EXPLORING JUSTICE PRACTICES:
STAKEHOLDER CONCEPTUALIZATIONS OF THE REGINA MENTAL HEALTH
DISPOSITION COURT

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Brittany Mario, candidate for the degree of Master of Arts in Justice Studies, has presented a thesis titled, *Exploring Justice Practices: Stakeholder Conceptualizations of the Regina Mental Health Disposition Court*, in an oral examination held on January 29, 2016. The following committee members have found the thesis acceptable in form and content, and that the candidate demonstrated satisfactory knowledge of the subject material.

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Abstract
Mentally ill people are overrepresented in the criminal justice system. Correctional statistics report that these individuals compose 13% and 29% of the male and female population respectively at the time of admission into a prison facility, which is two to three times the prevalence of the general Canadian population. Mental health courts can help alleviate this problem as they seek to divert individuals from the criminal justice system to the various community services and resources that are required. This thesis investigated the Regina Mental Health Disposition Court. Stakeholders in this study included the professional individuals who are involved with the mental health court process and clients. Stakeholder perspectives were explored through open-ended, semi-structured interviews, specifically how these individuals conceptualize the court, if it is different than traditional criminal courtroom settings, and whether the court engages in an alternative form of justice. The data was analyzed using thematic network analysis. Findings reveal that the Regina Mental Health Disposition Court employs a therapeutic jurisprudence framework by engaging in a holistic approach to justice. This research addresses a gap in qualitative literature and contributes to the growing body of Canadian literature on mental health courts and demonstrates that the court is addressing a critical need in the justice system.

Keywords: mental health courts, overrepresentation, Saskatchewan, diversion, criminal justice, mental health, neoliberalism, therapeutic jurisprudence, justice practices, qualitative research
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Dedication

I would like to dedicate this thesis to my family and friends. To my parents, for putting off empty nesting for a few years and letting me come back home to pursue my academic career. For keeping me grounded when I am stressed, making me eat when I would have skipped meals, and for your encouragement, pride, and most of all for your love. Mom, my role model and mentor, thank you for reading over my papers time and time again and offering your critical and scholarly eye, for giving me grammar lessons, and for instilling in me a passion for education, feminism, and a need to give a voice to marginalized persons. To my dad, for making me laugh and giving me space to relax when I needed it the most. I would like to also dedicate this thesis to my siblings, for being my rocks and closest friends, for making me laugh and being silly with me. Thank you, family, for being my biggest fans, my support system, and for keeping my feet on the ground.

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# Table of Contents

Abstract ................................................................................................................................. i  
Acknowledgements ........................................................................................................... ii  
Dedication ............................................................................................................................ iii  
Table of Contents ............................................................................................................... iv  
List of Tables ...................................................................................................................... viii  
List of Figures .................................................................................................................... ix  

**Chapter One: Introduction** .............................................................................................. 1  
1.1 Research Problem ....................................................................................................... 1  
1.2 Issues in the Saskatchewan Justice System ............................................................... 4  
1.3 The Regina Mental Health Disposition Court ............................................................ 6  
1.4 Purpose of Research .................................................................................................. 8  
  1.4.1 Research Questions .............................................................................................. 9  
  1.4.2 Method ................................................................................................................ 9  
  1.4.3 Significance of Research ...................................................................................... 10  
  1.4.4 Researcher Bias .................................................................................................. 11  
1.5 Operational Definitions ............................................................................................. 12  
  1.5.1 Mental Illness ....................................................................................................... 12  
  1.5.2 Mental Health Courts ......................................................................................... 14  
  1.5.3 Clients ................................................................................................................ 15  
  1.5.4 Stakeholders ....................................................................................................... 15  
  1.5.5 Diversion ............................................................................................................ 16  
  1.5.6 Adversarial vs. Non-adversarial Justice ............................................................... 17  
  1.5.7 Therapeutic Jurisprudence .................................................................................. 17  

**Chapter Two: Literature Review** .................................................................................... 19  
2.1 Neoliberalism and Deinstitutionalization ................................................................... 19  
  2.1.1 Criminalization of the Mentally ill ..................................................................... 23  
2.2 Overview of Justice Practices ..................................................................................... 27  
2.3 Therapeutic Jurisprudence ........................................................................................ 30
2.3.1 Background .................................................................................................................. 31
2.3.2 The role of Therapeutic Jurisprudence in MHCs ....................................................... 33
2.3.3 Restorative Justice in Therapeutic Jurisprudence ....................................................... 35
2.3.4 Procedural Justice in Therapeutic Jurisprudence ....................................................... 38

2.4 Mental Health Courts ..................................................................................................... 39
  2.4.1 Objectives and Principles of Operation ................................................................. 42
  2.4.2 Inclusion Criteria ..................................................................................................... 43
  2.4.3 Perceived Outcomes and Effectiveness ................................................................. 47
  2.4.4 Socio-legal Concerns in MHCs ............................................................................... 51

Chapter Three: Methods ..................................................................................................... 56
  3.1 Research Paradigm ....................................................................................................... 57
  3.2 Methods ....................................................................................................................... 58
  3.3 Rigour ........................................................................................................................... 61
  3.4 Participant Selection ................................................................................................... 63
  3.5 Data Analysis ............................................................................................................... 64
  3.6 Limitations .................................................................................................................... 66
  3.7 Ethical Considerations ................................................................................................. 66

Chapter Four: Data and Analysis ......................................................................................... 68
  4.1 Barriers for the Client .................................................................................................. 73
    4.1.1 Clients have complex needs due to their mental illness ..................................... 73
    4.1.2 Clients face challenges in addition to mental illnesses ...................................... 74
    4.1.3 The justice system is difficult to navigate ......................................................... 76
    4.1.4 Consideration of Charter violations .................................................................. 77
    4.1.5 Summary of organizing theme 1: Barriers for the client .................................. 78
  4.2 Barriers for the Court .................................................................................................. 80
    4.2.1 General barriers .................................................................................................... 81
    4.2.2 The criminal justice system is inherently coercive ............................................ 82
    4.2.3 Entrance criteria not fully understood by all .................................................... 83
    4.2.4 The mental health court as time consuming ..................................................... 84
    4.2.5 Large, systemic barriers ..................................................................................... 85
    4.2.6 Summary of organizing theme 2: Barriers for the court .................................. 86
4.3 Mental Health Court as Less Adversarial .................................................. 92
   4.3.1 Clients are engaged in the process.................................................. 93
   4.3.2 Clients treated more humanely....................................................... 94
   4.3.3 Individualized client plans are generated ................................. 94
   4.3.4 The process is slow in a beneficial way..................................... 96
   4.3.5 Mental health court as problem solving in nature ...................... 96
   4.3.6 Pre-court is collaborative and multidisciplinary....................... 98
   4.3.7 Unique role of judge ..................................................................... 99
   4.3.8 Unique roles of legal counsel ...................................................... 100
   4.3.9 Summary of organizing theme 3: Mental health court as less
       adversarial.......................................................................................... 101
4.4 Meaningful Outcomes ........................................................................... 107
   4.4.1 Jail is not always appropriate....................................................... 107
   4.4.2 Alternative dispositions ................................................................. 108
   4.4.3 Balancing the safety needs of both clients and community.... 109
   4.4.4 Reducing contact with the criminal justice system is important . 110
   4.4.5 MHC facilitates access to community services that could not be
       accessed otherwise............................................................................. 111
   4.4.6 A successful outcome is increased stability.................................. 112
   4.4.7 Summary of organizing theme 4: Meaningful outcomes .......... 114
4.5 Global Theme: The Mental Health Court as a Holistic Approach to Justice
....................................................................................................................... 120
Chapter Five: Conclusion............................................................................. 128
   5.1 Theoretical Implications.................................................................. 129
      5.1.1 Therapeutic Jurisprudence......................................................... 129
      5.1.2 Restorative Justice ................................................................. 130
      5.1.3 Procedural Justice ...................................................................... 134
   5.2 Implications for Further Research.................................................. 135
   5.3 Policy Implications........................................................................... 138
   5.4 Conclusion and Final Remarks........................................................ 140
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bibliography</td>
<td>142</td>
</tr>
<tr>
<td>Appendix A: Ethics Approval Form</td>
<td>154</td>
</tr>
<tr>
<td>Appendix B: Consent Form</td>
<td>155</td>
</tr>
<tr>
<td>Appendix C: Interview Guide</td>
<td>156</td>
</tr>
</tbody>
</table>
List of Tables

4.1 Identification of Themes ........................................................................................................... 71
List of Figures

4.1 Thematic Network Map ........................................................................................................ 72
Chapter 1: Introduction

The overrepresentation of mentally ill individuals in the criminal justice system is an unsettling problem in Canada. Incarceration rates are disproportionately high for these individuals—in Canadian prisons, mental health issues are 2-3 times more prevalent than in the general population (Sapers, 2014). Even though persons with mental illness make up 10.1% of the general population (Pearson, Janz & Ali, 2013), 13% of males and 29% of females have been identified as having mental health issues at the time of admission into a correctional facility (Correctional Service Canada, 2009). These numbers do not include individuals who do not display symptoms or who may not yet have been clinically diagnosed with a mental illness. Also noteworthy is that the population of mentally ill individuals in the Canadian justice system increased 10% per year from 1995 to 2007 (Schneider, Bloom, & Hereema, 2007). In light of the fact that arrest rates in general have been decreasing and that crime rates are going down, this trend is rather disquieting.

1.1 Research Problem

The rate of incarcerated individuals who suffer from a mental illness in Canada has increased 60% since the 1960s (Correctional Service Canada, 2009). Significant governmental reform across North America was happening concurrently to a period of institutional restructuring (Balfour, 2006). Particular regimes of governance shifted such that the relationship between state and society changed (Dean, 2010). Critiques of a welfare state that dominated North American governments led to what a Foucauldian would label “social and cultural emancipation” (Dean, 2010, p. 531), meaning those who were oppressed were seen to be liberated. Neoliberalism became the predominant regime
of governance. Proponents of neoliberalism argued that the welfare state was paternalistic, coercive, and oppressive (Dean, 2010). Neoliberalism replaced the welfare state through logics that argued individuals should be autonomous and able to exercise their freedom without what was thought to be an overbearing government (Dean, 2010).

Prior to the 1970s, neoliberalism was simply a concept that signified economic ideas that originated with the Freiburg school of neoliberalism in Germany, or the Ordoliberals (Venugopal, 2015). However, in the 1970s, neoliberalism became the dominant way of governing in North America and the United Kingdom. By the 1980s, neoliberalism was no longer just a concept but a “political, ideological, cultural, spatial phenomenon” (Venugopal, 2015, p. 168). It was the new way to describe market deregulation and welfare-state withdrawal that resulted in cuts to social services, health, and education while emphasizing privatization, individualization, and responsibilization (Balfour, 2006; Ratner & McMullan, 1983; Venugopal, 2015). Neoliberal forms of governance sought to shift the responsibility away from the government and onto individual subjects, where techniques were developed to control individuals while not maintaining responsibility for them (Lemke, 2001). Neoliberal governments altered the governmental responsibility for social risks, such as unemployment, illness, and poverty by placing the onus on individuals and emphasizing “self-care” (Lemke, 2001). Lemke employs a Foucauldian approach and argues that individuals within a neoliberal regime of governance are encouraged to “give their lives a specific entrepreneurial form” (Lemke, 2001, p. 202). In other words, rather than simply provide for its citizens, neoliberal governments sought to empower individuals by encouraging them to participate in the solution to their own problems (Lemke, 2001). Lemke (2001) states
that the rationale behind empowering individuals is “the expression of free will on the basis of a self-determined decision, the consequences of the action are borne by the subject alone, who is also solely responsible for them. Social responsibility is now a matter of personal choice” (p. 201).

Despite the intention of the government to empower its citizens to embrace self-care (Lemke, 2010), some were left behind, as they were not able to care for themselves and uphold the notion of individualization and responsibilization. Those who could not compete during this shift, such as the homeless, incarcerated, and mentally ill, were not considered to be participating members of society (Bockman, 2013). Government-funded institutions that housed and treated mentally ill individuals closed down due to many factors, but in part due to a significant reduction in welfare services and the reduction of many parts of the social safety net (Lemke, 2001); mental health became a matter of individual responsibility (Perez, Leifman, & Estrada, 2003). Lemke (2001) argues that either closing institutions or altering institutions to be flexible and autonomous is a “technique of power” (p. 203). Here, closing state-funded facilities for the mentally ill and assuring community-based treatment was how the government exerted its power over its subjects without specifically controlling them. This governmental shift to neoliberalism had detrimental consequences for mentally ill individuals due to the fact that they relied on institutional care for treatment, housing, and overall stability. Although the government intended to create outpatient community programs for the mentally ill individuals who had been forced to leave institutions, these programs did not materialize (Chaimowitz, 2012). Many individuals who comprised this vulnerable population were abandoned and left to fend for themselves (Bockman, 2013).
Individuals who were no longer provided with state-funded housing were now required to partake in society, yet their untreated symptoms created strange and bizarre behaviours that were misunderstood and not tolerated by society or police officers who directly came in contact with them (Charette, Crocker, & Billette, 2011; Lamb, 1998). No longer within the safety of institutionalized living, the mentally ill had more opportunities to come to the attention of the police for committing minor crimes that were aiding in their survival (Lamb, 1998). Instead of being directed to treatment and care, these individuals were directed to wherever there was a bed, which was most commonly the local jail (Lamb, 1998). Individuals who were caught committing minor offences were charged and often incarcerated rather than directed to services that could provide treatment (Lamb, 1998). The onus of responsibility for the care of the mentally ill who came in contact with police was on the criminal justice system, not the mental health system (Lamb & Weinberger, 2013). Thus began a criminal justice cycle for mentally ill people: untreated mental illness led to criminal behaviour where contact with police and the justice system was made. Individuals were often incarcerated and subsequently released from correctional facilities without receiving adequate treatment. Following release, they experienced moments of crisis due to untreated symptoms such as delusional thinking patterns or hallucinations, and eventually ended up in contact with police once again.

1.2 Issues in the Saskatchewan Justice System

“Saskatchewan boasts one of the most highly strained provincial prison systems in the country” (Demers, 2014, p. 5). One significant cause for concern is that prisons in Saskatchewan are overcrowded, where it is difficult to deal with the revolving door of
inmates with mental illnesses or cognitive impairments (Demers, 2014). Prisons are operating far over-capacity; double-bunking has become the norm—gyms, classrooms, visiting rooms, and programming rooms have been transformed into sleeping quarters for more inmates (Demers, 2014). Programming for inmates has also been reduced, particularly due to overcrowding (Demers, 2014). Rooms intended for group meetings, religious worship, recreation, education, and therapy are now occupied by beds, thus reducing the chances of inmates being able to access programs they require (Demers, 2014). According to Demers (2014), there are also concerns about the quality of health care in Saskatchewan prisons. Many inmates do not receive their medication on time or are not adequately monitored when health issues do arise (Demers, 2014). For individuals suffering from mental illness in correctional institutions, this is undoubtedly an issue.

Another significant cause for concern is that minorities are severely overrepresented in the province’s justice system. More specifically, the population in Saskatchewan of Aboriginal offenders in correctional institutions is the highest of all the Canadian provinces (Perreault, 2014). The province of Saskatchewan is comparable to Manitoba in having the highest population of Aboriginal persons per capita in the country (Anderson, 2006), which also contributes to systemic justice issues, as it has been found that mental health issues in Aboriginal populations are higher than those in the non-Aboriginal Canadian population (Kirmayer, Brass, & Tait, 2000). Kirmayer et al. (2000) state that studies have shown higher rates of mental health problems in Aboriginal communities, which are direct consequences of historical displacement and colonization. In regards to mental health issues in provincial correctional institutions,
statistics are not available. However, according to the *Annual Report of the Correctional Investigator*, 36% of federal offenders were acknowledged as requiring psychological follow-up upon their admission into prison (Sapers, 2012). One can deduce that Saskatchewan is reflective of this Canadian average. The systemic issues that Saskatchewan faces in its justice system are very apparent, and it is for this reason that the Regina Mental Health Disposition Court was established.

1.3 The Regina Mental Health Disposition Court

The Regina Mental Health Disposition Court is a relatively new mental health court (MHC) and is one of two MHCs in Saskatchewan. It saw its first cases in late 2013 and convenes twice per month (Saskatchewan Law Courts, 2012). The Regina Mental Health Disposition Court accepts individuals with psychiatric disorders, Fetal Alcohol Spectrum Disorder, acquired brain injuries, and cognitive disabilities (Saskatchewan Law Courts, 2012). The court does not accept individuals who have committed driving offences, offences with mandatory minimum penalties as per the *Criminal Code*, or cases where the Crown prosecutor is seeking a federal penitentiary term (Saskatchewan Law Courts, 2012). Clients are referred to the court through the Crown Prosecutor if a mental health issue is related to the criminal activity that has been engaged in (Saskatchewan Law Courts, 2012). The client is connected with Legal Aid, a case management plan is established, and a guilty plea is entered if it is agreed upon by the client to follow the individualized treatment plan (Saskatchewan Law Courts, 2012).

This court engages in therapeutic jurisprudence and employs a collaborative approach to justice by using a case management team that includes social service, health, and criminal justice professionals as well as representatives from community-based
organizations (CBOs; Saskatchewan Law Courts, 2012). These key stakeholders of the court aim to facilitate access to services and treatment in an urgent way for the clients, with community safety at the forefront (Saskatchewan Law Courts, 2012). Incarceration is generally avoided but used when necessary, as it is important to balance public safety and the mental health needs of the client (Toth, 2014). According to the court’s objectives, the goals of the case management model are to create avenues for services and treatment for the clients and to reduce criminal behaviour by encouraging a healthy lifestyle (Saskatchewan Law Courts, 2012). The case management team and the judge monitor progress, and the length of time under the court’s supervision and eventual sentence are contingent upon the client’s progress during his or her time in the court (Toth, 2014).

The Regina Mental Health Disposition Court is still in a fledgling stage and was in the process of its first scholarly analysis and evaluation during the writing of this thesis. The study was a result of a collaborative partnership between academic, legal, and government sectors and investigated the mental health court using mixed methods. In two years of the court’s operation, 79 individuals appeared in court and 36 cases were concluded (Stewart & Mario, 2016). Of those 36 concluded cases, 22 individuals were sentenced to a community-based disposition, 5 were sentenced to a short period of incarceration, and the remainder had their charges stayed, withdrawn, or were sentenced to time served (Stewart & Mario, 2016). The average number of appearances for all cases was 5.4 times from November 2013 until November 2015 (Stewart & Mario, 2016). Among the concluded cases, system-generated offences, such as breaches of probation, failure to comply with conditions of an undertaking, or failure to attend court,
are the most common types of charges. Also common are assault charges, indecent acts, mischief, and property offences (Stewart & Mario, 2016).

1.4 Purpose of Research

This research investigated the ways that the Regina Mental Health Disposition Court may assist in alleviating the problem of an overrepresentation of mentally ill individuals in the province’s justice system. The goals of the study were to gain an understanding of the general processes of the Regina Mental Health Disposition Court, its objectives, its challenges, and its philosophy. This study also investigated the perspectives of the key stakeholders who compose the case management team of the court as to how mentally ill individuals in the justice system can be diverted to the mental health system and other services that will facilitate an increase in community stability. The research aimed to understand how these key stakeholders conceptualize the mental health court itself and whether or not the court delivers an effective form of justice for the clients, where this research considers effective justice to be non-adversarial, problem-solving oriented, inclusive, accessible, communicative, and collaborative. The intent of the research was to search for common themes between stakeholder conceptions to gain a better understanding of the forms of justice that are undertaken within the MHC and how these justice practices may or may not compare to the forms of justice in traditional criminal courtroom settings. Although outcomes are important to address, it is difficult to measure what a successful outcome might look like. Measuring success in any MHC is difficult because “[it] is a subjective quality based on the perceived purpose of the mental health court” (Schneider et al., 2007, p. 195). As success is subjective and varies among clients and mental health courts, it is necessary to
take a step further to understand the wide range of potential outcomes that are present in a mental health court process (Schneider et al., 2007). It was necessary for this study to address the complexities of success by investigating how the key stakeholders of the court conceptualized successful outcomes.

1.4.1 Research Questions

The research was guided by the following primary research questions: How do stakeholders conceptualize the Regina Mental Health Disposition Court and in what ways is this court different from traditional criminal courtroom settings? The secondary research questions that were investigated based on the primary research questions are: Do stakeholders perceive the court to employ alternative justice practices relative to traditional criminal courts; and, how do alternative justice practices in mental health court address the needs of clients and affect their outcomes in the court?

1.4.2 Method

To answer the research questions, the project employed a qualitative method. Semi-structured interviews have been conducted with key stakeholders of the court to attain data. For the purpose of this research, key stakeholders include legal and justice professionals, community workers, client advocates, representatives from CBOs, and health representatives. Clients are also considered to be stakeholders in a mental health court, as these individuals are a significant part of the process. It is also the connecting of these individuals to treatment and rehabilitation that is the primary focus of the court. However, the intent of this study was not to seek these opinions, but rather the opinions of the stakeholders who are part of the pre-court case management team in order to examine the work that is done to produce positive outcomes for clients. Interviews
focused on stakeholders’ perceptions of the court and how they conceptualized the delivery of justice in the mental health court. All interviews have been analyzed using Attride-Stirling’s thematic network analysis.

1.4.3 Significance of Research

This research contributes to the extant literature on MHCs and the growing body of research on Canadian MHCs specifically. Canadian mental health courts are not as prevalent across the country as they are in the United States. In order to increase their prevalence, research on these courts must also increase. There are also direct implications in Saskatchewan for this research. There are currently two mental health courts in operation in Saskatchewan and research projects within both of these courts. This study allows further insight into the mental health court in Regina, alongside a larger project in this court. I intend to raise awareness about this problem-solving court and its contribution to the alleviation of the problem of the overrepresentation of mentally ill individuals in Saskatchewan’s justice system.

There also lies a gap in the mental health court literature that is relevant to the present study. The qualitative research has not often focused on what mechanisms have an effect on the outcomes of clients or how and why MHCs influence positive change in clients, where positive change includes reducing justice system contact, decreasing severity of offenses, establishing or improving a treatment regimen, and improving the overall quality of life among clients (Almquist & Dodd, 2009; Canada & Gunn, 2013; Canada & Watson, 2013; Lurigio & Snowden, 2009). Further, examining and comparing justice models within the court system is not common in qualitative MHC research. The study investigated this gap in the literature and aimed to go beyond a statistical analysis
of reduced recidivism rates, which is the most common measure of MHC results. This study provides an understanding of justice practices in the Regina Mental Health Disposition Court and what the consequences are of alternative justice models. It is possible to reduce the number of mentally ill people in the justice system; mental health courts can aid in improving this problem that the justice system faces, but in order to address this, studies that demonstrate the positive impacts of MHCs must be conducted and shared with not only the academic world but also the public. Realistically, a paradigmatic shift is not attainable solely with mental health courts, but they will be able to begin to address this problem by providing a vehicle for a systemic change in justice.

1.4.4 Researcher Bias

As the researcher, I am aware of the bias that I bring to the writing of this thesis. I have been observing in the Regina Mental Health Disposition Court and the pre-court collaborative meetings for more than a year, where in 15 months I have seen the court grow, transform, and become more cohesive in many ways. I have developed a rapport with the individuals who attend court each time. I have also interacted with clients and grown familiar with the courthouse staff, such as court clerks and security personnel. I am also aware of the level of privilege I have in my position as a researcher in the court. As an academic and student I am free to come and go from the courtroom as I please, without restrictions, without a worry of where I will sleep for the night, when I will consume my next meal, or when my next treatment appointment is. Bias within this research also stems from my belief in the success of this court. Because I have already witnessed what I deem to be successes of the Regina Mental Health Disposition Court, this thesis is written with undertones of subjective optimism.
Berger (2015) asserts that it is crucial the researcher understand that they play a role in the creation of knowledge in their research. The construction of knowledge is a process that occurs not only in research interviews, but also when the researcher has become familiar with the setting and the participants of the study (Berger, 2015). Berger (2015) also sates that researchers must “carefully self monitor the impact of their biases, beliefs, and personal experiences in their research” (p. 220). Inevitably, bias affects the interpretation and analysis of data. It is with this bias, however, that I have conducted detailed interviews and attained data that is rich in narrative, and with that, demonstrate a holistic yet detailed image of justice in this mental health court.

1.5 Operational Definitions

1.5.1 Mental Illness

Mental illness refers to a wide range of conditions and disorders that affect one’s state of mental health (Mayo Clinic, 2014) and refers to any diagnosable mental disorder (Almquist & Dodd, 2009). The term mental illness is part of the more general concept of mental health, which is “the capacity of each and all of us to feel, think and act in ways that enhance our ability to enjoy life and deal with the challenges we face” (Health Canada, 2006, p. 2). More specifically, mental illnesses are “characterized by alterations in thinking, mood or behaviour—or some combination thereof—associated with some level of distress, suffering, or impairment in one or more functional areas” (Health Canada, 2006, p. 2).

Historically, mental illness was known as “madness,” a term which Foucault theorizes in a history of the asylum. Foucault argues that madness is not a naturally occurring or universal problem, but instead madness is characterized by the society it
exists within (Foucault, 1961). It is in a particular society that madness is constructed based on cultural, intellectual, and economic apparatuses (Foucault, 1961). Therefore, different societies construct mental illnesses according to their own culture and beliefs and define how it is to be known within that society.

MHCs conceptualize mental illness in varying ways and do so via the *Diagnostic and Statistical Manual* (DSM). The DSM allows society to label mental illnesses, and it is this document that MHCs use to categorize individuals within MHCs accordingly and/or permit individuals to participate in the court. Labeling an individual with a mental illness is important in an MHC, as it is a diagnosis that allows the court to facilitate connections to appropriate services, acquire funding or to link clients with programming. While some MHCs accept only individuals with mental illnesses that can be assessed and diagnosed using the *Diagnostic and Statistical Manual, 4th Edition, text revised* (DSM-IV-TR), others include those with cognitive impairment or intellectual disabilities. Various mental health courts only include participants with an Axis I disorder, which, according to the DSM-IV-TR\(^1\), are clinical disorders that include depression, bipolar disorder, schizophrenia and a variety of other mental illnesses (American Psychiatric Association, 2000). Other MHCs include individuals with Axis I and individuals with Axis II disorders. Axis II covers personality disorders and mental retardation, such as paranoid personality disorder, borderline personality disorder, or antisocial personality disorder (American Psychiatric Association, 2000). For the purpose of this study, mental illness includes conditions such as psychiatric disorders as

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\(^1\) The DSM-IV-TR is not the latest version of the DSM but is referred to here because it was the most recent version when much of the literature was published.
per the DSM-V\(^2\), cognitive impairments such as intellectual disabilities and Fetal Alcohol Spectrum Disorder, as well as acquired brain injuries that cause behavioural deficits.

1.5.2 Mental Health Courts

Mental health courts have been created as a diversionary tactic to slow the perpetual justice cycle of arrest, incarceration, release, and re-arrest of mentally ill individuals, to ease the burden that lies heavily on the justice system to continually process the mentally ill, and to counter the overrepresentation of these persons in correctional populations (Canada & Watson, 2013; Hughes & Peak, 2013; Moore & Hiday, 2006). The needs of mentally ill individuals are adequately met and the safety of the public is also understood to be crucial. MHCs seek to direct the individuals to the various systems and areas that they require access to, which may include but is not limited to the mental health and social systems, housing, mentorship programs, and community programs. By diverting the mentally ill from the criminal justice system through MHCs, the goal is that the individuals be provided with a plan of treatment, support, and rehabilitation to encourage general life stability and a continuation of care, in turn decreasing the likelihood that they will reoffend in the future (Hughes & Peak, 2013). Case management teams made up of justice professionals, mental health professionals, advocates, and mentors from CBOs create individual treatment plans and goals for clients to facilitate rehabilitation and reduce the individual’s involvement with the justice system (Schneider et al., 2007).

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\(^2\) The DSM-V was released in 2013 and is the most recent publication by the American Psychiatric Association. In referencing mental illnesses in this study, the DSM-V will be used.
1.5.3 Clients

Clients are considered to be individuals in the court who have committed a criminal offense. This term has been chosen over offender because I intend to reject the label of offender in referring to mentally ill individuals in the justice system. These individuals have many different labels and it is my intent to reduce further stigmatization and avoid the negative labels by instead referring to persons with a mental illness as clients. However, I am aware that the term client is part of a neoliberal vocabulary; this is the language that the mental health court uses to produce neoliberal subjects. In the Regina Mental Health Disposition Court, clients are those whose mental illness is related to their offense(s), who have plead guilty to their crimes, and who have subsequently chosen to accept participation in the court and abide by its rules and conditions.

1.5.4 Stakeholders

Stakeholders are persons who are involved in or affected by a course of action. McNiel and Binder (2010) consider stakeholders of a mental health court to be the team of court staff and mental health professionals who have significant interest and involvement with the mental health court. In the present research, stakeholders include the individuals who participate each time court is in session or who contribute substantially to the court process because they are representing a client. Although clients are also considered to be stakeholders, their perspectives were not sought in this particular study. For this study, all stakeholders of the court would include: a judge, Crown prosecutor, defence lawyer, government representatives from social services and probation services, various health professionals, and representatives from CBOs. Each
individual’s role as a stakeholder in the case management group is different, but all are
essential to the operation of the MHC.

1.5.5 Diversion

Diversion generally means to change the direction of something. MHCs aim to
divert the mentally ill from the direction of the criminal justice system to the mental
health system, which arguably is the required avenue of care. Although mental health
care does exist within the criminal justice system (e.g., in prisons), the argument is that
incarceration is not always the most appropriate disposition for the mentally ill, as they
are at risk of symptom exacerbation while in custody (Canada & Gunn, 2013). Diversion
is important in order to reduce the negative consequences of incarceration for this
vulnerable population (Canada & Gunn, 2013). DeMatteo, LaDuke, Locklair, and
Heilbrun (2012) refer to diversion in problem-solving courts as:

A general term that includes all community-based alternatives to standard
prosecution that occur before an offender has entered a plea or goes to trial; thus,
the offender is ‘diverted’ from standard prosecution and into specialized
community-based programming that is better able to address his or her needs. (p. 66)

For the purpose of this research, the term diversion is used in the context of directing
individuals away from one system and into another system (i.e., from the criminal justice
system to the mental health care system), in line with DeMatteo et al.’s (2012) definition.
Although the Regina Mental Health Disposition Court requires a guilty plea to be
entered prior to service and treatment access, diversion nevertheless occurs following the
plea entrance. The intention is to divert individuals from justice system contact and
incarceration to mental health resources and community programming.
1.5.6 Adversarial vs. Non-adversarial Justice

Adversarial justice is characterized by arguments being presented before a judge or neutral deciding party, confrontation between an accused and accuser, as well as legal representation (Rossner & Tait, 2011). Non-adversarial justice is contrastive to adversarial justice and takes form in many aspects of the justice system, including but not limited to restorative justice, therapeutic jurisprudence, dispute resolution and mediation, preventive law, diversion, and problem-solving courts (Freiberg, 2011). Freiberg (2011) states that non-adversarial justice is “a broad interdisciplinary approach that has . . . a desire to broaden the scope of the study of law by focusing differing conceptual lenses upon the nature and operation of legal rules, legal procedures, legal roles, and legal education” (p. 304). It is important to explore non-adversarial justice in relation to mental health courts, as it is this justice practice that is employed and allows mental health courts to operate.

1.5.7 Therapeutic Jurisprudence

Therapeutic jurisprudence is a sympathetic approach to law and is the theoretical foundation of problem solving courts (Schneider et al., 2007). Therapeutic jurisprudence focuses on the emotional and psychological impacts of the law on the well being of an individual (Winick, 2003). Respect, active listening, empathy, and non-coercion are encouraged in a therapeutic jurisprudence framework (Goldberg, 2011). Therapeutic jurisprudence is also a mental health approach to law that emphasizes the rehabilitation of an individual who has found himself or herself in the grasp of the justice system (Winick, 2003). Winick (1997) asserts that the law can be used as a therapeutic agent where either healthy or unhealthy consequences may arise due to legal rules and
procedures and the roles of lawyers and judges. The aim of therapeutic jurisprudence is for negative consequences, or antitherapeutic results, to be reduced without sacrificing due process or the value of the law itself (Winick, 1997).
Chapter 2: Literature Review

2.1 Neoliberalism and Deinstitutionalization

Neoliberal societies move from national government to public-private governance and entrepreneurial citizenship. Those who cannot compete—such as the homeless, the incarcerated, or the formerly incarcerated—are excluded from full citizenship, abandoned. (Bockman, 2013, p. 15)

Neoliberalism as a governing regime was one of the factors that contributed to deinstitutionalization and is an approach to government that created a significant shift away from a welfare state ideology. The welfare state emphasized a healthy and secure society and economy by way of direct state intervention and economic regulation (Dean, 2011). When this was thought to be a paternalistic and oppressive approach to governing subjects (Dean, 2011; Lemke, 2001), governing techniques shifted toward a regime that emphasized privatization, deregulation, individualization, and responsibilization (Bockman, 2013; Comack & Balfour, 2004; Venugopal, 2015). Lemke (2001) asserts that neoliberal governments created an “artificially arranged liberty” (p. 200) in the sense that freedom and rational choice are simultaneously encouraged and controlled by the government. A neoliberal ideology seeks to facilitate freedom and lead individuals without maintaining responsibility for them (Lemke, 2010). At the same time, Dean (2011) posits that a government becomes more “disciplinary, stringent, and punitive” (p. 586) and takes on a more coordinative and preventative role.

In a neoliberal opposition to the welfare state, social intervention ceased, while regulation and control were restructured and shifted on to responsible and rational citizens (Lemke, 2010). This came at a cost, however, as individuals were required to take responsibility for their actions and to accept the consequences if they should fail (Lemke, 2010). Rather than rely on collective responsibility, individualism was
encouraged, leaving behind those who were not able to take responsibility for their “freedom” because they were part of a vulnerable or marginalized population (Comack & Balfour, 2004). Massive cuts to social expenditures (Steger, 2010) and a removal of welfare policies created negative effects for individuals who were reliant on state support, such as the mentally ill (Bockman, 2013). Morrow, Wasik, Cohen, and Perry (2009) assert that mentally ill individuals were required for the first time to take responsibility for the state of their mental health. The government removed its contribution to institutional funding, which had various side effects, one of which being the closing of state institutions and government-funded care for the mentally ill (Morrow et al., 2009). Neoliberal governing practices encouraged citizens to engage in self-care and treatment practices as consumers in the economy in order to gain access to services (Dean, 2011); thus access to social care and treatment came at a cost.

In Canada, neoliberalism took effect under the governing power of Prime Minister Brian Mulroney in the 1980s. This governing regime spanned political ideologies, parties, and provinces across the nation (Albo, 2002). Albo (2002) states, “Regimes of different political stripes have all endorsed capitalist globalization and implemented policies of deregulation, privatization, and social austerity. We get neoliberalism even when we elect social democratic governments” (p. 47). Major spending reductions to education, health and welfare sectors dominated the 1980s and 1990s, where restructuring the state included program cutbacks, downsizing public sector employees, and deregulation within the economic sector (Clark, 2002). One consequence of state restructuring was that institutions across Canada for the mentally ill began reducing their numbers.
Deinstitutionalization in Canada began as far back as the 1960s, among the provinces of British Columbia, Alberta, Saskatchewan, Ontario, and Nova Scotia, who were among the first to significantly reduce the populations in their psychiatric hospitals and to provide fewer days of in-hospital treatment (Dooley, 2012; Sealy, 2012). Between 1960 and 1976, the number of beds in Canadian institutions for the mentally ill decreased by over half (Sealy, 2012). Although deinstitutionalization had been in effect for many years, the most significant reduction in Canadian institutional populations came in the 1980s and continued well into the 1990s and early 2000s. Sealy (2012) reports that from 1994 to 2003 the Canadian average days of care in psychiatric hospitals decreased from 418 days/1,000 population, to 99 days/1,000 population. One of the factors that motivated deinstitutionalization across Canada was that resources from psychiatric hospitals were reallocated to community-based mental health services (Sealy, 2012). There was a shift in government expenditures from public institutions to general hospitals as well as a shift from government-employed medical specialists in institutions to general practitioners in private practices (Dooley, 2012), an effect of a neoliberal ideology. Dooley (2012) describes this as part of a wider project within “Canada’s evolving welfare state apparatus” (p. 102).

While neoliberal reform in Canada predominantly took place under the governing regime of Brian Mulroney, Saskatchewan experienced systemic shifts in mental health policy long before this under the Liberal government in the mid- to late 1960s. Saskatchewan was one of the first provinces to drastically reduce the population of institutions for the mentally ill. Deinstitutionalization in Saskatchewan particularly was “driven by political ideology and economics without due consideration of the human
costs” (Dooley, 2012, p. 105). The government was committed to removing state involvement and was attached to ideological doctrines of individual and family responsibility (Dooley, 2012). With the implementation of new mental health policy, privatized psychiatric services became common and institutions were depopulated “almost overnight” (Dooley, 2012, p. 105). Although outpatient programming was supposed to be implemented, few programs were in place when many of the formerly institutionalized mentally ill individuals were released and one hospital closed all together (Dooley, 2012). Deinstitutionalization left a mark on the mentally ill citizens of Saskatchewan; it left many without homes, without individual care, and without treatment. Many mentally ill persons ended up re-institutionalized in the criminal justice system as a result of committing minor offenses for their own survival (Perez et al., 2003).

Prior to the beginning stages of deinstitutionalization, criminal law in Canada also underwent substantial changes (Ranasinghe, 2010). Vagrancy laws in Canada were first modeled upon English laws against vagrancy and continued to influence subsequent changing legislation into the 1950s and 1970s (Ranasinghe, 2010). Some examples of vagrancy offenses that originated in England and were adopted by Canada were: being able to work but refusing or neglecting to do so, loitering on any street, road, or in a public place, and causing a disturbance in a public place (Ranasinghe, 2010). Even after profound changes to the writing of vagrancy laws in the 1950s, begging became entirely prohibited, which changed from laws that allowed certain people to profit from the act, such as the poor, lame, disabled, sick, and disbanded soldiers (Ranasinghe, 2010). Ranasinghe (2010) asserts that vagrancy laws in Canada that were supposed to change
Vagrancy was a social problem, and one that did not coincide well with the depopulating of institutions for the mentally ill and subsequently for those who did not attain residence or support following their discharge from institutions.

2.1.1 Criminalization of the Mentally Ill

The mentally ill population has long been a highly vulnerable sector of society. In *Madness and Civilization*, Foucault provides a history of mental illness, or what he calls “madness” or “insanity,” from the Renaissance period through the classical period and into the modern era (Foucault, 1961). He describes how madness has evolved over time—a concept that is ever changing due to the ways in which society conceptualizes madness (Foucault, 1961). Madness, according to Foucault, takes up a certain space in society. In the Renaissance period, madness was accepted and even liberated; it was thought to characterize the era’s creative minds (Foucault, 1961). This changed in the classical period, however, where madness was silenced and confined in order to control it (Foucault, 1961). It was in the classical period that madness was given a new meaning. Madness was a social outcast; it became associated with criminal behaviour and deviance and went hand in hand with poverty and abnormality (Foucault, 1961). Foucault (1961) asserts, “Madness was thus torn from that imaginary freedom [of the Renaissance] which still allowed it to flourish about in broad daylight . . . But in less than a half-century, it had been sequestered and, in the fortress of confinement, bound to Reason, to the rules of morality and their monotonous nights” (p. 60). Another shift occurred in the nineteenth century, where it was difficult to determine the space that madness was to occupy within society. Madness again was being restructured;
confinement was condemned and there was a need to separate criminals and madmen. Thus, the asylum was born. In this era, the doctor-patient relationship developed and psychoanalysis became the way to understand madness (Foucault, 1961). For the first time, medical and psychiatric practices were used to control and treat mental illness.

In *Madness and Civilization*, Foucault seeks to disrupt the notion of mental illness and how it is conceptualized. He argues that mental illness itself is a societal construction, born out of practices, culture and beliefs within a particular society. Mental illness is a transitory category, a changing idea that depends upon the structures of the society it exists within. In his writing, Foucault seeks to unpack how madness is constructed beneath the surface. It is important to understand Foucault’s argument in order to understand the criminalization of the mentally ill in the current time period and to challenge how mental illness is conceptualized. As in every time period, madness, or mental illness, takes up a certain space in society (Foucault, 1961). Currently, the space it takes up is one surrounded by stigmatization, criminalization, and often negativity; madness is neither celebrated nor confined. Western society has chosen to define mental illness using the *Diagnostic and Statistical Manual*. By defining mental illness through a resource that has been constructed by those of the ‘psy’ disciplines and identifying the space in which mental illness exists, it is possible to see that it is not an unchanging and inevitable truth. Comprehending how mental illness exists within our society is crucial to see that this is not a contemporary issue. With the beginnings of deinstitutionalization in the 1960s, mental illness again took up a new place in society.

A motivating factor of deinstitutionalization was a prominent removal of welfare services due to a shift in governing regimes. State institutions no longer received
adequate funding to house and treat mentally ill individuals for several reasons, including but not limited to: neoliberal governments believing the government was too involved with its citizens, that the economic cost of running the institution was too high, and that community care was a more humane treatment practice (Cummins, 2010; Dean, 2010); therefore, the institutions ceased to remain open. Individuals with mental illness were vulnerable upon their discharge from psychiatric hospitals, as their lifetime of institutionalized living did not prepare them to be released (Lamb, 1998). Upon the closure of state-run mental institutions, the mentally ill were required to take responsibility for their self-care. However, most did not possess the requisite coping skills, some had a tendency toward physical aggression, and all had significant psychiatric disorders (Lamb, 1998). Regardless, thousands of individuals were released into society to “face the stresses of the world” (Lamb & Weinberger, 2013, p. 287). Although community-based programs and services were promised, they did not materialize (Chaimowitz, 2012; Lamb & Weinberger, 2013; Perez et al., 2003). The shortfalls of community-based care were evident, and re-integration of mentally ill individuals from institutions to society became difficult (Cummins, 2010). Many individuals suffering from mental illness therefore did not receive the treatment and support they required (Perez et al., 2003, p. 63).

Without adequate treatment services or a sufficient number of psychiatric beds, many individuals with mental illness were also left without housing (Lamb, 1998). Encounters with police became common, as untreated psychiatric symptoms resulted in criminal behaviour (Lamb, 1998; Lamb & Weinberger, 2013). General society and police officers did not understand these behaviours, because in the past, the mentally ill
had been separated from society in institutions (Chaimowitz, 2012; Lamb, 1998).

However, as Lamb (1998) notes, mentally ill individuals who commit crimes are more often than not experiencing a “manifestation of [a mental] illness” (p. 13). When mental illness goes untreated, Lamb and Weinberger (2013) posit that various facets of the psyche are significantly affected; impaired judgment and cognition, aggressive impulses, and paranoia are all behaviours that can lead to criminal behaviour (Lamb & Weinberger, 2013). Individuals who came into contact with front-line police officers for committing minor crimes were often arrested and subsequently incarcerated, as no alternative was available or feasible (Lamb, 1998). The criminal justice system became a more efficient option than seeking out mental health care and thus was more frequently chosen for processing the mentally ill (Perez et al., 2003). According to Lamb (1998), several factors may influence the decision that police officers make to arrest the mentally ill or direct them to mental health services, including long waiting periods in the hospitals, questions of officers’ professional judgment, and problematic behaviour and aggravation from the individual who is under arrest.

Mentally ill persons who did not receive adequate treatment and who came into contact with police were filtered through the criminal justice system rather than through the system they required, the mental health system (Lamb, Weinberger, & Reston-Parham, 1996). This process was identified by Dr. Marc Abramson, a psychiatrist who studied mentally ill offenders in the 1970s, as the criminalization of the mentally ill (Lamb et al., 1996). These individuals were committing minor crimes as a result of untreated symptoms of mental illness (Lamb, 1998). This became known as the revolving door of the justice system and it remains relevant in today’s society. The
justice system does not provide adequate treatment and rehabilitation for mentally ill offenders; the root causes of behaviours are not focused on and individuals are released, and not long after, they find themselves in contact with the police once again (Wells & Schafer, 2006). The ongoing negligence of the root causes of the criminal behaviour is never addressed; therefore, the cycle continues.

2.2 Overview of Justice Practices

Adversarialism is associated with verbal jousting between lawyers over irrelevant matters, procrastination and time-wasting, victims being humiliated and intimidated and defendants marginalized. (Rossner & Tait, 2011, p. 241)

Traditional criminal justice practices within the justice system are adversarial in nature, where an adversarial system of justice is defined by three characteristics: a verbal contest in front of a neutral deciding party, a confrontation between the accused and accuser, and legal representation (Rossner & Tait, 2011). Blumberg (1967), on the other hand, argues that courtrooms are not always adversarial, although they seem to be. The author states that cooperation is essential to players of the court to allow for them to exist and work as professionals in a courtroom. Bargaining, Blumberg (1967) asserts, is not fierce but reasonable and necessary. Despite this notable argument, it is predominantly thought that criminal courtrooms are adversarial environments where a retributive attitude prevails (Carlsmith & Darley, 2008; Nolan, 2001).

The goal of retribution is to punish individuals for the harms they have caused (Carlsmith & Darley, 2008; Nolan, 2001). Punishment is justified because an individual has violated society’s rules and therefore the offender must “suffer in proportion to his or her wrongdoing” (Carlsmith, 2006, p. 437). In traditional criminal courtrooms that employ retributive justice practices, punishment must reflect the degree of the offence
that was committed, which is also known as the “just deserts” perspective (Carlsmith, 2006). When it comes to punishment in Canada, the fundamental goals of sentencing according to the *Criminal Code* are denunciation of the crime, deterrence, incapacitation, rehabilitation, reparation of harms, and acknowledgement of the wrongs committed (*Criminal Code*, 1985, s. 718). Although rehabilitation and reparation of harms are, in theory, part of Canadian law, the reality of attaining these goals is called into question when one looks to the critical capacity at which the Canadian justice system is and the lack of resources available to address vulnerable populations, such as the mentally ill (Sapers, 2014). Adversarial justice procedures, including retributive characteristics, predominantly prevail. Traditional criminal courts do not always have the ability, resources, or expertise to address the state of mental health among those who are charged with a crime (Winick, 2013). In criminal courtroom settings it is difficult to deal with problems of mental illness (or various other specialized issues that problem-solving courts deal with) because key court players, (i.e., the judge and legal counsel) lack the time and the tools to adequately handle vulnerable populations, such as the ability to facilitate access to resources that can provide housing, treatment, and mentorship for the mentally ill accused (Winick, 2013).

Carlsmith (2006) has studied how people conceptualize retributive justice principles and found that participants in his study punished offenders based on notions of retribution. Participants demonstrated that punishment is justified based on what the offender is seen to deserve based on how the law has been violated (Carlsmith, 2006). Participants in this study were required to seek out the necessary information with which to use to deliver punishment to an offender. The more information they had, the more
they were inclined to deliver retributive punishment, and the more confident they were in doing so (Carlsmith, 2006). This study demonstrates that people conceptualize retribution in the form of punishment as necessary to achieve justice, although in reality, this is not always the most appropriate course of action. Instead, non-adversarial justice practices are necessary.

Rossner and Tait (2011) describe non-adversarial justice as an “inclusive and accessible” process (p. 241) where participants’ wellbeing is sought after. Additionally, Freiberg (2011) highlights several key elements to non-adversarial justice practices. One element is that non-adversarial justice sees the criminal justice system more broadly than traditional forms of justice and sees a sole purpose of the courts: to resolve disputes (Freiberg, 2011). Further, non-adversarial justice practices emphasize problem-solving and recognize that social, economic, or psychological problems may all contribute to an individual’s entanglement with the justice system and must be addressed (Freiberg, 2011). An emphasis is also placed on the particular processes of problem solving, not necessarily the outcomes (Freiberg, 2011). Freiberg (2011) also posits that non-adversarial justice encourages collaboration between government agencies, public and private spheres, different professions, and communities, which also creates an interdisciplinary aspect of the practice. A full and comprehensive understanding of the case at hand is another key element of non-adversarial justice according to Freiberg (2011), meaning it is important to know more than just the facts of the case. Finally, prevention of future harmful behaviours is encouraged, where a holistic approach is engaged in to understand the client and to resolve problems (Freiberg, 2011).
It is the deployment of non-adversarial justice practices that sets problem-solving courts apart from traditional courts. Mental health courts use non-adversarial justice to seek out the underlying problem of the individual who has caused harm (Winick, 2013). Treatment is the priority for the individual and society alike (Nolan, 2003). Within problem-solving courts and MHCs specifically, facilitating healing and rehabilitation is, according to Nolan (2003), how justice is achieved. In mental health courts, non-adversarial justice takes the form of therapeutic jurisprudence, restorative justice, and procedural justice specifically and will be discussed in the following section.

2.3 Therapeutic Jurisprudence

*Law is not an artifact on display in the museum: It is a living, breathing organism. Law functions within a particular society, absorbing and reflecting the culture in which it exists. Judges, although acting within a framework of precedent, are political actors who make law in the process of applying it.* (Winick, 1997, p. 186)

Therapeutic jurisprudence is the theoretical foundation of problem-solving courts (Barber-Rioja & Rotter, 2014; Schneider et al., 2007). This theory of law emerged in the early 1990s as a theoretical framework for mental health law and over time has been widely received in other areas of law (Schneider et al., 2007). Therapeutic jurisprudence is suggested to be the backbone of problem-solving courts in general and MHCs specifically, as it emphasizes a multidisciplinary, non-adversarial process and encourages treatment and rehabilitation rather than punitive sanctions (Barber-Rioja & Rotter, 2014; Wexler & Winick, 2003).

It is also important to be critical of therapeutic jurisprudence in MHCs, as the approach should not intrude on the fundamental principles of rights and justice of those who are part of the process (Nolan, 2001). Coercion cannot be entirely avoided in
MHCs, as it is inherent within the criminal justice system. In a neoliberal society, the state exerts control over subjects through certain technologies of power (Dean, 2010). Subjects must alter behaviour to fit within a societal norm at the will of the state, which is enforced through laws and rules; accordingly, subjects succumb to social pressures by adjusting perceived disobedient behaviours (Foucault, 1977). The criminal justice system is a technology of power that enforces such laws and rules and in turn requires subjects to govern themselves in order to abide by the norm (Foucault, 1977). Although an MHC attempts to limit the coercive effects of the state, it is nevertheless a branch of the justice system. In late neoliberalism, MHCs require subjects to adjust perceived disobedient behaviours and to self-govern. Accordingly, coercion remains inherent.

2.3.1 Background

David Wexler and Bruce Winick conceptualized the theory of therapeutic jurisprudence in the early 1990s as an approach to mental health law (Wexler & Winick, 2003). The concept became popular in many other legal areas and eventually became a way to practice law in general for lawyers and judges if they chose to do so (Wexler & Winick, 2003). Wexler and Winick discovered that the law can be both a therapeutic (favourable and healthy) agent and an antitherapeutic (unfavorable and unhealthy) agent, as it produces consequences that have an effect on an individual’s emotions and psychological well-being, for better or for worse (Lurigio & Snowden, 2009; Wexler & Winick, 2003). From the initial conceptualization of this theoretical framework, Wexler and Winick have argued that therapeutic jurisprudence must be used to make courtroom players aware that the law has an impact on emotional life. Winick (1997) posits that therapeutic jurisprudence must be factored into legal decisions to minimize
antitherapeutic consequences and to aim for the law to have a positive impact on the individual who is affected by it. Therapeutic jurisprudence is also a multidisciplinary approach. It seeks to incorporate psychology, social work, and criminology in the law, the lawyer’s office, and the courtroom (Wexler & Winick, 2003). By using this framework, the intent of therapeutic jurisprudence is to look at law from many standpoints to truly understand its effects on an individual.

Therapeutic jurisprudence was, and still is, a recommended solution to the shortcomings of the criminal justice system (Schneider et al., 2007). The number of mentally ill people going through the system after deinstitutionalization in the 1970s in Canada was astounding, and the criminal justice system was not meeting the needs of this vulnerable population (Schneider et al., 2007). Therapeutic jurisprudence became a means by which to address the onus that was placed on the criminal justice system to handle individuals who required mental health care (Schneider et al., 2007). Schneider et al. (2007) assert that change was necessary and needed to happen within the system itself, as the reality of a tough on crime approach was ever present and the prosecution of persons with mental illness was common (Schneider et al., 2007). Therapeutic jurisprudence was the suggested answer. It is premised on the concept that traditional justice goals are not displaced or ignored but rather are used to produce positive results for offenders (Schneider et al., 2007; Winick, 1997). Mental health courts are built upon a foundation of therapeutic jurisprudence. These courts concurrently seek to address the underlying problem of criminal behaviours and focus on rehabilitation by using the law as a therapeutic means (Barber-Rioja & Rotter, 2014).
Nolan (2003) argues that therapeutic jurisprudence in problem-solving courts in general is a result of a therapeutic mentality within American culture. He comments that American society has been restructured to embrace a therapeutic sensibility, where there is a reliance on the ‘psy’ disciplines and social work. With this in mind, Nolan (2003) asserts that courtrooms that embrace therapeutic ideals should not be a surprise within the context of this dominant therapeutic culture. Justice is altogether redefined in therapeutic jurisprudence and problem-solving courts, where justice embraces and is defined by treatment, healing, and problem-solving (Nolan, 2003). Therapeutic jurisprudence is deeply embedded within problem-solving courts, but Nolan encourages a critical view of this overlap. It is also important, Nolan (2003) posits, that traditional legal principles of rights and of justice not be undermined in the process of a jurisprudential change.

2.3.2 The Role of Therapeutic Jurisprudence in MHCs

Therapeutic jurisprudence is the approach that sets mental health courts apart from traditional criminal courtroom settings. Schneider et al. (2007) argue that therapeutic jurisprudence is inherently the foundation of MHCs. By having a thorough understanding of the theory of therapeutic jurisprudence, achieving the goals of MHCs and understanding their purpose is possible (Schneider et al., 2007). Therapeutic jurisprudence is argued to be an applicable framework for MHCs because it seeks to address the underlying issues that have led an individual with mental illness to engage in criminal behaviour in order to cease the cycle of justice system involvement (Winick, 2013). Furthermore, Wexler states that therapeutic jurisprudence is effective for MHCs because it allows legal professionals to think outside the box and to consider law in a
broad manner (Schneider et al., 2007). It also emphasizes a multidisciplinary, non-adversarial and collaborative approach (Portillo, Rudes, Viglione, & Nelson, 2013). All members of a case management team are essential to improving outcomes in a mental health court because they are the agents of therapeutic change (Portillo et al., 2013; Redlich & Han, 2014). Therapeutic jurisprudence in mental health court emphasizes the protection of due process rights and strives for justice as it pertains to each individual case (Lurigio & Snowden, 2009). Furthermore, rehabilitation is the predominant focus when therapeutic jurisprudence is employed in MHCs. Both the legal process and judge are the vehicles that facilitate access to treatment and health services in order to target untreated illnesses that perpetuate the cycle of arrest, incarceration, release, and re-arrest (Barber-Rioja & Rotter, 2014).

It is important to investigate whether the outcomes in MHCs can be predicted by the presence of therapeutic jurisprudence. Redlich and Han (2014) argue that research of mental health courts has not empirically identified whether outcomes can be predicted by therapeutic jurisprudence. These authors sought to fill this scholarly gap by conducting a study on whether therapeutic jurisprudence was a factor in MHC outcomes. Redlich and Han (2014) hypothesize that greater success is predicted in participants of MHCs who understood court procedures and requirements, chose to enter the court, and felt more respected, which they argue are characteristics of therapeutic jurisprudence. Although the results of their study were not statistically significant, the authors implore for further research on therapeutic jurisprudence in MHCs.
2.3.3 Restorative Justice and Therapeutic Jurisprudence

Defining restorative justice has not been an easy feat among academics. Although most agree on the premise of such a framework, one consolidated or consistent definition does not exist (Braithwaite & Strang, 2001; Van Ness & Strong, 2006). Restorative justice is a complex idea that has continued to develop with new discoveries and research (Van Ness & Strong, 2006). Van Ness and Strong (2006) provide their own, concise definition: “Restorative justice is a theory of justice that emphasizes repairing the harm caused or revealed by criminal behaviour. It is best accomplished through cooperative processes that include all stakeholders” (p. 43). These authors also suggest three principles of restorative justice. The first is that victims, offenders, and communities who have been injured by crime must be healed through justice (Van Ness & Strong, 2006). The second principle of restorative justice is that victims, offenders, and communities should be able to involve themselves in the process (Van Ness & Strong, 2006). The third principle is that the roles of government and community involve preserving a just order and a just peace (Van Ness & Strong, 2006). A thorough understanding of restorative justice is necessary to understand the elements of it that are present in mental health courts and its intricate entwinement with therapeutic jurisprudence. Although MHCs do not employ all elements of restorative justice, such as circle sentencing or having the victim present, Van Ness and Strong’s (2006) three principles do exist within the courts and are crucial to their operation.

“Perhaps the reality is that both movements have radical wings that are interested in transformatively restructuring access to justice and conservative wings that privilege the traditional values of the legal system” (Braithwaite, 2002, p. 254). Restorative justice
and therapeutic jurisprudence go hand-in-hand in problem-solving courts. Therapeutic jurisprudence focuses on how the law can act as a therapeutic agent by addressing the underlying problem of individuals’ criminal actions (Canada & Watson, 2013). Therapeutic jurisprudence recognizes that punitive sanctions in the form of incarceration are not the most appropriate treatment for all individuals, particularly those with mental illness, and asserts that rehabilitation through legal procedures has the greatest impact on people with mental illness (Barber-Rioja & Rotter, 2014). Restorative justice is therapeutic and considers emotions, empathy, healing, and the psychological well-being of the clients who interact with the justice system (Nolan, 2003). John Braithwaite, who is a founding theorist of restorative justice, encourages the concurrent enactment of restorative justice and therapeutic jurisprudence (Braithwaite, 2002). Like therapeutic jurisprudence, restorative justice recognizes that the law has both a psychological and physical impact on the well-being of individuals and focuses on the effects that the offender and victims suffer from when the impact is not addressed (Braithwaite, 2002). Braithwaite (2002) argues that both therapeutic jurisprudence and restorative justice emphasize “problem-oriented adjudication” (p. 246), in that legal decisions are made to rehabilitate the individual and to seek out the root causes of behaviour.

Schneider et al. (2007) posit that restorative justice is essential in MHCs, as it emphasizes repairing harm that has been caused by the criminal behaviour. In an MHC, stakeholders are engaged in a rehabilitative, therapeutic process that allows restoration of the harm done and reintegration of the individual back into society (Schneider et al., 2007). It must also be noted that the stakeholders in MHCs compared to restorative justice practices do vary slightly. Although stakeholders are involved and contributing
participants of both processes, restorative justice stakeholders can include the offender, victims, and interested members of the community (Van Ness & Strong, 2006) and in an MHC, the group of stakeholders does not always include the victim. Although this is an important difference between the two, and arguably one to be critical of, one cannot deny the restorative nature of an MHC. Schneider et al. (2007) argue that MHCs are essential in the reintegration process by diverting the client from the justice system to the necessary system(s) of care. Mentally ill individuals who find themselves caught within the justice system deserve compassion and intervention (Schneider et al., 2007). Reintegrative shaming is an aspect of restorative justice that is also present in MHCs.

Reintegrative shaming is a component of restorative justice and contributes to the role of therapeutic jurisprudence in MHCs (Dollar & Ray, 2015). Braithwaite (2002) argues, “Reintegrative shame is fundamental to understanding restoration as a process” (p. 257). It maintains respect for the individual who has caused harm while disapproving the criminal actions, and the individual is eventually accepted and reintegrated instead of stigmatized (Braithwaite, 2002). Despite the intuitive ties between therapeutic jurisprudence and restorative justice, some therapeutic jurisprudence theorists argue that reintegrative shaming is unnecessary in therapeutic courtroom practices because it might be negatively conceptualized (Nolan, 2003). Further, therapeutic jurisprudence theorists argue that reintegrative shaming lessens the emphasis on rehabilitation. Restorative justice theorists might also take issue with the lack of emphasis that therapeutic jurisprudence places on the impact of the harms on the victim(s). Despite these differences, reintegrative shaming is fundamental in MHCs and therapeutic jurisprudence as it focuses on using the law as an aid in the reintegration and
rehabilitation of an individual (Dollar & Ray, 2015). Dollar and Ray (2015) state that reintegrative shaming separates the criminal behaviour from the individual and encourages the concurrent expression of shame for the behaviour and respect for the individual. The individual is held accountable for the personal progress that is made under court supervision and the court encourages positive reintegration into society (Dollar & Ray, 2015). Although victims are not always directly involved in the process, legal counsel has the option to contact the victim and ensure that their voice is heard as well. In MHCs, the judge plays a significant role in the reintegrative shaming of individuals by encouraging them when they are doing well and respectfully scolding them when they are not (Canada & Watson, 2013; McNiel & Binder, 2010; Wales, Hiday, & Ray, 2010). Reintegrative shaming and therefore restorative justice are offered as an explanation as to why therapeutic jurisprudence is essential in MHCs and in diverting mentally ill individuals from the justice system.

2.3.4 Procedural Justice in Therapeutic Jurisprudence

Procedural justice is a characteristic of therapeutic jurisprudence because it is an example of the law being a therapeutic agent to create healthy benefits for clients. According to Canada and Watson (2013), procedural justice involves:

The subjective experience of being heard by a decision maker, being treated with dignity and respect, and perceiving concern by figures of authority, [which is] influential in the assessment of fairness and cooperation with the decision, regardless of the favorability of the outcome for the individual. (p. 212)

Further, procedural justice is part of the problem-solving process in an MHC in that it aims to give clients a voice, influences perceptions of fairness among clients, and most of all, positively influences perceptions of respect among clients (Canada & Watson, 2013). Dollar and Ray (2105) assert that procedural justice and reintegrative shaming are
conceptually different on the surface, but procedural justice is “consistent with several components of reintegrative shaming theory” (p. 33). Canada and Watson (2013) posit that procedural justice is a necessary component of MHCs because it produces client satisfaction with court proceedings.

Studies have found that clients of MHCs often perceive moderate to high levels of procedural justice in the proceedings (Canada & Watson, 2013; Dollar & Ray, 2015; Wales et al., 2010). Wales et al. (2010) found that clients who feel they have had positive encounters with the judge are more likely to experience higher levels of procedural justice overall. Participants in MHCs who feel they are being treated fairly in the legal process are more likely to be motivated to change their behaviour in the future than those who go through the traditional criminal court process (Dollar & Ray, 2015). Procedural justice is arguably one of the variables that produces positive outcomes in a mental health court.

2.4 Mental Health Courts

*Buoyed by therapeutic jurisprudence and the steadily growing problem-solving court movement, mental health courts have gathered momentum as mentally disordered individuals continue to flood the criminal justice system.* (Schneider et al., 2007, p. 68)

The first formal mental health court in North America emerged in Florida in the late 1990s as a response to the increasing number of mentally ill individuals in the justice system (Stefan & Winick, 2005). By the year 2000, the U.S. federal government had allocated state funds to create MHCs all over the country to address the problem of overrepresentation of mentally ill persons in the justice system (Schneider et al., 2007). Canada saw the creation of its first formal MHC in Toronto in 1998. Toronto’s MHC emphasized diversion of the mentally ill from the justice system to the mental health
system and ignited the emergence of MHCs across the country (Schneider et al., 2007; Slinger & Roesch, 2010). Currently, MHCs are in operation throughout Canada (Slinger & Roesch, 2010), including in the provinces of New Brunswick, Nova Scotia, Ontario, Manitoba, and Saskatchewan. Although MHCs are critiqued by the public and by academics alike (Canada & Watson, 2013; Stefan & Winick, 2005), these specialized courts continue to emerge in jurisdictions all over the world (Schneider, 2010). MHCs were modeled off of the most prevalent form of problem-solving courts, drug treatment courts.

Drug treatment courts were the first generation of problem-solving courts and originated in the late 1980s (Lurigio, 2008). Drug treatment courts were developed in response to the “war on drugs” in the 1980s, when arrests and prison sentences for drug use were at an all time high, and have spread rapidly throughout the U.S. and Canada since their inception (Lurigio, 2008). In fact, Schneider et al. (2007) identified that there were over 1000 drug treatment courts operating in North America in 2007, and this number has only increased over the years. Drug treatment courts identify that drug use is both a community health issue and a criminal justice issue (Lurigio, 2008) and aim to slow the revolving door of justice for drug-related offences that is a consequence of substance abuse (Goldberg, 2011; Slinger & Roesch, 2010). The courts engage in a non-adversarial, case management approach, impose mandatory drug treatment, and provide access to various services with the goal of ceasing justice system contact (Goldberg, 2011; Lurigio, 2008; Slinger & Roesch, 2010). It is the drug treatment court model that inspired the establishment of many other problem-solving courts, including MHCs (Lurigio & Snowden, 2009; Schneider et al., 2007). Like drug treatment courts, MHCs
have taken on a similar growth rate since their initial emergence (Schneider et al., 2007). The latest statistics presented by Goodale, Callahan, and Steadman (2013) state that there are almost 400 MHCs operating in the United States. There is no formally reported number of MHCs in Canada.

Mental health courts have been created as a response to the criminalization and overrepresentation of the mentally ill in the criminal justice system (Schneider et al., 2007). These problem-solving courts are part of the solution to an over-burdened criminal justice system that has upheld the responsibility of handling and processing persons with mental illness since government run mental institutions closed down (Schneider et al., 2007). The justice system and the mental health system have been thrust together, though they maintain different mandates (Almquist & Dodd, 2009). In the United States, the criminal justice system is responsible for public safety and the punishment and prevention of criminal behaviour, while the mental health system focuses on public health, harm reduction, and treating illness (Almquist & Dodd, 2009). The Canadian criminal justice system places more emphasis on rehabilitation and reparation of harms, but one must not look further than overcrowded remand centres and prisons, particularly with mentally ill persons, and the reduction in available programming within correctional institutions to question whether this remains the priority (Demers, 2014). As long as there is an overlap of mental illness in the justice system, there must be an attempt to bridge the two sectors to ensure communities are safe and to establish the best possible outcome for people with mental illness (Almquist & Dodd, 2009). Mental health courts aim to bridge this gap.
2.4.1 Objectives and Principles of Operation

Although MHCs across North America vary in their specific operation, they generally maintain a similar organization and share a common goal of using the law to provide access to services and to provide treatment (Dollar & Ray, 2015; Redlich, Steadman, Monahan, Robbins, & Petrila, 2006). MHCs are criminal courts with separate docketes for individuals who wish to voluntarily participate, have committed a criminal offense, suffer from a mental illness and thus are not best served by traditional justice practices of incarceration and harsh penalties (Redlich et al., 2006). These courts address mentally ill persons who rotate in and out of the justice system by diverting them from the cycle of arrest, incarceration, release, and re-arrest and facilitating rehabilitation and treatment (Dollar & Ray, 2015; Ray, 2014; Redlich et al., 2006; Schneider et al., 2007). The main objective of MHCs is to direct the mentally ill to the systems of care they require, i.e., mental health, social services, addiction services, probation services, from the criminal justice system (Redlich et al., 2006; Schneider et al., 2007). By linking these individuals to community treatment, the intent of MHCs is essentially to encourage compliance with the individualized plan under the supervision of the court (Hughes & Peak, 2013; Redlich et al., 2006).

In MHCs, the judge provides praise and encouragement for compliance with conditions or court-mandated orders (Redlich et al., 2006; Wales et al., 2010). MHCs further recognize that incarceration produces negative impacts for individuals suffering from mental illness (Canada & Gunn, 2013), and therefore use punitive sanctions with infrequency, caution, and as a last resort (Barber-Rioja & Rotter, 2014; Canada & Watson, 2013; Dollar & Ray, 2015; Tyuse & Linhorst, 2005). Barber-Rioja and Rotter
and Canada and Watson (2013) concur that MHCs aim to address the overrepresentation of mentally ill individuals in corrections populations and attempt to ease the overburdened criminal justice system. Although the similarities in operation are apparent, there are also variations among these specialized courts.

### 2.4.2 Inclusion Criteria

MHCs are all based on similar objectives, maintain similar operational principles, and are premised on a model of therapeutic jurisprudence, but variations among jurisdictions do exist (Goodale et al., 2013; Hughes & Peak, 2013). Hughes and Peak (2013) assert that the structure and organization of MHCs are often unique; there is not one generally accepted model that is the basis for each court. The authors also suggest that such differences and the lack of one cohesive model are the consequences of a lack of implementation of the critical components of an MHC. Some courts require a guilty plea to be entered before participation in the court while others do not require a guilty plea (Canada & Gunn, 2013; Canada & Watson, 2013; McNiel & Binder, 2010). MHCs also vary in the types of mental illnesses and the types of offences they will accept (Palermo, 2010; Schneider et al., 2007). A client’s length of time spent under supervision of the court also varies by jurisdiction. Schneider et al. (2007) point out differences between courts and assert that there are varying entrance requirements as well as different objectives and outcomes of MHCs across jurisdictions. The varying criteria of eligibility are listed below.

The first criterion of eligibility that differs across MHC models is in regards to the offence(s) committed. Slinger and Roesch (2010) report that some courts only accept
individuals who have committed minor summary\textsuperscript{3} or misdemeanor\textsuperscript{4} offences, and others permit both summary/misdemeanor and indictable\textsuperscript{5} or felony\textsuperscript{6} offenses. A summary or misdemeanor offence might include minor property offences or public intoxication, while indictable or felony offences might include more serious charges of assault with a weapon or dangerous driving. One MHC in the US uses judicial discretion when evaluating eligible offenses—the context and circumstances of the violent offense are examined to determine whether the individual is an appropriate candidate for mental health court inclusion (Moore & Hiday, 2006). Just because an offense is violent does not mean the individual will be excluded from court (Moore & Hiday, 2006). The judge or the Crown Prosecutor (in Canada), or District Attorney (in the US), are the agents who screen individuals for offenses that the court will accept (Moore & Hiday, 2006; McNiel & Binder, 2010). The earliest MHC models only accepted misdemeanor offences (Lurigio & Snowden, 2009; Stefan & Winick, 2005), but since then, MHCs more frequently accept both misdemeanors and non-serious felonies, at the discretion of the legal team (Canada & Watson, 2013; Dollar & Ray, 2015; Kennedy, 2013; Palermo, 2010; Schneider et al., 2007). It is also becoming increasingly common for an MHC to only accept felony offences (Canada & Watson, 2013; Stefan & Winick, 2005). Also important to note is that most MHCs do not accept individuals who have committed driving-under-the-influence offenses, sexual offenses, domestic violence charges, or murder, either because there are separate problem-solving dockets for some of these or

\textsuperscript{3} Summary offences are crimes in Canada that are less serious and punishable by shorter prison sentences and fines (Criminal Code, 1985).

\textsuperscript{4} Misdemeanors are American offences and are similar to a summary offence in that they are less serious and warrant less serious punishment (Legal Information Institute, 2015b).

\textsuperscript{5} Indictable offences are crimes in Canada that are more serious than summary offences, are punishable by greater penalties, and allow the option of trial by jury (Criminal Code, 1985).

\textsuperscript{6} Felony offenses are the equivalent of indictable offences in Canada. They warrant harsh punishment and potentially the death penalty in many states (Legal Information Institute, 2015a).
they are violent offences that are not meant to be dealt with in a therapeutic court (Dollar & Ray, 2015; Lurigio & Snowden, 2009).

The second criterion of inclusion in an MHC that is different across jurisdictions is that varying mental illnesses are accepted. To be eligible for participation in any MHC, there must be some kind of evident—as noticed by legal professionals in the courtroom—and diagnosable mental health issue (Lurigio & Snowden, 2009). The MHC literature demonstrates that most mental health courts accept individuals with serious and persistent mental illness in the form of an Axis I disorder, such as schizophrenia or bipolar disorder, as per the DMS-IV-TR (Kennedy, 2013; Lurigio & Snowden, 2009; Nochomovitz & Hickman, 2009; Palermo, 2010). Although many courts primarily accept individuals with Axis I disorders, some permit those with developmental disabilities and a smaller number allow those with Axis II disorders, such as borderline personality disorder or antisocial personality disorder (Dollar & Ray, 2015; Lurigio & Snowden, 2009; McNiel & Binder, 2010). Furthermore, other MHCs distinguish an eligible mental illness by its severity, regardless of which Axis the illness lies on (Lurigio & Snowden, 2009).

The third criterion of eligibility that varies across MHC jurisdictions is whether a participant must plead guilty before entry into the court is permitted (Dollar & Ray, 2015). Some courts allow a pre-conviction agreement where the client does not plead guilty prior to admittance into the court, while others require post-conviction agreements to be made, where a guilty plea must be entered to be eligible for acceptance (Canada & Watson, 2013; Dollar & Ray, 2015). It is most common for MHCs to require full admittance of guilty before the individual is eligible to participate in the proceedings.
Post-conviction agreements are more common in Canada than the US. They emphasize judicial discretion and are dependent upon the client’s progress in the individualized plan (Schneider et al., 2007). The Toronto Mental Health Court and a mental health court in San Francisco are examples of a pre-plea agreement court, where intervention occurs before adjudication of the charges (McNiel & Binder, 2010; Slinger & Roesch, 2010). Other courts allow both pre- and post-conviction agreements to be made (Canada & Watson, 2013).

The final criterion of eligibility that differs among MHC models is the length of time the individual is required to participate in court proceedings. In one Canadian MHC, the length of time the client must spend under the supervision of the court is contingent upon their progress with the case management plan and the pace at which treatment access occurs (Saskatchewan Law Courts, 2012). Some courts require a designated amount of time to complete a mandated program, such as six to twelve months (Dollar & Ray, 2013; McNiel & Binder, 2010), four to six months (Wales et al., 2010), or one to three years (Canada & Watson, 2010). The intention of requiring a specific amount of time that the client must spend under the supervision of an MHC, either pending their sentence or pending completion of a program in a pre-conviction court, is for individuals to be appropriately reintegrated into society (Schneider et al., 2007). This often depends on the severity of the mental illness, whether treatment has progressed, and if participants are abiding by court orders. Schneider et al. (2007) argue that the length of time should vary case by case, as not every individual is ready to leave the program at the same time. Schneider et al. (2007) state, “success is a relative concept that will have vastly different outcomes for different individuals” (p. 83).
2.4.3 Perceived Outcomes and Effectiveness

Researchers who study MHCs often point out the need for more comprehensive studies that are empirically efficacious to be conducted (Canada & Gunn, 2013; Canada & Watson, 2013; Ray, 2014; Sarteschi, Vaughn & Kim, 2011). Statistically significant results have been difficult to produce (Ray, 2014; Sarteschi, et al., 2011), even among mixed-methods studies where the quantitative measures have been informed by qualitative data (Canada & Gunn, 2013; Canada & Watson, 2013; Wales et al., 2010). It is most common for researchers of MHCs to study recidivism rates as a measure of court effectiveness and client success. In contrast, qualitative studies allow for data that is rich with narrative and that provides context regarding the effects of an MHC on the overall quality of life of clients.

Effectiveness of the MHC process is commonly measured through examining recidivism rates, which is the rate of reoffending after clients have completed the MHC process (Ray, 2014). Sarteschi et al. (2011) conducted a quantitative meta-analysis that reviewed the findings of eighteen studies in seeking whether or not MHCs are an empirically proven form of intervention for mentally ill offenders. The authors’ findings suggest that re-offense rates among the 18 studies are moderately lower upon MHC completion compared to non-participants, implying MHCs may be somewhat effective in reducing recidivism. Further, they found that MHCs have the potential to produce positive clinical outcomes, such as fewer hospital visits (Sarteschi et al., 2011).

Two studies that measure reductions in recidivism in MHCs produced statistically significant reductions in recidivism (Moore & Hiday, 2006; Ray, 2014). Ray (2014) compiled long-term data on recidivism rates of clients who completed an MHC
program. For clients who completed the MHC program, re-arrest rates were lower than those who did not fully complete the program or who did not participate in the process at all. Clients who completed also had a longer time in the community before reoffending. Those who did reoffend after the court process were most likely to do so within two years of program completion and had a higher long-term re-arrest rate than clients who completed the MHC program (Ray, 2014). Moreover, Moore and Hiday (2006) found that subjects who went through traditional criminal court and individuals who did not complete an MHC program were both re-arrested at a significantly higher rate and committed more severe crimes than those who completed the MHC program.

Although it is highly common to study recidivism rates, it should not be the sole measure of effectiveness because these individuals have been recognized by the justice system and are therefore comprehensively known to justice professionals, and will also suffer from a pervasive mental illness for the entirety of their lives (Nolan, 2001; Schneider, 2010). Some mental illnesses that are prevalent in MHCs are not treatable, such as Fetal Alcohol Spectrum Disorder, a genetic disorder or illnesses that are the result of acquired brain injuries. Psychiatric disorders such as schizophrenia are manageable by treatment and medication, but illness is neither cured nor goes away completely. Schneider (2010) argues that recidivism may actually increase once an individual has made an appearance on the criminal justice system’s radar and is “being monitored quite closely under the watchful eye of a mental health court” (Schneider, 2010). Once an individual has gone through the MHC process, key stakeholders who compose the case management team have a new and comprehensive understanding of the client, which is not the case in traditional criminal court settings (Nolan, 2001). Reports
of the clients’ character are made, and information from every aspect of their life is gathered (Nolan, 2001). A comprehensive understanding of the personal lives of clients creates significant judicial involvement (Nolan, 2001). In turn, clients are monitored more closely after entrance into an MHC program than if they had gone through a regular criminal court process.

Researchers have found valuable insight into the court by way of interviewing its participants and the involved professionals (Barber-Rioja & Rotter, 2014; Canada & Gun, 2013; Canada & Watson, 2013; Dollar & Ray, 2015; McNiel & Binder, 2010). Qualitative studies, such as Canada and Gunn’s (2013) on social support in MHCs, demonstrate the importance of moving beyond statistical measures of recidivism. The results of Canada and Gunn’s (2013) research demonstrate a positive relationship between supports gained through an MHC process and the rehabilitation and success of the participant. Canada and Gunn (2013) found that success for clients includes receiving a formal diagnosis, following a treatment and/or medication regimen, connecting with community resources, gaining assistance in transportation and vocational aspects, and personal motivation to change criminal behaviour. Moreover, many researchers have found that participants and stakeholders of the court indicate an overall satisfaction with the process and a perception of positive changes among the majority of clients (Canada & Gunn, 2013; Canada & Watson, 2013; McNiel & Binder, 2010).

Canada and Watson (2013), by investigating perceptions of procedural justice among clients, found that participants feel they have a voice in MHC proceedings, have an overall positive relationship with court staff, feel respected, and feel more encouraged to succeed (Canada & Watson, 2013). Furthermore, McNiel and Binder (2010)
conducted interviews with stakeholders of a mental health court, including judges, attorneys, probation officers, case managers, mental health professionals, and agency administrators to find out how the court works and what the potential benefits and outcomes are (McNiel & Binder, 2010). McNiel and Binder (2010) found that stakeholders emphasized a noticeable improvement in clients who participated in the MHC program, such as reduced incarceration, increased treatment, reduced symptoms, reduced substance abuse, reduced homelessness, and improved quality of life. Participants in this study also indicated that ongoing supervision is important to encourage compliance to the individualized treatment plan (McNiel & Binder, 2010).

By employing an observational method of research, Dollar and Ray found that a non-adversarial approach that MHCs engage in is valuable. A non-adversarial approach aids in understanding the complex behaviour behind the criminal actions and thus allows the individual to be directed to the necessary avenue of care (Dollar & Ray, 2015). Dollar and Ray’s (2015) findings indicate reintegrative shaming, a component of restorative justice, is a prevalent characteristic of the MHC. It was found that clients are respected and encouraged during MHC proceedings. Moreover, the criminal behaviour that had led participants to the MHC was separated from the participant, and instead, the participant was seen as an individual and the criminal label was avoided. Finally, the authors’ observational data indicated that reintegrating the participant into society as a law-abiding member was a crucial aspect of the restorative justice and mental health court process (Dollar & Ray, 2015).
2.4.4 Socio-legal Concerns in MHCs

The frequent emergence of MHCs has brought upon an influx of critiques of their process. Some authors have argued that mental health courts are under-inclusive as they limit the types of offenses and the types of mental illnesses that are eligible for inclusion (Nochomovitz & Hickman, 2009; Sarteschi et al., 2011; Schneider et al., 2007). Nochomovitz and Hickman (2009) argue that there is evidence of racial and ethnic disparities in MHCs in the U.S. In their quantitative meta-analysis of MHC studies, Sarteschi et al. (2011) found a disproportionate number of White persons represented in U.S. mental health courts, arguably implying racial privilege of treatment and service access. Moore and Hiday (2006)’s study also confirms a race disproportion in a U.S. mental health court. Less than half of their MHC study sample is African American and the remaining participants are White.

In Canada, racial disproportions are evident among the Aboriginal population. Contrastive to racial disparities in the U.S., White individuals are underrepresented in Canadian MHCs. Aboriginal persons are significantly over-represented in the Canadian Criminal Justice System in general. In fact, the latest Canadian statistics demonstrate that Aboriginal individuals comprise 18.5% of federally incarcerated inmates in Canada but only make up 3.8% of the total population (Correctional Service Canada, 2012). In one Canadian MHC, there is twice the number of Aboriginal clients than Caucasian clients (Hornick, Kluza, & Bertrand, 2011). Notably, of the few Canadian MHCs that do exist, race demographics are seldom part of the court’s evaluation.

It is likely that Gladue is a force behind a high representation of Aboriginal participants in MHCs. The Gladue principle for Aboriginal offenders asserts that an
Aboriginal person’s background must be considered in sentencing and “all available sanctions other than imprisonment that are reasonable in the circumstances should be considered for all offenders, with particular attention to the circumstances of Aboriginal offenders” (Criminal Code, 1985, s. 718.2(3)). Arguably, this explains the high proportion of mentally ill Aboriginal clients in Canadian MHCs as it is the justice system’s solution to seeking alternate sanctions for this marginalized population.

Coercion and voluntariness are both common themes in a discussion of socio-legal issues that pertain to MHCs (Sarteschi et al., 2011; McNiel & Binder, 2010). Although court staff emphasize to the client that their participation is voluntary, one can discern that when given a choice between participation in a mental health court and punitive sanctions that may be received in a regular criminal court process, such as spending time in jail, many would choose mental health court (McNiel & Binder, 2010).

A study conducted by Redlich, Hoover, Summers, and Steadman (2010) on the perceived levels of voluntariness by participants indicates that this is indeed a point of concern. Most participants in the study claimed they agreed to participate in the MHC program, but were not in fact told that the program was voluntary in nature (Redlich et al., 2010). In regards to coercion it is also important to consider whether the individual is of the psychological capacity to make a clear judgment and decision to participate voluntarily in court (Watson, Hanrahan, Luchins, & Lurigio, 2001). Fitness to stand trial or even whether the individual should be held criminally responsible or not due to their mental disorder are two further considerations in psycho-legal issues.

Voluntariness is also a significant issue in the context of guilty pleas. The majority of MHCs require a guilty plea to be entered before case management occurs and
before treatment and resources can be attained (Schneider et al., 2007). Although the guilty plea is seen to be voluntary, the underlying coercion is clear. Nolan (2003) is critical of such coercion and encourages problem-solving courts to ensure they do not challenge or undermine fundamental principles of justice. Although it is implied that this is the approach that MHCs take to help individuals, this criticism remains a very serious problem (Nolan, 2003). The fairness of MHCs is called into question if a mentally ill accused is required to plead guilty in order to access mental health services and resources in the community (Schneider et al., 2007). Although mental health services should be available in prisons, it has been found that these are severely lacking in Canadian prisons (Demers, 2014; Sapers, 2014). This begs the question: is participation truly voluntary if “liberty is dangled in front of the accused” (Schneider et al., 2007, p. 89)? In traditional criminal courtrooms, the accused would have an opportunity to argue their innocence and therefore would have the potential to avoid a conviction. When the “reward” is avoiding incarceration through an alternative disposition or perhaps an adjudication of charges all together, it is not difficult to surmise that a guilty plea would be entered most often in order to access treatment and resources (McNiel & Binder, 2010). The consequences of such are lasting, as entering guilty plea, especially without an opportunity to prove one’s innocence, establishes a criminal record for the individual who is charged (Sarteschi et al., 2011). Although in some MHCs there is potential to have this charge dismissed once the court’s conditions have been followed, this is not guaranteed (Sarteschi et al., 2011).

Schneider et al. (2007) discuss additional issues that pertain to MHCs: confidentiality, sanctions, and stigmatization are also necessary to consider.
Confidentiality is of concern in MHCs because a full disclosure of all aspects of an accused’s life is brought forth in pre-court conference meetings where the client is not present. Comprehensive, personal reports are generated for the clients, which is necessary for service access, but arguably is also very invasive (Nolan, 2001). Rather than just legal counsel being privy to all charges and legal considerations as usual, each member of the case management team is also aware of the client’s background for it to be possible to create an individualized and thorough treatment plan (Nolan, 2001; Schneider et al., 2007). Although confidentiality is sworn to and ensured, the issue is one of privacy in general for the client.

Schneider et al. (2007) also point out the issue of sanctions being used for non-compliance. Although most courts aim to avoid sanctions of jail time when clients do not abide by program conditions, an increasing amount of MHCs are using jail as a penalty. Nolan (2003) has stated that many problem-solving courts use coercive intervention not as punishment but to help restructure clients’ behaviour. Despite this intention, straying from the treatment plan should arguably not result in punitive consequences because treatment for the mentally ill does not happen all at once; seeking treatment and rehabilitation is typically a gradual process (Schneider et al., 2007). Further, problem-solving courts should stray from the controversial approach of using jail time sanctions because they should be aware that punishment does not decrease future offending (Canada & Gunn, 2013).

A final issue is the stigmatization that participation in a mental health court brings upon for a client (Schneider et al., 2007). Some authors argue that grouping mentally ill offenders together further stigmatizes and marginalizes them (Stefan &
Winick, 2005). Schneider (2010) asserts that once these individuals are brought to the attention of the system through MHCs, they will continue to be watched more closely than if they had gone through traditional court proceedings, which may also increase the likelihood of involvement with the justice system if supports are not adequately in place for the individual. Because they are more closely monitored by multiple agencies, individuals may be at risk of experiencing increased stigmatization. However, monitoring clients more closely to facilitate stability in the community is the inevitable intention of the court.
Chapter 3: Methods

While much research has been conducted on mental health courts, the research has been predominantly quantitative and has sought to identify statistically significant reductions in recidivism rates. This study used a qualitative approach to seek perspectives of key stakeholders of the Regina Mental Health Disposition Court. Qualitative studies in MHC research have not often investigated the specific mechanisms that are impacting outcomes or how and why MHCs foster positive change in clients (Canada & Gunn, 2013; Canada & Watson, 2013). Hughes and Peak (2013) assert there is also minimal evidence suggesting whether MHCs contribute to outcomes other than recidivism, such as improved clinical outcomes that involve improved mental health status and overall quality of life. The present study addresses this notable gap in qualitative research in the MHC literature. The study investigated how stakeholders conceptualize a mental health court and how these conceptualizations may or may not differ from other traditional criminal courtroom settings. Notions of justice are also delved into, as well as how an alternative justice practice in mental health court may affect client outcomes. A qualitative framework is used to address this understudied area of research.

Qualitative research, according to Creswell (1998),

is an inquiry process of understanding based on distinct methodological traditions of inquiry that explore a social or human problem. The researcher builds a complex, holistic picture, analyzes words, reports detailed views of informants, and conducts the study in a natural setting. (p. 15)

Qualitative research is valuable to this study, as it provides a holistic picture of how stakeholders conceptualize a mental health court. The present qualitative research investigates the overrepresentation of mentally ill individuals in the criminal justice
system by shedding light on the Regina Mental Health Disposition Court and investigating how this court can aid in alleviating the problem that the justice system faces.

3.1 Research Paradigm

This qualitative research employs an interpretivist-constructivist epistemological position, which Tuli (2010) asserts is a way of seeing the world as experienced by individuals who are interacting with one another within a social system. Creswell (1998) suggests that qualitative inquiries are guided by a certain set of beliefs or assumptions that are related to the nature of reality, the relationship between the researcher and that being researched, and the process of the research. The interpretive research paradigm in this study views reality as socially constructed (Tuli, 2010); therefore, both the participant and the researcher co-construct a reality through interaction, which would result in various knowledges and ways of knowing.

Multiple realities exist in the construction of social reality within research (Creswell, 1998). I have interpreted many versions of reality by exploring various conceptualizations and experiences of stakeholders within the Regina Mental Health Disposition Court. Ontological issues are addressed in qualitative research by exploring social realities and knowledges of participants (Creswell, 1998). Creswell (1998) states that there is value in seeking multiple perspectives because of the diverse nature of individuals’ realities. Ormston, Spencer, Barnard, and Snape (2014) further suggest that knowledge is not passively received by individuals but rather is actively constructed. A social constructivism perspective was employed in this research. Creswell (2003) posits that varied subjective meanings of experiences are developed in qualitative research and
it was my aim to explore the deep complexity of these varied views and experiences. The goal of a social constructivist perspective is to “rely as much as possible on the participants’ views of the situation being studied” (Creswell, 2003, p. 8); therefore, this research investigated how others make sense of the world by understanding how they conceptualize their knowledge of the MHC. In qualitative research, the goal is to create a holistic conceptualization of individuals’ views because it is these views that shift and shape understandings of the world (Ritchie et al., 2014).

3.2 Methods

Interviews use verbal communication and spoken narrative to produce data (Yeo et al., 2014). Eight open-ended, semi-structured interviews were conducted with ten stakeholders of the court. In one interview three participants were present, as they worked together in the same building and felt more comfortable when all three could participate. Interviews were chosen over other qualitative methods, such as self-report surveys, because there is value in seeking out those individuals who construct their social world and to give them the opportunity to verbally communicate insight regarding this construction (Yeo et al., 2014). Within the construction of their social world, stakeholders create a version of their own reality and therefore it is these understandings and conceptualizations that construct the mental health court. It is also important to distinguish between the value of individual interviews and focus groups, as both strategies provide rich data. While group discussions allow for the context of interaction between participants to create a dialogue from which to extract data, individual interviews allow for a greater depth and intricate detail in participant responses and were the preferred method of data collection in this study (Lewis & McNaughton Nicholls,
The participants who compose this study are a unique group who were given an opportunity to discuss complex issues that are potentially delicate in nature (Lewis & McNaughton Nicholls, 2014). One-on-one interviews allowed for an open discussion as participants could speak more freely about their perspectives of the court with a certain level of confidentiality.

Interviews took place from July 2015 through September 2015 as part of a larger research partnership in the Regina Mental Health Disposition Court. I was serving as a co-principle investigator on this project, titled *Confronting the Challenge: Community Supports, Stability and the Role of the Mental Health Disposition Court*, and had access to the data collected in the research partnership that pertains to the current thesis. This approach was employed, in part, because this thesis research replicated many elements of the research partnership that was in data collection mode at the same time. Because of this, there was concern about research fatigue of stakeholders as the sample size is small and there would likely have been excessive repetition between the thesis research and the partnership project. To manage research fatigue, only one round of interviews was conducted for both studies using the same interview guide.

Interviews were conducted in a location that was most accessible for the participant, whether it was in their place of employment or in a quiet corner of a restaurant. Interviews began after gaining informed consent. It was stated to the participant the purpose and procedure of the interview, that the participant may withdraw from the study at any time, and that they will be given the opportunity to ask questions and clarify concerns. A consent form was signed; one copy was securely stored and the other copy was given to the participant. Open-ended, semi-structured interviews were
conducted using an interview guide, with a goal of 30-45 minutes of discussion. Open-ended, semi-structured interviews were employed because they allowed flexibility in participant responses, as the interviewer is given space to follow-up with particular points made in a response.

Interviews were recorded, after being given permission from the participant, using a handheld recording device. Brief notes were also taken during the interview. These notes served as a back-up in the event of technology failure. The notes also allowed for immediate reflections on key ideas or themes that arose during the interview.

At the end of the interview, participants were debriefed: they were asked if they needed any clarification on the process, had any concerns or any questions about the project and were told that if they have any follow up questions or comments to send Dr. Stewart or me an email. Yeo et al. (2014) argue that debriefing is a very important part of the interview process, as it gives participants a chance to process the discussion and allows space for clarification and concerns. During the debrief, participants were also given an opportunity to provide further comments and input if they chose to do so. The course of action following the interview was discussed, i.e., what will happen with the data, when results will be compiled, and how participants can learn about the study’s results.

Data in the form of interview transcripts was stored in a locked cabinet throughout the project, and will be stored in a secure electronic file and in a locked desk drawer for five years following completion of the project, as per the Research and Ethics Board of the University of Regina. Data will be securely destroyed by deleting files securely or shredding paper content following the five-year storage requirement. Dr. Michelle Stewart, the principle investigator of the partnership project, was responsible
for storing the audio recordings and notes from all interviews. Findings will be disseminated to participants at a luncheon that Dr. Stewart will be hosting as part of the MHC partnership project.

3.3 Rigour

Guba (1981) argues that the rigour, or trustworthiness, of qualitative research is demonstrable through credibility, transferability, dependability, and confirmability. This study was conducted in a way that incorporated these elements. Credibility is achieved through prolonged engagement at the site (Guba, 1981). At the mental health court, I spent fifteen months attending, observing, and building a valuable rapport with stakeholders. Because of this extended period of time, it was understood that I, the researcher, was part of the process and allowed “locals to adjust to the presence of researchers and to satisfy themselves that they do not constitute a threat” (Guba, 1981, p. 84). Credibility was also established through peer debriefing (Guba, 1981), where observations and interviews were debriefed with the principle investigator of the partnership project, Dr. Stewart.

In demonstrating transferability, the researcher understands that generalizations are not always possible, as social or behavioural phenomena vary based on the context in which they are found (Guba, 1981). Guba (1981) argues that one can attain transferability by constructing descriptive or interpretive statements within a certain context. Transferability was also achieved in the present study through purposive sampling in order to select participants who were representative of the object of study in order to “maximize the range of information uncovered” (Guba, 1981, p. 86). Guba (1981) argues that transferability is demonstrated when findings can move between
settings if the investigator is attentive to contextual factors in the research. Key contextual factors are discussed throughout this thesis that outline a Saskatchewan-specific setting.

Dependability is another element of a rigorous study and allows for the awareness and recognition of different perspectives during the research process by establishing an “audit trail” of the research process (Guba, 1981). Through documentation during interviews and keeping an ongoing account of observations, I was able to step back and examine the process that I engaged in to become familiar with the mental health court. Guba (1981) also posits that dependability is achieved through “overlap methods” (p. 86), where different methods are used to attain data. Although observation data was not used for this thesis, observations were conducted in order to become familiar with the court setting.

Finally, confirmability is a shift away from objectivity and can be achieved through triangulation, which can include the discussion of findings with another researcher, and practicing reflexivity, or continued introspection and debriefing (Guba, 1981). Triangulation and reflexivity both occurred in this study by discussing findings with Dr. Stewart. Confirming observations in the present study allowed for continued reflection on my own interpretations of the court and of the process through which I was studying the court (Guba, 1981). Trustworthiness has been established in this study as indicated by these four elements.

Based on the rigour of analysis, it is also important to identify the wider resonance of the findings (Mason, 2002). Rather than generalizing findings to other courts, it is instead important for other MHCs to learn from the holistic explanation of
the Regina Mental Health Disposition Court as presented in this study. This would imply that the explanations and lessons learned in this research would have a wider resonance—that is, other MHCs could identify the factors and elements specific to the Regina Mental Health Disposition Court and ask questions about how to learn from this particular study relative to their own context and setting (Mason, 2002).

3.4 Participant Selection

Ten participants were selected purposively based on their consistent involvement with the court. Consistent involvement implies that participants had either been involved with the court for an extended period of time due to the fact that they had taken on the role as part of their job or had a client going through the process, therefore providing a thorough understanding of the mental health court. They were considered primary stakeholders or key players of the court because they are an integral aspect to the case management of clients of the MHC. Participants were chosen because they provided insight to the object of study and were able to provide knowledge that pertained to the research questions (Creswell, 1998). These individuals are crucial to the operation of the Regina Mental Health Disposition Court and therefore were intentionally sought out due to their experience with and knowledge of both the court itself and the clients of the court.

The presiding judge of the court, a Crown Prosecutor, a defence counsel, a probation officer, a representative from the Regina Mental Health Clinic, and workers from local community based organizations are all considered to be key stakeholders of the court and were considered for participation in the study. Specific demographics of participants will not be disclosed, as the sample size was small and it was my intent to
uphold confidentiality as much as possible. The sample was, however, representative of the stakeholders who participate in the mental health court. Those who were chosen were initially approached before or after a pre-court meeting where contact information was exchanged. I then followed up with an email to the potential participant to set up an interview time. Upon deciding whether to participate, an interview time was chosen that worked best for the participant and in a location that was the most appropriate or comfortable.

3.5 Data Analysis

Interviews were transcribed using a reputable transcription service. Analysis of the interviews was then conducted. Data analysis involves forming a logical map or making sense out of the data and requires continuously delving deeper and deeper into the data by creating an interpretation that best reflects a thorough understanding (Creswell, 2003). Creswell (1998) states there is not one agreed-upon method to analyze qualitative data and provides six generic steps in data analysis, including organizing and preparing data, making general sense of the data, coding chunks of data in a detailed analysis, generating a description of categories to create themes, deciding on how the themes will be represented, and finally, making an interpretation of the data. Although these generic steps are useful, a more detailed analysis was used in this study. Attride-Stirling’s thematic network analysis was deployed, as it provides a flexible approach to data analysis that can “potentially provide a rich and detailed, yet complex, account of data” (Braun & Clarke, 2006, p. 78).

Attride-Stirling (2001) describes thematic networks as “web-like illustrations” that represent the common themes that are found in data. By employing a thematic
network analysis, I was able to extrapolate themes at multiple levels, which allowed for an organized depiction of these themes (Attride-Stirling, 2001). A theme is a common response in the data, a noticeable pattern that possesses decipherable meaning (Braun & Clarke, 2006). Themes relate directly to the research question and are used to provide answers to it. Thematic networks, Attride-Stirling (2001) argues, allow for the labeling of three levels of themes: basic, organizing and global, which are represented in a web that illustrates the relationships between all levels.

Attride-Stirling (2001) describes several steps for conducting thematic network analysis. The first step is coding the material, which is influenced by the theoretical concepts that have informed the research question. A coding framework is used, where it is important that codes have explicit definitions to ensure their significance and to confirm they are not redundant. The coding framework that was used for data analysis was neither solely based on a priori themes from the literature nor from emergent themes from the data, but rather was a combination of the two. The coding framework employed was partly premised on the literature, which was also responsible for the development of the interview guide, and allowed new codes to emerge that were not thought of prior to conducting the research.

The next step, according to Attride-Stirling (2001), is creating themes. Themes are created from the coded text and are extracted, reframed, and refined. Basic themes are selected from the text and are arranged into organizing themes, which are larger themes that identify clusters of similar issues. Finally, global themes are deduced and allow a holistic interpretation of the text. Thematic networks are then explored,
described, and are summarized. The final step involves an interpretation of emergent patterns in light of the original research questions.

3.6 Limitations

One limitation is that the understandings and conceptualizations of the key stakeholders may be specific to the court being studied. Although it is the intent of the research to provide a broad picture of a mental health court process, alternative justice practices, and how outcomes are affected, it is likely that perceptions of the process vary among other MHCs, in part because there is not one universal model employed in all courts (Canada & Gunn, 2013; Hughes & Peak, 2013). Generalizing findings was, however, not the intent in this study, nor it is easy to do in qualitative research (Mason, 2002). This research instead sought to understand the practices and processes that were specific to this court and therefore intends to seek a wider resonance among other MHCs. The small sample size of participants is also a limitation that should be considered. There was a limited pool of participants to select for the study, as the case management team in the Regina Mental Health Disposition Court is a relatively small group. It must also be noted that participants may not have been quick to disclose information openly. Some individuals who were interviewed were agents of the provincial government and therefore may have felt limited in their openness for multiple reasons, not least of which is that they were aware of the small sample size and therefore the repercussions of their statements.

3.7 Ethical Considerations

In regards to confidentiality, there are certain limitations that must be considered. Full confidentiality cannot be guaranteed in this study. As there are only two mental
health courts in Saskatchewan, one with knowledge of the courts can reasonably deduce the key players of the Regina Mental Health Disposition Court who have participated. To ensure some level of confidentiality, participants were told that their names would not be used. Instead, participants have only been referred to as a number. Again, it is possible that someone with knowledge of the court will be able to deduce who the specific individual that was being referred to is. These limits to confidentiality were fully disclosed to and discussed with each participant.
Chapter 4: Data and Analysis

This chapter provides an analysis of the data that inevitably answers both the primary and secondary research questions. “Thematic analyses seek to unearth the themes salient in a text at different levels, and thematic networks aim to facilitate the structuring and depiction of these themes” (Attride-Sterling, 2001, p. 387). Attride-Sterling (2001) asserts that by using a web-like network the researcher is able to clearly describe how the text was interpreted and the procedure for doing so. From analyzing data using a coding framework and identifying emergent codes, the construction of a thematic network begins. In thematic network analysis, networks are explored and described as part of the analytic process, providing a deeper understanding of the data (Attride-Stirling, 2001). The network itself, Attride-Stirling (2001) argues, is a tool for data analysis, not the analysis itself. Basic themes are described within the context of their organizing theme and inevitably the global theme. These are all presented within a thematic network (Figure 4.1), which are “web-like illustrations that summarize the main themes constituting a piece of text” (Attride-Sterling, 2001, p. 386).

In employing Attride-Stirling’s thematic network analysis, the first step in the current analysis involved coding the data, which consisted of going through the transcribed interviews. Coding reduces the data into “manageable and meaningful text segments” (Attride-Sterling, 2001, p. 390). Codes were clearly defined and had clear boundaries to ensure they were not redundant (Attride-Sterling, 2001). Coding was completed both using a coding framework and by allowing codes to emerge from the data. The coding framework consisted of a priori themes from the literature regarding
how to measure the effectiveness of a mental health court through a therapeutic lens. Themes were then extracted from the segments of coded data.

To construct the network, themes were first arranged into basic themes, which were derived from the codes or common issues found within participant responses. Basic themes were then re-arranged into organizing themes, which encompassed the larger, shared issues among the basic themes. Finally, a global theme was deduced that summarized the main claims and assertions that the organizing themes were about. Attride-Sterling (2001) argues that the global theme is “the core, principal metaphor that encapsulates the main point in the text” (p. 393). The themes that emerged are depicted in Table 4.1, which demonstrates each basic theme as part of an organizing theme, all encompassed within the global theme. A thematic map is essential in depicting the themes that emerge in a thematic network analysis (Attride-Sterling, 2001). The thematic map in Figure 4.1 represents each level of themes and depicts the relationship between them. Attride-Sterling asserts (2001) that thematic networks should be “presented graphically as web-like nets to remove any notion of hierarchy, giving fluidity to the themes and emphasizing the interconnectivity throughout the network” (p. 389). The thematic network should be read clockwise, starting with Barriers for the Client and ending with Meaningful Outcomes.

Before the thematic network is unpacked, it is first necessary to address the notion of success, as this concept is present throughout the chapter. It was noted in Chapter 1 that success in mental health court settings is subjective in nature; it can mean something different for each stakeholder depending on how they perceive the court’s purpose (Schneider et al., 2007). This creates a challenge in measuring success in a
meaningful way in mental health court settings. Meaningful measures of success would involve understanding the concept to be broader in nature than simply reducing recidivism or ceasing contact with the justice system completely. This study examined the complexities of this concept of success and how stakeholders conceptualized it. An analysis of the data has revealed that success was defined in varying ways among participants, but all definitions fit within a broad measure of the concept—success was conceptualized in a way that encompassed many different aspects of clients’ lives. An improvement in community stability was found to be the most significant measure of a successful outcome in the Regina Mental Health Disposition Court. This topic of success in the court will be discussed in further detail in the following analysis of themes.

Each basic theme will be summarized according to the underlying relationship to the organizing theme. Quotations from interviews are used to describe the themes and are used because themes are “best conveyed by example” (Attride-Stirling, 2001, p. 393). Each section concludes with a summary and analysis of how the basic themes relate to the organizing theme.
<table>
<thead>
<tr>
<th>Basic Themes</th>
<th>Organizing Themes</th>
<th>Global Theme</th>
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<tbody>
<tr>
<td>Clients have complex needs due to their mental illness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clients face challenges in addition to mental illnesses</td>
<td>Barriers for clients</td>
<td></td>
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<tr>
<td>The justice system is difficult to navigate</td>
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<tr>
<td>Consideration of Charter violations</td>
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<tr>
<td>General barriers</td>
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<tr>
<td>The criminal justice system is inherently coercive</td>
<td>Barriers for the court</td>
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<td>Entrance criteria not fully understood by all</td>
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<tr>
<td>MHC as time consuming</td>
<td></td>
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<tr>
<td>Large, systemic barriers</td>
<td></td>
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<tr>
<td>Clients are engaged in process</td>
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<tr>
<td>Clients are treated more humanely</td>
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<tr>
<td>Individuated client plans generated</td>
<td>MHC as less adversarial</td>
<td>The mental health court as a holistic approach to justice</td>
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<tr>
<td>Court process is slow in a beneficial way</td>
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<tr>
<td>MHC as problem-solving in nature</td>
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<td>Pre-court is collaborative and multidisciplinary</td>
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<td>Unique role of judge</td>
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<td>Unique roles of legal counsel</td>
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<td>Jail is not always appropriate</td>
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<td>Alternative dispositions</td>
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<tr>
<td>Balancing the safety needs of both clients and the community</td>
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<td>Reducing contact with the criminal justice system is important</td>
<td>Meaningful outcomes</td>
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<tr>
<td>MHC facilitates access to community services that could not be accessed otherwise</td>
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<tr>
<td>A successful outcome is increased stability</td>
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</tbody>
</table>
Figure 4.1 Thematic Network Map

- Clients have complex needs due to their mental illness
- Clients face challenges in addition to mental illness
- The justice system is difficult to navigate
- Consideration of Charter violations

Barriers for the client

- General barriers
- The criminal justice system is inherently coercive
- Entrance criteria not fully understood by all
- The mental health court as time consuming
- Large, systemic barriers

Barriers for the court

Mental health court as a holistic approach to justice

Meaningful outcomes

- Jail is not always appropriate
- Alternative dispositions
- Balancing the safety needs of both clients and community
- Reducing contact with the justice system is important
- MHC facilitates access to community services that could not be accessed otherwise
- A successful outcomes is increased stability

MHC as less adversarial

- Clients are engaged in the process
- Clients are treated more humanely
- Individualized client plans are generated
- The process is slow in a beneficial way
- MHC as problem-solving in nature
- Pre-court is collaborative and multidisciplinary
- Unique role of judge
- Unique roles of legal counsel
4.1 Barriers for the Client

The organizing theme of barriers for the client will be described and explored in this section by analyzing basic themes that were derived from interview material. Many participants discussed the various barriers that clients are faced with that hinder their outcomes in the court. These barriers are often unavoidable due to the nature of their illness or the nature of the court. The complex needs that mentally ill clients have as a result of their mental illness was a common point of discussion among participants. Other barriers for clients that were common among participant responses were experiencing challenges other than mental illnesses, having difficulties navigating the justice system, and potential violations of their Charter rights.

4.1.1 Clients have complex needs due to their mental illness

Participants expressed that there are certain barriers to success that clients face in the mental health court that interfered with their ability to experience success in the court. The court attempts to address some barriers, while others are inherent due to the mental health issues that these individuals suffer from. Clients experience many complex issues and have complicated needs that are difficult to address in court settings. This population is vulnerable and many do not possess effective coping mechanisms due to their mental illness. Participants discussed the complex issues that clients face which stem from their disability and directly relate to justice contact and outcomes.

Many of these clients are vulnerable so they get taken advantage of. So let’s say someone offers to take them in [to a residence] and they get kicked out two weeks later, and they don’t have the ability to problem solve. They don't have those adaptive day-to-day living skills. So then they maybe turn to crime, whatever. (Participant #8)

But 100% it’s a memory thing. For example, today [the client] was adamant that he had a probation appointment and then he goes no he doesn’t have a probation
appointment. So literally if I’m not there to remind him that day within the hour he’s not going to make it. (Participant #1)

We are taking into account mental health issues they are facing that may be contributing to their being in the criminal justice system. Whether they’re able to successfully complete their sentence is kind of a different issue I guess. (Participant #5)

Another participant discusses how a client’s background and familial upbringing have contributed to a potentially complex misunderstanding of a diagnosis.

We’re dealing with a couple clients in the mental health court that are adopted from other countries, and they’re suspected FASD [Fetal Alcohol Spectrum Disorder]. But those particular clients also have a number of other diagnoses. So is it possible that they have it all? Is it possible that one is manifesting itself as the other? (Participant #2)

Being misdiagnosed has emerged as a significant issue that adds a layer of complexity to the needs of clients.

...We’ll see clients that have every combination of three alphabets behind their name and what is the real one? They have all of these, they’ve been diagnosed from the time they were 7 until they’re 27. They’ve got 15 different diagnoses, ranging from the time they were 7 to 27. (Participant #2)

A further complicated issue that clients may face as a result of their mental illness is that they may not be able to link the offense to the punishment that is received.

So for people in mental health court there are a lot of clients who are so borderline they may not connect the punishment they’re getting with the wrong they did, and then modify their behaviour in the future. (Participant #3)

I think especially with mental illness and [the client’s] disorders is that it’s now been a year [since the offence]. Is he feeling this punishment because of what he did back then or is he making the connection? It’s really hard to know. (Participant #1)

4.1.2 Clients face challenges in addition to mental illnesses

There are certain challenges that mentally ill individuals face in the justice system. These challenges result in very large barriers for clients when seeking an
increase in general stability. Most participants stated that a lack of supported, affordable, and available housing or residence was one of the greatest challenges that clients face in addition to their mental illness.

I think residence. It doesn’t solve all the problems but if we had sufficient residences that had the support – and not just an apartment – supervised residences and supervised placements that had support components with them. (Participant #2)

There are lots of people that seem to be connected with the system but I think that there are some people that probably need to be in institutions and group homes and there just isn’t the space. (Participant #3)

No housing. They just bounce from place to place. It’s very difficult for some of them, maybe most of them. (Participant #4)

[It] is hard to maintain your mental health if you don’t know where you’re going to live. Nobody necessarily knows how to contact you where you are. If you’re worried about where you’re going to live that night you might not be as worried about filling a prescription or any of those things. (Participant #5)

The majority of people who may be on the radar with us are people who struggle to maintain residency...There are so many gaps in services for these vulnerable people that the court may wish to indicate housing must be found, for example, but the reality is there may not be housing available. (Participant #6)

Homelessness, homelessness, homelessness. If you have a psychiatric disorder no one wants you. If you’re cognitively impaired you need a supportive living environment or it breaks down. The reality is that those are at a premium in the community. (Participant #7)

Aside from their mental health issues, participants indicated that there are many other challenges facing clients, which include but are certainly not limited to poverty, addictions, negative peer influences, familial background, and transportation.

Poverty, negative peer influences. 100% if [the client], if he’s busy, he’s occupied for the most part he’s quite a happy settled individual. But then if he goes off onto his own ... they can go and do those things [inaudible]. So really the negative peer influence. Poverty would be a big one as well. There’s always the gaps in services but we try to offer as much as we can but there’s certain things that we don’t [inaudible] and we don’t always have that. (Participant #1)
A lot of the people in the mental health court system and in my system didn’t have parenting that most of us would consider to be a minimum standard. A lot of them were wards of the State, a lot of them have histories of problems with alcohol and drugs and everything that comes with that. Not being able to get up in the morning, maybe not knowing how to prepare for a job interview. Not having role models that we all need, even as adults. Transportation can be an issue. (Participant #3)

Their friends, they call them their friends. Addiction issues. ... Follow through is their biggest challenge that they have, because they’re impulsive and right at the moment they forget about their goals and things. (Participant #4)

Housing, addictions and they all kind of play one off against the other. (Participant #5)

4.1.3 The justice system is difficult to navigate

Another barrier for clients of the court is that they face difficulties when it comes to navigating the justice system. Without supports or mentorship, it is easy for clients to fall through the cracks of the system because they may struggle to understand the complexity of legal processes. In regular docket courts, hundreds of cases are addressed each day. For clients without supports, there is pressure on the overburdened system and the legal professionals within it to guide clients through this complicated and fast-paced legal process and help them understand it. With adequate supports in place in the mental health court, however, the client is able to engage in the process and is therefore less likely he or she would fall through the cracks.

I think there’s a high volume of people that there’s a bit of a misunderstanding on what it is they’re pleading guilty to, and what the impact of it is. ... I think too often in regular court people with complex needs get up and plea guilty to offences they have no understanding of and they “plead guilty to get it over with.” And I don’t think there’s any justice in that. (Participant #2)

If your client understands what’s going on or even where the room is or all those pieces...it might be able to help alleviate some of the intake pressure on prosecutions. (Participant #6)
Like I have seen a few people there that they don’t have the support person. I don’t know if they’re at the level to [my client] but if they’re active in their mental illness that they’re not receiving treatment or anything [the court] could be really confusing. (Participant #1)

In docket court is seems like 300 to 400 people a day go through that court and there’s a lot of pressure on counsel to try and move things through the system as quickly as possible. (Participant #3)

4.1.4 Consideration of Charter violations

Another barrier that clients of the mental health court face is the potential for their rights to be violated. Some participants questioned whether or not their client’s Charter rights were handled properly. They also expressed concern about the privacy and confidentiality surrounding the open discussions in pre-court. Some concerns included: fitness to stand trial, being found not criminally responsible for an offence on account of mental disorder, and the right to have a trial within a reasonable time.

Although participants raised general concern over whether or not their clients’ Charter rights are violated in the court, some expressed that an attempt is certainly made to identify these instances.

Because with mental illness there is a component of they have to be criminally responsible. If they’re not criminally responsible as a result of mental illness [the defence] is very good at picking up on that ... if it’s an NCR issue [the defence] will actually hold request that the court hear whether or not there is sufficient evidence to demonstrate that the client is not criminally responsible because of mental illness. (Participant #2)

In mental health court ... because of the relationship that [Crown and defence have], [defence] is not going to bring a delay argument. [It is known] very well that the reason it’s delayed is because it’s in mental health court. (Participant #3)

In discussing the issue of fitness, one participant stated that the defence is ethically required to bring this up in court.

One of the problems defence lawyers face is that when you have somebody who is that bad, at some point you’re probably ethically bound to raise whether
they’re fit to even have a trial, because they can’t effectively defend themselves. (Participant #3)

One participant mentioned a specific situation that was encountered in court when it came to whether a client was fit: at the time, the client was in custody and came into the “prisoner’s box” in the courtroom and did not even acknowledge that the judge was speaking to him and asking him questions.

I was there before with somebody else, just an adjournment and my other client just happened to be at that same time. I knew he was going to be there because of his mental health issues and he couldn’t speak for himself and the judge was talking to him and he was looking somewhere else. (Participant #4)

Although client rights are an issue that has been questioned by participants, there is also evidence that the court attempts to protect these rights or to recognize what is best for clients.

But in mental health court most of the people there are going to plead guilty and because of the relationship that I have with the Crown I’m not going to bring a delay argument. I know very well that the reason it’s delayed is because it’s in mental health court. (Participant #3)

4.1.5 Summary of organizing theme 1: Barriers for the client

The organizing theme was emergent in the data as stakeholders all conceptualized complex issues and challenges very similarly across interviews. It became evident that there are significant barriers facing clients that hinder their potential success in the mental health court. This is a vulnerable group of individuals whose needs have not or cannot be met in regular criminal justice processes. With the emergence of the Regina Mental Health Disposition Court, individuals who may have fallen through the cracks of the health system and appear in the justice system are increasingly identified. This mental health court attempts to identify these individuals and better match their needs in the community (rather than in jails and the justice system). In part
what makes this problem-solving court stand out against traditional criminal courts, among many reasons, is that there is an attempt made to address the barriers that clients face. These challenges are many and may include: housing, treatment and medication, poverty, negative peer influences, addictions, transportation, and family background. Notably, participants pointed out that there are certain issues that the court simply cannot address, as the issues are either inherently tied to the clients’ past or to the complexity of the mental illnesses suffered from. However, stakeholders gather in pre-court meetings to discuss these many challenges and an effort is made to help the client overcome as many challenges as possible. Due to their complex needs, not all clients are capable of overcoming the barriers, even with the help of community partnerships working together, as the barriers are systemic in nature or directly tied to their mental illness.

The outcome of individuals falling between the cracks is the ongoing fallout of neoliberal economic and governance reform. When neoliberal ideology became the dominant form of governance, there was a shift away from the welfare state. One consequence was the closure of some facilities that might have supported individuals with complex needs, as well as the defunding of many community organizations that similarly provided support. Accordingly, the justice system was not prepared to address the influx of individuals who had fallen through the reduced social safety net. At the present moment, mentally ill individuals continue to struggle navigating various systems and acquiring adequate supports. Hopefully as the Regina Mental Health Disposition Court evolves, more individuals will be identified and receive the support they require to be able to navigate the system when necessary.
Finally, the issue of Charter violations is pertinent in a therapeutic court. Before the existence of the mental health court in Regina, mentally ill individuals were required to go through the regular criminal court system, which is fast-paced and can easily overlook the question of fitness to stand trial. Mental health court, in contrast, slows down the process. In so doing, it seeks to address the complex needs of individuals and is able to address the issue of fitness when it arises. A few participants discussed this, and there was confidence in the process and the ability of the defence counsel to identify and carry through with potential violations of Charter rights. Nolan (2001) has stated that this is certainly a criticism of mental health courts. He argues that the therapeutic approach employed in mental health courts should not in turn permit fundamental principles of rights and justice to be intruded upon (Nolan, 2001). Evidence presented here demonstrates that participants are aware of the potential for this violation of fundamental rights and freedoms and that the court is attempting to mitigate this outcome.

4.2 Barriers for the Court

While there are certain barriers that the clients themselves face, the mental health court and its professionals also face barriers to the operation and effectiveness of the court. The court experiences challenges such as identifying coercion, understanding entrance criteria, addressing the unwillingness of clients, engaging in a time consuming process, and recognizing larger political barriers that may hinder the court’s operation and its ability to produce intended outcomes.
4.2.1 General barriers

There are general barriers that the court faces that inevitably prevent it to operate successfully. There are certain components of the court that are missing, creating a challenge when it comes to generating individualized case management plans. For example, at the present time there is no psychologist or psychiatrist attached to the court and assessments/diagnoses are not being done. Without a diagnosis, clients are often unable to receive appropriate services or funding that are targeted towards the particular issue that they face.

I think that key component is missing from time to time is the assessment piece, the psychological or psychiatric assessment. When [a psychiatrist] was attached and she was doing them, that by far is the – in my opinion – one of the most important pieces that we’re missing right now. (Participant #2)

We don’t have access to any – of course the court can order a psychiatric or psychological assessment, I have to try and get a busy mental health clinic to give some priority to people. I have to ask every helping institution in town to do a little extra. (Participant #7)

Another barrier for the court is the willingness of clients themselves to engage in the process. In an attempt to avoid coercion, clients have to voluntarily accept participation in the court, and therefore must also admit that they have a mental health issue.

And I think one of the barriers is the unwillingness. People with mental illness don’t necessarily recognize their mental illness nor do they want help. (Participant #2)

They can’t see their own issues. And whatever progress that you would do, get them a house and all that, next couple weeks they’re back in the same place. (Participant #4)

He comes and sees me, he does whatever he needs to do but he has no illness and he will not admit to doing anything. Now he couldn’t go through mental health court with that, so he went through the regular court system and ended up with a conditional sentence. ... It was terrible for him because he would just sit there and say no I did not do that, I’m not ill. (Participant #8)
4.2.2 The criminal justice system is inherently coercive

Although the court attempts to avoid coercing clients, the justice system itself is inherently coercive. The mental health court is coercive in that it requires a guilty plea to be entered to allow a client to participate in court, even though many mentally ill clients may not have the ability to fully comprehend what it means to enter this plea. When clients agree to participate in mental health court, they must enter a guilty plea in order to be engaged, be provided with access to services, and to be sentenced appropriately.

Although it is therapeutic in nature, the mental health court is nevertheless part of the criminal justice system. Traditional criminal courtrooms are also coercive; however, the mental health court seeks to minimize such coercion, whereas in regular courtrooms this is not a focus.

It’s naïve to blame society for everything, but you have to understand when someone is a lifelong drunk you can’t put them on a do not consume alcohol clause. And what ends up happening is people accumulate breaches that way and then one day they try to get bail and the prosecutor stands up and says look at this history of breaching court orders and all of a sudden they’re sitting in remand and they plead guilty to things that they didn’t do so they can get out of remand and onto general population. (Participant #3)

So for example clients that are going to be presenting at this court, they have to plead guilty because this is a pre-sentence court. It’s not during trial so they have had to have pled guilty because we’re going to look at sentencing options. So they had to provide consent to exchange information with the clinic and others like justice and whatever. (Participant #10)

I have to say I think pleading guilty for some folks who are really ill is not a good thing. ... When you’re dealing with folks who could be psychotic or really extremely ill, they’re not going to admit what they did was wrong. (Participant #8)
The need for a mental health court was recognized because of the coercive nature of traditional criminal courtrooms and the consequences this had on mentally ill individuals.

...I began to see again very clear clientele who simply lack executive function were often before the courts because their structures had broken down, they were left to their own devices with inadequate coping skills, and who would often plead guilty when they shouldn’t immediately. We would process without understanding because it’s a spectrum disorder and [they] received sentences that were disproportionate to their culpability. (Participant #7)

One participant brought up a story of a client who did not want to plead guilty to be in mental health court because he was in a psychotic episode at the time of his offence.

For instance, and I can speak generally for one of my clients is he was floridly psychotic when he did the things he did and will not admit that they did the things he did because he was ill. So in turn he couldn’t go through mental health court because he would not plead guilty to something he didn’t think he did. So we got caught in a loop there and I tried to discuss that with him. (Participant #9)

4.2.3 Entrance criteria not fully understood by all

Another barrier that the court faces is that the entrance criteria are not entirely clear to both non-legal and legal professionals. Although the Crown is supposed to be the one who filters clients into the court, there are times where a prosecutor in another courtroom adjourns a case into the mental health court without the mental health court Crown knowing. This is an indication that other legal professionals also do not understand the criteria for clients to be permitted to mental health court. Non-legal professionals also struggle to understand who is or is not eligible to participate in court.

My initial understanding was ... they weren’t initially going to look at sexual offenders to be eligible...but [one client] was clearly someone that, after an assessment, could be safely managed in the community. So I think there needs to be some clear indication. Because what you don’t want to happen is that people think that this is a get out of jail thing. It’s not that. (Participant #10)
People get referred there without [Crown] or [defence] knowing, either by a judge or by another prosecutor and then it turns out they’re not going to plead guilty. (Participant #3)

I’ve asked [what the entrance criteria are] several times and I don’t know. I can honestly tell you I don’t know, so if you have that information I would love it. (Participant #8)

Like we talked about before I think clear understanding of who is going to go into court. Because one of my clients just has another charge and I know he’s going to want to go through mental health court. Is he appropriate? I don’t think so. (Participant #9)

4.2.4 The mental health court as time consuming

For many stakeholders who attend pre-court meetings, mental health court is an added duty to their already lengthy list of job tasks. Because the docket is twice a month and generally lasts the duration of the morning, it is a significant time commitment.

Because of this time commitment, many participants expressed that they are required to work off the ‘side of their desk’ to fulfill mental health court tasks. For a few participants, the time commitment is still significant, but mental health court duties get folded into their existing workload.

Significant. Absolutely. For example I get there, it’s Friday so every Friday it’s about 3 hours of my day that I’d be taking out. And then explaining the processes to [client], setting up probation appointment and legal Aid appointments, writing the letters to the courts and to the Crown. So it does take quite a bit of my time that’s not necessarily in my role but it’s slid into that. (Participant #1)

Well, I spend I wouldn’t say a significant amount of time but I don’t tend to do anything halfway. So I’m going to say that the court takes up about 6 hours every two weeks of my time, directly. And that involves no client supervision. Like that is just administrative. (Participant #2)

With these clients I have to meet with them more and for longer to have them understand, to make sure that they feel like they’re in control, to make sure they know that even though they’re sick and everybody thinks they’re sick, ... they still get to decide what they want to do. Yeah it’s significantly longer than a person who doesn’t have these issues. (Participant #3)
The files, there’s not as many files but they’re fairly labour intensive in talking to other people, and getting that information, formulating opinions. (Participant #5)

Legal Aid as a mandate doesn’t really include the kinds of things I’m asking defence counsel to do because we don’t have a case manager. Defence counsels normally don’t have time to even consider trying to help somebody find a place to live or connect with a service. But again, so that’s really extra to what they would normally do. (Participant #7)

So it’s not that much of a difference. Like with me my calendar I can schedule things. It just goes with the work that I do so it’s nothing extra. (Participant #4)

4.2.5 Large, systemic barriers

In addition to general barriers for the court, such as the significant time commitment, confusion surrounding entrance criteria, and the coerciveness of the criminal justice system, the court faces other barriers that are systemic. These large-scale barriers prevent the court from reaching its full, therapeutic potential. Some systemic barriers would include:

Poverty is an issue that the justice system can’t fix. The disproportionate amount of Aboriginal people in jail can’t be fixed by just saying well we’re going to have lighter sentences for Aboriginal people. ... It’s a reflection of a long history and the solutions are large scale political ones. They’re not ones that judges can craft I guess is what I’m saying. (Participant #3)

But the current situation is very unsettled and at the moment continues to be a long continuing uphill battle where you have to every year apply for funding as an unestablished NGO. ... And without community resources being available then you simply fall back into how the system has been dealing with people for several hundred years. (Participant #7)

...People sometimes have the idea that it’s the court and the judge can kind of do whatever – the judge can make it so. And we’re still limited by the law and judicial authority and all of that. (Participant #5)

Certainly the Conservatives have made more mandatory minimum sentences, which does limit the judge’s discretion. (Participant #3)

A few participants also discussed a disconnect between the mental health and justice systems as large-scale barriers within the mental health court.
I saw two things happening. I saw people with psychiatric disorders not being able to engage in the system. They didn’t have an external brain so they would not come back to the court or see their lawyer and so on and they’d eventually end up being re-arrested with no supports and in as poor as possible situation. I knew that they weren’t getting justice because they were deemed to be uncooperative but there were underlying reasons. (Participant #7)

They can put on [the condition] to attend mental health – like there’s a standard condition that says to attend for [inaudible] mental health counseling – but there’s no teeth to that. … But if they go there and they get put on a 9 month waiting list, that’s the end of it. And the wait list at mental health, my understanding is they’re really, really long. (Participant #2)

Attaining housing and funding are two additional barriers the court faces. All participants indicated the housing challenge facing clients of the court which also creates a barrier for the court itself. The housing problem was a funding issue, but if left unchecked becomes a criminal justice problem.

There are some places [of supportive residence] but of course there’s always the funding, like who’s going to fund that and how do we get them connected to a possible system that could fund that. That’s a huge challenge. (Participant #9)

[Housing] is a community problem and a funding problem. … But the problem is that comes at a serious cost to already tapped ministries. There’s a need for mentorship and coordination. So you get a guy, you’d get him a place to live that has supports but at the end of the day he still doesn’t know how to grocery shop. He’s still going to steal for food, or some version of that. (Participant #2)

4.2.6 Summary of organizing theme 2: Barriers for the court

The organizing theme of barriers for the court is composed of several basic themes that have emerged within participant responses. Stakeholders discussed many challenges for the Regina Mental Health Disposition Court that prevent it from improving clients’ stability and achieving its goals as a problem-solving court. Although the court attempts to overcome these barriers, the young age of this court prevents it from currently breaking them down entirely. However, by simply existing, the mental health court attempts to address the challenges that are a result of systemic shortcomings.
Coercion is one of the barriers for the court, as it inevitably removes clients’ free will from the process. Nolan (2001) argues that coercion must not play a central role in guiding an individual who is participating in a problem-solving court to rehabilitation. The mental health court uses health legislation as a tool of coercion as well. Legislation in the form of community treatment orders in the mental health court exists as an authoritative hand; clients who require medication for their illness are bound by the law to receive it. Arguably this is necessary in many circumstances but nevertheless coercive.

Coercion was also a concern particularly in light of guilty pleas. When clients have not been able to appreciate the nature of their offense, participants pointed out that this is where they have identified an issue, and it could be argued that this is where the inherently coercive nature of the justice system is playing a role. One participant stated quite frankly that she felt uncomfortable that clients are required to plead guilty in order to be engaged with services and support. This participant expressed that due to the nature of psychiatric or cognitive challenges that clients face, the ability to appreciate the consequences of a guilty plea may be inhibited. Conditions that are handed down by the court also arose as a concern, whether such conditions are given upon clients being released from remand or when they are being sentenced in the court. The conditions that the court mandates can be stringent and inappropriate in relation to the offence committed, which is an indication that the system’s coercive nature remains even in a mental health court setting. In comparing mental health court to traditional criminal court, it could be argued that the mental health court nevertheless remains far less coercive for this particular population than in traditional criminal court. This issue will
continue to be a barrier to success for the court due to the inherently coercive nature of the criminal justice system.

A Foucauldian analysis would suggest that the justice system, as a branch of the state, uses various mechanisms to execute control over its subjects (Foucault, 1977). Subjects are required to modify behaviour to fit within a societal norm at the will of the state, which is enforced through mechanisms and rules (Foucault, 1977). Subjects adjust to social pressures and change disobedient behaviours (Foucault, 1977). Moreover, Foucault (1977) argues that institutions act to control people through technology and power. In *Discipline and Punish*, his history of punishment, Foucault (1977) historicizes this power such that the state produces control over its subjects, from highlighting the violent and torturous punishment of quartering in the eighteenth century to nuancing the tactics of punishment in prisons in the eighteenth century. Foucault demonstrates a shift in punishment throughout history towards a neoliberal governmentality that is present in today’s society. In a neoliberal society, subjects govern themselves and therefore the violent punishment of the past is not necessary, yet the state’s power remains present.

While the mental health court attempts to limit coercive effects of the state itself, it is nevertheless a mechanism of the state; coercion is inherent. It is therefore important that mental health courts seek to avoid or limit coercion when possible.

Entrance criteria, or which clients qualify as suitable candidates for participation in the court process, is a basic theme that also fits under the organizing theme of barriers for the court. Arguably, the court has failed to address this thus far. A few participants expressed how the entrance criteria was not clear for them or that they did not know who is or is not appropriate for the court. It is crucial that this information be communicated
clearly by the court in order for legal and non-legal professionals to know which of their clients would be suited for the process. Community workers, support workers or mentors are there to advocate for their client(s) they are representing. In order to fulfill their roles as advocates, it is essential that all stakeholders know who is eligible to participate. This must be addressed in a timely manner, and until it is, it remains a barrier to the court’s success as it demonstrates a breakdown in the court’s operation. The literature suggests that issues with entrance criteria are fairly common (Schneider et al., 2007) because there is no universal model accepted among mental health courts (Hughes & Peak, 2013).

The significant time commitment that mental health court is for stakeholders is also a barrier for the court. Many stakeholders expressed concern with their workload, as most take on mental health court duties in addition to their already heavy workloads. Because a community need has been recognized, the time is committed regardless of resources. However, for some stakeholders who do not fold mental health court tasks into their regular roles, it may take away from the time that could be spent on fulfilling regular duties. It also means that some stakeholders are not able to attend each pre-court meeting. This increased workload of stakeholders is a reflection of the government’s allocation of resources, or perhaps the lack thereof. Such a necessary court needs to be adequately and consistently funded, with the appropriate supports in place to continue operating as long as the need remains. That it is time consuming is indicative of funding issues, which are arguably due to larger systemic barriers. With the implementation of neoliberal practices, the social safety net was reduced such that funding and resources that would reduce crime and increase overall safety for society are not filtered to the
appropriate systems. As long as the government continues to provide inadequate social and welfare services, this barrier for the court will persist and funding will be difficult to acquire.

The mental health court does attempt to mitigate such large-scale systemic barriers it faces, yet many of the issues are inherently tied to the political system itself and therefore the court simply cannot overcome all of these challenges. One of the underlying concepts within the data that connects this basic theme to the organizing theme of barriers for the court is that there is a noticeable gap between the criminal justice system and the mental health system. Although one of the main goals of the mental court is to reduce this gap, participants expressed that the gap remains and individuals fall through the cracks of both systems. While this disconnect is a larger barrier that the court faces, presumably as the court evolves and grows over time, this gap will continue to narrow.

A lack of housing and supportive residence has been a common theme within the data. Not only is a lack of housing a challenge that clients face, but also there are greater systemic housing challenges. The court is limited in what it can mandate when there is no funding to support health and community services. In fact, there are significant limitations in assessments and diagnoses, cognitive strategy programs, and housing. When housing, programs, or psychiatric care is not available, mandating these in release or probation conditions or facilitating access to them is not achievable, and the problem will continue to appear in the court.

Taking another step back to even broader issues is poverty and large-scale political problems. Poverty is not only a worldwide issue, but it is also one that plagues
the province of Saskatchewan. In fact, 11.9% of Saskatchewan’s population was in poverty in 2010 (Douglas, 2012), and as one participant bluntly stated, the justice system cannot fix this. Many mentally ill individuals who have continued to fall through the social safety net are deprived of the necessities that can contribute to daily function and alleviate many of the challenges they are faced with. With added complex issues that are a result of mental illness, poverty is a noticeable and significant barrier to this population and to this mental health court. Although the court can do its best to connect clients to the supports they require, some individuals are simply unwilling to engage, which the court cannot change. Another systemic and a historical barrier the court faces is the disproportionate number of Aboriginal people in the justice system. There are many effects of a historic oppression of Aboriginal peoples, one of which has surfaced as an overrepresentation of this population within the justice system. As stated previously, Aboriginal persons compose 18.5% of federal inmates in Canada but only make up 3.8% of the population (Correctional Service Canada, 2012). Additionally troubling is that Saskatchewan has the highest portion of Aboriginal inmates per capita in its prison system compared to the rest of the Canadian provinces (Perrault, 2014). This is an enormous barrier to overcome, one that the court is not able to address alone. However, by providing an alternative to traditional criminal court, the mental health court is able to slow down the criminal justice process and at the very least acknowledge that these barriers exist.

In addition to such systemic barriers as race and poverty issues is legislative authority and political power. The court is restricted due to laws that the Conservative government put in place to “crack down on crime.” Legislation surrounding mandatory
minimums can be dealt with in the court to an extent, and one participant expressed that the judge does a very good job at being creative with this. However, *Criminal Code* legislation has been and certainly remains a complex and significant barrier to success for the court in this regard. It also limits the individuals who the Crown is able to filter in to participate in the court process, as those who have committed crimes that have mandatory minimum sentences are generally excluded from the court. These barriers are contrary to the overall intent and goals of the mental health court and do impact its operation.

The Regina Mental Health Disposition Court will have to rely on large-scale systemic change to fully address these barriers, and until then, will continue to serve as a temporary solution to the problem. This begs two questions, however: how can justice be achieved if the court faces such barriers, and, what then does justice look like?

Participants conceptualized justice in the mental health court in the following two organizing themes.

### 4.3 Mental Health Court as Less Adversarial

The next organizing theme that has been interpreted based on several basic themes is that the mental health court is less adversarial in nature than traditional criminal courts. All participants, in one way or another, made comparisons of mental health court and traditional criminal court. Themes that arose out of these comparisons were that the mental health court engages the clients in the process and in turn addresses them in a more humane way, as individuals who need help rather than as criminals. Further, individualized client plans are generated in the mental health court, which does not occur in traditional criminal dockets. The process is also much slower than
traditional criminal courtrooms, which benefits both clients and stakeholders. Moreover, the mental health court is problem-solving-oriented, where collaboration occurs on a multidisciplinary level.

4.3.1 Clients are engaged in the process

Participants expressed that they felt clients were engaged in the process because they were more informed and communicated with, and were able to have a better grasp of the process. According to participants, this was due to clients’ experiences with the legal professionals and increased communication between all parties. This engagement has led stakeholders to believe that clients are satisfied with the court process.

I found [client] was in the loop by meeting with me, his probation officer, by meeting with [defence counsel] his lawyer. (Participant #1)

They’re informed. In every way. Like it’s hard to explain. The work that I see that [the defence] does, with making sure that his clients are informed of everything that’s going on. (Participant #2)

I always refer to my last client. He was talking, like sometimes he’s on board and sometimes he’s not. The last one-on-one I had with him – usually you meet with a lawyer or something like that, forget about them right away. But he brought up his legal aid. He must have made quite an impression. (Participant #4)

The unique experience that clients have with the judge is a common theme and will be discussed further on, but that stakeholders noticed their clients were engaging with this figure is also important.

Being able to talk to the judge on their own in an informal manner. There’s still some formality, he still sits up higher and he still wears his fancy outfit. But other than that they deal with them on a much more human level and having that extra time that it takes to get the information and the extra time that I take with them... (Participant #3)

[The judge] tries to call them by their first name and tries to engage them in doing stuff that will keep them from coming back. (Participant #7)
4.3.2 Clients treated more humanely

Traditional criminal courtrooms are fast-paced and generally the individuals going through these courts are one file of many for legal counsel. In mental health court, participants posited that because clients are engaged in the process, they are seen more as individuals, ones who have unaddressed or untreated mental illness and/or a lack of connection to community services. Stakeholders discussed how clients are understood to be people who might lack specific understandings or executive functioning rather than as criminals with full knowledge of wrongdoing.

They feel more in control. They feel more like human beings and less like pieces of paper. I don’t know, you have to try and make sure that they have that experience I guess, which [would be much harder] if it was in normal court because there wouldn’t be the time. (Participant #3)

There’s a certain mechanical process that happens in our traditional court. We make assumptions. We assume that people are actually rationally acting and they’re committing criminal offences and both how we treat them and the punishments in that context make some sense. And [the mentally ill] population doesn’t respond the same way that you or I would. [Mental health court is] far more effective both for the protection of the public and for the public purse and there is the human aspect obviously. And we’ve simply forgotten that. (Participant #7)

I think it’s sort of looking at people through a slightly different lens. (Participant #8)

It looks at their criminal behaviour as mental health rather than it being their own kind of personal motives and actions. [My client] isn’t a criminal, it’s his mental and his genetic disorders that are influencing that type of behaviour. (Participant #1)

4.3.3 Individualized client plans are generated

Each client who comes across the mental health court docket is unique and, as demonstrated previously, has his or her own set of complex needs and challenges. It is therefore essential that stakeholders of the court generate individualized plans for each
client. A plan such as this involves a discussion of the specific resources the client is in need of and subsequently working out a way to connect the client with these resources.

What sets the mental health court apart from traditional criminal courts is that stakeholders work together to create a plan for clients that addresses their offending behaviour, the mental illnesses they face, and the types of services that are necessary.

The most important aspect of this is that the process is client-centred.

Sometimes [in other situations] it becomes whose territory is what or whose role is what rather than looking at it as a client-centred model. It’s kind of whose turf is what? Where [pre-court] I just found it to be, there wasn’t any division of roles...we’re just here for that individual. It was how we can serve the best needs of the client. (Participant #1)

Because the mental health court employs a client-centred approach, individuals in the justice system who have mental illnesses are identified and in turn (hopefully) engaged in the process where individualized plans are created that are tailored to their complex needs.

This way I think that the court is being, we’re talking about those needs up front and I think one of the biggest advantages is that the clients with complex needs are able to be identified... (Participant #2)

He ended up on an order with probation and thanks to several discussions about his situation, given his charges at a pre-court level, stable housing and supported housing was finally found for him. (Participant #6)

In pre-court meetings, stakeholders come together to focus on each separate client, and as this participant states, they identify the client’s background and present issues and create a plan that best suits the client’s needs and eventually facilitates improvements in overall stability.

In mental health court, members of the community that actually work with these people come and meet with the judge and we have a frank discussion about what’s going on in their lives, what is going to work, and what’s not going to work. (Participant #3)
4.3.4 The process is slow in a beneficial way

A few participants pointed out that a significant difference between the mental health court and a traditional criminal court is the pace at which the court operates. With the opportunity to have more time per client and having fewer cases than in regular docket court, it is possible to gather more information on clients and seek out the most realistic yet suitable plan and provide the most appropriate sentence for clients’ needs.

The process is much slower. In docket court it seems like 300 to 400 people a day go through that court and there’s a lot of pressure on counsel to try and move things through the system as quickly as possible. In mental health court that pressure isn’t really there. (Participant #3)

...and having that extra time that it takes to get information and the extra time that [the defence] takes with them and quite honestly most of the time the Crown is very reasonable...and that’s because normal docket is extremely busy, and mental health court is still busy but significantly less busy. (Participant #3)

Well certainly it’s a different pace which can make a big difference. Traditional dockets move at a fairly quick pace, this one moves a bit slower, so things can be explained differently and more time is taken with each accused who is appearing in the court. (Participant #5)

4.3.5 Mental health court as problem solving in nature

Part of the initial coding framework involved “legal professionals thinking outside the box.” It became increasingly obvious that the greater theme for this was that stakeholders were problem solving in pre-court in order to reach appropriate solutions for clients, to facilitate access to treatment and services, and to connect clients to agencies often by thinking creatively. One participant discussed how stakeholders’ contributions in pre-court discussions are valued and taken into consideration in the judge’s final decision.
I felt that [my opinion] was very well received and obviously they took the suggestion so that the courts and the prosecutor really do take into account what the support workers are saying. (Participant #1)

In order to problem solve effectively, stakeholders often did think outside of the box, meaning their solutions were not traditional solutions that would be found in regular criminal dockets. In pre-court meetings, all voices are important and having all voices contribute to and compromise on a solution is an aim of this court. Participants indicated that there are creative ways that the court is able to handle some of the systemic and legal issues that arise as well.

Sometimes it just takes another person to go, “have you thought about this, from this perspective?” It meets a) your concerns as defence and b) it meets your concerns as Crown. So if it’s going to meet both people’s needs can we each compromise a little? And there’s been a couple examples like that. (Participant #2)

I think one of the most unique things I’ve seen is when we’re using a sentence of time served, because they spent some time on remand, to look at, to legally get around the mandatory minimums. ... So we’ve been able to use some unique...alternatives, in order to still meet the parameters of the Criminal Code of Canada. (Participant #2)

According to one participant, problem solving means coming up with a long-term solution for the client whether they end up incarcerated or not. Providing clients with programming and services should be the intention of the court.

So not jailing them firstly makes financial sense, it makes long-term sense. And when we do jail they come with enough information they were rationally dealt with within the system because they know from the get-go there are problems and here they are and you might want to do some different routing. (Participant #7)

One participant gave a particularly telling example of how problem solving was demonstrated around the pre-court table.

And so part of the debate was we don't really want to put [the client] on a new CSO [conditional sentence order], that’s just going to generate new violations.
Because then we have more system related offences, the end result will be eventual incarceration. Yet on some level she’s demonstrated that she has been able to maintain it in the community, not necessarily healthfully, but not criminally either. Also so there was trying to solution focus on (a) how do we get her involved somehow without bulking up the system with more system-generated offences? So we used the [new] CSO to do that. (Participant #2)

The following participants are not necessarily convinced that problem solving has made a difference for them or their clients, but nevertheless they identified that problem solving and creative thinking have occurred.

But I don’t think it’s going to necessarily change the outcome but you have all these people like you say around the table and they’re thinking differently about the client. And that impacts the judge’s decision. (Participant #8)

Well there’s only so many ways you can ask is there housing. [The judge] gets kind of creative about what he says, and we’re just like no. He’s like well what if you put an order in? (Participant #9)

4.3.6 Pre-court is collaborative and multidisciplinary

All participants indicated that one of the most noticeable differences they have discovered in mental health court was the collaborative and multidisciplinary nature of pre-court meetings. Participants conceptualized collaboration and the multidisciplinary element in different ways, whether it was discussing how information is shared and gathered, by explicitly stating collaboration is key to pre-court, or asserting that the presence of multiple agencies was imperative to connecting individuals and seeking the most appropriate path to increased community stability for clients.

What I found to be different and amazing was, we’d have a group of multiple community members from different agencies and maybe 3 of us would be talking about [a client] but then the Crisis Response Team or someone from a different mental health clinic, they would pop up and they would offer their services. I don’t think any other court would have that. 100% it was collaboration. ... That was really a first for me, really seeing that collaborative effort from all different social workers, to health professionals, to everybody working together. (Participant #1)
Typically what I would do is go to the pre-court and share information, get information on clients, and [the judge] was very good at getting feedback from case workers and stuff in the community. (Participant #8)

You meet with everybody involved and speak openly. (Participant #9)

One of the biggest differences is the pre-court meeting style, is collecting the information up front and getting a team approach on the front end as opposed to the back end. ... With a collaborative approach you make a connection with all the partners up front. (Participant #2)

I think there’s a lot more people involved in the information gathering and to some degree in the decision making. ...We get a lot more input from other community resources that we might normally do in a traditional docket court. If it’s a traditional docket where you have 4, 5, or 6 baskets of files you look at the bare facts and the criminal record and make your call and move on. [In mental health court] we get a lot more information, we have more reports, more information from community resources and input from people. (Participant #5)

The truth is sovereignty comes from the people. The justice system belongs to the people in Saskatchewan. And when those people that are working with mentally ill people are a part of that system, that’s a good thing, when it’s not just lawyers and judges – when it’s broader than that, that’s a good thing. (Participant #3)

4.3.7 Unique role of judge

The role of the judge in mental health court is perhaps one of the most telling indications that this court is less adversarial than traditional criminal courts. The judge plays a unique role, and it is this role that stood out to participants as a noticeable difference between the mental health court and regular court. Many participants stated that the difference in the judge’s role had an effect on the process itself and/or their clients.

Also just having the Judge stand up and recognizes, “[the client] you’re doing a really good job.” I just found that it was more positive and proactive rather than reactive. ... That’s the first time that I really had seen that judge-offender interaction in that way before. It was quite unique. But you can even tell just by sitting in pre-court that [the judge] is quite a unique individual. He makes the experience that much better. (Participant #1)
It was quite surprising when I went to the first mental health court, usually judges when they come they have this stern face but here the sweetest person is the judge. ... The judge is very approachable. (Participant #4)

Although they are very friendly, the judges, my last client he said, “I don't want to see you back here.” (Participant #4)

And the dockets are obviously much smaller so that plays into there being more time to take with each person and the judge takes a bit different role I think in more direct interaction with people who appear in court, as compared to other docket courts. If you’re represented by a lawyer it’s fairly rare that a judge would talk to you directly the way that they do in therapeutic courts. (Participant #5)

From what I’ve observed in the mental health or drug treatment court is there is a much more concerted effort by the judges to be more appropriate in how they are speaking to the client based on the clients’ abilities to understand. (Participant #6)

[The judge] calls them by their first name and tries to engage them in doing stuff that keeps them from coming back. (Participant #7)

My client thinks that [the judge] is his bro. ... I think [the judge] is a judge who cares and who really wants to add extra supports to these clients, so it’s different. I think the clients have noticed. My clients have noticed a difference. (Participant #9)

4.3.8 Unique roles of legal counsel

Not only is the role of the judge unique in mental health court, but so too are the roles of legal counsel. Participants have found both the defence counsel and the prosecutor to be approachable and have said that it is clear that counsel wants what is best for their clients. In a traditional criminal courtroom, legal counsel play an adversarial role and their roles are much more black and white. In mental health court, on the other hand, counsel work together in order to achieve the best possible outcome for both the client and society.

The prosecutor and the defence lawyer, my last [client] they were actually working with each other because they said he doesn’t belong in jail. ... So they worked very hard to make sure he didn’t go back. (Participant #4)
It was refreshing just to see the Crown’s efforts that nobody wanted to see [client] in jail. The Crown wasn’t pushing for that. She was wanting a positive outcome for [client] as well. ... Even though defence and Crown they’re opposite to each other in terms of who they’re representing it still seemed that they were representing [the client] even though the Crown Prosecutor was representing the community and the courts, she still seemed to be wanting to help [the client]. (Participant #1)

The Crown is very reasonable. More so than you would get in a normal docket. (Participant #3)

One of the things that’s unique is just how broad the Crown has been prepared to go to deal with the clientele. (Participant #7)

It is also important to note that although the mental health court seeks to employ non-adversarial justice practices, adversarial justice is inevitably still present within the courtroom.

The defence has their position and they need to have their position. The Crown has their position and they need to have their position. And sometimes the defence doesn’t like the Crown’s position and the Crown doesn’t like the defence’s position. (Participant #2)

4.3.9 Summary of organizing theme 3: Mental health court as less adversarial

Several basic themes compose the organizing theme of mental health court as less adversarial. It is in this theme particularly where justice practices in the mental health court are conceptualized. Non-adversarial justice practices emerged in the coding process and have been interpreted in the basic themes that constitute this organizing theme. Although participants did not explicitly state the term “non-adversarial justice,” various elements of it arose many times within responses and were expressed in different ways by stakeholders.

Stakeholders articulated that clients are engaged in the MHC process, that they are treated more humanely than they would be in traditional criminal courts, and that the
court employs a client-centred approach, which are all elements of procedural justice enacted within the courtroom. Procedural justice involves giving clients a voice, influencing perceptions of fairness among clients, and positively influencing perceptions of respect among clients of the court (Canada & Watson, 2013). By engaging clients in the process and employing an individualized approach to improve stability, procedural justice is evident in the Regina Mental Health Disposition Court and it is clear that non-adversarial justice practices are employed. This evidence is consistent with the literature that finds clients generally hold positive beliefs about the procedural justice that is experienced in a mental health court (Wales et al., 2010).

Another basic theme was that the court process is slow in a beneficial way. A slow process is advantageous to the clients, as stakeholders are able to gather more information on clients and a client’s progress can be monitored for a longer duration. This in turn allows more time for workers and defence counsel to work with clients and help them understand the court process. A slower process also allows the law to be used therapeutically, according to a therapeutic jurisprudence framework, because it produces favourable and healthy consequences for the individual rather than antitherapeutic consequences that are adverse to an individual’s well-being (Wexler & Winick, 2003).

Another basic theme that composes the organizing theme of the mental health court as less adversarial is that the court is problem solving in nature. The problem solving nature of pre-court meetings is a marked difference between traditional criminal courtrooms and mental health court. Rather than only legal professionals coming up with solutions and discussing the case, community workers, justice professionals, health professionals, and various other members of the community together come up with a
plan to connect clients to community services. Legal counsel make decisions based on the information that is shared around the pre-court table and the judge subsequently delivers a sentence that is informed by this shared information. By adding many more individuals to the equation who come to pre-court with different areas of knowledge and expertise, the court is well-rounded. Compromises are made while creative discussions surrounding what is best for the client and society are based on safety, advocacy, intelligence, and experience. Even when clients are sentenced to a period of incarceration, problem-solving has allowed stakeholders to create a plan for the client’s release, hoping that he or she does not fall through the cracks once more but instead seeks out the community resources he or she is being provided access to. Sometimes it takes one stakeholder around the pre-court table to come up with an idea that no one else had thought of. Often times clients’ needs are so complex and the challenges they face are many, that what it takes to connect them to the community is not one legal professional thinking outside of the box, but a group of individuals thinking outside of the box. The problem-solving nature of the court is part of what makes it less adversarial. It was also indicated that the problem-solving nature provides an opportunity for legal professionals to engage collegially rather than in a divisive manner. The literature suggests that non-adversarial justice practices emphasize problem solving and knowing more than just the facts at hand (Freiberg, 2011). By viewing justice in a more broad sense than in an adversarial courtroom (Freiberg, 2011), stakeholders are able to take a collective step backwards in viewing each case and work together to come up with a individualized plan of rehabilitation for all clients.
The court as collaborative and multidisciplinary is another basic theme under the organizing theme of the mental health court as less adversarial. This is one of the greatest differences between traditional criminal court and mental health court. Stakeholders communicated that the collaboration aspect of mental health court is what is most unique and what is crucial to their clients’ success as well as the success of the court. Sharing information on a client, or legal counsel hearing information on a client, is how the most appropriate plan is put in place. It also allows stakeholders to monitor the client’s progress. Without collaboration, the problem-solving aspect could not occur. It is also important that there are multiple agencies present that are contributing to pre-court information sharing. Intuitively, if there were many individuals at the pre-court table but they were all from the same sector, results in the court would be far different and arguably more one-sided. Because of the wide array of professionals who are part of the process, each client’s case has different input from varying community agencies, thus allowing the client to receive a well-balanced, individualized plan towards overall improvements in stability. Collaboration and a multidisciplinary approach are two more elements of non-adversarial justice practices (Freiberg, 2011). Collaboration between multiple government agencies, public and private sectors, different professions, and members of the community allow the mental health court to be less adversarial than traditional criminal courts (Freiberg, 2011).

The final basic themes that compose the organizing theme of the mental health court as less adversarial are the unique roles of the judge and legal counsel, including defence counsel and the crown prosecutor. Upon analysis of the data, it was evident that stakeholders place a great deal of the court’s success upon the judge. Some described
him as charismatic, kind, and unique. Inevitably, the judge interacts with clients in such a way that it engages them and makes them want to improve. One participant discussed how her client understands authoritative hierarchy and therefore knows that he needs to listen to the judge when he is told to “keep up the good work” or to “not come back here.” In a traditional criminal courtroom, judge-client interaction is rare or happens only when the offender does not have legal representation. In a traditional adversarial courtroom, the judge acts as a neutral arbitrator; he or she must listen to the evidence and sentence an offender based merely on facts presented in court (Portillo et al., 2013). In mental health court, or in a less adversarial environment, the judge is more passive, hearing information and contributions from many stakeholders, but nevertheless maintaining judicial authority over final decisions (Freiberg, 2011). The literature also suggests that judges in problem-solving courts often assume a paternal role and interact with court participants on a personal level (Portillo et al., 2013). The intention is that by engaging with the clients in perhaps a paternalistic way, the clients will internalize the interaction and modify their behaviour. Reintegrative shaming is one of the theoretical implications of this interaction, which is the encouragement of both shame and respect for the individual (Dollar & Ray, 2015). Reintegrative shaming is fundamental to the process of rehabilitation by holding the client accountable for the progress (or lack of) they make within the court (Braithwaite, 2002; Dollar & Ray, 2015). This theme is consistent with the literature that finds mental health court participants to hold strongly positive beliefs about their engagement with the judge (Wales et al., 2010).

The lawyers within the mental health court also play a unique role, which was a consistent response from participants. Stakeholders have pointed out that unlike
adversarial courtrooms or traditional criminal courts, lawyers in the mental health court work together and establish a cooperative relationship that results in positive outcomes for both the client and for society. Rather than having a verbal contest in front of a neutral deciding party, which is characteristic of adversarial justice practices (Rossner & Tait, 2011), legal counsel work together to facilitate rehabilitation and community connections. Many participants expressed surprise towards the broad and supportive position of the Crown in most instances. Both the Crown and defence share the understanding that clients of the mental health court should not always be incarcerated. They seek to gather as much information from many different agencies to facilitate access to resources and to the supports that clients need in order to avoid a punitive sentence. Evidently, this creates a less adversarial environment than in traditional criminal dockets.

It must also be noted that what makes this court “less” adversarial rather than “non-adversarial” is that traditional formalities remain—the judge still wears his formal courtroom robe, the lawyers still represent their respective parties, and each still comes to the pre-court table with a position on the case that is in line with who they are representing. Participants took notice that these adversarial aspects remain. In spite of the predominant non-adversarial justice practices that are evident within the mental health court, adversarialism is still inherent. Blumberg (1967) would argue that adversarial practices do not necessarily have to be negative or harsh in nature, but that certain elements, such as bargaining, are part of counsel’s roles.
4.4 Meaningful Outcomes

This organizing theme demonstrates how participants conceptualized outcomes in the mental health court. The mental health court does not avoid punishment entirely, but instead ensures that it is more appropriate for the clients. There was a general understanding that the sentences clients receive are less punitive than they would be in traditional criminal courtrooms, as it is believed that incarceration is not always the best option for the clients. Many participants also discussed the court’s ‘solution’ to avoiding jail time—sentences are meaningful and alternative dispositions are sought where it is important that the safety needs of both the client and the community are balanced. In discussing what a successful outcome looks like, participants generally conceptualized success as reducing contact with the criminal justice system and as overall stability for the client.

4.4.1 Jail is not always appropriate

For the mentally ill population that the mental health court encounters, incarceration is not always the most appropriate option due to increased vulnerability to victimization and an exacerbation of mental illness related symptoms in jail. Although custodial sentences are necessary in some instances, participants often indicated that avoiding jail time is important for clients.

There’s definitely a difference in the severity of the penalty, on average. I say that with complete confidence. I’ve had lots of clients who I would have had to fight to keep out of jail that once they’re in mental health court there’s almost no chance they’re going. (Participant #3)

Well there’s certainly some people once we’ve gathered up more information that probably avoided a jail sentence or certainly avoided – there’s a couple that most definitely probably avoided going to the penitentiary once we gathered up the information, learned what challenges they were facing... (Participant #5)
[Jail] is very expensive, a very harsh way to treat someone with a brain disorder. A jail sentence is not a deterrent because [clients] can’t control behaviour at the time. ... This is a population we don’t want in jail. It’s expensive, there’s no point in it, they fare poorly, they do this and are released. (Participant #7)

If they’re put in jail it’s a huge disruption [to their care] and they may not get the same services in jail and things like that. So I think the ultimate benefit is that [the mental health court] provides continuity of care which is ultimately going to benefit them in the long run. (Participant #10)

There are times when sentences that include incarceration are unavoidable for the court. Nevertheless, the amount of time that clients are given jail time is reduced (as compared to what a “normal” sentence for a serious offence would look like) and plans are made for their release in order for clients to be able to connect to the community right away.

We’ve had offenders in there that have done some things that are simply too serious to not go to jail over but it doesn’t mean they have to go to jail for the same time as someone else because we take into account diminished responsibility and even when they do go to jail we try and pass on background material and ensure that they have a staged release plan and will connect them with services so hopefully they will come back less. (Participant #7)

**4.4.2 Alternative dispositions**

Although the mental health court is not punitive in nature, punishment still exists. Many participants indicated that sentences were instead more meaningful, holistic, and appropriate for mentally ill clients than would be received in regular criminal courts. Sentencing focuses on facilitating treatment and rehabilitation and is reflective of the cognitive and mental capacity of the individual who has committed an offence.

I find that they have a really holistic approach to their sentencing, that [the client] has to complete community service, he had to write apology letters. So I think they really took a whole scope of how to do the sentencing rather than just the CSO [conditional sentence order] or just going to jail or just probation, he has a scope of what he has to do. (Participant #1)

From my perspective it’s been very successful because my clients normally get much better dispositions than they would have got otherwise. (Participant #3)
Through mental health court we were able to get [a $1800 fine] down to $180 and [the client] was able to pay them off. And my other client would still be in jail if it wasn’t for [the mental health court]. (Participant #4)

I think the sentences are being reflective. Like we’re not putting people on probation orders, or on community treatment orders when a [community treatment order] is going to take care of the mental health piece of it. ... I think the mental health court is doing a good job of identifying that, in some cases, and are going to be able to put or realize that there is no need for a judicial sanction when mental health is stabilized and taken care of. There needs to be a therapeutic sanction. (Participant #2)

One participant provides an example of a client whose charges were dropped all together after going through the process.

While he certainly could have ended up with a criminal record I think that’s an example of a different disposition and certainly wouldn’t have happened because [in courtroom] number one we would never have had all that information about what was going on with his mental health situation. (Participant #5)

4.4.3 Balancing the safety needs of both clients and community

While non-punitive sentencing is the intent and alternative dispositions are sought in mental health court, it is also important that the safety needs of the community in which the client lives and the safety needs of the client him or herself remain paramount. Participants discussed this as a balancing act; there are specific ways that society can safely benefit from the clients receiving treatment for their mental health issues and also benefits for the client. Getting to the root problem of criminal behaviour is important in the mental health court, as it reduces the likelihood of future contact with the justice system and therefore creates safer communities.

Better outcomes means everybody benefits. It means the society benefits because [the client] comes back less, the family benefits, the victims benefit. (Participant #7)
We did not want to see [the client] have jail time, so we worked really hard on doing different initiatives [within a CBO] that we could protect the community and protect [the client]. (Participant #1)

I also think it’s better for society because the decisions that come out of that court are normally more thought out and careful and I would think would be more effective in doing what they’re supposed to be doing which is preventing people from committing more crimes. (Participant #2)

So as you’re aware the mentally ill are way over represented in our custody facilities and sometimes an alternative to custody is much better for the client and definitely for the community. (Participant #10)

The intent of the court would be to be less abstract and more concrete in addressing individuals as seeing the people involved in the court as people with unique needs and seeing the larger picture of their life circumstance in order to better address their behaviours and to meet the criteria for safety at community and personal levels. (Participant #6)

4.4.4 Reducing contact with the criminal justice system is important

Many participants stated that it is important for the court to reduce the criminal justice cycle that their clients are within. The connection must be made between the client and the health system in order to reduce contact with the justice system. Recidivism was a common point of discussion, where most did not believe it to be an appropriate indication of court effectiveness or client success. Only one participant stated that reducing re-offense rates was important in measuring success. What seemed to be the main theme was that it is important for the court to aid in reducing overall contact with the criminal justice system, including reduced severity and frequency of offences.

If the goal is no crime whatsoever then you’re going to have a tough time. But if you have somebody who is breaking into cars or assaulting people and then they have a few years where they do a couple of breaches and a shoplifting I would call that success. (Participant #3)

I don’t believe that the reoffending is the most paramount concern. I think these clients will reoffend and in my opinion, is if they reoffend less frequently and if their offending is less harmful. (Participant #2)
For two participants, connecting clients with complex mental health needs to the health system will in turn reduce contact with the justice system. Without addressing these issues, the criminal justice system cycle is perpetuated.

Sometimes it’s not the first time that’s the successful one it takes 2 or 3 times before people come in and it really clicks. But the fact that they’ve made those connections starts the ball rolling in terms of getting out of the justice system or getting back in the health system in a more beneficial way. (Participant #5)

And there’s a real disconnect when someone’s executive function is not in place. Someone with FASD as a spectrum disorder can go undiagnosed and unless you know what you’re looking for and will simply continue to reappear in the system. And often are seen committing the same silly offences. (Participant #7)

One participant conceptualized success of the court as eliminating justice system contact completely; however, this participant was an outlier in the data pertaining to this basic theme.

I think the ultimate goal is if they’re diverted from custody, stay out of custody, they do not re-offend and again recidivism is still the best outcome. (Participant #8)

4.4.5 MHC facilitates access to community services that could not be accessed otherwise

One of the objectives across mental health court models is for the court to facilitate access to services for clients. A common theme in participant responses was that the Regina Mental Health Disposition Court is doing just this. There are certain court-mandated conditions that require, under the law, clients to seek out services to aid in their treatment. Participants indicated the benefit of clients being required to access community services, programs, or treatment.

What I have found is there’s certain things that the court has mandated in ways that normally it hadn’t been. Like in mandating certain services that it gave different resources the leeway to have to do things. ... [My client] wasn’t able to get counselling until he’s sentenced or there’s not enough funding for [the client]
to get counselling. Without the courts having that, [the client] wouldn’t be able to access that. (Participant #1)

I think the other benefit is the client being connected to services that they may not have been connected to before. (Participant #2)

For the people that have never had any connection with the mental health system, yes it does [address the challenges they face]. (Participant #3)

We’re looking to connect someone with services and we’re looking to do a disposition that takes into account whatever is wrong, bluntly, with whatever is above their shoulders. Be it a cognitive disability like FASD, be it a psychiatric disorder and ensure in the long-term interest of the public and the accused and everyone, that if they are connected with services they need they’re less likely to reoffend. (Participant #7)

So the mental health court I think would benefit the clients because there’s usually a lot of members in pre-court and then they have the option to add some supports, like some connections to the clinic or connections to other resources. (Participant #9)

4.4.6 A successful outcome is increased stability

Success is difficult to measure with the mentally ill clients in this court—this was an evident and recurring theme within the data. Participants conceptualized success in varying ways; however, all conceptualizations demonstrate that improving stability for the client is the most positive outcome in the mental health court. Common measures of success did include attaining (supportive) housing, receiving a diagnosis, receiving treatment or medication, being connected to services, avoiding jail time, complying with the court, identifying mental health needs, and gaining supports in the community.

How would I measure success... Do they get connected to mental health clinic? Were they diagnosed? If diagnosed are they all on their medications? If on medications are they following through with the treatment order? Do they have a place to live and is that place to live safe? And I think in order to determine success you have to measure that. (Participant #2)

Even if they’re not necessarily successful on this particular sense it doesn’t mean that long term they’re not going to see more success in the community because
they have had to chance to be connected with resources, get back on medication. (Participant #5)

But he’s been sentenced now and so he goes [to treatment appointments]. It is fortunately the forced treatment is what’s keeping him out of trouble. (Participant #8)

We can measure that success by saying that they’re not in jail right now although they should have been given their offences, because of the active supports that are in place. (Participant #2)

Overall stability. I think you could look at it in a year from now or 18 months from now and look at it on one level ... We have to measure [success] based on the infrequency or frequency of non compliance with the court. But I think the more important success is that they are connected, have they been assessed, are they on their proper medications, do they have some supports? (Participant #2)

And I think there is a lot of success in the sense that we’ve had reduced sentences, significantly reduced sentences based on the fact that we were able to identify the complex needs of the clients. And as a result of that and as a result of the clients’ compliance with the process they’ve been successful sentenced to a sentence that’s meaningful, as opposed to punitive or any of the other words we can come up with when it comes to the justice system. (Participant #2)

Sometimes due to the nature of the disability they don’t understand the consequences of what has been managed to get them a better outcome. So that can be anyone with mental health issues. When they’re stable and back on their meds they may understand what happened and appreciate the outcome. (Participant #6)

Some participants discussed specific examples of success they saw as a result of the mental health court, some in relation to securing supportive housing.

[A client] ended up being sentenced through the court and got a conditional sentence order and she would have been probably facing at least a year in jail. So in measuring success because she was back on her meds, we presented to the probation board, a sentence report on her identifying what successes or what steps had been taken to get her stabilized. And because she was stabilized the judge put her on a conditional order instead of putting her in jail. (Participant #2)

[The client] ended up on an order with probation and thanks to several discussions about his situation, given his charges at a pre-court level, stable housing and supported housing was finally found for him. (Participant #6)
It’s going to be good for [the client], really good. Because he’ll have more support here, he’s in a different house... (Participant #1)

4.4.7 Summary of organizing theme 4: Meaningful outcomes

The organizing theme of meaningful outcomes is composed of several basic themes that constitute how participants conceptualize clients succeeding and the court achieving justice. What was paramount in these discussions was that mentally ill individuals who commit crimes do not always have the capacity to fully appreciate their actions and therefore custodial sentences are not always suitable. On the other hand, participants indicated that although incarceration is not always appropriate, punishment in some form still occurs. The intent of the mental health court is to avoid punitive sanctions and instead provide clients with meaningful sentences that aid in improving the quality of their lives. Therapeutic jurisprudence is a theoretical explanation for this, as the law is being used as an agent of therapeutic change for clients (Wexler & Winick, 2003). By delivering meaningful sentences that include mandatory counseling or conditions pertaining to housing, medication, and/or program attendance, the judge is using judicial power to connect clients to the community in order to facilitate stability. However, this also indicates that coercion is an ever-present element of the MHC.

Coercion is present within the court particularly at sentencing with the intent that clients alter their behaviour by encouraging a more stable lifestyle and thus reducing criminal justice involvement. Fostering a shift in behaviour is a neoliberal technology of power and is subsequently how the court creates neoliberal subjects. However, this form of coercion is arguably one that seeks justice, leaving one to ask, is this “just coercion?” The mental health court could be seen as using just coercion within a neoliberal regime
to influence self-accountability. The court achieves this by delivering meaningful sentences for clients in order to avoid incarceration.

Nearly every participant expressed that jail is not always an appropriate solution for this group of vulnerable people because it does not address the root cause of offending behaviours, their mental illness. Jail disrupts the continuity of care that mentally ill individuals must receive and some participants believed that jails do not provide the same psychiatric services that can be found in the community. A study of Saskatchewan prisons has confirmed this, concluding that inmates who require medications do not always receive them on time and individuals who require closer monitoring of health issues are not always provided with such (Demers, 2014). Sending individuals with complex needs to an institution that is not entirely prepared to meet these needs is concerning. A neoliberal governing regime has pulled back on welfare policies so that prisons have become the catch basins for many individuals who fall through the cracks of the justice, social, and health systems. These individuals are not able to achieve neoliberal standards of individualization due to their mental illnesses or disabilities (Lemke, 2010). Because governments have cut social expenditures and reduced many welfare policies that might cease this cycle (Dean, 2011), many of these individuals will deteriorate in prisons and in communities where their primary needs are not met. Jail is also very expensive; one participant stressed that because of the complex needs of this population, jail becomes an even more costly solution, and one that also does not deter individuals from committing more crime. Fortunately, the mental health court has sent very few clients into custody.
Stakeholders have expressed that dispositions in the mental health court are different than one might see in traditional criminal courtrooms. By using a problem-solving approach and a collaborative effort, sentences that are more appropriate and more realistic for mentally ill clients are delivered. One participant stated that a client’s fine to be paid was significantly reduced to a point where it was possible for him to pay off. Because of the client’s mental health issues, employment was not an option. For this stakeholder, seeing this client being given an opportunity to succeed with a meaningful yet realistic form of punishment was an important difference between traditional criminal court and mental health court. Sentences in the mental health court encompass many different ways for clients to repay society for harms that were caused. Sentences are also intended to reflect the cognitive and psychiatric capacity and culpability of the clients. Other times, when mental health legislation is in effect, i.e., a community treatment order, criminal sanctions are not necessary, as the behaviour that led to the offence(s) is being treated and thus the behaviour is managed.

Balancing the safety needs of both clients and the community is another basic theme composing this organizing theme. For stakeholders in the mental health court it is important to look at who will be affected by an outcome of the court, such as the community and the client. Participants indicated that it was crucial that in sentencing a client, the safety needs of the community must be balanced with the safety needs of the individual. By sending a mentally ill individual to jail, it is not only costing the system mass amounts of money, but it is also a detriment to society. When this population is in prison, their needs are not met; they are released back into the community where
offences will most likely continue to occur because they have not received treatment for recurring mental health issues that lie at the root of offending behaviours.

Many of the clients who have come across the mental health court docket have fallen through the cracks of the system for many years, or sometimes for their entire lives. Mental health court is a vehicle that allows these clients to connect to government services, the health system, community programming, or various other programs and services that are necessary and appropriate. By connecting clients with services, the intention is that when there are more supports in place, contact with the justice system will decrease. The mental health court facilitates access to community services that could not be accessed otherwise for clients of the court. It has been demonstrated in the literature that mental health courts “offer a promising bridge between the mental health and criminal justice systems” (Hughes & Peak, 2013). The intent of connecting clients to the community is that contact with the criminal justice system will in turn be reduced.

Participants discussed that many of the clients have never been connected to community resources, and others discussed that even when their clients had been connected in the past, the court facilitated a re-connect. It is because of this court-facilitated connection that clients are able to attain programming or treatment when they would not have been able to access it previously due to funding issues or simply because they had no prior supports in place.

Stakeholders expressed that an important outcome for their clients is that they make less contact with the justice system after going through mental health court. In fact, one participant stated that one of the clients who has gone through the process has not recommitted an offence since concluding in the court. Contrary to much of the
quantitative literature and to what was discussed by this particular participant, most stakeholders indicated that they did not feel that reduced recidivism was an accurate measure of success. For mental health court stakeholders, it was more important that clients reduce contact with the system by reducing the frequency and severity of their offences. Because of the complex issues and challenges these clients face, engaging in the services required for improved stability can be difficult. For clients with genetic disorders, cognitive impairments such as fetal alcohol spectrum disorder, or acquired brain injuries, medication will not be able to completely stabilize behaviour like it would be intended for individuals with psychiatric illnesses. Therefore, completely reducing recidivism in this mental health court is not realistic, as “the court cannot require clients to stop being mentally ill” (Lurigio & Snowden, 2009, p. 207). However, by connecting these individuals to community resources, the goal is that problematic behavioural consequences of the condition be reduced due to the appropriate supports that are put in place as a result of the mental health court. Therefore, contact with the justice system will be reduced.

The final basic theme in the organizing theme of meaningful outcomes is increased stability as success. Success is difficult to define in these courts, and it has been argued that identifying success must be done case by case (Lurigio & Snowden, 2009). Stakeholders conceptualized success in many different ways that all stem from the previous two basic themes of connecting clients to services and reducing contact with the justice system. When these two mechanisms are in place, stakeholders expressed many different indicators of success that led to the conclusion that increased stability for
the client is the most ideal outcome. These measures of success themselves are in stark contrast to how success may be seen in traditional criminal courtrooms.

Retribution is the dominant form of justice practice in traditional criminal courts. In this framework, an offender receives a deserved punishment (Carlsmith, 2006). Success in these settings may be calculated through punitive sanctions such as a custodial sentence or harsh and inappropriate conditions. In the mental health court, however, success was conceptualized as clients receiving treatment for their illnesses, abiding by a medication regimen, increased healthy life choices and goal follow through, receiving a diagnosis, following court conditions, avoiding jail time or receiving a non-punitive sentence, attaining housing, and attending programing. Canada and Gunn (2013) outlined how the participants of their study measured success: receiving a formal diagnosis, receiving and abiding by a treatment and/or medication regimen, connecting with community services, gaining assistance in transportation and job aspects. There is a very clear overlap in perceptions of success in both studies.

Success was initially difficult to define for a few participants. Perhaps this is because this measure is subjective in nature; success looks different for each participant depending on the nature of a client’s illnesses or who the stakeholder represents in court. This is supported by the literature pertaining to mental health court success. Schneider et al. (2007) assert that success is difficult to measure because it depends on how the stakeholders perceive the purpose of the mental health court. Is it that the mental health court ensures jail time is avoided? Is it that participants leave mental health court without a criminal record at all? As all courts vary in these elements, success will continue to look different in each court, including the Regina Mental Health Disposition Court. But
for now, stakeholders will hope to see their clients on medication, connected to the community, not in prison, living in a stable residence, and complying with the court, which are outcomes that are meaningful for the client, the court, and the community.

4.5 Global Theme: The Mental Health Court as a Holistic Approach to Justice

In thematic network analysis, the global theme is “an argument, or a position or an assertion about a given issue or reality” (Attride-Sterling, 2001, p. 389). A global theme encompasses the organizing themes by summarizing and making sense of all the basic themes (Attride-Sterling, 2001). All 23 basic themes in this network compose the organizing themes of barriers for the client, barriers for the court, mental health court as less adversarial, and meaningful outcomes. The global theme of mental health court as a holistic approach to justice integrates all basic themes and subsequently all four organizing themes.

But what is justice? And who achieves it in the mental health court? Crank (2003) states that justice “seems to defy clear definition” (p.11) because there is a clash between trying to provide a clear meaning of the term while also trying to provide an inclusive meaning. In this research, the concept of justice has emerged through stakeholder responses and is conceptualized throughout the organizing themes. To be holistic is to approach something as a whole rather than in separate parts. A holistic approach to justice then would be all encompassing, broad, and would look at how all the parts act as a whole. Summaries will be given of each organizing theme in their relation to the global theme and how each relates to the concept of a holistic approach to justice.
Within the theme of barriers for the client, certain challenges and complex issues that face clients are handled to the best of the mental health court’s ability and capacity. Participants expressed that part of the process in mental health court is addressing the challenges that clients face by gathering together to identify the most pressing needs of the clients and facilitating a connection to address the needs in a timely and appropriate manner. By addressing such barriers and challenges that mentally ill clients face, the court is able to approach justice holistically for that client. Within this theme, justice is conceptualized as facing a challenge and aiming to overcome it. Justice is achieved in the mental health court by identifying the complex needs and challenges of clients who perhaps have never been identified in the past and attempting to minimize the adverse effects that individuals with mental illness experience when they do not have adequate supports in place. By engaging in therapeutic jurisprudence practices that seek to address the underlying problem of the behaviours that have led to contact with the justice system (Barber-Rioja & Rotter, 2014), the mental health court is able to take a step back from traditional criminal justice practices. The court identifies the barriers that the clients face and approaches justice through a therapeutic lens by engaging stakeholders to be agents of change for the clients (Portillo et al., 2013). Therapeutic jurisprudence also emphasizes the protection of due process rights for each individual (Lurigio & Snowden, 2009), which is another barrier the clients face in the court. By employing therapeutic jurisprudence in the mental health court, the rights of clients should not be subjugated in the process, and justice can be approached holistically. Although participants expressed that they are concerned about the violation of their clients’ rights, it was also stated that the defence counsel is able to identify these instances and proceeding accordingly.
Not only do clients face barriers, but the mental health court itself does also. The mental health court faces barriers that have potential to hinder the court’s operation. Although the court endures significant challenges, stakeholders have suggested that it has attempted to overcome these challenges thus far. To overcome barriers of coercion, stakeholders must ensure that principles of rights and justice are neither intruded upon nor subjugated (Nolan, 2001). Therapeutic jurisprudence is a framework that can be used to seek out solutions to the shortcomings of the justice system (Schneider et al., 2007). In line with therapeutic jurisprudence, the court and all of its shortcomings must use the law to produce positive results; this how the mental health court approaches justice holistically in this organizing theme. By understanding the barriers that stakeholders face in the court, steps are taken to improve and evolve the process and practices.

To be holistic is to be whole and to include all separate parts, including the negative aspects. Therefore it could be argued that a holistic approach to justice would necessarily include attention to the aspects of the mental health court that are perceived as negative. Addressing the barriers that the court faces is how the mental health court can approach justice in a holistic manner. In this organizing theme, justice is conceptualized as facing difficult challenges, large or small, overcoming barriers such as heavy time commitments and confusing entrance criteria, and attempting to reduce the coercive nature of the justice system as adequately as possible.

Mental health court as less adversarial is composed of basic themes that essentially outline the non-adversarial elements that are employed within the court. The mental health court is problem solving in nature, it is collaborative and multidisciplinary, clients are engaged in the process and treated more humanely than they are in a
traditional criminal courtroom, individualized plans are generated, the process is slow with the aim of benefitting the client, and finally the roles of the judge and legal counsel are unique. Non-adversarial justice in a courtroom is a broad approach that seeks to widen the scope of law (Freiberg, 2011). It is an inclusive and accessible process whereby the main goals are to resolve disputes and tend to the well-being of clients of the court (Freiberg, 2011). As previously stated, the Regina Mental Health Disposition Court is not completely void of adversarial practices, as these are inherently tied to a formal courtroom, making this court less rather than non-adversarial. In widening the scope of the law, non-adversarial justice practices allow stakeholders to engage in a holistic approach to justice in the mental health court. Stakeholders are able to identify clients and their complex needs, gather information that would not have been gathered in a traditional criminal court, collaborate and problem-solve in order to reach a solution or to generate a plan for clients that facilitates an improvement in overall stability, one that intends to address the daily challenges clients face.

A less adversarial approach also takes the form of therapeutic jurisprudence in the mental health court. Therapeutic jurisprudence encourages the court to be multidisciplinary and to seek out treatment for its clients, understanding that punitiveness is not appropriate in all cases (Barber-Rioja & Rotter, 2014). By broadening the scope of the law and engaging in non-adversarial justice practices that include therapeutic jurisprudence, stakeholders of the mental health court are engaged in a holistic approach to justice. Justice within this organizing theme is conceptualized as working together to engage clients in the process in order for these individuals to be viewed as people who are not necessarily criminals, but as individuals with an illness who have committed
offences as a result of not receiving medication, not having somewhere to live, or not having adequate supports in place. Justice is collaboration; it is gathering different agencies and partners and encouraging them to think outside the box, to aim to get to the root of the problem and to be proactive rather than reactive. Justice is legal professionals seeking out what is best for the client. A holistic approach to justice is ensuring that the mental health court process remains less adversarial and is inclusive, communicative, and accessible.

Participants defined success in varying ways; however, the theme that arose was that success means increased stability. To participants, a meaningful outcome is conceptualized as jail not being appropriate for mentally ill clients in all situations. It is therefore essential that alternatives to custodial sentences are sought that will adequately address the clients’ needs. Meaningful outcomes are conceptualized as ensuring the safety needs of both clients and the community are balanced and as facilitating access to community services, in turn encouraging stability in the community and reducing contact with the criminal justice system. Measuring successful outcomes was a complex topic of discussion, as many participants still had clients going through the court process and had not seen first hand what success might look like for them. All were able to envision how they could perceive success, however. One participant did suggest that success looks different for everyone, which is an important point—just as non-adversarial justice practices would emphasize, looking at success must be done broadly because specific aspects of this concept might vary among clients (Freiberg, 2011). Many participants also expressed that they did not think recidivism was the best measure of a successful outcome. This implies that outcomes cannot be looked at narrowly or in separate parts,
they must be examined more broadly. This is an objective of the mental health court: to produce outcomes that allow clients to access treatment, counseling, assessments, and residence that inevitably improve their stability in the community. The aim is to avoid incarceration by providing the clients with meaningful and realistic sentences that they are able to complete, in turn reducing contact with the justice system.

An analysis of this theme prompts the question: how is justice conceptualized in regards to meaningful outcomes? Justice is safety for society and clients of the court. It is connecting individuals with resources that they require to stabilize their mental illness and therefore to live a healthier lifestyle in the community. Justice is stakeholders facilitating change to create a safer community. Mental health court as a holistic approach to justice encompasses all of these conceptualizations of the term.

To return to the research questions—the primary research questions asked in this study are: how do stakeholders conceptualize the Regina Mental Health Disposition Court and in what ways is this court different from traditional criminal courtroom settings? The stakeholders conceptualized the Regina Mental Health Disposition Court as a holistic approach to justice where the law is engaged with broadly to ensure that the outcomes produce an alternative experience with justice for clients than they would have in traditional criminal courts. Justice has been conceptualized in varying ways. Justice in this mental health court is identifying and overcoming complex barriers, both large and small. It is stakeholders working together, collaborating, seeking out what is best for clients by looking at them as individuals with complex needs who need to be connected to the community. Justice is proactive rather than reactive and it encourages the balance of safety needs for the community and for the client. Justice is increased client stability,
connecting clients to necessary resources while reducing the frequency and severity of contact with the criminal justice system.

Stakeholders conceptualized the mental health court to be different than a traditional criminal court because it engages in non-adversarial justice practices and is founded on the theoretical framework of therapeutic jurisprudence. To reiterate, therapeutic jurisprudence is a sympathetic approach to law and it aims to use the law to address underlying issues that an individual with mental illness faces to reduce the anti-therapeutic consequences and to produce healthy and favourable, or therapeutic, consequences for the client (Wexler & Winick, 2003). By using the law to produce therapeutic outcomes, the intention is that there is a reduction in clients’ involvement with the justice system (Winick, 2013).

Based on the primary research questions, the secondary research questions are: do stakeholders perceive the court to employ alternative justice practices relative to traditional criminal courts; and how do alternative justice practices in mental health court address the needs of clients and affect their outcomes in the court? An analysis of the data demonstrates that stakeholders do perceive the court to employ alternative justice practices. In the exploration of the basic and organizing themes in the thematic network, stakeholders described many elements of non-adversarial justice practices, which can be seen in the basic themes, for example, problem solving, collaboration, individualized plans, alternative dispositions, unique role of judge and legal counsel, to name a few. It was also discovered that because the mental health court is less adversarial, it is able to address the various barriers that both the clients and the court face when these non-adversarial elements are engaged with in pre-court meetings. The
mental health court addresses the needs of clients by engaging in a multidisciplinary, collaborative approach and creating individualized plans that connect clients to the mental health system, community resources, and other supports. By connecting clients to the necessary agencies and services, successful outcomes are produced, where success implies an increase in community stability.

The findings of this study indicate that this mental health court is addressing a critical need in the criminal justice system. An analysis of the data has revealed that the Regina Mental Health Disposition Court approaches justice in a holistic manner. In the following chapter, this global theme will be put within a wider theoretical context, policy implications will be discussed, and directions for future research will be considered.
Chapter 5: Conclusion

The overrepresentation of mentally ill people in the criminal justice system is a persistent and troubling problem. Research has demonstrated that mental health courts can help alleviate this problem by diverting mentally ill individuals from the justice system to community services that will improve their overall stability as well as reduce contact with the justice system. Many researchers have studied mental health courts, but much of the research is quantitative, focuses on recidivism, and does not address the mechanisms that produce positive outcomes. The current research has aimed to address the qualitative gap in the literature by investigating how mental health courts produce improvements in overall stability in clients. This study has generated qualitative research that provides an alternative to measuring recidivism and attempts to understand the court through its key stakeholders.

This study investigated the Regina Mental Health Disposition Court from the perspective of stakeholders and demonstrated what justice looks like within this court. This was achieved by conducting interviews with stakeholders of the court. Interviews were transcribed and the data was analyzed using thematic network analysis. By employing this method of qualitative data analysis, the process revealed three levels of themes. The themes barriers for the court, barriers for the client, the court as less adversarial, and meaningful outcomes were encompassed by a global theme: the mental health court as a holistic approach to justice. This chapter will provide a final analysis of the theoretical and policy implications of the research, and suggest directions for future research.
5.1 Theoretical Implications

5.1.1 Therapeutic Jurisprudence

Participants conceptualized the court as a holistic approach to justice and a positive experience for both clients and professionals. The findings suggest that therapeutic jurisprudence is the foundation of the Regina Mental Health Disposition Court and is the theoretical framework upon which the court was built. It is also therapeutic jurisprudence that distinguishes the mental health court from traditional criminal courtrooms. Participants suggested many differences between mental health court and traditional criminal court settings that are evidence of a therapeutic jurisprudence framework. For example, stakeholders expressed that clients are engaged in a slower court process and treated in a more humane manner than in traditional criminal courts. Analysis of the data demonstrates that this is due to the client-centred model the court employs. The literature suggests that the role of therapeutic jurisprudence in mental health courts is to address underlying issues that have caused an individual to engage in crime (Winick, 2013). Because of the nature of pre-court meetings, the filter of information is expanded relative to a regular court docket, and stakeholders are able to share information on clients that would not have been known otherwise. Information on diagnoses, past history with the justice system, family background, and much more (if known) is shared to provide legal professionals with the opportunity to understand the underlying issues that have led clients to an encounter with the justice system. These elements allow for a client-centred approach to be engaged in and allow therapeutic jurisprudence to be the foundation of the court.
A non-adversarial and collaborative process is also an element of therapeutic jurisprudence (Portillo et al., 2013). Therapeutic jurisprudence incorporates a multidisciplinary approach that includes psychology, social work, and criminology in the law and courtroom (Wexler & Winick, 2003). This approach has been identified in the pre-court meetings, which are composed of various health professionals, legal professionals, community workers, and advocates. Stakeholders discussed the necessity of having all of these individuals present in pre-court meetings. Whether stakeholders have knowledge of a particular client or not, all contribute to offering services and problem solving for the client, which is a characteristic of therapeutic jurisprudence. By engaging in a collaborative approach in pre-court meetings, law is looked at from multiple standpoints to understand how it affects individuals (Wexler & Winick, 2003). This gives stakeholders the opportunity to be agents of therapeutic change (Portillo et al., 2013). By contributing to the problem-solving process, stakeholders inevitably affect the outcomes of the court, thereby facilitating therapeutic change for clients. The pre-court process employs therapeutic jurisprudence by facilitating connections to community resources that can aid in improving the overall health and stability of clients and addressing the behaviours that have led to a criminal justice cycle (Barber-Rioja & Rotter, 2014).

5.1.2 Restorative Justice

Restorative justice is also an aspect of therapeutic jurisprudence, and elements of this justice practice are also present in the Regina Mental Health Disposition Court. According to Braithwaite (2002), when restorative justice is engaged in, legal decisions are made to facilitate rehabilitation for clients and to address the root causes of their
behaviour (Braithwaite, 2002). The literature demonstrates that a punitive sanction, or incarceration, is not the most appropriate response for all individuals, especially those with mental illness (Barber-Rioja & Rotter, 2014). An analysis of the data reveals that an important outcome for stakeholders is that their clients avoid jail sentences and instead receive more appropriate and realistic dispositions that meet their needs. Avoiding a jail sentence does not make this court restorative, but focusing on rehabilitation and repairing harms through community sentencing is certainly a restorative element that is present within the court.

Restorative justice further encourages addressing the psychological well-being of clients and emphasizes the presence of emotions and empathy when interacting with clients of the mental health court (Nolan, 2003). Advocates who are present in pre-court aim to ensure the psychological well-being of their clients. It has been evidenced through analysis of the data that this is because of the open discussions in pre-court meetings, the slower pace of the court process, and the less formal nature of the courtroom itself. These elements allow the well-being of clients to be the focus and for empathy and emotion to play a role. Another element of restorative justice that is present within the mental health court is repairing harms (Van Ness & Strong, 2006). Two participants discussed how a victim of assault was supportive of an alternative sentencing model for a client, whose charges were eventually stayed. It was evident that the court sought to repair the harm caused to the victim by involving him or her in the process. This is also evidence that victims are involved in the mental health court process.

Reintegrating a client back into society is another element of restorative justice that is present in the mental health court (Schneider et al., 2007). One participant
discussed having a release plan for a client when the custodial sentence was complete to ensure programming and service access were sought upon release into the community. It is essential that appropriate reintegration of clients take place to give individuals an opportunity to seek out the resources they need and to reduce the frequency of reoffending. Although plans and reintegration strategies are to be established with all individuals who are released from custody, the mental health court generates plans at both the front end (prior to the custodial sentence) and the back end (following release).

These elements of restorative justice that have been evident in the data are parallel with Van Ness and Strong’s (2006) definition: “Restorative justice is a theory of justice that emphasizes repairing the harm caused or revealed by criminal behaviour. It is best accomplished through cooperative processes that include all stakeholders” (p. 43). Van Ness and Strong’s (2006) three principles of restorative justice can also be identified.

The first principle states that all those who have been harmed by a crime must be healed through justice (Van Ness & Strong, 2006). An analysis of the data demonstrates that justice is sought for both society and victims (when possible) by ensuring the safety needs of the community are met, by reducing justice involvement for clients, and by reaching out to victims. Additionally, unlike a traditional criminal courtroom, the mental health court emphasizes healing and rehabilitation for clients, as they too have experienced harm that either contributed to the crime or was the result of the crime (Van Ness & Strong, 2006). By addressing the root causes of offending behaviours, injuries of the client are repaired and justice is achieved.

The second principle suggests that victims, offenders, and communities should be given the opportunity to actively participate in the process (Van Ness & Strong, 2006).
In the Regina Mental Health Disposition Court, pre-court meetings as well as the sitting of the docket are indicative of this principle. Stakeholders come together to collaborate and problem-solve with the intent of improving clients’ stability. Clients are not present in pre-court meetings, but in most instances have community workers present to advocate on their behalf. During the court sitting, clients are present and spoken to directly by the judge. They are involved in a verbal exchange during court when they are present. Although in most cases victims do not have direct involvement, the Crown and defence ensure that those who have been harmed by the offence can share their version of the wrongdoing and have a say during the court process.

Finally, Van Ness and Strong (2006) suggest that it is necessary to “rethink the relative roles and responsibilities of government and community: in promoting justice, government is responsible for preserving a just order and the community for establishing a just peace” (p. 46). In other words, public safety is achieved through both order and peace in the third principle of restorative justice (Van Ness & Strong, 2006). In the mental health court, the Crown prosecutor and the judge act on behalf of the government, while representatives of CBOs, community workers, advocates, and the defence counsel act on behalf of the client and/or the community. However, all individuals (except the client) come together through a multidisciplinary collaboration in pre-court meetings to achieve order and peace in society by placing emphasis on safety for both the client and the community. All three of Van Ness and Strong’s (2006) principles of restorative justice are crucial to the Regina Mental Health Disposition Court’s operation. Notably, although the court is not explicitly a restorative justice process, it brings together restorative and retributive practices to achieve a therapeutic and unique justice process.
5.1.3 Procedural Justice

Procedural justice emphasizes that clients are to be treated with dignity and respect, they are heard by the judge, and they perceive the process to be fair regardless of the outcome (Canada & Watson, 2013). Many participants expressed that their clients were satisfied with the process and felt that clients’ interaction with the judge was positive. Studies have shown that clients who have positive encounters with the judge in a mental health court are more likely to experience higher levels of procedural justice (Canada & Watson, 2013; Wales et al., 2010). Another common theme that arose through data analysis was that clients were engaged and treated on a more humane level than is evident in traditional criminal courtrooms. Some participants found that in regular docket courts, clients are considered to be just another piece of paper among hundreds of files that these high-volume courtrooms see in a day. In mental health court, however, the docket is smaller and therefore more time is taken with each client, providing an opportunity for clients to be treated with fairness, dignity, and respect. These elements of procedural justice indicate the importance of self-accountability, which traditional criminal courtrooms do not emphasize. To achieve self-accountability, clients must engage in self-improvement strategies and abide by the individualized plan so as not to disappoint the judge, legal counsel or their community worker and in order to become more stable in the community. This could be considered a neoliberal technology of power as the client alters his or her behaviour to demonstrate change and improvement and therefore is engaging in self-governing.

On the surface, procedural justice and restorative justice are two explicitly different theories. However, there is an evident overlap between the two that is
characterized by an emphasis on the process of how the law is carried out by key players of the justice system. Both theories consider how justice can be achieved for all who have been affected by harms instead of focusing solely on the law itself. Both restorative and procedural justice emphasize respect, dignity, and communication throughout the justice process. These theories are not mutually exclusive; they co-exist to produce therapeutic effects for clients with the intention of addressing the root causes of criminal behaviour and therefore reducing justice involvement.

5.2 Implications for Further Research

This research has demonstrated that the Regina Mental Health Disposition Court is not only addressing a community need, but is a valuable and integral part of Regina’s criminal justice system. Participants have expressed that this court is engaging in a holistic approach to justice by attempting to overcome barriers and challenges, employing non-adversarial justice practices, and by producing outcomes that are meaningful. After an examination of the findings, it is evident that therapeutic jurisprudence is at the centre of the Regina Mental Health Disposition Court and is the reason that it approaches justice holistically. Much of the literature has focused on the principles of therapeutic jurisprudence within mental health courts (i.e., procedural justice, therapeutic outcomes), but very few researchers have specifically studied the link between therapeutic jurisprudence and outcomes (Redlich & Han, 2014). Although this study does not quantify this noticeable link, it does paint a vivid picture of how therapeutic jurisprudence is demonstrated in the mental health court and how it can impact client outcomes. Further research must be conducted on this topic in order to
better understand the reasons why mental health courts are producing positive outcomes, or improving client stability and engagement.

It is crucial that more studies be conducted on Canadian mental health courts to increase their prevalence. Relative to the United States, Canadian mental health courts have not emerged as quickly (Slinger & Roesch, 2010), yet intuitively, the same pressing need exists in Canada. There are many mentally ill Canadians who have suffered from the consequences of neoliberal governing practices—they have fallen through the reduced social safety net and are entangled with the criminal justice system. These individuals need to be connected to community resources and treatment services to address the underlying issues that have led to contact with the justice system. Published research on Canadian mental health courts is severely lacking (Slinger & Roesch, 2010). The studies that do exist, Slinger and Roesch (2010) argue, “reflect unscientific methodology and superficial analyses” (p. 260). The authors go on to state that this trend runs parallel with the early implementation and subsequent research of mental health courts in the United States. Rigorous research, both quantitative and qualitative, must increase to ensure that the justice system implements mental health court models in communities throughout Canada.

The increasing rate of mentally ill individuals in prison populations is a cause for concern and highlights the need to continue research of mental health courts. Further qualitative research must be conducted, particularly by studying clients of a mental health court. Although the mental illness that these individuals suffer from presents a challenge when studying clients of the court, it is necessary to gain an understanding of the court from this particular perspective. By interviewing clients, it is possible to gain
knowledge on the challenges that they face according to them, in turn helping the court to address their needs more appropriately. Further research must also focus on the barriers that have been discussed in the present study. Barriers such as a lack of funding and psychologist, coercive aspects, and poorly communicated entrance criteria are inevitably preventing the court to operate at its fullest potential and its maximum capacity. There is a pressing need to focus on the concerns that have arisen among participants, from legislation to resource and housing problems.

Future research needs to deviate from measuring recidivism when it comes to identifying success, as there are other valuable ways of measuring the success of a mental health court. Instead of focusing on ceasing reoffending, it is more important that the needs of clients are met in order to increase their stability in the community. In this study, most stakeholders indicated that they did not feel that completely avoiding contact with the justice system was an accurate measure of success. This is also contrary to much of the mental health court research, which places heavy emphasis on a reduction of re-offense rates. For stakeholders in the Regina Mental Health Disposition Court, it was more important that clients reduce contact with the system by reducing the frequency and severity of their offences. It was also more important that clients become engaged with community services to access treatment, support, housing, and assessments. For stakeholders in this study, improving the overall stability of a client was more significant than reducing recidivism, as all stakeholders were aware of the complex issues and challenges the clients face that may prevent reducing contact with the justice system entirely. In future research, other ways to describe success must be sought. It will be important to include alternative ways to measure success, such as qualifying and
expanding recidivism to be understood as less frequent and less severe re-offending. As indicated, stakeholders have expressed nuanced concepts of recidivism that could be deployed as measurements of success.

Finally, it will be important for the Regina Mental Health Court to look at long-term outcomes for clients. Research in this court must continue in order to identify whether or not the court is producing a long-term effect on clients. Are they staying connected to the services that the mental health court facilitated access to? Do clients receive treatment or counseling for the illnesses they suffer from after the court-mandated conditions expire? Are they able to maintain a stable residence that is in turn sustaining their stability? These questions must be addressed in future studies of this mental health court. As this court continues to evolve and grow in its capacity, identifying long-term effects is imperative for its continued operation.

5.3 Policy Implications

Policy-related implications must stem from the many barriers that the clients and court both face. The system needs to look at continuing to evolve this court. One participant indicated that what the court needs to be is a diversion and mediation program, similar to Toronto’s mental health court (Schneider et al., 2007). By looking to other mental health court models, the young Regina Mental Health Disposition Court can implement policies of courts that have been around for much longer. Implementing an added model of diversion or a “pre-plea arrangement” (i.e., pleas do not have to be entered to participate in court) can reduce coercion. This is important because of the repercussions of guilty pleas for mentally ill people. “A guilty plea could result in the creation of future barriers for [persons with mental illness], and these should be
negotiated only with the help of an advocate” (Lurigio & Snowden, 2009 p. 211). By
pleading guilty and subsequently receiving a criminal record, mentally ill individuals
face further negative stigmatization and will continue to face barriers throughout their
lives. Notably, a diversion model is one that should be added to the court, not how the
court operates completely. Some individuals in the Regina Mental Health Disposition
Court have committed serious offences that must be dealt with through judicial
sentencing and, in rare cases, incarceration. It is important that the court allow for a
balance of appropriate sentences and public safety.

The court faces barriers such as funding, access to housing, being able to expand
its capacity, and a lack of psychological assessments. In order for the court to overcome
these barriers, funding must come from policies that are implemented by the provincial
government. The reality is, by implementing policies on the front end as opposed to the
back end, fewer individuals will fall through the cracks of the system. It is essential that
funding be targeted towards community and health services in order for mentally ill
individuals in the court to be diagnosed or assessed by a psychologist and to continue
improving their health after having gone through the process. With increased funding to
the court itself, the mental health court would be affected in various ways. One, the court
could employ a court coordinator to improve the function and effectiveness of the court
and to ensure clients have the adequate support they need to be guided through the
process. Two, the court would be able to expand its capacity by sitting every week
instead of every two weeks. This would allow more individuals in the court system to be
identified and subsequently be directed to the mental health court and have their needs
met, in turn reducing the overrepresentation of the mentally ill in the justice system. By
increasing the capacity, the time between adjournments for clients could also be reduced and some cases could be resolved more quickly. Three, it would allow for an education and awareness component of the court to be implemented. The concept of mental health courts is certainly not a common one within the general public, but it is also not common within the health and community sectors. It is important for legal and non-legal professionals alike to be educated to increase awareness of the court, its objectives, and inevitably what it hopes to achieve.

5.4 Conclusion and Final Remarks

The mentally ill have long be a vulnerable sector of society. Part of the reason for this problem is that neoliberal governing regimes in North America and Saskatchewan in particular took the place of a welfare state. Neoliberal governance placed emphasis on self-care and individualization, but many mentally ill individuals were not able to engage in these practices (Lemke, 2001). Neoliberalism remains a dominant regime of governance today and creates barriers for vulnerable groups of individuals, such as the mentally ill, who have fallen through a shrunken social safety net. The Regina Mental Health Court is embedded within a neoliberal regime, uses neoliberal language, and attempts to produce subjects who fit within a neoliberal ideology. The court is a technology of power and seeks to facilitate change for clients, while encouraging them to adjust behaviours to better fit within the societal norm. To achieve this form of governance, mechanisms are employed through coercion that encourage self-accountability and stability to reduce ‘deviant’ behaviour. The case management group delivers this neoliberal intervention because there is a common understanding of the
court’s value as it seeks to deliver an alternative form of justice for a vulnerable group of people who have long-suffered from the ongoing dominance of neoliberal practices.

This study has highlighted the Regina Mental Health Disposition Court, which seeks to divert mentally ill individuals from the criminal justice system, engage them with community services, and produce outcomes that increase their stability in the community. The research particularly investigated how key stakeholders conceptualized the court and whether they perceived the court to be engaging in alternative justice practices. This research was conducted for a few reasons, not least of which is that mental health courts in Canada are few and far between and subsequently the research is sparse. I intend to contribute to the growing body of literature on Canadian MHCs and provide a spotlight for this particular court in Regina, Saskatchewan. Another reason the research was conducted is because I wanted to facilitate awareness of the operation of this court. It is important for those working with mentally ill individuals who are involved in the justice system to be cognizant of this court process so clients’ needs can be appropriately met. The findings of this study will be shared with different sectors and agencies with the intention of increasing education and awareness of the Regina Mental Health Disposition Court. In conclusion, this mental health court is addressing a need in the community and generating outcomes that are meaningful by improving clients’ stability in the community. Findings of this study reveal that the mental health court is engaging in a holistic approach to justice by employing the theoretical framework of therapeutic jurisprudence.
References


Dooley, C. (2012). “The older staff, myself included, we were pretty institutionalized ourselves”: Authority and insight in practitioner narratives of psychiatric deinstitutionalization in Prairie Canada. *Canadian Bulletin of Medical History, 21*(1), 101-123.


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Appendix A: Research and Ethics Board Approval

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**Research Ethics Board Certificate of Approval**

<table>
<thead>
<tr>
<th>PRINCIPAL INVESTIGATOR</th>
<th>DEPARTMENT</th>
<th>REB#</th>
</tr>
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<tbody>
<tr>
<td>Dr. Michelle Stewart</td>
<td>Justice Studies</td>
<td>2015-077</td>
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</tbody>
</table>

**FUNDER(S)**
University of Regina Partnership Grant

**TITLE**
Confronting the Challenge - Community Supports, Stability and the Role of the Mental Health Disposition Court

**APPROVAL OF**
- Application for Behavioural Research Ethics Review
- Consent form for clients
- Consent for professionals
- Interview script (professionals)
- Interview script (clients)

**APPROVED ON**
- June 1, 2015

**RENEWAL DATE**
- June 1, 2016

**CERTIFICATION**
The University of Regina Research Ethics Board has reviewed the above-named research project. The proposal was found to be acceptable on ethical grounds. The principal investigator has the responsibility for any other administrative or regulatory approvals that may pertain to this research project, and for ensuring that the authorized research is carried out according to the conditions outlined in the original protocol submitted for ethics review. This Certificate of Approval is valid for the above time period provided there is no change in experimental protocol, consent process or documents.

Any significant changes to your proposed method, or your consent and recruitment procedures should be reported to the Chair for Research Ethics Board consideration in advance of its implementation.

**ONGOING REVIEW REQUIREMENTS**
In order to receive annual renewal, a status report must be submitted to the REB Chair for Board consideration within one month of the current expiry date each year the study remains open, and upon study completion. Please refer to the following website for further instructions: [http://www.uregina.ca/research/REB/main.shtml](http://www.uregina.ca/research/REB/main.shtml)

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Dr. Larena Hoeber, Chair
University of Regina
Research Ethics Board

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Please send all correspondence to:
Office for Research, Innovation and Partnership
University of Regina
Research and Innovation Centre 109
Regina, SK S4S 0A2
Telephone: (306) 585-4775  Fax: (306) 585-4893  research.ethics@uregina.ca
Appendix B: Participant Consent Form

Project Title: Confronting the Challenge—Community Supports, Stability and the Role of the Mental Health Disposition Court

PI: Michelle Stewart, Assistant Professor, Department of Justice Studies, University of Regina, Regina, SK S4S 0A2; Phone: 306-585-4873; Email: michelle.stewart@uregina.ca

Research & Procedure:
This research project will investigate how the Mental Health Disposition Court engages with key stakeholders, the perspectives of those stakeholders and the impacts (if any) of the court on the lives of those involved with the court (clients and workers). These findings will inform reports and future research grants; the research will also have preliminary evaluative benefit. Research will involve asking a series of open-ended questions about your experience working in the court, the challenges of the court and the potential successes associated to the court. The interview times will vary; estimated duration of interview will be 60 minutes. This project is funded by an internal grant at the University of Regina and has been created in partnership with the presiding Judge and the Ministry of Justice.

Risks & Benefits:
There are no known or anticipated risks to you by participating in this research and you retain the right to end the interview at any time. This will be a local investigation of a small court and while the researcher will not name individuals directly, there is not an assurance of anonymity because of the small number of individuals involved with the court. That said, your name will be withheld from any scholarly writing or dissemination and individuals will be identified only by their sector/background. Alternative justice practices that seek to address the challenges facing complex-needs clients are important. This research is a preliminary investigation of the court and how it is perceived by key stakeholders. Your insights will greatly assist in this research.

Right to Withdraw:
Your participation is voluntary and you can answer only those questions that you are comfortable with. You may withdraw from the research project for any reason, at any time without explanation or penalty of any sort. Should you choose to withdraw please tell the interviewer that you wish to end the interview. If requested at this time, data from the interview will be destroyed. If you wish to interrupt the interview and reschedule please tell interviewer.

Consent:
This project has been approved on ethical grounds by the UofR Research Ethics Board on ___________. Any questions about your rights as a participant may be addressed to the committee at 306-585-4775 or research.ethics@uregina.ca.

ORAL CONSENT:
Oral Consent will be secured prior to the interview. Interviewer will review the project, risk and consent. Please sign and date the form if you consent to participate. All follow-up interviews will require that the subject be re-consented.

______________________________  ________________________________  ______________
Name of Participant                  Researcher's Signature                  Date
Appendix C: Interview Guide

INTERVIEW SCRIPT (Professionals)

Open-ended interview questions will focus on the operations of the MHDC in Regina and the workings of this court. Research questions may include:

1. Which sector best reflects your current position:
   a. Legal professional
   b. Advocate/Community worker
   c. Other: _______________________

2. How long have you been in your field?

3. How long have you been involved with the MHC and do you attend regularly?

4. Can you please describe your role in the court and how you became involved?

5. What other experiences have you had with alternative or traditional courts?

6. The MHC is described as a community court and is seen as an alternative to traditional justice models. Can you describe some of the differences you see in this style of justice?

7. Do you believe clients have a different court experience when engaged in the MHC? Whether yes or no, please explain.

8. Based on your experiences, in what ways does the MHC impact client outcomes that might be different from a traditional court model?

9. In addition to the mental health issues facing the clients that use the MHC, please indicate the key challenges that are facing clients when they are in the community.

10. In what ways does the court help to address, or not address, these challenges?

11. Please explain what training or preparation you were given prior to involvement; do you believe the partners involved in the court have adequate training to understand their role in the court?

12. What impacts, if any, does the court have on your workload (this could include additional hours of preparation, coordination or other impacts)?
13. Do you believe that some of workload could be alleviated if there was a formal coordinator to assist in the court? If yes, what would that coordinator do to assist you in your work as it relates to the court?

14. Do you believe the overall outcome for the clients is beneficial?

15. If you were asked to measure the impact or success of the court, how would you measure it?

16. Based on your previous answer: how successful is the court at this time?

17. Where are the areas for improvement and what is needed to assist in that improvement?

18. Thinking over your experiences in the court can you share a story in which you believe a client experienced success because of their involvement in the court?

19. If there was one thing you could change about the MHC what would it be?

20. Do you have any questions for us?

Gender:
Interview #: _______________
Misc. Notes: