Athabasca University
FACULTY OF GRADUATE STUDIES

The future of learning.

ATHABASCA UNIVERSITY

SUBSTITUTE DECISION-MAKING FOR INDIVIDUALS UNDER PUBLIC GUARDIANSHIP INVOLVED WITH THE CRIMINAL JUSTICE SYSTEM IN NEW SOUTH WALES, AUSTRALIA

BY

ALISON F. PERRY

A THESIS

SUBMITTED TO THE FACULTY OF GRADUATE STUDIES

IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR

THE DEGREE OF MASTER OF COUNSELLING PSYCHOLOGY

GRADUATE CENTRE FOR APPLIED PSYCHOLOGY

ATHABASCA, ALBERTA

SEPTEMBER 2015

Athabasca University
FACULTY OF GRADUATE STUDIES

The future of learning.

Approval of Thesis

The undersigned certify that they have read the thesis entitled

"Substitute Decision-Making for Individuals Under Public Guardianship Involved with the Criminal Justice System in New South Wales, Australia"

Submitted by

Alison Perry

In partial fulfillment of the requirements for the degree of

Master of Counselling Psychology

The thesis examination committee certifies that the thesis
and the oral examination is approved

Supervisor
Dr. Jeff Chang
Athabasca University

Committee members

Dr. Paul Jerry
Athabasca University

Dr. Brian Guthrie
Mount Royal University

February 3, 2016

1 University Drive, Athabasca, AB, T9S 3A3 Canada

P: 780.509.7536 | Toll-free (CAN/U.S.) 1.800.561.4650 (7536)

fgs@athabascau.ca | fgs.athabascau.ca | athabascau.ca

Dedication

This thesis is dedicated to my mother, who has supported me through everything in my life, even if she did not always agree with my choices. During this educational journey, she has provided me with unconditional love and encouragement at every step of the way. Without my mum, this never would have been a reality.

I would also like to dedicate this thesis to my much loved animals. They have always been there for me through the good and bad. Although they do not really have much of a choice for who their owner is, I would like to think they would still choose me and would take pride in knowing that their sheer presence has kept me going and helped me achieve this huge accomplishment.

Finally, I would like to dedicate this to my family and friends who have offered me unrelenting and unconditional love and support. Thank you!

Acknowledgements

I am grateful to my family for giving me the support and encouragement to pursue my masters. Mum and Dad, you have shaped me, supported me, guided me, and loved me. I would have never made it this far without you believing in me and providing me with ongoing, constructive feedback. I am eternally grateful for the sacrifices you have made to support me throughout this journey and my life. You have given me many opportunities that have allowed me to pursue my dreams. I would also like to thank Gloria Folden for her ongoing support and enthusiasm about this project; you sure knew how to put a positive spin on everything!

I would like to acknowledge Jay and his parents. Although you came into my life nearing the end of my thesis, your support and positivity have helped encourage me to finish this stage in my life more than I think you will ever know. For that, I thank you!

Dr Jeff Chang, thank you for giving me the freedom to pursue a project that was so meaningful to me and for giving me "gentle" nudges when I waivered. Your guidance has been tremendous and I appreciate you openness, approachability, and honesty.

I appreciate the time and effort so generously put forth to serve on my committee by Dr Paul Jerry and Dr Brian Guthrie. I would like to thank both of you for picking this up to help and support me in completing this project. I would also like to acknowledge the Graduate Centre for Applied Psychology and Athabasca University for their generous funding through scholarships for my degree and this project.

To Public Guardianship staff near and far, I could not have done this without you, literally and figuratively. Thank you to all of the NSW Public Guardian staff for generously spending time with me during the interviews and for any follow up questions I had. I appreciated your ongoing and forthcoming feedback and recommendations. I would particularly like to thank Graeme Smith, NSW Public Guardian, and Amanda McDonagh, Regional Manager in Parramatta, for directly supporting me while completing the initial stages of my research. I would also like to thank my current boss and Public Guardian, Graham Badry, for his ongoing encouragement to pursue my dreams and complete my masters. All of your support will always be greatly appreciated.

I would also like to pay tribute to a dear friend who agreed to help me complete my transcripts before she knew what doing them would entail. Tazmin Ng, your amazing transcription of the interviews and ongoing support throughout my thesis and at work has meant the world to me. You are an amazing friend.

I would also like to thank my many dear friends and supporters who have continuously given me words of encouragement and always remained positive. They have also told me to carry on despite set-backs and have given me the tough love I needed, but may not have appreciated at the time. Thank you. Thank you for being such wonderful friends! Onwards and Upwards!

Lastly, to the 11 participants that informed this research: our conversations meant so much more to me than a necessary step in data collection. Thank you for sharing your experiences and opinions so freely.

Abstract

This qualitative study investigated the decision making process and subjective experiences of guardianship staff. Specifically, grounded theory was utilized to examine the central research question: "What is the decision-making process of guardians of adults under the care of the NSW Public Guardian, who are charged and proceed through the criminal justice system?" Another question based on the central research question was, "What decisions are required, how are these decisions made and implemented, and what are the outcomes of those decisions?" Eleven participants were interviewed using an open-ended interview format. The results are represented in 8 themes and 35 categories. It was hoped that the description of these processes could assist in future decisions being made on behalf of individuals under Guardianship by: specifying what information is considered and valued when making decisions; how the decisions are implemented; how the guardians felt about the decisions; and the outcome of those decisions. From there, recommendations would be provided for guardianship staff, legal and justice practitioners, support workers, and researchers who work with individuals involved with criminal justice system.

Keywords: Guardianship, criminal justice system, mental illness, developmental disability, decision making, recidivism.

Table of Contents

List of Tables

List of Figures

CHAPTER ONE: INTRODUCTION

Overview

The term *criminalisation of the mentally ill* was coined by Abramson (1972) to refer to individuals diagnosed with mental illnesses who engage in criminal activities. More often than not, these individuals are arrested and prosecuted rather than taken to hospital or other psychiatric facilities (Abramson, 1972), which reduces the likelihood that they receive the necessary treatment for their mental illnesses (Lamb & Weinberger, 2006; Moore & Hiday, 2006). This is concerning because mentally ill individuals who actually commit crimes might not have done so had they been receiving adequate treatment within the community in the first place (Steadman, 1990). Steadman (1990) goes on to assert that mentally ill offenders, whose illegal behaviour tends to be related to survival behaviour, should be diverted into appropriate mental health treatment services as opposed to going through the criminal justice system (CJS). This assertion highlights the importance of considering alternative approaches as opposed to involvement with the CJS for mentally ill and developmentally disabled offenders.

Traditionally, literature on working with mentally ill and developmentally disabled individuals involved with the CJS primarily focused on specialised courts, such as mental health and drug courts, the plausibility of diversion programs, or the use of community treatment orders. Extant literature also addresses the services that are or should be available to these offenders as well as the legal ramifications of their offences, including the individual's capacity to accept a guilty plea or to access alternative routes to adjudication. What remains relatively untouched in current literature is what role a statutory body, such as the Public Guardian, could

play whilst working with mentally ill and developmentally disabled offenders. There is little research describing the decisions being made on behalf of this population and how these decisions are impacting this population's involvement with the CJS, such as potentially reducing recidivism rates.

The proposed study coincides with my personal and professional experiences working with mentally ill and developmentally disabled offenders. Prior to my acceptance into a graduate counselling psychology program, I worked as an Addictions Resource Counsellor and Outreach Worker at a facility for homeless adults struggling with addictions. We provided a drop-in shelter, a non-medically supervised detoxification program, and assistance with accessing services, such as accommodation, medical, and treatment programs. Throughout my employment, I saw a number of clients encounter the CJS, which often led to incarceration for indictable offences or, more often, summary offences commonly known as 'nuisance' offences, such as urinating in public, public intoxication, or being unable to pay their multiple fines. Frequently, I questioned the ability of our clients to accept guilty pleas; if they fully understood the charges against them; and what could be done to better assist them when they had to navigate the CJS.

In October 2007, I moved to Sydney, Australia and began my employment at the NSW Public Guardian, Department of Attorney General and Justice. I became interested in working with the individuals appointed to Public Guardianship who were involved with the CJS. It became evident that there is a need to actively support these individuals and to strongly advocate for additional services to avoid further involvement with the CJS. I learned this population appeared to be largely underserved and did not or could not access the services needed, such as

secure accommodation and support from professional agencies. I found I was required to advocate above and beyond simply referring these individuals for support. This is because many service providers denied the referral based on the client's criminal activity or diagnoses (or both) as opposed to their need for specialised assistance. This often led to the client's ongoing incarceration well past his or her release date; being incarcerated for minor offences; being placed in psychiatric hospitals with no specific plans to reintegrate him or her back into society; or simply discharged back into the community without any form of assistance. My experience working with these clients made it apparent that research is required to explore what role a statutory body, such as the Public Guardian, could do to better assist this population access much needed support and potentially avoid further recidivism.

When I became interested in the role of the Public Guardian with mentally ill and developmentally disabled offenders, I discovered that there was little research on having a substitute decision maker involved with these individuals. Moreover, while there appeared to be some services available to this population, it was very difficult to access the services without a professional involved who could navigate the system. Consequently, I am both personally and professionally interested as to what role a statutory body could play in working with mentally ill and developmentally disabled offenders and whether this would be a plausible way to reduce recidivism.

The Present Study

The purpose of this research is to examine how a statutory body, such as the Public Guardian, could help mentally ill and developmentally disabled offenders avoid further criminal

involvement. This will be examined based on the decisions made by NSW Public Guardian staff on behalf of mentally ill and developmentally disabled offenders as well as the decision-making process by each guardian. This information may assist in determining the need for a substitute decision-maker to ensure developmentally disabled and mentally ill offenders receive the appropriate support and assistance whilst navigating through the CJS.

The Domain of Inquiry

By conducting individual interviews with Public Guardianship staff, I hope to explore what decisions are required for this population; how these decisions are made and implemented; the subjective experiences of guardianship staff making these decisions; and the perceived or real outcomes of those decisions. I aim to look for common themes or issues in relation to whether the Public Guardian could successfully assist in reducing the continued involvement of mentally ill and developmentally disabled offenders with the CJS. From there, I hope to provide recommendations to guardianship staff and other mental health professionals to guide in providing adequate support and assistance to mentally ill and developmentally disabled offenders.

Social context. Many researchers have identified the prevalence of criminal activity among mentally ill individuals (Abramson, 1972; Lamb & Weinberger, 2006; Moore & Hiday, 2006; Steadman, 1990). Although not all mentally ill or developmentally disabled individuals commit offences, it is imperative to explore how services could be improved for those that do. Furthermore, millions of dollars each year are spent incarcerating mentally ill and developmentally disabled offenders, yielding minimal rehabilitation and extremely high

recidivism rates (Moore & Hiday, 2006). This emphasises the need to explore what can be done to prevent further incarceration and recidivism within this population.

Practical context. The present study relates to the fields of psychology, criminology, social work, sociology, law, and counselling. This study will primarily focus on the need to implement access to much needed services for mentally ill and developmentally disabled offenders through the decisions made by a statutory official. Consequently, this study will include theory and practice, while suggesting approaches that may better assist professionals working with this population. The results could identify what may help prevent further recidivism and suggest practices to better support and assist mentally ill and developmentally disabled offenders.

Purpose of the Study and its Potential Significance

Gibbs (1983) highlighted how the presence of inmates with psychological problems within the CJS is a serious concern for correctional staff, second only to overcrowding. To add to this, Lamb and Weinberger (2006) found that an average of 10 to 15% of the prison population suffer from poor functioning, severe, acute, and chronic mental illness, and have extensive experience with both the mental health and criminal justice systems. Teplin (1990) discovered that just over 6% of male offenders met the diagnostic criteria for mental illnesses, with the most common diagnoses being schizophrenia, mania, or major depression and the prevalence of serious mental illnesses within the prison population was four to eight times higher than in the general population. Teplin, Abram, and McClelland (1996) in Cook County (Chicago) Jail found 15% of the female prisoners were found to have serious psychiatric

disorders, just over 2% were manic, and almost 14% had major depression.

Related to concerns raised regarding rates of mental illness within prisons, Lamb and Weinberger (1998) noted that society has limited tolerance for the deviant behaviour of people with mental illnesses and disabilities. This is particularly true for "those who have direct contact with mentally ill persons, namely, the courts, families, and other citizens" (Lamb & Weinberger, 1998, p. 488). This intolerance is further heightened by a perceived relationship between mental illness and violence, especially when violent behaviour tends to escalate when mentally ill individuals do not take their medication, do not receive treatment, refuse appropriate accommodation, or abuse substances (Borzecki & Wormith, 1985; Lamb & Weinberger, 1998).

The purpose of this study is to highlight the main themes and specific issues that arise for guardians throughout the decision-making process. The intention is to develop a theory based on the perceptions and observations of the guardians to potentially assist mental health, psychological, and legal professionals to be better equipped to support mentally ill and developmentally disabled offenders. Moreover, Steadman, Morris, and Dennis (1995) asserted that mentally ill individuals come in contact with the CJS as a result of "fragmented service systems, the nature of their illnesses, and the lack of social support and other resources" (p. 1634) which demonstrates the need to examine what role a statutory body could play in working with this population. Therefore, this study may shed some light onto options for mentally ill and developmentally disabled offenders as opposed to criminal convictions and incarceration. This could potentially help reduce recidivism rates among this population. In addition, this could bring awareness to the general population of the obstacles faced by this population whilst providing insight to guardians, counsellors, family members, police, and service providers into

the unique circumstances the lead mentally ill and developmentally disabled individuals to become involved with the CJS.

Posing the Research Questions

This research aims to explore the experiences of guardians of working mentally ill and developmentally disabled individuals. Thus, the primary research question is, "What is the decision-making process of guardians of adults, under the care of the Public Guardian, who are charged and proceed through the criminal justice system?" This will include the examination of the decisions required, how these decisions are made and implemented, and their actual or perceived outcomes.

The next chapter will review the literature to provide the conceptual framework for this study.

CHAPTER TWO: LITERATURE REVIEW

In this chapter, I will review the literature to articulate the conceptual framework for this study. First, I will describe the prevalence of mentally ill and developmentally disabled offenders imprisoned in western countries as well as the factors that contribute to their involvement with the CJS. Then, I will explore the "revolving door" of the CJS, and explore the factors leading to higher recidivism rates within this population. From there, I will explore the research on services for mentally ill and developmentally disabled offenders, including specialised courts, diversion programs, and community treatment. Finally, the role of a statutory official, such as the Public Guardian, will be introduced to demonstrate the need for further research on what role the Public Guardian could play to assist this population navigate through, and potentially avoid future involvement with, the CJS.

Criminalisation of the Mentally Ill

Mentally ill and developmentally disabled offenders are often arrested and prosecuted rather than taken to hospital or other psychiatric facilities to receive appropriate treatment and services for their mental illnesses (Lamb & Weinberger, 2006; Moore & Hiday, 2006). This is concerning because mentally ill and developmentally disabled offenders, whose illegal behaviour tends to be related to survival behaviour (Steadman, 1990), should be given appropriate support in the community to avoid criminal activity (Dvoskin & Steadman, 1994; Torrey & Zdanowicz, 1999; Lamb, 1994); diverted into appropriate mental health treatment services as opposed to incarceration (Rogers & Bagby, 1992); and provided assistance in the community once released to reduce the risk of further recidivism (Martell, Rosner, & Harmon, 1995; Moore & Hiday,

2006; Lamberti, Weisman, & Faden, 2004; Steadman, 1992).

Prevalence of Mentally Ill Offenders

Fazel and Danesh (2002) conducted a systematic review of over 62 studies completed from 1966 to 2001, which examined the prevalence of mental illnesses in general prison populations in western countries. This review included a total of 22,790 prisoners (18,530 men [81%] and 4269 women [19%], noting the prevalence of psychotic illnesses, major depression, and personality disorders. The authors found that 3.7% of the male prisoners were diagnosed with psychotic illnesses; of those diagnosed with psychotic illnesses, 10% were diagnosed with major depression and 65% were diagnosed with a personality disorder. Of the prisoners diagnosed with a personality disorder, 47% were diagnosed with antisocial personality disorder. Comparatively, 4% of the female prisoners were diagnosed with psychotic illnesses; of those, 12% were diagnosed with major depression and 42% were diagnosed with some type of personality disorder, with 21% having a diagnosis of antisocial personality disorder. Fazel and Danesh (2002) assert that, "the risks of having serious psychiatric disorders are substantially higher in prisoners than in the general population" (p. 548).

To examine the rates of mental illnesses within American prisons, Teplin (1990) interviewed 728 randomly selected male detainees at Cook County Jail, Illinois, using a standardised interview, the National Institute of Mental Health Diagnostic Interview Schedule (Robins, Helzer, Croughan, & Ratcliff, 1981). This study found that just over 6% of male offenders in prisons met the diagnostic criteria for mental illnesses, with the most common diagnoses being schizophrenia, mania, or major depression. The prevalence of serious mental

illnesses was four to eight times higher than the general population. Teplin, Abram, and McClelland (1996) interviewed 1272 randomly selected female arrestees awaiting trial at a county jail in Chicago, Illinois, using the Diagnostic Interview Schedule. They found that over 80% of the arrestees met diagnostic criteria for one or more lifetime psychiatric disorders, with drug and alcohol abuse or dependence, post-traumatic stress disorder, and major depressive episode being the most prevalent mental disorders. In addition, this study found that just over 2% of the women were manic, 1.8% had schizophrenia or a schizophreniform disorder, 15% had serious psychiatric disorders, and almost 14% had major depression. In 2006, Lamb and Weinberger reviewed the literature on the rates of mental illnesses within US prison populations since the 1970s. They found that an average of 10 to 15% of the prison population suffer from severe, acute, and chronic mental illness and have extensive experience with both the mental health and criminal justice systems (Lamb & Weinberger, 2006).

In 2009 it was estimated that more than one in 10 men and one in three women held in Canadian federal prisons had a diagnosable mental illness (Correctional Services Canada, 2009). Although most people with a mental illness do not come into contact with the CJS, psychosis, depression, anxiety, and substance-related disorders are over-represented in Canadian correctional facilities (Canadian Institute for Health Information, 2008). For example, Brink, Doherty, and Boer (2001), examined 267 new intakes in British Columbian federal penitentiaries and found 31.7% had a diagnosis of a mental disorder, with 12% meeting the criteria for a serious mood or psychotic disorder. Roesch (1995) used the Diagnostic Interview Schedule with 790 inmates detained for their third time in Vancouver jails and found that 5% of the detainees had schizophrenia, 10% had affective disorders, 7% had dysthymia, 41% had anxiety disorders,

64% were drug dependent, and 78% were alcohol dependent. In another Canadian study, Motiuk and Porporino (1991) also utilised the Diagnostic Interview Schedule on a stratified random sample of 2812 prisoners. Within this study, 3% of the population were found to be psychotic, 5% were diagnosed with depression, 13% had phobias, 18% had general anxiety, and 47% were dependent on alcohol.

In an Australian study conducted by Hermann, McGorry, Mills, and Singh (1991), 158 male and 31 female prisoners were randomly selected to complete the Structural Clinical Interview for DSM-III-R. They found that 3% of the prisoners were psychotic, 10% had depression, 2% had dysthymia, and 69% suffered from drug and/or alcohol abuse. In a more recent Australian study, Butler, Andrews, Allnutt et al. (2006) sought to examine the differences of psychiatric morbidity within prisoners compared to the community. Data were obtained from reception prisoners admitted into the correctional system in 2001 and from the 1997 Australian National Survey of Mental Health and Wellbeing. The Composite International Diagnostic Interview was used to determine mental health diagnoses. The researchers found that the prevalence of any psychiatric illness within the last 12 months was 80% in prisoners and 31% in the community, with the most common diagnoses being psychosis (11.8%), substance use disorders (11.4%), and personality disorders (8.6%).

Prevalence of Developmentally Disabled Offenders

In western correctional systems, individuals with developmental disabilities are over-represented in the CJS, but their involvement is not consistent and varies markedly from each individual, jurisdiction, and country (Owen & Griffiths, 2009). This over-representation is

highlighted by the significant variation in prevalence rates reported within western countries, which often ranges from 2% to upwards of 40% (Holland, 2004; Jones, 2007; Lindsay, Law, & Macleod, 2002; Noble & Conley, 1992). Interestingly, Day (1994) asserts that statistics may be an underestimate because the numbers do not take into consideration cases where an offender's disability may not be detected and when they are involved with agencies or services that prevent involvement with, or are a substitute to, the CJS. There is also considerable discretion over whether a person with a disability who engages in challenging and potentially criminal behaviours, is in fact reported to the police and subsequently charged (Holland, 2004). Regardless, research completed thus far has been at a disadvantage because there is no consensus on the diagnostic criteria for developmental disabilities and prevalence rates are, therefore, difficult to obtain (Holland, 2004; Lyall, Holland, & Collins, 1995). What is consistent within the research is that there appears to be an increased rate of offending behaviours amongst individuals with mild to borderline intellectual disabilities compared to the general population (Søndenaa, Rasmussen, Palmstierna & Nøttestad, 2008), with very few offenders having moderate to severe intellectual disabilities (Holland, Clare, & Mukhopadhyay, 2002). The offences committed by this population vary from crimes of misdemeanour to public nuisance, and crimes against the person to crimes against property (Baroff, 1996).

Like all individuals, some individuals with developmental disabilities will either knowingly or unknowingly commit crimes (Conley, Luckasson, & Bouthilet, 1992). There have been several hypotheses to explain why developmentally disabled individuals may become involved with the CJS. For example, Petersilia (2000) asserts that "most have a deep need to be accepted, and sometimes agree to help with criminal activities in order to gain friendship…[and]

are frequently used by other criminals to assist in law-breaking activities without understanding their involvement in a crime or its consequences" (p. 5). Further, individuals with developmental disabilities are more likely to be apprehended for crimes, confused by judicial proceedings (Owen & Griffiths, 2009). They are more likely to incriminate themselves, waive their rights, be led by the police interviewing them, and plead guilty due to an inability to completely comprehend the process (Glaser & Deane, 1999; Linhorst, Bennett, & McCutchen, 2002; Owen & Griffiths, 2009; Petersilia, 1997). Offenders with developmental disabilities are also less likely to be able to afford appropriate defence counsel or understand the need for legal representation, and, are therefore less likely to plea bargain, appeal judgements made against them, and understand the implications of their actions and statements (Glaser & Deane, 1999; Linhorst et al., 2002; Petersilia, 1997). However, Day (1994) argues that offending behaviours in this population is not as common as believed. Holland (2004) asserts that few individuals with developmental disabilities offend, but the few who do offend do so because their environment as well as their individual and social circumstances.

In 2002, the Prisoners' Health Coalition conducted a qualitative study with prisoners by sending out approximately 1600 questionnaires to adult inmates in Vermont and Virginia, where 190 responses were received (Smith, 2005). It was found that 26.3% had some kind of learning disability and 22.6% reported both learning and psychiatric disabilities (Smith, 2005). Comparatively, Taylor (1997), who completed a survey on incarcerated adults in a Maine county jail, found that almost 28% of prisoners reported they had learning disabilities. In a systematic review of ten relevant surveys, including a total of 11, 969 prisoners, Fazel, Xenitidis, and Powell (2008) found approximately 0.5% to 1.5% of prisoners were diagnosed with a

developmental disability, which is less than the reported 4% in American correctional systems in 1996 (Veneziano & Veneziano, 1996). In contrast, Noble and Conley (1992) conducted a review of epidemiological reports from several US states and found prevalence rates of developmental disabilities ranged from 0.5% to 19.1%. Interestingly, it is estimated that up to 11% of inmates held in maximum security in the USA have developmental disabilities (Everington & Fulero, 1999). This variation in prevalence rates for individuals identified and diagnosed with developmental disabilities within the CJS further demonstrates how data is dependent on the jurisdictions and countries, which was identified previously in this chapter (Owen & Griffiths, 2009).

Within Australia, prison is considered as a last resort for offenders with disabilities and only when there are no other appropriate alternatives or community-based programs have failed (Simpson, Joe, Rowan-Szal, & Greener, 1997). Disability rates within the Australian general population have been estimated to be approximately 1.85% (Wen, 1997). Hayes and McIlwain (1988) found 12.9% of NSW inmates were assessed either with an intellectual disability (2.5%) or within the borderline range (10.4%). Further studies within Western Australian (WA) prisons have estimated that 3.6% of inmates could be diagnosed with an intellectual disability (Hayes, 1991). In a longitudinal study in WA, Cockram and Underwood (2000) found no difference in arrest and charge rates between the disabled and general population. Finally, data from the NSW Department of Corrective Services (2002) indicates that the rate of recidivism among offenders with an intellectual disability compared to total inmate population was 68% to 38%, whereby the recidivism rate among offenders with an intellectual disability with no prior convictions was over twice as high compared to the total inmate population rate (60% to 25%) and with prior

convictions was 72% to 49%. Similar to the rates of developmental disabilities within the United States, the prevalence rates vary from jurisdictions and States within Australia, demonstrating the importance of having clear definitions and diagnostic criteria to determine if an offender do have a diagnosable developmental disability.

In a Canadian study, Raina and Lunsky (2010) compared 78 profiles of patients with developmental disabilities with and without involvement with the CJS, and found that the forensic sample was more likely to have a diagnosis of borderline to mild IQ. Hassan and Gordon (2003) reviewed the literature, estimating that the percentage of developmentally disabled offenders ranged from 2-36%; however, the range was attributed to the wide variations in how offenders were identified as developmentally disabled. Although these findings may be indicative of criminal justice involvement in this population, there is little research in Canada within this field (Raina & Lunsky, 2010), making it difficult to obtain a clear estimate of the prevalence of the developmentally disabled in the Canadian CJS. The consensus within the research is that health care professionals and social service providers tend to have higher tolerance, being overprotective and underreporting the delinquent behaviours of this particular population (Holland et al., 2002; Jones, 2007; Thompson & Brown, 1997). Thus, reported statistics likely underestimate the actual frequency of contact with the CJS (Jones, 2007).

Prevalence of Offenders with Dual Diagnoses

When an individual is referred to as having a dual diagnosis, this often includes individuals with mental illnesses and substance abuse disorders. However, for the purposes of this study, dual diagnosis will refer to individuals with developmental disabilities who also have

diagnosable mental health disorders. Within Canada, 12.5% of individuals in psychiatric hospitals have both a developmental disability and mental illness (Lunsky, Bradley, Durbin et al., 2006) and, according to the Canadian National Coalition on Dual Diagnosis (2012), many individuals with dual diagnoses often have more than one mental health problem. In an Australian study, Riches, Parmenter, Wiese, and Stancliffe (2006), found people with developmental disabilities were at considerably greater risk of having mental illnesses than the general population, whereby developmental disability "is, in itself, a risk factor for the development of both mental ill-health and behaviour disorder" (p. 387). Vanny, Levy, and Hayes (2008) also studied the prevalence rates of dual diagnoses in a sample of accused individuals appearing before four Magistrate's Courts within metropolitan and urban areas in NSW, Australia. Using the Kaufman Brief Intelligence Test – Second Edition (Kaufman & Kaufman, 2004), Vineland Adaptive Behaviours Scales – Second Edition (Sparrow, Cicchetti, & Balla, 2005), and the Psychiatric Assessment Schedules for Adults with Developmental Disabilities Checklist (Deb, Matthews, Holt, & Bouras, 2001), 10% of the participants were found to score below the mild intellectual disability range, with 20% scoring within the borderline range. The prevalence of mental illness within this group was 46%. These results demonstrate the need to consider the prevalence and impact of dual diagnoses on individuals encountering the CJS, along with the unique challenges faced by those individuals (Riches et al., 2006).

The Revolving Door of the Criminal Justice System

There are several explanations for the higher proportion of individuals with a mental illness or developmental disability in the CJS compared to the general population. These

explanations include daily living effects; societal impacts and public attitudes; lack of adequate support systems and accommodation in the community; inappropriate services offered in the community; the idea that all offenders should be treated and punished equally; and the possibility of not having a fair trial and defence because of a mental illness or disability (Lamb & Weinberger, 2006). Additionally, many offenders become involved with the CJS because of their own inability or unwillingness to access necessary mental health or primary care medical services (Steadman, 1992; Weisman, Lamberti, & Price, 2004).

Daily Living Effects

Lack of access to various social determinants of health has negative implications on individuals in general, let alone individuals diagnosed with a mental illness or developmental disability. Often, it is the lack of access to these services and supports that causes an individual to turn to crime or inadvertently become involved with the CJS. Lindsay, Smith, Law et al., (2002) believe that the increasing demands associated with community living, along with this population's vulnerabilities, poor coping strategies, and limited independence is why they become involved with the CJS. Another explanation is that criminal behaviours within individuals with mental illnesses or developmental disabilities often are more a cry for help or are survival behaviour as opposed to having malicious intent (Steadman, 1990). As a result, the effects of deinstitutionalisation, homelessness, poverty, and substance abuse have all had detrimental impact on individuals with mental illnesses and developmental disabilities, which could contribute to some individuals becoming involved with the CJS.

History and Asylums. In the United States, asylums for individuals with severe mental

illnesses were first opened in the 1830's; however, they became prevalent after Dr Kirkbride (1854) asserted that such institutions were a duty of the country and a matter of humanity. In fact, Kirkbride (1854) argued that these asylums were necessary not only for the protection of the insane, but also to protect their families and members of the community from their morally irresponsible and dangerous behaviours. Thus, these institutions took members of society who were deemed insane into custody and offered "enlightened treatment" without keeping the patients confined in jails or poorhouses (Foucault, 1990). In addition, placing individuals in the asylums was supported by Isaac Ray (1863), the founder of the American Psychiatric Association, as he felt isolation and segregation was in their best interest as well as in the best interest of the larger society around them. As a result, asylums became prevalent throughout the United States, Europe, Canada, Australia, and many other countries in the nineteenth century to control a disruptive population whilst offering, what was believed to be, moral treatment in a humanitarian way (Foucault, 1990).

In the twentieth century, asylums lost favour among professionals and the public alike, with many considering these institutions as simply a place to isolate and segregate the mentally ill and developmentally disabled, where the person's right to liberty was denied (Johnson 1998). McCandless (1996, p. 622) argued that these institutions and the popular orthodox psychiatry used within them were repressive and that "mental illness [was used] as a social construct designed to justify the incarceration and control of individuals whose behavior was socially disruptive, economically unproductive, politically deviant, or morally objectionable." As a result, the deinstitutionalisation movement began in the 1950's and 1960's with a strong push for community based care as the alternative (Bachrack, 1983).

Deinstitutionalisation. Deinstitutionalisation is the term given to the policy of moving severely mentally ill individuals out of large institutions and closing part or all of those institutions (Torrey, 1997). This movement was a product of "overcrowding and deterioration of hospitals; new medications that significantly improved the symptoms of about half of patients; and a failure to understand that many of the sickest patients were not able to make informed decisions about their own need for medication" (Torrey, Kennard, Eslinger, Lamb, & Pavle, 2010, p. 2). At this time, deinstitutionalisation aligned with a shift in psychiatric approaches to mental illnesses and gained in popularity when the cost of the mental hospitals was compared to the alternatives; professional literature clearly documented the detrimental effects on the patients; and court decisions began to mandate the least restrictive setting, which was community based treatment and not hospitalisation (Torrey, 1997; Shadish, Doherty, & Montgomery, 1989). Although this movement focussed on providing more humane treatment to mentally ill patients and focussed on community treatment and integration, there were also negative side effects, due to insufficient planning, funding, and lack of community supports (Bachrack, 1989), which was referred to as the "mental illness crisis" (Torrey, 1997). Torrey (1997) argues that deinstitutionalisation contributed to the mental illness crisis because people with severe mental illnesses, disabilities, and comorbid disorders were discharged into the community without ensuring they received the appropriate medication and rehabilitation services required to live in the community successfully.

Markowitz (2006) argued that "psychiatric deinstitutionalisation has led to an increased presence of persons with mental illness in urban areas, many "falling through the cracks" of community-based services… contribut[ing] to homelessness, crime, and arrests" (p. 45).

Between 1971 and 1996, deinstitutionalisation in the United States was found to be directly responsible for 4.5 to 14% of the total prison population (Raphael, 2000). In fact, Abramson (1972), studying the rate of mental illness in the San Mateo County (California) jail after deinstitutionalisation, found that there was a 36% increase in mentally ill prisoners in jail and 100% increase in mentally ill individuals deemed unfit to stand trial. Whitmer (1980) also conducted a study of 500 mentally ill people who had been charged with crimes and found that at the time of their arrests only 6% were involved in a treatment program. He concluded that the reforms brought about by deinstitutionalisation forced a large number of those patients into the CJS. Finally, Belcher (1988) studied the effects of deinstitutionalisation by following 132 patients discharged from Columbus State Hospital in Ohio 1, 3, and 6 months post-discharge. Sixty-five participants had been diagnosed with schizophrenia, manic-depressive illness, or severe depression; among them, 32% (n = 21) had been arrested and jailed. Interestingly, all 21 of those individuals also became homeless during the 6-month follow-up period.

Homelessness. Lamb and Grant (1982) were among the first to research the direct link between homelessness and crime. They found that more than half of inmates in a county jail charged with misdemeanours had been living on the streets, on the beach, in missions, in homeless shelters, or in cheap hotels. Most of the current literature available identifies the relationship between homelessness and mental illnesses with crime is strongly correlated. Research indicates that mentally ill offenders who were homeless at the time of their alleged crime(s) tend to be overrepresented among the defendants entering the criminal justice and mental health systems (Martell, Rosner, & Harmon, 1994). However, researching the direct link between homelessness, mental illnesses, and crime is difficult because of the transient nature of

homeless individuals (Canadian Alliance on Mental Illness and Mental Health, 2014).

Zapf (1995) found that, in a Vancouver pre-trial facility, formerly homeless individuals were significantly more likely to have a juvenile criminal history (64%) and adult criminal record (93%) compared to individuals who were not homeless (50% and 82% respectively). Zapf, Roesch, and Hart (1996) found that, of 790 men admitted to the same Vancouver pre-trial centre over a 12 month period, almost 8% of the offenders had been homeless at least 6 months prior to their arrest and 36% of the homeless people detained had a severe mental illness. Zapf et al. (1996), also studied inmates in a New York City pre-trial facility and found that 21% of inmates were homeless the night prior to their arrest, whilst 40% had been homeless at some point in the three years leading up to their arrest. Seventy-seven percent of homeless individuals in Calgary had been jailed at some point in their lives (Calgary Homeless Foundation, 2002), whereas in Toronto, in a sample of 300 homeless individuals 73% of men and 27% of women had been arrested since the age of 18 and 49% of men and 12% of women had been incarcerated at least once (Mental Health Policy Research Group, 1997). Kellough and Wortley (2002) examined over 1800 hearings in Toronto and found that offenders with no fixed address at the time of their hearing are more likely to be denied bail. These individuals were held in custody because of concerns that they would not appear in court or maintain the necessary contact with their lawyers or probation officers (Eberle, Kraus, Pomeroy, & Hulchanski, 2001). As a result, these individuals are often detained in remand centres throughout Canada, Australia, and the United States.

Hewitt (1994) and Fischer (1992a) offer some explanations for why homeless individuals may be predisposed to crime, are detained longer, and are more likely to be denied bail. First,

criminal activity, such as petty theft, shoplifting, small scale drug dealing, and prostitution, may be the only way to survive, especially for individuals unable or unwilling to access social services or public support programs. Second, some offenders may be habitual offenders who also have chronic deviant behaviours, antisocial personalities, or addictions (Fischer, 1992b). Third, police may arrest certain individuals who manipulate the system into temporary refuge within jails and, finally, there are the individuals who display inappropriate or bizarre behaviours often associated with mental illnesses (Fischer, 1992c).

When mentally ill or disabled offenders are released, they also face many more obstacles, which can often lead to increases in recidivism rates. Zapf et al. (1996) found that mentally ill offenders who were homeless prior to their arrest faced homelessness once again upon release from custody. This is often due to a number of factors, such as refusing to participate in discharge planning, reduced availability of health and social services, and a lack of affordable housing (Riordan & Dewing, 2004). In addition, housing providers are often reluctant to serve high risk individuals, a significant barrier to obtaining existing community housing, thus leading to a return to criminal activity (Lamberti &Weisman, 2004). Similarly, Metraux and Culhane's (2004) analysis of administrative data from both prisons and homeless shelters in New York City found that individuals who were homeless before incarceration were five times more likely to be homeless once released from custody compared to those individuals who were not homeless prior to incarceration. This demonstrates the need for appropriate housing when an individual, irrespective of mental illness or disability, is released from prison or jail, simply to help avoid the revolving door of the CJS.

Another problem for mentally ill and disabled offenders is that incarceration increases the

risk of becoming homeless whilst incarcerated or once released from custody. Often, if an individual is held on remand, it is not possible to continue working or remain engaged with social and disability services. This makes it difficult to maintain paying rent, mortgage payments, and various other bills, thus placing the stability of their housing in jeopardy (Metraux & Culhane, 2004). There are also few services available that assist inmates in retaining their accommodation while incarcerated (Fischer, 1992b). Therefore, any housing that may be available to mentally ill and developmentally disabled offenders is seriously jeopardised when they are incarcerated.

Poverty. The link between poverty and mental illness was first established in a landmark study conducted in New Haven, Connecticut by Hollingshead and Redlich (1958). Using the Index of Social Position (Hollingshead, 1957), they concluded that there was a significant relationship between social class and mental illness. Moreover, the authors found that individuals below the poverty line had the highest incidence of mental illness but yet received the least adequate forms of treatment. Poverty rates in the USA continued to rise in the early 1960's, which coincided with the closure of large state hospitals and institutions (Smith, 1987). In more recent studies examining the link between poverty and mental illness, the social causation hypothesis was confirmed by Hudson's (2005) longitudinal study conducted in Massachusetts between 1994 and 2000. This study examined 34,000 individuals who were considered poor and had been admitted at some point into an acute psychiatric institution. Their employment status and place of residence throughout the course of the study was tracked and Hudson (2005) found that increased economic hardship across a community resulted in increased rates of mental illness and psychiatric hospitalisations within that community compared to

individuals who were not considered poor and had not been admitted to an acute psychiatric institution. This study further highlighted that 79% of the subjects showed no change in their employment status, 14% became employed, and 6% lost their jobs. Based on these findings, Hudson (2005) concluded that there is a strong and consistent negative correlation between socio-economic conditions and mental illness, which cannot be accounted for by geographic or economic downward mobility.

In Canada, poverty is determined by using Statistics Canada's Low Income Cut-Offs (LICO), which varies depending on family and settlement size. Thus, people are considered poor if they spend more than 56.2% of their gross income on necessities such as food, clothing, and shelter (Wilton, 2004). Wilton (2004) asserts that almost 27% of Canadian adults with mental illnesses live in poverty, compared to 12.6% of non-disabled individuals. This further heightens this population's risk of not being able to access the basics in life, such as shelter, jobs, treatment, and community supports. Furthermore, the Federal, Provincial and Territorial Advisory Committee on Population Health (1999) found that poverty has negative implications on an individual's physical and mental health, as well as on other variables such as safety, housing, and social networks.

Poverty does not necessarily beget criminal activity; however, poverty can have a negative effect on people's quality of life. This includes the opportunities available to them, along with their ability to access health care, proper legal representation, and to participate fully in society in general (Wilton, 2004). Poverty can also be transitional in the sense that an individual can be above the poverty line and then experience a chronic illness, such as a mental illness or traumatic brain injury, causing him or her to fall below the poverty line (Steadman,

1990). Poverty can also lead to individuals committing crimes, simply as a way to survive. If an individual requires food to survive, he or she will likely commit petty crimes, such as theft, to access the necessary food or to obtain a means to get the food (Steadman, 1990). Finally, if an individual has a disability or is suffering from a mental illness, he or she may not have the ability or support to work and will find themselves below the poverty line (Zapf et al., 1996). These individuals may not have the capacity to seek the help needed to avoid living in poverty or may be unable or unwilling to access the support services to help maintain living above the poverty line (Hudson, 2005).

Substance abuse. Substance abuse can increase the risk of violent behaviour, especially when in combination of severe mental illnesses (Applebaum, 1994). Jones (2009) asserts that drug prohibition, which has been adopted by many governments in western countries, has transformed a public health issue into a criminal justice issue, filling "prisons with people who need medical attention, psychiatric care and substance abuse treatment" (p. 2). Substance abuse is also often related to an underlying mental illness, brain damage, developmental disability, or untreated trauma whereby these individuals will self-medicate with substances that exacerbate their underlying disorders (Jones, 2009; Kessler, Crum, Warner, Nelson, Schulenberg, & Anthony, 1997). A review of recent epidemiological research on the age-of-onset of mental disorders found that there is a temporal sequence between mental illness and substance abuse, whereby a mental illness or disability almost always precedes the onset of substance abuse by approximately ten years (Kessler, Amminger, Aquilar-Gaxiola, Alonso, Lee, & Ustun, 2007).

Within Canada, about 80% of offenders have substance abuse problems; with 12% having a concurrent mental health diagnosis (Head, 2006). The link between offenders'

psychological state and abuse of substances has led to a number of studies that examine the effects of drugs and alcohol on individuals diagnosed with mental illnesses and developmental disabilities. For example, the MacArthur Violence Risk Assessment Study (Steadman, Mulvey, & Monahan, et al., 1998) assessed the rates of violence and violent criminal acts among individuals diagnosed with a psychiatric disorder and substance abuse. Using a stratified random sample of 1136 male and female patients discharged from mental health and acute inpatient facilities in Pittsburgh, Pennsylvania, Kansas City, Missouri, and Worcester, Massachusetts, it was found that people diagnosed with a major mental disorder but did not abuse substances were involved in significantly less community violence incidents than participants with comorbid disorders (Steadman et al., 1998). Additionally, 31% of people who had a dual diagnosis of substance abuse and a psychiatric disorder committed at least one act of violence in a year, whereas 18% of the participants with a psychiatric disorder alone committed an act of violence.

Fazel, Långström, Hjern, Grann, and Lichtenstein (2009) conducted a longitudinal study that investigated the risk of violence in over 8000 individuals diagnosed with schizophrenia. For this study, and within other literature examined, violent crime is frequently defined as "homicide, assault, robbery, arson, any sexual offense (rape, sexual coercion, child molestation, indecent exposure, or sexual harassment), illegal threats, or intimidation" (Fazel & Grann, 2006, p. 1398). Fazel et al. (2009) found the rate of violent crimes in individuals diagnosed with schizophrenia and substance abuse was significantly higher (27.6%) than those without comorbidity (8.5%). Also, 10.1% of patients with schizophrenia without concurrent substance abuse had at least one violent offense compared to 28.9% of patients with substance abuse comorbidity. Based on these findings, the authors concluded that the association between schizophrenia and violent

crime is minimal unless the patient is also diagnosed with a substance abuse disorder.

In another study examining the relationship between substance abuse and mental illnesses, Katz (2003) analysed four data sets from the Bureau of Justice Statistics and the Mental Health Services Administration to examine 7,623 individuals who were homeless, mentally ill, had a substance abuse problem, and a criminal history. Individuals with mental illnesses and who abused substances were three times more likely to be charged with vagrancy, twice as likely to be convicted of loitering, and had higher incidence of public drunkenness, disorderly conduct, and minor traffic offenses compared to individuals who were not mentally ill and did not abuse substances. Of these individuals, 53.6% were more likely to be incarcerated for these offences, compared to 47.1% of the individuals not diagnosed with a mental illness or substance abuse. This study also found that mentally ill individuals with a substance abuse disorder were more likely to be charged with fraud (19.1% compared to 9.1%), robbery (8.3% compared to 4.6%), physical assault (26.9% compared to 14%), drug trafficking (7.6% compared to 5.4%), drug possession (29.5% compared to 20.1%) and public order offenses, such as prostitution (23.7% compared to 10.2%).

It is possible that substance abuse can trigger violence in individuals with or without mental illnesses or developmental disabilities as these substances can impair judgment, change a person's emotional equilibrium, and remove cognitive inhibitions (Applebaum, Robbins, & Monahan, 2000). However, substance abuse in people with psychiatric disorders can exacerbate some symptoms, such as paranoia, grandiosity, and hostility (Applebaum et al., 2000). The research to date has demonstrated the link between substance abuse, mental illnesses, and criminal justice involvement; however, the major issue still surrounds how to effectively assist

this population without further exacerbating their addictions, mental illnesses, or criminal justice involvement.

Societal Impacts

Society has limited tolerance for the deviant behaviour of people with mental illnesses within the community (Lamb, 1994). The idea that individuals with developmental disabilities and mental illnesses are predisposed to criminal activity has also had significant impact on the way society treats individuals with disabilities who encounter the CJS (Hassan & Gordon, 2003). For example, local businesses will put pressure on law enforcement to have "undesirables" such as mentally ill, homeless, or disabled individuals removed from their place of business, which is especially the case in popular tourist locations (Wolff, 1998). As a result, the role society, the media, and police play when they encounter individuals with mental illnesses and developmental disabilities involved with the CJS will be examined.

Societal views. Society has limited tolerance for mentally ill individuals exhibiting deviant behaviour, which is particularly true for "those who have direct contact with mentally ill persons, namely the courts, families, and other citizens" (Lamb & Weinberger, 1998, p. 488). This intolerance is further heightened by a demonstrated relationship between mental illness and violence, especially when violent behaviour tends to escalate when mentally ill individuals do not take their medication or receive treatment (Lamb & Weinberger, 2005). This escalation in criminal behaviour could also be attributed to how these individuals may refuse referral to treatment; may not keep appointments; may not be compliant with psychoactive medications; may not abstain from substance abuse; and may refuse appropriate accommodation (Borzecki &

Wormith, 1985; Lamb & Weinberger, 1998). Unfortunately, all of these attributes are often observable or stereotyped by members of society and subsequently generalised to all individuals with mental illnesses or developmental disabilities (Lamb & Weinberger, 1998). Limited tolerance within society has led to a pervasive public perception that focuses on the dangerousness of mentally ill and disabled individuals, which is a key factor in further stigmatising this population (Fazel et al., 2009; Wolff, 1998). As a result, some western governments have introduced specific laws for these offenders to primarily focus on the assessment of dangerousness and determine potential risk to public safety, thus prioritising public protection (Fazel et al., 2009). As a response to these laws, along with the general fear within society of individuals with mental illnesses and developmental disabilities, the World Health Organisation lodged an international campaign in 2001 to draw awareness to the importance of understanding, as opposed to fearing these individuals (Satcher, 2001). This is important because society frequently criminalises mental illness, developmental disabilities, and homelessness (Katz, 2003).

Media influence. The public perception of mentally ill and developmentally disabled individuals is continually reaffirmed by the selective reporting of mass media on high profile cases (Scheff, 1966). Within media coverage, it is common practice to refer to a perpetrator's history of mental illness or previous psychiatric treatment. As a result, a large majority of people within any western culture will admit that they get most of their knowledge about mental illnesses and developmental disabilities from mass media sources, such as television, radio, films, and newspapers (Angermeyer & Matschinger, 1996). Either hearing or seeing troubling depictions of mental illnesses often contributes to the negative stereotypes held by members of

society. This is supported in a nationwide survey of over 1300 participants, Wahl (2003) found that 77% of media consumers had sometimes, often, or very often seen hurtful or offensive depictions of mental illnesses, where 43% had seen these depictions often or very often. This research further demonstrates that mass media often treats individuals with mental illnesses or disabilities as objects of ridicule; frequently uses psychiatric terminology incorrectly or out of context; overuses slang and disrespectful terms for diagnoses; and depicts these individuals as fundamentally different, whereby they are portrayed as violent, criminal, and dangerous.

Police involvement. Many researchers have investigated how police contact impacts individuals with mental illnesses and developmental disabilities. According to Lamb and Weinberger (2006), there is a perception within law enforcement that deviant behaviour can be managed effectively and efficiently through the CJS as opposed to the mental health system, with all offenders being treated equally (Steadman, 1992). It is also common practice for police to refer mentally ill offenders to the CJS because they think the offenders will be dealt with more systematically than if they took them to a hospital emergency room, due to the misperception that these individuals will be seen by a mental health professional within the local jail or court, leading to faster psychiatric evaluation and treatment, as opposed to remaining in the community (Holley & Arboleda-Florez, 1988). Finally, mentally ill or developmentally disabled individuals may also be jailed because it can expedite their referral into psychiatric facilities since priority for admission into hospitals is frequently given to individuals with criminal charges against them (Torrey, 1995).

Police may be more inclined to take mentally ill offenders to jail if they believe no appropriate community alternatives are available, which is often known as “mercy bookings”.

Disorderly conduct charges, such as public urination, being too loud, or property damage, are often used by police to arrest a mentally ill person when no other charge is available (Holley & Arboleda-Florez, 1988). Trespassing is also another charge commonly used by police to remove mentally ill or developmentally disabled persons from the street or community. Often these types of charges and bookings may be the only way police can protect vulnerable adults, especially women and disabled, who are easily victimised on the streets (Torrey, 1995). In addition, charges end up being laid against these individuals because they may be unwilling or unable to go to local shelters, family members may not want to take them or they may not have any family, hospitals may not accept them, and police cannot force an individual to take medications (Steadman, 1992). As a result, police will resort to pressing charges simply to protect the individual and surrounding community. It is also common to find mentally ill or developmentally disabled individuals seeking mercy bookings simply to secure a safe place to stay and regular meals for a short period of time (Torrey, 1995).

Individuals with disabilities and mental illnesses tend to be overwhelmed by police presence. As a result, many problems arise which can lead to further convictions often associated with the police misunderstanding an individual's disabilities or limitations. These problems include: not wanting their disability or mental illness to be recognised; not understanding their rights, basic commands, or requests; acting upset when being detained; running away; saying what they believe the police or others want them to say; having difficulty describing facts or details of the offence; being the first to leave a crime scene and the first to get caught; and being confused about who is responsible for an offence and subsequently confessing when they are in fact innocent (Dagher-Margosian, 2006). This raises concerns regarding how

individuals encountering the CJS are being treated and managed, especially if they have an unrecognised or undiagnosed mental illness or developmental disability. Further, it is not clear whose role it is within the criminal justice and mental health systems to recognise when an individual potentially has a physical or psychological disability, often leaving these individuals and their families to try to navigate the CJS on their own (Dagher-Margosian, 2006).

Services Available to Mentally Ill and Developmentally Disabled Offenders

The assertion that mentally ill and developmentally disabled offenders become involved with the CJS because of their own difficulty in gaining access to mental health services or primary care medical services is supported throughout research on the criminalisation of the mentally ill (Steadman, 1992; Weisman et al., 2004). Professionals generally believe that mentally ill and developmentally disabled offenders should be diverted into appropriate mental health treatment services as opposed to going through the CJS (Lamb & Grant, 1982; Martell et al., 1995). In addition, many of these individuals are often arrested for minor offences, which are due to manifestations of their illness or disability, lack of treatment available, and the lack of structure in their lives (Lamb & Weinberger, 2005). Should a disabled or mentally ill offender become involved with the CJS, advocacy may be necessary to seek alternative solutions as opposed to incarceration, thus, reducing the ongoing and revolving door of the CJS. This indicates the need to explore what alternative services are available to better assist this population if and when they do encounter the CJS. Therefore, community based treatment services and approaches to treating mentally ill and developmentally disabled offenders will be explored.

The Importance of Community Based Treatment Services

Steadman, Morris, and Dennis (1995) found that, even though some individuals with mental illnesses need to be in the custody of the CJS due to the seriousness of their offence, many mentally ill offenders could be diverted to community-based mental health programs. Professionals working with this population also assert that individuals who become involved with the CJS might not have done so had they been receiving adequate and appropriate mental health support and treatment (Dvoskin & Steadman, 1994; Lamb & Weinberger, 1998). For example, Torrey and Zdanowicz (1999) asserted that, on average, one thousand homicides in the US, or approximately 5%, are committed each year by untreated mentally ill individuals. This finding highlights the need to develop appropriate mental health support and treatment within the community, which would either prevent initial contact with the CJS or may assist in preventing future recidivism.

Approaches to Treating Mentally Ill Offenders

Preventative commitment approaches are used to try to prevent involvement with the CJS in the first place by focusing on mentally ill or developmentally disabled individuals who are the "revolving door" offenders (Moore, 1995). Unfortunately, many of these individuals are not compliant with their medications and do not receive community support and treatment so they are, subsequently, not placed into or referred to programs that do offer preventative commitment. Moreover, many chronically ill individuals become trans-institutionalised into nursing homes, prisons, or jails (Hinds, 1990). The programs that are already in place to prevent involvement with the CJS for these individuals will be examined.

Diversion Programs. Diversion programs are community-based programs and treatments designed to break an offender's continued cycle through the criminal justice, mental health, and substance abuse treatment systems. The intention is to reduce the number of individuals with mental illnesses or disabilities within jails and prisons (Steadman, Deane, Morrissey, Westcott, Salasin, & Shapiro, 1999). These programs have been around for nearly 30 years and came about because these particular "individuals come in contact with the criminal justice system as a result of fragmented service systems, the nature of their illnesses, and the lack of social support and other resources" (Steadman et al., 1995, p. 1634). Diversion programs have offered ways to prevent individuals with mental illnesses, substance abuse disorders, and developmental disabilities from unnecessarily entering the CJS (Steadman et al, 1999). To do so, these programs screen arrestees and detainees for the presence of a mental illness or disability, use mental health professionals to evaluate those detainees, and then negotiate with prosecutors, defence attorneys, and community-based services to determine mental health dispositions as a condition of bond as opposed to criminal convictions (Steadman et al., 1995; Steadman et al., 1999). Based on the dispositions, the offenders will be linked to the appropriate and available services within their community (Steadman et al., 1995).

Steadman et al. (1995) examined the number and kinds of diversion programs currently existing, how they were set up, and what programs were effective. A national mail survey was sent out to all US jails with 50 or more detainees, followed by telephone interviews and site visits. Of the 685 responses received, 34% of the respondents initially reported that their institution had a formal diversion program for mentally ill offenders. However, in the follow-up telephone survey, only 18% of the jails were identified to actually have diversion programs.

After the site visits, it was determined that only about 50 to 55 diversion programs existed nationwide (Steadman et al., 1995).

According to Steadman et al. (1995/1999), there are a number of factors that contribute to the effectiveness of diversion programs. First, there is early identification of offenders with mental health treatment needs and all relevant and available services are involved in the program development from the start. Regular meetings are held by the integrated services within the criminal justice and mental health systems, where a high level of cooperation and communication among the professionals involved is imperative. Second, there is direct management of the interactions between correctional, mental health, and judicial staff, where one identified individual is responsible for liaison between the systems involved. This includes the necessity for strong leadership with clear understanding of all the roles each system involved with the offender has. Finally, distinctive and non-traditional case management services are utilised. It was concluded that the "program effectiveness depended on building new system linkages, viewing detainees as citizens, and holding the community responsible for the full array of services needed by the detainees" (Steadman et al., 1999, p. 1621).

Assertive Community Treatment. Assertive community treatment programs are an emerging model for preventing arrest and incarceration of individuals with mental illnesses who have criminal justice histories (Lamberti et al., 2004). This approach engages high-risk individuals by offering comprehensive services that include mental health and addiction treatment, transportation, accommodation, financial services, and vocational support (Lamberti et al., 2004), mobile and around the clock. One such program is Project Link, which was developed by the University of Rochester, Department of Psychiatry and was designed to

integrate criminal justice, healthcare, and community support services for individuals with mental illnesses who are involved with the CJS or to prevent further recidivism among mentally ill offenders (Weisman et al., 2004). The intent of this approach is to have services, such as appropriate residential services, social services funding, and linkage with medical providers available prior to the release. Weisman et al. (2004) asserted that multiple points of contact promote the integration of clinical, criminal justice, and social services, while ensuring that participants receive access to treatment, culturally competent staff, and close coordination with the CJS.

To determine the effectiveness of Project Link, the first 60 patients enrolled in the program were examined. The largest source of referrals was from the local county jail, followed by state psychiatric hospitals (Weisman et al., 2004). The authors found that 80% of the individuals referred were male with an average age of 37 years. All of the individuals referred met diagnosable criteria from the *Diagnostic and Statistical Manual for Mental Disorders* (5th ed.; *DSM–5*; American Psychiatric Association, 2013). From clinical interviews conducted and collection of data from medical and criminal justice records, 32% of the participants admitted to the program were on parole, 15% were on probation, and 13% had charges pending. Additionally, over 60% of the participants reported prior felony convictions, representing both violent and non-violent crimes (Weisman et al., 2004). In addition, one year prior to enrolment in Project Link, the participants were incarcerated in jail an average of 103 days and were admitted to hospital an average of 114 days. However, during the first year of enrolment in the program, the authors found that service utilisation of jails and hospitals decreased significantly to a mean of 45 jail days and almost 8 hospital days. Significant reductions were also noted in the

mean number of arrests, along with the average number of incarcerations and hospitalisations (Weisman et al., 2004). Unfortunately, assertive community treatment may not be effective for persons with personality disorders (Weisbrod, 1983), which necessitates the need to further research the effectiveness of these programs for a variety of offenders suffering from a number of different mental illnesses.

Forensic Assertive Community Treatment. Like Project Link, Forensic Assertive Community Treatment (FACT) is a service offered through community based programs in an attempt to prevent arrest and incarceration of adults with mental illnesses. It is an adaptation of the Assertive Community Treatment model which is designed to engage mentally ill adults in outpatient psychiatric treatment by using assertive outreach and comprehensive services (Lamberti et al., 2004). FACT has legal leverage in the form of judicial monitoring, which includes comprehensive, high intensity, and mobile psychiatric treatment. The program requires: clients to have a history of involvement with the CJS; a criminal justice agency as the primary source of referral; and close partnership with a criminal justice agency to perform jail diversion (Lamberti et al., 2004).

To examine the effectiveness of FACT, Lamberti et al. (2004) conducted a two-phase survey of members of a non-profit organisation that supervised the planning and delivery of FACT services. A Web-based survey was emailed out and followed up with a phone survey with the members and supervisors of the programs who offer FACT services. It was found that the mean level of enrolment in these programs was 53 clients with a maximum capacity that averaged 63 clients. Of the referred clients, 69% were men and a majority of the diagnoses were schizophrenia or schizoaffective disorder (56%) and bipolar disorder (21%). 89% of the clients

had co-occurring substance use disorders, 52% were homeless, and 55% were on probation at the time of enrolment into the program. The authors found that 42% of the clients had previous felony convictions and 37% had histories of committing violent crimes. Reductions were noted in the number of arrests and hospitalisations, along with improved community functioning, which was measured by the Multnomah Community Ability Scale (Barker, Barron, McFarland, & Bigelow, 1994; Barker, Barron, McFarland, Bigelow, & Carnahan, 1994).

Minimal Effect of Current Programs

Although assertive community treatment programs have demonstrated success in reducing hospitalisations and encouraging community tenure, they have had minimal effect on rates of arrest and incarceration (Mueser, Bond, Drake, & Resnick, 1998). In effective assertive community treatment programs, Lamberti et al. (2004) recommended development and incorporation of a residential treatment component; however, this is not currently offered within any of these programs. This places the clients at risk of not having appropriate accommodation, which could lead to further criminal behaviours (Borzecki & Wormith, 1985; Steadman, 1990). The reluctance of housing providers to serve high risk individuals could be a significant barrier to obtaining existing community housing, which could lead to a return to criminal actions (Lamberti et al., 2004).

Role of a Statutory Official to Assist Offenders

Individuals with mental illnesses and developmental disabilities can be a particularly vulnerable population, especially when they come into contact with the CJS. Often, the onus is placed on an individual's legal defence to determine their state of mind when they committed a

crime or when facing court proceedings; however, mental illnesses or disabilities tend to go unnoticed or the offender hides their disability or illness (Dagher-Margosian, 2005). This population also faces many disadvantages in the CJS, as they frequently do not understand their rights, can be overwhelmed by police involvement, may say what they think others want to hear, and may be confused about who is responsible for the crime or confused by the entire investigation process (Dagher-Margosian, 2005). When an individual does encounter the CJS with a mental illness and/or a disability, trying to determine who is responsible for protecting this person's interests when they become involved in a police interrogation; who to obtain instructions from; who will advocate for support and services for this individual; and who will decide if it is necessary for the person to testify within court or even go through the court process become a priority (Ierace, 1987). At this time, there is no specific individual or organisation to take on this responsibility other than lawyers.

The Public Guardian

The Public Guardian is appointed by court order to make decisions for individuals who have been deemed to lack the capacity to make major life decisions due to a mental disability (developmental disability or chronic mental illness), an acquired brain injury, or dementia only if there is no other individual willing, able, and suitable to act as that individual's guardian (Government of Alberta, 2014; NSW DJAG, 2014). For the purposes of this literature review, the role of the Public Guardian was examined in Ontario and Alberta, Canada, as well as in New South Wales, Australia.

The Public Guardian in Canada. In Ontario, the role of the Public Guardian and Trustee is to safeguard the legal, personal, and financial interests of individuals who have been deemed "mentally incapable" (Government of Ontario, 2014). A person is found mentally incapable under the *Substitute Decisions Act* (1992) when he/she are not able to understand the information that is relevant to making decisions or to appreciate the reasonably foreseeable consequences of a decision or lack of decision concerning his or her own health care, medical and dental care needs, hygiene, nutrition, accommodation, clothing, and safety (Government of Ontario, 2014). In order for the Public Guardian and Trustee to be appointed, a person's incapacity must be determined by a formal assessment that is conducted by a recognised professional Capacity Assessor, including licensed Physicians, Psychologists, Registered Nurses, Occupational Therapists, and/or Social Workers (Government of Ontario, 2014).

In Alberta, the Office of the Public Guardian is responsible for addressing the current needs of vulnerable adults by providing options and safeguards to protect them; to provide assistance to adults who are no longer able to make all of their own decisions; and to provide a range of decision-making options, such as less intrusive options like supported decision-making or co-decision-making (Government of Alberta, 2014). The Public Guardian is legally appointed under the *Adult Guardianship and Trusteeship* Act (2010) and is responsible for making decisions for individuals determined to lack capacity based on the *Personal Directives Act (2000)*, the *Adult Guardianship and Trusteeship Act* (2010), and the *Mental Health Act (2000).* Accordingly, the Public Guardian has authority to make decisions regarding the adult's health care; where, with whom, and under what conditions the adult is to live both temporarily and permanently; with whom the adult may associate; the adult's participation in social activities,

education, vocational, or other training; the adult's employment; the carrying of any legal proceeding that does not relate to financial matters; and other personal matters the Court considers necessary (Government of Alberta, 2014).

The Public Guardian in Australia. In New South Wales (NSW), the Public Guardian is a legally appointed substitute decision-maker for people who do not have the capacity to make their own major life decisions. The Public Guardian is a statutory official, meaning that legislation empowers the Public Guardian to have power or authority that is derived from the *NSW Guardianship Act* (1987) in order to make a variety of decisions on a person's behalf (NSW DJAG, 2014). The Public Guardian is appointed by the Guardianship Tribunal after a hearing is held to determine whether a person has a disability and if there is no other person suitable or capable of being the person's guardian (Creyke, 1991; NSW DJAG, 2014*).* Like the Public Guardian in Canada, the NSW Public Guardian is responsible for making decisions for people who have a disability, such as dementia, brain injury, intellectual disability, or mental illness (NSW DJAG, 2014). The NSW Public Guardian operates with the belief system that people with impaired decision-making abilities are included and accepted as valued members of their society which coincides with the values of the *NSW Disability Services Act* (1993). To do so, the Public Guardian ensures that the human rights of individuals appointed are recognised and, when decision-making is required, it is in accordance with the principles of the *NSW Guardianship Act* (1987). The main roles of the Public Guardian are to make health and welfare decisions on behalf of a person under guardianship; to provide or withhold consent to medical and dental treatment on behalf of a person under guardianship; advocate on behalf of the person under guardianship for services the person may need; be the guardian for the time specified in the

guardianship order; and provide information on the role and function of the guardians to the general community (NSW DJAG, 2014; Office of the Public Guardian, 2014).

Role of the Public Guardian in the Criminal Justice System

After examining the research available and in forming the basis of this study, I concluded that the Public Guardian could take on the role of ensuring the integration of the mental health and criminal justice systems by leveraging the expertise and resources necessary from these systems to the benefit of the offenders with diagnosable mental illnesses and developmental disabilities. Ideally, a referral could be made to the Public Guardian, if not already involved, when the individual is evaluated by the police or at the jail and then remain involved throughout the entire criminal justice process. This would include during the offender's transition back into mainstream mental health and community services (Steadman et al., 1995). For example, Lamb and Weinberger (1998) highlighted how courts and parole boards have a right to set conditions for the release of an offender into the community, which could include mandatory treatment. However, mental health professionals have an ethical and legal obligation to fully inform their patients about the nature of the treatment and obtain their consent (Lamb & Weinberger, 1998). This gives the patient the right to refuse treatment, which could place them at risk of further recidivism. Therefore, it is proposed that the Public Guardian's authority could override a person under guardianship's objections to treatment and, subsequently, consent to the proposed treatment on their behalf. This is because the offender would have already been determined to lack the capacity to make major life decisions, including deciding whether to participate in the court ordered treatment.

Case management. The Public Guardian could advocate for and consent to case management services for a mentally ill or developmentally disabled offender who is under guardianship and becomes involved with the CJS. Dvoskin and Steadman (1994) believe that accessing case management services is important because the case manager designated to the offender has the overall responsibility for his or her care. This includes formulating an individualised treatment and rehabilitation plan in conjunction with the offender, the person responsible for the offender, and the supervision of the court (Lamb & Weinberger, 1998). As a result, the offender receives appropriate case management and is linked to necessary services to rehabilitate them as opposed to being incarcerated (Dvoskin & Steadman, 1994). Case management also assists offenders by offering them an alternative to being processed through the courts and provides them with the treatment they need. For example, a case manager, in conjunction with the Public Guardian, could suggest to the court that the offender be referred to a diversion program or an assertive community treatment program (Dvoskin & Steadman, 1994). Interestingly, the research completed by Steadman et al. (1995) demonstrated that the most effective diversion programs had regular meetings of the key agencies to encourage coordination of services and sharing of necessary information. This could be overseen by the Public Guardian and organised by the case manager.

Transfer of knowledge. Steadman et al. (1995) strongly argued that "rapid and regular use of both the mental health and criminal justice information systems to learn more about an individual's prior criminal justice and mental health treatment histories is crucial for systematic case identification" (p. 1633). Broner, Franczak, Dye, and McAllister (2001) also highlight how it is imperative that knowledge is shared when new programs and policies are created to assist

mentally ill or developmentally disabled offenders. The authors proposed that the transfer of knowledge between policy makers and other stakeholders would create a "community of knowing" (p. 79), which would allow a program to be successfully implemented and sustained by all of the participating organisations, communities, and individuals. The Public Guardian could, therefore, take on the role of ensuring that appropriate and important information regarding a particular individual is exchanged and released between the key stakeholders as long as it was demonstrated to be in his or her best interest. The Public Guardian could also ensure that unnecessary delays in information exchange are avoided and ensure that necessary stakeholders are contacted in appropriate time and fashion. Finally, in order for interventions to be successful, Broner et al. (2001) argued that proposed programs need to be structurally, financially, and politically prepared to assume the responsibility of the interventions. For example, a successful community-based intervention includes a broad based network that bi-directionally informs each other to further develop and implement proposals for training, research, treatment, and policy, which results in better approaches and interventions for mentally ill offenders (Lamb, Greenlick, & McCarty, 1998).

A collaborative approach. Weisman et al. (2004) argued that "due to the very significant healthcare needs of mentally ill offenders, access and continuity of care… integration between a number of mental health and medical services within the community" (p. 78) is required. The proactive approach taken by Project Link demonstrated the successful outcomes that are a result of increased access to care for mentally ill and developmentally disabled offenders (Weisman et al., 2004). This includes the engagement of both mental health and primary care providers to ensure the offenders receive appropriate mental health and medical

care to promote their ongoing wellbeing and to encourage avoiding criminal activities and behaviours. Weisman et al (2004) further highlighted the importance of a collaborative approach by ensuring medical care providers remain sensitive to the special needs of the severely mentally ill or disabled offenders and the need to reduce any delays to medical care. The authors identified that this would result in a reduction of unnecessary use of emergency rooms for the primary care needs of these individuals. The authors demonstrated how a substitute decision-maker, like the Public Guardian, could play a fundamental role in ensuring these individuals do receive the same medical care and mental health treatment that members of the general public receive, which would assist in reducing hospital admissions. The Public Guardian could also advocate for and consent to necessary treatment to maintain an offender's ongoing mental health, which would promote their overall wellbeing by possibly preventing further incarceration.

The 1999 Surgeon General's Report on Mental Health emphasised the vital role that advocates, consumers, family members, practitioners, service providers, scientists, and government agencies played in advancing mental health treatment during the past century (U.S. Department of Health and Human Services, 1999). To add to this, Carr and Littman (1991) asserted the need for government organisations to go beyond their organisational boundaries to involve stakeholders and consumers to develop systems of care that are beneficial to individual consumers, such as mentally ill and developmentally disabled offenders. Furthermore, Yukl (1989) highlighted the importance of allowing stakeholders to participate in making a decision and allowing a degree of influence over the decision, because they are likely to become more committed to carrying out and following through with the decision. This would increase the chance that a program implemented in the relevant community for mentally ill or

developmentally disabled offenders is successful due to individual stakeholders' empowerment and collaboration (Yukl, 1989). Consequently, the need to collaborate with all stakeholders coincides with the Principles of the *NSW Guardianship Act* (1987), along with the *Personal Directives Act (2000)*, the *Adult Guardianship and Trusteeship Act* (2008), the *Mental Health Act (2000), and the Substitute Decisions Act (1992)* whereby all stakeholders involved with an individual under guardianship are consulted prior to any decisions being made. Therefore, the collaboration of stakeholders could assist an offender to access the necessary support in the community as opposed to being incarcerated (Carr & Littman, 1991; Yukl, 1989). A collaborative group thoroughly considers each issue before consensus is attempted and optimises participation by all members (Yukl, 1989). This ensures that the offender is given fair treatment by the courts and is able to access the necessary support services that will ideally prevent them from becoming further involved with the CJS (Broner et al., 2001). The Public Guardian could play a fundamental role to promote collaboration between all agencies and ensure stakeholders involved are given the opportunity to play a role in the prevention of recidivism among mentally ill and developmentally disabled offenders.

Current Roadblocks to Effective Support and Guardianship

Even well-planned and adequately executed programs do not guarantee the safety of the participants or the efficacy of the program; therefore, further evidence is required to identify effective programs to reduce crime. Furthermore, most diversion programs currently in place use strategies that are designed to prevent incarceration by diverting high-risk individuals into treatment, but are not always available to individuals with mental illnesses (Steadman et al., 1995). In addition, diversion programs' effectiveness is dependent on the availability of

appropriate services in the community. This lack of availability to services is a significant roadblock to a number of mentally ill and developmentally disabled offenders (Hinds, 1990). For example, many diversion programs lack effective linkages to community-based care, few have specific procedures for following up diverted offenders, and only a handful of programs have procedures in place to ensure referrals and linkages to programs are maintained (Steadman et al., 1999).

Criticisms of the Public Guardian. The best interests approach is used by Public Guardians to make decisions based on the value system of the individual decision-maker and based on what he/she would perceive to be in the person's best interests given the circumstances (Creyke, 1991). Creyke (1991) noted that there is some criticism about the reliance of this approach as it offers no hierarchy of values for the client and is based solely on the decision maker's value system. Further, every person is entitled to make decisions and act on their wishes, with the Public Guardians' authority only being able to extend so far, irrespective of whether a decision made is in a person's best interest (Swanson, Swartz, Essock et al., 2002). Therefore, decisions can be made in a person's best interest; however, the ability to enact such decisions would be entirely based on the offender's willingness to cooperate, irrespective of their capacity or lack thereof, demonstrating the limitations of a guardian.

Proposed Research to Examine the Role of the Public Guardian

Bonta, Law, and Hanson (1998) found that criminal history variables were the best predictors of recidivism, which have been discussed throughout this chapter. It would be helpful to consider these variables when determining whether the Public Guardian would be an effective

tool to assist mentally ill and developmentally disabled offenders in relation to their involvement with the CJS. As a result, this research will explore the role the Public Guardian could play to potentially assist in reducing the involvement of mentally ill and developmentally disabled offenders with the CJS.

It is evident throughout this chapter that the CJS should not be viewed as an appropriate substitute for the mental health system (Lamb & Weinberger, 1998). Further, the development of an integrated model of care would best be understood as a long-term goal for the Public Guardian, the individuals under the care of the Public Guardian, and various stakeholders. Therefore, it would be beneficial to explore the approach used by guardians to work with agencies and organisations committed to finding approaches that could potentially prevent future recidivism of mentally ill and developmentally disabled offenders.

CHAPTER THREE: METHODOLOGY

This chapter will describe how the study will be conducted. For this study, the primary research question is: "What is the decision-making process of guardians of developmentally disabled and/or mentally ill adults, under the care of the NSW Public Guardian, who are charged and proceed through the criminal justice system?" A secondary question concerns the decisions the participants believe are required, specifically, how those decisions are made and implemented and the real and/or perceived outcomes of those decisions. Based on the review of the relevant literature and my experience, I believe that by answering these questions, professionals working for the Public Guardian, as well as Private Guardians, could be more effective at helping adults with disabilities and mental illnesses navigate the criminal justice system (CJS). A description of decision processes could also assist in future decisions being made on behalf of individuals under Guardianship by: specifying what information is considered and valued when making such decisions; how the decisions are implemented; how the guardians felt about the decisions; and the outcome of those decisions. Although the proposed research examines workings of the NSW Public Guardian, this research may also be useful to those making decisions on behalf of criminally involved adults with disabilities and mental illnesses in other jurisdictions.

Research Design

Qualitative research is an interpretive, naturalistic approach that allows researchers to study phenomena in their natural setting by interpreting the meanings people bring to them (Denzin & Lincoln, 2011). Creswell, Hanson, Plano, and Morales (2007) further this definition

by articulating that the individual's experiences and interpretations can be explored in greater detail by using an array of empirical and interpretive practices through observation or experimentation. In qualitative research, the researcher is the research tool (Goulding, 2002), thus, personal discipline is imperative as it assists the researcher to avoid excessive subjectivity. Further, qualitative researchers utilise rigorous and self-conscious examination for bias at each stage of their research; check for negative incidents in the data and account for occurrences that do not fit with the emerging information; make use of external referees, such as academics and the participants themselves, to check for accuracy of their interpretation; and utilize comparative procedures through related literature (Goulding, 2002).

As discussed in previous chapters, there is little research regarding mentally ill and developmentally disabled individuals under guardianship who are involved with the CJS. Extant literature primarily addresses the services that are or should be available to the offenders with mental illnesses and developmental disabilities, along with the legal ramifications of their offences, including the capacity to accept a guilty plea to access alternative routes to adjudication. None of the sources examined thus far explore the decision-making processes and experiences of the guardians who are appointed to make decisions for the offenders. As a result, this exploratory study will examine the decisions made by guardians and their experiences; therefore, a qualitative research design will be most appropriate.

Grounded Theory

The methodology that guides this study is grounded theory. Grounded theory is intended as a methodology for developing theory that is grounded in the data that are systematically

gathered and analysed (Goulding, 2002). Further, grounded theory is most often used to generate theory where little is already known and the researcher must work in natural environments to analytically relate participants' perspectives to their environments (Goulding, 2002). Grounded theory methods are flexible and allow researchers to focus their data collection to build on the themes that become apparent through constant and simultaneous data analysis and conceptual development (Charmaz, 2006; Denzin & Lincoln, 2011). The domain of enquiry is context bound, whereby facts are viewed as both theory and value laden, and knowledge is seen as being actively constructed with meanings that are only relevant to the experienced world (Glaser & Strauss, 1967). Finally, theory begins to emerge and evolve during the research process and is a product of continuous interplay between data collection and analysis (Glaser & Strauss, 1967; Glaser, 1978; Strauss & Corbin, 1990).

Data was collected prior to developing hypotheses or completing other research that may support this study through the use of one thorough semi-structured interview (Creswell, 2007). Key points from the interviews were identified through the use of codes, which were grouped together into similar concepts (Glaser & Strauss, 1967). From there, the principal concepts guided the development of categories, which are the basis for the development of a theory and hypotheses (Glaser & Strauss, 1967). The codes and concepts were identified throughout the initial interview and then the themes and categories that are common to the experiences of the participants were developed. Throughout the interview process, certain hypotheses were identified through the emerging themes and were then explored and supported in existing literature. Finally, through the exploration of the outcomes of the participant's decisions as well as their subjective experiences in relation to such decisions, it was hoped that this research would

indicate whether the use of a statutory body, like the Public Guardian, could assist in working with developmentally disabled and mentally ill offenders whilst navigating the CJS.

Strengths and Weaknesses of Grounded Theory

The notion of generating new theory from data initially made grounded theory a popular choice for social scientists. It is a powerful research method for collecting and analysing data that investigates the actualities in the real world and then analyses the data without preconceived ideas or hypotheses (Glaser & Strauss, 1967). Grounded theory is an effective approach to build new theories and to understand phenomena within its natural environment. The emergent theory is usually high quality as the research design reflects the idiosyncratic nature of the qualitative study (Charmaz, 2006). In addition, the findings and methods used in grounded theory allow further refinement through the use of detailed and systematic procedures for data collection, analysis, and development of theory. This encourages and generates future investigation into the phenomenon and requires the researcher to be open-minded and unbiased. This approach is also more likely to determine what actually happens rather than some official version of practice (Glaser, 1978). Finally, data collection occurs over time and at many levels, which allows for meaningful results.

Despite the many strengths of grounded theory, this methodology is still not widely used or understood by researchers in many disciplines (Charmaz, 2006; Creswell, 2007). In order to successfully conduct this theoretical approach, huge volumes of data are required, which can be daunting, difficult to manage, time consuming, and the acumen of data can make it difficult to develop a precise process for data collection and analysis (Creswell et al., 2007). In addition,

there are tensions between the evolving and inductive style of a flexible study and the systematic approach of grounded theory. Another criticism to this technique is that it is not possible to start a research study without some pre-existing theoretical ideas and assumptions and it requires high levels of experience, patience, and social skills on part of the researcher (Charmaz, 2006). Therefore, a researcher should acknowledge his/her theoretical ideas and assumptions and be mindful of them throughout the study in order to look beyond potential biases that may cloud the research being conducted.

When completing grounded theory research, reaching theoretical grounding is difficult to determine (Glaser, 1978). Often researchers justify the type, relative depth, and extent of the data collection and analysis on only one criterion, which is saturation of categories, and then end their data collection (Creswell, 2007). However, it is not clear what saturation means and often researchers only invoke the criterion of saturation to justify small samples, which indirectly diminishes the credibility of grounded theory (Charmaz, 2006). Finally, relying on interview studies on focused topics may also preclude attention to context, especially when participants often take the context of their lives for granted and do not elaborate on certain elements that could help with the research, thus, limiting what researchers may learn (Charmaz, 2006).

Given the potential for complications using grounded theory, I was mindful of the above mentioned weaknesses and made allowances to ensure the strength and integrity of my research. First, I was drawn to grounded theory as it allowed me to develop my theory of the role the Public Guardian can play with individuals involved with the CJS whilst conducting research. I was not required to have formed any hypotheses; however, I was aware that I had worked as a guardian for many years and did have preconceived notions of what role(s) guardians could play

with this client population. As a result, I utilised a semi-structured interview to avoid any leading questions or probes that could elicit answers from the participants to support my beliefs. I also noted any biases I had throughout the interviews or if I felt I was directing the participants to answer questions in particular ways. For example, I was aware that I wanted to demonstrate that the Public Guardian would be effective at reducing recidivism among this population. Therefore, I asked very basic questions around the participants' opinions about the role of the Public Guardian and reducing criminal behaviours. I also noted how surprised I was when most participants felt the role of the Public Guardian in reducing recidivism was minimal as that disproved my preconceived notion. This study was extremely time consuming and difficult to manage across time and in two separate countries. I needed to remain extremely focused and motivated throughout the process, which was hard, especially when attempting to transcribe the lengthy and detailed interviews. To compensate for any discouragement I encountered, I did hire a professional transcriptionist half way through the process, which helped me refocus on the data collected and transcribed. I did take time off to focus on other parts of my life, such as my practicum, moving back to Canada and my new position with the Public Guardian in Calgary to take breaks from the research. This often gave me a fresh set of eyes looking at the data and analysing the hypotheses I was forming. It was an extremely lengthy process but once I began noticing recurring themes, I was confident that I had gathered enough research and conducted enough interviews to reach true saturation.

Rationale for a Grounded Theory Approach

The research question that guides this study is a reflection of my experience working for the NSW Public Guardian in Parramatta, NSW. Choosing a methodology that allows for

flexibility in gathering data and developing theories based on the research conducted and data collected was an appropriate choice for this research. Since there is minimal research available exploring the effectiveness of the Public Guardian when working with individuals involved with the CJS, the Public Guardian was excited for the prospective study. As a qualitative researcher, it was imperative for me to select a methodology that would value the use of interviews as a primary research technique whilst incorporating a clear procedure for analysis. I selected this methodology as it would allow me to identify common themes in the participants' experiences when making decisions for individuals under guardianship involved with the CJS. Finally, grounded theory has specific criteria for assessing the rigour of the study including, how well the categories relate to the data and are derived from constant comparison and conceptualisation of the data (fit and relevance); the integration of the categories into the core category that emerges (workability); and ensuring that all the concepts important to the theory are incorporated into it by the constant comparison process (modifiability) (Glaser, 1978). Once I decided grounded theory was the methodology I would use for my proposed study, I sought ethical approval from the Athabasca University's Research Ethics Board in July 2011.

The Participants

The participants were Public Guardian employees from a large inner city office and two offices in the suburbs in New South Wales, Australia. Within these teams there are six Principal Guardians and six Senior Guardians, which meant there was a maximum of 36 potential participants. According their internal record-keeping system, at the time of the interviews only approximately 5% of people under guardianship in NSW were involved with the CJS.

Participation was strictly voluntary and was supported by the Public Guardian who sent an email recruiting participants. I also described the study at staff meetings. The initial recruitment email (Appendix A) elicited responses from 16 potential participants. Two potential participants did not meet the criteria to participate in the study, as their client(s) were not involved with the CJS. One participant was unable to participate in the study as she was leaving the country for 6 months on extended leave. Another participant withdrew from the study due to time constraints and another because he did not feel he met the eligibility criteria. The eleven remaining participants chose their pseudonyms (Table 1). When data saturation was reached, I stopped recruiting participants. Saturation was reached after ten individuals were interviewed, and data from all eleven participants was still analysed.

Table 1
Participant Pseudonyms and Descriptions

Chosen Name	Sex	Age
Audrey	Female	34 years
Betty	Female	60 years
Brad	Male	54 years
Burt	Male	36 years
Cameron	Female	32 years
Claire	Female	51 years
George	Male	48 years
June	Female	39 years
Marilyn	Female	46 years
Odette	Female	28 years
Rose	Female	30 years
Total	11 Participants	11 Participants

Participants ranged in experience from three to nine years. Eight females and three males took part in the study (age range: 28 to 60). At the time of the interviews, three participants were in the Senior Guardian position, six were Principal Guardians, and two were Information and Support Officers position, and were Principal Guardians when making decisions for their clients. Eight had achieved at least an undergraduate degree, two had a Master's degree, and one had a PhD. However, their level of education did not correlate with the level of complexity of the files assigned to them. All eleven participants identified as Caucasian and were Australian citizens. Every participant had extensive experience making decisions for clients involved with the CJS and highlighted how every decision required a significant amount of time and dedication. Interviews were conducted during office hours for the participants. Participants chose the time and location of their interviews, with most electing to meet in the boardroom at their respective offices, and one requesting to meet at her home on a weekend. Table 2 identifies more detailed information than Table 1 on the participants' demographic information, outlining their gender, ethnicity, age, education, office location, position, and length of employment at the NSW Public Guardian.

Table 2

Participant Demographic Information

Variable	Frequency	Percentage
Gender		
Male	3	27.3%
Female	8	72.7%
Race/Ethnicity		
Australian – Caucasian	10	91%
Other (English – Caucasian)	1	9%
	Mean	*Range*
Age	41.6 years old	28-60 years old
Highest Level of Education Received		
Bachelor's	6	54.5%
Master's	4	36.3%
PhD	1	9%
	Mean	*Range*
Years working for the Public Guardian	6.73 years	3-13 years
	Mean	*Range*
Total	**11 participants**	**11 participants**

Data Collection

Participants were given a $20 gift voucher for their participation. Informed consent was obtained (Appendix B), which included identifying the purpose of the study, what was expected from the participants, what information would be collected, risks and benefits of participation,

how the information collected would be managed, contact information for the researcher and supervisor, and how to withdraw from participation if required. To date, none of the participants have withdrawn from the study since the initial interview.

Data collection in a grounded theory study is based on theoretical sampling, enabling the researcher to select participants who maximise the potential to discover as many dimensions and conditions related to the phenomenon as possible (Strauss & Corbin, 1998). Due to time constraints of the researcher and participants, and as directed by the Public Guardian, one interview was conducted. Therefore, a specific outline was designed (Appendix C) to ensure all information was collected.

Audio Recordings

Participants were individually interviewed and all interviews were audiotaped on two digital recorders. This digital information will be stored for a maximum of 5 years from the date of the completion of my thesis. Interviews ranged from 55 minutes to 180 minutes. The interview focused on the kind of decisions made, the guardian's involvement with the client and CJS, the content of the actual decisions, the action taken to implement those decisions, the participant's experiences whilst making decisions, and the result of the Public Guardian's involvement. An interview guide was utilised to ensure consistency in the questioning and to remain focussed (Appendix C). The primary focus of the interview was broken up into four sections:

1) General questions;
2) Personal experience questions;

3) Specific case example; and
4) Wrap up and self-care.

A majority of the interview questions were open-ended questions, declarative probes, and prompts, which provide the basis for textural and structural descriptions, as well as provide an understanding of the common experience of the participants (Creswell, 2007). During the interview, I noted certain words and phrases the participants used that highlighted an issue of importance. After each interview, I debriefed the participants and answered any questions they had.

Data Analysis

During the interviews, noted common themes that began to arise and commonalities between the interviews, the participants, and the topics discussed. A transcriptionist transcribed each interview and I used the transcripts to identify the issues mentioned repeatedly during the interview, which formed the main themes and categories. Transcription of the interviews was completed by a transcriptionist who signed a confidentiality agreement (Appendix D). Once the transcripts were completed, I compared the transcripts to the digital recording to ensure accuracy. From there, I began to identify and develop the codes, memos, and categories by utilising constant comparison.

Codes. Glaser (1967) identified the need to use coding throughout the research process, from the beginning interviews through to the final stages of writing the completed research report. Coding identifies important words and label some of the reoccurring themes. For the purposes of this study, coding assisted in setting aside my personal experiences and biases so I

could best focus on the experiences of the participants. In addition, extensive field notes of observations, respondents' personal accounts, and detailed narratives helped to ensure effective coding. Codes were further identified and refined whilst constant comparison of the codes determined the importance and meaning (Charmaz, 2006). Following the initial coding process, intermediate coding was utilised to assist in the development of individual categories, followed by axial coding to link the emerging concepts (Strauss & Corbin, 1990).

Categories. Although grounded theory researches usually recommend not conducting a literature review, in this case I conducted a literature review to fulfil university requirements. I was mindful of the need to avoid the temptation to force any emerging categories to fit with the literature I already reviewed. Therefore, I used my literature review to compare what was already known to the emerging categories from the codes I identified. From there, I integrated the categories into the core category to develop my theoretical framework to explore the decision-making process and subjective experiences of guardianship staff when they made decisions for developmentally disabled or mentally ill individuals involved with the CJS.

Memos. Throughout the research process, I kept as many memos as possible to help focus the emerging codes and categories. This was done during the interviews, to highlight emerging themes and categories, followed by using different coloured pens when reviewing the transcripts to help me recognise my own assumptions and inferences about common themes and categories that developed from the interviews. This ongoing analysis informed the direction of my research and helped formulate the developing theories that arose from the interviews. Since memos are an ongoing record and can help identify how thinking changes during the research process, this enhanced the development of theory and helped test out any assumptions and

inferences I made. Once I reviewed the notes I made during the interviews and the coloured memos in the transcripts, I utilised many coloured post-it notes to collectively gather all of the memos. This helped group them together to develop the various codes and categories. I used textual, theoretical, and analytic memos the most as they allow for self-reflection throughout the interview and research synthesis process. These memos assisted me to keep track of the hypotheses forming in regards to codes and the relationships between the emerging categories. Textual memos are direct quotes from the participants which assisted me in supporting the themes and categories that were emerging from the data (Glaser & Strauss, 1967). An example would be the participants' descriptions of personal experiences working with this population and are evidenced in the following chapter. Theoretical memos capture the meaning and ideas of the growing theory at the moment they occur (Glaser, 1978). An example is when I noted on my interview outline recurring themes that came up in each and every interview. Finally, analytic memos consist of questions and speculation about the data and emerging theory (Glaser, 1978). These helped me avoid potential bias and helped me reflect inwards of my own personal experiences that may impose on the research. An example would be the notation of three question marks beside a memo which indicated that the potential emerging category should be further explored to support the development of the codes and subsequent categories.

Constant comparative analysis. Constant comparative analysis is a method used to analyse data in order to develop a grounded theory (Glaser & Strauss, 1967). By identifying a phenomenon, object, event or setting of interest, along with concepts, principles, and processes of the experience or phenomenon of interest, a researcher is able to make decisions based on his or her initial understanding of the phenomenon (Strauss & Corbin, 1990). Theoretical sensitivity

allows the researcher to work with data theoretically and conceptually (Glaser, 1978). The data can be analysed from a distance while maintaining a close level of sensitivity and understanding about the process by immersing oneself in the data and using specific analytical tools such as specific questioning and analysis of words (Glaser, 1978; Strauss & Corbin, 1990). For this study, I used both constant comparative analysis and theoretical sensitivity with the intention of immersing myself in the data by building theory from the data using codes, categories, and memos (Glaser, 1978). I was mindful to cross reference information, remained aware of my own level of insight into myself and the area of research, and tried to have as few predetermined ideas as possible. This was achieved by utilising memos, as previously discussed, at every point in the research process. I then began to develop hypotheses about the relationship between the codes and categories and by also seeking examples that contradict those hypotheses. I continued to collect more data and refine the emerging hypotheses and themes until I could account for and explain all contradictions.

Theoretical integration. Theoretical integration is achieved by drawing from an existing theoretical body of knowledge to enhance the explanatory power of themes being developed (Glaser, 1978). To achieve successful integration, I sought feedback from peer reviewers about my developing codes and categories, compare them to the existing literature, and submitted them to two participants I was able to contact via email. They reviewed my conclusions and either supported my theories or highlighted areas of inconsistency for further revision. As a neophyte researcher, I strongly believe that allowing my conclusions about core categories and themes to be reviewed by the participants and my peers helped me clearly, accurately, and respectfully represent the experiences of the participants.

Trustworthiness of this Study

Criteria for assessing the validity of qualitative research, in particular grounded theory, are typically vague (Creswell, 2007). Usually, researchers view bias as a threat to the validity of their studies and will take every effort to eliminate that threat; however, in grounded theory, this is not the case. The goal of grounded theory is not to eliminate the subjectivity of the researcher but to understand and appreciate how the researcher's values and expectations influence the conclusions of their study (Creswell, 2007). I repeatedly reflected on my own values and expectations throughout this study, primarily during the interview process, the research analysis, and the synthesis. In doing so, I ensured I was aware of how my own biases, values, and expectations may influence my participants, interpretations of the literature, and the development of codes, categories and emerging theories.

Strauss and Corbin (1990) identify the four primary requirements for judging grounded theory. First the theory should fit the phenomenon so long as it has been derived from diverse data. Second, it should provide understanding and be understandable. Third, the data should be comprehensive yet provide generality whereby the theory includes extensive variation and is abstract enough to be applicable to a range of contexts. Finally, it should provide control by stating the conditions in which the theory applies. If these four requirements are met, Strauss and Corbin (1990) assert that grounded theory is both valid and reliable as long as the constant comparative method is utilised, thus, there is conformity and coherence of codes, concepts, and categories and no new categories in the data are collected.

Given the vague criteria for assessing validity and reliability for qualitative studies in general (Creswell, 2009), grounded theorists primarily focus on trustworthiness of their study. There are four main indictors of trustworthiness that the researcher should establish, including: credibility, transferability, dependability, and confirmability (Creswell, 2009).

Credibility. Credibility is the qualitative counterpart to internal validity in quantitative studies. To achieve credibility, the researcher must utilise multiple methods, data sources, and theories. Prolonged contact with participants around the phenomenon of interest, along with respondent validation of research findings and hypotheses are imperative. Theoretical saturation, as previously discussed, must be achieved to maintain that no additional data would yield different findings.

Transferability. When a researcher utilises field notes to capture ideas, connections, methodological notes, codes, and memos that relate and assist in the understanding of the phenomenon being studied, it allows the research to be transferable to other applicable research, thus, it is generalisable. Comprehensive notes and memos ensure my research maintains this study's credibility, whilst having peers, the participants, and my supervisor review the data and findings will ensure on-going reliability of my study.

Dependability. To achieve dependability of my grounded theory study, I maintained an audit trail through the use of memos. Continuing to utilise peer reviews and my supervisors to reflect on emerging theories ensured my study was dependable. Further, comprehensive notes related to my understanding of the phenomenon were maintained to enhance the transparency of this study and the emerging codes, categories, and themes.

Confirmability. Confirmability, which is likened to being the qualitative counterpart to objectivity, was established through the use of field notes, memos, development of codes and categories, and triangulation of data toward a common finding, primarily the core category and themes.

Ethical Considerations

Ethical considerations relative to this study include confidentiality, freedom of consent, conflict of interest, participant distress, researcher self-disclosure, and data management.

Confidentiality. Each participant's confidentiality was respected and maintained throughout the creation, storage, access, transfer, and disposal of interview records and any written materials created throughout the data collection and analysis. The list of the participants names and chosen pseudonyms is kept in a secure document on my personal computer, which is password protected until July 2020 after which it will be appropriately destroyed. In addition, all electronic data is saved on this computer, which has the appropriate security safeguards. Research data and interviews will not be released to any third party except to my supervisor, Dr Jeff Chang. The data obtained on hard copy (paper files) is stored in a locked filing cabinet in my office for a period of 5 years, after which it will be destroyed.

Freedom of consent. Participants were guided through an informed consent process prior to signing forms (Appendix B). Since informed consent is a process and not simply just obtaining a signature, I provided information to the participants about the purpose of the proposed research, the interview process, and the use of the data (Creswell, 2007). Although the research was supported by the Public Guardian (Appendix E), I reiterated to the participants the

voluntary nature of their participation, and could withdraw at any time without consequence. Every effort was made to prevent the participants from being coerced into participating in the research project, which included explicitly stating to the participants that their decision to not participate in the research would have no impact on their employment within the Public Guardian.

Conflict of interest. There was the potential for conflict of interest when conducting this research because I was also a colleague of the participants. Concerns arise when there is a potential for the participants to be influenced by a person in a position of power or could indirectly impact their employment (Creswell, 2007). Although I worked in the same position as most of the participants, there were no supervisory roles between the participants and myself. In addition, only about one third of the participants were from the same office as me.

Participant distress. Participants discussed their personal feelings and subjective experiences about their clients and the decisions they made on their behalf. Accordingly, there was a remote possibility that they could have become emotionally distressed during or after the interview. For this reason, if a participant became uncomfortable at any point during the research process, they were given the opportunity to have a break or stop the interview. Debriefing was also offered to every participant after every interview. Participants were given my contact information should they have ever felt the need to discuss any concerns or issues that may have arisen from the research process. Finally, participants were encouraged to discuss situations with their work supervisor, seek support from a trusted colleague or, in the unlikely event that a research interview triggered preexisting psychological distress, they were given the opportunity to be referred to therapy. None of the participants required any support associated

with their interview, all reported they were pleased with how the interview was conducted and were comfortable with what was discussed. To date, none have sought contact with me, nor have they pursued support to my knowledge.

Researcher self-disclosure. A critical concern to this research is the issue of self-disclosure of relevant personal experiences by the researcher. The participants were aware that I have worked for the NSW Public Guardian for over four years and had made similar decisions for the population we were discussing. Therefore, it is my belief that limiting disclosure of my own experiences when making similar decisions contributed to the development of rapport and trustworthiness with the participants. This decreased the likelihood of affecting the responses of the participants. However, I answered any questions the participants had after the interviews.

Summary

This chapter provided a description of the research design and methods that were employed and guided my research. By completing this research, it was hoped that the findings will help new and old employees of the Public Guardian, along with private guardians when they encounter similar decisions in the future.

CHAPTER FOUR: RESULTS

The purpose of this grounded theory study was to generate a theory to explain the process of decision-making by guardians on behalf of individuals appointed to the NSW Public Guardian who are involved with the criminal justice system (CJS). Throughout the data analysis, advocacy and the importance of working collaboratively were generally defined as the key qualities to effectively work with this population and provide the foundation to navigate the CJS. The results section is organised following the process of data analysis found in grounded theory research as discussed in Chapter 3 (Creswell, 2007). Open coding is briefly discussed in table form at the beginning of each section in this chapter.

Overview

The central requirement of an effective guardian is to utilise experience, advocate on the behalf of the client involved with the CJS, work through the decision(s) required of them, and ensure they care for themselves. This chapter presents the findings from the data and identifies and discusses the emergent categories that arose from the interviews with the 11 participants. I derived seven main themes from the interviews with the participants: *Experience Matters, Guardianship: Decisions and Diagnoses, Advocacy over Decisions, Making Effective Decisions, Systemic Issues and Ethical Dilemmas, The Criminal Justice System,* and *Self Awareness*. A theme was noted if more than three categories fit into the same criteria. A category was noted if at least 6 of the 11 participants (54.5% criteria) described it in an interview.

An overarching theme of *Advocacy, Advocacy, Advocacy!* emerged. The categories, themes, and subthemes are illustrated in Table 3 (below), and are supported by exemplars from

the interviews with participants throughout this chapter. The sequence of themes presented in this chapter does not represent the significance or importance of the theme, nor are the themes universal, but they do reflect the experiences of the majority of participants.

Table 3

Categories, Themes, and Subthemes

Advocacy, Advocacy, Advocacy!
Experience Matters
1. Being a Guardian 2. Facilitating the Transfer of Skills a) Initiation into Guardianship b) Supervision 3. A Team Approach 4. The Promise: Decisions do Become Easier
Guardianship: Decisions and Diagnoses
1. Appointment of the Public Guardian a) Liaising with legal professionals 2. Caseloads and Clientele a) Diagnoses of Offenders b) Diagnoses within Case Examples c) Offending Behaviours Leading to Criminal Justice Involvement 3. Reasons for Offending
Definitive Decisions
1. The Frequent Four 2. Access 3. Accommodation and Authorise Others 4. Health Care and Medical and Dental Consents 5. Legal 6. Services a) Consent to Obtain and Release Information 7. Restrictive Practices

Advocacy Over Decisions
1. Types: Escalating Matters 2. Types: Lack of Understanding 3. Types: Helping the Community Understand 4. On-going Need for an Advocate over Substitute Decision Maker
Making Effective Decisions: The Decision Making Process
1. The Beginning of the File: Important Source of Information 2. Stakeholders 3. Preparedness: Taking a File and Running with it. 4. The Squeaky Wheel of Files a) Managing the Squeaky Wheel: Mind Mapping 5. Pushing the Envelope: The Need for Confidence a) Again with the Advocacy 6. Collaborative Process 7. Retrospect is a Beautiful Thing a) Do Decisions Become Easier? b) With Experience come Resiliency
Systemic Issues and Ethical Dilemmas
1. Principles of Guardianship 2. Best Interest Approach 3. Pertinent Issues a) Residential Settings b) Concerns about the Legislation
The Criminal Justice System
1. Breaking the Bond and Treatment Orders 2. Implementing the Impossible 3. Prevention of Recidivism a) Minor Successes
Self-Awareness and Personal Experiences
1. Any Recommendations a) Balancing Act 2. Most Important Role of the Public Guardian a) Is the Public Guardian Effective 3. Aha Moments 4. Self-Care: The Importance of Debriefing

Experience Matters

Table 4

Examples from Participant Interviews on Experiences

OPEN CODE	Example Sentence
Being a Guardian	"*You do steel yourself a bit for what you're going to read you know, because some of it is awful, some of it is horrific*." (Marilyn)
Transfer of Skills	"*There should be more buddying, close monitoring, more assistance to build up the staff's development.*" (Odette)
A Team Approach	"*To see our Public Guardian involved in that level of case conference too. It was highly effective and it was a really good think tank of individuals who were really clear around what her individual support needs were and how to get there."* (Audrey)
The Promise	"*You need to be on your game about ADHC policies, understanding complex behaviour plans, restrictive practices, the legal system, and department policies. Once there, decisions do become easier based on your confidence and experience*." (Cameron)

Being a Guardian

Extensive information is required to make the decisions on behalf of clients involved with the CJS. Guardians need to excel in being as thorough as possible and cognizant of their clients' needs to ensure the proposed services and accommodations meet his or her ongoing needs, especially once released from custody. For example, a service proposal cannot have the client having three hours of independent time daily when they require line of sight observation at all times. Therefore, all participants asserted the importance of understanding the legislation and policies applicable to their client population. Accordingly, the most common legislation cited by participants were the *NSW Guardianship Act* (1987), *Mental Health Act* (2007), and the *Mental Health (Forensic Provisions) Act* (1990). Further, participants were unanimous that all

guardians should have the appropriate knowledge and expertise to be able to work with these types of files:

> *If you're trying to get something in particular for this population, you need a level of clinical expertise to be providing guidance to the stakeholders and service providers and how to support the person, but to get that level of support, there are only limited options and you need to recognise those options.* (Burt)

Facilitating the Transfer of Skills

Participants agreed on the importance of sharing the skills acquired from these files across the team. To facilitate the transfer of skills and to build professional competence, participants suggested there should be more opportunities for staff to be offered these files through supervision or to be mentored by a more experienced guardian.

Initiation into guardianship and supervision. Participants valued working in collaboration with a new staff member on a CJS file. When introducing a guardian to the process of making decisions, the first priority is to rely on internal documents, such as the Guardianship Tribunal's Reason for Decision (RFD). External resources are also important for a guardian including speaking to various professionals, researching agencies, and referring to various legislation. Becoming well versed in these resources is achieved by seeking as much information as possible from different stakeholders, case workers, and agency staff, along with attending the court to get a feel for the environment. Further, the importance of external training was valued by the participant throughout every interview as it keeps staff up to date with services available to offenders, who the primary stakeholders are, and how to work with this client group.

Participants recommended offering staff external training on assessment, conflict resolution, and risk factors for involvement with the CJS. Participants favoured training that would give information around the legal system, in particular how Australian law operates. The participants stressed the importance of having training to understand a client's behaviour holistically rather than solely on diagnoses and incapacity, including how to motivate them to change. Finally, participants also prioritised understanding behaviour plans, restrictive practices, the provisions of relevant legislation, information on people's right to legal representation, how to navigate the prison systems, and information about what support services are available.

When acting as a supervisor, which is part of a Principal Guardian's role, the participants highlighted offering continued assistance, feedback, and suggestions to best support Guardians and Senior Guardians. The participants recommended developing a strong understanding of the client, primarily who the client is and what the client wants, along with developing relationships with the stakeholders. The participants agreed that this builds up the guardian's necessary confidence to make a decision and enforce it.

Model supervisors. The participants found that supervising the new guardian throughout the decision-making process was imperative. The preceding discussion indicates that all supervisors must be approachable and available. They should be available to attend meetings with stakeholders and should educate new staff on the support services uniquely catered to this client group. When asked what she would do to help train a new guardian, Rose eloquently stated:

I would initially walk you through how you would gather the relevant information... do

> *you have charge sheets, police fact summaries, do you have incident report, are you are clear about why the person is in custody or when they are leaving custody? Just the basic facts because often people tell you information that is important to them that isn't necessarily critical information… then I would ask them to summarise to me the situation like where does the person find themselves and then ask them to relate to me what they thought appropriate action was and then I guess ascertain their level of knowledge regarding the process of the client. So whether the client is going to court, whether the client is being released from custody, are they familiar with the probation and parole stuff, are they familiar with engaging the legal aid solicitor, how that solicitor is allocated, and how they can work with that person and what's required by the court?* (Rose)

A Team Approach: Systems Theory and Strengths Based Approach

Systems theory posits that a system seeks to achieve homeostasis: a state in which there is balance (Dore, 2008). The participants identified helping, and seeking help from, their colleagues to ensure and maintain homeostasis while working with these files. They asserted that a strong team assists in the development of a competent guardian. Participants stated that this team comprised of colleagues and a manager, with whom they could freely and safely consult, share, and debrief. Figure 2 demonstrates how various systems can interact and cross over, directly and indirectly influencing each other and the individual. It represents factors contributing to an effective guardian, independently and within the guardian's system. In particular, the participants identified the importance of social support from different systems, including family, friends, colleagues, and their community.

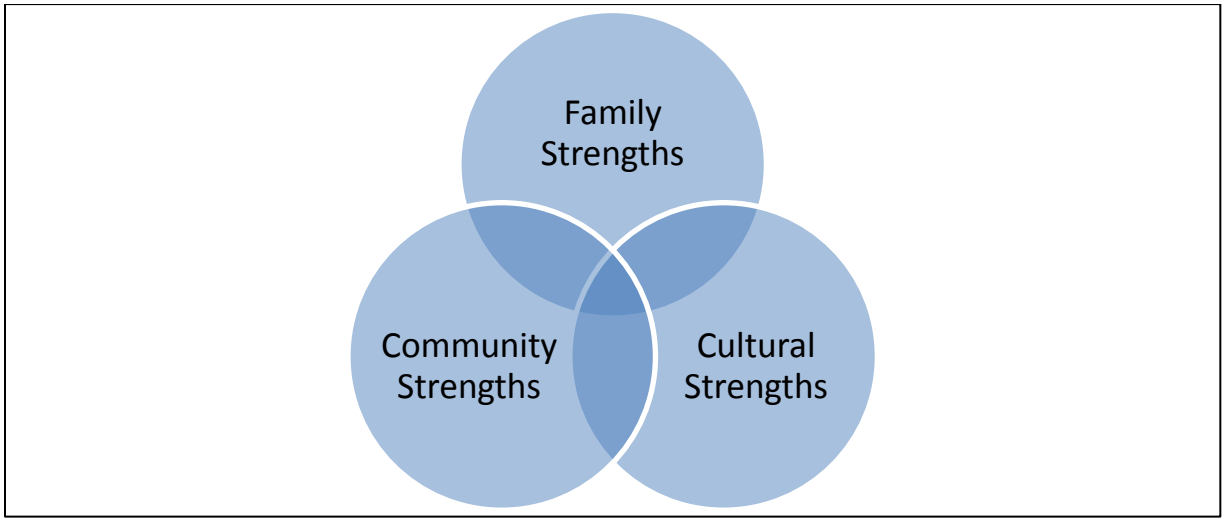

Figure 1. Adapted from "The Relationships of Family, Community, and Cultural Strengths: A Venn Diagram" (DeFrain & Asay, 2007)

Systems theory in action. Guardians expressed the pressure they feel to advocate for their clients involved with the CJS to ensure they continue to get treated the same as the general population. However, the participants found that when their client was labelled as involuntary, court mandated, or there is a reference to the CJS, options for rehabilitation and supports greatly diminished, making the participants feel that their advocacy was redundant. Further, many systems would fail to support the individuals, deferring them to other services who would either deny them services or would not be able to manage their complex behaviours. For example, Audrey's client repeatedly bounced between prison and hospital, as there were concerns about her safety in custody due to her mental illness and extremely violent tendencies. At the same time, she was believed to not have a diagnosable mental illness that would warrant a hospital admission.

Strengths based approach when systems fail. Due to the ongoing need for advocacy

and many system failures, the guardians would rely on a strengths based approach. They would find themselves assessing their client's strengths and talents, and then emphasising to other stakeholders the need to accept their client for who they are, irrespective of antisocial behaviours, disability, and diagnoses. Participants noted the importance of treating their client's mental illnesses and managing their developmental disabilities, but they consistently highlighted the need to address the other factors that are more directly responsible for the criminal behaviour, such as the individual's environment and social supports. As a result, they would advocate for the services to be tailored to the client, often having case managers go to the client rather than passively offering services in a centralised setting. This required the service providers, stakeholders, and the guardian to seek out the client in his or her home, workplace, or community for meetings, as opposed to an office.

The Promise: Decisions do Become Easier

Although the participants did not feel decisions became less complicated since these files were complex, they agreed that they became easier as they progressively came to understand the various systems involved. This includes the professional terminology used by various professionals, such as lawyers, judges, psychiatrists, hospital staff, and prison workers. They also developed an appreciation for the welfare workers in prisons, along with the process through NSW Justice Health, which is a very complex and sophisticated system that is part of the Forensic Mental Health Network. It is a board-governed network which specialises in the delivery of health care to individuals in contact with the forensic mental health and CJS in the community and in either inpatient or custodial settings.

Guardianship: Decisions and Diagnoses

Table 5

Examples from Participant Interviews on the Clients Appointed to the NSW Public Guardian

OPEN CODE	**Example Sentence**
Appointment	"*The public guardian [was] appointed because…she was in a mental health facility and required somebody to help make decisions regarding her health care, even though she was on a CTO, her accommodation she needed assistance there, and what services would be needed*." (Brad)
Caseload Clientele	"*Quite often the mental health issue is unspecified, or there are multiple diagnoses around the mental health aspect, but it has always been a dual diagnosis. There have been a couple that might have had possible brain injury, through a traumatic brain injury or through alcohol and substance abuse [but] I think more about the ones that have personality disorders as their primary diagnosis and then the secondary diagnoses that come with that in relation to unspecified psychotic features*." (Rose)
Definitive Decisions	"*For the ones coming from jail it looks at their aspects around behaviour support, access to ongoing mental health services…so that the model reconciles the risks, leads them to try to be as independent as possible but mitigating those risks which might involve restricted practices for line of sight issues, or containment in the community, seeking law enforcement agencies and ambulances to affect transfers when it is needed."* (Audrey)

Appointment of the Public Guardian

In most cases, the Public Guardian was appointed when an individual became involved with the CJS and was unable to consent to the accommodation and services required in order for them to be discharged from prison, jail, or a hospital mental health unit. Staff from mental health units, community agencies, Ageing, Disability and Home Care (ADHC) probation and parole, and prison staff most frequently requested the appointment of the Public Guardian (Figure 2).

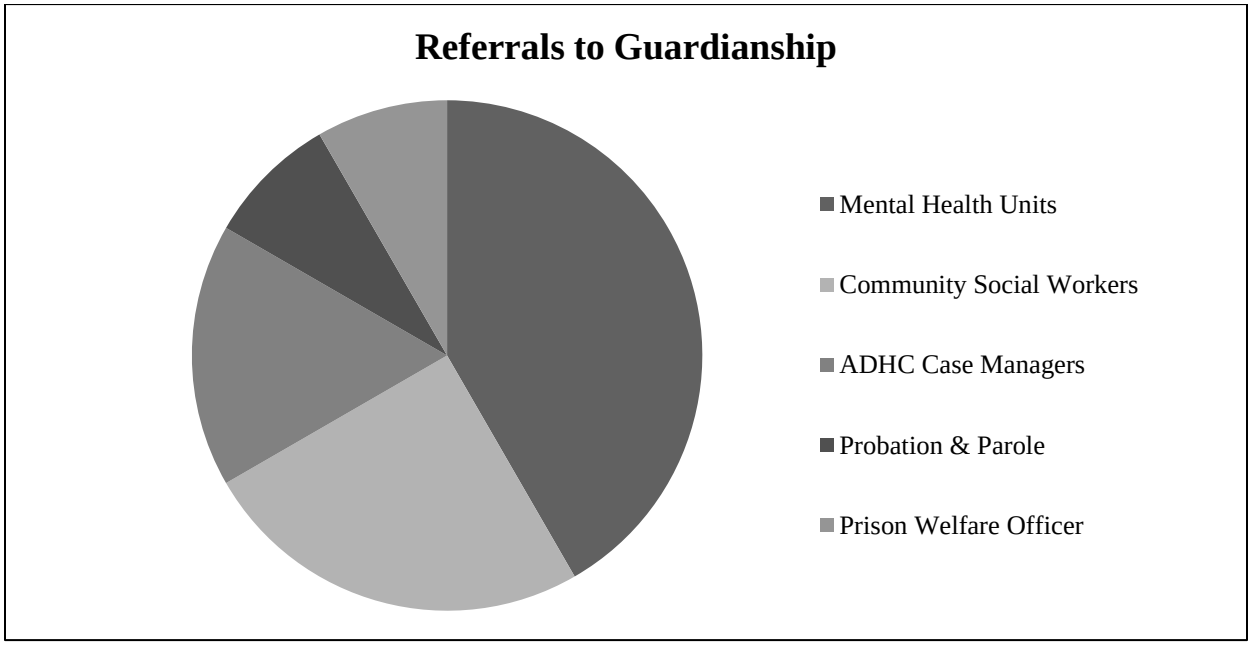

Figure 2. Referrals to NSW Public Guardian from the case examples.

In one case, a client was referred to Guardianship as her social worker from the community compliance group (a group through NSW Corrective Services who supervises offenders on correction orders, such as Community Treatment Orders, and is responsible for monitoring high risk and high profile offenders) had exhausted all options for getting her services. In an attempt to prevent her from reoffending due to escalating aggressive behaviours, which were placing herself and the community around her at risk, the Public Guardian was appointed. The social worker from the community compliance group hoped that this referral could offer the client some degree of stability in her life, including liaising with legal professionals, obtaining and releasing client information, and managing the client under different legislation.

Liaising with legal professionals. Rarely was the Public Guardian appointed to an individual with a developmental disability and/or mental illness prior to becoming involved with

the CJS. Participants reported that their clients' initial interactions with the CJS consisted of minor offences that would result in police involvement but no formal charges. The police would infrequently arrest the individuals unless the minor offences increased in frequency or severity to the point when they were considered a nuisance or a danger to themselves or others. Once the individual was appointed to the Public Guardian, it was the guardian's role to liaise with police to try to prevent further charges from being laid.

In many cases, guardianship was sought for an individual whom the police deemed a nuisance. This is when a client is not committing a serious offence but is running the risk of being charged with a nuisance offence, such as repeatedly and inappropriately contacting "triple zero" (emergency services). When a person under guardianship did commit a more serious offence and found him- or herself due before the courts, participants were required to liaise with Legal Aid lawyers to try to get the best outcome for the individual. In these situations, the guardian would request the solicitor pursue the "unfit to plead" route based on their disability and diagnoses. This is because the participants found that their clients would often, mistakenly, enter a guilty plea as it could potentially resolve the matter faster and without further incident. Other times, guardians would have to express their wishes and intentions for the clients since being sent to any criminal institution, such as remand or jail, would not be in the client's best interest.

Once the participants had secured the assistance of a Legal Aid lawyer, they were required to write to the magistrate to advocate on the client's behalf for a variety of reasons. During this contact, they would reference their client's diagnoses along with future plans to support them. This was a common tactic by guardians to help the court gain context of the client

and the guardian's desire to prevent further criminal justice involvement. Finally, the participants noted that the impact of liaising with the lawyers and advocating to the magistrate was entirely overshadowed by the ongoing need to make personal appearances before the court often on behalf of the individual under guardianship. In every instance, the participants felt they had to go above and beyond the scope of their delegated duties to try to get the best outcome:

> *I had to make a lot more representations in person, which I would not ordinarily do on other types of files, so actually just by physically being there in a court room.* (Audrey)

Caseloads and Clientele

The common theme among participants was that their clients were 'younger', primarily in their twenties and thirties; however, the range of clients' ages did vary:

> *Younger generally but [there is] no average age…[the] frontal lobe veterans are usually in their late 50's and early 60's and the others are scattered…what I mean is not the elderly so up to the mid-60's.* (Brad)

The average percentage of clients involved with the CJS on the participants' respective caseloads was approximately 24%, with a range between 9% and 60%. However, the average of CJS files throughout the NSW Public Guardian was only 4% to 5%, which is based on an internal reporting system. The excerpts from the participants, which are presented below, provide an insight into their opinions of these types of files:

> *They're frustrating…they're difficult…probably the most difficult because, firstly, they [the clients] have no awareness of what they are doing, they have no awareness of their*

disability, no insight. (Brad)

Diagnoses of the offenders. In order for a person to be appointed to the NSW Public Guardian he or she must be 16 years and older, have a disability that affects his or her ability to make decisions, and there is a need for a decision to be made. In order to be appointed to the Public Guardian, the person must be found to lack decision-making capacity due to a disability such as dementia, intellectual disability, brain injury, or mental illness and may live an at risk or an itinerant lifestyle. The most common diagnoses encountered were intellectual disability (developmental disability for the purpose of this study), acquired brain injury, mental illness and dual diagnoses. Dual diagnoses often included intellectual and developmental disabilities comorbid with schizophrenia, borderline personality disorder, post-traumatic stress disorder, or anxiety disorder. In almost every participant's experience, clients had a dual diagnosis:

> *Quite often the mental health issue is unspecified, or there are multiple diagnoses around the mental health aspect, but it's always been a dual diagnosis. There have been a couple that might have had possible brain injury, through a traumatic brain injury or through alcohol and substance abuse [but] I think more about the ones that have personality disorders as their primary diagnosis and then the secondary diagnoses that come with that in relation to unspecified psychotic features.* (Rose)

The individuals on the guardians' caseload were noted to have challenging behaviours usually associated with a developmental disability and a mental health diagnosis, and often combined with drug and alcohol abuse. It was unclear whether the clients had the brain injury or mental health issues prior to the substance abuse or as a consequence of the abuse.

Diagnoses within the case examples. Every participant was asked to provide case examples of clients who had been involved with the CJS within the last 12 months. The most commonly encountered diagnoses are shown in Table 5 and the complexity of the cases are presented in the following summaries.

Example 1: Audrey. Audrey's case example was of a 36 year old female who had a twenty year history of mental illnesses. The treating forensic psychiatrist diagnosed Audrey's client as a dangerous individual with severe borderline personality disorder characterised by poor mood regulation, recurrent rage, impulsivity, and self-harm. This psychiatrist also noted that this individual displayed features of a psychopathic personality. At various times during Audrey's involvement with this client, she had an extensive history of involvement with the CJS.

Example 2: Burt. Burt's case example was unique, as the client did not have a developmental disability or mental illness; however, he was in his late 20s and suffered a traumatic brain injury when he was 17. Prior to the brain injury, there was a long history of him being a child at risk in the home, with allegations of abuse and neglect, truancy at school, and antisocial behaviour. He progressed to marijuana and amphetamines abuse. When he sustained his catastrophic injury, he had permanent damage to his frontal lobe, resulting in him being impulsive, aggressive, and unpredictable. He also had psychotic features and was prescribed anti-psychotic medication but was never formally diagnosed due to his unwillingness to engage with the medical profession.

Example 3: Cameron. Cameron's case example was a 21 year old young woman serving a custodial sentence for 3 years for grievous bodily harm. She had an intellectual disability and

bipolar disorder, with a long history of physical and sexual abuse. She was appointed to the Public Guardian since she was 16 due to the complexity of her needs and extensive involvement with the criminal justice system.

Example 4: Rose. Rose was assigned a 37 year old female who had drug dependency issues and it was unclear if she had an intellectual disability or brain injury prior to the age of 18. She had previously been medicated for schizophrenia. She was in custody at a women's correctional centre when she came under guardianship and, prior to that, she had been living an itinerant lifestyle with her partner who passed away while she was in custody. She was of Aboriginal background, had 4 children from different partners, and had been addicted to illicit drugs (including opioids and hallucinogens) since she was 15 years old.

Table 6

Most Commonly Encountered Diagnoses in the Participants Case Examples

Common Diagnoses Encountered	Total Case Examples	Percentages
Anxiety Disorder	3	27.3%
Bipolar Disorder	1	0.9%
Brain Injury	3	27.3%
Traumatic	*1 (of the 3)*	*33.3%*
Drug and Alcohol Abuse	*2 (of the 3)*	*77.7%*
Depression	3	27.3%
Intellectual Disability	11	100%
Mild	*8*	*72.7%*
Moderate	*3*	*27.3%*
Oppositional Defiance Disorder	2	18.2%
Personality Disorder	7	63.6%
Antisocial	*1 (of the 7)*	*14.3%*
Borderline	*4 (of the 7)*	*57.1%*
Unspecified	*2 (of the 7)*	*28.6%*
Post-Traumatic Stress Disorder from Abuse	3	27.3%
Physical and Mental Abuse	*3 (of the 3)*	*100%*
Sexual Abuse	*2 (of the 3)*	*66.7%*
Psychosis	2	18.2%
Schizophrenia	6	54.5%
Substance abuse	4	36.4%
Dual Diagnoses	11	100%
Total	11 cases	11 cases

Offending behaviours leading to criminal justice involvement. Participants' clients committed a variety of offences that ultimately led to their involvement with the CJS. Unanimously, participants reported that the primary offences revolved around some type of assault, often assault causing bodily harm. One client, despite extensive supports, continued to offend, charged with assault, theft, cruelty to animals, armed robbery, and property damage. Participants also identified sexual-type offences, including voyeurism and exhibitionism, as common offending behaviours. Others reported breaking and entering, auto theft, possession of drugs, weapon charges, resisting arrest, soliciting, and sex work. A poignant example was of a sex worker diagnosed with HIV. She was deemed dangerous to others under the *Public Health Act (2010)* and, as a result, the police took out a full page advertisement in the newspaper because she was sex-working and was deemed a public health hazard.

Reasons for offending: Not justifying but explaining. The main theme throughout the interviews was that the individuals' offending behaviours related not only to his or her specific disability but also, quite often, to horrific backgrounds of abuse, neglect, poverty, and substance abuse. When speaking about an individual on his caseload who had burnt down three of her public housing units, George felt she did so because "*she really just cannot help herself and she just does not have the appropriate level of support that would enable her to not do that."*

Definitive Decisions

Every guardian at the NSW Public Guardian will eventually have a client assigned who has, or will be, involved with the CJS. This section focuses on the recurring decisions the guardians encounter for this population.

The frequent four. When a person is first appointed to the Public Guardian, the initial guardianship order almost always includes four functions: Accommodation, Health Care, Medical and Dental Consent, and Services. The additional functions frequently included in the guardianship orders catered to offenders include Access, Coercive Accommodation, Restricted Practices, and Legal Services.

Accommodation. In most cases, guardians were required to make accommodation decisions when there was a breakdown in their client's placement or upon release from custody. With this authority, the Public Guardian may make decisions about where a person should live temporarily or permanently, including holidays, and whether they should be admitted to a health care facility. The Public Guardian's accommodation decision-making authority is suspended when a person is incarcerated or is an involuntary patient. When a client is incarcerated, the Public Guardian is required to advocate for appropriate models of accommodation to be developed prior to his or her release from custody. Rose described a situation where her client was incarcerated and approaching release, but there was nowhere for her to go. Unfortunately, in order for her to be released into crisis accommodation, she was required to contact most agencies herself. This was not possible due to limited access to a phone whilst incarcerated and her inability to follow through with the regular contact required by the agencies:

> *We only found one service in the whole of Sydney that was willing to take her sight unseen so that there was some guarantee they were willing for us to put it to the court that was where she was going to stay* (Rose).

More often than not, the participants reported that their clients inevitably ended up in

unsuitable accommodation, such as the streets, missions, and caravan parks, which were always in poor locations with bad reputations and unfavourable residents. Even if their client was discharged to more suitable accommodation, participants noted that on more than one occasion, the neighbours became vigilantes and ended up chasing the clients away, often quite aggressively, maliciously, and violently.

Health care and medical and dental consents. The health care function gives the authority to determine the treating doctor, dentist, or other health care practitioners for the individual under guardianship. This includes psychiatrists and psychologists. The medical and dental consent function allows the guardian to provide or withhold consent to proposed treatments to promoting and maintaining the individual's health and wellbeing. Throughout the interviews, the participants made it clear that their commitment was to ensure their clients had access to medical services and treatments they required.

The primary decisions the participants made were designed to ensure their clients received the appropriate assessments and subsequent treatments that were recommended by the court or legal representative. This would include psychological assessments, functional assessments, a psychiatric review or referral, and medication reviews. More specialised consents focussed on forensic assessments and referrals to forensic mental health units.

All guardians prioritised the need to have clear medical diagnoses for their clients, with assessments, risk profiles, and risk management plans developed prior to making any further decisions. The participants were unanimous that clear clinical information was imperative to these files, to effectively and safely work with the clients, and to advocate in their best interest:

> *For this client, it's certainly in regards to her risks and her clinical information so her medical needs, the behaviour data information we get from service providers around her ability to be rehabilitated, to live independently, to manage her psychotic disorders and other mental health issues…so a lot of it is clinically based. (*Audrey)

Services. Participants identified the decisions they made under the services function as a significant portion of their decision making capacity. The most common decisions made by the participants were to determine the services could be put into place to make their clients eligible for accommodation. Guardians were also required to consent to requests for information, advocate for assessments or access to information, consent to agencies becoming involved, and consent to referrals generated by the prison system:

> *For the ones coming from jail it looks at their aspects around behaviour support, access to ongoing mental health services…so that the model reconciles the risks, leads them to try to be as independent as possible but mitigating those risks which might involve restricted practices for line of sight issues, or containment in the community, seeking law enforcement agencies and ambulances to affect transfers when it is needed.* (Audrey)

Another common decision the guardians were required to make under the services function was involvement with specialised programs funded by ADHC. These programs are designed to try to minimise the possibility of recidivism among individuals with a developmental disability upon release from a correctional centre, mainly by fostering appropriate community integration of the individual through specialised accommodation and support, along with clinical and case management. The primary goal of these programs is to offer services to individuals

with complex needs and challenging behaviours and reduce the cost this client group has on the service system. However, the participants explained that access to such services is so limited and that it is progressively becoming more difficult to support this population, which is resulting in decisions being made that will not necessarily be implemented because the paucity of the resources.

A combination of decisions. Guardians noted that once a person under guardianship was entrenched in the CJS, referrals were required to secure appropriate accommodation and support services upon release. Ideally, the participants would like to see planning begin months before the offender is due to be released, but this is rarely the case. As a result, they were left scrambling at the last minute to find the most suitable option for their client. This caused enormous strife among the participants as they felt they were being backed into a corner and forced to make decisions they did not believe would be sustainable, practical, or in their client's best interest:

> *I often think if I just had the balls to say we're pulling him out and changing service providers that would have led to different outcomes for him.* (Rose)

Consent to obtain and release information. If a person under guardianship comes into contact with the CJS, the guardians need to ensure police are advised that he or she has a disability and/or mental illness to ensure adequate support is provided when interviewed by the police. The Intellectual Disability Rights Service could also be contacted and there is the opportunity available to access Legal Aid. In these situations, guardians would need to release information to the relevant individuals and agencies to ensure the client obtained appropriate

support and assistance.

Although the release of a person's information is supposed to be in his or her best interest, conversely, one participant refused to consent to the release of her client's information because she believed the information would not be used in the client's best interest:

> *More often than not, the decisions for the release of information are sometimes to withhold it in order to protect them in their legal proceedings…. We had a request from Cumberland hospital to access police records and fact sheets and we withheld consent to the hospital having access to that because they had an intention of discharging her from hospital and actually charging her with offences that were committed inside the hospital.* (Audrey)

In this scenario, the confidential information on the client's medical file was going to be used by the legal team from the hospital to make a stronger case to the magistrate that she should be incarcerated as opposed to being treated for her significant and extensive mental illnesses.

Access. When the Guardianship Order contains such authority, the Public Guardian may make decisions about who the client should have contact with. The responsibility of the guardian is to protect their client from neglect, abuse, and exploitation. Hostile relationships and negative interactions between the client and his or her family are most common reasons for limiting access. For example, one participant limited access to family members as her client's biological father was procuring her for sexual services for fellow residents at the facility where he lived.

Coercive accommodation. The Public Guardian is given the authority to authorise others to take a client from their present location to accommodation consented to by the guardian, to keep the client at that residence, and bring the client back should they leave. The guardian can liaise with members of the NSW Police Service and Ambulance Service to initiate this order. This is usually put in place for the client's personal safety and well-being; however, it does not always impact the client in the desired way:

> *[S]he was staying at a long term refuge and she left and I wanted her to return to it and now I have coercive accommodation but she just said 'no, no way I want to go to this place' and I said 'what happens if I get the cops to bring you back?' and she said ''well you know I don't care I'll just sneak off again*. (Brad)

Another common coercive accommodation decision is to admit a client into mental health facilities under Section 7(1) of the *Mental Health Act (1990).* Using this authority, the Public Guardian can apply for voluntary admission into hospital. Once the client has received the necessary treatment and is found to be fit for discharge, the Public Guardian must make decisions about discharge planning, consistent with the legislation and policy. The participants explained that this policy has been quite helpful to negotiate a more desirable discharge option for their clients, as it requires that a comprehensive discharge care plan be developed prior to discharge, that individuals cannot be discharged to the streets resulting in homelessness, and that this planning should be done in a consultative manner. The patient should be consulted if possible. The guardian, primary carers, external clinicians, and support agencies must be involved to negotiate appropriate accommodation and supports prior to the client being discharged.

Legal. With the legal function, the Public Guardian has the authority to provide and withhold consent to the involvement of legal services. It is the guardian's role to liaise with counsel to ensure their client has access to the necessary representation during legal proceedings. When proceedings commence against an individual under guardianship, the guardian must ensure an attorney applies to the Court to become the individual's 'tutor' or 'next friend'. The Court will then determine who will be recognised to act for the person. The participants often encountered some issues as they could only liaise with a lawyer and provide information, but they were not permitted to instruction counsel or enter a plea for a person under guardianship.

Section 32 of the Mental Health Act. The Public Guardian can request that the legal representative pursue Section 32 of the *Mental Health (Forensic Provisions) Act 1990.* Section 32 allows for developmentally disabled and/or mentally ill individuals to be diverted from the CJS into appropriate treatment enforced by the court. Through this route, clients are found to be mentally ill at the time of the criminal act(s) or are unable to comprehend what they were doing or the severity of their actions. Therefore, the court would dismiss the charges against them. Accordingly, in lieu of incarceration, clients were either released into the community with a requirement to undergo various assessments, attend medical and psychiatric appointments, and complete treatment, or they were sent to a mental health unit within their local hospital. This route was very appealing to all of the participants.

There was only one case when Section 32 was not in the client's best interest. This client would often be assessed as mentally unwell while being held in remand. She would then be presented to the court by her lawyer, in consultation with her guardian, as needing to be managed under Section 32 and moved to a mental health facility, only to be reassessed at the hospital as

not being mentally unwell and sent back into custody. In this case, it was an ongoing cycle through the courts and hospital, resulting in her being court ordered to the forensic hospital at a prison as a civil patient. This meant she was not charged or found guilty of her many charges due to a mental illness, but she was found by the court to be a risk to the community and herself; she could not be managed in a mental health facility but also could not be kept in custody because she had no formal charges to answer for. Thus, the only placement for her was the forensic hospital which is extremely restrictive and is only offered to offenders with a significant mental illness who are deemed a threat to society. It is only a temporary solution, with a maximum of 12 months admission, after which time the offender is ideally rehabilitated, properly treated and medicated, and successfully managed in the community. This client was nearing the end of her sentence at the time of the interview with no real progress and not much hope from any stakeholders involved that she could successfully and safely return to the community.

Section 32 does not require a specific end date. This means that, although the offenders are not formally charged, they are sent to hospital or a support service that could and would essentially hold them in restrictive environments, often indefinitely. Many participants queried how this alternative was in their client's best interests as, if they had simply gone to prison, they would have completed their sentence much quicker than what is offered through Section 32.

Restrictive practices. Most behaviour support plans can be consented to under the Services function; however, when restrictive practices including (a) chemical restraint; (b) physical restraint; (c) loss of privileges; (d) seclusion; (e) confinement; and (f) denial of access to certain areas or objects, such as sharps or the internet, are required, specific authorization is

needed from the Public Guardian. This is because these restrictive practices could constitute an assault or wrongful imprisonment without lawful authorization. In the case examples, most participants decided to restrict their clients' access to sharps, lighters and other fire starting equipment, inappropriate material on the internet, certain areas in the community, or accessing the community without staff support. One participant justifies the need for this function in the excerpt below:

> *[It's] always very difficult when you are talking about a client who, say, sex offends and the level of restrictions that are going on and it's always a tricky debate about the route justifying restrictions which are affecting the community, [but it] can't be about the community, it has to be about the roundabout route, it's not in their interest to commit an offence and end up [reoffending]*. (Burt)

In this example, although a decision to restrict the client's access to the community is primarily to protect the community, it was also in the client's best interest as it reduced their chances of offending again.

Another participant restricted access for one of his clients who would frequent the King's Cross area in Sydney, which is known as Sydney's red light district and Australia's crime and drug capital. She was a known drug user, was HIV positive, and would frequently and recklessly engage in sex work, leading to ongoing arrests:

> *[S]he was always at risk of just returning to the Cross and repeating the cycle and getting lost to it, so it was a restricted access type, restrictive practice decision, that needed to be made for her so that she was 24 hour supervision and…confined to the*

home, and then gradual ventures out into the community with support workers.

Advocacy over Decisions

Table 7

Examples from Participant Interviews on the Need for Advocacy

OPEN CODE	**Example Sentence**
Advocacy	*"I would say about 90% of the work I've done on those files have been advocacy rather than decision making…I've needed to write letters on behalf of people, provide evidence in court, so they aren't decisions as such but advocacy*." (Rose)
Types	"*It's just what people do. People go to court, people do bad things, and get into trouble, you know, same as everyone."* (Brad)

As previously described, the overarching theme of this entire study is the ongoing need and extensive pressure participants experienced to advocate for their clients, given that "*traditional systems were unable to advocate sufficiently for the person; the Public Guardian could provide a level of advocacy, systemic advocacy"* (Odette). Further, the participants agreed that, once their client was involved with the CJS, the file became quite intensive, as the amount of advocacy required was, at times, overwhelming.

Types of Advocacy: Escalating Matters

In many situations, guardians were required to escalate matters, as there are many system gaps and systemic issues related to this population, with the hope of drawing attention to the lack of supports available. In many cases, the participants felt the major funding body for individuals with disabilities had done nothing to get a support agency to assist their clients in the

community, which resulted in ongoing offences. In Odette's example, her client was in and out of jail on numerous nuisance offences, and continued to not have appropriate support or accommodation from any agency. As a result, he continued to assault women in the community, his mental illness remained untreated, and he was incessantly under the scrutiny of the police. Further, the community was intolerant of his behaviour, which resulted in numerous arrests and incarceration. The paucity of resources was eventually escalated to the Ombudsman as a final attempt to access more funding from ADHC. This is one example of the dire situations the participants found their clients faced, resulting in the guardians thinking they consistently needed to escalate matters to obtain an appropriate response.

Types of Advocacy: Lack of Understanding

Unfortunately, some of the guardians had a defeatist perspective, as they felt that they were not successful in understanding their clients' needs, or determine the best option to support them in the community. In every case, they believed the lack of services and resources would result in the clients' demise. Therefore, helping the community to understand this group of people and their additional needs was important to the participants:

> *It's too often where the ones that we have that are engaged with the criminal justice system because of other secondary issues, like mental health issues and that sort of stuff, and if they were appropriately supported in the community, then they wouldn't have had to offend or to meet their needs in other ways.* (Betty)

Ongoing Need for an Advocate over Substitute Decision Maker

A recurring theme in this study is that a strong advocate is required for these clients,

more than a substitute decision-maker. This is because the participants asserted that the fluctuating capacity of mentally unwell individuals is difficult to manage. For example, when a client is unwell, the guardian is limited in his/her decision-making discretion, but when the client is well, the need for a guardian is questionable, as the client often is able to make informed decisions. Therefore, the participants asserted that an advocate would be better able to support these individuals. However, none of the participants could identify an agency or association that could take on an advocacy role with the same legal authority as the Public Guardian.

> *I know certainly that having attended court, having prepared reports for magistrates and solicitors, that advocacy and that representation for the magistrate to see me sitting in the court, that has made the court more sympathetic to the fact that this person was unwell, mentally unwell, was unable to make decisions...so that provided some relative sympathy from the court to moderate the court sentencing and recommendations.* (Claire).

Making Effective Decisions: The Decision Making Process

Table 8

Examples from Participant Interviews on Making Effective Decisions

OPEN CODE	**Example Sentence**
Information	"*I don't want to be sitting with someone who targets women my age for example or has got a history…I like to know what I'm dealing with*." (Marilyn)
Preparedness	"*The beginning of a file that is new under guardianship is probably the most exciting time to be able to review the history and get a really good understanding of what their support needs are.*" (Audrey)

Squeaky Wheel	"*It's a bit like the squeaky wheel…clients in crisis generate, and legitimately so, generate a quicker response and often, because they don't have a clearly identified case manager, can sometimes mean that you inadvertently do more of the advocacy and more of the phoning around.*" (Claire)
Push the Envelope	"*If you think there is a better outcome for your client, then go for it, try everything, exhaust all options*." (Audrey)
Collaboration	"*Often clients that are engaged with the criminal justice system are in crises so it is about getting your head around the full picture of the crises and bringing everyone together to try and start problem solving…more often than not, engagement with the criminal justice system is because inadequate supports are in place and that people with this level of disability cannot respond differently and make different choices themselves but in a different environment, things can change so it's about bringing everyone together to change the environment*." (Rose)
Hindsight	"*I underestimated initially how important having everything documented and in writing was…[which] can assist in the challenging process*" (Rose)

Staff utilise various strategies in an effort to make effective decisions for this population; however, the participants did not always have the options they thought were necessary. There are frequently minimal options available to this client group, and the participants found they were required to make less than ideal decisions, which would inadvertently lead clients back into the revolving door of the CJS.

The Beginning of a File: Important Sources of Information

Usually, the beginning of a file did not bring about anxiety or significant distress in the participants; however, one participant noted during the information gathering stage:

> *You do steel yourself a bit for what you're going to read you know, because some of it is awful, some of it is horrific… reminding yourself as you're going through that file that*

you're there for the rights of that person (Marilyn).

Information was obtained by the participants in a variety of ways and contexts, but the most common route was meeting with the key stakeholders, and reading through the file. The participants thought discharge planning meetings, for example, were advantageous so he/she could learn what support a client requires for their successful integration back into the community. The participants also prioritised information on their client's mental stability and prognosis. After gaining an understanding of the client's needs, the participants prioritised meeting with the client to seek the client's views prior to making any decisions on his or her behalf.

Hospital and community staff with direct experience working with the client were important sources of information. The participants identified police fact sheets and charge sheets as important to their decision-making process as the reports describe the current charges and other charges on their clients' record:

> *What are the actual charges, how did they come about when you know statements were given, and what available support did the person actually have when giving the statement; getting copies of that information if possible, which sometimes is more tricky than you can imagine.* (Betty).

Professional reports. The participants would rely on a range of assessments and reports from professionals, including occupational therapy assessments, neuropsychological assessments, functional capacity assessment, and any other assessments that assist the guardian to understand the availability and timing of services. Different behaviour management plans

were also valued by the participants, especially if they were from specific units such as the challenging behaviour unit at the local prison. Participants found these assessments useful as they identified the triggers for a client's escalating behaviour, along with what could potentially compromise the safety of the client or the community, and the recommended supports associated with his or her care.

Stakeholders. The stakeholders are responsible for informing and implementing the decision made by the guardian. Participants would frequently familiarize themselves with the stakeholders (e.g., family members, caseworkers, and doctors) specified in the guardianship order. Participants reported family members to be excellent sources of information because they could provide thorough historical backgrounds and knew what the client's needs were, both past and present. However, participants had to tread carefully when consulting with the family. Some other common stakeholders include medical teams, justice connections, disability advocates, case managers, welfare officers, forensic psychiatrists, justice health staff, corrections staff, psychologists, social workers, and service providers.

Preparedness: Taking a File and Running with it

The participants highlighted the need to determine if a decision was needed immediately when first assigned a file. If not, they would take the time to read every document on file to get an idea of who they would be working with and any obstacles they may encounter:

> *The beginning of a file that is new under guardianship is probably the most exciting time to be able to review the history and get a really good understanding of what their support needs are.* (Audrey)

When a decision was required, participants would begin with some preliminary factual questions, including, where the client was located, why the Public Guardian was appointed, what the client wanted, and how to meet with the client. It is clear that seeking information is the most important first step a guardian can take:

> *To get the best background you can get of what the current issues are…history of what has and what kind of supports they have had before, what's worked and what hasn't worked to get an idea of who the main people are in the person's life…seeking the person's view … reading all the information and identifying where the gaps of information are and find what information is pertinent to the decision making and then work out a bit of a plan of action.* (Cameron)

Often decisions for these files are required immediately due to clients' urgent circumstances, thus, guardians are not always given the opportunity to review information before making a decision. One participant noted:

> *[M]y role as a guardian always feels to be reactive rather than just responsive and initiating so you're just kind of working with what you get presented on a daily basis*. (Audrey).

The "Squeaky Wheel"

Despite the intensity of these files, all of the participants noted the intensity was episodic, the "squeaky wheel":

> *When the person may be appearing before the magistrate or they're just being held in the cells, they're very intense. There are lots of phone calls, it's a lot of liaising with criminal justice support network to get a support person, they're just quite intensive.* (Claire)

Thus, participants stated that it is not so much about equal distribution of time dedicated to each file, but more which file would require being prioritised and, therefore, required more time and effort compared to files where the client was in a stable living situation and no decisions or guardian involvement was required at that time. This delicate balance made the participants feel that it was difficult to have a balanced caseload when a number of their files had a forensic factor. Nonetheless, most found these files exciting:

> *They were actually really exciting. They were inspiring because when it got to that level, the individuals involved were so knowledgeable around the issue that we could see was pretty clear and they weren't trying to bargain this woman's life away like the other psychiatrists were in the local mental health facility. They were really inspiring and to see our Public Guardian involved in that level of case conference too.* (Audrey)

Managing the squeaky wheel: Mind mapping. A number of the participants identified the strategies they used to better understand and approach these files. Participants often described using a 'mind map', which is depicted in Figure 3.

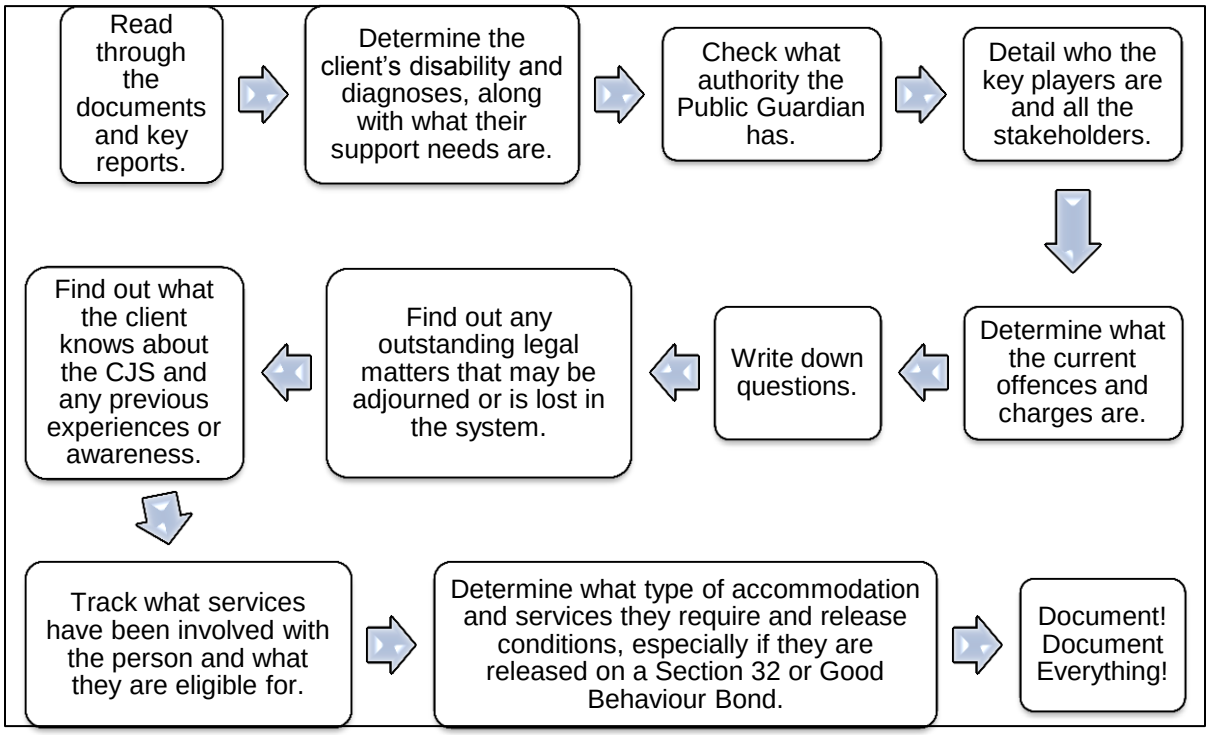

Figure 3. The main points of information used in the participant's mind map.

Pushing the Envelope: The Need for Confidence

The participants highlighted the need to develop knowledge and understanding of what options are available for this population. By being exposed to these types of files, all of the participants were able to develop an understanding and build the confidence necessary to approach these files. However, participants found the lack of options available for support and accommodation was the major challenge. *"[F]or me is the powerlessness I feel with the lack of resources, how the hell does the client feel?"* (June). Despite this common theme of frustration, it seemed to make the participants more passionate about obtaining the best possible outcome for their client.

Another hurdle encountered was the ongoing push from prisons and hospitals to have quick decisions with very little planning, information, and collaboration. The participants often

fell into the trap of acting like 'a rubber stamp' and needed the confidence to take a step back and delay the process, despite external pressure:

> *Sometimes I get a little bit blinded by an idea, I need to slow down a bit and actually have a look at the facts and evidence and not just want to make it fit into a decision.* (Audrey)

There were times when the participants conceded early on a decision by assuming the options that were presented were the only viable options. However, in retrospect, participants thought that taking advocacy to another level could have benefitted the clients. One participant made the recommendations, *"[I]f you think there is a better outcome for your client, then go for it, try everything, exhaust all options*". (Audrey)

Taking advocacy to a new level. The participants agreed they need to be prepared to encounter up against opposition. Therefore, they prepared to advocate, to fight for what is in the client's best interest, or at least be ready for that conflict and opposition by having a plan to counteract it. The recommendation was to:

> *[P]re-empt what you might be denied and pre-empt exactly what you can do to flog out of that and follow on and have like a direction of around 'where to from here?' sort of thing.* (Odette)

Collaborative Process

After gathering information and identifying the key stakeholders, working collaboratively with those individuals was the strongest recommendation made by all guardians. Having regular

meetings, offering transparency among the key players, and including everyone in group emails were all tactics recommended by the participants to ensure an effective approach to getting the best outcome for their clients:

> *My experience has been that there is more to be gained where you have a collaborative process for bringing in as many of the parties into some sort of strategic process by which you are trying to identify the decisions that need to be made and how those decisions are going to be implemented, and in fact that you may use that collaborative process to broaden what may be some of the options or some of the solutions.* (Claire)

Further, one well-structured meeting with all key stakeholders could deal with major concerns and reduce hundreds of emails and unhelpful phone conversations. It also further reduces the possibility of triangulation by the client or by some of the individuals involved in the decision making process.

> *My approach is not to get caught up in the immediate crises but avert the crises, the cycle of crises, by looking bigger and get everyone on board in creating a different environment and approach to the person.* (Rose)

Managing Forensic Files

When approaching these files, the participants reported using strategies that are similar to some popular therapeutic approaches.

A solution focussed approach. The solution focussed approach begins with finding out what the client wants (De Jong & Berg, 2001), which aligns with a guiding principle of

guardianship. The client takes an important role in setting the direction and making any required changes according to their views (De Jong & Berg, 2001). The participants expressed the need for their client to 'buy in' to any decision made in order to set the direction or make the changes required to avoid further involvement with the CJS. The consensus was that clients were more invested when his/her opinions and views were respected, thus, the more confident and willing they were to comply with the guardian's direction.

Although not distinctively solution focussed, all participants deferred to their dream world of where clients could have free and unrestricted access to appropriate accommodation and support services. With the realisation that those ideals do not exist, the guardians became inventive in how they would support their clients. All guardians could think of an ideal solution to their client's problems which helped them collaborate with the various stakeholders involved to begin to develop some degree of support and work towards an agreeable solution. Throughout the interviews, the participants continued to envision an ideal, where they did not view any variations from their goals as failures. Accordingly, they suggested looking at those variations as setbacks that could help further identify the problem and then begin to determine ways to successfully work toward a solution.

Problem solving. The process of making decisions for individuals under the care of the Public Guardian is similar to the problem-solving paradigm. This approach begins with assessing or identifying the problem(s) in detail and then finding a fit between the problem and solution. The participants would evaluate the progress to ensure they are acting in the person's best interests while making decisions that align with the client's needs and wishes.

A focus on the client. Guardians noted they would try to change their demeanour and attire to ensure they did not intimidate or threaten the clients by dressing too formally. By being mindful of how services were offered to their clients, how and when meetings were organised, and even how their appearance could impact their client, guardians were constantly utilising a client centred approach.

Hindsight is 20/20

Every guardian agreed that they would not change their approach but appreciated the learning curve associated with these types of files. They appreciated their experience and training, along with access to the colleagues and managers for assistance and feedback. However, all of the participants believed they dealt with these files confidently and competently. In hindsight, the participants emphasized how a protocol would be beneficial for dealing with matters that are before the courts. This protocol would contain information on how to address the court, who to contact if any matters arise before the court, and having template letters to assist in writing documents to the magistrates regarding the Public Guardian's involvement or to provide information about the client. The participants believed that a protocol would shed light on what would be expected of a guardian if and when they are required to make representations to the court in writing or in person. Finally, participants explained how these files often begin extremely intensively, requiring immediate actions. In a perfect world, the guardians would have liked more time to familiarise themselves with the file and clients before they had to make any decisions. However, using these experiences helped the guardians continue to make effective decisions for their clients.

With experience comes resiliency. Participants noted that far too often, when support services or the general population encounter issues with individuals with disabilities and mental illnesses, the initial reaction is to call emergency services. Although the participants agreed that it is important to remain safe, alternative options should be in place to prevent CJS involvement. Should the client become involved with the police, the guardians recommended that they would like to see staff not feel entirely responsible since the clients still lead autonomous lives:

> *Our role is to make decisions based on what is realistic and what's out there but then there is the criminal justice system that will deal with crime…so understanding about not getting too worried that they committed another offense.* (George)

Systemic Issues and Ethical Dilemmas

Table 9

Examples from Participant Interviews of Systemic Issues and Ethical Dilemmas Encountered

OPEN CODE	Case Examples
Principles	*"[T]he important thing is that you…don't make judgements about the person in the decisions that you're making. You follow the principles. I mean you always come back to the principles."* (George)
Best Interest	*"I think it's because she is so endearing and I know that's a terrible thing to say, but my experience is being clients that are liked tend to get more than the clients that aren't liked."* (June)
Issues	*"I find them very challenging, I find it extremely frustrating, I feel strongly about their rights and so I enjoy the process of being involved in complex cases."* (Claire)
Encounters	*"He was previously appointed to the Public Guardian but his order lapsed in 2006 as it was found to be an 'unworkable order'."* (Burt)

Principles of Guardianship

All of the guardians referred to the principles of the *Guardianship Act (1987)* when making decisions, irrespective of whether their client was involved with the CJS or not. These principles are in Section 4 of the Act and are outlined in Figure 4.

> *I can't make decisions in a person, in the interest of a third person. The guardianship act doesn't permit me to do so. Sometimes you've got to make decisions that are…there's the ideal of the guardianship order and then there's the reality of what's available. I may feel differently about the person depending on my own personal view about the crimes that the person has committed and my knowledge of them, but I will always strive to not allow that to influence me.* (George)

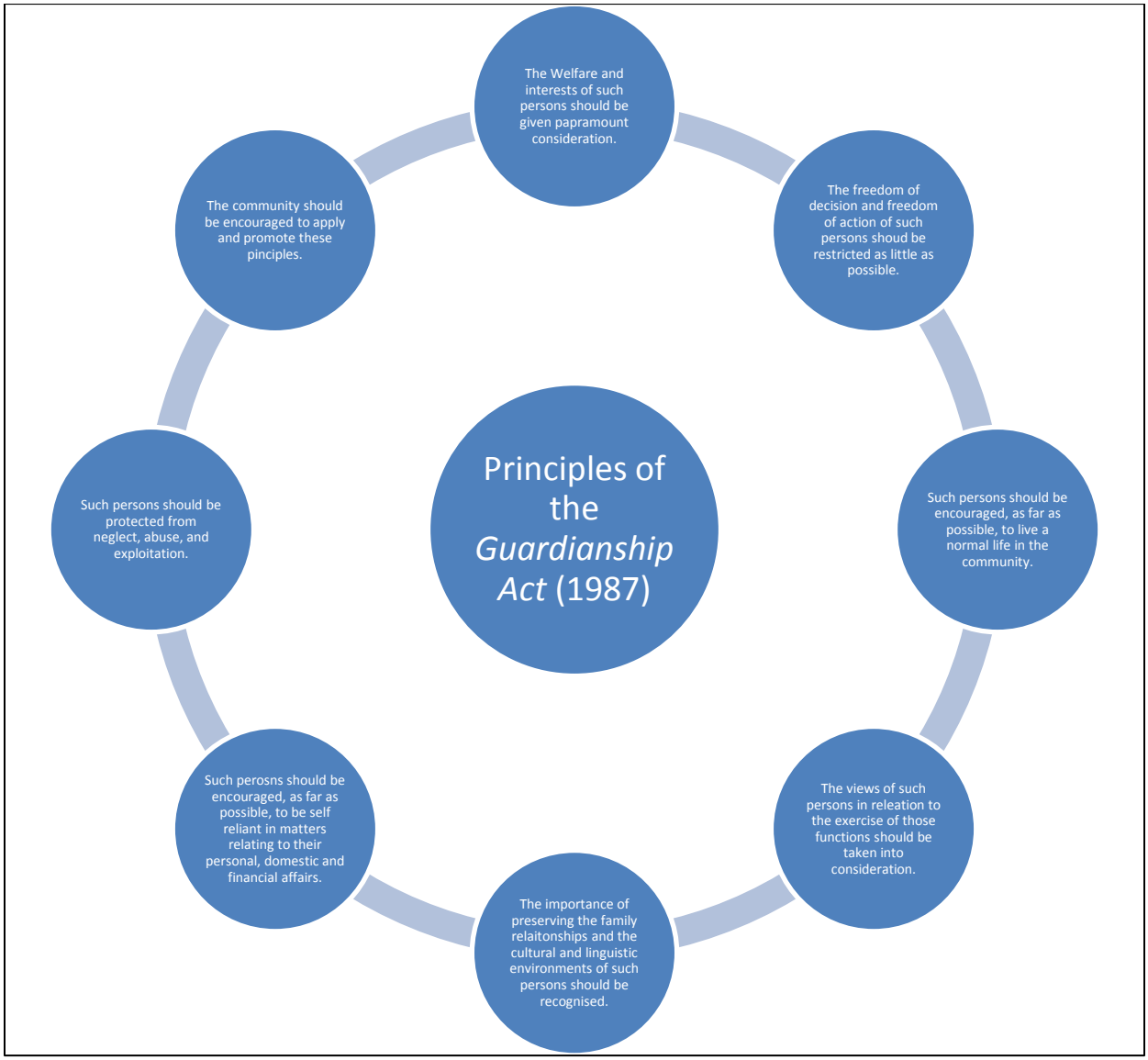

Figure 4. The guiding principles of the *Guardianship Act (1987)*

Best Interest Approach

Participants identified the best interests of the adult under guardianship as a primary consideration. In all actions concerning an adult, whether undertaken by public or private institutions, courts of law, administrative authorities, or legislative bodies, the best interests are

required to be prioritised by guardians when making decisions for their clients. The common theme of making the best possible decisions to achieve the desired outcome was apparent in every interview. However, what is in the client's best interest is not always clear:

> *They are walking with their feet and making their own choices, whether it is to use illicit substances or the company they keep, so often you go through the process of decision making but it will not lead to a suitable or desired outcome that is in their best interest* (Rose)

Far too often, participants felt the pressure to make a decision not only to protect their client, but to also protect the community and others around them. This was a dilemma for the participants as they believed that making decisions to protect the community was contradictory to making decisions in the best interest of their client:

> *When you are talking about a client who's, say a sex offender, and the level of restrictions that are going on and it's always a tricky debate about the route for justifying restrictions which are affecting the community but it cannot be about the community… It's not in their interest to commit an offence but where to draw the line where you should be making decisions on the biases of the community needs not this person's…[so] being mindful that it really is justifiable based on the persons best interest as opposed to the community's.* (Burt)

To manage this dilemma, the guardians were judicious and rationalised that, if their client was going to harm another individual, then there would be a high risk they would come into contact with the CJS, which is also not in his or her best interest.

Pertinent Issues

The most pertinent issues for the participants revolved around getting the appropriate services for their clients; however, there were a number of factors that placed their clients at further risk of incarceration. This included the clients' fluctuating views of their own needs for mental health services and wanting different things based on where they were located. For example, the participants explained that clients want different supports and services from when they are in custody compared to in the community. Further, the participants explained that another key factor that influenced their clients' risk for recidivism as the influence of external factors, such as illicit substances or undesirable associates. Most clients would engage in a variety of reckless behaviours including but not limited to drug taking, impulsivity, risky sexual interactions, assault, vandalism, stalking, and arson. From the participants' perspective, every other factor that could place this population at risk for recidivism boils down to simply not having enough resources:

> *I've had one client who sat in jail for 6 months. He was actually on parole in jail as he had nowhere to go so the main problem is not having anywhere to go and especially for people who have mental illnesses.* (Brad)

Unfortunately, this causes ambiguity among the participants, resulting in a sense of hopelessness. Betty noted that when there are no services available for a client who is then facing homelessness, he or she becomes more visible on the streets. This becomes more pertinent, as they become known to the police and may be charged with misdemeanours when they may not actually be offending at all, which was identified in Chapter 2 as mercy bookings. Therefore, the

cycle of offending continues and recidivism rates are perceived by the participants to remain the same.

Residential settings. Although there has been significant movement throughout the world to deinstitutionalise, participants frequently experienced this as an ethical dilemma. One participant recalled a decision she made for a male client to be sent to a large residential facility where he was effectively kept behind closed doors because it was the only way to keep him out of custody:

> *That was a very political decision because, well, it wasn't a decision as such, it was a proposal that the department put to us and, even though it was against our policy in terms of, you know, getting people out of large residential institutions, it really at the end of the day was identified and clinically identified as the only appropriate option for him and that is a consequence for him.* (June)

Participants also experienced the ethical dilemma of keeping clients in restrictive housing. This was upsetting to the participants because, although their clients had completed their sentences, the sentence really had not ceased because they were still being held in a restrictive setting through the coercive accommodation authority.

> *We can juggle our words very carefully to say holding somebody is the less restrictive alternative because otherwise they would go back into a prison…I think the community needs to be safe, this person needs to be protected as much as possible from themselves and from committing another crime and all that stuff but I don't know necessarily whether it's the guardianship legislation that should be used for this type of thing. There*

> *probably needs to be a separate type of legislation…I have concerns of the way the guardianship legislation is used in this area* (Marilyn).

Difficult Encounters

Participants described difficult encounters, including differing professional opinions, getting clinical advice about what would be in the client's best interest, the client not being able to articulate his/her views, and not having the role of the Public Guardian recognised and appreciated by key stakeholders. Guardians also faced the difficulty of having clients recognised for service by the funding body (ADHC), obtaining appropriate housing, locating what support service would be able to cater to the client's need, determining if the client could live independently or not, and weighing any risks associated with the client living independently as opposed to living in a supported environment such as a group home. In one case example, the Public Guardian's role was to negotiate with service providers and housing to get a male client a hotel room in the interim until services and accommodation could be secured. Unfortunately, whilst in the hotel, he re-offended and returned to jail. All services were subsequently withdrawn as the service providers refused to work with him due to his history of violence.

> *[T]he Public Guardian's authority was futile and no decisions could be made or implemented due to the client being noncompliant.* (Burt)

The Criminal Justice System

Table 10

Examples from Participant Interviews of Their Involvement with the Criminal Justice System

OPEN CODE	Case Example
Bonds	*"[S]he would no doubt break the bond and then I don't know by maybe assaulting somebody."* (Brad)
Implementing	*"Don't even bother unless that is what is in line with what he is wanting."* (Burt)
Recidivism	*"I don't think it's the Public Guardian that prevents recidivism. I don't think it's at all. I think we advocate for services and accommodation that meet's people's needs and it's that that changes recidivism so I don't think we really do that, it's not right to claim that we do it, certainly not independently."* (Rose)

The participants highlighted how it is common for the local mental health associations to become involved with the individuals once they are processed through the CJS. Participants found that after the first encounter with emergency services, clients would be assessed by the mental health workers and then taken to hospital from the court right away for further psychiatric assessment and likely admission. This can be difficult as Claire noted that "*there are frequent issues around disputed diagnoses and treatment between hospitals both in prison and out of prison, which are outside of your control*".

Breaking the Bond

Often clients involved with the CJS are not incarcerated; instead, they are released on a good behaviour bond which is considered a non-custodial alternative under Section 9 of the *Crimes (Sentencing Procedure) Act (1999).* This allows the court to direct an offender to enter

into a bond of good behaviour, which is predetermined by the court based on the individual, his/her criminal offence, diagnosis and prognosis, and support system(s). This can only be in place for a maximum of 5 years and cannot exceed the sentence that is appropriate for the original offence. If a court suspects that an offender has failed to comply with the conditions of this bond, the court may call on the offender to appear before it or may issue a warrant for the offender's arrest.

> *[S]he would no doubt break the bond and then I don't know by maybe assaulting somebody… she does get delusional and she thinks, she gets quite paranoid, and then she acts very impulsively so she thinks somebody might be trying to poison her or looking at her kind of funny or in some way she feels she's being threatened so then she'll lash out and that may become her undoing. It would be so much better if she would take her medications.* (Brad)

Community Treatment Orders

Similar to good behaviour bonds, another option is a community treatment order (CTO). A CTO directs mentally ill offenders to receive the treatment they require while remaining in the community. It is implemented when the individual has suitable accommodation and supports in place; however, the participants noted that compliance with psychiatric medications by the individual is difficult to monitor and even more difficult to enforce without the assistance of emergency services which the participants believed makes this option restrictive. Therefore, the participants often sought this option when they found every other option to support their clients had been exhausted. Although restrictive, participants frequently advocated for a CTO when

nothing else was working, and when clients' pervasive mental health issues and behaviours posed a risk to themselves and others.

Implementing the Impossible

The participants were unanimous in stating that the success of their decisions depended on the availability of resources within the community, the willingness of the key stakeholders to initiate effective support, and, most importantly, the willingness of the individual. Unfortunately, the participants noted that their decisions were very difficult to implement. The common theme through this grounded theory is the paucity of resources which makes implementing any decisions more difficult. In one instance, the participant's decision was not implemented for a client who lived in King's Cross in Sydney and was frequently arrested for soliciting and possession of drugs and was facing eviction from a public housing unit:

> *You can make decisions about anything but you can't if there's no option available or if there is no partner to work with, then it makes it extremely awkward and, my experience is that the agencies don't want to be involved in these really complicated, difficult people.* (George)

Finally, significant delays in actually providing services interfered with implementing a decision. Often, during these lengthy periods, the guardians' clients would be charged again and held in remand. Thus, the decision was made but it was never implemented due to a systems failure.

Self-Awareness and Personal Experiences

Table 11

Examples from Participant Interviews of Their Needs for Self Care

OPEN CODE	**Case Examples**
Recommendations	"*All these fantastic ideas…that aren't successful is a whole other ball game…it just depends on the decision that you're making"* (Marilyn)
Role of OPG	*"[T]he Public Guardian is recognised…it's inequitable, it's not just, but it does empower the rights of people who are pretty invisible."* (Claire)
Aha!	*"Even when you've pushed it so far, if it's still isn't right, you have to keep pushing even though people are going to hate your guts for doing it because the bottom line is like, unless it's right, you're going to be back in that situation again in 5 minutes and what that does to the person is totally erode their self-confidence, their self-concept…it's so bad for people who keep finding themselves in that cycle and situation."* (Rose)
Debrief	*"[T]hinking about other things and having other things happening like dancing, having a bath, relaxing, all those good things in life…it balances out the drama in the work place."* (Rose)

Any Recommendations?

Although this seems like an obvious question, I felt it was important as the participants would hopefully speak from the heart and from their personal experiences. The consensus was the dire need for appropriate community housing. Although the participants did not support institutionalisation in general, all participants agreed that greater options for larger premises, such as supportive community housing and community cottages where staff and support are available at all times to varying degrees, could help these individuals access appropriate facilities and professionals to support their mental health and reduce their chances of becoming involved

with the CJS.

Most Important Role of the Public Guardian

The guardians were unanimous that advocacy was the most important role of the Public Guardian. Participants also explained it is the responsibility of the Public Guardian to ensure that their clients are being properly represented and that their disabilities are actually being taken into account:

> *More often than not, if you need to be able to provide a report to the magistrate or to a solicitor, it is the guardian who can only provide the report*. (Burt)

Further, the participants all agreed that the Public Guardian was effective in supporting this population if the right supports were in place. This is because the responsibilities of exercising guardianship are clearly specified. Accordingly, guardians should be contacted when individuals with mental illnesses and disabilities do encounter the CJS. Therefore, the participants felt that onus should be on the front line workers, such as police, jail welfare workers, and the courts to identify these individuals and seek information about a client's guardianship status to ensure these individuals are not lost in the system.

Aha! Moments

I asked participants about an "aha moment", which for the purpose of this study, means a moment of sudden realisation, inspiration, insight, recognition, or comprehension. This is a concept that dates back to the Greek philosopher, Archimedes, which is known as the "eureka moment":

> *The aha moment is the magistrate wants a reason to let him off to put him somewhere other than jail give the magistrate a reason so that means show the magistrate the evidence that they have a disability and that their behaviour can be traced to the fact they are delusional or impulsive…chances are the magistrate will let them go.* (Brad).

Self-Care: The Importance of Debriefing

The participants had many ways to manage the stress associated with not only these files but their work for the Public Guardian in general. The participants utilised resources within their office and also external resources. Within the office, guardians would talk to their colleagues, supervisors, and regional managers. For example, the participants would seek out advice from their colleagues who had similar cases by discussing the intricacies of each case. Participants reported that team meetings were also helpful as they could bring complex cases forward to get input and more broad-based views and recommendations from colleagues and supervisors. Additionally, participants found it helpful to separate their emotions and morals from the person under guardianship because the crimes guardians deal with are what the client has done. It is, therefore, the guardian's job to act in their client's best interests without preconceived notions or judgements based on the crime.

Away from the office, the guardians relied on a range of self-care techniques. These included activities outside, such as gardening, exercising, cycling, and being active in general. Spending time with family and friends were also identified as a good way to distract from the dilemmas encountered working with these files. Others enjoyed taking on household projects, such as building things and home renovations. Finally, the participants relied on depersonalising

his or her work:

> *I know that the person's issues, particularly around conflict and when they disagree with a decision I've made, it's not about me as a person, it's about the Public Guardian as an institution; it's about legislation; and it's about the difference in people's own agendas.* (Audrey)

Summary

The thematic descriptions best summarise the essences of participant experiences in relation to making decisions for individuals appointed to the NSW Public Guardian who are involved with the CJS. Although participant experiences varied greatly, many common categories and themes emerged, as discussed throughout this chapter. The preceding framework underwent numerous revisions through the use of codes and memos that are utilised in the grounded theory approach. The following chapter will present these themes in relation to current literature, propose recommendations for practice, and highlight limitations of this study.

CHAPTER FIVE: DISCUSSION AND FUTURE DIRECTIONS

The aim of this study was to develop a substantive theory that explained how guardians experienced making decisions for individuals on their caseloads who were involved with the criminal justice system (CJS). The primary research question addressed by this study was: "What is the decision-making process of guardians of individuals appointed to the NSW Public Guardian who are charged and proceed through the CJS?" In this chapter, I will relate the findings of this study to the literature. I will discuss this in terms of five key areas: criminal justice involvement, approaches to decision making, the need for advocacy, barriers to making decisions, and the importance of self-care. Next, I will explore the limitations of the study and make recommendations for further research. Lastly, I will discuss the personal impact this study had on me and my work.

Findings

Criminalisation of the Developmentally Disabled and Mentally Ill

In this study, I found that Abramson's (1972) *criminalisation of mentally ill* also applies to people with developmental disabilities. This study found that the criminalisation of mentally ill also occurs to individuals with a developmental disability, along with individuals with comorbid developmental disabilities and mental illnesses. In particular, this study found that, regardless of diagnoses or disability, the alternatives to incarceration are frequently not offered to this population because the individual is required to have capacity to consent those alternatives. However, Lamb and Weinberger (2006) clarified that for these alternatives, a third party cannot consent. Further, health care professionals have an ethical and legal obligation to fully inform their patients about the nature of the treatment and subsequently obtain their consent (Lamb &

Weinberger, 1994). For individuals appointed to the Public Guardian in this study, they are not able to provide informed consent to their own treatment. Therefore, they were often overlooked.

Causes for Criminal Justice Involvement

Developmental disabilities comorbid with a mental illness occurred in 100% of the case studies provided by the participants in this study. In this study, the most common co-occurring mental illnesses with a developmental disability included personality disorders (63.6%), schizophrenia (54.5%), post-traumatic stress disorder (27.3%), anxiety (27.3%), brain injury (27.3%), and depression (27.3%). This finding aligns with previous research conducted by Teplin (1990) and Teplin et al. (1996) where the most common diagnoses within general prison populations are schizophrenia, mania, major depression, drug and alcohol abuse, and post-traumatic stress disorder.

The common offences committed by the participants' clients included some type of assault, often assault occasioning actual bodily harm, theft, robbery, prostitution, and property damage. This study demonstrated a link between mental illnesses and unlawful behaviour such as assault, disorderly conduct, criminal trespass, vandalism, disturbing the peace, petty theft, prostitution, and public intoxication. This link has also been identified in previous research, in particular the Sentencing Project in 2002.

Finally, the "revolving door" of the CJS was identified in this study as being linked to homelessness and untreated disabilities comorbid with mental illnesses. This was the leading cause for repeat "nuisance crimes" and inevitable contact with the CJS within the participants' clients.

Identification Leads to Advocacy

Early identification of offenders with a mental illness or developmental disability is critical to provide appropriate treatment within the CJS (Dagher-Margosian, 2006). Without knowledgeable advocates, such as guardians, these offenders may not obtain equal justice and could fall through the cracks. Unfortunately, most problems arise when a person is arrested and his/her disabilities are not identified. Far too often, mental illnesses and developmental disabilities are misdiagnosed and misunderstood, resulting in lower tolerance by various professionals throughout the CJS (Kirby & Keon, 2004). As a result, the guardians identified that their role is more reactive where they are expected to speak on behalf of the individual and make subsequent decisions with very minimal information, yet they need to ensure equal access to justice and fair treatment of their client.

Up Close and Personal: Approaches to Decision-Making

Individuals who have mental illnesses and developmental disabilities face many disadvantages at the various stages of their involvement with the CJS (Kirby & Keon, 2004). This study demonstrated the importance of a guardian becoming involved with the CJS on behalf of their client at any of these stages.

Police Contact

Since police are generally the first on the scene when there is a disturbance or a crime committed, the offender is at the discretion of the responding officer(s). Anything from arrest to hospitalisation to informal disposition is dependent on the officer(s) view of the severity of the disturbance, the behaviour of the offender, the frequency of his or her behaviours and diagnoses,

and the resource options available to them (Lamb & Weinberger, 2006). For some individuals, the police are often faced with no alternative but arrest, which includes mercy bookings simply to remove the individual from a dangerous or unhealthy environment (Holley & Arboleda-Florez, 1988). Within this study, the participants found that the police are lenient and compassionate to this population as they often provided warnings or returned them to their place of residence. It is suspected that this is because this may be the only way police can protect vulnerable adults who are easily victimised or are committing crimes simply to survive (Steadman, 1992; Torrey, 1995).

This study demonstrated that, if the Public Guardian is involved, there are more alternatives available if the police make contact with the guardian. However, this did not occur very often with the guardians in this study. Regardless, intervention at this stage of the CJS could be an effective early intervention instead of incarceration. This study identified how police could take an offender to his or her place of residence instead of jail, which would be initiated by the guardian. More specifically, the Guardian could utilise the coercive accommodation authority to have members of the NSW Police or Ambulance Service transport the offender from their current location to a consented upon location. Unfortunately, this does not guarantee that the individual will remain at that residence without the need for restraints or further police assistance. However, guardianship staff struggle with how restrictive this function is because at the end of the day everyone, irrespective of disability or diagnoses, has free will and, without formal charges, are entitled to come and go from their place of residence.

There are times when police and emergency services can initiate hospitalisations for people who are either a danger to themselves or others. Consent can be provided by the Public

Guardian through the "Accommodation" function for a voluntary admission or the individual can be admitted through the *Mental Health Act* as an involuntary patient. At this stage, the person under guardianship could avoid charges and any subsequent incarceration, while receiving the necessary treatment he or she requires to avoid future contact with the law. Unfortunately, the Public Guardian is rarely contacted at this point unless the guardian has initiated the contact or the individual is well known to emergency services.

Jail Booking

This study demonstrated that there are ways for guardians to prevent jail bookings; however, it was difficult for the participants to intervene on their clients' behalf at this point in the CJS involvement because the Public Guardian was rarely contacted by jail officials or police. This is unfortunate as studies have indicated the importance of diverting an individual with mental illnesses or developmental disabilities from jail to community services (Lamb & Weinberger, 1994), especially when the person has been arrested for less serious, non-violent crimes. Further, this study demonstrated that it is preferable for guardians to become involved at this stage as there are more opportunities available to clients before they receive a formal criminal record, which inevitably can help reduce further recidivism within the clients. This finding is supported by the Policy Research Associates (2014) who identified that people receiving the appropriate treatment and support in the community generally have a better long-term prognosis and are less likely to return to jail for a similar offence. However, the guardians surmised that minimal contact at this stage is likely because the diversion services available are very limited in urban areas and essentially non-existent in rural areas. The paucity of resources became a common theme throughout this study, which only further makes the implementation of

any decision more difficult.

Court, Trial, and Sentencing

Many guardians identified recurring obstacles to successfully navigating the court system on behalf of their clients, primarily, they frequently found out their clients were due before the court shortly before the court date. Irrespective, every guardian identified the need to ensure the magistrate or judge, along with others involved with the court process, were aware of the role of the Public Guardian and how a mental illness, development disability, or both may have played a role in the current charges faced by the individual. This is because courts are, by nature, a fact-finding body (Zapf, 1995).

If a guardian was not able to attend court, they would write letters to the magistrate explaining their client's disability and diagnoses and would provide a copy of the guardianship order along with any support plans developed for the client with the hopes for a more lenient sentence. This is because there are strict rules related to the conduct within a courtroom, which the guardians found only further alienated and subsequently punished their clients. For example, one participant explained how their client was charged with being in contempt of the court, simply because they addressed the court and continued to speak in their defence when directed to stop by the Magistrate. The stress of attending court was noted in this study for both clients and guardians alike, which aligns with the fact that mentally ill and developmentally disabled individuals have difficulty understanding these court processes and etiquette, making it incredibly difficult for them to function in such a formal and strenuous environment (Dagher-Margosian, 2005; Pfeiffer, 2005). Commonly, the desired outcome of the participants in this

study was to obtain clear instructions from the court to assist in getting the offender into the services they need through specific direction from the court to health care and service providers. There were a number of alternatives identified by the participants, such as hospitalisation or community treatment orders, but the recurring theme of a lack of resources made it difficult for the courts to even grant orders to sanction health care and service providers to offer these alternatives.

Incarceration

Many participants in this study were anxious about their clients being incarcerated; however, there were a few who hoped incarceration would act as a deterrent for further criminal behaviours. A recurring theme was that prison and remand facilities were used to manage the offenders when there were no services available, a Community Treatment Order could not be enforced, and the hospitals refused admission. This coincides with research that shows that prisons are frequently used as a means to manage offenders with mental illnesses and disabilities (Torrey, 1997).

The fear that the participants had in this study surrounding incarceration for their clients is supported in the research available. In particular, prison conditions have been found to be detrimental to this population (Chappell, 2004). For example, individuals with a disability and/or mental illness may have more difficulty learning and understanding the rules and regulations of correctional facilities which could result in the accumulation of rule infractions and could lead to denial of early parole (Bodna, 1987). Further, many prison programs do not accept individuals with mental illnesses and struggle to work with individuals with

developmental disabilities (Fisher, 1992). Therefore, all of the guardians in this study emphasised the need to pursue alternatives to or prevent incarceration whenever possible.

When incarceration was inevitable, guardians can step in to ensure the various institutions involved are aware of their client's diagnoses and attempt to ensure they are protected whilst serving their sentence. To do so, the most common route is to consent to the release of the individual's information to the various stakeholders involved, including prison officials, welfare officers, and the medical team serving the facility. In this study, the participants would do this in an attempt to protect their clients from potential harm since research has demonstrated that this population is at risk for being the targets of assault, exploitation, extortion, and sexual abuse when incarcerated (Smith, 2005).

Accessing Legal Representation

Throughout this study, it was noted that the Public Guardian is increasingly appointed the legal function in a guardianship order, which allows the guardians authority to appoint and instruct legal practitioners for a person under guardianship who has become involved with the CJS. In these situations, guardians work closely with their client's lawyers to ensure every reasonable effort is made to prevent further incarceration or to ensure he or she receives alternatives to incarceration. Since there is a chance of mentally ill and developmentally disabled individuals missing out on alternatives to incarceration, guardians are required to interact with the CJS at varying levels and to differing degrees. Thus, the onus is placed on the guardian to ensure that their clients' rights are protected and to ensure all options are explored. Knowing what options are available through the courts was paramount to the participants' legal

decision making and will subsequently be discussed.

Alternatives to the CJS: Diversion Programs

In this study, the participants emphasised the need to take every opportunity to pursue diversion into the community. This is because correctional facilities are poor settings for providing mental health care to individuals with mental illnesses and developmental disabilities (Riches et al., 2006). A number of programs were identified in this study as potential diversions from the CJS; however, the common theme of paucity of resources limited the participants in what diversion programs were available. Another theme of ethical dilemmas also revealed concerns guardians had about pursuing this alternative to incarceration.

Diversion programs are appealing as they can potentially help save money by lowering the recidivism rates of mentally ill and developmentally disabled offenders (Steadman et al., 1999). The Substance Abuse and Mental Health Services Administration (SAMHSA) described how the best diversion programs view the offenders as members of the community who require a broad array of services, both general and specialised, including mental health and substance abuse treatment, housing, and social services. However, the participants identified that, due to the deinstitutionalisation movement, there are limited options and alternatives available within the community. The participants in this study were, therefore, sceptical of the success of these options without having the services and support in their entirety, including community based treatment, case management services, and accommodation.

Another concern raised by the guardians, which aligns with current research, is that these types of alternatives to prison end up lasting significantly longer than a simple prison sentence

(Steadman et al., 1995; Steadman et al., 1999). The guardians noted that some of their clients wanted to serve time and be done with their sentences as opposed to the alternatives that were being advocated for and would subsequently last longer than the standard prison sentence. Additionally, participants noted that when offenders were released from prison into community based support, ethical boundaries were crossed as the individuals had served their time; however, using the coercive authority of the Public Guardian, restrictions and boundaries were placed on the individual for a significantly longer period of time than if he or she simply did their time.

Finally, another conundrum for the participants was how the objective of the *Guardianship Act* (1987) is to ensure decisions are made in the person's best interest, yet, diversion from the CJS to civil or treatment systems must be designed to not only protect the individual but also to protect the community around them. Diversion programs cannot solely take into consideration the best interest of the individual and the question becomes if the alternatives to prison truly are in the person's best interest.

Alternatives to the CJS: Community Treatment Order

Another alternative to incarceration was identified in this study, which is placing an offender with mental illnesses on a community treatment order (CTO). This is a legal order made by the mental health tribunal or a magistrate under the *Mental Health Act (1990)* and orders a person to accept treatment, medication, therapy, counselling, care, rehabilitation, and management provided in the community by a nominated mental health facility. To pursue this route, guardians are required to advocate to the court and identify the services available within the community to ensure the appropriate degree of support is available to curb the individual's

offending behaviour whilst providing them the necessary support and treatment. Often a CTO requires a plan be prepared by a case manager, psychiatrist, or other mental health professional that outlines how the person will be managed while in the community (Lamberti et al., 2004). This plan is presented to the court or tribunal for approval and is specific to the individual's diagnoses and conditions while outlining the obligations of the client, guardian, and treating team (Lamberti & Weisman, 2004). If the person refuses or fails to comply with the treatment plan and there is a significant risk of mental or physical deterioration, they can be found in breach of the order and taken back to a mental health facility or returned into custody (Lamberti et al., 2004). Unfortunately, many guardians did not find this was an influential deterrent to their clients, nor did the CTO influence positive change in their clients criminal behaviours, such as reducing contact with the Police or being found in breach of their CTO. Instead, they often encountered noncompliance and disregard of the consequences of their noncompliance.

Alternatives to the CJS: Addictions Treatment

The participants in this grounded theory found that, predominantly, mental health centres decline to treat alcoholics and drug addicts; emergency rooms are unwilling to treat the mentally ill who are under the influence of substances; and addiction treatment programs find the mentally ill and developmentally disabled too disruptive so refuse them entry. A major caveat of any treatment approach is that the individual is willing and able to participate in the treatment program (Borzecki & Wormith, 1985) and the treatment cannot have a coercive component (Urbanoski, 2010). This brings up the debate around whether a person under guardianship can consent and is agreeable, thus willing, to engage in treatment programs. In addition, with reduced capacity, mental health professionals often query whether these individuals can

successfully complete certain addiction treatments without having to cater the program to meet their needs.

This study proposed that the Public Guardian's authority could override a person under guardianship's objections to treatment and, subsequently, consent to the proposed addictions treatment on their behalf. However, in the guardians' recounts of the decisions they made regarding addiction treatment programs, these types of decisions were rarely successful.

It Is Not Just Decision Making, It Is Advocacy

While there are many aspects of each guardian's decisions that are similar, such as utilising solution focused approaches, there are also differences between the approaches and how decisions are made. For example, the primary difference was how guardians viewed the decisions they were making and whether they felt those decisions were ethical. Irrespective of the differences in approach, the route of all decisions was the need to advocate and seek what is in the best interest of the individual. Advocacy was, therefore, the central phenomenon of every guardian and their approach to working with this population. The themes and underlying categories that emerged from participant interviews indicates that guardians are required to advocate for their clients more so than make decisions. In addition, guardians are responsible for advocating for a more coordinated system follow-up and aftercare through support services. Unfortunately, very few programs exist that cater to individuals with disabilities and mental illnesses. For example, service providers often lack the specialist training and have insufficient resources to deal with dual or multiple disabilities (Human Rights and Equal Opportunity Commission, 1993). Research continues to support the assertions that, if a lack of adequate

community resources and services is one of the main reasons for the criminalisation of the mentally ill, then the improvement of community services is key to making systemic change and to appropriately support this population. This is precisely what the guardians found they were advocating for.

An Important Facet of Advocacy: Collaboration

This study consistently demonstrated the importance of stakeholders and guardians working collaboratively in order to achieve a successful outcome for developmentally disabled and/or mentally ill offenders, especially when the goal is to reduce recidivism among this population. This fits with research completed by Weisman and colleagues (2004) who argued that "integration between a number of mental health and medical services within the community is imperative" (p. 78). A major theme of this study aligns with this research: the need to work as a collaborative team to ensure transparency and consistency among professionals, the guardian, and the client.

Barriers to Decision Making

Growing literature demonstrates the need for a better fit between client motivation, their best interests, and the services provided (Prochaska, DiClemente, & Norcross, 1992). If there is a lack of services available or there is minimal "buy in" from the client or their support team, the participants found that decision making was redundant. This left the guardians with feelings of helplessness and that it was only a matter of time before their client would engage with the CJS again. Thus, many participants reported that they did not feel the Public Guardian's involvement with this population was effective at reducing recidivism.

In this study, it was noted that utilising the guardianship principles identified in the *NSW Guardianship Act* (1987) and having years of experience and training assisted the decision making process for the guardians working with this population of individuals who find themselves entangled in the CJS. The effectiveness and implementation of those decisions is, however, dependent on many other factors, often ones that are outside of the guardian's control and decision making ability. Beings knowledgeable of the applicable legislation and to work collaboratively with the services and supports available was a priority for the participants as it assisted them in implementing decisions and to further advocate for the clients. However, issues surrounding accommodation and services continue to remain the caveat for successful support for any individual under guardianship as evidenced by this recurring theme throughout this study.

Implementing the Impossible

Guardians found that one of the most difficult factors was trying to implement the decision, which was found to be impossible a majority of the time. Since the decisions required for this population are primarily accommodation and services, the participants felt their decisions could have had all the right parts to work effectively, but the lack of resources made them impossible. The United Nations Office on Drugs and Crime (2006) identified strategies on how to best support individuals returning to the community following incarceration:

> *[T]his is not an issue that can be resolved by legislation and institutions alone, however. The families of offenders, their immediate circle of friends, and the community have a fundamental role to play in assisting the offenders' return to society and supporting ex-*

offenders in rebuilding their lives.

In the few cases where the guardians were involved prior to the release of the offender, success was noted when an emphasis was placed on the provision of appropriate care based on the individual's needs and the natural supports they had. However, due to minimal resources available to this population, the guardians were left to feel like they could not enact positive change and that their involvement was not helpful at reducing recidivism.

Ethical Dilemmas

Although making decisions in a person's best interest can be simple on paper, making a decision on behalf of an individual involved with the CJS caused significant distress among the participants. For example, many guardians were asked to make decisions that were conducive to keeping the community safe, but would render their client in extremely restrictive environments, often indefinitely. Further, guardians would be asked to consent to medications that would ultimately alter their client's demeanour and behaviour or was simply used to sedate the individual to prevent recidivism. Irrespective of the decision being requested, the participants encountered an array of ethical dilemmas along the way, which will be discussed.

Accommodation. Although deinstitutionalisation was supposed to uphold the rights of mentally ill and developmentally disabled individuals, if one examines the UN Convention requirement of least restrictive treatment, it has resulted in further abuses of and discrimination against the exact population it was supposed to help. In this study, I found that most clients were often kept in secure and restrictive environments in the community to try to prevent further involvement with the CJS. Irrespective of whether the clients were in the community through

diversion programs, the use of a Section 32 order, or a probation and parole order, the participants found their clients inevitably had longer "sentences" because of the restrictive accommodation models that were required or were the only option available. This led to distress among the participants as they did not feel that their clients should be subjected to such punitive approaches or constraints and were essentially another form of imprisonment and institutionalisation. Although the participants were required to consent to such restrictive environments, they would often advocate for greater options in alternative accommodation. This fits with current research, which demonstrates that the most effective protection for this population arises from earlier access to better treatment delivered in non-custodial environments by natural supports, psychologists, psychiatrists, and doctors (Hickie, Groom, & Davenport, 2004).

Coercive accommodation and involuntary admissions. In this study, the guardians identified that they pursue an alternative avenue to prison for the purpose of obtaining a report on their client's mental condition to avoid incarceration and pursue treatment. This alternative is to utilise the coercive accommodation function within the Guardianship Order to have an individual admitted to hospital instead of going to prison. This fits with Humphrey's (2000) assertion that individuals with mental illnesses should be sent to hospital as opposed to prison by making them subject to a hospital order with or without restrictions on their discharge. To pursue this route, the person must be actively engaged with the CJS or are an active threat to their own safety or the safety and wellbeing of others and the community around them (Kitchener & Harding, 1990).

The guardians in this study valued a clear understanding of the mental health and guardianship legislation, along with an understanding of the laws surrounding civil detention. It

was believed by the participants that this would ensure the best possible avenue was taken for their clients by allowing the guardian to offer guidance to individuals, agencies, and various stakeholders who are less familiar with that legislation (Humphrey, 2000). However, guardians noted they must avoid 'institutional discrimination' which is defined as the unjust and discriminatory mistreatment of individuals by organisations, governments, public institutions, and societal entities based on their identity, race, ethnicity, gender, sexual orientation, and, in the case of this study, their disabilities and mental illnesses (Aronson, Wilson, & Akert, 2010). Thus, the guardians identified the continued discrepancy surrounding whether a person engaging in criminal activity who has a mental illnesses or developmental disability warrants an admission to hospital.

Administration of medication and hospitalisations. Guardians noted the difficulties in securing hospital admissions due to a shortage of beds and the strict referral and diagnosis criteria if utilising the *Mental Health Act* (2007). Therefore, the participants found this necessitates 'arrest by default' (Davis, 1992) which they felt condemns disadvantaged and mentally ill members of society to more years of potential abuse, neglect, and further deterioration of mental and physical health due to the very system that is put in place to try to protect them. This then places the wellbeing of those individuals at risk, sparking further increases in the need to access mental health care services (Mental Health Commission Association, 2012).

The UN Convention for Human Rights makes it very clear that people cannot be hospitalised against their will without legal representation or under mental health legislation. Further, treatment with medication that has potentially harmful side effects frequently deters

individuals from voluntarily seeking treatment, irrespective of their capacity to consent to such treatment (Lamberti et al., 2004). Therefore, when an individual is refusing treatment, it is not always clear if they are lacking capacity or simply being oppositional. It is much clearer for psychiatric teams when an individual has a guardian appointed. This is because guardianship does not leave any grey areas as to who the decision maker is and, therefore, who should be contacted when individuals with mental illnesses and disabilities do encounter the CJS and are taken to hospital as opposed to incarceration.

Services. In this study, I found that most clients would engage in a variety of reckless behaviours without understanding the consequences. From the participants' perspective, this is a problem with simply not having enough resources and services available to their clients. This fits with research conducted by Ball (2001), highlighting how individuals diagnosed with mental illnesses and developmental disabilities are charged with criminal offences due to a lack of community and mental health services, particularly in rural and regional areas. Further, as available resources shrink, fewer services are targeted to high risk offenders, who were found to be the bulk of the clients on the guardian's caseloads in this study. In those situations, the guardians would default to advocating for services but often this was for naught.

Another Hurdle: Client 'Buy In'

In this study, the decisions made on behalf of an individual under the care of the Public Guardian must be in line with what their client's wishes are to get commitment to those decisions. This is required for the successful implementation of any decisions made by the guardian, otherwise, they are moot. Even with client buy in, the participants unanimously agreed

that the success of their decisions was dependent on the availability of resources within the community, the willingness of the key stakeholders to initiate effective support, and, most importantly, the willingness of the individuals themselves to cooperate with the implementation of the decision. Ultimately, the client does what he or she wants to do because there has to be a degree of autonomy, freedom, and independence. Thus, they run the risk of recidivism despite the guardian's best efforts to the contrary.

The Ever Important Need for Self-Care!

The need for self-care was a common theme in every participant interview. This is supported by Krauss-Whitbourne (2015) who asserted that knowing how to care for oneself is just as important as and the most effective way to care for others. Consistent with Krauss Whitnourne, the participants identified the importance of leaving work at their office and enjoying what their lives had to offer outside of work. For example, they would participate in a range of physical activities, including cycling home from work, attending dance lessons, or going for a hike. Other activities were less physically demanding but still offered a release from their day to day stresses associated with the guardian role. This is consistent with finding that developing an alternative, healthy activity allows a person to withstand the stress of their work. The participants also identified spending time with their loved ones, enjoying a glass of wine (or two), cooking, or simply reading a good book would help them release their stress. Being with people outside of the work situation has been demonstrated as being an effective way to restore mood stability and a sense of normalcy (Bamonti, Keelan, Larson, Mentrikoski et al., 2014).

Appreciating the need for confidentiality given the vulnerable adults the participants

worked with, they ensured they would not discuss any cases with their friends or family; however, all of the participants valued the need for formal and informal supervision, opportunities to debrief with their colleagues or supervisors, and the ability to discuss these cases at team meetings to share experiences and ideas. This normalised what the guardians experienced and gave them opportunities to discuss alternatives to their approaches or to create new ideas and approaches. All of these approaches prevented burn out among the participants and research demonstrates that having a work environment that promotes self-care is imperative to a happy and healthy employee, thus, workplace (Bamonti et al., 2014).

Future Directions

When participants were asked to determine who could take on an advocacy role to better support offenders with mental illnesses and developmental disabilities, the suggestions were inconsistent and difficult to identify. The guardians could not come up with an alternative that would have the authority to access confidential information and instruct legal professionals, while being able to effectively support the client. Further, it is impossible to prevent clients from committing offences irrespective of what type of statutory official is appointed or support service is in place. DeJong and Berg (2001) believe that by giving a client a sense of choice and control is essential when working with them; however, as every guardian noted, having the capacity to make a decision and choosing to make bad decisions are two different things. Thus, the Public Guardian, regardless of what authority is granted by the courts, cannot prevent recidivism because a guardian is a decision maker at any point in time; what happens thereafter is beyond their control. Therefore, this research did not offer any alternatives to having a guardian appointed for individuals involved with the CJS. More research would be beneficial to

determine if another advocacy-type role would better serve this population and assist in the reduction of recidivism.

Bringing it All Together

The guardians in this grounded theory unanimously noted that the role and the authority of the Public Guardian is recognised in a court of law and in many systems, ranging from health to criminal justice, and within service providers to the lay person. It is inequitable, but it does empower the rights of people who are potentially invisible to all of these systems. The Public Guardian can play important roles at various stages of involvement with the CJS. For example, guardians can consent to release or withhold information; advise police about the need to interview a person in the presence of an "appropriate adult"; advocate for a person to be assisted by a service provider; make representation to the Police; seek the advice of legal professionals; and make written representation to the Court advising of the Public Guardian's involvement with a person. They appreciate the collaborative team approach and acknowledge that effective multi-disciplinary teamwork is central to the management of this population at almost every stage of their care and treatment; however, there are limitations.

Limitations to Guardianship

The Public Guardian should play a more active role in seeking to ensure that the rights and liberties of people with mental illness and developmental disabilities are upheld within the context of matters coming before the courts in NSW. Currently, there is no way to determine if a person is under the care of the NSW Public Guardian. If a guardian is not contacted when a person becomes involved with the CJS, they could potentially fall through the cracks or may not

receive the services they require and are entitled to. Further, there is no evidence within this study or other research currently available that the Public Guardian can effectively reduce recidivism. Swanson, Swartz, Essock, Osher, Wagner, Goodman et al (2002) noted that modest reductions in recidivism are likely because some programs targeted criminogenic needs and mental health. These needs include the established history of benefitting from criminal activity; a social environment that encourages and tolerates crime/criminals; the personal attitudes and values supportive of criminal behaviour; personality styles that find impulsive, high risk behaviour rewarding; and substance abuse (Swanson et al., 2002).

Study Limitations

Although grounded theory seeks to identify the knowledge that is faithful to the local circumstances and the interpretations of individuals in those situations, the common themes derived from this study are only reflective of the participants who took part in the research (Creswell, 2007). This study sample was limited to only 11 individuals, a concentration of which was from the NSW Public Guardian. Further expansion of the participant pool could have been explored to include Public Guardians in other states and/or territories in Australia, along with Public Guardians in Canadian provinces. Although the Canadian counterparts were discussed briefly in Chapter 2, a comparison of approaches to guardianship among the countries would also be beneficial to determine the strengths and weaknesses of the Public Guardian's involvement with this population. A second phase of this study could compare the approaches utilised by the NSW Public Guardian to the Alberta Public Guardian, for example.

There is minimal research available to support some of the assertions and theories that

arose from this study. Therefore, this does not completely align with grounded theory in its purity as the research in this study is not entirely grounded in the literature available. However, this study did successfully examine and catalogue conceptual models that accurately describe the guardians' experiences and identified the common themes that influence decisions made for developmentally disabled and/or mentally ill offenders.

Further, this study was unable to compare mentally ill and/or developmentally disabled offenders who do have an appointed guardian to those without. This would be beneficial to see if the guardian's involvement does have an impact on recidivism rates. It could also shed light on whether having a guardian better assists in access to appropriate housing and much needed services. Finally, as one participant identified, the courts do place more weight on the Public Guardian's authority but determining to what degree, if any, would be beneficial. However, this could lead to abuse of the Public Guardian's authority and seeking the appointment of the Public Guardian as offenders may begin to demand they have a guardian. In this situation, a survey could have been sent to the magistrates and judges involved with these cases to see how they would respond to an individual with and without a Public Guardian appointed, along with their preferred judgements for this population.

Suggestions for Future Research

Since this study was exploratory, there are many possibilities for future research in relation to this specific topic, and more general research into Public Guardianship. Little research exists on the effectiveness of the Public Guardian in making decisions on behalf of developmentally disabled and mentally ill offenders, so the opportunities to further this research

are endless. For example, a comparison of approaches to guardianship in different countries that have a Public Guardian would be beneficial to determine the strengths and weaknesses of each. Another area of exploration could involve a longitudinal study to see results of specific decisions made by participants and determine if those decisions do impact the rates of recidivism. Finally, comparing mentally ill and developmentally disabled offenders who do have an appointed guardian to those without could be beneficial to see if the guardian's involvement does have an impact on recidivism.

Personal Reflections

I had selected the topic of my thesis at least a year before I started to work on it. I began with investigating mental health courts and progressed to querying what role, if any, the Public Guardian could play in potentially reducing recidivism among mentally ill offenders. I realised I needed to incorporate developmentally disabled offenders as, in order for a guardian to be appointed, a person must be lacking capacity to make informed major life decisions due to a developmental disability, brain injury, or age related illness (*NSW Guardianship Act*, 1987). Just because a person has a mental illness does not mean they are lacking capacity. Similarly, just because someone is making poor life choices, does not mean they are mentally ill and/or developmentally disabled. Thus, in order to investigate whether the Public Guardian plays a role in reducing recidivism, I needed to look at the larger picture by incorporating how a guardian plays a role with this population, how decisions are made, and if participants did believe they had a positive impact on reducing recidivism.

Participants flocked to me with little effort, all eager to share their experiences. I believe

this was also a way they could debrief about their experiences in a safe and confidential manner. Participants were forthcoming with information about their clients as this study was supported by the Public Guardian. There was no concern with breaching confidentiality as I was also a member of the NSW Public Guardian team and could appreciate the need to protect the identity of this vulnerable population.

If the reader takes anything from this project, I hope it is a heightened awareness of the plight developmentally disabled and mentally ill offenders face, along with everyone who supports them, ranging from family and friend, to professionals and guardians.

I found tremendous strength, patience, sacrifice, and humour in my participants. I was inspired by their journeys. Listening to their self-care strategies gave me new perspectives on how to debrief and approach decision making for this population

Conclusion

Guardianship laws appoint the Public Guardian for people who do not have the capacity to make their own decisions about important personal matters or lifestyle decisions (Rees, 2010). There is a strong emphasis on promoting autonomy of people to make their own decisions whenever possible; however, a guardian is required when individuals are no longer able to make informed decisions that are in their best interests (Guardianship Act, 1987). This study set out to explore the participants' experiences when making decisions for individuals on their caseloads who were involved with the CJS. The participants explained a range of reasons why a person under the care of the NSW Public Guardian may become involved with the CJS. They explained the disabilities and diagnoses they often encountered, along with the most common crimes

committed by their clients. Finally, they explained the decisions they had to make and how they made them. The most recurrent theme that arose from this study was the need to advocate for this vulnerable population at any stage of involvement. Although the guardians noted they were always reactionary and had to make decisions with minimal information or at later stages in the CJS than desirable, they always tried to advocate for alternatives, for more services, and to ensure they were acting in their clients' best interests. At all times, they valued making effective decisions by using tried and tested approaches, which they happily shared, or accept recommendations from their colleagues. Finally, the guardians emphasised the need for self-care to ensure they could remain in their roles and offer the best assistance to their clients, irrespective of whether they were effective at reducing recidivism.

References

Abramson, M. F. (1972). The criminalization of mentally disordered behavior: Possible side-effect of a new mental health law. *Psychiatric Services, 23*(4), 101-105. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/5023600

Adult Guardianship and Trusteeship Act (2010). Retrieved from the Government of Alberta, Human services website: http://www.humanservices.alberta.ca/documents/opg-guardianship-publication-opg0680.pdf

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders-IV-TR* (Fourth ed.). Arlington, VA: American Psychiatric Publishing Inc.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders (5th ed.)*. Washington, DC: American Psychiatric Publishing Inc.

Angermeyer, M., & Matschinger, H. (1996). The effect of personal experience with mental illness on the attitude towards individuals suffering from mental disorders. *Social Psychiatry and Psychiatric Epidemiology, 31*(6), 321-326. doi:10.1007/BF00783420

Appelbaum, P. S. (1994). New directions in the assessment of dangerousness of the mentally ill. *Psychiatry and Clinical Neurosciences, 48*(s1), 77-83. doi:10.1111/j.1440-1819.1994.tb03042.x

Appelbaum, P. S., Robbins, P. C., & Monahan, J. (2000). Violence and delusions: Data from the MacArthur violence risk assessment study. *American Journal of Psychiatry, 157*(4), 566-572. doi:10.1176.157.4.566

Arboleda-Florez, J., & Holley, H. L. (1988). Criminalization of the mentally ill: Part II. Initial detention. *Canadian Journal of Psychiatry. Revue Canadienne De Psychiatrie, 33*(2), 87-95. Retrieved from http://www.researchgate.net/publication/19789964_Criminalization_of_the_mentally_ill_Part_II._Initial_detention

Aronson, E., Wilson, T. D., & Akert, R. M. (2010). Social Psychology (7th edition). New York: Pearson.

Bachrack, L. (1983). An overview of deinstitutionalization. In L. Bachrack (Ed.), *New direction for mental health services: Deinstitutionalization* (pp. 5-14). San Francisco: Joseey-Bass.

Ball, W. D. (2010). E Pluribus Unum: Data and Operations Integration in the California Criminal Justice System. *Stanford Law & Policy Review*, *21*, 277-291. Retrieved from http://heinonline.org/HOL/LandingPage?handle=hein.journals/stanlp21&div=18&id=&page

Bamonti, P. M., Keelan, C. M., Larson, N., Mentrikoski, J. M., Randall, C. L., Sly, S. K., Travers, R. M., &McNeil, D. W. (2014). Promoting ethical behavior by cultivating a culture of self-care during graduate training: A call to action. *Training and Education in*

Professional Psychology, *8*(4), 253-260. Retrieved from http://dx.doi.org/10.1037/tep0000056

Barker, S., Barron, N., McFarland, B. H., & Bigelow, D. A. (1994). A community ability scale for chronically mentally ill consumers: Part I. reliability and validity. *Community Mental Health Journal*, *30*(4), 363-383. doi:10.1007/BF02207489

Barker, S., Barron, N., McFarland, B. H., Bigelow, D. A., & Carnahan, T. (1994). A community ability scale for chronically mentally ill consumers: Part II Applications. *Community Mental Health Journal*, *30*(5), 459-472. doi:10.1007/BF02189063

Baroff, G. S. (1996). The mentally retarded offender. In J. W. Jacobson, & J. A. Mulick (Eds.), *Manual of diagnosis and professional practice in mental retardation* (pp. 311-321). Washington, DC: American Psychological Association. doi:10.1037/10203-024

Belcher, J. R. (1988). Are jails replacing the mental health system for the homeless mentally ill? *Community Mental Health Journal*, 24(3), 185-195. doi: 10.1007/BF00757136

Bodna, B. (1987). People with intellectual disability and the criminal justice system. In D. Challinger (Ed.), *Intellectually Disabled Offenders.* (pp. 11-36). Australian Institute of Criminology. Retrieved from https://www.ncjrs.gov/pdffiles1/Digitization/109708-109719NCJRS.pdf

Bonta, J., Law, M., & Hanson, K. (1998). The prediction of criminal and violent recidivism among mentally disordered offenders: A meta-analysis. *Psychological Bulletin, 123*(2), 123. doi:10.1037/0033-2909.123.2.123

Borzecki, M., & Wormith, J. (1985). The criminalization of psychiatrically ill people: A review with a Canadian perspective. *Psychiatric Journal of the University of Ottawa, 10*(4), 241-247. Retrieved from http://psycnet.apa.org/psycinfo/1987-01428-001

Brink, J.H., Doherty, D., & Boer, A. (2001). Mental disorder in federal offenders: A Canadian prevalence study. *International Journal of Law and Psychiatry, 2*, 330-356. doi:10.1016/S0160-2527(01)00071-1

Broner, N., Franczak, M., Dye, C., & McAllister, W. (2001). Knowledge transfer, policy making and community empowerment: A consensus model approach for providing public mental health and substance abuse services. *Psychiatric Quarterly, 72*(1), 79-102. Retrieved from http://link.springer.com/article/10.1023/A:1004814220940#

Butler, T., Andrews, G., Allnutt, S., Sakashita, C., Smith, N. E., & Basson, J. (2006). Mental disorders in Australian prisoners: A comparison with a community sample. *Australian and New Zealand Journal of Psychiatry, 40*(3), 272-276. doi:10.1111/j.1440-1614.2006.01785.x

Calgary Homeless Foundation. (2002). *2002 Calgary homelessness study: Final report.* Calgary, AB. Retrieved from http://homelesshub.ca/ResourceFiles/Calgary%20Homelessness%20Study%202002.pdf

Canadian Institute for Health Information (2008). *Health Indicators*. Ottawa, ON. Retrieved from https://secure.cihi.ca/free_products/HealthIndicators2008_ENGweb.pdf

Canadian alliance on mental illness and mental health. (2014). Retrieved from http://www.camimh.ca/

Carr, D. K., & Litmann, I. D. (1991). *Excellence in government: Total quality management in the 1990s*. Arlington, VA: Coopers & Lybrand.

Chappell, D. (2004). Protecting the human rights of the mentally ill: Contemporary challenges for the Australian criminal justice system. *Psychiatry, Psychology and Law, 11*(1), 13-22. doi: 10.1375/pplt.2004.11.1.13

Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis.* London: Sage Publications Ltd.

Cockram, J., & Underwood, R. (2000). Offenders with an intellectual disability and the arrest process. *Law in Context, 17*(2), 101. Retrieved from http://search.informit.com.au/documentSummary;dn=145852620032220;res=IELHSS

Conley, R. W., Luckasson, R., & Bouthilet, G. N. (1992). *The criminal justice system and mental retardation: Defendants and victims.* Baltimore, MD: PH Brookes Publishing Company.

Correctional Services Canada. (2009). *Report on plans and priorities 2008-2009.* Retrieved from https://www.tbs-sct.gc.ca/rpp/2008-2009/inst/pen/pen-eng.pdf

Creswell, J. W. (2007). *Qualitative research inquiry and research design: Choosing among five approaches.* (2nd ed.). Thousand Oaks, CA: Sage Publications Ltd.

Creswell, J. W., Hanson, W. E., Plano, V. L. C., & Morales, A. (2007). Qualitative research designs selection and implementation. *The Counseling Psychologist, 35*(2), 236-264. doi:10.1177/0011000006287390

Creyke, R. (1991). Enduring powers of attorney: Cinderella story of the 80s. *University of Western Australia Law Review, 21*, 122-124. Retrieved from http://heinonline.org/HOL/LandingPage?handle=hein.journals/uwatlw21&div=9&id=&page

Dagher-Margosian, J. (2006). Representing the cognitively disabled client in a criminal case. *State Bar of Michigan Annual Meeting, 2*(2). Retrieved from http://www.michbar.org/programs/disabilitynews/disabilities_news_6

Day, K. (1994). Male mentally handicapped sex offenders. *The British Journal of Psychiatry: The Journal of Mental Science, 165*(5), 630-639. doi:10.1192/bjp.165.5.630

Deb, S., Matthews, T., Holt, G., & Bouras, N. (2001). Practice Guidelines for the Assessment and Diagnosis of Mental Health Problems in Adults with Intellectual Disability. Retrieved from https://www.iassidd.org/uploads/legacy/images/documents/other/deb_et_al_european_id_practice_guidelines_29_10_09.pdf

De Jong, P., & Berg, I. K. (2001). Co-constructing cooperation with mandated clients. *Social work, 46*(4), 361-374. doi: 10.1093/sw/46.4.361

Denzin, N. K., & Lincoln, Y. S. (. (2011). *Handbook of qualitative research* (4th ed.). Thousand Oaks, CA: Sage Publications Inc.

Disability Service Act (1993). Retrieved from NSW Government, NSW Legislation website: http://www.legislation.nsw.gov.au/viewtop/inforce/act+3+1993+FIRST+0+N/

Dvoskin, J. A., & Steadman, H. J. (1994). Using intensive case management to reduce violence by mentally ill persons in the community. *Hospital & Community Psychiatry, 45*(7), 679-684. doi: 10.1176/ps.45.7.679

Eberle, M., Kraus, D., Pomeroy, S., & Hulchanski, D. (2001). The costs of homelessness in British Columbia. *Homelessness: Causes and Effects, 3*, 1-88. Retrieved from http://www.housing.gov.bc.ca/pub/Vol3.pdf

Everington, C., & Fulero, S. M. (1999). Competence to confess: Measuring understanding and suggestibility of defendants with mental retardation. *Mental Retardation. 37*(3), 212-220. doi:10.1352/0047-6765

Fazel, S., & Danesh, J. (2002). Serious mental disorder in 23 000 prisoners: A systematic review of 62 surveys. *The Lancet, 359*(9306), 545-550. doi:10.1016/S0140-6736(02)07740-1

Fazel, S., & Grann, M. (2006). The population impact of severe mental illness on violent crime. *American Journal of Psychiatry, 163*(8), 1397-1403. Retrieved from

http://www.academia.edu/3373809/The_Population_Impact_of_Severe_Mental_Illness_on_Violent_Crime

Fazel, S., Långström, N., Hjern, A., Grann, M., & Lichtenstein, P. (2009). Schizophrenia, substance abuse, and violent crime. *Journal of the American Medical Association, 301*(19), 2016-2023. doi:10.1001/jama.2009.675

Fazel, S., Xenitidis, K., & Powell, J. (2008). The prevalence of intellectual disabilities among 12000 prisoners—A systematic review. *International Journal of Law and Psychiatry, 31*(4), 369-373. doi:10.1016/j.ijlp.2008.06.001

Federal, Provincial and Territorial Advisory Committee on Population Health (1999). *Statistical report on the health of Canadians.* Ottawa, Ontario: Health Canada. Retrieved from http://www.statcan.gc.ca/pub/82-570-x/4227734-eng.pdf

Fischer, P. J. (1992a). The criminalization of homelessness. *Homelessness: Topics in Social Psychiatry*, 57-64. doi:10.1007/978-1-4899-0679-3_5

Fischer, P. J. (1992b). Criminal behavior and victimization among homeless people. In P. J. Fischer, & R. I. Jahiel (Eds.). *Homelessness: A prevention-oriented approach.* (pp. 87-112). Baltimore, MD: Johns Hopkins University Press.

Fischer, P. J. (1992c). Victimization and homelessness: Cause and effect. *New England Journal of Public Policy*, *8*(1), 229-246. Retrieved from http://scholarworks.umb.edu/nejpp/vol8/iss1/20

Foucault, M. (1990). *The history of sexuality: The use of pleasure*. New York, NY: Random House Inc.

Gibbs, J. J. (1983). Problems and priorities: Perceptions of jail custodians and social service providers. *Journal of Criminal Justice, 11*(4), 327-338. doi:10.1016/0047-2352(83)90072-7

Glaser, B. G. (1978). *Theoretical sensitivity: Advances in the methodology of grounded theory.* San Francisco: Sociology Press.

Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory: Strategies for qualitative research*. Chicago: Aldine Publishing Company.

Glaser, W., & Deane, K. (1999). Normalisation in an abnormal world: A study of prisoners with an intellectual disability. *International Journal of Offender Therapy and Comparative Criminology, 43*(3), 338-356. doi:10.1177/0306624X99433007

Goulding, C. (2002). *Grounded theory: A practical guide for management, business and market researchers*. London: Sage Publications Ltd.

Guardianship Act (1987). Retrieved from NSW Government, NSW Legislation website: http://www.legislation.nsw.gov.au/inforcepdf/1987-257.pdf?id=580b32d3-f8fd-4a1f-dc87-c6d1f165a95b

Hassan, S., & Gordon, R. M. (2003). Developmental disability, crime, and criminal justice: A literature review. *Criminology Research Centre: School of Criminology*. Retrieved from http://www.sfu.ca/crc/fulltext/hassangordon.pdf

Hayes, S. (1991). Pilot prison programs. *Australia and New Zealand Journal of Developmental Disabilities, 17*(2), 209-216. doi:10.1080/07263869100034421

Hayes, S., & McIlwain, D. (1988). *The prevalence of intellectual disability in the New South Wales prison population: An empirical study*. Report to the Criminology Research Council, Canberra. Retrieved from http://www.academia.edu/678934/The_Prevalence_of_Intellectual_Disability_in_the_New_South_Wales_Prison_Population_an_Empirical_Study._1988_._Hayes_and_McIlwain_

Head, D. (2006). 2005-2006 year-end review. *Executive Development Symposium, Correctional Service of Canada.* Retrieved from http://infonet/pa/documents/2005-06_YearEndReview_e.ppt#1

Hermann, H., McGorry, P., Mills, J., & Singh, B. (1991). Hidden severe psychiatric morbidity in sentenced prisoners: An Australian study. *American Journal of Psychiatry, 148*(2), 236-239. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/1987824

Hewitt, P. (1994). Families in flux. *The Political Quarterly*, *65*(2), 168-178. doi:10.1111/j.1467-923X.1994.tb00443.x

Hickie, I., Groom, G., & Davenport, T. (2004). *Investing in Australia's future: the personal, social and economic benefits of good mental health*. Mental Health Council of Australia. Retrieved from https://mhaustralia.org/sites/default/files/imported/component/rsfiles/mental-health-services/Investing_In_Australia_s_Future_Full_Report_.pdf

Hinds, J. T. (1990). Involuntary outpatient commitment for the chronically mentally ill. *Nebraska Law Review, 69*(2), 346-412. Retrieved from http://digitalcommons.unl.edu/cgi/viewcontent.cgi?article=1751&context=nlr

Holland, A. J. (2004). Criminal behaviour and developmental disability: An epidemiological perspective. In W. R. Lindsay, J. L. Taylor, & P. Sturmey (Eds.). *Offenders with Developmental Disabilities.* (pp. 23-34). West Sussex, England: John Wiley & Sons Ltd.

Holland, T., Clare, I., & Mukhopadhyay, T. (2002). Prevalence of 'criminal offending' by men and women with intellectual disability and the characteristics of 'offenders': Implications for research and service development. *Journal of Intellectual Disability Research, 46*(1), 6-20. doi:10.1046/j.1365-2788.2002.00001.x

Holley, H. L., & Arboleda-Florez, J. (1988). Criminalization of the mentally ill: Part I. police perceptions. *Canadian Journal of Psychiatry. Revue Canadienne De Psychiatrie, 33*(2), 81-86. Retrieved from http://europepmc.org/abstract/MED/3365645

Hollingshead, A.B. (1957). *Two Factor Index of Social Position. Mimeo*. New Haven, Connecticut: Yale University.

Hudson, C. G. (2005). Socioeconomic status and mental illness: Tests of the social causation and selection hypotheses. *American Journal of Orthopsychiatry, 75*(1), 3-18. doi:10.1037/0002-9432.75.1.3

Human Rights and Equal Opportunity Commission (1993). *Australian Human Rights Commission: 1993 Issues Paper on disability standards.* Retrieved from https://www.humanrights.gov.au/1993-issues-paper-disability-standards

Humphrey, L. (2000). *Quinine and quarantine: Missouri medicine through the years* (Vol. 1). Columbia, Missouri: University of Missouri Press.

Ierace, M. (1987). Acting for the intellectually disabled offender. *Intellectually Disabled Offenders: Proceedings of a Seminar, Held 22-24 April 1987*, New South Wales. Retrieved from https://www.ncjrs.gov/pdffiles1/Digitization/109708-109719NCJRS.pdf#page=71

Jones, C . (2009). *Submission to the standing committee on public safety and national security investigating federal corrections, mental health and addictions.* (Submission No. 40 Parliament, 2nd Session). Kingston, Ontario: John Howard Society of Canada. Retrieved from http://www.johnhoward.ca/media/JHSC%20Submission_Oct%2027_Mental%20Illness%20and%20Substance%20abuse.pdf

Katz, J. (2003). *Homelessness, crime, mental illness, and substance abuse: A core population with multiple social service needs.* Master's in City Planning at the Massachusetts Institute of Technology. Retrieved from http://dspace.mit.edu/handle/1721.1/42829#files-area

Johnson, M. (1998). Genetic technology and its impact on culpability for criminal actions. *Cleveland State Law Review*, *46*(4), 443-472. Retrieved from http://engagedscholarship.csuohio.edu/cgi/viewcontent.cgi?article=1523&context=clevstl

rev

Jones, C. (2009). Submission to the Standing Committee on Public Safety and National Security investigating Federal Corrections. *Mental Health and Addictions*. Retrieved from http://www.johnhoward.ca/media/JHSC%20Submission_Oct%2027_Mental%20Illness%20and%20Substance%20abuse.pdf

Jones, J. (2007). Persons with intellectual disabilities in the criminal justice system: Review of issues. *International Journal of Offender Therapy and Comparative Criminology, 51*(6), 723-733. doi:10.1177/0306624X07299343

Kaufman, A. S., & Kaufman, N. L. (2004). *Kaufman brief intelligence test: Second Edition*. John Wiley & Sons, Inc. doi: 10.1002/9781118660584.ese1325

Kellough, G., & Wortley, S. (2002). Remand for plea. Bail decisions and plea bargaining as commensurate decisions. *British Journal of Criminology, 42*(1), 186-210. doi:10.1093/bjc/42.1.186

Kessler, R. C., Crum, R. M., Warner, L. A., Nelson, C. B., Schulenberg, J., & Anthony, J. C. (1997). Lifetime co-occurrence of DSM-III-R alcohol abuse and dependence with other psychiatric disorders in the national comorbidity survey. *Archives of General Psychiatry, 54*(4), 313-321. doi:10.1001/archpsyc.1997.01830160031005

Kessler, R. C., Amminger, G. P., Aguilar-Gaxiola, S., Alonso, J., Lee, S., & Ustun, T. B. (2007). Age of onset of mental disorders: A review of recent literature. *Current Opinion in Psychiatry, 20*(4), 359-364. doi:10.1097/YCO.0b013e32816ebc8c

Kirby, M. J., & Keon, W. J. (2004). *Mental Health, Mental Illness and Addiction: Report 1: Overview of Policies and Programs in Canada: Interim Report on Mental Health, Mental Illness and Addiction*. Senate Canada, Standing Senate Committee on Social Affairs, Science & Technology. Retrieved from http://www.cmha.ca/download.php%3Fdocid%3D77&rct=j&frm=1&q=&esrc=s&sa=U&ved=0CBMQFjAAahUKEwiomqazmfLGAhUNpIgKHQyCD4s&usg=AFQjCNGVjoYYbLq_6hEBpVgY8cGk1N_iCA

Kitchener, K. S., & Harding, S. S. (1990). Dual role relationships. In B. Herlihy and L. Golden (Eds.), *Ethical Standards Casebook* (4th ed., pp 146-154). Alexandria, VA: American Association for Counseling and Development.

Kirkbride, T. S. (1854). Remarks on the construction, organization and general arrangements of hospitals for the insane. *American Journal of Psychiatry, 11*(2), 122-163. doi: doi.org/10.1176/ajp.11.2.122

Krauss-Whitbourne, S. (2015, January). 6 ways to take better care of yourself. *Psychology Today*. Retrieved from https://www.psychologytoday.com/blog/fulfillment-any-age/201501/6-ways-take-better-care-yourself

Lamb, H. R. (1994). Reform of mental health laws: Not repeating the mistakes made in the United States. *Psychiatry and Clinical Neurosciences, 48*(s1), 105-110. doi:10.1111/j.1440-1819.1994.tb03045.x

Lamb, H. R., & Grant, R. W. (1982). The mentally ill in an urban county jail. *Archives of General Psychiatry, 39*(1), 17-22. doi:10.1001/archpsyc.1982.04290010003001

Lamb, S., Greenlick, M. R., & McCarty, D. (1998). *Bridging the gap between practice and research: Forging partnerships with community-based drug and alcohol treatment* National Academies Press.

Lamb, H. R., & Weinberger, L. E. (1998). Persons with severe mental illness in jails and prisons: A review. *Psychiatric Services, 49*(4), 483-492. doi: org/10.1176/ps.49.4.483

Lamb, H. R., & Weinberger, L. E. (2005). The shift of psychiatric inpatient care from hospitals to jails and prisons. *The Journal of the American Academy of Psychiatry and the Law, 33*(4), 529-534. doi:33/4/529 [pii]

Lamb, H. R., & Weinberger, L. E. (2006). Persons with severe mental illness in jails and prisons: A review. *New Directions for Mental Health Services, 2001*(90), 29-49. doi:10.1002/yd.23320019005

Lamberti, J. S., & Weisman, R. L. (2004). Persons with severe mental disorders in the criminal justice system: Challenges and opportunities. *Psychiatric Quarterly, 75*(2), 151-164. doi:10.1023/B:PSAQ.0000019756.34713.c3

Lamberti, J. S., Weisman, R., & Faden, D. I. (2004). Forensic assertive community treatment: Preventing incarceration of adults with severe mental illness. *Psychiatric Services, 55*(11), 1285-1293. Retrieved from http://czresearch.com/dropbox/Lamberti_PsychiatrServ_2004v55p1285.pdf

Lindsay, W. R., Law, J., & MacLeod, F. (2002). Intellectual disabilities and crime: Issues in assessment, intervention and management. *Applying Psychology to Forensic Practice*, 97-114. doi:10.1002/9780470693971.ch6

Lindsay, W. R., Smith, A. H., Law, J., Quinn, K., Anderson, A., Smith, A., . . . Allan, R. (2002). A treatment service for sex offenders and abusers with intellectual disability: Characteristics of referrals and evaluation. *Journal of Applied Research in Intellectual Disabilities, 15*(2), 166-174. doi:10.1046/j.1468-3148.2002.00111.x

Linhorst, D. M., Bennett, L., & McCutchen, T. (2002). Development and implementation of a program for offenders with developmental disabilities. *Mental Retardation*, *40*(1), 41-50. doi: http://dx.doi.org/10.1352/0047-6765(2002)040<0041:DAIOAP>2.0.CO;2

Lunsky, Y., Bradley, E., Durbin, J., Koegl, C., Canrinus, M., & Goering, P. (2006). The clinical profile and service needs of hospitalized adults with mental retardation and a psychiatric diagnosis. *Psychiatric Services, 57*(1), 77-83. doi: http://dx.doi.org/10.1176/appi.ps.57.1.77

Lyall, I., Holland, A., & Collins, S. (1995). Offending by adults with learning disabilities and the attitudes of staff to offending behaviour: Implications for service development. *Journal of Intellectual Disability Research, 39*(6), 501-508. doi:10.1111/j.1365-2788.1995.tb00570.x

Markowitz, F. E. (2006). Psychiatric hospital capacity, homelessness, and crime and arrest rates. *Criminology, 44*(1), 45-72. doi:10.1111/j.1745-9125.2006.00042.x

Martell, D. A., Rosner, R., & Harmon, R. B. (1994). Homeless mentally disordered defendants: Competency to stand trial and mental status findings. *Journal of the American Academy of Psychiatry and the Law Online, 22*(2), 289-295. doi: http://www.jaapl.org/content/22/2/289.full.pdf+html

Martell, D. A., Rosner, R., & Harmon, R. B. (1995). Base-rate estimates of criminal behavior by homeless mentally ill persons in New York City. *Psychiatric Services, 46*(6), 596-601. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/7641002

McCandless, P. (1996). Institutional Solutions? *Reviews in American History, 24*(4), 618-623. doi: 10.1353/rah.1996.0099

Mental Health Act (2000). Retrieved from the Government of Alberta, Queen's Printer website: http://www.qp.alberta.ca/1266.cfm?page=m13.cfm&leg_type=Acts&isbncln=9780779779390

Mental Health Act (2007). Retrieved from NSW Government, NSW Legislation website: http://www.legislation.nsw.gov.au/fullhtml/inforce/act+8+2007+FIRST+0+N

Mental Health (Forensic Provisions) Act (1990). Retrieved from NSW Government, NSW Legislation website: http://www.legislation.nsw.gov.au/inforcepdf/1990-10.pdf?id=c4711a47-c3f5-4632-ed64-980509bde7ca

Mental Health Policy Research Group. (1997, November 3). *Mental illness and pathways into homelessness: Findings and implications.* Paper presented at the mental illness and pathways into homelessness conference, Toronto, Ontario. Retrieved from http://mentalhealth.samhsa.gov/cmhs/Homelessness/default.asp

Metraux, S., & Culhane, D. P. (2004). Homeless shelter use and reincarceration following prison release. *Criminology & Public Policy, 3*(2), 139-160. doi:10.1111/j.1745-9133.2004.tb00031.x

Moore, M. H. (1995). Public health and criminal justice approaches to prevention. *Crime and Justice, 19*, 237-262. Retrieved from http://www.jstor.org/stable/1147598

Moore, M. E., & Hiday, V. A. (2006). Mental health court outcomes: A comparison of re-arrest and re-arrest severity between mental health court and traditional court participants. *Law and Human Behavior, 30*(6), 659. doi:10.1007/s10979-006-9061-9

Motiuk, L. L., & Porporino, F. J. (1991). *The prevalence, nature and severity of mental health problems among federal male inmates in Canadian penitentiaries.* Correctional Service

of Canada. Communications and Corporate Development.

Mueser, K. T., Bond, G. R., Drake, R. E., & Resnick, S. G. (1998). Models of community care for severe mental illness. *Schizophrenia Bulletin*, *24*(1), 37-74. Retrieved from http://schizophreniabulletin.oxfordjournals.org/content/24/1/37.full.pdf+html

National Coalition on Dual Diagnosis (2012). *Directions, Changing Lives: The Mental Health Strategy for Canada.* Retrieved from http://care-id.com/wp-content/uploads/2012/09/NCDD_update_2012-Sep.pdf

Noble, J. H., & Conley, R. W. (1992). Toward an epidemiology of relevant attributes. . In R. W. Conley, R. Luckasson, & G. N. Bouthilet (Eds.), *The criminal justice system and mental retardation: Defendants and victims* (pp. 17-53). Baltimore: Brookes. NSW Department of Corrective Services (2002). *Justice Annual Report*. Department of Attorney General and Justice. Retrieved from http://www.justice.nsw.gov.au/publications-research/justice-annual-reports

Owen, F. & Griffiths, D. . (Ed.). (2009). *Challenges to the human rights of persons with intellectual disabilities.* London: Jessica Kingsley Publishers.

Personal Directives Act (2010). Retrieved from the Government of Alberta, Human Services website: http://humanservices.alberta.ca/guardianship-trusteeship/personal-directives-how-it-works.html

Petersilia, J. (1997). Justice for all? Offenders with mental retardation and the California corrections system. *The Prison Journal, 77*(4), 358-380. doi:10.1177/0032855597077004002

Petersilia, J. (2000, November). When prisoners return to the community: Political, economic, and social consequences. *Sentencing and Corrections,* 9, 1-8. Retrieved from http://www.hawaii.edu/hivandaids/When_Prisoners_Return_to_the_Comm_Political_Econ_and_Soc_Consequences.pdf

Policy Research Associates (2014). *Criminal Justice.* Retrieved from http://www.prainc.com/projects-services/specialty-areas/criminal-justice/

Prochaska, J. O., DiClemente, C. C., & Norcross, J. C. (1992). In search of how people change: Applications to addictive behaviors. *American Psychologist, 47*(9), 1102- 1114. Retrieved from http://dx.doi.org/10.1037/0003-066X.47.9.1102

Raina, P., & Lunsky, Y. (2010). A comparison study of adults with intellectual disability and psychiatric disorder with and without forensic involvement. *Research in Developmental Disabilities, 31*(1), 218-223. doi:10.1016/j.ridd.2009.09.008

Raphael, S. (2000). *The deinstitutionalization of the mentally ill and growth in the US prison population: 1971 to 1993.* Unpublished manuscript. Retrieved from http://www.antoniocasella.eu/archipsy/Raphael_2000.pdf

Ray, I. (1863). *Mental Hygiene.* Boston: Ticknor and Fields. Retrieved from https://books.google.ca/books?hl=en&lr=&id=qz1OwzgacJYC&oi=fnd&pg=PA1&dq=Ray,+I.+(1863).+Mental+hygiene+Ticknor+and+Fields.+&ots=FGQXHKLpBd&sig=v5MfXHcYRQ3mfxJ1r4PVfbN2hlE#v=onepage&q=Ray%2C%20I.%20(1863).%20Mental%20hygiene%20Ticknor%20and%20Fields.&f=false

Riches, V. C., Parmenter, T. R., Wiese, M., & Stancliffe, R. J. (2006). Intellectual disability and mental illness in the NSW criminal justice system. *International Journal of Law and Psychiatry, 29*(5), 386-396. doi:10.1016/j.ijlp.2005.10.003

Riordan, T., & Dewing, M. (2004). *Exploring the circle: Mental illness, homelessness and the criminal justice system in Canada.* Library of Parliament, Political and Social Affairs Division, Parliamentary Information and Research Service. Retrieved from http://carrieresantementale.ca/Resource%20Library/Social%20Determinants%20of%20Health/Exploring%20the%20Circle%20-%20Mental%20Illness,%20Homelessness%20and%20the%20Criminal%20Justice%20System%20in%20Canada%20-%202004.pdf

Robins, L. N., Helzer, J. E., Croughan, J., & Ratcliff, K. S. (1981). National Institute of Mental Health diagnostic interview schedule: Its history, characteristics, and validity. *Archives of General Psychiatry, 38*(4), 381-389. doi:10.1001/archpsyc.1981.01780290015001

Roesch, R. (1995). Creating change in the legal system: Contributions from community psychology. *Law and Human Behavior, 19*(4), 325. doi:10.1007/BF01499135

Rogers, R., & Bagby, R. M. (1992). Diversion of mentally disordered offenders: A legitimate role for clinicians? *Behavioral Sciences & the Law, 10*(3), 407-418. doi:10.1002/bsl.2370100310

Satcher, D. (2001). Global mental health: Its time has come. *Journal of the American Medical Association, 285*(13), 1697-1697. doi:10.1001/jama.285.13.1697

Scheff, T. J. (1966). Users and non-users of a student psychiatric clinic. *Journal of Health and Human Behavior, 7*(2), 114-121. doi: 10.2307/2948727

Shadish Jr, W. R., Doherty, M., & Montgomery, L. M. (1989). How many studies are in the file drawer? An estimate from the family/marital psychotherapy literature. *Clinical Psychology Review, 9*(5), 589-603. doi:10.1016/0272-7358(89)90013-5

Simpson, D. D., Joe, G. W., Rowan-Szal, G. A., & Greener, J. M. (1997). Drug abuse treatment process components that improve retention. *Journal of Substance Abuse Treatment, 14*(6), 565-572. doi:10.1016/S0740-5472(97)00181-5

Smith, C. J. (1987). Progress report: Mental health and the fiscal crisis: The prospects for a socially conscious urban geography. *Urban Geography, 8*(1), 55-64. doi:10.2747/0272-3638.8.1.55

Smith, P. (2005). "There Is No Treatment Here": Disability and Health Needs In A State Prison System. *Disability Studies Quarterly, 25*(3). Retrieved from http://www.dsq-sds.org/article/view/571/748

Sparrow, S. S., Cicchetti, D. V., & Balla, D. A. (2005). *Vineland adaptive behavior scales: (Vineland II), survey interview form/caregiver rating form*. Livonia, MN: Pearson Assessments.

Søndenaa, E., Rasmussen, K., Palmstierna, T., & Nøttestad, J. (2008). The prevalence and nature of intellectual disability in Norwegian prisons. *Journal of Intellectual Disability Research, 52*(12), 1129-1137. doi:10.1111/j.1365-2788.2008.01072.x

Statistics Canada (2008). *Canadian institute of health information: Health indicators.* Retrieved from https://secure.cihi.ca/free_products/HealthIndicators2008_ENGweb.pdf

Steadman, H. J. (1990). *Effectively addressing the mental health needs of jail detainees.* Rockville, MD: National Coalition for the Mentally Ill in the Criminal Justice System and National Institute of Justice.

Steadman, H. J. (1992). Boundary spanners: A key component for the effective interactions of the justice and mental health systems. *Law and Human Behavior, 16*(1), 75. doi:10.1007/BF02351050

Steadman, H. J., Deane, M. W., Morrissey, J. P., Westcott, M. L., Salasin, S., & Shapiro, S. (1999). A SAMHSA research initiative assessing the effectiveness of jail diversion programs for mentally ill persons. *Psychiatric Services, 50*(12), 1620-1623. doi:10.1176/ps.50.12.1620

Steadman, H. J., Mulvey, E. P., Monahan, J., Robbins, P. C., Appelbaum, P. S., Grisso, T., . . . Silver, E. (1998). Violence by people discharged from acute psychiatric inpatient facilities and by others in the same neighborhoods. *Archives of General Psychiatry, 55*(5), 393-401. doi:10.1001/archpsyc.55.5.393

Steadman, H. J., Morris, S. M., & Dennis, D. L. (1995). The diversion of mentally ill persons from jails to community-based services: A profile of programs. *American Journal of Public Health, 85*(12), 1630-1635. doi:10.2105/AJPH.85.12.1630

Strauss, A. L., & Corbin, J. M. (1990). *Basics of qualitative research: Grounded theory procedures and techniques.* Thousand Oaks, CA: Sage Publications Inc.

Substitute Decisions Act (1992). Retrieved from the Government of Ontario, Ministry of the Attorney General website: http://www.attorneygeneral.jus.gov.on.ca/english/

Swanson, J. W., Swartz, M. S., Essock, S. M., Osher, F. C., Wagner, H. R., Goodman, L. A., . . . Meador, K. G. (2002). The social-environmental context of violent behavior in persons treated for severe mental illness. *American Journal of Public Health, 92*(9), 1523-1531. doi:10.2105/AJPH.92.9.1523

Taylor, S. D. (1997). Education within Corrections: A study pertinent to Cumberland County. Retrieved from http://files.eric.ed.gov/fulltext/ED408504.pdf

Teplin, L. A. (1983). The criminalization of the mentally ill: Speculation in search of data. *Psychological Bulletin, 94*(1), 54-67. doi: 10.1037/0033-2909.94.1.54

Teplin, L. A. (1990). The prevalence of severe mental disorder among male urban jail detainees: Comparison with the epidemiologic catchment area program. *American Journal of Public Health, 80*(6), 663-669. doi:10.2105/AJPH.80.6.663

Teplin, L. A., Abram, K. M., & McClelland, G. M. (1996). Prevalence of psychiatric disorders among incarcerated women: I. pretrial jail detainees. *Archives of General Psychiatry, 53*(6), 505-512. doi:10.1001/archpsyc.1996.01830060047007

Thompson, D., & Brown, H. (1997). Men with intellectual disabilities who sexually abuse: A review of the literature. *Journal of Applied Research in Intellectual Disabilities, 10*(2), 140-158. doi:10.1111/j.1468-3148.1997.tb00014.x

Torrey, E. F. (1995). Jails and prisons: America's new mental hospitals. *American Journal of Public Health, 85*(12), 1611-1613.

Torrey, E. F. (1997). Psychiatric survivors and nonsurvivors. *Psychiatric Services, 48*(2), 143. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/9021843

Torrey, E. F., Kennard, A. D., Eslinger, D., Lamb, R., & Pavle, J. (2010). *More mentally ill persons are in jails and prisons than hospitals: A survey of the states.* National Sheriffs' Association, Treatment Advocacy Center: Arlington, VA. Retrieved from http://coos.or.networkofcare.org/library/final_jails_v_hospitals_study1.pdf

Torrey, E. F., & Zdanowicz, M. T. (1999). We've tried mandatory treatment-and it works. *City Journal, 9*, 82-85. Retrieved from http://s3.documentcloud.org/documents/1095567/

United Nations Office on Drugs and Crime (2006). *World drug report.* Retrieved from https://www.unodc.org/pdf/WDR_2006/wdr2006_volume1.pdf

United States Department of Health and Human Services. (1999). *Mental health: A report of the surgeon general.* Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Centre for Mental Health Services, National Institutes of Health, National Institute of Mental Health.

Urbanoski, K. A. (2010). Coerced addiction treatment: Client perspectives and the implications of their neglect. *Harm Reduction Journal*, *7*(1), 13-23. doi:10.1186/1477-7517-7-13

Vanny, K., Levy, M., & Hayes, S. (2008). People with an intellectual disability in the Australian criminal justice system. *Psychiatry, Psychology and Law*, *15*(2), 261-271. doi:10.1080/13218710802014535

Veneziano, L., & Veneziano, C. (1996). Disabled inmates. In M. D. McShane & F. P. Williams III (Ed.), *Encyclopedia of American prisons* (pp. 262-268). New York: Garland Publishing.

Wahl, O. F. (2003). News media portrayal of mental illness implications for public policy. *American Behavioral Scientist, 46*(12), 1594-1600. doi:10.1177/0002764203254615

Weisbrod, B. A. (1983). A guide to benefit-cost analysis, as seen through a controlled experiment in treating the mentally ill. *Journal of Health Politics, Policy and Law, 7*(4), 808-845. doi:10.1215/03616878-7-4-808

Weisman, R. L., Lamberti, J., & Price, N. (2004). Integrating criminal justice, community healthcare, and support services for adults with severe mental disorders. *Psychiatric Quarterly, 75*(1), 71-85. doi:10.1023/B:PSAQ.0000007562.37428.52

Wen, X. (1997). *The definition and prevalence of intellectual disability in Australia.* Canberra: Australian Institute of Health and Welfare. Retrieved from http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=6442455468

Whitmer, G. E. (1980). From hospitals to jails: The fate of California's deinstitutionalized mentally III. *American Journal of Orthopsychiatry, 50*(1), 65-75. doi:10.1111/j.1939-0025.1980.tb03263.x

Wilton, R. (2004). Putting policy into practice? Poverty and people with serious mental illness. *Social Science & Medicine, 58*(1), 25-39. doi:10.1016/S0277-9536(03)00148-5

Wolff, N. (1998). Interactions between mental health and law enforcement systems: Problems and prospects for cooperation. *Journal of Health Politics, Policy and Law, 23*(1), 133-174. doi:10.1215/03616878-23-1-133

Yukl, G. (1989). Managerial leadership: A review of theory and research. *Journal of Management, 15*(2), 251-289. doi:10.1177/014920638901500207

Zapf, P. A. (1995). *Assessing fitness to stand trial: Characteristics of fitness remands and a comparison of institution based evaluations and the fitness interview test - revised* (Masters of Arts Psychology). Available from Simon Fraser University. (1753257).

Retrieved from http://summit.sfu.ca/system/files/iritems1/6750/b17573257.pdf&rct=j&frm=1&q=&esrc=s&sa=U&ved=0CBMQFjAAahUKEwj-vMmc1P7GAhXQK4gKHaaNCQI&usg=AFQjCNHMzRTjJ4BNn4erkpcNfVSASiBO2A

Zapf, P. A., Roesch, R., & Hart, S. D. (1996). An examination of the relationship of homelessness to mental disorder, criminal behaviour, and health care in a pretrial jail population. *Canadian Journal of Psychiatry*, *41*(7), 435-440. Retrieved from https://ww1.cpa-apc.org/French_Site/publications/Archives/PDF/1996/Sep/roesch.pdf

Appendix A

Email Recruitment

Dear Prospective Participant,

I am currently seeking volunteers to participate in research being conducted for my thesis. This research will explore the decision-making process of guardianship staff for clients who are involved with the criminal justice system. If you have completed a decision for a person under guardianship that is involved with the criminal justice system (or was at the time of your decision), you are invited to participate in this study:

SUBSTITUTE DECISION-MAKING FOR INDIVIDUALS UNDER PUBLIC GUARDIANSHIP INVOLVED WITH THE CRIMINAL JUSTICE SYSTEM

This research is being conducted as a component of my Master's studies in the Graduate Centre for Applied Psychology through Athabasca University. The primary purpose of the study is to describe the decision-making process of guardianship staff when making decisions for people under the care of the Public Guardian who are involved with the criminal justice system. I hope that the understandings gained in the context of this study will contribute to improvements in the service delivery of the Public Guardian, guardianship education, and what viable options are available to dependent adults who are involved with the criminal justice system.

A full description of the study's purpose benefits, expectations for participation, and other details is located on the attached information form. Please read this carefully before agreeing to participate. In my opinion, there is little, if any, risk to you as a result of participating in the study. Your participation is unlikely to have a negative effect on your emotional well-being, your decision-making abilities, your development as a Guardian, or your employment at the Public Guardian.

I anticipate that at least two, and possibly three research interviews will be required. Time commitment would be approximately one to two hours for the first interview and a follow up interview that will likely take another hour. I will ask that you review your decision(s) for individuals under guardianship involved with the criminal justice system and ensure that you are familiar with the details of the individual, their offence(s), their diagnoses, and full details of your decision(s) you have made for that particular individual. Client details will only be requested to the extent needed for me to understand your decision-making process. The interviews may take longer if you have made a number of decisions for a variety of individuals under guardianship who are involved with the criminal justice system. In addition, you have the choice to participate in the study during office hours or after work. Regardless of your chosen

time, every participant will receive a $20 gift voucher to “Max Brenner”.

Thank you for your time. If you are interested in participating in the study, please read the attached information form. This will provide you with all the necessary information for your informed consent. If you have any other questions, please feel free to contact me on (02) 8688 6165 or email alison.perry@gcap.ca.

Thank you,

Alison Perry B. A. Psych.

Master's Candidate

Appendix B

Informed Consent

Research conducted for the proposed study will abide by the Canadian Psychological Association (2000) *Canadian Code of Ethics for Psychologists: Third Edition.* Each participant will be informed about:

1. The purpose of the research, expected duration of each interview, and procedures;
2. Their right to decline to participate and to withdraw from the research at any point once research has begun;
3. Any foreseeable consequences of declining or withdrawing, which would primarily impact the research, not the participant in any negative way;
4. Any possible factors that may influence the participants willingness to participate including potential risks, discomfort, or adverse effects; however, there are no major foreseeable negative effects that would impact the participant's willingness to participate as all information about their files is confidential (ie. they do not need to identify who they are talking about) and the time requirement will not impact their work performance as the managers are aware and supportive of the research being conducted;
5. Any prospective research benefits (ie. They will receive a copy of the final report, which may assist them in future decisions for individuals involved with the criminal justice system;
6. Limits of confidentiality, such as data coding, disposal, sharing and archiving, and when confidentiality must be broken;
7. Incentives for participation, which include the ability to conduct research during work hours, so the participants are inadvertently paid for their time at work whilst being interviewed;
8. Whom to contact for questions about the research and their rights;
9. Opportunity to ask and receive answers about the research;

Informed consent will specifically be sought for the use of the digital voice recorder prior to the beginning of the research interviews with assurances that it is not anticipated for the recordings to be used in a manner that could cause potential identification or harm. After each interview, the participant will be given the opportunity to debrief and will be able to obtain information

about the nature, results, and conclusions of the research. The researcher will also take reasonable steps to correct any misconceptions that participants may have that arise during the research process. In addition, this research is not expected to distress or harm the participants because the study is focused on factors related to job or organization effectiveness in substitute decision making for individuals involved with the criminal justice system. It will also be conducted in organizational settings for which there is no risk to participants' employability, and confidentiality will be protected. Finally, limitations of confidentiality will be discussed with each participant when obtaining informed consent. This includes having to breach confidentiality when required or justified by law, or in circumstances of actual or possible serious physical harm or death (CPA, 2000).

Title of Study: Substitute decision-making for individuals under Public Guardianship involved with the criminal justice system.

Principal Investigator: Alison Perry, BA Psych

Research Supervisor: Dr Jeff Chang, Ph.D., R.Psych.

Institution: Graduate Centre for Applied Psychology, Athabasca University

Introduction:

I am Alison Perry from the Graduate Centre of Applied Psychology, Athabasca University. I am completing research on the decision-making process of Public Guardianship staff in NSW, Australia. I would like to examine what types of decisions are being made, how and why those decisions are made, the process to make decisions for this population, and the outcome of the decisions. Since you are a staff member of the NSW Public Guardian and if you have made decisions for individuals under guardianship involved with the criminal justice system, I would like to invite you to join this research study.

Background Information:

The term *criminalisation of the mentally ill* was coined by Abramson (1972) to refer to individuals diagnosed with mental illnesses that engage in criminal activities. The term further identifies how these individuals are usually arrested and prosecuted rather than taken to hospital or other psychiatric facilities to receive treatment for their mental illnesses (Lamb & Weinberger, 2006; Moore & Hiday, 2006). To add to this, many studies have revealed that there are more people with serious mental illnesses involved with the criminal justice system than there are among the general population (Teplin, 1990). Steadman (1990) asserted that mentally ill offenders, whose illegal behaviour tends to be related to survival behaviour, should be diverted into appropriate mental health treatment services as opposed to going through the criminal justice system. This assertion highlights the importance of considering alternative approaches to

dealing with mentally ill offenders as opposed to involvement with the criminal justice system and subsequent incarceration. Therefore, it is hypothesised that the Public Guardian could successfully assist in the implementation of services to effectively reduce continued involvement of mentally ill offenders with the criminal justice system.

Purpose of this research study:

The purpose of this study is to explore the decision-making process of Public Guardian's for dependent adults who are involved with the criminal justice system. This study will attempt to examine decisions made, how/why they are may, and whether the decisions made have assisted in preventing or reducing further involvement with the criminal justice system. Essentially, this research would like to examine the decisions made by guardians for people involved with the criminal justice system, whilst considering their unique experiences and interpretations of the whole decision-making process. In addition, this research would like to determine whether Guardianship staff feel well equipped to assist in effectively working with and making decisions for this population and whether they feel they assist in the reduction of recidivism in this population.

Procedures

In this study, one to two interviews will be conducted that will ask a number of questions about the individual you have made decisions for, the decisions you have made, why and how you made those decisions, how the decisions were implemented, and if you feel your decision was successful at helping reduce or prevent the dependent adult under guardianship from continuing to be involved with the criminal justice system. Each interview should not last more than one hour. Every interview will be recorded using a digital voice recorder which will be transferred onto my personal computer and password protected. Two assistants will help transcribe each interview from the digital recorder; however, they will not have access to any of your identifying information. Transcripts will also be securely stored on my personal computer with password protection and my computer has all the up-to-date security, anti-virus, and firewall protection to ensure ongoing security of your information. At the initial interview, you will be given the opportunity to create a pseudo-name that only I will know. This will ensure that all of the information you discuss and disclose will remain strictly confidential between you and I.

Possible risks or benefits

There is no risk involved in this study except your valuable time. There is no direct benefit to you also. However, the results of the study may help formulate guidelines for making decisions for this particular population and may assist in the decision-making process in the future. This research may also help guide decisions and will hopefully reveal whether the Public Guardian is a useful tool in preventing recidivism in mentally unwell and dependent adults.

Right of refusal to participate and withdrawal

You are free to choose to participate in the study. You may refuse to participate without any loss of benefit which you are otherwise entitled to. You may also withdraw any time from the study without any adverse effect from management at the Public Guardian. You may also refuse to answer some or all of the questions if you do not feel comfortable with those questions.

Confidentiality

The information provided by you will remain confidential and securely stored. Nobody, except the principal investigator and research supervisor may have access to the data. The research supervisor will have access for verification purposes only. Your name and identity will also not be disclosed at any time. However, the data may be seen by the Athabasca University's Ethical Review Committee and may be published in a journal and elsewhere without giving your name or disclosing your identity. All information gathered will be securely destroyed five (5) years after the completion of this study.

Data Destruction

All information gathered during this study will be deleted no later than five (5) years after the commencement of the research. Therefore, all information gathered for the purpose of this research will be destroyed by no later than June 2016. In addition, research data and the data key will be stored separately from consent forms and, accordingly, the digital recordings will be stored separately from the research data (ie. Transcripts), data key, and consent forms. Digital recordings will be deleted and destroyed, paper files of the interview transcripts will be shredded and the saved documents will be deleted from the researcher's computer, and any data backed up onto CDs will be deleted and the CDs destroyed.

Available Sources of Information

If you have any further questions, you may contact the Principal Investigator, Alison Perry, Graduate Centre for Applied Psychology at Athabsca University, on the following phone numbers (02) 8688 6165 or 0422 520 800 or email alison.perry@gcap.ca. You may also contact Jeff Chang, Research Supervisor via email at jeffc@athabascau.ca for any questions you may have about your rights as a research subject or any general questions you may have or concerns held about the how the study is being conducted.

This study has been reviewed by the Athabasca University Research Ethics Board. Should you have any comments or concerns regarding your treatment as a participant in this study, please contact the Office of Research Ethics at 1-(780)-675-6718 or by email to rebsec@athabascau.ca.

Dissemination of the Results of this Study

The existence of the research will be listed in an abstract posted online at the Athabasca University Library's Digital Thesis and Project Rooms; and the final research paper will be publicly available. In addition, research results will be submitted as an article to academic and professional journals for publication and the results will be presented to the Public Guardian teams at a staff development and training day. Finally, a final report and executive summary will be available to the Public Guardian as the host organisation and will be made available to participants upon request.

AUTHORIZATION

I have read and understand this consent form, and I volunteer to participate in this research study. I understand that I will receive a copy of this form. I voluntarily choose to participate, but I understand that my consent does not take away any legal rights in the case of negligence or other legal fault of anyone who is involved in this study. I further understand that nothing in this consent form is intended to replace any applicable Federal, state, or local laws.

_____ _____

Participant's Name (Printed or Typed): Participant's Signature

Date: _____

_____ _____

Principal Investigator's Signature: Signature of Person Obtaining Consent

Date: _____

Chosen pseudonym : _____

Appendix C

Interview Guide

Interview #1 **Participant:** **Date:**	
1. Summarize Purpose of Interview and what information is being sought a) seek informed consent - form signed b) confidentiality c) storage of information d) information and data will be destroyed after 5 years	
2. Explain Interview Process and use of Digit Voice Recorder and notes	
3. Confirm position at PG and age of consent	
4. Advise they do not need to disclose any identifying information of the person under guardianship that they may discuss aside from diagnoses, involvement with CJS, and information used to make a decision. *explain that when I say "client" I am referring to a person under guardianship involved with the criminal justice system (CJS)*	

5. Choose a pseudonym - reassuring only researcher will know their identifying information.	
6. Any questions they may have. Explain that they can withdraw from the research at any point without any negative consequences.	

General Questions	
What position are you in?	
How long have you worked for the PG?	
How long have you been in your current position? What previous positions did you hold?	
How many decisions would you say you have made for people involved with the CJS?	
How many people have you worked with that have been involved with the CJS?	
What are the most common types of decisions would you say you	

encounter with this population? a) explain to me the types of decisions you have made for people under guardianship involved with the CJS? use a specific example if you can b) what are the most common functions you find are assigned to these files? What are the most common functions you have had to make decisions under? c) in your experience, explain to me the most common decisions you have had to make for these clients	
Describe to me the most common diagnoses that you encounter with this population Prompt: Intellectual disability, personality disorder	
What average age would you say are the people you are making these decisions for? Prompt: Are they older? Possibly in their 20s, 30s, etc	
On average, how many of your clients within the last year have been involved with the CJS?	
How often would you say you encounter these types of files?	
Do you like working with these types of clients/files? Would you prefer more of these types of files (or less)?	

General Person's Experience Questions	
How do you feel when you are first assigned a file that has a person involved with the CJS? Explain to me the thoughts that go through your head when you are assigned these types of files	
Do you feel capable of picking up the file and running with it?	
What type of information do you look for when you are first assigned the file?	
How do you feel when you are asked to make a decision on behalf of the person involved with the CJS?	
How do you approach making decisions for these types of files? Do you find your approach different from how you approach other files, such as making a decision for a nursing home?	
Do you find these files involve more or less work than other files?	
Do you feel the time that you have to dedicate to these files detracts from your other work (with other clients)? Explain	
What problems do you face in your current position when making decisions for these clients?	

Do you prefer having these types of files? Why or why not?	
Based on your experience with these types of files, how would you change your approach to working with these clients? Is this significantly different from when you began working with these clients? Explain	
How has your work changed in relation to clients involved with the CJS over the last year?	
Do you find there is an increase in these types of files? If they feel there is an increase - Do you feel prepared for this increase?	
If I stated "specific guardians should have these types files" what would you say? Do you agree or disagree? Why?	
If I was a new guardian and had a client assigned to me involved with the CJS, walk me through what would you tell me to do if you were responsible for training me.	
Do you think staff should have special training when working with this population? Explain to me training you would suggest	
How do you prepare yourself for these types of files?	
Explain to me how you would approach a file where the client is	

involved with the CJS in the future.	
If you could go back to any decisions you made for these clients, what would you change regarding your approach to decision making? Provide me with an example of a decision you made that you would approach differently now. What would you do differently and why?	
Specific Case Example	
Walk me through a file you have been assigned recently or that is very familiar to you that has a client involved with the CJS What are some of the clients characteristics? What is the client's diagnosis or reason for incapacity? When was the Public Guardian appointed? Why was the person placed under guardianship? Was the person already involved with the CJS when the PG was appointed? OR did they become involved whilst under guardianship? What is their involvement with the CJS?	
When were you assigned the file? Were you assigned prior to any decisions required to be made?	
What sparked the PGs involvement?	

What decisions have you made regarding this client?	
Who requested the decisions to be made for this client? Prompt: family, service provider - which service provider, doctors, social worker, friends, court/magistrate, etc	
What information did you rely on to make the decision for this particular client?	
What were the most important sources of information? Who supplied that information?	
What information did you find the most helpful when making this decision? Who provided that information?	
Who were the key stakeholders involved with this client and contributed to you making a decision?	
What were the most pertinent issues in this particular case?	
Explain to me how you made this decision?	
How was your decision implemented? Explain to me how you think this decision was successfully implemented	

How do you feel the decision worked out? Was it successful?	
How do you feel your decision assisted in preventing the client from becoming further involved with the CJS?	
Has this client become further involved with the CJS? If so, what else have they done? Have you had to make more decisions?	
What would you do differently in retrospect if you were able to make this decision all over again?	
What other decisions have you had to make for this particular client?	
Take me through the other decisions you have had to make for clients involved with the CJS in general Clients basic information, why they were assigned to the PG, their involvement with the CJS, what decisions you made for those clients	
Back to More General Questions to Wrap UP	
Over time, have decisions become easier to make for this particular population?	

What is the most important information you utilise when making decisions for these clients?	
In general, explain to me how your decisions for all of the clients you have encountered have helped prevent them from becoming further involved with the CJS	
In a few sentences, explain to me what you feel is the most important role of the PG is with these clients? Do you feel the PG should be involved with these clients? Do you feel staff are equipped with the right tools to make effective decisions for this population? What would you recommend to others when first working with these clients? Who else do you think should make decisions for this population if it was not the PG? Do you think the PG is an effective tool to prevent recidivism (further criminal involvement)? Explain to me whether you think these types of individuals should be under guardianship. If not, what would you recommend to assist in preventing recidivism within this population?	
What else can you tell me about making decisions for people under guardianship involved with the CJS?	
What do you think would be useful to help you making effective decisions for this population in the future?	

How has your experience with these types of files contributed to your own competence in making decisions ad working through the process?	
How has your sense of yourself as a professional developed since you began working with these types of files?	
Tell me about any particular instances or important turning points in your approach to working with these types of clients	
How clear or coherent do you feel in your work as a guardian after holding these types of files? Clarity of Role Professional Identity Approach to Guardianship Approach to these files	
What do you do to debrief or relax after a stressful decision or confrontational situation in relation to these particular clients?	

Appendix D

Transcription Confidentiality Agreement

Name of Study: Substitute decision-making for individuals under Public Guardianship involved with the criminal justice system

Principal Investigator: Alison Perry

In undertaking the transcription of digital voice recordings for the above-named research study, I understand that I will be working with data gathered from individual participants whose identities I may or may not come to know.

I understand that all possible precautions are to be undertaken to protect the identities of the participants as well as the information they share during their involvement with the research study. I hereby pledge to keep all the information that I see or hear during my work as a transcriptionist strictly confidential, and I agree not to discuss the information or the identities of any of the participants with anyone other than the researcher, Alison Perry.

My signature (below) indicates that I understand the importance of, and agree to maintain, confidentiality.

Transcriptionist's Signature: _____

Date: _____

Principal Investigator's Signature: _____

Appendix E

Public Guardian Support Letter

NSW GOVERNMENT | Public Guardian
Justice & Attorney General

Ms Alison Perry
161 Somerside Park SW
Calgary, Alberta
T2Y 3W3

26 May 2011

Dear Ms Perry,

I am writing in response to your letter seeking approval to conduct research with staff of the Public Guardian. I am happy to support your proposed research exploring the decision making process used by guardianship staff for clients who are involved with the criminal justice system. I believe this research will inform our induction and training program for staff, as well as shine a light on the complexities involved with all who become involved in supporting people with disability as they navigate the criminal justice system.

I will be contacting the managers and staff to ensure they are aware that I am supportive of this research and that the research will be conducted during office hours. However, you will need to liaise with each individual staff member and their Regional Manager to arrange interview times that avoid any disruptions to the staff members work.

I would encourage you to present your research findings to the staff of the Public Guardian once you have finalised your interviews in Australia. Once your research is completed, I would appreciate some discussion with prior to any publication of your findings.

Yours sincerely,

Graeme Smith
NSW Public Guardian

Central Office | Western Regional Office | Registry | www.lawlink.nsw.gov.au/opg
L7 160 Marsden St Parramatta 2150 | Locked Bag 5116 Parramatta 2124 | DX 1335 Sydney
Tel 02 8688 2650 Freecall 1800 451 510
Fax 02 8688 9797 TTY 1800 882 889

Private Guardian Support Unit
Information & Support | Complaints Support Unit
L7 160 Marsden St Parramatta 2150 | Locked Bag 5116 Parramatta 2124 | DX 1335 Sydney
Tel 02 8688 6060
Tel 02 8688 6070
Fax 02 8688 9797

After Hours Emergency Contact
Tel 02 8688 2650 Freecall 1800 451 510