A Radical New Approach for Mental Health Diversion

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The criminalization of mental illness is a national tragedy. Over the past three decades there have been numerous programs and initiatives designed to reduce the number of people with mental illness incarcerated in jails and prisons. Despite such efforts, incarceration rates have not fallen and have actually climbed in many jurisdictions. One major consequence of the criminalization of mental illness has been a large increase in referrals for evaluation for competency to stand trial and, consequently, in the need for competency restoration services. Many states have been unable to keep up with the demand for such services, causing patients to languish in jails with their criminal proceedings suspended, awaiting transfer to a state hospital. Expedited Diversion to Court-Ordered Treatment (EDCOT) is a new model for diversion that has great potential to drastically improve the diversion process, bypass the competency restoration system, and reduce the criminalization of mental illness. Successful implementation of EDCOT would result in more humane treatment of people with mental illness, without jeopardizing public safety; furthermore, it would pay for itself with the savings from reductions in the use of competency restoration services.

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In criminal justice, "mental health diversion" is a term used to refer to a variety of approaches to reduce the arrest and incarceration of individuals with mental illness. Diversion aims to reverse the criminalization of mental illness that has been such a large, and growing, problem in the United States over the past several decades.[1] When public safety can be protected without incarceration, and an individual's offense was driven to a substantial degree by symptoms of an untreated or inadequately treated mental illness, it is both just and a prudent use of public resources to divert that individual to treatment in a community setting.

Challenges to Traditional Diversion

Mental health diversion programs face a number of challenges and obstacles. As a result, despite more than three decades of initiatives, both the absolute number of individuals with mental illness in America's jails and prisons and the percentage of the total incarcerated population that has mental illness remain at levels that virtually all informed observers agree are unacceptable. Although this criminalization of people with mental illness is cruel, unnecessary, and wasteful, a variety of systemic factors have thus far prevented any sweepingly successful reductions in incarceration rates. In fact, in many jurisdictions, the trend has been in the opposite direction. For example, in California, there was an overall 42 percent increase in the number of jail inmates with an open mental health case between 2009 and 2019; and the percentage of incarcerated people with an open mental health case increased by 63 percent, from 19 to 31 percent. Prescriptions for psychotropic medications in California jails increased 81 percent over the same time period.[2] In the largest county in California, Los Angeles County, the increase has been even more drastic. Between 2012 and 2021, the percentage of Los Angeles County jail inmates who are on the mental health caseload more than doubled, from 17 to 40 percent. The percentage of female inmates in the Los Angeles County jail who are receiving mental health services is now an astounding 68 percent, up from 24 percent in 2012.[3]

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In this issue of The Journal, Hoge and Bonnie[4] review several of the difficulties confronted by efforts at mental health diversion and present their vision of a new type of diversion that could overcome such barriers and lead to meaningful, sustained reductions in the incarceration of people with mental illness. One of the challenges to building a successful diversion program is the sheer variety of approaches that have been tried throughout the country, most often at the level of an individual county or even a single courtroom. This makes standardization impossible and collection and analysis of outcome data difficult. Small programs are also prone to cancellation in the wake of local changes in leadership, budgetary concerns, or various bureaucratic considerations.

A second challenge is the fact that people with serious mental illness often have symptoms of sufficient severity to preclude their knowing and voluntary acceptance of an offer of diversion. Under our existing system, such patients typically remain incarcerated while awaiting services to restore their competency to stand trial; these services may take place in a state or other hospital, a jail-based program, or, rarely, in the community. In many states, the competency to stand trial (CST) system is being overwhelmed by an ever-increasing number of referrals, leading to long delays in adjudication of the original charges.[5]

A third challenge to successful diversion is the fact that many defendants with mental illness refuse to comply with the diversion conditions after their release to community treatment, resulting in re-arrest or the commission of new criminal offenses. Many existing diversion programs lack sufficient authority to ensure treatment compliance, and incarceration is their primary response to deviation from program rules. With such an arrangement, noncompliance can lead to starting over at the beginning, with the once-diverted person back in jail.

A New Approach

Hoge and Bonnie propose a bold approach that would address the barriers just described, among others. Their blueprint for a civil commitment regime for individuals with serious mental illness arrested for misdemeanors or felonies of low or moderate severity has the potential to reduce lengths of stay in jails and forensic hospital settings, increase community treatment rates for a difficult-to-engage population, and improve public safety.

The name they have given this new category of commitment, Expedited Diversion to Court-Ordered Treatment (EDCOT), highlights its advantages: it is expedited, meaning that the individual, and the entire system, benefit from a drastic reduction in the length of incarceration prior to diversion out of jail; and treatment after diversion is mandated by the court, including inpatient psychiatric hospitalization when necessary. This latter aspect of EDCOT is in many ways analogous to a well-functioning outpatient commitment or Assisted Outpatient Treatment (AOT) program.

Benefits of EDCOT

As envisioned by its creators, the passage of a state law, creating a new form of civil commitment, is required for EDCOT. Although this will not guarantee uniform implementation across jurisdictions within the state (the history of other civil commitment laws such as conservatorship and AOT proves that), it will increase the ease of introducing it, as individual jurisdictions will not have to "reinvent the wheel" when they decide to make a push for diversion. The standardization of the diversion regime will also facilitate data collection and analysis, enhancing the ability to fine tune the decision-making process in terms of suitable candidates and appropriate treatment resources and monitoring.

There is a consensus that America's CST system is in crisis.[5–9] Hoge and Bonnie point out that as referrals have increased drastically, delays prior to CST evaluation or while waiting for transfer to a forensic hospital for restoration have increased apace; state CST systems have been unable to keep up with resource allocation. Many states have been subject to lawsuits demanding a shortening of the time frame for restoration.

Among the problems within the competency restoration domain is the inappropriate use of CST referrals by attorneys and judges as an expedient way to obtain treatment for the defendant. Securing treatment for people with serious mental illness who become involved with the criminal justice system can be quite difficult, especially given that they often have fewer social supports, as well as comorbid substance use disorders. Well-meaning public defenders, prosecutors, and judges are typically unfamiliar with the nuances of CST and may believe that referral for competency evaluation is likely to provide a significant benefit to the individual with serious mental

illness in terms of long-term treatment, housing assistance, and so forth. The reality, as Hoge and Bonnie note, is that the CST system has a narrow focus; it is not designed to provide long-term treatment planning. Thus, its use in less serious criminal cases, or when the patient is already close to achieving competency, often proves counterproductive, as defendants end up waiting in jail for long periods, while typically not receiving robust services once their criminal proceedings and sentence ultimately conclude.

The EDCOT system completely bypasses CST, as trial competence is not required for a defendant to be mandated to receive diversion and treatment. In addition to drastically shortening the entire timeline from arrest to exit from the criminal justice system, the savings in terms of money, hospital beds and staffing resources EDCOT would generate by avoiding CST proceedings would clearly be quite substantial, given the known costs of state CST regimes. In fact, Hoge and Bonnie indicate that these savings are what would allow EDCOT to be financially viable as a long-term proposition. An additional significant benefit is that EDCOT ensures longer-term treatment, which the CST process typically does not.

A court-mandated outpatient schema already exists in most states: AOT. Hoge and Bonnie point out that such programs are most likely to be successful when sustained for at least 18 months. Most AOT programs only mandate treatment for six or 12 months, though this may be renewed if the patient has remained in treatment and still meets the criteria for involuntary outpatient commitment. The proposal for EDCOT envisions a maximum of 12 months for misdemeanor defendants, and longer for felonies, with three years being suggested as a reasonable norm, but potentially allowing for a duration up to the maximum prison sentence that would have been faced if there had been a criminal conviction in the case. Note that this would not be indeterminate, as the EDCOT proposal is not intended for defendants facing very serious felony charges. Hoge and Bonnie specifically mention murder and armed robbery, but it is safe to assume that defendants with other serious charges such as attempted murder, kidnapping or rape, which could lead to sentences counted in decades (or a life term) would also be excluded from consideration.

In any case, as Hoge and Bonnie describe, the monitoring and sanctions of outpatient treatment under EDCOT would be tailored to maximize treatment compliance, without going so far as to mimic, for example, conditional release for an insanity acquittee, where return to a secure state hospital setting is common even for minor violations. EDCOT will resemble other types of mental health diversion programs, and differ from traditional civil AOT programs, in having brief incarceration in jail available as a corrective measure for noncompliance. Close monitoring through court reports at regular intervals and the threat of possible incarceration together are likely to increase rates of retention in treatment.

Challenges to Implementation of EDCOT

Hoge and Bonnie have developed a promising framework for a new approach to mental health diversion. They acknowledge that it is "a preliminary proposal intended to stimulate further discussion" and not a "finished product." (Ref. 4, p 518) Given the worsening crisis of the criminalization of mental illness, a robust discussion among key stakeholders in one or many states would be an extremely welcome development. The current system is broken, and by many measures it is getting worse. Though EDCOT may seem drastic, even radical, there is a strong argument to be made that such a clear step forward, away from failing traditional approaches, is sorely needed. Certainly, we must hope that EDCOT will not meet the same fate as some previous proposals, such as the American Bar Association's 1986 recommendation for how to deal with defendants charged with serious violent felonies who were found incompetent to stand trial and unrestorable, which, as Hoge himself noted in 2010, has been essentially ignored throughout the nation.[10] In anticipation of a sustained and serious dialogue about this proposal, it may be useful to point out some of the potential challenges to the adoption and implementation of EDCOT.

Barriers to EDCOT can be divided into the practical and the philosophical. The practical obstacles are those faced by any effort to create a new law or government program. Unlike many diversion programs, EDCOT requires passing laws. State legislatures tend to be quite slow and cautious when it comes to making significant changes to long-established codes. As Hoge and Bonnie have eloquently explained, EDCOT would have an impact on major facets of both criminal and mental health law. In addition to creating a new diversion pathway in criminal justice, it would dramatically affect the CST system and create a new civil commitment law. There are many moving parts and feedback loops. Clearly, it will take

highly motivated state legislators, in addition to strong advocates in the mental health and legal fields, to shepherd an EDCOT law to final passage.

EDCOT would also require significant improvements in the outpatient and inpatient mental health resources available to diverted individuals. Thus, it will be critical that the savings EDCOT would generate from (for example) reductions in CST services not be spent by state governments on other priorities, leaving the public (nonforensic) mental health system no better off than it is at present. Without sufficient resources available to provide for successful diversions, EDCOT would not be sustainable.

On the philosophical side, there are stakeholders in the United States who oppose the concept of AOT.[11] EDCOT would create a new AOT-like system, and thus may encounter opposition from such stakeholders. A recent California bill would allow placement in AOT for patients who are on a mental health conservatorship that is being terminated. In response to the bill, the advocacy group Disability Rights California stated that it "opposes legislative efforts to expand involuntary mental health treatment to anyone who is not imminently dangerous to themselves or others, or gravely disabled."[12] Of course, many states have AOT laws despite the opposition of such groups, so this is not necessarily an insurmountable barrier for EDCOT. But it should be taken into account, and steps should be taken to minimize opposition to EDCOT on liberty grounds.

Conclusion

Those whose work involves people with mental illness in the criminal justice system (whether that work is clinical, administrative, or policy-related) recognize that the criminalization of mental illness in the United States in the third decade of the 21st century can be described, without any exaggeration, as a tragedy of epic proportions. Despite the best efforts of brilliant and dedicated mental health and legal professionals, little progress has been made, at least if the benchmark is defined as a large-scale reduction in the unnecessary incarceration of people with mental illness. Hoge and Bonnie's EDCOT proposal may seem radical, but, given the seemingly intractable nature of the problem, the time has certainly come to try something which may finally begin to turn the tide. We must hope that some state legislature will take up Hoge and Bonnie's blueprint, act as a laboratory of democracy, and conduct the experiment.

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