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## The Criminalization of Mental Illness and Substance Use Disorder: Addressing the Void Between the Healthcare and Criminal Justice Systems

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**THE CRIMINALIZATION OF MENTAL ILLNESS  
AND SUBSTANCE USE DISORDER: ADDRESSING  
THE VOID BETWEEN THE HEALTHCARE AND  
CRIMINAL JUSTICE SYSTEMS**

*Emily B. Egart*

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## I. INTRODUCTION

Through the War on Drugs and the deinstitutionalization movement, our criminal justice system became quicksand for individuals afflicted with mental illness and substance use disorder.<sup>1</sup> We criminalized minor offenses,<sup>2</sup> imprisoned those who needed treatment rather than incarceration,<sup>3</sup> and provided few safe spaces for those individuals to receive proper medical treatment and housing.<sup>4</sup> As a result, homelessness skyrocketed, and a mass shuttling of individuals through the criminal justice system's revolving door began.<sup>5</sup>

The criminal justice system serves an important purpose for the safety of our nation. But it also serves, inappropriately, as a void that swallows people in the throes of mental illness and substance use disorder. This void that exists between the healthcare and criminal justice systems was created by social and political movements over the past fifty years.<sup>6</sup>

For too many individuals with serious mental illness, substance use disorder, or both, the

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<sup>1</sup> *Criminalization of Mental Illness*, TREATMENT ADVOC. CTR. (2018), <https://www.treatmentadvocacycenter.org/key-issues/criminalization-of-mental-illness> [<https://perma.cc/Y7HQ-CFA6>]; *A History of the Drug War*, DRUG POL'Y ALL., <https://drugpolicy.org/issues/brief-history-drug-war> [<https://perma.cc/9H57-XFZS>]; see *DSM-5 Criteria for Addiction Simplified*, ADDICTION POL'Y F. (Aug. 17, 2020), <https://www.addictionpolicy.org/post/dsm-5-facts-and-figures> [<https://perma.cc/A2V8-28PF>]; see *Substance Use and Co-occurring Mental Disorders*, NAT'L INST. OF MENTAL HEALTH (Mar. 2023), <https://www.nimh.nih.gov/health/topics/substance-use-and-mental-health> [<https://perma.cc/93VX-A53G>] (explaining that substance use disorder and addiction are classified as mental illnesses and are, therefore, often referred to within the confines of mental illness).

<sup>2</sup> *A History of the Drug War*, *supra* note 1; Teneille R. Brown, *Treating Addiction in the Clinic, Not the Courtroom: Using Neuroscience and Genetics to Abandon the Failed War on Drugs*, 54 IND. L. REV. 29, 47–48 (2021).

<sup>3</sup> *Criminalization of Mental Illness*, *supra* note 1; Megan Testa, *Imprisonment of the Mentally Ill: A Call for Diversion to the Community Mental Health System*, 8 ALB. GOV'T L. REV. 405, 408 (2015).

<sup>4</sup> See generally Risdon N. Slate, *Deinstitutionalization, Criminalization of Mental Illness, and the Principle of Therapeutic Jurisprudence*, 26 S. CAL. INTERDISC. L.J. 341 (2017) (discussing the lack of available treatment and care for individuals with mental illness after the deinstitutionalization movement).

<sup>5</sup> Testa, *supra* note 3, at 408 (explaining the cyclical nature between the criminal justice system and the community for individuals with untreated mental illness and substance use disorder).

<sup>6</sup> *Criminalization of Mental Illness*, *supra* note 1 (“Fifty years of failed mental health policy have placed law enforcement on the front lines of mental illness crisis response and turned jails and prisons into the new asylums.”).

justice system is the de facto entry point for obtaining treatment and services. There are many causes, not the least of which is the criminalization of mental illness and the lack of alternative approaches and resources to support the diversion of individuals from the courts and into treatment.<sup>7</sup>

Under the current legal framework, we are left with an ineffective, piecemeal approach of how to care for individuals afflicted by mental illness and substance use disorder as they become part of the criminal justice system. The treatment and care they require creates a heavy burden on our legal system—a punitive system built without any intention nor capability to provide extensive health care. Although the solutions discussed in this Note move the needle slightly, they do not holistically provide an effective framework to attack this issue at its roots and break the cycle.

Imagine an individual with a severe mental illness who is homeless and addicted to drugs or alcohol, or both, as a form of self-medication. Now picture her<sup>8</sup> repeatedly caught in a cycle of arrests based on her substance use, public drunkenness, public urination, homelessness, and other forms of disorderly conduct. Unfortunately, this individual is only one out of the hundreds of thousands of people who are swept into the vast void of criminalization and incarceration brought about by the deinstitutionalization of state psychiatric facilities and the War on Drugs. Is it fair and reasonable to criminalize her for conduct that was arguably forced on her for her inherent survival? Is it more reasonable to punish the system that created this hole for her to fall into rather than the individual? Consider these questions over the next few sections.

Following this introduction, Parts II and III of this Note review the historical background of the deinstitutionalization movement, the War on Drugs, and the

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<sup>7</sup> NAT'L JUD. TASK FORCE, STATE COURTS LEADING CHANGE: REPORT AND RECOMMENDATIONS 9 (2022),

[https://www.ncsc.org/\\_\\_data/assets/pdf\\_file/0031/84469/MHTF\\_State\\_Courts\\_Leading\\_Change.pdf](https://www.ncsc.org/__data/assets/pdf_file/0031/84469/MHTF_State_Courts_Leading_Change.pdf) [<https://perma.cc/G95M-EHBH>].

<sup>8</sup> As the author, I chose to use mostly female pronouns where I reference any hypothetical scenario in which the individual afflicted by mental illness and substance use disorder is presented and described. This is intentional based on my own personal history, struggle, and experience with substance use disorder and mental health imbalances as a person who identifies as female.

legal framework that has shaped how our system approaches “criminal” acts related to substance use.<sup>9</sup> Part IV addresses the overarching problems the system currently faces including the prevalent comorbidity of mental illness and substance use disorder, the surrounding systemic stigmas, trans-institutionalization, and involuntary civil commitment.<sup>10</sup> Finally, Part V discusses solutions, both currently available and proposed, and the outcomes they would have on the issues and affected individuals.<sup>11</sup>

## II. HISTORICAL BACKGROUND

The U.S. incarceration rate is significantly higher than any other country in the world.<sup>12</sup> Individuals affected by mental illness and substance use disorders make up more than half of the U.S. prison population.<sup>13</sup> Two major events throughout the mid-to-late twentieth century arguably contributed to the staggering number of vulnerable people being funneled into the criminal justice system: the deinstitutionalization movement and the War on Drugs.<sup>14</sup> These two movements cataclysmically altered our nation’s ability—and interest—to care for our own to such an extent that we turned on our most vulnerable individuals by marking

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<sup>9</sup> See *infra* Parts II–III.

<sup>10</sup> See *infra* Part IV.

<sup>11</sup> See *infra* Part V.

<sup>12</sup> *United States Profile*, PRISON POL’Y INITIATIVE, <https://www.prisonpolicy.org/profiles/US.html> [<https://perma.cc/J8LD-3Q2T>] (explaining that the incarcerated population of the United States of “nearly two million people behind bars at any given time” means the United States has “the highest incarceration rate of any country in the world”).

<sup>13</sup> NAT’L JUD. TASK FORCE, *supra* note 7, at 9 (“People with mental illnesses in the U.S. are 10 times more likely to be incarcerated than they are to be hospitalized. Every year, approximately 2 million arrests are made of people with serious mental illnesses. As a result, more than 70 percent of people in American jails and prisons have at least one diagnosed mental illness or substance use disorder, or both. Up to a third of those incarcerated have serious mental illnesses, a much higher rate than is found at large. On any given day, approximately 380,000 people with mental illnesses are in jail or prison across the U.S., and another 574,000 are under some form of correctional supervision.”).

<sup>14</sup> See Testa, *supra* note 3, at 412 (arguing that deinstitutionalization, “strict drug laws[,] and iron-fisted crime control policies” were potential colliding factors that led to the criminalization of mental illness and addiction); see also Slate, *supra* note 4, at 349 (explaining the arguments that coexist for the disproportionate number of people currently in the criminal justice system with mental illness and addiction); see also Brown, *supra* note 2, at 46–47 (discussing how the War on Drugs not only criminalized drug use, but also furthered the stigma of individuals affected by mental illness and substance use disorder).

a disproportionate percentage of them as criminals.<sup>15</sup> In order to address the void that deinstitutionalization and the War on Drugs created, we must shift our sociocultural paradigm for how our criminal justice and healthcare systems should function in relation to one another.

Prior to these two movements, a phenomenon called the “Penrose Effect” foreshadowed the mass incarceration of individuals with mental illness and substance use disorder.<sup>16</sup> The Penrose Effect describes an “inverse relationship between mental health treatment infrastructure and prison populations.”<sup>17</sup> Where the infrastructure of mental health treatment declines, a rise in incarceration rates tends to follow.<sup>18</sup> This effect, first described by Lionel Penrose in 1939, predicted the aftereffects of the deinstitutionalization movement well before the movement took shape.<sup>19</sup> At the time this phenomenon was introduced, additional exacerbating factors, such as the War on Drugs and comorbidity of substance use disorder and mental illness, were unanticipated.<sup>20</sup> Unfortunately, these additional, unanticipated factors have accelerated the Penrose Effect over

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<sup>15</sup> Brown, *supra* note 2, at 47 (“[T]he criminalization of drug use has led to greater stigma for affected individuals.”); Slate, *supra* note 4, at 347 (The “mass encounters of persons with mental illnesses leading to arrest (often for minor offenses) and/or imprisonment are referred to as the ‘criminalization of mentally disordered behavior’ and have come to be known as the criminalization of mental illness.”).

<sup>16</sup> Gregory G. Grecco & R. Andrew Chambers, *The Penrose Effect and Its Acceleration by the War on Drugs: A Crisis of Untranslated Neuroscience and Untreated Addiction and Mental Illness*, TRANSLATIONAL PSYCHIATRY, Nov. 28, 2019, at 2, <https://www.nature.com/articles/s41398-019-0661-9.pdf> [<https://perma.cc/4JGB-KZY3>].

<sup>17</sup> *Id.*

<sup>18</sup> *Id.* Penrose’s theory showed that “in industrialized nations, a decline of mental health treatment infrastructure is linked with reciprocal increases in incarcerations.” *Id.* The analysis by Penrose included data from eighteen European countries showing where the number of psychiatric beds declined, the number of prisoners rose. *Id.*

<sup>19</sup> *See id.* The deinstitutionalization movement “was poorly organized and conducted without adequate build-up of supportive housing, social services, or outpatient-community mental health infrastructure.” *Id.* The movement “has not only created unprecedented waves of homelessness, but it has, consistent with the Penrose Effect, forced the criminal justice system to assume the role of mental health care, as untreated, unsheltered individuals were relabeled as ‘criminals.’” *Id.*

<sup>20</sup> *Id.* at 7.

the last thirty years.<sup>21</sup>

### A. *Deinstitutionalization*

The deinstitutionalization movement<sup>22</sup> ramped up in the 1960s when state hospitals were shut down, and the individuals dependent on these institutions were released into communities without immediate resources to meet their basic needs, much less their treatment needs.<sup>23</sup> Between 1955 and 1976, state psychiatric hospitals reduced the number of patients in their care from 559,000 to 171,000.<sup>24</sup> By 1980, fewer than 100,000 patients were in state hospital care.<sup>25</sup>

Deinstitutionalization was motivated by multiple factors with the overall intention of safely shifting individuals

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<sup>21</sup> *Id.* at 6–7. The authors explain the neuroscience of the mental illness and substance use disorder dual diagnosis as “tightly interlinked brain diseases.” *Id.* at 6. The significance of this neuroscience shows that the War on Drugs and the Penrose Effect are not simply “parallel social processes but are interlinked and mutually reinforcing.” *Id.* Where treatment and care for mental illness declines, more individuals are arrested and incarcerated for untreated mental illness behavior. *Id.* At the same time, these individuals are “biologically, involuntarily predisposed to acquiring addictions,” and therefore the United States has more individuals with very limited—or completely without—mental illness treatment access “acquiring addictions.” *Id.* These individuals demonstrate the “behavioral consequences of untreated addiction” and are then “criminalized by the War on Drugs.” *Id.* The authors share observations and research suggesting that “deinstitutionalization and the War on Drugs may have intersected to accelerate the Penrose Effect,” and the core dynamic facilitating this acceleration is a “fundamental epidemiological and neurobiological linkage between mental illness and addiction.” *Id.* at 6–7. This biological link was only established in the last thirty years and, therefore, Penrose could not have predicted the accelerating effect the War on Drugs and deinstitutionalization would have on the Penrose Effect phenomenon. *Id.* at 7.

<sup>22</sup> “Deinstitutionalization is the name given to the policy of moving severely mentally ill people out of large state institutions and then closing part or all of those institutions . . . .” *Deinstitutionalization: A Psychiatric “Titanic,”* PBS: FRONTLINE (May 10, 2005), <https://www.pbs.org/wgbh/pages/frontline/shows/asylums/special/excerpt.html> [<https://perma.cc/T7JF-U65B>] (citing E. FULLER TORREY, M.D., *OUT OF THE SHADOWS: CONFRONTING AMERICA’S MENTAL ILLNESS CRISIS* (1997)).

<sup>23</sup> See Testa, *supra* note 3, at 410; see also Slate, *supra* note 4, at 347 (explaining through a 1970s case study in San Mateo County, California, the challenges that these individuals were met with and the void that many fell into); *Deinstitutionalization: A Psychiatric “Titanic,” supra* note 22 (describing the magnitude of deinstitutionalization and arguing that this movement was “one of the largest social experiments in American history”).

<sup>24</sup> Julia Schon, *Why Are California’s Prisons and Streets Filled with More Mentally Ill Than Its Hospitals?: California’s Deinstitutionalization Movement*, 59 SANTA CLARA L. REV. 269, 274–75 (2019).

<sup>25</sup> Slate, *supra* note 4, at 341.



from state hospitals back into their communities.<sup>26</sup> One of these many factors was the advent of antipsychotic drugs.<sup>27</sup> As these drugs came on the market, it was considered a hopeful sign that individuals might be able to manage their illnesses with medication and thus fewer would require long-term hospitalization.<sup>28</sup> Another factor was the research that exposed the deplorable conditions, inhumane treatment, and abuse of patients within state hospitals—ultimately drawing the attention of policymakers and humanitarians.<sup>29</sup> For example, President Kennedy proposed the Community Mental Health Center (CMHC) Act in 1963 that promoted the relocation of patients in state psychiatric hospitals to new, alternative treatment centers located within the community.<sup>30</sup>

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<sup>26</sup> Schon, *supra* note 24, at 274–80 (explaining the causes of the deinstitutionalization movement); Slate, *supra* note 4, at 341 (“In theory, deinstitutionalization was a great strategy. Minimizing institutionalization in hospitals would benefit the public, as community mental health treatments would cost less than in a state hospital, and patients would be returned to their communities. Additionally, accountability for treating persons with mental illnesses would be the responsibility of local clinicians instead of the more removed state and federal government authorities.”).

<sup>27</sup> See Schon, *supra* note 24, at 275–76.

<sup>28</sup> See *id.* Before antipsychotic drugs, controversial methods of treatment were used including “electroshock therapy, insulin coma therapy, and lobotomies.” *Id.* at 275. Thorazine was introduced as the first widely available antipsychotic drug that created a “tranquilizing effect” on patients and was prescribed to over two million patients by 1956. *Id.* Hospitals were able to use less staff to manage more patients on Thorazine, provide more outpatient therapy, and the public perception shifted to a belief that individuals with mental illness “were no longer incurable members of society.” *Id.* at 275–76. “Thus, antipsychotic medications provided both a new mechanism and a new willingness to treat mentally ill individuals amongst the community.” *Id.* at 276.

<sup>29</sup> *Id.* Studies of state-run psychiatric hospitals were completed in the 1950s and 1960s revealing horrid conditions and maltreatment of patients which both “shocked and educated” the general public, ultimately unleashing a view of institutionalization “as an intrusion on personal liberties and self-autonomy.” *Id.* Eventually, litigation arose and mental health policy reform similar to the civil liberties movement was underway with the intent “to deteriorate the [then] current institutions of psychiatric care.” *Id.*

<sup>30</sup> *Id.* at 277. Kennedy’s sister, Rosemary Kennedy, received a lobotomy as an “experimental procedure meant to make mentally ill patients more docile” and was left almost completely disabled in 1941. *Id.* This experience thrust Kennedy into advocacy for the mentally ill. *Id.* Kennedy’s CMHC Act transferred the funding responsibility for the new community treatment centers from the states to the federal government, but the funding would not be allocated to state hospitals for the purpose of incentivizing the states to fully migrate individuals back into the communities. *Id.* at 277–78. Kennedy also relied on the use of newly available antipsychotic medications to treat individuals with mental illness in the communities rather than the state-run institutions. *Id.* at 278. When the CMHC Act passed, the “largest institutional migration that has ever occurred in this country” was set in motion. *Id.* (quoting Bernard E. Harcourt, *Reducing Mass Incarceration: Lessons from the Deinstitutionalization of Mental Hospitals in the 1960s*, 9 OHIO ST. J. CRIM. L. 53, 53–54 (2011)).

Alongside President Kennedy, many activists and politicians included deinstitutionalization in their platforms.<sup>31</sup> With the passage of Medicaid and Medicare, the state hospital population declined even further due to the program's coverage for treatment within private facilities and not state hospitals.<sup>32</sup> Finally, the economic incentive to shift costs from the states to the federal government factored into fueling the deinstitutionalization movement for the past half century.<sup>33</sup> Although these factors seemed well-intentioned, the most important piece of the puzzle—the safety net intended to catch all the displaced individuals to implement this movement safely and effectively—was lost in the fray.

### 1. *Colliding Sociopolitical Movements, Legislation, and Jurisprudence*

Before the funding for the CMHC Act was ever fully distributed, President Kennedy was assassinated, and any funding still available was reallocated to finance the Vietnam War.<sup>34</sup> Ironically, the full funding for the CMHC Act's treatment centers would have benefitted the veterans who were plagued by trauma and a host of mental health issues after returning home from the war.<sup>35</sup> Following Kennedy's

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<sup>31</sup> *Id.*

<sup>32</sup> *Id.* (explaining how Medicaid and Medicare provided “financial incentives to states,” which increased the value of the deinstitutionalization movement to fiscal conservatives).

<sup>33</sup> *Id.* Due to the funding nature of the CMHC Act and the shift of costs from states to the federal government, the deinstitutionalization movement's popularity increased, especially because the state-run hospitals were overcrowded and because the states would have needed to allocate more funds to build new facilities. *Id.* at 278–79. The new community treatment centers and antipsychotic medications gave states the means to deinstitutionalize, while the Medicare and Medicaid programs provided incentives to migrate patients from state facilities into federally funded community treatment centers. *Id.* at 279. Additionally, because closing beds in state hospitals saved the states money, and there was a need at the time to build more state hospitals, the cost-saving and cost-shifting factors were too good to pass up. *Id.*

<sup>34</sup> Slate, *supra* note 4, at 342.

<sup>35</sup> See *Addiction and Alcoholism in Vietnam War Veterans*, AM. ADDICTION CTRS.: RECOVERY FIRST TREATMENT CTR. (Sept. 13, 2011), <https://recoveryfirst.org/blog/about-addiction/addiction-and-alcoholism-in-vietnam-war-veterans> [<https://perma.cc/3WMC-KB5G>]. Because of the post-traumatic stress disorder (PTSD) that affected many veterans after the war, substance use disorder has been traditionally high among Vietnam veterans since 1975 when the conflict ended. *Id.* This is largely because the veterans were

assassination, opposition to the CMHC Act rose due to the lack of governmental and community support.<sup>36</sup> Citizens of the communities where these treatment centers were to be placed developed a “not in my backyard” mentality.<sup>37</sup> Ordinances and other legal barriers were enacted to stop the CMHC Act in its tracks.<sup>38</sup>

At the same time, the civil rights movement was well underway, and individuals with mental illness were included in the periphery.<sup>39</sup> A joint effort between the civil and disability rights movements “sought to restrict involuntary hospitalizations unless fully required, and pursued humane conditions in state hospitals via the courts by demanding that patients have a constitutional right to appropriate treatment.”<sup>40</sup> Together, these movements highlighted the inhumane treatment of patients and produced a drastic pendulum shift toward correcting the wrongs of these institutions.<sup>41</sup>

In 1967, California’s Lanterman-Petris-Short (LPS) Act was enacted as a result of the efforts of these social movements.<sup>42</sup> The LPS Act limited the ability to involuntarily

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“subject to a hostile return when the war was over,” so many turned to alcohol and drugs to self-medicate the trauma from the war and the country’s cold response to them when they returned. *Id.* The veterans were “shunned, ridiculed and expelled from their customary peer groups” and “found it difficult to reintegrate into a workforce that largely had no use for their military skills.” *Id.* As a result, “many of America’s most courageous veterans became disillusioned addicts and alcoholics with few opportunities to better their lives.” *Id.*

<sup>36</sup> Slate, *supra* note 4, at 342.

<sup>37</sup> *Id.* (discussing the “not in my backyard” mentality arising from citizens fearful of their communities becoming inundated with the mentally ill).

<sup>38</sup> *Id.*

<sup>39</sup> *Id.*

<sup>40</sup> *Id.*

<sup>41</sup> *Id.* (“Legislation and jurisprudence emerged on the periphery of the civil rights era focusing on the civil liberties of persons with mental illnesses due to the lack of proper infrastructure to ensure that people with mental illness are afforded appropriate care when reentering their communities.”).

<sup>42</sup> Lanterman-Petris-Short Act, CAL. WELF. & INST. CODE § 5000 et seq. (West 1967); see Slate, *supra* note 4, at 342; see also Schon, *supra* note 24, at 280. See generally *Understanding the Lanterman-Petris-Short (LPS) Act*, DISABILITY RTS. CAL. (May 1, 2023),

<https://www.disabilityrightsca.org/publications/understanding-the-lanterman-petris-short-lps-act> [<https://perma.cc/4KZ5-8MFR>] (“[T]he LPS Act sought to, ‘end the inappropriate, indefinite, and involuntary commitment of persons with mental health disorders.’ It also established a right to prompt psychiatric evaluation and treatment, in some situations, and set out strict due process protections for mental health clients.”).

hospitalize an individual with mental illness.<sup>43</sup> The Act served as a precedent for other states to amend their civil commitment statutes accordingly.<sup>44</sup>

In the years following the LPS Act, jurisprudence also narrowed the scope of involuntary civil commitments. Case law produced a new dangerousness standard, which replaced the previous *parens patriae* doctrine in most jurisdictions.<sup>45</sup> In order for an individual to be involuntarily committed under the new dangerousness standard, it must be found that she was incapable of meeting her own needs and a danger to herself or others.<sup>46</sup> Unfortunately, it can be difficult to recognize when an individual has met this requirement.<sup>47</sup> This often creates a serious risk to the individual and the community at large if the court determines that one did not—at a specific moment in time—meet the extremely high bar for the dangerousness standard.<sup>48</sup>

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<sup>43</sup> Slate, *supra* note 4, at 343; *see* Doe v. Gallinot, 486 F. Supp. 983 (C.D. Cal. 1979), *overruled by* Doe v. Gallinot, 657 F.2d 1017 (9th Cir. 1982) (holding that under the LPS Act, an individual must meet the dangerousness standard in involuntary commitment proceedings and that the standard may be met when the individual is unable to meet her essential needs because she is at greater risk of harm to herself when these needs are not met); *see* Rouse v. Cameron, 373 F.2d 451, 452–53 (D.C. Cir. 1966) (holding that involuntary commitments should not be for punishment, but for treatment, and that the individual has a right to treatment); *see* Lake v. Cameron, 364 F.2d 657 (D.C. Cir. 1966) (holding that the court has a duty to place an individual in a less restrictive environment if such an option is available and safe for the individual).

<sup>44</sup> Slate, *supra* note 4, at 343.

<sup>45</sup> *Id.* at 345 (“*Parens patriae* literally translated means ‘parent of the country,’ and refers to the state’s responsibility to intervene and protect those who cannot protect themselves—such as children and persons with mental illnesses in crises.”).

<sup>46</sup> O’Connor v. Donaldson, 422 U.S. 563, 575 (1975) (“A finding of ‘mental illness’ alone cannot justify a State’s locking a person up against his will and keeping him indefinitely in simple custodial confinement. Assuming that that term can be given a reasonably precise content and that the ‘mentally ill’ can be identified with reasonable accuracy, there is still no constitutional basis for confining such persons involuntarily if they are dangerous to no one and can live safely in freedom.”); Lessard v. Schmidt, 349 F. Supp. 1078, 1093–97 (E.D. Wis. 1972), *vacated*, 414 U.S. 473 (1974) (“Even if the standards for an adjudication of mental illness and potential dangerousness are satisfied, a court should order full-time involuntary hospitalization only as a last resort. A basic concept in American justice is the principle that ‘even though the governmental purpose be legitimate and substantial, that purpose cannot be pursued by means that broadly stifle fundamental personal liberties when the end can be more narrowly achieved.’”).

<sup>47</sup> *See infra* Section IV.E.

<sup>48</sup> *See infra* Section IV.E.

## 2. *The Aftermath of Deinstitutionalization*

Following the narrowing of civil commitments, a shift occurred, moving the decision-making power from the medical field to the criminal justice system.<sup>49</sup> The individuals who previously may have been committed to state hospitals were now bound to the court's determination of their medical state.<sup>50</sup> The CMHC Act, the LPS Act, and the judicial decisions on the unconstitutionality of involuntary civil commitments coalesced over the course of the 1960s and 1970s.<sup>51</sup> Although these legislative and legal shifts were initially meant to preserve the civil liberties of individuals affected by mental illness, the opposite happened.<sup>52</sup>

The community mental health centers proposed by the CMHC Act were never implemented, involuntary civil commitments were drastically narrowed, and hundreds of thousands of individuals with severe mental illness were released into communities without the ability or resources to care for themselves—much less seek or obtain treatment—after years of consistent hospitalization.<sup>53</sup> Many of these individuals became homeless, and due to society's distaste for homelessness, police interactions were frequent and usually ended in arrests.<sup>54</sup> Most were arrested for publicly engaging in disruptive or annoying behavior, but in reality, many simply needed assistance due to crisis or victimization.<sup>55</sup> Law enforcement often used arrests to get individuals off the street, but without the ability to be admitted to a treatment facility—because few existed anymore—the individuals were placed in the court system.<sup>56</sup> A California study later found that former state hospital patients—most of whom did not have a prior criminal history—were arrested at triple the rate of the general public.<sup>57</sup> With the pendulum swinging so far in the opposite direction and no safety net in place, many individuals were forced to succumb to homelessness,

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<sup>49</sup> Slate, *supra* note 4, at 346.

<sup>50</sup> *Id.* (discussing that the *Lessard v. Schmidt* holding had a nationwide effect on each jurisdiction and drastic implications for the jurisdictional commitment guidelines).

<sup>51</sup> *See id.* at 343–49; *see also* Testa, *supra* note 3, at 409–13.

<sup>52</sup> Slate, *supra* note 4, at 347; Testa, *supra* note 3, at 410–11.

<sup>53</sup> Slate, *supra* note 4, at 347.

<sup>54</sup> Testa, *supra* note 3, at 410–11.

<sup>55</sup> *Id.*

<sup>56</sup> *Id.* at 411.

<sup>57</sup> *Id.*; Slate, *supra* note 4, at 348.

incarceration, and even death because of deinstitutionalization.<sup>58</sup>

### *B. The War on Drugs*

Around the same time of the deinstitutionalization movement, the War on Drugs commenced.<sup>59</sup> This movement expanded the already gaping hole left from deinstitutionalization by exacerbating the stigma surrounding mental illness and exploiting a lack of awareness around the disease of addiction.<sup>60</sup>

Started by President Nixon in the early 1970s, this “war” supposedly against drugs—but in reality, against drug *users*—led to changes in law enforcement policies that sent the already skyrocketing incarceration rates into never-before-seen territory.<sup>61</sup> Because comorbidity of drug addiction and mental illness is common, deinstitutionalization and the War on Drugs were tightly interwoven.<sup>62</sup> In turn, individuals affected by this comorbidity were at a much higher risk of being swept into the criminal justice system.<sup>63</sup>

Further promoting the stigma that drug addicts are inherent criminals, a number of “tough on crime” policies and campaigns emerged from the War on Drugs in the 1970s and 1980s, including the Controlled Substances Act of 1970, the Anti-Drug Abuse Act of 1986, the Fair Sentencing Act, Nancy Reagan’s “Just Say No” campaign, and the Drug Abuse Resistance Education (D.A.R.E.) program.<sup>64</sup> Highlighting this stigma, the D.A.R.E. program’s founder, former Los Angeles Police Chief Daryl Gates, stated that “casual drug users should be taken out and shot.”<sup>65</sup> Even further, the 1986 Anti-Drug Abuse Act disproportionately affected people of color.<sup>66</sup> The Act was enacted in response to the apparent cocaine overdose of NBA recruit Len Bias and led to disparities in the

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<sup>58</sup> Slate, *supra* note 4, at 347.

<sup>59</sup> See Testa, *supra* note 3, at 412; see also *A History of the Drug War*, *supra* note 1.

<sup>60</sup> See Testa, *supra* note 3, at 412; see also Brown, *supra* note 2, at 47.

<sup>61</sup> See Testa, *supra* note 3, at 412; see also Brown, *supra* note 2, at 47.

<sup>62</sup> Testa, *supra* note 3, at 412; see *Substance Use and Co-occurring Mental Disorders*, *supra* note 1 and accompanying text.

<sup>63</sup> Testa, *supra* note 3, at 412.

<sup>64</sup> See *A History of the Drug War*, *supra* note 1; see also Brown, *supra* note 2, at 47.

<sup>65</sup> *A History of the Drug War*, *supra* note 1.

<sup>66</sup> Brown, *supra* note 2, at 47–48.

sentencing of powder cocaine, which was “associated with a wealthier, whiter class of drugs users,” and crack cocaine, which was “regarded as a drug of the black urban ghetto.”<sup>67</sup>

Not only was the War on Drugs instrumental in continuing blatant discrimination against Black Americans, but it also amplified the effects of the deinstitutionalization movement for people struggling with substance use disorder.<sup>68</sup> Arrest rates exponentially increased when these two events collided, making the criminal justice system the ultimate decision-maker for these individuals.<sup>69</sup>

### III. CASE HISTORY: THE QUESTION OF STATUS VS. CONDUCT

Two Supreme Court decisions in the 1960s, *Robinson v. California* and *Powell v. Texas*, produced separate and competing interpretations around whether an individual with an addiction or mental illness—status—can be held criminally responsible for committing a crime—conduct—that is symptomatic of the addiction.<sup>70</sup>

#### A. *Robinson v. California*

In *Robinson v. California*, Lawrence Robinson was arrested on a street in Los Angeles for being “addicted to the use of narcotics” when an officer noticed marks and scabs on his arm consistent with regular needle injection.<sup>71</sup> The officer testified that Robinson admitted to using narcotics

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<sup>67</sup> *Id.* “It is impossible to speak of the War on Drugs without acknowledging how disproportionately it affected people of color.” *Id.* (examining the racial bias inherent in the War on Drugs and how Black individuals were disproportionately targeted under the new harsh penalties). Ironically, despite the fact that Len Bias died after using powder cocaine, he “became a symbol of the dangers of the drug” of crack cocaine, further emphasizing the racial disparity inherent in the War on Drugs.” Jonathan Gelber, *How Len Bias’s Death Helped Launch the US’s Unjust War on Drugs*, THE GUARDIAN (June 29, 2021), <https://www.theguardian.com/sport/2021/jun/29/len-bias-death-basketball-war-on-drugs> [https://perma.cc/5V7T-S6NT]. Ultimately, the death of Len Bias “was a catalyst for drug laws that would end up hurting, rather than helping, young black men.” *Id.*

<sup>68</sup> Brown, *supra* note 2, at 48; Schon, *supra* note 24, at 291.

<sup>69</sup> See Testa, *supra* note 3, at 412.

<sup>70</sup> *Robinson v. California*, 370 U.S. 660 (1962); *Powell v. Texas*, 392 U.S. 514 (1968); see Dawinder S. Sidhu, *Criminal Law x Addiction*, 99 N.C. L. REV. 1083, 1115 (2021).

<sup>71</sup> *Robinson*, 370 U.S. at 660–62.

occasionally, but at the time of arrest, Robinson did not have any narcotics in his system nor was he withdrawing.<sup>72</sup>

The Supreme Court overruled the California statute, forbidding states to punish the status of an individual.<sup>73</sup> The Court acknowledged that “addiction is an illness,” and the statute amounted to cruel and unusual punishment in violation of the Eighth and Fourteenth Amendments.<sup>74</sup>

The Court expressed concern that the statute made “the status of narcotic addiction a criminal offense, for which the offender may be prosecuted at any time before he reforms.”<sup>75</sup> This is because “a person can be continuously guilty of this offense, whether or not he has ever used or possessed any narcotics within the State, and whether or not he has been guilty of any antisocial behavior there.”<sup>76</sup> In addition to acknowledging that “addiction is an illness . . . which may be contracted innocently or involuntarily,” the Court held that the statute was in violation of the Eighth Amendment for amounting to cruel and unusual punishment, analogizing it to spending one day in prison “for the crime of having a common cold.”<sup>77</sup> In essence, the Court acknowledged an individual’s need for care of an illness, not punishment.

### *B. Powell v. Texas*

Six years later, the Court in *Powell v. Texas* addressed a question left unanswered by *Robinson*: whether conduct that is symptomatic of addiction should not be punished since it is arguably involuntary.<sup>78</sup>

Leroy Powell was convicted over one hundred times for public drunkenness, typically for passing out in public spaces, and at no point during this span of arrests did he seek or receive treatment for alcoholism.<sup>79</sup> During trial, Powell claimed that his public drunkenness was “not of his own volition” because he was “afflicted with the disease of chronic alcoholism.”<sup>80</sup> Therefore, “to punish him criminally for that conduct would be cruel and unusual, in violation of the Eighth

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<sup>72</sup> *Id.* at 661–62.

<sup>73</sup> *Id.* at 667–68; Sidhu, *supra* note 70, at 1110.

<sup>74</sup> *Robinson*, 370 U.S. at 666–67.

<sup>75</sup> *Id.* at 666 (internal quotation marks omitted).

<sup>76</sup> *Id.*

<sup>77</sup> *Id.* at 667 (internal quotation marks omitted).

<sup>78</sup> *Powell v. Texas*, 392 U.S. 514 (1968); *see* Sidhu, *supra* note 70, at 1112–15.

<sup>79</sup> *Powell*, 392 U.S. at 555–56 (Fortas, J., dissenting).

<sup>80</sup> *Id.* at 517.



and Fourteenth Amendments to the United States Constitution.”<sup>81</sup>

The Court accepted that addiction and alcoholism are *likely* diseases but could not accept Powell’s involuntary act argument.<sup>82</sup> The Court cited the work of E.M. Jellinek, a renowned addiction disease scholar; Jellinek insisted that to make a constitutional defense, an individual would have to display both a “loss of control” once they start drinking and an “inability to abstain” from drinking to begin with.<sup>83</sup> With Jellinek’s work in mind, the Court argued that Powell was able to control his drinking because he admitted that he had one drink the morning of the trial and discontinued drinking after that one drink.<sup>84</sup> Additionally, a psychiatrist testified that even though Powell had a compulsion to drink, he could have abstained from drinking—as long as he was not suffering from withdrawals—by avoiding the first drink, which would have been, at that initial point in time, an act of free will.<sup>85</sup> Further, the plurality in *Powell* interpreted *Robinson* to stand for the notion that the criminal punishment for an act involving addiction must apply only to the act that breaks the law.<sup>86</sup> The Court’s decision in *Powell* was consistent with *Robinson* in that the statute did not unconstitutionally punish Powell “for being a chronic alcoholic,” but rather “for being in public while drunk on a particular occasion.”<sup>87</sup>

The bright-line reading of *Robinson* and *Powell* is that the government may impose criminal punishment on an individual for their alcohol or drug-related conduct, but not for their status as an individual with substance use disorder or mental illness.<sup>88</sup> The statute at issue in *Robinson* lacked actus reus (an evil act), and therefore Robinson’s status, not his actions, were punished under the law.<sup>89</sup> The statute at issue in *Powell* did contain actus reus and, therefore, did not violate the Eighth Amendment as it was interpreted in *Robinson*.<sup>90</sup> The issue of whether an individual with an addiction may be held criminally responsible for conduct that

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<sup>81</sup> *Id.*

<sup>82</sup> *Id.* at 532–38.

<sup>83</sup> *Id.* at 524–25.

<sup>84</sup> *Id.* at 519–21.

<sup>85</sup> *Id.* at 525.

<sup>86</sup> *Id.* at 533; Sidhu, *supra* note 70, at 1115.

<sup>87</sup> *Powell*, 392 U.S. at 532.

<sup>88</sup> *Id.* at 532–38.

<sup>89</sup> Sidhu, *supra* note 70, at 1115.

<sup>90</sup> *Id.* at 1115–16.

is symptomatic of the addiction continues to divide the courts.<sup>91</sup>

### C. *Manning v. Caldwell*

A more recent decision out of the Fourth Circuit in 2019, *Manning v. Caldwell*, tackled the issue of determining status versus conduct and left the court sharply divided in an 8-7 en banc opinion.<sup>92</sup>

In *Manning*, a Virginia statutory scheme criminalized the use, possession, or purchase of alcohol for “habitual drunkards.”<sup>93</sup> The plaintiffs in this case were a group of homeless individuals who were addicted to alcohol.<sup>94</sup> They argued that they had “a profound drive or craving to use alcohol that is compulsive or non-volitional” and their “homelessness exacerbates [their] addiction, mak[ing] it nearly impossible . . . to cease or mitigate alcohol consumption.”<sup>95</sup> The plaintiffs alleged that the Virginia statutory scheme, “which has resulted in their repeated arrest and imprisonment, violates the Constitution.”<sup>96</sup>

The majority invoked the involuntary-voluntary distinction discussed by Justice White’s concurrence in *Powell* as the standard to assess whether criminal statutes, as they apply to individuals with addiction, are constitutional.<sup>97</sup> Even though Justice White provided the fifth and determining vote to uphold Powell’s conviction, he “voted to affirm Powell’s conviction *not* because of the act-status theory relied on by the plurality, but *solely* because Powell had not produced facts establishing the involuntariness of his public alcoholism.”<sup>98</sup> “Thus, if individuals could show *both* that resisting drunkenness [was] impossible *and* that avoiding public places when intoxicated [was] also impossible, a statute banning public drunkenness would be unconstitutional as

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<sup>91</sup> *Id.* at 1116.

<sup>92</sup> *Manning v. Caldwell*, 930 F.3d 264 (4th Cir. 2019) (en banc); Sidhu, *supra* note 70, at 1115.

<sup>93</sup> *Manning*, 930 F.3d at 268; Sidhu, *supra* note 70, at 1116–17.

<sup>94</sup> *Manning*, 930 F.3d at 268.

<sup>95</sup> *Id.* at 269 (internal quotation marks omitted).

<sup>96</sup> *Id.* at 268.

<sup>97</sup> *Id.* at 280–81 (citing *Powell v. Texas*, 392 U.S. 514, 548–54 (1968) (White, J., concurring)).

<sup>98</sup> *Id.* at 282 (citing *Powell*, 392 U.S. at 549 (White, J., concurring)) (alteration in original).

applied to them.”<sup>99</sup> Here, the majority accepted the plaintiffs’ claim that drinking is compelled by their addiction and held that the statute was unconstitutional because behavior that is symptomatic of an illness and otherwise legal cannot be criminalized.<sup>100</sup>

The dissent in *Manning* challenged the compelled-conduct rationale accepted by the majority.<sup>101</sup> Judge Wilkinson, in his dissent, pointed toward Justice White’s question in his concurrence in *Powell*, as to “whether conduct compelled by addiction might be protected under *Robinson*.”<sup>102</sup> Because “Powell’s behavior involved a volitional act,” namely, he was in public, that act allowed for the dissent in *Manning* to acknowledge that the *Powell* case was resolved “without reaching the broader question of compulsion.”<sup>103</sup> Furthermore, the dissent argued, because the majority’s compelled-conduct exception constitutionally protects an “act that is alleged to be ‘non-volitional,’ i.e. the result of some compulsion, . . . it has discarded any pretense of a workable limiting principle, expanded the Eighth Amendment beyond any discernable limits, and overturned sixty years of controlling Supreme Court precedent.”<sup>104</sup> Because there is essentially no workable or reliable standard to analyze whether conduct is compelled by a current status, the compelled-conduct issue lands outside the bounds of the law and the majority effectively “strand[ed] the doctrine at sea.”<sup>105</sup>

Unfortunately, the legal views stemming from *Robinson* and *Powell* remain considerably polarized with a vast area of uncertainty between the two. The gray area in between, where most individuals fall, accounts for the vast multitude of ways this issue can present itself among the

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<sup>99</sup> *Id.* at 280 (citing *Powell*, 392 U.S. at 549 (White, J., concurring)) (internal quotation marks omitted).

<sup>100</sup> *Id.* at 282, 285; Sidhu, *supra* note 70, at 1118.

<sup>101</sup> *Manning*, 930 F.3d at 288 (Wilkinson, J., dissenting).

<sup>102</sup> *Id.* at 289 (Wilkinson, J., dissenting).

<sup>103</sup> *Id.* (Wilkinson, J., dissenting); see also *id.* at 290 (explaining that the *Powell* decision does not, in any way, disrupt or overturn *Robinson*).

<sup>104</sup> *Id.* at 287 (Wilkinson, J., dissenting).

<sup>105</sup> *Id.* at 291 (Wilkinson, J., dissenting).

varied manifestations of substance use disorder and mental illness in each individual.<sup>106</sup>

#### IV. CURRENT PROBLEMS

##### A. *Universally Interwoven Factors Inhibit Appropriate Care*

Comorbidity or co-occurring illnesses and the continued systemic stigma surrounding mental illness and substance use disorder are two factors deeply engrained in the criminalization of these illnesses. Fortunately, light is increasingly shed on the importance of understanding how these factors play a role in this issue.

##### 1. *Comorbidity and Co-occurring Mental Illness and Substance Use Disorder*

Having a dual diagnosis or comorbidity of both mental illness and substance use disorder is extremely common. In the United States, one in five individuals will meet the criteria for a mental health disorder every year, and one in seven individuals will pick up a drug or alcohol use habit.<sup>107</sup> Combined, one in four individuals with severe mental illness develop alcohol *and* drug addictions.<sup>108</sup> Among adults in the United States in 2019, 3.8% (or 9.5 million people) had *both* a mental illness and substance use disorder.<sup>109</sup> When looking at

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<sup>106</sup> See Sidhu, *supra* note 70, at 1121–22. The author argues that the “courts should probe whether, according to the facts—not merely the label of addiction—the individual with an addiction could exercise [the] choice” to address the addiction. *Id.* at 1121. If the individual can prove that making an intentional choice to address the addiction is not possible, then she “lacks the culpability or blameworthiness necessary for criminal liability to attach.” *Id.* at 1122.

<sup>107</sup> Testa, *supra* note 3, at 406.

<sup>108</sup> *Id.* at 407. It is important to note that these numbers are likely much higher because so many individuals do not admit to or seek treatment for mental health or substance use disorders, typically due to the underlying stigma surrounding them. *Id.*

<sup>109</sup> SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., KEY SUBSTANCE USE AND MENTAL HEALTH INDICATORS IN THE UNITED STATES: RESULTS FROM THE 2019 NATIONAL SURVEY ON DRUG USE AND HEALTH (Sept. 2020), <https://www.samhsa.gov/data/sites/default/files/reports/rpt29393/2019NSDUHFFRPDFWHTML/2019NSDUHFFR090120.htm#mhisud> [<https://perma.cc/EEA5-EE86>] (emphasis added).

these rates inside state and federal jails and prisons, a study by the Department of Justice found that 55% of more than one million incarcerated persons had symptoms or a recent history of a mental health issue.<sup>110</sup> Between 64% and 76% of these individuals had a co-occurring substance use disorder.<sup>111</sup>

“Comorbidity is so common that dual diagnosis should be expected rather than considered an exception.”<sup>112</sup> Treatment effectiveness is reduced when the two are treated separately, and unfortunately, there is a low integration rate of these dual services.<sup>113</sup> The training of medical professionals for these services is vastly different, and so failure to treat both simultaneously causes patients to fall into the void between the healthcare and criminal justice systems instead of being treated as a whole person.<sup>114</sup>

A 1972 California study following the LPS Act found that this lack of proper dual treatment caused prison rates to skyrocket following deinstitutionalization.<sup>115</sup> The study determined that many individuals were arrested for minor crimes, such as possession or disorderly conduct.<sup>116</sup> Realistically, however, most of them were likely attempting to self-medicate while living on the streets, and law enforcement had nowhere else to take them.<sup>117</sup> Individuals in prison with a substance use disorder have higher odds of a comorbid diagnosis with mental illness; about one in two individuals in

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<sup>110</sup> Sara Gordon, *About A Revolution: Toward Integrated Treatment in Drug and Mental Health Courts*, 97 N.C. L. REV. 355, 359 (2019).

<sup>111</sup> *Id.*

<sup>112</sup> *Id.* at 376 (quoting Kenneth Minkoff, *Developing Standards of Care for Individuals with Co-occurring Psychiatric and Substance Use Disorders*, 52 PSYCHIATRIC SERVS. 597, 597 (2001)).

<sup>113</sup> *See id.* at 381–86 (noting that a coordinated system for treatment would allow providers to combine treatments or modify them as needed so the individual receives a more cohesive approach rather than separate providers attempting to piecemeal create a treatment plan).

<sup>114</sup> *Id.* at 384–85.

<sup>115</sup> Schon, *supra* note 24, at 289–90.

<sup>116</sup> *Id.*

<sup>117</sup> *See id.*; *see also* Krystina Murray, *Homelessness and Addiction: The Connection Between Homelessness and Addiction*, ADDICTION CTR. (Apr. 17, 2023), <https://www.addictioncenter.com/addiction/homelessness> [<https://perma.cc/LS2F-JZES>].

prison with mental illness have a comorbid substance use disorder.<sup>118</sup>

Where an individual has this comorbid diagnosis, her chances of breaking free of the criminal justice cycle are slim.<sup>119</sup> Her post-release outcomes are anticipated to be unfortunate with a high probability of reincarceration or suicide.<sup>120</sup> Additionally, her response to treatment, wherever she is able to receive it, is likely to be poor as well.<sup>121</sup> In essence, many individuals receive their first treatment *because of* their involvement with the criminal justice system, and our criminal justice system was not built to support these individuals.<sup>122</sup>

## 2. *Systemic Stigmas Surrounding Mental Illness and Substance Use Disorder*

In addition to the deinstitutionalization movement and the War on Drugs, another constant and major contributing factor to the criminalization of mental illness and substance use disorder is the ever-present stigma that prevails against individuals affected by these diseases.<sup>123</sup> The aftereffects of the two movements inhibited our society's ability to shift its perspective on these diseases.<sup>124</sup>

Our societal perspective plays a huge role in how the individuals affected by these diseases ultimately function in our country. Individuals affected by mental illness and substance use disorder operate in a society that is not

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<sup>118</sup> Gergő Baranyi et al., *The Prevalence of Comorbid Serious Mental Illnesses and Substance Use Disorders in Prison Populations: A Systematic Review and Meta-Analysis*, 7 THE LANCET: PUB. HEALTH 557, 558 (June 2022), <https://www.thelancet.com/action/showPdf?pii=S2468-2667%2822%2900093-7> [<https://perma.cc/829B-5NNA>]. Incarcerated individuals with co-occurring mental illness and substance use disorders “are associated with more severe criminal histories, poorer post-release outcomes, and poorer treatment responses.” *Id.*

<sup>119</sup> *See id.*

<sup>120</sup> *Id.*

<sup>121</sup> *Id.*

<sup>122</sup> Gordon, *supra* note 110, at 358–59 (explaining how individuals with either mental illness or substance use disorder, or both, have historically “endured institutions that offered no treatment, ineffective treatment, or well-intentioned treatment that did harm” (quoting Larry Davidson & William White, *The Concept of Recovery as an Organizing Principle for Integrating Mental Health and Addiction Services*, 34 J. BEHAV. HEALTH SERVS. & RES. 109, 110 (2007))).

<sup>123</sup> *See* Brown, *supra* note 2, at 46–47 (analyzing the stigma that persists around mental illness and substance use disorder, which ultimately leads to the criminalization of these diseases).

<sup>124</sup> *Id.*

supportive of their well-being, regardless of the rhetoric displayed by our political leaders and advocates.<sup>125</sup> Stigma is typically generated by overgeneralizations, which are first produced among members of society, then further into legal and social institutions, and eventually internally within the individual affected by the subject of the stigma.<sup>126</sup> Stigma is produced and exacerbated by power structures and perpetuates inequities within disparate and under-privileged groups.<sup>127</sup>

Substance use disorder is one of the most stigmatized disorders among mental illnesses, which generally are highly stigmatized.<sup>128</sup> In a study by the World Health Organization listing eighteen stigmatized social problems, drug addiction is number one.<sup>129</sup> When our collective society labels and perceives individuals with substance use disorder as dangerous and at fault for their diseases, eventually the blame becomes a moral judgment.<sup>130</sup> Just the stigma alone can cripple an individual from seeking the care and support she needs because of the fear that seeking help will harm her well-being in our society even further.<sup>131</sup> In fact, the stigma can be so influential that it can lead to the development of a comorbidity because an individual may succumb to drugs and alcohol to “medicate” her mental illness rather than seek help and risk being labeled by the stigma.<sup>132</sup>

Not only does the societal stigma harm the individual emotionally from the weight of “being labeled as mentally ill, judged, rejected, and marginalized,” but it also contributes to

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<sup>125</sup> See *id.*; see Testa, *supra* note 3, at 406; see also John K. Cornwell, *The Search for Answers: Overcoming Chaos and Inconsistency in Addressing the Opioid Crisis*, 47 MITCHELL HAMLINE L. REV. 419, 443 (2021) (explaining the stigma associated with opioid abuse).

<sup>126</sup> Brown, *supra* note 2, at 31.

<sup>127</sup> *Id.* at 30; see also *id.* at 51–54 (explaining the complexity of an additional issue regarding stigma involving anti-discrimination statutes and the inability to thwart stigma and protect the individual). The Americans with Disabilities Act (ADA) technically protects individuals with mental illness and substance use disorder, but the protections are slim. *Id.* at 52. In essence, “employees are not fully protected from discrimination while they are keeping their behavior under control, while they are using, while they are exhibiting behavior of intoxication, or when they are in recovery.” *Id.* at 53. “Given the problems with addiction being a heavily stigmatized disorder based on biology *and* behavior, it does not fit neatly within the classes protected under various anti-discrimination statutes.” *Id.*

<sup>128</sup> *Id.* at 31.

<sup>129</sup> *Id.*

<sup>130</sup> *Id.*

<sup>131</sup> See *id.* at 31–32.

<sup>132</sup> *Id.* at 30; Gordon, *supra* note 110, at 377–78.

the individual's ability to access care, take steps to receive care if she can access it, and comply with the care if she receives it.<sup>133</sup> Medical advancements in the study of mental illness and substance use disorder now acknowledge these illnesses as “diseases of the brain that *can* be treated.”<sup>134</sup> Unfortunately, society's undercurrent of bias and stigma toward these diseases and the individuals affected by them is slow to catch up to modern-day science.

### *B. Trans-institutionalization*

The aftermath of the deinstitutionalization movement and the War on Drugs brought about a new movement referred to as “trans-institutionalization.”<sup>135</sup> Here, individuals with mental illness were kicked out of hospitals and, instead of being transferred to community mental health centers, because they were never built, found themselves on the streets or incarcerated—or in a cycle of both.<sup>136</sup>

Los Angeles County Jail, Rikers Island in New York City, and Cook County Jail in Chicago are considered the largest inpatient psychiatric facilities in the United States.<sup>137</sup> It is common for a jail or prison today to hold more individuals with mental illness and substance use disorder than any remaining state psychiatric hospital.<sup>138</sup> As of 2022, the number of individuals incarcerated with severe mental illness is ten times the number of patients within state psychiatric hospitals.<sup>139</sup>

After the deinstitutionalization movement and the War on Drugs, prison populations dramatically increased.<sup>140</sup>

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<sup>133</sup> Testa, *supra* note 3, at 407.

<sup>134</sup> *Id.* (emphasis added).

<sup>135</sup> *See id.* at 409–12 (explaining the correlation between the deinstitutionalization movement and the War on Drugs, and the causation of trans-institutionalization).

<sup>136</sup> *Id.* Following deinstitutionalization, most individuals were discharged from state hospitals and entered the communities without treatment. *Id.* at 410. Many became homeless and found themselves in continuous contact with law enforcement for being publicly disruptive or annoying due to their need of assistance or the nature of their living situation on the streets. *Id.* at 410–11.

<sup>137</sup> Slate, *supra* note 4, at 349.

<sup>138</sup> *Id.*; *Criminalization of Mental Illness*, *supra* note 1.

<sup>139</sup> Judy Ann Clausen & Joanmarie Davoli, *No-One Receives Psychiatric Treatment in A Squad Car*, 54 TEX. TECH. L. REV. 645, 653 (2022).

<sup>140</sup> *See* Testa, *supra* note 3, at 411–12; *see* Joshua Shane Horton, *Drug War Reform: Criminal Justice, Recovery, and Holistic Community Alternatives*, 53 CRIM. L. BULL. 1 (2018) (acknowledging the rise in incarceration rate over the last forty years is over 700%).



Because of the comorbidity of substance use disorder and mental illness, minor drug offenses, “mercy bookings,” and public nuisance offenses led to the dramatic spike in arrests.<sup>141</sup> Drug violations account for over one million arrests in the United States each year with the majority being for personal possession alone.<sup>142</sup> At the time of incarceration, around 60% of prisoners test positive for drug use and substance use disorder, which is common among individuals considered repeat offenders.<sup>143</sup> Similarly, individuals with severe mental illness are four times more likely than others to be arrested and incarcerated for minor offenses.<sup>144</sup> It has been estimated there are one million individuals with severe mental illness booked into the system each year.<sup>145</sup>

Among individuals struggling with mental illness, Black, Latinx, and Indigenous people and low-income individuals also account for a disproportionate number of drug-related arrests.<sup>146</sup> Despite the fact that Black people make up only 13% of the U.S. population, they represent 24% of the individuals arrested, even though it has been recorded that people of all races use and sell drugs at similar rates.<sup>147</sup>

### C. *The System’s Response to Mental Health Crises*

The lack of care options for many individuals leads to high rates of arrest among those with mental illness and substance use disorder. Because many will experience mental health crises in public to which law enforcement officers are the first responders, arresting an individual is often the only

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<sup>141</sup> Testa, *supra* note 3, at 411–12; see Clausen & Davoli, *supra* note 139, at 653. Individuals with severe mental illness are “more likely to be arrested for symptoms” of their severe mental illness, especially in the parts of the United States “where there are limited treatment options, resulting in ‘mercy bookings’—a process of using low-level misdemeanor charges to facilitate treatment.” *Id.* Additionally, “treatment is more accessible in jail than in the community” in some areas. *Id.*

<sup>142</sup> *Drug War Stats*, DRUG POL’Y ALL., <https://drugpolicy.org/drug-war-stats> [<https://perma.cc/8T6T-YFAS>]; *Crime Data Explorer*, FED. BUREAU OF INVESTIGATION, <https://cde.ucr.cjis.gov/LATEST/webapp/#/pages/home> [<https://perma.cc/4R6G-LWDN>].

<sup>143</sup> Testa, *supra* note 3, at 416.

<sup>144</sup> Clausen & Davoli, *supra* note 139, at 653.

<sup>145</sup> Testa, *supra* note 3, at 414.

<sup>146</sup> *Drug War Stats*, *supra* note 142; *On 50th Anniversary of “War on Drugs,” Poll Shows Majority of Voters Support Ending Criminal Penalties for Drug Possession, Think Drug War Is a Failure*, ACLU (June 9, 2021), <https://www.aclu.org/press-releases/50th-anniversary-war-drugs-poll-shows-majority-voters-support-ending-criminal> [<https://perma.cc/9YAY-MY7E>].

<sup>147</sup> *Drug War Stats*, *supra* note 142; *Crime Data Explorer*, *supra* note 142.

option available to responding officers.<sup>148</sup> Moreover, this initial encounter with law enforcement presents a very real and heightened risk of harm or death even before individuals are arrested or incarcerated. Although some officers are appropriately trained to respond to mental health crises, many may not respond appropriately in these situations.<sup>149</sup> Even further, many officers and law enforcement agencies are inadequately trained or lack training altogether.<sup>150</sup> Oftentimes, law enforcement may fail to recognize or misinterpret an individual's symptoms of a mental health crisis and go so far as to assume the individual is fabricating or exaggerating her symptoms when, in reality, she is not.<sup>151</sup>

On November 9, 2018, two Minneapolis police officers fatally shot Travis Jordan after receiving a call from Jordan's girlfriend requesting a welfare check on Jordan because he had told her over the phone that he was going to commit suicide.<sup>152</sup> "Fourteen minutes after the call, Jordan was dead."<sup>153</sup> Upon arriving on the scene, the officers attempted to get Jordan to open the front door, but he didn't comply.<sup>154</sup> At one point, Jordan opened the window to swear at the officers and then slammed it shut.<sup>155</sup> The officers noticed that Jordan was holding a large chef's knife, his speech was slurred, and his temperament was escalating.<sup>156</sup> When Jordan finally opened the front door, the officers told him to put down the knife.<sup>157</sup> He screamed, "Let's do it! Come on!"<sup>158</sup> Jordan

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<sup>148</sup> Testa, *supra* note 3, at 407–08.

<sup>149</sup> Zoé R. Fiske et al., *A National Survey of Police Mental Health Training*, 36 J. POLICE & CRIM. PSYCH., 236, 236–37 (2021); Clausen & Davoli, *supra* note 139, at 658.

<sup>150</sup> Clausen & Davoli, *supra* note 139, at 658.

<sup>151</sup> *Id.*; see Karen Zraick, *Dallas Officers Pinned Tony Timpa and Joked During Fatal Encounter, Video Shows*, N.Y. TIMES (Aug. 1, 2019), <https://www.nytimes.com/2019/08/01/us/tony-timpa-dallas-police-body-cam.html> [<https://perma.cc/R8RS-XURD>] (demonstrating the lack of awareness and understanding of mental illness symptoms among law enforcement through an incident in which a man with schizophrenia was pinned to the ground and killed while officers joked about his mental illness).

<sup>152</sup> *Minneapolis Police Officers Not Charged in Shooting Death of Travis Jordan*, CBS NEWS MINN. (Jan. 3, 2019), <https://www.cbsnews.com/minnesota/news/police-officers-not-charged-in-fatal-north-minneapolis-shooting> [<https://perma.cc/9R6J-CSHU>].

<sup>153</sup> *Id.*

<sup>154</sup> *Id.*

<sup>155</sup> *Id.*

<sup>156</sup> *Id.*

<sup>157</sup> *Id.*

<sup>158</sup> *Id.*

continued to yell and started to approach the officers.<sup>159</sup> Both officers fired shots at Jordan, three of which hit and eventually killed him.<sup>160</sup> A note to his friend who owned the home was later found: “Paul I’m so sorry this happened at your house.”<sup>161</sup>

At the time of this incident, the Minneapolis police did not have a “mental health co-responder on staff.”<sup>162</sup> The executive director of the National Alliance on Mental Illness Minnesota, Sue Abderholden, posed the question: “We know he was suicidal, so are there some other ways to engage someone so that they are not wanting to die[?]”<sup>163</sup>

In another incident in August 2016, Tony Timpa called the Dallas Police asking for help because he had schizophrenia and had not taken his medicine.<sup>164</sup> Instead of providing the support Timpa needed, five Dallas police officers “handcuffed him behind his back, zip-tied his feet, and Officer Dustin Dillard put his knee and bodyweight on Timpa’s back.”<sup>165</sup> The body camera footage recorded Timpa pleading for help and saying, “[Y]ou’re gonna kill me!” again and again.<sup>166</sup> Timpa stopped moving after nine minutes under Officer Dillard’s knee.<sup>167</sup> The officers joked and laughed that he had fallen asleep, and Officer Dillard even said jokingly, “I hope I didn’t kill him.”<sup>168</sup> Paramedics pronounced Tony Timpa dead at the scene.<sup>169</sup>

Responses to mental health crises should not be in the hands of untrained or poorly trained individuals. These tragedies will continue to occur unless our healthcare and criminal justice systems find an innovative, cohesive approach to manage these issues further upstream.

#### *D. The Privatization of Mental Health Care and Medicaid Restrictions*

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<sup>159</sup> *Id.*

<sup>160</sup> *Id.*

<sup>161</sup> *Id.*

<sup>162</sup> *Id.*

<sup>163</sup> *Id.*

<sup>164</sup> Joanna C. Schwartz, *He Died After a Cop Kneeled on His Neck for 14 Minutes. Now, His Family Can Finally Sue*, USA TODAY (Dec. 29, 2021),

<https://www.usatoday.com/story/opinion/2021/12/29/police-force-officers-killed-him-when-he-asked-help/9024452002> [<https://perma.cc/8ZA4-M4MX>].

<sup>165</sup> *Id.*

<sup>166</sup> *Id.*

<sup>167</sup> *Id.*

<sup>168</sup> *Id.*

<sup>169</sup> *Id.*

The privatization of the mental health system is another factor that contributes to the gaping hole so many individuals with mental illness and substance use disorder fall into. Managed care systems and organizations “strictly scrutinize services” that an individual may receive with many requiring prior approval.<sup>170</sup> The purpose is, not surprisingly, to save money and, even further, make money on commissions of service denial.<sup>171</sup>

Managed care companies have paid commissions of over \$800—per denial—to psychiatrists and treatment providers to deny an individual admission to a hospital for needed psychiatric care.<sup>172</sup> Just as the deinstitutionalization movement provided a false promise of community mental health centers for state psychiatric hospital patients, managed care and health maintenance organizations (HMOs) provide the false promise of a comprehensive system of preventative services and early intervention.<sup>173</sup>

If an individual is incarcerated or on Medicaid, the medication that may have worked for her in the past may no longer be available because of restricted formulary and preferred drug list laws.<sup>174</sup> These laws were projected to save millions of dollars at the expense of the individual in need, much like managed care’s strict scrutiny of services.<sup>175</sup> Ironically, the cost-saving measures put in place by our healthcare systems and lawmakers not only harm the individuals in need of care but simply shift the cost to a different sector of the government by housing these individuals in jails and prisons.<sup>176</sup> An example of the negative consequences of a Medicaid restricted formulary can be seen in the case of Keith Howard:

[Howard] had been dealing with schizophrenia for twenty years and reportedly had never been

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<sup>170</sup> Slate, *supra* note 4, at 351 (emphasizing that the role of managed care organizations is to increase profits, not necessarily to deliver quality services to the individuals under their care).

<sup>171</sup> *Id.*

<sup>172</sup> *Id.*

<sup>173</sup> *Id.* at 351–52.

<sup>174</sup> *Id.* at 350 (explaining how a person on Medicaid or who is incarcerated will likely be forced to substitute the drug that is known to work for her for a cheaper alternative drug and the grave consequences of this policy).

<sup>175</sup> *Id.*

<sup>176</sup> *Id.* at 352.

violent toward anyone but himself. However, once subjected to Florida's cost-cutting measure for Medicaid, his brand name drug, not on the preferred drug list, was discontinued, substitutes did not work, and he decompensated. Within two months of having his medication that had successfully kept his hallucinations in check taken away, he spiraled out of control, and on November 8, 2005, Howard killed his mother, believing that she had associated with serial killer Danny Rolling and had assisted Lee Harvey Oswald in the assassination of President Kennedy. Howard remains institutionalized, having later been determined to be not guilty by reason of insanity—an insanity contributed to by the State of Florida.<sup>177</sup>

Although Medicaid was enacted by the federal government with good intentions of providing care to the impoverished, unfortunately—much like deinstitutionalization—the repercussions have instead caused significant harm, especially among vulnerable individuals.<sup>178</sup> For example, Medicaid's exclusion of institutions for mental disease (IMDs) restricts payment for mental health care at psychiatric hospitals and residential treatment facilities.<sup>179</sup> This arguably discriminatory exclusion was implemented when Medicaid was enacted in 1965 and was essentially Congress's way of incentivizing the states to provide the community mental health centers envisioned during the deinstitutionalization movement.<sup>180</sup> Although funding is available for *limited* psychiatric treatment, a vast majority of individuals with severe mental illness require longer-term inpatient care so they can stabilize the illness, meet basic

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<sup>177</sup> *Id.* at 351.

<sup>178</sup> Clausen & Davoli, *supra* note 139, at 650–51.

<sup>179</sup> *Id.* at 650; *Medicaid IMD Exclusion*, NAMI, <https://www.nami.org/NAMI/media/NAMI-Media/Public%20Policy/Medicaid-IMD-Exclusion-for-web-3-2021.pdf> [<https://perma.cc/3XHH-GQ4F>] (“This is the only part of federal Medicaid law that prohibits payment for the cost of providing medically necessary care because of the type of illness being treated.”).

<sup>180</sup> Clausen & Davoli, *supra* note 139, at 651; *Medicaid IMD Exclusion*, *supra* note 179.

needs, and start to foster critical skills before being released back into communities on their own.<sup>181</sup>

### *E. Involuntary Civil Commitment and Treatment Compliance*

When an individual desperately needs mental health care but is not in the right state of mind to agree to treatment, involuntary civil commitment may be necessary for safety purposes but may not be an option depending on their respective state. Each state addresses involuntary civil commitment in its own way.<sup>182</sup> Six states require harm to be imminent to either oneself or others to qualify for inpatient commitment.<sup>183</sup> Seven states require the harm to only be self-imminent, specifically from a failure to meet basic needs, to qualify for inpatient commitment.<sup>184</sup> Five states do not presently provide any path to inpatient treatment for an individual who cannot meet her basic needs due to her mental illness.<sup>185</sup> Three states do not even have a law that allows for civil commitment in an outpatient setting.<sup>186</sup>

Not only do individuals suffering from untreated mental illness and substance use disorders have a greater chance of incarceration, but because of strict involuntary commitment laws, they have a greater chance of causing harm to others or themselves.<sup>187</sup> A 2012 case out of Florida exemplifies the harm possible when these laws prevent healthcare providers from providing longer-term care.<sup>188</sup>

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<sup>181</sup> Clausen & Davoli, *supra* note 139, at 651; *Medicaid IMD Exclusion*, *supra* note 179.

<sup>182</sup> LISA DAILEY ET AL., TREATMENT ADVOC. CTR., GRADING THE STATES: AN ANALYSIS OF INVOLUNTARY PSYCHIATRIC TREATMENT LAWS 4 (2020), <https://www.treatmentadvocacycenter.org/storage/documents/grading-the-states.pdf> [<https://perma.cc/C9RE-2XNP>]. Even though the Treatment Advocacy Center ranked Minnesota first for the quality of its involuntary psychiatric treatment law, Minnesota still “incarcerates more individuals with severe mental illness than it hospitalizes.” *Id.* at 5–6; *Minnesota*, TREATMENT ADVOC. CTR., <https://www.treatmentadvocacycenter.org/browse-by-state/minnesota> [<https://perma.cc/P3EU-DSJH>].

<sup>183</sup> DAILEY, *supra* note 182, at 6 (listing Alabama, Delaware, Georgia, Oklahoma, Pennsylvania, and Tennessee).

<sup>184</sup> *Id.* (listing Georgia, Ohio, Oklahoma, Oregon, Rhode Island, Wisconsin, and Wyoming).

<sup>185</sup> *Id.* (listing Alabama, Delaware, the District of Columbia, Maryland, and New York).

<sup>186</sup> *Id.* (listing Connecticut, Maryland, and Massachusetts).

<sup>187</sup> Clausen & Davoli, *supra* note 139, at 660.

<sup>188</sup> *Id.*

In *Tuten v. Fariborzian*, James Tuten admitted himself to a treatment facility after a suicide attempt but requested discharge after only a couple of days due to his inability to recognize his need for continued treatment.<sup>189</sup> Even though he was not stabilized, the doctors were required to release him upon his request because he did not meet the state of Florida's involuntary hold criteria.<sup>190</sup> He was released, and after just two months, admitted again to a facility due to another suicide attempt.<sup>191</sup> Once again, after only a short few days, Tuten refused treatment and demanded discharge.<sup>192</sup> The day after he was discharged, Tuten shot his wife and then shot and killed himself.<sup>193</sup>

At issue in this case was the dangerousness standard that regulates involuntary commitments in Florida, particularly the liability a psychiatrist or hospital may face when attempting to comply with this standard.<sup>194</sup> The court acknowledged the unreliability of this standard in explaining a physician's duty to warn that a patient may be dangerous, even when the patient is involuntarily committed.<sup>195</sup> The court relied on a previous case which explained "that no such duty exists because of the inherent unpredictability associated with mental illness and the near-impossibility of accurately or reliably predicting dangerousness."<sup>196</sup>

In addition to the strictness of involuntary civil commitment standards, a contributing factor that further inhibits an individual's ability to receive treatment is when her illness deceives her into believing she does not need treatment.<sup>197</sup> The preventable death of Vance Perry, an Iraq

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<sup>189</sup> *Tuten v. Fariborzian*, 84 So. 3d 1063, 1065 (Fla. Dist. Ct. App. 2012).

<sup>190</sup> *Id.*

<sup>191</sup> *Id.*

<sup>192</sup> *Id.*

<sup>193</sup> *Id.*

<sup>194</sup> *Id.* at 1068.

<sup>195</sup> *Id.*

<sup>196</sup> *Id.* (quoting *Mental Health Care, Inc. v. Stuart*, 909 So. 2d 371, 374 (Fla. Dist. Ct. App. 2005)) (internal quotation marks omitted).

<sup>197</sup> *Clausen & Davoli*, *supra* note 139, at 647–48 (explaining the "patchwork system" of mental health care in our country and the restrictions around involuntary treatment when an individual refuses treatment because her illness impedes her capacity to make a lucid decision about her health); *see Testa*, *supra* note 3, at 409–10 (acknowledging that most individuals that were discharged from the state hospitals as they started to shut down were uninsured or severely underinsured and that private psychiatric care was inaccessible to them).

War veteran, is a prime example.<sup>198</sup> In January of 2018, Perry was found dead in a parking garage in Wisconsin in below freezing temperatures wearing only a light jacket.<sup>199</sup> He had recently been picked up for a routine appointment by a Veterans Affairs (VA) van and transported to the VA Hospital in Madison.<sup>200</sup> He suffered from paranoid schizophrenia and was admitted for mental instability at the time of this routine appointment.<sup>201</sup> Despite his clear need for treatment, the VA was unable to hold him once he decided he wanted to leave.<sup>202</sup> According to the VA Hospital's statement after his death, Perry voluntarily checked out of the facility and the hospital "had no grounds to prevent him forcibly from doing so."<sup>203</sup> He had veterans' benefits because of his status as an Iraq War veteran and was in a safe treatment facility "when his illness led him back onto the streets."<sup>204</sup> Neither his death nor his inability to find proper shelter were products of poverty.<sup>205</sup> Instead, they were products of his untreated severe mental illness which caused his illness-induced treatment refusal that neither he, nor the hospital, could override.<sup>206</sup>

Even if an individual receives outpatient treatment, or a brief seventy-two-hour hold within an inpatient psychiatric hospital, the individual is unlikely to comply with continued mental health treatment due to the nature of her illness.<sup>207</sup> One of the main factors in the decision to shut down the state psychiatric hospitals during the deinstitutionalization movement was the advent of antipsychotic drugs, but these drugs only work if the patient maintains compliance over an extended period of time.<sup>208</sup> Many individuals do not take their

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<sup>198</sup> *Army Veteran Freezes to Death After Being Released from VA Hospital*, 11 ALIVE (Jan. 5, 2018), <https://www.11alive.com/article/news/local/army-veteran-freezes-to-death-after-being-released-from-va-hospital/85-504901459> [<https://perma.cc/N7S2-6KAT>] [hereinafter *Army Veteran Freezes to Death*].

<sup>199</sup> *Id.*

<sup>200</sup> *Id.*

<sup>201</sup> *Id.*

<sup>202</sup> *Id.*

<sup>203</sup> *Id.*; Clausen & Davoli, *supra* note 139, at 657.

<sup>204</sup> Clausen & Davoli, *supra* note 139, at 657; see *Army Veteran Freezes to Death*, *supra* note 198.

<sup>205</sup> See *Army Veteran Freezes to Death*, *supra* note 198.

<sup>206</sup> *Id.*; see also Clausen & Davoli, *supra* note 139, at 657.

<sup>207</sup> See *Army Veteran Freezes to Death*, *supra* note 198; see also *What Is a 72-Hour Psychiatric Hold?*, MEDCIRCLE (Aug. 16, 2022), <https://medcircle.com/articles/what-is-a-72-hour-psychiatric-hold> [<https://perma.cc/ADE3-FKYC>] (explaining the history of seventy-two hour holds and what they consist of).

<sup>208</sup> Testa, *supra* note 3, at 409–10.



medications because they are either unable to recognize the severity of their active disease or they are fearful of the side-effects of the medication and how it makes them feel.<sup>209</sup> For example, if an individual is experiencing paranoid delusions, she is highly unlikely to be compliant with antipsychotic medications.<sup>210</sup> The illness might temporarily stabilize after a few days in an inpatient setting, but once an individual is thrust back into society, her illness is likely not stabilized enough to stay maintained without long-term care.<sup>211</sup> The greatest hindrance is simply the nature of these diseases and the constant need for more barriers to protect from preventable harm.<sup>212</sup>

#### *F. Access to Treatment and Care Within the Criminal Justice System*

Once an individual with mental illness and substance use disorder finds herself within the criminal justice system, her treatment and care needs do not disappear. However, because an overwhelming number of individuals with mental illness and substance use disorder are under the system's care, treatment needs must be addressed.

Of the individuals incarcerated from 2007 to 2009, 63% of those in jail and 58% of those in prison experienced drug dependence or substance use abuse.<sup>213</sup> According to a 2011 to 2012 survey, 44% of those in jail and 37% of those in prison had a diagnosis of a mental illness prior to incarceration.<sup>214</sup> In that same survey, around 44% of those in jail and 63% of those in prison with a mental illness or substance use disorder were not receiving any treatment or mental health care since being incarcerated.<sup>215</sup>

Through the Eighth and Fourteenth Amendments, the

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<sup>209</sup> *Id.* at 407–08.

<sup>210</sup> *Id.* at 407.

<sup>211</sup> See Clausen & Davoli, *supra* note 139, at 661.

<sup>212</sup> *Id.* at 647–48; see Testa, *supra* note 3, at 408.

<sup>213</sup> JENNIFER BRONSON ET AL., DRUG USE, DEPENDENCE, AND ABUSE AMONG STATE PRISONERS AND JAIL INMATES, 2007-2009 3 (2017), <https://bjs.ojp.gov/content/pub/pdf/dudaspij0709.pdf> [<https://perma.cc/4CZH-37CL>].

<sup>214</sup> JENNIFER BRONSON & MARCUS BERZOFKY, INDICATORS OF MENTAL HEALTH PROBLEMS REPORTED BY PRISONERS AND JAIL INMATES, 2011-12 1 (2017) <https://bjs.ojp.gov/content/pub/pdf/imhprpji1112.pdf> [<https://perma.cc/S8RP-NNXU>].

<sup>215</sup> *Id.*

Supreme Court has decided that the Constitution mandates that incarcerated individuals are entitled to psychiatric treatment for their mental illness.<sup>216</sup> The Court held in *Estelle v. Gamble* that because individuals are incarcerated and therefore unable to meet their medical needs without the assistance and support of those that deprive them of their liberty, it is the responsibility of correctional facilities to provide such care.<sup>217</sup> If they do not provide these services, the facilities are in violation of the Constitution's prohibition of cruel and unusual punishment.<sup>218</sup>

Even with this constitutional requirement, correctional facilities were not built to support and meet these needs.<sup>219</sup> The environmental stressors of incarceration, such as isolation, idleness, and violence, only exacerbate mental illness symptoms.<sup>220</sup> Medication, if it is administered, is only one piece to the holistic and comprehensive puzzle needed to start the recovery process.<sup>221</sup> In addition to the therapeutic treatment that tends to be inadequate and often difficult to receive in a punitive environment, individuals with substance use disorder must also be properly detoxed, which is only the

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<sup>216</sup> Testa, *supra* note 3, at 421.

<sup>217</sup> *Id.*; *Estelle v. Gamble*, 429 U.S. 97, 104–05 (1976) (“We therefore conclude that deliberate indifference to serious medical needs of prisoners constitutes the ‘unnecessary and wanton infliction of pain’ . . . proscribed by the Eighth Amendment. This is true whether the indifference is manifested by prison doctors in their response to the prisoner’s needs or by prison guards in intentionally denying or delaying access to medical care or intentionally interfering with the treatment once prescribed.”) (quoting *Gregg v. Georgia*, 428 U.S. 153, 173 (1976)).

<sup>218</sup> *Estelle*, 429 U.S. at 103–05 (1976); *Robinson v. California*, 370 U.S. 660, 667 (1962); *see supra* Section III.A (explaining why the Court held in *Robinson v. California* that a statute making the status of addiction a criminal offense was in violation of the Eighth Amendment for amounting to cruel and unusual punishment).

<sup>219</sup> Testa, *supra* note 3, at 421 (explaining that the criminal justice system was built for punitive purposes, not therapeutic and restorative purposes that are inherently necessary to care for an individual’s well-being).

<sup>220</sup> *Id.* at 423.

<sup>221</sup> *See id.* at 422–25. “The treatment needs of people who have mental illness are many and varied” and access to such treatment, such as medication, is limited. *Id.* at 422. “Often, jails and prisons have access to a limited and restricted repertoire of medications, and the psychiatrist’s difficult task of finding a medication that is both likely to help a patient and have a side-effect profile that will be acceptable to him or her, is made even harder.” *Id.* at 424. *See also* Julia Durst, *Barring Methadone Behind Bars: How Prisons Err When Denying Methadone Treatment to Inmates with Opioid Use Disorder*, 48 MITCHELL HAMLIN L. REV. 235, 236 (2022) (explaining the more recent issue of barring methadone and other medication-assisted treatment to incarcerated individuals at risk for withdrawals from opioid use disorder).

first step in long-term recovery.<sup>222</sup> In a correctional facility setting, drug use is likely to continue, especially if the individual is not ready to quit or has not been exposed to proper treatment.<sup>223</sup> Additionally, medication-assisted treatment, which has proven its efficacy in preventing opioid overdose in prison and after release,<sup>224</sup> is rare within correctional facilities and drug courts.<sup>225</sup>

Beyond just the inadequate treatment services available while incarcerated, the reentry issues presented after release produce yet another layer of barriers reducing the individual's chances of recovery and stability.<sup>226</sup> Not only does the individual need to navigate finding a home, work, and social support, but she also needs to navigate the limited available treatment options due to her likely reduced financial means and insurance options post-incarceration.<sup>227</sup> If an individual received any treatment within a correctional facility, she is often released with a very limited supply of medications and may not be appropriately or effectively connected with a community mental health provider.<sup>228</sup>

Nearly 66% of individuals with mental illness and substance use disorder are rearrested and between 33% to 50% are hospitalized in the first year-and-a-half after release.<sup>229</sup> Additionally, many individuals die from suicide, homicide, or drug overdose due to their reduced tolerance of drugs post-incarceration.<sup>230</sup>

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<sup>222</sup> Testa, *supra* note 3, at 422–27 (noting the similar therapeutic needs of individuals with mental illness and those with substance use disorders, including lifestyle modifications like nutrition, exercise, sleep, treatment options, medication, and therapy to develop coping skills or process trauma).

<sup>223</sup> *Id.* at 427.

<sup>224</sup> Durst, *supra* note 221, at 239–41. A study by Yale School of Medicine found that individuals “who continued methadone during incarceration—thus avoiding forced opioid withdrawal—were approximately three times less likely to receive disciplinary tickets.” *Id.* at 241. These same individuals “were also thirty-two times more likely to visit a community-based methadone program within a day of release.” *Id.* The individuals “who maintained methadone treatment before, during, and after incarceration were five times less likely to be re-arrested for a felony and ten times less likely to be charged for a drug offense after release.” *Id.*

<sup>225</sup> *Id.* at 242–43 (The Federal Bureau of Prisons in the United States “does not permit methadone treatment for inmates, with the exception of pregnant females with [Opioid Use Disorder].”); *Drug War Stats*, *supra* note 142.

<sup>226</sup> Testa, *supra* note 3, at 428–29.

<sup>227</sup> *Id.*

<sup>228</sup> *Id.* at 429.

<sup>229</sup> *Id.*

<sup>230</sup> *Id.*

1. *The Siloed Approach to Drug, Alcohol, and Mental Health Courts*

Although drug, alcohol, and mental health courts have moved the needle slightly for the criminal justice system, the siloed approach of separating the courts can often cause more harm than good.<sup>231</sup> Because of the comorbidity between mental illness and substance use disorder, and because substance abuse is technically a mental illness,<sup>232</sup> the siloed approach lacks the fundamental holistic nature of treatment necessary for any individual affected by either or both diseases to succeed.<sup>233</sup>

Typically, first-time, nonviolent offenders have cases transferred from a traditional criminal court to a specialty court based on the kind of offense, such as drug offenses, alcohol-related offenses, or offenses seemingly due to underlying mental illness.<sup>234</sup> The individual is offered an opportunity to seek treatment and follow a twelve- to eighteen-month plan as an incentive to reduce recidivism.<sup>235</sup> In theory, this system has its benefits, but because the criminal justice system is built on punishment, the individual is still at the mercy of the court system and prosecution looms if the individual is unsuccessful during the twelve- to eighteen-month “probationary” period.<sup>236</sup>

Even though the siloed approach has been praised as a pathway to criminal justice reform, it is still a method that refers individuals to criminal courts untrained in mental illness or substance use disorder.<sup>237</sup> For instance, many drug

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<sup>231</sup> Gordon, *supra* note 110, at 360. Mental health courts “have the stated goal of connecting participants to available community resources” while drug and alcohol courts “often have a more punitive focus.” *Id.* Because these courts are segregated, they showcase how we are “out of step with our current understanding of both the nature of the disease of addiction, as well as the existence of high rates of co-occurring disorders.” *Id.* This, in turn, “perpetuate[s] the stigma” around substance use disorder. *Id.*

<sup>232</sup> See *supra* Section IV.A.I (discussing the comorbidity of mental illness and substance use disorder); see also *supra* note 1 and accompanying text (stating that substance use is considered a mental illness).

<sup>233</sup> Gordon, *supra* note 110, at 360–61. Because of the segregated nature of these courts, “both drug and mental health courts often fail to provide appropriate treatment for the multiple disorders a single individual might present.” *Id.*

<sup>234</sup> See Cornwell, *supra* note 125, at 422.

<sup>235</sup> *Id.* at 423.

<sup>236</sup> *Id.* (“Most programs last from twelve to eighteen months, during which relapse is not uncommon. Those who falter are held accountable for their failure to remain abstinent, with the sanctions’ nature and severity determined by the court.”).

<sup>237</sup> Gordon, *supra* note 110, at 388.

courts, much like correctional facilities, refuse to allow medication-assisted treatment for individuals struggling with opioid addiction.<sup>238</sup> Most drug courts only allow for the abstinence model of recovery, and the low-level opioid medication used in medication-assisted treatment does not fit within this model.<sup>239</sup> Courts must realize that the need for medication-assisted treatment is critical to save the lives of individuals whose bodies have become dependent on a chemical to survive.<sup>240</sup> The concept of “cold turkey” is no longer considered safe by medical professionals studying addiction, especially with the more recent use of the potent and powerful opioid fentanyl mixed with other street drugs.<sup>241</sup> The recovery trajectory of individuals within these specialty courts is almost entirely dependent on a system of medically untrained legal professionals deciding which court structure and treatment pathways they can access.<sup>242</sup>

## V. CURRENT AND POTENTIAL SOLUTIONS

### A. *Diversion Strategies and Solutions*

Arrests and incarceration are clearly not solutions for individuals with mental illness and substance use disorder. When an individual’s offending behavior results from mental illness or substance use disorder rather than a criminal motivation, the better alternative to criminal justice would be holistic treatment and therapeutic intervention.<sup>243</sup> Fortunately, many of these alternatives are garnering attention and becoming more commonplace.<sup>244</sup> This is likely due to the critical reporting on deadly police response to individuals facing mental health crises like Travis Jordan and Tony Timpa.<sup>245</sup>

One example of a prebooking diversion strategy is the implementation of alternative response teams.<sup>246</sup> Crisis intervention training and community mental health crisis

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<sup>238</sup> Cornwell, *supra* note 125, at 424–25; Durst, *supra* note 221, at 241–43 (discussing the use of medication-assisted treatment in correctional facilities).

<sup>239</sup> Cornwell, *supra* note 125, at 424–25.

<sup>240</sup> *Id.* at 425.

<sup>241</sup> *Id.*

<sup>242</sup> See Gordon, *supra* note 110, at 387–88.

<sup>243</sup> Testa, *supra* note 3, at 429–30.

<sup>244</sup> *Id.*

<sup>245</sup> See *supra* Section IV.C and accompanying text.

<sup>246</sup> Testa, *supra* note 3, at 431.

response teams assist law enforcement with responding to crimes and emergencies.<sup>247</sup> Another strategy is the implementation of a mental health service department within a police department.<sup>248</sup> Under that model, when an arresting officer brings the individual into the police station, a mental health professional assists in determining the next steps for the individual.<sup>249</sup>

As part of the American Rescue Plan Act of 2021, Medicaid coverage was expanded for a five-year period to allow states to pay for mobile crisis intervention services to respond to mental health or substance use crises.<sup>250</sup> The law provided \$15 million for states to develop these programs but required the mobile crisis units to comply with regulations, including providing 24/7 response availability and de-escalation training.<sup>251</sup> The new federal proposals like the 988 hotline,<sup>252</sup> mobile crisis units, and Certified Community Behavioral Health Clinics (CCBHCs)<sup>253</sup> are a positive shift in response to these tragedies. However, the piecemeal approach may not be enough. Even if police continue to transport individuals to treatment facilities or jails in response to mental health crises, individuals will still need to “obtain effective intervention.”<sup>254</sup>

### *B. Certified Community Behavioral Health Clinics*

A possible intervention solution is the expansion of the CCBHCs first implemented in 2014.<sup>255</sup> The American Rescue Plan Act of 2021 granted funds to expand the clinics, and

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<sup>247</sup> *Id.* Crisis intervention training teams are “specialized police forces” and “consist of officers trained to recognize signs and symptoms of mental illness among offenders and use discretion to determine the most appropriate disposition for such individuals.” *Id.*

<sup>248</sup> *Id.* at 432.

<sup>249</sup> *Id.*

<sup>250</sup> Clausen & Davoli, *supra* note 139, at 665.

<sup>251</sup> *Id.*

<sup>252</sup> *Id.* at 664 (explaining the new 988 three-digit hotline replacing the ten-digit suicide prevention hotline for mental health emergencies).

<sup>253</sup> *Id.* at 665–66; *see infra* Section V.B (discussing the CCBHCs in further detail).

<sup>254</sup> Clausen & Davoli, *supra* note 139, at 664; *see* Stuart M. Butler & Nehath Sheriff, *Innovative Solutions to Address the Mental Health Crisis: Shifting Away from Police as First Responders*, BROOKINGS (Nov. 23, 2020), <https://www.brookings.edu/research/innovative-solutions-to-address-the-mental-health-crisis-shifting-away-from-police-as-first-responders> [<https://perma.cc/W4W4-GD87>] (discussing different approaches to mental health crisis response throughout the United States).

<sup>255</sup> Clausen & Davoli, *supra* note 139, at 665.

“there are now over four hundred CCBHCs in over forty states.”<sup>256</sup> To receive funding, each clinic must maintain compliance with regulations and “provide a comprehensive range of addiction and mental health services to vulnerable individuals while meeting additional requirements related to staffing, governance, data and quality reporting and more.”<sup>257</sup>

CCBHCs exhibit the coordinated, holistic care that many individuals require to lead successful lives outside of the criminal justice system cycle. This includes a clinic regulation that allows treatment teams to share patient histories among each other to ensure the most appropriate and effective care.<sup>258</sup> This prevents the individual from repeated questions, consultations, and being shuttled from provider to provider with no cohesive treatment plan.<sup>259</sup>

CCBHCs are located within communities and essentially serve as the community treatment centers initially proposed during the deinstitutionalization movement. The expanded funding will allow for more CCBHCs to open and broaden services for each clinic, but because the funding is directly tied to consistent compliance with federal regulations, many clinics may struggle to remain open.<sup>260</sup>

### *C. National Alliance on Mental Illness Competency Restoration Bill in Minnesota*

In May of 2022, the Minnesota Legislature passed a historic reform proposed by the National Alliance on Mental Illness (NAMI) Minnesota to facilitate filling the void between the state’s mental health system and the criminal justice system.<sup>261</sup> The bill was passed while a man, Gregory Ulrich, was standing trial for a mass shooting at an Allina Health clinic in Buffalo, Minnesota.<sup>262</sup> Two years earlier, Ulrich made similar threats of a mass shooting and, based on those threats, was found incompetent to stand trial, forcing the prosecutor

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<sup>256</sup> *Id.*

<sup>257</sup> *Id.* at 665–66.

<sup>258</sup> *Id.* at 666.

<sup>259</sup> *Id.*

<sup>260</sup> *Id.*

<sup>261</sup> Brandon Stahl, A.J. Lagoe & Steve Eckert, *KARE 11 Investigates: Historic Reforms Approved to Treat the Mentally Ill and Protect the Public*, KARE 11 (May 23, 2022), <https://www.kare11.com/article/news/investigations/the-gap/kare-11-investigates-historic-reforms-approved-to-treat-the-mentally-ill-and-protect-the-public/89-fee08597-1756-4c26-8b4f-aa792f998cd8> [<https://perma.cc/4SC7-R3CH>].

<sup>262</sup> *Id.*

to drop the case.<sup>263</sup> Ulrich never received treatment.<sup>264</sup> Two years later, Ulrich acted on those threats and killed a mother of two young children and shot four others at the clinic.<sup>265</sup> The NAMI bill that passed while Ulrich was standing trial “[c]reate[d] the process in statute when a person is found incompetent to proceed with their trial because of a mental illness or cognitive impairment.”<sup>266</sup>

When an individual’s competency is first questioned in Minnesota, she will be assigned a “forensic navigator” who will assist in creating a “bridge plan” so that before the charges are dismissed, she is set up with the resources necessary for treatment, benefits, and stable living conditions.<sup>267</sup> This aims to disrupt the revolving door phenomenon of returning to jail or the emergency room.<sup>268</sup> Forensic navigators also assist the court in finding appropriate placements for individuals and keep the lines of communication open between the courts, the individual, and the mental health system.<sup>269</sup>

One of the most important aspects of this plan is the authority bestowed on the court to order individuals to participate in competency restoration programs rather than civil commitments.<sup>270</sup> The competency restoration programs will provide care in inpatient, residential, and home-based settings, and if necessary for public safety, some locked and jail-based settings.<sup>271</sup> The bill provides clear directives and timelines to simultaneously address community concerns and protect the constitutional rights of the individual.<sup>272</sup> It provides a personalized, tiered approach, creating a net to catch any individual found incompetent to stand trial.<sup>273</sup>

A new State Board of Competency Restoration will oversee the forensic navigators and certify the programs and

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<sup>263</sup> Brandon Stahl, A.J. Lagoe & Steve Eckert, *KARE 11 Investigates – The Gap: Failure to Treat, Failure to Protect*, KARE 11 (Oct. 25, 2021), <https://www.kare11.com/article/news/investigations/kare-11-investigates-the-gap-failure-to-treat-failure-to-protect-mental-health/89-b56dcfba-3016-407f-ba11-72819c671652> [https://perma.cc/UCZ7-TJRA].

<sup>264</sup> *Id.*

<sup>265</sup> *Id.*

<sup>266</sup> *Competency Restoration Bill Moves Forward*, NAT’L ALL. ON MENTAL ILLNESS: MINN., <https://namimn.org/competency-restoration-bill-moves-forward> [https://perma.cc/F7DT-V8KT].

<sup>267</sup> *Id.*

<sup>268</sup> *See id.*

<sup>269</sup> *Id.*

<sup>270</sup> *See id.*

<sup>271</sup> *Id.*

<sup>272</sup> *Id.*

<sup>273</sup> *Id.*



curriculum to maintain quality assurance.<sup>274</sup> Additionally, an advisory committee for the board will provide the specific mental health expertise necessary for implementation and operational standards.<sup>275</sup>

#### *D. Medicaid Restriction Workaround*

In 2018, the Centers for Medicare & Medicaid Services (CMS) created a workaround to the IMD exclusion.<sup>276</sup> This is critical because “Medicaid is the single largest payer of behavioral health services, including mental health and substance use services in the [United States],” and yet Medicaid refuses to cover the necessary inpatient and residential treatment options that are crucial for so many.<sup>277</sup> Through the CMS workaround, states can “receive authority to pay for short-term residential treatment services in an institution for mental disease.”<sup>278</sup> In essence, states can apply to waive the exclusion rules so that certain individuals may receive inpatient care and Medicaid can effectively pay for it.<sup>279</sup> By allowing more treatment options for serious mental illness and substance use disorder, including inpatient and residential treatment options, the U.S. Department of Health and Human Services believes this exception “will . . . emphasize that inpatient treatment is just one part of what needs to be a complete continuum of care, and participating states will be expected to take action to improve community-based mental health care.”<sup>280</sup> Necessary state improvements include the following: ensuring quality treatment to individuals with mental illness and substance use disorder as soon as possible, making connections between community-based care and individuals after discharge from an institution, and providing a wide array of stabilization services for individuals in crisis.<sup>281</sup>

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<sup>274</sup> *Id.*

<sup>275</sup> *See id.*

<sup>276</sup> *CMS Announces New Medicaid Demonstration Opportunity to Expand Mental Health Treatment Services*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Nov. 13, 2018), <https://www.cms.gov/newsroom/press-releases/cms-announces-new-medicaid-demonstration-opportunity-expand-mental-health-treatment-services> [<https://perma.cc/2T88-6Q65>]; *see Medicaid IMD Exclusion*, *supra* note 179.

<sup>277</sup> *CMS Announces New Medicaid Demonstration Opportunity to Expand Mental Health Treatment Services*, *supra* note 276.

<sup>278</sup> *Id.*

<sup>279</sup> *Id.*

<sup>280</sup> *Id.*

<sup>281</sup> *Id.*

Additionally, some of the states under these waivers are addressing “social determinants of health” like “housing, food, education, employment, healthy behaviors, transportation, and personal safety.”<sup>282</sup> Typically, states are limited in their ability to pay for non-medical costs like housing and food with federal Medicaid funds.<sup>283</sup> However, the waiver will allow for states to request that these non-medical or non-clinical services be included in the Medicaid benefit package.<sup>284</sup> Eighteen states are approved, and eight states have pending requests for this waiver as of November 2, 2022.<sup>285</sup>

### *E. Integrated Drug Courts and Mental Health Courts*

Integrating drug, alcohol, and mental health courts would allow for the many individuals with co-occurring disorders to receive more tailored treatment plans and resources, such as a case management and provider team, vocational services, family and individual therapy, housing resources, and medication.<sup>286</sup> As specialty courts become integrated, the judges and judicial system personnel will have more experience and opportunities for training on co-occurring disorders and thus will be better equipped to select the appropriate treatment and screening.<sup>287</sup>

The integration of specialty courts would assist in closing the gap that individuals with co-occurring disorders often fall into between mental health and substance use

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<sup>282</sup> Madeline Guth, *Section 1115 Waiver Watch: Approvals to Address Health-Related Social Needs*, KFF (Nov. 15, 2022), <https://www.kff.org/medicaid/issue-brief/section-1115-waiver-watch-approvals-to-address-health-related-social-needs> [<https://perma.cc/VN6W-NSCF>]; see *Section 1115 Demonstrations: Substance Use Disorders, Serious Mental Illness, and Serious Emotional Disturbance*, MEDICAID.GOV, <https://www.medicaid.gov/medicaid/section-1115-demonstrations/1115-substance-use-disorder-demonstrations/section-1115-demonstrations-substance-use-disorders-serious-mental-illness-and-serious-emotional-disturbance/index.html> [<https://perma.cc/C6DS-XB83>] (“[T]he Centers for Medicare & Medicaid Services (CMS) created an opportunity under the authority of section 1115(a) of the Social Security Act (Act) for states to demonstrate and test flexibilities to improve the continuum of care for beneficiaries with substance use disorders (SUDs) including Opioid Use Disorder. In addition, CMS created similar flexibility to test more comprehensive approaches to care for beneficiaries with serious mental illness (SMI) or serious emotional disturbance (SED).”).

<sup>283</sup> Guth, *supra* note 282.

<sup>284</sup> *Id.*

<sup>285</sup> *Id.*

<sup>286</sup> Gordon, *supra* note 110, at 392.

<sup>287</sup> *Id.*

treatment systems.<sup>288</sup> A coordinated system will provide the resources and treatment necessary to reduce recidivism and, hopefully, end the cycle for these individuals within the criminal justice system.<sup>289</sup> Additionally, it will reduce the financial burden on state and federal government because the individual will be more likely to succeed rather than repeatedly revisit the courts.<sup>290</sup>

In addition to integrated specialty courts, some jurisdictions have experimented with specialized drug courts tailored toward individuals affected by opioid addiction.<sup>291</sup> These courts embrace the medication-assisted treatment that the traditional drug courts tend to reject.<sup>292</sup> Alongside medication-assisted treatment, these courts have also implemented a holistic approach to the individual's well-being, providing other resources such as mental health and substance abuse therapy for the individual and family, sober housing options, transportation resources, and job training.<sup>293</sup>

Regardless of the type of court or how it is defined, the common theme necessary for improving an individual's chance of success is the concept of "therapeutic jurisprudence."<sup>294</sup> This less punitive approach is especially necessary while the criminal justice system has so many individuals with mental illness and substance use disorder under its care.<sup>295</sup>

#### *F. National Center for State Courts: Mental Health Task Force*

It is evident from the research and reporting on our news channels every day that incarceration is not the solution

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<sup>288</sup> *Id.*

<sup>289</sup> *See id.*

<sup>290</sup> *Id.* at 393.

<sup>291</sup> Cornwell, *supra* note 125, at 425–26.

<sup>292</sup> *Id.*

<sup>293</sup> *Id.*

<sup>294</sup> *Id.* at 430; Slate, *supra* note 4, at 353.

<sup>295</sup> *See* Slate, *supra* note 4, at 353. The author distinguishes between the traditional criminal justice system which "tends to look backward, finding fault, making accusations, and inflicting punishment" with "decisions rendered in the spirit of therapeutic jurisprudence." *Id.* The therapeutic jurisprudence model "reflect[s] concern for the future consequences on individuals, relationships, and the community long after a person's contact with the justice system is over." *Id.* The author argues that, in turn, this effect will "prevent constant recycling through the criminal justice system of persons with mental illnesses and be of benefit to all over time." *Id.*

to the growing mental illness and substance use disorder issue hammering our country. In fact, incarceration only exacerbates the issue while simultaneously creating new issues.<sup>296</sup> The cycle of incarceration that has viciously grown over the last fifty years is not only ineffective, but also deadly and expensive.<sup>297</sup> Solutions need to be integrated within the present system as well as upstream before the individual falls into the criminal justice system cycle. In fall of 2022, these solutions finally took center stage at a national level.

On October 26, 2022, the National Center for State Courts released its final report from the National Judicial Task Force to Examine State Courts' Response to Mental Illness (Task Force).<sup>298</sup> The Task Force is a continued collaboration between the courts, government agencies, and mental health providers, among others, and will be critical to effecting the systemic change necessary to improve how our courts respond to individuals with mental illness and substance use disorder.<sup>299</sup> Some of the recommendations the report provides include the following: how state and trial courts can lead the change to increase support of individuals with substance use disorders and mental illness, deflection and diversion strategies, a reformation of trial competency processes, and development of guides for court and community collaboration for "person-centered justice."<sup>300</sup> The Task Force's holistic approach to confront the issues discussed in this Note is a hopeful sign that the foundational paradigm shift so desperately needed is on the near horizon.<sup>301</sup>

## VI. CONCLUSION

The criminal justice system has become enmeshed with a population it is not built to support. The punitive nature of the criminal justice system is not conducive to the therapeutic and holistic approach required to support individuals with

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<sup>296</sup> Horton, *supra* note 140.

<sup>297</sup> *Id.*

<sup>298</sup> NAT'L JUD. TASK FORCE, *supra* note 7.

<sup>299</sup> *Id.*

<sup>300</sup> *Id.* at 21–29.

<sup>301</sup> The National Judicial Task Force has been implementing the strategies and recommendations over the course of the last year since the report was published. This is the extent that this Note will cover the Task Force's efforts, but the author encourages anyone interested in learning more about the current state of this effort to follow along at: <https://www.ncsc.org/behavioralhealth>.

mental illness and substance use disorder. The structural gaps are massive, and the rebuilding process will be extensive. Fortunately, there are temporary and long-term solutions arising out of the grave realization that our country has failed to protect so many of our own.

As an individual in recovery from substance use disorder and underlying mental illness imbalances, I can attest that the issues presented in this Note are mere snapshots of the larger systemic issue. The problems and solutions presented are so interwoven, there is rarely one sweeping solution that addresses every issue. Although this Note magnifies the complexity of the general issue, I am optimistic in the continued awareness and advocacy efforts that have grown significantly over the past twenty years, especially through the efforts of the National Judicial Task Force. It is my hope that the paradigm will continue to shift, *one day at a time*, and a safety net will ultimately fill the void swallowing so many individuals like myself who live with the diseases of addiction and mental illness.