# People Living with a Mental Health Condition in the Criminal Justice System

A Justice Reform Initiative Briefing Paper

October 2025

**Suggested citation:** Schetzer, L & Sotiri, M (2025) People living with a Mental Health Condition in the Criminal Justice System, Justice Reform Initiative, Australia.

A Justice Reform Initiative Briefing Paper

# People Living with a Mental Health Condition in the Criminal Justice System

October 2025

# Contents

**Introduction** 6

**Policing people with mental illness** 8

The need for a health-first response 8

Police discretion – an opportunity to de-escalate and divert 10

Police and mental health co-responder models 10

**Difficulties for people with mental illness in obtaining bail** 11

**Court-based diversion for people with mental illness** 12

In-court diversion programs 12

Specialist courts for people with mental illness 12

Community justice courts 13

**Sentencing options for people with mental illness** 14

**People with mental illness in custodial settings** 15

Access to healthcare and mental health programs in prison 15

**People with mental illness leaving prison** 17

**Conclusion** 18

**Appendix A: police and mental health co-responder models** 19

Australian models 19

*Police, Ambulance and Clinician Early Response (PACER) ACT, NSW, Tasmania* 19

*Mental health and police, Victoria* 19

*Mental health co-responder models – South Australia, Western Australia, Queensland, Northern Territory* 20

USA models 20

*Cahoots (Crisis Assistance Helping Out On The Streets), Eugene, Oregon* 20

*The Behavioral Health Emergency Assistance Response Division - B-HEARD, New York City* 21

*Portland Street Response, Portland Oregon* 21

*Street Crisis Response Teams, San Francisco, California* 21

**Appendix B: specialist courts for people with mental illness** 22

Australian models 22

*Victoria - Assessment and Referral Court (Victoria)* 22

*Special Circumstances List, Melbourne Magistrates' Court (Victoria)* 23

*Start Court (Western Australia)* 23

*Special Circumstances Court, Brisbane Magistrates' Court (Queensland)* 24

International models 24

*Brighton Mental Health Court and Stratford Mental Health Court (UK)* 24

*United States Of America* 25

*The Bronx Mental Health Court* 25

*Brooklyn Mental Health Court* 26

# Introduction

**People living with mental illness are significantly over-represented amongst those who have contact with the criminal justice system.[1] Disproportionately high rates of people with mental illness are arrested by police, appear before the courts, and are incarcerated in prisons. This does not mean that people who live with mental illness are more likely to commit crimes or are more pre-disposed to criminal behaviour. People with mental illness are more likely to come to the attention of police, sometimes because their illness requires intervention, and sometimes because of compounding factors that intersect with the experience of mental illness.**

Mental illness is often related to other factors of disadvantage and hardship, such as homelessness, poverty, family violence and substance abuse. In addition, the absence of appropriate and tailored support and mental health services increases the likelihood of contact with the criminal justice system. When complex and multiple disadvantages occur simultaneously, this can have a profound impact on mental health and wellbeing and increase the likelihood of contact with the justice system.[2]

> **The inability to access appropriate and tailored mental health services in order to live and thrive in the community is a key causal factor in the over-incarceration of people with mental health conditions.**

A lack of crisis mental health services contributes to an increased reliance on the police to respond to people experiencing mental illness or psychological distress, and a lack of supported accommodation options in the community contributes to the overuse of pre-sentence incarceration.

Australian prisons are disproportionately filled with people who experience mental illness. **40%** of people incarcerated in Australian prisons have a history of mental illness and **21%** have a history of self-harm.[3] Incarcerated women report even higher rates of mental illness. According to the Australian Institute of Health and Welfare (AIHW), based on information collected from 117 women as they entered prison, **65%** said that they had one or more diagnosed mental illnesses and **31%** reported a history of self-harm.[4] Figures collected by AIHW do not include people who do not identify with a diagnosis, have been misdiagnosed, never diagnosed, or who are undiagnosed. Almost **1 in 4 people** in prison are currently taking mental health-related medication.[5]

Not only are prisons across Australia disproportionately filled with people who experience mental illness; these same institutions also cause mental illness in people who did not previously experience it and can exacerbate mental illnesses for those people in prison who were previously managing their illness. Of people who were leaving prison who were surveyed in 2018, **1 in 10 men** (10%) and **1 in 12 women** (8%) reported their mental health had *deteriorated* during their time in prison.[6] For First Nations people, **1 in 7 people** leaving custody reported their mental health had **become worse** during their time in custody.[7]

1 Mental Health Commission of New South Wales, 'Towards a just system: Mental illness and cognitive impairment in the criminal justice system' (July 2017) 4.

2 McCausland, R. and Baldry, E. (2023) "Who does Australia Lock Up? The Social Determinants of Justice", International Journal for Crime, Justice and Social Democracy, 12(3), pp. 37-53. doi: 10.5204/ijcjsd.2504.

3 Australian Institute of Health and Welfare (AIHW), *The health of Australia's prisoners 2018*, Report, 2019. Cat. no. PHE246. Canberra: AIHW. 27.

4 Ibid.

5 Ibid, 4.

6 AIHW. 2022. The health of prisoners. 7 July 2022. <https://www.aihw.gov.au/reports/australias-health/health-of-prisoners#_Toc30748009> (accessed 11 May 2023).

7 AIHW. 2024. Health of people in prison. 2 July 2024. <https://www.aihw.gov.au/reports/australias-health/health-of-people-in-prison>.

Mental illness is a significant health and social issue in Australia and requires a health and social policy response. The lack of adequate, appropriate mental health services in the community has resulted in the criminal justice system becoming the default option to respond to a serious community health issue. Too often this occurs in a cruel and punitive manner, which only serves to exacerbate existing mental health problems for affected individuals, ultimately undermining community safety. A punitive law and order approach is not appropriate to deal with mental illness.

**This briefing paper outlines options to shift the focus in addressing mental illness from a punitive law and order approach to a therapeutic response that focuses on individual and community health and wellbeing, reducing stigma and raising awareness. This can occur at all stages of contact with the criminal justice system including;**

- Initial interactions with police;
- Consideration of eligibility for bail and the opportunity to divert a person to receive treatment;
- The opportunity for in-court diversion to mental health treatment;
- Alternative sentencing options allowing for referral to community-based treat-ment services;
- Accessible, culturally appropriate, strengths-based mental health programs in custodial settings that are tailored to each person, and
- The provision of effective post-release reintegration programs that work with people holistically around a range of issues, including housing, drug and alcohol treatment, employment, mental health and disability.

# Policing people with mental illness

**Most people experiencing a mental health crisis have done nothing illegal. However, due to a lack of mental health services police are often called upon to assist people experiencing an acute episode of mental illness, particularly where they pose a risk of harm to themselves or others.[8] The involvement of police can be humiliating, traumatic and confusing for the people involved and inappropriately draws people with mental illness into the criminal justice system.[9]**

The current nature of policing results in many people with mental illness being unnecessarily or inappropriately funnelled into the criminal justice system, rather than receiving the supports, care and connection they require in the community.[10] Too often people with mental health conditions are 'criminalised' in their interactions with police because alternative pathways outside of the criminal justice system are not available.

This paper outlines the significant benefits in building alternative pathways for people with mental illness before police become involved.

**People living with mental illness should be able to access the required care, support and assistance in the community and when facing a health crisis, should be provided a health-focused response, rather than a punitive response. Additional resources should be provided to community sector supports and other programs and services that operate outside of the justice system.**

## The need for a health-first response

The Royal Commission into Victoria's Mental Health System ('the Royal Commission') found that police are often on the frontline **due to a lack of alternative services** and that as a result, the mental health system defaults to police as the first responders to mental health crises. This has the natural flow on effect that people with mental illness are more likely to become involved in the criminal justice system.[11]

According to an internal review of the NSW Police Force response to mental health incidents in the community, in 2022 NSW Police recorded over **61,000 incidents** in relation to people experiencing a mental health emergency or incident where there was not an associated criminal offence. This represented a **41.6% increase** from the number of incidents recorded in 2018. The review recognised that using police officers as the primary response to mental health crisis increases the risk of adverse outcomes for people living with mental illness, limits appropriate service engagement and treatment, and increases missed opportunities to address mental ill health. The review noted that involvement of police is often perceived as a threat, an authoritarian response and an escalating factor.[12] Police as first responders often exacerbate the situation, which can result in worse outcomes for those in psychological

8 Royal Commission into Victoria's Mental Health System (RCVMHS). Final Report Volume 1. 2021. 514-515.

9 Legislative Council, Legal and Social Issues Committee, Parliament of Victoria (Victoria Parliament CLSIC), *Inquiry into Victoria's criminal justice system,* (Report, March 2022), 198.

10 Leanne Dowse, Simon Rowe, Eileen Baldry and Michael Baker. 2021. *Police Responses to People with disability*, (Research Report for the Disability Royal Commission, 2021).

11 RCVMHS, n 8, 558.

12 NSW Police Force (NSWPF). 2024. *Summary Internal Review of the NSW Police Force response to mental health incidents in the community.* April 2024. 4, 6.

distress. Police are often not trained or equipped to respond to those experiencing a mental health crisis and this can lead to escalating situations instead of de-escalating situations, resulting in further distrust of police and of systems, as well as retraumatisation, disengagement from services, physical injury or even fatal outcomes.[13]

> **Police are not clinicians and should not be expected to be experts in responding to people experiencing mental illness or crisis.**

In such circumstances a health-led response involving specialist mental health support workers, rather than a police-led response, is more appropriate.[14] This could include support workers with lived experience who are appropriately supported, who can step into spaces alongside social workers or other allied health staff, to provide a more holistic, human centred approach.

According to the Royal Commission, greater emphasis on mental health interventions in community and primary care could both reduce the reliance on and prevent the escalation of circumstances that result in an emergency law enforcement intervention.[15]

**The Royal Commission recommended the following to implement a health-led response for people in mental health crisis:**

- **Alternative first-responder models** where specialist mental health support workers respond to people in mental health crisis instead of police. Unless there is a clear risk of harm, all alternatives should be explored before police are involved.
- **Where there are co-first responder models, health professionals should 'lead' the response wherever possible** (with the police there as support). Police have a role in terms of referral to appropriate services and supports but should not be responsible for the provision of mental health support.
- **Cultural change within the police through a commitment to diversity in employment and promotion, cultural awareness training, and public reporting on community engagement initiatives**, to ensure that policing practices and procedures do not disproportionately contribute to the incarceration of people with mental illness.[16]

13 National Justice Project. 2025. *Alternative First Responders – Position Paper*. February 2025. <https://alternativefirstresponders.com.au/wp-content/uploads/2025/05/AFR_PositionPaper2025.pdf>.

14 Ibid 6; Victoria Parliament CLSIC, n 9, 201.

15 RCVMHS, n 8, 560.

16 Ibid 564-567.

## Police discretion – an opportunity to de-escalate and divert

There are occasions when police are needed when people are experiencing  an acute episode of mental illness or psychological distress. Police in these situations have to make difficult decisions that balance the rights and needs of the person in crisis with the safety of others at the scene. How police use their powers and discretion determines whether - and how far - a person with mental illness further progresses in the criminal justice system. Every decision made (such as whether to investigate, question, search, arrest, caution, charge and prosecute) involves an element of discretion on the part of the officer, which can be exercised either to escalate or de-escalate.

There is considerable evidence to suggest that police discretion is often used in ways that discriminate against people with mental illness. The adverse effects for police exercising their discretion in a manner that results in targeted policing of people who are homeless, or overcharging a defendant, can be exacerbated for people with mental illness.[17]

Arrest and charge should not be the default discretionary option for police when responding to a person in crisis or having an actue episode of mental illness. Rather, police should utilise other discretionary options available to them, including calling emergency mental health services for assistance. The introduction of specific mental illness diversionary options, including tailored warnings and cautions, to manage low-level offending attributable to mental illness would also assist police being able to respond appropriately in such circumstances, as well as provide opportunities for a person to access mental health support services.[18]

In addition, all police services need to ensure that their members are adequately trained to work effectively and safely with people experiencing mental illness, and in a way that carries **minimal risk of harm** to any person. This includes ensuring that the use of minimum force and preservation of life are top priorities when responding to mental health crises and that police officers are accountable for their interactions with vulnerable members of the community.

## Police and mental health co-responder models

In Australia and internationally, models of police and mental health clinician partnerships have consistently demonstrated considerable improvements in response times to people experiencing a mental health crisis, and interactions with and the outcomes for people in crisis, when compared with usual services. These include:

- The **PACER** (Police, Ambulance and Clinician Early Response model) in operation in the ACT, NSW and Tasmania;
- The **Mental Health and Police** programs in Victoria; and
- The **Mental Health Co-Responder** programs in SA, WA, Queensland and the NT.

Details of these programs and other effective programs in operation in the USA are included in **Appendix A**.

The 2023 internal review of the NSW Police Force response to mental health incidents in the community found that the effective operation of PACER in NSW was undermined due to its lack of state-wide availability, lack of 24/7 service provision, and inconsistent data recording, processes and responses. Even where PACER is available, access varies widely. No Police Area Commands or Police Districts have 24/7 access to the program.[19]

17 Ibid paragraphs 14.41, 14.46.
18 Victoria Parliament CLSIC, n 9, 215.
19 NSWPF, n 12, 8.

# Difficulties for people with mental illness in obtaining bail

**According to the Australian Institute of Criminology (AIC) people with particular complex vulnerabilities such as mental illness and disability are over-represented amongst bail refusals. This reflects the limited availability of and access to appropriate support services that would enable people to remain in the community pending their court hearing.[20]**

Many people are refused bail not because they are 'dangerous', but because they are homeless, have mental illness, or other forms of disadvantage, and are experiencing a combination of vulnerabilities that influence court decisions around their reliability of attending court when required. However, being refused bail means that people do not receive the support and assistance that they need in the community - assistance that seeks to address their underlying vulnerabilities that may significantly contribute to any offending behaviour.

Increasingly restrictive bail laws in all states and territories have **unintended consequences** on populations that were not the target of the legislative changes. For example, when the Victorian Government restricted access to bail in response to the 2017 Bourke Street Mall attack[21] the consequence was that some of the most vulnerable members of the community who were charged with criminal offences, including those with mental illness, were remanded in custody.[22]

> **Bail laws should be informed by an evidence-based approach that genuinely centres community safety. Remanding people in custodial settings should only be used as a last resort for people who are waiting for their court hearing.**

There is a need for each state and territory to establish and appropriately resource bail support services including accommodation support and pre-trial diversionary support options. Provision of appropriate diversion and bail support services (such as drug and alcohol services, mental health and disability support and accommodation) assist in addressing the needs of people charged with criminal offences with vulnerabilities, reduces the likelihood of reoffending while on bail or not appearing in court, and provides alternatives to detention. Providing support and accommodation services to people in need who have been charged with a criminal offence serves to enhance both community safety and the interests and welfare of the person facing criminal charges.

The Magistrates Court of Victoria has established a bail support program as part of the Court Integrated Services Program (CISP). The CISP is available in 20 Magistrates Courts across Melbourne and regional Victoria. It can provide support for a person who is on bail awaiting their court hearing, by coordinating referrals to drug and alcohol treatment services, crisis and supported accommodation, disability and mental health services, acquired brain injury services, or Koori specific services. The person is assigned a case manager with whom they meet regularly to help them through the program, review their progress and provide updates to the magistrate. To be eligible the person must be charged with an offence, consent to be involved with CISP, and be experiencing: physical or mental disabilities or illnesses; drug and alcohol dependency and misuse issues; inadequate social, family and economic support; or homelessness.[23]

CISP has been favourably evaluated for its effectiveness and cost benefit. People involved in CISP showed a **33% reduction** in reoffending. Where a person did reoffend, the offending was less frequent (30.4% less) and less serious.[24]

20 Max Travers, Emma Colvin, Isabelle Bartkowiak-Théron, Rick Sarre, Andrew Day, Christine Bond. 2020. *Bail decision-making and pre-trial services: A comparative study of magistrates courts in four Australian states.* Australian Institute of Criminology. Report to the Criminology Research Advisory Council Grant: CRG 34/16–17, October 2020. 19-20.

21 Gareth Boreham, 'How Victoria's bail laws are changing following the Bourke St deaths', SBS News, 23 January 2017, <https://www.sbs.com.au/news/article/how-victorias-bail-laws-are-changing-following-the-bourke-st-deaths/x551pua8k> (accessed 11 Mary 2023).

22 Emma Russell, Bree Carlton and Danielle Tyson, '"It's a gendered issue, 100 per cent": How tough bail laws entrench gender and racial inequality and social disadvantage' (2022) 11 *International Journal for Crime, Justice and Social Democracy* 107.

23 Magistrates Court of Victoria, Bail Support, CISP, <https://www.mcv.vic.gov.au/find-support/bail-support-cisp> (accessed 11 May 2023).

24 Ross, S., *Evaluation of the Court Integrated Services Program: Final Report* (December 2009); Price Waterhouse Coopers, *Economic Evaluation of the Court Integrated Services Program (CISP): Final Report on economic impacts of CISP* (November 2009).

# Court-based diversion for people with mental illness

## In-court diversion programs

In-court diversion to practical, alternative programs provides an opportunity to address some of the underlying causes of offending including mental illness. The effectiveness of these programs relies on the early identification of people with mental illness to enable appropriate assessment and referral. Examples of such services include:

- **The Victorian Mental Health Court Liaison Service** - The service aims to provide early intervention within criminal justice processes by identifying individuals living with mental illness at the post-charge, pre-sentence stage. It provides assessment and advice to courts and referrals to treatment providers.[25]
- **(NSW) Statewide Community and Mental Health Support Liaison Service** - Provides assessment and diversion options in NSW Courts. Evaluations of the service have found it reduces the frequency of contact with the justice system for people living with mental illness.[26]
- **Victorian Mental Health Advice and Response Service** - Currently operating in the Magistrates Court of Victoria, this service provides advice and support to individuals within the court system as well as specialist clinical mental health advice to judges and community corrections services regarding appropriate mental health interventions.[27]

## Specialist courts for people with mental illness

Diversion can form part of the court system itself through specialist courts specifically set up to respond to particular needs for people facing criminal charges. Problem solving courts have been developed to respond to mental health concerns and drug dependency. These courts work on the principle of 'therapeutic jurisprudence' - that positively impacting the psychological well-being of a person accused of criminal offending will result in better outcomes. The aim of these specialised problem-solving courts is to overcome the inadequacies of traditional court systems by providing long-term solutions to address the drivers of crime, including addressing the underlying mental health and drug dependency issues which have contributed to criminal offending.[28]

There are a variety of models of specialist courts for people living with mental health conditions. These specialist courts combine intensive judicial monitoring and treatment in order to ensure that people are able to access treatment while being subject to proceedings and supervision. Some are specifically targeted at people living with mental illness who also have co-occurring substance dependency issues. These approaches seek to stabilise mental health while targeting

25 Forensicare – Community Foresnic Mental Health Service. 2025. *Mental Health Court Liaison Service* (pamphlet). <https://www.forensicare.vic.gov.au/wp-content/uploads/2016/09/Forensicare-MHCLS-6pp-DL_v6-Final-Spread.pdf>.

26 Justice Health NSW locations, Statewide Community and Court Liaison Service (website). <https://www.nsw.gov.au/health/justicehealth/about-us/our-locations>; See also Deborah Bradford and Nadine Smith. 2009. *An Evaluation of the NSW Court Liaison Services.* NSW Bureau of Crime Statistics and Research. 2009.

27 Forensicare. Victorian Institute of Forensic Mental Health. Mental Health Advice and Response Service (courts) (webpage). <https://www.forensicare.vic.gov.au/our-services/community-operations/court-mental-health-response-service/>.

28 Lacey Schaefer and Mary Beriman. 2019. Problem-Solving Courts in Australia: A Review of Problems and Solutions. Victims & Offenders, 14:3, 344-359 at 344.

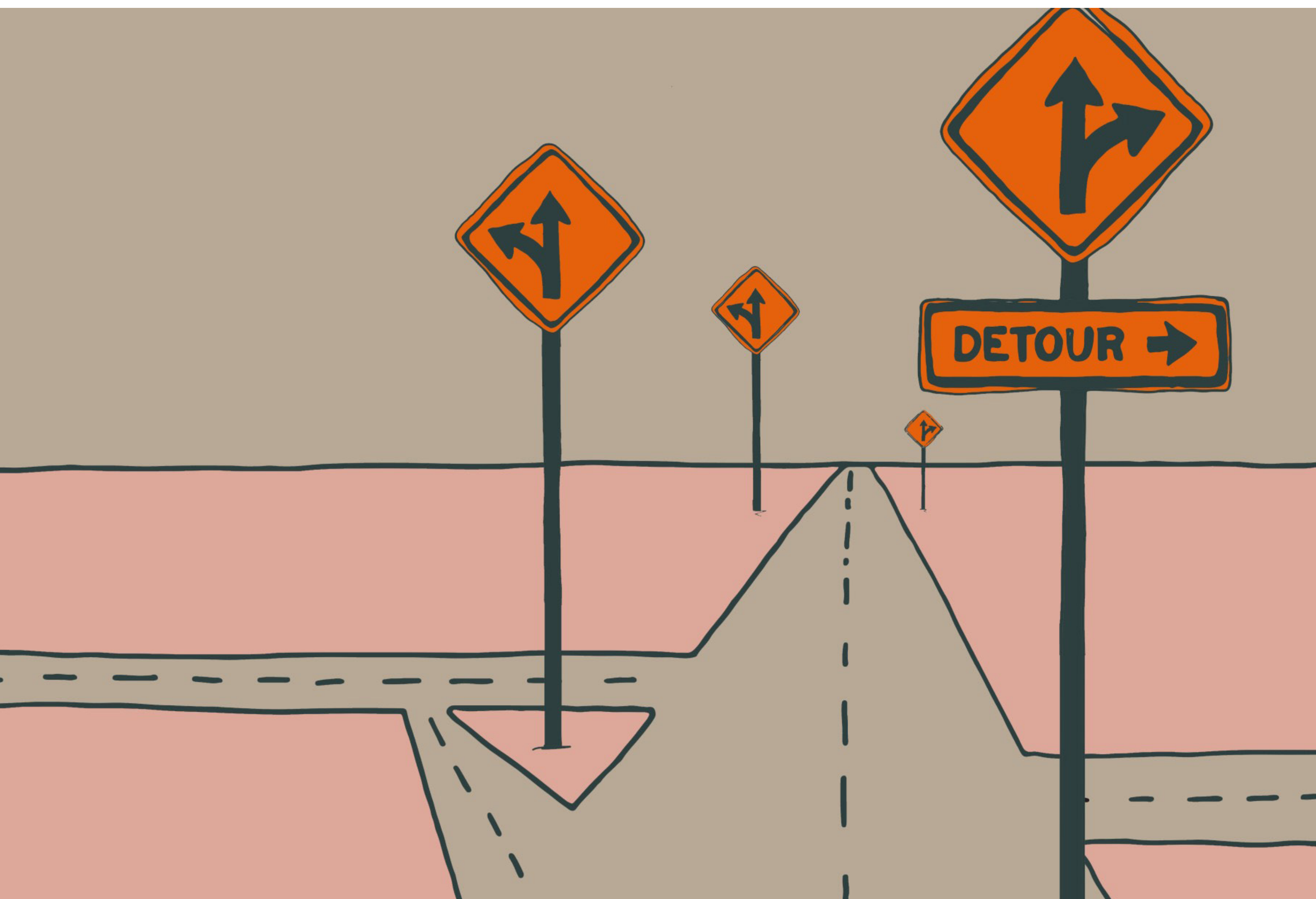
dependency in a drug-court style treatment and testing regime. In some mental health courts, this approach includes being a specific alternative to custody.

International evidence suggests that mental health courts are likely to reduce reoffending and facilitate access to support and treatment services. Specific details of the models of specialist courts for people with mental illness both in Australia and internationally are included in **Appendix B**.

## Community justice courts

Based on the model developed in the Red Hook precinct in New York City, community justice courts or community justice centres aim to provide a broad range of therapeutic justice services to victims of crime, persons who have committed an offence, civil litigants and the community. A key feature of these courts are the specialist services and processes made available to people with mental illness. Such a court model was implemented in inner-Melbourne in 2007, with the establishment of the Neighbourhood Justice Centre (NJC). A 2015 evaluation conducted by the AIC found that the NJC had **25% lower rates** of reoffending than other Magistrates' Courts.[29]

29 Stuart Ross. 2015. *Evaluating neighbourhood justice : Measuring and attributing outcomes for a community justice program.* Trends and Issues in crime and criminal justice. Australian Institute of Criminology. No. 499 November 2015. 3-6.



# Sentencing options for people with mental illness

**The over-representation of people with mental illness in custodial settings is also a product of the lack of alternative criminal justice programs and sentencing options for people with a mental health issue. The absence of sufficient diversionary programs for people with mental illness means that judges and magistrates have limited options in terms of sentencing, resulting in many people with mental illness convicted of criminal offences being sentenced to a term of imprisonment.**[30]

The lack of appropriate, diversionary sentencing options was recognised in the Victorian parliamentary Inquiry into Victoria's Criminal Justice System in 2022. The inquiry noted that if a person is not considered suitable for a community corrections order (CCO) (for example, because they have breached an earlier CCO, or because Community Correctional Services cannot provide the necessary supports and resources for that person), then the next alternative in the sentencing hierarchy is imprisonment. If the Court deems that a CCO is not warranted, the next step 'down' in the sentencing hierarchy is a fine. **There is no intermediate sentencing option with a focus on rehabilitation.**[31]

The inquiry recognised a need for more tailored CCOs for people who have mental illness or cognitive disability, and for more options for community-based sentencing outside of just CCOs. This would include additional options that **incorporate psychological and psychosocial support**, **education** and **vocational counselling**, and **partnerships with organisations for paid and volunteer work**. Judicial officers would then have greater flexibility to tailor community-based sentences, to promote greater use of alternatives to full-time imprisonment, and to allow for the imposition of treatment and programs which aim to address underlying causes of offending.[32]

30 Victoria Parliament CLSIC, n 9, 499, 558

31 Ibid 558; Australian Law Reform Commission 'Pathways to Justice–Inquiry into the Incarceration Rate of Aboriginal and Torres Strait Islander Peoples', Report No 133 (2017) (ALRC Report 2017, paragraphs 7.57, 7.68.

32 Victoria Parliament CLSIC, n 9, 558.

# People with mental illness in custodial settings

**As noted previously, 40% of people incarcerated in Australian prisons have a history of mental illness.[33] People in prisons are more likely to be experiencing mental illness than the general population. In some cases the experience of incarceration itself can either exacerbate existing mental illness, or cause deterioration in mental health (even when someone has not previously experienced mental illness).[34]**

Prison conditions and practices such as solitary confinement, strip-searching and the use of physical restraints are likely to exacerbate existing mental illness and cause new illnesses among people who are incarcerated. This is particularly the case given that people in prison with mental illness or physical disabilities are more likely to be subjected to solitary confinement or kept in isolation as part of behaviour management. Extended periods of incarceration can result in further trauma and lead to challenging behaviour patterns that will make it more difficult for a person to engage with support and integrate back into the community upon release.[35]

There are some incarcerated populations for whom the experience of imprisonment can have a particularly harmful impact on mental health. For instance LGBTQIA+ communities are over-represented in the Australian criminal justice system, with evidence suggesting that LGBTQIA+ people in prison experience discrimination, ostracism and victimisation.[36] LGBTQIA+ people who are incarcerated also experience much higher rates of mental illness.[37]

The prison environment and the circumstances of imprisonment can also impact on mental health. For people denied bail the experience of remand is one that is often characterised by high levels of frustration and stress due to sudden separation from family, uncertainty about their future, loss of employment and housing, and sudden loss of existing mental health supports.[38]

## Access to healthcare and mental health programs in prison

According to the AIHW almost 1 in 4 people in prison are currently taking mental health-related medication.[39] However, people in prison lose access to Medicare services and the Pharmaceutical Benefits Scheme (PBS) subsidies under s19(2) of the *Health Insurance Act 1973* (Cth). This means that when people go into prison they cannot access Medicare funded services such as mental health plans (and counselling), and they cannot access particular medications that they may have had access to when they were in the community.

Given the over-representation of people with mental health conditions in prisons, there is the need for quality mental health services to be available for people who are incarcerated. This should in no way be seen as a justification for the incarceration of people with mental illness. Support and treatment is much more effective outside of custodial environments.[40] However, if people with mental health conditions are incarcerated, then mental health needs should be responded to in custody and followed up post-release. The University of Melbourne based Justice Health Unit has noted that most jurisdictions fail to take this opportunity and poor transition planning and inadequate resourcing of transitional programs creates a risk that any health gains may be lost after release.[41]

33 AIHW 2019, n 3.

34 Victoria Parliament CLSIC, n 9, 581-582.

35 Victoria Parliament CLSIC, n 9, 593.

36 Paul Simpson, Danika Hardiman and Tony Butler, Understanding the Over-representation of lesbian and bisexual women in the Australian prisoner population' 31 (2019) 365.

37 The Fenway Institute, 'Emerging Best Practices for the Management and Treatment of Incarcerated Lesbian, Gay, Bisexual, Transgender, and Intersex (LGBTI) Individuals' (November 2019), 50.

38 Victoria Parliament CLSIC, n 9, 586.

39 AIHW 2019, n 3.

40 Katie Rosie Quandt and Alexi Jones. 2021. *Research Roundup: Incarceration can cause lasting damage to mental health.* Prison Policy Initiative. 13 May. 2021. <https://www.prisonpolicy.org/blog/2021/05/13/mentalhealthimpacts/>.

41 Justice Health Unit, Melbourne School of Population and Global Health, The University of Melbourne. 2019. *The role of incarceration in addressing inequalities for people with mental illness in Australia.* Submission to the Productivity Commission's Issues Paper on The Social and Economic Benefits of Improving Mental Health. 5 April 2019.

While all Australian jurisdictions provide mental health treatment to people in prison, there is limited information about how prison mental health services are structured, funded and delivered. There is also a lack of reliable and publicly available information about the scale of mental health services provided in correctional settings. What is clear is that there are inadequate prison mental health services in almost all jurisdictions.[42]

Of particular concern is the lack of mental health services for those who spend only a short time in custody or on remand, who make up the vast majority of people who are incarcerated with mental illness.[43] Although individuals incarcerated on sentences of three months or more may, in some jurisdictions, receive treatment for mental illness in prison, they are often released without adequate supports in place to assist them with their mental health in the community.[44]

Specialist mental health services in prison need to be **adequately resourced**. All people entering a custodial setting should be assessed to identify and target mental health needs. Appropriate access to mental healthcare treatment should be available for all incarcerated people, including those on remand and short sentences, and those with mild or moderate mental illness as well as people with substantial and complex mental health needs.

In addition, **responsibility for delivery of mental health services in custodial settings should rest with the respective Government Health Departments** as recommended by the World Health Organisation (WHO), rather than the departments responsible for justice.[45] This approach is more likely to enable incarcerated people to access **continuity of care** and access to mental health services when they are released from custodial settings and re-enter the community.[46]

Dedicated funding should also be provided for dual diagnosis services for people in prison with co-morbid alcohol and drug and mental illness issues, and also for those with both intellectual disability and mental illness.[47]

The prison system needs to provide access to culturally appropriate, strengths-based mental health programs that are tailored to each person and that promote connection to family and community.

**These programs should include the following elements:**

- Prison reception and assessment processes need to include a **comprehensive assessment** of incoming people to **identify** and **assess mental health**.
- **Improved access to specialist services and programs** for people with mental health needs in prison.
- **Mental health programs that are culturally safe and readily available** for all people in prison, including those on remand and serving short-term sentences.
- **Tailored mental health programs for women in prison.** As part of this it is essential that programs assist people in prison to maintain meaningful contact with their families as this is critical for their mental wellbeing and ability to reintegrate into the community.[48] Many women entering the prison system have carer responsibilities that they are forced to relinquish while in custody. This separation often detrimentally impacts their mental and emotional wellbeing.[49]
- **Support to maintain family and community connection.** Relationships between families can be difficult to maintain during a period of incarceration and can lead to feelings of anger, anxiety, depression shame, guilt and grief.[50] Maintaining familial and parental connections whilst in prison delivers psychosocial benefits for parents and children, and can reduce parental recidivism.[51]

42 Fiona Davidson, Bobbie Clugston, Michelle Perrin, Megan Williams, Edward Heffernan, Stuart A Kinner. 2020. Mapping the prison mental health service workforce in Australia. *Australian Psychiatry* 2020, Vol 28(4) 442-447 at 443.

43 Justice Health Unit, 2019, n 41.

44 Victoria Parliament CLSIC, n 9, 653.

45 United Nations Office on Drugs and Crime, World Health Organization. 2013. Good governance for prison health in the 21st century: A policy brief on the organization of prison health' (2014) <https://www.unodc.org/documents/justice-and-prison-reform/WHO_Europe.pdf> (accessed 11 May 2023).

46 Stuart Kinner. 2020. Witness Statement, Royal Commission into Victoria's Mental Health System. <http://rcvmhs.archive.royalcommission.vic.gov.au/Kinner_Stuart.pdf> (accessed 11 May 2023).

47 Ibid.

48 Dr Lorana Bartels and Antonette Gaffney, 'Good Practice in Women's Prisons: A literature Review' (AIC Reports Technical and Background Paper 41, 2011) 58 citing Ian Mulheirn, Barney Gough and Verena Menne 'Prison Break: Tackling recidivism, reducing costs' (The Social Market Foundation, 2010).

49 Victoria Perry, Catherine Fowler, Kyleigh Heggie and Karen Barbara. 2011. 'The Impact of Correctional-based Parenting Program in Strengthening Parenting Skills of Incarcerated Mothers' (2011) 22(3) *Current Issues in Criminal Justice* 457, 459; Penal Reform International, 'The rehabilitation and social integration of women prisoners: Implementation of the Bangkok rules' (Thailand Institute of Justice, May 2019), 26.

50 Victoria Parliament CLSIC, n 9, 664.

51 Bartels and Gaffney, n 48, 58, citing Ian Mulheirn, Barney Gough and Verena Menne 'Prison Break: Tackling recidivism, reducing costs' (The Social Market Foundation, 2010).

# People with mental illness leaving prison

**The transition from prison to the community is particularly difficult for people with mental illness. Transition support is often inadequate, with people who commenced treatment or treatments in prison not being provided with assistance or referrals to continue treatment post-release.**

In addition, multiplicity and complexity of need means that many people leaving prison are excluded from support in the community. For instance, many people are not able to access drug and alcohol services if they have a complex mental health condition, and many people are not able to access mental health services if they have an ongoing drug and alcohol problem.[52] In 2021, around 9,000 clients of specialist homelessness services (SHS) were people exiting from custodial arrangements (or 3.3% of all SHS clients). Of these 44% had mental health issues and 27% had drug and alcohol issues.[53]

> **Successful post-release reintegration programs work with people holistically around a range of issues, including housing, drug and alcohol treatment, employment, mental health, disability, and cultural and community connection alongside the formulation of a sense of identity and belonging outside of the justice system.**

Of vital importance for people with mental illness leaving prison is the availability of supported accommodation. Over the last decade the availability of housing for formerly incarcerated people has significantly reduced.[54] As prison populations have increased, the need for housing and assistance post-release has likewise increased.[55] There is considerable evidence to indicate the social and economic effectiveness of supportive housing models for those people who also experience mental health and drug and alcohol problems.[56]

People exiting prison who also have a mental illness require access to appropriate models of supportive housing to facilitate transition back into the community. Supports should enable people to address particular identified needs including mental illness, drug and alcohol dependency, and all necessary supports and assistance that will make re-offending more likely.

Effective post-release and housing programs which have had positive outcomes for people with mental illness leaving prison are outlined in the **JRI Post-Release position paper**.[57]

52 Victoria Parliament CLSIC, n 9, 654.

53 AIHW. 2022. Specialist homelessness services annual report 2021-22. Clients exiting custodial arrangements. 8 December 2022.

54 UNSW Sydney. 2020. *Obstacles to Effective Support of People Released from Prison: Wisdom from the Field*, 25.

55 Chris Martin, Rebecca Reeve, Ruth McCausland, Eileen Baldry, Pat Burton, Rob White, Stuart Thomas. 2021. *Exiting prison with complex support needs: the role of housing assistance.* AHURI Final Report No. 361.August 2021. 24.

56 Parsell C, Moutou O, Lucio E & Parkinson S. 2015. *Supportive housing to address homelessness.* AHURI final report no. 240. Melbourne: Australian Housing and Urban Research Institute. 11.

57 Sotiri, M & Schetzer, L (2024) 'Post-release, re-entry and breaking cycles of disadvantage and imprisonment', Justice Reform Initiative, Australia.

# Conclusion

**The over-representation of people living with mental illness in the criminal justice system is one of the system's most tragic failings. The lack of mental health services in the community combined with a criminal justice system that is ill equipped to support recovery leads to this cycle of over-representation.**

People living with mental illness are more likely to come into contact with police than those who do not have mental illness. They are more likely to be the subject of arrest and criminal charges. They are more likely to be refused bail. They are less able to access community-based sentencing alternatives and consequently they are more likely to be sentenced to a term of imprisonment. In prison they may not have access to appropraite treatment and medication. Upon release, there are limited supports and they are more likely to reoffend and cycle back into the criminal justice system.

> **A failure to adequately resource mental health services in the community has meant that the criminal justice system has become the default mechanism to respond to people living with mental illness who experience crisis.**

There are a range of measures that all state and territory governments can implement to develop a health-led response (as distinct from a punitive law and order response) to people living with mental illness who may be experiencing a crisis. These include ensuring that mental health professionals rather than police become the first option to respond to people in crisis. In addition, where police need to assist in response, all police members need to be adequately trained to work effectively and safely with people experiencing mental illness, and in a way that carries minimal risk of harm to any person. Police must also exercise their discretion in a way that places a priority on diverting people with mental illness away from further contact with the criminal justice system, rather than resorting to arrest and charge.

Where people living with mental illness are charged with a criminal offence it is vitally important that they are not by default denied bail. Each state and territory government needs to establish and appropriately resource bail support services including accommodation support and pre-trial diversionary services for people with mental illness. Likewise, state and territory governments should establish specialist in-court diversion programs to respond to the particular needs for people with mental illness who face criminal charges, and to address the underlying mental health issues which have contributed to criminal offending.

For those who are found guilty of a criminal offence, there is a need for people living with mental illness to be able to access tailored community corrections orders and community-based sentencing alternatives, so that there is not a default option of a term of imprisonment.

Finally, for those people with mental illness who are incarcerated it is vitally important that they can access specialist services and programs whilst in prison, including those people who are on remand or serving short-term sentences. Each state and territory government must also increase funding and other resources to community-based services that provide mental health, alcohol and other drug treatment, disability support, education and training to assist people exiting prison to reintegrate back into the community.

Ultimately, the key element in recalibrating the emphasis from a punitive law and order focus to a health focus, is to ensure that there are accessible, culturally appropriate, well-resourced mental health services in the community. The availability of such services will make an important difference in ensuring that the criminal justice system does not continue to be the default option to respond to those people living with mental illness.

# Appendix A: Police and mental health co-responder models

## Australian models

### Police, Ambulance and Clinician Early Response (Pacer) ACT, NSW, Tasmania

The PACER program is designed to provide a specialist mental health early response to people experiencing a mental health crisis. It embeds mental health experts with first responders to support them to appropriately recognise, assess and respond to psychiatric incidents. It usually includes a police respondent, a paramedic and a mental health respondent working together. The paramedic is there to assess and treat any physical health emergencies. The police officer is there to make sure the PACER team, the person, and the community are kept safe. The mental health clinician is there to assess mental health needs and support the person in crisis.

During the ACT 2020 pilot, of the 1,200 callouts to the PACER team, **900 people seen by the PACER team were able to stay in the community**. 300 people still required hospitalisation either because PACER was unavailable at their point of distress or they needed a high level of care from the emergency department. The program has expanded to 7-days per week.[58]

In Tasmania, PACER was launched as a two-year pilot in January 2022. By September it had assisted 1,000 people experiencing an acute mental health issue. Of these, **almost 80% were supported to remain in the community**. On average there were 45 fewer mental health related presentations to the Royal Hobart Hospital emergency department every month.[59]

The NSW model has seen cross-agency response to people experiencing mental health crisis, avoidance of emergency department presentations, provision of alternate pathways to care and avoidance of coercive measures. From November 2018-September 2020, of the more than 1,500 PACER contacts, only 500 required further hospital-based assessment or treatment.[60]

A 2023 internal review of the NSW Police Force response to mental health incidents in the community found that the effective operation of PACER in NSW was undermined due to its lack of state-wide availability, lack of 24/7 service provision, and inconsistent data recording, processes, and responses. Even where PACER is available, access varies widely. No Police Area Commands or Police Districts have 24/7 access to the program.[61]

### Mental Health and Police, Victoria

In Victoria the PACER program has operated for several years. In 2014 the name of the initiative was changed to Mental Health and Police. A 2019 departmental evaluation indicated the effectiveness of the program, reporting that Mental Health and Police units are effective in diverting people from emergency departments and that the co-response model helps improve the skills and knowledge of the police who work alongside mental health clinicians. The evaluation also noted that the effectiveness of the program is hampered by workforce shortages, especially in rural areas.[62]

58 Cassandra Power. 2021. 'ACT Government recommits to PACER mental health election promise'. *Canberra Weekly*. 3 February 2021. <https://canberraweekly.com.au/act-government-recommits-to-pacer-mental-health-election-promise/> (accessed 11 May 2023).

59 Megan Whitfield. 2022. 'New Tasmanian PACER program aims to ease ED pressure with mental health aid'. *ABC News*, 14 September 2022. <https://www.abc.net.au/news/2022-09-14/pacer-program-aims-to-ease-ed-pressure-with-mental-health-aid/101440808> (accessed 11 May 2023).

60 Robert Fedele. 2020. 'On the beat: Mental health nurses join forces with NSW police to improve care'. *Australian Nursing & Midwifery Journal*. 11 September 2020. <https://anmj.org.au/on-the-beat-mental-health-nurses-join-forces-with-nsw-police-to-improve-care/> (accessed 11 May 2023).

61 NSWPF, n 12, 8.

62 RCVMHS, n 8, 565.

### Mental Health Co-Responder Models – South Australia, Western Australia, Queensland, Northern Territory

In South Australia the Mental Health Co-Responder Program was established as a trial in 2022. Under the program a mental health clinician is paired with a police officer to respond to triple-0 call outs. **It is estimated that the program has prevented 2,472 emergency department presentations.** In 2025, the South Australian Government announced additional 5-year funding for the program, and funding for it to expand across Adelaide.[63]

In January 2016, the WA Police Force implemented the WA Police Force Mental Health Co-Response (MHCR) Commissioning Trial. The MHCR involved mental health practitioners co-located with police at the Police Operations Centre, two mobile teams operating in Northwest Metropolitan and Southeast Metropolitan Districts and the Perth Watch House. Mental health practitioners were involved at each stage of a police response to and management of people experiencing a mental health crisis.

An independent evaluation of the trial found that it had improved the safety and wellbeing of police and mental health consumers and increased collaboration between the relevant services. Mental health consumers and families, carers and supporters saw the model as a considerable improvement over the traditional police crisis response.[64] In 2025 the model was expanded to provide coverage to East, North and South Metropolitan areas.[65]

Following a successful pilot in South-East Queensland in 2019, a Mental Health Co-Responder Program was rolled out to 20 sites across Queensland including districts in Cairns, Townsville, Mackay, Central Queensland, Sunshine Coast, Metro North, Metro South, West Moreton, Gold Coast, Darling Downs and Wide Bay. The program sees a Queensland Ambulance Service senior paramedic paired with a senior mental health clinician from the local mental health service, to provide timely and appropriate care for those experiencing a mental health crisis.[66]

A Mental Health Co-Responder Project in the Northern Territory commenced in Darwin and the surrounding area in October 2020. Under the trial, a mental health clinician responds to a mental health triple-0 emergency with a police officer or a paramedic to provide specialised care on a call-out, with the Co-Response Team operational five evenings a week.[67]

## USA models

### CAHOOTS (Crisis Assistance Helping Out On The Streets), Eugene, Oregon

CAHOOTS is a mental health crisis intervention program founded in 1989 by the Eugene Police Department and White Bird Clinic, a non-profit mental health crisis intervention initiative. Calls to 911 related to drug use, disorientation, mental health crises and homelessness are routed to CAHOOTS. Staff members respond in pairs; usually one has training as a medic and the other has experience in street outreach or mental health support. Responders attend to immediate health issues, de-escalate, and help formulate a plan, which may include finding a bed in a homeless shelter or transportation to a healthcare facility.

63 Government of South Australia. 2025. 'Successful community mental health program to expand to all of Adelaide.' *Media Release*. 30 May 2025. <https://www.premier.sa.gov.au/media-releases/news-items/successful-community-mental-health-program-to-expand-to-all-of-adelaide#:~:text=The%20Malinauskas%20Labor%20Government%20is,outcomes%20and%20greater%20community%20safety.>

64 Pamela Henry and Nikki Rajakaruna. 2018. *WA Police Force Mental Health Co-Response Evaluation Report*. The Sellenger Centre for Research in Law, Justice and Social Change, Edith Cowan University. 29 March 2018.

65 Government of Western Australia. 2025. 'Successful Mental Health Ambulance Co-Response service expands.' *Media Release*. 2 June 2025 <https://www.wa.gov.au/government/media-statements/Cook%20Labor%20Government/Successful-Mental-Health-Ambulance-Co-Response-service-expands-20250602>.

66 Queensland Ambulance Service, Queensland Government. 2025. 'Our patients: Models of Care'. *Website*. 10 June 2025. <https://www.ambulance.qld.gov.au/about/performance-data/our-patients>.

67 Office of the Chief Minister, NT. 2020. 'Tripke-0 Co-Response Election Commitment Commences.' Media Release 18 October 2020. <https://newsroom.nt.gov.au/article?id=33897#:~:text=%E2%80%9CThe%20Co%2DResponse%20model%20is,help%20in%20time%20of%20crisis>.

The service operates 24 hours a day. Cahoots diverts close to **8%** of all police calls, reducing the load on the police department. Evaluations of CAHOOTS have found it to improve access to health and welfare services as well as saving an estimated **$8.5 million annually** in public safety spending.[68]

### The Behavioral Health Emergency Assistance Response Division - B-HEARD, New York City

The B-HEARD Team is an alternative first responder model in New York City. Responders use their mental health expertise in crisis response to de-escalate emergency situations and provide immediate care. Evaluation of the pilot found that the project reduces unnecessary transports to hospitals, increases connection to ongoing mental health care and reduces the number of times police respond to 911 mental health calls. In the 12 months to June 2022, there were approximately 11,000 mental health 911 calls in the pilot area.

#### Of people assisted by B-HEARD:

- **54%** were transported to a hospital for additional care (compared to 87% under the traditional response).
- **36%** were supported in their community.
- **24%** were supported onsite, including de-escalation, counselling, or referral to community based care.
- **12%** were transported to a community-based healthcare or social service location.[69]

### Portland Street Response, Portland Oregon

Portland Street Response (PSR), a program within Portland Fire & Rescue (PF&R), assists people experiencing mental health and behavioural health crises. The team is made up of mental health crisis responders, community health medics, community health workers, and peer support specialists. In their outcome evaluation it is noted that, in the six months between April and September 2022, PSR responded to 3228 incidents. This represented a reduction of more than 3.2% of total calls to police; **an 18.7% reduction for the police in non-emergency responses**; and reduced the numbers of people called out to emergency departments. Most people were responded to by PSR, with only 1.9% of all calls resulting in a hospital admission.[70]

### Street crisis response teams, San Francisco, California

The street crisis response teams are a community health approach for people who are experiencing mental health and/or substance abuse crises in San Francisco. Early evaluation shows 5,338 calls were responded to in the six-month evaluation period. The evaluation reported successful diversion of 911 calls for mental health matters, **only 3% of interactions required police involvement**, and only 7% of matters required further urgent medical attention. The evaluation also reported high levels of engagement and referrals to other services.[71]

68 What Works Cities, Alternative emergency response: Exploring innovative local approaches to public safety (Web Page). <https://whatworkscities.medium.com/exploring-innovative-emergency-responses-with-cahoots-499c5b8920c8>.

69 New York City Mayor's Office of Community Mental Health, B-HEARD – A news health-centered approach to mental health emergencies, <https://mentalhealth.cityofnewyork.us/b-heard> (accessed 11 May 2023)

70 The History of the Portland Street Response, City of Portland, Oregon, <https://www.portland.gov/hardesty/news/2022/3/24/history-portland-street-response> (accessed 11 May 2023); G.Townley and E.Leickly. 2022. Portland Street Response: Year Two Mid-Point Evaluation. Portland State University Homelessness Research & Action Collaborative. <https://www.pdx.edu/homelessness/sites/g/files/znldhr1791/files/2022-12/PSR%20Year%20Two%20Mid-Point%20Evaluation%20Report_For%20Public%20Release.pdf> (accessed 11 May 2023).

71 San Francisco Street Crisis Response Team Final Report, <https://sf.gov/sites/default/files/2022-06/SCRT%20Final%20Report_FINAL-%201%20year.pdf> (accessed 11 May 2023).

# Appendix B: Specialist Courts for People with Mental Illness

## Australian models

### Victoria – Assessment and Referral Court (Victoria)

The Assessment and Referral Court (ARC) is a court list for persons accused of an offence who have a mental illness and/or cognitive impairment. Sitting within the Magistrates' Court, it aims to help people address underlying factors that contribute to their offending behaviours. For a person to be referred to the ARC, the following steps must be followed:

- **Confirm availability** – The person must be charged with an offence within the catchment area of an existing ARC (i.e. Frankston, Latrobe Valley, Korumburra, Melbourne and Moorabbin) and be on bail at the time of referral.
- **Check eligibility** – The person must be diagnosed with a mental illness, intellectual disability, acquired brain injury, autism spectrum disorder, or neurological impairment. The diagnosis must cause a 'substantially reduced capacity' in the areas of self-care, self-management, social interaction or communication. The person must also be able to benefit from receiving services through a support plan, such as psychological or welfare services.
- **Seek a referral** – A referral can be made at a bail hearing or mention hearing by the person accused of an offence or their family, a community service organisation, magistrates, Victoria Police, or lawyers of the Court Integrated Services Program (CISP). The individual must consent to being referred to the ARC.
- **Attend an assessment** – Eligibility must be assessed by a case manager at the ARC. If accepted, the person must enter a formal plea in order to access a support plan. If a guilty plea is entered, sentencing will occur within the ARC.[72]

The ARC delivers mental health treatment and case management under the supervision of the court. This produces substantial reductions in both the frequency and seriousness of offending that persist over time, reducing incarceration rates.

**Recommendations for improvements have included:**

- Expanding the ARC to additional locations, particularly in rural and regional areas;
- Additional therapeutic support and treatment services in regional areas;
- Expanding the eligibility criteria for the ARC as people are required to be on bail in order to be referred to ARC.[73]

The ARC has been found to provide a therapeutic response to persons accused of an offence who have a mental illness and/or cognitive impairment, and has demonstrated success in supporting them to address the underlying causes of their offending.[74] The Royal Commission into Victoria's Mental Health System recommended that the Assessment and Referral Court list be expanded to each of the 12 Magistrates' Court locations by 2026.[75]

72 Magistrates' Court of Victoria, *Assessment and Referral Court (ARC)*, 2018, <https://www.mcv.vic.gov.au/criminal-matters/assessment-and-referral-court-arc> (accessed 11 May 2023).

73 Centre for Justice Innovation. *Problem solving courts: An evidence review*. June 2016. 15.

74 Victoria Parliament CLSIC, n 9, 482.

75 Ibid 85.

## Special Circumstances List, Melbourne Magistrates' Court (Victoria)

The Melbourne Magistrates' Court Special Circumstances List commenced operation in June 2002. The list is presided over by a single magistrate who has a personal commitment to the goals of the program. The list was initially only targeted at persons with mental illness, intellectual disability, acquired brain injury, physical disability or drug or alcohol addiction. The definition of "special circumstances" was also extended to include homelessness, where it results in a person being unable to control conduct which constitutes an offence.

A person with special circumstances can only be dealt with under the Special Circumstances List if they have received one or more infringement notices for an offence, have failed to pay the infringement penalty, have forwarded an application for revocation of these fines, and the infringements registrar is satisfied that the matter would be more appropriately dealt with by the court.

Cases involving "special circumstances" in Melbourne most often result in an adjournment or dismissal, often with an undertaking to be of good behaviour and/or to comply with a treatment regime. The list has been heralded a great success, with most defendants taking their undertakings to the court seriously and continuing their treatment as ordered.[76]

## Start Court (Western Australia)

Start Court is a Magistrates' Court that specialises in dealing with people who have mental health issues. It is a holistic support program that seeks to address the underlying causes of offending behaviour. Referrals to the Start Court are made by Magistrates in general court lists and can be suggested by the individual, family members, the defence lawyer or a dedicated duty lawyer. To be eligible the individual must have a mental health condition, plead guilty and be eligible for bail.[77]

### A review of the Start Court found that between March 2013 and 30 September 2015:

- **92%** of participants demonstrated clinical improvement;
- **80%** of participants who completed the Start Court program in that period either ceased offending or committed less serious offences;
- **49%** of Start Court program participants reoffended (compared to 62% reoffending rate for individuals who were not processed through the Start Court program).
- **58%** of Start Court participants were assessed as posing a lower risk of violence after engagement with the program.[78]
- Engagement with the Start Court was also often perceived as a mitigating factor in sentencing, leading to **higher rates of diversion** from incarceration.[79]

76 Tamara Walsh, 'The Queensland special circumstances court' (2007) 16(4) *Journal of Judicial Administration* 225.

77 Magistrates Court of Western Australia, Start Court, <https://www.magistratescourt.wa.gov.au/S/start_court.aspx> (accessed 11 May 2023).

78 Mental Health Court WA. 2015. Summary of Mental Health Court Diversion Program, 2. <https://www.mhc.wa.gov.au/media/1557/summary-of-court-diversion-evaluation-2015-for-mhc-website.pdf>

79 Ibid.

### Special Circumstances Court, Brisbane Magistrates' Court (Queensland)

In 2006 a Special Ccircumstances List was established at the Brisbane Magistrates' Court. The list was aimed at finding an alternative way of dealing with people charged with public order-type offences who had impaired capacity at the time of the offence, as a result of mental illness or intellectual disability, and homelessness.

A person is eligible to be dealt with under the special circumstances list if they are 17 years of age or older, homeless, and appear to be suffering from impaired decision-making capacity as a result of either mental health issues, intellectual disability or brain/neurological disorder. Further, they must have been charged with, and pleaded guilty to, an "eligible offence" (i.e. an offence which arises from circumstances which have an aspect of "public order", including offences such as failing to appear, breach of bail, etc in respect of another eligible offence). This also includes offences like public nuisance, begging, public drunkenness and failing to properly dispose of a syringe. Serious drug offences, sexual offences and serious offences of personal violence are disqualifying offences.[80]

Court observation of the Brisbane Special Circumstances List was conducted for a period of nine weeks between August and October 2006. The penalties imposed on participants for the designated offences were more likely to be aimed at addressing the underlying causes of offending (i.e. court supervision, referral to for psychiatric or drug/alcohol treatment, referral to cognitive/life skills course) than for defendants facing similar charges in the generalist courts.[81]

## International Models

### Brighton Mental Health Court And Stratford Mental Health Court (UK)

Two dedicated Mental Health Courts (MHCs) were set up in England, in Brighton and Stratford, for one year only. Both Brighton and Stratford operated within regular magistrate court provisions. The key elements of the MHCs were to:

- **Identify defendants with mental health and/or learning disability issues** through screening and assessments;
- **Provide the court with information on a defendant's mental health needs** to enable the court to effectively case manage the proceedings;
- **Offer sentencers credible alternatives** to custody to support people with mental health/learning disability needs by way of a Community Order with a supervision requirement or mental health treatment requirement;
- **Offer enhanced psychiatric services at court**;
- **Implement regular reviews of orders**; and
- **Signpost those individuals not suitable for the MHC community order** to mental health and other services that could appropriately address their needs.

The pilots were subject to a process evaluation. This indicated that extensive multi-agency collaboration and data sharing arrangements were achieved on both sites but that the caseload was low. Out of 180 people facing court identified as having mental health issues, 55 were given Community Orders with mental health requirements. Of these, nine breached their orders.

The evaluation also noted that the eligibility could be widened to also include those with dual diagnosis.[82]

80 Walsh, n 76, 228.
81 Ibid 228-229.
82 Winstone, J. & Pakes, F. (2010). *Process evaluation of the Mental Health Court Pilot.* London: Ministry of Justice.

## United States Of America

Mental Health Courts (MHCs) first began operations in the USA in the late 1990s and there are now over 250 MHCs operating across the USA. A 2011 meta-analysis showed that USA mental health court participants had better criminal justice outcomes such as reduced reoffending and further imprisonment than similar comparison groups. The analysis found that a number of studies had shown that MHCs can reduce recidivism, and that MHCs link individuals to mental health treatment and provide significant savings for governments. The studies also suggested that individuals with severe mental illnesses who participate in MHC programs are less likely to commit and be arrested for offences caused by untreated illness symptoms.[83]

## The Bronx Mental Health Court

The Bronx Mental Health Court (Bronx MHC) began as a pilot in 1999 and started taking case referrals in 2001. It is a collaboration comprised of criminal justice personnel (judge, defence attorneys, and prosecuting attorneys), a clinical team and coordinating staff.

Defendants are referred to the program, screened for eligibility, enter the court through a formal plea process, are matched with community-based treatment, and then participate in court monitoring, case management, and treatment services. Duration of participation can vary based on the charge and mental illness characteristics, with a minimum 6-month treatment mandate for misdemeanor crimes. Treatment mandates for felony crimes typically last 18-24 months. The mandated length of treatment begins upon entry into a treatment program, rather than the plea date.

**According to program data from 2002-2006, 81% who pled into the Bronx MHC were successfully placed into treatment. Of these:**

- **52%** of clients successfully completed their treatment mandates;
- About one-quarter of program failures were due to rearrest, having a warrant, or violation of conditions.[84]

**Participants in the MHC were less likely to experience recidivism than those who did not participate. The evaluation found that:**

- Being in the MHC program would reduce the chance of re-arrest by approximately **29%**;
- People arrested with diagnosed mental illness and charged with violent offences are associated with positive recidivism outcomes compared to similar people arrested and charged with other offences;
- Individuals diagnosed as hard drug users may be at a greater risk of recidivism, thereby necessitating more attention in MHC.[85]

83 Christine M. Sarteschi, Michael G. Vaughn, Kevin Kim. 2011. Assessing the effectiveness of mental health courts: A quantitative review. *Journal of Criminal Justice* 39 (2011) 12–20.

84 Shelli B. Rossman, Janeen Buck Willison, Kamala Mallik-Kane, KiDeuk Kim, Sara Debus- Sherrill, P. Mitchell Downey. *Criminal Justice Interventions for Offenders with Mental Illness: Evaluation of Mental Health Courts in Bronx and Brooklyn, New York – Final Report*. 2012.

85 Ibid 101-112.

### Brooklyn Mental Health Court

Established in 2002, the Brooklyn Mental Health Court (MHC) was developed collaboratively by the Center for Court Innovation and the New York State Office of Court Administration, in partnership with the New York State Office of Mental Health. The Brooklyn MHC is a post-indictment problem-solving court that handles primarily people charged with felony offences (roughly 80%). It links defendants with serious, persistent mental illness to long-term treatment as an alternative to incarceration and, by doing so, works to effectively address both the needs of defendants with mental illness and the public safety concerns of the community.

The underlying assumption of the Brooklyn MHC is that defendants' criminal behaviours are the result, at least in part, of untreated or inadequately treated mental illness.[86]

Defendants are referred to the Brooklyn MHC program, screened for eligibility, matched with community-based treatment, enter the court through a formal plea process, and then participate in court monitoring, case management, and treatment services. Duration of participation in the program varies based on charge and mental illness characteristics.

Participants enter the court by agreeing to a guilty plea with a sentence comparable to what they would have received in a traditional courtroom. Although a sentence is agreed upon at the time of the guilty plea, formal sentencing is suspended while the defendant participates in the court and associated treatment.

**A total of 519 individuals were referred to the Brooklyn MHC program between 2002 and 2006, of whom, 327 participated in the program. Of these:**

- **74%** successfully completed the program;
- Nearly **40%** of graduates had their charges dismissed, and about one-half had their felony cases reduced to misdemeanor sentences;
- In **21%** there were no further supervision requirements.[87]

The evaluation found that MHC participation lowers the chance of recidivism. The odds of being re-arrested are **46% lower** for the Brooklyn MHC treatment groups than for non-participants. Similarly, having participated in the Brooklyn MHC treatment lowers the chance of re-conviction. People who had committed serious offences who participated in the MHC program were more likely to reoffend than others in the program.[88]

86 Ibid 57.
87 Ibid 77.
88 Ibid 118-119.

The Justice Reform Initiative is an advocacy organisation working to reduce the use of harmful incarceration and build communities in which disadvantage is no longer met with a criminal justice system response.

We work in partnership with other organisations and individuals seeking to bring about justice system change.

The Initiative respectfully acknowledges and supports the current and longstanding efforts of Aboriginal and Torres Strait Islander people to reduce the numbers of First Nations people incarcerated in Australia and, importantly, the leadership role which First-Nations-led organisations continue to play on this issue.

The Justice Reform Initiative is backed by eminent patrons, including former Governors-General Dame Quentin Bryce AD CVO and Sir William Deane AC KBE as patrons-in-chief. A full list of patrons is available on our website.

The Justice Reform Initiative is also supported by hundreds of organisations who are also working to reduce incarceration. A list of supporter organisations is also available on our website.

Visit our website at:

www.jailingisfailing.org.au

Connect with our campaign 'Jailing is Failing' on social media:

@JailingIsFailing

@JailingIsFailing

@Justice Reform Initiative

Contact us at:

info@justicereforminitiative.org.au