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Reducing the hyper-incarceration of First Nations people by addressing barriers to mental health diversion

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Positionality statement

This research study was led by Dr Elizabeth McEntyre, who is a Worimi Guringai and Wonnarua Elder. Dr McEntyre is an experienced researcher who led the data collection and analysis process, ensuring that First Nations participants felt comfortable in sharing their lived and living experiences. The remaining authors identify as white researchers and acknowledge that their life experiences may impact the collection and interpretation of the data. All researchers engaged in a continuous process of reflexivity to understand how their beliefs, actions and experiences may influence the research process.

Acronyms and abbreviations

ABS	Australian Bureau of Statistics
ACCSO	Aboriginal client community service officer
AOD	alcohol and other drugs
AIC	Australian Institute of Criminology
AIHW	Australian Institute of Health and Welfare
ALS	Aboriginal Legal Service
AMS	Aboriginal Medical Service
BOCSAR	Bureau of Crime Statistics and Research
CI	confidence interval
GP	general practitioner
HR	hazard ratio
Justice Health	Justice Health and Forensic Mental Health Network
MHCIFPA	*Mental Health and Cognitive Impairment Forensic Provisions Act 2020* (NSW)
OR	odds ratio
ROD	Reoffending Database
SCCLS	Statewide Community and Court Liaison Service
SEIFA	Socio-Economic Indexes for Areas

Abstract

This study examines the barriers to accessing mental health diversion at Local Court for First Nations people in New South Wales, Australia. It aimed to identify how these barriers might be overcome so that diversion can be used as an appropriate mechanism for reducing the unrelenting hyper-incarceration rates experienced by First Nations people. The study adopted a mixed-methods approach, using quantitative data collected by the NSW Statewide Community and Court Liaison Service, linked to a statewide justice dataset, and qualitative interviews, both with First Nations people who had lived and living experience of mental illness and criminal justice system contact and with professional stakeholders working in the sector.

Quantitative analyses confirmed that First Nations people were less likely than non-First Nations people to be granted mental health diversion at court. Participants in the qualitative interviews provided key insights into the nature of barriers experienced by First Nations people trying to access mental health diversion at court. Potential facilitators of diversion that should be explored in the development of culturally appropriate and responsive diversion policies and programs are also highlighted.

Executive summary

Background

A substantial proportion of people in contact with the criminal justice system, including in Australia, are living with mental illness (Fazel & Seewald 2012; Yee et al. 2024). In many jurisdictions, there are legal and service provisions in place to divert people away from the justice system into appropriate treatment and support, including through court-based mental health diversionary programs. In New South Wales, mental health diversion at the Local Court is supported by the *Mental Health and Cognitive Impairment Forensic Provisions Act 2020* (MHCIFPA). Mental health diversion aims to address mental health needs—and thus underlying causes of non-indictable offending—by redirecting people with mental illness or cognitive impairment into treatment and support services. In Australian jurisdictions, research findings have highlighted the benefits of mental health diversion, including a reduction in reoffending rates and improvement in social outcomes following diversion (eg Albalawi et al. 2019; Gaskin et al. 2024; Lim & Day 2014; Soon et al. 2024). However, diversion programs remain underused, with under three percent of NSW Local Court appearances in 2023 resulting in charges being dismissed on the grounds of mental health or cognitive impairment (Bureau of Crime Statistics and Research (BOCSAR) 2024a).

First Nations people appear to be less likely to access mental health diversion at court, despite their over-representation in the criminal justice system (eg Albalawi et al. 2019; Soon et al. 2024, 2018). The lower rates of diversion for First Nations people suggests that they may face specific barriers to accessing diversion. Research exploring this issue, especially from the perspective of people with lived or living experience, remains limited; but barriers to diversion for First Nations people may include: strict eligibility criteria for diversion, limited understanding of the legal system and the availability of diversionary programs, lack of access to programs and services necessary for diversion, distrust of legal systems, and factors influencing magistrate decision-making (Australian Institute of Criminology (AIC) 2011). There is also evidence that First Nations people who do access diversion experience less favourable outcomes than non-First Nations people (eg Albalawi et al. 2019; Bradford & Smith 2009; Soon et al. 2024), representing a major failure of systems and services in responding to the needs of First Nations people, families and communities.

Study aims and objectives

The current study aimed to address a significant gap in the evidence base about First Nations people's experiences of mental health diversion in the Local Court in New South Wales. Using a mixed-methods approach, it aimed to address the following research questions:

- What is the relative rate of mental health diversion for First Nations people in New South Wales, and what individual or group-level factors contribute to any disparity identified?
- What are the perceived barriers to mental health diversion for First Nations people, and what are the underlying factors responsible for the identified barriers?
- What changes to current systems, policies and laws may be needed to reduce the barriers to mental health diversion for First Nations people?

Research findings

The study found that First Nations people were significantly less likely than non-First Nations people to be granted mental health diversion. Among those deemed eligible for diversion, just under half (49%) of First Nations people were granted diversion, compared with 61 percent of non-First Nations people. First Nations people were more likely to be granted diversion if they identified as female, lived in less disadvantaged areas, had a diagnosis of a common mental disorder, had committed a violent offence and had no history of prior offending. Similar trends were observed for the sample as a whole, with the addition of defendant age and provision of legal representation as significant factors influencing diversion.

Diversion was significantly associated with lower rates of reoffending for both the First Nations and non-First Nations samples. Among those in the total sample of people deemed eligible for court diversion, those who were granted diversion had significantly lower rates of reoffending. Lower rates of reoffending for those diverted than for those not diverted were observed among both First Nations (54% vs 63%) and non-First Nations people (34% vs 44%). However, reoffending rates remained higher for First Nations people than non-First Nations people, with First Nations defendants being significantly more likely to reoffend. For the whole sample, controlling for First Nations and diversion status, individuals were significantly more likely to reoffend if they were male, were aged under 40, lived in a major city, had a personality or substance use disorder and had a history of prior offending.

The study findings highlight the multiple barriers to mental health diversion in New South Wales and resulting vulnerabilities First Nations people experience. A range of barriers were associated with reduced access to diversion for First Nations people, including eligibility criteria for diversion, particularly in relation to offending history and prior diversion orders; discretion exercised by Local Court magistrates; distrust of legal systems; a lack of access to programs and services, particularly in remote and rural areas; and funding and resourcing limitations.

The study also identified positive facilitators that should be leveraged to enable mental health diversion for First Nations people. These included the critical role of the Statewide Community and Court Liaison Service (SCCLS) clinical nurse consultants, representation from the Aboriginal Legal Service (ALS), support from Aboriginal liaison officers and collaboration and coordination across services. The availability of First Nations-specific services and supports was identified as a key facilitator of diversion. The study also highlighted the importance of addressing the health and social and emotional wellbeing needs of First Nations people through appropriate mental health care, support from a skilled and understanding general practitioner (GP), opportunities for education and employment, suitable and stable housing, financial security and opportunities for social connection.

Implications and recommendations for policy and practice

The findings of this study provide new evidence about the lived or living experiences of First Nations people and mental health diversion in New South Wales, barriers and facilitators of diversion and areas for reform. Based on the study findings, taken together with prior research conducted in this area, the following specific recommendations for policy and practice are proposed.

- Recommendation 1: Consider First Nations people's and communities' histories of personal and collective trauma and resistance in the design of policies related to mental health court diversion and the delivery of mental health and related services.
- Recommendation 2: Strengthen the role of SCCLS by expanding the service and increasing resources available to meet the needs of all eligible people, with a particular focus on the specific needs of First Nations people. It is heartening to acknowledge that, since the current study commenced, funding has been committed to provide SCCLS clinicians in all NSW Local Courts—a key step towards ensuring equitable access to mental health court diversion, particularly for those in non-urban centres.
- Recommendation 3: Conduct a comprehensive, culturally informed assessment of system-initiated vulnerability and need for First Nations people in contact with the SCCLS.
- Recommendation 4: Apply eligibility for mental health diversion broadly, to ensure that diversion is accessible for First Nations people with prior contact with the criminal justice system.
- Recommendation 5: Incorporate a holistic approach to care and treatment in treatment plans for First Nations people, including referrals to culturally appropriate and responsive services and strategies to maintain connections to family, carers and community.
- Recommendation 6: Increase the availability of diversionary programs and other relevant services in rural and remote areas through adequate funding and resource allocation.
- Recommendation 7: Enhance interagency collaboration between the justice, health, legal and social service sectors to ensure seamless referrals and continuity of care for First Nations people who receive diversion.

- Recommendation 8: Prioritise the recruitment of First Nations staff, including mental health clinicians and liaison officers in courts. Adequately support and remunerate all First Nations staff to maintain their employment and provide them with funded opportunities to advance their skills and qualifications through training and education.
- Recommendation 9: Provide ongoing education and cultural competency training to all non-First Nations staff working with First Nations people, including magistrates, SCCLS clinicians and other legal professionals, to address racism and bias within the criminal justice system. This training should leverage the knowledge and expertise of First Nations professionals and people with lived or living experience.
- Recommendation 10: Increase the availability of First Nations-led community services and programs, including the ALS, through adequate funding and resource allocation.
- Recommendation 11: Build the cultural responsiveness of mainstream services and service providers who work with First Nations people with mental health or cognitive impairment, including through the provision of ongoing training and education informed by the lived experiences of First Nations people.
- Recommendation 12: Provide accessible and culturally appropriate information and resources to First Nations communities, families and carers to increase community awareness of diversion programs.
- Recommendation 13: Implement a formal and standardised framework for tracking diversion outcomes and mechanisms for magistrates and service providers, including SCCLS clinicians, to receive feedback on the outcomes of diversion orders and provide ongoing support where needed.
- Recommendation 14: Conduct further research to evaluate the effectiveness of the SCCLS and examine the medium- and long-term outcomes for First Nations people who are diverted. In addition to examining rates of reoffending, research should pay attention to other post-diversion outcomes, such as individuals' physical and mental health and alcohol and other drug use. Now that funding has been committed to ensure that the SCCLS is expanded across all courts in New South Wales, research should explore the impact of this expansion on diversion and reoffending rates, including for First Nations people. Future research should also examine post-diversion outcomes over time, to determine the effectiveness of mental health support provided to First Nations people and whether any positive outcomes are sustained.

Introduction

It is well established that a substantial proportion of people in contact with the criminal justice system are living with mental illness, including severe psychotic illnesses such as schizophrenia (Fazel & Seewald 2012; Yee et al. 2024). In Australia, the over-representation of people with mental illness in prison settings has been demonstrated in all jurisdictions where research has been undertaken, with evidence that rates of psychosis may be increasing over time (Yee et al. 2024). People living with mental illness are also at higher risk of repeated contact with the criminal justice system than those without mental illness (Baillargeon et al. 2009; Chesser & Smith 2016). In many jurisdictions, opportunities for people with mental illness to be diverted away from the criminal justice system and into appropriate mental health treatment and support services through court-based mental health diversionary programs have been developed.

Diversion from the criminal justice system into mental health services can assist individuals to focus on the underlying and immediate causes of their offending behaviour and the reasons for criminal justice contact. This approach can reduce the risk of repeat criminal justice contact and incarceration (Chesser & Smith 2016; Lim & Day 2014). In New South Wales, diversion on the grounds of mental health or cognitive impairment is governed by the MHCIFPA. Recent data from BOCSAR suggest that such diversion is not necessarily common, with under three percent of NSW Local Court appearances in 2023 resulting in charges being dismissed on the grounds of mental health or cognitive impairment (BOCSAR 2024a).

Despite any potential underuse of diversion provisions in New South Wales, the evidence base about the positive experiences and outcomes of people who are diverted from the criminal justice system on the grounds of mental health or cognitive impairment has been increasing. Several Australian studies have demonstrated a reduction in reoffending among defendants who have been diverted into and completed mental health support programs (eg Albalawi et al. 2019; Chesser & Smith 2016; Soon et al. 2024; Weatherburn et al. 2021).

The hyper-incarceration of First Nations people in Australia is striking even in international terms and appears to be increasing (Australian Bureau of Statistics (ABS) 2024a). Despite the success of mental health court diversion programs in reducing subsequent reoffending, there is evidence that First Nations people with mental illness face barriers to accessing mental health diversion in the Local Court (Soon et al. 2024, 2018). This results in a relative further increase in imprisonment rates among First Nations people and represents a failure to meet mental health and social and emotional wellbeing needs. However, research examining the cause of these barriers, as well as the lived or living experience of First Nations people eligible for mental health diversion, remains limited. Such research is fundamental, to inform the development of effective and culturally responsive diversionary policies and programs in the criminal justice and forensic mental health systems and to reduce the hyper-incarceration rates experienced by First Nations people. The current study aims to address this gap in the literature and knowledge base.

Aims of mental health diversion

Given the significant numbers of people in contact with the criminal justice system who are living with mental illness, mental health court diversion programs have been established in most Australian jurisdictions (Albalawi et al. 2019; Davidson et al. 2019). Consistently with the concept of therapeutic jurisprudence (Wexler 2000), the primary aim of mental health diversion is to address the mental health needs and underlying causes of criminal behaviours for people with mental illness and/or cognitive impairment through referrals to appropriate services (AIC 2011).

Common approaches to mental health diversion internationally include specialist mental health courts, particularly in the United States (Lange, Rehm & Popova 2011), and court-based diversion and liaison services, common in the United Kingdom (James 2010).

Under the MHCIFPA in New South Wales, a defendant facing criminal charges in the Local Court can apply to have their charges dismissed on the basis that they are suffering from a mental health and/or cognitive impairment. Defendants who meet the criteria can be diverted away from the criminal justice system towards appropriate mental health services and treatment (Bradford & Smith 2009).

The AIC (2011) has summarised key principles for an effective court-based mental health diversion program, many of which are reflected in the approach adopted in New South Wales. These principles include:

- integrated services and a multi-disciplinary approach;
- regular meetings of key agency representatives;
- strong leadership from diversion program directors or coordinators;
- clearly defined eligibility criteria and terms of participation;
- client informed consent and confidentiality;
- a dedicated court team who are trained in the identification and management of a broad range of mental health issues;
- early identification of potential clients during their contact with the criminal justice system;
- close monitoring of client engagement with the program; and
- formalisation and institutionalisation of the program to ensure long-term sustainability (AIC 2011).

Diversion programs ultimately seek to create a more efficient and effective justice system by helping to achieve better outcomes for individuals and communities most in need (Department of Communities and Justice 2024). A combination of holistic, targeted and early intervention and support for people with mental illness and cognitive impairment who are in contact with the criminal justice system can also reduce the significant human and economic costs of entrenchment within the system (McCausland et al. 2013).

Mental health diversion in New South Wales

Legislative framework

In New South Wales, the most populous state in Australia, diversion on the grounds of mental health or cognitive impairment in the Local Court is governed by the MHCIFPA. This legislation replaced the *Mental Health (Forensic Provisions) Act 1990*, which previously gave the courts power to divert an offender who was suffering from a mental health condition towards treatment and support using a section 32 (community-based diversion) or 33 (hospital inpatient-based diversion) order. Section 14 and 19 diversions are provided under the current legislation governing diversion (the MHCIFPA), while section 32 and 33 diversions were provided under the previous legislation (*Mental Health (Forensic Provisions) Act 1990* (NSW)). The new legislation also extended the period of enforcement for section 32/14 orders from six to 12 months and introduced a list of factors that magistrates may consider when making diversion decisions.

'Mental health impairment' and 'cognitive impairment' are defined in the current legislation under sections 4 and 5 respectively. A person is considered to have a mental health impairment if:

- they have a temporary or ongoing disturbance of thought, mood, volition, perception or memory (s 4(1)(a));
- the disturbance would be regarded as significant for clinical diagnostic purposes (s 4(1)(b)); and
- the disturbance impairs their emotional wellbeing, judgement or behaviour (s 4(1)(c)).

The legislation also provides a non-exhaustive list of relevant mental health disorders, including anxiety disorders, affective disorders—such as depression and bipolar disorder–and psychotic disorders. A person is considered not to have a mental health impairment if the impairment arises solely from the temporary effect of ingesting a substance or a substance use disorder (s 4(2)(a)–(d)).

A person is considered to have a cognitive impairment if:

- they have an ongoing impairment in adaptive functioning (s 5(1)(a));
- they have an ongoing impairment in comprehension, reason, judgement, learning or memory (s 5(1)(b)); and
- the impairment results from damage to, dysfunction, developmental delay or deterioration of their brain or mind resulting from a range of conditions including, but not limited to, intellectual disability, borderline intellectual functioning, dementia, an acquired brain injury, drug or alcohol related brain damage or autism spectrum disorder (ss 5(1)(c), 5(2)(a)–(f)).

Under the current MHCIFPA, mental health diversion is primarily granted by way of a section 14 order (community-based diversion), whereby magistrates may dismiss a charge for defendants with a mental health or cognitive impairment and instead order that the defendant be discharged:

- into the care of a responsible person, with or without conditions;
- to a person or place specified by the magistrate for assessment, treatment or the provision of support for the defendant's mental health or cognitive impairment; or
- unconditionally.

Section 15 of the legislation sets out a range of factors that the magistrate may consider when deciding whether to divert a defendant under the relevant section of the MHCIFPA. These factors include:

- the nature of the defendant's mental health or cognitive impairment (s 15(a));
- the nature, seriousness and circumstances of the alleged offence (s 15(b));
- the suitability of sentencing options if the defendant were to be found guilty (s 15(c));
- any changes in the defendant's circumstances since the offence occurred (s 15(d));
- the defendant's criminal history (s 15(e));
- whether the defendant has received any prior mental health diversions (s 15(f));
- whether a treatment plan has been developed (s 15(g)); and
- the safety of the defendant, victim and the community (s 15(h)).

Sections 16 and 17 of the MHCIFPA set out the procedure for handling a defendant's failure to comply with the conditions of a section 14 order. Under section 16, if the court becomes aware that a defendant is not complying with the conditions of their order, they may order that the defendant reappear before the court. Section 17 allows service providers who are assessing or treating a person under section 14 to report a failure to comply with the conditions of the order.

If it appears that the defendant is a 'mentally ill or mentally disordered person', the magistrate may order the defendant to be detained in a mental health facility for assessment under section 19 (hospital inpatient-based diversion) of the MHCIFPA. The term 'mentally ill persons' is defined under section 14 of the *Mental Health Act 2007* as a person suffering from a mental illness where there are reasonable grounds for believing that care, treatment or control of the person is necessary for the person or others' protection from serious harm. 'Mentally disordered persons' is defined under section 15 as a person whose behaviour is so irrational as to justify a conclusion on reasonable grounds that temporary care, treatment or control of the person is necessary to protect the person or others from serious physical harm. Following the section 19 assessment, if the defendant is assessed as not being a 'mentally ill person or mentally disordered person', they will be brought back before the court unless bail is granted.

NSW Statewide Community and Court Liaison Service

In New South Wales, the SCCLS is a service operated by the Justice Health and Forensic Mental Health Network (Justice Health), the public health service responsible for meeting the health needs of people in contact with the NSW criminal justice system. The NSW SCCLS has operated in many Local Courts across the state. Clinicians working for the health service advise Local Court magistrates making decisions about mental health diversion. The primary aim of the SCCLS is to divert people with serious mental illness away from the criminal justice system and connect them with appropriate treatment and support services (Bradford & Smith 2009).

The SCCLS clinical team provides a mental health assessment for adults appearing before the Local Court in New South Wales for a non-indictable offence (Bradford & Smith 2009). Following assessment, the clinician provides a report to the Local Court which details whether the assessed individual is eligible for diversion. While the SCCLS clinicians do not provide mental health treatment or intervention, clinicians liaise with relevant community and/or hospital-based services to facilitate treatment if the magistrate makes an order for diversion (Soon et al. 2024).

To improve support for people with mental health issues, the Mental Health Commission has recently recommended the continued enhancement and expansion of the service across juvenile and adult courts (Mental Health Commission of NSW 2020). Because of previous analyses of an earlier version of the linked database used in the current study (Soon et al. 2024, 2018), the SCCLS has received $13.5m in funding to expand the service in New South Wales over a four-year period (NSW Government 2023).

Existing research on mental health court diversion

Given that diversion on the grounds of mental health and cognitive impairment has been broadly adopted in Australia and internationally, there is an emerging evidence base about the implementation and effectiveness of such approaches. This literature is summarised below.

Predictors of diversion

Several studies have identified factors that may make an individual more likely to receive a mental health diversion. In Albalawi and colleagues' (2019) study of 7,743 individuals diagnosed with a psychotic disorder in New South Wales, individuals were more likely to receive a treatment order rather than a punitive sanction if they had a diagnosis of schizophrenia and related psychosis before the court finalisation date. Conversely, individuals were more likely to receive a punitive sanction if they had a substance-related psychosis. Other studies have noted that diversion is more likely to be granted for defendants who are female (Macdonald & Weatherburn 2023; Soon et al. 2018), who are aged over 40 (Soon et al. 2018), who have no prior criminal history (MacDonald & Weatherburn 2023) or who received legal representation (Macdonald et al. 2024; Soon et al. 2024).

Interestingly, Macdonald and Weatherburn (2023) found that individuals who had received previous mental health diversions had increased odds of receiving a further diversion. This may suggest that past treatment mandated by the court has not been effective; however, the authors suggest that a history of diversion may increase the perceived validity of the defendant's mental health diagnosis. There is also inconsistent evidence about the impact of offence seriousness on the likelihood of receiving a diversion. Several studies have found that individuals who had committed violent offences were more likely to receive a diversion than those who committed less serious or summary offences (Macdonald et al. 2024; Soon et al. 2024). However, other studies have found the opposite, noting higher rates of diversion among defendants who had committed less serious offences (Macdonald & Weatherburn 2023).

Given that magistrates are required to consider offence history, the seriousness of the offence and community safety when making diversion decisions, it seems plausible that defendants committing less serious offences would be more suitable for diversion. Still, as Macdonald and colleagues (2024) note, violent or serious offending may suggest a stronger link between the defendant's mental illness and offending behaviour.

Diversion outcomes

Diversion programs have demonstrated success in keeping people with mental health and cognitive impairment away from the criminal justice system and diverting them towards effective clinical treatment in the community (Mental Health Commission of NSW 2020).

Existing research on the effectiveness of mental health diversion has predominantly focused on mental health courts in the United States (eg Fox et al. 2021; Hiday, Wales & Ray 2013; Loong et al. 2019; Lowder, Rade & Desmarais 2018). Evaluations of such programs have been positive, showing lower rates of reoffending, improvement in social outcomes and economic benefits (Albalawi et al. 2019). A systematic literature review conducted by Loong et al. (2019) identified evidence that mental health courts help to reduce recidivism rates. Several studies identified in the review reported significantly lower overall rearrest rates and new charges among participants who enrolled in a mental health court program, matched against comparison groups (eg Han & Redlich 2016; Steadman et al. 2011). The study also highlighted access to case managers and vocational or housing services as important elements of mental health court programs. Another US study examined the impact of a mental health court on criminal recidivism one year after exit from the program (Hiday, Wales & Ray 2013). The rates of rearrest among the mental health court participants were significantly lower than the 'treatment as usual' comparison group (28% vs 38% respectively), with most rearrests being for minor, rather than violent, offences.

Emerging evidence shows that mental health court diversion is also associated with reduced rates of reoffending in Australian jurisdictions. In Albalawi and colleagues' (2019) study focused on people in New South Wales with health service contact for psychotic illnesses, the rate of reoffending among the diverted group was 12 percent lower than for those who received a punitive sanction. Similarly, Soon and colleagues (2024) examined rates and patterns of mental health court diversion in a sample of 2,476 adults (a precursor sample to the current study). They found that individuals who were diverted were less likely to reoffend than individuals deemed eligible for diversion by the SCCLS but not subsequently diverted by the magistrate (53% vs 65% respectively), including on multivariable analyses. Similar positive results have been observed for adolescents granted diversion; for example, Gaskin and colleagues (2024) examined a cohort of young people referred to the NSW Adolescent Court and Community Team, which provides assessments for young people to determine eligibility for mental health court diversion. This study found that young people granted diversion were also significantly less likely to reoffend, including after controlling for a range of potential confounding factors.

The positive impact of mental health diversion on reoffending has also been observed in other Australian jurisdictions. In Lim and Day's (2014) study of 219 individuals accepted into the South Australian Magistrates Court Diversion Program, over half (56%) of the sample did not reoffend in the two years following completion of the program. Successful completion of the program was the strongest predictor of not reoffending, followed by having a lower number of offences before participating in the program, being female, and having a comorbid diagnosis of substance use disorder.

The role of Local Court magistrates

Local Court magistrates play a key role in diverting defendants with a mental illness away from the criminal justice system and into appropriate mental health care and treatment. Magistrates exercise a considerable degree of discretion in making decisions under the MHCIFPA, balancing the need for defendants to be subject to the law and ensuring that those with mental illness receive appropriate treatment in order to protect the community (Fernandez 2007, as cited in Macdonald, Weatherburn & Lappin 2024; Gotsis & Donnelly 2008, as cited in Macdonald, Weatherburn & Lappin 2024). As we noted above, section 15 of the MHCIFPA sets out a range of factors that may be considered by magistrates making decisions about diversion. The ability of magistrates to consider 'other relevant factors' under s 15(i) of the MHCIFPA also allows broad discretion in considering diversion matters (Judicial Commission of NSW 2023). Macdonald and Weatherburn (2023) identified significant variation in the willingness of magistrates to grant a diversion to defendants, even when controlling for the factors that must be considered as specified in the legislation.

To further understand the factors that influence magistrates' decisions around diversion, Macdonald, Weatherburn and Lapin (2024) conducted a survey of 62 magistrates to explore their perceptions of the salient issues relevant to diversion decisions, along with an analysis of treatment plans and reports provided to the courts. The issues that were rated as most important to magistrates in making diversion decisions included the quality and detail of the treatment plan, the seriousness of the offence, the availability of treatment and the severity of the mental health impairment. Study participants also expressed a desire for more feedback on the outcome of their diversion decisions; however, the authors noted that issues may arise if services are required to formally report noncompliance with orders to the courts.

The experiences of First Nations people and communities

Extensive research has documented the over-representation of First Nations people within the criminal justice system. Specifically, the hyper-incarceration of First Nations people has been regularly reported by BOCSAR when publishing details about the characteristics of defendants presenting to criminal courts in New South Wales. In 2023, when First Nations people comprised three percent of the NSW population, approximately 28 percent of defendants with a finalised court appearance in NSW Local Courts were recorded as Aboriginal (BOCSAR 2024b). The rates of imprisonment for First Nations people continue to increase, with 31 percent of the NSW prison population now identified as Aboriginal (BOCSAR 2024a). Despite this, First Nations people appear to be comparatively under-represented within the forensic mental health system in New South Wales. In Dean and colleagues' (2023) study of a cohort of 477 forensic patients found not guilty because of mental illness, First Nations people were found to be under-represented within this group, comprising only 11 percent of the sample.

This lived or living experience of First Nations people in contact with the criminal justice and forensic mental health systems must be understood within the context of ongoing colonisation and dispossession from land, sea and waters and the continuation of racist systems and policies affecting First Nations people today (Australian Law Reform Commission 2018; McEntyre et al. 2024). This, along with the taking of children, splitting of families and threatening of cultural and community connections, contributes heavily to the elevated rates of criminal justice system contact for First Nations people (Aboriginal Justice Victoria 2022; Krakouer, Wise & Connolly 2018).

The social, emotional and mental wellbeing of First Nations people and communities is a holistic concept influenced by connection to land, culture, spirituality and ancestry (Gee et al. 2014). Intergenerational trauma, disruptions to family and kinship connections, racism and other life stressors also have significant impacts (Dudgeon et al. 2021; Gee et al. 2014). According to the 2022–23 National Aboriginal and Torres Strait Islander Health Survey, over one-quarter (29%) of First Nations people reported having a mental or behavioural condition, and three in 10 (30%) reported experiencing 'high' or 'very high' levels of psychological distress (ABS 2024b). First Nations people in contact with the criminal justice system are also known to experience high rates of poor mental health and wellbeing (McCausland, McEntyre & Baldry 2017). A comprehensive survey of prisoner health conducted by Justice Health found that 66 percent of Aboriginal men and 80 percent of Aboriginal women in custody reported having received a diagnosis of some type of mental illness (Justice Health 2015).

Providing access to appropriate and high-quality health care is essential in addressing the health and social and emotional wellbeing needs of First Nations people, but barriers to accessing services persist (Australian Institute of Health and Welfare (AIHW) 2024). A study of First Nations people's experiences of healthcare services in New South Wales identified a range of barriers that limit access to services (Nolan-Isles et al. 2021). These included poor coordination of healthcare services; poor communication between healthcare services and communities; fear of racism, judgement and negative government intervention; and the failure of services to recognise cultural obligations and practices. The study also identified enablers that would improve access to health services, including the provision of financial assistance, access to transportation, interagency communication and coordination, continuity and consistency of care, case management and understanding of factors competing with healthcare access.

Emerging evidence suggests that First Nations people are less likely than non-First Nations people to be granted mental health court diversion. In Albalawi and colleagues' (2019) study of court diversion in New South Wales, First Nations people with psychosis were significantly less likely than non-First Nations people to receive a treatment order rather than a punitive sanction. Similarly, Macdonald and colleagues (2024) found that First Nations defendants were less likely than non-First Nations people to be granted diversion, even when controlling for other relevant factors such as age, remoteness of residence and prior contact with the court system. Both NSW studies based on the SCCLS and linked data conducted by Soon and colleagues (2024, 2018) found that First Nations defendants assessed as eligible for diversion were less likely than non-First Nations people to be granted a diversion by a magistrate. Reduced access to diversion has also been observed among First Nations adolescents (Gaskin et al. 2024). It should be noted that these studies were quantitative in nature, based on analysis of routinely recorded data, and were limited in their ability to shed light on the underlying causes of these barriers.

Although the extant literature on First Nations people's lived or living experiences of diversion remains limited, some authors have provided insight into the specific nature of the barriers First Nations people face; these may begin to explain the lower rates of diversion for this group. These barriers include, but are not limited to:

- strict eligibility criteria for diversion, particularly the requirement to have no or limited previous offending;
- limited understanding of the legal system and the availability of diversionary programs;
- lack of access to programs and services, particularly in rural and remote areas;
- distrust of legal systems and harmful engagement with the police, magistrates and solicitors; and
- discretion of the magistrate in determining whether to grant a diversion (AIHW 2013).

A study conducted by Baldry and colleagues (2015) also shed light on the barriers faced by First Nations people with mental and cognitive disabilities in contact with the criminal justice system and highlighted the need for these challenges to be urgently addressed to reduce the over-representation of First Nations people within courts and prisons. Consistently with previous research, the study found that First Nations people were less likely to be granted a mental health diversion, with qualitative data suggesting that this may be because of the extremely high volumes of matters that magistrates, the ALS solicitors and NSW Legal Aid lawyers are required to deal with in the Local Courts in New South Wales (Baldry et al. 2015). Service capacity was also identified as a key challenge, because community services may lack the required expertise to appropriately support First Nations people with multiple and complex support needs (Baldry et al. 2015). The authors concluded that an expansion of diversionary options for First Nations people with mental and cognitive disability is urgently required—particularly specialist women's programs and services for people living in regional and remote areas.

There is also evidence that First Nations people who are granted mental health court diversion experience less favourable outcomes than diverted non-First Nations people, representing a major failure of systems and services in responding to the needs of First Nations people and communities. Studies have demonstrated that First Nations defendants have higher rates of post-diversion reoffending than non-First Nations defendants. Albalawi et al. (2019) and Soon et al. (2024), for example, found that First Nations people were significantly more likely to reoffend than non-First Nations people. In Bradford and Smith's (2009) evaluation of the NSW SCCLS, First Nations people also had a higher mean number of offences per month than non-First Nations people in the post-diversion period.

This disparity in access and outcomes points to an urgent need for research to inform the development of effective and culturally responsive diversionary policies and programs in criminal justice and forensic mental health systems. These disparities suggest that the criminal justice system in New South Wales has not adequately reformed its processes to be inclusive of the lived and living experiences of First Nations people. This research addresses a significant gap in the evidence base by exploring the lived and living experiences of First Nations people and capturing the perspectives of professional stakeholders involved in the decision-making and care of people diverted on mental health grounds. Such research is urgently needed to inform culturally safe policies and programs that not only acknowledge the impacts of colonisation, systemic racism and socio-economic factors on First Nations people's health and social and emotional wellbeing, but also highlight the importance of partnership, collaboration and empowered decision-making (Waterworth 2024).

Methodology

Study aims and research questions

The current study aimed to address a significant gap in the evidence base about First Nations people's experiences of mental health diversion in the Local Court in New South Wales. It sought to generate a deeper understanding of the needs of First Nations people with mental illness who are in contact with criminal justice and mental health systems and the barriers they face to mental health diversion. Ultimately, the study aimed to inform the development of policies, programs and services to ensure that mental health diversion at court is a culturally appropriate and effective mechanism for reducing the hyper-incarceration of First Nations people.

Specifically, the study used a mixed-methods approach to address the following research questions:

1. What is the relative rate of mental health diversion for First Nations people in New South Wales, and what individual or group-level factors contribute to any disparity identified? (Quantitative analysis)
2. What are the perceived barriers to mental health diversion for First Nations people, and what are the underlying factors responsible for the identified barriers? (Qualitative analysis)
3. What changes to current systems, policies and laws may be needed to reduce the barriers to mental health diversion for First Nations people? (Qualitative analysis)

Data sources

The study used two main data sources to address the research questions:

- quantitative data collected by the NSW SCCLS and linked to the BOCSAR Reoffending Database (ROD); and
- qualitative data collected from semi-structured interviews with First Nations people with lived and living experience of mental illness and justice contact and with professional stakeholders working in the sector.

NSW SCCLS dataset

Sampling and data collection

The study used data collected by the NSW SCCLS on all individuals seen by the service between 1 July 2008 and 30 June 2022. Clinicians working for the SCCLS operated out of Local Courts across New South Wales and recorded data on each individual's sociodemographic characteristics, along with clinical information, and made an assessment of their eligibility for mental health court diversion. Defendants were deemed eligible for diversion if they had a mental health and/or cognitive impairment. The SCCLS clinicians also made recommendations to the court about the types of services and supports that might be appropriate for the individual. Individuals were included in the study if they were aged 18 years or over and assessed by SCCLS clinicians as being eligible for any type of mental health court diversion under the MHCIFPA.

SCCLS clinicians identified 16,217 individuals as eligible for diversion during the study period. For those who had multiple service contacts recorded in the dataset, the most recent contact was selected for the purposes of analysis, to ensure that analyses reflect individuals' current mental health status. The SCCLS dataset was matched to the BOCSAR ROD, with linkage conducted by the NSW Centre for Health Record Linkage using key identifying information for the cohort members (eg name, date of birth and criminal justice record number). The BOCSAR ROD contains detailed information on criminal charges, convictions and mental health dismissals for finalised court appearances in New South Wales. Data from the ROD were obtained for the period 1 July 2008 to 31 December 2022. A total of 6,188 individuals were identified as having a documented index offence in the BOCSAR ROD and a relevant SCCLS contact leading to determination of eligibility for community-based or hospital inpatient-based diversion, comprising the final sample for the study.

Data variables

The primary outcome variables for the study included diversion status and reoffending. The diversion status variable was coded based on whether individuals had a confirmed court diversion granted under sections 32/14 (community-based diversion) or 33/19 (hospital-based diversion). Section number combinations reflect current and previous legislation details, as we explained earlier. For the purposes of the study, reoffending was defined as any finalised and proven charge where the offence occurred after the index court finalisation date. Reoffending was examined both in relation to any offence type and for violent offences. Cohort members were followed from their court finalisation date for their index offence until their first incident of reoffending recorded in the ROD or the end of the follow-up period (31 December 2022), whichever came first.

Study covariates included First Nations status, age, sex, location, offence type, mental health diagnosis, legal representation and prior offending. Cohort members were coded as having a First Nations background if they were identified as Aboriginal and/or Torres Strait Islander in either the SCCLS dataset or the BOCSAR ROD. The cohort was categorised into three age groups (18 to 29 years, 30 to 39 years, 40 years and over) based on their age at the time of assessment by the SCCLS clinician. Clinicians assessed each person's primary mental health issue and recorded the diagnosis based on the ICD-10 Classification System. Diagnoses were then grouped into serious mental disorders (eg schizophrenia-related and other psychotic disorders, bipolar affective disorder), personality or substance use disorders and common or other mental disorders (eg depressive, stress-related somatoform and affective disorders; Soon et al. 2024).

The BOCSAR ROD also contained information on socio-economic status and residential remoteness. The Socio-Economic Index for Areas (SEIFA) score is determined by the average income and employment status of individuals residing in a particular location (ABS 2023c). The socio-economic status of cohort members was analysed according to their SEIFA score based on their postcode of residence at the time of the court appearance. Remoteness of individuals' residential area was defined based on the remoteness structure of the Australian Statistical Geography Standard, using the Accessibility/Remoteness Index of Australia Plus (ARIA+) score to determine the number of services available within a specific population (ABS 2023b).

Criminal charges obtained from the BOCSAR ROD were classified according to the Australian and New Zealand Standard Offence Classification system (ABS 2023a). Offences were defined as 'violent', 'non-violent' or 'minor'. Violent charges included offences such as acts intended to cause injury and sexual assault, while non-violent charges included offences such as theft, fraud and property damage. Minor offences included those related to traffic and vehicle offences (Soon et al. 2024). Prior offending was defined as proven finalised charges recorded as occurring prior to the index offence date corresponding with SCCLS contact.

Data analysis

Quantitative data were analysed using SPSS version 28 (IBM Corp 2021). Descriptive statistics were generated to establish the sociodemographic, clinical and forensic characteristics of the sample. The characteristics of the First Nations and non-First Nations samples were compared using univariate and multivariate logistic regression analysis, with measures of association reported as odds ratios (ORs) with 95% confidence intervals (CI). Characteristics of the whole sample were also compared for those who were granted court diversion and those who were not granted court diversion. The same comparison was made for the First Nations subsample.

Descriptive statistics were obtained for the number and proportion of individuals who reoffended after the index court finalisation date, stratified by First Nations and non-First Nations background and diversion status. The timing of an individual's first reoffence following diversion was also examined by calculating the time between the court finalisation date resulting in a diversion and the first reoffence date. The time to first reoffence was then stratified into time bands (0–30 days; 31–90 days; 91 days – 12 months; 13–24 months; 25–36 months), where only individuals with a post-diversion follow-up period consistent with the time bands specified were included in the analysis.

Reoffending after the court finalisation date was analysed in several ways. Firstly, univariate and multivariate logistic regression analysis was used to compare the First Nations and non-First Nations samples who were granted diversion and had reoffended following the court finalisation date. The samples were then compared among those who were not granted diversion and had reoffended following the court finalisation date. Finally, predictors of reoffending after diversion were identified among the First Nations subsample using logistic regression and Cox proportional hazards regression.

Qualitative interviews

Recruitment

The qualitative component of the study aimed to elicit in-depth information about First Nations people's experiences of Local Court mental health diversion, both from First Nations people with lived experience and from stakeholders working in the sector. Interview participants were recruited using purposive and snowball sampling techniques (Palinkas et al. 2016). Interview participants were deliberately recruited from several key groups who were identified as well positioned to provide in-depth information about First Nations people's experiences of mental health diversion. Interview participants were recruited from the following groups:

- First Nations people with lived and living experience of mental illness and criminal justice contact, including mental health diversion in the Local Court;
- Local Court magistrates responsible for making determinations about mental health diversion;
- NSW Justice Health workers, including clinical nurse consultants with the SCCLS; and
- legal professionals.

Several recruitment strategies were used to engage with individuals from each of the participant groups. Lived experience participants were recruited by Dr McEntyre through established and trusted relationships with members of First Nations communities. The research team liaised with key contacts from government service organisations to assist in recruiting stakeholders to participate in interviews. These contacts then circulated an invitation to participate to stakeholders within their organisations. Stakeholders were identified for participation based on their employment related to mental health diversion in the Local Court, including Local Court magistrates and Justice Health workers. Participants were also encouraged to pass on information about the study to other individuals who may be interested or eligible to participate.

All potential interview participants were provided with a participant information statement and consent form which contained detailed information about the study and eligibility criteria. To ensure informed consent, potential participants were asked to read the form carefully before agreeing to participate in an interview. An easy-read consent form was also provided to ensure participant accessibility. Potential participants were advised to contact a member of the research team to register their interest in participating. Once the potential participant provided informed consent to participate, an interview time was organised.

Data collection

Semi-structured interviews were conducted with a total of 17 participants: three lived experience participants, six Local Court magistrates, seven SCCLS clinicians and one legal professional. A semi-structured approach allowed interviews to be focused on the topic of interest while still allowing the flexibility to explore pertinent ideas that came up during the interview (Adeoye-Olatunde & Olenik 2021). All interviews were conducted by qualified members of the research team with experience in carrying out qualitative research.

Interviews were conducted in person, online or by telephone, according to the interviewee's preferences, using interview guides developed by the research team. Separate interview guides were developed for the lived experience group and the professional stakeholder groups. These interview guides were modified from a previous study conducted by the researchers examining the lived and living experience of First Nations people in the forensic mental health system, which were developed in consultation with First Nations organisations supporting the research (McEntyre et al. 2024). Interviews with the lived experience group focused on:

- participant experiences of the criminal justice system, including contact with police, courts and prison;
- whether the participant had received any type of support throughout their life, particularly from mental health services, and whether this support was helpful;
- the types of support the participant would like to have received; and
- participant experiences of mental health diversion in the Local Court, including how they had come into contact with the court, the types of support received and the types of support that would have been helpful.

Interview guides were tailored according to the different professional stakeholder groups (Local Court magistrates, Justice Health staff). Broadly, these interviews focused on:

- participant job role and the types of services provided to First Nations people;
- participant perceptions of whether their services were culturally appropriate for First Nations people;
- participant experiences of mental health diversion in the Local Court, including their perceptions of the barriers faced by First Nations people in being granted diversion; and
- participant perceptions of how the criminal justice and forensic mental health systems could be improved to meet the needs of First Nations people.

On average, interviews took approximately 45 minutes to complete. The interviews were audio recorded with each participant's permission and transcribed by a professional transcription agency. All First Nations lived experience participants were reimbursed with a $50 gift card.

Data analysis

The qualitative interview data were analysed using NVivo version 12. Thematic analysis was used to identify key patterns, similarities and differences in relation to participants' perceptions and experiences of mental health diversion in the Local Court. A coding frame was developed inductively by the research team to identify key codes, categories, patterns and themes that emerged from the data, rather than relying on a pre-established set of codes (Bingham 2023; Tsindos 2023). The text was coded line by line according to the coding frame, ensuring flexibility by allowing new themes to be integrated into the coding frame as they emerged during the analysis process. Emerging themes were discussed among the researchers to ensure consistency and validity of the research findings.

Research oversight and ethical approval

Ethical approval to conduct the research was provided by the Justice Health and Forensic Mental Health Network Human Research Ethics Committee (HREC Reference: 2020/ETH03094) and the NSW Aboriginal Health and Medical Research Council (HREC Reference: 1749/20).

Mindaribba Local Aboriginal Land Council, the legislated authority for culture and heritage in the Maitland and Lower Hunter areas of New South Wales and a social, health and learning hub for the Aboriginal community, provided cultural oversight for the research.

Findings

Research question 1: What is the relative rate of mental health diversion for First Nations people in New South Wales, and what individual or group-level factors contribute to any disparity identified?

Characteristics of people deemed eligible for mental health court diversion, including a comparison of First Nations and non-First Nations people

The study sample included 6,188 individuals eligible for mental health court diversion. The average number of service contacts per individual was 2.2 (median=2.0, *SD*=2.2, range=1–32). Approximately one-quarter (27%) were recorded as having a First Nations background (see Table 1). The largest group of the study cohort was aged over 40 years (*n*=2,390, 39%), male (71%) and lived in the second most disadvantaged areas (2nd SEIFA quartile (36%)) and in major urban areas (66%). The most common diagnoses recorded by SCCLS clinicians were serious mental disorders (56%), including schizophrenia and bipolar disorder. Most of the cohort had a principal offence that was minor or non-violent (66%), such as theft, drug-related offences or traffic offences. Most of the cohort had legal representation (91%), and three-quarters (75%) had a record of prior offending.

Table 1: Sample characteristics and differences between First Nations and non-First Nations people deemed eligible for mental health court diversion

Sociodemographic, clinical and forensic characteristics	Total sample (*n*=6,188)	First Nations (*n*=1,655)	Non-First Nations (*n*=4,533)	Unadjusted odds ratio (95% CI)	Adjusted odds ratio (95% CI)
	n (%)	*n* (%)	*n* (%)		
Age group (years)					
18–29	1,997 (32.3)	628 (37.9)	1,369 (30.2)	1.62 (1.42, 1.86)	1.87 (1.62, 2.17)
30–39	1,801 (29.1)	500 (30.2)	1,301 (28.7)	1.36 (1.18, 1.57)	1.29 (1.11, 1.50)
40+	2,390 (38.6)	527 (31.8)	1,863 (41.1)	1.00 (ref)	1.00 (ref)
Sex					
Female	1,812 (29.3)	502 (30.3)	1,310 (28.9)	1.07 (0.95, 1.21)	–
Male	4,376 (70.7)	1,153 (69.7)	3,223 (71.1)	1.00 (ref)	–
SEIFA quartile (missing *n*=228)					
4th (least disadvantage)	737 (12.4)	143 (9.1)	594 (13.5)	0.66 (0.53, 0.82)	0.81 (0.65, 1.02)
3rd	1,492 (25.0)	381 (24.3)	1,111 (25.3)	0.94 (0.80, 1.11)	–
2nd	2,167 (36.4)	624 (39.8)	1,543 (35.1)	1.11 (0.96, 1.28)	–
1st (most disadvantage)	1,564 (26.2)	418 (26.7)	1,146 (26.1)	1.00 (ref)	1.00 (ref)
Remote residential area (missing *n*=227)					
Outer regional/ remote/very remote area	311 (5.2)	115 (7.3)	196 (4.5)	1.97 (1.55, 2.52)	2.11 (1.61, 2.75)
Inner regional	1,735 (29.1)	554 (35.4)	1,181 (26.9)	1.59 (1.39, 1.79)	1.61 (1.39, 1.86)
Major cities	3,915 (65.7)	897 (57.3)	3,018 (68.7)	1.00 (ref)	1.00 (ref)
Diagnosis (missing *n*=151)					
Serious mental disorder	3,387 (56.1)	911 (56.4)	2,476 (56.0)	1.12 (0.98, 1.27)	–
Personality or substance disorder	657 (10.9)	210 (13.0)	447 (10.1)	1.43 (1.18, 1.73)	1.42 (1.15, 1.74)
Common mental disorders/other disorder	1,993 (33.0)	494 (30.6)	1,499 (33.9)	1.00 (ref)	1.00 (ref)
Principal offence at court finalisation					
Minor/non-violent offence	4,080 (65.9)	1,121 (67.7)	2,959 (65.3)	1.12 (0.99, 1.26)	–
Violent offence	2,108 (34.1)	534 (32.3)	1,574 (34.7)	1.00 (ref)	–
Legal representation					
Represented	5,649 (91.3)	1,513 (91.4)	4,136 (91.2)	1.02 (0.84, 1.25)	–
Not represented/ unknown	539 (8.7)	142 (8.6)	397 (8.8)	1.00 (ref)	–
Prior offending					
Yes	4,666 (75.4)	1,434 (86.6)	3,232 (71.3)	2.61 (2.24, 3.05)	3.00 (2.54, 3.55)
No	1,522 (24.6)	221 (13.4)	1,301 (28.7)	1.00 (ref)	1.00 (ref)

Note: SEIFA=Socio-Economic Indexes for Areas. Adjusted odds ratios are adjusted for all other variables

Table 1 also details comparisons of the sociodemographic, clinical and forensic characteristics for First Nations and non-First Nations people in the study cohort. In the univariate analyses, First Nations people were significantly more likely to be in the younger age categories (18–29 years, OR=1.62, 95% CI [1.42, 1.86]; 30–39 years, OR=1.36, 95% CI [1.18, 1.57]). They were more likely to live in outer regional/remote (OR=1.97, 95% CI [1.55, 2.52]) or inner regional areas (OR=1.59, 95% CI [1.39, 1.79]) than non-First Nations people but less likely to live in the least disadvantaged areas (4th SEIFA quartile; OR=0.66, 95% CI [0.53, 0.82]). First Nations people were more likely to have a personality or substance use disorder (OR=1.43, 95% CI [1.18, 1.73]). They were also more likely to have a history of prior offending (OR=2.61, 95% CI [2.24, 3.05]). Following adjustment for all significant covariates, all associations, apart from SEIFA, remained statistically significant.

Factors associated with being granted diversion, including for First Nations people

Table 2 presents associations between sociodemographic, clinical and forensic characteristics and the odds of an individual being granted diversion by the magistrate. Just over half of the cohort of people determined by SCCLS clinicians to be eligible for diversion were granted diversion (58%). First Nations people were significantly less likely to be granted diversion than non-First Nations people (OR=0.62, 95% CI [0.55, 0.69]). Individuals less likely to be diverted were in younger age categories (18–29 years, OR=0.87, 95% CI [0.77, 0.98]; 30–39 years, OR=0.81, 95% CI [0.71, 0.91]), with a diagnosis of personality or substance use disorder (OR=0.56, 95% CI [0.47, 0.67]) and a principal offence at the court finalisation that was minor or non-violent (OR=0.58, 95% CI [0.52, 0.65]). People with a history of prior offending were also less likely to be diverted (OR=0.49, 95% CI [0.44, 0.56]). Women were more likely than men to be granted diversion (OR=1.35, 95% CI [1.21, 1.51]). Those living in the least disadvantaged areas (4th SEIFA quartile; OR=1.25, 95% CI [1.04, 1.49]) or in the second most disadvantaged areas (2nd SEIFA quartile; OR=1.23, 95% CI [1.08, 1.41]) were also more likely to be diverted than those living in the most disadvantaged areas (1st SEIFA quartile). Individuals who had legal representation were more likely to be diverted (OR=1.46, 95% CI [1.22, 1.74]). After adjusting for all significant covariates, all associations, except the age group of 18–29 years, remained statistically significant.

Table 2: Associations between sociodemographic and clinical characteristics and the granting of mental health diversion among those deemed eligible for diversion

Sociodemographic, clinical and forensic characteristics	Diverted (*n*=3,582)	Not diverted (*n*=2,606)	Unadjusted odds ratio (95% CI)	Adjusted odds ratio (95% CI)
	n (%)	*n* (%)		
First Nations background				
Yes	814 (22.7)	841 (32.3)	0.62 (0.55, 0.69)	0.70 (0.62, 0.79)
No	2,768 (77.3)	1,765 (67.7)	1.00 (ref)	1.00 (ref)
Age group (years)				
18–29	1,141 (31.9)	856 (32.8)	0.87 (0.77, 0.98)	0.88 (0.76, 1.01)
30–39	995 (27.8)	806 (30.9)	0.81 (0.71, 0.91)	0.86 (0.76, 0.99)
40+	1,446 (40.4)	944 (36.2)	1.00 (ref)	1.00 (ref)
Sex				
Female	1,142 (31.9)	670 (25.7)	1.35 (1.21, 1.51)	1.31 (1.16, 1.48)
Male	2,440 (68.1)	1,936 (74.3)	1.00 (ref)	1.00 (ref)
SEIFA quartile (missing *n*=228)				
4th (least disadvantage)	451 (12.9)	286 (11.7)	1.25 (1.04, 1.49)	1.25 (1.04, 1.51)
3rd	865 (24.7)	627 (25.6)	1.09 (0.95, 1.26)	–
2nd	1,319 (37.6)	848 (34.6)	1.23 (1.08, 1.41)	1.27 (1.11, 1.46)
1st (most disadvantage)	873 (24.9)	691 (28.2)	1.00 (ref)	1.00 (ref)
Remote residential area (missing *n*=227)				
Outer regional/remote/very remote area	191 (5.4)	120 (4.9)	1.12 (0.88, 1.41)	–
Inner regional	1,016 (29.9)	719 (29.3)	0.99 (0.88, 1.11)	–
Major cities	2,302 (65.6)	1,613 (65.8)	1.00 (ref)	–
Diagnosis (missing *n*=151)				
Serious mental disorder	2,051 (58.6)	1,336 (55.7)	1.10 (0.98, 1.23)	–
Personality or substance disorder	288 (8.2)	369 (14.6)	0.56 (0.47, 0.67)	0.65 (0.54, 0.78)
Common mental disorders/other disorder	1,163 (33.2)	830 (32.7)	1.00 (ref)	1.00 (ref)
Principal offence at court finalisation				
Minor/non-violent offence	2,108 (60.9)	1,900 (72.9)	0.58 (0.52, 0.65)	0.59 (0.53, 0.67)
Violent offence	1,402 (39.1)	706 (27.1)	1.00 (ref)	1.00 (ref)
Legal representation				
Represented	3,316 (92.6)	2,333 (89.5)	1.46 (1.22, 1.74)	1.50 (1.24, 1.81)
Not represented/unknown	266 (7.4)	273 (10.5)	1.00 (ref)	1.00 (ref)
Prior offending				
Yes	2,512 (70.1)	2,154 (82.7)	0.49 (0.44, 0.56)	0.54 (0.47, 0.62)
No	1,070 (29.9)	452 (17.3)	1.00 (ref)	1.00 (ref)

Note: SEIFA=Socio-Economic Indexes for Areas. Adjusted odds ratios are adjusted for all other variables

The associations between sociodemographic, clinical and forensic characteristics and the odds of an individual being granted diversion were examined among the First Nations subsample (Table 3). First Nations women were more likely than First Nations men to be diverted (OR=1.51, 95% CI [1.23, 1.87]). Those living in the least disadvantaged areas (4th SEIFA quartile; OR=1.94, 95% CI [1.32, 2.85]) or in the 3rd (OR=1.51, 95% CI [1.1.4, 1.99]) or 2nd SEIFA quartile (OR=1.56, 95% CI [1.21, 2.00]) were more likely to be diverted than those living in the most disadvantaged areas (1st SEIFA quartile). Among those with a First Nations background, people with a personality or substance use disorder diagnosis were less likely than those with a common mental disorder/other disorder diagnosis to be granted diversion (OR=0.43, 95% CI [0.31, 0.61]). Those with a minor/non-violent offence at court finalisation (OR=0.75, 95% CI [0.61, 0.92]) and those with a prior offending history were also less likely to be granted diversion (OR=0.70, 95% CI [0.52, 0.93]). All significant covariates, except for prior offending, remained statistically significant after adjustment.

Table 3: Associations between sociodemographic and clinical characteristics and the granting of mental health diversion among cohort members with a First Nations background

Sociodemographic, clinical and forensic characteristics	Diverted (*n*=814)	Not diverted (*n*=841)	Unadjusted odds ratio (95% CI)	Adjusted odds ratio (95% CI)
	n (%)	*n* (%)		
Age group (years)				
18–29	297 (36.5)	331 (39.4)	0.82 (0.65, 1.03)	-
30–39	241 (29.6)	259 (30.8)	0.85 (0.66, 1.08)	-
40+	276 (33.9)	251 (29.8)	1.00 (ref)	-
Sex				
Female	283 (34.8)	219 (26.0)	1.51 (1.23, 1.87)	1.38 (1.11, 1.73)
Male	531 (65.2)	622 (74.0)	1.00 (ref)	1.00 (ref)
SEIFA quartile (missing *n*=89)				
4th (least disadvantage)	84 (10.6)	59 (7.6)	1.94 (1.32, 2.85)	2.05 (1.38, 3.05)
3rd	200 (25.2)	181 (23.4)	1.51 (1.14, 1.99)	1.50 (1.12, 2.00)
2nd	333 (41.9)	291 (37.7)	1.56 (1.21, 2.00)	1.56 (1.21, 2.02)
1st (most disadvantage)	177 (22.3)	241 (31.2)	1.00 (ref)	1.00 (ref)
Remote residential area (missing *n*=89)				
Outer regional/remote/ very remote area	59 (7.4)	56 (7.3)	1.03 (0.70, 1.52)	–
Inner regional	282 (35.5)	272 (35.2)	1.02 (0.82, 1.26)	–
Major cities	453 (57.1)	444 (57.7)	1.00 (ref)	–

Table 3: Associations between sociodemographic and clinical characteristics and the granting of mental health diversion among cohort members with a First Nations background (cont.)

Sociodemographic, clinical and forensic characteristics	Diverted (*n*=814)	Not diverted (*n*=841)	Unadjusted odds ratio (95% CI)	Adjusted odds ratio (95% CI)
	n (%)	*n* (%)		
Diagnosis (missing *n*=40)				
Serious mental disorder	477 (60.1)	434 (52.9)	1.06 (0.85, 1.31)	–
Personality or substance disorder	65 (8.2)	145 (17.7)	0.43 (0.31, 0.61)	0.46 (0.32, 0.65)
Common mental disorders/other disorder	252 (31.7)	242 (29.5)	1.00 (ref)	1.00 (ref)
Principal offence at court finalisation				
Minor/non-violent offence	525 (64.5)	596 (70.9)	0.75 (0.61, 0.92)	0.75 (0.60, 0.93)
Violent offence	289 (35.5)	245 (29.1)	1.00 (ref)	1.00 (ref)
Legal representation				
Represented	753 (92.5)	760 (90.4)	1.32 (0.93, 1.86)	–
Not represented/unknown	61 (7.5)	81 (9.6)	1.00 (ref)	–
Prior offending				
Yes	688 (84.5)	746 (88.7)	0.70 (0.52, 0.93)	0.75 (0.55, 1.02)
No	126 (15.5)	95 (11.3)	1.00 (ref)	1.00 (ref)

Note: SEIFA=Socio-Economic Indexes for Areas. Adjusted odds ratios are adjusted for all other variables

Patterns of reoffending among First Nations and non-First Nations people deemed eligible for mental health court diversion, including by diversion status

Over the total period of observation, the prevalence of reoffending among all those deemed eligible for court diversion was 43 percent. Table 4 presents a summary of the number and proportion of individuals deemed eligible for court diversion and their subsequent reoffending outcomes, according to diversion status and First Nations background. Overall, those who were granted diversion had a lower rate of reoffending than those who were not diverted among both First Nations (54% vs 63%) and non-First Nations people (34% vs 44%). The most common type of reoffence was minor/non-violent among both First Nations and non-First Nations people who were diverted or not diverted. By the end of the follow-up period (36 months), non-diverted First Nations people had a higher proportion of reoffending than diverted First Nations people (56% vs 45%). This pattern was also observed for non-First Nations people (38% vs 26%).

Table 4: Reoffending outcomes for First Nations and non-First Nations people, in relation to diversion status

Reoffending outcome	First Nations background (*n*=1,655)		Non-First Nations background (*n*=4,533)	
	Diverted *n*=814 (49.2%)	Not diverted *n*=841 (50.8%)	Diverted *n*=2,768 (61.1%)	Not diverted *n*=1,765 (38.9%)
	n (%)	*n* (%)	*n* (%)	*n* (%)
Reoffending over total period of observation				
Yes	443 (54.4)	533 (63.4)	928 (33.5)	784 (44.4)
No	371 (45.6)	308 (36.6)	1,840 (66.5)	981 (55.6)
Type of first reoffence among those who reoffended				
Minor/non-violent reoffence	337 (76.1)	411 (77.1)	661 (71.2)	587 (74.9)
Violent reoffence	106 (23.9)	122 (22.9)	267 (28.8)	197 (25.1)
Time between court finalisation date and first reoffence (mutually exclusive groups)				
0–30 days (*n*=6,188)	57 (7.0)	55 (6.5)	94 (3.4)	78 (4.4)
31–90 days (*n*=6,182)	62 (7.6)	78 (9.3)	90 (3.3)	106 (6.0)
91 days – 12 months (*n*=6,168)	151 (18.6)	217 (25.8)	268 (9.7)	264 (15.0)
13–24 months (*n*=5,847)	60 (7.4)	77 (9.2)	178 (6.4)	146 (8.3)
25–36 months (*n*=5,153)	37 (4.5)	46 (5.5)	97 (3.5)	73 (4.1)
Time between court finalisation date and first reoffence (cumulative percentage)				
30 days (*n*=6,188)	57 (7.0)	55 (6.5)	94 (3.4)	78 (4.4)
31–90 days (*n*=6,182)	119 (14.6)	133 (15.8)	184 (6.6)	184 (10.4)
91 days – 12 months (*n*=6,168)	270 (33.2)	350 (41.6)	452 (16.3)	448 (25.4)
13–24 months (*n*=5,847)	330 (40.5)	427 (50.8)	630 (22.8)	594 (33.7)
25–36 months (*n*=5,153)	367 (45.1)	473 (56.2)	727 (26.3)	667 (37.8)

Note: Only those with sufficient follow-up time are included in each analysis

Predictors of reoffending

Table 5 presents the results of Cox proportional hazards regression analyses for any reoffending among the total study cohort. The univariate analysis found that First Nations background was significantly associated with reoffending after finalised court appearance (HR=1.98, 95% CI [1.83, 2.14]). Also significantly associated with reoffending were: no diversion (HR=1.51, 95% CI [1.40, 1.63]); younger age (18–29 years, HR=1.52, 95% CI [1.38, 1.66]; 30–39 years, HR=1.51, 95% CI [1.37, 1.65]); and being male (HR=1.31, 95% CI [1.20, 1.43]). People living in inner regional areas had a lower incidence of reoffending (OR=0.82, 95% CI [0.76, 0.90]).

Those who were diagnosed with serious mental disorder (HR=1.20, 95% CI [1.10, 1.31]) or personality disorder (HR=1.63, 95% CI [1.44, 1.85]) had a higher incidence of reoffending than those diagnosed with common mental disorders/other disorders. Those with a minor or non-violent offence at court finalisation (HR=1.18, 95% CI [1.09, 1.29]) and those with a history of prior offending (HR=2.50, 95% CI [2.24, 2.78]) had a higher incidence of reoffending. However, there was no significant difference in reoffending by SEIFA or based on whether the defendant received legal representation.

The inclusion of all significant covariates in the same multivariable model revealed a similar pattern of statistically significant results, except for offence type and having a serious mental disorder, which were no longer significantly associated with reoffending.

Table 5: Incidence of reoffending among those with First Nations and non-First Nations background, by sociodemographic, clinical and forensic characteristics

Sociodemographic, clinical and forensic characteristics	First offence after finalised court appearance (*n*)	Reoffence rate per 100 person-years	Unadjusted hazard ratio (95% CI)	Adjusted hazard ratio (95% CI)
First Nations background				
Yes	976	20.27	1.98 (1.83, 2.14)	1.72 (1.58, 1.87)
No	1,712	8.96	1.00 (ref)	1.00 (ref)
Diversion status				
Not diverted	1,317	14.78	1.51 (1.40, 1.63)	1.28 (1.18, 1.38)
Diverted	1,371	9.21	1.00 (ref)	1.00 (ref)
Age group (years)				
18–29	958	13.76	1.52 (1.38, 1.66)	1.61 (1.46, 1.78)
30–39	885	13.02	1.51 (1.37, 1.65)	1.38 (1.25, 1.53)
40+	845	8.41	1.00 (ref)	1.00 (ref)
Sex				
Male	2,013	12.24	1.31 (1.20, 1.43)	1.23 (1.12, 1.35)
Female	675	9.17	1.00 (ref)	1.00 (ref)
SEIFA quartile (missing *n*=228)				
4th (least disadvantage)	321	12.97	1.07 (0.94, 1.22)	–
3rd	670	12.17	1.09 (0.98, 1.21)	–
2nd	902	10.19	0.94 (0.85, 1.04)	–
1st (most disadvantage)	677	11.19	1.00 (ref)	–
Remote residential area				
Outer regional/remote/very remote area	132	9.39	0.85 (0.71, 1.02)	–
Inner regional	707	9.38	0.82 (0.76, 0.90)	0.78 (0.71, 0.85)
Major cities	1,731	12.42	1.00 (ref)	1.00 (ref)
Diagnosis				
Serious mental disorder	1,499	11.40	1.20 (1.10, 1.31)	1.03 (0.94, 1.13)
Personality or substance disorder	355	17.23	1.63 (1.44, 1.85)	1.31 (1.15, 1.49)
Common mental disorders/ other disorder	769	9.61	1.00 (ref)	1.00 (ref)
Principal offence at court finalisation				
Minor/non-violent offence	1,846	11.95	1.18 (1.09, 1.29)	1.08 (0.99, 1.17)
Violent offence	842	10.08	1.00 (ref)	1.00 (ref)
Legal representation				
Represented	2,418	11.47	0.93 (0.82, 1.06)	–
Not represented/unknown	270	9.93	1.00 (ref)	–
Prior offending				
Yes	2,309	14.18	2.50 (2.24, 2.78)	2.21 (1.96, 2.48)
No	379	5.04	1.00 (ref)	1.00 (ref)

Research question 2: What are the perceived barriers to mental health diversion for First Nations people, and what are the underlying factors responsible for the identified barriers?

Interview participants identified a range of barriers that First Nations people face in accessing mental health court diversion, including:

- the level of discretion exercised by Local Court magistrates;
- First Nations people's entrenchment within the criminal justice system;
- the nature of the offence;
- lack of services and treatment options;
- lack of accessible and transparent court processes;
- stigma and racism;
- funding and resourcing limitations;
- having a history of diversion orders; and
- other layered factors impacting health and wellbeing and the likelihood of diversion.

Discretion exercised by Local Court magistrates

Local Court magistrates exercise a considerable degree of discretion when making diversion decisions. Section 15 of the MHCIFPA sets out a range of factors that may be relevant to their decision-making, but this list is not exhaustive or prescriptive. However, when asked about the types of factors taken into consideration when making section 14 diversion decisions, magistrates interviewed generally identified factors consistent with those set out in section 15 of the legislation. Factors they considered relevant to their decisions included:

- the nature of the defendant's mental health diagnosis (s 15(a));
- the nature of the offence resulting in the diversion application (s 15(b));
- the defendant's criminal history (s 15(e));
- whether the defendant has received any prior diversion orders (s 15(f));
- the quality and appropriateness of the treatment plan (s 15(g)); and
- the safety of the community (s 15(h)).

Asked about considerations relevant to their diversion decisions, magistrate participants did not mention two factors set out in the legislation: the suitability of the sentencing options available if the defendant is found guilty of the offence (s 15(c)) and relevant changes in the circumstances of the defendant since the alleged commission of the offence (s 15(d)).

Generally, magistrates thought that the diversion legislation was sufficiently broad and comprehensive in guiding their diversion decisions. One magistrate noted:

> [I]f you have a mindset where you're prepared to divert then you can kind of find it in the legislation, I find it's broad enough to do that. (Magistrate 1)

Magistrate 3 also commented that the legislation allows for a 'broad discretion' in dealing with diversion matters and that the legislation is 'comprehensive'. This magistrate summarised the different orders that they could make in diversion decisions:

> If they are suitable for diversion, the next step is considering a number of different categories set out in section 15 … and consider whether or not it would be more appropriate in the circumstances, which is a broad discretion, to deal with them by way of mental health diversion or in accordance with law. A diversion order goes up to 12 months. It can have considerable conditions, including putting them into the care of a responsible person. It could be without condition, it could be just dismissing it and discharging them, depending on the seriousness of the offence. There would need to be a treatment plan in each of the cases under section 15. That's one of the criteria you've got to consider. (Magistrate 3)

In addition to the factors set out in the MHCIFPA, magistrates also carefully considered the quality of the SCCLS report:

> You've got to look closely at the legislation, you've got to look at the quality of the report that's prepared, and if the report itself persuades you and if there's some good advocacy then that's probably enough. (Magistrate 1)

While it is positive that the magistrates interviewed found the legislation useful in guiding their decision-making, some noted that they sometimes faced challenges in getting all the information necessary to make an informed diversion decision, including health records and information on prior treatment received. This was significant for First Nations defendants, who may not have accessed healthcare services in the past. The high cost of preparing reports that the magistrate may then use to inform their decisions was also noted as a significant barrier for First Nations people:

> Well, the ALS doesn't seem to have funding for [reports]. So often these things are cobbled together with bits and pieces. You get a letter from a court liaison nurse saying, 'I've had a look at the file. There appears to be a diagnosis that would bring them within it.' And then you get a whole lot of motherhood statements about what the treatment plan should be. So one of the biggest hurdles in my view in terms of getting Aboriginal people diverted is to get the funding to get the medicolegal report together. So I mean, I've been on the bench for 15 years, so I'm out of touch with the cost of those, but there's something like $1,500 to get a medicolegal report for that. (Magistrate 6)

The discretion exercised by magistrates may ultimately assist in facilitating diversion if the magistrate is willing to grant a diversion; however, interviews with other participants suggested that this discretion may also act as a barrier to diversion. Some participants observed that the success of the diversion application often depended on which magistrate was presiding over the Local Court on the day when the matter was being heard. This was more relevant for participants who worked in the busier metropolitan courts where there are many magistrates working on the same day. One participant commented on this issue, also highlighting the view that some magistrates may lack cultural competency in some instances:

> … some magistrates are very understanding but some magistrates will sort of if you're not there at 9.30 they'll mark the papers 'failed to appear', they'll issue a warrant, you know, no attempt to enquire into a person's circumstances, apparently no understanding of why it might be difficult for a person to appear at court. So yeah, I think there's enormous variations between magistrates and their attitudes and some just really don't have the cultural understanding or sensitivity that they need. (Legal practitioner 1)

Participants also suggested that the approach to treatment planning may vary depending on the magistrate hearing the matter. Some participants believed that some magistrates could be 'overly rigorous' when reviewing the treatment plan:

> I mean it's kind of good to be rigorous but like I think a lot of magistrates are overly rigorous, you know, like for example they say 'Well this case plan doesn't guarantee that he's never going to drink alcohol ever again and therefore it's not good enough,' you know, really? (Legal practitioner 1)

Similarly, when discussing the specifics of the treatment plan, one Magistrate 1 commented that they would 'send back' plans to be rewritten if they were deemed to be insufficiently detailed. Other magistrates suggested that they preferred a 'simple' treatment plan that is easier for defendants to follow over a plan that is too thorough and complex, particularly for First Nations defendants who may have had limited engagement with health services. One participant made a comment to this effect while also acknowledging that the approach to treatment planning tended to vary among magistrates:

> … it's discretionary, so it depends on the individual decision of each magistrate. Sometimes they can be very detailed treatment plans … And I am much more conducive to more simple guidelines rather than very detailed requirements about what they have to do and medication they have to take and counselling they have to go to, and this sort of thing. I think that risks setting them up to fail, that's just my view … And often the people who are getting the plans are not necessarily well educated or capable in every sense of the word of understanding every written requirement and following it to the letter. (Magistrate 5)

Some participants strongly believed that magistrate discretion was the key barrier to diversion for First Nations people. The legal practitioner participant noted that legislative changes implemented to improve the clarity and comprehensibility of diversion legislation may have had the effect of reducing access to diversion:

> … when the legislation changed in 2021 and it's now section 14 and not section 32, I mean ostensibly the aim of that was to try to make diversion more available but I think there's also—I don't know, I think there's been these sort of forces going in the opposite direction and it may be I think a few particular magistrates on the bench who have particular views, and I think a lot of them have just become harder about it, you know, they've just taken a hard line. (Legal practitioner 1)

However, another clinician thought that the magistrate at their Local Court was generally fair when considering diversion matters, took their report and treatment plan seriously and ultimately tended to grant section 14 diversions:

> We've got a particular magistrate—I mean they're all really lovely here. We've got one bloke that's been here for a really long time, and I think … he mostly does grant, if he doesn't grant my section 14s, I never take it personally or anything like that … Like he's generally really good when he sees my reports come, like he'll take them into consideration for sure. (Clinical nurse consultant 5)

Entrenchment within the criminal justice system

Interview participants discussed the impact of First Nations people's repeated contact within the criminal justice system. All service provider participants acknowledged that First Nations people are over-represented in the criminal justice system, suggesting that this over-representation is normalised. Participants discussed the impact of criminal justice system involvement on the wellbeing of First Nations people, with most participants noting that the system is typically unhelpful in addressing their mental health and social and emotional wellbeing needs. Asked about the impact of criminal justice system contact on First Nations people with mental health or cognitive impairment, participants described it as a 'disastrous combination', 'a bad thing' and 'a very difficult experience'.

Lived experience interview participants provided valuable insight into their involvement with the criminal justice system, discussing their negative experiences with the police, court and prisons. These negative experiences had impacts across generations, kinship networks and communities, with some participants having lost contact with family and community. It was common for participants to cycle in and out of prison. Lived experience participant 2 reported that they had been 'in and out … pretty much every year since 2006'. The same participant described the experience as being like a 'revolving door' and was unable to remember the exact number of times they had been in prison.

Underlying this picture of entrenchment within the criminal justice system, participants highlighted overpolicing of First Nations people, especially in public spaces:

> And the way that people are just picked up off the street, it is, they are targeted in that 'well, you did it'. Because people … they tend to be doing it very openly as well … Aboriginal people will have a fist fight, a couple would have a fist fight in the square, like on the main street. Whereas the non-Aboriginal people will do that at home. Or Aboriginal people will get drunk and belligerent, or aggressive and abusive on the street, whereas non-Aboriginal people do that at home. (Clinical nurse consultant 3)

It is also well established that First Nations people are more likely to encounter the criminal justice system for minor charges and be treated more harshly. One clinical nurse consultant explained that these minor charges may still result in a period of incarceration if the person is unable to meet bail conditions. A clinician who regularly works with First Nations people who apply for diversion reflected that most of their clients were presenting to court for minor, non-violent charges:

> I'm going to say that personally from an anecdotal point of view, that most First Nations people that I interview tend to be in for very small matters compared to non-Indigenous people. And I'm very well aware they're more likely to come in first time in custody on the first charge, they're more likely to get a lengthier sentence, they're more likely, and this is not just a police issue, this is a whole justice system issue, because it can't just be the police that gets them lengthy sentences. (Clinical nurse consultant 1)

Participants reported that these negative experiences resulted in a lack of trust in the system. Lived experience participant 1 reported definitively: 'I hate authority, I hate police.' A lack of trust in the broader court system and in legal representatives also acted as a barrier to diversion. Clinical nurse consultants observed that pleading guilty, rather than applying for a diversion order, was sometimes viewed as an 'easy option' because it allowed defendants to have the matter 'over and done with'. Magistrates also agreed with this sentiment:

> You know, for a lot of them it's quite an intensive order, it's probably—it's not a soft option, and it's probably more prescriptive than often a community corrections order say if they're placed on an order that they don't have to have any supervision. So I always sort of remind people that it's not a soft option, it is actually more—possibly more intrusive. (Magistrate 1)

Participants thought that the overpolicing of First Nations people and their entrenchment within the criminal justice system ultimately culminate in one of the strongest barriers to mental health diversion—defendants' prior criminal history. Participants noted that defendants' history of 'complex', 'detailed' and 'lengthy' involvement with the criminal justice system was a strong factor influencing whether diversion would be granted. Consistently with the quantitative findings of the current study, participants commented that First Nations defendants typically have lengthy histories of criminal justice system involvement, which acts as a significant barrier to diversion when they present to court for the divertible offence:

> I think also a challenge that of course First Nations people are criminalised as we all know at a much greater rate than non-Aboriginal people at a younger age, so by the time they sort of are 18, 19, 20, you know, they may have built up quite a long criminal history and the courts might go 'Oh no, why should I divert you? You've already got a really terrible record, you've had all these chances, and no,' so the pre-existing criminal history can be an issue. (Legal practitioner 1)
>
> And that's why sometimes they are not successful—for want of a better word, I don't like using that word—but the magistrate won't make one if they've got a whopping big criminal record because they are not left with much choice. And so that's again a problem for Aboriginal people because they've already got massive records. (Clinical nurse consultant 3)

Nature of the offence

Consistent with the factors set out in the MHCIFPA, the nature of the offence leading to the diversion application was identified as a key consideration for magistrates in making diversion decisions. Magistrates discussed the types of offences that may be less likely to receive a diversion. The two types of offences that participants frequently raised were domestic and family violence offences and driving offences. In the following interview extract, a magistrate discussed the intersecting considerations about the nature of the offence, safety of the community and political implications of granting diversion:

> I mean certainly serious matters can be diverted under section 14 and there's case law that supports that but, you know, you have to be a bit careful in terms of the politics of, you know, serious domestic violence offending often is not going to be diverted under a section 14 just in terms of the public policy. Weighing up community safety and public policy it often is certain types of offending that tend not to be as sort of conducive to be finalised by way of a section 14. Drink driving related offending often is not diverted … (Magistrate 1)

Other participants also noted this trend, with clinical nurse consultant 3 noting that magistrates tended to 'frown upon' domestic and family violence offences and that the prosecution was more likely to 'argue a lot more' against diversion in these cases. However, one magistrate suggested that diversion may be more appropriate in these cases because they do not pose a risk to the safety of the community as a whole, unlike offences such as drink driving which 'expose huge numbers of the public to danger'. The magistrate went on to say:

> So to give you an example, a person who's charged with drink driving is less likely to get a discharge even if they have a diagnosis … If it's a domestic violence thing, well they've exposed their own family and their intimate partners to danger, but it may well be that the partner is supportive of the application, et cetera. So those sorts of things also flow into the appropriateness test, appropriateness or otherwise test. (Magistrate 6)

These findings suggest that there may be inconsistent views among magistrates about the types of offences that should receive a mental health diversion. Again, this highlights the concern that magistrate discretion may act as a barrier to diversion. Issues may arise where magistrates hold a strict view about the types of offences that are 'divertible', while the MHCIFPA does not specify certain types of offences as ineligible for diversion. Rather than considering the nature of the offence in isolation, the MHCIFPA supports the notion that it should be understood in the context of other relevant factors set out in the legislation. Magistrate 2 explained: 'It just depends on the specific circumstances and the weighing up of factors.' Another magistrate also adopted a flexible approach in their decision-making:

> … there's no offences I would immediately say 'no' … I mean the individual circumstances that we get put up to us on a weekly basis is so variable, I never feel that I approach it with a fixed mind that I'm going to grant or I'm not going to grant it. (Magistrate 5)

While the quantitative analysis conducted for this study revealed that defendants, including First Nations people, were significantly more likely to be granted diversion for a violent offence than a non-violent or minor offence, interview participants indicated that serious violent offences were less likely to be appropriate for diversion. Magistrate 2 said: 'If it's too serious, the court may not be prepared to divert.' While the nature of the offence may act as a barrier to diversion for all defendants, regardless of First Nations background, First Nations defendants may also face unique challenges relating to the nature of the offence. Some clinical nurse consultants observed that First Nations people often presented to court for 'minor' or 'mediocre' offences such a low-level theft. While several clinical nurse consultants held the view that diversion for minor offences is often the best option for First Nations defendants, the quantitative and qualitative findings taken together may, in part, explain some barriers to diversion for First Nations people.

Lack of services and treatment options

An important barrier to successful diversion was the lack of appropriate treatment and support options for First Nations people, who often presented with multiple and complex support needs. It is well established that First Nations people face specific barriers to accessing healthcare services. Participants highlighted barriers including the compounding problem of distrust or fear of services, limited treatment options in custody and a lack of First Nations-specific services, particularly in regional and remote areas. Findings from the interviews suggested that the impact of the shortage of services and treatment options was twofold. Firstly, the lack of culturally appropriate and responsive services contributed to the hyper-incarceration of First Nations people and entrenchment within the criminal justice system. Extensive involvement with the criminal justice system ultimately acted as a further barrier to diversion, because magistrates may be less likely to grant diversion when the defendant has a lengthy criminal history. Secondly, the suitability and effectiveness of the treatment plan may be limited if proper services are not available in the community.

Participants commented on the lack of services and early support to prevent First Nations people from encountering the criminal justice system. Lived experience participants reported early and frequent contact with the criminal justice system, often resulting from undiagnosed or untreated mental health conditions and the lack of appropriate support options available. Lived experience participant 2 stated that they had never received any diversion to mental health services: 'There was no nothing, like no putting me into any [treatment] or referring, not even a referral, nothing.' Participants emphasised that treatment and support options in custody were extremely limited. One magistrate commented:

> The custodial environment isn't the best place for somebody with a mental illness … I think it's quite a negative impact on those suffering from mental illness to be in a custodial setting. (Magistrate 2)

Clinical nurse consultants also observed that their First Nations clients typically had limited histories of engagement with health services:

> Like I've seen people in their 40s go 'Hang on a minute, something's wrong, where's all the background info?' They've never been seen. They've never even made it to court liaison; they've never even been referred to me. They've never been referred to mental health or seen a doctor and I don't know how; I don't know why. But I think it's just because they are very quick 'just plead, just plead', they will say 'I did it.' (Clinical nurse consultant 3)

Another participant noted the difficulties that their clients with mental health or cognitive impairment faced in attending appointments:

> … possibly the idea of keeping appointments and going to see the specialist for the report to be prepared, sometimes people's lives are so chaotic that they can't even keep these basic appointments, which means that often the reason that they might breach say a community corrections order … when they're sentenced according to law, will be the same reason and they may not necessarily do well on the section 14 because they might not follow through with their appointments. (Clinical nurse consultant 1)

A lack of engagement with services and treatment options also made it difficult for the clinical nurse consultants to prepare their reports for the court. Asked about their job role, one participant described the process of gathering information as difficult when corroborating information from other services about the client's mental illness or cognitive impairment was limited:

> Then when I try to get some information on them, there's nothing and that's because they haven't accessed any healthcare services … that's just how it is, that's just how some people are, they're not going to go and get care, like they're not going to go to the doctor, they may be frightened to go to the doctor, or their family is when they're younger. (Clinical nurse consultant 5)

A lack of First Nations-specific services was also identified as a key barrier to diversion. Some participants noted that First Nations people may be reluctant to engage with mainstream services because of negative past experiences. Mistrust of services also arises from the role of government agencies in the ongoing colonisation, fracturing of families and widening of the justice gap for First Nations people. One participant summarised this issue:

> I think that there is reluctance. I think people who have had long involvements with mental health services, there's a reluctance there to engage … I think that trauma around the removal of children probably is a big barrier to mental health treatment because they'd probably be concerned about the impact that that's going to have on access to children or parental responsibility. (Magistrate 3)

Another key theme that emerged from the interviews was the lack of services and professionals with appropriate knowledge and training in regional and remote areas. Clinical nurse consultant 3 provided the example of a First Nations woman who would have been eligible for a section 14 diversion, except that a suitable treatment plan could not be developed because there were no services available for referrals. The participant also highlighted the difficulties they faced in referring clients to see psychiatrists in rural towns; psychiatry services are extremely limited, and there may be only one private psychiatrist available to service a large area, meaning that potential clients often must travel several hours to neighbouring towns.

Lack of accessible and transparent court processes

Underlying the negative experiences of First Nations people in contact with the criminal justice system was a lack of accessible and transparent court processes. Lived experience interview participants discussed how the court system often did not appropriately cater to their needs—including mental health, cognitive impairment and alcohol and other drug (AOD) issues. Participants described the difficulties they faced in navigating a complex and demanding criminal justice system. Some participants felt that the magistrates 'look down at you' and are 'really unfair'. Lived experience participant 3 described the confusion they experienced when their matter was presented; the court process was 'too hard for me … I can't understand, it's too confusing.'

Even when their mental health or cognitive impairment was raised in court, lived experience participants did not always understand what this meant or how to access a mental health assessment or specific treatment. Participants thought that the process of obtaining a mental health report for the diversion application was not transparent. Asked whether a mental health report was completed and provided to the magistrate, lived experience participant 1 responded: 'I don't know … [I] never ever saw it.' Others said:

> Well you don't give someone a diagnosis and then go 'Alright, this is your diagnosis and this is why you're getting this sentence but I'm not going to tell you what it means, I'm not going to tell you anything about it man, I won't give you any kind of help, treatment, nothing.' (Lived experience participant 2)
>
> My solicitor didn't even tell me that I was supposed to go and get an assessment done with one of the court's mental health things … I didn't know until I went there allegedly for sentencing and they're like 'Oh, have you done it?' 'No.' 'Oh, now we've got to wait another month.' (Lived experience participant 2)

One lived experience participant reported that she was not aware that mental health diversion options were available, despite having a diagnosed mental illness and presenting to court over five times. Discussing their experiences of mental health diversion, lived experience participant 2 said that she had 'never heard that term'. When asked whether she was aware of services where she could get support for her mental health, the participant responded: 'They don't even tell you that.'

Magistrate interview participants emphasised that mental health diversion is not a 'soft option', meaning that defendants may prefer to plead guilty to get the matter 'over and done with' and avoid the requirements of a diversion order. Another issue identified by some participants was the tendency for defendants to agree to conditions set by the court without fully understanding them, particularly for defendants with cognitive impairment. Clinical nurse consultant 3 said:

> People will just go 'yes, yes, yes' and agree to everything, but people don't often understand what they are agreeing to.

Interviewees noted that, if defendants do not understand the requirements of the diversion order and treatment or the order is not implementable, the effectiveness of such orders is ultimately limited.

Stigma and racism

First Nations people with mental illness who are in contact with the criminal justice system may experience stigma and racism as barriers to diversion. Participants discussed the institutional racism and discrimination that continue to affect First Nations people and contribute to their ongoing and worsening over-representation within the criminal justice system. Lived experience participant 1 commented: 'The blacker you are, the longer you get.' Clinical nurse consultant 1 discussed racism and discrimination as barriers to diversion:

> And I'm very well aware of the systemic racism and I'm very well aware of the trauma that our group of patients have experienced and continue to experience through systematic racism, but also direct racism and the accumulation of so many stories of other people's experiences with racism and absolute discrimination. It's just so, so obvious as someone who interviews patients regularly. Absolutely. There are two law courts. There is one for persons of colour and there's one for [everyone else]. They get treated very differently. (Clinical nurse consultant 1)
>
> I can't guarantee that there's not discrimination at court based on ethnicity. And certainly, like I've seen multiple times persons of colour get a DUI [driving under the influence] sentence, first time, never been in trouble with the law before, ever. Where it's absolutely divertible at court … so when you ask me what are the barriers, I'm going to say the magistrates. (Clinical nurse consultant 1)

Clinical nurse consultant 1 reflected on the importance of 'assessing' racism as a form of trauma, observing that this was a significant gap in the SCCLS's assessment process with First Nations people. They noted that this was particularly important because 'a large proportion of that population that come [into contact with the courts], certainly racism got them there in custody either the first time or at least as I said, as a consequent time.' This same participant expressed her poignant feelings when speaking with First Nations clients about racism:

> I feel very uncomfortable talking to patients about their experiences with racism, but [it's] something I'm starting to do, even if it's just a way of relieving and being heard and having their story heard. Because that is what we do is outside of just treatment of medication is having those human moments where they can hurt and listen. And I'll admit I'm very, very uncomfortable with those conversations because I'm not Aboriginal and I don't want to make it worse, but I think it's actually, it's a form of neglect to not have those conversations … It's not about my feelings. If I can in any way help or acknowledge the pain and suffering that they've gone through, then it's in the end for benefit. (Clinical nurse consultant 1)

Several magistrates also raised issues with the adequacy of the response from mental health services and the possibility of discrimination influencing the outcomes of section 19 diversion orders. Under section 19 of the MHCIFPA, the magistrate may order a defendant to be detained in a mental health facility for assessment if it appears that the defendant is a 'mentally ill or mentally disordered person'. Magistrates noted that a key issue that consistently arose in relation to section 19 diversions was patients 'bouncing back' to the Local Court after being assessed as not mentally ill by the hospital. One magistrate suggested that defendants may not receive an adequate mental health assessment despite clear signs that the person is suffering from a psychotic disorder such as schizophrenia:

> The ones that really frustrate me are the ones who arrive who are clearly mentally ill and under section 19, you try and send them to hospital and they bounce back. This is a major, major problem in the system. There is a level of dishonesty in the system from the medical side … I know that they have sometimes just attended to the police car and interviewed the person in the police car and then sent them on their way … I know that [magistrate] at [Local Court] has on three or four occasions sent somebody back until eventually a file emerged which is four inches thick of previous admissions because they've got schizophrenia, because he's refused to accept that the person was not unwell, which is what [the hospital] were suggesting. (Magistrate 4)

It was suggested that there may be a stigma operating against patients in contact with the criminal justice system that results in a reluctance by hospital staff to accept and treat patients who are deemed 'violent' or 'antisocial'. One magistrate noted:

> … there is a reluctance … maybe based on the fact that these people are dangerous and difficult to deal with, and so maybe the health system is not able to deal with them. (Magistrate 4)

This issue applied to service delivery more generally, with clinical nurse consultant 1 observing: 'There's a stigma attached to our patients, not just because they have mental health issues but because they've been in custody.' The participant reflected that they sometimes experienced resistance from health services when trying to refer patients.

Interview participants had mixed views on whether stigma prevented discussions of social and emotional wellbeing issues within First Nations communities. Several clinical nurse consultants noted that First Nations clients have reported particular concerns about privacy and may be reluctant to speak to Aboriginal workers if the worker knows people in their family or community. One participant stated:

> I've spoken to clients, First Nations clients, and I've suggested talking to the Aboriginal mental health worker, and they'll go 'Oh no, don't tell her … she knows so and so.' So you do come up—like sometimes blocked with who you can talk to because they want their privacy, which is fair enough. It's interesting because even though there's a big family culture, there's also the divisions as well and wanting privacy. Some clients I've spoken to, oh, they get really frustrated because the family knows everything. (Clinical nurse consultant 6)

However, another clinical nurse consultant believed that their First Nations clients were more open in discussing their mental health symptoms, noting:

> … when you do an assessment on an Aboriginal person it's just very frank often … whereas we are used to people being very guarded about their symptoms and not being open. (Clinical nurse consultant 3)

Funding and resourcing limitations

Almost all interview participants noted that funding and resourcing limitations are a major barrier to diversion for First Nations people. Specifically, participants noted:

- limited ALS funding;
- the SCCLS and clinical nurse consultants not being available at every court;
- limited resourcing in the Local Courts to deal with the high volume of cases; and
- lack of funding and resources for mental health services.

Participants highlighted the importance of having ALS or Legal Aid solicitors at the Local Court to facilitate diversion applications. However, most participants also recognised that these services are underfunded, and this acts as a barrier to diversion for First Nations people. Participants noted that the lack of government funding for legal services in particular Local Courts across New South Wales, especially in areas with high First Nations populations, affected the accessibility of diversion in these courts. The legal practitioner participant specifically noted that the number of lawyers employed in these settings had been reduced in order to 'pay the lawyers properly'. Asked whether they thought that First Nations people were less likely to be granted diversion, one magistrate responded:

> "No, I don't think so. I mean, the one thing I would say is this: I don't think Aboriginality really is a relevant factor in diversion or non-diversion. It's relevant for its consequences. And what I mean by that is that the organisations don't have a great deal of money. So the Indigenous specific organisations, the ALS, the AMS [Aboriginal Medical Service], don't have tons of money to facilitate these sorts of applications. (Magistrate 6)

Several participants commented that the ALS has limited or no funding for the psychological reports needed for a diversion application. One magistrate believed that this was one of the most significant barriers to diversion for First Nations people. Another magistrate commented that the ALS tended to hire junior lawyers, potentially because of funding constraints:

> "Some of the solicitors are inexperienced, particularly for ALS, they have a model where they get young people in. And that's great, and they are great people, but they are not necessarily, you can't just learn this stuff in two years, in your first two years of practice. This is really very difficult, it's high level and difficult and nuanced, you know. (Magistrate 4)

The availability of the SCCLS was also considered critical in facilitating mental health diversion applications for First Nations people. In the absence of SCCLS professionals, mental health diversion was essentially unavailable in some locations. Some magistrates believed strongly that this was a major issue needing to be addressed:

> Often the clinical nurse is great if they're there, but they're not in every court. So report writing and also just in some areas around New South Wales there just is not the opportunity to even get a psychologist to do a report—you know, Bourke, Brewarrina, Lightning Ridge, Coonamble. They just don't have access to psychologists. They have a huge problem in Broken Hill and other areas. (Magistrate 1)
>
> But I have very strong views and I have tried to agitate for a mental health nurse at Taree and Forster, Worimi Country. Because there's no mental health nurse, there's no circle sentencing, there's nothing, there's no MERIT [Magistrates Early Referral Into Treatment] … So that's a location, I do not understand how it is that that mob have missed out on everything … I don't know what it is, I don't know who to blame. But there is a community that is crying out for a court with services. (Magistrate 4)

Even at Local Courts where the SCCLS is available, clinical nurse consultants reported challenges with inadequate resources. Some participants reported difficulties gaining access to the documentation needed to write mental health reports for the magistrate. One participant discussed challenges that arose when clients were referred from remote areas, and they were unable to conduct assessments in person:

> I had to do an assessment on her via video conference, which is difficult anyway I think for some people, let alone those with a major mental illness or a cognitive impairment, and that was her case … It can be very hard to just assess people via video conference anyway, it's impersonal. (Clinical nurse consultant 5)

A major theme that emerged from the interviews related to resourcing in the Local Courts themselves. Magistrate interview participants emphasised the 'huge pressure' to clear lengthy court lists. Participants acknowledged that, because of the high volume of cases, there was often inadequate time to consider a defendant's matter in detail. This was a particular challenge for defendants applying for diversion, because these defendants had complex support needs, and understanding them sufficiently takes time. Magistrates illustrated the lack of resources in the Local Court:

> You know in some criminal courts in some list days you might have 150 people, 120 people, on the list. On sentence days you might be able to spend 10 minutes with a person. So just the sheer volume is a huge problem in the Local Court. (Magistrate 1)
>
> The difficulty is that taking the time to go through and recognise this is a matter which somebody needs to pay attention to, this mental health issue. You hope that the solicitor has picked up on it, usually they have … The difficulty is you can't do it properly. That's the thing that's frustrating. It cannot be done properly, it's not possible to do it properly by virtue of the way it is working. If you are getting lists over 110 in size in the list day, it can't be done. (Magistrate 4)

The lack of time and resourcing in the Local Court appeared to intersect with the issue of magistrate discretion on diversion matters. We noted that many participants viewed magistrate discretion as a potential barrier to diversion for First Nations people. One magistrate raised concerns about this, noting that the magistrates may be required to weigh up the need to clear extensive court lists with the need to engage with defendants and ensure they are referred to appropriate services:

> The magistrate at [Local Court] was less inclined to do that because it delayed matters. So he was all about clearing his list. So I was more about trying to get people engaged with things that might make a difference. But see, unfortunately when I left, to a large extent that fell apart … (Magistrate 6)

Interestingly, it was common for lived experience participants to prefer to have their matter heard in the District Court rather than the Local Court; lived experience participant 1 stated of the District Court: 'I thought they were very fair.' Participants felt that the District Court had more time to understand their circumstances and took their mental health into consideration:

> It all depends on a lot of things, like I find District Court much easier than Local Court because they're more educated and they understand more, you know, they're more empathetic towards you. (Lived experience participant 1)
>
> Districts are the best, for sure … they look right into your life, they take all the mitigating factors into consideration, most District Court judges. (Lived experience participant 2)

A lack of services and treatment options has been identified as a key barrier to diversion for First Nations people. Participants emphasised the need for additional funding for culturally appropriate and responsive services that can support the health and social and emotional wellbeing needs of First Nations people. While these services do exist in some locations, participants reflected that the workers are often 'overworked' or 'overloaded', which posed challenges for the SCCLS in gaining access to information for psychological reports or referring clients to services.

History of diversion orders

Having a history of earlier diversion orders was considered a key barrier to diversion for First Nations people. This is unsurprising, given that the MHCIFPA specifies that magistrates may consider whether the defendant has been granted a diversion order in the past when making diversion decisions. Speaking about defendants who keep coming back to the SCCLS for multiple section 14 applications, clinical nurse consultant 5 noted: 'Sometimes the only option for the magistrate is to send them to jail.' Magistrates acknowledged that defendants who present with a history of 'failed' diversion orders are less likely to be diverted:

> The other problems, of course, arise when somebody has previously been diverted and they come back asking for a further diversionary order. That's difficult because obviously the court has to ask, 'Well, if diversion hasn't worked in the past, why will it work now?' and that type of thing. (Magistrate 2)

> … some practitioners utilise the applications more than others and not always appropriately. I struggle when a person has previously been diverted pursuant to section 32 or 14. I struggle with the appropriateness. (Magistrate 6)

Other factors

Interview participants identified a range of other layered factors that impacted the health and social and emotional wellbeing of First Nations people and that may act as a barrier to mental health diversion. These included:

- issues with alcohol and other drugs;
- socio-economic factors;
- lack of stable and suitable housing; and
- trauma—historical and current or recent.

Nearly all interview participants discussed the layered issues of AOD use, mental illness and offending behaviour, identifying AOD use as a significant contributing factor to offending—exacerbated by the lack of First Nations-specific rehabilitation services available in the community. It was common for First Nations people applying for diversion to have comorbid mental health and substance use problems. One clinical nurse consultant stated:

> The vast majority of people I see there's comorbid issues … whether it be mental illness and cognitive impairment and substance use disorder, or mental illness and substance use disorder. (Clinical nurse consultant 7)

Historical and current or recent trauma First Nations people experience may also, as Magistrate 3 noted, 'dovetail into drug and alcohol use'. Interview participants also suggested that it was common for defendants with comorbid mental health and substance use problems to be rejected from mental health services. One clinical nurse consultant highlighted the importance of holistic services that can respond to these issues:

> … the thing is that they have very complex problems, and even though there might be underlying mental health problems, the drug and alcohol problems seem to take over and they'll often get rejected from mental health services because they'll go 'Oh they've just got a drug and alcohol problem.' Whereas the best way to approach a comorbidity like that is to treat both, like that's the evidence to treat both, but they will often get rejected from health services until their drug and alcohol problem is addressed. (Clinical nurse consultant 6)

Interview participants observed that substance use issues may 'mask' a person's mental illness or may be considered the primary issue although a person is experiencing an underlying mental illness. Challenges with section 19 diversions to inpatient hospital mental health care were again raised; one magistrate commented that defendants may be deemed 'not mentally ill' but rather experiencing the effects of substance use, despite there being clear evidence that the person has a severe mental health condition:

> But there's no doubt that there are mentally ill people that are being referred at first instance when they arrive in court charged with something, but then police-bail refused, they are being referred to the health system under section 19 of the Act, and they are being brought back to court having been seen by a psychiatric registrar usually and basically being sentenced dual diagnosis drug dependency, it's all drug related, even if they've got a prior history of admission for schizophrenia, or some other major disease, major psychotic disease or they are just not showing any signs of self-harm, they are mentally unwell, in circumstances where the offence suggests and the interaction of the solicitor suggests, I'm told, that they are very unwell. (Magistrate 4)

Factors such as socio-economic disadvantage, unstable and unsuitable housing and a lack of engagement in employment or education may also influence a magistrate's decision not to grant diversion for First Nations people. Several participants mentioned the challenges with preparing treatment plans and getting access to services for First Nations people who do not have a fixed address. One clinical nurse consultant comprehensively summarised this issue:

> There's also situations where I think First Nations people are more likely to be moving around … going between Sydney and Kempsey or Walgett or, you know, wherever their mob's from … and this has implications for diversion, because generally if you're going to be diverted under the mental health legislation you kind of need to have a case plan or support plan, usually you need to be sort of discharged into the care of a responsible person or to go to a particular service, and if you're kind of moving between Sydney and Walgett and whatever you're not necessarily going to have a consistent pattern of treatment or care, and that might mean the court's going to say 'Oh no, well you don't have a good enough care plan. Sorry, we can't do that.' (Legal practitioner 1)

Again, the impact of historical and present trauma experienced by First Nations people was highlighted. Participants identified substantial impacts of trauma, including the impact on people's trust in services and their ability to keep healthcare appointments. One clinical nurse consultant noted:

> To make a good application for a [section] 14 we need a treatment plan, we need the person to be actively engaged in care, and I think it's reasonable to say that the First Nations clients that I see, you know, there's so much vulnerability in terms of that longstanding trauma, shall we say, you know, trauma going back generational, and then I think—I don't know whether it's fair to say more trauma in their own individual childhood, development, adolescence, but I mean it's there, I see it like across all the people I see. So it's difficult to make a sweeping generalisation but definitely, you know, there's things there from the start. (Clinical nurse consultant 7)

Research question 3: What changes to current systems, policies and laws are needed to reduce the barriers to mental health diversion for First Nations people?

Facilitators of mental health diversion

Before considering the changes that are needed to systems, policies and laws to reduce barriers to mental health diversion for First Nations people, we should consider the factors that may support their diversion and ensure positive outcomes after diversion. Interview participants noted a range of enabling factors, including:

- the availability of services and cross-agency collaboration;
- the role of the SCCLS clinical nurse consultants;
- having a strong ALS presence at court; and
- the availability of Aboriginal support/liaison officers at court.

Service availability and collaboration

Participants raised the importance of having culturally appropriate and responsive services in the community to support First Nations people eligible for mental health diversion. These included community mental health teams, peer support, medical services and AOD support services. The SCCLS reported having 'good relationships' with services in the community. Participants spoke particularly highly of AMS and Aboriginal mental health workers with whom they regularly had contact:

> The other thing is that we work really well with all the services that are here because [location] has a specific AMS that works here as well. So we work pretty closely with them. There's also a couple of Aboriginal support workers who work here in the court as well. I've got a very good relationship with them. (Clinical nurse consultant 2)
>
> So at the community mental health team they have peer workers, they have Aboriginal mental health workers. I spend a lot of time talking to them because they're the ones that are doing the groundwork, they're the ones that are out there in the community, they know where people are, if they're not at home they know where to find them … so yes, there's one bloke in particular at community mental health, he's a peer worker and he's Aboriginal … he's excellent, so I've got his personal number and he's amazing. (Clinical nurse consultant 5)

Clinical nurse consultant 1 thought that First Nations people received 'really good care' from the AMS. They also commented on the effective record keeping of AMS staff, which assisted clinicians seeking corroborative information for their court reports. The participant compared this to instances where they had to request information from GPs, which was a more difficult process:

> I've wasted many an hour with GPs trying to get information on patients just to find out what the dose of the medication is, what's the dose of the depot when they last had it. And it's like pulling teeth. (Clinical nurse consultant 1)

Collaboration across services and agencies relates to the need for culturally appropriate services and supports. SCCLS clinicians highlighted their strong relationships with stakeholders as a key enabler of the effectiveness of the service. Stakeholder collaboration was identified as a key priority for Justice Health, with managers encouraging staff to collaborate:

> Our managers do that as well … one of the ways our manager wants to get us to do that is to deliver regular education to relevant stakeholders so they get to know who we are and feel more comfortable about phoning us. (Clinical nurse consultant 5)

Asked about how well the service works with other agencies and organisations, one clinical nurse consultant replied:

> I think it does very well. We're always communicating with community teams, hospitals, other health services, cognitive impairment services like Justice Advocacy Service and things like that. We're always communicating with them as well. (Clinical nurse consultant 4)

Another participant noted the benefits of working in a regional area, where it was easier to get to know the local services:

> Like I think in this role people have got to kind of get to know you as well, some of those non-government organisations. I'm fortunate because I was born and raised here, I've worked in the community inpatient and community setting, so I know these staff, it's easy for me … But there are a lot of services that I don't know. I think it's made easier to kind of do referrals and to get to know services when you know people but not so much when you don't. So I don't know how the guys in the metropolitan areas do it. (Clinical nurse consultant 5)

The importance of service availability also extended to the resourcing of the Local Court itself. Resourcing for each Local Court varies; Magistrate 5 commented that their court was 'reasonably well resourced', meaning that First Nations people were provided with opportunities for treatment and ongoing support. Their definition of sufficient resourcing included the availability of SCCLS clinicians and high calibre ALS or Legal Aid lawyers and assistance from community services. Additionally, one clinical nurse consultant noted that the rollout of the Justice Advocacy Service across select Local Courts in New South Wales, aiming to support people with cognitive impairment in contact with the criminal justice system, was a useful resource that reduced their workload.

Role of the SCCLS clinical nurse consultants

The SCCLS clinical nurse consultants were identified as playing a crucial role in facilitating mental health diversion for First Nations people by assisting magistrates, lawyers and other court staff with mental health diversion matters, providing advice about whether a defendant may be eligible for diversion and developing treatment plans. Diversion was, however, described by Magistrate 2 as 'quite a process'. One magistrate summarised the vast responsibilities of the SCCLS clinicians:

> Typically if the report hasn't been privately obtained, commissioned, which is often the case that it's not, it's dealt with by the court clinician, the person appointed by or employed by the Department of Health … [the clinician] investigates background, identifies what the diagnosis has been, the personal background of the person, the circumstances of the offending, makes recommendations about diversion and also designs the treatment plan and liaises with the responsible persons to make sure they're prepared to agree to notify the court of any breaches. (Magistrate 2)

Magistrate 1 was clear that they needed 'a good treatment plan to be able to approve the [diversion] order'. SCCLS clinicians were recognised as working closely with other stakeholders to develop these treatment plans. One clinical nurse consultant commented on the way they adapted their treatment plans and reports to meet the needs of First Nations clients:

> There is a growing number of Aboriginal mental health workers, so when I'm making the referral I will be very clear that they are an Aboriginal client and keep that in mind. I always write in my reports … I will always point out to the magistrate that somebody is an Aboriginal client and what their treatment and care needs to be … I'm quite specific in my reports to the court just to remind the magistrate and in my referrals to the community mental health team. I will still be outlining that this is an Aboriginal client and you need to arrange treatment and follow-up that is suitable for them, and that they deserve that treatment. (Clinical nurse consultant 3)

The SCCLS were reported to have a stable, experienced and dedicated workforce; many clinical nurse consultant participants have been employed by the service for over 10 years. This was identified as a key facilitator in ensuring an effective service, because clinicians were evidently committed to supporting and advocating for their First Nations clients and addressing barriers to successful diversion. Overall, while acknowledging that there are always areas for improvement, the SCCLS clinicians believed that the service is committed to helping First Nations people:

> We really advocate for them to get into treatment and we will really be advocating for them to get a fair go in court. We make sure we refer them to the right people, make sure things are culturally appropriate and all of that stuff … And so then we will argue and advocate for them when the time comes, I know I jump up and down when things aren't going well, I will say what needs to happen and throw myself on the sword and say 'This is what needs to happen for my client.' And I think we do a good job with the clients. (Clinical nurse consultant 3)

Clinical nurse consultant participants reflected on the positive outcomes they have observed for their First Nations clients. Participants acknowledged that the scope of their role meant that they often are not kept up to date about outcomes. However, most participants were still able to make some comment about client outcomes, because they often had relationships with stakeholders and services who provided them with feedback. Clinical nurse consultant 2 noted that the service sees a lot of 'real successes' and believes that they are making a difference in the lives of their clients. Such experiences included providing First Nations clients with a treatment plan that is tailored to their needs, facilitating their engagement with First Nations-specific services and referring them to other relevant services such as mental health and AOD support. Another participant reflected on their intention to ensure that First Nations clients felt heard and respected, an approach critical for clients with previous lack of engagement with, or negative experience of, other services:

> There's so many conversations with patients where they're like, the last time they were on this medication was in custody, or the last time they saw a doctor, a psychiatrist or a nurse was in custody … And that could have been six months ago, two years ago. They're not going to outside services. And I don't know if that is because of that feeling of discrimination, of not being heard and not being seen and not being believed … They feel like they are believed here. I hope that, I mean, it's hard because I can't speak for other clinicians. I can only speak for myself that I hope that's what a patient walks away from feeling, that they were heard and believed and acknowledged and respected. (Clinical nurse consultant 1)

Local Court magistrates also discussed the importance of the SCCLS service in facilitating successful diversion. Magistrate 6 described the SCCLS as 'an extraordinary service'. Magistrate 5 thought that the SCCLS made it easier for them to do their job, because having the service available meant 'it's easy to access reports and they are provided for free'. This sentiment was echoed by the legal practitioner participant, who noted how the SCCLS reduces barriers to diversion for those who cannot afford private psychiatric or psychological assessments. They also provided examples of clients who were granted diversion and avoided further contact with the criminal justice system:

> Sometimes it is successful. I mean I have had a couple of them in the last say 12 months where we have had successful diversions and, you know, one of them we just haven't seen again … I think he was a real success story and we haven't seen him again, I think he's still got really quite good support … that's been very positive. Another one who was successfully diverted … she hasn't reoffended and probably won't. (Legal practitioner 1)

Strong Aboriginal Legal Service presence

The ALS plays a vital role in facilitating access to mental health diversion for First Nations people in New South Wales. Despite the resourcing challenges, participants discussed the importance of the ALS in providing free and culturally appropriate legal advice and representation. Clinical nurse consultant 5 commented on the practical support provided by the ALS, which was 'just brilliant'. This included reminding people about upcoming court dates and organising transport to attend court. Another participant highlighted the commitment of the ALS to supporting First Nations people:

> I think the Aboriginal Legal Service … do their utmost to assist the clients and their families. But they're quite underfunded … so the solicitors that they do get have a lot of compassion about First Nations people and helping them because they have a choice of where they'd like to work. (Clinical nurse consultant 6)

Clinical nurse consultants reported that the ALS was one of their main referral sources for assessments. One participant reflected on the strong ALS presence at their court and how this reduced barriers to diversion for First Nations people:

> I feel like at our court, I think they have as fair a chance. I mean, we have a very active Aboriginal Legal Service there and I think that helps a lot. My experience has been that if they do have someone that they think may be eligible, they certainly do refer to us. That's definitely what I've noted anyway. (Clinical nurse consultant 4)

Magistrates also discussed the importance of the ALS. It was noted that ALS practitioners generally had a good understanding of mental health diversion processes and were attuned to asking the SCCLS to be involved when necessary. Magistrate 2 described the ALS as 'excellent' and 'quite aware of some of the options when their clients come before the court'. Discussing the proportion of their work that is spent dealing with diversion applications, one magistrate commented that this often depended on the court and the extent of ALS or Legal Aid involvement:

> It depends a lot on regions too. I notice some areas are more—there's a greater sort of cultural awareness around the section 14 application. It often is if you've got a good strong Legal Aid presence and the Aboriginal Legal Service, good and experienced practitioners, you might get some good applications made. (Magistrate 1)

Discussing post-diversion outcomes, Magistrate 2 noted that they sometimes receive feedback about defendants from the ALS. In some instances, the ALS have shared that 'diversion has worked, that it has been effective for people'.

Availability of Aboriginal support/liaison officers

Several interview participants discussed the role of Aboriginal client community service officers (ACCSOs) and how they support First Nations people attending court. Participants noted that ACCSOs offer a wide range of assistance to First Nations people, including providing information and support to defendants, victims and their families; helping people coordinate and attend appointments; and assisting defendants to understand their bail conditions. ACCSOs were described as 'lovely', 'fantastic' and 'approachable'.

SCCLS clinicians believed that it was important to involve ACCSOs wherever possible, to ensure that First Nations people receive culturally appropriate support and are assisted to understand criminal justice system processes. ACCSOs also assisted clinicians in gathering information about clients and provided advice about how to engage with First Nations people and their families and carers. One clinical nurse consultant discussed the value of having a First Nations support person attend when they are conducting an assessment:

> "I think the difficulty we have coming from a different cultural background is that we take into account all of their considerations … but it is difficult to … have that real insight into what it's been like for them … I've done a couple of interviews where the court support person has been around and I think that does help because there are points during the interview where you feel like maybe you haven't got their trust. I think that sort of approach does help as well because I think sometimes we don't necessarily get the true story because … there's some trust issues or previous traumas, et cetera and it's hard to work out whether that's the case in one interview. (Clinical nurse consultant 4)

Funding constraints also affect the availability of ACCSOs. One clinical nurse consultant discussed how the ACCSO service was withdrawn from their court. The clinician then advocated to have the service reinstated, because it addressed an essential need for First Nations people in contact with the criminal justice system.

Areas for reform

Interview participants were asked to share their perspectives on how the criminal justice system could be improved to better meet the needs of First Nations people and communities and reduce barriers to mental health diversion. Their suggestions included:

- increasing the number of First Nations-specific programs and clinicians;
- increased funding and resources;
- judicial education for magistrates and other relevant stakeholders;
- ensuring that the support needs of First Nations people are at the forefront of programs and services;
- reforming criminal justice system processes, including reducing the number of matters dealt with by magistrates daily to allow for appropriate time to make decisions; and
- providing feedback to the courts on diversion outcomes and ongoing support for those granted diversion.

Increasing the number of First Nations-specific programs and clinicians

Participants noted that, while there are culturally based programs available at some courts and in the community, these are often limited. A lack of appropriate treatment and support options was identified as a key barrier to diversion. Asked about the challenges in meeting the needs of First Nations people in contact with the criminal justice system, clinical nurse consultant 2 mentioned 'not having enough Aboriginal-specific services here at the court'. Overall, a key theme that emerged was the need for more First Nations-specific programs and First Nations-identifying workers, including psychologists, mental health nurses and court liaison officers, who have the skills to provide specialist care for First Nations people. Participants highlighted the need for more First Nations support workers providing practical assistance to First Nations people attending court—including transport—and having ongoing engagement with families and carers.

Engagement with First Nations-specific services was considered an enabler of successful diversion outcomes, further emphasising the need for these services. Clinical nurse consultant 4 commented that she had received positive feedback from First Nations clients who were engaged with these services, noting: 'The Aboriginal clients I've spoken to seem to be more than happy to engage with those services.' Local Court magistrates also thought that First Nations people would benefit from engagement with these services. Magistrates appreciated treatment plans that outlined this course of action.

Participants also highlighted the value of incorporating lived experience perspectives in support and treatment for First Nations people with mental health and cognitive impairment. One lived experience participant valued support from someone who understood them, noting:

> The rehabilitation thing they need to … if they can tweak that … and have people like us come in and teach, the people that have been there and done it. I'll listen to people that have been there … I won't listen to anyone else. (Lived experience participant 2)

Similarly, a magistrate participant suggested that a First Nations mental health network, developed and delivered in partnership with First Nations people and communities, could assist in providing a culturally appropriate, trauma aware and healing informed service.

Increased funding and resources

Participants commented on the need for increased funding and resources in a variety of areas to improve access to diversion and to promote positive outcomes for First Nations people. Magistrate 6 described increased funding as 'absolutely critical' in addressing the barriers discussed previously. Participants argued that increased funding was needed for legal services; medical, mental health and AOD services; services in regional and remote areas; alternatives to court; and further research on mental health diversion.

ALS staff were described as 'working under the pump', indicating the need for more funding to expand and improve the service. This included funding for senior solicitors and lawyers, experienced mentors to support junior workers and support staff to provide practical assistance to First Nations people attending court and to liaise with other key services, such as the AMS. Participants highlighted the onerous costs and waitlists for specialists in private practice, with clinical nurse consultant 7 commenting: 'I think just the whole mental health system is really under a level of pressure that I've never seen since I started in it.' The need for more funding for services that address mental health and AOD issues was also noted, with one magistrate stating:

> Unless we are able to provide mental health resources and drug dependency treatment for that group of people, then we are not going to ever change anything. (Magistrate 4)

A key theme was the need for increased funding in remote and regional areas. Magistrate participants highlighted the gaps in service provision and how the availability of services tended to differ across each Local Court:

> Well better resources in the country, you know, outside of Sydney, in rural and regional areas. Better mental health resources for all people, particularly Indigenous people out there. I think there's a real gap there. Because there's just not the resources … Just from my personal experience of going out there, there's not the same availability of reports, certainly not the same resources to provide them with mental health treatment, you know, regular appointments. Even drug and alcohol counselling, there's just less of it out there. (Magistrate 5)

> It's just so strange because every Local Court is treated differently. Some places we've got circle [sentencing], some we don't. When you have got circle, sometimes you have trouble getting the local Elders on because they are not being paid so you get other mobs being involved. (Magistrate 4)

It was also suggested that resources should be invested in research to further understand the experiences of First Nations people attending court. Clinical nurse consultant 1 considered that this research should not just be 'high level' but instead should involve 'entering the communities and having those conversations' to understand people's lived experience.

Judicial education

Judicial education was considered critical to ensuring that magistrates are equipped to make informed, equitable and effective decisions about mental health diversion. This is especially important because of the complex intersection between mental health, cognitive impairment and criminal behaviour. Magistrates strongly advocated for this, highlighting the need for a genuine commitment to understanding the experiences of First Nations people. One participant commented on the disparity in attitudes among magistrates, noting that those who had been working in the profession for many decades may have outdated views:

> “I think there needs to be good serious judicial education for magistrates and judges, not just sort of ticking the box that they’ve done it but like genuine commitment to be prepared to shift their thinking, to change their attitudes. A lot of the older longer-term appointed magistrates … they don’t have the same awareness or preparedness to think outside the square, they’re just so grilled into the routine of the way they do their job, so a lot of them just don’t think therapeutic programs, they don’t think how you can be creative within the confines of what you’re doing. (Magistrate 1)

Participants provided suggestions for improving judicial education. One magistrate commented:

> “There’s a need for them to probably get out and sort of see things differently, get off the bench and do some serious orientation of what is going on in First Nations people’s lives. (Magistrate 1)

Suggestions included orientation or training to enhance magistrates’ understanding of First Nations people’s experiences of the criminal justice system, including the historical and socio-economic factors contributing to hyper-incarceration; fostering genuine connections with First Nations communities and organisations; and regularly attending First Nations organised conferences that address these topics.

Prioritising First Nations people’s support needs

Prioritising the lived experience and support needs of First Nations people is critical in considering changes to practice and policy about mental health diversion at Local Court. Lived experience participants discussed the types of support that have helped them over their lifetime and the types of support they would like to have received—including mental health support, education and employment, housing and financial security, support from a skilled and understanding GP and social connection. Unfortunately, most participants reported that they had not received any such support before encountering the criminal justice system.

A key theme that emerged from the interviews was the importance of education and employment in reducing recidivism, promoting social integration and improving overall wellbeing. Addressing barriers to employment and education was considered essential, because meaningful employment provides people with financial stability, structure and a sense of purpose. One lived experience participant discussed the link between unemployment and involvement in the criminal justice system: 'It's hard, it's probably why most of them are doing crime … you can't get a job if you can't read and write.' The participant also highlighted the importance of education programs in prison:

> The jails … they should start putting some education in, like it's not so just remedial and repetitive … give us some reasons, something else to do man, and then focus our mind, like give us a goal to kick for. (Lived experience participant 2)

Lived experience participants noted that access to stable housing is also critical in preventing recidivism. Asked what types of support First Nations people need, lived experience participant 2 responded: 'Housing first and foremost.' They reflected that having access to housing was one of their main protective factors against recidivism: 'That's my primary thing that gets me reoffending … because if you haven't got a home, like eventually you're going to start doing something illegal.'

Participants discussed the importance of high-quality and responsive healthcare services in addressing physical and mental health needs. This included support with medication, management of chronic health conditions and mental health treatment and counselling. Lived experience participant 2 valued their GP, whom they described as a 'legend' because 'He's helping me with everything, you know, and he'll even just sit there and talk to me, he can see when something's wrong, he cares.' The same participant was also referred by Corrective Services to a psychologist who took their issues seriously.

Criminal justice system reform

A key theme that emerged from the interviews was the need for criminal justice system reform to reduce the barriers to mental health diversion for First Nations people and to address the over-representation of First Nations people in the criminal justice system more broadly. Participants discussed the critical need for services and support to prevent First Nations people from encountering the criminal justice system in the beginning. Underlying this was the need for early intervention programs that address social determinants of health, such as education, employment, housing and mental health care. One magistrate summarised this issue:

> I think that there should be a raft of interventions prior to involvement in the criminal justice system such as interventions geared towards keeping children in homes of Aboriginal people, dealing with drug and alcohol problems, dealing with domestic violence problems, dealing with socio-economic issues, children's education, just I guess things that the vast majority of Australians have in terms of access to … sports and recreational activities that people from lower socio-economic backgrounds just don't have. So I think that there's a whole raft of things. (Magistrate 3)

Participants highlighted the need for better interventions and diversionary measures to prevent First Nations young people from encountering the criminal justice system. One magistrate noted that First Nations young people are over-represented among those in contact with courts and police:

> I would imagine you would also need to just look at the reasons why there's such over-representation of First Nations people in all parts of the criminal justice system, from police cautions, even in the Children's Court to diversion for a youth justice conference, to the possibility of people getting a warning or moving on, not even being put on bail and not being granted bail. I mean it's just the whole process there's over-representation. So what needs to be addressed is really looking at the reasons for all that over-representation, unpacking all of that, and then trying to do something about it. (Magistrate 1)

Participants also discussed the need for criminal justice system processes that are culturally appropriate, accommodating the cultural needs of First Nations people. Asked whether the cultural needs of First Nations people are being met in their interactions with the Local Court, Magistrate 4 responded: 'I think it's the luck of the draw.' This sentiment was echoed by the legal practitioner participant, who thought that it 'depended on particular individuals or the culture at a particular Local Court'. Participants noted that some NSW courts offer a range of First Nations-specific programs but suggested that increased funding and statewide accessibility could be improved.

Feedback on diversion outcomes and ongoing support for those diverted

Effective mental health diversion programs require robust mechanisms for feedback and ongoing support, to ensure that First Nations people diverted from the criminal justice system achieve positive long-term outcomes. Participants observed that the court and SCCLS typically did not receive feedback on diversion outcomes—or only in an ad hoc way. Diversion was typically considered 'successful' if the person did not present to court again. Magistrate 4 commented: 'The trouble with this job is that you don't see the people that succeed.' Magistrate 5 expressed the desire for better monitoring and follow-up processes, so that they could get 'a better idea of what happens to [defendants] at the end'. Similarly, some SCCLS clinicians wanted to have more of an ongoing role in the care of diverted clients:

> "I would actually like to have a bit more ongoing care with some of my clients … not case management as such, but like touching base with them, because by the time you finish doing the assessment and you've maybe seen them a couple of times and spoken with family you know all about them. I mean that could be an idea of how the service could expand, but it's not how it's set up at the moment. (Clinical nurse consultant 6)

Other interview participants raised the question of how diverted clients could maintain positive outcomes without the provision of follow-up support. One magistrate believed that section 14 orders were limited because they expired after 12 months, while many defendants were dealing with lifelong mental illness or cognitive impairment. The legal practitioner participant observed that many of their diverted clients were at least successful in avoiding further criminal justice contact in the short term, but things would then 'fall apart' if they weren't being supported in the long term.

Although the responsible person specified in the diversion order is technically required to report breaches of diversion orders, Magistrate 2 noted 'an element of non-reporting of breaches'. Some participants ultimately thought that better monitoring of diversion orders could improve insight into recidivism and treatment compliance, but strict requirements for the reporting of breaches could raise further issues: service providers may be reluctant to provide treatment to diverted people if they are required to formally report noncompliance, negatively impacting the therapeutic relationship between clinicians and clients.

Discussion

Mental health court diversion is a key tool for addressing the mental health needs of people in contact with the criminal justice system and for reducing the likelihood of repeated justice contact. Initial investigations in Australian jurisdictions have suggested that, despite rising rates of over-incarceration, First Nations people experience barriers to accessing mental health court diversion and have poorer outcomes when they are granted such diversion. The current study explores these issues in detail, using both quantitative and qualitative research methodology, with the aim of providing the evidence required to inform the development of culturally appropriate and effective interventions to improve diversion access and outcomes for First Nations people.

Summary of main findings

Taken together, the quantitative and qualitative findings from the current study highlight the nature of the barriers to access and the subsequent poor outcomes experienced by First Nations people in relation to mental health court diversion. The study draws upon the lived or living experience of First Nations people and professionals involved in diversion, combined with analysis of linked administrative datasets, to identify how a blend of policies, programs and services can ensure that mental health court diversion is a culturally appropriate and responsive mechanism for reducing the hyper-incarceration of First Nations people.

First Nations people are significantly less likely to be granted diversion

Quantitative analysis of the SCCLS dataset confirmed that, among those accessing the service between 1 July 2008 and 30 June 2022, First Nations people in New South Wales were significantly less likely than non-First Nations people to be granted diversion. Among those deemed eligible for diversion, just under half (49%) of First Nations people, compared with 61 percent of non-First Nations people, were granted diversion. This finding is consistent with previous research that identified disparities in access to mental health court diversion for First Nations people (Albalawi et al. 2019; Macdonald et al. 2024; Soon et al. 2024, 2018). Building on previous research evidence, the current study further finds that the decreased likelihood of being granted diversion for First Nations people persisted in multivariable analysis, when adjustment was made for other covariates, including sex, socio-economic status, diagnosis type and the principal offence leading to the diversion application.

It is also useful to place the findings for mental health court diversion in the context of the wider criminal justice system. In New South Wales, where First Nations people make up 31 percent of people in prison, they accounted for 27 percent of those deemed eligible for diversion by the SCCLS (similar to the proportion in contact with Local Courts) but only 23 percent of those ultimately granted diversion. The under-representation of First Nations people among those granted Local Court mental health diversion is also consistent with previous research focused on the forensic mental health system more generally (Dean et al. 2023; McEntyre et al. 2024). Research conducted by Dean and colleagues (2023) demonstrated that First Nations people were also less likely to be diverted to the forensic mental health system in the higher courts through a finding of not guilty by reason of mental illness.

Systemic barriers to diversion for First Nations people

This study identified a range of barriers associated with reduced access to diversion for First Nations people. These included the eligibility criteria for diversion, particularly in relation to offending history and prior diversion orders; discretion exercised by Local Court magistrates; distrust of legal systems; and a lack of access to programs and services, particularly in rural and remote areas.

The entrenchment of First Nations people within the criminal justice system may act as a barrier to diversion, because study participants noted that having a prior criminal history often meant that defendants were less likely to be granted a diversion order. To some extent, the significant impact of the defendant's criminal history on diversion decisions is unsurprising, given that section 15 of the MHCIFPA specifies that the defendant's criminal history and the safety of the community are factors magistrates may consider when making diversion decisions. However, the legislation does not automatically preclude a defendant from being diverted because of prior offending. Moreover, criminal history alone appears to be an inadequate basis on which to base diversion decisions if the defendant's past criminal behaviour is the result of a long and untreated mental illness. While univariate analysis showed that defendants with a history of prior offending were significantly less likely to be granted diversion, this association remained significant even when controlling for other factors, including First Nations background. This suggests that prior criminal history alone may not sufficiently explain the barriers to diversion faced by First Nations people.

The study also found that past diversion orders could act as a barrier to diversion, because magistrates may be less likely to grant a diversion order if defendants have been subject to 'unsuccessful' orders in the past. However, given the complex and enduring needs of First Nations people with mental illness or cognitive impairment, repeat diversion applications are to be expected, to some extent. This issue also calls into question the appropriateness and effectiveness of treatment and support being provided to First Nations people, if they are repeatedly presenting to court with diversion applications. Although this issue was not examined in the quantitative analysis of the current study, further research should explore the impact of past diversion orders on future diversion applications and the reasons underlying repeat applications. This issue warrants particular attention, given that previous research has identified an opposite effect, with individuals who had received previous mental health diversions having increased odds of receiving a further diversion (Macdonald & Weatherburn 2023).

The study found that discretion exercised by magistrates could act as either a facilitator of or a barrier to diversion. SCCLS clinicians participating in the study noted that whether a diversion order was successfully granted often depended on the magistrate overseeing the matter. The legislation governing diversion in New South Wales is very broad in outlining the factors relevant to diversion decisions, and magistrates may exercise discretion about whether they consider these factors. However, the study demonstrated that magistrates tended to pay particular attention to specific factors. Factors such as prior offending, the nature of the offence and the nature of the defendant's mental illness had a measurable effect on whether First Nations defendants were granted diversion. This is consistent with previous research that examined magistrates' perceptions of the most important factors in diversion decisions (Macdonald, Weatherburn & Lapin 2024). It should be acknowledged that magistrate decision-making is complex, and magistrates are often required to make orders within unrealistic timeframes and to balance competing interests such as the need for treatment and ensuring the safety of the community. Ultimately, ensuring that mental health diversion plays an effective role in addressing the hyper-incarceration of First Nations people requires equitable and consistent approaches to decision-making.

Institutional racism, stigma and discrimination continue to affect First Nations people and contribute to their ongoing and worsening over-representation within the criminal justice system. Distrust of legal systems and harmful engagement with police, magistrates and solicitors may lead First Nations people to avoid diversion options altogether, preferring to get the matter 'over and done with' rather than being subjected to ongoing conditions imposed by the court. The study also identified inadequate responses from mental health services and possible stigma against people with mental illness in contact with the criminal justice system, in relation to hospital-based diversion. Despite clear signs that defendants were suffering from a severe mental illness, they often 'bounced back' to court after being deemed 'not mentally ill'. Finally, study findings suggest that the main disparity is not whether First Nations people are being considered for mental health diversion in the first place but whether, once found eligible for diversion by SCCLS clinicians, they are actually diverted by magistrates.

Some groups were more likely to be granted diversion

Among First Nations people identified in the SCCLS dataset, some groups were more likely to be granted diversion than others. Specifically, First Nations people were more likely to be granted diversion if they identified as female, lived in less disadvantaged areas and had a diagnosis of a common mental disorder or disorder other than a personality disorder, substance use disorder or serious mental disorder. First Nations people were also more likely to be granted diversion if they had committed a violent offence and had no history of prior offending. This is consistent with previous research indicating that diversion is more likely to be granted to women (Macdonald & Weatherburn 2023; Soon et al. 2018), those with no prior criminal history (MacDonald & Weatherburn 2023) and those without a substance use related diagnosis (Albalawi et al. 2019). Interestingly, those who had committed a violent offence were more likely to be granted diversion. This may be because magistrates perceive a clearer correlation between the defendant's mental illness and their offending behaviour. However, given that previous research has yielded inconsistent findings about the impact of offence seriousness on the likelihood of being granted diversion (Macdonald et al. 2024; Macdonald & Weatherburn 2023; Soon et al. 2024), further research should explore this issue in more detail.

While these factors were also significant for the entire study sample (both First Nations and non-First Nations people), some differences were also noted for First Nations people. Analysis of the whole sample indicated that defendants were more likely to be granted diversion if they were aged 40 or above or had legal representation—again, consistent with prior research (Macdonald et al. 2024; Soon et al. 2024, 2018). Defendant age and access to legal representation were, however, not significant predictors of diversion for the First Nations subsample. The pattern of younger people being less likely to be diverted was seen for First Nations people (as well as the total sample), but the First Nations subsample appeared to be underpowered to clearly establish the association. A similar situation was apparent for the association between being legally represented and odds of diversion, although the rates of representation were particularly high for First Nations people, both diverted and undiverted (93% of those diverted vs 90% of those not diverted).

The availability of First Nations-specific services and supports was a key facilitator of diversion

The study found that access to programs and services, particularly in rural and remote areas, was key for community-based diversion to be considered likely to succeed. This included culturally appropriate and responsive services in the community to support First Nations people eligible for mental health diversion, such as the ALS, Aboriginal liaison officers, community mental health teams, peer support, medical services and AOD support services. The availability of these services is critical to addressing the hyper-incarceration of First Nations people—unavailability acts as a barrier to diversion—and to ensure appropriate care and support for those granted diversion. Moreover, given that magistrates paid particular attention to the quality and appropriateness of the treatment plan and histories of 'failed' diversion orders, increasing the availability of First Nations-specific services may increase the likelihood of diversion being granted.

The AIHW (2013) identified a best practice approach to supporting engagement and completion of diversion programs for First Nations people. This included the employment of culturally qualified workers for screening and assessment of First Nations clients, caseworkers to liaise with First Nations-specific and other services and acknowledging and respecting First Nations people's cultural and familial obligations. Several elements of this approach were identified in the current study and should be prioritised to ensure positive outcomes for First Nations people in contact with the criminal justice system.

Successful diversion was associated with lower rates of reoffending for First Nations people

Among those in the total sample of people deemed eligible for court diversion, those who were granted diversion had significantly lower rates of reoffending. Lower rates of reoffending were observed among both First Nations (54% vs 63%) and non-First Nations people (34% vs 44%). However, reoffending rates remained higher for First Nations people than for non-First Nations people, with First Nations defendants being significantly more likely to reoffend. For the whole sample, controlling for First Nations and diversion status, individuals were significantly more likely to reoffend if they were male, lived in a major city, had a personality or substance use disorder and had a history of prior offending. All these factors are known to be associated with offending and reoffending, and this study confirmed them as independently associated with reoffending among those deemed eligible for diversion. They represent factors that can help to identify individuals at particularly high risk of repeat justice contact or, in the case of personality or substance use disorder, represent potential targets for interventions aimed at improving prevention of reoffending among those with mental illness.

Among First Nations people who were deemed eligible for diversion and had available follow-up data for at least 12 months after the last finalised court appearance, 33 percent reoffended over those 12 months, compared with 42 percent of those who were not granted diversion. However, the rate of reoffending, even for those diverted, was still greater for First Nations than non-First Nations people.

The findings of this study highlight the effectiveness of diversion in reducing rates of reoffending, including for First Nations people. However, diversion is currently not as effective in reducing reoffending for First Nations people as it is for non-First Nations people. This indicates that the specific needs of First Nations people with mental illness are not being adequately met by current criminal justice and service responses. This may result from insufficient assessment of First Nations people's needs and risks and a lack of high-quality and effective mental health services, including limited availability of culturally appropriate services and supports in rural and remote areas.

The health and wellbeing needs of First Nations people must be supported to enable successful diversion outcomes

The study identified a range of factors that impacted the health and social and emotional wellbeing of First Nations people, including AOD issues, socio-economic factors, a lack of stable and suitable housing and historical, recent or current trauma. First Nations people participating in the study reported that they had not received any support before encountering the criminal justice system. Consistent with previous research, the study identified barriers to service access, including a shortage of programs and services; distrust; fears of racism and judgement; and poor coordination between services (AIHW 2013; Nolan-Isles et al. 2021). First Nations people in contact with the criminal justice system ultimately require First Nations-led, wraparound services that are available for as long as necessary to address their complex support needs (McEntyre et al. 2024). These include mental health care; support from a skilled and understanding GP; opportunities for education and employment; suitable and stable housing; financial security; and opportunities for social connection.

Implications and recommendations for policy and practice

The findings of this study provide new evidence about First Nations people's lived and living experiences of mental health diversion in New South Wales, including the barriers to, and facilitators of, diversion. They highlight areas for reform. These insights are critical to informing the design of effective criminal justice policies and strategies to address the clear discrepancy in the granting of diversion to First Nations people compared with non-First Nations people. To address this disparity in access and outcomes, the development of effective and culturally safe diversion policies and programs is urgently needed. Policies and programs should acknowledge the ongoing impacts of colonisation, systemic racism and other socio-economic factors on First Nations people's health and wellbeing and should highlight the importance of partnership, collaboration and empowered decision-making.

Based on the study findings, taken together with prior research conducted in this area, the following specific recommendations for policy and practice are proposed.

- Recommendation 1: Consider First Nations people's and communities' histories of personal and collective trauma and resistance in the design of policies related to mental health court diversion and the delivery of mental health and related services.
- Recommendation 2: Strengthen the role of the SCCLS by expanding the service and increasing resources available to meet the needs of all eligible people, with a particular focus on the specific needs of First Nations people. It is heartening to acknowledge that, since the current study commenced, funding has been committed to provide SCCLS clinicians in all NSW Local Courts—a key step towards ensuring equitable access to mental health court diversion, particularly for those in non-urban areas.
- Recommendation 3: Conduct a comprehensive, culturally informed assessment of system-initiated vulnerability and need for First Nations people in contact with the SCCLS.
- Recommendation 4: Apply eligibility for mental health diversion broadly, to ensure that diversion is accessible for First Nations people with prior contact with the criminal justice system.
- Recommendation 5: Incorporate a holistic approach to care and treatment in treatment plans for First Nations people, including referrals to culturally appropriate and responsive services and strategies to maintain connections to family, carers and community.
- Recommendation 6: Increase the availability of diversionary programs and other relevant services in rural and remote areas through adequate funding and resource allocation.
- Recommendation 7: Enhance interagency collaboration between the justice, health, legal and social service sectors to ensure seamless referrals and continuity of care for First Nations people who receive diversion.
- Recommendation 8: Prioritise the recruitment of First Nations staff, including mental health clinicians and liaison officers in courts. Adequately support and remunerate all First Nations staff to maintain their employment and provide them with funded opportunities to advance their professional skills and qualifications through training and education.
- Recommendation 9: Provide ongoing education and cultural competency training to all non-First Nations staff working with First Nations people, including magistrates, SCCLS clinicians and other legal professionals, to address racism and bias within the criminal justice system. This training should leverage the knowledge and expertise of First Nations professionals and people with lived or living experience.
- Recommendation 10: Increase the availability of First Nations-led community services and programs, including the ALS, through adequate funding and resource allocation.
- Recommendation 11: Build the cultural responsiveness of mainstream services and service providers who work with First Nations people with mental health or cognitive impairment, including through the provision of ongoing training and education informed by the lived experiences of First Nations people.

- Recommendation 12: Provide accessible and culturally appropriate information and resources to First Nations communities, families and carers to increase community awareness of diversion programs.
- Recommendation 13: Implement a formal and standardised framework for tracking diversion outcomes and mechanisms for magistrates and service providers, including SCCLS clinicians, to receive feedback on the outcomes of diversion orders and provide ongoing support where needed.
- Recommendation 14: Conduct further research to evaluate the effectiveness of the SCCLS and examine the medium- and long-term outcomes for First Nations people who are diverted. In addition to examining rates of reoffending, research should pay attention to other post-diversion outcomes, such as individuals' physical and mental health and alcohol and other drug use. Now that funding has been committed to ensure that the SCCLS is expanded across all courts in New South Wales, research should explore the impact of this expansion on diversion and reoffending rates, including for First Nations people. Future research should also examine post-diversion outcomes over time, to determine the effectiveness of mental health support provided to First Nations people and whether any positive outcomes are sustained.

Strengths and limitations

The study provides new insights into First Nations people's experiences of mental health diversion and barriers to diversion in New South Wales. A key strength of the study was the inclusion of several different participant groups in qualitative interviews, including First Nations people with lived experience, Local Court magistrates, Justice Health professionals and legal practitioners. This allowed a diverse range of perspectives to be collected and used to inform recommendations for new policy and practice. The study also benefited from the use of administrative records collected by the SCCLS and BOCSAR. These datasets were accessed via third-party linkage methods that protected individual privacy and enabled analysis to be conducted on a large and total population sample, reducing the risk of sampling and information biases that can often arise in studies of this type.

Several limitations affect the interpretation of the findings. The sample size of lived experience interview participants was small (*n*=3), because of challenges in participant recruitment. Recruitment for the study occurred during the lead-up to the First Nations Voice to Parliament Referendum. The process caused considerable hurt, pain, stress and uncertainty, and many First Nations people and communities experienced increased racism (Thurber et al. 2023). It is extremely likely that this significant event impacted the capacity of First Nations people to participate in research.

The use of administrative data for the quantitative component of the study presented some limitations. Data were limited to those recorded in the SCCLS dataset and BOCSAR ROD, meaning that post-diversion outcomes beyond further criminal justice contact could not be determined. Future research could examine First Nations people's experiences of other post-diversion outcomes, including contact with health services. The limitations of relying on administrative data to identify First Nations individuals is also noteworthy, because First Nations background is typically under-reported in these datasets (Nelson et al. 2020). The study also relied on a dichotomised 'prior offending' variable that did not account for offence severity or the length of a person's involvement with the criminal justice system. Finally, this study focused on the NSW context, and approaches to mental health diversion differ across states and territories, so the findings of the current study cannot be fully generalised to other jurisdictions.

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Research Report

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