Liaison between criminal justice and psychiatric systems: Diversion services

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The recent *Vision for Change* document[1] 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 surveys[2] 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.[3] 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.[5] 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'

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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 ser vice 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 multidisciplinary 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,[7] reducing time spent on remand[8] and have been shown to be associated with improved clinical outcomes[9,10] and reduced recidivism.[10] 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

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When discontinuing after more than 1 week of therapy, the dose should be tapered over no less than 2 weeks before discontinuation, generally reducing the treatment to half-dose or alternate day dosing, and accounting for individual patient circumstances, such as duration of treatment and final dose. *Diabetic Peripheral Neuropathic Pain:* Starting and maintenance dose is 60mg daily, with or without food. The plasma concentration displays large inter-individual variability. Hence, some patients that respond insufficiently to 60mg may benefit from a higher dose. The medicinal response should be evaluated after 2 months treatment. Additional response after this time is unlikely. The therapeutic benefit should regularly be reassessed. **Contra-indications** Hypersensitivity to any of the components. Combination with MAOIs. Liver disease resulting in hepatic impairment. Use with potent inhibitors of CYP1A2, eg, fluvoxamine, ciprofloxacin, enoxacine. Severe renal impairment (creatinine clearance <30ml/min). Should be used in pregnancy only if the potential benefit justifies the potential risk to the foetus. Breast-feeding is not recommended. **Precautions** Duloxetine should not be used in children and adolescents under the age of 18 years for the treatment of major depressive episode. The safety and efficacy of duloxetine in these age groups have not been studied. No dosage adjustment is recommended for elderly patients solely on the basis of age. However, as with any medicine, caution should be exercised. Use with caution in patients with a history of mania, bipolar disorder, or seizures. Caution in patients with increased intra-ocular pressure or those at risk of acute narrow-angle glaucoma. In patients with known hypertension and/or other cardiac disease, blood pressure monitoring is recommended as appropriate. Caution in patients taking anticoagulants or products known to affect platelet function, and those with bleeding tendencies. Hyponatraemia has been reported rarely, predominantly in the elderly. Depression is associated with an increased risk of suicidal thoughts, self-harm, and suicide. As with other drugs with similar pharmacological action, isolated cases of suicidal ideation or behaviours have been reported during therapy or early after treatment discontinuation. Close supervision of high-risk patients should accompany drug therapy. Patients (and caregivers) should be alerted about the need to monitor for the emergence of suicidal ideation/behaviour or thoughts of harming themselves and to seek medical advice immediately if these symptoms present. Since treatment may be associated with sedation, patients should be cautioned about their ability to drive a car or operate hazardous machinery. Duloxetine is used under different trademarks in several indications (major depressive episodes, as well as stress urinary incontinence and diabetic neuropathic pain). The use of more than one of these products concomitantly should be avoided. **Interactions** Caution is advised when taken in combination with other centrally acting medicinal products and substances, including alcohol and sedative medicinal products; exercise caution when using in combination with antidepressants. In rare cases, serotonin syndrome has been reported in patients using SSRIs concomitantly with serotonergic products. Caution is advisable if duloxetine is used concomitantly with serotonergic antidepressants like SSRIs, tricyclics, St John's Wort, venlafaxine, or triptans, tramadol, pethidine, and tryptophan. Undesirable effects may be more common during use with herbal preparations containing St John's Wort. *Effects on other drugs:* Caution is advised if co-administered with products that are predominantly metabolised by CYP2D6 if they have a narrow therapeutic index. **Undesirable Effects** The most common adverse reactions in patients with depression were nausea, dry mouth, and constipation. However, the majority of common adverse reactions were mild to moderate, usually started early in therapy, and most tended to subside even as therapy was continued. The most common adverse reactions in patients with diabetic neuropathic pain were: nausea, somnolence, dizziness, constipation, and fatigue. Those occurring in placebo-controlled clinical trials in depression and diabetic neuropathic pain at a rate of >1% and significantly different to the placebo rate, or where the event is clinically relevant, are: *Very common (≥10%):* Insomnia, dizziness, somnolence, nausea, dry mouth, and constipation. *Common (≥1% and <10%):* Appetite decreased, weight decreased, anorexia, middle insomnia, sedation, hypersomnia, yawning, libido decreased, anorgasmia, tremor, blurred vision, hot flushes, diarrhoea, vomiting, sweating increased, night sweats, muscle tightness, lethargy, feeling jittery, erectile dysfunction, ejaculation delay or disorder, fatigue. Common symptoms, particularly on abrupt discontinuation, include dizziness, nausea, insomnia, headache, and anxiety. In trials, treatment was associated with numerically significant, but not clinically related, increases in ALT, AST, alkaline phosphatase, and creatinine phosphokinase. These transient, abnormal values were infrequently observed compared with placebo-treated patients. In clinical trials in patients with DNP, small but statistically significant increases in fasting blood glucose were observed in duloxetine-treated patients compared to placebo at 12 weeks and routine care at 52 weeks. The increase was similar at both time points and was not considered clinically relevant. Duloxetine is known to affect urethral resistance. In placebo-controlled trials, urinary hesitation was reported rarely (<1%) in male patients. If symptoms develop during treatment, consideration should be given that they might be drug-related. Cases of suicidal ideation and suicidal behaviours have been reported during duloxetine therapy or early after treatment discontinuation. ECGs evaluated during the clinical trials demonstrated no difference in QTc intervals in duloxetine-treated patients compared with those on placebo. No clinically significant differences were observed for QT, PR, QRS, or QTcB measurements between duloxetine-treated and placebo-treated patients. There is limited clinical experience of overdose with duloxetine. No fatal overdose was demonstrated, including doses up to 1400mg either alone or in combination with other medicinal products. No specific antidote is known but routine monitoring and appropriate symptomatic supportive measures should be used, including, if appropriate, early gastric lavage or activated charcoal. For further information see Summary of Product Characteristics, which is available at http://www.medicines.ie/ **Legal Category** POM. **Marketing Authorisation Numbers and Holder** EU/1/04/296/001, EU/1/04/296/002, EU/1/04/296/003, EU/1/04/296/004. Eli Lilly Nederland BV, Grootslag 1-5, NL-3991 RA Houten, The Netherlands. **Date of Preparation or Last Review** August 2005. **Full Prescribing Information is Available From** Eli Lilly and Company Limited, Lilly House, Priestley Road, Basingstoke, Hampshire, RG24 9NL. Telephone: Basingstoke (01256) 315 999 *or* Eli Lilly and Company (Ireland) Limited, Hyde House, 65 Adelaide Road, Dublin 2, Republic of Ireland. Telephone: Dublin (01) 661 4377. *CYMBALTA (duloxetine) is a trademark of Eli Lilly and Company. **References: 1.** Brannan SK, Mallinckrodt CH, et al. *J Psychiatr Res* 2005; 39: 161-172. **2.** Hirschfeld RMS, Mallinckrodt CH, et al. Early Symptom Response During Treatment with Duloxetine 60mg QD: HAMD-17 Items. Poster presented at the American Psychiatric Association, May 1-6, 2004, New York. **3.** Thase M. *J Clin Psychiatry* 2003; 64 (Suppl 18): 3-7.

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