Factors Associated with the Diversion of Mentally Disordered Offenders

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This study is an examination of the process of pre-trial diversion, in which prosecutors use their discretion to drop criminal proceedings against mentally disordered persons on the condition that such persons be certified and detained for treatment in a hospital setting. An attempt was made to uncover the factors relevant to understanding why mentally disordered offenders are diverted in some instances but not in others. Using data from the forensic psychiatric system of a Canadian province, it was found that accused persons were diverted into the mental health system in 13.4 percent of cases over a three-year period. Three factors were found to be significantly associated with the diversion decision: 1) offense seriousness, with persons facing less serious charges being diverted in a greater proportion of cases; 2) court jurisdiction, with courts in smaller centres and outlying areas being more likely to divert; and 3) psychiatrist, with considerable variability between psychiatrists in their use of the diversion mechanism. The significance of these results and implications for forensic psychiatric policy-making are discussed.

There are several points in the criminal justice process where a mentally disordered person may be diverted into the mental health system. This may occur at the initial point of contact, when police officers may try to get the accused person admitted to hospital, rather than arrest the individual.[1] Diversion may also occur at the pre-trial stage, where a prosecutor may agree to a stay of criminal proceedings on the condition that the accused person receive treatment in a psychiatric facility; this type of diversion, at the pre-trial stage, is the subject of this paper.

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The present study took place in a western province of Canada. In Canada, under provisions of the federal *Criminal Code*, a court may order an accused person to undergo a pre-trial psychiatric assessment when there is reason to believe the accused is incompetent to stand trial. In most cases these assessments are ordered when the accused first appears in court, shortly after arrest. The assessments are usually performed in custody, at a forensic psychiatric facility. During the assessment, if the accused is acutely disordered, he or she may be treated with psychotropic medication, either voluntarily or after civil certification. After the assessment there are two possible outcomes for the accused person. First, the

accused may be returned to court, with an opinion that the person is either competent or incompetent to stand trial. Secondly, in some cases the accused may be diverted into the mental health system; this occurs when the prosecutor agrees to stay the criminal proceedings (in effect, drop the charges) on the condition that the accused, if certifiable, be kept on as a civilly committed patient at the forensic hospital. Certification, rather than voluntary hospitalization, is a condition presumably because it ensures the detention and treatment of the accused.

Arguments can be made both for and against the practice of diversion.[2] It may be that diversion is the most humane course to follow, particularly in view of the fact that treatment resources in correctional and pre-trial facilities are often inadequate.[3, 4] The Law Reform Commission of Canada[5] in fact suggested that pre-trial diversion of the mentally disordered offender might often be in the best interests of the accused and the public, particularly where the offense was minor. The Commission added, however, that prosecutorial policy concerning the practice of diversion should be "visible" and "consistent." Further, with more and more mentally ill persons winding up in the criminal justice system, due at least in part to diminishing resources in the mental health system, the courts will be forced to act as a triage station for the community.[6, 7]

On the other hand, some have been critical of the practice of diversion. It has been argued, for instance, that it is unfair to the accused to use the criminal route as a way of detaining the person, involuntarily, in a psychiatric hospital;[8] the accused may not appreciate the label of "mental patient," and, moreover, may end up spending more time in detention under civil commitment than he or she would have under criminal sanctions. Further, as Rogers and Bagby[2] note, there is a "lack of both legal standards and specific clinical guidelines for whom to divert and under what circumstances." Thus, there may well be inconsistencies, with respect to how (or whether) diversion is used, from case to case and jurisdiction to jurisdiction. It was this latter concern—the question of how discretion is used, and why some persons are diverted into the mental health system while others are not—that provided the impetus for the present study.

Although this is a potentially important area for analysis, there have been virtually no published studies of decision-making practices concerning diversion at the pre-trial stage. One exception is a study by Rogers and Bagby;[2] this study did not actually use diversion as the dependent variable, but rather looked at factors associated with *recommendations* of diversion by forensic psychiatrists (following pre-trial assessments). Further, the authors considered recommendations of *treatment* to be indicators of diversion recommendations. In brief, these authors found significant associations between treatment recommendations and gender, degree of mental impairment, offense seriousness, and the individual psychiatrist.

The present study extends the work of Rogers and Bagby by looking at factors

associated with the actual diversion of mentally ill persons at the pre-trial stage.

Method

Data for this study were gathered from the clinical files of persons admitted to a western Canadian provincial forensic hospital for pre-trial psychiatric assessment during the period January 1, 1990–December 31, 1992 (a three-year span). Persons who were returned to court after the assessment were compared with persons who were diverted into the mental health system, i.e., kept on at the forensic hospital under civil certification after having their charges stayed.

The comparison was made on the basis of several variables, specifically: charge seriousness, jurisdiction of the referring court, age, diagnosis, gender, and attending psychiatrist. It was assumed, for instance, that persons diverted from the criminal process would be more likely to have less serious charges, and more likely to have a DSMIII-R axis I psychotic disorder (such as schizophrenia). The effect of the patient's gender was considered as well because there is some suggestion that this factor may be significant in forensic psychiatric decision-making; that is, there may be a "chivalry" effect, with women offenders more likely to be "medicalized" (recommended for treatment) while men are "criminalized" (recommended for penal sanctions).[9, 10] And, as Rogers and Bagby[2] suggest, who the psychiatrist is may be relevant to understanding diversion, in that decisions about diversion may be idiosyncratic, having to do with personal inclinations. The study also tried to account for any prosecutorial idiosyncrasy, by taking into account the referring court.

While conducting the study it became apparent (from file information and from discussions with clinical staff) that not all the persons undergoing pre-trial assessment were candidates for diversion; that is, not all persons were seriously ill enough to be certified under the provincial *Mental Health Act*, which was a condition of diversion. As readers may be aware, possible incompetence to stand trial does not always mean that the accused person is acutely psychotic (see Roesch & Golding[11]); persons may be incompetent without meeting the threshold for certification. Thus, in the present study, there were several individuals who were referred for competency evaluation, but who, because of an absence of acute psychosis, could not have been diverted, by definition. The fact that these persons could not have been diverted was a problem for the researcher, because the purpose of the study was to compare cases of persons actually diverted with cases of persons who *could have been* diverted, but were not. To overcome this problem, the decision was made to compare cases of persons diverted with cases of persons who were *certified* (under the *Mental Health Act*) while in pre-trial assessment, but not diverted; this latter group were thus considered to be cases of persons who "could have" been diverted, at least on the basis of the criterion of certifiability. Determining why this latter group was not diverted, by examining

how they differed from persons who were diverted, was the basis for the study.

Results

During the period January 1, 1990 to December 31, 1992, 771 persons were seen at the provincial forensic hospital for pre-trial assessment. Of this number, 103 (13.4%) had their charges stayed and were diverted into the mental health system. Of the 670 persons not diverted, 129 were certified while in assessment.

As noted, this study was a comparison of diverted persons (n = 103) with persons certified but not diverted (n = 129); this comparison is summarized in Table 1. The significance of charge seriousness, psychiatrist, court jurisdiction, gender, and diagnosis were tested with the chi-square statistic. The significance of age was tested with the "t" statistic.

"Charge seriousness" was determined by a scheme suggested by Ogloff;[12] in this scheme murder, for example, is classified as a "major" offense, aggravated assault a "serious" offense, burglary a "moderate" offense, and trespassing a "minor" offense. A complete list is available from the author upon request. For the present study, charges were categorized as "minor" (using Ogloff's list of minor offenses) or "serious" (collapsing Ogloff's categories of moderate, serious, and major offenses).

The variable "court jurisdiction" was problematic in that there was such a large number of referring courts, with

Table 1
Association between Diversion and Demographic/Clinical Factors

	Diverted (n = 103)	Not Diverted (n = 129)
Psychiatrist[1]: Chi-square sig. at 22.2, $p = .05$, 5 *df*		
Dr. A	38 (60.3%)	25 (39.7%)
Dr. B	16 (31.4%)	35 (68.6%)
Dr. C	2 (12.5%)	14 (87.5%)
Dr. D	12 (36.4%)	21 (63.6%)
Dr. E	9 (64.3%)	5 (35.7%)
Dr. F	3 (30.0%)	7 (70.0%)
Court: Chi-square sig. at 5.5, $p = .05$, 1 *df* (one case missing)		
Metropolitan	48 (36.9%)	82 (63.1%)
Outlying	54 (53.5%)	47 (46.5%)
Offense[2]: Chi-square sig. at 7.0, $p = .05$, 1 *df* (three cases missing)		
Serious	45 (36.9%)	77 (63.1%)
Minor	58 (54.2%)	49 (45.8%)
Mean age: Difference not significant		
	34.6	35.3
Sex: Association not significant		
Male	86 (44.3%)	108 (55.7%)
Female	17 (44.9%)	21 (55.3%)
Diagnosis: Association not significant (nine cases missing)		
Major mental disorder	93 (44.9%)	114 (55.1%)
No major mental disorder	4 (25.0%)	12 (75.0%)

[1] Only psychiatrists with at least ten assessments included in analysis.
[2] See text definition of charge seriousness.

some referring only a small number of cases. To simplify the analysis, courts were categorized as being either "metro", i.e., falling within the one major metropolitan area of the province (which makes up about one half the population of the province), or "outlying", i.e., located in smaller towns and semi-rural areas outside the major metropolitan area.

The variable "diagnosis" was defined as follows: patients were categorized as either having a "major mental disorder" or "no major mental disorder." For the purposes of this study, "major mental disorder" included schizophrenic disorders, mood disorders (such as bipolar) or organic brain disorders; and "no major mental disorder" included personality disorders, substance abuse disorders, or psychoses precipitated by substance abuse.

Three factors were found to be significantly associated with diversion. First, perhaps not surprisingly, there was an association between diversion and charge seriousness. "Minor" cases were diverted 54 percent of the time, whereas "serious" cases were diverted 37 percent of the time. (Although the figure of 37 percent may seem rather high, it should be noted that the category "serious" covered quite a range of offenses; serious offenses that were in fact capital offenses were obviously never diverted. It can also be seen from Table 1 that among the minor offenses a substantial number—46 percent—were *not* diverted.)

Secondly, there was an association between diversion and the court jurisdiction. Persons coming from "outlying" courts were diverted 53 percent of the time, whereas persons coming from the "metropolitan" courts were diverted only 37 percent of the time. In trying to account for this, the data were analyzed to see whether there was any difference between the jurisdictions with respect to the nature of the cases they referred; i.e., were accused persons from "outlying" courts facing less serious charges? There was found to be no significant difference between jurisdictions with respect to charge seriousness; in fact, outlying courts referred a somewhat *higher* proportion of "serious" cases.

Thirdly, there was an association between diversion and psychiatrist; that is, psychiatrists varied significantly with respect to whether or not the patient they were attending was diverted. The analysis only included psychiatrists who had performed at least 10 assessments (to meet the requirements of the chi-square test); this produced a chi-square value of 22.2, significant at $p = .05$. As an example of the variation, in comparing the two psychiatrists who handled the most assessments during the study period, "Dr. A" had patients that were diverted 60 percent (38 of 63) of the time, but "Dr. B" had patients that were diverted only 31.4 percent (16 of 51) of the time. As with court jurisdiction, the "psychiatrist effect" cannot be explained by differences in charge seriousness; it was found that each doctor handled more or less equal proportions of "serious" and "minor" cases (this is not surprising, since cases were assigned on the basis of a random rotation). Similarly, there was no significant difference between psy-

chiatrists with respect to the court jurisdiction their cases were coming from.

There is still a question of who was the most instrumental in getting a patient diverted: the psychiatrist or the prosecutor. This question was difficult to answer in the present study in that there was usually no explicit reference to diversion made in communications in the patient's file (presumably these decisions were often made *via* phone conversations). Anecdotal evidence (from interviews conducted by the author) suggested that, although the prosecutor had the authority to veto diversion suggestions, the psychiatrist usually played a very prominent role in the initiation and/or approval of diversion, in part because the psychiatrist was the one most aware of treatment resources and bed availability.

Finally, as can be seen from Table 1, no significant association was found between diversion and the gender, age, or diagnosis of the patient. Diagnosis was not found to be a useful discriminating variable in that the vast majority of patients, in both the "diverted" and "certified but not diverted" groups, were found to have serious psychotic or mood disorders (usually schizophrenia or bipolar mood disorder) or organic brain disorders. It should not be surprising that the two groups were very similar clinically, because both groups were ill enough to be certified while in assessment; in fact, including in the study only persons who were certified had the effect of holding the "major mental disorder factor" constant.

Discussion

In the present study, three variables were found to be significantly related to the decision to divert a mentally disordered person at the pre-trial stage of the criminal justice process: charge seriousness, court jurisdiction, and who the attending psychiatrist was.

First, with respect to charge seriousness, it is perhaps not surprising that legal and clinical personnel would be more likely to divert persons charged with less serious offenses. While prosecutors are given fairly broad discretionary authority to suspend criminal proceedings in Canada,[13] it is likely that they would be very reluctant to do this when a major crime had been committed, because of a view that justice was being subverted, or perhaps because of apprehension about a public outcry. Conversely, diverting persons charged with less serious offenses may be less controversial. For one thing, the purpose of detaining and treating the individual is achieved; indeed, the accused persons may spend more time in-custody (in a hospital) as "diverted" than if they had been sentenced. Further, clinical and legal personnel may feel it is unfair, or inappropriate, to subject the seriously mentally ill accused person (who may be charged, for instance, with failing to pay a check at a restaurant) to the criminal justice process. A number of prosecutors the author interviewed felt frustrated about the "mental disorder" cases; a typical comment was, "This is the sort of case that should be dealt with by the mental health system." Several of the legal and clinical personnel interviewed

held the opinion, expressed for some time in the academic and professional literature,[14] that deinstitutionalization had resulted in the "criminalization" of nuisance behaviors that previously would have been dealt with in the mental health system.

The second variable found to be associated with diversion, court jurisdiction, was somewhat unexpected. Specifically, it was found that courts outside of the major metropolitan area were *more* likely to have their cases diverted than courts within this area. It is impossible to definitively explain this finding, given the limitations of the study; it may be that several different factors are contributing to the "court jurisdiction" effect.[15] It is possible, for instance, that courts in the smaller centers are less familiar with "mental disorder" cases (because they see fewer of them), and are more comfortable with discharging responsibility for the management of the accused person to a specialized treatment facility. A related factor, concerning the difference found between regions, has to do with availability of treatment resources. The reader should be aware that, in the province where the present study took place, the smaller, outlying towns and municipalities in general had fewer resources for mentally ill persons; further, in a number of instances, persons from the outlying areas did not return to those areas after the diversion process, but rather were referred to the more comprehensive housing and treatment resources available in the metropolitan area, where the forensic hospital was located. In other words, what may be happening—at least in some instances—is that courts in the areas where there are fewer resources are, in effect, transferring the responsibility for mental disorder cases to an area where there are greater resources for such cases.[16] If this is happening, this is a process that seems difficult to justify: it can be argued that case outcomes should be determined by relevant legal factors, not by factors such as the availability of treatment and housing resources. Realistically, however, it must be recognized that the criminal justice system sometimes operates in an expedient fashion, and decisions may in fact be determined by "extra-legal" factors such as resource availability. Webster, Menzies and Jackson[17] comment on this matter as follows:

> [E]xtra-legal factors (such as the availability of treatment resources) are not laid down in the objective, impartial nature required of the trial process. It is not that they are to be criticized for failing to adhere to the traditional adversary model, but they should be recognized and considered openly as discretionary practices which may actually be essential to the everyday functioning of the courts (p. 19).

The third variable associated with diversion was the "psychiatrist" effect; simply put, some doctors were more disposed to using the diversion route than others. The fact that there is such variability between psychiatrists is not a novel finding; indeed, as Webster, Menzies & Jackson[17] suggest:

> An abundance of data has alerted us to the broad individual differences among psychiatrists in professional orientation, attention to civil liberty issues, influence by extra-psychiatric variables, and adherence to the medical

> model.... Unconscious factors, idiosyncrasies, experience, political perspective, tolerance for deviance and sensitivity to due process have all been discussed as personal variables affecting the ultimate outcome of psychiatric decision making (p. 134).

As Robitscher[18] notes, psychiatrists may vary with respect to seeing patient behavior as "mad" (stemming from a mental illness, and requiring treatment), or simply "bad"; in the latter instance, recommendations for diversion will presumably be less likely, whereas in the former they may be more likely.

The use of clinical discretion, and the question of individual variability, are complex matters for analysis. On the one hand, it may be argued that some room for clinical discretion is necessary, to provide for the unique aspects and demands of particular cases. Indeed, the fact that the criminal justice system gives some leeway to divert persons who, in the opinion of a number of people, are not appropriate subjects for the criminal process, is arguably a positive feature of the system. Further, it must be stressed that psychiatrists are not the lone actors with respect to the use of discretion; discretion exercised by the police, by prosecutors, and by judges will also affect the ultimate dispositions of mentally disordered offenders. On the other hand, the fact that diversionary practices may vary *so* widely between clinicians, particularly in forensic psychiatry, where legal doctrines demand a measure of dispositional equality,[17] suggests that more consistent policies and protocols should be developed concerning a decision that may constitute a significant event in the life of the patient.

Determining what factors underlie diversion decisions is a difficult matter. This study attempted to gain at least a partial understanding of the issue by extracting quantifiable data from clinical files. This approach found, for this particular setting, that the decision to divert a mentally disordered offender from the criminal justice system was influenced by the nature of the offense, who the attending psychiatrist was, and which court was making the referral. The results suggest that "extra-legal" factors such as variability between psychiatrists and resource limitations may be important determinants of the process.

The results, however, give only a preliminary picture of a complex phenomenon; clearly, further study and analysis of this issue is required. It would be worthwhile, for instance, to complement quantitative approaches with more qualitative designs, such as questionnaires and interviews of clinical and legal personnel; this is because diversion involves discretionary practices, and prosecutor-psychiatrist communications that are for the most part unrecorded, and thus difficult to access by quantitative file studies. It would also be useful to undertake comparative research between jurisdictions, to see if diversion is a practice followed in all areas of Canada and the United States, to see what protocols (if any) have been developed with respect to this practice, and to see if limiting factors such as resource availability are relevant in other settings as well. Such research may be instrumental in developing more effective policies for managing the mentally disordered offender.

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15. It is possible that individual prosecutors may vary with respect to their tendency to use diversion; this would explain differences between individual *courts*, but would be less adequate as an explanation of differences between *regions*.
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