The disproportionate representation of individuals with mental illness and/or substance use disorders within the criminal justice system is widely recognized and increasingly the focus of public policy and practice reforms. Many untreated and undertreated individuals revolve from the streets to hospital emergency rooms to jails, through the courts and then back to the streets with little pause, their care and support for stability and recovery disrupted at every transition.

Because multiple systems may be involved in a single individual’s case, judges have a unique opportunity to examine whether service providers for detainees, defendants and inmates with behavioral health conditions are connected sufficiently to assure uninterrupted services and support during handoffs between systems. When such connections are absent or insufficient to promote successful transitions, continuity can be built into court dispositions.

This Mental Health Facts in Brief reviews the meaning and significance of continuity of care for individuals moving among health, homelessness, criminal justice and other systems, and presents considerations for improving handoffs that may produce more beneficial individual and public outcomes.

**BRIEF HISTORY**

Beginning in the mid-1850s and continuing for roughly a century, mental illness treatment in the United States was delivered primarily through state-operated psychiatric hospitals, often called “asylums.” In the 1950s, the convergence of clinical, social, political and other forces led to a widespread closure of state-operated psychiatric beds, a movement known as “deinstitutionalization.”

Today, fewer than 2% of all public mental health care clients are being treated in state-run hospitals. The vast majority of individuals once treated in these facilities now live successfully in the community, a transition made possible by the development of effective psychiatric medications and the emergence of community-based treatments. Additionally, a number of non-psychiatric conditions once addressed in state hospitals are now managed with medications or are otherwise

**COMMUNITY POLICIES AND PRACTICES**

To meet this challenge, strategies to establish and sustain connections among behavioral health service providers are increasingly being examined and implemented by cities, counties, courts and advocacy groups. Approaches take many forms, including among others:

- **Financial**: Spreading funding for an individual’s care across systems supporting the person (e.g., from behavioral health, where the person is seen as a patient, to the correctional system, if they become incarcerated)

- **Clinical**: Assuring that treatments provided in one setting are maintained when the person is treated within other service systems (e.g., medication assisted treatment for addiction being supported in both the substance use and homelessness systems, or the psychiatric medications prescribed in the community also being supplied in the jails)

- **Psychosocial**: Incorporating re-entry specialists and professional peer support in jail/prison discharge planning

- **Operational**: Combining professionals from different systems to collaborate and respond to situations where combined expertise may produce a better result (e.g., adding mental health professionals to law enforcement crisis response)
no longer considered a cause for inpatient
treatment (e.g., epilepsy, intellectual
disabilities).

One of the unforeseen byproducts
of deconstructing the mental illness
treatment system was the proliferation of
service silos wherein providers address
different needs of the same individual
in isolation from other providers. By the
turn of the 21st century, President George
W. Bush’s New Freedom Commission on
Mental Health to transform mental health
care identified the “fragmented mental
health delivery system” as one of the key
challenges in mental health care in the
nation.

The challenge has yet to be met, a
reality that has been no less true for
treatment of substance use. Individuals
with psychiatric and/or substance use
disorders routinely intersect with systems
such as mental health, substance use,
primary medical care, emergency services,
homelessness, veterans’ affairs or criminal
justice. Yet, typically, these systems are
not set up to share information, much
less coordinate inter-system handoffs
(e.g., when an individual moves from a
community setting to a jail and back).
This discontinuity inevitably disrupts
treatment and thus contributes to high re-
arrest and re-incarceration rates, chronic
homelessness, poor health, early death
and other undesirable outcomes.

- **Navigational:** Convening stakeholders from multiple
  systems to map pathways that reduce or eliminate
  roadblocks to the continuity of care between providers

- **Educational:** Developing programs that raise awareness of
  the importance of continuity of care and promote strategies
  for achieving it, this *Facts in Brief* among them

- **Legal:** Developing memoranda of agreement that create
  a foundation for different systems to work together by
  addressing privacy and other legal barriers to collaboration
  (e.g., authorizing emergency medical departments to share
  medical information with homelessness programs)

### SUPPORTING EVIDENCE

Although most people with mental health conditions function
successfully in the community and never intersect with the
criminal justice system, individuals with psychiatric disorders
make up a disproportionate share of jail and prison inmates
and are overrepresented in the juvenile justice system. Studies
overwhelmingly show this population has a higher risk of poor
outcomes than the general inmate population.

When systems do not connect and gaps are left in the safety net,
the outcomes are even worse for those individuals who need to
remain engaged in treatment to thrive in their communities (e.g.,
increased rates of reoffending, re-incarceration and relapse of
symptoms). Examples of connection strategies that have shown
positive results include critical time intervention (a graduated
system of linkages that begin intensively and moderate over
time); assertive community treatment (wherein representatives
from multiple professional disciplines serve on one community-
based team); MISSION (a transitional support model for persons
with co-occurring conditions); and intensive case management (a
community-based package of care across systems).
JUDICIAL CONSIDERATIONS

Circumstances and resources vary tremendously across systems and regions in the United States, but judicial inquiry into the following questions will help supply critical background about the continuity of care to assist with informing judicial decision making.

- Are alternatives to incarceration available that would address public safety? Was the individual previously connected with community-based treatment?

- Is the individual coming from a mental health or substance use treatment program where medications have been prescribed for a mental illness or substance use disorder? If so, what mechanisms can be put in place to assure the medication therapy will not be interrupted?

- Is there a clinical treatment plan in place for this individual, and how can the court support the clinical recommendations? If no treatment plan exists, what is the appropriate course of action to mobilize mental health professionals to develop one?

- What is the mechanism for the individual’s service providers to share information across systems, and is there something the court can do to promote its use? For example, is there a need for a court order authorizing or ordering such information-sharing?

- Are there other circumstances that may dissuade the individual from remaining in care, such as distrust of treatment providers, lack of awareness of treatment recommendations, unwanted side effects from treatment interventions, transportation obstacles? Identifying barriers to continuity can shed light on strategies to overcome them.

SUMMARY

Fragmentation in care disrupts treatment and support for individuals with serious mental illness and/or substance use disorders and thus places them at risk for poor health, social and economic outcomes. These outcomes include re-arrest, re-incarceration, homelessness, family disruption and trauma, suicide and others. Court appearances represent an opportunity for the justice system to identify gaps in the continuity of care and to promote connections that benefit the individuals, the systems and the community at large.


ABOUT THE AUTHORS

Debra A. Pinals, MD, serves as the director of the program in law, psychiatry and ethics at the University of Michigan and the state medical director for behavioral health and forensic programs for the Michigan Department of Health and Human Services. Widely published and nationally recognized as a policy advisor, educator and leader in her field, she has served as a forensic psychiatrist expert witness in courts and has consulted to numerous systems on topics pertaining to mental health, intellectual and developmental disabilities, forensic processes, substance use and the law.

Doris A. Fuller, MFA, is a personal and professional mental health advocate and researcher whose work has been published on three continents and widely reported by general media. At the nonprofit Treatment Advocacy Center, Fuller authored groundbreaking studies about the role of serious mental illness in the criminal justice system and produced the judicial education documentary video Mental Illness on Trial.

The views in this fact sheet are those of the authors and do not represent the positions of any agency or institution with which they are affiliated.