Liaison between criminal justice and psychiatric systems: Diversion services

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The recent Vision for Change document1 published by the Mental Health Commission echoes policy in other jurisdictions in stating that “every person with serious mental health problems coming into contact with the forensic system should be afforded the right of mental healthcare in the non-forensic mental health services unless there are cogent and legal reasons why this should not be done”.

Diversion may be broadly defined as the transfer of persons with mental illness from the criminal justice system to locations where they may receive appropriate treatment. One reason for the development of diversion schemes and associated legislation in many jurisdictions has been the alarming accumulation of mental illness in prisons. A meta-analysis of 62 international surveys2 found mean prevalence rates for psychosis in prisons of 3.7%. In Ireland, the six-month prevalence rate for psychosis among male remand populations is over double this, at 7.6%3 with 4.5% actively psychotic.

Prisons are toxic and inappropriate environments in which to manage people with major mental illnesses. The mentally ill are vulnerable in such settings. Where involuntary treatment is required, this is not permissible in a prison setting. The poor conditions in prison settings have been highlighted in the wake of a recent homicide at Mountjoy prison. The right of the mentally ill to the best available healthcare in the least restrictive appropriate environment has been made clear by the United Nations and should apply to mentally disordered offenders “to the fullest extent possible”.4

It may be argued from “normalisation” principles that persons with mental illness should be dealt with in a similar fashion to the non-mentally ill, should they commit an offence, and that the law should take its course. However, persons with mental illness are likely to face greater obstacles to receiving bail, even where a minor offence has been committed. Factors generally required for bail, such as the ability to access a sum of money, provide an address and have a family member available in court are often more difficult for the mentally ill than for non-mentally ill defendants.

This group contains a small number who have committed serious crimes while the overwhelming majority have committed relatively trivial offences for which bail would normally be considered. However, minor offenders are often remanded into custody by the courts, an order being made that the person receive psychiatric treatment and that a psychiatric report be prepared. Such a report is expected to provide information regarding background history and the psychiatric treatment the defendant would receive in the community once granted bail. It is clearly preferable that any such process should be performed as expeditiously as possible.

These are typically not “new” patients, hitherto unknown to local psychiatric services. In Irish prisons, 91% of those with major depressive disorder and 66% of those with a psychosis were already known to community psychiatric services.5 Such patients are generally young, male and often socially disconnected. They are frequently homeless or have regular changes of address. They tend to have had previous contact with multiple psychiatric services and other agencies, including Probation & Welfare, Homelessness, and Addiction Services. Such patients have previously been described as akin to a “stage army”, giving the impression of greater numbers through continual movement between services.6

This may be in part related to the “three month rule” by which persons require an address for three months before many services will formally accept their care. The lack of clear guidelines regarding catchment area responsibility for this group may place a barrier to accessing services at times of greatest need since loss of accommodation is frequently a consequence of mental illness. Psychiatric services for the homeless are markedly underfunded and may not have direct access to beds. Relative underfunding of Irish health board areas has been previously demonstrated to be associated with increased use of psychiatric inpatient facilities via the prisons.6

There may be cogent and legal reasons for not returning mentally ill defendants to local services. Defendants may have committed more serious offences or may pose a risk to others such that a secure setting may be required. Sentenced prisoners and those for whom non-custodial disposals cannot be considered are appropriately diverted to forensic settings. At present the only designated centre for such diversions is the Central Mental Hospital, Dundrum. Diversion to local services is indicated where illness is severe and the offence minor, particularly where the sequelae of mental illness act as impediments to bail or other non-custodial disposal. It is inaccurate to regard diversion as a “get out of jail free card”, since diversion does not equate with discontinuation of prosecution.

The Vision for Change document also recommends that specific enabling legislation be developed to facilitate the process of court diversion. At present, diversion takes place from Irish remand centres in the absence of specific legislation, albeit at a low level. At the Irish College of Psychiatrists’
Spring Meeting, 26 such diversions recorded during 2005 were described. Of these, 85% had schizophrenia or bipolar disorder. 92% had previous recorded contact with local services, 77% in the previous year. All but three had their cases dealt with at District Courts, which deal with the least severe offence types. These patients had spent an average of 66 days on remand prior to being diverted. It is unlikely that persons who have acute psychotic illnesses will be able to benefit from the punishment model of rehabilitation. It is probable that prolonged exposure to prison will have an adverse effect on mental health. In most jurisdictions, the focus for the process of diversion is in the court, to minimize the amount of time spent in custody and accelerate assessment and access to appropriate treatment.

A number of models exist for development of court diversion services. The process typically involves screening all defendants before the court followed by interview and collateral gathering for those identified as suffering from mental illness. The relevant local service is contacted and an appropriate care plan discussed in the event of bail or other non-custodial disposal being ordered by the court. Such a care plan may involve admission if required, or a suitable plan for outpatient treatment. A report is then prepared for the court outlining treatment options in the event of custodial and non-custodial disposals.

One such model involves the development of “Mental Health Courts”. These courts aim to deal primarily with mentally disordered offenders, with appropriate clients being referred mainly by lawyers, judiciary and probation and welfare services. Mental Health Courts will also receive referrals from other courts where mental health issues are felt to be relevant. Where such courts are held on a daily basis, the service is generally operated by a clinical nurse specialist under consultant supervision. An alternative model whereby mental health courts are held less frequently, involves a multi-disciplinary team. Referrals can be made from other courts not receiving such a service directly. To operate effectively, such services involve education of legal staff about mental health issues and close liaison with local services (where court diversion is not developed by the local service itself).

While diversion services can and do operate effectively in the absence of specific legislation (most patients diverted being generally entitled to bail or other non custodial disposal), legal models in other jurisdictions could be usefully adopted in Ireland. In many jurisdictions the court can order assessment at a local hospital where admission is felt to be required, but in most locations cannot order admission. While this should be performed with the client’s consent, there will be occasions when the client’s mental state is such that they are unable to give informed consent in situations where involuntary admission is recommended. Court mandated treatment orders, involving a contract undertaken by the client to follow a treatment plan developed in consultation with local services have been shown to be effective and acceptable to both patients and local services, particularly where clients have proven difficult to engage in the past. Such orders, with the consent of the client, typically involve a commitment to attend appointments and engage with treatment for a defined period. This provides for a balance between rights and responsibilities.

Diversion services have demonstrated efficacy in early identification of mental illness, reducing time spent on remand and have been shown to be associated with improved clinical outcomes and reduced recidivism. In general patients likely to meet criteria for diversion will have committed relatively minor offences and will suffer from major mental illness. Those where the primary presenting issue is substance misuse or personality disorder would not generally be considered as appropriate for diversion to local psychiatric services. The great majority of such patients will already be known to local services and as such will not involve a significant increase in workload. The process would be considerably simplified by the development of clear guidelines regarding catchment area responsibility for those unable to provide a regular address. Court diversion does not equate with discontinuation of prosecution, but does permit rapid access to best quality healthcare in appropriate environments.

Declaration of Interest: None

References
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