

**“WHO’S PRETENDING TO CARE FOR HIM?” HOW  
THE ENDLESS JAIL-TO-HOSPITAL-TO-STREET-  
REPEAT CYCLE DEPRIVES PERSONS WITH MENTAL  
DISABILITIES THE RIGHT TO CONTINUITY OF CARE**

NAOMI M. WEINSTEIN<sup>†</sup> & MICHAEL L.  
PERLIN<sup>††</sup>

I. INTRODUCTION

Over thirty years ago, the late Professor Bruce Winick called our attention to “the well-known chain of events [involving criminal defendants with mental disabilities] from incompetency determination to hospital to stabilization to return to jail to decompensation to *re*-determination of incompetency to *re*-hospitalization several times.”<sup>1</sup> Some seventeen years ago, one of the authors of this article, Professor Emeritus Michael L. Perlin, noted how psychiatric hospital commitments of this population “are frequently followed by a ‘shuttle process’ by which defendants are stabilized, returned to jail to await trial, and returned to the hospital following relapse.”<sup>2</sup> A decade ago, a trial judge in

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<sup>†</sup>. Associate Attorney, Mental Hygiene Legal Service (The views expressed in this article are of the author and may not be representative of those of Mental Hygiene Legal Service.) naomi.weinstein@gmail.com.

<sup>††</sup>. Professor Emeritus of Law, New York Law School. Founding Director, International Mental Disability Law Reform Project. Co-founder, Mental Disability Law and Policy Associates. michael.perlin@nyls.edu. Both authors would like to thank Henry Dlugacz for his invaluable help. Portions of this paper were presented in Nov. 2017, at the annual conference of the American Criminology Society, in Philadelphia, PA, and at the Forensic Psychiatry Grand Rounds Seminar at the University of Pennsylvania in March 2018.

1. Bruce J. Winick, *Restructuring Competency to Stand Trial*, 32 UCLA L. REV. 921, 934 n.52 (1985) (internal citations omitted).

2. Michael L. Perlin, “*For the Misdemeanor Outlaw*”: *The Impact of the ADA on the Institutionalization of Criminal Defendants with Mental Disabilities*, 52 ALA. L. REV. 193, 204 (2000); *see also* Joanmarie Ilaria Davoli, *Physically Present, Yet Mentally Absent*, 48 U. LOUISVILLE L. REV. 313, 320 n.56 (2009) (citing Shauhin Talesh, *Mental Health Court Judges As Dynamic Risk Managers: A New Conceptualization of the Role of Judges*, 57 DEPAUL L.

Vermont outlined the problem succinctly: “Discharge into the community without planning or supervision is likely to result in a repetition of the cycle of violent offense, incarceration, overt signs of mental illness in jail, commitment, and reduced or largely absent signs of mental illness in the hospital which has marked [the defendant’s] adult life.”<sup>3</sup>

Just three years ago, a student note came to the same conclusions, noting that members of this cohort “continue to cycle in and out of mental hospitals.”<sup>4</sup> Likewise, earlier this year former President Barack Obama noted the existence of “a relatively small number of highly vulnerable individuals [who] cycle repeatedly not just through local jails, but also hospital emergency rooms, shelters, and other public systems.”<sup>5</sup>

In short, the way we criminalize behavior that disproportionately affects people with mental illness is a problem that has not gone away, and is one that any of us who take seriously the entire bundle of issues that are raised by this phenomenon—how we treat this population; how we fail to learn from our history of failure; how we ignore options that might potentially ameliorate the underlying situation; how we demand quick fixes, and ignore the “long game”—must take equally seriously.<sup>6</sup> This shuttling or cycling is bad for many reasons, not least of which is the way that it deprives the cohort of individuals at risk from any meaningful continuity of care and how it exacerbates the problems caused by the unnecessary and counterproductive arrests of persons with mental disabilities for

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REV. 93, 101–02 (2007) (emphasizing how prisoners cycle in and out of the criminal justice system and rarely receive hospital treatment while incarcerated).

3. State v. Swift, No. 1191-8-00 Wncr, 175-5-04 Oecr, 2006 WL 2627322 (Vt. Dist. Ct. Mar. 24, 2006).

4. Renee Gruber, Note, *A Civil Prison—Fear or Reason? Unbiased Reform of Involuntary Commitment Proceedings for Non-Criminals Admitted into Mental Facilities*, 90 U. DET. MERCY L. REV. 203, 211 (2013).

5. Barack Obama, *The President’s Role in Advancing Criminal Justice Reform*, 130 HARV. L. REV. 811, 848 (2017); see also THE WHITE HOUSE, FACT SHEET: LAUNCHING THE DATA-DRIVEN JUSTICE INITIATIVE: DISRUPTING THE CYCLE OF INCARCERATION (June 30, 2016), [www.obamawhitehouse.archives.gov/the-press-office/2016/06/30/fact-sheet-launching-data-driven-justice-initiative-disrupting-cycle](http://www.obamawhitehouse.archives.gov/the-press-office/2016/06/30/fact-sheet-launching-data-driven-justice-initiative-disrupting-cycle).

6. See, e.g., Michael L. Perlin, “*Wisdom Is Thrown into Jail*”: *Using Therapeutic Jurisprudence to Remediate the Criminalization of Persons with Mental Illness*, 17 MICH. ST. U. J. MED. & L. 343 (2013).

“nuisance” crimes.<sup>7</sup> By the phrase “continuity of care,” we adopt the definition offered by Bruce Frederick: “1) continuity of control, 2) continuity in the range of services, 3) continuity in service and program content, 4) continuity of social environment, and 5) continuity of attachment.”<sup>8</sup> Beyond this, continuity of care requires “effective interagency and provider communication to share information, facilitate access, and integrate care across providers and settings,”<sup>9</sup> and the “development of caring, respectful relationships with caregivers so that needs are identified and consumers are engaged in care.”<sup>10</sup>

Continuity of care further requires: (1) treatment in facilities that prepare offenders for reentry into the specific communities to which they will return, (2) making the necessary arrangements and linkages with people, groups and agencies in the community that relate to known risk and protective factors, and (3) ensuring the delivery of required services and supervision.<sup>11</sup> Without this continuity, it is far less likely that any therapeutic intervention will have any long-lasting ameliorative effect.<sup>12</sup>

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7. See, e.g., Michael L. Perlin & Alison J. Lynch, “To Wander Off in Shame”: Deconstructing the Shaming and Shameful Arrest Policies of Urban Police Departments in Their Treatment of Persons with Mental Disabilities, in SYSTEMIC HUMILIATION IN AMERICA: FINDING DIGNITY WITHIN SYSTEMS OF DEGRADATION 175 (Daniel Rothbart ed. 2018) [hereinafter *To Wander Off*]; Alison J. Lynch & Michael L. Perlin, “Life’s Hurried Tangled Road”: A Therapeutic Jurisprudence Analysis of Why Dedicated Counsel Must Be Assigned to Represent Persons with Mental Disabilities in Community Settings, 35 BEHAV. SCI. & L. 353 (2017); Michael L. Perlin & Alison J. Lynch, “Had to Be Held Down by Big Police”: A Therapeutic Jurisprudence Perspective on Interactions Between Police and Persons with Mental Disabilities, 43 FORDHAM URB. L.J. 685 (2016) [hereinafter *Big Police*].

8. David M. Altschuler & Troy L. Armstrong, *Juvenile Corrections and Continuity of Care in a Community Context—The Evidence and Promising Directions*, 66 FED. PROB. 72, 73 (Sept. 2002) (citing BRUCE FREDERICK, FACTORS CONTRIBUTING TO RECIDIVISM AMONG YOUTH WITH THE NEW YORK STATE DIVISION FOR YOUTH 20–21 (1999)).

9. Rebecca Spain Broches, *Creating Continuity: Improving the Quality of Mental Health Care Provided to Justice-Involved New Yorkers*, 21 GEO. J. ON POVERTY L. & POL’Y 91, 100 (2013) (quoting Janet Durbin et al., *Continuity of Care: Validation of a New Self-Report Measure for Individuals Using Mental Health Services*, 31 J. BEHAV. HEALTH SERVS. & RES. 279, 280 (2004)).

10. *Id.* at 100 (quoting Durbin et al., *supra* note 9, at 280).

11. See generally Durbin et al., *supra* note 9, at 293.

12. Related to this are other ploys used by state prison systems that thwart authentic continuity of care efforts: the retention of persons in prisons after their conditional release dates in residential treatment facilities (see, e.g., *People ex rel. Green v. Superintendent of Sullivan Corr. Facility*, 25 N.Y.S.3d 375 (N.Y. App. Div. 2016)); or the transfer of some of this cohort of individuals to state hospitals via what is known as the “two PC” method of commitment; for a prototypical example, see N.Y. MENTAL HYG. LAW

Our current system fails to meet any of these prescriptive standards, and as long as the state of affairs remains the same we are doomed to decades more of scholarship and case law—by law professors, judges, students and former Presidents—appropriately decrying what has happened.<sup>13</sup> The current system, in addition to being utterly counter-productive (and in many ways destructive), is also violative of the constitutional right to treatment and the statutory right to non-discrimination as provided in human rights law both domestically (the Americans with Disabilities Act) (“ADA”) and internationally (the Convention on the Rights of Persons with Disabilities) (“CRPD”).

This article will first discuss the current state of affairs. Then, we will review the valid and reliable research as to why continuity of care, which is clinically necessary, is so often missing and how the failure to provide this continuity leads to the problems we currently face. We then set out the legal arguments, constitutional and statutory, that we believe need to be relied on to remediate the current situation. In this context, we will also discuss the implications of the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”),<sup>14</sup> the Patient Protection and Affordable Care Act (“ACA”),<sup>15</sup> and Medicaid regulations<sup>16</sup> for the population in question, and consider the viability of using advance psychiatric directives.<sup>17</sup> After this, we show how our current system violates every precept of therapeutic jurisprudence,

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§ 9.27 (McKinney 2011) (“Involuntary admission on medical certification.”). On the double stigmatization of this population in general, see Michael L. Perlin & Alison J. Lynch, *Toiling in the Danger and in the Morals of Despair: Risk, Security, Danger, the Constitution, and the Clinician’s Dilemma*, 5 IND. J.L. & SOC. EQUAL. 409, 410 (2017); Michael L. Perlin, *On “Sanism,”* 46 SMU L. REV. 373, 398–99 (1992) (quoting Ellen Hochstedler, *Twice-Cursed? The Mentally Disordered Criminal Defendant*, 14 CRIM. JUST. & BEHAV. 251 (1987)).

13. One of the co-authors, Michael L. Perlin, represented this cohort of individuals in the 1970s–1980s; the other co-author, Naomi M. Weinstein, has represented like cohorts since the late 2000s. Our discussions of what we have observed have revealed similar situations.

14. Health Insurance Portability and Accountability Act of 1996 (HIPAA), 29 U.S.C. § 1181 (2012); 42 U.S.C.A. § 300gg (2012); 42 U.S.C.A. § 1320d (2011).

15. Patient and Affordable Care Act (“ACA”), 42 U.S.C. § 18001 (2010).

16. Centers for Medicare & Medicaid Services, Department of Health and Human Services, 42 C.F.R. § 400 (2017).

17. On the use of such directives in general in this context, see Michael L. Perlin & Naomi M. Weinstein, *“Said I, ‘But You Have No Choice’”: Why a Lawyer Must Ethically Honor a Client’s Decision About Mental Health Treatment Even if It Is Not What S/he Would Have Chosen*, 15 CARDOZO PUB. L. POL’Y & ETHICS J. 73, 106–08 (2016/2017).

as well as the basic principles of international human rights law, and argue for the enhanced use of mental health courts. We conclude by offering some suggestions that, we believe, will ameliorate the current situation.

Our title comes from Bob Dylan's brilliant song, *Visions of Johanna*,<sup>18</sup> and comes from this couplet: "The peddler now speaks to the countess *who's pretending to care for him/ Sayin', 'Name me someone that's not a parasite and I'll go out and say a prayer for him'*"<sup>19</sup> *Visions of Johanna* is universally seen as one of Dylan's greatest songs, an "undisputed master-work," according to eminent Dylanologist Oliver Trager.<sup>20</sup> In part, the song is about nightmares and hallucinations.<sup>21</sup> This couplet has been characterized by as a reflection of Dylan's "hunger for the authentic,"<sup>22</sup> although the countess figure demonstrates only a "pretense of care."<sup>23</sup> We chose this—admittedly, ambiguous—lyric to use in our article title for several reasons: first, the economic and social status contrast between the "peddler" and the "countess" parallels the contrast between the status of the marginalized persons of whom we write<sup>24</sup> and the power of the state; second, we believe that our rejection of the importance of continuity of care demonstrates the reality that the state is only "pretending to care" for those of whom we write; and third, this population is seen, unfortunately, as "parasit[ic]," and thus, of less value than others.<sup>25</sup>

18. BOB DYLAN, *Visions of Johanna*, on *BLONDE ON BLONDE* (Dwarf Music 1966).

19. *Id.* at 5:42–5:59 (emphasis added).

20. OLIVER TRAGER, *KEYS TO THE RAIN: THE DEFINITIVE BOB DYLAN ENCYCLOPEDIA* 653 (Bob Nirkind & Marian Appellof eds., 2004).

21. ROBERT SHELTON, *NO DIRECTION HOME: THE LIFE AND MUSIC OF BOB DYLAN* 213 (1997). One of the co-authors, Michael L. Perlin, has drawn on *Visions* for a title lyric once before. See Michael L. Perlin, "Infinity Goes up on Trial": *Sanism, Pretextuality, and the Representation of Defendants with Mental Disabilities*, 16 *QUT L. REV.* 106 (2016).

22. MIKE MARQUSEE, *WICKED MESSENGER: BOB DYLAN AND THE 1960S*, at 207 (2011).

23. Tony Attwood, *Visions of Johanna: The Meaning of the Music, the Lyrics and the Rewrites*, *UNTOLD DYLAN* (Nov. 1, 2008), <http://bob-dylan.org.uk/archives/7>. In the same paper, Attwood suggests that the "cynical peddler [is] the drug supplier, representing a false escape from reality." *Id.*

24. It should be no surprise to any reader that US incarceration policies, in this specific context as in others, have a disproportionate impact on other marginalized populations—African-Americans and Latinos. See Nicholas Freudenberg, *Jails, Prisons, and the Health of Urban Populations: A Review of the Impact of the Correctional System on Community Health*, 78 *J. URB. HEALTH* 214, 214–15 (2001).

25. In one analysis of *Visions*, a critic has connected the song to *George Jackson*, a "naturalistic tale of fury that recounts the prison death of Jackson, a Black Panther who

We have chosen to write this article in an effort to make it more likely that the population about which we are concerned will be seen as having the same value as all others, and that policies (both official and unwritten) be restructured so as to provide the level of clinical care needed by this population in ways that comport with constitutional, statutory, and international human rights law, and with the precepts of therapeutic jurisprudence.

## II. ON CONTINUITY OF CARE

### A. Introduction

As previously stated, the concept of continuity of care includes continuity of control, of services, of program content, of social environment, and of attachment.<sup>26</sup> It requires re-entry preparation, the creation of community linkages, and insurance that the required services will be delivered.<sup>27</sup> There is no question that the lack of continuity of mental health services<sup>28</sup> severely impairs the ability of community-based mental health providers to have any therapeutic impact on this population.<sup>29</sup> Henry Dlugacz and Luna Droubi state the problem succinctly: “While incarcerated, many of these people received inadequate treatment and deficient, if any, reentry planning. Once released to the

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was a major figure in radical racial politics in the late 1960s, and whose prison letters evidenced the systemic racist brutality of the American prison system.” Michael L. Perlin, *Tangled Up in Law: The Jurisprudence of Bob Dylan*, 38 FORDHAM URB. L.J. 1395, 1412–14 (2011) (citing Mark Jones, *Visions of Visions of Johanna*, [www.marknjones.com/visions\\_of\\_visions\\_of\\_johanna.pdf](http://www.marknjones.com/visions_of_visions_of_johanna.pdf); DYLAN, *supra* note 18) (concluding “[s]ome of us are prisoners, the rest of us are guards”).

26. Altschuler & Armstrong, *supra* note 8, at 73.

27. *Id.*

28. This should not be read to imply that *only* mental health services should be “at play” here. See, e.g., Emily A. Wang et al., *Engaging Individuals Recently Released from Prison into Primary Care: A Randomized Trial*, 102 AM. J. PUB. HEALTH 22, 27 (2012) (describing the importance of continuity of care for released older prisoners with chronic medical conditions).

29. David Katner, *The Mental Health Paradigm and the MacArthur Study: Emerging Issues Challenging the Competence of Juveniles in Delinquency Systems*, 32 AM. J.L. & MED. 503, 549 (2006); see also T. Howard Stone, *Therapeutic Implications of Incarceration for Persons with Severe Mental Disorders: Searching for Rational Health Policy*, 24 AM. J. CRIM. L. 283, 296 (1997) (“Lack of coordination . . . may jeopardize continuity of care for persons who attempt to access these services.”).

community, many received insufficient support and subsequently were incarcerated.”<sup>30</sup>

Failures in treatment are frequently attributed, at least in part, to discontinuity<sup>31</sup> and to lack of coordination.<sup>32</sup> There is little consistency in approach, and there is a lack of understanding as to the scope of protections that must be provided.<sup>33</sup> For years, both the prevalence of medical errors arising in cases in which there discontinuity of care<sup>34</sup> and the fact that our incarceration policies have had unintended adverse health consequences have been well-known.<sup>35</sup> The range of negative outcomes includes, but is not limited to, having no permanent residence post-release and a suicide rate eight times higher than the general population.<sup>36</sup>

It is indisputable that there is a positive impact when models of care are in place,<sup>37</sup> and that such models improve post-release engagement with mental health services.<sup>38</sup> There is now widespread agreement that transition planning is essential to facilitating continuity of care for soon-to-be released inmates with

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30. Henry A. Dlugacz & Luna Droubi, *The Reach and Limitation of the ADA and Its Integration Mandate: Implications for the Successful Reentry of Individuals with Mental Disabilities in a Correctional Population*, 35 BEHAV. SCI. & L. 135, 139 (2017).

31. Wade Askew, *Keeping Promises to Preserve Promise: The Necessity of Committing to a Rehabilitation Model in the Juvenile Justice System*, 20 GEO. J. ON POVERTY L. & POL’Y 373, 386 (2013).

32. See Sean K. Sayers et al., *Connecting Mentally Ill Detainees in Large Urban Jails with Community Care*, 88 PSYCHIATRIC Q. 323, 329 (2016) (stressing the need for greater information sharing and collaboration with community mental health agencies to minimize jail use and to facilitate successful community reentry for detainees with severe mental illness).

33. Dlugacz & Droubi, *supra* note 30, at 143.

34. Carlton Moore et al., *Medical Errors Related to Discontinuity of Care from an Inpatient to an Outpatient Setting*, 18 J. GEN. INTERNAL MED. 646, 646 (2003) (showing there was error found in forty-nine percent of cases involving discontinuity of care; the prevalence of medical errors related to the discontinuity of care from the inpatient to the outpatient setting “high” and “may be associated with an increased risk of rehospitalization”).

35. Nicholas Freudenberg & Daliah Heller, *A Review of Opportunities to Improve the Health of People Involved in the Criminal Justice System in the United States*, 37 ANN. REV. PUB. HEALTH 313 (2016).

36. Manuela Jarrett et al., *Continuity of Care for Recently Released Prisoners with Mental Illness: A Pilot Randomised Controlled Trial Testing the Feasibility of a Critical Time Intervention*, 21 EPIDEMIOLOGY & PSYCHIATRIC SCI. 187 (2012).

37. Brian McKenna et al., *Mental Health Care and Treatment in Prisons: A New Paradigm to Support Best Practice*, 16 WORLD PSYCHIATRY 3, 3 (2017) (citing Krishna Pillai et al., *From Positive Screen to Engagement in Treatment: A Preliminary Study of the Impact of a New Model of Care for Prisoners with Serious Mental Illness*, 16 BMC PSYCHIATRY 1, 6 (2016)).

38. *Id.* (citing Ingrid A. Binswanger et al., *Release from Prison — A High Risk of Death for Former Inmates*, 356 NEW ENG. J. MED. 157, 164 (2007)).

mental illness,<sup>39</sup> and that correctional systems can have a “direct effect” on the health of urban populations by linking inmates to urban services after release.<sup>40</sup> Of course, forensic practitioners will need new skills to make sure that continuity is in fact provided.<sup>41</sup> Additionally, it goes without saying that implementation requires “political and constituent support and investment of resources.”<sup>42</sup>

### *B. Role of Correctional Facilities*

Correctional facilities must engage in clinically-oriented reentry programs.<sup>43</sup> In addition to access to health care services, as part of a successful re-entry program, ex-prisoners must also have access to meaningful peer mentoring programs,<sup>44</sup> supported employment, and supported housing.<sup>45</sup> As Henry Dlugacz has stressed, successful reentry programs—programs that are collaborative as between the criminal justice system and the behavioral health system<sup>46</sup>—must be a “primary focus of correctional mental health care, [and] not an afterthought.”<sup>47</sup> While the scope of obstacles to successful programs may be “daunting,”<sup>48</sup> it is incumbent upon existing professional

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39. Jacques Baillargeon et al., *Addressing the Challenge of Community Reentry Among Released Inmates with Serious Mental Illness*, 46 AM. J. COMMUNITY PSYCHOL. 361, 368 (2010).

40. Freudenberg, *supra* note 24, at 214.

41. Jamie O'Donahoo & Janette Graetz Simmonds, *Forensic Patients and Forensic Mental Health in Victoria: Legal Context, Clinical Pathways, and Practice Challenges*, 69 AUSTL. SOC. WORK 169 (2016).

42. Broches, *supra* note 9, at 122.

43. Henry A. Dlugacz & Eric Roskes, *Clinically Oriented Reentry Planning*, in HANDBOOK ON CORRECTIONAL MENTAL HEALTH 395, 424 (Charles L. Scott ed., 2010).

44. LaVerne D. Miller, *Reentry as Part of the Recovery Process*, in REENTRY PLANNING FOR OFFENDERS WITH MENTAL DISORDERS: POLICY AND PRACTICE 10-2 (Henry Dlugacz ed., 2010).

45. Jeffrey Draine & Daniel Herman, *Critical Time Intervention*, in REENTRY PLANNING FOR OFFENDERS WITH MENTAL DISORDERS: POLICY AND PRACTICE, *supra* note 44, at 6-1.

46. Henry A. Dlugacz, *Community Re-entry Preparation/Coordination*, in OXFORD TEXTBOOK OF CORRECTIONAL PSYCHIATRY 76–77 (Robert L. Trestman et al. eds., 2015) [hereinafter Dlugacz, *Community Re-entry Preparation/Coordination*]; Henry A. Dlugacz et al., *Implementing Reentry—Establishing a Continuum of Care of Adult Jail and Prison Releases with Mental Illness*, in CORRECTIONAL PSYCHIATRY: PRACTICE GUIDELINES AND STRATEGIES 12-1 (Ole J. Thienhaus & Melissa Piasecki eds., 2007).

47. Dlugacz, *Community Re-entry Preparation/Coordination*, *supra* note 46, at 76.

48. *Id.* at 77.



organizations to support systemic change to make the success of such intervention-based programs more likely.<sup>49</sup>

For such programs to be successful, initially there must be a critical assessment of the mental health services typically available in a correctional institution,<sup>50</sup> an assessment that must be carried out in light of the “overarching resistance to considering rehabilitation” as a primary goal of corrections.<sup>51</sup> Dlugacz and a colleague note ruefully that this attitude contributes to the “isolation” that care providers in correctional settings often experience, and that it further “reinforces the disconnection of care and inadequate attention to clinically oriented reentry programs in clinical settings.”<sup>52</sup> Moreover, a proper assessment of the needs of inmates in this context requires an “interdisciplinary and integrated approach that includes the active participation of the individual, custody staff, family and treatment providers.”<sup>53</sup> Only in this way can we ever actualize this “core function” of correctional mental health.<sup>54</sup>

### III. CURRENT STATE OF AFFAIRS

Mental illness affects approximately 44 million adults in the United States alone, or about one in five Americans.<sup>55</sup> There are currently over 40,000 persons with mental illness institutionalized in psychiatric hospitals across the country.<sup>56</sup> It is estimated that in

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49. *Id.* On the different models of assessment, treatment and supervision of offenders with mental illness in efforts to minimize recidivism, see Evan M. Lowder et al., *Models of Protection Against Recidivism in Justice-Involved Adults with Mental Illness*, 44 CRIM. JUST. & BEHAV. 893 (2017) (demonstrating empirical support for the role of protective factors in risk assessment and management of adult offenders with mental illness).

50. Dlugacz & Roskes, *supra* note 43, at 396.

51. *Id.* at 400.

52. *Id.*

53. *Id.* at 410; *see also id.* at 423 (“In our view, preparing incarcerated inmates and detainees for release requires as much integration as possible.”).

54. *Id.* at 425.

55. SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., DEP’T OF HEALTH & HUMAN SERVS., BEHAVIORAL HEALTH TRENDS IN THE UNITED STATES: RESULTS FROM THE 2014 NATIONAL SURVEY ON DRUG USE AND HEALTH 2 (Sept. 2015), <https://www.samhsa.gov/data/sites/default/files/NSDUH-FRR1-2014/NSDUH-FRR1-2014.pdf> (showing that in 2014 43.6 million adults in the U.S. reportedly suffered from “any mental illness” (“AMI”), of whom 9.8 million suffered from “serious mental illness” (“SMI”)).

56. *American FactFinder*, U.S. CENSUS BUREAU, [http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=DEC\\_10\\_SF1\\_PCT20&prodType=table](http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=DEC_10_SF1_PCT20&prodType=table) (last visited May 12, 2018) (providing table of U.S. population living in “Group Quarters”

the United States fourteen and a half percent of male adults in prisons and jails have a mental illness, as do thirty-one percent of female adults—a rate of two to four times that of the general population,<sup>57</sup> with some studies concluding that over *half* of inmates have been diagnosed with mental illness or are receiving treatment for a mental health-related issue.<sup>58</sup>

Jail staff workers often have no education or training in the appropriate treatment of detainees with a mental illness, and thus may respond with aggressive measures that ultimately exacerbate symptoms of the detainees' conditions,<sup>59</sup> and it is therefore no surprise that thirty percent of inmates in solitary confinement are mentally ill.<sup>60</sup> Suicide is the leading cause of death in both jails and prisons, and research suggests that the high suicide rates are correlated with untreated depression.<sup>61</sup> In 2015, a quarter of all police shooting deaths involved persons with signs of a mental illness.<sup>62</sup> These startling statistics show that continuity of care is a pressing need for persons with mental illness who are subject to

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organized by type, listing total U.S. population in psychiatric hospitals and units as 42,035).

57. Henry Steadman et al., *Prevalence of Serious Mental Illness Among Jail Inmates*, 60 PSYCHIATRIC SERVS. 761, 761 (2009); see also Christina Canales, *Prisons: The New Mental Health System*, 44 CONN. L. REV. 1725 (2012), as discussed in this context in Perlin, *supra* note 6, at 345; Edward Mulvey & Carol A. Schubert, *Mentally Ill Individuals in Jails and Prisons* 46 CRIME & JUST. 231 (2017). See generally Jamie Fellner, *A Corrections Quandary: Mental Illness and Prison Rules*, 41 HARV. C.R.-C.L. L. REV. 391 (2006).

58. See U.S.: *Number of Mentally Ill in Prisons Quadrupled*, HUM. RTS. WATCH (Sept. 5, 2006, 8:00 PM), <http://www.hrw.org/news/2006/09/05/us-number-mentally-ill-prisons-quadrupled>.

59. Michael L. Perlin & Meredith R. Schriver, "You Might Have Drugs at Your Command": *Reconsidering the Forced Drugging of Incompetent Pre-trial Detainees from the Perspectives of International Human Rights and Income Inequality*, 8 ALB. GOV'T L. REV. 381, 396 (2015).

60. Michael L. Perlin, "God Said to Abraham/Kill Me a Son": *Why the Insanity Defense and the Incompetency Status Are Compatible with and Required by the Convention on the Rights of Persons with Disabilities and Basic Principles of Therapeutic Jurisprudence*, 54 AM. CRIM. L. REV. 477, 508 (2017) (citing Jessica Knowles, "The Shameful Wall of Exclusion": *How Solitary Confinement for Inmates with Mental Illness Violates the Americans with Disabilities Act*, 90 WASH. L. REV. 893, 907 (2015)).

61. Freudenberg, *supra* note 24, at 221. Half of all prison suicides are committed by persons with serious mental illness. Kanya D'Almeida, *In US Prisons, Psychiatric Disability Is Often Met by Brute Force*, TRUTHOUT (July 18, 2015, 12:00 AM), <http://www.truthout.org/news/item/31886-in-us-prisons-psychiatric-disability-is-often-met-by-brute-force#>.

62. *995 People Shot Dead by Police in 2015*, WASH. POST, <https://www.washingtonpost.com/graphics/national/police-shootings> (last visited Mar. 24, 2018) (providing a database of fatal police shootings nationwide in 2015 with data showing 257 of those killed had signs of mental illness).

the shuttling process between hospitals and prisons that is so disruptive to actual treatment.

#### A. Impacts of Deinstitutionalization<sup>63</sup>

Deinstitutionalization refers not just to the release and reduction in numbers of persons who are institutionalized in psychiatric hospitals, but also to the “diversion of potential new admissions to alternative facilities, and the development of special services for the care of a noninstitutionalized mentally ill population.”<sup>64</sup> It was spurred by technological advancements in drug therapy, economic incentives to shift care to community-based outpatient facilities, and changing societal attitudes regarding mental illness.<sup>65</sup> Several landmark Supreme Court cases guaranteed due process protections for persons with mental illness, applying the due process and equal protection clauses to institutionalization in psychiatric institutions,<sup>66</sup> ruling it unconstitutional to indefinitely civilly commit a person without a finding of dangerousness<sup>67</sup> and articulating a right to the least restrictive alternative in institutionalization decision-making.<sup>68</sup> Other federal courts have guaranteed the right to treatment<sup>69</sup> and the right to refuse treatment.<sup>70</sup>

Deinstitutionalization is often seen as the reason for the current state of affairs,<sup>71</sup> yet the greatest problems stem from the

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63. See generally MICHAEL L. PERLIN & HEATHER ELLIS CUCOLO, *MENTAL DISABILITY LAW: CIVIL AND CRIMINAL* § 10-4 (3d ed. 2017). For an earlier consideration, see Michael L. Perlin, *Competency, Deinstitutionalization, and Homelessness: A Story of Marginalization*, 28 HOUS. L. REV. 63 (1991).

64. H. Richard Lamb & Leona L. Bachrach, *Some Perspectives on Deinstitutionalization*, 52 PSYCHIATRIC SERVS. 1039, 1039 (2001).

65. Bernard E. Harcourt, *Reducing Mass Incarceration: Lessons from the Deinstitutionalization of Mental Hospitals in the 1960s*, 9 OHIO ST. J. CRIM. L. 53, 65 (2011).

66. *Jackson v. Indiana*, 406 U.S. 715 (1972); see also *Backstrom v. Herold*, 383 U.S. 107 (1966).

67. See *O'Connor v. Donaldson*, 422 U.S. 563 (1975).

68. *Olmstead v. LC*, 527 U.S. 581 (1999).

69. E.g., *Wyatt v. Stickney*, 325 F. Supp. 781, 784 (M.D. Ala. 1971), *aff'd sub nom.*, *Wyatt v. Aderholt*, 503 F.2d 1305 (5th Cir. 1974).

70. See, e.g., *Rennie v. Klein*, 720 F.2d 266, 270 (3d Cir. 1983).

71. See, e.g., *Olmstead*, 527 U.S. at 609 (Kennedy, J., concurring) (quoting, in part, E. FULLER TORREY, *OUT OF THE SHADOWS: CONFRONTING AMERICA'S MENTAL ILLNESS CRISIS* 11 (1997)).

For a substantial minority . . . deinstitutionalization has been a psychiatric *Titanic*. Their lives are virtually devoid of “dignity” or “integrity of body,

lack of adequate and accessible community resources for persons with mental illness.<sup>72</sup> This has led to many people with mental illness becoming homeless,<sup>73</sup> and thus easily jailed for minor offenses such as trespassing, disturbing the peace, or disorderly conduct.<sup>74</sup> Further, police may be more inclined to use the criminal justice process over the civil commitment process because medical providers may refuse to civilly commit someone or release the person in a short period of time. In contrast, the criminal justice system is much more onerous and, in some instances, almost guarantees a longer period where the person is not in the community.<sup>75</sup> Police also use these tactics because it is easier and quicker for them to do so,<sup>76</sup> and because of stereotypical beliefs<sup>77</sup>

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mind, and spirit.” “Self-determination” often means merely that the person has a choice of soup kitchens. The “least restrictive setting” frequently turns out to be a cardboard box, a jail cell, or a terror-filled existence plagued by both real and imaginary enemies.

*Id.* On this point, we endorse the conclusions of Professor Samuel Bagenstos that “deinstitutionalization has been a success in many significant respects.” Samuel R. Bagenstos, *The Past and Future of Deinstitutionalization Litigation*, 34 CARDOZO L. REV. 1, 7 (2012).

72. See Lamb & Bachrach, *supra* note 64, at 1041. On the need to balance community protection and individual healing in community mental health ventures, see Philip T. Yanos et al., *Community Protection Versus Individual Healing: Two Traditions in Community Mental Health*, 35 BEHAV. SCI. & L. 288, 300 (2017) (recommending that the community mental health system be “more honest with itself” as to what the “common good” is that it is designed to promote).

73. It must be emphasized that deinstitutionalization is *not* the primary cause of homelessness. See generally, Perlin, *supra* note 63.

74. Destiny Howell, *The Unintended Consequences of Deinstitutionalization*, 54 AM. CRIM. L. REV. ONLINE 17, 20 (2017); see also Bruce J. Winick, *Outpatient Commitment: A Therapeutic Jurisprudence Analysis*, 9 PSYCHOL. PUB. POL’Y & L. 107, 124 (“Arrest, [for people with untreated mental illnesses who have committed minor offenses], is inappropriate because the real problem is not criminality, but untreated mental illness.”). See generally Lynch & Perlin, *Big Police*, *supra* note 7, at 687 n.8.

75. Risdon N. Slate, *Deinstitutionalization, Criminalization of Mental Illness, and the Principle of Therapeutic Jurisprudence*, 26 S. CAL. INTERDISC. L.J. 341, 348–49 (2017).

76. E.g., Randy Borum et al., *Police Perspectives on Responding to Mentally Ill People in Crisis: Perceptions of Program Effectiveness*, 16 BEHAV. SCI. & L. 393 (1998) (as discussed in Perlin, *supra* note 6, at 351 n.41).

77. See generally Camille Gear Rich & Elyn R. Saks, *Introduction: Beating Mental Illness Symposium*, 26 S. CAL. INTERDISC. L.J. 299 (2017) (discussing symposium entitled *Beating Mental Illness: A Dialogue on Race, Gender, and Disability Stereotypes in Police Use of Force Cases*, held in 2016 at the University of Southern California).

that persons with mental disabilities cannot be reasoned with and are incapable of conducting a meaningful conversation.<sup>78</sup>

Another factor to consider is the privatization of the mental health system.<sup>79</sup> Managed care has restricted what services are covered including psychotropic medication as well as medical benefits that are typically lost when a person with mental illness is incarcerated.<sup>80</sup> While psychiatric hospitals have fewer beds today, the largest mental health facilities are now found in urban jails in Los Angeles, New York, and Chicago.<sup>81</sup>

It is necessary to consider all of this in the context of the research done by Professor Jennifer Skeem and her colleagues, who recommend three policy priorities: (1) identifying offenders for whom mental illness directly causes criminal behavior; (2) identifying “evidence-based corrections,” including, isolating “the ingredients of existing programs that reduce recidivism;” and (3) assessing and addressing system bias, whether this bias is “motivated by fear or paternalism.”<sup>82</sup> By identifying these key areas, unnecessary incarceration and institutionalization for persons with mental illness can be avoided.

### *B. Conditions of Confinement*

Persons with mental disabilities are disproportionately involuntarily committed to institutions where they are deprived of their freedom, dignity, and basic human rights.<sup>83</sup> Even in the United States, persons with mental disabilities are still frequently housed in institutions that shock the conscience and humiliate

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78. Robert Panzarella & Justin O. Alicea, *Police Tactics in Incidents with Mentally Disturbed Persons*, 20 POLICING 326, 335–36 (1997) (as discussed in Lynch & Perlin, *Big Police*, *supra* note 7, at 703).

79. Slate, *supra* note 75, at 350.

80. *Id.* at 352.

81. Freudenberg, *supra* note 24, at 220; *see also* Lynch & Perlin, *Big Police*, *supra* note 7, at 685 (“It is a truism that the nation’s largest urban jails are the largest mental health facilities in the nation.”).

82. Jennifer L. Skeem et al., *Correctional Policy for Offenders with Mental Illness: Creating a New Paradigm for Recidivism Reduction*, 35 LAW & HUM. BEHAV. 110, 120–22 (2011) (as discussed in Perlin, *supra* note 6, at 371). In this context, consider also, Mulvey & Schubert, *supra* note 57, at 234 (“The vast majority of cases involving mentally ill individuals in the criminal justice system do not mirror those seen in the media. Most mentally ill people in the criminal justice system did not get there as a result of psychiatric deterioration precipitating crime or violence.”).

83. *See generally* PERLIN & CUCOLO, *supra* note 63, § 3-3.1, at 3-18–23.

those incarcerated there.<sup>84</sup> This isolation leads to feelings of shame and can discourage treatment.<sup>85</sup> Institutional settings include not just psychiatric hospitals, but also adult homes, nursing homes, and prisons.<sup>86</sup> The process of transferring individuals from psychiatric hospitals to such other facilities is known as “transinstitutionalization,” which can be defined as “the transfer of a population from one institutional system to another as an inadvertent consequence of policies intended to deinstitutionalize the target population.”<sup>87</sup>

Prisons and jails are often not properly equipped to handle persons with mental disabilities because they were never meant to function as mental health facilities.<sup>88</sup> They are “crippled by understaffing, insufficient facilities, limited programs, and the restrictions imposed on them by prison rules and prison culture.”<sup>89</sup> In many instances, prisoners with mental illness who refuse to comply with orders are subject to physical force such as chemical sprays, electric shocks, and long-term physical restraints.<sup>90</sup> Inmates with mental health conditions are at a higher risk of being victims of violence and displaying more violent behavior compared to inmates without disabilities.<sup>91</sup> “The absence of timely and effective reasonable accommodations, as well as the lack of effective communications and physical accessibility, significantly increases the likelihood of present and future injury and illness facing prisoners with disabilities.”<sup>92</sup> The shame that these individuals experience as a result of the loss of their rights and liberties is rarely, if ever, discussed even though it is readily

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84. *Id.*

85. Michael L. Perlin & Naomi M. Weinstein, “*Friend to the Martyr, a Friend to the Woman of Shame*”: *Thinking About the Law, Shame, and Humiliation*, 24 S. CAL. REV. L. & SOC. JUST. 1, 29 (2014).

86. See Dominic A. Sisti et al., *Improving Long-term Psychiatric Care: Bring Back the Asylum*, 313 JAMA 243, 243 (2015).

87. Lois Weithorn, *Mental Hospitalization of Troublesome Youth: An Analysis of Skyrocketing Admission Rates*, 40 STAN. L. REV. 773, 805 (1988).

88. Jamie Fellner, *A Conundrum for Corrections, A Tragedy for Prisoners: Prisons As Facilities for the Mentally Ill*, 22 WASH. U. J.L. & POL'Y 135, 136 (2006).

89. *Id.* at 137.

90. Howell, *supra* note 74, at 21.

91. Peter Blanck, *Disability in Prison*, 26 S. CAL. INTERDISC. L.J. 309, 314 (2017).

92. *Id.*

acknowledged after the fact by individuals who have faced these circumstances.<sup>93</sup>

The policies implemented in jails and prisons have both direct and indirect consequences on urban communities.<sup>94</sup> The results include reduced employability of young men, precipitated homeless, destabilized neighborhoods, disrupted family life, all leading to disenfranchisement and negatively impacted mental health.<sup>95</sup> Providing appropriate mental health treatment in jails and prisons can reduce the negative impacts of incarceration by “[1] minimizing mental health problems suffered as a result of incarceration; [2] minimizing conflicts among inmates and between inmates and correctional staff; and [3] reducing substantially the post-release risk for recidivism of inmates with serious mental disorders.”<sup>96</sup>

### C. New York Policies As an Example

We turn here to the situation in New York, as that state is a good example of what happens when continuity of care issues emerge, despite the best efforts of some state and city agencies to prevent the cycle in question. The issues in New York are not unique, as the same issues persistently arise in other jurisdictions throughout the country.<sup>97</sup> We will look at New York through the filter of a recent case (partially litigated by one of the co-authors, Naomi M. Weinstein) that illustrates the problems of continuity of care.

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93. *To Wander Off*, *supra* note 7. Such shame permeates all systems. *See, e.g.*, Heather Ellis Cucolo & Michael L. Perlin, *Promoting Dignity and Preventing Shame and Humiliation by Improving the Quality and Education of Attorneys in Sexually Violent Predator (SVP) Civil Commitment Cases*, 28 FLA. J.L. & PUB. POL’Y 291 (2017); Michael L. Perlin & Alison J. Lynch, *She’s Nobody’s Child/The Law Can’t Touch Her at All: Seeking to Bring Dignity to Legal Proceedings Involving Juveniles*, 56 FAM. CT. REV. 79 (2018).

94. Freudenberg, *supra* note 24, at 222.

95. *Id.* at 223–25.

96. James R.P. Ogloff et al., *Mental Health Services in Jails and Prisons: Legal, Clinical, and Policy Issues*, 18 LAW & PSYCHOL. REV. 109, 118 (1994); *see also* Mulvey & Schubert, *supra* note 57, at 231 (“[Recommending these solutions] expand the reach of standard and innovative mental health services, divert mentally ill individuals early in the criminal justice process, enrich training of criminal justice personnel, use data more effectively, and promote interdisciplinary aftercare programs for people with mental illness when they are released from jails and prisons.”).

97. Joseph P. Morrissey et. al, *The Role of Medicaid Enrollment and Outpatient Service Use in Jail Recidivism Among Persons with Severe Mental Illness*, 58 PSYCHIATRIC SERVS. 794 (2007).

Billy<sup>98</sup> was a patient in a long-term state psychiatric hospital. While at the unit, he assaulted a staff member, and was given a desk appearance ticket.<sup>99</sup> Two months later, Billy was arraigned on the misdemeanor assault charge. For the first criminal court appearance, Billy was brought to the state trial court in the custody of hospital peace officers and was returned to the hospital thereafter. At Billy's next court appearance, he "acted out" in court,<sup>100</sup> and the judge remanded him to jail instead of returning him to the custody of the state hospital.<sup>101</sup> While in jail, Billy decompensated (he stopped taking his psychiatric medication and began exhibiting symptoms of his mental illness including displaying paranoia and aggressive behaviors). During this time he was waiting for an evaluation to determine whether he was competent to stand trial.

Eventually, Billy was transferred to the jail psychiatric ward where he was treated with medication over his objection.<sup>102</sup> Over the course of several months, Billy was evaluated twice to determine if he was competent to stand trial.<sup>103</sup> Consequently, he was found incompetent to stand trial, and his misdemeanor assault

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98. A pseudonym.

99. A desk appearance ticket is issued in lieu of detention for misdemeanors, violations, and certain Class "E" felonies for hospitalized prisoners. It is an order to appear in New York City Criminal Court for arraignment. It allows the person to remain in the community until they are scheduled to appear in court for arraignment. *See* N.Y. CRIM. PROC. LAW § 150.20 (McKinney 2004).

100. Billy allegedly tried to reach for a court officer's weapon.

101. In other situations, had Billy not been "remanded" into jail, he would have been "released on his own recognizance"; however, since, he was brought in the custody of the Office of Mental Health and still subject to a civil status at the state hospital, he would have been brought back to that state hospital. Even if Billy had tried to challenge his civil inpatient legal status, it would have been unlikely that he would have been released to the community at that point based on his actions in court. This was an unusual disposition, complicated by the fact that Billy displayed alarming behavior in court.

102. This objection raises the issue of the constitutional rights of a defendant awaiting an IST finding to avoid unintended side effects and the potentially legally prejudicial side effects of medication. *See, e.g.,* Perlin & Schriver, *supra* note 59, at 402 n.123.

103. In New York, the process of raising competency to stand trial is governed by N.Y. CRIM. PROC. LAW § 730 (known as fitness to proceed). Under that statute, the prosecutor, defense, or court can raise competency as an issue. *See generally* N.Y. CRIM. PROC. LAW § 730 (McKinney 2011). For persons charged with misdemeanors and who are found incapacitated to stand trial, a final order of observation is issued, the charges are dismissed and the person is sent to a psychiatric hospital for an evaluation to determine if they meet inpatient civil commitment. *Id.* § 730.40. For persons charged with felonies and found incapacitated to stand trial, a temporary order of observation is issued and the person is sent to a secure psychiatric facility and treated until the person regains capacity, subject to periodic court review of the person's continued confinement. *Id.* § 730.50.



charge was dismissed; he was sent back to the same state psychiatric hospital from which he had come for an evaluation to determine if he met inpatient civil commitment under New York Mental Hygiene Law Article 9.<sup>104</sup>

The irony of Billy's case is that he had spent more time in jail than he ever would have served if he had pled guilty to the misdemeanor,<sup>105</sup> and, in the end, he was institutionalized in the same facility from which this saga began where he started about four months prior. This highlights some of the issues surrounding the decision as to whether or not to raise the incompetency status, and why a competent defense attorney may be reluctant to raise issues like the lack of availability of bail,<sup>106</sup> the conditions of institutionalization, the possible iatrogenic or ameliorative impact of psychiatric institutionalization on the defendant, and the length of institutionalization versus the potential length of incarceration.<sup>107</sup> By addressing issues that relate to continuity of care, similar situations as to what occurred with Billy can be avoided, leading optimally to a reduction in unnecessary institutionalization and incarceration, saving time and resources and ensuring due process rights are upheld.

The questions we consider go far beyond those that could be resolved in an individual case. A settlement order has recently been entered in litigation brought by Disability Advocates, Inc. against the New York State Office of Mental Health ("OMH") and Department of Correctional Services ("DOCS") seeking to improve the conditions for persons with mental illness in prisons in New York.<sup>108</sup> In its complaint, Disability Advocates Inc. alleged

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104. *Id.* § 730.40.

105. *See* Perlin, *supra* note 2, at 203–05.

106. Missing from the usual conversations about this topic is the reality that *bailed* defendants have the right to exercise "voluntary" choice in deciding whether to take drugs or, if they do decide to, what drugs to take. Such voluntariness is entirely missing in the cases of economically disadvantaged defendants who cannot afford bail. *See* Perlin & Schriver, *supra* note 59, at 402 (raising this issue).

107. Perlin, *supra* note 6, at 360. On how this decision must be a "nuanced" one, see Christopher Slobogin & Amy Mashburn, *The Criminal Defense Lawyer's Fiduciary Duty to Clients with Mental Disability*, 68 *FORDHAM L. REV.* 1581, 1622 (2000); *see also* Keri A. Gould, *A Therapeutic Jurisprudence Analysis of Competency Evaluation Requests: The Defense Attorney's Dilemma*, 18 *INT'L J.L. & PSYCHIATRY* 83, 91–95 (1995) (arguing that the Sixth Amendment right to effective counsel may ethically support the decision to ignore the competency question entirely).

108. *See* Complaint at 2–3, *Disability Advocates, Inc. v. N.Y. State Office of Mental Health*, No. 1:02-cv-04002-GEL (S.D.N.Y. filed May 28, 2002).

that the defendants failed to provide adequate mental health services, including necessary inpatient and residential mental health programs, and imposed punishments that aggravated the mental illness of prisoners in violation of 42 U.S.C. § 1983, the Eighth and Fourteenth Amendments of the Constitution, and the ADA.<sup>109</sup> Part of the settlement required improved mental health treatment, additional beds for mental health hospital and program beds, limits on punishment of prisoners with mental illness, and the elimination of isolated confinement of prisoners with serious mental illness.<sup>110</sup>

Yet, despite the terms of this settlement, the treatment of prisoners with serious mental illness in New York state prisons is still problematic, as is the treatment of people in jail, a population not covered in the lawsuit.<sup>111</sup> There is currently pending litigation, *Alcantara v. Annucci*, brought by prisoners (sex offenders) who are being housed in “residential treatment facilities” that are actually converted correctional facilities in which prisoners are held beyond their release dates.<sup>112</sup> Under New York corrections law, residential treatment facilities are defined as community based residences in or near a community where employment, educational, and training opportunities are available.<sup>113</sup> Although *Alcantara* involves sex offenders, the ruling could also affect how persons with mental illness are treated in terms of release from prisons. In addition, prisoners are often sent directly from prison to be civilly committed in a psychiatric hospital after the expiration of their sentence.<sup>114</sup> These case examples from New

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109. *Id.* at 50–51.

110. Private Settlement Agreement at i, *Disability Advocates, Inc.*, No. 1:02-cv-04002-GEL (Apr. 27, 2007).

111. Jamie Fellner, *Callous and Cruel: Use of Force Against Inmates with Mental Disabilities in US Jails and Prisons*, HUM. RTS. WATCH (May 12, 2015), <https://www.hrw.org/report/2015/05/12/callous-and-cruel/use-force-against-inmates-mental-disabilities-us-jails-and>; Benjamin Weiser & Michael Schwartz, *Prison Guards Will Not Be Charged in an Inmate’s Death in 2015, Prosecutors Say*, N.Y. TIMES, Aug. 3, 2017, at A15.

112. Verified Petition at 1–2, *Alcantara v. Annucci*, No. 2543-16, 55 Misc. 3d 1216(A) (N.Y. Sup. Ct. 2017).

113. N.Y. CORRECT. LAW § 2(6) (McKinney 2014).

114. *Cf.* Perlin, *supra* note 60, at 505 n.201 (discussing how, in *State v. Krol*, 344 A.2d 289, 297 (N.J. 1975), the New Jersey Supreme Court interpreted *Baxstrom* and *Jackson v. Indiana*, 406 U.S. 715 (1972), as “plainly attempt[ing] to enunciate a broad principle—that the fact that the person to be committed has previously engaged in criminal acts is not a constitutionally acceptable basis for imposing upon him a substantially different standard or procedure for involuntary commitment”).

York highlight some of the systemic problems that exist in the treatment of persons with mental illness in prison. Continuity of treatment is not possible when the conditions of mental health treatment are substandard and carried out within a system where the shuttling of persons with mental illness between jails and prisons and hospitals is routine.

#### IV. RESEARCH ON WHY CONTINUITY OF CARE IS CLINICALLY NECESSARY

Research has shown that continuity of care leads to improvement of clinical and functional outcomes for persons with mental illness.<sup>115</sup> Persons with fewer gaps in mental health service have better rehabilitative outcomes.<sup>116</sup> Further, continuity of care health initiatives contribute to lower health care costs by reducing the rate of psychiatric hospitalization.<sup>117</sup> In addition, receipt of outpatient mental health services is associated with reduced risks of arrests, at least in the near future.<sup>118</sup>

The transition from prison to community for a person with mental illness can lead to negative outcomes, including homelessness, higher suicide rate, and higher risk of overdose for those prisoners with substance abuse problems.<sup>119</sup> A 2007 study involving local prisons in London found that continuity of care for prisoners with serious mental illnesses can be improved by working with the individuals prior to release to identify their needs and assisting them in engaging in necessary agencies in the community.<sup>120</sup> In addition, it is important for mental health treatment to begin during incarceration because treatment gains

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115. Carol E. Adair et al., *Continuity of Care and Health Outcomes Among Persons with Severe Mental Illness*, 56 PSYCHIATRIC SERVS. 1061, 1068 (2005); John S. Brekke et al., *Intensity and Continuity of Services and Functional Outcomes in the Rehabilitation of Persons with Schizophrenia*, 50 PSYCHIATRIC SERVS. 248, 255 (1999).

116. Adair et al., *supra* note 115, at 1068. For a discussion on the role of therapeutic jurisprudence, see Priscilla Ferrazzi & Terry Krupa, *Re: Mental Health Rehabilitation in Therapeutic Jurisprudence: Theoretical Improvements*, 46 INT'L J.L. & PSYCHIATRY 42 (2016); *see also infra* text accompanying notes 186–215 (discussing how the use of therapeutic jurisprudence practices enhances the likelihood of authentic rehabilitation).

117. Craig R. Mitton et al., *Continuity of Care and Health Care Costs Among Persons with Severe Mental Illness*, 56 PSYCHIATRIC SERVS. 1070, 1075 (2005).

118. Robert J. Constantine et al., *The Impact of Mental Health Services on Arrests of Offenders with Serious Mental Illness*, 36 LAW & HUM. BEHAV. 170, 173 (2012).

119. Jarrett et al., *supra* note 36, at 187.

120. *Id.* at 192.

coupled with concomitant services in the community are likely to decrease recidivism, criminally or psychiatrically, for the offender.<sup>121</sup> It is also essential for offenders with mental illness to receive services upon incarceration in order to eliminate any gaps in service and improve outcomes.<sup>122</sup>

## V. LEGAL ARGUMENTS

There are legal issues that both support and complicate continuity of care efforts. In this section, we first discuss the legal right to continuity of care, and then we address some complications that may arise regarding a person's individual rights in the context of systemic problematic issues within the healthcare system.

### A. Right to Continuity of Care

Not only has valid and reliable behavioral research shown why continuity of care is important, but it is also legally mandated. It has long been established that prisoners have a right to mental health treatment while incarcerated.<sup>123</sup> Providing such services ensures that correctional facilities remain safe for inmates and staff and that persons with mental illness assimilate into the correctional facility and back into society upon their release.<sup>124</sup> Courts have also recognized the importance of continuity of care for prisoners reentering the community.<sup>125</sup>

Continuity of care is also required under the ADA.<sup>126</sup> In *Olmstead v. L.C. ex rel. Zimring*, the Supreme Court held that unjustified isolation is discrimination based on disability and that the ADA requires states to provide community-based treatment.<sup>127</sup> Further, the Supreme Court has held that Title II of the ADA

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121. Robert D. Morgan et al., *Treating Offenders with Mental Illness: A Research Synthesis*, 36 LAW & HUM. BEHAV. 37, 46–47 (2012).

122. *Id.* at 47.

123. *Burchett v. State Dep't of Corr.*, 564 P.2d 87, 90 (Ariz. Ct. App. 1977).

124. Ogloff et al., *supra* note 96, at 124.

125. *See United States v. Collado*, No. 07 Cr. 1144(HB), 2008 WL 2329275 (S.D.N.Y. 2008).

126. 42 U.S.C. § 12132 (2012).

127. *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581, 597 (1999).

“unambiguously extends to state prison inmates.”<sup>128</sup> Thus it logically follows that if the ADA applies both to community integration and inmates, then persons with disabilities are guaranteed the right to continuity of care. Absent reasonable accommodations, prisoners with disabilities are less likely to benefit from prison activities that can reduce recidivism and “are more vulnerable to misunderstanding and exploitation by other prisoners and correctional staff” increasing the likelihood of present and future injury.<sup>129</sup>

Courts, however, are split on whether the ADA requires police officers to accommodate an individual’s disability upon arrest.<sup>130</sup> While the Supreme Court in *City and County of San Francisco v. Sheehan* did not directly decide the question as to whether the ADA applies to arrests, the Court did state that arrests would be subject to Title II if the arrest is an activity in which the arrestee participates or may benefit from and if that failure to arrest the individual in a manner that reasonably accommodates the disability constitutes discrimination.<sup>131</sup>

Although this question of whether the ADA applies to arrests has not been decided by the Supreme Court on the merits, there are advocacy and law enforcement agencies that have already identified the importance of this issue and taken steps to implement more accommodating policies and practices.<sup>132</sup> Comprehensive police officer training can enable officers to make accurate individualized assessments about the level of threat posed and the best way to modify police procedures to accommodate the

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128. Pa. Dep’t of Corr. v. Yeskey, 524 U.S. 206, 213 (1998); see Perlin, *supra* note 2, at 221–22 (noting that *Yeskey* found that the ADA’s language “unmistakably includes State prisons and prisoners within its coverage,” and that the law contained no “exception that could cast the coverage of prisons into doubt” (quoting *Yeskey*, 524 U.S. at 209)).

129. Blanck, *supra* note 91, at 314.

130. Hainze v. Richards, 207 F.3d 795, 800 (5th Cir. 2000) (Title II does not apply to officer’s on-the-street decisions). *But see* Bircoll v. Miami-Dade Cty., 480 F.3d. 1072, 1085 (11th Cir. 2007) (plain language of Title II supports inclusion of arrest); City & Cty. of S.F. v. Sheehan, 743 F.3d. 1211, 1217 (9th Cir. 2014) (police officers are required to accommodate a disability in arrest), *reversed in part & cert. dismissed in part*, 135 S. Ct. 1765, 1773 (2015).

131. *Sheehan*, 135 S. Ct. at 1773.

132. Michael Pecorini, Note, *Trying to Fit a Square Peg into a Round Hole: Why Title II of the Americans with Disabilities Act Must Apply to All Law Enforcement Agencies*, 24 BROOKLYN J.L. & POL’Y 551, 594 (2016).

individual.<sup>133</sup> The most common method of safely accommodating persons with mental disabilities is through the use of a Crisis Intervention Team which has been shown to reduce the incidence of arrest by as much as nineteen percent.<sup>134</sup>

Finally, as we discuss subsequently,<sup>135</sup> there is also an obligation under the CRPD to accommodate persons with disabilities and the failure to do so constitutes discrimination.<sup>136</sup>

### *B. Legal Issues Potentially Complicating Continuity of Care*

Continuity of care should never override individual rights, especially the right to medical privacy and the right to refuse treatment. Treatment providers have to balance the ability to share information to allow for more effective treatment with the patient's right to privacy. Due to the ease of accessing electronic medical records, a patient's history can "follow the person" throughout hospitalizations, and these records can include various diagnoses, the number of times a patient has been psychiatrically hospitalized, the psychotropic medication they have taken, and any seclusion or restraint experiences.<sup>137</sup> Mistakes in the medical record can mutate as information is often copied over into multiple databases, making it nearly impossible for the patient to correct.<sup>138</sup> The right to privacy is especially important for persons with mental illness because of the stigma and shame that surrounds mental illness.<sup>139</sup>

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133. Shanna Rifkin, Note, *Safeguarding the ADA's Antidiscrimination Mandate: Subjecting Arrests to Title II Coverage*, 66 DUKE L.J. 913, 935 (2017).

134. Carly A. Myers, *Police Violence Against People with Mental Disabilities: The Immutable Duty Under the ADA to Reasonably Accommodate During Arrest*, 70 VAND. L. REV. 1393, 1412 (2017).

135. See *infra* text accompanying notes 201–33.

136. Janet E. Lord, *Shared Understanding or Consensus-Masked Disagreement? The Anti-Torture Framework in the Convention on the Rights of Persons with Disabilities*, 33 LOY. L.A. INT'L & COMP. L. REV. 27, 60 (2010).

137. *What Is HIE?*, HEALTHIT.GOV, <https://www.healthit.gov/providers-professionals/health-information-exchange/what-hie> (last visited Feb. 27, 2018).

138. See generally Arthur Allen, *Electronic Record Errors Growing Issue in Lawsuits*, POLITICO (May 4, 2015, 6:40 AM), <https://www.politico.com/story/2015/05/electronic-record-errors-growing-issue-in-lawsuits-117591>.

139. The stigma that accompanies mental illness has been characterized by one state supreme court as "carr[ying] with it a stigma similar to that associated with a criminal record," and likened by another court to the stigma that attaches to "dishonesty . . . serious felony . . . [or] manifest racism." Michael L. Perlin, "What's Good Is Bad, What's Bad

HIPAA governs whether covered entities, such as hospitals or medical facilities, can disclose protected health information (“PHI”) to other parties.<sup>140</sup> In general, HIPAA prevents covered entities from disclosing PHI except in certain prescribed circumstances.<sup>141</sup> In New York, the highest court has held that admitting medical records from other hospitalizations without notice or consent of the patient in an assisted outpatient treatment proceeding, is a violation of HIPAA.<sup>142</sup> While HIPAA provides important protection of medical privacy, some family members of persons with mental illness argue that HIPAA prevents them from being able to adequately care for their loved ones.<sup>143</sup>

Health insurance coverage can determine which psychotropic medications<sup>144</sup> are available both in in-patient and out-patient settings.<sup>145</sup> The ACA greatly expanded and overhauled health care coverage for persons in the US, and required that all individuals either obtain minimum essential coverage through employer-sponsored health programs, an individual health plan, or government health plan, or face a financial penalty in form of a tax.<sup>146</sup> It was designed to expand coverage of mental health and substance use disorder benefits at parity with medical coverage.<sup>147</sup> Under the ACA, insurers are prohibited from discriminating

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*Is Good, You'll Find Out When You Reach the Top, You're on the Bottom”: Are the Americans with Disabilities Act (and Olmstead v. L.C.) Anything More than “Idiot Wind”?*, 35 U. MICH. J.L. REFORM 235, 238 (2001-02) (quoting Nelson v. Ferguson, 399 S.E.2d 909, 913 (W. Va. 1990), and Green v. St. Louis Hous. Auth., 911 F.2d 65, 69 (8th Cir. 1990)).

140. Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936; *see also* 29 U.S.C. § 1181 (2012); 42 U.S.C. § 300gg (2010); 42 U.S.C. § 1320d (2012).

141. *Id.*

142. *In re Miguel M.*, 950 N.E.2d 107, 109 (N.Y. 2011).

143. Jorgio Castro, *Piercing the Privacy Veil: Toward a Saner Balancing of Privacy and Health in Cases of Severe Mental Illness*, 66 HASTINGS L.J. 1769, 1772 (2015).

144. Beyond the scope of this paper is an inquiry into whether these prescribed medications actually do improve the individual’s mental health in all cases. *See, e.g.*, James B. Gottstein, *Involuntary Commitment and Forced Psychiatric Drugging in the Trial Courts: Rights Violations As a Matter of Course*, 25 ALASKA L. REV. 51, 51 (2008).

145. *Supreme Court Upholds Affordable Care Act; Makes Medicaid Expansion Optional*, DEV. MENTAL HEALTH L., July 2012, at 1, 8.

146. 26 U.S.C. § 5000A (1989).

147. Samantha M. Behbahani et al., *The Patient Protection and Affordable Care Act: Will Parity for Mental Health Care Truly Be Achieved in the 21st Century*, 10 INTERCULTURAL HUM. RTS. L. REV. 153, 160 (2015).

based on a preexisting condition.<sup>148</sup> Marketplaces were also created in order to assist people in comparing competing health programs.<sup>149</sup> The ACA also expanded Medicaid eligibility for individuals.<sup>150</sup>

Although the ACA does not directly address medical care for prisoners, there are ways that the ACA can benefit inmates and formerly incarcerated individuals.<sup>151</sup> “ACA reforms pave the way for new and stronger partnerships among those institutions involved in correctional health and community health.”<sup>152</sup> The ACA also allows for the enrollment of individuals who are incarcerated pending the disposition of charges.<sup>153</sup> Further, the expansion of individual insurance coverage should lead to broader benefits including the reduction of infectious diseases and lower rates of drug use and re-arrest.<sup>154</sup>

The Psychiatric Services and Clinical Knowledge Enhancement System (“PSYCKES”) is an online database in New York that contains information on persons who receive Medicaid. It is designed to identify individuals who could benefit from clinical review and provide help to treatment providers to develop treatment plans.<sup>155</sup> PSYCKES uses information from Medicaid claims data such as history of illnesses or injuries, outpatient services, medications, hospital services, labs performed,<sup>156</sup> and information that comes from consumers who are subject to court-ordered assisted outpatient treatment plans.<sup>157</sup>

Although this all appears to be salutary and geared toward greater continuity of care, PSYCKES nonetheless raises multiple important ethical issues that cannot be ignored. For example, PSYCKES begs the question of whether or not it fair for only individuals on Medicaid to be subject to such a database whereas

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148. 45 C.F.R. § 147.108 (2015).

149. 45 C.F.R. § 146 (2011).

150. 42 U.S.C. §1396a(a)(10) (1973).

151. Joel B. Teitelbaum & Laura G. Hoffman, *Health Reform and Correctional Health Care: How the Affordable Care Act Can Improve the Health of Ex-Offenders and Their Communities*, 40 FORDHAM URB. L.J. 1323, 1348 (2013).

152. *Id.*

153. 42 U.S.C. § 18032(f)(1)(B) (2010).

154. Teitelbaum & Hoffman, *supra* note 151, at 1356.

155. *About PSYCKES*, N.Y. ST. OFF. MENTAL HEALTH, [https://www.omh.ny.gov/omhweb/psyckes\\_medicare/about](https://www.omh.ny.gov/omhweb/psyckes_medicare/about) (last visited Aug. 30, 2017).

156. *Id.*

157. *Id.*



anyone with private health insurance would not be part of the database and whether this information be used as evidence in cases in which patients challenge their hospital retention or assert their right to refuse medication.<sup>158</sup> PSYCKES thus highlights the need to balance medical privacy rights with the need to facilitate continuity of care through the electronic sharing of medical information. A careful balance must be achieved, protecting individual rights for all individuals, no matter whether the individual in question receives Medicaid or has private insurance.

*C. Advance Psychiatric Directives*<sup>159</sup>

Advance psychiatric directives can be used in order to address continuity of care issues. A psychiatric advance directive is a legally enforceable document that specifies the manner in which treatment decisions are to be made in the event the person later becomes incompetent.<sup>160</sup> It can specify both who should make treatment decisions and also what specific treatment should be administered, including psychiatric medication, in the event of incapacity.<sup>161</sup> In theory, it should “follow” the person no matter where they are hospitalized or incarcerated.<sup>162</sup> In order to execute a psychiatric advance directive, an individual must have the ability to: understand and appreciate the risks and benefits of treatment; engage in rational deliberation; and understand the meaning and significance of the delegation.<sup>163</sup>

The use of these psychiatric advance directives may have significant therapeutic value.<sup>164</sup> Such directives can empower persons with mental illness to have control over their treatment

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158. Information from PSYCKES is regularly contained in patient’s medical records that are admitted into evidence when a patient is subject to a civil proceeding like a retention hearing or treatment over objection hearing. PSYCKES is also unavailable to patient’s attorneys. Office of Mental Health, *PSYCKES – Frequently Asked Questions*, N.Y. ST. OFF. MENTAL HEALTH, [https://www.omh.ny.gov/omhweb/psyckes\\_medicaid/faq/#A1](https://www.omh.ny.gov/omhweb/psyckes_medicaid/faq/#A1) (last updated Aug. 2013).

159. *Infra* text accompanying notes 165–83 is generally adapted from Perlin & Weinstein, *supra* note 17.

160. Elizabeth M. Gallagher, *Advance Directives for Psychiatric Care: A Theoretical and Practical Overview for Legal Professionals*, 4 PSYCHOL. PUB. POL’Y & L. 746 (1998).

161. *Id.* at 749.

162. *See id.* at 777.

163. *Id.*

164. Bruce J. Winick, *Advance Directive Instruments for Those with Mental Illness*, 51 U. MIAMI L. REV. 57, 81 (1996).

and may encourage their clinicians to treat them with dignity and respect, rather than paternalistically.<sup>165</sup> They can foster a more collaborative model of care for psychiatric treatment and encourage voluntary treatment.<sup>166</sup> They may also avoid the need for a judicial finding of incapacity<sup>167</sup> and could avoid the need for a guardian.<sup>168</sup>

Nevertheless, psychiatric advance directives raise serious ethical issues when the issue of potential revocation is raised.<sup>169</sup> The most important issue to be considered is whether psychiatric advance directives should override the constitutional right to refuse medication.<sup>170</sup> This issue applies not just to persons facing institutionalization but also persons with mental illness who are in the criminal justice system.<sup>171</sup> Some psychiatric advance directives purport to be irrevocable which can cause particular problems for patients who have chosen to be treated with specific medication.<sup>172</sup> Even if refusing psychiatric treatment may limit the person's ability to act autonomously and even to lose competency, the person may authoritatively choose that course of action while still competent.<sup>173</sup>

Psychiatric advance directives also create issues when a treating clinician who is unfamiliar with the patient and is reluctant to administer the patient's specific treatment,<sup>174</sup> or does not think following the patient's advance directives would be in

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165. *Id.* at 81, 83.

166. Gallagher, *supra* note 160, at 783.

167. Winick, *supra* note 164, at 84.

168. Judy A. Clausen, *Making the Case for a Model Mental Health Advance Directive Statute*, 14 YALE J. HEALTH POL'Y & ETHICS 1, 19 (2014).

169. Winick, *supra* note 164, at 86. On the question of increased costs connected to the use of such directives, see Nancy Rhoden, *The Limits of Legal Objectivity*, 68 N.C. L. REV. 845 (1990).

170. *See generally* Gallagher, *supra* note 160, at 762–67.

171. *See* Robert D. Miller, *Advance Directives for Psychiatric Treatment: A View from the Trenches*, 4 PSYCHOL. PUB. POL'Y & L. 728, 742–43 (1998).

172. Gallagher, *supra* note 160, at 779.

173. Mark J. Cherry, *Non-Consensual Treatment Is (Nearly Always) Morally Impermissible*, 38 J.L. MED. & ETHICS 789, 792 (2010).

174. Winick, *supra* note 164, at 71; *see also* Bruce J. Winick, *Client Denial and Resistance in the Advance Directive Context: Reflections on How Attorneys Can Identify and Deal with a Psycholegal Soft Spot*, 4 PSYCHOL. PUB. POL'Y & L. 901, 903 (1998) (“A court may, in the event of their incompetency, choose someone else to play this role, perhaps someone unfamiliar with the person's values and preferences.”).

the patient's best interests.<sup>175</sup> Failure to follow a patient's advance directive may violate the ADA's antidiscrimination clause.<sup>176</sup> It can also create issues if certain prescriptions are not covered by insurance.<sup>177</sup> Furthermore, patients may be subject to coercion with regard to their decision-making as to whether or not to accept a psychiatric advance directive.<sup>178</sup>

In an ideal world, psychiatric advance directives could provide a meaningful way for clients to direct their care according to their own wishes, leading to more congruity between their quality of life in the community and that quality post-hospitalization.<sup>179</sup> Advance directives can be a tool used to help patients advocate for consistent treatment that is both voluntary and based on decisions made when the person had the capacity to make such decisions. By having clear directives in writing, persons with mental illness can dictate exactly what treatment they would agree to, including specific medications they are willing or unwilling to take, no matter where they are being treated and even if they are dealing with different treatment providers. This can thus avoid many of the issues that arise when persons with mental illness shuttle between hospitals, jails, and the community, and, as a result, lack consistent treatment.

## VI. THERAPEUTIC JURISPRUDENCE<sup>180</sup>

One of the most important legal theoretical developments of the past three decades has been the creation and dynamic growth of therapeutic jurisprudence.<sup>181</sup> Therapeutic jurisprudence

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175. Judy A. Clausen, *An Americans with Disabilities Act Critique of Advance Directive Override Provisions*, 71 N.Y.U. ANN. SURV. AM. L. 25, 50 (2015).

176. *Id.* at 51.

177. INSTRUCTIONS AND FORMS: MENTAL HEALTH ADVANCED DIRECTIVES FOR PENNSYLVANIANS 7 (2005), [http://dhs.pa.gov/cs/groups/webcontent/documents/manual/s\\_002548.pdf](http://dhs.pa.gov/cs/groups/webcontent/documents/manual/s_002548.pdf).

178. Winick, *supra* note 164, at 88.

179. Gallagher, *supra* note 160, at 782.

180. *Infra* text accompanying notes 186–94 is generally adapted from Michael L. Perlin & Alison J. Lynch, "All His Sexless Patients": *Persons with Mental Disabilities and the Competence to Have Sex*, 89 WASH. L. REV. 257, 277 (2014); Perlin & Lynch *supra* note 12, at 433; Perlin & Weinstein, *supra* note 17, at 111. See generally Michael L. Perlin, *What Is Therapeutic Jurisprudence?*, 10 N.Y.L. SCH. J. HUM. RTS. 623 (1993).

181. See, e.g., DAVID B. WEXLER, THERAPEUTIC JURISPRUDENCE: THE LAW AS A THERAPEUTIC AGENT (1990); DAVID B. WEXLER & BRUCE J. WINICK, LAW IN A THERAPEUTIC KEY: RECENT DEVELOPMENTS IN THERAPEUTIC JURISPRUDENCE (1996);

presents a new model for assessing the impact of case law and legislation, recognizing that, as a therapeutic agent, the law can have therapeutic or anti-therapeutic consequences.<sup>182</sup>

Therapeutic jurisprudence asks whether legal rules, procedures, and lawyer roles can or should be reshaped to enhance their therapeutic potential while not subordinating due process principles.<sup>183</sup> David Wexler clearly identifies how the tension inherent in this inquiry must be resolved: “the law’s use of mental health information to improve therapeutic functioning [cannot] impinge upon justice concerns.”<sup>184</sup> Such an inquiry into therapeutic outcomes does not mean that “therapeutic concerns ‘trump’ civil rights and civil liberties.”<sup>185</sup>

Using therapeutic jurisprudence, we “look at law as it actually impacts people’s lives”<sup>186</sup> by assessing the law’s influence on emotional life and psychological well-being.<sup>187</sup> One governing principle of therapeutic jurisprudence is that “law should value psychological health, should strive to avoid imposing anti-

BRUCE J. WINICK, CIVIL COMMITMENT: A THERAPEUTIC JURISPRUDENCE MODEL (2005). Wexler first used the term in a paper he presented to the National Institute of Mental Health in 1987. See David B. Wexler, *Putting Mental Health into Mental Health Law: Therapeutic Jurisprudence*, 16 LAW & HUM. BEHAV. 27, 27, 32–33 (1992); David B. Wexler, *Therapeutic Jurisprudence Forum: The Development of Therapeutic Jurisprudence: From Theory to Practice*, 68 REV. JURÍDICA U. P.R. 691, 693–94 (1999).

182. See Michael L. Perlin, “His Brain Has Been Mismanaged with Great Skill”: How Will Jurors Respond to Neuroimaging Testimony in Insanity Defense Cases?, 42 AKRON L. REV. 885, 912 (2009); see also Kate Diesfeld & Ian Freckelton, *Mental Health Law and Therapeutic Jurisprudence*, in DISPUTES AND DILEMMAS IN HEALTH LAW 91, 91 (Ian Freckelton & Kerry Peterson eds., 2006) (showing a transnational perspective).

183. Michael L. Perlin, “Everybody Is Making Love/Or Else Expecting Rain”: Considering the Sexual Autonomy Rights of Persons Institutionalized Because of Mental Disability in Forensic Hospitals and in Asia, 83 WASH. L. REV. 481 (2008); Michael L. Perlin, “And My Best Friend, My Doctor, Won’t Even Say What It Is I’ve Got”: The Role and Significance of Counsel in Right to Refuse Treatment Cases, 42 SAN DIEGO L. REV. 735, 751 (2005); see also Ian Freckelton, *Therapeutic Jurisprudence Misunderstood and Misrepresented: The Price and Risks of Influence*, 30 T. JEFFERSON L. REV. 575, 585–86 (2008).

184. David B. Wexler, *Therapeutic Jurisprudence and Changing Concepts of Legal Scholarship*, 11 BEHAV. SCI. & L. 17, 21 (1993); see also David Wexler, *Applying the Law Therapeutically*, 5 APPLIED & PREVENTIVE PSYCHOL. 179, 185 (1996).

185. Michael L. Perlin, *A Law of Healing*, 68 U. CIN. L. REV. 407, 412 (2000); Michael L. Perlin, “Where the Winds Hit Heavy on the Borderline”: Mental Disability Law, Theory and Practice, “Us” and “Them,” 31 LOY. L.A. L. REV. 775, 782 (1998).

186. Bruce J. Winick, *Foreword: Therapeutic Jurisprudence Perspectives on Dealing with Victims of Crime*, 33 NOVA L. REV. 535, 535 (2009).

187. David B. Wexler, *Practicing Therapeutic Jurisprudence: Psychological Soft Spots and Strategies*, in PRACTICING THERAPEUTIC JURISPRUDENCE: LAW AS A HELPING PROFESSION 45, 45 (Daniel P. Stolle et al. eds., 2006).

therapeutic consequences whenever possible, and when consistent with other values served by law should attempt to bring about healing and wellness.”<sup>188</sup> In other words, therapeutic jurisprudence supports an ethic of care.<sup>189</sup>

The question to be posed here is this: does our current system comply with these precepts of therapeutic jurisprudence? Remarkably, this is an inquiry that has been considered only once before in legal scholarship.<sup>190</sup> In that instance, Rebecca Spain Broches concluded—with total accuracy—that “criminal justice system procedures that disrupt the course of treatment are contrary to the vision, developed by therapeutic jurisprudence and adopted by this paper, that law should further therapeutic ends.”<sup>191</sup> Broches points out that disruption in continuity of care makes relapse or decompensation more likely,<sup>192</sup> and that criminal justice system procedures that disrupt the course of treatment are “contrary to the vision, developed by therapeutic jurisprudence . . . that law should further therapeutic ends.”<sup>193</sup>

We agree entirely with Broches, and suggest that her findings be the first building block in the creation of new policies that break the cycle of continuity-disruption. Using the words of an important report by the Rutgers Center for Behavioral Health Services and Criminal Justice Research, we also acknowledge that each individual in question “having [both] a serious mental illness and entanglements with the justice system, is more than an illness or an offender.”<sup>194</sup> If we acknowledge, again, as Broches points out, that “symptoms of mental illness [are] the manifestations of a health problem, rather than . . . byproducts of criminality,”<sup>195</sup> we

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188. Bruce Winick, *A Therapeutic Jurisprudence Model for Civil Commitment*, in INVOLUNTARY DETENTION AND THERAPEUTIC JURISPRUDENCE: INTERNATIONAL PERSPECTIVE ON CIVIL COMMITMENT 23, 26 (Kate Diesfeld & Ian Freckelton eds., 2003).

189. See, e.g., Bruce J. Winick & David B. Wexler, *The Use of Therapeutic Jurisprudence in Law School Clinical Education: Transforming the Criminal Law Clinic*, 13 CLINICAL L. REV. 605, 605–06 (2006).

190. Broches, *supra* note 9.

191. *Id.* at 100.

192. *Id.*

193. *Id.*

194. MATTHEW EPPERSON ET AL., RUTGERS CTR. FOR BEHAVIORAL HEALTH SERVS. & CRIMINAL JUSTICE RESEARCH, THE NEXT GENERATION OF BEHAVIORAL HEALTH AND CRIMINAL JUSTICE INTERVENTIONS: IMPROVING OUTCOMES BY IMPROVING INTERVENTIONS 29 (Sept. 2011), [https://csgjusticecenter.org/documents/0000/1173/9.21.11\\_The\\_next\\_generation\\_Monograph\\_Sept\\_2011.pdf](https://csgjusticecenter.org/documents/0000/1173/9.21.11_The_next_generation_Monograph_Sept_2011.pdf)

195. Broches, *supra* note 9, at 100.

can begin to apply therapeutic jurisprudence insights to this problem in ways that might, in fact, begin to ameliorate the woeful situation that we face.

To do this effectively, we must demand that the discharge procedures in place actually serve the individual so as to provide a foundation for successful reentry.<sup>196</sup> These procedures must be ones that will help determine whether any “mental health gains made during incarceration will translate into the outside world”<sup>197</sup> Although there has been some notable litigation that has resulted in *jail* officials being ordered to arrange discharge planning services for inmates with mental illness being released into the community,<sup>198</sup> there has been a paucity of such litigation in the cases of *prison* release.<sup>199</sup>

These points are not novel and have previously been considered. Over twenty years ago, Professor James Ogloff and his colleagues advocated that community mental health centers provide assessments and treatment services while an inmate is in prison and services following release if the inmate remains in the local community.<sup>200</sup> Subsequent studies demonstrated that continuity was also significantly associated with a better quality of life, better community functioning, lower severity of symptoms, and greater service satisfaction.<sup>201</sup> Yet, still today, the evidence is clear that prisons have continuously failed to provide adequate

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196. *Id.*

197. *Id.* at 111.

198. *See, e.g.*, Heather Barr, *Transinstitutionalization in the Courts: Brad H. v. City of New York, and the Fight for Discharge Planning for People with Psychiatric Disabilities Leaving Rikers Island*, 49 CRIME & DELINQ. 97 (2003).

199. *See* Wakefield v. Thompson, 177 F.3d 1160, 1164 (9th Cir. 1999) (requiring the state “to provide outgoing prisoners being treated for a medical condition with a sufficient support of medication to cover their transition to the outside world”); Lugo v. Senkowski, 114 F. Supp. 2d 111 (N.D.N.Y. 2000); Fox v. Peters, No. 16-cv-01602, 2016 WL 4265736 (D. Or. Aug. 11, 2016) (following Wakefield’s reasoning); *see also* Simone S. Hicks, *Behind Prison Walls: The Failing Treatment Choice for Mentally Ill Minority Youth*, 39 HOFSTRA L. REV. 979, 1007 (2011); Dlugacz & Droubi, *supra* note 30, at 141 (referring to the “limited” number of prison cases adopting the Wakefield approach). *But see* Brown v. Plata, 563 U.S. 493, 511(2011) (noting that if a court determines that overcrowding in a juvenile detention center is the primary reason for the inadequate provision of mental health services, the court should issue a prison release order).

200. Ogloff et al., *supra* note 96, at 129.

201. Adair et al., *supra* note 115, at 1061.

mental health care services for inmates with mental illness,<sup>202</sup> a failure that mocks the principles of therapeutic jurisprudence.

Empirically, there is no question that evidence shows that therapeutic jurisprudence “works” in reducing post-release recidivism by promoting “active and productive community participation by ex-offenders.”<sup>203</sup> For example, in a work release project in Delaware sponsored by the National Institute on Drug Abuse, prisoners who participated in prison-based treatment and post-release care “were seven times more likely to be drug-free and three times more likely to be arrest-free after three years than those who received no treatment.”<sup>204</sup> Another study concluded that reentry programs “had a larger effect on recidivism when they lasted long enough (thirteen weeks or more) and provided continuity of care (had multiple phases, beginning in the institution and extending into the community upon release).”<sup>205</sup> Such post-release care, again, comports with therapeutic jurisprudence principles.<sup>206</sup>

As previously discussed, the clear evidence of the value of continuity of care—how it improves post-release engagement with mental health services,<sup>207</sup> how transition planning facilitates such continuity of care,<sup>208</sup> and how a correctional system that adopts such transitional services can have a “direct effect” on post-release

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202. Desirae Hutchison, *Inadequate Mental Health Services for Mentally Ill Inmates*, 38 WHITTIER L. REV. 161, 179 (2017).

203. Christy A. Visher, *Returning Home: Emerging Findings and Policy Lessons About Prisoner Reentry*, 20 FED. SENT’G REP. 93, 99 (2007).

204. Beth A. Colgan, *Teaching a Prisoner to Fish: Getting Tough on Crime by Preparing Prisoners to Reenter Society*, 5 SEATTLE J. FOR SOC. JUST. 293, 305 n.103 (2006) (discussing findings reported on in Nora D. Volkow, *Treat the Addict, Cut the Crime Rate*, WASH. POST, Aug. 19, 2006, at A17); see also Robert J. Constantine et al., *The Impact of Mental Health Services on Arrests of Offenders with a Serious Mental Illness*, 36 LAW & HUM. BEHAV. 170, 173 (2012) (“[R]eceipt of outpatient services is associated with reduced risks of arrests in the relatively immediate future.”).

205. Cheryl Lero Jonson & Francis T. Cullen, *Prisoner Reentry Programs*, 44 CRIME & JUST. 517, 551 (2015).

206. On how such programs also offer opportunities to counteract racism, see Adrienne Lyles-Chockley, *Transitions to Justice: Prisoner Reentry As an Opportunity to Confront and Counteract Racism*, 6 HASTINGS RACE & POVERTY L.J. 259 (2009). On the relationship between race and arrest policies (policies that lead to the underlying problems), see, for example, BRUCE WESTERN, PUNISHMENT AND INEQUALITY IN AMERICA 46 (2006); Katherine Beckett et al., *Race, Drugs, and Policing: Understanding Disparities in Drug Delivery Arrests*, 44 CRIMINOLOGY 105 (2006); Scott Holmes, *Resisting Arrest and Racism – The Crime of “Disrespect,”* 85 UMKC L. REV. 625 (2016).

207. McKenna et al., *supra* note 37 (citing Binswanger et al., *supra* note 38).

208. Baillargeon et al., *supra* note 39.

physical and mental health<sup>209</sup>—is totally consonant with therapeutic jurisprudence values.

## VII. MENTAL HEALTH COURTS

Consider the potential role of “mental health courts” (“MHCs”) as a partial remedy for the problems that we have been discussing.<sup>210</sup> Indisputably, one of the most important developments in the past two decades in the treatment of criminal defendants with mental illness within the criminal justice system is the creation and the expansion of mental health courts. Mental health courts are a kind of “problem-solving court,”<sup>211</sup> and their importance grows as society come to grips with how badly it has failed to provide the sort of continuity of care that should be required legally, ethically and morally.<sup>212</sup> There is a wide range of dispositional alternatives available to judges in these cases,<sup>213</sup> and an even wider range of judicial attitudes.<sup>214</sup>

209. Freudenberg, *supra* note 24, at 214.

210. See generally Michael L. Perlin, ‘*There Are No Trials Inside the Gates of Eden*’: *Mental Health Courts, the Convention on the Rights of Persons with Disabilities, Dignity and the Promise of Therapeutic Jurisprudence*, in COERCIVE CARE: RIGHTS, LAW AND POLICY 193 (Bernadette McSherry & Ian Freckelton eds., 2013); Michael L. Perlin, “*The Judge, He Cast His Robe Aside*”: *Mental Health Courts, Dignity and Due Process*, 3 MENTAL HEALTH L. & POL’Y J. 1 (2013); Perlin & Lynch, *supra* note 92; Michael L. Perlin, “*Who Will Judge the Many When the Game Is Through?*”: *Considering the Profound Differences Between Mental Health Courts and “Traditional” Involuntary Civil Commitment Courts*, 41 SEATTLE U. L. REV. (2018) [hereinafter Perlin, *Who Will Judge*] (forthcoming).

211. See, e.g., Greg Berman & John Feinblatt, *Problem-Solving Courts: A Brief Primer*, 23 L. & POL’Y 125, 127 (2001); Greg Berman & Aubrey Fox, *The Future of Problem-Solving Justice: An International Perspective*, 10 U. MD. L.J. RACE RELIGION GENDER & CLASS 1, 3 (2010); see also Ursula Castellano, *The Politics of Benchcraft: The Role of Judges in Mental Health Courts*, 42 L. & SOC. INQUIRY 398, 398 (2017).

212. See *supra* Parts III-VI.

213. See, e.g., Henry J. Steadman et al., *From Referral to Disposition: Case Processing in Seven Mental Health Courts*, 23 BEHAV. SCI. & L. 215, 220 (2005).

214. See, e.g., Michael S. King, *Should Problem-Solving Courts Be Solution-Focused Courts?*, 80 REV. JURÍDICA U. P.R. 1005, 1021 (2011). On why judges in mental health courts should model their courts after the work done in Florida by Judge Ginger Lerner-Wren and in New York by Judge Matthew D’Emic, see also Perlin, *Who Will Judge*, *supra* note 210, at 21–22, 32. We concede that the entire concept of “mental health courts” is certainly not without controversy. See, e.g., Tammy Seltzer, *Mental Health Courts: A Misguided Attempt to Address the Criminal Justice System’s Unfair Treatment of People with Mental Illness*, 11 PSYCHOL. PUB. POL’Y & L. 570, 576 (2005). We take the position, though, that it is the efforts to squelch the growing mental health court movement that are misguided. See Perlin, *Who Will Judge*, *supra* note 210, at 13–15.



These courts offer a radically new approach to the problems at hand.<sup>215</sup> They offer an approach that incorporates an articulated focus on dignity,<sup>216</sup> that optimally embrace of therapeutic jurisprudence, and that focus on procedural justice, and uses of the principles of restorative justice.<sup>217</sup> We believe that we need to begin to take seriously the potential ameliorative impact of such courts on the ways that continuity of care can meaningfully be provided to criminal defendants with mental disabilities.<sup>218</sup>

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215. Some jurisdictions are beginning to seek out other alternative and complementary solutions to these issues. For recently passed New York City local laws addressing the issue of mental health in the criminal system, see, for example, *Arrestee Health Screenings and the Exchange of Health Information of Inmates in the Custody of the Department of Correction*, N.Y. CITY COUNCIL (Oct. 18, 2016), <http://legistar.council.nyc.gov/LegislationDetail.aspx?ID=2735148&GUID=44E35DA3-1843-4456-95B6-511D0FF7EFB7>; *Requiring the Use of Trauma-Informed Care in City Correctional Facilities*, N.Y. CITY COUNCIL (Oct. 18, 2016), <http://legistar.council.nyc.gov/LegislationDetail.aspx?ID=2683868&GUID=50FF659A-5D11-42BC-A364-C15155C237CC&Options=&Search=>. On the need for trauma-informed lawyering in dealing with the population in question, see Sarah Katz & Deeya Haldar, *The Pedagogy of Trauma Informed Lawyering*, 22 CLINICAL L. REV. 359, 359 (2016); see also Mehgan Gallagher & Michael L. Perlin, “*The Pain I Rise Above*”: *How International Human Rights Can Best Realize the Needs of Persons with Trauma-Related Mental Disabilities*, 29 FLA. J. INT’L L. 217 (2018).

216. See Ginger Lerner-Wren, *Mental Health Courts: Serving Justice and Promoting Recovery*, 19 ANNALS HEALTH L. 577, 593 (2010) (explaining dignity in the context of mental health courts).

217. See MICHAEL L. PERLIN, *A PRESCRIPTION FOR DIGNITY: RETHINKING CRIMINAL JUSTICE AND MENTAL DISABILITY LAW* 88–96 (2013); Jessica Burns, *A Restorative Justice Model for Mental Health Courts*, 23 S. CAL. REV. L. & SOC. JUST. 427 (2014); Thomas L. Hafemeister et al., *Forging Links and Renewing Ties: Applying the Principles of Restorative and Procedural Justice to Better Respond to Criminal Offenders with a Mental Disorder*, 60 BUFF. L. REV. 147, 201–02 (2012); Henry J. Steadman et al., *Mental Health Courts: Their Promise and Unanswered Questions*, 52 LAW & PSYCHIATRY 457, 457–58 (2001) (discussing therapeutic jurisprudence in this context). On the relationship between these three approaches, see *id.* at 96–98; Michael L. Perlin, *Considering the “Alternative Jurisprudences” As a Tool of Social Change to Reduce Humiliation and Uphold Dignity* (Dec. 6, 2012) (paper presented to the 20th annual conference of the Human Dignity and Humiliation Studies Network). For a comparative law consideration of the role of procedural justice in democratic policing in Taiwan, see Yuning Wu et al., *Procedural Justice Received and Given: Supervisory Treatment, Emotional States, and Behavioral Compliance among Taiwanese Police Officers*, 44 CRIM. JUST. & BEHAV. 963 (2017).

218. On the utility of mental health courts in other jurisdictions, see, for example, Katey Thom, *New Zealand Mental Health Review Tribunal Characteristics and Outcomes 1993-2011*, 22 AUSTRAL. PSYCHIATRY 341 (2014) (N.Z.); Penelope Weller, *Taking a Reflexive Turn: Non-Adversarial Justice and Mental Health Review Tribunals*, 37 MONASH U. L. REV. 81 (2011) (Austl.). On why the proposed Disability Rights Tribunal for Asia and the Pacific should, in part, operate under these principles, see Michael L. Perlin & Mehgan Gallagher, *Why a Disability Rights Tribunal Must Be Premised on Therapeutic Jurisprudence Principles*, 10 PSYCH. INJ. & L. 244 (2017). On why mental health courts should be premised on therapeutic

It needs to be stressed that such courts are set up differently in different jurisdictions. Although there is not one single prototype of MHCs,<sup>219</sup> virtually all include the creation of a special docket that is handled by a particular judge, with the primary goal of diverting defendants from the criminal justice system and into treatment.<sup>220</sup> As part of the commitment of these courts to team approaches,<sup>221</sup> representatives from justice and treatment agencies assist the judge in screening offenders to determine whether they would present a risk of violence if released to the community, in devising appropriate treatment plans, and in supervising and monitoring the individual's performance in treatment.<sup>222</sup>

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jurisprudence and procedural justice, see Kimberly A. Kaiser & Kristy Holtfreter, *An Integrated Theory of Specialized Court Programs Using Procedural Justice and Therapeutic Jurisprudence to Promote Offender Compliance and Rehabilitation*, 43 CRIM. JUST. & BEHAV. 45 (2016).

219. Such courts are set up very differently in different jurisdictions. There are now, according to the Council of State Governments' Justice Center, over 375 such courts in operation in the United States, some dealing solely with misdemeanors, some solely with non-violent offenders, and some with no such restrictions. See, e.g., Ursula Castellano, *Courting Compliance: Case Managers as "Double Agents" in the Mental Health Court*, 36 LAW & SOC. INQUIRY 484, 490 (2011); Julie E. Grachek, *The Insanity Defense in the Twenty-First Century: How Recent United States Supreme Court Case Law Can Improve the System*, 81 IND. L.J. 1479, 1495 (2006); Donald M. Linhorst & P. Ann Dirks-Linhorst, *Mental Health Courts: Development, Outcomes, and Future Challenges*, 54 JUDGES' J. 22, 22 (2015) (citing E. Leah Johnston, *Theorizing Mental Health Courts*, 89 WASH. U. L. REV. 519, 521 (2012); *How Many Problem-Solving Courts Are There?*, NAT'L DRUG CT. RESOURCE CTR. (2012), <http://www.ndc.rc.org/content/how-many-problem-solving-courts-are-there>). See generally Perlin, *Who Will Judge*, *supra* note 210. On the expansion of these courts to include felony prosecutions, see Carol Fidler, *Building Trust and Managing Risk: A Look at a Felony Mental Health Court*, 11 PSYCHOL. PUB. POL'Y & L. 587 (2005).

220. Roger Boothroyd et al., *The Broward Mental Health Court: Process, Outcomes, and Service Utilization*, 26 INT'L J.L. & PSYCHIATRY 55, 55 (2003). At least one evaluation of such courts has concluded: "Most . . . defendants have been nuisance offenders who have a high incidence of drug co-morbidity, treatment plan noncompliance, and recidivism. Their high recidivism rate and the problem of severe jail overcrowding made the mental health court experiment especially attractive to some county policy makers." Gerald Nora, *Prosecutor As "Nurse Ratched"? Misusing Criminal Justice As Alternative Medicine*, 22 CRIM. JUST. 18, 22 (2007).

221. See, e.g., Arthur J. Lurigio & Jessica Snowden, *Putting Therapeutic Jurisprudence into Practice: The Growth, Operations, and Effectiveness of Mental Health Court*, 30 JUST. SYS. J. 196, 210 (2009); Marlee E. Moore & Virginia A. Hiday, *Mental Health Court Outcomes: A Comparison of Re-Arrest and Re-Arrest Severity Between Mental Health Court and Traditional Court Participants*, 30 LAW & HUM. BEHAV. 659, 660 (2006). On variances in team approaches, see Sheryl Kubiak et al., *Assessing the Role of Legal Actors Across Eight Mental Health Courts*, 17 MICH. ST. U. J. MED. & L. 301, 304 (2013).

222. Bruce J. Winick, *Outpatient Commitment: A Therapeutic Jurisprudence Analysis*, 9 PSYCHOL. PUB. POL'Y & L. 107, 125-26 (2003). On the role of jail as a potential sanction in

The MHC judge functions as part of a mental health team that decides whether the individual has treatment needs and can be safely released into the community.<sup>223</sup> First, the team formulates a treatment plan; then, a court-employed case manager and court monitor track the individual's participation in the treatment program and submit periodic reports to the judge concerning his or her progress.<sup>224</sup> Participants are required to report to the court periodically so that the judge can monitor treatment compliance.<sup>225</sup> Moreover, additional status review hearings are held on an as-needed basis.<sup>226</sup> These courts provide “nuanced” approaches,<sup>227</sup> and may signal a “fundamental shift” in the criminal justice system.<sup>228</sup>

By increasing the likelihood of a person with mental disability being diverted out of the criminal justice system, such courts both make it less likely that the person with mental disabilities will suffer at the hands of others because of their status,<sup>229</sup> and make it more likely that continuity of care can be achieved in their cases. The non-coercive nature and dignitarian

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the cases of non-compliant defendants, see Allison Redlich et al., *Patterns of Practice in Mental Health Courts: A National Survey*, 30 LAW & HUM. BEHAV. 347, 355–56 (2006).

223. On the often-conflicting roles of case managers in mental health courts, see Castellano, *supra* note 219, at 490–91. On the how caseworkers, in other contexts, “transform traditional courtroom justice,” see URSULA CASTELLANO, *OUTSOURCING JUSTICE: THE ROLE OF NONPROFIT CASEWORKERS IN PRETRIAL RELEASE PROGRAMS* 9 (2011).

224. LAUREN ALMQUIST & ELIZABETH DODD, *MENTAL HEALTH COURTS: A GUIDE TO RESEARCH-INFORMED POLICY AND PRACTICE* 5 (2009).

225. Susan Stefan & Bruce J. Winick, *A Dialogue on Mental Health Courts*, 11 PSYCHOL. PUB. POL'Y & L. 507, 520–21 (2005). For a recent article articulating strategies to optimize criminal justice-treatment collaborations, see J. Steven Lamberti, *Preventing Criminal Recidivism Through Mental Health and Criminal Justice Collaboration*, 67 PSYCHIATRIC SERVS. 1206 (2016). On how the adoption of a consumer-participation model in mental health courts can improve mental health court participants' capacity for voluntary participation, see McDaniel M. Kelly, *Rehabilitation Through Empowerment: Adopting the Consumer-Participation Model for Treatment Planning in Mental Health Courts*, 66 CASE W. RES. L. REV. 581, 584 (2015).

226. *Id.*

227. Patricia C. McManus, *A Therapeutic Jurisprudential Approach to Guardianship of Persons with Mild Cognitive Impairment*, 36 SETON HALL L. REV. 591, 598 (2006).

228. *Developments in the Law—The Law of Mental Illness: Mental Health Courts and the Trend Toward a Rehabilitative Justice System*, 121 HARV. L. REV. 1168, 1176 (2008).

229. Terry Carney et al., *Mental Health Tribunals: “TJ” Implications of Weighing Fairness, Freedom, Protection and Treatment*, 17 JUD. ADMIN. 46, 54 (2007); Risdon Slate, *From the Jailhouse to Capitol Hill: Impacting Mental Health Court Legislation and Defining What Constitutes a Mental Health Court*, 49 CRIME & DELINQ. 6, 6 (2003).

values of MHCs result in a more favorable response to offered care from defendants.<sup>230</sup> When these courts “buy into” the precepts of therapeutic jurisprudence, their likelihood of success is enhanced.<sup>231</sup> “Even a well-resourced problem-solving court may not work if the judge fails to adopt therapeutic jurisprudence and other problem-solving strategies effectively.”<sup>232</sup> Furthermore, if MHC judges “selectively apply, blend and transform” elements from the treatment and legal spheres to adjudicate cases therapeutically so as to “generate more effective solutions,”<sup>233</sup> it is more likely that authentically meaningful continuity of care can be maintained.<sup>234</sup>

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230. See, e.g., Joseph A. DaGrossa, *Improving Legitimacy in Community-Based Corrections*, 78 FED. PROB. 22 (June 2014) (citing C. Pratt et al., *Predictors of Criminal Justice Outcomes among Mental Health Courts Participants: The Role of Perceived Coercion and Subjective Mental Health Recovery*, 12 INT’L J. FORENSIC MENTAL HEALTH 116 (2013) (“In a 2013 study based on a sample of criminal defendants admitted into a mental health court and diversion program in New York, Pratt et al. observed a negative correlation between perceptions of coercion into treatment and perceptions of recovery.”)).

231. See, e.g., Patrick Geary, *Juvenile Mental Health Courts and Therapeutic Jurisprudence: Facing the Challenges Posed by Youth with Mental Disabilities in the Juvenile Justice System*, 5 YALE J. HEALTH POL’Y L. & ETHICS 671 (2005). This “buy in” is not universal. We do have some concerns about the operationalization of the courts in some jurisdictions. See E. Lea Johnston & Conor Flynn, *Mental Health Courts and Sentencing Disparities*, 62 VILL. L. REV. 685, 693 (2017) (empirically studying MHCs in Erie County, PA, and concluding that anticipated treatment court sentences—for all grades of offense—typically exceed county court sentences by more than a year).

232. Vicki Lens, *Against the Grain: Therapeutic Judging in a Traditional Family Court*, 41 L. & SOC. INQUIRY 701, 704 (2016). Beyond the scope of this paper is an evaluation of the potential role of independent expert witnesses. On the use of such experts in traditional civil commitment cases, see Dlugacz & Roskes, *supra* note 43. Although one analysis of mental health courts touts, as a court advantage, the “elimination of dueling experts,” see Andrew Wasicek, *Mental Illness and Crime: Envisioning a Public Health Strategy and Reimagining Mental Health Courts*, 48 NO. 1 CRIM. L. BULL. ART 6 (2012), and one judge has noted that, in his court, at least, “Not infrequently there can be a request for a second opinion,” John Shepard Wiley, Jr., *Taming Patent: Six Steps for Surviving Scary Patent Cases*, 50 UCLA L. REV. 1413, 1426 (2003), there is virtually no research literature whatsoever on the use of independent experts in these courts. Professors Baker and Zawid note that “expert testimony is common in mental health courts.” Gregory Baker & Jennifer Zawid, *The Birth of a Therapeutic Courts Externship Program: Hard Labor but Worth the Effort*, 17 ST. THOMAS L. REV. 711, 739 (2005). However, from the context of the Baker-Zawid article, they appear to be referring to testimony by team members, not independent expert witnesses.

233. Castellano, *supra* note 211, at 405. Professor Castellano—in her study of four separate mental health courts—found that the judges she observed were “deeply involved in investigating problems, collecting personal client information, and actively consulting with treatment professionals and law enforcement offices.” *Id.*

234. It should be noted that mental health courts actually work as they are intended to. Participants had significantly lower arrest rates after enrollment than before enrollment and lower post-enrollment arrest rates than comparison groups, and in fact,

Finally, and most importantly, research also suggests that mental health court participation increases access to and utilization of mental health care,<sup>235</sup> reduces the use of crisis or high-intensity services, and reduces substance use.<sup>236</sup> The most recent relevant study—authored by a sitting trial judge—has concluded that “problem-solving treatment courts are the best way to supervise criminal defendants in the community who present both high needs and a high risk to re-offend absent intervention.”<sup>237</sup> In short, they are the best way to ensure that continuity of care is actually provided.<sup>238</sup>

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were more successful at reducing recidivism—recidivism rates of twenty-five percent versus ten to fifteen percent—than were drug courts. Greg Goodale et al., *What Can We Say About Mental Health Courts Today?*, 64 PSYCHIATRIC SERVS. 298 (2013). On the role of perceived coercion in the mental health court process, see Sarah Kopelovich et al., *Procedural Justice in Mental Health Courts: Judicial Practices, Participant Perceptions, and Outcomes Related to Mental Health Recovery*, 36 INT’L J.L. & PSYCHIATRY 113 (2013) (procedural justice positively correlated with participants’ attitudes toward their own recovery); Evan Lowder et al., *Recidivism Following Mental Health Court Exit: Between and Within-Group Comparisons*, 40 LAW & HUM. BEHAV. 118 (2016) (noting mental health courts are particularly effective for high-risk participants, and time spent in such courts have positive effects on recidivism); Allison Redlich & Woojae Han, *Examining the Links Between Therapeutic Jurisprudence and Mental Health Court Completion*, 38 LAW & HUM. BEHAV. 109 (2014) (explaining increased levels of procedural justice and perceived voluntariness led to decreased rates of new arrests in mental health court populations).

235. See, e.g., Boothroyd et al., *supra* note 220; Christine M. Sarteschi, *Mentally Ill Offenders Involved with the US Criminal Justice System*, 3 SAGE OPEN, no. 3 (2013). See generally Woojae Han & Allison Redlich, *The Impact of Community Treatment on Recidivism Among Mental Health Court Participants*, 67 PSYCHIATRIC SERVS. 384 (2016) (showing increases in receipt of community treatment among MHC participants, and decreased recidivism).

236. Kellie Canada et al., *The Emergence of Mental Health Courts in the United States: Intersecting Innovation Between Psychiatric Care and the Law*, 5 MENTAL HEALTH L. & POL’Y J. 31, 57 (2016) (citing Erin Comartin et al., *Short and Long-Term Outcomes of Mental Health Court Participants by Psychiatric Diagnosis*, 66 PSYCHIATRIC SERVS. 923, 926 (2015); Kelly Fraling, *How Mental Health Courts Function: Outcomes and Observations*, 33 INT’L J.L. & PSYCHIATRY 207, 212 (2010)).

237. Kerry Meyer, *Hennepin County Criminal Mental Health Court: Experiences in a Large Metropolitan Mental Health Court*, 42 MITCHELL HAMLINE L. REV. 485, 521 (2016). On how MHCs in some states can vary radically from county to county, see Monte Staton & Arthur Lurigio, *Mental Health Courts in Illinois: Comparing and Contrasting Program Models, Sanction Applications, Information Sharing, and Professional Roles*, 79 FED. PROB. 21 (2015).

238. But see Johnston & Flynn, *supra* note 231 (critically reviewing the operation of such courts in Erie, PA).

## VIII. INTERNATIONAL HUMAN RIGHTS LAW

*A. Introduction*

It is essential for those who are concerned with the questions that we raise in this paper to take a hard look at international human rights law,<sup>239</sup> especially the United Nations' Convention on the Rights of Persons with Disabilities ("CRPD").<sup>240</sup> Although this may appear counter-intuitive—given the United States' record of failing to ratify the most important human rights treaties of the past decade<sup>241</sup>—we argue that, given the fact that President Obama signed the CRPD,<sup>242</sup> the United States is now obligated by the Vienna Convention of the Law of Treaties, which requires signatories "to refrain from acts which would defeat [CRPD's] object and purpose."<sup>243</sup>

In this section, we initially consider the CRPD and how it has created a new framework of disability, looking briefly at the key articles for the purpose of this paper. We then argue that continuity of care, as we described it here, is required by international human rights law.

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239. See generally MICHAEL L. PERLIN, INTERNATIONAL HUMAN RIGHTS AND MENTAL DISABILITY LAW: WHEN THE SILENCED ARE HEARD (2011).

240. *United Nations Convention on the Rights of Persons with Disabilities*, UNITED NATIONS (Dec. 6, 2006), [http://www.un.org/disabilities/documents/convention/convention\\_accessible\\_pdf](http://www.un.org/disabilities/documents/convention/convention_accessible_pdf).

241. See, e.g., Curtis Bradley, *The Juvenile Death Penalty and International Law*, 52 DUKE L.J. 485 (2002); Amy Harfeld, *Oh Righteous Delinquent One: The United States' International Human Rights Double Standard—Explanation, Example, and Avenues for Change*, 4 N.Y. CITY L. REV. 59 (2001).

242. Former President Obama signed the CRPD five years ago. See Michelle Diamant, *Obama Urges Senate to Ratify Disability Treaty*, DISABILITY SCOOP (May 18, 2012), <http://www.disabilityscoop.com/2012/05/18/Obama-Urges-Senate-Treaty/15654>. However, the Senate failed to ratify on December 4, 2012, because of a lack of a "super majority" of votes. *U.N. Treaty on Disabilities Falls Short in Senate*, CBS NEWS (Dec. 4, 2012), <https://www.cbsnews.com/news/un-treaty-on-disabilities-falls-short-in-senate>.

243. Henry A. Dlugacz & Christopher Wimmer, *The Ethics of Representing Clients with Limited Competency in Guardianship Proceedings*, 4 ST. LOUIS U. J. HEALTH L. & POL'Y 331, 362–63 (2011).

*B. The Convention on the Rights of Persons with Disabilities (“CRPD”): Moving Toward a New Framework of Disability*<sup>244</sup>

The CRPD “is regarded as having finally empowered the ‘world’s largest minority’ to claim their rights, and to participate in international and national affairs on an equal basis with others who have achieved specific treaty recognition and protection.”<sup>245</sup> This Convention is the most revolutionary international human rights document ever created that applies to persons with disabilities.<sup>246</sup> The Convention furthers the human rights approach to disability and recognizes the right of people with disabilities to equality in almost every aspect of life.<sup>247</sup> It firmly endorses a social model of disability, a clear and direct repudiation of the medical model that traditionally was part-and-parcel of mental disability law.<sup>248</sup> “The Convention responds to traditional models, situates disability within a social model framework, and sketches the full range of human rights that apply to all human beings, all with a particular application to the lives of persons with disabilities.”<sup>249</sup> It provides a framework for ensuring that mental health laws “fully recognize the rights of those with mental illness.”<sup>250</sup> There is no question that it has “ushered in a new era of disability rights policy.”<sup>251</sup>

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244. This section is largely adapted from Michael L. Perlin, “*Striking for the Guardians and Protectors of the Mind*”: *The Convention on the Rights of Persons with Disabilities and the Future of Guardianship Law*, 117 PENN ST. L. REV. 1159, 1173–76 (2013).

245. Rosemary Kayess & Phillip French, *Out of Darkness into Light? Introducing the Convention on the Rights of Persons with Disabilities*, 8 HUM. RTS. L. REV. 1, 4 n.17 (2008). See generally Kristin Booth Glen, *Changing Paradigms: Mental Capacity, Legal Capacity, Guardianship, and Beyond*, 44 COLUM. HUM. RTS. L. REV. 93, 134–37 (2012).

246. See generally COERCIVE CARE: RIGHTS, LAW AND POLICY (Bernadette McSherry & Ian Freckelton eds., 2013).

247. *Committee on the Rights of Persons with Disabilities*, UNITED NATIONS HUM. RTS., <http://www.ohchr.org/EN/HRBodies/CRPD/Pages/ConventionRightsPersonsWithDisabilities.aspx>.

248. See generally Michael L. Perlin, “*Abandoned Love*”: *The Impact of Wyatt v. Stickney on the Intersection Between International Human Rights and Domestic Mental Disability Law*, 35 LAW & PSYCHOL. REV. 121 (2011).

249. Janet E. Lord & Michael A. Stein, *Social Rights and the Relational Value of the Rights to Participate in Sport, Recreation, and Play*, 27 B.U. INT’L L.J. 249, 256 (2009).

250. Bernadette McSherry, *International Trends in Mental Health Laws: Introduction*, 26 LAW CONTEXT 1, 8 (2008).

251. Paul Harpur, *Time to Be Heard: How Advocates Can Use the Convention on the Rights of Persons with Disabilities to Drive Change*, 45 VAL. U. L. REV. 1271, 1295 (2011).

The CRPD calls for “respect for inherent dignity”<sup>252</sup> and “non-discrimination.”<sup>253</sup> Subsequent articles declare “freedom from torture or cruel, inhuman or degrading treatment or punishment,”<sup>254</sup> “freedom from exploitation, violence and abuse,”<sup>255</sup> and a right to protection of the “integrity of the person.”<sup>256</sup> It not only clarifies that states should not discriminate against persons with disabilities, but also explicitly sets out the many steps that states must take to create an enabling environment so that persons with disabilities can enjoy authentic equality in society.<sup>257</sup> The CRPD mandates that “States Parties shall take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity.”<sup>258</sup> Elsewhere, the Convention commands:

States Parties shall ensure effective access to justice for persons with disabilities on an equal basis with others, including through the provision of procedural and age-appropriate accommodations, in order to facilitate their effective role as direct and indirect participants, including as witnesses, in all legal proceedings, including at investigative and other preliminary stages.<sup>259</sup>

Other articles in the CRPD speak directly to the questions under consideration in this paper. The Convention requires, by way of example, that “States Parties shall promote appropriate training for those working in the field of administration of justice, including police and prison staff.”<sup>260</sup> In an important article about

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252. *United Nations Convention on the Rights of Persons with Disabilities*, *supra* note 240, art. 3(a), at 5.

253. *Id.* art. 3(b), at 5.

254. *Id.* art. 15, at 12.

255. *Id.* art. 16, at 12.

256. *Id.* art. 17, at 13.

257. *See* Perlin & Weinstein, *supra* note 85, at 15 (discussing, *inter alia*, Bryan Y. Lee, *The U.N. Convention on the Rights of Persons with Disabilities and Its Impact upon Involuntary Civil Commitment of Individuals with Developmental Disabilities*, 44 COLUM. J.L. & SOC. PROBS. 393, 413–30 (2011) (discussing the changes that ratifying states need to make in their domestic involuntary civil commitment laws to comply with CRPD mandates)).

258. *United Nations Convention on the Rights of Persons with Disabilities*, *supra* note 240, art. 12(3), at 10.

259. *Id.* art. 13(1), at 11.

260. *Id.* art. 13(2), at 11.



the relationship of the CRPD to prison conditions, Janet Lord also focuses on Article 15 that mandates, as noted above, the right to “freedom from torture or cruel, inhuman or degrading treatment or punishment.”<sup>261</sup> Lord notes that “conditions within prisons and other institutional settings have long been the subject of scrutiny by disability organizations.”<sup>262</sup>

Perhaps most importantly for our purposes, the CRPD provides an affirmative right to health care, finding that member States must:

(a) Provide persons with disabilities with the same range, quality and standard of free or affordable health care and programmes as provided to other persons, including in the area of sexual and reproductive health and population-based public health programmes;

(b) Provide those health services needed by persons with disabilities specifically because of their disabilities, including early identification and intervention as appropriate, and services designed to minimize and prevent further disabilities, including among children and older persons;

(c) Provide these health services as close as possible to people’s own communities, including in rural areas;

(d) Require health professionals to provide care of the same quality to persons with disabilities as to others, including on the basis of free and informed consent by, inter alia, raising awareness of the human rights, dignity, autonomy and needs of persons with disabilities through training and the promulgation of ethical standards for public and private health care;

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261. Lord, *supra* note 136, at 54.

262. *Id.* at 69.

(e) Prohibit discrimination against persons with disabilities in the provision of health insurance, and life insurance where such insurance is permitted by national law, which shall be provided in a fair and reasonable manner; [and]

(f) Prevent discriminatory denial of health care or health services or food and fluids on the basis of disability.<sup>263</sup>

The ratification of the CRPD marks the most important development ever seen in institutional human rights law for persons with mental disabilities.<sup>264</sup> The CRPD is detailed, comprehensive, integrated, and is the result of a careful drafting process. It seeks to reverse the results of centuries of oppressive behavior and attitudes that have stigmatized persons with disabilities.<sup>265</sup> Its goals are clear: to promote, protect, and ensure the full and equal enjoyment of all human rights and fundamental freedoms of all persons with disabilities, and to promote respect for their inherent dignity.<sup>266</sup> Whether these goals can actually be accomplished is still far from a settled matter.

Professor Meghan Flynn has argued that these Articles “guarantee persons with disabilities rights to enjoy freedom from institutionalization and live in the community setting of their choice.”<sup>267</sup> If Professor Flynn is correct—as we believe she is—then, clearly, continuity of care must be considered as a fundamental right under the CRPD. In an earlier article about juvenile punishment facilities, one of the co-authors has argued that “our current system of warehousing juveniles with mental illnesses in juvenile detention facilities and reformatories and in prisons following pre-adjudication transfers violates international

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263. *United Nations Convention on the Rights of Persons with Disabilities*, *supra* note 240, art. 25; see Paul Harpur, *Old Age Is Not Just Impairment: The CRPD and the Need for a Convention on Older Persons*, 37 U. PA. J. INT'L L. 1027, 1045–46 (2016).

264. See, e.g., Perlin & Weinstein, *supra* note 85, at 31, n.187.

265. *United Nations Convention on the Rights of Persons with Disabilities*, *supra* note 240, art. 8, at 8.

266. *Id.* art. 1, at 4.

267. Meghan Flynn, *Olmstead Plans Revisited: Lessons Learned from the U.N. Convention on the Rights of Persons with Disabilities*, 28 LAW & INEQ. 407, 424 (2010).

human rights law, including, but not limited to, the CRPD.”<sup>268</sup> This analysis applies equally to the cohort that we discuss in this paper.

Historically, there has traditionally been robust literature about the relationship between correctional facilities and international human rights law.<sup>269</sup> But there has, to this date, been no scholarship at all that considers the application of international human rights law to the need for continuity of care that we discuss in this paper. A consideration of the relevant Articles of the CRPD makes it clear that our current policies (*not* providing the sort of continuity of care that would protect the persons in question from “exploitation, violence and abuse,”<sup>270</sup> and not guaranteeing the right to protection of the “integrity of the person”)<sup>271</sup> violate international human rights law. If we are to provide “authentic equality”<sup>272</sup> to this population so that they can truly “enjoy freedom from institutionalization,”<sup>273</sup> then we must reconceptualize these policies and provide the sort of continuity of care that we urge here. An important article some fifteen years ago by the former Director of the National Institute of Justice and his colleagues asked, “Has the health care system in prison created linkages with the health care system in the returning prisoner’s community to ensure continuity of care?”<sup>274</sup> If we cannot answer

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268. Michael L. Perlin, “Yonder Stands Your Orphan with His Gun”: *The International Human Rights and Therapeutic Jurisprudence Implications of Juvenile Punishment Schemes*, 46 TEX. TECH L. REV. 301, 306 (2013); *see also* Astrid Birgden & Michael L. Perlin, “Tolling for the Luckless, the Abandoned and Forsaked”: *Therapeutic Jurisprudence and International Human Rights Law As Applied to Prisoners and Detainees by Forensic Psychologists*, 13 LEGAL & CRIMINOLOGICAL PSYCHOL. 231 (2008).

269. *See, e.g.*, Alvin J. Bronstein & Jenni Gainsborough, *The International Context of U.S. Prison Reform: Using International Human Rights Laws and Standards for U.S. Prison Reform*, 24 PACE L. REV. 811, 814–15 (2004); Fellner, *supra* note 57, at 405–10; Sara A. Rodriguez, *The Impotence of Being Earnest: Status of the United Nations Standard Minimum Rules for the Treatment of Prisoners in Europe and the United States*, 33 NEW ENG. J. ON CRIM. & CIV. CONFINEMENT 61, 62 (2007); *see also* Kathryn D. DeMarco, *Disabled by Solitude: The Convention on the Rights of Persons with Disabilities and Its Impact on The Use of Supermax Solitary Confinement*, 66 U. MIAMI L. REV. 523 (2012) (surveying the application of the CRPD to solitary confinement in correctional institutions).

270. *United Nations Convention on the Rights of Persons with Disabilities*, *supra* note 240, art. 16, at 12.

271. *Id.* art. 17, at 13.

272. Perlin & Weinstein, *supra* note 85, at 15.

273. Flynn, *supra* note 267, at 424.

274. Jeremy Travis et al., *Prisoner Reentry: Issues for Practice and Policy*, 17 CRIM. JUST. 12, 14 (Spring 2002).

this question today in the affirmative (and we cannot), then we fail under prevailing international human rights law standards.<sup>275</sup>

Writing about the plight of incarcerated women in California, Angela Wolf and her colleagues have recommended that “[c]ommunity programs should link to in-prison programs to provide continuity of care so as to meet women’s basic needs upon release, such as subsistence, shelter, and health care.”<sup>276</sup> Each of these is mandated by the CRPD<sup>277</sup> and as such, policies that do not include a robust continuity-of-care program thus violate the document.

#### IX. WAYS TO IMPROVE CONTINUITY OF CARE

There are many ways that the quality of continuity of care can be improved. Initially, diversion programs keep persons with mental illness away from the criminal justice system and instead place them on special mental health-oriented tracks.<sup>278</sup> Diversion can occur at various stages including prior to arrest or after arrest.<sup>279</sup> Certainly, well-operating MHCs<sup>280</sup> are a proven means of improving diversion, leading to better outcomes for the cohort of individuals involved.<sup>281</sup>

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275. In addition to the CRPD, there are other international human rights instruments relevant to this question. *See, e.g.*, Danielle Drissel, *Massachusetts Prison Mental Health Services: History, Policy and Recommendations*, 87 MASS. L. REV. 106, 107–08 (2003) (discussing the Standard Minimum Rules for the Treatment of Prisoners); Dlugacz & Droubi, *supra* note 30, at 141–42 (discussing the International Covenant on Civil and Political Rights).

276. Angela Wolf et al., *The Incarceration of Women in California*, 43 U.S.F. L. REV. 139, 166 (2008).

277. *See, e.g.*, Harpur, *supra* note 251, at 1045–46 (health); Michael Ashley Stein & Janet E. Lord, *Enabling Refugee and IDP Law and Policy: Implications of the U.N. Convention on the Rights of Persons with Disabilities*, 28 ARIZ. J. INT’L & COMP. L. 401, 429 n.166 (2011) (“It should be noted that the CRPD emphasizes universal design as a concept to be applied across all contexts covered by the treaty, which would include all housing, including temporary shelter designed for use in humanitarian crisis contexts.” (interpreting *United Nations Convention on the Rights of Persons with Disabilities*, *supra* note 240, art. 4(1)(f))); *see also* Harpur, *supra* note 251, at 1051 (discussing, in an international human rights context, Peter Townsend, *Policies for the Aged in the 21st Century: More ‘Structured Dependency’ or the Realization of Human Rights?*, 26 AGING & SOC’Y 161, 165 (2006) (arguing that the plight of millions of older people in many developed countries is rooted in the evolution of social policy, not old age itself)).

278. Howell, *supra* note 74, at 32.

279. *Id.*

280. *See supra* Section VII.

281. *See, e.g.*, Meyer, *supra* note 237.

Additionally, providing mental health screening for every arrestee can lead to that person being diverted into mental health treatment.<sup>282</sup> The initial intake interview is a critical component of effective mental health treatment as it allows officials to ascertain whether the person was receiving treatment in the community, and also connects inmates with treatment, especially in those cases where they were not receiving adequate treatment in the community.<sup>283</sup> Mental health screening should be validated to accurately identify mental illness.<sup>284</sup> The intake process should be formulated to identify how a prisoner's areas of need overlap, such as mental illness and unemployment or educational issues.<sup>285</sup> Mental health screenings should also be administered routinely upon any transfer between prisons, upon admission to a segregation unit within a prison, and also on an ad-hoc basis.<sup>286</sup> In addition, mental health screening should include assessment of suicidal risk.<sup>287</sup>

Improving conditions in prisons and jails can also improve continuity of care for persons with mental illness.<sup>288</sup> Proper mental health training for corrections officers can also help identify inmates should they need mental health treatment during their incarceration and ensure that the interactions between staff and inmates with mental illness are therapeutic.<sup>289</sup> Punitive treatment like segregation and use of restraints should be eliminated.<sup>290</sup> In addition, psychiatric rehabilitation programs are needed including education and vocational training, social skills training, anger management, and substance abuse treatment.<sup>291</sup> Intermediate care, between inpatient and outpatient treatment, is also a crucial component.<sup>292</sup>

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282. See, e.g., Christy P. Johnson, *Mental Health Care Policies in Jail Systems: Suicide and the Eighth Amendment*, 35 U.C. DAVIS L. REV. 1227 (2002).

283. Broches, *supra* note 9, at 101.

284. Matti Hautala, *In the Shadow of Sandra Bland: The Importance of Mental Health Screening in U.S. Jails*, 21 TEX. J. ON C.L. & C.R. 89, 120 (2015).

285. Colgan, *supra* note 204, at 310.

286. Terry A. Kupers, *A Community Mental Health Model in Corrections*, 26 STAN. L. & POL'Y REV. 119, 130 (2015).

287. Fellner, *supra* note 88, at 142.

288. *Id.*

289. Howell, *supra* note 74, at 33.

290. Hautala, *supra* note 284, at 122.

291. Kupers, *supra* note 286, at 134.

292. *Id.*

Beyond this, discharge planning is also an important point to ensure that a person continues to receive proper mental health care in the community.<sup>293</sup> Discharge plans must be tailored towards individual needs and must be culturally relevant.<sup>294</sup> Aftercare programs are not always adequate or sufficient, and it is important that inmates work with discharge planners for longer periods of time prior to release in order to ensure a smooth transition.<sup>295</sup> Comprehensive transitional services provide access to mental health treatment, job opportunities, family unification, and cognitive skills training.<sup>296</sup> It is also important to make sure the individual has the ability to pay for mental health services and medication upon release.<sup>297</sup>

Finally, the availability and quality of community mental health treatment should be improved to address continuity of care issues.<sup>298</sup> The key to quality and effective mental health care is the relationship between the provider and the consumer receiving services.<sup>299</sup> Increasing the availability of educational and vocational training and mental health and substance use treatment increases the chance of successful reentry and reduces recidivism.<sup>300</sup> The first days and weeks that an inmate is released are crucial in that the inmate poses the most danger to themselves, their families, and peers.<sup>301</sup> By investing greater resources in using this vulnerable time to achieve socially desirable outcomes, public health workers can interrupt the cycle of relapse and recidivism.<sup>302</sup> Of course, more research is still needed to determine the most effective social interventions.<sup>303</sup>

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293. Broches, *supra* note 9, at 110.

294. Lamb & Bachrach, *supra* note 64, at 1043.

295. Howell, *supra* note 74, at 34.

296. Colgan, *supra* note 204, at 318.

297. Shane Levesque, *Closing the Door: Mental Illness, the Criminal Justice System, and the Need for a Uniform Mental Health Policy*, 34 NOVA L. REV. 711, 738 (2010).

298. See, e.g., Domenico Giacco & Stefan Priebe, *Using Routine Quality of Life Assessment to Improve Effectiveness of Community Mental Health Care*, in BEYOND ASSESSMENT OF QUALITY OF LIFE IN SCHIZOPHRENIA 145 (A. George Awad & Lakshmi N.P Voruganti eds., 2016).

299. Miriam Ruttenger, *Choice and Continuity of Care As Significant Issues for Equality in Mental Health Care*, 10 J. HEALTH & BIOMEDICAL L. 201, 205 (2014).

300. Colgan, *supra* note 204, at 322.

301. Freudenberg, *supra* note 24, at 227.

302. *Id.*

303. *Id.* at 228.

## X. CONCLUSION

The right to continuity of care is guaranteed under both domestic and international law. Providing effective continuity of care for persons with mental illness can lead to better outcomes and reduce the shuttle of this population between jails and hospitals. However, there are many factors complicating the issue of continuity of care with no easy solutions. Currently the constant shuttling treatment of the current, relevant population is in violation of the ADA, the CRPD, and therapeutic jurisprudence principles. The ADA guarantees freedom from discrimination based on disability and applies both to persons in the community and individuals who are incarcerated, guaranteeing a right to continuity of care. Yet individuals also have a right to medical privacy, as HIPAA prevents medical information from being shared except in certain prescribed circumstances. Furthermore, although the ACA has greatly expanded access to health care, it currently does not apply to incarcerated individuals. Health insurance can complicate issues of continuity of care in cases where only certain treatment providers or medications are covered for the individual.

Continuity of care can be improved through interventions through the use of MHCs, diversion practices, mental health screening, and, potentially, the use of psychiatric advance directives. More research is needed to determine what interventions work best for this population. Better training for corrections employees, court personnel, lawyers, judges, and police officers can lead to better therapeutic outcomes.<sup>304</sup>

Our title comes in part from Bob Dylan's masterpiece *Visions of Johanna*. Writing about that song, Tim Riley has characterized it as "rich with psychological peril."<sup>305</sup> Critic Mike Marqusee has characterized *Visions* as "Dylan's definitive treatment of 'strandedness.'"<sup>306</sup> The cohort of individuals we write about here are in persistent "psychological peril," and, whether they are in a correctional facility, a hospital or on the street, they

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304. See generally Perlin & Lynch, *Big Police*, *supra* note 7.

305. TIM RILEY, *HARD RAIN: A DYLAN COMMENTARY* 134 (1992).

306. MIKE MARQUSEE, *CHIMES OF FREEDOM: THE POLITICS OF BOB DYLAN'S ART* 195 (2003).

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are “stranded” from society.<sup>307</sup> No one, in many instances, is even “pretending to care for [them].”<sup>308</sup> We hope that our suggestions here may ameliorate this set of circumstances in the future.

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307. DYLAN, *supra* note 18.

308. *Id.*