# Commentary: Coerced Community Mental Health Treatment—An Added Burden on an Overstretched System

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The sudden and massive depopulation of psychiatric institutions that occurred in the 60s and 70s overwhelmed a fragmented and undersourced community mental health system, leading, in part, to the high number of chronically mentally ill individuals currently residing in jails and prisons, a situation that has been described as reinstitutionalization or transinstitutionalization. Any process that forces more people out of jails into mental health treatment in the community without a sound, effective, available, and accessible community mental health system of care is potentially catastrophic.

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The recent article by Redlich et al.[1] provides an interesting description of the characteristics and attitudes of individuals diverted from jails and prisons to community mental health treatment and enriches the burgeoning literature on jail diversion. As the number of inmates in U.S. jails and prisons continues to escalate at an alarming rate, so does the population of incarcerated individuals with serious mental illness. According to the Bureau of Justice Statistics, on December 31, 2003, state prisons were estimated to be at capacity or 16 percent above capacity, while Federal prisons were operating at 39 percent above capacity.[2] Individuals with serious mental illness (SMI) account for a significant proportion of inmates nationwide. It has been estimated that up to 16 percent[3] of all inmates and 7 percent[4] of jail inmates specifically in the United States experience SMI. It is indeed a sad state of affairs when the Los Angeles County jail system is referred to as "the largest mental institution in the country."[5] It is more troubling to consider that the majority of these individuals with mental illness in the criminal justice system were arrested for minor crimes that were directly related to their illness and rarely for violence.[6] Statistics such as these, as well as the negative effects of incarceration on mental illness, have led to the proliferation of jail diversion programs across the country.

Jail diversion programs are joint efforts among prosecutors, defense attorneys, courts, other criminal justice professionals, and community mental health providers to prevent incarceration and promote community involvement of detainees with SMI who have committed minor crimes. The goal is to divert these individuals into established treatment programs that meet their needs in the least-restrictive environment. Hence, for these individuals, the criminal justice system serves as a link to treatment.

Many individuals with SMI have well-documented factors that put them at risk of being apprehended by the police. They are typically well known to the mental health system and have a history of inconsistent adherence to or frank refusal of medications. Thus, violent and bizarre behavior that results from untreated psychosis may attract the attention of the criminal justice system. Social factors that put them at risk include unstable housing and homelessness and poor employment skills. When these are coupled with substance abuse, a major co-morbidity in this population, the risk rises exponentially.

The rapid increase in jail diversion programs across the country in the past decade is a proactive attempt to decrease the burden imposed on the criminal justice system by individuals with SMI by diverting them from jails and prisons into community

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mental health agencies for treatment. How effective these programs are at preventing re-arrests has not been rigorously analyzed. A study[7] comparing outcomes for diverted and non-diverted jail detainees surprisingly showed that, while there was an increase in hospitalization rates among the diverted compared with the non-diverted group, there was no difference in the re-arrest rates of both groups. In addition, the non-diverted group showed more improvement in psychiatric symptoms and in some quality-of-life subscales. The diverted group, on the other hand, had less incarceration days than did the non-diverted group.

Another study[6] comparing a group of seriously mentally ill individuals who were diverted from jail into mental health treatment with a comparable group who were eligible for diversion but were not diverted, showed that diversion significantly reduced jail time only among those who were arrested for more serious "minor" offenses (Class D felonies and Class A misdemeanors). Among individuals with SMI and co-occurring substance use disorders, jail diversion programs also showed a reduction in jail time without increasing public safety risk.[8] Diverted participants had re-arrest rates comparable with those of the non-diverted.

In terms of economics, jail diversion leads to substantial savings in the criminal justice system by reducing the length of detention in jails, court time, and prosecution of individuals with SMI. Unfortunately, the cost of caring for these individuals then shifts to the mental health agencies, most of which are already burdened by lack of resources. Jail-diverted individuals with SMI not only need increased input from community mental health agencies, but also need inpatient services. Of the 35 diverted subjects in a study,[7] 20 percent were re-hospitalized, as opposed to none of the non-diverted group of 45 subjects. The increased monitoring of the diverted group in the community may have played a role in the observed paradox: any decompensation is detected earlier, and short-term inpatient hospitalization may be warranted. It has been estimated that the additional treatment cost to mental health agencies is often higher than the criminal justice savings in the short term.[8]

Individuals with SMI diverted from the criminal justice system into mental health treatment do not receive treatment voluntarily; treatment is coerced or mandated. Coercive outpatient treatment of psychiatric patients is controversial. One study concluded that coercive treatment arouses negative feelings in the patient, creates negative expectations about the outcome of the treatment, and fails to result in a trusting treatment relationship between the patient and the professionals.[9] Some clinicians resist being placed in a "police" role and see the added responsibility of monitoring the patients' treatment compliance as problematic and in conflict with their therapeutic role. Other clinicians fear liability for actions of patients for whom they are responsible by virtue of a court order.

Despite these problems, there is evidence that coerced patients are not necessarily unwilling patients or resistant to the idea of treatment. A study[10] of a sample of mentally ill parolees ($n = 97$) who had been admitted to an outpatient clinic as a condition of their parole showed an acknowledgment of the need for treatment and a stated willingness to continue treatment at the end of their parole—that is, without criminal justice leverage; 87.5 percent reported that they needed to come to a clinic, 91.7 percent reported that they needed to be in the clinic now, and 100 percent reported that they planned to continue taking their medications after their discharge from parole, without coercion.

Perhaps the most difficult problem with such mandated treatment is lack of adequate and sufficient resources to meet the needs of such diverted individuals, creating even more competition for limited community-based treatment resources. The clinical profile of jail-diverted individuals includes serious mental illness, poor adherence to medication regimens, and serious problems with illicit substance and alcohol abuse. Such individuals require community mental health centers that offer a variety of treatment options, including intensive case-management services, assertive community treatment (ACT), and integrated programs for substance use disorders. Generally, these programs are not readily available or easily accessible, a problem that would ultimately dilute the effect of criminal justice system leverage to mental health treatment. Thus, it remains unclear whether jail-diverted individuals with SMI receive the type of services and evidence-based practices they need for positive outcomes. More long-term studies are needed to evaluate fully the effect of criminal justice leverage on mental health treatment outcomes.

## References


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