parties which result in conflict. Learning the boundaries of each stakeholder, including their ability to help within their professional confines, can impede on the mental health court process. That is to say, stakeholders share the same goal (i.e., to provide treatment to the offender and to afford the offender appropriate consideration under the law), however, the means by which this goal is achieved differs according to the one's

role in the system (i.e., court and mental health system). The CMHA Court Coordinator states:

I don't always agree with the Crown and I get frustrated with the defense who often only want the best result for their client. That means the most lenient sentence and no jail time. Often this means that offenders get out too soon without any assistance or community support.

Clearly, the legal system and mental health system must work according to their own institutional goals and mandates which result in occasional conflict between the two parties. The CMHA Court Coordinator recognizes the challenges facing the system in which he works. He identifies several of the CMHA's concerns relating to mental health services during the interview such as: 1) how substance abuse complicates the case management process; 2) the limited availability of case managers to handle the volume of mental health patients; 3) the lack of reporting function back to the courts in cases in which the accused is not eligible for diversion; and 4) how the mental health system intends to deal with persons with mental disorders who become overly dependant on formal mental health treatment supports within the community. These are issues which are more likely to be effectively dealt with by the mental health system. Once these issues are addressed, it is then up to the mental health courts to make adjustments accordingly in order to satisfy its own institutional objectives. Until that time, the legal system and mental health system must patiently work together to resolve these conflicts.

(C) Families of Mental Health Court Clients

An interview with a family member of a mental health court client reveals that family members experience great frustration with mental health court system if they decide to remain supportive throughout the legal process. A mother of one of the accused explains:

The parents under this system always pay the price. My son has been stigmatized because of his disorder and it isn't his fault because he became this way after a car accident when he was young. I am always calling the police because that is what the court tells me to do but they just throw him in jail. I called his caseworker to talk to him about the food spoilage in my son's apartment and their response was that due to backlog they couldn't get anyone out to monitor him. Ten years have gone by and I have lost my job, my husband has given up and I am in financial ruins.

She angrily states:

The mental health court is a bullshit system and people like me give up or don't want to be stigmatized themselves or called "crazy".

Arguably, family members who choose to support their loved one's face a different set of challenges. The mother of the accused interviewed repeatedly approached the Crown and CMHA Court Coordinator over the course of months to ask questions regarding her son's case. When interviewed, she comments:

No one wants to speak to me. I keep getting re-directed by the courts. I am confused about what is happening with my son and no one has any answers for me.

Other courtroom observations expose the frustration of families who have loved ones in the mental health court system. Family members who sat in the courtroom would approach the Crown, defense attorneys, CMHA Court Coordinator, and CSA workers asking for advice and direction with respect to obtaining representation, providing surety, and connecting with treatment support agencies. There appears to be a level of disconnect, from the perspective of families, between the court system and mental health system despite interview responses from the Crown, defense, and CMHA Court Coordinator. These three respondents, clearly, empathize with families and they want to work with them to help the accused. The defense explains:

Families contact me to tell me how things are going and to express how frustrated they are, and that they don't know what to do.

He further comments that one of the challenges facing family and caretakers is that:

Families don't always understand what resources are available under these circumstances. They struggle to understand that the criminal justice system is not necessarily there to help persons with their problems. The criminal justice system is there to hold the individual accountable for their behavior under the circumstances. The criminal justice system can't fix people. We can only assess if a person is responsible for conduct (by act and intent) and the consequences for that.

The CMHA and other CSAs argue that they provide services to families of mental health court clients. Perhaps the limited availability of case management, as remarked by the CMHA Court Coordinator, is one of the contributing factors to the disconnect between families and mental

health system and mental health court system. Or perhaps the families' frustration and confusion is an intrinsic part or inevitable outcome of a regular person (i.e., an individual with no expertise in mental health or law) attempting to navigate two complex social systems (i.e., the mental health system and legal system).

5.9 Conclusion

This chapter discusses the role that community support agencies play in facilitating the mental health court process. This chapter discussed the research findings which included: a) a description of the characteristics of mental health court clients; b) the types of proceedings, charges, and dispositions; c) the factors influencing the criminal behavior of mental health court clients; and d) mental health courtroom behavior. The latter portion of this chapter discussed and focused on three major themes which have emerged around the role of CSAs. These include the following: a) the role of the Crown and defense attorneys; b) the role of CSAs within the mental health court including the provision of resources; and c) knowledge sharing. Following this discussion, a critique of the Kitchener Mental Health Court system was provided. Two case examples were included in this chapter to illustrate the mental health court processes under examination.

The overall findings reveal that mental health courts require community support agency involvement to function. The legal system is bound by procedural rules that limit the degree to which it can carry through treatment to persons with mental disorder in order to reduce recidivism and protect public safety. Court workers must work within the confines of the law and uphold their professional obligation to the legal system and offender. However, professional obligations place restrictions on their capacity to address all issues facing persons with mental disorders. The mental health court has been established so that it can work with community health agencies to provide persons with mental disorders with support services. In essence community support

agencies provide the support systems that allow the courts to employ alternative measures, avoid incarceration, and divert mentally disordered offenders into treatment programs.

CHAPTER 6: Conclusion

6.1 Summary of Findings

This research investigates how the Canadian criminal justice system handles persons with mental disorders who come into conflict with the law. The goal of this study is to provide an analysis of the diversion process including the legal procedures and key players required for diverting offenders away from incarceration and placing them into appropriate mental health treatment.

The researcher conducted a single-site examination of the Kitchener Mental Health Court (Courtroom 101) which is located at the Ontario Court of Justice, a provincial criminal division, at 200 Frederick Street Kitchener, Ontario, Canada. The study employed a combination of unobtrusive observations of the mental health court over a six-month period and semi-structured in-depth interviews with the Crown prosecutor, defense attorney, CMHA Court Coordinator, Salvation Army representative, and a mother of one of the accused.

The findings from this research reveal that the majority of Kitchener Mental Health Court clients are male and between the ages of 20 to 40 years old and suffer from schizophrenia or bipolar mood disorder. The most common types of criminal charges are breach of probation and assault and the majority of cases result in probation sentences. The analysis also suggests that the four most prevalent contributing factors to criminal behavior and re-arrest are homelessness, treatment and compliance issues with respect to medication, lack of family support, and substance abuse.

The treatment ideologies within the medical model and therapeutic jurisprudence are evident in mental health court practices through an examination of language used by different stakeholders to describe components of the mental health court system. The Kitchener Mental Health Court is guided according to the principles of these theoretical frameworks each of which prioritize the appropriate treatment of offenders via a therapeutic, empathetic approach. The

courts recognize and understand that criminal behavior is often the result of mental health issues and not deliberate criminality. This is demonstrated through lenient sentencing which guarantees legal accountability for criminal activity while, at the same time, an opportunity for offenders to receive treatment for their conditions within the community. This objective is made possible by the court's partnership with mental health agencies who locate and provide the support and treatment for diverted offenders.

The most significant finding, however, is the role that community support agencies play within the courtroom setting and behind-the-scenes. The study finds that CSAs fulfill a variety of crucial roles in the mental health court system. CSAs help to ensure due process by acting as neutral third parties. They make certain that mental health court clients voluntarily consent to participating in the diversion program and they are afforded the legal right to obtain information from clients when privacy and confidentiality laws restrict legal professionals. CSAs are responsible for locating and providing mental health treatment through their extensive knowledge of available resources within the community. CSAs are also committed to educating and enlightening the public and legal professionals about mental disorder, its effects on the individual and family/caretakers, and directing people to available resources.

This research provides sufficient evidence to argue that mental health courts cannot successfully function without the existence of community support agencies. They are integral to facilitation of diversion programs for persons with mental disorders and critical to the efficacy of specialized courts.

6.2 Limitations of the Research Study

The limitation of this research is its scope of inquiry. Because of time and financial restraints this research was limited to a single-site study of the Kitchener Mental Health Court. Interviews with mental health court clients were not possible due to legal concerns. In addition,

the limited scope and design of the study does not allow any evaluation of the effectiveness of mental health courts or their impact on recidivism rates.

6.3 Recommendations for Future Research

This research is a first step towards understanding the mental health court system including its various processes and stakeholders. After careful analysis of the data, it is clear that four major areas require further attention and investigation. These four areas of research include: 1) funding; 2) the role of family and caretakers; 3) the role of victims; and 4) the role of community support agencies.

The research reveals that the Kitchener Mental Health Court faces funding issues with respect to hospital beds for assessments and a designated mental health court psychiatrist. It would be beneficial to conduct further research in order to determine the number of current funding agencies and the nature of those organizations including their mandates and goals. The research should also attempt to determine how funding is allocated and the criteria for allocation. If the research can identify the level and nature of current funding, perhaps it can determine what funding gaps exist. Once these gaps become visible, researchers can explore potential areas for new funding opportunities for the mental health courts and present the findings to policy makers and government funding agencies in the hopes of placing more resources into the system.

Additional research is required to investigate the role of family and caretakers. It is important to research their perceptions, opinions, and experiences of the mental health court system because they too are affected by its outcomes. Family and caretakers play an integral part in the diversion process and it is vital that the mental health court and mental health system be made aware of their needs. That is to say, research should be directed at determining what resources are available to family and caretakers and which resources are the most helpful or heavily utilized, and which resources they require that do not already exist. For instance, is there sufficient literature outlining the mental health court process? Are there step-by-step guidelines

for family members and caretakers to follow on how to locate legal representation or what actions are appropriate or inappropriate under certain circumstances (e.g., “Should I speak to the Crown about my son or daughter’s case or could that put his/her case in jeopardy?” and “Should I call the police every time my partner has a manic episode?”).

Along the same lines, the role of victims should be examined closely as well. The bulk of the literature discusses the benefits of diversion for offenders but fails to address the advantages and disadvantages of diversion for victims. The legal system attempts to reduce the number of persons with mental disorders from being incarcerated for summary offences and provides a therapeutic approach as the solution. At the same time, the Crown is obligated to protect the interests of society while the defense works in the best interest of his or her client. But, are the victims satisfied with mental health court outcomes? The research must begin to address their experiences and perceptions of the mental health court system to determine what resources they need (e.g., victim counseling) and to measure the courts effectiveness in satisfying its obligation to protect victims.

Extensive research should be conducted with respect to the community support agencies that work with the mental health court system. It would be valuable to conduct in-depth analyses of the various organizations and to investigate how they adjust their objectives in order to accommodate the courts and how they determine the allocation of their resources. It cannot be assumed that community support agencies are working solely for specialized courts. They have responsibilities in other areas and must satisfy their organizational objectives and mandates which are separate from their involvement in the mental health court system. Interviews should be conducted with key individuals from community health and support agencies to explore the challenges of working with the legal system and to determine how the health and legal system can improve their relationship, thereby, reducing the level of disconnect which was apparent in the findings of this study.

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Appendices

Appendix A: Research Proposal

University of Waterloo

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RESEARCH PROPOSAL—THE MENTAL HEALTH COURT

Project Description

This is a pilot study that will examine the manner in which the criminal justice system deals with offenders with mental health problems. The research will investigate the establishment of the Kitchener Mental Health Court including the laws under which it functions, the philosophy of the court, principles of sentencing, the involvement of community mental health personnel, the protection of society, diversionary programs, and the role of the accused, judge, defense attorney, and Crown prosecutor.

The study aims to analyze the types of problems dealt with in Mental Health Courts, issues related to due process, relevant laws and significant sociological and legal issues in relation to how offenders with mental health problems are identified, how legal rights and treatment needs are addressed, and the use of community treatment orders. The study will also examine the role of community agencies in the social control and treatment of offenders with mental health problems.

Research Methodology

The Kitchener Mental Health Court was established in the summer of 2005 and currently meets each Tuesday. This is the second court of its kind in the Province of Ontario (Toronto also operates a mental health court) and was established to deal with offenders suffering from mental disorders, intellectual impairments, or brain injuries. The court is intended to prevent mentally disordered persons from languishing in jail and to link them with community agencies and psychiatric services so they can be provided with treatment, have their medications monitored, and offered assistance with accommodation and employment.

The research will gather data through two main strategies: interviews with various officials in the criminal justice and mental health system; and observation of legal proceedings in the Kitchener Mental Health Court.

The researcher will attend and observe sessions of the Kitchener Mental Health Court. Interviews will also be conducted with a Crown attorney, defense attorney, and mental health professional.

Appendix B: Information Letter and Consent Form

University of Waterloo

Carlie L. Leroux
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INFORMATION LETTER FOR INTERVIEW STUDY—THE MENTAL HEALTH COURT

Dear Participant,

This letter is an invitation to participate in a study on the manner in which persons with mental health problems are handled in the criminal justice system.

Project Description

This is a pilot study that will examine the manner in which the criminal justice system deals with offenders with mental health problems. The research will investigate the establishment of the Kitchener Mental Health Court including the laws under which it functions, the philosophy of the court, principles of sentencing, the involvement of community mental health personnel, the protection of society, diversionary programs, and the role of the accused, judge, defense attorney, and Crown prosecutor.

The study aims to analyze the types of problems dealt with in Mental Health courts, issues related to due process, relevant laws and significant sociological and legal issues in relation to how offenders with mental health problems are identified, how legal rights and treatment needs are addressed, and the use of community treatment orders. The study will also examine the role of community agencies in the social control and treatment of offenders with mental health problems.

Participation in this study is voluntary. It will involve periodic interviews at your time and convenience. You are free to decline to answer any of the interview questions if you so wish. Further, you may decide to withdraw from this study at any time by advising the researcher.

All information provided will be treated as strictly confidential and will be used for research purposes. No names will be used in the final research report. With your permission, anonymous quotations may be used. All data will be kept in a secure place throughout the study. Only research assistants associated with the project will have access. There are no known anticipated risks to you as a participant.

If you have any questions regarding this study, or would like additional information to assist you in reaching a decision about participation, please contact me at (519) 888-4567 X 32421, (519) 721-5589, or my e-mail at clleroux@artsmail.uwaterloo.ca.

This study has been reviewed and has received ethics clearance through the Office of Research Ethics at the University of Waterloo. The final decision about participation is yours. If you have any comments or concerns resulting from your participation in this study, please contact Dr. Susan Sykes of this office at (519) 888-4567 X 6005.

It is my hope that the study will be of benefit to organizations directly involved in the study as well as the broader research community.

Thank you for considering participating in this project.

CONSENT FORM

Consent of Participant

I have read the description of the research project dealing with the Mental Health Court being conducted by Carlie L. Leroux under the supervision of Dr. Frederick Desroches, Director of Legal Studies and Criminology, St. Jerome's University, University of Waterloo. I have had the opportunity to ask any questions related to this study, to receive satisfactory answers to my questions, and any additional details I require. I am aware that I may withdraw from the study without penalty at any time by advising the researcher of this decision.

This project has been reviewed by, and received ethics clearance through the Office of Research Ethics at the University of Waterloo. I was informed that if I have any comments or concerns resulting from my participation in this study, I may contact the Director, Office of Research Ethics at (519) 888-4567 X 6005.

With full knowledge of all foregoing, I agree, of my own free will, to participate in this study.

Print Name

Signature

Date

Witness

Appendix C: Interview Questions

The Mental Health Court: Interview Questions

MHC: General Questions

How long have you worked with the mental health court and why did you become involved?

What do you see as the purpose of the mental health court?

How does the mental health court serve the community and the accused?

What are the roles of the judge, Crown prosecutor, defense, and community service agencies and how are the roles different from the traditional criminal court?

What legal issues arise in the mental health court (e.g., voluntariness vs. coercion) and are there critics?

How is 'mental disorder' defined and by whom? Is there any resistance by the accused to assume this role?

MHC: The Accused

At what point do you come into contact with the accused?

What is the process you engage in once the accused has been referred to the mental health court? Specifically, what are your duties and responsibilities to the accused?

Are there any special challenges you face working with persons with mental disorder that differ from regular criminal offenders?

What are the benefits of the mental health court for the accused? Are there any disadvantages to the accused partaking in the mental health court diversionary program?

MHC: Outside Community Support Services

In what capacity do you work alongside community support services? What are these services?

What makes the community support services work?

What are the benefits of working with the community? Are there any disadvantages and or challenges?

Do community support services and/or the court offer follow-ups?

Which services are most crucial to the mental health court (specifically for the accused) and why are these services most crucial?

Who funds the mental health court? Are there any funding issues?

How do you perceive the community support services willingness to co-operate with the mental health court?

Have you experienced any resistance from community support services?

MHC: Family and Caretakers

How does the mental health court handle the family and caretakers of the accused?

If ever, do you come into contact with family/caretakers of the accused? If yes, what is your role, duties and responsibilities to them? If no, are there any mental health court workers/teams who are responsible for handling this area?

If known, what are some of the challenges facing/caretakers of the accused?

MHC: Challenges and Future Direction

In general, what are some of the challenges the mental health court faces to-date?

Are there ways in which the mental health court could improve? If yes, how so?

Where do you see the mental health court in 5 to 10 years?

Appendix D: Mental Health Court Forms

Reproduced Copy of Form 2

Source: The Ontario Central Forms Repository at

([http://www.forms.ssb.gov.on.ca/mbs/ssb/forms/ssbforms.nsf/AttachDocsPublish/014-6428-41~1/\\$File/6428-41_.pdf](http://www.forms.ssb.gov.on.ca/mbs/ssb/forms/ssbforms.nsf/AttachDocsPublish/014-6428-41~1/$File/6428-41_.pdf))

Ministry
of
Health

Form 2
Mental Health Act

**Order for Examination
under Section 16**

To the police officers of Ontario.

Whereas information upon oath has been brought before me, a justice of the peace in and for the province of Ontario

by _____

(print full name of persons bringing information)

of _____

(address of person bringing information)

in respect of _____

(print full name or other description of person to be examined)

of _____

(home address, if known)

Part A or B must be completed

Part A- Subsection 16 (1)

Information has been brought before me that such person

has threatened or attempted or is threatening or attempting to cause bodily harm to himself or herself;

has behaved or is behaving violently towards another person or has caused or is causing another person to fear bodily harm from him or her; or

has shown or is showing a lack of competence to care for himself or herself.

In addition based upon the information before me I have reasonable cause to believe that the person is apparently suffering from mental disorder of a nature or quality that likely will result in,

serious bodily harm to the person;

serious bodily harm to another person;

serious physical impairment of the person.

Part B- Subsection 16 (1.1)

Information has been brought before me that such person

a) has previously received treatment for mental disorder of an ongoing or recurring nature that, when not treated, is of a nature or quality that likely will result in serious bodily harm to the person or to another person or substantial mental or physical deterioration of the person or serious physical impairment of the person; and

b) has shown clinical impairment as a result of the treatment;

In addition based upon the information before me I have reasonable cause to believe that the person,

c) is apparently suffering from the same mental disorder as the one for which he or she previously received treatment or from a mental disorder that is similar to the previous one;

d) given the person's history of mental disorder and current mental or physical condition, is likely to

cause serious bodily harm to himself or herself;

cause serious bodily harm to another person;

suffer substantial mental or physical deterioration of the person, or

suffer serious physical impairment of the person; and

e) is apparently incapable within the meaning of the Health Care Consent Act, 1996 of consenting to his or her treatment in a psychiatric facility and the consent of his or her substitute decision-maker has been obtained.

Now therefore, I order you, the said police officers, or any of you, to take the said person in custody forthwith to an appropriate place for examination by a physician.

(date of signature)

(Municipality where order signed)

(signature of Justice of Peace)

(print name of Justice of Peace)

Notes for Applicant/ Informant

- 1. You may wish to provide your telephone number on this form so that you can be contacted by the police or the examining physician after this order is issued. This is entirely voluntary. ***You are not required to give this information for the order to be issued or for the order to be legally valid.***

(print name)

(telephone number)

- 2. You may wish to seek legal advice concerning this order, including the effect of this order and your legal rights.
- 3. You may wish to inform the police, the examining physician and/or an appropriate health care professional of the evidence you gave to the justice of peace, if you consider it appropriate in all the circumstances to do so. If you decide to do so, please use the space provided below. Use the back of this form if necessary. ***You are not required to give information for the order to be issued or for the order to be legally valid.***

Reproduced Copy of Form 8

Source: The Ontario Central Forms Repository at

([http://www.forms.ssb.gov.on.ca/mbs/ssb/forms/ssbforms.nsf/AttachDocsPublish/014-1980-41~1/\\$File/1980-41E_.pdf](http://www.forms.ssb.gov.on.ca/mbs/ssb/forms/ssbforms.nsf/AttachDocsPublish/014-1980-41~1/$File/1980-41E_.pdf))

Ministry
of
Health

Form 8
Mental Health Act

**Order for Admission
Subsection 22 (1) of
the Act**

In the _____ held at _____
(name of court) (address)

TO the Peace Officer in the _____ of _____

AND TO _____
(name of psychiatric facility)

WHEREAS _____
(name of person in full)

(address)

is a person in custody charged with _____
(offence)

contrary to section _____ of the _____

AND WHEREAS he/she has appeared before me and I have reason to believe that she/she suffers from mental disorder;

AND WHEREAS I have ascertained from

(name of senior physician, as defined in the Act)

the senior physician of _____
(name of psychiatric facility)

that the services of the said psychiatric facility are available to the above-named person;

I HEREBY ORDER that the above-named person be remanded for admission as a patient to the said psychiatric facility for a period of not more than

AND I FURTHER ORDER and direct you, the said Peace Officers, or any of you, to convey him/her to the said psychiatric facility;

AND I AUTHORIZE you, the authorities at the said psychiatric facility, to admit him/her in accordance with this order.

(Judge)

Date _____
(day/ month/ year)

Appendix E: Mental Health Court Diversion Legislation and Crown Policy Manual (2005)

Reproduced First Page of Crown Policy Manual (2005)

Source: (<http://www.attorneygeneral.jus.gov.on.ca/english/crim/cpm/default.asp>)

PROVINCE OF ONTARIO
MINISTRY OF ATTORNEY GENERAL

CROWN POLICY MANUAL

March 21, 2005

MENTALLY DISORDERED/DEVELOPMENTALLY DISABLED OFFENDERS

PRINCIPLES

Mentally disordered or developmentally disordered people often come into contact with the criminal justice system. These offenders should not be subjected to more onerous consequences than the general population, solely as a function of their disorder/disability.

In recognition of their particular circumstances, mentally disordered or developmentally delayed offenders may warrant special consideration within the criminal justice system, depending on the nature and circumstances of the offence and the background of the offender. This may require an emphasis on restorative and remedial measures, such as specialized treatment options, supervisory programs or community justice programs, as alternatives to prosecution. To the extent consistent with public safety, and in appropriate circumstances, offenders with mental disorders, and those who are developmentally delayed, should be given access to alternatives to prosecution.

Protection of the public, including the victim, if any, is the paramount consideration in the assessment of whether alternatives to prosecution are appropriate. No single factor will be determinative; however Crown counsel should consider the seriousness of the offence, public safety, and whether the consequences of prosecution would be unduly harsh, among other factors.

3. Eligibility of Offences

- a. ***Offences that are not eligible*** (also known as Class III for purposes of other practice memoranda)

The following classes of offences will not be eligible for treatment plans or supervisory programs as an alternative to prosecution, regardless of the circumstances of the alleged offence or the accused:

- **murder, manslaughter, infanticide, criminal negligence causing death;**
- **causing death or bodily harm by dangerous or impaired driving;**
- **any offence causing serious bodily harm;**
- **simple impaired driving or driving with a prohibited blood alcohol concentration;**
- **offences involving firearms;**
- **criminal organization offences;**
- **kidnapping;**
- **spouse/partner offences [1]**
- **child abuse;**
- **offences involving child pornography**
- **sexual offences including sexual assault, interference and exploitation, invitation to sexual touching and incest;**
- **specific hate offences [2]**
- **home invasions;**
- **perjury;**

- b. ***Offences that are presumptively eligible*** (also known as Class I for purposes of other practice memoranda)

The following offences are presumptively eligible for consideration, depending on the circumstances of the offence and the accused, especially for, but not necessarily restricted to, first offenders:

- theft and possession under \$5000
- joyriding
- mischief under \$5000
- fraud and false pretenses under \$5000
- food, travel and accommodation frauds
- causing a disturbance

- c. ***Other offences*** (also known as Class II for purposes of other practice memoranda)

All other offences are eligible in the discretion of Crown counsel. The decision about eligibility will depend on Crown counsel's assessment of:

- the circumstances of the offence;

- the circumstances of the accused, and
- the needs of the community, including the victim.

The more an offence resembles an ineligible offence, the less likely it is to be acceptable for a program of treatment or supervision. The more it resembles a presumptively eligible offence, the more likely it is to be acceptable.

Minor non-spouse/partner assaults (i.e. without injuries or weapons) and property offences where the value in question does exceed \$5000 are examples of the kinds of charges that may be acceptable. Offences involving greater violence and/or injury or offences in which a weapon was used will not usually be suitable for diversion to a treatment or supervisory program as an alternative to formal criminal court proceedings.

Section 717 of the Canadian *Criminal Code*: Alternative Measures Legislation

Source: Part IV LITIGATION FRAMEWORK Chapter 14 of the “The Federal Prosecution Service Deskbook” at <http://www.justice.gc.ca/eng/dept-min/pub/fps-sfp/fpd/ch14.html>

When alternative measures may be used

717. (1) Alternative measures may be used to deal with a person alleged to have committed an offence only if it is not inconsistent with the protection of society and the following conditions are met:

- (a) the measures are part of a program of alternative measures authorized by the Attorney General or the Attorney General's delegate or authorized by a person, or a person within a class of persons, designated by the lieutenant governor in council of a province;
- (b) the person who is considering whether to use the measures is satisfied that they would be appropriate, having regard to the needs of the person alleged to have committed the offence and the interests of society and of the victim;
- (c) the person, having been informed of the alternative measures, fully and freely consents to participate therein;
- (d) the person has, before consenting to participate in the alternative measures, been advised of the right to be represented by counsel;
- (e) the person accepts responsibility for the act or omission that forms the basis of the offence that the person is alleged to have committed;
- (f) there is, in the opinion of the Attorney General or the Attorney General's agent, sufficient evidence to proceed with the prosecution of the offence; and
- (g) the prosecution of the offence is not in any way barred at law.

Restriction on use

(2) Alternative measures shall not be used to deal with a person alleged to have committed an offence if the person

- (a) denies participation or involvement in the commission of the offence; or
- (b) expresses the wish to have any charge against the person dealt with by the court.

Admissions not admissible in evidence

(3) No admission, confession or statement accepting responsibility for a given act or omission made by a person alleged to have committed an offence as a condition of the person being dealt with by alternative measures is admissible in evidence against that person in any civil or criminal proceedings.

No bar to proceedings

(4) The use of alternative measures in respect of a person alleged to have committed an offence is not a bar to proceedings against the person under this Act, but, if a charge is laid against that person in respect of that offence,

(a) where the court is satisfied on a balance of probabilities that the person has totally complied with the terms and conditions of the alternative measures, the court shall dismiss the charge; and

(b) where the court is satisfied on a balance of probabilities that the person has partially complied with the terms and conditions of the alternative measures, the court may dismiss the charge if, in the opinion of the court, the prosecution of the charge would be unfair, having regard to the circumstances and that person's performance with respect to the alternative measures.