Mental Health
FACTS IN BRIEF

Connecting Care for Better Outcomes

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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.

RESOURCES

- Hwang YIJ et al. Disengagement from mental health treatment and re-offending in those with psychosis: a multi-state model of linked data. Social Psychiatry and Psychiatric Epidemiology (vol. 55[12], 2020 Dec, pp 1639-1648). Retrieved from https://www.researchgate.net/publication/341151686_Disengagement_from_mental_health_treatment_and_re-offending_in_those_with_psychosis_a_multi-state_model_of_linked_data

- Bronson J et al. Systematic review and inventory of programs and practices for justice-involved adults with serious mental illness, across the sequential intercept model. Alexandria, VA: National Association of State Mental Health Program Directors Research Institute (2020). Retrieved from https://www.nri-inc.org/media/1678/final-pew.pdf

- SMI Adviser. (Search results for "continuity of care.") SMIadviser.org. Substance Abuse and Mental Health Services Administration. Accessed 12 Oct 2021 at https://smiadviser.org/?s=continuity+of+care

ABOUT THE AUTHORS

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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*.

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SJI State Justice Institute

NCSC National Center for State Courts

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