Involuntary Commitment as "Carceral-Health Service": From Healthcare-to-Prison Pipeline to a Public Health Abolition Praxis

Rafik Wahbi and Leo Beletsky

Keywords: Abolition, Public Health Law, Mental Health Treatment, Drug Policy, Health Services Research

Abstract: Involuntary commitment links the healthcare, public health, and legislative systems to act as a "carceral health-service." While masquerading as more humane and medicalized, such coercive modalities nevertheless further reinforce the systems, structures, practices, and policies of structural oppression and white supremacy. We argue that due to involuntary commitment's inextricable connection to the carceral system, and a longer history of violent social control, this legal framework cannot and must not be held out as a viable alternative to the criminal legal system responses to behavioral and mental health challenges. Instead, this article proposes true alternatives to incarceration that are centered on liberation that seeks to shrink the carceral system's grasp on individuals' and communities' lives. In this, we draw inspiration from street-level praxis and action theory emanating from grassroots organizations and community organizers across the country under a Public Health Abolition framework.

"Yea, the guilty is oftentimes the victim of the injured,
And still more often the condemned is the burden bearer for the guiltless and unblamed"

-Kahlil Gibran, *The Prophet*, 1923

"The call for social justice is 'an implicit call for solutions, a call for remedies, a call for action' (Coates, 2004). As we have seen, the call for social justice cannot rely on civil justice or macro-level remedies alone; law has been the handmaiden of what hooks (1992) has termed 'the white supremacist capitalist patriarchy'

Rafik Wahbi, M.P.H., *is an educator, student and scholar of abolition and harm reduction. He is a fellow with the UCLA Prison Education Program, an NIH Justice Community Opioid Innovation Network (JCOIN) LEAP Scholar, and a Graduate Student Instructor at the UCLA Center for Community Engagement in Los Angeles, California, USA.* **Leo Beletsky, J.D., M.P.H.**, *a Professor of Law and Health Sciences at Northeastern University, Boston, Massachusetts, USA, where he also directs the Health in Justice Action Lab. He is also an Associate Adjunct Professor in the Division of Infectious Disease and Global Public Health at UC San Diego School of Medicine, La Jolla, California, USA.*

The Journal of Law, Medicine & Ethics, 50 (2022): 23-30. © 2022 The Author(s)
DOI: https://doi.org/10.1017/jme.2022.5

in the ever-evolving political and economic exploitation of persons of color. To paraphrase Bell (1992), the 14th Amendment cannot save us. The call for social justice requires more."

-Rose M. Brewer and Nancy A. Heitzeg

Introduction

On April 23, 2011, a North Carolina Police officer killed Ronald Armstrong (Armstrong), a 43-year-old Black man with bipolar disorder and paranoid schizophrenia, shortly after the police department finalized an involuntary commitment, which was ordered by a physician.[1] The previous week, Armstrong had been off his medication for five days for unknown reasons. His sister Jinia Lopez saw that Armstrong had been self-harming, and so she talked with her brother, and they agreed together that they would go to the hospital. While he was being checked in and evaluated into the hospital, Armstrong became nervous and frightened by the environment, so he ran away. The physician examining Armstrong concluded that he was a danger to himself and began issuing an involuntary commitment order, which under North Carolina law, and laws across the country, is within his power as a physician. The doctor made this conclusion based on Armstrong's flight from the hospital, and the "odd behavior" that was noted from earlier in the week. Police officers were immediately called as soon as Armstrong left the hospital. When they found him, not too far from the hospital, the involuntary commitment order had not been fully processed yet, so the officers began talking with Armstrong. They had found him wandering around a roadside and convinced him to come to the sidewalk. Armstrong then began to eat grass and dandelions and continued to self-injure himself. As soon as the officers were alerted that the commitment order was processed, they began to approach Armstrong. Seeing the officers quickly approach him, Armstrong sat down on the floor, and wrapped himself around a four-by-four post near a stop sign. The officers attempted to pry Armstrong from the pole. The court notes detail that Armstrong was "anchored to the base of a stop signpost…in defiance of the [commitment] order." By this point, two hospital security guards and 3 police officers arrived, with his sister, who was pleading with Armstrong to come back to the hospital. With five law enforcement officers present, this did not last long — only 30 seconds passed after the court order was finalized that Lieutenant McDonald instructed Officer Gatling to tase Armstrong. Armstrong said, "I ain't got to go." Armstrong clung to the post. Over the next two minutes, Officer Gatling tased Armstrong five separate times. When Armstrong did not respond to the tasing, the five officers in total, pulled Armstrong off the post and pinned him down. Armstrong exclaimed that he was being choked and could not breathe. After the officers applied the handcuffs and stood up to "collect themselves," they began to walk away. Armstrong's sister noticed that he was unresponsive and pleaded with the officers to check on him. By the time the officers returned to Armstrong, he was not breathing. The police had just murdered Armstrong. The police report states that it was a total of six-and-a-half minutes between when the involuntary commitment order was finalized and when the EMS was radioed. Six-and-a-half minutes.

In *Armstrong v. Village of Pinehurst*, later known as the "Taser case," the court considered whether use of the taser repeatedly was considered excessive force.

We propose to follow a public health abolition framework that disrupts, dismantles, and abolishes carceral-health services, and shifts from modes and systems of punishment and cages to models of community public health. Grassroots organizations, activists, and community organizers across the country are currently resisting carceral logics and services and instead are embodying a public health abolition politic by demanding real investments in alternatives to incarceration, instead of relying on punishment tactics like involuntary commitment. Beyond demanding these alternative systems of care, these movements are actively working and building programs and spaces to safeguard and heal community members.

The Journal of Law, Medicine & Ethics, 50 (2022): 23-30. © 2022 The Author(s)

The Fourth Circuit ruled that the officers did indeed use excessive force but were still protected by qualified immunity.[2] The ethics, effectiveness, or existence of the involuntary commitment order were not questioned in this case at all. Involuntary commitment laws are based on the state's *parens patrei* power, which is the power for the state to act as a guardian or "parent" for those who are unable to care for themselves, including children and those with substance use disorders and disabilities.[3] States across the country have various standards for involuntary commitment in terms of what classifies as "dangerous," or if dangerousness is even a standard (see Delaware and Iowa).[4] Armstrong's story is not uncommon in the United States. The data and evidence are clear: law enforcement kill Black men with mental illness at significantly greater rates than white men.[5] In cases where law enforcement do not kill the individual during apprehension, involuntary commitment cases involve individuals with serious mental health issues or substance use disorders. After being violently restrained individuals are committed to so-called treatment centers for "rehabilitation," but these sites are far from treatment or rehabilitation, but rather another form of prison or jail.[6] And yet since its inception, the law has consistently been shown to be ineffective, unethical, and racist.[7] Some keenly assert that involuntary commitment is worse than punishment, and is also in violation of the United States Constitution.[8] And yet, involuntary commitment not only continues to be used nationally, it's use is increasing significantly.[9] The question remains, why?

This paper attempts to answer the following question: given that involuntary commitment is neither ethical nor effective at accomplishing its purported goals of "treatment" and "rehabilitation," why is it still a regularly practiced law? Drawing from critical race theory, and a feminist abolition praxis, we will explain how involuntary commitment links the criminal legal, health care, public health, and legislative systems to act as a "carceral-health service" (based off of the concept of "carceral-service" introduced by Richie and Martensen in the field of social work).[10] We will answer this question by situating involuntary commitment within a social and historical analysis of the U.S. Prison Industrial Complex (PIC). In this way, we aim to reframe involuntary commitment as a carceral-health service, not an alternative of the carceral system, but as part of a larger socio-political system of racial and class control.

Involuntary commitment acts as one public health/medical to prison pipeline. For example, emergency departments/rooms can be sites for carceral reach and control, with police officers frequently working with physicians and medical personal to conduct their searches.[11] By situating involuntary commitment within a racially conscious history, we aim to follow the wisdom of Dr. Helena Hansen et al. to "detect and represent power relations that are not transparent, have been forcibly erased, and exist only in traces."[12] Thus, we argue that due to involuntary commitment's inextricable connection to the carceral system, it is not a reformable law and must be abolished under a larger framework of police and prison abolition, while in it's stead, building and supporting systems of community care, utilizing evidence-based treatments and approaches. We propose to follow a public health abolition praxis that disrupts, dismantles, and abolishes carceral-health services, and shifts from modes and systems of punishment and cages to models of community public health.[13] Grassroots organizations, activists, and community organizers across the country are currently resisting carceral logics and services and instead are embodying a public health abolition politic by demanding real investments in alternatives to incarceration, instead of relying on punishment tactics like involuntary commitment. Beyond demanding these alternative systems of care, these movements are actively working and building programs and spaces to safeguard and heal community members.

Critical Race Theory and Involuntary Commitment

Critical race theory (CRT) can be defined as "a framework that can be used to theorize, examine and challenge the ways race and racism implicitly and explicitly impact on social structures, practices, and discourses."[14] In other words, CRT is an orientation to address observed racial stratification, viewing racism as a central component to understanding how people of different races have variable social positions in society and are given access to different rights and privileges,[15] thus resulting in harm, violence, or premature death.[16] Professor Kimberlee Crenshaw explains how critical race scholarship is centered around two primary ideas:

> The first is to understand how a regime of white supremacy and its subordination of people of color have been created and maintained in America, and, in particular, to examine the relationship between that social structure and professed ideals such as "the rule of law" and "equal protection." The second is a desire not merely to understand the vexed bond between law and racial power but to *change* it.[17]

The Journal of Law, Medicine & Ethics, 50 (2022): 23-30. © 2022 The Author(s)

In the context of involuntary commitment, CRT will be used as a framework to theorize and understand the racial logics that are used to maintain the existence of an unethical and ineffective health law such as involuntary commitment.

While much of disparities research seeks to compare non-white groups to white groups and eliminate risk or reward with regards to an intervention or negative exposure/outcome, in this paper we will be considering the concept of racial arithmetic, described by sociologist Dr. Michael Rodriquez-Muniz. Racial arithmetic is how ethnoracial statistics are used by various political actors to make decisions regarding treatment, distribution of resources, or policy.[18] In the context of involuntary commitment, it applies to how ethnoracial statistics have historically been used to justify or even uphold the use of involuntary commitment. So while Black individuals are "disproportionately" involuntarily committed, the goal is not to bring the ratio of being involuntarily committed between Black and White groups to one. In this case, there is no such thing as a proportionate amount of involuntary commitment. The racial stratification of involuntary commitment doesn't reveal a deficiency in how the law or practice is enacted, but rather are a reflection of a society and mental health system founded on settler colonialism, white supremacy, and ableism.[19] The racialization of involuntary commitment is a feature not an error of the law.

Involuntary Commitment as a Carceral-Health Service

To understand involuntary commitment as an extension of the carceral system, we need to situate it within the larger history of social, racial, and class control of the earliest penal systems. Michel Foucault's analysis of the earliest "reforms" of the 16th century French penal system explained how the "criticism of the reformers was directed not so much at the weakness or cruelty of those in authority, as at a bad economy of power." This "bad economy of power" refers to the ways in which the early penal system made unilateral decisions with regards to criminal doctrine, procedure, and punishment, etc. Since the earliest reforms of the punishment and penal system (prisons and jails), the goal has been to disperse the "bad economy of power," not to eliminate it or transform it. Reforming the penal, or criminal justice system, as it is commonly referred to today, has never been to provide more "humane" treatment, but rather as

> a strategy for the rearrangement of the power to punish, according to modalities that render it more regular, more effective, more constant, and more detailed in its effects; in short, which increase its effects while diminishing its economic cost (that is to say, by dissociating it from the system of property, of buying and selling, of corruption in obtaining not only offices, but the decisions themselves) and its political cost (by dissociating it form the arbitrariness of monarchical power). The new juridical theory of penality corresponds in fact to a new 'political economy' of the power to punish.[20]

This dispersal of power can be seen not just from one system to the next (carceral to medicine) but must be understood relationally. That is, power is not merely an object given from one system or individual to the next, but instead it describes sets of relationships. In the case of involuntary commitment, we must not view it just as a health law that has power to "treat" individuals with serious mental health issues or SUDs, but to examine the power relationships and this new "political economy of the power to punish." This includes the relationships between various actors (family members, medical staff, law enforcement, etc.), as well as the power relationships between the various systems that govern or maintain these actors (e.g., public health, healthcare, the carceral system).

In order to understand how to examine such power relations between the various actors involved in involuntary commitment, we look to the work of sociologist and disability studies scholar Liat Ben-Moshe, who argues that since its earliest conceptions, the project of social control by the state, through the penal system, was connected to the targeted control and elimination of those with disabilities, including psychiatric, developmental, and physical.[21] But it is not strictly in the form of "incarcerating" an individual in a criminal jail or prison; rather, she contends that disability has "always been central to diverse practices of incarceration, alongside and interlocking with other forms of stratification." She explains that the "diverse practices of incarceration" produce "diverse sites of confinement."[22] While these sites of confinement might not be traditionally regarded as jails or prisons, or even arrests, we can see how involuntary commitment serves the same purpose as incarceration, when these "sites of confinement" are compared with regards to whom they target and confine, and the way in which they do it. Foucault explains that to understand the logic and history behind these diverse sites of confinement the "form of rationality at stake" must be questioned. He continues,

The Journal of Law, Medicine & Ethics, 50 (2022): 23-30. © 2022 The Author(s)

> The criticism of power wielded over the mentally sick or mad cannot be restricted to psychiatric institutions; nor can those questioning the power to punish be content with denouncing prisons as total institutions. The question is: how are such relations of power rationalized? Asking this is the only way to avoid other institutions, with the same objectives and the same effects, taking from their stead.[23]

Involuntary commitment is not treatment for the sake of public safety, but rather a "form of rationality" that takes on from its "stead," the penal system. If the goals of the penal system are to punish through violence, then involuntary commitment's goals will be relationally connected to commit such violence on people and bodies that are deemed deviant.

In order to understand how involuntary commitment has continued to grow, despite its failed results, we will connect it to the larger prison industrial complex.[24] We will use the concept of the "carceral state" or "carceral expansion" interchangeably, which refers to "the ways that ideology, economic policy, and legal/legislative initiatives have supported the growth of legal apparatuses associated with punishment."[25] Richie and Martensen explain the expanding carceral state has three characteristics:

> (1) that carceral expansion is not related to crime rates, (2) that the investment in punishment is directly related to divestment in other aspects of society that create equitable opportunity, and (3) that it is targeted toward the literal capture and metaphorical containment of black and other people of color, Indigenous peoples, transgender and gender-non-conforming people, young people from poor communities, people with mental health issues, and other groups who are disadvantaged by institutionalized oppression, and as such, it is an artifact of social control and exclusion.[26]

In the field of social work, and in particular feminist social work, recent attention has been given to how social services frequently adopt carceral logics and create partnerships with the carceral system. Richie and Martensen identify these types of services as "carceral services" that "replicate the control, surveillance, and punishment of the Prison Nation, and thus, punitive and social services can become indistinguishable."[27] Similar to how there are carceral services in social work, we argue that involuntary commitment laws act as one of many "carceral-health services" in health related fields.

Involuntary commitment can be seen as a carceral-health service very vividly through the various power relations and dynamics in the killing of Ronald Armstrong. The hospital that intimidated and frightened Armstrong, the physician that called the involuntary commitment order, the two hospital security guards, and the three law enforcement officers. Together these actors were following the law by executing Armstrong for resisting the commitment order.

A Public Health Abolition Praxis: Abolishing Carceral-Health Services

Black and Brown led resistance against prisons and police in the United States have a long history.[28] But many draw the beginnings of the current movement to abolish prisons and police to the 1998 international conference titled: *Critical Resistance: Beyond the Prison Industrial Complex*.[29] Together, they came to "address the alarming growth of the prison system, popularize the idea of the 'prison industrial complex' (PIC), and make 'abolition' a practical theory of change."[30] Abolitionist scholars explains how the theories, practices, writings, and strategies of the modern prison abolition movement can be found throughout the academic literature, as well as in the mass media and art.[31] Mariame Kaba, an abolitionist educator and organizer based in New York City, explains how prison industrial complex (PIC) abolition is

> "a political vision, a structural analysis of oppression, and a practical organizing strategy. While some people might think of abolition as primarily a negative project — "let's tear everything down tomorrow and hope for the best" — PIC abolition is a vision of a restructured society in a world where we have everything we need food shelter, education, health, art, beauty, clean water, and more things that are foundation to our personal and community safety … PIC abolition is a positive project that focuses, in part, on building a society where it is possible to address harm without relying on structural forms of oppression or the violent systems that increase it."[32]

The relationship between public health and abolition is not new and others have begun to recognize that "Public Health is strategy for Abolition," as critical resistance and other public health organizers and professionals expressed in an American Public Health Association (APHA) statement in 2018.[33] Recently, the statement was fully adopted by the APHA and affirms moving towards "the abolition of carceral systems and building in their stead just and equitable structures that advance the public's health."[34] PIC abolition,

The Journal of Law, Medicine & Ethics, 50 (2022): 23-30. © 2022 The Author(s)

according to Kaba, is much more than just eliminating laws such as involuntary commitment, or getting rid of armed officers that respond to mental health crises. It is about preventing further harm and violence from happening, and when it does occur, to not respond with more violence. A public health abolition praxis must follow what Mariame Kaba describes as the "positive project" of abolition. The positive project in public health abolition is to support existing systems of care, as well as creating new systems of care for those who use drugs or who have mental health crises. These alternative systems are not just often underfunded, many are just not funded at all. The existence of laws like involuntary commitment creates legislative and legal boundaries around who and how a community can intervene for those with substance use disorders or serious mental health issues. To prevent further harm, one must recognize that carceral-health services and health equity cannot co-exist. The PIC and health equity cannot co-exist. In an article published in *BMJ Global Health*, the authors emphasized how police violence and the larger carceral system extends beyond the U.S.[35] Additionally, an abolitionist public health is defined as "work directed towards at the dissolution of the Prison Industrial Complex, recognition of its discriminatory roots, and the implantation of interventions that tackle the social economic and political determinants of health at the root of societal problems, thus making policing obsolete."[36]

Utilizing a public health abolition framework, we contend that involuntary commitment must be abolished, along with all other carceral-health services, which are the conduits of the public health/healthcare to prison pipeline. Involuntary commitment and other carceral-health services will continue to exist in our public health system unless organized action is taken. We call on the fields of health law, public health, medicine, and all health-related fields to adopt a public health abolition praxis. With regards to involuntary commitment, an integrated evidence-based health and social service model in tandem with non-carceral community-based emergency and crisis response teams has the potential to respond to the wide range of crises that individuals can be in. By responding with compassion and practices that do not further harm the individual (punishment and incarceration), these alternative approaches exceed involuntary commitment because they actually address the issues, instead of caging them away.

In Los Angeles, grassroots organizations, organizers, and those directly impacted by the carceral system are a clear example of an abolitionist public health framework. In 2017 several community-based organizations in Los Angeles formed JusticeLA to collectively work toward shifting the city's dollars and investment away from police and prisons and into community-based systems of care.[37] In November of 2020, Los Angeles County voters approved the historic Measure J, which would dedicate 10% of the County's unrestricted budget, to fund alternatives to incarceration.[38] Through this coalition, and others like Re-imagine LA,[39] the LA County Alternatives to Incarceration (ATI) Workgroup report was produced to create a roadmap for how the county can be begin to fund the services and programs it needs to better respond to substance use or mental health related crises.[40] The recommendations in the ATI report include increasing non-carceral crisis mobile response teams, creating an alternate crisis response system (988 number), funding harm reduction services, supervised consumption sites, expanding access to medication for addiction treatment, and much more.

With regards to involuntary commitment, an integrated evidence-based health and social service model in tandem with non-carceral community-based emergency and crisis response teams has the potential to respond to the wide range of crises that individuals can be in. By responding with compassion and practices that do not further harm the individual (punishment and incarceration), these alternative approaches exceed involuntary commitment because they actually address the issues, instead of caging them away.

Conclusion

For far too long the fields of public health, medicine, and law have engaged in carceral-health services, that have shown to be harm and death producing, and not reducing. Carceral-health services disperse carceral power, reifying systems of punishment under the auspices of "treatment." Carceral-health services

The Journal of Law, Medicine & Ethics, 50 (2022): 23-30. © 2022 The Author(s)

https://doi.org/10.1017/jme.2022.5 Published online by Cambridge University Press

co-opt terms like "treatment" "rehabilitation," in order to maintain their power. Advocates are beginning to push back against the expanding carceral state, by resisting these carceral logics, and specifically seeking true alternatives to systems of punishment, including carceral-health services like involuntary commitment. In North Carolina, mental health and community health advocates point to how the carceral system and hospital emergency departments act as safety nets for all social ills, including those that result in anxiety, suicide, depression and substance use disorders. But they also express concern over the 91% increase in use of involuntary commitment in their state. One advocate explained how their grassroots efforts to provide mental health care that "is shifting from authoritative approaches to more responsive ones that engage individuals more effectively and with greater safety."[41] Advocates and organizers in North Carolina, Los Angeles, and around the world are continuing to resist and abolish carceral-health services and laws such as involuntary commitment. The work of the JusticeLA and Reimagine LA coalitions shows that an abolitionist public health framework works to dismantle systems and sites of oppression, and instead builds and reinforces systems and sites of care that address the root causes of violence and harm. Ronald Armstrong needed care and support. Involuntary commitment is unreformable and incapable of addressing crises. For this reason, involuntary commitment and all public health and medical partnerships with the carceral system should be abolished.

Note

The authors have no conflicts to disclose.

Acknowledgements

The authors would like to thank Emma Tran, M.P.H. for her work on reviewing earlier drafts.

References

1. J. Ryan, Attorney, "US Supreme Court United States Court of Appeals for the 4th Circuit Decides Limitations on TASER Use. LLRMI - Training and Expert Services for Law Enforcement, Jails & Corrections, Insurance Pools, Risk Managers, and Attorneys," October 27, 2016, *available at* <https://www.llrmi.com/articles/legal_update/2016_armstrong_v_village_of_pinehurst/> (last visited December 10, 2021).
2. *Id.*
3. M. Testa and S.G. West, "Civil Commitment in the United States," *Psychiatry Edgmont* 7, no. 10 (2010): 30-40; P.P. Christopher, B. Anderson, and M.D. Stein, "Civil Commitment Experiences among Opioid Users," *Drug Alcohol Dependence* 193 (2018): 137-141; P.P. Christopher, D.A. Pinals, T. Stayton, K. Sanders, and L. Blumberg, "Nature and Utilization of Civil Commitment for Substance Abuse in the United States," *Journal of the American Academy of Psychiatry and the Law* 43, no. 3 (2015): 8.
4. The Public Surveillance Program, "Long-Term Involuntary Commitment Laws," *available at* <https://lawatlas.org/datasets/long-term-involuntary-commitment-laws> (last visited December 10, 2021).
5. M.D. Thomas, N.P. Jewell, and A.M. Allen, "Black and Unarmed: Statistical Interaction between Age, Perceived Mental Illness, and Geographic Region among Males Fatally Shot by Police Using Case-Only Design," *Annals of Epidemiology* 53 (2021): 42-49, at e3.
6. L. Beletsky and D. Tomasini-Joshi, "Opinion: 'Treatment Facilities' Aren't What You Think They Are," *New York Times*, September 3, 2019, *available at* <https://www.nytimes.com/2019/09/03/opinion/opioid-jails-treatment-facilities.html> (last visited December 16, 2021).
7. K.P. Lindsey and G.L. Paul, "Involuntary Commitments to Public Mental Institutions: Issues Involving the Overrepresentation of Blacks and Assessment of Relevant Functioning," *Psychology Bulletin* 106, no. 2 (1989): 171-183; L. Hallam, "How Involuntary Commitment Impacts on the Burden of Care of the Family," *International Journal of Mental Health Nursing* 16, no. 4 (2007): 247-256; J. Swanson, M. Swartz, R.A. Van Dorn et al., "Racial Disparities in Involuntary Outpatient Commitment: Are They Real?" *Health Affairs (Millwood)* 28, no. 3 (2009): 816-826; O. Bennewith, T. Amos, G. Lewis G et al., "Ethnicity and Coercion among Involuntarily Detained Psychiatric In-Patients," *British Journal of Psychiatry* 196, no. 1 (2010): 75-76; M.L. Perlin, "Who Will Judge the Many When the Game Is Through: Considering the Profound Differences between Mental Health Courts and Traditional Involuntary Civil Commitment Courts," *Seattle University Law Review* 41, no. 3 (2017): 937-964; M.S. Swartz, S. Bhattacharya, A.G. Robertson, and J.W. Swanson, "Involuntary Outpatient Commitment and the Elusive Pursuit of Violence Prevention," *Canadian Journal of Psychiatry* 62, no. 2 (2017): 102-108; J. Cantarero, "The Ethics of Civil Commitment," *Journal of Health Biomedical Law* 16, no. 2 (2019): 105-126; H. Carlos and C. Pontiff, "Trick or Treatment? Confronting the Horrific Intersection of Race, Mental Health, Poverty, and Incarceration in Louisiana," *SSRN Electron Journal* (2019), *available at* <https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3383838> (last visited December 15, 2021); S.M. Caspar and A.M. Joukov, "Worse Than Punishment: How the Involuntary Commitment of Persons with Mental Illness Violates the United States Constitution," *Hastings Constitutional Law Quarterly* 47, no. 4 (2019): 499-532; M.S. Sinha, J.C. Messinger, and L. Beletsky, "Neither Ethical nor Effective: The False Promise of Involuntary Commitment to Address the Overdose Crisis," *Journal of Law, Medicine & Ethics* 48, no. 4 (2020): 741-743; P.P. Christopher, P.S. Appelbaum, and M.D. Stein, "Criminalization of Opioid Civil Commitment," *JAMA Psychiatry* 77, no. 2 (2020): 111-112; A. Feeney, E. Umama-Agada, A. Curley, M. Asghar, and B.D. Kelly, "Police Involvement in Involuntary Psychiatry Admission: A Report from the Dublin Involuntary Admission Study," *Psychiatric Services* 71, no. 12 (2020): 1292-1295; M.S. Swartz, "The Urgency of Racial Justice and Reducing Law Enforcement Involvement in Involuntary Civil Commitment," *Psychiatric Services* 71, no. 12 (2020): 1211-1211; G. Lee and D. Cohen, "Incidences of Involuntary Psychiatric Detentions in 25 U.S. States," *Psychiatric Services* 72, no. 1 (2021): 61-68.
8. *Id.* (Caspar and Joukov).
9. Lee and Cohen, *supra* note 7.
10. B.E. Richie and K.M. Martensen, "Resisting Carcerality, Embracing Abolition: Implications for Feminist Social Work Practice," *Affilia* 35, no. 1 (2020): 12-16.
11. J.S. Song, "Policing the Emergency Room," *Harvard Law Review* 134 (2021): 2646, *available at* <https://harvardlawreview.org/2021/06/policing-the-emergency-room/> (last visited December 16, 2021).
12. H. Hansen, "Assisted Technologies of Social Reproduction: Pharmaceutical Prosthesis for Gender, Race, and Class in the White Opioid 'Crisis,'" *Contemporary Drug Problems* 44, no. 4 (2017): 321-338.

The Journal of Law, Medicine & Ethics, 50 (2022): 23-30. © 2022 The Author(s)

13. Chief Executive Office: Los Angeles County, "The L.A. County Alternatives to Incarceration Initiative," October 5, 2020, *available at* <https://ceo.lacounty.gov/ati/> (last visited December 16, 2021).
14. T.J. Yosso, "Whose Culture Has Capital? A Critical Race Theory Discussion of Community Cultural Wealth," *Race Ethnicity and Education* 8, no. 1 (2005): 69-91.
15. C.I. Harris, "Whiteness as Property," *Harvvard Law Review* 106, no. 8 (1993): 1707-1791.
16. R.W. Gilmore, *Golden Gulag: Prisons, Surplus, Crisis, and Opposition in Globalizing California,* 1st ed. (Oakland: University of California Press: 2007).
17. K. Crenshaw, N. Gotanda, G. Peller, K. Thomas, "Critical Race Theory: The Key Writings That Formed the Movement," Columbia Law School: Scholarship Archive, 1995, *available at* <https://scholarship.law.columbia.edu/books/101> (last visited December 26, 2021).
18. M. Rodríguez-Muñiz, "Racial Arithmetic: Ethnoracial Politics in a Relational Key," in N. Molina, ed., *Relational Formations of Race* (Oakland: University of California Press, 2019): at 278-295.
19. S. Ware, J. Ruzsa, and G. Dias, "It Can't Be Fixed Because It's Not Broken: Racism and Disability in the Prison Industrial Complex," in L. Ben-Moshe, C. Chapman, A.C. Carey, eds., *Disability Incarcerated: Imprisonment and Disability in the United States and Canada* (New York: Palgrave Macmillan, 2014): at 163-184.
20. M. Foucault, *Discipline and Punish* (New York: Vintage Books, 1975).
21. L. Ben-Moshe, "Disabling Incarceration: Connecting Disability to Divergent Confinements in the USA," *Critical Sociology* 39, no. 3 (2013): 385-403.
22. C. Chapman, A.C. Carey, and L. Ben-Moshe, "Reconsidering Confinement: Interlocking Locations and Logics of Incarceration," in L. Ben-Moshe, C. Chapman, A.C. Carey, eds., *Disability Incarcerated: Imprisonment and Disability in the United States and Canada.* (New York: Palgrave Macmillan, 2014): at 3-24.
23. Foucault, *supra* note 20.
24. Critical Resistance: Beyond the Prison Industrial Complex 1998 Conference — Critical Resistance, September 1998, University of California, *available at* <http://criticalresistance.org/critical-resistance-beyond-the-prison-industrial-complex-1998-conference/> (last visited December 26, 2021).
25. Richie and Martensen, *supra* note 10.
26. *Id.*
27. *Id.*
28. D. Berger, *The Struggle Within: Prisons, Political Prisoners, and Mass Movements in the United States* (PM Press: 2014), *available at* <https://www.pmpress.org/index.php?l=product_detail&p=632> (last visited December 26, 2021).
29. See *supra* note 24.
30. *Id.*
31. D.E. Roberts, "The Supreme Court 2018 Term," *Harvard Law Review* 133 (2019): 122; D. Rodríguez, "Abolition as Praxis of Human Being: A Foreword," *Harvard Law Review* 132 (2019): 38; C. Nast, "The Emerging Movement for Police and Prison Abolition," *The New Yorker*, May 21, 2021, *available at* <https://www.newyorker.com/news/our-columnists/the-emerging-movement-for-police-and-prison-abolition> (last visited December 26, 2021).
32. M. Kaba, *We Do This 'Til We Free Us: Abolitionist Organizing and Transforming Justice*, 2021, *available at* <https://bookshop.org/books/we-do-this-til-we-free-us-abolitionist-organizing-and-transforming-justice-9781642595253/9781642595253> (last visited December 26, 2021).
33. "A National Abolitionist Victory for Public Health!" Critical Resistance, *available at* <http://criticalresistance.org/apha/> (last visited December 26, 2021).
34. End Police Violence Collective, *available at* <https://www.endingpoliceviolence.com> (last visited December 26, 2021).
35. T.A. Deivanayagam, S. Lasoye, J. Smith, and S. Selvarajah, "Policing Is a Threat to Public Health and Human Rights," *BMJ Global Health* 6, no. 2 (2021): e004582.
36. *Id.*
37. JusticeLA, "Fighting the L.A. County Jail Expansion," January 30, 2021, *available at* <https://justicelanow.org/> (last visited December 26, 2021).
38. Los Angeles County, "Measure J Background," November 17, 2020, *available at* <https://ceo.lacounty.gov/measure-j-background/> (last visited December 26, 2021).
39. Re-Imagine L.A. County, *available at* <https://reimagine.la/> (last visited December 26, 2021).
40. See *supra* note 13.
41. R. Craver, "Mental Health Advocates Say North Carolina Is Headed toward Crisis. They're Asking Lawmakers for Help," *Winston-Salem Journal*, June 21, 2021, *available at* <https://journalnow.com/news/local/mental-health-advocates-say-north-carolina-is-headed-toward-crisis-they-re-asking-lawmakers-for/article_ec710aa6-d2cc-11eb-8033-03936e2cbdab.html> (last visited December 26, 2021).

The Journal of Law, Medicine & Ethics, 50 (2022): 23-30. © 2022 The Author(s)