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Court diversion

SIR: Joseph & Potter (*Journal*, March 1993, **162**, 325–334) are to be congratulated for their work on court diversion. Their studies had clear objectives, sound methodology, and provided lucid discussion of the findings. Two of their principal results, notably the difference in the rates of custodial remands depending on which psychiatrist took responsibility for the case, and that the admissions via custody had a better outcome, were surprising.

The authors' tacit assumption of an apparent causal relationship between the drop in the combined psychiatric in-patient population between 1962 and 1990, and the rise in the combined prison population in the same period reopens an old debate on a complex issue (Penrose, 1939). Although most studies, supported by anecdotal and clinical impressions, sustain the notion that there is a discernible increase in the number of mentally ill in prison populations in recent years, and would tend to confirm Penrose's hypothesis, whether or not there is a direct effect of de-institutionalisation remains contentious. Differential arrest rates (Teplin, 1985) and changing mental health policies (Whitmer, 1990) may contribute to this increase.

The absence of any discussion on the ethical issues of obtaining informed consent and possible interference in the due process of law was disappointing (Carson, 1992). The identification of those included in the study population depended on court officials acting as 'filters', yet the discussion failed to highlight potential difficulties such 'filters' have, both in detection rates (i.e. what proportion of the target population had been already diverted, such as by use of Section 136 of the Mental Health Act (MHA) 1983 for instance?), and in their ability to discriminate (were the quiet, withdrawn individuals missed because they were not so obviously 'strange in manner'? Was there a bias towards not referring those on more serious charges?).

The authors emphasise that in order to secure admission to hospital, either informally or under the civil provisions of the MHA 1983, it was necessary to persuade the Crown Prosecution Service (CPS) to discontinue proceedings. It is certainly inaccurate to suggest that if the CPS will not discontinue proceedings, there is no possibility of either formal or informal admissions to hospital under the civil provisions. Furthermore, the criminal provisions of the MHA 1983 allow for admissions for assessment (Section 35) from the magistrates' court without a need for the CPS to discontinue proceedings. Thirty-four per cent of the psychotic group were considered unfit to plead. This is a high figure and we would appreciate further information on the criteria used.

The interesting finding that the psychiatric recommendations differed significantly depending on which psychiatrist was involved, especially if considered in the light of the better outcome in the group admitted via custody, seems to make the point that what appears best in principle (i.e. early diversion) is not necessarily borne out in practice. It is impossible to ignore that the important factor determining a better outcome was the time spent in custody before admission to hospital.

Although we were not surprised that 31% of those assessed had a lifetime history of drug abuse, we were surprised that those with a history of illicit drug abuse did not have significantly more convictions than the rest of the sample.

We feel that the resource implications outlined in their second paper are inconclusive. Various opportunity costs such as 'wear and tear' on staff and on other patients were notable by their absence. If one uses the findings to inform debate on an options appraisal for determining the service that maximises utility, there is a suggestion that one should concentrate more on the prison medical service and further explore the use of Sections 35, 36 and 48 of the MHA 1983. Greater emphasis could be placed on helping prisons improve their methods of tracking and identifying the mentally disordered as a prelude to planning treatment strategies (Jemelka *et al*, 1989).

The alarming discovery that, whereas 70% of those assessed had previously been in-patients (of whom over three-quarters had been detained under the provision of the MHA 1983), only one-quarter of those with previous admissions were receiving psychiatric support at the time of the study, makes one wonder whether it is appropriate to detect those in 'need' if efforts at follow-up are so poor. Finally, the stark reality that 22 of the 51 direct admissions from court, admitted because they were psychotic were later discharged because they continued to be psychotic is a sobering reminder of

the enormity of the challenge that care in the community poses!

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AUTHORS' REPLY: We thank Travers & Brabbins for their comments. We share their scepticism concerning the Penrose hypothesis but there is, undoubtedly, a small but important group of mentally disordered defendants who previously would have spent substantial periods in hospital but are now as likely to receive their psychiatric care in the remand prison as in hospital or in a community setting.

The process and ethical issues of obtaining informed consent was omitted from this paper, but has been covered in some detail by Joseph (MD thesis: available from the University of London and Institute of Psychiatry Libraries). Briefly, the independent and research role of the interviewing psychiatrist was stressed to the defendant and the courts, thereby avoiding adversarial implications. We disagree that there is an ethical dilemma in "interfering" in the due process of law. The discontinuance of a criminal case by the CPS is carried out under the due process of law, as set out in the Code for Crown Prosecutors issued pursuant to Section 10 of the Prosecution of Offences Act 1985. By focusing on the court, psychiatrists, in a similar way to the bail information and public interest case-assessment initiatives run by the Probation Service, can help to provide sufficient information to the CPS to enable them to carry out their proper function. A much more serious interference in the due process of law, in our view, is when psychiatrists take on a quasi-judicial role and insist on the prosecution of patients in their care, when there is sometimes a reluctance to proceed by police and prosecutors.

There will always be cases who slip through the 'filters', either at the police station, the court, or even the remand prison, and as the study of Gunn *et al* (1991) shows, appreciable numbers of psychotic individuals are found in the sentenced-prisoner population. The purpose of assessment at court is to provide an additional safety net while recognising that some will escape detection and others will have to continue in the criminal justice system because of the seriousness of the charge. The provision of a community psychiatric nurse at court on a daily basis has been described, but there are resource implications in trying to identify every case at court.

We had hoped it was clear from our papers that admission to hospital was still possible even if the CPS did not discontinue the case. However, it was necessary to suggest discontinuance, not for the benefit of the CPS or the legal process, but to placate the hospital to which admission was required. We found great difficulty in using Section 35 of the MHA, and it appears this difficulty is encountered across England and Wales (Gunn & Joseph, 1993). District hospitals also had a reluctance to admit patients while the criminal case was continuing. One example was a case where the hospital refused to admit a patient under Section 35 without a nursing assessment, but the same patient was accepted an hour later after the charge was dropped and a Civil Section 2 applied.

The criteria used in deciding on fitness to plead were the usual legal criteria which psychiatrists adopt in their psychiatric reports to court. Our high figure shows how the issue is fudged at the magistrates' court and rarely tested in practice. Those psychotic patients who were discharged precipitously remained psychotic but that was not the reason for discharge: rather it was their 'challenging' behaviour. The poor outcome for many of those diverted to hospital reinforces the statement in the Reed Report (Department of Health & Home Office, 1992) that diversion is the "end of the beginning". Without suitable hospital resources, namely readily accessible locked wards, and without adequate community facilities there is a danger that early diversion from custody, either at the police station or at the court, will simply speed up the revolving door.

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