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About a Revolution: Toward Integrated Treatment in Drug and Mental Health Courts

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ABOUT A REVOLUTION: TOWARD INTEGRATED TREATMENT IN DRUG AND MENTAL HEALTH COURTS*

SARA GORDON**

This Article examines specialty courts, including drug, alcohol, and mental health courts, which proponents claim created a revolution in criminal justice. Defendants whose underlying crime is the result of a substance use disorder or a mental health disorder can choose to be diverted into a specialty court, where they receive treatment instead of punishment. Many of these individuals, however, do not just suffer from a substance use disorder or a mental health disorder; instead, many have a “co-occurring disorder.” Approximately 8.9 million American adults have co-occurring mental health and substance use disorders, and almost half of individuals who meet diagnostic criteria for one disorder will also meet criteria for the other. Moreover, an extensive body of literature has shown that treatment for co-occurring disorders should be integrated and that individuals should receive appropriate mental health and substance abuse treatment from a single clinician or clinical team.

This Article argues that the segregation of drug, alcohol, and mental health courts is out of step with our current understanding of the high rates of co-occurring disorders, and often fails to provide integrated treatment for the multiple disorders a single specialty-court participant might present. Moreover, by segregating specialty courts, we are further stigmatizing addiction and failing to acknowledge that drug and alcohol use disorders are some of the many types of mental illnesses recognized by the medical community. Drug, alcohol, and mental health courts should therefore move away from their traditional siloed approach to the selection and treatment of participants and instead provide individuals with comprehensive and integrated

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treatment for co-occurring substance use and mental health disorders.

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INTRODUCTION

*I didn't realize I actually had post-traumatic stress disorder at the time, but why would I think I had that? Anyway, how would I know which was post-traumatic stress, which is addiction, which is bipolar, which is Libra?*¹

Although she is perhaps best known as Princess Leia, the actress Carrie Fisher also spoke openly about her history of addiction and mental illness and “once joked that she wanted to start a ‘Bipolar Pride Day’ to help erase the stigma of the disease.”² When she died in December 2016 after suffering a heart attack on a flight to Los Angeles, many of her fans remembered Fisher not only for her career as an actress, author, and screenwriter but also for her nearly life-long struggle with what mental health professionals describe as a “co-

1. CARRIE FISHER, *WISHFUL DRINKING* 143 (2008).

2. Ryan Bursleson & Tara Parker-Pope, *Fans Tweet About Mental Illness to Honor Carrie Fisher*, N.Y. TIMES (Dec. 27, 2016), <https://www.nytimes.com/2016/12/27/arts/carrie-fisher-bipolar-disorder.html> [<https://perma.cc/ZM38-K4BG> (dark archive)]. At the beginning of her memoir, Fisher notes that if her life were not funny, “it would just be true, and that is unacceptable.” FISHER, *supra* note 1, at 17. She describes “Bipolar Pride Day” this way: “You know, with floats and parades and stuff! On the floats we would get the depressives, and they wouldn’t even have to leave their beds. . . . And then for the manics, we’d have the manic marching band. . . .” *Id.* at 127.

occurring disorder,” or a diagnosis of at least one mental health condition and one substance use disorder.³

As Fisher described it: “I used to think I was a drug addict, pure and simple—just someone who could not stop taking drugs willfully. . . . And I was that. But it turns out that I am severely manic depressive.”⁴ Fisher started using drugs around the age of thirteen,⁵ continued taking drugs like LSD and Percodan during the 1970s and 1980s,⁶ and admitted to a reporter that she “did cocaine on the set of [The] Empire [Strikes Back], in the ice planet”⁷ In 1985, after filming a role in the Woody Allen film *Hannah and Her Sisters*, she nearly overdosed and entered an inpatient rehabilitation facility in Los Angeles.⁸ When she died in 2016, an autopsy found cocaine, methadone, heroin, and MDMA in her system.⁹ In addition to illegal substances, Fisher was taking Lamictal, a commonly prescribed bipolar medication, along with the antidepressants Prozac and

3. Burluson & Parker-Pope, *supra* note 2 (“Legions of fans seemed to grant her wish on Tuesday in the hours after her death at age 60. One after another, in words both plain-spoken and deeply personal, admirers paid tribute to Ms. Fisher by ‘coming out’ on Twitter with their own stories of mental illness.”); *see also* U.S. DEP’T OF HEALTH & HUM. SERVS., SUBSTANCE ABUSE TREATMENT FOR PERSONS WITH CO-OCCURRING DISORDERS: A TREATMENT IMPROVEMENT PROTOCOL TIP 42, at 3 (2013) [hereinafter TIP], <https://store.samhsa.gov/file/23170/download?token=FBHtrcSs> [<https://perma.cc/W5FU-ZCPP> (staff-uploaded archive)] (“Clients said to have co-occurring disorders have one or more disorders relating to the use of alcohol and/or other drugs of abuse as well as one or more mental disorders.”); Mary Ann Priester et al., *Treatment Access Barriers and Disparities Among Individuals with Co-Occurring Mental Health and Substance Use Disorders: An Integrative Literature Review*, 61 J. SUBSTANCE ABUSE TREATMENT 47, 47 (2016) (“[A] diagnosis of [a co-occurring disorder] requires that at least one mental illness and one substance use disorder (SUD) must be able to be diagnosed independently.”).

4. *PrimeTime: Carrie Fisher Interview*, ABC NEWS (Dec. 21, 2000), <https://abcnews.go.com/Primetime/story?id=132315&page=1> [<https://perma.cc/Q8N2-FY32>].

5. FISHER, *supra* note 1, at 131.

6. Dave Itzkoff, *Carrie Fisher, Child of Hollywood and ‘Star Wars’ Royalty, Dies at 60*, N.Y. TIMES (Dec. 27, 2016), <https://www.nytimes.com/2016/12/27/movies/carrie-fisher-dead-star-wars-princess-leia.html> [<https://perma.cc/7LRL-7ASA> (dark archive)].

7. Ben Child, *Carrie Fisher Admits Taking Cocaine on Set of The Empire Strikes Back*, GUARDIAN (Oct. 12, 2010), <https://www.theguardian.com/film/2010/oct/12/carrie-fisher-cocaine-star-wars> [<https://perma.cc/YMF6-DE3Y>].

8. Itzkoff, *supra* note 6.

9. Gene Maddaus, *Carrie Fisher Had Cocaine, Heroin, Ecstasy in Her System, Autopsy Shows*, VARIETY (June 19, 2017, 9:15 AM), <https://variety.com/2017/biz/news/carrie-fisher-autopsy-cocaine-heroin-ecstasy-1202470282/> [<https://perma.cc/G7CN-K23A>] (“The coroner’s report listed sleep apnea as the primary cause of death, with drug intake as a contributing factor. . . . Fisher died on Dec. 27, four days after going into cardiac arrest on an airplane arriving at LAX from London. The report states that Fisher’s assistant was on the plane with her. The assistant reported that she was awake and normal at the beginning of the flight, but had ‘multiple apneic episodes, which was her baseline’ during the flight. At the end of the flight, she could not be awoken.”).

Abilify.¹⁰ In her memoir, Fisher described her bipolar states by name: Rollicking Roy, “the wild ride of a mood,” and Sediment Pam, “who stands on the shore and sobs.”¹¹

Although Fisher is a well-known example of a person with both a substance use disorder and a mental health disorder, this type of diagnosis is not uncommon. Like Fisher, when an individual meets clinical criteria for both a substance use disorder and a mental health disorder, that person is said to have a co-occurring disorder, or a “dual-diagnosis.”¹² Approximately 8.9 million American adults have co-occurring mental health and substance use disorders,¹³ and “the services of the mental health and substance abuse treatment systems will be needed by a substantial number of Americans at one time or another in their lifetime.”¹⁴ Rates of co-occurring disorders are high because addiction often occurs concurrently with or contributes to many different medical conditions, including physical conditions like heart disease,¹⁵ as well as mental health and behavioral disorders like depression and anxiety.¹⁶ In fact, a major risk factor for addiction is the presence of mental illness.¹⁷

Addiction and mental illness also share a painful history in which people with one or both diagnoses “endured institutions that offered no treatment, ineffective treatment, or well-intentioned treatment that did harm.”¹⁸ Because of historical stigmatization, some individuals with substance use disorders, mental health disorders, or

10. *Id.*

11. FISHER, *supra* note 1, at 121 (“One mood is the meal and the next mood is the check.”).

12. Priester et al., *supra* note 3, at 47; *see also* TIP, *supra* note 3, at 3.

13. Priester et al., *supra* note 3, at 47.

14. Stanley Sacks, Redonna Chandler & Junius Gonzales, *Responding to the Challenge of Co-Occurring Disorders: Suggestions for Future Research*, 34 J. SUBSTANCE ABUSE TREATMENT 139, 140 (2008).

15. *See Mental Health and Heart Health*, AM. HEART ASS’N (Apr. 18, 2018), <https://www.heart.org/en/healthy-living/healthy-lifestyle/mental-health-and-wellbeing/mental-health-and-heart-health> [<https://perma.cc/5KD7-8M4H>].

16. *See* Kathleen T. Brady & Rajita Sinha, *Co-Occurring Mental and Substance Use Disorders: The Neurobiological Effects of Chronic Stress*, 162 AM. J. PSYCHIATRY 1483, 1483 (2005) (“The high rate of co-occurrence of substance use disorders and other psychiatric disorders is well established.”).

17. M. Tyler Boden & Rudolf Moos, *Dually Diagnosed Patients’ Responses to Substance Use Disorder Treatment*, 37 J. SUBSTANCE ABUSE TREATMENT 335, 335 (2009) (“The prevalence of psychiatric disorders among individuals with substance use disorders (SUDs) is quite high, with estimates ranging from 18% to 70% among those seeking treatment for SUDs.”).

18. 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).

some combination of the two first receive treatment as a result of their involvement with the criminal justice system. A recent study by the Department of Justice assessed over one million state prison, federal prison, and local jail inmates for mental health problems and found that 55% of all inmates had “a recent history or symptoms of a mental health problem” that had occurred in the previous twelve months.¹⁹ Moreover, among inmates with a mental health problem, between 64% and 76% had a co-occurring substance use disorder.²⁰ Those with mental health problems were also more likely to abuse illegal drugs and alcohol and to have a family history of substance abuse.²¹

While all federal penitentiaries and most state prisons and jails do provide some mental health services to inmates,²² many other individuals first enter into treatment after they have been arrested and diverted to a specialty court. The first specialty courts were drug courts, which were created to provide treatment and services to individuals whose involvement with the criminal justice system was likely due to an underlying addiction.²³ The first drug court was established in Florida in 1989, and today there are over 2500 drug courts across every state in the country.²⁴ As the drug court model grew in popularity, states began establishing other specialty courts,

19. DORIS J. JAMES & LAUREN E. GLAZE, *MENTAL HEALTH PROBLEMS OF PRISON AND JAIL INMATES 1* (Tina Dorsey et al. eds., 2006) (“At midyear 2005 more than half of all prison and jail inmates had a mental health problem, including 705,600 inmates in State prisons, 78,800 in Federal prisons, and 479,900 in local jails. These estimates represented 56% of State prisoners, 45% of federal prisoners, and 64% of jail inmates. The findings in this report were based on data from personal interviews with State and Federal prisoners in 2004 and local jail inmates in 2002.”).

20. *Id.* at 6 (“Among inmates who had a mental health problem, local jail inmates had the highest rate of dependence or abuse of alcohol or drugs (76%), followed by State prisoners (74%), and Federal prisoners (64%) Substance dependence or abuse was measured as defined in the DSM-IV. Among inmates without a mental health problem, 56% in State prisons, 49% in Federal prisons, and 53% in local jails were dependent on or abused alcohol or drugs.”).

21. *Id.* at 6 tbl.6.

22. *Id.* at 9 (“State prisoners who had a mental health problem (34%) had the highest rate of mental health treatment since admission, followed by federal prisoners (24%) and local jail inmates (17%).”).

23. RYAN S. KING & JILL PASQUARELLA, *THE SENTENCING PROJECT, DRUG COURTS: A REVIEW OF THE EVIDENCE 1* (2009), <http://www.sentencingproject.org/wp-content/uploads/2016/01/Drug-Courts-A-Review-of-the-Evidence.pdf> [https://perma.cc/H45F-K2P2].

24. *Id.*; see also JUSTICE POLICY INST., *ADDICTED TO COURTS: HOW A GROWING DEPENDENCE ON DRUG COURTS IMPACTS PEOPLE AND COMMUNITIES 18–20* (2011), http://www.justicepolicy.org/uploads/justicepolicy/documents/addicted_to_courts_final.pdf [https://perma.cc/5AV2-SV37].

including mental health courts,²⁵ as well as alcohol and driving while intoxicated (“DWI”) courts.²⁶

These specialty courts offer would-be defendants “the choice of participating in an intensive court-monitored treatment program as an alternative to the normal adjudication process.”²⁷ As this Article will explore, however, not all specialty courts are created equal. Unlike drug and alcohol courts, which focus on drug- and alcohol-related charges and often have a more punitive focus,²⁸ mental health courts are often described as “treatment courts” and have the stated goal of connecting participants to available community resources.²⁹ Furthermore, this segregated specialty court model is 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. As a result, these segregated courts perpetuate the stigma surrounding addiction by categorizing individuals with a substance use disorder differently than individuals with a broader mental health disorder. Moreover, both drug and mental health courts often fail to provide appropriate treatment for the multiple disorders a single

25. Other specialty courts include tribal courts, reentry courts, DWI courts, juvenile drug courts, domestic violence courts, truancy courts, prostitution courts, and homelessness courts, among others. JUSTICE POLICY INST., *supra* note 24, at 18–20; see also WEST HUDDLESTON & DOUGLAS B. MARLOWE, U.S. DEP’T OF JUSTICE, PAINTING THE CURRENT PICTURE: A NATIONAL REPORT ON DRUG COURTS AND OTHER PROBLEM-SOLVING COURT PROGRAMS IN THE UNITED STATES 68 (2011), <http://www.ndci.org/sites/default/files/nadcp/PCP%20Report%20FINAL.PDF> [<https://perma.cc/WH65-WD7Y>] (“The extraordinary success of Adult Drug Courts has produced a wide variety of other types of Drug Court programs.”).

26. SUZANNE M. STRONG, RAMONA R. RANTALA & TRACEY KYCKELLHAHN, U.S. DEP’T OF JUSTICE, CENSUS OF PROBLEM-SOLVING COURTS, 2012, at 1 (2016), <https://www.bjs.gov/content/pub/pdf/cpsc12.pdf> [<https://perma.cc/5EZ3-GDUW>].

27. JAMES L. NOLAN, JR., REINVENTING JUSTICE: THE AMERICAN DRUG COURT MOVEMENT 5 (2001).

28. Patricia A. Griffin, Henry J. Steadman & John Petrila, *The Use of Criminal Charges and Sanctions in Mental Health Courts*, 53 PSYCHIATRIC SERVS. 1285, 1288 (2002) (“The use of punishment is considered a core feature of drug courts and is used routinely in that setting.”); see also U.S. DEP’T OF JUSTICE, MENTAL HEALTH COURTS: A PRIMER FOR POLICYMAKERS & PRACTITIONERS 9 (2008), <https://csgjusticecenter.org/wp-content/uploads/2012/12/mhc-primer.pdf> [<https://perma.cc/VH7M-33UG>] (noting the difference between drug courts and mental health courts).

29. LAUREN ALMQUIST & ELIZABETH DODD, COUNCIL OF STATE GOV’TS JUSTICE CTR., MENTAL HEALTH COURTS: A GUIDE TO RESEARCH-INFORMED POLICY AND PRACTICE 2 (2009), https://www.bja.gov/Publications/CSG_MHC_Research.pdf [<https://perma.cc/9FVV-H42F>] (citing several studies and observing that “[m]ental health courts have several goals: to improve public safety by reducing the recidivism rates of people with mental illnesses, to reduce corrections costs by providing alternatives to incarceration, and to improve the quality of life of people with mental illnesses by connecting them with treatment and preventing re-involvement in the criminal justice system”).

individual might present. This Article argues that drug, alcohol, and mental health courts should move away from their traditional, siloed approach to the selection and treatment of participants and instead provide individuals with comprehensive, evidence-based treatment for co-occurring substance use and mental health disorders.

Part I of this Article examines the evolution of the current specialty court model, including the historical forces that helped create the current siloed approach to treatment. This Part also considers some of the obstacles to the provision of integrated treatment for co-occurring mental health and substance use disorders. Part II discusses contemporary scientific understanding of the disease of addiction and its diagnosis. Part III explores the prevalence of co-occurring disorders, focusing particularly on the rates of co-occurring substance use and mental health disorders. Part IV describes current best practices for treatment of individuals with co-occurring disorders, as well as the significant dearth of training opportunities for treatment providers. Finally, Part V examines the role of specialty courts in the provision of treatment services for co-occurring mental health and substance use disorders. This Part argues that drug, alcohol, and mental health courts should be integrated both because substance use disorder is a mental illness that should no longer be relegated to the fringes of the mental health system and because co-occurring disorders in specialty court participants should be “expected rather than considered an exception.”³⁰ Finally, this Part highlights the need for specialty court judges, staff, and policymakers to become better educated about advances in the research and treatment of co-occurring disorders because our greater understanding of co-occurring disorders “will be useful only if there is a treatment system in place to implement these findings.”³¹

I. ABOUT A REVOLUTION: SPECIALTY COURTS AND THE CRIMINAL JUSTICE SYSTEM

*The Miami-Dade Drug Court sparked a national revolution that has forever changed our justice system.*³²

30. Kenneth Minkoff, *Developing Standards of Care for Individuals with Co-Occurring Psychiatric and Substance Use Disorders*, 52 PSYCHIATRIC SERVS. 597, 597 (2001).

31. Brady & Sinha, *supra* note 16, at 1490 (“[C]hange at public policy levels will be necessary to maximize the benefits derived from the findings of neurobiological explorations in order to improve the lives of individuals with comorbidity.”).

32. *History*, NAT’L CTR. FOR DWI CTS., <https://www.dwicourts.org/uncategorized/drug-court-history/> [https://perma.cc/9U7N-JRC3].

The first drug court was established in Miami-Dade County, Florida, in 1989.³³ This special court was originally conceived as a way to divert individuals with drug addiction out of the criminal justice system and address the underlying addiction that led to the individual's arrest.³⁴ Drug courts draw on therapeutic goals and seek to provide addiction treatment to individuals whose involvement with the criminal justice system is likely due to an underlying addiction.³⁵ Drug courts offer criminal defendants with substance use disorders the option of receiving court-monitored treatment, where the court itself directs and guides the treatment process.³⁶ In addition to these therapeutic goals, however, drug courts also evolved as a more practical response to the huge number of criminal cases on court calendars, where many defendants with substance use disorders "swamped the unprepared criminal justice system."³⁷

Drug and other specialty courts have been widely praised as "revolutionary" and "innovative."³⁸ Indeed, "[t]he idea that the drug court is an innovative form of justice is repeated like a mantra by its supporters."³⁹ Moreover, as one Louisville drug court judge observed,

33. KING & PASQUARELLA, *supra* note 23, at 1; *see also* NOLAN, *supra* note 27, at 5 ("The burgeoning drug court movement first developed in response to the growing number of drug cases overcrowding America's criminal court calendars.").

34. STRONG ET AL., *supra* note 26, at 1.

35. KING & PASQUARELLA, *supra* note 23, at 1; *see also* Michelle Edgely, *Why Do Mental Health Courts Work? A Confluence of Treatment, Support & Adroit Judicial Supervision*, 37 INT'L J.L. & PSYCHIATRY 572, 572 (2014) (describing mental health courts, which grew out of the original drug court model, as "us[ing] a therapeutic jurisprudence orientation to seek to reduce recidivism"); Michael L. Perlin, "The Judge, He Cast His Robe Aside": *Mental Health Courts, Dignity and Due Process*, 3 MENTAL HEALTH L. & POL'Y J. 1, 2-3 (2013) (describing mental health courts as "significant because of their articulated focus on dignity, as well as their embrace of therapeutic jurisprudence, their focus on procedural justice, and their use of the principles of restorative justice").

36. NOLAN, *supra* note 27, at 39-40.

37. JANINE M. ZWEIG ET AL., URBAN INST. JUSTICE POLICY CTR., 2 THE MULTI-SITE ADULT DRUG COURT EVALUATION 7 (Shelli B Rossman et al. eds., 2011) (citing various studies). The report details a number of reasons for the increase in criminal drug charges, including "drug use prevalence, the crack cocaine epidemic of the 1980s, and changes in legislation and criminal codes." *Id.* These factors resulted in a "nearly three-fold increase in drug and drug-related arrests" during the last quarter of the twentieth century. *Id.*; *see also* Peggy Fulton Hora, William G. Schma & John T.A. Rosenthal, *Therapeutic Jurisprudence and the Drug Treatment Court Movement: Revolutionizing the Criminal Justice System's Response to Drug Abuse and Crime in America*, 74 NOTRE DAME L. REV. 439, 449 (1999) (noting that the focus of the first drug courts was "aimed squarely at preventing the collapse of local court systems under the weight of drug cases").

38. NOLAN, *supra* note 27, at 5 ("Judges celebrate the drug court as an exciting movement, a new way of justice, even a revolution in American jurisprudence.").

39. Eric J. Miller, *Embracing Addiction: Drug Courts and the False Promise of Judicial Interventionism*, 65 OHIO ST. L.J. 1479, 1503 n.137 (2004); *see also* Hora et al.,

the drug court model is “totally a grassroots kind of thing.”⁴⁰ These courts typically developed as a way to address a jurisdiction’s particular needs at a local level.⁴¹ The courts are often created by individual judges who then work to gain public support, gathering at national conferences to “strategize about the ways they can get outsiders to accept and support the drug court program.”⁴² This is not entirely surprising, given that judges are on the ground—witnesses to the institutional realities of enormous criminal calendars, overcrowded prisons, and huge recidivism rates—and need to come up with some other method for dealing with the large number of criminal defendants charged with drug crimes.⁴³ As one author put it, “[t]he first [drug] courts were the product of local innovation and ‘elbow grease[]’”⁴⁴

While the praise has not been unanimous,⁴⁵ the drug court model has proved popular and received generally positive news coverage and public support.⁴⁶ Inspired by the success of the original drug court model, judges began creating other specialty courts, including mental health courts, family courts, youth specialty courts, DWI courts, domestic violence courts, veterans courts, tribal wellness courts, and

supra note 37, at 440 (describing the “existence, breadth, and importance of the [drug court] movement in this country”).

40. NOLAN, *supra* note 27, at 42 (quoting Louisville Drug Court Judge Henry Weber, who notes that while drug courts do receive federal dollars, the movement itself is “not something where the bureaucrats in Washington tell you what to do”).

41. *Id.*

42. *Id.* at 42–43 (“The Drug Court movement is essentially a judge-led movement.”); see also MITCHELL B. MACKINEM & PAUL HIGGINS, *DRUG COURT: CONSTRUCTING THE MORAL IDENTITY OF DRUG OFFENDERS* 61 (2008) (“[J]udges often lead the effort for the establishment of drug court.”).

43. NOLAN, *supra* note 27, at 44 (noting that “the criminal justice system was faced with a situation where something new had to be tried” and citing a common refrain from drug court officials that “what we were doing before simply was not working”).

44. John S. Goldkamp, *The Drug Court Response: Issues and Implications for Justice Change*, 63 ALB. L. REV. 923, 948 (2000).

45. For an excellent overview of some of the common objections to the drug court model, see generally JUSTICE POLICY INST., *supra* note 24; Sara Gordon, *The Use and Abuse of Mutual-Support Programs in Drug Courts*, 2017 ILL. L. REV. 1503, 1541 (2017) (“Even when individuals are required by courts to receive treatment, much of the treatment they receive is not evidence-based and is not delivered in licensed facilities by qualified providers.”); Morris B. Hoffman, *The Drug Court Scandal*, 78 N.C. L. REV. 1437, 1477 (2000) (“By simultaneously treating drug use as a crime and as a disease, without coming to grips with the inherent contradictions of those two approaches, drug courts are not satisfying either the legitimate and compassionate interests of the treatment community or the legitimate and rational interests of the law enforcement community.”).

46. NOLAN, *supra* note 27, at 5 (noting that problem-solving courts received “almost uniformly positive media coverage and overwhelming public support at both the national and local levels”).

many others.⁴⁷ The Bureau of Justice Statistics's most recent census of specialty courts counted 3052 specialty courts in the United States.⁴⁸ Other researchers suggest the number of drug and other specialty courts is even higher, estimating that there are over 2400 drug treatment courts and more than 1000 additional specialty courts in the United States, the majority of which use the same drug court model.⁴⁹

47. Edgely, *supra* note 35, at 572; *see also* JUSTICE POLICY INST., *supra* note 24, at 18–20; STRONG ET AL., *supra* note 26, at 1. Other specialty courts include gambling court, prostitution court, campus court, and many others. JUSTICE POLICY INST., *supra* note 24, at 18–20.

Due to the popularity of drug courts, many states and localities have expanded on this model to address other social issues experienced by people involved in the justice system. . . . Here are some of the current specialty courts in place around the country[:]

Tribal Healing and Wellness Court

A component of the tribal justice system, the Tribal Healing and Wellness Courts were created to address alcohol and drug misuse in tribal communities. It is based on the traditional drug court model, but is tailored to the unique needs of the tribal community and incorporate[s] culture and tradition. . . .

Reentry Court

Started in 2000 by the Office of Justice Programs' Reentry Court Initiative, reentry drug courts were created to aid the unique process of moving from prison into the community. . . .

Juvenile Drugs Court

The juvenile drug court is a special docket within a juvenile court that is assigned to a designated judge and involves intensive treatment and supervision services for youth with delinquency or status offenses who are considered drug-involved. . . .

Community Court

The community courts deal with quality of life crimes within a community, such as prostitution, vandalism, or petty theft. . . .

Gambling Court

Gambling court operates through existing drug courts, selecting specific cases involving people who have a pending criminal charge and suffer from pathological or compulsive gambling disorders that may have resulted in illegal activity. . . .

Truancy Court

Truancy courts are designed to identify and assist with the underlying causes of truancy occurring in a child's life. . . .

Id. at 18–19.

48. STRONG ET AL., *supra* note 26, at 1.

49. HUDDLESTON & MARLOWE, *supra* note 25, at 1. According to this report, as of December 31, 2009, there were a total of 3648 drug courts and other specialty courts. *Id.* Of these, approximately 2459 were drug courts and the remainder were other specialty courts. *Id.*

One recent study found that more than 55,000 people enter drug court each year and “about 515 million dollars is spent annually to treat those drug court clients.”⁵⁰

In the early days of drug courts, messaging was key, as was the need for funding. In 1994, a group of “pioneers” from twelve early drug courts formed the National Association of Drug Court Professionals (“NADCP”), a nonprofit group tasked with creating “a common-sense approach to improving the justice system by using a combination of judicial monitoring and effective treatment to compel drug-using offenders to change their lives.”⁵¹ The NADCP is committed to persuading legislators, local judges, and the general public of these “guiding principles” through legislative lobbying, press conferences, and an “ongoing media blitz that landed Drug Courts and the NADCP on all major television networks and in *Newsweek*, *USA Today*, *The Washington Post*, *The New York Times*, and countless other newspapers.”⁵² The NADCP has also worked to improve the public’s perception of drug and specialty courts and recently launched “All Rise,” a public awareness campaign starring celebrities, including Matthew Perry, Martin Sheen, and Trey Anastasio.⁵³

According to the NADCP, these efforts have resulted in “historical” and “staggering” increases in federal funding for specialty

50. AVINASH SINGH BHATI, JOHN K. ROMAN & AARON CHALFIN, URBAN INST. JUSTICE POLICY CTR., *TO TREAT OR NOT TO TREAT: EVIDENCE ON THE PROSPECTS OF EXPANDING TREATMENT TO DRUG-INVOLVED OFFENDERS* xi–xii (2008), <https://www.urban.org/sites/default/files/publication/31621/411645-To-Treat-or-Not-to-Treat.PDF> [<https://perma.cc/6DGH-7865>]; see also NOLAN, *supra* note 27, at 43 (noting that the drug court model has spread to other countries, including Canada, Australia, and England).

51. *About NADCP*, NAT’L CTR. FOR DWI CTS., <https://www.dwicourts.org/uncategorized/about-nadcp/> [<https://perma.cc/39KR-KLGV>].

52. *Id.* (“In 2006, NADCP launched a massive campaign to put a Drug Court within reach of every American in need. NADCP has aggressively pursued its vision and achieved a renewed commitment for Drug Courts among Congress and the general public alike.”).

53. Nick Gillie & West Huddleston, “*All Rise!*”: *A Better Way of Justice Is Now in Session*, HUFFPOST (Aug. 21, 2009, 5:12 AM), https://www.huffingtonpost.com/nick-gillie/all-rise-a-better-way-of_b_242101.html [<http://perma.cc/84WH-SDTM>]; see also All Rise, *Martin Sheen: All Rise!*, YOUTUBE (Nov. 29, 2011), <https://www.youtube.com/watch?v=YjVQB4EvytI> [<http://perma.cc/AQ5Z-544L>]; All Rise, *Matthew Perry Accepts the All Rise Ambassador Award for His Dedication to Drug Court Advocacy*, YOUTUBE (Aug. 3, 2011), <https://www.youtube.com/watch?reload=9&v=1SJSblulFqA> [<http://perma.cc/242E-XJ8R>]; *Trey Anastasio Given Award by National Association of Drug Court Professionals*, HEADCOUNT (Jul. 22, 2011), <https://www.headcount.org/trey-anastasio-given-award-by-national-association-of-drug-court-professionals/> [<http://perma.cc/9CP2-PL3A>].

courts.⁵⁴ Whether due to the promotional work of the NADCP or to other factors, it is the case that drug and other specialty courts receive significant financial support from both the federal government and from state and local entities.⁵⁵ In 1995, the U.S. Department of Justice opened the Drug Courts Program Office, which awards grants to existing and emerging drug courts.⁵⁶ Today, however, the majority of specialty courts are funded by state grants or through the state budget. In 2012, for example, 60% of courts received some funding from the state, 23% were funded entirely by the state, and 20% received up to half of their funding from court fees or fines.⁵⁷

In addition to support from individual states, federal funding for specialty courts has remained robust, in part due to the increasing recognition of a nationwide opioid epidemic.⁵⁸ In July 2017, for example, the U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration (“SAMHSA”) announced grant funding of up to \$80.8 million for adult drug courts.⁵⁹ And in September 2017, Attorney General Jeff Sessions announced that the Department of Justice would award about \$24 million in federal grants to assist state and local governments in creating “comprehensive diversion and alternatives to incarceration programs for those impacted by the opioid epidemic.”⁶⁰

In addition to its fundraising initiatives, the NADCP also considers itself responsible for much of the training received by specialty court judges and court personnel. As part of these training

54. *About NADCP*, *supra* note 51.

55. NOLAN, *supra* note 27, at 42 (“It’s probably the only movement in the judicial system that has bubbled up from the grassroots to the Federal government.”).

56. *Id.* at 41–42 (“In fiscal year 1995 the office granted \$12 million in grants to drug courts. This increased to \$15 million in 1996, to \$30 million in both 1997 and 1998, and then to \$40 million in 1999.”).

57. STRONG ET AL., *supra* note 26, at 12.

58. *See, e.g.*, Maya Salam, *The Opioid Epidemic: A Crisis Years in the Making*, N.Y. TIMES (Oct. 26, 2017), <https://www.nytimes.com/2017/10/26/us/opioid-crisis-public-health-emergency.html> [<https://perma.cc/S268-RE7A> (dark-archive)].

59. *Announces \$80.8 Million in Grants for Adult and Family Treatment Drug Courts, and Adult Tribal Healing to Wellness Courts*, U.S. DEP’T HEALTH & HUM. SERVS. (July 14, 2017), <https://www.hhs.gov/about/news/2017/07/14/hhs-announces-808-million-grants-adult-and-family-treatment-drug-courts-and-adult-tribal-healing.html> [<https://perma.cc/FW28-BARJ>] (“The actual award amounts may vary, depending on the availability of funds.”). However, “[f]ewer than a quarter (23%) of these courts operating in 2012 reported that they received some federal grants to support their programs.” STRONG ET AL., *supra* note 26, at 12.

60. *Department of Justice Awards Nearly \$59 Million to Combat Opioid Epidemic, Fund Drug Courts*, U.S. DEP’T JUST. (Sept. 22, 2017), <https://www.justice.gov/opa/pr/departement-justice-awards-nearly-59-million-combat-opioid-epidemic-fund-drug-courts> [<https://perma.cc/4WUS-WYVL>].

efforts, the NADCP created the National Drug Court Institute, “the definitive authority on the latest research, best practices, and cutting-edge innovations to treat offenders facing substance use and mental health disorders.”⁶¹ According to its website, the NADCP has trained over 36,000 drug court judges and court personnel and distributes its educational materials to drug courts nationally and internationally.⁶² The NADCP also hosts an annual conference on specialty courts and criminal justice reform and drew more than 6000 drug court personnel to its 2018 conference in Houston, Texas.⁶³

The NADCP does recognize that large numbers of individuals who enter a drug, alcohol, or mental health court meet diagnostic criteria for both a substance use and mental health disorder. In 2011, it issued a resolution from its Board of Directors concluding that the NADCP will “actively collaborate with other organizations to advocate expansion of Drug Courts and Mental Health Courts which also effectively meet the needs of those participants with co-occurring disorders.”⁶⁴ Notwithstanding this recognition, however, and perhaps in part due to its history of individual judges tackling local problems, the vast majority of specialty courts are still targeted toward small segments of the population, accepting individuals into segregated gambling courts, homeless courts, or veterans courts.⁶⁵ In particular, the majority of individuals who enter a specialty court are referred into either drug, alcohol, or mental health court.⁶⁶

The original drug court model served as a basis for the development of alcohol and DWI courts, as well as mental health courts.⁶⁷ But, unlike drug courts, which focus on drug-related charges and often have a more punitive focus,⁶⁸ mental health courts are often

61. *About NDCI*, NAT’L DRUG CT. INST., <https://www.ndci.org/about-ndci/> [https://perma.cc/4Q7Q-7JLK].

62. *About NADCP*, *supra* note 51 (noting that it has “developed 37 publications, disseminating them to 456,166 professionals worldwide”).

63. Chris Deutsch, *Conference May Be Over but the Mission Continues*, NAT’L ASS’N DRUG CT. PROFS., <http://www.nadcp.org/nadcp-conference/conference-may-be-over-but-the-mission-continues/> [https://perma.cc/GRS2-VAY7].

64. NAT’L ASS’N OF DRUG COURT PROF’LS, RESOLUTION OF THE BOARD OF DIRECTORS ON IMPROVING OUTCOMES FOR JUSTICE INVOLVED PERSONS WITH MENTAL ILLNESSES INCLUDING THOSE WITH CO-OCCURRING SUBSTANCE ABUSE DISORDERS 3 (2011), <http://ndcrc.org/resource/improving-outcomes-for-justice-involved-persons-with-mental-illnesses-including-those-with-co-occurring-substance-abuse-disorders/> [https://perma.cc/QUB4-2RPD].

65. *See supra* Part I.

66. *See infra* Part V.

67. *See* JUSTICE POLICY INST., *supra* note 24, at 18; Edgely, *supra* note 35, at 572.

68. U.S. DEP’T OF JUSTICE, *supra* note 28, at 9; Griffin et al., *supra* note 28, at 1288; *see also* Philip Bean, *America’s Drug Courts: A New Development in Criminal Justice*, 1996

described as treatment courts and have the stated goal of connecting participants to available community resources.⁶⁹ As one author noted, “punishment is considered a core feature of drug courts and is used routinely in that setting,” while there is more reluctance to impose punishment “if the perceived cause of the criminal behavior is mental illness.”⁷⁰ Mental health courts, therefore, have a different focus than drug courts, and have been described as “not merely drug courts for people with mental illnesses.”⁷¹

When individuals are arrested for a drug-related charge, they are often diverted into a drug court.⁷² In contrast, mental health courts admit defendants charged with a variety of offenses.⁷³ Significantly, drug courts and mental health courts are often distinguished from one another due to the fact that “mental illness, unlike drug use, is, in and of itself, not a crime”⁷⁴ Moreover, unlike drug courts, which typically limit participants to nonviolent drug crimes,⁷⁵ many mental health courts are willing to accept participants who are charged with more serious felony offenses or violent crimes, in part because the longer sentences available for participants charged with felonies allow the court to coordinate and supervise community-based treatment for longer periods of time.⁷⁶

CRIM. L. REV. 718, 719 (“[T]he control exercised by Drug Courts means offenders can no longer manipulate the system as they have done hitherto. With up-to-date urinalysis, and daily reports from treatment providers, control is firm and obvious.”).

69. ALMQUIST & DODD, *supra* note 29, at 2 (describing a variety of goals for mental health courts, including goals “to improve public safety by reducing the recidivism rates of people with mental illnesses, to reduce corrections costs by providing alternatives to incarceration, and to improve the quality of life of people with mental illnesses by connecting them with treatment and preventing re-involvement in the criminal justice system”).

70. Griffin et al., *supra* note 28, at 1288.

71. U.S. DEP’T OF JUSTICE, *supra* note 28, at 9; John Petrila et al., *Preliminary Observations from an Evaluation of the Broward County Mental Health Court*, CT. REV., Winter 2001, at 14, 20 (noting that the difference between drug courts and mental health courts “is a fundamental one”).

72. Similarly, individuals arrested for an alcohol-related offense, like a DWI charge, are referred to an alcohol or DWI court, where the focus is “on changing the behavior of the alcohol-dependent offender” STRONG ET AL., *supra* note 26, at 2; *see also infra* text accompanying note 209.

73. U.S. DEP’T OF JUSTICE, *supra* note 28, at 9.

74. *Id.*

75. Few drug courts will accept a defendant who is charged with a violent crime, including felony domestic violence (20.1%) or misdemeanor violence (16.3%). ZWEIG ET AL., *supra* note 37, at 25–26, 26 tbl.2-2.5. Many courts explicitly exclude individuals charged with crimes against other people or against children. *See id.*

76. ALMQUIST & DODD, *supra* note 29, at 9 (“[S]ome jurisdictions decided to focus on people with felony charges to allow court professionals to engage participants in community-based treatment for longer periods of time, which was perceived as necessary

Yet high rates of co-occurring mental illness and substance use disorders “also suggests significant overlap in the target populations of these related court programs.”⁷⁷ In fact, some jurisdictions initially established mental health courts because existing drug courts did not have the resources to manage participants with serious mental illnesses.⁷⁸ Additionally, numerous studies have confirmed that rates of co-occurring disorders among mental health court participants are similar to those seen among the general population.⁷⁹ For example, 83% of participants in a Santa Barbara, California, mental health court had a co-occurring substance use diagnosis, while 59% of participants in the Anchorage, Alaska, mental health court and 56% of participants in the San Francisco, California, mental health court had a similar diagnosis.⁸⁰

This piecemeal approach where individuals with drug or alcohol related charges are assigned to drug court and other individuals are assigned to mental health court is contrary to the literature on co-occurring disorders, which indicates that co-occurring mental health and substance use disorders occur so frequently that they “should be expected rather than considered an exception.”⁸¹ If specialty courts are to continue providing “cutting-edge innovations to treat offenders facing substance use and mental health disorders,”⁸² the structure of the specialty court system should itself be changed to provide comprehensive and integrated treatment to participants. Unless specialty courts are restructured to eliminate the artificial barriers between drug, alcohol, and mental health courts, it seems unlikely that individual courts will be able to adequately address the huge

to produce positive outcomes. The longer stays for individuals charged with serious crimes was not longer than the prison sentences they would have faced if convicted.”). *But see* E. Lea Johnston & Conor P. Flynn, *Mental Health Courts and Sentencing Disparities*, 62 VILL. L. REV. 685, 693 (2017) (finding that mental health court sentences in an Erie County, Pennsylvania, court “typically exceed county court sentences by more than a year”); Ira Glass, *Very Tough Love*, THIS AM. LIFE (Mar. 25, 2011), <http://www.thisamericanlife.org/radio-archives/episode/430/very-tough-love> [https://perma.cc/Z5JX-D3DH] (describing the story of Lindsey Dills, a seventeen-year-old girl who forged two checks from her parents’ bank account, “one for \$40 and one for \$60,” and was a participant in drug court for almost six years. This time period included “14 months behind bars, and then . . . another five years after that—six months of it in Arrendale State Prison, the other four and a half on probation”).

77. U.S. DEP’T OF JUSTICE, *supra* note 28, at 9.

78. *Id.*

79. *See infra* Part III.

80. ALMQUIST & DODD, *supra* note 29, at 10.

81. Minkoff, *supra* note 30, at 597.

82. *About NDCI*, *supra* note 61.

number of individuals with co-occurring disorders who are diverted out of the criminal justice system and into specialty courts.

Moreover, and as discussed in the next part, substance use disorder is a brain disease, which is recognized and diagnosed like any other mental illness. The segregation of drug, alcohol, and mental health courts is yet another barrier to the widespread acceptance of addiction as a disease, one that should be evaluated and treated like any other mental health disorder, and not relegated to the fringes of mainstream medicine.

II. SUBSTANCE USE DISORDER: A MENTAL ILLNESS ON THE FRINGES

Substance use disorder—or addiction⁸³—is a complex brain disease that affects multiple parts of the brain, “including those involved in reward and motivation, learning and memory, and inhibitory control over behavior.”⁸⁴ The disease of addiction affects nearly 16% of Americans over the age of twelve—over forty million people—more than the number of people with heart disease, diabetes, or cancer.⁸⁵ An additional 31.7%, or 80.4 million people, “engages in risky use of addictive substances in ways that threaten [their] health and safety,” or the safety of others.⁸⁶ Addiction is also a chronic disorder, one that requires ongoing treatment and management.⁸⁷

83. Although the DSM-5 has eliminated the word “addiction,” many clinicians and researchers continue to use the term, and this Article will use both “addiction” and “substance use disorder” to encompass “substance use disorder” as it is defined in the DSM-5. AM. PSYCHIATRIC ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 483 (5th ed. 2013) [hereinafter DSM-5].

84. Nora D. Volkow, *Preface to the Third Edition* of NAT’L INST. ON DRUG ABUSE, PRINCIPLES OF DRUG ADDICTION TREATMENT: A RESEARCH BASED GUIDE 3, 3 (3d ed. 2018), <https://d14rmgtrwzf5a.cloudfront.net/sites/default/files/675-principles-of-drug-addiction-treatment-a-research-based-guide-third-edition.pdf> [<https://perma.cc/44T4-5QEY>]; Charles Dackis & Charles O’Brien, *Neurobiology of Addiction: Treatment and Public Policy Ramifications*, 8 NATURE NEUROSCIENCE 1431, 1431 (2005) (noting that, in the United States, the “public . . . views addiction more as a social problem than an actual disease, despite scientific evidence supporting a disease concept of addiction based on neuronal mechanisms, heritability, treatment responses and a characteristic progressive clinical course”).

85. Drew E. Altman, *Preface* to NAT’L CTR. ON ADDICTION & SUBSTANCE ABUSE AT COLUMBIA UNIV., ADDICTION MEDICINE, CLOSING THE GAP BETWEEN SCIENCE AND PRACTICE, at i, i (2012) <https://www.centeronaddiction.org/download/file/fid/1177> [<https://perma.cc/R5Z5-4E4H>] (“Addiction affects 16 percent of Americans ages 12 and older—40 million people. That is more than the number of people with heart disease (27 million), diabetes (26 million) or cancer (19 million).”).

86. *Id.* at 1.

87. *Id.* at 7.

The field of addiction research has grown significantly over the last several decades, beginning with animal models and expanding to include neuroimaging studies of the brains of individuals with addiction.⁸⁸ The literature on addiction has consistently demonstrated a biological basis for the disease and has established that addiction is a disease that affects the reward centers of the brain.⁸⁹ In turn, these reward centers affect motivation and have evolved to control human behavior that is directed toward survival goals, even in the presence of danger.⁹⁰ Addictive substances “essentially hijack brain circuits that exert considerable dominance over rational thought, leading to progressive loss of control over drug intake in the face of medical, interpersonal, occupational and legal hazards.”⁹¹ The continued use of addictive substances can physically alter the structure and functioning of the brain and result in changes to the brain that remain even after the individual has stopped taking the drug.⁹² Moreover, the disease has significant behavioral characteristics; addiction to a substance can cause the individual to engage in behavior even when that behavior results in unfavorable consequences.⁹³

There is some debate in the addiction literature about how to appropriately characterize the disease of addiction, and “the discourse around addiction remains contentious and complex.”⁹⁴

88. Dackis & O’Brien, *supra* note 84, at 1431 (“Much of our knowledge about addiction neurobiology is based on decades of animal studies that model the dynamic clinical components of the illness.”).

89. *Id.*

90. *Id.* (“Given their function, reward centers have evolved the ability to grip attention, dominate motivation and compel behavior directed toward survival goals, even in the presence of danger and despite our belief that we are generally rational beings.”).

91. *Id.*; see also Alan I. Leshner, *Addiction Is a Brain Disease*, ISSUES SCI. & TECH., Spring 2001, at 75, 75 [hereinafter Leshner, *A Brain Disease*] (“It is as if drugs have hijacked the brain’s natural motivational control circuits, resulting in drug use becoming the sole, or at least the top, motivational priority for the individual.”).

92. NAT’L INST. ON DRUG ABUSE, *supra* note 84, at 5; see also DSM-5, *supra* note 83, at 483 (“An important characteristic of substance use disorders is an underlying change in brain circuits that may persist beyond detoxification, particularly in individuals with severe disorders.”); Alan I. Leshner, *Addiction Is a Brain Disease, and It Matters*, 278 SCIENCE 45, 46 (1997) (“Significant effects of chronic use have been identified for many drugs at all levels: molecular, cellular, structural, and functional. The addicted brain is distinctly different from the non-addicted brain, as manifested by changes in brain metabolic activity, receptor availability, gene expression, and responsiveness to environmental cues.”).

93. NAT’L INST. ON DRUG ABUSE, *supra* note 84, at 3.

94. Rachel Hammer et al., *Addiction: Current Criticism of the Brain Disease Paradigm*, 4 AM. J. BIOETHICS NEUROSCIENCE 27, 28 (2013); see also Daniel Z. Buchman, Wayne Skinner & Judy Illes, *Negotiating the Relationship Between Addiction, Ethics, and Brain Science*, AM. J. BIOETHICS NEUROSCIENCE 36, 42 (2010) (“Neuroethics challenges arise when knowledge exclusively from neuroscience is deemed adequate to

Some researchers believe that the current emphasis on a brain-disease model is a well-intentioned attempt to “debunk[] the moralized argument that addiction is a problem for weak-willed people.”⁹⁵ These commentators suggest a biological understanding of addiction, one that uses biology to explain a condition with social ramifications. Viewed in this light, addiction is “a chronic, relapsing, biopsychosocial disorder that cannot be understood apart from social context” and not simply a brain disease.⁹⁶

Further complicating the conversation about addiction as a disease is the fact that it is a disease that begins when an individual voluntarily engages in substance use, and many “erroneously still believe that drug addiction is simply a failure of will or of strength of character.”⁹⁷ And even if we accept that addiction is a disease of the brain, it is still the case that the addicted individual has a significant role to play both in her illness and her recovery. Yet, while it is true that “having this brain disease does not absolve the addict of responsibility for his or her behavior, . . . it does explain why an addict cannot simply stop using drugs by sheer force of will alone.”⁹⁸ The literature on addiction also overwhelmingly supports the need for a “much more sophisticated approach to dealing with the array of problems surrounding drug abuse and addiction in our society.”⁹⁹

Even in the face of this ongoing debate about the definition of addiction, however, “the majority of the biomedical community now considers addiction, in its essence, to be a brain disease: a condition caused by persistent changes in brain structure and function.”¹⁰⁰ And whether we characterize addiction as a brain disease, a

obtain a full understanding of a mental health disorder as complex as addiction. While the practicality of a biopsychosocial systems model may allow for a more integrative explanation for addiction, it does not explain addiction entirely.”).

95. Hammer et al., *supra* note 94, at 28. This article describes the concept of “othering” as a way in which human groups react to other “groups of people who exhibit unfavorable behavior or characteristics against the backdrop of cultural norms” and argues that “[t]hose who believe that diseasing addiction will reduce stigma fail to recognize how disease itself has its own stigma; the diseased are often just as set apart as ‘wretches’ and ‘sinners.’” *Id.* at 30.

96. *Id.* at 31 (“We are embodied beings. Biologically, that addiction rests on a neurochemical platform is evident and potentially useful. However, it is not necessary to frame addiction as a disease to access the benefits from biological addiction research.”); *see also* Buchman et al., *supra* note 94, at 37 (advocating “a biopsychosocial systems model of, and approach to, addiction, in which psychological and sociological factors complement and are in a dynamic interplay with neurobiological and genetic factors”).

97. Leshner, *A Brain Disease*, *supra* note 91, at 76.

98. *Id.*

99. *Id.*

100. *Id.* at 75.

biopsychosocial disorder, or “somewhere in a middle ground,”¹⁰¹ clinicians diagnose addiction using behavioral components. This diagnosis—like all other mental health diagnoses—is made using the Diagnostic and Statistical Manual, or DSM-5.¹⁰²

According to the DSM-5 diagnostic criteria, individuals can be diagnosed with a “substance use disorder” on a continuum from mild to severe.¹⁰³ Unlike older versions of the DSM, the most recent edition does not distinguish among substances, and almost all substances are diagnosed using the same set of behavioral criteria.¹⁰⁴ Significantly, the DSM-5 does not use the word “addiction”; although the word “addiction” is often used to describe “severe problems related to compulsive and habitual use of substances,” the DSM-5 uses the “more neutral term substance use disorder . . . to describe the wide range of the disorder, from a mild form to a severe state of chronically relapsing, compulsive drug taking.”¹⁰⁵

Perhaps mindful of the historical stigma associated with substance use, the authors of the DSM-5 chose to eliminate the word “addiction” “because of its uncertain definition and its potentially negative connotation.”¹⁰⁶ Similarly, and despite its longstanding inclusion in the DSM, substance use disorder and its treatment have

101. Hammer et al., *supra* note 94, at 27. As one author frankly notes,

The United States is stuck in its drug abuse metaphors and in polarized arguments about them. Everyone has an opinion. . . . People see addiction as either a disease or as a failure of will. None of this bumper sticker analysis moves us forward. The truth is that we will make progress in dealing with drug issues only when our national discourse and our strategies are as complex and comprehensive as the problem itself.

Leshner, *A Brain Disease*, *supra* note 91, at 75.

102. See DSM-5, *supra* note 83, at 483. The DSM is used by clinicians to identify and diagnose mental illness. The new version eliminated the separate diagnoses of substance “dependence” and “abuse” and replaced them with a single diagnosis of substance use disorder. AM. PSYCHIATRIC ASS’N, SUBSTANCE-RELATED AND ADDICTION DISORDERS 1 (2013) [hereinafter SUBSTANCE-RELATED AND ADDICTION DISORDERS], https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/DSM/APA_DSM-5-Substance-Use-Disorder.pdf [<https://perma.cc/8GYK-R7WA>].

103. DSM-5, *supra* note 83, at 484 (“Substance use disorders occur in a broad range of severity, from mild to severe, with severity based on the number of symptom criteria endorsed.”).

104. As the DSM-5 notes, “the diagnosis of a substance use disorder can be applied to all 10 classes included in this chapter except caffeine. For certain classes some symptoms are less salient, and in a few instances not all symptoms apply.” *Id.* at 483. The ten classes of addictive substances referenced in the DSM-5 include alcohol, caffeine, cannabis, hallucinogens, inhalants, opioids, sedatives, stimulants, and tobacco, among others. *Id.* at 482.

105. *Id.* at 485.

106. *Id.*

been historically marginalized “as a social problem rather than [treated] as a medical condition.”¹⁰⁷ In fact, few people who engage in either risky use or abuse of substances receive adequate, ongoing, evidence-based treatment.¹⁰⁸

Like treatment for other chronic diseases, “best practices for the effective treatment and management of addiction must be consistent with the scientific evidence of the causes and course of the disease.”¹⁰⁹ Evidence-based addiction treatment requires an initial comprehensive assessment of the patient, including a thorough history, physical exam, and psychosocial evaluation.¹¹⁰ Next, and before treatment begins, patients should be stabilized and receive medical management of withdrawal, or detoxification, if necessary.¹¹¹ The patient should then receive acute treatment, which should be provided by qualified health care professionals and should include treatment for any co-occurring physical or mental health conditions.¹¹² Next, the individual should receive chronic disease management to assist with maintenance of the progress achieved during treatment and to help prevent relapse.¹¹³ Finally, the patient should receive support services, which include wraparound services in the community, like legal, educational, employment, and housing support, and community-based mutual support programs.¹¹⁴

Despite our growing understanding of effective treatment for addiction, few people with a substance use disorder receive appropriate and ongoing evidence-based treatment.¹¹⁵ Unlike treatment for other mental health conditions, which is based on best

107. NAT'L CTR. ON ADDICTION & SUBSTANCE ABUSE AT COLUMBIA UNIV., *supra* note 85, at 4 (“This profound gap between the science of addiction and current practice related to prevention and treatment is a result of decades of marginalizing addiction as a social problem rather than treating it as a medical condition.”).

108. *Id.* at 131.

109. *Id.* at 9; *see also* AM. SOC'Y OF ADDICTION MED., PUBLIC POLICY STATEMENT ON TREATMENT FOR ALCOHOL AND OTHER DRUG ADDICTION 2 (2010), https://www.asam.org/docs/default-source/public-policy-statements/1treatment-4-aod-1-10.pdf?sfvrsn=4d7d8b19_0 [<https://perma.cc/Y3EA-9SK4>].

110. AM. SOC'Y OF ADDICTION MED., *supra* note 109, at 2; *see also* NAT'L CTR. ON ADDICTION & SUBSTANCE ABUSE AT COLUMBIA UNIV., *supra* note 85, at 9.

111. NAT'L CTR. ON ADDICTION & SUBSTANCE ABUSE AT COLUMBIA UNIV., *supra* note 85, at 9; *see also* AM. SOC'Y OF ADDICTION MED., *supra* note 109, at 2.

112. NAT'L CTR. ON ADDICTION & SUBSTANCE ABUSE AT COLUMBIA UNIV., *supra* note 85, at 9; *see also* AM. SOC'Y OF ADDICTION MED., *supra* note 109, at 2.

113. NAT'L CTR. ON ADDICTION & SUBSTANCE ABUSE AT COLUMBIA UNIV., *supra* note 85, at 9; *see also* AM. SOC'Y OF ADDICTION MED., *supra* note 109, at 2.

114. NAT'L CTR. ON ADDICTION & SUBSTANCE ABUSE AT COLUMBIA UNIV., *supra* note 85, at 9; *see also* AM. SOC'Y OF ADDICTION MED., *supra* note 109, at 2.

115. *See infra* Part IV.

practices and administered by highly trained medical professionals, the disease of addiction is often treated on the fringes of mainstream medicine. The treatment is provided in mutual support programs by individuals with little or no medical training and is rarely supervised by trained medical professionals.¹¹⁶ Physicians, nurses, and other trained medical professionals are typically consulted only when necessary.¹¹⁷ Often, individuals who seek out or are ordered into treatment receive “brief, episodic interventions,” which might be part of the explanation for high rates of relapse among substance abusers.¹¹⁸

Some researchers suggest that this disconnect between mainstream medicine and substance use treatment is due to the societal stigma of addiction, and that this stigma “contribute[s] to policies that would be simply unacceptable if applied to ‘real’ medical disorders.”¹¹⁹ Individuals with addiction are often treated not as patients but are instead blamed or criminalized for their behavior.¹²⁰ In turn, these attitudes are embraced by “[a]n uneducated yet strongly opinionated public [that] does not understand the technical field of addiction neurobiology and is more likely to conceptualize addiction as a character flaw . . . than a brain disease.”¹²¹

Instead of receiving evidence-based treatment for their illness, many individuals with a substance use disorder therefore go untreated, and for some, their first exposure to treatment can come as a result of diversion into a drug, alcohol, or mental health court. By segregating specialty courts in this way, however, we are further stigmatizing addiction and failing to acknowledge that drug and alcohol use disorders are one of the many types of mental illnesses recognized by the DSM-5.¹²² Furthermore, individuals who are diverted into drug or alcohol court often receive one type of

116. NAT’L CTR. ON ADDICTION & SUBSTANCE ABUSE AT COLUMBIA UNIV., *supra* note 85, at 212.

117. *Id.* (“Physicians and other medical professionals typically are absent from or on the periphery of the treatment process, occasionally being called in to provide a prescription or medically monitor a detoxification protocol.”).

118. *Id.* at 7.

119. Dackis & O’Brien, *supra* note 84, at 1431 (“Stigma and misconception create formidable obstacles to a more enlightened public policy toward addictive illness.”).

120. *Id.*

121. *Id.*

122. For a comprehensive discussion of the stigmatizing effects of the specialty court model, see generally Lea Johnson, *Theorizing Mental Health Courts*, 89 WASH. U. L. REV. 519, 540–43 (2012) (noting that mental health courts contribute to “impressions about offenders with mental illnesses that act synergistically to deepen and reinforce the stigma and isolation associated with mental illness”).

treatment—substance use treatment—much of which is not evidence based and is not delivered in licensed facilities by qualified providers.¹²³ Moreover, as discussed in the next part, many of these individuals are also likely to meet diagnostic criteria for an additional mental health disorder, a diagnosis that may remain unidentified and untreated in a traditional drug court.

III. PREVALENCE OF CO-OCCURRING MENTAL HEALTH AND SUBSTANCE USE DISORDERS

*Comorbidity is so common that dual diagnosis should be expected rather than considered an exception.*¹²⁴

Although many individuals will have some combination of mental health and substance use disorder at some point in their lifetime,¹²⁵ this Article focuses on individuals with a co-occurring substance use disorder and serious mental illness. As described above, substance use disorder refers to abuse or dependence on alcohol or illicit drugs and “is used to describe the wide range of the disorder, from a mild form to a severe state of chronically relapsing, compulsive drug [or alcohol] taking.”¹²⁶ “Serious mental illness” refers to individuals with a mental, behavioral, or emotional disorder that substantially interferes with or limits one or more major life activities.¹²⁷ Among individuals with a serious mental illness, “the most common and clinically significant” type of co-occurring disorder is substance use disorder.¹²⁸ About 1%, or 2.3 million American

123. Gordon, *supra* note 45, at 1539–41.

124. Minkoff, *supra* note 30, at 597.

125. See H. Westley Clark et al., *Policy and Practice Implications of Epidemiological Surveys on Co-Occurring Mental and Substance Use Disorders*, 34 J. SUBSTANCE ABUSE TREATMENT 3, 4–5 (2008). See generally U.S. DEP’T OF HEALTH & HUM. SERVS., THE EVIDENCE: INTEGRATED TREATMENT FOR CO-OCCURRING DISORDERS (2013) [hereinafter INTEGRATED TREATMENT], <https://store.samhsa.gov/system/files/theevidence-itc.pdf> [<https://perma.cc/QED4-GYZF>] (discussing effective treatment options for co-occurring disorders).

126. DSM-5, *supra* note 83, at 485.

127. According to the U.S. Department of Health and Human Services, mental illness “is the term that refers collectively to all diagnosable mental disorders. Mental disorders are health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning.” U.S. DEP’T. OF HEALTH & HUM. SERVS., MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL 5 (1999), <https://profiles.nlm.nih.gov/ps/access/NNBBHS.pdf> [<https://perma.cc/PG6C-SYYQ>]. A serious mental illness is one that “interferes with some area of social functioning.” *Id.* at 46.

128. Robert E. Drake et al., *A Review of Treatments for People with Severe Mental Illnesses and Co-Occurring Substance Use Disorders*, 27 PSYCHIATRIC REHABILITATION J. 360, 360 (2004) [hereinafter Drake et al., *A Review of Treatments*] (noting that while

adults, had both a serious mental illness and a substance use disorder in 2014.¹²⁹

Among individuals with a serious mental illness, as many as 40% have a co-occurring substance use disorder.¹³⁰ Similarly, among individuals with a substance use disorder, almost half have a co-occurring mental health disorder.¹³¹ Recent research into co-occurring disorders supports a strong association between mental health disorders and substance use disorders, but “the nature of the relationship is complex.”¹³² For a small number of individuals, one disorder can be caused by the other; for instance, long term substance use can, in some cases, damage the brain and lead to chronic mental health disorders.¹³³ Some studies have also found that the use of addictive substances like nicotine, alcohol, or marijuana actually increase an individual’s risk for developing a mental health condition like anxiety or depression.¹³⁴ In other cases—particularly in

terms like “dual diagnosis” and “dual disorders” are often used in the literature, they are “clearly misnomers, because the individuals with a co-occurring severe mental illness and a substance use disorder typically have multiple impairments rather than only two illnesses and because there are several other groups with dual diagnoses, such as people with developmental disabilities and mental illnesses”).

129. SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., BEHAVIORAL HEALTH TRENDS IN THE UNITED STATES: RESULTS FROM THE 2014 NATIONAL SURVEY ON DRUG USE AND HEALTH 33 (2015), <https://www.samhsa.gov/data/sites/default/files/NSDUH-FRR1-2014/NSDUH-FRR1-2014.pdf> [<https://perma.cc/9YZH-9M5D>] (noting that 3.3%, or 7.9 million people, met diagnostic criteria for any mental illness and a substance use disorder). *But see* Clark et al., *supra* note 125, at 5 (“[W]hen treating substance use disorders that co-occur with mental illness, the illness can be either severe or mild to moderate.”).

130. Katherine E. Watkins et al., *A National Survey of Care for Persons with Co-Occurring Mental and Substance Use Disorders*, 52 PSYCHIATRIC SERVS. 1062, 1062 (2001) [hereinafter Watkins et al., *A National Survey*]; *see also* Ronald C. Kessler et al., *The Epidemiology of Co-Occurring Addictive and Mental Disorders: Implications for Prevention and Service Utilization*, 66 AM. J. ORTHOPSYCHIATRY 17, 25 (1996) (noting in a discussion of two different studies, that “the [National Comorbidity Survey] found that 51% of those with a lifetime addictive disorder also had a lifetime mental disorder, compared to 38% in the [Epidemiological Catchment Area]”).

131. Watkins et al., *A National Survey*, *supra* note 130, at 1062.

132. Brady & Sinha, *supra* note 16, at 1484 (noting that “[s]everal theories have been proposed to explain the high co-occurrence”).

133. Watkins et al., *A National Survey*, *supra* note 130, at 1062.

134. Jeffrey G. Johnson et al., *Association Between Cigarette Smoking and Anxiety Disorders During Adolescence and Early Adulthood*, 284 [J]AMA 2348, 2350 (2000) (“Our findings are consistent with research suggesting that cigarette smoking may increase risk for certain anxiety disorders.”); *see also* George C. Patton et al., *Cannabis Use And Mental Health in Young People: Cohort Study*, 325 BRIT. MED. J. 1195, 1198 (2002) (“[F]requent use of cannabis in young people increases the risks of later depression and anxiety.”); Paul Rhode et al., *Natural Course of Alcohol Use Disorders from Adolescence to Young Adulthood*, 40 J. AM. ACAD. CHILD ADOLESC. PSYCHIATRY 83, 83 (2001) (“Adolescent [alcohol use disorder], significantly predicted [alcohol use disorder], substance use

individuals with mood disorders¹³⁵—individuals may first develop a mental illness and begin using addictive substances as a means of treating the symptoms of those disorders, a practice commonly referred to as “self-medicating.”¹³⁶ In the majority of cases, however, “the temporal relationships between the disorders and the high proportion of primary lifetime conditions suggest that most of them are primary independent disorders—that is, one did not cause the other.”¹³⁷

While rates of co-occurring mental health and substance use disorders can vary somewhat across population, substance, and type of mental illness, they remain high and consistent within and among groups. For instance, rates of a co-occurring substance use disorder are high regardless of whether the individual meets diagnostic criteria for an anxiety disorder or a mood disorder, like depression.¹³⁸ Among individuals with a current substance use disorder, about 20% also

disorder, depression, and elevated levels of antisocial and borderline personality disorder symptoms by age 24.”); Traci L. Steuber & Fred Danner, *Adolescent Smoking and Depression: Which Comes First?*, 31 ADDICTIVE BEHAVS. 133, 136 (2006) (“Results of the analyses revealed that adolescents who smoked currently or in the past were more likely to experience depression, with regular smokers showing the highest levels of depression, even after controlling for previous depression.”).

135. Joel Swendsen et al., *Mental Disorders as Risk Factors for Substance Use, Abuse and Dependence: Results from the 10-Year Follow-Up of the National Comorbidity Survey*, 105 ADDICTION 1117, 1125 (2010) (“The broad categories of any mood or anxiety disorder were also associated frequently with the onset of substance dependence over the subsequent decade.”).

136. *Id.* (noting that the association of a primary mental illness and an increased risk for later substance abuse “may reflect self-medication as well as a number of other causal mechanisms”); see also Kessler et al., *supra* note 130, at 28 (“[S]ubstance abuse occurs as an unintended consequence of self-medicating a mental disorder.”); Timothy E. Wilens et al., *Further Evidence of an Association Between Adolescent Bipolar Disorder with Smoking and Substance Use Disorders: A Controlled Study*, 95 DRUG AND ALCOHOL DEPENDENCE 188, 195 (2008) (“It may be that adolescents self medicate their irritable mood, aggressivity, and ‘affective storms’ with substances of abuse or alcohol.”).

137. Watkins et al., *A National Survey*, *supra* note 130, at 1062. While the correlation between mental illness and addiction can be viewed as either a high incident of mental illness in individuals with addiction, or as a high incident of addiction in individuals with mental illness, “both views suggest that there may be common neurobiological substrates for substance abuse and mental disorders.” Nora D. Volkow, *What Do We Know About Drug Addiction?*, 162 AM. J. PSYCHIATRY 1401, 1401 (2005); see also Brady & Sinha, *supra* note 16, at 1484 (“A growing body of evidence from basic science and translational studies implicates common neurobiological pathways and abnormalities involved in addiction and a number of psychiatric disorders.”).

138. At any given time, approximately 19.2 million American adults meet diagnostic criteria for a mood disorder, and 23 million meet diagnostic criteria for an anxiety disorder. Bridget F. Grant et al., *Prevalence and Co-Occurrence of Substance Use Disorders and Independent Mood and Anxiety Disorders*, 61 ARCHIVES GEN. PSYCHIATRY 807, 814 (2004). The numbers are similar for substance use disorder, which affects approximately 19.4 million American adults. *Id.*

have an independent mood disorder, and 18% have an independent anxiety disorder.¹³⁹ Similarly, among individuals with a current mood disorder, about 20% have a substance use disorder, and among individuals with a current anxiety disorder, about 15% also have a substance use disorder.¹⁴⁰ Even higher numbers are seen in individuals with psychotic disorders; one study of 1219 individuals with schizophrenia, for instance, found that 54% of the participants also met diagnostic criteria for a substance use disorder.¹⁴¹

Similarly, individuals with “behavioral addictions,” or nonsubstance addictions, also have high rates of co-occurring disorders.¹⁴² For example, a study of problem gamblers found that 57% of participants also met criteria for a substance use disorder.¹⁴³ A co-occurring substance use disorder may develop concurrently with a gambling disorder, or an individual may use gambling as a way to alleviate symptoms and cope “with a more general underlying psychopathology involving a mood or anxiety disorder.”¹⁴⁴ In still other individuals, mood disorders are secondary symptoms that occur in response to significant financial losses.¹⁴⁵ But whether a substance

139. *Id.*

140. *Id.* at 814–15.

141. Berit Kerner, *Comorbid Substance Use Disorders in Schizophrenia: A Latent Class Approach*, 225 *PSYCHIATRY RES.* 395, 397 (2015) (“Substance use disorders preceded the onset of schizophrenia in about two-third of cases with substance use, and in about one-third of cases substance use disorders had been diagnosed after the onset of schizophrenia.”).

142. These types of disorders are “analogous to substance addiction, but with a behavioral focus other than ingestion of a psychoactive substance.” Jon Grant et al., *Introduction to Behavioral Addictions*, 36 *AM. J. DRUG & ALCOHOL ABUSE* 233, 233 (2010). Apart from gambling disorder, which the most recent edition of the DSM has moved to a new section entitled “Non-Substance-Related Disorders,” DSM-5, *supra* note 83, at 585–86, these types of behaviors are typically classified as impulse control disorders, and include things like kleptomania, Grant et al., *supra*, at 233. The DSM-5 also created a separate section for “Non-Substance-Related Disorders,” which includes gambling disorder as its only condition. *Id.* “Although some behavioral conditions that do not involve ingestion of substances have similarities to substance-related disorders, only one disorder—gambling disorder—has sufficient data to be included in this section.” DSM-5, *supra* note 83, at 586. As the American Psychiatric Association notes, “[t]his new term and its location in the new manual reflect research findings that gambling disorder is similar to substance-related disorders in clinical expression, brain origin, comorbidity, physiology, and treatment.” *SUBSTANCE-RELATED AND ADDICTION DISORDERS*, *supra* note 102, at 1.

143. Felicity K. Lorains et al., *Prevalence of Comorbid Disorders in Problem and Pathological Gambling: Systematic Review and Meta-Analysis of Population Surveys*, 106 *ADDICTION* 490, 493 (2010) (noting that among problem gamblers, “57.5% [were also diagnosed] for any substance use disorder, 28.1% for alcohol use disorder, 17.2% for illicit drug abuse/dependence and 60.1% for nicotine dependence”).

144. *Id.* at 495.

145. *Id.*

use disorder or other mental health disorder preceded, developed concurrently with, or was a result of problem gambling, the research consistently shows that individuals with gambling disorder “have high prevalence rates for many comorbid disorders.”¹⁴⁶

Finally, studies examining specific populations also find high rates of co-occurring substance use and mental health disorders. For example, one study of veterans returning from wars in Iraq and Afghanistan found that of 103,788 users of U.S. Department of Veterans Affairs services, 25% sought treatment for a mental health condition, and many sought services for multiple mental health disorders.¹⁴⁷ Veterans most often sought services for PTSD,¹⁴⁸ which similarly “has a high co-occurrence with other mental health diagnoses.”¹⁴⁹ Among individuals with PTSD, rates of co-occurring depression are between 48% and 60%, and rates of substance use disorder are between 34% and 88%.¹⁵⁰ As one author noted, “[t]hese results indicate a large burden of co-occurring mental health disorders associated with service in Iraq and Afghanistan.”¹⁵¹

These are only a few examples. A review of the literature reveals hundreds of studies detailing high and consistent rates of co-occurring mental health and substance use disorders, rates that hold across disorder, substance, and population.¹⁵² Furthermore, individuals with co-occurring disorders have higher morbidity and mortality rates, and treatment for more than one disorder can be difficult to coordinate.¹⁵³ Yet the research consistently demonstrates that integrated treatment programs are more effective and have better outcomes for patients

146. *Id.* at 496.

147. Karen H. Seal et al., *Bringing the War Back Home: Mental Health Disorders Among 103,788 US Veterans Returning from Iraq and Afghanistan Seen at Department of Veterans Affairs Facilities*, 167 ARCHIVES INTERNAL MED. 476, 478 (2007) (“The median number of different diagnoses was 3 . . . ; 44% had a single mental health diagnosis, 29% had 2 different diagnoses, and 27% had 3 or more different mental health diagnoses.”).

148. *Id.* (“The single most common mental health diagnosis was PTSD . . . , representing 52% of those receiving mental health diagnoses.”).

149. Tracy Stecker et al., *Co-Occurring Medical, Psychiatric, and Alcohol-Related Disorders Among Veterans Returning from Iraq and Afghanistan*, 51 PSYCHOSOMATICS 503, 504 (2010).

150. *Id.* (citing various studies).

151. Seal et al., *supra* note 147, at 479.

152. For an excellent review of the research literature on co-occurring disorders and appropriate treatment, see INTEGRATED TREATMENT, *supra* note 125, at 1–5.

153. Katherine E. Watkins et al., *Prevalence and Characteristics of Clients with Co-Occurring Disorders in Outpatient Substance Abuse Treatment*, 30 AM. J. DRUG & ALCOHOL ABUSE 749, 750 (2004).

than programs that focus on only one disorder.¹⁵⁴ As discussed in the next part, however, individuals with co-occurring disorders who enter treatment often encounter a segregated treatment system—if they encounter one at all—and few practitioners are trained in the appropriate and effective treatment of this population.

IV. INTEGRATED TREATMENT AND BARRIERS TO TREATMENT

*Although integrated dual diagnosis services and other evidence-based practices are widely advocated, they are rarely offered in routine mental health treatment settings. The barriers are legion.*¹⁵⁵

A recent review of twenty-six controlled studies of treatment for co-occurring mental health and substance use disorders found that the most effective treatments for co-occurring disorders “are integrated, which means that they combine mental health and substance abuse interventions at the clinical interface.”¹⁵⁶ In an integrated treatment setting, individuals receive appropriate mental health and substance abuse treatment from a single clinician or clinical team.¹⁵⁷ Because the clinical team is responsible for providing cohesive treatment, the individual experiences the treatment as “singular, because it entails a consistent approach, philosophy, and set of recommendations.”¹⁵⁸ When clinicians take responsibility for providing a cohesive set of services to patients, mental health and substance abuse interventions are therefore better coordinated and more accessible to patients.

Treatment within a coordinated system allows providers to “modify[] as well as combin[e] the treatments for both disorders” in a

154. Robert E. Drake et al., *Implementing Dual Diagnosis Services for Clients with Severe Mental Illness*, 52 PSYCHIATRIC SERVS. 469, 471 (2001).

155. *Id.* at 472–73.

156. Drake et al., *A Review of Treatments*, *supra* note 128, at 367 (“Despite enormous variance in designs, interventions, and outcome measures, several consistent themes appear across the studies and thus emerge as principles of care. The most consistent finding across recent studies is that effective dual disorders treatments are integrated.”); *see also* Clark et al., *supra* note 125, at 7 (“There is growing consensus that for COD treatment to be effective, mental health and substance abuse interventions should be integrated at the clinical interface.”); Susan Foster et al., *Services and Supports for Individuals with Co-Occurring Disorders and Long-Term Homelessness*, 37 J. BEHAV. HEALTH SERVS. & RES. 239, 241 (2010) (“Although the treatment field has not coalesced to define the specific practices and interventions to serve the full range of client populations with COD, integrated treatment for persons with severe levels of psychiatric and substance use issues has received strong research support.”).

157. Drake et al., *A Review of Treatments*, *supra* note 128, at 367.

158. *Id.* (noting that in an integrated system, patients “are not required to negotiate with separate clinical directives, teams, programs, or treatment systems”).

way that helps individuals address both conditions.¹⁵⁹ For example, when an individual with a serious mental illness receives substance abuse counseling, that treatment should be “slower, less confrontational, more repetitive, more focused on motivation, and more behavioral than what is provided in many traditional substance abuse treatment settings”¹⁶⁰ Similarly, individuals who receive pharmacological treatments for one or both disorders will often need to be prescribed medications that pose less risk for abuse or drug interactions.¹⁶¹

Despite what we know about effective and integrated treatment for individuals with co-occurring disorders, however, a recent study by the U.S. Department of Health and Human Services found that of the four million American adults with a co-occurring substance use and mental health disorder, about half of them received some type of treatment, either for substance use or mental illness, but only 11.8% received treatment for both conditions.¹⁶² Another study put the number slightly lower, finding that “[d]espite the recommendation that individuals who have co-occurring disorders receive treatment for both their mental health and substance use problems, only 8 percent received either integrated or parallel treatment.”¹⁶³ Not surprisingly, treatment rates are lowest in traditionally underserved groups, including people with low incomes and no health insurance, elderly people, racial and ethnic minorities, and people in rural areas.¹⁶⁴

Part of the reason for low rates of integrated treatment stems from the bifurcation of mental health and addiction services, a divide

159. *Id.* at 367.

160. *Id.* (recognizing “the special needs of many individuals with severe mental illnesses”).

161. See Jean-Michel Azorin et al., *Pharmacological Treatment of Schizophrenia with Comorbid Substance Use Disorder*, 17 EXPERT OPINION ON PHARMACOTHERAPY 231, 231–32 (2016); Lana A. Vornik et al., *Management of Comorbid Bipolar Disorder and Substance Abuse*, 67 J. CLINICAL PSYCHIATRY 24, 24–26 (2006).

162. EPSTEIN ET AL., U.S. DEP’T OF HEALTH & HUM. SERVS., SERIOUS MENTAL ILLNESS AND ITS CO-OCCURRENCE WITH SUBSTANCE USE DISORDERS 2–3 (2002), <http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.361.9429&rep=rep1&type=pdf> [<https://perma.cc/Y2UW-J3X7>].

163. Watkins et al., *A National Survey*, *supra* note 130, at 1066; see also Clark et al., *supra* note 125, at 6 (finding that of the 5.2 million American adults identified as having co-occurring substance use and mental health disorders, “[o]nly 8.5% received treatment for both their mental health and substance use problems”); Foster et al., *supra* note 156, at 240.

164. Clark et al., *supra* note 125, at 5 (citing Wang et al., *Twelve-Month Use of Mental Health Services in the United States: Results from the National Comorbidity Survey Replication*, 62 ARCHIVES GEN. PSYCHIATRY 629, 629 (2005)).

one author describes as “two distinct and heavily bounded territories.”¹⁶⁵ Instead of receiving treatment for both conditions, individuals with co-occurring disorders “tend to be assigned to one system or the other, which would view them through its own particular lens”¹⁶⁶ This divide between mental health and addiction services has created structural barriers to integrated treatment that can prevent or reduce the likelihood that people with both addiction and mental illness will receive care.¹⁶⁷ In particular, individuals seeking treatment for a co-occurring mental health and substance use disorder are often unable to find providers in their geographic area or are unable to find providers trained in the integrated treatment of co-occurring disorders.

Many individuals who need treatment for a co-occurring mental illness and substance use disorder are simply unable to find or access available services. This lack of services is particularly pronounced in rural areas, where “medical providers . . . often fail to address co-occurring disorders”¹⁶⁸ Even in larger areas, however, there are few available treatment providers for co-occurring disorders and few residential or rehabilitation programs geared toward individuals with co-occurring disorders.¹⁶⁹ A recent study interviewed clinicians with experience in treating patients with co-occurring substance use and mental health disorders, many of whom “expressed frustration about the lack of integrated psychiatric and substance use treatment, and patients falling into the gap between the two services.”¹⁷⁰

165. Davidson & White, *supra* note 18, at 110 (describing the “importance of providing integrated care for persons with co-occurring disorders” and obstacles to integration that range from “historical, political, ideological, professional, and fiscal/structural issues at one end of the spectrum . . . to practical and logistical issues at the other end”).

166. Robert E. Drake et al., *A Systematic Review of Psychosocial Research on Psychosocial Interventions for People with Co-Occurring Severe Mental and Substance Use Disorders*, 34 J. SUBSTANCE ABUSE TREATMENT 123, 123 (2008) (noting that “[s]uch problems continue in the fragmented U.S. healthcare system”).

167. Priester et al., *supra* note 3, at 56.

168. Ronald D. Hester, *Integrating Behavioral Health Services in Rural Primary Care Settings*, 25 SUBSTANCE ABUSE 63, 63 (2004) (“Substance abuse and mental health services treatment options in small towns are often very limited.”). Furthermore, many individuals in rural areas have little access to transportation, making it even more difficult to access services. Priester et al., *supra* note 3, at 55 (“Geographic proximity to services and lack of transportation or resources to obtain transportation to reach these limited services are commonly cited in the literature as a barrier to treatment access.”).

169. *Id.* at 55 (“A primary barrier to treatment access for individuals with COD is service availability.”).

170. Kate B. Carey et al., *Treating Substance Abuse in the Context of Severe and Persistent Mental Illness: Clinicians’ Perspectives*, 19 J. SUBSTANCE ABUSE TREATMENT 189, 195 (2000). As one clinician noted,

Other clinicians identified a need for more training for health care professionals who work with individuals with co-occurring disorders.¹⁷¹ Mental health treatment providers and substance use treatment providers receive vastly different types of training, “probably because health care professionals often were not interested in treating addiction problems,”¹⁷² and few receive training in both fields.¹⁷³ Many addiction treatment providers have little or no medical training, and in many cases their only qualification is a personal history of addiction.¹⁷⁴ Even among medical doctors, “most psychiatric programs do not provide training in co-morbid disorders and many family practice residents do not feel confident in discussing substance use issues with their patients.”¹⁷⁵ And while medical schools

[W]e’re not a substance abuse treatment center so that when we’re doing this work, it’s over and above the mental health treatment. And [it involves] resource stretching. . . . Oh, yeah, let’s add this other layer of treatment that we’re not licensed for, we don’t get paid for. . . . That makes it tough.

Id. (alterations in original); see also Watkins et al., *A National Survey*, *supra* note 130, at 1062 (“Substance abuse and mental health treatment programs are funded and managed separately, and coordination of treatment regimens across established bureaucracies has been difficult.”).

171. Even among clinicians with experience in treating this population, much of the training they have received is informal. As one person in the Carey study stated, “One [method] is taking a lot of workshops and courses. . . . The other [method] is investment in my own recovery and doing a lot of reading in the area and thinking about it. And third is just experience and just trying to keep my own eyes open.” Carey et al., *supra* note 170, at 192.

172. Mary Louise E. Kerwin et al., *Comparative Analysis of State Requirements for the Training of Substance Abuse and Mental Health Counselors*, 30 J. SUBSTANCE ABUSE TREATMENT 173, 173 (2006); see also Dackis & O’Brien, *supra* note 84, at 1431 (“Pejorative views toward addictive individuals also exist and contribute to policies that would be simply unacceptable if applied to ‘real’ medical disorders.”); Elizabeth H. Hawkins, *A Tale of Two Systems: Co-Occurring Mental Health and Substance Abuse Disorders Treatment for Adolescents*, 60 ANN. REV. PSYCHOL. 197, 204 (2009) (“Traditional behavioral health treatment in this country revolves around separate and often disconnected systems.”).

173. Hawkins, *supra* note 172, at 204 (“In general, conceptualizations of illness and corresponding treatment philosophies are strikingly different, and required educational backgrounds, training experiences, and licensing requirements vary widely between mental health and substance abuse sectors.”).

174. NAT’L CTR. ON ADDICTION & SUBSTANCE ABUSE AT COLUMBIA UNIV., *supra* note 85, at 176.

175. Priester et al., *supra* note 3, at 55. While the American Psychiatric Association’s official position statement on substance use disorders recognizes that “[s]creening and brief intervention for substance use disorders, which frequently co-occur with other psychiatric disorders, should be a routine part of medical assessment,” AM. PSYCHIATRIC ASS’N, POSITION STATEMENT ON SUBSTANCE USE DISORDERS ¶ 1 (2012), <https://www.psychiatry.org/File%20Library/About-APA/Organization-Documents-Policies/Policies/Position-2012-Substance-Use-Disorders.pdf> [https://perma.cc/6HA5-5A63], the

and psychiatry programs have increased training for substance use disorders, most still fail to address the needs of patients with co-occurring disorders.¹⁷⁶ Finally, there are few opportunities for cross-training and few incentives or resources for practitioners to seek out dual certification.¹⁷⁷ As one author noted, there are few accepted models for co-occurring disorders specialists, and “becoming dually certified or licensed is an onerous burden that most do not undertake.”¹⁷⁸

Because of this lack of cross-training among addiction treatment and mental health care providers, there is a corresponding lack of providers with experience in co-occurring disorders and fewer resources available to individual patients.¹⁷⁹ Moreover, because they lack training in both fields, many treatment providers “may identify a substance use disorder or a mental health disorder but not the co-occurrence of both.”¹⁸⁰ Underidentification of co-occurring disorders means that few patients “who could benefit from treatment receive it, and those who do often get it after their problems are severe and co-occurring with medical and psychiatric conditions.”¹⁸¹

Our historically bifurcated approach toward the treatment of mental illness and substance use disorders has therefore created entrenched structural barriers to integrated treatment. As a result, many individuals who attempt to access treatment for co-occurring

majority of psychiatry residencies “do not provide adequate training in the management of complicated patients with these comorbid disorders,” John A. Renner, Jr., *How to Train Residents to Identify and Treat Dual Diagnosis Patients*, 56 *BIOLOGICAL PSYCHIATRY* 810, 810 (2004).

176. Renner, *supra* note 175, at 810 (“Psychiatry training in the United States has failed to adequately address the needs of patients with comorbid substance use disorders (SUD) and major psychiatric disorders. . . . Medical schools rarely provide adequate training in the management of these patients.”); Stacy Sterling et al., *Access to Treatment for Adolescents with Substance Use and Co-Occurring Disorders: Challenges and Opportunities*, 49 *J. AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY* 637, 641 (2010) (noting that medical providers “rarely receive adequate training to manage [substance use] problems, and even less to manage co-occurring problems”).

177. Hawkins, *supra* note 172, at 204.

178. *Id.*

179. *Id.* (“As a result, few providers at the local level are knowledgeable and capable of treating co-occurring disorders.”).

180. Priester et al., *supra* note 3, at 55; *see also* Alan I. Green et al., *Schizophrenia and Co-Occurring Substance Use Disorder*, 164 *AM. J. PSYCHIATRY* 402, 403 (2007) (“Co-occurring substance use disorders are often underdetected and undertreated in mental health settings, where the traditional separation between mental health and substance abuse training programs and service delivery systems results in a lack of knowledge about co-occurring disorders . . .”).

181. Sterling et al., *supra* note 176, at 638 (noting that “[t]hey are then more difficult to treat, and more expensive to health care systems”).

disorders “frequently fall through the cracks” between the two systems.¹⁸² And while one clear barrier to integrated treatment is the lack of trained providers, another less obvious structural barrier is the organization—and segregation—of drug, alcohol, and mental health courts.

Many individuals receive mental health or substance use treatment as a result of their diversion into a specialty court. And while these courts claim to have created a revolution in the criminal justice system, their basic organizational structure has not kept pace with what we now know about the appropriate—and integrated—treatment of co-occurring mental health and substance use disorders. As discussed in the next part, if specialty courts are to stay on the cutting edge of criminal justice reform, they must take a bigger role in the identification and treatment of individuals with co-occurring disorders who are diverted out of the criminal justice system. In this way, specialty courts can help improve the often fragmented and confusing treatment system encountered by individuals with co-occurring mental illness and substance use disorders.

V. TOWARD INTEGRATED TREATMENT IN DRUG AND MENTAL HEALTH COURTS

The drug court model is ubiquitous, and many individuals will become involved in a drug or other specialty court in the United States each year. In its most recent Census of Problem-Solving Courts, the Department of Justice counted 3052 specialty courts in the United States, 44% of which were drug courts and 11% of which were mental health courts.¹⁸³ Moreover, there are an additional 400 DWI and hybrid DWI/drug courts, which together comprise approximately 13% of all specialty courts.¹⁸⁴ Although alcohol and DWI courts are technically distinct from drug courts, this Article uses the general term “drug court” to encompass both traditional drug

182. Clark et al., *supra* note 125, at 6.

183. STRONG ET AL., *supra* note 26, at 1. As of the 2012 census, only Connecticut, Kansas, Nebraska, North Dakota, Puerto Rico, Rhode Island, South Dakota, West Virginia, and Wyoming did not have at least one mental health court. *Id.* at 3–4. Every state has at least one drug court, and many states have dozens of such courts, including California with eighty-three, Florida with sixty-eight, Missouri with sixty-two, and New York with fifty. *Id.*

184. *Id.* at 1 fig.1 (counting 183 DWI courts and 217 hybrid DWI/drug courts). DWI courts “focus on changing the behavior of the alcohol-dependent offender or offenders with a high blood alcohol content who were arrested for DWI or driving under the influence,” while hybrid DWI/drug courts “handle alcohol or drug-dependent offenders who have also been charged with a driving offense.” *Id.* at 2.

courts and these other alcohol and DWI courts, which “focus on changing the behavior of the alcohol-dependent offender”¹⁸⁵

Given their large numbers and diverse locations, it is not surprising that individual specialty courts vary tremendously.¹⁸⁶ Moreover, due in part to the many varieties of specialty courts, individual courts employ vastly different structures and procedures, leading some researchers to describe specialty courts as a kind of “black box.”¹⁸⁷ As one author noted, “when you’ve seen one mental health court, you’ve seen one mental health court.”¹⁸⁸ Other researchers have suggested that the roots of the drug court movement—which was developed by individual judges and without an underlying theoretical model—are in some ways responsible for this lack of consistent structure.¹⁸⁹

This lack of uniform structure extends to the selection of specialty court participants. While eligibility and placement requirements are often dictated by statute, they vary tremendously from court to court, and other aspects of the specialty court model are far less transparent. In particular, it is difficult to ascertain the specific procedures by which individuals are sorted into a *particular* specialty court. In many jurisdictions, referral into a drug court is generally up to the prosecutor,¹⁹⁰ and drug courts primarily accept individuals

185. *Id.*

186. For an excellent overview of the history of drug courts and the similarities and differences among various courts, see NOLAN, *supra* note 27, 39–60.

187. Jeff Bouffard & Faye Taxman, *Looking Inside the “Black Box” of Drug Court Treatment Services Using Direct Observations*, 34 J. DRUG ISSUES 195, 195 (2004); John S. Goldkamp, Michael D. White & Jennifer B. Robinson, *Do Drug Courts Work? Getting Inside the Drug Court Black Box*, 31 J. DRUG ISSUES 27, 27 (2001); Deborah Koetzle Shaffer, *Looking Inside the Black Box of Drug Courts: A Meta-Analytic Review*, 28 JUST. Q. 493, 493 (2010).

188. Ursula Castellano & Leon Anderson, *Mental Health Courts in America: Promise and Challenges*, 57 AM. BEHAV. SCI. 163, 170 (2013); *see also* Bean, *supra* note 68, at 720 (“What one finds is that there are as many variations in the locus of Drug Courts within the legal system as there are Drug Courts themselves.”).

189. Shaffer, *supra* note 187, at 494–95 (2010) (“The lack of a theoretical model during the model’s infancy, coupled with a lack of guidance on how to implement the key components resulted in considerable inconsistency in the structure of the model across jurisdictions.”); *see also* Hora et al., *supra* note 37, at 449 (“Few early [drug court] practitioners worried about the jurisprudential theory behind the [drug court] movement. [Drug courts] seemed to work, and the absence of analysis or debate coming from the ‘ivory towers’ of academia about the efficacy of drug treatment in a criminal justice setting did not much matter.”).

190. *See, e.g.*, *People v. Sturiale*, 98 Cal. Rptr. 2d 865, 867 (Cal. Ct. App. 2000) (noting that the prosecutor has sole discretion under California law to determine eligibility for a drug court program); *State v. Upshaw*, 648 So. 2d 851, 852 (Fla. Dist. Ct. App. 1995) (noting that “the law is well settled that the State Attorney has the sole discretion to prosecute” and “offer [the defendant] a drug court program”).

charged with drug crimes.¹⁹¹ In mental health courts, however, many referrals come from the prosecutor, but referrals may also come from other judges, treatment providers, family members, or even staff members at the county jail.¹⁹²

An individual with a co-occurring disorder may therefore be assigned to a mental health court or a drug court based in large part on the crime that led to her arrest or by the source of her referral. In many cases, however, if an individual with a co-occurring mental health and substance use disorder is charged with a drug crime or with driving while intoxicated, they are likely to be referred to a drug court or a DWI court, with little attention given to the possible presence of multiple disorders. Moreover, judges and court personnel in these segregated courts have differing levels of expertise and knowledge of available community resources. Specialty court participants with co-occurring disorders may (or may not) receive treatment for each disorder, but the focus of their rehabilitation will in many cases depend simply on the particular specialty court they enter. Appropriate and integrated treatment therefore becomes a game of chance for many specialty court participants.

Perhaps mindful of the limitations of segregated specialty courts and the high rates of co-occurring disorders, a handful of jurisdictions have established “co-occurring disorder courts,” though these appear to be the exception rather than the rule. Although it is difficult to identify exact numbers, there appears to be four specialty courts around the country that are explicitly devoted to serving individuals with co-occurring disorders. The Jasper County, Missouri, Co-Occurring Disorder Court, for example, admits defendants who “have a mental illness and substance abuse disorder which is related to their current charge and/or for whom mental health [and] substance abuse treatment in a court supervised program can be expected to foster

191. U.S. DEP'T OF JUSTICE, *supra* note 28, at 9. Similarly, DWI and hybrid DWI/drug courts generally accept alcohol- or drug-dependent offenders who have been charged with a driving offense. STRONG ET AL., *supra* note 26, at 2.

192. See ALMQUIST & DODD, *supra* note 29, at 15 (citing various studies). Similarly, “any interested party may request that a criminal case be transferred” to a Boston Mental Health Court. W. ROXBURY DIV. OF THE BOS. MUN. COURT, RECOVERY WITH JUSTICE PROGRAM: MENTAL HEALTH SESSION, <http://www.mass.gov/courts/docs/specialty-courts/mental-health-court-brochure.pdf> [<https://perma.cc/9LLG-BACP>]. In other specialty courts, referral to a particular court appears to be self-directed. In Nevada, for instance, veterans “can be self-referred, their attorneys may refer them, or other judges and other jurisdictions may refer them” to veterans court. Robert Horne, *Nevada Veteran's Specialty Courts*, NEV. L., Nov. 2016, at 25, 25. Signs are posted on courtroom doors asking veterans “to please notify their public defender or attorney if they are a veteran” so the court can be made aware of potential candidates for the Veterans Treatment Court. *Id.*

recovery and reduce recidivism.”¹⁹³ Similarly, Maine has created a co-occurring disorder court that admits “adults with significant substance abuse disorders and mental illnesses and serious criminal charges.”¹⁹⁴

The remaining two co-occurring disorder courts—in Reno, Nevada, and Los Angeles County, California—limit eligibility to misdemeanor and drug charges, respectively. For example, the Reno, Nevada, Misdemeanor Co-Occurring Mental Health and Substance Abuse Disorder Specialty Court only accepts low-level offenders, limiting eligibility to offenders “who appeared for misdemeanor charges and exhibited or had a previous diagnosis of a mental health condition coupled with alcohol or other drug use”¹⁹⁵ The Los Angeles County Co-Occurring Disorders Court appears to be directed toward the city’s homeless population and limits eligibility to “non-violent felony drug offenders who have both a severe, chronic substance abuse disorder and serious, persistent mental illness are homeless or at risk for homelessness and have had frequent contacts with the criminal justice system.”¹⁹⁶ Although these courts’ recognition of individuals with co-occurring disorders is commendable, many critics argue that this type of cherry picking of court participants excludes individuals who would benefit most from participation in the court¹⁹⁷ and also discriminates against people of color.¹⁹⁸

193. 29TH JUDICIAL CIRCUIT, JASPER COUNTY CO-OCCURRING DISORDERS COURT PARTICIPANT’S MANUAL 3 (2017), <http://www.jaspercounty.org/pdf/courts/treatmentcourt/CoOccuringManual.pdf> [<https://perma.cc/865Y-uzvl>].

194. *Maine Co-Occurring Disorders and Veterans Court*, ST. ME. JUD. BRANCH http://www.courts.maine.gov/maine_courts/drug/codvc.html [<https://perma.cc/6WBL-Z8DD>]. Even this innovative court, however, further segregates participants into two tracks: participants are assigned to either civilian or veteran’s co-occurring disorders court, in recognition of the fact that “criminal conduct as well as behavioral disorders may be attributable to their service” *Id.*

195. KEVIN CROWE, RENO MUN. COURT, CO-OCCURRING DISORDER SPECIALTY COURT (COD) PROGRAM EVALUATION REPORT 3 (2014), <https://www.reno.gov/home/showdocument?id=48292> [<https://perma.cc/PJ8Y-PNQS>].

196. CTY. OF L.A. DEP’T OF PUB. HEALTH, CO-OCCURRING DISORDERS COURT PROGRAM FACT SHEET, <http://www.publichealth.lacounty.gov/sapc/resources/Co-OccurringDisorderCourt.pdf> [<https://perma.cc/9EJT-NNQT>].

197. JUSTICE POLICY INST., *supra* note 24, at 21 (“Drug courts that receive federal discretionary grants are required to focus on people accused of nonviolent offenses and those without a violent record. Yet research shows that drug courts have the greatest benefit for people who have more prior felony convictions and have previously failed other dispositions.”).

198. *Id.* (“Since people of color are more likely to have a felony conviction on their record at the time of an arrest related to drug abuse, they are more likely to be excluded from consideration for drug court participation.”); *see also* Josh Bowers, *Contraindicated Drug Courts*, 55 UCLA L. REV. 783, 807 (2008) (“Consequently, addicts, minorities, and

Despite some of these drawbacks, however, the existence of these few co-occurring disorder courts is one example of the progress that we have seen in the integration of mental health and substance use treatment systems in communities around the country. The mental health system has begun “providing or encouraging training in [alcohol and drug] problems for some time, and the general level of skill of practitioners is improving.”¹⁹⁹ At the same time, many addiction treatment providers now have a better understanding of how to treat individuals who have a co-occurring mental illness.²⁰⁰ Notwithstanding these advances, however, “[a]rtifacts of the structural and organizational disconnect between the mental health and substance abuse treatment systems persist.”²⁰¹ Even with increasing numbers of practitioners trained in the treatment of co-occurring disorders, structural barriers—including thousands of segregated drug and mental health courts—prevent individuals from receiving appropriate and integrated treatment. Better training for practitioners, standing alone, will not create lasting improvements in integrated treatment. As one author noted, “without structural, regulatory, and funding changes required to reinforce training, newly acquired expertise will not be used and will soon disappear.”²⁰²

The existing research overwhelmingly supports the propriety and efficacy of integrated treatment for co-occurring mental health and substance use disorders.²⁰³ Yet our current national system of segregated and fractured treatment of individuals with co-occurring disorders makes it more difficult for individuals to obtain appropriate

the underprivileged are terminated more frequently from drug courts, even perhaps in circumstances where they are doing just as well (or as badly) as their white and affluent counterparts.”); John R. Gallagher, *African American Participants’ Views on Racial Disparities in Drug Court Outcomes*, 13 J. SOC. WORK PRAC. ADDICTIONS 143, 156 (2013) (finding that minority participants in one drug court reported feeling that “it was common in court for the audience and drug court staff to laugh” when African American participants were given sanctions).

199. Joan E. Zweben, *Severely and Persistently Mentally Ill Substance Abusers: Clinical and Policy Issues*, 32 J. PSYCHOACTIVE DRUGS 383, 384 (2000); see also Clark et al., *supra* note 125, at 7 (“Although mental health and substance abuse treatment systems have historically been separate, the mental health system has been providing and encouraging more training on substance use disorders, and addiction treatment providers are increasing their capacity to deal with clients who have mental disorders.”).

200. Zweben, *supra* note 199, at 384 (“More and more addiction treatment providers are developing the capability of dealing with a population that has thought disorders for periods of time.”).

201. Clark et al., *supra* note 125, at 7.

202. *Id.* (“Even when qualified and well-trained clinicians are available, however, evidence suggests that training alone is not sufficient to sustain changes in clinical practice that are needed to promote integrated care.”).

203. See *supra* Part IV.

treatment and reduces the efficacy of the treatment that individuals do receive. Our system of treatment must be integrated to improve accessibility and the quality of treatment for individuals with co-occurring disorders. Similarly, “[s]creening and referral must become routine so that mental and substance use disorders receive equal treatment.”²⁰⁴ The integration of drug, alcohol, and mental health courts would improve the treatment received by individuals who are diverted into specialty courts and correspondingly increase courts’ ability to “reach people who have co-occurring mild to moderate mental and substance use disorders before their conditions become more severe.”²⁰⁵

In an integrated treatment setting, individuals receive appropriate mental health and substance use treatment from a single clinician or clinical team.²⁰⁶ Specialty courts already embrace this team approach to treating individuals. In the specialty court model, the judge approaches each case as the leader of a team that includes prosecutors, probation officers, defense attorneys, and social workers.²⁰⁷ The team creates a treatment plan that the defendant must agree to. Defendants participate in a variety of treatments, but those treatments are focused differently in different specialty courts.²⁰⁸ For example, drug courts “handle an underlying drug problem contributing to criminal behavior”²⁰⁹ In drug court, “the goal remains consistent—drug treatment for addicted drug offenders instead of incarceration and/or probation.”²¹⁰ Similarly, alcohol and DWI courts “focus on changing the behavior of the alcohol-dependent offender”²¹¹ Mental health courts, in contrast, divert defendants into “judicially supervised, community-based

204. Clark et al., *supra* note 125, at 6.

205. *Id.*

206. Drake et al., *A Review of Treatments*, *supra* note 128, at 367.

207. Edgely, *supra* note 35, at 572 (“A judge supervises a multi-disciplinary team that determines the most appropriate interventions for the offender, who is required to report back to the court at periodic status hearings.”). The judge and court personnel typically meet to review cases prior to status hearings with defendants. The team often includes prosecutors and defense attorneys, probation officers, and service providers. STRONG ET AL., *supra* note 26, at 9.

208. *Id.* at 9.

209. *Id.* at 2.

210. Hora et al., *supra* note 37, at 453.

211. STRONG ET AL., *supra* note 26, at 2.

treatment”²¹² and have the stated goal of connecting participants to available community resources.²¹³

The integration of drug, alcohol, and mental health courts would allow courts to tailor treatment plans to address co-occurring disorders simultaneously, which would ideally include “case management, vocational rehabilitation services, family counseling, housing, and medications.”²¹⁴ Although many segregated specialty courts provide some or all of these services, most do not provide them with the explicit goal of addressing both disorders concurrently, resulting in inadequate treatment for both disorders. Moreover, the integration of segregated specialty courts would provide more opportunities for specialty court judges and court personnel to be appropriately trained in the screening and appropriate treatment of individuals with co-occurring mental health and substance use disorders.

The literature on co-occurring disorders makes it overwhelmingly clear that individuals with co-occurring disorders “frequently fall through the cracks between the mental health and substance abuse treatment systems, are shuttled between systems that can only treat one type of disorder, or receive simultaneous care from clinicians in segregated treatment systems that do not have the capacity to share information.”²¹⁵ This results in lower rates of treatment and poor treatment outcomes. Specialty courts, individual judges, and policymakers can take part in addressing this challenge by considering the integration of mental health and drug courts, which will allow the specialty court model to better adapt to our current understanding about the appropriate and integrated treatment of co-occurring mental health and substance use disorders.

While the integration of drug and mental health courts would be one step toward addressing these structural barriers to the appropriate treatment for co-occurring disorders, courts cannot take

212. *Id.*

213. ALMQUIST & DODD, *supra* note 29, at 2 (describing a variety of goals for mental health courts, including goals “to improve public safety by reducing the recidivism rates of people with mental illnesses, to reduce corrections costs by providing alternatives to incarceration, and to improve the quality of life of people with mental illnesses by connecting them with treatment and preventing re-involvement in the criminal justice system”); *see also, e.g., Mental Health Court Explained*, COUNSELING WASH., <https://www.counselingwashington.com/FAQS/Mental-Health-Court-Explained/> [<https://perma.cc/GS99-GTHS>] (“[T]he goal is . . . improved access to public mental health treatment services . . .”).

214. Lana A. Vornik & E. Sherwood Brown, *Management of Comorbid Bipolar Disorder and Substance Abuse*, 67 J. CLINICAL PSYCHIATRY 24, 28 (2006).

215. Clark et al., *supra* note 125, at 66.

on this task alone. As noted above, there is a significant lack of cross-training in both mental health and substance abuse fields, and educational and training programs must be improved to address the specific challenges posed by this population.²¹⁶ But the current organizational model of segregated specialty courts only exacerbates the challenge of appropriately treating individuals with co-occurring disorders. This lack of coordinated treatment “results in high recidivism, poor retention, poor treatment outcomes, and increased burden, not only for persons in need of care but also for service delivery systems.”²¹⁷

Finally, it is important that legislators and other policymakers be informed about the prevalence and appropriate treatment of individuals with co-occurring mental health and substance use disorders. States and the federal government continue to allocate hundreds of millions of dollars annually to the establishment and support of specialty courts.²¹⁸ A better understanding of the efficacy of integrated treatment for co-occurring disorders can help guide legislators and policymakers as they look for ways to make “scarce dollars do more for a population known for the high cost of its treatment”²¹⁹

CONCLUSION

Specialty courts claim to have created a revolution in criminal justice, and, indeed, these diversionary programs do represent an important improvement. But the existing specialty court model, where individuals are segregated into drug, alcohol, or mental health courts, is contrary to the literature on both the disease of addiction and the prevalence of co-occurring substance use and mental health disorders. Moreover, segregated specialty courts are yet another barrier to the widespread acceptance of addiction as a brain disease, one that should be evaluated and treated like any other mental health disorder.

216. Hawkins, *supra* note 172, at 217 (“A significant barrier to the provision of integrated services is a lack of cross-training in both mental health and substance abuse fields. Educational and training programs can begin to address this by offering courses on co-occurring disorders and by providing clinical opportunities to work with this population.”); *see also supra* Part IV.

217. Foster et al., *supra* note 156, at 240.

218. Due to the large number of drug and mental health courts and their geographical diversity, it is difficult to identify precisely how much funding is received by these individual courts. One recent study, however, found that drug courts spent approximately \$515 million per year on treatment. BHATI ET AL., *supra* note 50, at xi–xii.

219. Clark et al., *supra* note 125, at 3.

Drug, alcohol, and mental health courts should be integrated, both in recognition that substance abuse is a mental illness and not a crime and because co-occurring disorders in specialty court participants should be expected and appropriately treated. Specialty court judges, staff, and policymakers should similarly become better educated about advances in the research and integrated treatment of co-occurring disorders. Perhaps most importantly, by providing integrated treatment to specialty court participants, courts and policymakers can dramatically improve treatment outcomes for individuals who are diverted out of the criminal justice system and into a specialty court.