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Perceived Coercion among Jail Diversion Participants in a Multi-site Study

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Abstract

Objective—Although jail diversion is considered an appropriate and humane answer to the problem of mentally-ill persons in jail, little is known regarding the perceptions of jail diversion participants, the extent to which they feel coerced into participating, and whether perceived coercion reduces involvement in mental health services. This study addressed perceived coercion among participants in post-booking jail diversion programs in a multi-site study and examined characteristics associated with the perception of coercion.

Methods—Data collected in interviews with 905 jail diversion participants from 2003–2005 were analyzed using random effects proportional odds models.

Results—Ten percent of participants were considered coerced, and another 26% moderately coerced. Having a drug charge was associated with lower perceived coercion to enter the program. In addition, an interaction between sexual abuse and substance abuse indicated that recent sexual abuse was associated with higher levels of perceived coercion, but only among those *without* current substance abuse. Variables associated with higher perceived coercion to receive behavioral health services included spending more time in jail, and higher perceived coercion at baseline. The amount of behavioral health service use was not predicted by perceived coercion at baseline. Rather, being older, having greater symptom severity, and having a history of sexual abuse was associated with higher levels of outpatient service use.

Conclusions—Overall, one-third of jail diversion participants reported some level of perceived coercion. Important determinants of perceived coerced included charge type, length of time in jail, and sexual abuse history. Engagement in treatment was not affected by perceived coercion.

Introduction

Individuals with serious mental illness (SMI) are significantly over-represented in the criminal justice system. Recent estimates suggest that approximately two million people with SMI are booked into U.S. jails each year (1). Moreover, after this initial arrest, people with SMI are more likely to be detained in jail (as opposed to being released or have the cases dismissed), and once jailed, stay incarcerated 2 ½ to 8 times longer in comparison to their non-mentally ill counterparts (2).

To address this growing problem, jail diversion programs for people with mental illness have dramatically increased in the U.S. (3). Jail diversion programs divert people with mental illness from jails and connect them to community-based behavioral health services with the explicit goal of decreasing future criminal justice involvement and improving mental health outcomes. Despite the popularity of jail diversion, evidence of its effectiveness is limited (3–6). Further, little is known regarding the extent to which participants feel coerced into diversion programs and how perceived coercion may undermine the goals of the diversion program.

Studies of perceived coercion among patients in mental health treatment suggest that although legally mandated treatment is often associated with higher levels of perceived coercion, considerable variation exists and other factors such as respect, empathy, choice are often more important than legal status in explaining perceived coercion (7–10). Findings are also mixed with regard to the association between perceived coercion and adherence to outpatient treatment or medication (9,11–13).

Unlike court ordered (involuntary) treatment, there is no objective coercion involved in jail diversion since it is voluntary for participants. However, jail diversion takes place within the criminal justice system, and it is the *perception* of coercion (i.e., lack of choice, control) in the process of receiving treatment that is most important. Therefore, it seems especially important to examine perceived coercion within the context of jail diversion, and to better understand the effect perceived coercion may have on the ability of diversion programs to engage and maintain participants in behavioral health services. The current study was designed to address the following questions: What factors account for perceived coercion to enter the diversion program? What factors account for perceived coercion to receive behavioral health services? Finally, does perceived coercion at baseline predict use of behavioral health services over the following year?

Methods

Procedures

Thirteen jail diversion programs funded from 2002–2004 through the Targeted Capacity Expansion (TCE) Jail Diversion Initiative of the Substance Abuse and Mental Health Services Administration (SAMHSA) were included in the current study. Funding provided over three years was used to develop the diversion programs and establish links across service systems to facilitate access to treatment for diverted individuals. Participants at each of the sites were eligible for diversion if they were identified in jail as having a DSM-IV axis I diagnosis. Most programs focused on nonviolent misdemeanants, although felonies and some violent charges were allowed. Data were collected from February, 2003 – July, 2005. Baseline interviews were conducted with 905 individuals enrolled in the post-booking jail diversion programs. Participants were interviewed by trained independent interviewers at baseline, six months, and again at 12 months after the baseline interview. Data from the baseline and 12 month interviews are reported in the current study. Informed consent was obtained from participants and study protocols were approved by Institutional Review Boards at each of the 13 sites.

Measures

An interview protocol required by SAMHSA for purposes of program evaluation was administered to all participants. The interview included Government Performance Reporting Act (GPRA) questions on demographics (gender, race, ethnicity, date of birth), education level, employment, income, housing status, and alcohol and drug use. Questions on alcohol and drug use assessed days of use in past 30 days (prior to arrest/jail detention). The number of reported days of drinking to intoxication and using illegal drugs was used to construct a substance abuse variable with three levels: none, moderate, heavy.

Participants were asked dichotomous (yes/no) questions regarding the experience of a range of traumatic events. The questions assess whether participants experienced physical assault (i.e., “has anyone choked, kicked, bit, or punched you?”), threat or use of a weapon (i.e., “has anyone threatened you with, or actually used, a knife, gun, or other weapon to scare or hurt you?”), sexual abuse (i.e., “has anyone forced you to have sex when you did not want to?”), and witnessing violence (i.e., “have you witnessed a physical or sexual assault against a family member, friend, or other significant person?”), over the lifetime and in the past 12 months.

Perceived coercion was assessed with the MacArthur Perceived Coercion Scale (PCS). The PCS includes five items from the MacArthur Admission Experience Survey and was originally developed to assess perceived coercion associated with the process of hospital admission (14). The wording was modified for the baseline administration to reflect perceived coercion to enter the jail diversion program. Items included, “I felt free to do what I wanted about going to the diversion program,” “I chose to go to the diversion program,” “It was my idea to go to the diversion program,” “I had a lot of control over whether I went to the diversion program,” and “I had more influence than anyone else on whether I went to the diversion program.” At the 12-month interview, participants who received any mental health or substance abuse services responded to PCS items in regards to perceived coercion to receive outpatient services. Cronbach's alpha was .69 in the current study.

Mental health symptoms were assessed with the Colorado Symptom Index (15), which consists of 14 self-reported mental health symptom items rated on a five-point frequency scale. Higher scores are associated with greater symptom severity. Cronbach's alpha was .90 in the current study.

Arrest data for 12 months prior to the target arrest/incident date and 12 months post target arrest release date was collected by each of the 13 jail diversion programs and submitted to the coordinating center. Data on mental health and substance abuse service use was available for six of the 13 jail diversion sites. These data were collected by the diversion program for 6 months post-baseline for outpatient services and 12 months post-baseline for hospitalizations and emergency room use.

Statistical Analyses

First, simple two-way associations between each predictor variable and the dependent variables were conducted. The five items regarding perceived coercion to enter the jail diversion program were summed with a mean score of 1.4 ± 1.4 . Because the scores on the PCS were not normally distributed, an ordinal variable was created with three levels: coerced, moderately coerced, and not coerced. Participants were categorized as coerced if they answered “false” to four or five of the five items; moderately coerced if the answered “false” to 2–3 of the items; and not coerced if 4–5 of the items were true. Potential predictors of coercion to enter the jail diversion program (baseline) or to receive behavioral health services (12-month) included characteristics of the violation such as charge type (drug, minor, or person/violent/sex), and charge level (misdemeanor, felony, or violation) of the index violation, point of diversion (booking or parole/probation violation), days from arrest to diversion (quartiles) and number of previous arrests; demographic variables, including age (dichotomized at age 35), gender, black race, Hispanic ethnicity, income (dichotomized at the median of \$596/mo.), employment status, education (dichotomized at 12 years) and homeless status (have housing vs. shelter/street); clinical variables, such as diagnosis (schizophrenia, bipolar, depression/anxiety, or other) and severity of symptoms on the CSI (in quartiles); substance abuse status (non-user of drugs or alcohol, moderate user or abuser, heavy abuser); and exposure to violence (indicator of witnessed violence in past 12 months, indicator of lifetime witnessed violence, indicator of physical violence victimization in past 12 months, indicator of lifetime physical violence victimization; indicator of sexual abuse in past 12 months; indicator of lifetime sexual abuse; sum of traumatic life events in past 12 months; sum of lifetime traumatic events). Interactions chosen *a priori* for investigation were the interactions between race and gender, sexual abuse and gender, physical abuse and gender, sexual abuse and drug use, and physical abuse and drug use. The race by gender interaction term was chosen because past research has indicated Caucasian women are most likely to be diverted (3). Gender by physical/sexual abuse interaction terms were chosen because of the potential for the abuse variables to measure vastly different experiences for women compared to men. The physical and sexual abuse by substance

abuse terms were chosen because: 1) a history of sexual abuse or posttraumatic stress disorder (PTSD) is associated with reporting more coercive experiences in the psychiatric setting (16); and 2) the greater mental illness severity found among individuals with a history of interpersonal abuse and also substance abuse problems was assumed to amplify the effects of the interpersonal abuse on coercion. No other interactions were considered.

A random effects model was used to account for the dependence among participants within site. The SAS GLIMMIX procedure was used with a multinomial response distribution, cumulative logit link function, and maximum likelihood estimation in order to model the dependent variables, coercion to enter the diversion program and coercion to receive behavioral health services. The proportional odds model was selected for the ordinal coercion outcomes after testing in a saturated model whether the fit of the generalized logistic model was superior. Starting with a model containing all main effects and the *a priori* selected interactions, a stepwise model selection procedure was implemented.

To model outpatient service counts, we used a random effects model with a negative binomial distribution and log link, accounting for potential correlation among subjects from a given study site using a random effect in SAS PROC GLIMMIX. Backward selection was used to select a final model.

Results

Participants

The distribution of participants from the 13 sites is shown in Table 1. Just over half of the sample was male (53%), 29% were black and 20% were Hispanic (see Table 2). The most common diagnoses were depression/anxiety disorders (30%), followed by bipolar disorder (26.7%), schizophrenia-spectrum (26%), and other (18%). Roughly three quarters of the sample (74%) reported moderate to heavy substance use, and 55% had been sexually abused in their lifetime. The majority of the participants were arrested on a misdemeanor charge (66%) and diverted as a condition of bail (42%) or probation (24%). More than half of the sample (56%) had a prior arrest in the past year.

Perceived Coercion to Enter Jail Diversion Program

Nine hundred and five participants completed the baseline interview. Thirty-four of these individuals had at least one item missing from the PCS, resulting in 871 participants with complete responses. Ten percent (10%) reported perceived coercion, 26% reported moderate coercion, and 64% reported no coercion. Significant unadjusted relationships were found for coercion and race $\chi^2=14.52$, $df=4$, $p=.01$, and coercion and substance use $\chi^2=12.5$, $df=4$, $p=.001$. Specifically, higher levels of coercion were more likely to be reported by African-Americans and those reporting high levels of substance abuse.

Results of the best fitting proportional odds model are summarized in Table 3. Individuals with a drug charge were less likely to report higher levels of coercion than individuals with a minor charge, though risk of reporting coercion did not differ between individuals with a minor charge and those with a violent charge. Specifically, individuals with a drug charge had .55 (.34–.89) times the odds of reporting moderate coercion versus no coercion (or of reporting high coercion versus moderate coercion) than individuals with a minor charge. The association between past year sexual abuse and perceived coercion depended on the level of substance use – that is, sexual abuse was associated with an increased likelihood of reporting higher levels of coercion but only among those with no current substance abuse. Among participants with no current substance abuse, those reporting sexual abuse in the past year had 2.96 (1.14–7.67) times the odds of reporting moderate coercion versus no coercion (or of reporting high coercion versus

moderate coercion) than individuals with a minor charge. While CSI symptoms and amount of time in jail prior to entering the diversion program were both associated with coercion (Table 3), there was no monotonic relationship between these variables and level of coercion.

Perceived Coercion to Receive Behavioral Health Services

Forty-four percent (44%, N=398) of the baseline sample participated in the 12-month interviews. This substantially reduced 12-month sample differed from the baseline sample on several variables. They were more likely to be male, less than 35 years old, Hispanic, employed, have a drug charge, and a bipolar diagnosis. The 12-month sample did not differ from the baseline sample on baseline coercion score. Therefore, despite the possibility for selection bias we chose to report these results. Only participants who self-reported receiving any outpatient services were asked the PCS items regarding receipt behavioral health services, resulting in a sample of 281 participants. The PCS rating for the 283 participants was 1.03 ± 1.4 . A total of 27% were categorized as coerced, another 18% moderately coerced, and 55% not coerced. Unadjusted models for coercion to receive behavioral health services found associations with charge level $\chi^2=11.33$, $df=4$, $p=.02$, homelessness $\chi^2=6.04$, $df=2$, $p=.05$, days to diversion $\chi^2=12.52$, $df=6$, $p=.05$, and baseline level of coercion $\chi^2=19.94$, $df=4$, $p=.001$. Individuals with a misdemeanor level charge were less likely to report feeling coerced than those with a felony or technical violation. Homeless individuals were less likely to report coercion but more likely to report moderate coercion than their non-homeless counterparts. Finally, individuals who reported moderate coercion at baseline were more likely to report higher coercion to receive services at the 12-month interview.

Results of the best fitting multivariate proportional odds model are summarized in Table 4. Individuals with longer delays to diversion had increased odds of reporting a higher level of coercion, with individuals in the 2nd quartile having 2.97 (1.35–6.55) times the odds of reporting a higher level of coercion (either moderate versus none, or high versus moderate) as individuals in the 1st quartile; individuals in the 3rd quartile having 2.94 (1.35–6.40) times the odds of reporting a higher level of coercion as individuals in the first quartile, and individuals in the 4th quartile having 3.38 (1.46–7.84) times the odds of reporting a higher level of coercion as individuals in the first quartile. Finally, participants who reported moderate levels of coercion at baseline had 3.65 (2.07, 6.42) times the odds of reporting higher levels of coercion to receive services at 12 months, though individuals reporting high levels of coercion at baseline were not at significantly increased risk of reporting higher levels of coercion to receive services.

The Effect of Coercion on Behavioral Health Service Use

Service use data was obtained for six of the 13 sites (N=348). The most common services included case management (92%), outpatient services other than case management (89%), and medication management (61%). A random effects model of outpatient service use indicated no significant relationship between coercion to enter the jail diversion program and the number of behavioral health service visits while controlling for other demographic, clinical, and criminal justice factors. However, older participants had 1.26 (1.05–1.51) times the outpatient service counts as younger participants. Hispanic males had .50 (.27–.93) times the service counts as Hispanic females. Those with the highest symptom severity have 1.35 (1.04–1.75) times the service counts as those with the lowest symptom severity. Those reporting lifetime sexual abuse but no substance abuse and no history of physical abuse have 1.84 (1.21–2.78) times the outpatient service counts as those not reporting sexual abuse. Those with physical abuse but no sexual abuse nor substance abuse have .54 (.32–.88) times the service counts as those with no interpersonal abuse and no substance abuse.

Discussion

We found the majority of participants in this study did not feel coerced to enter the jail diversion program or to receive behavioral health services during the year following diversion. Ten percent (10%) of the sample was considered “coerced” and 26% “moderately coerced” to enter the jail diversion program. Responses regarding the receipt of services at the 12-month interview indicated 27% were “coerced” and 18% “moderately coerced.” This level of perceived coercion reported among jail diversion participants is actually no greater than that reported for voluntary psychiatric outpatients (10) or participants in a mental health court (17), and considerably lower than the level of coercion reported for involuntary psychiatric inpatients (8,18) or psychiatric outpatients (10).

Participants with a drug charge were less likely to report higher levels of perceived coercion. Presumably, people facing drug charges (vs. minor charges) may have greater incentive to consider alternatives to incarceration and therefore view the diversion program as a positive choice. Experiencing sexual abuse in the past 12 months was associated with higher levels of perceived coercion – but only among non-substance abusers. In other words, sexual abuse is likely to lead to feelings of lack control and possibly greater sensitivity to coercion, but the opposite effect produced by engaging in substance abuse (and possibly drug-related charges) changes this relationship.

After a year of involvement in the jail diversion program, the only variables that explained level of perceived coercion to receive behavioral health services were higher level of baseline coercion and longer wait from arrest to diversion. These findings must be interpreted cautiously due to the substantial attrition rate (56%) from baseline to the 12-month interview.

An important question this study sought to address is whether feeling coerced would lead to poorer engagement in services and lower overall levels of service contact. We found no evidence to support this hypothesis. Factors that did predict level of service use included older age, higher symptom severity, and lifetime history of sexual abuse among those *without* a history of physical abuse or current substance abuse. On the other hand, male gender among Hispanics and experiencing physical abuse without a history of sexual abuse or substance abuse were associated with fewer outpatient visits.

A significant strength of the current study is that the findings are based on data from a large, multisite jail diversion initiative. A number of important limitations also exist. While the study identified characteristics that are associated with perceived coercion, it does not permit a full explanation of *why* participants might have felt coerced. Questions regarding the process of diversion including the role of participants' views of procedural justice, negative pressures, comprehension of the voluntary nature of their participation, and the perceived need for treatment would provide a more thorough understanding of coercion in jail diversion. Each of these variables has been found to be important considerations in previous research on persons with mental illness in other settings (19–21) and should be further explored in future studies of jail diversion.

Conclusion

Most participants in this multi-site study did not perceive coercion in the jail diversion process. Further, coerced was unrelated to the overall level of service use. Additional research is needed to further understand coercion in jail diversion programs by examining the perceived need for treatment among participants, negative pressures placed on participants, and their views of procedural justice.

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Table 1

Participants by Site Location

Site	N	%
Hartford	67	7
Hawaii	53	6
Iowa	54	6
Maine	41	5
Tulsa	35	4
Virginia	40	4
New Britain, Bristol	62	7
Nebraska	113	12
Texas	163	18
Tennessee	136	15
Miami	56	6
Alaska	34	4
Orlando	51	6
	905	100%

Table 2Participant Characteristics^a

	N	%
Age	35.2±10.3	
Gender (N=903)		
Male	474	52
Female	429	48
Race (N=903)		
African-American	291	32
Caucasian	515	57
Other	97	11
Ethnicity (N=904)		
Hispanic	189	21
Non-Hispanic	715	80
Primary Diagnosis - Schizophrenia spectrum	237	30
Primary Diagnosis - Depression/anxiety disorder	267	23
Primary Diagnosis - Bipolar disorder	242	27
Primary Diagnosis - Other	159	6
Alcohol/Drug Use (N=899)		
Heavy substance abuse	265	30
Moderate substance abuse	483	54
No substance use	151	17
Charge level		
Misdemeanor	572	63
Felony	259	29
Violation	74	8
Charge type		
Minor	591	65
Drug	127	14
Person, violent, or sexual	187	21
Diversion point		
postbooking	815	90
parole/probation violation	90	10
Diversion condition		
charges dropped	37	4
Condition of bail	379	42
Deferred prosecution	74	8
Condition of probation	213	24
Deferred sentencing	49	5
other	153	17
Coercion to enter program (N=871)		
None	555	64
Moderate	230	26

	N	%
High	86	10
Coercion to receive services (N=281)		
None	154	55
Moderate	51	18
High	76	27

^abased on N= 905 unless otherwise noted

Table 3

Random effects proportional odds model for coercion to enter the diversion program

Predictor	OR	95% CI
Drug charge	.55	.34 – .89*
Violent charge	.97	.65 – 1.45
Minor charge	Referent	
Heavy substance abuse/no sexual abuse	1.55	.95 – 2.53
Moderate substance abuse/no sexual abuse	1.03	.65 – 1.64
Heavy substance abuse/sexual abuse	.31	.11 – .85*
Moderate substance abuse/sexual abuse	.30	.11 – .88*
No substance abuse/no sex abuse	Referent	
Age ≥35	.75	.55 – 1.03
Age <35	Referent	
Sexual abuse/no substance abuse	2.96	1.14 – 7.67*
Sexual abuse/moderate substance abuse	.87	.45 – 1.69
Sexual abuse /heavy substance abuse	.59	.33 – 1.03
No sexual abuse/no substance abuse	Referent	
CSI highest quartile	1.33	.85 – 2.09
CSI third quartile	.87	.55 – 1.35
CSI second quartile	1.50	.97 – 2.34
CSI lowest quartile	Referent	
Days to diversion highest quartile	1.27	.74 – 2.17
Days to diversion third quartile	1.39	.83 – 2.31
Days to diversion second quartile	.63	.38 – 1.05
Days to diversion lowest quartile	Referent	

* confidence intervals that do not contain 1 are significant at the .05 level

Table 4

Random effects proportional odds model for coercion to receive behavioral health services

Predictor	OR	95% CI
Days to diversion highest quartile	3.38	1.46 – 7.84 *
Days to diversion third quartile	2.94	1.35 – 6.40 *
Days to diversion second quartile	2.97	1.35 – 6.55 *
Days to diversion lowest quartile	Referent	
Baseline high coercion	1.57	.67 – 3.70
Baseline moderate coercion	3.65	2.07 – 6.42 *
Baseline low coercion	Referent	

* confidence intervals that do not contain 1 are significant at the .05 level