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Report by - DAN HOWARD SC – 2008 Churchill Fellow

To study the forensic mental health systems of Canada and the United States

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INTRODUCTION

During June and July 2009 I travelled to the USA and to Canada in order to study and observe, at first hand, the forensic mental health systems in those countries and, more particularly, how they adjudicate and dispose of criminal cases involving the mentally ill. I was particularly interested in seeking out innovative programs that might provide models for better handling of such cases in New South Wales and, more broadly, Australia.

EXECUTIVE SUMMARY

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Summary

My Churchill Fellowship was undertaken in North America (USA and Canada) during six weeks throughout June and July, 2009. My purpose was to examine closely Forensic Mental Health systems; this included examining the laws, procedure and practice relating to the disposition of cases involving the mentally ill throughout the criminal justice process, observing mental health courts and diversionary programs, attending various support agencies for mentally ill persons in the criminal justice system, attending Review Board hearings considering requests for release of forensic patients back into the community, attending Consent & Capacity Board hearings (dealing with the civil detention of mentally ill persons) examining the availability of suitable community programs, treatment in the community and release
criteria. I was particularly interested in any innovative programs that may be of relevance to New South Wales and Australia.

I was greatly impressed by the various models of Mental Health Courts that I observed and examined in detail, and see this as an innovation that could be introduced in New South Wales and, more widely than it is, in other jurisdictions in Australia.

I made a number of observations in relation to the adversarial system in the context of mental health determinations and came to the firm conclusion that more professional education of lawyers is required in this area, in order to achieve the correct/optimum balance between the sensitivities of the therapeutic jurisprudence necessary in this context, and traditional adversarial/rights based advocacy.

The New South Wales Mental Health Review Tribunal has, as recently as March 2009, acquired power to release forensic patients – a power previously vested in the Minister of Health and inevitably tied to the political process. Attendant with this new power will be a significant growth in legal representation at hearings before the Tribunal in release applications, and the lessons I have learnt in North America, where rights based advocacy is entrenched, will be of great relevance to the debate as to how we should manage these hearings, and how lawyers practicing in this area should be encouraged to present their cases.

I was thoroughly impressed with the aggressive provision of supervision and support from relevant agencies and welfare groups that is being brought to bear in Canada and the USA in order to maintain the progress of the mentally ill who have participated in court diversion programs, and to assist them to re-integrate into the community. This is largely a matter of passion of those involved in supporting the mentally ill and also, inevitably, the extent of resources allocated to this area of need. Far more allocation of resources is required in New South Wales and in other Australian jurisdictions.

The comprehensive integration of forensic services in Canada, and their constant drive for innovation, was another standout from which Australia can learn a great deal.

I propose to disseminate the knowledge and experience I have gained during my fellowship through advocacy, among the legal profession and other groups such as the membership of the New South Wales Mental Health Review Tribunal, and by lecturing at conferences of relevant groups, and through my university lecturing.

These matters are dealt with in more detail below.
Programme of Places Visited

In San Francisco, California (June 1 – 9):

• Met with lawyers in the District Attorney’s Office involved with Mental Health Prosecutions, and with the Behavioural Health Court
• Observing close up the Behavioural Health Court including meeting with Judge Mary Morgan, attending innovative pre-hearing conferences presided over by her, watching numerous cases being disposed of in the court
• Meeting with Public Defenders involved in the Behavioural Health Court
• Spending a day with Kathleen Lacey, the Program Director of Citywide Case Management Forensics who provide comprehensive case management services to the court and a remarkable ‘wrap around’ array of vital programs for patients in the Behavioural Health Court program.
• Meeting with Staff Attorneys Pamela Cohen and Steve Rosenbaum of Disability Rights California (a very prominent patient’s advocacy rights organisation)
• Meeting with George Jurand of the San Francisco Sherriff’s Office, and discussing the “Man Alive” program for the rehabilitation of felons through peer engagement and counselling, including confrontation of the harm they did to victims through the use of group sessions with ‘surrogate’ victims.
• Meeting with Patricia Ryan, Executive Director of the California Mental Health Directors’ Association
• Meeting with Stephen Mayberg, Director of the California Department of Mental Health (Sacramento)

In Vancouver, British Columbia (June 10 – 18):

• Meeting with Lyle Hillaby, Crown Counsel (Ministry of Attorney General for BC) – Lyle is the recognised mental health expert in the Ministry and was a wonderful source of information about the laws and practices in BC
• Meeting with Crown Counsel Debbie Granger and Andrew Cochrane who prosecuted cases in the Vancouver “Downtown Community Court” which is an innovative program that, inter alia, seeks to address and break the cycle of mentally ill persons in the criminal justice system by diversion and extensive co-ordinated provision of welfare, treatment and case management in the community.
• Observing the Court and meeting with the presiding Judge Gove
• Meeting with Dr. Johann Brink, the Director of the Port Coquitlam Forensic Hospital (Colony Farm) and touring the facilities
• Attending a Review Board Hearing involving a release application that examined the issue of dangerousness of the applicant.
• Meeting with Berndt Walter, the Chairman of the British Columbia Review Board
In Ottawa, Ontario (June 29 – July 3):

- Attending the Royal Ottawa Mental Health Centre (a world centre of excellence in this field) and meeting with many professional staff members including:
  - Wendy Stewart, Project Director
  - Joan Dervin (overview of diversion programs)
  - Dr. Zul Merali, President of the Institute of Mental Health Research
  - Dr. Paul Fedoroff, Director of the Sexual Behaviours Clinic (attending a cognitive-behavioural group therapy session)
  - Attending the Brockville Secure Treatment Unit and touring this with Forensic Psychiatrist and Director Dr. John Bradford (and Staff including the program manager Stephen Duffy, Social Worker Michael Whalen and Native Inmate Liaison Officer Melinda Turcotte - an Algonquin Indian, each of whom gave me some important and special insights into forensic patient management). Dr. Bradford is a renowned forensic psychiatrist; he is Associate Chief of Forensic Psychiatry Services, Royal Ottawa Hospital, and Professor and Head of the Division of Forensic Psychiatry of the University of Ottawa. He is a Past President of the American Academy of Psychiatry and the Law; Past President and Founder of the Canadian Academy of Psychiatry and the Law. He is an adviser to the DSM IV publication of the American Psychiatric Institute. Subsequent to our meeting, he has invited me to co-author a paper with him comparing aspects of fitness and the mental illness defence in Australia and Canada. I hope to do this in the course of 2009.

- Meeting with Crown Prosecutor Donna Eastwood who spent a morning explaining the procedures of the Ottawa Mental Health Court, which I observed.

In Toronto, Ontario (July 9 – 17):

- Meeting with Dr. Howard Barbaree, Director of the Centre for Addiction and Mental Health (CAMH) and having lengthy discussions with him and staff members (including legal counsel to the Centre) about the forensic mental health system and services in Ontario. CAMH is a world renowned centre of excellence in this field. Dr. Barbaree gave me an escorted tour of the facilities there.
- Attending and observing two hearings of the Ontario Review Board and meeting with several Board members including presiding member Joe Neuberger to discuss its function and procedure for review of forensic patients.
Meeting with Judge Richard Schneider, presiding judge of the Toronto Mental Health Court and discussing the function and procedure of this court. I observed many hearings and dispositions of matters during the course of the day in this innovative court. Judge Schneider is a world leader in the establishment and use of mental health courts and has included me in his Mental Health Courts newsletter. He is the author of numerous books on mental health law, including “Mental Disorder and the Law” (which I have now read) and “Mental Health Courts” (which I am currently reading).

Meeting with Anita Szigeti, a leading mental health defence counsel in Canada and author of their leading text book on the law of Capacity. She is currently involved in presenting an appeal to the Supreme Court of Canada arguing that the Review Boards in Canada should exercise Charter of Justice jurisdiction. She also introduced me to Michael Feindel, a senior Crown Attorney with the Ministry of Justice in Ontario, who is an expert in mental health law.

Attending a hearing of the Ontario Consent & Capacity Board (which deals with review of civil commitment of the mentally ill as well as issues of guardianship) and observing an extremely interesting contested hearing of an application for discharge by a patient. His provided real insights into the adversarial process in this context.

Meeting with Joaquin Zuckerberg, Legal Counsel for the Ontario Consent & Capacity Board and discussing the function and procedures of the Board.

Meeting with Staff Superintendent Mike Federico and with Constable Patricia Fleishmann of the Community Mobilisation Unit – Vulnerable Persons Issues at the Toronto Police Headquarters. The Toronto Police are leaders in community policing and have remarkably comprehensive and impressive programs in place for addressing and supporting the plight of the mentally ill; they provide a 24/7 rapid response patrol that includes several units comprising a police officer and a mental health nurse who are able to attend at crises and assist front line police with this type of matter. They have a comprehensive community liaison network to assist and support the mentally ill.

Meeting with Riun Shandler and Joan Bennett, both Counsel with the Crown Law Office in Ontario and co-authors of “Mental Disorder in Canadian Criminal Law” (published by Thomson Carswell) – the leading practice text in Canada in this field.

Meeting with Chris Higgins, Team Leader, Forensic Mental Health Section, with the Department of Health in Ontario. He provided much useful information about the forensic system in Ontario and we discussed funding issues and the problem of the homeless in detail.

In Washington DC, USA (July 26 – 28)

Meeting with Thomas Zeno, Assistant United States Attorney, an expert in mental health prosecutions and discussing with him the famous case of John Hinckley which brought about great change in the law relating to the insanity defence in the United States. He also arranged for me to speak with Dick Chapman, who was one of the prosecutors involved in that case.
• Meeting with Director Joseph Henneberry of Saint Elizabeth’s Hospital, a famous Mental Hospital in the United States that has recently had a major new hospital built for forensic patients – I was given a full tour of this state of the art hospital that will soon be opening.

• Attending the DC Mental Health Court and observing hearings and meeting with presiding Judge Joan Goldfrank and discussing the philosophy & operation of the court.

• Attending the Superior Court of the District of Columbia’s Mental Observation Calendar, presided over by Judge Ann Keary (who was formerly chief legal counsel for St. Elizabeth Hospital), and observing a number of cases and meeting with Judge Keary.

• Meeting with Colleen Kennedy, Assistant U.S. Attorney and specialist in mental health issues, attending with her and observing Federal Court (US District Court of DC, Judge Sullivan presiding) and observing forensic review of (query delusional/bi-polar) detained accused who had threatened the then President (by throwing a Molotov cocktail at the White House).

In Charlottesville, Virginia (July 29-30)

• Attending at the University of Virginia Law School to meet with Professor Richard Bonnie and Professor John Monaghan. Professor Bonnie is perhaps the most distinguished academic in the United States in the field of psychiatry & the law and public policy in this area, and is widely published including an excellent book on the John Hinckley trial and its impact on American Jurisprudence. Professor Monahan, Director of the MacArthur Foundation Research Network on Mandated Community Treatment, is world famous, inter alia, as an expert on the assessment of dangerousness. They provided me with numerous very current papers and articles on these topics and we discussed a number of issues, in particular the right to refuse treatment in the US that seems to be a major hurdle in the adequate provision of care to the mentally ill.

FELLOWSHIP EXPERINECES IN MORE DETAIL

The entire experience of this Fellowship was a rich ‘learning curve’ of the actual practice of forensic mental health in North America. There were many lessons learnt, and these are some of the prominent ones.

Homelessness and the mentally ill in North America

The extent of this problem, particularly on the West coast (e.g. San Francisco in California, and Vancouver in British Columbia) was nothing short of astonishing and breathtaking. The downtown streets of these two cities were full of homeless and mentally ill persons who have drifted there, both because it is easier to survive on the streets in the warmer Pacific climate, and because there is a perception that more
services are available – although the level of service apparent in California was very patchy, and very dependant on a confused array of unstable sources of revenue support from the City, the State and the Federal Government; the near bankruptcy of the State of California is being played out in a reduction of services (the Department of Mental Health retrenched 200 employees on the day I visited the Director of the Department; the Public Defender numbers were being cut by approximately 8 – these lawyers provide vital legal services to the mentally ill).

The so-called ‘Tenderloin” District of downtown San Francisco is a large, depressed area to which gravitate the unemployed, homeless and the mentally ill, with ‘crack’ houses where cocaine is a serious problem, low rent hostels - a breeding ground for crime and despair. The streets are full of persons just standing about with nothing to do, or sleeping all day on footpaths or in doorways of empty buildings; the smell of urine is almost always in the air. The desperation is palpable. One frequently observed persons who were clearly mentally ill ‘talking to their voices’ and on one occasion the writer was accosted by a delusional man who was upset by my presence (for whatever reason I cannot imagine) by the simple fact that I was standing in a queue waiting for a cable car.

It became apparent to me in discussion with the professional contacts I made, that there is in the United States something approaching a constitutional right to be mentally ill and to refuse treatment, if you are not a danger to yourself or to any member of the public. This seems to be borne out by the surprising statistic that California, with a population of some 37 million people, has only 500 civil involuntary commitment hospital beds, but 5,000 beds for forensic patients.

The device that we use to great effect in Australia (and varieties of which are effectively used in a number of other countries) is the Community Treatment Order. This enables mandated treatment – including with antipsychotic medication - of an individual who may relapse into a state of being a mentally ill person who poses a danger to themself or any member of the public if they are not medicated) – an order that is regularly reviewed and monitored by a specialist Tribunal.

This kind of community treatment is either not available or, in my view, ineffectively deployed by the law in the United States – it is extremely difficult to mandate treatment with anti-psychotic medication even to persons who would very clearly benefit enormously from it; this can only be done in true medical emergencies, or if

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1 See Washington v Harper, 494 US 210 (1990) the US Supreme Court held that The Due Process Clause in the Constitution permits the State to treat a prison inmate who has a serious mental illness with antipsychotic drugs against his will, if he is dangerous to himself or others and the treatment is in his medical interest. In re Qawi (2004) 32 Cal.4th 1, in which the California Supreme Court held that in a non emergency situation, a Mentally Disordered Offender can only be compelled to be treated with antipsychotic medication if determined by a court to be incompetent to refuse medical treatment or to be a danger to others. See also R. Bonnie & J Monahan “From Coercion to Contract: Reframing the Debate on Mandated Community Treatment for People with Mental Disorders” in Law and Human Behaviour, Vol. 29 No. 4 (August 2005) p. 485, who advocate the use of contract rather than coercion for community treatment of the mentally ill. In Sell v United States (2003) 539 U.S. 166 the Supreme Court laid down stringent requirements for authorising involuntary administration of antipsychotic medication for the sole purpose of rendering a criminal defendant competent to stand trial.
the person’s is unable to exercise their capacity to choose whether or not to take such medication, or if there is a serious risk of violence to oneself or to others. It can also be done, subject to very restricted guidelines, to render a person competent to stand trial (a matter in which the interest of the State in proceeding with a prosecution is weighed against the individual’s right to refuse treatment) – see Sell v United States (2003) 539 U.S. 166. Sometimes compliance with medication will be made a condition of a probation or parole order, but even then, it cannot be enforced other than by conventional sanctions for breach.

Even progressive legislation mandating outpatient treatment such as New York’s so called ‘Kendra’s Law’ (1999) and California’s ‘Laura’s Law’ (both named after victims of untreated mentally ill persons) do not authorise forced medication in the face of refusal, but merely authorise the return to hospital for observation and possible involuntary commitment if certain quite strict criteria are met\(^2\).

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“Thus a statute ostensibly designed to enable patients to be stabilized in the community and avoid hospitalization precludes enforcement of the court order until patients are in such poor condition that they already qualify for involuntary hospitalization.”\(^3\)
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Indeed, it has been said that California’s Laura’s Law appears to be ‘virtually ignored’ in practice, as has outpatient treatment legislation in Florida\(^4\).

The Role of the Adversary System

After discussing this issue with Academics, Patients’ rights advocates, Public Defenders, Prosecutors and observing the mental health courts, Review Board, Consent & Capacity Board and other proceedings, I formed the view that (with some notable exceptions that I will mention later) the great civil rights traditions in the US (where there is a Bill of Rights) and in Canada (where there is a Charter of Rights) whilst admirable in so many ways, have given rise to an approach to adversarial process that, in my view, often does a disservice to persons caught up in the forensic or civil mental health system. I was left wondering if some of these persons may be ‘dying with their rights on’ – not literally dying, but having their rights so strenuously guarded that their true needs from a therapeutic point of view were being sacrificed.

One example that was of concern was a hearing I observed in Canada in which the patient, who suffered from a long standing mental illness, had applied to be discharged and the evidence clearly suggested this was premature but that he would

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\(^2\) the mentally ill person must be unlikely to survive safely in the community without supervision; have a history of noncompliance that has led to two hospitalizations or incarcerations in which psychiatric services were provided in the previous 36 months, or at least one act or threat of violence toward self or others in the previous 48 months; and require outpatient commitment to prevent relapse or deterioration that would be likely to result in serious harm to the mentally ill person or to others or in grave disability. There are additional criteria in the California legislation.

\(^3\) This quotation is taken from an article Law & Psychiatry: Ambivalence Codified: California’s New Outpatient Commitment Statute by Paul Applebaum MD in Psychiatric Services 54, 26-28 January 2003

be able to be discharged in the near future. The application was being resisted by the
treating psychiatrist and a close family member of the patient was called to give
evidence on behalf of the hospital, in support of the position that the patient needed to
remain in hospital for the present; they were also cross-examined. This family
member was sitting on one end of the hearing room table next to the hospital
psychiatrist and the hospital lawyer who was opposing the application. At the other
end of the table sat the patient and his counsel. The lawyers and the legal argument
became, in effect, the ‘centrepiece’ of the hearing, a wedge between the patient and
the family member, and between the psychiatrist and the patient. The family member
was close to tears. The damage to the patient’s most important family relationship that
was done by the fact that the relative (who, the evidence clearly demonstrated, was a
very loving, caring and sensible person with nothing but the best interests of the
patient at heart) had been called as a witness against the patient in this adversarial
process, appears not to have been given any thought – the relationship became simply
a casualty of the legal process, as did the ongoing therapeutic relationship between the
treating psychiatrist and the patient.

I also became aware of a pending appeal in the Supreme Court of Canada where an
argument is being run that the Review Boards (which are responsible for the ongoing
review of forensic patients) ought be required to exercise ‘Charter Jurisdiction’ – that
is, that applications arising out of alleged breaches of rights under the Canadian
Charter of Rights, ought be allowed to be made before Review Boards. Whatever may
be the best position in Canada, a jurisdiction such as this, if required to be exercised in
New South Wales by the Mental Health Review Tribunal, would (in my opinion)
completely swamp and paralyse its work by myriad legal arguments of little relevance
to the Tribunal’s functions, and would be inappropriate in the New South Wales
context, and certainly is best left to the review power of the Supreme Court.

In New South Wales the Mental Health Review Tribunal has only just acquired (in
March 2009) the power to discharge forensic patients (this power had previously
vested in the Minister for Health and was seen as a having an unhealthy political
component). There will inevitably be more intense advocacy before the Tribunal over
release applications.

It is clear that it is extremely important, in the field of mental health law, to strike the
right balance in the role of advocate; whilst it is obviously important to jealously
guard the rights of the patient through rigorous and competent advocacy, it is vital
that those who practice in this area not loose sight of the therapeutic imperatives of
each case. Lawyers are rarely trained in the subtleties of this, and it is my view that
this is an important target area for continuing education⁵.

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⁵ See Bonnie & Monahan, ibid. at 500, where they state: “The language of coerced treatment tends to
lead opponents to stand their ground and draw lines in the sand. Much of the currently stalemate
debate on mandated community treatment, we believe, can be traced to the framing of the arguments in
unyielding rights-discourse terms".
The Benefits of Integrated Services in Forensic Mental Health

I was extremely impressed by the extent of integration of forensic mental health services in Canada generally, and in certain instances in the United States.

The Royal Ottawa Hospital’s Centre for Mental Health had a remarkable range of facilities and dedicated experts all working co-operatively under the one institution that provided a comprehensive range of services to patients, not just in a mission statement, but in fact. My visit to the Centre in Ottawa and its forensic facility at Brockville, Ontario, gave me an ‘up close’ look at the effectiveness of this integrated approach. Under the one roof the Centre provides violence prevention programs, court diversion programs, pre-trial assessment and treatment, inpatient services, support for the mental health court in Ottawa and for the Ontario Review Board, outpatient and consultation services. It was impressive that both outpatients and forensic detainees (including those being assessed as to their fitness to stand trial) were being dealt with through the Centre – a recognition that the patient’s mental health is given primacy over the route by which the patient came to be in care or detention. A brochure published by Royal Ottawa Health Care Group indicates that it provides: “varying levels of security are provided within a structured treatment environment that creates a therapeutic milieu of supportive care that promotes safe re-integration into the community”. I saw all of this in reality – backed up by a highly dedicated and professional staff of innovative psychiatrists, mental health nurses, social workers and other disciplines. The efforts made by social workers to assist forensic patients with community leave privileges to find work and decent accommodation in the community at Brockville was impressive indeed, with fine community liaison and garnering of community support by personal engagement. I was extremely impressed by the provision of a highly skilled and dedicated Native American Inmate Liaison Officer who had a very clear understanding of the special problems facing this group.

The Centre for Mental Health also houses the University of Ottawa’s Institute of Mental Health Research (IMHR) – Director Dr. Zul Merali; this is a high level engagement with academic research in mental health across a number of critical disciplines identified in their strategic directions (set out in their most recent annual report). The presence of this Institute on site has an immediate benefit of rapid exchange of learning and experience between researchers and those engaged in clinical practice. Whilst I was in Ottawa a very significant breakthrough in research was announced by the Institute that their research on the human genome had identified certain genes, the presence of which enable treating doctors to know and predict more accurately what the likelihood will be of a given patient having side effects from various medications – often a critical thing to know to avoid the distress and ‘backsliding” that can occur through finding the correct medication by trial and error.

I observed equally impressive integration of services and research at CAMH in Toronto. A current and highly innovative project being developed there is the creation of an urban village community (the Queen Street Re-Development Project6) where it

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6 See CAMH information on this project at [http://www.camh.net/News_events/Redeveloping_the_Queen_Street_site/Master%20Plan%20and%20Other%20Documents/Master_Plan_and_other_documents.html](http://www.camh.net/News_events/Redeveloping_the_Queen_Street_site/Master%20Plan%20and%20Other%20Documents/Master_Plan_and_other_documents.html)
is proposed that patients will be able to live among non-patients, and where there will be shop owners and other service providers from the general community who will be invited to establish businesses, to service the community, as well as the general public, thereby providing the patient community with a very real opportunity to engage in activities (such as working at one of these shops) that will prepare them for full reintegration into the community. This ‘lateral’ thinking of ‘bringing the community and its opportunities to the hospital’ is an outstanding example of the innovative thinking that is going on in Canada.

The Importance of Mental Health Courts

Justice Richard Schneider, who presides over the Toronto Mental Health Court in Canada, and who has published widely on this topic, writes:

“The provision of mental healthcare services in most western European and North American communities has witnessed a steady decline over the last few decades. Beginning with the deinstitutionalisation movement occurring in the later half of the twentieth century, adequate mental health care services became increasingly scarce. Despite what was promised, the money saved with the closure of hospitals has typically not been reinvested in community treatment.

In some jurisdictions, mentally disordered accused entering the criminal justice system have increased at a rate in excess of 10% per year over the past 12 years. A criminalisation of mental illness has occurred; a shifting of responsibility onto the criminal justice system for the provision of basic mental healthcare services…”

The great prevalence of mental illness among inmate populations in the gaols in many countries is now well established. A recent study of inmates in two gaols in Maryland and three in New York State established that 14.5% of the male and 31% of the female prisoners suffered from “Serious Mental Illness.” If one includes other psychiatric disorders, the figures are even worse – for example, one 2007 study in the state of Connecticut evaluated a cohort of inmates who were not identified at intake as having a mental illness and found that two thirds met criteria for a lifetime psychiatric disorder, including anxiety disorders and anti-social personality disorder. If one includes drug dependency disorders the numbers are worse still.

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7 Steadman & ors. “Prevalence of Serious Mental Illness Among Jail Inmates” in Psychiatric Services June 2009 Vol. 60 No. 6. The study defined as ‘serious mental illness’: major depressive disorder; depressive disorder not otherwise specified; bipolar disorder I, II, and not otherwise specified; schizophrenia spectrum disorder; brief psychotic disorder; delusional disorder; and psychotic disorder not otherwise specified.


9 See Butler & Allnutt “Mental Illness Among New South Wales Prisoners” State Publication No, (CHS) 030147 (2003) which found that over two-thirds of reception prisoners in New South Wales had
The importance and potential of Mental Health Courts was an issue that I grew increasingly interested in as my study tour progressed, and I made a concerted effort to observe a number of these in detail, including:

- The San Francisco Behavioural Health Court
- The Vancouver “Downtown Community Court”
- The Ottawa Mental Health Court
- The Toronto Mental Health Court
- The Washington DC Mental Health Court

In each case I met with the personnel involved, discussed with them the working of the court and observed the court in action.

I believe that there is an important role for specialist mental health courts to play in jurisdictions throughout the world. In North America there was a remarkably determined and integrated approach to linking the mentally ill with appropriate services and re-integrating them into the community with excellent and determined follow up. Yet even in North America, there still seems to be a scarcity of resources to address this problem. Spaces in programs were necessarily restricted, and the ongoing funding of programs appeared to be a frequent concern of mental health court administrators and supporting agencies. Universally, resources seem to be always limited in the provision of truly effective mental health services – governments must do better to resource these kinds of programs on an ongoing basis.

I met with Justice Schneider, who is a leading proponent of Mental Health Courts. His book (co-authored with Hy Bloom and Mark Heerema) “Mental Health Courts” (Irwin Law 2007) notes that there are a variety of models for this type of approach, and what will work best depends very much on the local needs and context and (of course) availability of resources. I will briefly describe the models that I observed.

The Models Observed

- **A Special Mental Health Court Program run as an adjunct to a Superior Court**

  This was the approach of the singularly impressive San Francisco ‘Behavioural Health Court’ (which is list run by the Superior Court of California) with aggressive, holistic and ‘wrap-around’ involvement of a wide range of services in collaboration with the Court, with intensive supervision and review of participants by the Court on a very regular basis.

  To be considered for the program, which typically would run for some 12 to 18 months, a defendant must be charged with, convicted of, or on probation for, a misdemeanour or felony offence where the behaviour that led to the offence was connected to mental illness. Homicide and sexual offenders are

  a 12 month diagnosis of substance abuse disorder; the study also found that 46% of reception inmates and 38% of sentenced inmates had suffered a mental disorder (psychosis, mood disorder, anxiety disorder) in the 12 months prior to the survey.
ineligible. The defendant’s prior criminal history and treatment history in the community mental health system are considerations in determining eligibility. Participants can enter the program if assessed as suitable for the program, in which case an agreement is entered into between the accused and the court, with the consent of the prosecution to defer the trial or sentence. By such agreement the accused importantly agrees to the sharing of private information by a variety of agencies (which cuts through much red tape on privacy issues and facilitates the entire process) and agrees to abide by the rules of the program and the orders of the court, on pain of expulsion from the program if persistently non-compliant (in which case the charges would proceed). Typically a participant would not be released from custody until appropriate accommodation became available in the community.

Perhaps the most striking feature of this model that I observed was that, prior to the commencement of the court list, the Judge held a meeting of all relevant stake-holders in the ‘team’ (in the absence of the accused). This included the prosecutor from the district attorney’s office, defence counsel, Jail Psychiatric Services (who would perform comprehensive assessments of the participants and would-be participants as required), case work managers (from the remarkably dedicated ‘Citywide Case Management Forensics group), representatives of any a vast array of relevant community treatment providers for the case in hand, the Adult Probation Department and the Office of Collaborative Court Programs.

Each matter in the day’s list would be discussed in this conference setting, addressing all aspects of the on-going management of the person’s case, and a disposition, to be announced in court, would be determined if possible (and it usually was); where prosecution and defence could not reach an accommodation, the judge would make a determination after argument and (though rarely necessary) after evidence and submissions were taken in court.

As a result of this conferencing practice, the presiding judge, Judge Mary Morgan, had a thorough knowledge of each person’s case (including their history, their treatment program and goals, and strategies being taken for re-integrating with the community) so that when the matter was called in court, she was able to deal with each case in a very straightforward and easy way with a minimum of procedural formality. Nevertheless, if persons were persistently failing their guideposts for the program, they would be ejected from the program to make way for others. If a participant was struggling to meet the goals of the program (for example, failing to keep appointments with their case worker or to attend therapy or to take their medication, or if they were taking illicit drugs, they would be closely monitored – usually firmly admonished and given an ultimatum for attendance/treatment etc., and if necessary were expelled from the program. Judge Morgan had an astonishing ability to communicate with the participants, and commanded enormous respect from them. The court proceedings were held openly in the presence of many other members of the program whose matters were also in the list, and successful achievement of goals was acknowledged by applause and, in some cases, even a small gift. There was a remarkable sense of family in the whole process – something I have never experienced before in a court of law.
Back up the court orders was an outstanding, dedicated and comprehensive case management service, with excellent access to therapies, sources of housing and employment, welfare agencies and other support mechanisms. I visited the Centre operated by Citywide in downtown San Francisco, and was greatly impressed by the array of personally tailored programs and services they were providing for the participants of the program.

This court sits two days a week (Tuesdays and Thursdays), Judge Morgan being a Superior Court Judge who attends to other matter on other days.

The Court has been in operation since 2003 and statistics measuring its success have been analysed by researchers at the University of California, San Francisco, which is associated with the program to provide expert academic analysis of its performance. A statistical study completed in 2006 indicates a remarkable success for many individuals and an overall reduction in the recidivism rate for this group at 18 months after graduation from the program (compared to the control group who did not go through the mental health court) for any kind of offence was 26% and for an offence of violence was 55%\(^\text{10}\). There can be no doubt that this approach is resource intensive, but this may be the best practice for these extremely difficult and otherwise intractable cases. The court is making a major contribution to ‘breaking the cycle’ of mentally ill persons remaining untreated, being arrested for criminal matters, and ending up in gaol after no realistic and sustained rehabilitation plan had ever been provided. Unfortunately due to resource limitations, places are currently limited to 140 participants, although it is hoped that this will expand significantly in the future. Until more resources can be brought to bear, this excellent and inspiring program is only able to address ‘the tip of the iceberg’ of the problem in San Francisco.

- **The Community Court Model\(^\text{11}\)**

Unlike the dedicated mental health court this model services the general needs of a targeted ‘community in need’. The example I observed at close quarters was the Downtown Community Court in Vancouver, British Columbia, Canada.

Downtown Vancouver, like San Francisco, has a vast community of disadvantaged souls including homeless, unemployed, drug addicted and, inevitably, the mentally ill. The Downtown Community Court is an attempt to

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\(^{10}\) D. McNeil & R. Binder “Effectiveness of a Mental Health Court in Reducing Criminal Recidivism and Violence” in *American Journal of Psychiatry*, 164:9, September 2007. A further study by the University of California, Berkley is to be released sometime this year.

\(^{13}\) For much of the material in this section I have drawn on information brochures and materials published by the Court describing its structure, programs and operation, and gratefully acknowledge these.
address the obvious needs of this highly troubled and disadvantaged group. It operates on the principle that collaborative case management can help offenders make long term changes to their behaviour.

The Court began operation on 10th September, 2008. It occupies two floors which hold two courtrooms and numerous conference/interview rooms. Most impressive, however, is the fact that housed on the same premises are offices for numerous staff and agencies that bring to bear a remarkable range of services and strategies for the cases that come before the court. These include:

- Crown Counsel
- Defence Counsel
- Victim Services Worker
- Local Probation Manager
- 8 Probation Officers
- A Native court worker
- 2 Nurses
- 4 Health-Justice liaison Workers
- A Forensic Psychiatrist (part time)
- A Vancouver Police Officer
- 2 Employment Assistance Workers
- B.C. Housing support worker

The court exercises jurisdiction chiefly in summary matters, but also indictable matters dealt with summarily (including drug possession), and in indictable matters where the accused is not held in custody, is prepared to plead guilty and a community supervision order is seen to be in the best interests of the offender and the community.

If an accused agrees to work with the community court, they have an interview with a member of a “Triage Team” made up of appropriate agencies, including representatives of probation, health, social services and housing. The interview will gather relevant information about the accused to assist the team to understand the needs of the individual accused, and to develop a plan for the judge’s consideration. Cases may be assessed as ‘simple’ or ‘complex’ which may require more detailed assessments in relation to psychiatric and/or drug addiction issues, which will further involve additional professionals attached to the court. A case management team may be assigned to ensure the offender follows through with the recommendations in the intervention plan.

In sentencing the offender, the judge has a full range of sentencing options from compensation, community service to jail.

The court maintains a close liaison with the community and community groups to maximise the opportunities for offenders to re-establish with the community – thus local businesses may provide employment opportunities, jobs to be performed as part of a community service order, local volunteer groups help offenders to attend programs, provide work experience and the like.
I observed a number of cases dealt with by this court and had a discussion with the presiding judge, Judge Thomas Gove of the British Columbia Provincial Court.

I was greatly impressed by the powerful array of on-the-spot professionals who could promptly bring to bear on each case their services and the support of the agencies that they represented. The presence of such services in the courthouse facilitated immediate access to information from all participating agencies and enabled a quick and well targeted response to the problems presented by an individual case. Accused persons agreeing to work with the court program were requested to authorise sharing of information to overcome privacy restrictions that would otherwise hamper and slow down the process.

The court procedure itself I thought was a little too formal and traditional – it was constrained by the fact that its innovative new functions had to be performed alongside with the more traditional jurisdiction of a Provincial Court servicing the local community – not all accused coming before the court wanted to participate in its program, and many were simply not eligible to be dealt with in anything other than a traditional way (for example, by a sentence of imprisonment). I felt that this tended to dilute the capacity of the court to perform as a ‘specialist’ court targeting specialised needs (such as those presented by mental illness and drug addiction); to use a metaphor - it was performing more as a ‘general practitioner’ rather than as a specialist ‘physician’.

The Attorney General of British Columbia in January 2009 noted that “It is still early going, but the approach looks to be effective and efficient in addressing the complex needs of offenders, who often face multiple challenges”. The Community Court is clearly a very promising initiative in Vancouver.

- **The Dedicated Mental Health Court**

I observed the operation of The Toronto Mental Health Court, which operates full time as a mental health court in the Old City Hall, Toronto, Ontario. It is a specialised court within the Provincial Court of Ontario. It has two primary objectives: to deal expeditiously with pre-trial issues of fitness to stand trial and to slow down the ‘revolving door’ by reducing the risk of re-offending. Matters from other courts that appear to involve issues of mental disorder are referred to the Mental Health Court.

Prior to the court’s establishment, there were a series of procedural delays that occurred in mental health cases, as a result of the lack of co-ordination of services. The need to obtain psychiatric assessments, for accused persons whose fitness to stand trial was in question, required the adjournment of cases with the inevitable delays resulting in mentally ill persons spending

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12 I am indebted to Judge Richard Schneider and the book he co-authored with H. Bloom & M. Heerema “Mental Health Courts – Decriminalising the Mentally Ill” (Irwin Law 2007) for much of the material I have used in this summary of the Toronto Mental Health Court.
significantly more time in custody than was necessary. The problem that this caused was that when the accused was finally treated and rendered fit for trial, they would frequently enter a guilty plea and, having by then spent more time in custody than the sentencing ‘tariff’ for the offence warranted, whereupon they would be released from custody and then lost to care without having been connected to any ongoing program of treatment or support in the community. Inevitably such persons, now untreated, would frequently deteriorate and then re-offend and the whole cycle would start all over again.

The Toronto Court introduced ‘same day’ assessments where a duty psychiatrist from the Centre for Addiction & Mental Health (CAMH) is available at the court each day, to assess fitness; this can usually be done on the same day, whereupon, if the accused is found unfit after the psychiatrist’s evidence is taken and counsel’s submissions are heard, the prosecution can apply for a treatment order of up to 60 days can be made for the purpose of rendering the accused fit for trial. Their matter, whether it is a felony or a misdemeanor, can then be dealt with by the court if it is a bail application, a guilty plea or if a verdict of Not Criminally Responsible (on the grounds of mental disorder) is entered ‘by consent’; if the plea is ‘not guilty’ the matter will be sent back to the referring court. This enables the court to concentrate its efforts on making dispositions of the matter that will address the needs of individual offenders. On the premises of the court are court mental health social workers who are able to assist in re-integrating the offender into the community, assist with housing, social welfare entitlements, regaining identification papers, clothing, medication, and connections with treatment teams and outpatient programs. They also assist in assessment of an accused person’s suitability for the diversionary programs and other appropriate dispositions that may be imposed and supervised by the court.

Diversion can occur pre-plea, post plea and post sentence; prospects of release are connected to compliance with a plan to keep the accused functioning optimally while on release. If the accused is not suitable for diversion, generally, between 80% and 90% of all accused resolve their criminal matters with a guilty plea, typically after pre-trial negotiations between the Crown and the defence 13.

- The Mental Health Diversion Court Model – The District of Columbia Mental Health Court

I visited this court and observed hearings, and discussed its jurisdiction with the presiding judge, Judge Joan Goldfrank.

This initiative of the Superior Court of the District of Columbia commenced in October 2007. It provides for the diversion of misdemeanor charges (excepting domestic violence) in cases involving mental disorders 14, through

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14 The defendant must have a psychosis or other disease which substantially impairs their mental health; they may also have a recurring substance abuse disorder. Eligible defendants may have prior criminal convictions but generally may not have any dangerous or violent felony convictions within the
the use of a Deferred Prosecution Agreement (DPA) usually entered into for a 4 month period (although this can be extended to 6 months) during which, in return for a promise to discontinue charges contingent upon compliance with the conditions of the diversion negotiated as appropriate for the individual accused, the accused agrees to comply with those conditions. The accused may also be required to make restitution to the victim. The Diversion program is not intended to be ‘sanction based’ although a bench warrant may be issued for failure to appear. If the diversion is terminated, for example, because of non-compliance with conditions for at least 30 days or the commission of another offence, the matter will be sent back to the referring court.

The accused does not need to admit guilt to enter a DPA, but must acknowledge that the prosecution has sufficient evidence to proceed with the matter.

The program is backed up by excellent liaison with support agencies through the Pretrial Services Agency’s Specialised Supervision Unit; accused are connected with mental health services (usually through the Department of Mental Health) and are evaluated for the program. Once a DPA has been made, the Court will closely monitor the progress of the agreement by regular ‘Status Hearings’ usually once a month, when the accused will come to court where their progress can be reviewed.

A very innovative addition was the availability on the court premises of a psychiatric clinic, where participants could attend for treatment – this significantly reduces the risk of a person being lost to care.

Also of note was the choice of court room for this court – it is a small intimate court, not intimidating and this seemed to facilitate proceedings being less formal and more conversational – all of which had the effect of setting the participants at ease. Nevertheless there was an appropriate level of dignity in the process, and the judge was robed.

After the first 18 months of operation of the program:

- 395 defendants were referred to the court
- 129 defendants successfully completed DPA’s
- 43 defendants had their DPA terminated
- 117 were sent back to the referring court
- 39 were rearrested for other offences
- 35 bench warrants were issued
- 112 cases were pending

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last five years. They may not be on probation, parole or supervised release for, or have any pending, violent offence matters.
CONCLUSIONS AND RECOMMENDATIONS

1. The extent of mental illness and homelessness in the streets of the major cities visited in Canada and North America was nothing short of extreme and comprises a major challenge for even these wealthy societies. Although not as extreme as in North America, the extent of these problems in Australia is unacceptably high and constitutes a problem needing urgent attention and more strategies and resources than are currently being brought to bear by government.

2. Both Canada and the USA demonstrate some truly excellent initiatives in their attempts to deal with this problem, but resources being brought to bear on the problem still remain inadequate, particularly in the United States, where sources of funding are fickle and complex. More reliable funding from government is necessary in order to ensure that programs that actually work are able to continue.

3. In my view (and no doubt this is an area where minds may differ) the great civil rights cultures in Canada and the United States have, ironically, led to a situation where the effective use of mandated treatment in the community for the mentally ill is severely under-utilised to the extent that the problem is aggravated rather than alleviated. Australia’s more therapeutic and supportive approach, in this respect at least, should be retained and promoted as a preferable policy choice.

4. The Adversarial approach in North America in many instances was counter-productive in this kind of case, if the advocate(s) involved had insufficient knowledge or understanding about what was in the best interests of the client’s/patient’s mental health. Sometimes ‘rights based advocacy’ seemed blind to these best interests. Australia is not immune from this.

5. It is vital that there be more professional development education in the legal profession about effective mental health advocacy and its subtleties. In New South Wales, where the Mental Health Review Tribunal has only this year acquired jurisdiction to release forensic patients, there will be a sudden and significant increase in the number of advocates appearing before the Tribunal, and it is vital that such advocates are appropriately trained and skilled in this area. Programs need to be established to promote and deliver proper education in this area to the legal profession including advocates and judges.

6. Integration of mental health services, such as was observed in Canada (The Centre for Mental Health at the Royal Ottawa Hospital being an excellent example) is highly effective and should be encouraged wherever possible. This should ideally also include the exchange of knowledge and experience between clinical practitioners with academic researchers, ideally co-located or in close proximity. Another example of successful outcomes through integration of services was seen in the various mental
health court models described above, where a powerful array of services and agencies were housed under the one roof where they could be brought to bear, swiftly and very effectively, on individual cases before the court (as in the San Francisco Behavioural Court and the Vancouver Community Court). Another example of highly effective integration was the provision of on-the-spot psychiatric assessments on the issue of fitness for trial (as in the Toronto Mental Health Court) and in the provision of a psychiatric clinic at the courthouse (as occurred in the Ottawa Mental Health Court and the in the District of Columbia Mental Health Court). Australia would benefit immensely from similar integration of services, a phenomenon far less developed here than it ought to be.

7. The use of Mental Health Courts was observed to be highly effective and efficient in addressing the problem of the mentally ill being caught up, often inappropriately, in the traditional criminal justice process, and the serious problem of the over-representation of the mentally ill in the prisons.

8. The variety of mental health court models examined all had something very positive to offer, although the correct assessment of the needs and priorities of the relevant community will determine which model is most appropriate. In my opinion New South Wales should establish a mental health court in Sydney, and would benefit greatly from a diversionary court model similar to the District of Columbia Mental Health Court, but extended to include cases where the accused has been charged with a felony, if the case is otherwise assessed as suitable. It would need to incorporate the features that were common to the models observed, which included:

- Agreements/contracts, allowing for:
  - Sharing of information/privacy waiver
  - Treatment program implementation and compliance
  - Avoidance or reduction of penalty/conviction
- Regular monitoring/review
- High intensity of support services
  - Psychiatric screening/treatment/on site clinic
  - ‘Triaging’/assessment of suitability for program/diversion
  - Multiple agency involvement & follow up with real delivery of relevant services in accordance with an appropriate treatment plan
- Diversion, which may also include provision for
  - Community service
  - Dismissal of charges
  - Restitution
- Follow up & sustainability in the community
Consideration should also be given to vesting such a court with the jurisdiction to determine the question of an accused person’s fitness for trial in indictable matters, adopting the efficient and timely approach of the Toronto Mental Health Court (as described above). Then all metropolitan District Courts where this issue is raised could refer the matter to the court, which could deal promptly and efficiently with this issue, utilising on-site psychiatric assessments, with the addition of a psychiatric clinic enabling the provision of treatment (and transfer to hospital where necessary) for persons requiring immediate psychiatric care.

9. Whilst the existing scheme in New South Wales under s 32 and s 33 of the Mental Health (Forensic Provisions) Act, 1990 offers a diversionary alternative to traditional criminal justice, the fact that this jurisdiction is exercised by magistrates in local courts located in a great many locations, works against the integration and concentration of the resources necessary (be they mental health professionals, support agencies, specialist judges and advocates, or others) to truly address this problem. Whilst local mental health care services can be excellent, they rarely provide the immediate and ‘wrap around’ services at a level of intensity needed for optimum results in these difficult cases. The Local Court jurisdiction is summary only, and this prevents the use of specialist diversion in felonies that cannot be dealt with summarily, whereas diversion may often be appropriate in these cases. Whilst magistrates should retain their powers under s 32 and s 33, I recommend that they also be given power to refer the more complicated and/or intractable cases to a specialist mental health court where the aforesaid resources, skills and supports would be available to properly address these matters.

10. Research on the efficacy of mental health courts is starting to accumulate – in a recent article Judge Schneider states:

There are now studies that support the previously intuitive projection that mental health courts do indeed reduce recidivism rates. Studies are showing that participation in mental health court programs is associated with longer time without new criminal charges, or charges for violent crimes. In addition to reducing the probability of future arrests, data are confirming that those who complete their mental

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health programs do better than those who do not\textsuperscript{18}. Other reports confirm that mental health courts improve access to care\textsuperscript{19}, save the taxpayers money by keeping mentally ill individuals out of prison, reducing drug abuse, improve overall level of functioning\textsuperscript{20}, and should no longer be funded on a ‘pilot project’ basis\textsuperscript{21}.

Among the stated goals of the Washington DC Mental Health Court is the reduction of the rate of gaol detention and involuntary forensic hospitalisation for program participants, thus reducing the overall costs in the Criminal Justice System, noting that the cost of one day in gaol (as at October 2007) was US$115.00 and one day at St. Elizabeth’s Mental Hospital was US$650.00.

11. There is a mounting and compelling body of evidence that Mental Health Courts work; indeed, they have been established, in one form or another, in a number of countries but could be established in a great many more. In jurisdictions where the lack of concerted programs for the support of mentally ill in the community keeps the ‘revolving door’ to the gaols going around, governments have an obligation to act. The establishment of mental health courts staffed by appropriate persons and backed up by proper, adequate and integrated support from government and community agencies is a proven way forward.

12. Finally, it was very apparent to me that courts exercising specialist jurisdiction in mental health matters require exceptional judges with outstanding communication skills, great patience and deep understanding of the many complex issues involved in the treatment and rehabilitation of the mentally ill. Similarly, lawyers need to be specialised and appropriately educated in this area and the importance of on-going education cannot be overstated.

\textbf{Proposals for Dissemination}

I was invited to speak at the 14\textsuperscript{th} Annual Conference of the International Association of Prosecutors in Kiev on 8\textsuperscript{th} September, 2009, about my Churchill experience, on the topic “\textit{Breaking the Crime Cycle for the Mentally Ill - An Examination of some Current Models in North America for Diverting the Mentally Ill}”. I presented a paper there including much of the material that I have set out under the heading “The Importance of Mental Health Courts” above. The Conference resolved, inter alia, to promote the further education of

\textsuperscript{18} Moore M. & Hiday V., \textit{Mental Health Court Outcomes: a comparison of re-arrest and re-arrest severity between mental health court and traditional court participants}; Journal of Law & Human Behaviour 2006; 30:659 - 674
\textsuperscript{19} Boothroyd & Ors., \textit{“The Broward Mental Health Court: process, outcomes, and service utilisation}, International journal of Law & Psychiatry 2003; 26:55-71
\textsuperscript{20} Kuehn B., \textit{“Mental Health Courts Show Promise”}; Medical News Perspect 2007; 279:1641 - 1643
\textsuperscript{21} Acquaviva, G., \textit{“Mental Health Courts: no longer experimental”}; Seaton Hall Law Review 2006; 36:971 - 1013
prosecutors on a variety of issues including innovative alternatives to prosecution (which encompasses such ideas as community courts and mental health courts).

I have also been invited to speak on this topic to the Institute of Australian Psychiatrists (IAP) Scientific Conference to be held on 17th October, 2009.

I propose to send an abstract of a paper on Mental Health Courts for consideration as a conference paper at the Australian Institute of Judicial Administration’s conference being held in May 2010.

I lecture regularly at the University of New South Wales and have already disseminated information gained from my Churchill Fellowship experiences in lectures to students in the Masters of Forensic Mental Health program.

I propose to give a lecture about my experiences at a continuing professional development session at the Mental Health Review Tribunal (of which I am a part time member).

I have many colleagues in the legal profession with whom I will discuss the prospects of a Mental Health Court in New South Wales, and I propose to advocate for the establishment of this.

**Expression of Thanks**

Finally, I wish to express my deep gratitude to the Winston Churchill Memorial Trust in Australia for making this fellowship possible. It has truly been one of the most enriching experiences of my life and has raised my awareness of many critical issues in the mental health area to a deeper level of understanding that only first hand experience and observation can provide.

I would also like to thank all of the helpful individuals and the many institutions and agencies that took the time and trouble to engage with me and to share their learning and understanding with me in so many generous ways.

Dan Howard SC

Dated: