Addis Ababa University

School of Graduate Programmes
College of Social Sciences
School of Social Work

Assessment on Offenders with Mental Health Problems at Lideta First Instance Court in Addis Ababa

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A Thesis submitted to the School of Graduate

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Requirements for the Master of Social Work

Advisor

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DECLARATION

I, the undersigned, declare that this is to certify that the thesis, which is entitled Assessment on Offenders with Mental Health Problems at Lideta First Instance Court in Addis Ababa, and submitted in partial fulfilment of the requirements for the Degree of Master of Arts in Social Work complies with the regulations of the University and meets the accepted standards with respect to originality and quality. Therefore, it is my original work and has not been presented for a degree in any other university, and that all sources of materials used for the study have been duly acknowledged.

Name: Selam Assefa

Signature _____

Date_____

CERTIFICATE

This is to certify that the thesis entitled Assessment on Offenders with Mental Health Problems at Lideta First Instance Court in Addis Ababa, submitted to Graduate Programmes of Addis Ababa University for the award of the Degree of Master of Social Work (MSW) and is a record of research work carried out by Selam Assefa under my guidance and supervision. Therefore, as advisor hereby declare that no part of this thesis has been submitted to any other university or institution for the award of any degree.

Advisor: Emebet Kebede (PhD)

Signature: _____

Date: _____

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Abbreviations and Acronyms

- **AAU:** Addis Ababa University
- **AAUCHSPD:** Addis Ababa University, College of Health Sciences, Psychiatry Department
- **AMI**: Acute mental illness
- **APA:** American Psychiatric Association; American Psychological Association
- **BLSH**: Bridge language school house
- **CAT:** Child abuse team
- **CER:** Centre for European reform
- **CERD:** Committee on Elimination of Racial Discrimination
- **CINAHC:** Committee on international, national health service
- **CJS:** Criminal Justice System
- **CPC:** Criminal procedure code
- **CRC:** Convention on rights of children
- **CRPD:** Convention on the Right of Persons with Disabilities
- **DSM:** Diagnostic and Statistical Manual
- **ECN:** Enteral clinical nutrition
- **FASD:** Fatal Alcohol Spectrum Disorder
- **FDRE:** Federal Democratic of Ethiopia
- **FFIC:** Federal first instance court
- **FFICLD:** Federal First Instance Court Lideta Division
- **FFICLDMHCB:** Federal First Instance Court Lideta Division Mental Health Court Bench
- **FMoH:** Federal Ministry of Health
- **ICCPR:** International covenant on civil and political rights
- **ICESCR:** International covenant on economic, social and cultural rights
- **ICF:** International classification of functioning

- **MHC:** Mental Health Court
- **MHCB:** Mental Health Court Bench
- **MSW:** Master of Social Work
- **NASW:** National Association for Social Workers
- **NZMHC:** New Zealand Mental Health Court
- **PsycINFO:** Psychological Information
- **PWMHP:** People with mental health problem
- **SMI:** Severe Mental Illness
- **UN:** United Nations
- **UNHR:** United Nations of Human Rights
- **UNDHR:** United Nations Declaration of Human Rights
- **UNICEF:** United Nations Children's Emergency Fund
- **US:** United States
- **USA:** United States of America
- **WHO:** World Health Organization

ABSTRACT

The study assessed court process on offenders with mental` health problems at Lideta First Instance Court in Addis Ababa. Qualitative research design and methods were employed to generate study participants' experiences at the Court. Qualitative data were collected from six case informants and 11 key informants using appropriate tools. To ensure the quality of the data, Data triangulation implemented and then collected them from different sources. To analyze qualitative data, phenomenological theme analysis and content analysis employed. Findings indicate the participants aware objectives of establishing the Court; there was screening, but no standardized practices of follow-up, supervision, and monitoring and evaluation; and the doctor engaged in psychoanalysis techniques supported by prosecutors and their families, but without social workers, sociologists, and psychiatrists' professional interventions in actual practice of handling offenders with mental problems. Opportunities created due to the MHC include: reducing time elapsed for trial of the cases, creating context for close consultation and easy exchange of information about the offenders' previous histories related to their mental health conditions by their families and the medical doctor, promoting ad sharing knowledge and skills related to handling cases on mental illness, and there were instances of establishing networks and partnerships between the Court and the relevant agencies in Addis Ababa. There were also inter-dependent gaps in the practice, including practice was not performed based on grassroots approach in that there were no required and relevant professionals as team members in the MHC; knowledge gaps in MHC principles and approach in the specialized Court; no triangulation of evidence on mental health status of the offenders diagnosed by the medical doctor; a violation of the offenders' rights; no established rehabilitation centre where the offender with mental problem would stay before and after Court's decisions; no well-coordinated and organized professional interventions provided; and no awareness creation of the problems among members of society. Consequently, there was no practice of registering insane persons at Ethiopian lowest administrative unit. Evidence further documented challenges like usage of improper words to express one's offence, being silent for longer time or throughout the interrogation session, being reluctant to go to the Court, and causing injuries to other criminals in the prison. In conclusion, actual practice at the Court is not comprehensive and lacks globally accepted standards for its establishment, creates certain limited opportunities for the offenders with mental illness, their families, and team members who participate in the process. Thus, all these have implications for social work practice at different levels in Ethiopian. Concomitantly, exploratory further studies using mixed methods in various Ethiopian contexts should be undertaken.

Key words: Mental health, practice, challenge, Addis Ababa, offenders

CHAPTER ONE

INTRODUCTION

1.1.BACKGROUND OF THE PROBLEM

In Western Europe and North America, there was deinstitutionalization movement in the latter half of 20th century as a result of which many mental health care institutions were underfunded and the number of mental health care was reduced (Schneider, 2003). Consequently, the number of persons with mental disability has increased tremendously which further increased the number of mentally disabled persons' involvement in the criminal justice system. The prevalence of mental health concerns is much higher among individuals involved in the criminal justice system than in the general population - a finding that also holds true for justice-involved youth (Chitsabesan & Bailey, 2006).

On the other hand, youth and adults in the juvenile and the criminal justice systems have the right to access mental health services. There is increasing number of individuals with mental health problems; the criminal justice system has enormous fiscal, health, and human costs (Ades, 2001). Diverting these individuals away from jails and prisons and toward more appropriate and culturally competent community-based mental health care is an essential component of national, state, and local strategies. These strategies may help provide people with the supports they need and to eliminate unnecessary involvement in the juvenile and criminal justice systems. In order to reduce involvement, support those who need services, and to promote fairness throughout the criminal justice system; leaders in the mental health system, law enforcement officers, public defenders, prosecutors, court personnel, advocates, legislators, and others in the criminal justice system must come together to create a system that will improve outcomes for all (Greville, 2016).

People with mental health problems tend to experience greater difficulties in accessing justice than other groups, and are one of the most socially excluded groups within society as they

experience greater discrimination, disadvantage, and stigma (Mind, 2001). This may result in psychological, social, structural, and cultural barriers to early identification of mental health needs and appropriate interventions (Walsh et al., 2011). Recently, the large number of individuals with mental illnesses involved in the criminal justice system has become a pressing policy issue within both the criminal justice and mental health systems (Council of State Governments Justice Centre, 2009). The prevalence of serious mental illnesses among all people entering jails, for example, is estimated to be 16.9 percent (14.5 percent of men and 31 percent of women) (Steadman, 2009). People with mental illnesses often cycle repeatedly through courtrooms, jails, and prisons that are ill-equipped to address their needs and, in particular, to provide adequate treatment (Ditton, 1999). Over the past decade or so, policy makers and practitioners have been exploring new ways of responding to these individuals' cyclical problems and to improve outcomes for the systems and individuals involved. One of the most popular responses is mental health court, which combines court supervision with community-based treatment services, usually in lieu of a jail or prison sentence (Grudzinskas, 2005).

Mentally disabled persons were incarcerated for minor offences. They were revolving in the criminal justice system for the reason that criminal justice system focuses on punishment rather than treatment. To tackle this problem, mental health court which was modelled after drug courts had been established in USA and Canada. Mental health court was established to treat the root cause of criminal behaviour rather than punishment. It has been therapeutic jurisprudence which advocates the justice system should deal with the main cause that makes a person to interact with the criminal justice system. Unlike traditional justice system, mental health court participants are required to undergo treatment if the accused successfully completed the treatment plan s/he will be released from criminal responsibility. Otherwise, s/he would be sent back to traditional system (Reich, 2014).

A mental health court is a court with a specialized docket for certain defendants with mental illnesses (Almquist & Dodd, 2009). Mental health courts divert select defendants away from the regular criminal courts into judicially supervised, community-based treatment to properly

address their overwhelming health needs. Mental health courts are … courtrooms "that are working to ensure not just that the punishment fits the crime . . . but that the process fits the problem" (Berman & Feinblatt, 2005). Mental health courts not only address issues of disputed fact, but also focus on underlying social or psychological problems responsible for the dispute (Winick, 2003).These courts further seek to connect defendants to therapeutic interventions, including rehabilitative and mental health treatment. These courts have a common underlying premise - courts should recognize and understand the social or psychological problems behind a dispute and solve these problems in a way that ensures that the offender will not return to jail (Berman & Feinblatt, 2005).

There is a lack of agreement regarding what constitutes a mental health court, leading to a difference among courts regarding several dimensions, including target population, accepted offenses, intensity of supervision, and programme duration (Behnken, Arredondo, & Packman, 2009). The caseload of the courts also varied. Mental health courts, unlike traditional courts, have therapeutic goals, including increasing participants' adherence to treatment and decreasing future involvement in the justice system (McNiel & Binder, 2007). Mental health courts are thus creating a great deal of discussion and have provoked a surprising variety of responses from stakeholders in the criminal justice system and the mental health system. Accordingly, scholars concerned with the practices and other relevant professionals have started investigating different aspects of the issues under discussion – accessibility of the courts, effectiveness of the courts, how mental health courts are handling offenders with mental illness in the world, for example.

Advocates for criminal justice reform often refer to America's jails and prisons as "de facto mental institutions," and cite a constellation of problems associated with confining individuals in a system not designed for their care and treatment (Greville, 2016). While estimates of the percentage of incarcerated individuals with mental illness vary, there is general consensus that significant overrepresentation of people with mental illnesses in the criminal justice system leads to a variety of complex problems (such as consequences for public safety, undue distress to individuals and families, and ineffective use of resources), as untreated mental illness

often results in problems from prison overcrowding to high rates of recidivism. One possible solution to these problems is the expansion of mental health courts (MHCs).

Mental health court generally describes a specialized court for certain defendants with mental illnesses who choose to eschew traditional court processing in favour of a problem-solving approach involving court-ordered and court-supervised treatment (Almquist & Dodd, 2009). Currently, mental health courts vary in the charges and mental illness diagnoses they accept, their consideration of individuals with a history of violence, plea requirements, treatments offered, intensity and length of supervision, potential sanctions, and the impact of program completion on participants' criminal cases.

Mental health courts are designed to divert offenders suffering from severe mental health issues, such as schizophrenia, major depression and bipolar disorder, towards treatment options rather than imprisonment (Greville, 2016). The MHC is available for adults (i.e. aged 18 years or older) who have been charged with a criminal offence and have an ongoing mental health issue that affects or impairs judgement. Individuals with a brain injury or head trauma, including fatal alcohol spectrum disorder (FASD) in some cases, and those with mental illnesses such as schizophrenia, bipolar disorder and major depression will also be considered.

New scientific and technological advances in treatment for mental illnesses have provided a means for the courts to help facilitate rehabilitation for offenders with mental illness (Winick & Wexler, 2003). Because a significant number of people with mental illness are involved in the criminal justice system, it is of paramount importance that the legal system reflects the new advances and incorporates the theoretical concepts of therapeutic jurisprudence (Spaulding, 2000).

Most of the previous studies on mental health courts highly focused on neuroscience, clinical research, structure and institutional roles among different professionals (Minas & Cohen, 2007). The same authors strongly contend that the global situation for people with mental illness (i.e. in developing and developed countries) is dire. Legislative and human rights protections are

frequently lacking. Mental health budgets are also inadequate. There are insufficient numbers of skilled policy makers, managers and clinicians. Similarly, communities are poorly informed about mental health and illness and they are not well organised for purposes of advocacy. In most parts of the world, mental health services are inaccessible or of poor quality. Most people who would benefit from psychiatric treatment and rehabilitation do not have affordable access to such services.

While mental health research attention and funds are devoted predominantly to neuroscience and clinical research, the authors believe that the highest global mental health research priority is mental health systems research. There is an urgent need to focus on the development of effective, appropriate, affordable mental health services in various contexts (Saxena et al., 2005). The evidence base for such development is currently weak. The need for increased attention to and investment in mental health has been repeatedly highlighted, often with recommendations about what should be done. Despite this, the situation for people with mental illness in low and middle-incomes countries in the world remains terrible (WHO, 2018).

Globally, Mental Health Court Diversion Programmes are characterized by three key components: screening, assessment, and negotiation between court diversion and criminal justice staff. *Screening* involves the identification of defendants who are suspected of having a mental illness. *Assessment* also involves the evaluation of identified defendants by a mental health professional. The last component involves court diversion staff negotiating with prosecutors, defence attorneys, the courts, and community-based mental health providers to work towards having charges reduced or even waived (Steadman et al., 1994 in Loong, Bonato, & Dawa, 2016).

In what follows, a number of scholars have conducted multi-dimensional aspects of mental health courts in the United States, Europe, Asia, Australia, Near East, Africa, including Southern and Eastern African countries like South Africa, Zimbabwe, Kenya, and Ethiopia. Lamberti and Weisman (2004) identified challenges and opportunities related to integrating mental health and

criminal justice services at each phase of the criminal justice process in New York. Erickson, Campbell and Lambareti (2006), based on secondary analysis of survey data, determined the similarities and difference among the available courts in terms of their challenges, opportunities, and a call caution of the United States. Sarteschi (2009) assessed the effectiveness of mental health courts by engaging in a meta-analysis of clinical and recidivism, and improving clinical and quality of life outcomes. The same author further states that Mental Health Courts (MHCs) are being implemented as a means of diverting the increasingly large number of persons with severe mental illnesses (SMI) who are incarnated due to such causes as deinstitutionalization, health policy influences, changes in drug laws, criminological theories/frameworks related to the increase in number of mentally ill inmates, the use of illegal substances by SMI, and conduct disorder and schizophrenia which have contributed to the origin of the Courts. Sarteschi, Vaughn, and Kim (2011) assessed the effectiveness of more than 100 MHCs across the United States in reducing recidivism.

These authors also assessed the effectiveness of mental health courts in the United States by reviewing the accumulating MHC studies. These studies were conducted and then provided a clearer picture as to whether mental health courts were an empirically ef fi cacious intervention for a signi fi cant health and criminological problem or not. Johnston (2012) further analyzes the theoretical basis of mental health courts, which currently exists approximately 250 courts in forty-three states of North America. The author furthermore examines therapeutic jurisprudence and therapeutic rehabilitation or a narrow form of rehabilitation. Rossman et al. (2012) examined the impact of two New York City mental health courts (i. e. the Brooklyn Mental Health Court and the Bronx Mental Health Court) on participant's outcomes, and determined if participation in mental health court had reduced subsequent criminal justice involvement (i.e. recidivism as measured by new arrests and new convictions). DeMatteo, LaDuke, Locklair, and Heilbrum (2013) similarity examined three community-based alternatives (i.e. diversion, problem-solving courts, and re-entry into the community) for justice-involved individuals with severe mental illness in the United States of America. Husman (2013) examined professionals' perspectives on positive impacts of a mental health court. Moreover, Sarah Dougau (2014) examined 14

frontline police officers' lived experiences who had been handling offenders with mental illnesses in southern Ontario of the USA. Alexander (2017) qualitatively explored the facets of effective treatment and the ways in which providers perceive the treatment they had provided in MHCs in different parts of the globe. Lauren Rubenstein (2018) also determined whether or not there was a relationship between previous mental health treatment and completion from MHC Programme in Brooklyn, New York of the States.

Based on administrative data on criminal justice and treatment events together with primary and secondary data on the costs of each event; Cowell, Hinde, Broner, and Aldridge (2013) estimated the impact on taxpayer costs of a Model Jail Diversion Programme for people with serious mental illness in different parts of the world. There are some scholars who have been interested in investigating cost-benefit analysis of practising MHC in reducing recidivism in jails and prisons found in New York. Rossman et al. (2012) finally provided guidance for conducting future cost analyses of mental health court programs.

Based on descriptive phenomenological study, Jane Kabuiku (2016) studied the lived experience of Kenyan immigrants by focusing on their integration experience and how the integration processes may have affected their mental health status in North-eastern, United States of America. Additionally, Hamdarf and Bruffett (2017) assessed how well the mental health system in Kansas serves the population; policymakers can consider the need for mental health services (e.g. serious mental illness, SMI, any mental illness, AMI, having suicidal thoughts, and having a major depressive episode in the past years), as well as the capacity of the current system.

Ryan and Whelan (2012), on the other hand, reviewed the background to mental health courts by focusing on the concept of diversion from the criminal justice system and the role of Therapeutic Jurisprudence Theory as an inspiration for the establishment of mental health courts. Consequently, the authors compared and contrasted the main features of mental health courts identified and the features of those in existence in the United States are contrasted with those in Canada and England and Wales.

Therefore, study on mental health courts has proliferated in recent years, and there is a need to synthesize contemporary literature on MHC effectiveness. Lowder, Candalyn, and Sarah (2018), for example, conducted a meta-analytic investigation of the effect on criminal recidivism (i.e. arrest, charge, conviction, and jail time) of adult MHC participation compared with traditional criminal processing in the United States.

In the United Kingdom, Winstone and Pakes (2010) evaluated the Mental Health Court (MHC) Model which was piloted at magistrates' courts in Stratford, East London, and Brighton, Sussex in 2009. Then, they developed a clear model which identified defendants and offenders with mental health issues, assessed the extent of those issues and ensured that (if convicted) the offender/defendant received the appropriate intervention(s); and finally identified the actual costs that would be incurred across the Criminal Justice System (CJS) and Health Services as a result of implementing the Model.

Staton and Lurigio (2016) explained similarities and variations in programme structures and professional roles in Midwestern Mental Health Courts. The researchers furthermore studied how legal and MHC professionals had been organized in the programmes and run their roles at the workers and thus identified very similar models of mental health court organizations in all the research sites - coercive, mimetic, and normative forms of institutional models of MHC.

In other European counties, there are some other empirical studies on another aspect of mental health courts – practitioners. Lundstrom et al. (2017) explained the meanings of the lived experience of lifestyle changes for people with severe mental illness by conducting narrative interviews with ten people who were recruited from three different psychiatric outpatient clinics in Lund Region located in southern Sweden, and then analysing these qualitative data using a phenomenological hermeneutic method of qualitative research method.

Mental health courts were first established in the United States in 1997 and then the courts started functioning in North America, Canada, England, and Australia in response to the large

number of people with mental illnesses being processed through the courts. The New Zealand Government (2016) thus considered that these courts are characterized as problem-solving courts which focus on addressing the underlying drivers of offending by offenders who are mentally ill. Lily Ryken (2016) then explored the functions of mental health courts (MHC) and discussed the way in which a New Zealand MHC (NZMHC) could and should operate within the current legal framework in the country.

On the other hand, some concerned researchers who are interested in issues of mental health courts argue that few studies have looked at the long-term outcomes of mental health courts on criminal recidivism. Of the studies evaluating the impact of those courts on criminal recidivism, most empirical studies follow defendants after entry into the court during their participation, and only a few have followed defendants after court exit for periods of one or two years. Accordingly, Ray (2014) examined recidivism post-exit with particular attention to MHC completion's effect by following defendants at mental health court for a minimum of five years.

In the same framework, Loong, Bonato, and Dewa (2016) assessed the current evidence on the effectiveness of mental health courts in reducing recidivism and police contact in United States and Canada depending systematic literature review protocol using eight search engines like PsycINFO, Medline, Medline In-Process, Embase, Web of Science, CINAHL, Social Work Abstracts, and Criminal Justice Abstracts and, thus, illuminated gaps in the existing literature, directed future research undertakings, and informed policy makers.

Lee and colleagues (2012) conducted six studies to examine the economic value of programmes that reduce crimes (including MHCs found in different parts of the world) or to examine the effect of MHCs on crime. The Utah Criminal Justice Centre (2012) also examined the economic and behavioural outcomes of interventions designed to prevent criminal behaviour, including MHCs. A comprehensive search of the literature was conducted between 1987 and 2011 to identify studies of adult MHCs in Utah.

Regarding stigma associated with mental health problems, there is a case study in Near East. Seham Alyousef (2016) identified the stigma surrounding mental health problems, the existing, and latent views of mental health professionals (i.e. mental health experts) holding a stigma towards people living with the problems in Riyadh, Saudi Arabia.

Jenifer Carter (2015) generally investigated professionals' (e.g. professionals from the mental health field, law enforcement, courts, and correctional institutions) perspectives at offenders in criminal justice system, including mental health court elsewhere in the world. Lowder, Candalyn, and Sarah (2018) similarly examined effect of MHC participation on recidivism (i.e. arrest, charge, conviction, and jail time) relative to traditional criminal processing in the world.

Bartlett, Jenkins, and Kima (2011) focused on mental health law in the African communities and then on the specific question of what mental health law looks like if it focuses outside the institution, but on community and primary care services. Accordingly, they looked at what the new paradigm of law (i.e. community-based mental health law) might look like in African contexts which have attracted a number of professionals who are concerned with the practical issues of service development in Africa.

In Africa, there are also some empirical studies on challenges related to the practice of mental health professionals working in the mental health courts. Bantjes, Swartz and Niewoudt (2017), for example, investigated and described the challenging experiences of mental health professionals working in prisons who had been providing care to suicidal prisoners in post-apartheid South Africa.

In Ethiopia, the majority of the people having mental illness are not getting professional consultations and clinical help. Instead, they are abandoned and left by themselves and most of them end up on street or in prison. Moreover, "mentally disabled persons in Ethiopia suffer from social, economic problems and human rights violations, and they and their families also experience stigma and discrimination daily in Ethiopia" (FMoH, 2015, p. 12).

Therefore, the same document indicates that a Mental Health Court was established in May 2015 in Ethiopia. The Court was established under the Federal First Instance Court Lideta Division in collaboration with Psychiatry Department of the College of Health Sciences at Addis Ababa University. The Court has three main objectives. Firstly, it determines the fitness of accused to stand trial. Secondly, it examines whether accused person is criminally responsible or not, while the third objective is diversion of accused to treatment if s/he is found to be mentally disabled. There are very few studies on role of the Mental Health Court in Lideta Sub City of Addis Ababa. For instance, Aberash (2015) conducted a study on the role of mental health court in the protection of the human rights of person with mental disability in Ethiopia. Additionally, Selamawit Wubet (2019) qualitatively assessed the role of social workers at Lideta Federal First Instance Mental Health Court in protecting the rights of children victims of sexual and physical abuses in Addis Ababa.

On other hand, as different countries in the world have employed various approaches to handle cases of offenders with mental health problems, and such have still remained under-researched and inconclusive; the litigation processes and outcomes of Mental Health Court at Lideta First Instance Court are not well-explored, documented, and understood in Addis Ababa, Ethiopia. Thus, it is significantly imperative to design and conduct an exploratory phenomenological study on the practices and challenges of the Mental Health Court as this involves collaboration between criminal justice agencies and mental/behavioural health care systems (Yuan & Capriotti, 2018).

1.2. Statement of the Problem

The purpose of the study is to assess practice and challenges of court process on offenders with mental health problems at Lideta Federal First Instance Court in Addis Ababa, Ethiopia. The practice of mental health court (MHC) has its philosophy and involves certain process which, in turn, includes a structure, referral, entry, assessment, evaluation, plea, sentencing, treatment and

treatment plans, service providers, outcomes, and court system exit. However, such practice has been encountered with multi-faceted challenges.

Incarcerating individuals with a mental illness is not a new problem. During the nineteenth century, it was not uncommon for the mentally ill to be housed with the paupers and criminals. There were few public hospitals. Since local towns and states were responsible for the care of the mentally ill, it was cheaper to confine them in jails (Deutsch, 1946 in WHO, 2003).

Mental health courts are based on a philosophy of therapeutic jurisprudence and restorative justice that offers a more "collaborative and individualized approach that differs from the traditional criminal justice system" (Slinger & Roesch, 2010, p. 258). An MHC, from a philosophical standpoint, assumes the perspective that the neurobiological basis of mental disorders is outside the wilful control of individuals. According to the Council of State Governments Justice Centre, people with mental illness cannot simply decide to change the functioning of their brain. As with physical illnesses, it is believed that mental disorders are caused by the interplay of biological, psychological, and social factors (Greville, 2016). Therefore, mental health courts offer participants a model that involves accountability for the actions that led to court involvement along with opportunities to engage in treatment on underlying mental health disorders.

Mental health courts are forensic courts that manage the cases of those with mental illness charged with committing misdemeanours and/or felony crimes (Redlich, 2005). While variation exists in administrative structure across programmes, generally an MHC which involves an integrated continuum of MHC team members typically includes the judge, prosecutor, defence attorney, case manager, court staff, criminal justice staff (i.e. probation, police, and jail representatives), and mental health or treatment staff. In contrast to a traditional court, the judge in an MHC is more involved in monitoring the treatment plan, including participation in time-intensive team reviews of each case on the docket. While high volume jurisdictions may administer stand-alone MHC; a mental health court can also refer to a specialized docket handled by a judge and team members that also handle traditional cases. Generally, the active

engagement of the defendant is paramount, beginning with the decision to accept the terms of participation in the programme on consent with the treatment plan. These are matters of the court, and there is a constant need to maintain balance between the expectations of the programme, as in the conditions of sentencing and participation, and accountability for treatment. Overall, the client's progress through the plan is carefully monitored by a responsible official.

Florida Courts (2018) state the origin of mental health courts stemmed from situations similar to those preceding the development of drug courts – repeat offenders in need of treatment services. With community mental health resources dwindling, the courts were seeing more repeat offenders with untreated serious mental illness. Florida's jails and prisons are not designed, equipped, or funded to deal with serious mental illness, so the creation of the mental health court model (a problem-solving court docket model) was a logical response.

Mental health courts generally share the following goals: to improve public safety by reducing criminal recidivism; to improve the quality of life of people with mental illnesses and increase their participation in effective treatment; and, to reduce court- and corrections-related costs through administrative efficiencies and often by providing an alternative to incarceration.

The components of mental health courts, from Improving Responses to People with Mental Illnesses – The Essential Elements of a Mental Health Court, Bureau of Justice Assistance:

- Target population;
- Timely participant identification and linkage to services;
- Terms of participation;
- Informed choice;
- Treatment supports and services;
- Confidentiality;
- Court team;
- Monitoring adherence to court requirements; and

- Sustainability (Florida Courts, 2018).

The courts are typically comprised of specially trained individuals (including judges, attorneys, and staffers with knowledge of mental illnesses who create treatment plans for defendants). These courts can be used either at pre-sentencing or post-sentencing to divert incarceration (Tyuse & Linhorst, 2005). Fundamentally, such courts seek to divert those with a mental illness into treatment instead of punishment in jails and prisons. Mental health courts therefore mandate that participants attend treatments presumably offered through the public mental health system. Contrarily, sanctions are utilized for offenders not adhering to an agreed upon treatment plan. Common sanctions include reprimands from the judge and, an increase in the number of court-ordered appearances in front of the judge and jail (Redlich, 2005). By quoting the Bazelon Center for Mental Health Law, D'Emic (2007) states that if mental health treatment is successfully completed, the participants' charges may be reduced or dismissed. Accordingly, these courts represent a collaborative approach between the mental health system and the criminal justice system.

The MHC process begins a referral from any other criminal term in a county or district. Judges, assistant district attorneys or defence lawyers may make the referrals. Once the case comes to the mental health court (if both sides agree), a psychiatrist and a social worker evaluate the defendant (D'Emic, 2007). The psychiatric and psychosocial evaluations report whether or not the defendant suffers from a serious and persistent mental illness for which there is a known treatment, which is a condition of eligibility for the court. In addition, a diagnosis, psychiatric history, and risk assessment are included. Finally, an opinion of eligibility is provided. These reports are given to the defence lawyer, assistant district attorney, and the judge. If the defendant is found eligible, the case is adjourned to allow the district attorney to come up with a plea offer and the clinical team to formulate a treatment plan. Once that is negotiated, the defendant enters the plea — outcomes for failure and success are placed on the record at that time — and the defendant is released to treatment.

In New York State, for example, the Brooklyn Mental Health Court has in-house clinical team which consists of a Clinical Director with a Master's Degree in Social Work who formulates all treatment plans; a senior forensic social worker who does the psychosocial evaluations; and three case coordinators who are responsible for daily contact with treatment providers, following up on the progress of each defendant, and preparing a one-page "report card" for the court and counsel at each court appearance. The team meets daily, which allows the court to advance the cases of struggling defendants or to order bench warrants for defendants who have left their treatment programmes (if necessary).

In contrast, in Ethiopia, although mental health courts were established in May 2015, and it is a new emerging phenomenon a research was conducted by Aberash (2015) on the role of mental health court in the protection of the human rights of person with mental disability. Since the establishment of a court which entertains the case of offenders with mental health problem is a new emerging phenomenon a lot of problems have been seen in the process. During the preliminary observation made by the researcher in 'Lideta' federal first instance mental health court, the researcher observed that the role of doctors is very high and the court made a decision based on the suggestion of the doctors besides this, although a social work team is assigned to this court their involvement is very less. However, the process doesn't incorporate a social worker and psychiatrist in order to view the offender's problem holistically. Hence, since the researcher had realized that this court process lucks the participation of other professional such as social workers and psychiatrist. Besides, it is observed that making a decision with a single observation of the offenders brings violation of rights on the offenders as well as the mentally ill offenders case has to be seen holistically. The researchers have been convinced to conduct a research to show the gap on the court process of offenders with mental health problem in Lideta first instance court.

In addition to those issues which have been investigated and discussed about multi-dimensional aspects of the practice at mental health courts in different countries of the world, including Ethiopia; there are encountered challenges in the due process. Although mental health courts

have become a popular approach for responding to offenders with mental illness, some concerns have surfaced. For instance, Sartesch and colleagues (2011) discussed thorny issues surrounding the extent of voluntariness and participant comprehension, dismissal practices for reduced or eliminated charges in post-adjudication models, possible gender and race selection biases, and "creaming" practices where mental health courts only accept clients with few risk factors who would be expected to succeed regardless of programme participation.

1.3. Research Questions

The study aims to answer the following research questions:

1. How does the mental health court make decisions with regard to offenders with mental health problems suspected of committing crimes?
2. What is the role of other professionals such as medical doctors, psychiatrist and social workers in working collaborate with the judge?
3. Is there any kind of gaps and opportunities seen in the practice of mental health court in Ethiopia?
4. Is there any kind of challenge and opportunity on the role expectation of "social workers" and their actual practice in the selected court setting with mentally disabled offender's case?

1.4. Objectives of the Study

1.4.1. General Objective

The general objective of the study is to assess court process on offenders with mental` health problems at Lideta First Instance Court in Addis Ababa.

1.4.2. Specific Objectives

Specifically, the researcher aims at answering the following questions:

- To assess actual practice of handling offenders with mental health problems at the Mental Health Court in the City;

- To investigate opportunities created and gaps identified in the establishment of the Mental Health Court;
- To identify challenges related to the implementation of Mental Health Court at Lideta First Instance Court; and
- To explore implications of Mental Health Court practice for social work practice at the MHC in Addis Ababa, Ethiopia.

1.5. Significance of the Study

The rationale for doing this study entails on exploring the overall process in mental health court. Above all, it would practically depict the specific roles of social workers, psychiatrist, and doctors in working with legal professionals' expected roles. This study possibly will help clearly identify the services provided by the Court and identify the expected roles of social worker, psychiatrist and doctors to improve the actual practice and to incorporate new client-friendly practices. This research could show the existing challenges and prospects with regard to the social work team which are seen in the court system. Besides, the research could serve as a preliminary input for law makers to draw a policy that clearly articulates clear proceeding on offenders with mental health problem. Moreover, the study could instigate other social workers to do studies on the various sects of mentally disabled offenders in the Court. Generally, the empirical evidence may serve as valuable inputs for social policy makers, social work practitioners, for the already existing literature reserves on the issues and the social work discipline, and as stepping-stone for conducting further studies on various aspects of the Mental Health Court using quantitative research methods and/or mixed methods research design in different socio-cultural, economic, political, and agro-ecological contexts at different levels in Ethiopia.

1.6. Operational Definition of Terms

- **Offender** refers to delinquents who are convicted under the law and commit illegal action.

- **Mental illnesses** are diseases that cause disturbances in one's thinking, perception, and behaviour. These disturbances can be mild, having minimal impact on one's functioning, or more severe, impairing the person's ability to think and function in a normal manner and environment. The term "mental illness generally encompasses numerous psychiatric disorders that can strike anyone regardless of age, economic status, race, creed, or colour" (Murray & Lopez, 2001, p. 198).
- **Mental disorder** is a disease that causes mild to severe disturbances in thought and/or behaviour, resulting in an inability to cope with life's ordinary demands and routines.
- **Mental health court** generally describes a specialized court for certain defendants with mental illnesses who choose to eschew traditional court processing in favour of a problem-solving approach involving court-ordered and court-supervised treatment (Almquist & Dodd, 2009).
- **Court process** refers to the criminal proceeding commonly refers from the first hearing of the case up to the final decision of the judge.

1.7. Scope of the Study

The study focused on offenders with mental health problems who entertain their cases at Lideta First Instance Court in Addis Ababa. Furthermore, the study incorporated the decisions of the Court beginning from 2007 to 2009 Ethiopian Fiscal Years. But this doesn't mean all cases entertained at Lideta First Instance Court have not been considered. Also, the researcher included the offenders' families, the medical doctors, and the social workers who are working in this Bench/Docket as sources of data collection.

1.8. Limitations of the Study

This research is limited to studying about the mental health court Addis Ababa who only vend in Lideta. There are three challenges that the researcher passed through in this study. The first challenge was the scarcity of relevant studies carried out on mental health court in Ethiopia. Consequently, the researcher was forced to use studies and journals that were conducted

generally on mentally ill people. Related to this, the second challenge was the difficulty in getting statistical data about the number of mentally ill offenders in Addis Ababa in particular, and in Ethiopia, in general. Particularly, due to the of challenges to get written documents on the issues under investigation. The other challenge was because the Medical Doctor (i.e. one of the study samples) was the only Medical professional in this area. The researcher faced difficulty to contact him for holding interview with him. On the whole, these and other related issues may have their direct and/or indirect influences on the findings of the study.

1.9. Organization of the Thesis

This thesis is organized into five chapters. The first chapter is Introduction which describes background of the study, statement of the problem, objectives of the study, operational definition of terms, scope of the study, significance of the study, and limitations of the study. Chapter Two dwells on review of conceptual literature, theoretical literature, and empirical literature which are available elsewhere in the world. It thus presents definitions of mental illness according to legal, medical and psycho-social perspectives. It also deals with the meaning of mental health court, the criminal responsibility of individuals with mental health problem. The international and regional mental health courts, including Ethiopia mental health court are also discussed. International and regional legislations regarding mental health will be discussed in detail. Furthermore, theoretical models related to mental health court are elaborated. Next, the methodology of the study is presented and explained. Chapter Four presents the phenomenological analyzed qualitative data and discusses the findings of the study in the light of the research questions and study objectives set. Finally, it draws conclusions based on those themes identified and ran throughout different sections of the thesis and then highlights their implications for social work practice in such context, and also suggests possible social work practices for action.

CHAPTER TWO

LITERATURE REVIEW

2.1. Introduction

This chapter presents review of relater literature on the practices and challenges of handling offenders with mental health problems as mental health courts in the world to situate the current empirical study within a wider context of mental health courts and their effectiveness n reducing recidivism in various socio-cultural, economic, and political background frameworks. The chapter describes meaning of mental illness based on the medical, legal, psychosocial, and cultural impact perspectives. Next, it discusses about theoretical models for mental illness like the Medical Model, Social Model, and the Bio-Psychosocial Model. In what follows, the historical background of mental health courts and theories related to them such as Therapeutic Jurisprudence, Procedural Justice Theory, Deterrence Theory, and Social Learning Theory are presented and described. The chapter also highlights criminal responsibility of mental disordered individual in the courts, considers social work and mental health problem. In addition, it reviews how scholars have conceptualization of mental health courts, and presents an overview of the development of mental health courts in different parts of the world.

Furthermore, the chapter explains on international mental health court process, and focuses on Mental Health Court in Ethiopia. Additionally, it brings in issues related to roles of social workers and their inter-disciplinary collaboration in the mental health courts. In order to use different windows in the same framework, the chapter discusses about the international legal instruments on the rights of persons with mental disabilities and the United Nations' Principles for protection of persons with disabilities and improvements of mental healthcare, and the United Nations' Convention on rights of persons with disabilities in the light of MI Principles. Finally, it dwells on legislations on persons with mental disabilities in the Ethiopia context.

2.2. Meaning of Mental Illness

Mental illnesses are diseases that cause disturbances in one's thinking, perception, and behaviour. These disturbances can be mild, having minimal impact on one's functioning, or more severe, impairing the person's ability to think and function in a normal manner and environment. The term "mental illness encompasses a number of psychiatric disorders that can strike anyone regardless of age, economic status, race, creed, or colour" (Murray & Lopez, 2001, p. 198).

A number of factors are commonly cited as causes of mentally ill persons being placed in the criminal justice system. These factors include: deinstitutionalization and the unavailability of intermediate and long-term hospitalization in state hospitals for persons with chronic and severe mental illness; more formal and rigid criteria for civil commitment; the lack of adequate support systems for mentally ill persons in the community as well as the difficulty mentally ill persons coming from the criminal justice system have gaining access to mental health treatment in the community; and a belief by law enforcement personnel that they can deal with deviant behaviour more quickly and efficiently within the criminal justice system than in the mental health system (Lamb, Weinberger, & Gross, 2004, p.109).

There is negative attitude towards mental disability in Ethiopia. Most of the time mental disability is associated with spiritual problem or being possessed with evil spirit (FMoH, 2015, p. 12). Due to this perception, the majority of the people having mental illness are not getting professional consultations and clinical helps. Instead, they are abandoned and left by themselves and most of them end up on street or in prison, while a few are taken to traditional healing places where they get no scientific treatment or the required treatment or care. Moreover, mentally disabled persons in Ethiopia suffer from social, economic problems and human rights violations. Stigma and discrimination is the daily life of mentally disabled persons and their Families in Ethiopia.

Ethiopia is in the process of developing a National Mental Health Policy. There is no emergency preparedness plan for mental health. Approximately, 1.7% of the national health expenditure for

2004 was spent on mental health. There is no external reviewing of the mental health facilities regarding human rights issues. The country's only mental health hospital also acts as the national coordinator of mental health services (WHO, 2005, p.7). The same source documents that the country has 53 psychiatric outpatient facilities, 6 in-patient facilities and 1 mental hospital. There is only one residential facility in the country for chronically mentally ill and several other residential facilities, which have mentally ill clients among their beneficiaries. There are three day- treatment facilities. There are 0.35 mental hospital beds and 0.14 community psychiatric impatient beds per 100,000 populations. The majority of users of mental facilities are generally males. Moreover, all facilities lack special programmes for children and adolescent.

There are also medical, legal, psycho-social, and cultural impact perspectives of mental illness. These perspectives look at the issue under consideration from different angles.

2.2.1. Medical Perspective of Mental Illness

Mental illness refers collectively to all diagnosable mental disorders, which are health conditions characterized by alterations in thinking, mood, or behaviour (either independently or in combination), associated with distress or impaired functioning. For example, antisocial personality disorder (ASPD) is an Axis II disorder characterized by a pervasive pattern of disregard for, and violation of the rights of others that begins in childhood or early adolescence and continues into adulthood (APA, 2000). Similarly, depression constitutes a mental disorder largely marked by alterations in mood, while attention- deficit/hyperactivity disorders are mental disorders largely identified with alterations in behaviour (over activity) or thinking (inability to concentrate). Alterations in thinking, mood, or behaviour contribute to a host of problems — patient distress, impaired functioning, or heightened risk of death, pain, disability, or loss of freedom (Rossman et al., 2012).

The medical definition of mental illness is far broader than the legal definition. A psychiatric diagnosis of a mental illness involves rigorously identifying a cluster of symptoms according to a standardized diagnostic classification system. Such systems are designed to provide consistency

in psychiatric diagnosis. The most widely accepted psychiatric classification system is outlined in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorder, IV (DSM-IV). The DSMIV Manual provides a description of the essential and associated features of over 300 mental disorders. A mental disorder is considered to be a group of clinically significant behaviors, or patterns that cannot be 'an expectable' response to a particular event or situation, and must be considered a 'manifestation of a behavioral, psychological or biological dysfunction in the person (Freeman, 1998, p. 1).

2.2.2. Legal Perspective of Mental Illness

As noted earlier, a clinical diagnosis of a mental disorder is generally not sufficient to establish the existence of a mental disorder for legal purposes. Furthermore, the definition of mental illness used in the Local Courts (which deal with less serious matters) is different from that used in the District and Supreme Courts (which deal with more serious matters). The definitions of mental illness and mentally ill persons used in relation to criminal matters in the local courts are set out in the Mental Health Act 1990 (NSW). The statutory definition of mental illness stipulates that it is a condition which severely impairs (temporarily or permanently) the mental functioning of the person and is characterized by the presence of one or more of the following symptoms: delusions, hallucinations, serious disorder of thought, a severe disorder of mood, and sustained or repeated irrational behavior indicating the presence of one of the symptoms already listed. From a medical perspective, these symptoms would most often be associated with a diagnosis of psychosis. A mentally ill person**,** according to the Act, is considered to be someone suffering from a 'mental illness' where there are reasonable grounds to believe that treatment or control of that person may be necessary.

The Act also outlines certain conditions under which a person cannot be considered mentally ill or mentally disordered. These conditions include a failure to express or engage in a particular political belief, religious opinion, philosophy or sexual preference. Furthermore, a person cannot be considered a mentally ill or disordered person merely because that person engages in sexual

promiscuity, immoral conduct, anti-social behavior, or has taken alcohol or any other drug, or if the person has a developmental disability (Freeman, 1998, p. 2).

Despite the issues of mental health violations documented in the literature, it has also been observed that significant legislations are documented pertaining to the treatment of individuals with disability including those with mental disorders. The Universal Declaration of Human Rights (UDHR) encompasses 30 articles. However, no articles identify the need for rights around mental health concerns, and only one article (Article 25) alludes to the importance of social service access (UN, 2006). Instead, information about mental health can be found in the United Nations Convention on the Rights of Persons with Disabilities. As defined here, disabilities include "long term . . . mental . . . impairments . . . which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others" (UN, 2006).

To ensure that human rights are honoured in relation to mental health, WHO developed the Mental Health and Human Rights Project, this focuses on mental health legislation within a global context (WHO, 2006). This project was supplementary to the United Nations' Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care, which was established in 1991 and created a minimum level of human rights required in mental health practice (WHO, 2005).

2.2.3. Psychosocial Impact of Mental Illness

Persons with schizophrenia experience more stress due to the nature of the symptoms as well as the prolonged duration of illness. The average prevalence of schizophrenia is 2–3/1000. The average incidence is 4.2/10,000 and 3/10,000 in the rural and urban areas, respectively (Murthy, 1997). The prevalence rate of schizophrenia explains the magnitude of the problem. The psychological reactions which the patient experiences are a feeling of loss, sadness, anxiety, and embarrassment in social situations, the stress of coping with disturbing behaviours, and the frustration caused by changing relationships (Ostman, 2004).

Persons with mental illness may face a number of psychosocial problems. Among the problems they faced, Stigmatization and discrimination are the first and the most common to different societies (Schulze, 2000). The most common consequences of discrimination for people with mental illness especially schizophrenia are social distancing, exclusion and being disadvantaged in regard to housing and employment opportunities (Crisp et al., 2000). As a result of the stigma associated with mental illness, and schizophrenia in particular; people suffering from mental illness often do not accept professional help until a late stage. Goffman (1963) defined stigma in terms of undesirable, "deeply discrediting" attributes that "disqualify one from full social acceptance" (preface) and motivate efforts by the stigmatized individual to hide the mark when possible. Stigmatization process includes consequences like cognitive (stereotypes), emotional (prejudice), and behavioral (discrimination) towards the targeted people. The other problem mental illness causes is disabilities which manifest in patient daily life function. These disability lead to poor adaptability in One`s personal life, family life and also outside family (Katsching et al., 1997) and poor quality of life which can be manifested in terms of economic hardships, social isolation and psychological strain.

Mental illness places a huge burden not only on the individuals afflicted, but also the people closest to them, termed caregivers, who live with the individuals, interact with them regularly and lend a helping hand in their day to day activities. Family members play a major role in providing care giving assistance to patients with mentally illness and while providing care they may experience considerable amount of distress and may have a poor quality of life, if they are unable to cope with the stress associated with the process of care giving. The demand of being involved in the case of severely mentally ill relative have both an emotional and a practical impact on the care giver (Provencher, 1996). The cost that families have incurred in terms of economic hardships, social isolation, and psychological strain is referred as family burden (Grad & Sainsbury, 1998). Families with mentally ill member's response to mental illness is often dichotomized, which includes phases like denial versus acceptance of situation or being certain or uncertain. Family stigma may include: the stereotypes of blame, shame, and contamination;

public attitudes which blame family members for incompetence may conjure the onset or relapse of a family member's mental illness.

2.2.4. Cultural Impact of Mental Illness

Mental health embodies the integration of psychological, emotional, and social harmony. It encompasses one's quality of life and general well-being. Culture, language, ethnicity, and religion play a significant role in the interpretation of mental health causes. Studies show that being diagnosed with or exhibiting symptoms of mental health issues exposes a person or community to labelling. Such people are branded as socially inadequate and are associated with resulting shame, humiliation, and loss of face. In most cultures, groups with low positions in hierarchical social structure experience high rates of mental health problems (Rosenfield, 2012). In modern society, connection with mental illness exposes a person to levels of medicalization and marginalization (Cathy & Huls, 2014, p. 6).

In certain cultures, mental illness is perceived as a sign of weakness or curse. This negative connotation results in family members distancing themselves from or maltreating those who are ill. Furthermore, those with mental illness are deemed unproductive and perceived as not contributing to the upkeep of the family. It is also argued that the lack of resources in African countries as well as in other developing countries makes it difficult for governments to enhance the treatment or improve the conditions of the mentally ill, which inevitably exposes many to abuses (Carthy & Huls, 2014, p. 7).

Further violations can be witnessed in a number of different countries. As described by Yamin and Rosenthal (2005), 300 mentally ill men were housed in a space that was built for 50 individuals and were not provided with treatment in Accra, Ghana. Violations in Zambia have included: denial of food, restriction of movement, poverty due to cost of treatment, and being brought to hospital in chains or in the company of armed officials (Mwanza et al., 2011). Treatment can also fail to involve basic social communication, as some believe that this would not be helpful to an individual with mental health concerns (Kogstad, 2009). In Hungary,

individuals were administered obsolete medication and kept in beds that were caged, thereby limiting their movement (Yamin & Rosenthal, 2005).

2.3. Theoretical Models for Mental Illness

It is underscored that the meaning of mental health problem varies according to the societal understanding and can be constructed in relation to several basic understandings of the phenomenon. Thus, instruments and methods of protecting PWMHP are likely to be based on different underlying interpretations of what constitutes the issue of mental illness (Catherine, 2009, p. 31). There are around six models of mental health problem. The first one is the charity model, which embraces the belief that PWMHP are "afflicted" with their mental illness which sought for protective care to be provided and society's responsibility is to meet the needs with very few expectations from the person (London School of Hygiene and Tropical Medicine [LSHTM], 2010). This is followed by the Medical Model, by which it is generally believed that a person with mental health problem has a part of the body that needs to be fixed and medical practitioners are the experts and mental illness is seen as an individual health issue. Gradually, the Economic Model, Social Model, Bio-psycho-social and Human Rights Models have evolved with the evolution of society.

These Models have been varying with the growth of society which impacts the evolution of the concept of mental illness. Each model approaches mental illness from a unique viewpoint. From this viewpoint, different limitations and facts are regarded as appropriate when defining mental illness. Moreover, these different models assume different ideological principles for how PWMHP are endowed rights and become eligible for protective programs. Though the above different models are developed at different socio-cultural systems and times, the medical model, the social model and the bio-psycho-social model are the common ones. Therefore, the discussion that follows is limited to these three models of mental illness in their order.

2.3.1. Medical Model

This emerged with the development of medical science in the 19th century that approaches mental illness as a medical problem and PWMHP are seen as sick and in need of treatment and rehabilitation. It locates the 'problem' within the individual rather than in society (Stone, 1984, p. 107) because it regards mental illness as a personal problem, directly caused by illness or other forms of health issues, that are assumed to be improved through medical intervention in the form of treatment methods or rehabilitation measures. That implies an individual faces problems because of his own defects and the only way to live a normal life is treating the defect (Tornes Ltd, 2002, p. 403). Mental illness by this model is therefore the deficits of the functional and physiological abilities of the impaired individual associated with diagnoses and pathological facts. Such a construction and understanding of mental illness emphasizes the problems associated with using confirmed medical conditions as a basis on which to describe the Impairments an individual suffers from and to determine how their situation can be compensated for or improved (Stone, 1984, p. 117). This Model promotes the view that PWMHP are dependent and needing to be cured or cared for, and it justifies the way in which PWMHP have been systematically excluded from society. In fact, this approach is useful if it is used to support the actual medical needs of PWMHP and to improve their ability to function as independently as possible.

This interpretation of mental illness is criticized heavily for focusing on the individual and the 'problem' rather than the possibilities and predisposition of the person with the disability. It is also criticized for assuming a medical pre-evaluation or definitional power over the problems related to mental illness (Thomas, 2004). Shortcomings in the way that society has adapted for the PWMHP and whether that individual has the opportunity to participate in various activities are not present. Furthermore, the Model is criticized for understanding mental illness according to medically accepted Factors and definitional procedures followed by medical science. Other types of impairments that are more or less difficult to clarify in medical terms are often excluded from this model. For example, it is difficult to define drug addicts, alcoholics and persons who deviate from the general population within the disability category; even if it is clear that these

individuals are impeded by their surroundings. As Lindquist has asserted, the medical model results in a "metallization" of social problems and living standards as a person who is disabled and has limited financial means will only be granted access to welfare benefits when he/she receives a diagnosis (ECN, 2004, p. 74).

When this Model has become seriously at odds with the daily lives and experiences of PWMHP, it was inevitable that change had to come on the approach towards mental illness. It was clear to PWMHP that (in the absence of any cure for their mental condition) the impairment must be regarded as given – a constant factor in the relationship between themselves and the society with which they attempt to interact (Grant, 2009). It follows from this that any failure in the interaction must be overcome through a restructuring of the social and physical environment. This requires an approach which takes account of the many individuals with their particular problems and deals with the effect on such individuals of their social and physical environment. Gradually, this Model therefore could not stand all the criticism and suffered a rejection. Researches in the field of mental illness studies have clamoured that it is society's failure to provide appropriate services and its failure to adequately ensure that the needs of PWMHP are taken into account which creates mental illness (Albert, 2006, p. 24). Therefore, the Social Model came to succeed the Medical Model of mental illness with a hope to meet the gaps that the former has failed to address on the rights of PWMHP.

2.3.2. Social Model

This Model arose in response to the critique of the Medical Model and stands as an antithesis of the medical understanding of mental illness. Hence, the Social Model emphasizes the social explanation for why the phenomenon of mental illness comes into being. According to the Social Model, mental illness is not something that is given to persons by nature; it is constructed through human interaction. It also opposes the idea that mental illness is something that can be "repaired" or improved through rehabilitation measures or intervention by medical or other professional fields. It advocates that the solution for PWMHP is within the control of the society,

attitudinal and physical accessibility can avoid the barriers against equal and effective participation.

Commenting on the revised understanding of mental illness, it is stated that:

> The notion of mental illness is not perceived in terms of an attribute of a person, but as a complex collection of conditions many of which are created by the social environment. Hence, the management of the problem requires social action and it is the collective responsibility of society to make the environmental modifications necessary for the full participation of PWMHP into all areas of social life. The issue is, therefore, an attitudinal or ideological one which requires social change, while at the political level it is a matter of human rights (WHO, 1997).

While writing about the North American context, mental illness stems from *"*The failure of a structured social environment to adjust to the needs and aspirations of citizens with mental illness rather than from the inability of the mentally ill individual to adapt to the demands of society*"* (Hahn, 1986). Mental illness is therefore not an individual quality based on the Social Model, but arises as a consequence of man-made conditions and a society that is poorly adapted and organized. The fact that persons become mentally ill is a by-product of the social environment resulting from a lack of response to the need to make adaptations, including neglecting and exclusion of the mentally ill individual from participating in the social environment.

This Model is not however free from limitations; it is criticized for the model disassociates impairment from mental illness when it focuses only on mental illness that are caused by the exclusion of the society, ignoring the mental illness which are purely medical. Moreover, if mental illness is socially constructed, as this model proposes, the value of the real life experiences of PWMHP will remain a puzzle. That is a question commonly posed to the Social Model as the latter does not go so far as to negate the existence of mental illness or to deny the existence of a person's pain, suffering or need for treatment and rehabilitation as it places the responsibility squarely on society (Barnes,1996). By refusing to discuss impairment, this Model

failed to acknowledge the subjective reality of PWMHP lives that experience pain, illness, shortened lifespan or other factors due to an impairment. As a result, they may seek treatment to minimize these consequences and, in extreme circumstances, may no longer wish to live.

Shakespeare and Watson (2002, p. 6) submit that: "Most activists concede that behind closed doors they talk about aches and pains and urinary tract infections, even while they deny any relevance of the body while they are out campaigning." Therefore, there is a need to ensure the availability of all the support and resources that an individual might need, whilst acknowledging that impairment can still be intolerable (Morris, 1996). This led to a paradigm shift from the mutually exclusive social and medical models to another model which could transcend the deficits of these two models and takes in to account mental illness together to help PWMHP participate equally in the mainstream society and all their human rights be respected and protected on an equal basis with others. This new model is known as the Bio-psycho-social Model which is going to be discussed below.

2.3.3. Bio-psychosocial Model

The Medical and Social Models appeared as mutually exclusive, but it has been shown that mental illness should be viewed neither as purely medical nor as social: PWMHP can often experience problems arising from medical problem and the socially constructed problem (Thomas, 1999, p. 4). On their own, neither model has failed to be adequate, although both are partially valid. The WHO has described mental illness as: "a complex phenomena that is both a mental problem at the level of a person's mind activity, and a complex and primarily social phenomena; mental illness is always an interaction between features of the person and features of the overall context in which the person lives, but some aspects of mental illness are almost entirely internal to the person, while another aspect is almost entirely external" (Watson, 2012, pp.12-29).

Thus, both medical and social responses are appropriate to the problems associated with mental illness and it is not possible to wholly reject either kind of intervention. A better model of mental

illness is therefore the one that synthesizes what is true in the two models, without making the mistake each makes in reducing the whole, complex notion of mental illness to one of its aspects. This more useful model of mental illness might be called the Bio-Psycho-Social Model. This is an integration of the Medical and Social Models. ICF provides, by this synthesis, a coherent view of different perspectives of health: biological, individual and social perspectives.

The Bio-Psycho-Social Model which evolves from the Social Model presents mental illness as a combination of medical and socially created phenomena which is viewed as a compromise between the two models as both models consider the problem only from one aspect and failed to appreciate the problem holistically (WHO, 2011, p. 11) . Thus, mental illness cannot be explained by medical, biological or social factors exclusively but by the interaction between all of them. To blame the society alone for the problems suffered by the PWMHP is too unfair and unrealistic. Rather than dichotomizing the solutions to mental illness as either medical or social, this Model looks to bridge the gap through flexibility by recognizing a range of instruments that can be employed to resolve the dilemmas faced by PWMHP. A mental health problem can be cured by the medicine if it is possible and it similarly applies to a socially addressed it where the medical science cannot afford a solution.

In addition to the lacunas of the two Models, Herbert (2012) summarized the other catalyzing reasons for the adoption of this model as:

> changing patterns in the distribution of mental health problem in the population including evidence that socio-economic status puts people at risk for a higher proportion of congenital abnormalities, illnesses and the emergence of new mental health problem: people in poverty, people that lack access to quality preventions and interventions, people that are exposed to additional external or lifestyle risk factors, the prevalence of mental illness related to an aging world population.

Thus, other socio-economic realities may expose PWMHP to greater degree of discrimination. The study of mental health problem and the protections of the targets shall therefore take in to account all these variables coupled with the evolution of other forms of mental health problem

and the predisposition of individuals based on the level of economic development, risk factors and access to education and health facilities (Elwan,1999).

2.4. History of Mental Health Courts

In response to the alarming rate of serious mental illness among incarcerated individuals, local communities have forged collaborations between the criminal justice and mental health communities through the establishment of mental health courts (Pelleg, 2013). Historically, there are about eleven stages in the origin and development of MHC. These include:

1. Define target population by specifying qualifying and disqualifying criteria which further help in defining the population. If we decide to start a mental health court, we will have admitted those individuals with a mental health diagnosis;
2. Determine goals and objectives of MHC Programme by developing the rationale for implementing the Court Programme which can be the basis for measuring its success;
3. Identify and contact key stakeholders and service providers for which the Court requires the presence of a comprehensive set of partners (i.e. both government agencies and community organizations with identified roles and responsibilities);
4. Conduct needs assessment or gap analysis based on some generalizations about the potential client group;
5. Develop eligibility criteria which can assist in determining group of clients to be served in the Programme;
6. Review existing literature on different aspects of MHC;
7. Conduct an environmental scan to identify and address internal and external supports and oppositions which are critical for long-term sustainability of the Programme;
8. Develop the comprehensive MHC Programme;
9. Determine resource capacity and needs;
10. Decide on how the Programme Administration will be handled; and
11. Develop an evaluation plan (evaluation) to decide on how the MHC success can be defined and measured (Rubenstein, 2018).

Mental health courts have specialized court dockets and employ a problem-solving, collaborative model of court processing for eligible mentally ill offenders (Pelleg, 2013). It is again time to reconsider the direction of mental health care in Africa. Based on a small inquiry to a number of experienced mental health professionals in sub-Saharan Africa, we discuss what a community concept of mental health care might mean in Africa. There is a general agreement that mental health services should be integrated in primary health care. Alem, Jacobson and Hanlon (2008) re-considered of African mental health professionals perceptions of and understanding about community-based mental health care because most of the psychiatric services are concentred in urban areas like Addis Ababa, Ethiopia. Moreover, there are many variations among African countries and differing needs of rural and urban settings.

2.5. Theories of Mental Health Court

Most of the published articles on mental health courts are relatively found to lack of theory. There exists a great need for theoretical and conceptual development to expand the understanding of the complex nature of the courts (Ridgely, et al., 2007). As noted by Roman, Rossman, and Rempel (2011), the drug court model and other problem-solving courts have adapted approaches that are consistent with several prominent crime reduction theories, including: therapeutic jurisprudence, procedural justice theory, deterrence theory, and social learning theory. Now, let us describe each theory separately.

2.5.1. Therapeutic Jurisprudence

It posits that legal rules and procedures can be used to improve psychosocial outcomes. This is an idea supported by a growing research consensus that has coerced treatment as effective as voluntary treatment (Belenko, 1999).

2.5.2. Procedural Justice Theory

The Theory predicts that individuals are as concerned about fair procedures and respectful treatment by legal authorities as they are about the outcomes of their interactions with the

criminal justice system. The literature suggests that individuals' judgments of procedural fairness shapes their perceptions of the legitimacy of and satisfaction with legal authorities, which in turn influences their compliance with the law and decisions made by those in authority (Gottfredson, Kearley, et al. 2007; Tyler, 2003). Procedural effects apparently are independent of outcomes produced. Thus, individuals who perceive they have been treated fairly by the system can demonstrate better procedural outcomes (e.g., compliance with court mandates), regardless of the outcome of their case (e.g., the length of the sentence).

2.5.3. Deterrence Theory

Deterrence Theory holds that the threat or experience of a punishment for an infraction will reduce the likelihood that the infraction will be repeated. That is, actual or threatened sanctions should deter crime (Roman, Rossman, & Rempel, 2011). Additionally, there are two subtypes of Deterrence Theory, namely, general deterrence and specific deterrence. *General deterrence* holds that by increasing the probability that a particular infraction will be punished, misbehaviour will be reduced.

Specific deterrence posits that an individual's own punishment experience will affect his or her future behaviour. For all facets of deterrence, the goal is to increase expectations that infractions will be punished; expectations can be changed either by directly punishing an individual, making highly visible punishments of others, or simply by increasing individuals' beliefs that punishment will follow an infraction. Three aspects of punishment ─ perceived certainty, severity, and celerity of the possible sanctions ─ are hypothesized to affect would-be offenders' decision-making and to be correlated with offending (Gibbs, 1975). The Theory is typically regarded as involving two linkages: 1) **a perceptual link**, where potential offenders form perceptions about the risks of committing the crime based on information regarding sanction policy and other experiences, and 2) **a behavioural link**, where the potential offenders' perceptions of sanction risk influence their behaviour (Scheider, 2001).

There have been few direct studies of the effectiveness of deterrence on client outcomes. Marlowe, Festinger, et al. (2005b) found correlational evidence that drug court clients with higher "elevated" perceptions of deterrence had better outcomes than those with lower levels of perceived deterrence; while Gottfredson et al. (2007) report that both were effective.

2.5.4. Social Learning Theory

This Theory states that humans learn behaviours (both positive and negative) from their environment. Hence, publicly rewarding pro-social behaviours can reinforce those behaviours in group settings (Akers & Sellers, 2008). Drug courts often combine deterrence-based approaches with positive rewards for good conduct based on Social Learning Theory.

Preliminary reviews of the existing peer-reviewed MHC studies indicated that few offered acceptably identifiable theoretical frameworks. But the majority of studies relied on empirical generalizations. Instead of operating under a well-specified theoretical framework, mental health courts seem to function generally under the guiding principle of therapeutic jurisprudence (Rottman & Casey, 1999). Similar to drug courts, the basic premise underlying therapeutic jurisprudence is that laws can be either therapeutic or anti-therapeutic. Accordingly, some laws have the potential to be helpful or unhelpful to defendants and sometimes even harmful. A commitment to therapeutic jurisprudence means that the courts will try to ensure that laws are, to the extent possible, fostering the most positive therapeutic outcome (Casey, & Rottman, 2000).

The goal of therapeutic jurisprudence is to produce the most constructive therapeutic outcome not only for the client, but also for the client's family and for the community and society at large. TJ requires that professionals from all disciplines collaborate and be sensitive to the possible outcomes of legal procedures and decisions (Madden & Wayne, 2003). Generally, the therapeutic jurisprudence philosophy is helpful in understanding mental health courts, but does little to reliably predict future outcomes.

2.6. Criminal Responsibility of Mentally Disordered Individual

The term of criminalization of the mentally ill was first used by Marc Abramson in 1972. Abramson was a California psychiatrist employed in the criminal justice system who saw the passage of new mental health law as an unintended consequence of deinstitutionalization. Once individuals were released into the communities, they drew attention to themselves through such crimes as public drunkenness, disorderly conduct, or malicious mischief. After the initial introduction to the criminal justice system, these mentally ill individuals never seemed to break the cycle of incarceration. It became increasingly difficult for hospitals to admit mentally ill individuals for more than a 72- hour stabilization period. Jails and prisons did not have the resources to deal with this increasing population.

Prior to 1976, research focusing on the mentally ill population in prisons and jails was non-existent. The first study that examined this issue was the Bolton Study in California in 1976 (Lamb & Weinberger, 2005). Therefore, it is unclear whether or not deinstitutionalization led to an increase in the prison and jail population of mentally ill offenders. While the decreasing numbers of patients in mental health facilities is documented, there is no way to definitively know if more of the mentally ill population was being funnelled through the criminal justice system.

While no empirical evidence exists to show that more mentally ill individuals are incarcerated today than before deinstitutionalization, numerous studies have found evidence to suggest that the mentally ills are being funnelled through the criminal justice system at a rate higher than the general population causing an increase in mentally ill offenders in jails and prisons (Lamb & Weinberger, 2005). Teplin (1983) identified three factors that relate to the criminalization of the mentally ill: an overall increase in the number of mentally ill individuals living in communities, the manner in which police handle situations involving the mentally ill, and the refusal of service to mentally ill patients by mental health facilities.

Besides showing that the person committed the unlawful act, a mental component must be satisfied. The mental component is referred to as the mensrea, meaning 'intention to do wrong'. This intention must be established for most findings of criminal responsibility. The importance of mensrea is obvious. If an accused person is suffering from a mental disorder which deprives them of reason and understanding, the mensrea necessary for criminal responsibility may be lacking. If an individual lacks the capacity for choice or voluntary action, it follows that (under the law); he or she should not be held responsible for performing a criminal act (Bulletin, 1998).

Johnston (2012) also examined the two justifications for the establishment of mental health courts - therapeutic jurisprudence and narrow form of rehabilitation. Therapeutic jurisprudence is inadequate to justify mental health courts because of its inability to resolve significant normative conflict. In essence, mental health courts express values fundamentally at odds with those underlying the traditional criminal justice system. - a form of therapeutic or medical rehabilitation. Quoting several authors (e.g. Maxwell, 2013), the same author continued,

> As therapeutic rehabilitation which gained prominence in the mid-twentieth century, it is based on a medical model of crime. According to this theory, criminal behaviour is symptomatic of mental illness or personality disorder. In essence, offenders are considered 'sick' and in need of a state-coerced 'cure' to address their underlying sources of criminality. Therapeutic rehabilitation also holds that treatment is necessary to transform criminals, whose acts are the product of pathology; into law-abiding individuals.

Mental health court proponents appear to embrace a brand of therapeutic rehabilitation based on two propositions. First, mental health courts justify segregating and diverting individuals with mental illnesses from the traditional justice system on the basis that their illnesses likely contributed to their criminal behaviour. Second, mental health courts operate under the assumption that the improvement of mental illness symptoms will reduce the likelihood of future criminal behaviour. In other words, by treating individuals' mental illnesses, mental health courts will rehabilitate offenders into law-abiding citizens. Implicitly, the two theoretical assumptions underpinning the mental health courts are found to be insufficient.

2.7. Social Work and Mental Health Problem

Professional social workers assist individuals, groups, or communities to restore or enhance their capacity for social functioning, while creating societal conditions favourable to their goals. The practice of social work requires knowledge of human development and behaviour, of social, economic and cultural institutions, and of the interaction of all these factors. Social workers help people overcome some of life's most difficult challenges: poverty, discrimination, abuse, addiction, physical illness, divorce, loss, unemployment, educational problems, disability, and mental illness. They help prevent crises and counsel individuals, families, and communities to cope more effectively with the stresses of everyday life (NASW, 2004)

Social worker uses the Bio-Psychosocial Approach. "Social work's Bio- Psychosocial Approach provides a carefully balanced perspective, which takes into account the entire person in his or her environment and helps social workers in screening and assessing the needs of an individual from a multidimensional point of view" (Berkman & Volland, 1997, p. 143). The Approach also considers three overlapping aspects of the patient's functioning: "bio" refers to the biological and medical aspects of the patient's health and wellbeing; "psycho" refers to the patient's self-worth, self-esteem, and emotional resources as they relate to the medical condition; and "social" refers to the social environment that surrounds and influences the patient. It behooves the social worker to assess each of these domains to gain a full understanding of the patient (Rock, 2002). This view of practice is also referred to as a holistic view because it seeks to encompass the whole picture of the individual and places the individual in a context that informs social work intervention.

Social workers are positioned to offer therapeutic intervention and work toward educating the patient and family about medication compliance, making efforts to reassure the patient, and developing a discharge plan that will enable the patient to be cared for in an outpatient facility or day treatment programme. As in the other units in the hospital, there is the mandate to stabilize the patient and arrange for a safe and carefully planned discharge in the shortest amount of time.

Social workers are part of a multidisciplinary team, consisting of nurses, psychiatrists, and psychologists, to facilitate inpatient care and discharge (Beder, 2000, p. 158).

In direct work with patients, the social worker employs the basic philosophy of psychiatric rehabilitation to teach people with serious mental illness the skills needed to function as normally as possible in the community. The goal is to increase community functioning, reduce the effect of psychiatric symptoms, and enable the mentally ill person (the consumer) to remain functional out of the hospital. The orientation to the work is grounded in the beliefs of empowerment, competence, and recovery. The principle of empowerment encourages consumers (patients) to actively manage their psychiatric symptoms, to make choices about their treatment, and to develop a positive sense of self. A focus on competence moves the focus away from symptoms to abilities, helping people build on their existing strengths and skills, rather than stressing symptoms and deviance. The focus on recovery suggests a positive goal in place of a negative one. Rather than attempting to reduce the risk of relapse, recovery is seen as moving people to fulfilling personal goals, reinforcing that there is life after hospitalization and beyond psychiatric diagnosis. During recovery, while acknowledging the variable course of mental illness, social workers shift the emphasis of intervention toward a mindset of possibility and capability (Carpenter, 2002; Stromwall & Hurdle, 2003; Turney & Conway, 2000).

Working with families is another vital social work role in the mental health arena. Aviram (2002) commented that the families need more information on the different aspects of mental illnesses. They ask for information about how best to manage the patient; they seek training and guidance on how best to deal with the burden of care of the mentally ill family member. They need help identifying and accessing community resources for their family members and themselves and want support and direction on how to advocate for their family member with mental illness. The same philosophical orientation to service is employed with families, stressing management, empowerment, and building on the strengths of the family system and resources (Beder, 2000, p. 159).

2.8. Conceptualization of Mental Health Court

A mental health court is a specialized court docket for certain defendants with mental illnesses that substitute a problem-solving model for traditional criminal court processing. Participants are identified through mental health screening and assessments and voluntarily participate in a judicially supervised treatment plan developed jointly by a team of court staff and mental health professionals. Incentives reward adherence to the treatment plan or other court conditions, non-adherence may be sanctioned, and success or graduation is defined according to predetermined criteria. Participants are under Australian Criminal Law (in most cases) for a person to be considered to have committed a criminal offence; there are several criteria which must be met identified through mental health screening and assessments and voluntarily participate in a judicially supervised treatment plan developed jointly by a team of court staff and mental health professionals.

Mental health courts have been established to help meet the treatment needs of the mentally ill offender. If mentally ill offenders commit crimes because of their mental illness, then by treating [them], society may benefit through reduced recidivism and improvements in social outcomes (Mears, 2004, p. 258). Mental health courts serve a significant role within this collection of responses to the disproportionate number of people with mental illnesses in the justice system. Like drug courts and other "problem-solving courts," after which they are modelled, mental health courts move beyond the criminal court's traditional focus on case processing to address the root causes of behaviours that bring people before the court. They work to improve outcomes for all parties, including individuals charged with crimes, victims, and communities.

Mental health courts represent a response to the influx of people with mental illnesses into the criminal justice system. They seek to use the authority of the court to encourage defendants with mental illnesses to engage in treatment and to adhere to medication regimens to avoid violating conditions of supervision or committing new crimes. Unlike some programmes that divert individuals from the justice system and merely refer them to community service providers; mental health courts can mandate adherence to the treatment services prescribed, and the

prospect of having charges reduced or dismissed provides participants with additional incentives. Communities start mental health courts with the hope that effective treatment will prevent participants' future involvement in the criminal justice system and will better serve both the individual and the community than does traditional criminal case processing.

2.9. Development of Mental Health Court: Overview

In Western Europe and North America, there was a deinstitutionalization movement in the latter half of the twentieth century. The purpose of deinstitutionalization was to give greater autonomy for adults that are affected by serious mental illness. In the contrary, this movement did not change the quality of life of these individuals; rather it would result in marginalization, homelessness, unemployment and engagement in criminal activities. As a result of deinstitutionalization movement, many mental healthcare institutions were underfunded and availability of mental healthcare services became scarce and even difficult to access. However, the fact that the number of mental healthcare institutions decreased did not lessen the number of persons that needs the treatment. The increased number of persons with mental disability in the society resulted in involvement of the group in to criminal justice system. Due to this, in USA, the prevalence of inmates with serious mental illness in jail ranges from 7-16 %.It rates four times in men and eight times in women than found in the general population. Other study indicated that half of the inmates with mental illness were reported for three or more prior offences.

The first mental health court was founded by the work of Mental Health Task Force that was established in 1994, as Wessel the idea of MHC came into picture in 1994 in Toronto in Canada. The first MHC in the United States was thus established in Broward Country of the Florida State in 1997 (Goldkamp & Irons-Guynn, 2000). In 1999, the Los Angeles county jail and New York Ricker Island jail were reported to accommodate more mentally ill persons than the largest psychiatrist institution in USA. It is this predicament that caused the establishment of MHC in United States. The main agenda of MHCs was to curb the root cause of criminality. MHC was

established with the assumption that, treatment of participants of crime reduces number of crimes and benefits the individual and the community in general. The idea of MHCs is derived from problem solving courts. Problem solving courts include drug courts, community courts, domestic violence courts, reentry courts and prostitution courts. These courts have been established with the purpose of addressing the underlying cause that leads to involvement in the criminal justice system.

Since then, the number of MHC has been increasing from time to time in Canada. Likewise, the idea of MHC has been expanded in different jurisdictions in US since the first court has been established. These courts would offer treatment than punishment.

The philosophy of the mental health courts was derived from the principle of therapeutic jurisprudence. Its principle advocates that the justice system should deal with the main cause that makes a person to interact with the criminal system (Greville, 2016). Sometimes, the problem of mentally accused persons can be solved by treatment rather than criminal penalties. It is based on this idea that these Courts focus on treatment, housing, substance addictions, job training and other matters than traditional crime systems (such as fines, jail, and probation). From the time MHC established, there is no standardized definition for these courts worldwide. That is, because of diversity in working procedures, charge accepted, targeted population, types of treatment available and intensity of supervision; it is difficult to reach on standardized definition.

However, there are common characteristics that are shared by all mental health courts. These include: caseload size, point of entry (i.e. It can be using either the Pre-adjudication Model or Post-adjudication Model), eligibility criteria (i.e. clinical eligibility and legal eligibility), philosophies on the role of mental illness must play), screening (i.e. how mental health courts determine individuals' mental health needs and how comprehensive their screening measures are detecting and identifying mental health problems, programme staffing and services (i.e. how mental health court team is constructed [e.g. rotating versus dedicated attorneys, internal versus external treatment and case management] and forms of treatment) (Almquist & Dodd, 2009),

supervision and monitoring (i.e. different forms of supervision of clients in MHC Programme and court monitoring), sanctioning (i.e. the practice of a variety of sanctions – punishments and rewards if the offenders with mental illnesses who are participating in MHC Programme are non-complaints with its requirements), and programme completion (i.e. failure in completing MHC Programme requirements) (Redlich et al., 2010).

In addition, there are key elements of such courts. The following are some defining features of mental health courts:

- Serve defendants with mental illness (i.e. provide diversion for justice-involved individuals with mental health problems);
- Involve stakeholders from multiple fields (i.e. involve stakeholders from the criminal justice, mental health, substance abuse, and related fields during the planning stages and administration);
- Voluntary and informed participation (require informed consent to participate from defendants);
- Link participants to community-based services (identify appropriate mental health (treatment options in the community and coordinate entry into these services [typically achieved through case management services]);
- Monitor treatment compliance (use court setting to monitor treatment compliance; track participation in treatment through regular meetings with defendants and communication with treatment providers);
- Use of sanctions and incentives (use sanctions and incentives to encourage treatment engagement and court compliance); and
- Therapeutic jurisprudence (rely on the principles of therapeutic jurisprudence to view the court as a potentially therapeutic experience (Almquist & Dogg, 2009; Thompson, Osher, & Tomasini-Joshi, 2008).

As previously mentioned, characteristics of mental health courts vary across jurisdictions with regard to a number of key court elements. These are: size, entry point, eligibility criteria,

screening, programme staffing and services, supervision and monitoring, sanctioning, and programme completion, and even philosophies on the role of mental health court.

2.10. International Mental Health Court Process

Just as the Mental Health Act states definitions of mental illness and mentally disordered persons in relation to criminal matters in the Local Courts, the Mental Health (Criminal Procedure) Act 1990 sets out procedures for dealing with mentally ill offenders in the Local Courts. The vast majority of criminal matters are heard in the NSW Local Courts, where there is no statutory defense of mental illness and although, in theory, the common law M'Naghten defense may still be raised, the magistrate is more likely to rely on the diversionary powers under the Mental Health (Criminal Procedure) Act. This Act has two sections that specify the conditions under which a magistrate can dismiss criminal matters due to the mental condition of the defendant. Section 33 of the Act applies to mentally ill persons, and s32 refers to defendants with a developmental disability and defendants with a mental illness or condition who do not fall under the definition of a mentally ill person. Under s33, a magistrate can order the defendant to be taken to hospital for an assessment and then, if the defendant is found not to be mentally ill, the matter is taken back to court to be heard. If the defendant appears to be a mentally ill person (within the meaning of the Mental Health Act), the magistrate has the power to discharge the defendant, with or without conditions, into the care of a responsible person.

If, after six months, the person is not brought back before the magistrate to deal with the charge, the charge is taken to have been dismissed. Section 32 states that Local Court magistrates have powers for dealing with defendants who have a developmental disability. Under this section, a magistrate can dismiss the charges against such a defendant and discharge the person (with or without conditions). For persons dismissed under s32 or s33, the fact that the charges have been dismissed does not constitute a finding that the charges against the defendant are proven or otherwise.

Mental health courts attempt to address issues associated with mental illness during the trial period. Jail sentences may be reduced or deferred and, in some cases, the charges against the defendant may be dropped. Mental health courts only deal with offenders that have mental disorders and the court officials are typically trained to handle these types of cases. These courts can differ in how they handle cases involving mentally ill defendants. In general, the mental health court tries to assess competency, find appropriate resources for the client, arrange treatment during incarceration if the defendant is sentenced, and link the individual with resources upon release (Watson et al., 2001, p. 478).

2.11. Mental Health Court in Ethiopia

In Ethiopia, the National Health Strategy shows that there are insufficient number of psychiatric units, beds, and mental health professionals. The country has only one psychiatric hospital where other general hospitals and private clinics have psychiatric units alone. Moreover, the number of mental health professionals in Ethiopia is inadequate to give service to 110 million people. There are only 40 psychiatric doctors in Ethiopia. Disaggregated by city administration and region; 30 psychiatric doctors in Addis Ababa and 10 in regions, and 461 psychiatric nurses and 120 in regions and the remaining in Addis Ababa. In addition, 14 psychologists were engaged in clinical services working in Addis Ababa, and 3 social workers were also working in Addis Ababa (FMoH, 2006). From these statistics, it can be inferred that there is shortage of mental health facilities and trained man power in Ethiopia. Hence, mentally ill persons cannot easily get access to treatment. In a society where there is insufficient mental health facility and trained man power, it is very likely that the number of mentally disabled persons increase. As the number of mentally disabled person increases, there is a high probability of increase in criminal activity. This is because untreated mental illness is the main cause that leads mentally disabled persons in to criminal act.

Mentally disabled persons that are already involved in criminal activity have difficulty of getting speedy justice. That is, when mentally disabled persons are involved in criminal activity and raise defence of criminal irresponsibility, the Court will send their case to Ammanuel Hospital

for examination of their mental condition in accordance with Article 51 of the Ethiopian Criminal Code. Once their cases are sent to Ammanuel Hospital in Addis Ababa getting examination result is a daunting task. It might take a minimum of one year. This is due to the imbalance between a few psychiatric doctors at service and the huge number of patients that seek hospitalization service. This situation causes delayed services whereby persons are denied their rights to liberty. It is to bridge the aforementioned gaps that an MHC was established in Ethiopia.

2.12. Social Workers Role and Interdisciplinary Collaboration in the MHC

Social work with its dual interest in "person changing" and "context- changing" intervention can and should play a significant role in responding to individual with mental health problem. Social workers are needed to view the wide range of possible effects of being mentally ill and social life of the mentally ill person and his family's psychology and provide a range of crisis and clinical interventions designed to minimize the immediate and the long-term effects of such a health problem.

Social workers are also needed to insure that other professional groups provide the necessary services to the individuals having mental health problems and families. These services are provided in a manner which does not further traumatize those who have been already victim of psycho-social problem. Besides, social workers should also advocate for the creation of special programmes for the mentally ill person (Conte & Shore, 1982). Accordingly, the NASW Code of Ethics (2009) confirms the essence of interdisciplinary collaboration and the need for encouraging social workers to participate in interdisciplinary team by drawing on the perspectives, values and experiences of the social work profession. An important key to cope with the court process thus comes into view as understanding how the system works and what roles the court participants can play (Davis, 2007).

On the issue of social workers' competence of working with sexually abused children and their interdisciplinary relation in protecting the person who is attach with mental health problem.

Different studies have been conducted in different contexts. A participant observation study conducted by (Berliner & Stevens, 1982) on social work practice with offenders having mental health problem in USA concluded in that; though many social workers existed in mental health courts, yet social workers has done a poor job of even acknowledging the problem of mental health problem. By alleging the fact that social work need to educate itself to learn the facts about mental health problem, and its outcomes; the profession can take more responsibility for advocating for the mentally ill offender and the family in the court system. However, the current study concluded social workers competence only based on the experience of the researcher in a context specific manner.

The professional relationships among social workers, prosecutors and judicial officers in the mental health court system are an issue of persistent concern for mentally ill persons' welfare agencies and the courts. Evidence of difficult relationships among social work and legal professionals in the court system can be found in studies conducted over 30 years ago (Fogelson, 1970). In spite of the prominence and persistence of tensions between the practitioners and court-related personnel, there has been little empirical study of professional relationships in the court system (Han, Caroche, & Austin, 2002).

Nonetheless, some studies have been conducted to explore the interaction between social workers and legal professions, as collaboration is necessary for delivery of services to offenders with mental health problem within the court system (Paul, 2004; Kisthardt, 2005). An exploratory study was conducted by (Carnochan, et.al 2001, p. 490) to promote the collaboration between legal and social work professionals. This study found out that social workers reported experiencing difficult relationships in the court much more frequently when compared to judges, attorneys and prosecutors. Such findings are also revealed by some researchers like (Kistahrdt, 2005; Seeling, 2008).

On the same issue of concern, another study conducted by Han, Carnochan, and Austin (2002) in seven North Californian counties disclosed that social workers' response on collaboration with

legal professionals is that; there is a high tension between social workers and legal professionals in handling cases of mentally ill offenders. The major factors stated arises from language use difference, communication gap, lack of knowledge of the legal process on the side of social workers' and lack of knowledge of the social workers ethics, and handling procedure on the side of legal professionals. This is also confirmed by Herring (1993), as the author states that social workers are usually not trained in the adversarial process, and may not be comfortable with. Similarly, legal officers may be unaccustomed to sharing responsibilities and information as is common in social work, role confusion, and lack of trainings on handling individual having mental problem.

Though literature concerning the roles and involvement of social workers within interdisciplinary team of court settings are plenty enough, but none has been done in Ethiopia. This gap in the literature can be attributed to the recent start of mental health bench and the development of social work profession in Ethiopia. Therefore, this study opts to explore the overall court process and the social workers role along with their involvement with legal professionals in handling the case of offenders having mental health problem in court settings.

2.13. International Legal Instrument on the Right of Persons with Mental Disabilities

Persons with mental disabilities may receive additional human rights protection from four other human rights treaties. These are CAT, CRC, CEDAW, and CERD. In some instances, these conventions give better protection to persons with mental disabilities than ICCPR and ICESCR. In addition, the conventions have binding effect on signatories besides they have committee which oversees the implementation of the convention by state parties. There are specific provisions in the right of children with mental disability under CRC; Article 23 recognizes that children with mental or physical disabilities have the right to enjoy a full and decent life in conditions that ensure dignity, promote self-reliance, and facilitate the child's active participation in the community. Article 25 further recognizes the right to periodic review of treatment

provided to children who are placed in institutions for the care, protection or treatment of physical or mental health. Article 27 recognizes the right of every child to a standard of living adequate for the child's physical, mental, spiritual, moral and social development. Article 32 recognizes the right of children to be protected from performing any work that is likely to be hazardous or to interfere with their education, or to be harmful to their health or physical, mental spiritual, moral or social development.

The CAT Convention is important tool in the protection of the rights of persons with mental disabilities. The Convention also protects persons with mental disabilities from torture inhuman and degrading treatment. Besides, protection is made under CEDAW and CERD to persons with mental disabilities.

2.13.1. UN Principles for Protection of Persons with Mental Illness and Improvement of Mental Healthcare: MI principles

These principles were adopted by the General Assembly in 1991. The principles are applied to persons with mental disabilities whether they are in psychiatric institution or outside the institution. They are also applicable to persons who are admitted to mental health facility irrespective of their mental health condition in other words whether they have mental disorder or not. MI Principles consist of the most direct human rights in the context of mental illness to date issued by UN. International monitoring bodies have used MI Principles as an authoritative interpretation of international conventions such as ICESCR on mental health. The MI Principles are framework for the development of mental health legislations of different countries such as Austria, Hungary Mexico and Portugal. These countries have incorporated MI Principles in their domestic legislations in whole or in part. The Principle begins by enunciating fundamental rights and freedoms (such as respect for inherent dignity, protection from exploitation, physical or other abuse, non-discrimination, and the right to exercise all rights that are found under International Bill of Human Rights).

The MI Principles furthermore recognize the inherent difficulties of protecting human rights in institutions by noting that care should (when possible) be administered in the community. The duty to treat patients in the least restrictive environment and to maintain and improve their autonomy reinforces this preference for community care. Therefore, MI Principle has influenced the legislations of different countries on the right of persons with mental disabilities.

2.13.2. UN Convention on Right of Persons with Disabilities (CRPD)

It is the most recent and extensive human right instrument that specifically recognizes the right of persons with disability. It is designed to providing international standard for persons with disability that will be binding on any country that commits to it. The Convention covered from specific right to equal recognition of persons with disabilities up to obligation of states to protect and promote full enjoyment of fundamental rights and freedoms of persons with disabilities without discrimination with others.

The Convention has also covered civil and political rights. Some of these rights are the right to life, the right to recognition as person everywhere, their right to be free from torture inhuman and degrading treatment, the right to respect for physical and mental integrity, freedom of expression and opinion right to liberty and security of person, etc. Similarly social, economic and cultural rights are covered under the Covenant. Some of these rights are right to education, right to health, right to work; right to adequate standard of life, etc. The Convention also addresses the specific rights of groups such as women and children. States are generally expected to ensure enjoyment of these rights by persons with disabilities on equal footing with others.

2.14. Legislations on Persons with Mental Disability in Ethiopia

In a dispersed approach, there is no separate mental health legislation mental health issues are inserted into different relevant laws. Dispersed mental health legislations have the advantage of avoiding stigma and discrimination of persons with mental disability. Additionally, they create good opportunity for better protection of the rights of mentally disabled persons because the law

exists in the law which benefits the wider public. Contrarily, the main disadvantage of dispersed mental health legislation is that they are unable to cover all matters that are relevant to persons with mental disability. Moreover, more legislative time is necessary because of the need for multiple amendments to existing laws.

It is a recent history that Ethiopia has adopted the First National Mental Health Strategy in 2012. Before the adoption of the Strategy, Ethiopia has scattered laws that deal with mentally disabled persons (such as FDRE Constitution, Criminal Code, Civil Code, Criminal Procedure Code and a Proclamation). From these approaches, it is possible to argue that Ethiopia follows dispersed approach for the fact that the laws concerning persons with mental disability is scattered in different laws. The main disadvantage of dispersed approach is its difficulty in ensuring coverage of all legislative matters of relevance to persons with mental disorders and that it takes the time of the legislator in case where amendment is needed. In the following section; the issue of mentally disabled persons under FDRE Constitution, Criminal code, CPC, Civil Code and a proclamation will be discussed.

2.14.1 Right of Persons with Mental Disability under FDRE Constitution

Under FDRE Constitution of 1995, one-third of its provisions are fundamental rights and freedoms. The Constitution's founding principle states that human rights and freedoms, emanating from the nature of mankind are inviolable and inalienable. Moreover, Article 25 of the Constitution provides that "every person is equal before the law and entitled to equal protection of the law. Accordingly, no discrimination based on race, sex, ethnic background, colour or other status." Under this Constitutional provision, there is no specific reference to discrimination based on disability but the term 'other status' includes disability. Hence, persons with mental disability are equal with any other person and entitled to equal protection of the law.

In addition, Article 41(5) in the Ethiopian Constitution provides that "the state shall within available means allocate resources to provide rehabilitation and assistance to the physically and mentally disabled, the aged, and to children without parents or guardian". As per this provision,

the state is bounded to give special attention to mentally disabled persons within the available resource. The state is under obligation to rehabilitate and assist mentally disabled persons.

Furthermore, the Constitution provides for the status of international human rights instruments ratified by Ethiopia. Accordingly, Article 9(4) provides that "international agreements ratified by Ethiopia are an integral part of the law of the land." As per wording of this Article, international agreements ratified by Ethiopia are considered as part of the law of the land. Moreover, Article 13(2) of the Constitution provides that "fundamental rights and freedoms specified in this chapter shall be interpreted in a manner conforming to the principles of UDHR and international instruments adopted by Ethiopia."

Ethiopia has ratified different human right instruments at different times. These are: ICCPR, ICESCR, CERD, CEDAW, CRC, CAT, and CRPD. Since these international human right instruments are ratified by Ethiopia as per the wording of Article 9(4), they are integral part of the law of the land. Therefore, the provisions of the instruments are applicable in Ethiopia. Further, fundamental rights and freedoms that are situated under chapter three of the FDRE Constitution shall be interpreted in accordance with spirit of these international human rights instruments.

2.14.2. Mental Disability under FDRE Criminal Code

In Ethiopia, criminal responsibility is covered under Article 48 of the Criminal Code. According to Article 48(1), a person can be held criminally liable if and only if he/she is responsible. Article 48(2) provides that "a person is not responsible for his acts under the law when, owing to age, illness, abnormal delay in his development, deterioration of his mental faculties, one of the causes specified under Article 49 sub article 1 or any other similar biological cause, he was incapable at the time of his act, of understanding the nature or consequences of his act, or of regulating his conduct according to such understanding.

In addition, there is Article 49 of the Criminal Code on partial or limited responsibility. A person is said to be partially responsible if he/she is in a condition of partially understanding the nature and consequence of his act and incapable of regulating his conduct in accordance with such understanding because of the causes specified under Article 48(2) or derangement or an abnormal or deficient condition or any other similar biological cause at the time of commission of the crime. In such case, the person shall be partially liable to the punishment specified for the committed crime. The court shall determine sentence in accordance with Article180. Additionally, the Court may order appropriate measure in decisions that is responsibility and irresponsibility in accordance with Articles 129-133 of the Criminal Code.

2.14.3. Mental Disability under 1960 Civil Code

Under the Ethiopian Civil Code on capacity of physical persons, all persons are presumed to be capable of entering in to juridical acts. But this presumption can be rebutted if evidence to the contrary is produced by the party alleging in capacity. Hence, in the Civil Code, there are grounds of incapacity; minority, notorious insanity, apparent infirmity, judicial interdiction and legal interdiction. The main purpose of incapacity is protecting these groups of persons from others who want to take advantage of their inexperience and their inferior judgment. Persons with mental disability are protected by the Civil Code as judicially interdicted person and notoriously insane person. Judicial interdiction is the best way of protecting the interest of persons with mental disability than through notorious insanity because the latter is difficult to prove.

2.14.4 Mental Disability under Proclamation on Right to Employment of Persons with Disability Proclamation No. 568/ 2008

Proclamation on the Right of Employment of Persons with Disability is designed to protect the right of persons with disability by providing for reservation of vacancies for disabled persons. It has the objective of changing the attitude of the society towards disabled persons as incapable of performing jobs based on merit and failed to guarantee their right to reasonable accommodation

and provide for proper protection. Moreover, the Proclamation lays down simple procedural rule that enable persons with disability to prove before any judicial organ discriminations encountered in employment. Thus, this Proclamation is a very important instrument in the protection of the right of disabled persons to equal employment opportunity.

CHAPTER THREE
METHODOLOGY

3.1. Study Area

The study was conducted at the 'Lideta' Federal First Instance Court in 'Lideta' Sub City, Addis Ababa, Ethiopia. The Court is commonly referred as the 4th Criminal Bench, especially known as Mental Health Court (MHC). The Court mainly has two rooms. The first is the room in which the medical doctors held conversations with the offenders and the other room is the normal bench. The Court entertains cases from the ten sub cities of Addis Ababa because there are no other courts which are established to entertain such kinds of cases.

MHC in Ethiopia is at its infant stage. The Mental Health Court has been launched under the Federal First Instance Court Lideta Division in May 2015. The Court was established based on the mandate given to the Federal First Instance Court to found specialty court whenever needed. The Court is designated as the Federal First Instance Court Lideta Division Mental Health Court Bench (FFICLDMHCB). This Court was also founded in collaboration with Addis Ababa University, College of Health Sciences; Psychiatry Department (AAUCHSDP). According to the Memorandum of Agreement signed between FFICLD and AAUCHSDP, the Court has the duty to support the MHC by arranging and organizing places where the Court can function. AAUCHSDP has also agreed to assign a professional psychiatrist to professionally and medically examine the mental health status of the accused person. After the pilot test has been completed, the Court will be expanded to other Federal First Instance Courts. Until the pilot test ends, this Court will serve as referral Court admitting referred cases from other federal courts.

MHC in Ethiopia is at infant stage. The Court has been launched under Federal First Instance Court Lideta Division on the 8th of May 2015. The Court was established based on the mandate given to Federal First Instance Court to found specialty court whenever needed. The Court is designated as FFICLDMHCB. This Court is generally founded in collaboration with AAUCHSDP.

The accused was brought before court within 24 hours of committing crime. Up on suspicion of his or her mental condition, his or her case was transferred to MHCB immediately. The Court requested BLSH Psychiatry Department to examine the mental condition of the accused. For the reason, there is Agreement between AAUCHSPD and FFIC. The accused was examined for getting priority over the trial. The examination result was announced without undue delay. It is based on this examination result and eye witness that the public prosecutor office discontinued the charge against the accused.

The MHCB has planned to do three major activities based on the request of other referring federal courts. Firstly, the Court will ascertain whether the accused is fit to stand trial or not. The question whether the accused is fit to stand trial or not can be posed by any federal court regardless of jurisdiction of the case, as well as severity of the crime. When the question is about fitness, the Court can further inquire whether or not the unfitness is temporary or permanent. If the unfitness is temporary, then the court will request whether it needs treatment and how much time the treatment plan will take.

Secondly, the referring court can request for the examination of the accused person's criminal responsibility in accordance with Article 48 of the Criminal Code. If the accused is found to be irresponsible whether or not the accused is dangerous to the community will be assessed by the Court. Moreover, upon request the Court is empowered to verify bail right of the accused. In other words, the Court is mandated to determine the possible consequences of releasing the accused on bail. In addition, if bail right is allowed the Court can determine the conditions up on which the accused can be released. The Court should allow release on bail by taking in to consideration different circumstances. The circumstances that the Court takes in to account while granting bail in most legal provisions is danger of abscond, risk of influencing witness, gravity of the offence, detainee's behaviour, and committing of another offence can be mentioned.

Additionally, the Court shall take into consideration the bail record of the defendant, the strength of evidence and the character antecedents of the association and community ties of the defendant. The Court may deny bail if it loses confidence on the appearance of the suspected person on the trial. The Court allows release on bail based on different conditions. Mostly, the Court is authorized to use only monetary condition or non- monetary or both simultaneously.

The other important point in relation to MHC is eligibility criteria. A person can participate in the Court's treatment plan if s/he is willing; if s/he has mental illness and if the crime the person is suspected to have committed is minor offence. These criteria work only for diversion programme. In the examination of fitness to stand trial and criminal responsibility, these criteria will not be required. As stated above, diversion is possible only in the case where the accused person has committed minor offences. That is, the jurisdiction of the Court for diversion programme is only limited to the Federal First Instance Court Criminal Jurisdiction. Persons charged with serious crimes cannot generally participate in the Court's Diversion Programmes.

3.2. Research Design and Methods

3.2.1. Research Design

In order to undertake an empirical study, the researcher first has to decide on research design and methods because these further determine the subsequent steps in the research process. Research design refers to approaches to qualitative research that encompass formulating research questions and procedures for collecting and analyzing qualitative data, and reporting findings (Creswell et al., 2014). Social workers have major qualitative approaches — narrative research, case study research, life history, grounded theory, phenomenology, ethnography, interpretive practices, and participatory action research (Creswell et al., 2007) from which to opt for when they conduct a qualitative study.

Here, one may pose a question: "What criteria should govern the selection process of one approach over another? Researchers should begin their inquiry process with philosophical assumptions about the nature of reality (ontology), how they know what is known

(epistemology), the inclusion of their values (axiology), the nature in which their research emerges (methodology), and their writing structures (Creswell, 2015). Qualitative researchers use various interpretive paradigms to address these assumptions, such as positivist or post-positivist, constructivist, critical, and feminist-post-structural (Denzin & Lincoln, 2005). Accordingly, the researcher agrees with Denzin and Lincoln (2005) that qualitative writers may take stances within all these diverse interpretive paradigms. After selecting an interpretive paradigm, the researcher identifies research questions that inform the research approach or design used in qualitative research to collect and analyze the qualitative data.

These questions are open-ended, calling for views supplied by the study participants; differ depending on design type; and span the scope of questions based on individual stories to collective views told by members of an entire community. The research questions focus on understanding a single concept (Kahn, 2006).

Other factors which may inform the selection of a qualitative research design are based on considerations (such as the audiences' familiarity with one approach or another, the researchers' training and experiences with different forms of qualitative designs, and the researchers' and departments' partiality to one approach or the other. Some other factors that are involved in the selection are researchers' comfort levels with structure, writing in a more literary or scientific way and the final written "product" that the design type produces. It is the final product, the data-collection strategies, and the procedures of data analysis that most distinguish the alternative inquiry designs (Suzuki et al., 2007). Therefore, the researcher opted for qualitative phenomenology research approach in this study depending on a combination of those above-stated considered factors.

A rigorous human science is prepared to be 'soft' and reflective in its efforts to bring the range of meanings of life's phenomena to reflective awareness. The meaning of human science notions such as 'method', 'objectivity', and 'subjectivity' and 'understanding', and the meaning of 'description', 'analysis', 'interpretation', etc. are always to be understood within a certain rational

perspective (Langdridge 2007). Phenomenology is an approach to qualitative research that focuses on the commonality of a lived experience within a particular group. The fundamental goal of the approach is to arrive at a description of the nature of the particular phenomenon (Creswell, 2013). With roots in philosophy, psychology and education, phenomenology attempts to extract the most pure, untainted data and in some interpretations of the approach, bracketing is used by the researcher to document personal experiences with the subject to help remove him or herself from the process. One method of bracketing is memoing (Maxwell, 2013).

As one of the rational perspectives, phenomenology is broadly defined as a theoretical point of view advocating the study of individuals' experiences because human behaviour is determined by the phenomena of experience rather than objective; physically described reality that is external to the individual (Cohen et al., 2007). As a methodology, phenomenology is qualitative research approach. In principle, phenomenology focuses on peoples' perceptions of the world or the perception of the 'things in their appearing' (Langdridge, 2007, p.11). Additionally, phenomenology is often defined in terms of the study of phenomena as people experience them – human experience in his or her life as quoted by Slogan and Bowe (2014).

It can also be seen as a methodology or method when employed to garner meanings for individuals through the analysis of informants' language as spoken or written (Kvale & Brinkmann 2008). When using phenomenology as a methodology, there are also criteria for data collection and data analysis. As a methodology, one follows a set of tasks that require the researcher to collect data, analyze them and report on findings. The findings or the outcomes of this type of study is a collection of descriptions of meanings for individuals of their lived experiences; experiences of concepts or phenomena (Cresswell, 2014). The descriptions will usually appear as written phrases or statements that represent the meaning that a person (or a study participant) attributes to a related experience (Smith et al., 2009). Consequently, phenomenology reduces a human subject's experiences with a phenomenon to a description of its 'essence', written down, usually, and so a qualitative researcher will identify a phenomenon as an 'object' of human experience (Cresswell et al., 2007) and give voice to it.

3.2.2. Research Methods

The main purpose of this study is to explore the Court process in dealing with offenders with mental health problem at 'Lideta' Federal First Instance Court. To this end, Creswell (2019) states that qualitative research is important when we need a complex, detailed understanding of the issue(s) and this detail can only be established by talking directly with people, going to their places of work and allowing them to tell their stories using their styles of expressions. Accordingly, qualitative research methods (like in-depth interviews with case informants through probing, semi-structured interviews with key informants, non-participant observations of case processes, and documentary analyses) were employed to generate study participants' experiences at the Federal First Instance Mental Health Court. Among the available qualitative research methods, the researcher considered phenomenology.

The goal of qualitative phenomenological research is to describe a "lived experience" of a phenomenon. As this is a qualitative analysis of narrative data, methods to analyze its data must be quite different from more traditional or quantitative methods of research. Essentially, you are focused on meaning, the meaning of the experience, behaviour, narrative, etc. Phenomenological research generally views study participants as "co-researchers" and in many cases will review their analysis of the meaning of an experience with the participant or the informant as an essential step in the analysis of meaning (Waters, 2017).

Generally, as s the overall objective of the research focused on exploring the Court process on offenders having mental health problems in the Mental Health court of the 'Lideta' Federal First Instance Court. Thus, the use of such research design and methods allows for the possibility of gaining significant knowledge about the case under study (Creswell, 2014).

3.3. Study Participants and Sampling

The Federal First Instance Mental Health Court located in 'Lideta' Sub City of Addis Ababa was purposefully selected. Specifically, the study was conducted at 'Lideta' Court commonly referred as 'the 4th Criminal Bench' which treats all cases of offenders with mental health

problems referred from the ten sub cities of Addis Ababa to the Court. Participants of the study were social workers, judges, prosecutors, medical doctors, psychiatrist, as well as those social workers who were working in other benches of the 'Lideta' Court - they are professionals who know how this Bench is functioning. Moreover, the judge of the Bench, three prosecutors who open the suit against the offender and two appointed medical doctors working in collaboration with the Bench, and also families and relatives of the offenders were selected as key informants in the study.

Study participant were further selected based on purposeful non-probability sampling method. Dettalo (2008, p. 146) contends that "purposive sampling involves the use of the researcher's knowledge of the population in terms of research goals. That is, elements are selected based on the researcher's judgment that they will provide access to the desired information." In addition, "researchers can sample at the site level, at the event or process level and at the participant level" (Creswell, 2007, p. 126). Generally, there were six case informants and 11 key informants in the study.

3.4. Data Collections Tools and Procedures

Creswell (2014) stated "once the inquirer selects the site or people, decisions need to be made about the most appropriate data collection approaches." Data collection is a series of interrelated activities aimed at gathering good information to answer emerging research questions. Hence, a phenomenological qualitative study involves detailed, in-depth data collection involving multiple sources of information rich in context (Creswell, 2019). According to Yin (2003, p. 86), "data for such studies may come from interviews, documents, archival records, direct observations, and physical artefacts." Meanwhile, for the purpose of this study, the researcher employed data collection instruments such as interview guides, observation checklist, and documentary analysis matrix/template to generate relevant primary and secondary data from those respective sources.

3.4.1. In-depth Interviews – Interview Guide/Protocol

In-depth interviewing is a qualitative research technique that involves conducting intensive individual interviews with a small number of respondents to explore their perspectives on a particular idea, programme, or situation (Creswell, 2015). For example, the qualitative might ask participants, staff, and others associated with a programme about their experiences and expectations related to the programme, the thoughts they have concerning programme operations, processes, and outcomes, and about any changes they perceive in themselves as a result of their involvement in the programme. In-depth interviews are useful when you want detailed information about a person's thoughts and behaviours or want to explore new issues in depth. Interviews are often used to provide context to other data (such as outcome data), offering a more complete picture of what happened in the programme and why.

On the other hand, in-depth interviews should be used in place of focus groups if the potential participants may not be included or comfortable talking openly in a group, or when you want to distinguish individual (as opposed to group) opinions about the program. They are often used to refine questions for future surveys of a particular group (Creswell, 2014). The primary advantage of in-depth interviews is that they provide much more detailed information than what is available through other data collection methods, such as surveys.

They may also provide a more relaxed atmosphere in which to collect information — people may feel more comfortable having a conversation with you about their program as opposed to filling out a survey. However, there are a few limitations and pitfalls in this qualitative research method like prone to bias, time-intensive, lack of proper interviewing skills on the part of interviewers, and the findings cannot be generalized for the study population. Hence, in-depth interviews were used to generate qualitative data from case informants using interview guide/protocol designed for this purpose. The researcher prepared pre-determined but flexibly worded questions in the instrument. In addition to posing pre-determined questions, the researcher used the informants' responses for asking follow-up questions designed to probe more deeply in to issues of interest in the study.

3.4.2. Semi-structured Interviews – Interview Guide

Semi-structured interviews are the most commonly used data collection technique in phenomenological studies. J. W. Creswell (2019) notes that, in undertaking phenomenological interviews, the researcher must 'bracket' or set aside his or her assumptions and theories and focus instead on the research participants' points of view and their unique lived experiences. If this does not occur, the description of the participants' experiences and the overall outcomes of the research will be unsound.

The general aim in the semi-structured interviews was to see through the participants' eyes by having them explain their experiences. Accordingly, open-ended questions were prepared in interview guide which were used to orient the participant to the phenomenon being examined. Unstructured follow-up probes were used to further explore points as they arose during the interview. Every effort was made on the part of the researcher/interviewer to create a comfortable and non-threatening approach. The interviews were conducted in an emphatic and conversational style (Creswell, 2014). Therefore, the researcher and the researched must begin with a certain kind of superficially shared topic that can be verbalised in terms which both of them will recognise as a meaningful one (Walters, 2017).

In addition to responding verbally to questions, participants or key informants were invited to share about their experiences or conceptions of the phenomenon. This approach helped to put the participant at ease and allowed them time to begin to reflect about their experiences. It also allowed participants to use different channels of communication to stimulate their thinking. Participants were asked to explain what they had expressed, which enabled the researcher to probe further to attempt to understand the experiences from the participants' perspectives. Two kinds of data were generally made available through the interview questions in the interview guide: reflected understandings of the phenomenon as well as reconstructions of experiences.

3.4.3. Observation Checklist

Observation evidence is often useful in providing additional information about the topic being studied. The observation can range from formal to causal data collection activity (Yin, 2003).

Unstructured observation is more likely to be used in exploratory studies. In unstructured observation, the researcher observes behaviour and events in an endeavour to explore the situation under investigation (Alston & Bowley, 2003). Using unstructured and non-participant observation method appears crucial for this particular study to observe the Court's setting, the way on how the judge made decision in the court system as well as how social workers, medical doctors and other professionals are dealing with other legal professionals. On account of this, The above-stated authors further argue that a researcher in a study using unstructured observation may record incidents, impressions, dialogue and other important points about the research situation because of the research deign. Such a kind of observation is also known as 'non participant observation' when the observer observes as a detached emissary without any attempt on his part to experience through participation what others feel' (Cohen, Manion, & Morrison,2007). For the purpose of this study, observational checklist as a method for recording notes, portraits of the informant, the physical setting, particular events and activities was employed to observe ten Court proceedings of offenders' cases with mental health problems in the Court.

3.4.4. Documents – Documentary Analysis Template/Matrix

In the study, documents are helpful and can provide special details to corroborate information from other sources and also important to make inferences (Yin, 2003). Regarding exploring the Court process on offenders with mental health problems in the Court System, the researcher explored existing Court reports made by the judge, prosecutors and the medical doctors using documentary analyses template/matrix consisting of researchable issues along rows and potential sources of information are presented in columns.

Procedurally, getting interested in the qualitative study of the experiences of study participants who are the team members of Lideta MHC, the researcher employed phenomenology as the research method which could provide the best opportunity to 'give voice' to the participants' experiences in the study context. Herewith, examples of finding experiences in samples of the interview transcripts of that study are presented as examples of data that were properly

phenomenological in nature. In the data collection, an interview could be used to gather the participants' descriptions of their experiences, or the participants' written or oral self-reports, an observation of their behaviour, or even their aesthetic expressions. The researcher thus held in-depth interviews with case informants through probing using interview guide, and semi-structured interviews with key informants through interview guide. These study participants described their lived phenomenal experiences which could be used as relevant qualitative data in the phenomenological qualitative study.

In this phenomenological study, the researcher tried to be as non-directive as possible in her instructions. The researcher would ask participants to describe their lived experiences of the phenomenon without in any way directing or suggesting their descriptions. However, I did encourage my participants to give me full description of their experiences, including their thoughts, feelings, images, sensations, and memories - their stream of consciousness - along with a description of the situation in which the experience had occurred. Generally, the researcher may need to ask for clarification of details in the self-report or interview. If so, my follow up questions should again ask her or him for further description of the detail without suggesting what I was looking for.

3.5. Data Quality Assurance

Quality concerns play a central role throughout all steps of the research process in qualitative methods, from the inception of a research question and data collection, to the analysis and interpretation of research findings. For instance, the type of instrument or procedure to collect data may be evaluated in relation to quality criteria, and these may be different from those which are used to judge the data obtained from such instruments or procedures. All these may yet again be different from quality criteria that may apply to the qualitative analyses of data.

There were certain measures taken to eliminate threats to trustworthiness of informants and participants in the study. Firstly, it has been made sure that all the data gathered was properly documented. There were three major threats to trustworthiness in qualitative studies. These

include: reactivity, researcher's bias, and informant's bias. Reactivity refers to the potentially distorting effects of the researcher's presence on the participant's belief and behaviors (Padgett, 2008). To minimize the reactivity and informant's bias, the researcher was able to establish a good rapport to and the objectives of the study was informed to the participants properly to increase the likelihood of getting genuine information. Moreover, the participants were informed about the confidentiality of the information they provided and clearly told about the significance of their information to the successful accomplishment of this academic research. On top of that, using probing, paraphrasing, confronting and other necessary interviewing skills were the other strategies used in order to maximize the likelihood of getting genuine pieces of information.

The researcher further used triangulation of data and then collected them from different sources using various methods of data collection to insure the quality of the data. Triangulation is a useful technique when a researcher is engaged in a phenomenological qualitative study, focusing on a complex phenomenon with the use of two or more methods of data collection in the study of some aspects of human behaviour (Cohen, 2007). Besides, since the data collected or generated was mainly from different method of data collection techniques; the data was triangulated. Obviously, the strength of data collection in this study is the opportunity of using many different source of evidence (Cohen, Manion, & Morrison, 2007). Thus, the researcher in this context triangulated the evidence gained from different sources such as data collected from in-depth interviews with case informants, semi-structured interviews, observations and documentary analyses. Hence, when data triangulates, the events or facts of the cases under study become supported by more than a single source of evidence, ensuring the trustworthiness of the data collected – qualitative data quality assurance.

3.6. Data Analysis Methods

Qualitative data analysis involves organizing, accounting for and explaining the data. In short, it is making sense of data in terms of the participants' definition of the situation, noting patterns, themes, categories and regulation (Cohen, Manion, & Morrison, 2007). At practical level, qualitative research rapidly amasses huge amount of data, and early analysis reduces the problem

of data overloaded by selecting out significant features for future focus. Then for analysis purpose the researcher set out the main outlines of the phenomenon that are under investigation (Creswell, 2014).

The first principle of analysis of phenomenological data is to use an emergent strategy which allows the method of analysis to follow the nature of the data itself which may emerge or change in the course of analysis. In all cases, the focus is on a deep understanding of the meaning of the description. To get at the essential meaning of the experience, a common approach is to abstract out the themes. These are essential aspects "without which the experience would not have been the same", discovered through a thoughtful engagement with the description of the experience to understand its meaning. The meanings are usually implicit, and need to be made explicit with thematic analysis.

In a narrative, consider aspects such as the physical surroundings, the objects, the characters or aspects of the characters (e.g. their relationship), the social interactions between the different characters (or groups), the type of activity, the outcome, the descriptive elements, the time reference, and the emotions, beliefs, attitudes, plans etc. If the narrative would keep its essential meaning even when several of these aspects are changed, then those specific aspects are not part of the essential theme. Only those elements that can't be changed without losing the meaning of the narrative contribute to the essential theme. Once you have fully abstracted and presented about the essential themes of the experience (as described by your respondents); you will be able to present the unique experience in a way that is understandable (and recognizable to anyone who has had the experience).

It would also be clear how the informants' experience of the phenomenon would differ from other, similar experiences. Differences with other experiences of the same phenomenon would therefore need to be made clear in any themes analysis.

The researcher then translated those specific elements which contributed essentially to the meaning into an abstract form of the concept. Here, the researcher tried to remain congruent with the meaning of the participant's description, especially in length of time. Accordingly, the researcher would have made it clear if the experience is one that would have on the issues under investigation.

In the theme analysis, meanings do rely on socio-cultural and linguistic or artistic context; just as in everyday conversations, you must often "go beyond the words" to the context "given with" the narrative or art. However, don't over-interpret from a pre-conceived theory which might seriously alter the meaning of the experience. Phenomenological Theme Analysis would avoid that this was actually an aspect of their meaning or understanding of the experience.

Usually, there are two types of themes – collective themes and individual themes. Collective themes those that occur across a group of participants who have a similar experience and individual themes that are unique to one or a few individual participants (Creswell, 2015). However, there is notice of the presence of these individual differences. Also, as a theme analysis, the researcher could also do a content analysis of the narrative or the art.

Particularly, for analyzing the phenomenological qualitative data that would be obtained, the researcher typically began by creating and organizing files of information on those researched issues. Next, the process of a general reading and memorizing of information occurred to develop a sense of the data and to begin the process of making sense of them. In the analysis process, the researcher broke down those issues into smaller sections and units and reflections of ideas, insights, and also made comments on the data. These were noted down in memos and, indeed, these became data themselves in the process of reflexivity of the study participants.

In line with the tenets of phenomenology, the study findings are presented in such a way as to invite the readers to move away from their own personal understanding of the world to enter the 'life world' of others (Allen, 2013). Although the results could be presented in other ways, it is also possible to use the standard APA Sixth Edition Style research report to present the results of

the phenomenological qualitative study. In the next chapter, the findings of the study are presented. That is, the themes of the descriptions of the participants' experiences. Generally, the researcher labelled and defined all themes, with excerpts (i.e. direct short and/or long quotations, and paraphrased narratives that could illustrate the identified themes in the qualitative data analyses.

3.7. Ethical Considerations

Ethical concerns are necessary to this study. The researcher has to take account of individual right, for the purpose of the study, the researcher used fictitious names in order to respect the principle of confidentiality. Noaks and Emmu (2004, p. 48) suggest that "when adopting an ethical based approach researcher will routinely follow policy of non disclosure of information shared and give research participant assurances about confidentiality." "Ethical consideration should be acknowledged before the commencement of data analysis" (Alston & Bowles, 2003, p.126). The researcher initially took the written letter of introduction from the School of Social of Addis Ababa University which gave recognition to collect data. Then, the researcher took the written informed consent of the participants to get support from participants because a qualitative researcher will convey to participants about the issue of their participation in a study, explains the purpose and the objectives of the study, but does not engage in deception about the nature of the study (Creswell, 2014). Likewise, the researcher employed a fair selection procedure of research participants which also resulted in fair selection outcomes.

Ethical principles tend to focus on protecting participants from harm or in some cases on empowering those (Someleh & Cathy, 2005). These include: the need to ensure confidentiality for informants and the need to gain permission from agencies to examine client records if these are to be used for gathering information (Alston & Bowles, 2003). At the outset of data collection process, participants were sought to permission in full knowledge of the purpose of the research and the consequences for them in taking part. Thus, a written informed consent form was signed by the intended participants. Moreover, Confidentiality as embodied in the principle

of respect for person, beneficiary and justice, has been given due attention. According to Marcyzk, DeMaffer, and Festinger (2005, p. 244): "Confidentiality involves both an individual's right to have control over the case or access of his or her personal information, as well as the right to have the information that he or she shares with the research team to be kept private."
During the study process, all issues related to confidentiality were discussed with the study participants. Anonymization was also kept by using pseudonyms (e.g. Case 1, Case 2, Case 3, Case 4, Case 5, and Case 6) in reporting the data collected for this study.

In the actual data collection process, the researcher generally started with simple question and empowered them to respond the complex subsequent questions, and the researcher established rapport to the participant in a good manner and avoid emotionally caught up with their traumatic events and suffers described by the offenders. Even, the researcher was selective in the language or expression usage because inappropriate terms and language could provoke the participants.

CHAPTER FOUR
DATA ANALYSIS AND DISCUSSION

4.1. Introduction

This chapter presents study findings, their interpretations, and discussions. It also dwells on description of the study participants, actual practice of mental health court at Lideta First Instance Court, created opportunities, existing gaps, and challenges encountered with handling offenders with mental health problems suspected of committing crimes at the Court. Finally, the chapter tries to pack up those major findings and logically lead to their discussions to answer the research questions and to address the research objectives.

4.2. Description of the Study Participants

A total of 17 persons (6 case informants and 11 key informants) participated in this study. Regarding these participants, there were three social workers, three prosecutors, one lawyer, one judge, one medical doctor, an administrator at *Lideta* Federal First Instance Court, as well as an administrator from the Federal Ministry of Health in this study. Two of the social workers were females, but one of them was male who are psychologists, and sociologist, respectively. Additionally, the social workers' work experience ranged from one year to seven years. The legal professionals were five individuals composed of three prosecutors, one judge, as well as one court appointed lawyer. The legal professionals in MHC had work experience of different duration – prosecutors' work experience ranged from two to six years, the judge's work experience was 15 years, and the court appointed lawyer's work experience was three years. To triangulate these primary data collected, the researcher organized and conducted a group interview with four informants (including one social worker, one prosecutor, one judge, and one medical doctor).

4.3 Practice of Mental Health Court (MHC)

The key informants were asked about the rationales for establishing the Mental Health Court at *Lideta* Federal First Instance Court in Addis Ababa. For the following fundamental reasons, the Court was established to handle cases related to offenders with mental health problems, as the key informants stated:

> This Court was established to minimize the time taken by Ammanuel Hospital to assure the mental status of the offender while committing a crime. Previously, when the offender behaves abnormally in the court room or when he reports to the court that he is insane during interrogation by the court, the court will order Ammanuel Hospital to check whether the offender is mentally ill or not. This process will take a minimum of a year. Until the Hospital confirms the mental status of the offender, the suspect will stay in a jail. Making the offender to stay in a jail more than a year without giving him any justice is punishing him without knowing his fault. Therefore, to protect the right of the offender the solution was to work in collaboration with the medical and other professionals. As the case of the mentally ill offenders was entertained in the court where the criminal act was committed, the decision is made by different judges. This brought variety of decisions/penalties for similar case. Therefore, to minimize this disparity of decision made for mentally ill offenders, the establishment of a single court which entertains the case of mentally ill offender was needed.

Accordingly, the Mental Health Court was established to minimize the time taken by *Lideta* Federal First Instance Court to make a decision, to minimize the time taken by Ammanuel Hospital to assure the health status of the offender, and to protect the rights of the mentally ill offenders by involving different professionals such as social workers, prosecutors, lawyers, and judges. However, although there is a variation in set up, design, and practice of MHC in the world; a review of the early MHC literature reveals that the majority of studies rely on empirical generalizations. Mental Health Clinics seem to be functioning generally under the guiding principle of therapeutic jurisprudence. The laws in the world are designed to help people, sometimes they are detrimental in practice, the courts will attempt to ensure that laws, to the extent possible, foster positive therapeutic outcomes and simultaneously respect due process and other constitutional measures. The goal of the MHC is to produce the most constructive

therapeutic outcome for client, the client's family, the community, and society at large. MHC necessitates inter-disciplinary approach because it requires professionals from legal and social science disciplines (including psychiatry, psychology, criminology, and social work) to collaborate and be sensitive to the possible outcomes of legal procedures and decisions.

Mental Health Court usually employs group based approach in which there are different "team members" consisting of professionals from various fields of specialization. In this study, there have been limited numbers of group members who work with cases of offenders with mental health problems. All of the key informants assured that, "there are social workers, legal professionals, judges, prosecutors, and administrators who are working as group members at the Mental Health Court of the Federal First Instance." Nevertheless, in addition to that, there should be representatives from the defence lawyer and the district social court's office, probation/parole officers, and case managers and/or representatives from the mental health system. It is possible to argue that the group members who are handling such cases are not selected from relevant constituencies in Ethiopia.

In most countries of the world, referrals to a Mental Health Court Programme most commonly come from defence attorneys, judges, jail staff, or family members. Regarding the practice of this issue at the Court, the public prosecutors mostly make the referrals. The police officer key informants confirmed, as they uttered: "The criminalization in our country starts in the police station. When an offender with mental health problems is suspected of committing a crime, he/she is taken to the nearby police station office for interrogation by police."

There are two main types of mental health courts. These are pre-booking (or pre-charge) and post-booking. Pre-booking Programmes involve diversion before a criminal charge and the individual is diverted into mental health treatment without further criminal justice involvement. The prosecutors use discretion to determine the necessity of arrest versus the appropriateness of diversion. Conversely, Post-booking Programmes consist of three primary components: screening, assessment, and negotiation between diversion staff and criminal justice personnel to

create a mental health treatment disposition and to waive or reduce charges or time spent incarcerated.

The practice of screening the suspected offenders with mental illness is conducted during pre-charge period, but not during post-booking session. The medical doctor has to say this about the screening practice,

> The medical doctor does not engage in medical diagnosis of the suspected offenders to identify whether they are persons with mental health illness or not. A mental health problem by its nature could not be identified through laboratory or other investigation like other health problems. The physician usually asks their respective families and relatives of the offenders about how the offenders have committed crimes, whether the offenders took a medication before or not, how he/she has been behaving at home for year(s), and about the offenders' detail information about the offenders. Generally, all these are performed through observations and conducted conversations with the offenders. The mental health problem is mostly identified through observations and having conversations with them.

From the above excerpt of the semi-structured interviews conducted with the physician key informant, it is possible to deduce that there is the screening practice during pre-booking, but not that of post-booking. This indicates that the actual practice in Addis Ababa seems to be unlike the usual screening practice undertaken in those countries which have successful practice of mental health courts for offenders with mental health problems in the world. In the same vein, there were practices related to assessment and negotiation at the particular MHC Bench of *Lideta* First Instance Court in Addis Ababa, Ethiopia.

Those team members of the Court, on the other hand, were not found to practise follow-up, supervision, and monitoring using standardized indicators set for these purposes in the criminal justice system of Addis Ababa in particular, and Ethiopia in general. Therefore, it is possible to conclude that the actual practice of MHC at the Federal First Instance Court regarding cases of the offenders with mental health problems is not in line with successful practices of mental health courts elsewhere in the world.

4.4 Opportunities in MHC

The practice of Mental Health Court in different parts of the world has documented various opportunities created due to such intervention. The establishment and practice of MHC in Addis Ababa have brought certain package of opportunities not only for the Ethiopian offenders, but for others in their social networks as well. Other empirical evidence generated elsewhere in the world has created opportunities for reducing recidivism, decreasing time spent in jail, reducing the cost of diversion, shortening the time that the diversion process takes, long term success, and quality of treatment.

The findings of the study reveal that there are certain opportunistic benefits created as a result of the practice of the Court for both the offenders and the families. The lawyer and the medical doctor informants expressed,

> The offenders got the opportunities to wind up their cases rapidly. They would get the doctor in the court-room instead of waiting their turn at Ammanuel Hospital. Rarely, they may get the chance to be taken by different agencies for provision of services. When we consider that of their families, they will have easy access to the medical doctor so that they could have pieces of information about the current health status of their suspected children with mental illness. Besides, the families would get have a chance to tell the history of their respective children to the Court. Unlike the previous court system, in this Mental Health Court, the families could use these created opportunities to play their roles in informing different issues about their children to the Court – they get a forum to play their great role in the trial process.

The same key informants continued, "Sometimes, the Court by its own initiation will contact some agencies which are working on mental health problems to improve the quality of life of the offenders." Similarly, the other opportunity created by the practice is reducing the duration of trail process at the Bench as all informants asserted, "Since this Court entertains only the case of mentally ill offenders, they get a rapid justice. Additionally, they will not stay long in prison waiting for medical diagnosis results from Ammanuel Hospital because there is a medical doctor who gives suggestions about their mental status." Implicitly, the medical doctor stated that the

establishment of the Mental Health Court could promote knowledge of and skills at handling offenders with mental illness based training experience got from Canada. Thus, the opportunities created due to the MHC at the Federal First Instance Court include: reducing time elapsed for trial of the cases, creating context for close consultation and easy exchange of information about the offenders' previous histories related to their mental health conditions by their families and the medical doctor, promoting ad sharing knowledge and skills related to handling cases on mental illness, and there are instances of establishing networks and partnerships between the Court and the relevant agencies working on mental health cases in Addis Ababa.

4.5 Gaps in MHC

The empirical evidence generated by conducting in-depth interviews with case informants (i.e. Case1, Case 2, Case, 3, Case 4, Case 5, and Case 6), semi-structured interviews with key informants, and observations of the actual processes at the Court asserted that there were very wide gaps in the actual practice of MHC at the specialized Bench of *Lideta* First Instance Court in Addis Ababa. The qualitative data collected from those six case informants showed that the actual practice of handling offenders with mental illness at the Court was performed by the medical doctor's engagement in psychoanalysis techniques, together with the prosecutors and their families without professional interventions of social workers, sociologists, and psychiatrists.

Findings of the study indicated that there were a number of inter-dependent gaps in the practice of handling offenders with mental illness who were suspected of committing crime of one sort or another. Generally, the actual practice of the Court at *Lideta* was performed not based on grassroots approach in that there were no required and relevant professionals as team members in the MHC. For example, there were no district attorneys from social court in each district of the City Government of Addis Ababa, defence lawyers, and specialized psychiatrists, social workers and sociologists, according to all key informants who participated in the study.

There are knowledge gaps in the proper implementation of MHC principles and approach in the specialized Court in Addis Ababa. The medical doctor states, "Based on my experience and training in Canada as a Forensic Psychiatrist, there is very wide gap in knowledge of implementation of global mental health activities at the Bench of MHC in the Federal First Instance Court in *Lideta* Sub City of Addis Ababa."

In the process of handling the cases, there is no triangulation of evidence on mental health status of the offenders diagnosed by the medical doctor with their previous histories which might be found elsewhere in respective district clinic of their respective residence area. To substantiate this claim, the judge, the police offers, and medical doctor as key informants reflected,

> If the suspected offenders with mental illness had been treated at another health institutions or hospitals, we did not try to refer any document elsewhere in their residence areas because it takes time. We also do not ask any information or document from *Kebele* because there is no system utilized in the kebele offices. Nevertheless, the medical doctor talks to parents separately and ask them about the behaviours of the offenders and whether or not they were taken to any mental institutions to get medical diagnosis and treatment. In addition, there is no social worker or other professionals assigned for this Bench in the Court who could have done this task. Therefore, the only means to gather information about the offenders when they have no respective family is through observation and by holding conversations with the offenders.

Another gap in the Court practice is related to violation of the offenders' rights owing to one reason or another, when the judge informant argued, "This Court was established is to protect the rights of the mentally ill offender. Practically, there is a gap in protecting the rights of the offender which may emanate from single source of information regarding mental health status of the offender written by the medical doctor from his diagnosis and observation which may result in a denial of fair justice."

As to the presence of rehabilitation centre, and treatment centre in the Court, the study participants stated that there was no established rehabilitation centre where the criminal would

stay before and after the Court's decisions. The practice in the country when the suspects are incapable the Court will free them. Meanwhile, when the suspected offenders are found to be criminals, but with mental illness they will directly join their local communities without getting any medical and psychological support. Additionally, there were no treatment centre when the offenders were identified mentally ill and no facilitating organ which was put in place for this purpose.

Concerning whether or not the practice at the Court has improved quality of life of the offenders, all key informants voiced that the practice had failed in improving their quality of life. There are no well-coordinated and organized professional interventions provided to these persons at the MHC. In the same framework, the informants adduced that this failure may originate from shortage of decent setting for the operation of the Court. Furthermore, "there were no judges and prosecutors who are specialized in handling mentally ill offenders," the two group of key informants stated.

The finding of the study also confirmed that there was no awareness creation of the mental health problems among members of society. Consequently, there was no practice of registering insane persons in Ethiopia beginning from the lowest administrative unit – *kebele* and/or district. In conclusion, the established Court has not realized the objectives of its establishment in their entirety. Therefore, these gaps in the Court may contribute further to challenges encountered in the proper and effective practice at the Bench set up in the Lideta First Instance Court in Addis Ababa.

4.6 Challenges Encountered with MHC

Those practitioners in MHC have encountered with certain challenges, unlike such practices elsewhere in the world, two of the key informants encountered with a challenge while they are engaged in screening the mental health status at the Court as they stated:

> The major challenge we have encountered during interrogation session at a police station. This means he/she may not tell the MHC team members about in a proper manner using appropriate words regarding his/her suspected offence. He/ She may keep silent during the interrogation session at all or he/she will talk about another thing that has no relation with the offence he/she committed. The other challenge is when we arrest him/her; he/she will mostly cause injuries to other criminals in the prison. Some other challenge we have encountered is that when we take him/her to the Court, most of the time they are not willing to go to the setting.

From the above-stated excerpt of the key informants' views on the issues under investigation, it is possible to generate the following themes related to challenges encountered with the practice at MHC. These are: usage of improper words to express one's offence, being silent for longer time or throughout the interrogation session, being reluctant to go to the Court, and causing injuries to other criminals in the prison.

4.7. Summary

It is apparent that those themes identified in this study indicate the actual practice of MHC at the Federal First Instance Court is not comprehensive as it lacks all the requirements of the international set standards for comprehensive mental health court practice which is acceptable in most parts of the world. However, the establishment of the specialized Bench at the Court partially achieved its objectives in terms of reducing the time taken to handle cases of the offenders with mental illness and in giving due considerations. Moreover, there are certain opportunities for those individuals who are being involved in the overall process at the Mental Health court. Notwithstanding, there were gaps high lightened in the practical process which had focused on multi-dimensional issues that have been encroached up on the comprehensive requirements for setting up, design, implementation, monitoring and evaluation of MHC practice in Addis Ababa. These gaps further were found to contribute their share to the challenges encountered with the actual practice in the Court.

On the other hand, this nexus between the practice at Mental Health Court and the social work practice has practical implications for professional interventions in terms of implementing global standards developed and set for handling offenders with mental illness in a comprehensive manner.

CHAPTER FIVE
CONCLUSION, RECOMMENDATION, AND IMPLICATIONS

5.1. Conclusion

The purpose of the study was to assess Court process on offenders with mental` health problems at *Lideta* First Instance Court in Addis Ababa. It has been argued that the actual practice at Mental Health Court in *Lideta* First Instance Court in Addis Ababa is not comprehensive and lacks globally accepted standards for its establishment, creates certain limited opportunities for the offenders with mental illness, their families, and team members who participate in the process, identifies multi-dimensional gaps in the Court, reveals the existence of challenges encountered while handling cases related to the offenders with mental health problems and, thus, all these reflections have implications for social work practice at different levels in the Ethiopian society.

In Mental Health Court, decisions on those offenders with mental health problems who are suspected of committing crimes are practised in a collaborative manner. The medical doctor engages in diagnosis of the suspected offender with mental health problem through psychoanalysis technique, collection of information from his/her family, and close observation of his/her behaviour. Based on the evidence of the physician, the judge makes decision and passes sentence in an informed way.

The actual practice in this Court has involved a number of professionals who are expected to play their respective role in handling the cases. The judge, the medical doctor, the part-time forensic psychiatrist, and sometimes appearing defence lawyer have been involved in the Court process. They usually contribute relevant pieces of information to make acceptable decision on the case under investigation at the Bench in the Federal First Instance Court in Addis Ababa.

The opportunities created due to the MHC at the Federal First Instance Court include: reducing time elapsed for trial of the cases, creating context for close consultation and easy exchange of information about the offenders' previous histories related to their mental health conditions by their families and the medical doctor, promoting ad sharing knowledge and skills related to handling cases on mental illness, and there are instances of establishing networks and partnerships between the Court and the relevant agencies working on mental health cases in Addis Ababa.

There are a number of inter-dependent gaps in the practice of handling offenders with mental illness who were suspected of committing crime of one sort or another. Generally, the actual practice of the Court at *Lideta* is performed not based on grassroots approach in that there are no required and relevant professionals as team members in the MHC. There are also knowledge gaps in the proper implementation of MHC principles and approach in the specialized Court in Addis Ababa. In the process of handling the cases, there is no triangulation of evidence on mental health status of the offenders diagnosed by the medical doctor with their previous histories which might be found elsewhere in respective district clinic of their respective residence area.

Another gap in the Court practice is related to violation of the offenders' rights owing to one reason or another. Regarding rehabilitation centre in this Court, it is possible to argue that there is no established rehabilitation centre where the criminal would stay before and after the Court's decisions. The practice in the country when the suspects are incapable the Court will free them. Meanwhile, when the suspected offenders are found to be criminals, but with mental illness they will directly join their local communities without getting any medical and psychological support. Additionally, there are no treatment centre when the offenders were identified mentally ill and no facilitating organ which was put in place for this purpose.

This study further indicates that practice at the Court has failed in improving their quality of life. There are no well-coordinated and organized professional interventions provided to these

persons at the MHC. This failure may originate from shortage of decent setting for the operation of the Court, and from the shortage of judges and prosecutors who are specialized in handling mentally ill offenders.

In the same vein, there is no awareness creation of the mental health problems among members of society. Consequently, there is no a practice of registering insane persons in Ethiopia beginning from the lowest administrative unit – *kebele* and/or district. Thus, the established Court has not realized the objectives of its establishment in their entirety. Consequently, these gaps in the Court may contribute further to challenges encountered in the proper and effective practice at the Bench set up in the Lideta First Instance Court in Addis Ababa.

It is further possible to consider the following themes related to challenges encountered with the practice at MHC. These are: usage of improper words to express one's offence, being silent for longer time or throughout the interrogation session, being reluctant to go to the Court, and causing injuries to other criminals in the prison.

In the final analysis, it can be concluded that the actual practice at MHC in *Lideta* Federal First Instance Court in handling cases related to offenders with mental health problems is not comprehensive in terms of setting up it using global standards. There are shortage of specialized professionals who should be team members in the Court. However, the actual practice in MHC has created limited types of opportunities and also highlighted the existence of multi-dimensional gaps which call for interventions. Accordingly, these gaps may serve as encountered challenges in contextualized practice in the Court. Consequently, all these issues may trigger for interventions from concerned bodies at different levels because the practices, opportunities, gaps, and challenges have paramount implications for social work practice in MHC in Addis Ababa in particular, and in Ethiopia in general.

5.2. Recommendations

Based on major findings and conclusions drawn from them, the researcher would suggest the following for actions by stakeholders as a group or by each concerned body in the MHC at the Court:

- As the MHC might be capable of operating effectively to reduce recidivism among the targeted offenders with mental health problems, the Court should engage in evidence-based interventions in close collaboration with other relevant rehabilitation centres and rehabilitation programmes in the City Government of Addis Ababa.
- The supervisory role of the judge in the Court should be empirically evidence-based. Accordingly, the judge in the MHC should establish a therapeutic alliance and then apply motivational psychology in that she/he would require an extra legal skill-set to ensure that status hearings are optimally used to assist the suspected offenders to become healthier and low-abiding citizens.
- Since the key to the successes of effectiveness of MHC at the Federal First Instance Court lie in multi-faceted activities, there should be comprehensive and integrated intervention with a range of legal, medical, psychological, social, and cultural elements and friendly context-sensitive approach.
- This study used exploratory qualitative research design using a sample of small numbers of key informants and case informants. Thus, it is possible to forward further studies on MHC and suspected offenders with mental problems and their multi-dimensional aspects using exploratory sequential mixed methods research in various contexts at different levels in Ethiopia.
- Finally, meta-analytic studies of Mental Health Centres should be conducted no less than every 5 years. Systematic reviews are also one way to continually contribute to the knowledge base of MHC research.

5.3. MHC: Implications for social work practice

In this study, the researcher convincingly argued for an increased level of such content. I have noted that social workers are increasingly in contact with individuals affected by the criminal justice system. MHC links participants to community mental health treatment services, which are at least in part being provided by social workers. Social workers, serve as the primary providers of clinical services to clients with mental health needs in the community. Social workers are also members of the very task forces that develop MHC programs and also serve as members of the interdisciplinary teams that typically characterize MHC professional staff. Thus, given the fact that social workers are increasingly interacting with individuals impacted by the criminal justice system and serve the needs of this ever-expanding population, schools of social work should adapt to this evolving reality. Therefore, the fact that social workers increasingly interact with individuals affected by or who are involved with the criminal justice system may have implications for their profession.

First, the professionals felt that the greatest benefit to participants was that they are connected with services in the community. The services that this Court connects participants with include: many different kinds of social service agencies. This means that social workers at a variety of programmes have the potential to come in contact with participants of this Court. A working knowledge of this Mental Health Court and its goals and requirements would help these social workers best serve their clients and collaborate with the professionals at this Court.

Second, the professionals interviewed felt that the greatest benefit to the community was reduced recidivism/increased public safety. One of the goals of this Court is to reduce taxpayer costs associated with recidivism including prosecution, incarceration, and hospitalization. This has implications on many levels, including social work. As recidivism goes down, the cost and burden on the criminal justice and health care systems also goes down. This has the potential to free up money and resources that could then be diverted into social service programming.

Third, the interviewed professionals felt that this Court's greatest challenge for participants was the amount of work they have to do. Social workers assisting clients who are involved with this court need to be aware of the requirements and how demanding participation can be. Then, they can be better able to fill the gaps identified and to help their clients prioritize what they need to accomplish. Social workers will also create goals with their clients that are in line with what they need to do for the Court.

Finally, the professionals felt that additional resources would improve this Court for participants, for service providers, and for the community. Increasing resources would allow the agencies that work with this Court's participants to take on more clients and to potentially do more with the clients that they have. One way to increase resources would be to ensure that funders and the public are aware of what this Mental Health Court does and how it improves participants' lives.

Some other implication is that there may be a notable increase in the number of social workers interacting with clients having a history of crime, potentially violent crime. Social workers may also be working with MHC participants who perceive that they been coerced into treatment. This perception might make them reluctant to fully participate in treatment. Individuals who perceive their treatment as being involuntary may be more clinically challenging than individuals who perceive their treatment as being voluntary.

Now, more than ever, social workers are poised with the unique opportunity to become leaders in the field of forensic social work. It is recommended that social work researchers begin addressing the needs of the ballooning incarcerated population, at least half of whom have mental illnesses, substance abuse issues, and histories of abuse and trauma. Researchers in social work and social development also need to expand their focus beyond MHCs and consider alternate programming. Such a programme is also particularly reliant on social workers who must possess the skills set necessary to work within the challenging legal environment.

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APPENDICES

Appendix A: Interview Guide for Judge

1. What are the reasons for establishing the Mental Health Court?#
2. Do you think that the establishment of the Mental Health Court has met its aim(s)?
3. What is the difference between the previous court and the Mental Health Court?
4. How could you differentiate whether the offender has a mental health problem or not?
5. Did you provide the offender with a medical treatment to identify whether he has had a mental problem or not?
6. Did you try to get information about the offender other than medical treatment?
7. If the answer is yes from whom you get the information?
8. Did you see his medical history about his mental status before you give the report to the court?
9. Does all kinds of offenses handled in this bench?
10. Do you think the process which is undertaken in this court respect human rights of the mentally ill offender?
10. Does our criminal justice system provide treatment for the mentally ill offender before and after arrest?
11. Based on your perception do you think the number of criminals of mentally ill offenders decreased after the establishment of this court?
12. If the answer for no 4 is yes, what do you think the reason? Do you have any data?
13. Do you think this court has met its establishment's goal?
14. If the answer or question no 14is No what are the reasons?
15. If the answer for question no 14 is yes in what aspect?
16. What is the role of the mental health court in improving the quality of life of the offender and in preventing the re-involvement in the criminal justice system?
17. What do you suggest to prevent mentally ill persons from engaging in criminal activities?

18. Where does the offender stay until they finished the criminalization process of the mental health court?
19. What will be the decision of the mental health court if the offender is incompetent to the court process?
20. Is there any rehabilitation center in our country where the criminals stayed after the court process wind up?
21. If the answer for question no 21 is yes, mention the name of the center? What kind of criminals is recommended to join to these centers?
22. If the answer for question no 21 is No, what is the fate of the criminals with serious mental illness?
23. To what extent is the role of the families of the offenders in the mental health court?
24. What benefit do the court brought both for the families and the offender's?
25. What other services do the offender's gain from the other than the legal service?
26. How could you see the mental health court of Ethiopia compare to others country's mental health court?
27. What do you think the short comings of this court?
28. Does this court collect information about the mentally ill offender from his residence like his Kebele or his village?
29. If the answer for question No 30 is No, do you think the information gathered from the offender's family is enough to make decision?

Thank you very much for your cooperation and precious time in responding to my question

Appendix B: Interview Guide for Police Officers

1. What is the role of the police in the criminalization process of the mentally ill offender?
2. How could you differentiate whether an offender is mentally ill or not while he is in the police station?
3. Did you gather information about the mentally ill offender from his residence before you present him to the court?
4. What do you do if you got a suspect with mental health problem?

5. Did you arrest a mentally ill offender?
6. If the answer for question no 4 is yes where do you arrest them?
7. Did you have a specific jail in the police station assigned for the mentally ill offender?
8. If the answer for question no 4 is NO, so what do you do?
9. How could the mental health court works?
10. What is the criminalization process for the mentally ill offender?
11. Is there a specific bench where the case of the mentally ill offender's case is seen?
12. If the answer for no 7 is yes where is this bench located?
13. Who are the parties that involve in this bench?
14. What is the role of the police officer in this bench?
15. What kind of challenge you got when the suspect has a mental problem?
16. In what kind of crimes the mentally ill offender is mostly suspected?
17. What do you think the opportunity this bench brought for the families and the offender's?
18. Where do the offender's stays until the court process ends?
19. Is there a rehabilitation centre where the offender's stays after the decision is made by the mental health court?
20. If the answer for question no 18 is yes, can you mention the name of the center?
21. If the answer for question no 18 is No, what will be the fate of the offender?
22. What do you think the reason for the establishment of the mental health court?
23. When does this court established?
24. Do you think the establishment of mental health court has met its goal?
25. What do you think the difference between the mental health court and the previous court?

Thank you very much for your cooperation and precious time in responding to my questions!

Appendix C: Interview Guide for Medical Doctor

1. What are the reasons for establishing the Mental Health Court?
2. Do you think that the establishment of the Mental Health Court has met its aim(s)?
3. What is the difference between the previous court and the Mental Health Court?
4. How could you differentiate whether the offender has a mental health problem or not?

5. Did you provide the offender with a medical treatment to identify whether he has had a mental problem or not?
6. Did you try to get information about the offender other than medical treatment?
7. If the answer is yes from whom you get the information?
8. Did you see his medical history about his mental status before you give the report to the court?
9. Does all kinds of offenses handled in this bench?
10. Do you think the process which is undertaken in this court respect human rights of the mentally ill offender?
11. Does our criminal justice system provide treatment for the mentally ill offender before and after arrest?
12. Based on your perception do you think the number of criminals of mentally ill offenders decreased after the establishment of this court?
13. If the answer for no 4 is yes, what do you think the reason? Do you have any data?
14. Do you think this court has met its establishment's goal?
15. If the answer or question no 14is No what are the reasons?
16. If the answer for question no 14 is yes in what aspect?
17. What is the role of the mental health court in improving the quality of life of the offender and in preventing the re-involvement in the criminal justice system?
18. What do you suggest to prevent mentally ill persons from engaging in criminal activities?
19. Where do the offender's stays until they finished the criminalization process of the mental health court?
20. What will be the decision of the mental health court if the offender is incompetent to the court process?
21. Is there any rehabilitation center in our country where the criminals stayed after the court process wind up?
22. If the answer for question no 21 is yes, mention the name of the center? What kind of criminals is recommended to join to these centres?
23. If the answer for question no 21 is No, what is the fate of the criminals with serious mental illness?
24. To what extent is the role of the families of the offenders in the mental health court?
25. What benefit do the court brought both for the families and the offender's?

26. What other services do the offender's gain from the other than the legal service?
27. How could you see the mental health court of Ethiopia compare to others country's mental health court?
28. What do you think the short comings of this court?
29. Does this court collect information about the mentally ill offender from his residence like his Kebele or his village?
30. If the answer for question No 30 is No, do you think the information gathered from the offender's family is enough to make decision?

Thank you very much for your cooperation and precious time in responding to my questions!

Appendix D: Interview Guide for Case Informants

1. When did you know that your daughter /son have a mental health problem?
2. Did you take him/her to a hospital?
   2.1. If the answer for Q. No. 2 is yes, then what kind of medical care did he/she got?
3. What kinds of behaviour did he/she show when the mental problem starts?
4. At what time, did he feel sick most of the time?
5. Did he/she commit any crime before?
6. For what kind of crime, was he/she suspected?
7. Staying now in the jail or in your home?
8. Did he/she see a medical doctor in the court?
9. How many time(s) did he/she see a doctor?
10. Did your son/daughter get the service of social worker in the court?
11. How many times did he/she get the service of social worker?
12. Do you have some more opinions regarding what we have been discussing about?

Thank you very much very your time and sincere cooperation in answering my questions!

Appendix E: Observation Checklist

1. How do/ in what way the judge communicates with the mentally ill offender?
2. How does the doctor communicate with the mentally ill offender? (Prompt for within and

outside of the court room).

3. How do the families of the mentally ill offender involved in the Court process?

4. How is the Mental Health Court room setting?

5. Any difference from other court setting?

Appendix F: Description of cases in the study

Case I

My Nephew has always been suffering from mental illness. He lives with me because he has lost both his mother and father. I took him to St. Paul's Hospital for the first time in 1998 and he has been following up his treatment ever since. One day I sent him to the shop in the village and he never returned back. I was worried and I went to the shop where I sent him. the shop owner told me that he never came, I was anxious and I did not know what to do, so I returned home trying to think what to do next. Time passed by and I decided to go out and look for him. I got a call from our sub city police station and I was told to come to the station as my nephew has been arrested. I was very nervous and run to the police station. The police informed me that they suspected him that he was on a mission to attack two federal offices who were guarding a well known minister's house. The federal polices asked him what he was doing there and he told them he was trying to pick some of the trash that he saw near the guarded house. However, the policemen did not believe what he was saying so they asked him to show them his ID card. He did not take it with him so, he was not able to show them. They suspected him and took him to the station. I went back home to bring his ID card and the hospital card that I have with me. His doctor has told me that he has a hoarding problem and that this problem is one of the symptoms of his illness. So, i tried to make the police men understand that he was mentally ill. They interrogated him badly before my arrival and it took me sometime to make them believe me that he is not dangerous. I felt very sorry! They gave him a name, they called him a terrorist. The police officers told me that if I receive a court order to go to the court and testify, I should go. I said I would and they released my nephew and we went home.

Case 2

An offender named NH suspected committing a crime of rape. The suit brought by the prosecutor said that the crime was committed on 6th of September, 2017. The crime was committed in the toilet of Ammanuel Hospital at 6:00pmwhile the offender and the compliant taking medical service there.The court asks the doctor to suggest the mental status of the offender. The court room is very small. The doctor talks to the offenders and their families in a separate room. The doctor takes an hour to talk to Nuredin and reports that even if Nuredin follows medical service at Ammanuel Hospital and takes medicine, he was in normal mental

condition when he commits the crime. This means he knows the result of his ac at the commission of the crime. Therefore, the doctor suggested that he has capacity to follow the court process. Based on the doctor report the court asks the offender whether he admit or deny the suit brought up on him. The offender denies that he didn't commit the crime.The court orders the prosecutors to bring his witness. At this time the father of the offender asks permission of the court to give information about their son. After the court gives them permission his father said that his son is normal during day time. He works with his father during day time. The mental problem starts during the night time. Therefore if anyone asks him during day time he can give the proper response. Therefore, the father refuses the doctor report because the doctor talks his son during day time. The doctor responds that as he talks to Nuredin he gives proper response for every question and told to the father that he is pretending as if he is sick. The court gives another appointment to the doctor to give the offender one chance and to check him again. On another day the doctor still talks the offender during day time and responds that the offender knows what he did. During this all court process the offender was denied his bail right and stayed in jail and there is no and social worker and psychiatrist involved in the court process. On another appointment the court hears the witness of the public prosecutor and asks whether the offender brought his defending witness or not. The offender refuses to bring his defending witness. On another day the court officially confirmed that the suspect is criminal and penalize him 3 years. I tried to ask the family of the offender, they told me that they were highly angry by the court. Because the court was not offering as proper justice. They told me that their son was taking medicine for the last 3years. He is normal person during day time. He also commits the crime during the night time because he didn't know what to do. Even if they explained this case to the court no one gives them a solution.

Case 3

A woman named SA was suspected committing a crime of causing injury on government bus by throwing stone on it. As the suit of the prosecutor state the crime was commited on 2nd Feb, 2018 at 4:00Am at Kirkos sub city the specific place was named kasanches. As to me the offender looks like insane. She wear out her closes repeatedly, she insults people and through stone to people. Before the bench has started the doctor was observing her and also I got the chance to observe her with the doctor. She was asking peoples who passed around the court to buy her a braid. If they refused to give her money she insulted and throws a stone up on them. But she selects people whom she throws a stone. For instance she didn't throw a stone on police officers and on boys. She usually throws a stone on girls. After the bench starts the court orders the doctor to give his medical suggestion about SA's mental status. The doctor took the girl to a separate room. I also got the chance to see how the doctor works with the mentally ill offender. The doctor starts to ask her so many questions about her past life, whether she had a family or not, asks the place where she found right know, asks the person who bring her to the court and the reason why she came. When she responded the doctor wrote on a paper. When she gave improper answer he asked her again after a while. The doctor took 45 min to interrogate her. After a min the doctor told the court that she knows what she did. Therefore, she has capacity to follow the court process. I asked the doctor why he reported that she is a normal person because

she was not giving him the right response for the right question and also she was wearing out her clothes in front of so many peoples. He responded that she is pretending that as if she is insane but she identifies everything for example she didn't beg the police officer as well as she didn't throw him a stone because she knows the consequence if she throw a stone on a police officer. Although the crime was not grave she denied her bail right because she had no family as well as permanent residence. She didn't get the chance to see the doctor again. The court asks her whether she admits or denies the crime she is suspected. She admitted that she commits the crime. Since she commits the crime there is no need to hear witness therefore the court punish her 2 month of imprisonment. The judge told me that she is for the 3rd time to commit similar cases. She only breaks government bus. As usual there were no any involvement of social worker and psychiatrist.

Case 4

An offender named BA was suspected a crime of theft on 21Aug, 2017. The crime was committed at Nazareth at 7:00 am. Based on the claim of the prosecutor, the offender was suspected on a car theft. A woman was travelling with her husband with their own car and her husband went out of car to shop something. At this time the offender came and drives the car to Addis with the women. When he reaches to Addis he forcefully took away the car. The court as usual asks the doctor to give his suggestion about the mental status of the offender during the commission of the crime. The doctor spends 1:30 for observation and to interrogate the offender. During the interrogation the offender responds completely wrong answer for the question he was asked by the doctor. The offender's family also came to the court and brings medical evidence that assure the offender has a mental illness. The doctor asks the court another appointment to see the offender again and to look out the medical certificate. After the 2nd observation the doctor reports that the person got a mental problem called schzephornia. He didn't know the result of his act during the commission of the crime because if he was not ill he could take the car and he may sold it or he may do some other thing but after the offender took the car what he did was just driving to Addis and park the car around Lideta. Therefore according to the medical history and my observation the offender's lucks capacity to follow the court process. He got mental illness. The court adjourned the case to another day and declares that the person is free of guilty according to the Eth criminal code because the person lucks a mental element during the commission of the crime. During this all process the offender was granted his bail right and stayed with his families. There was no involvement of social worker and psychiatrist. Since there is no rehabilitation centre the doctor and the judge suggestion was just the families has to take care of their child and advised them to make their son follow psychiatrist advice by themselves.

Case 5

An offender named YS was suspected by a mobile theft. As the claim brought by the prosecutor describes the offender commits the crime on 3rd Mar, 2018 at 12:00pm around the place called *ShiroMeda*. The offender took a mobile phone while the compliant was talking with it. He was caught by peoples while he was running. As usual the doctor took the offender and spends an

hour and reported the court that the offender has a capacity to follow his case. After the doctor report the court asked the offender whether he admits or denies the crime. the offender said he has a mental problem therefore he didn't remember whether he commits the crime or not. The court asks the offender to bring a medical certificate that assures his mental problem but the offender responds that he didn't go to hospital yet. He said he came from Gamo region and his families taught that it's a curse and took him to spiritual place. After hearing these court orders the doctor to see him again but there was no any different response from the doctor. Since there is no family who came in the court denies his bail right and orders the offender to stay in a jail. On another day the court asks the offender again whether he admits or denies the crime. The offender denies the crime. After this the court orders the prosecutor to bring his witness. The witness came and gives their words. The court asks them how he acts during the commission of the crime and whether he looks like an insane or not. The witness responds that he was normal while he took the phone. He run away and caught by peoples when the compliant shouts. After the witness hearing the court asks the offender whether he can bring a defense witness or not. The offender responded that he can bring a defence witness, So that the court gives him another appointment for hearing of defence witness. The defence witness came and gives their words. The court asks them whether they know about his mental problem. The witness responded that they told them he got a stress and sometimes he go to spiritual place. They responded that the offender works *shimena* around *Shiro Meda* with them and they told to the court that they don't know about the commission of the crime. The court declares that the person is guilty of theft crime and imprisoned him 8 month and orders the prison officer to stay in a jail and to take him to Ammanuel hospital if the offender acts in abnormal condition. Still there is no psychiatrist as well as social worker involved in this process.

Case 6

A woman named By A was suspected killing of her son which is an age of 1 day. The crime was committed on 16th ,July 2018.the women lives in a street around Metekel square. As the claim of the prosecutor describes the offender gives a birth for a baby on the 15th July, 2018 at Metekel Square Street and kills her son. The court as usual asks the doctor to give his suggestion about the mental status of the offender during the commission of the crime. The doctor couldn't speak to the women since she was in a bad mental situation. She continuously shouts and attacks people who approach to her. The doctor suggested the offender to go to Ammanuel hospital and he told the court that he will treat her there and will report her status on another day. The women stayed in the hospital for 3 weeks. After 3 weeks the doctor reported the court that she got a Severe mental problem. Therefore he recommends the women have to stay in a rehabilitation centre because she could be dangerous for the community. The court adjourned the case to another day and declares that the offender is free of guilty according to the Eth criminal code because the person lucks a mental element during the commission of the crime. After the decision has been made by the court, the judge contacts *Geregeselon* mental illness centre and they took her to their centre. During this all process there was no involvement of social worker and psychiatrist support as usual.