AN UNTENABLE SPACE: THE DILEMMA OF BLACK FAMILIES CARING FOR A LOVED ONE WITH SEVERE MENTAL ILLNESS AND AN ARGUMENT FOR A LEGISLATIVE SOLUTION

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The road from family member to advocate is marked by a desperate crash course in severe mental illness (SMI) and statutory law. The journey begins with the bizarre behavior of someone you care for and the legal obstacles that foster the continuation of the bizarre behavior. That troubling behavior, when left untreated, devolves into dangerousness while also ripping a family's sense of safety to pieces. The nature of my brother's SMI was so disruptive that my two younger sisters, while in grade school, moved out of our family home to live with relatives so they could finish school without the daily threat of insecurity.

My mother often missed work to provide the twenty-four-hour monitoring required for someone with the inability to decipher hallucination from reality. Our home, once the epicenter of holiday parties and family

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gatherings, became a desolate pseudo-asylum where my brother was given a wide berth to act out while under the care of my mother—a math professor.

Once my mother, due to leave for work, called me in a panic. My brother was lying in the backyard nude so that the sun could heal the scales that he believed covered his body. Over the phone she strategized through tears about who to call for help. It was not a decision to be made lightly. Does a Black mother call the police on her son, who is ill, and have him charged with a crime? Does she leave him there and go to work? Does she miss work and, having no prior training or experience with mental illness, try to address the crisis? These are the choices. This is the untenable space. I became an advocate when I realized we were not only expected to trudge through life this way but were legally prevented from saving our family.

Families taking care of a loved one with an untreated severe mental illness carry a burden that throws them into a daily existence of fight or flight, where they don't live, but navigate from crisis to crisis. Severe mental illness is all consuming; loved ones, like my brother, who lack the ability to volunteer for services or resources remain trapped in their own delusions and unable to make choices for themselves. Laws require us to watch as our loved ones languish untreated and fall into an abyss of refusing to bathe, eat or speak for weeks at a time; and somehow at the last possible minute, when they or someone else is on the brink of death, our only tool is to call the police.

Black families dealing with SMI embody an especially difficult predicament because of a documented higher likelihood of harm from police interaction with people who are Black and living with SMI.[1] The tools the police wield are especially troubling. At our loved ones' most vulnerable moments, we are forced to call officers who may have no SMI de-escalation or racial bias training. Instead of medical equipment, they respond to a vulnerable person, likely already hallucinating, with blinding flashing lights, handcuffs, and horribly, guns.

Families with a severely mentally ill individual living in their home must navigate a complex network of mental illness treatment in order to access psychiatric services for their relative. That existence is never easy for a family, but it is made more difficult by the necessary reality of involving law enforcement in what is a civil, and not criminal, ordeal. State civil commitment laws provide both the criteria and the process for committing a person to treatment over the patient's own objection.[2]

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1. Amam Z. Saleh et al., *Deaths of People with Mental Illness During Interactions with Law Enforcement*, 58 INT'L J. L. & PSYCHIATRY 110, 110–16 (2018).

2. *Know the Laws in Your State*, TREATMENT ADVOC. CTR., https://www.treatmentadvocacycenter.org/component/content/article/183-in-a-crisis/1596-know-the-laws-in-your-state (last visited June 12, 2021). The laws of every state provide for involuntary civil commitment to inpatient treatment and the laws of forty-six states allow involuntary commitment to outpatient treatment. *Id*. This Article deals exclusively with inpatient commitment.

This Article begins with the history of mental illness treatment in the United States as a context for involuntary commitment,[3] explains the predicament of family caregivers attempting to obtain appropriate treatment for someone with SMI,[4] expounds upon the untenable space occupied by Black families in these situations[5] and concludes with practical proposals for state legislative action in Texas that would greatly abate barriers to care and lessen the strain on those families.[6]

I. BACKGROUND: A BRIEF HISTORY OF MENTAL ILLNESS TREATMENT

The mental healthcare system in the United States is not one system at all, but rather at least fifty-six disjointed pieces—the fifty states, the District of Columbia, and the five territories with permanent civilian populations. At most, the mental healthcare system is thousands of pieces—those jurisdictions plus different levels of local governmental entities and quasi-governmental organizations that exercise policymaking power related to mental health treatment—with varying levels of consistencies and inconsistencies relative to the different parts.[7]

It is a "system" born of an unfortunate history prior to the mid-1960s, failed federal policy post-1960s, underfunding, and misguided spending at every level of government. If that were not enough to cripple any network of services, it is also constantly caught up in the public policy battles of federalism and the vital debates over civil liberties and social justice.[8] When viewed through the lens of history with a critical eye for effectiveness, it is astounding that healthcare professionals find a way to provide psychiatric services at all.

Prior to the 1960s, the history of mental illness treatment was fraught with pseudo-science and practices that were, by both subject-matter experts and the general public by the late 20th century, considered not only ineffective but inhumane.[9] This was a time of frontal lobe lobotomies and

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3. *See infra* Part II (examining a brief history of mental illness treatment in the U.S.).

4. *See infra* Part III (explaining the predicament family caregivers have in obtaining treatment for someone with SMI).

5. *See infra* Part III (expanding upon the untenable space occupied by Black families in situations when they are dealing with a SMI family member).

6. *See infra* Part IV (examining practical proposals for legislative action in the state of Texas that would help to lessen the strain on families and provide better access to care).

7. *See The U.S. Healthcare System: An International Perspective*, DEPT. FOR PROF. EMPS. (Aug. 15, 2016), https://www.dpeaflcio.org/factsheets/the-us-health-care-system-an-international-perspective.

8. *See Healthcare Crisis: Healthcare Timeline*, PBS, https://www.pbs.org/healthcarecrisis/history.htm (last visited June 12, 2021); *see* Mary Gerisch, *Health Care as a Human Right*, AM. BAR ASS'N (Oct. 23, 2018), https://www.americanbar.org/groups/gpsolo/publications/gpsolo_ereport/2018/october-2018/health-care-as-human-right/.

9. *See* GERALD N. GROB, MENTAL ILLNESS AND AMERICAN SOCIETY, 1875–1940 (1983); SANDER L. GILMAN, SEEING THE INSANE: A CULTURAL HISTORY OF MADNESS AND ART IN THE WESTERN WORLD (1982).

other treatments that were born of desperation in an attempt to find some solution to the overcrowded asylums.[10] People and families impacted by mental illness knew that the practice of confining anyone not well enough to function in society to asylums and psychiatric wards was not only unsustainable from a pragmatic point of view but an unacceptable way to treat patients.[11]

The 1960s brought major policy shifts regarding the medical treatment of people with mental illness.[12] As with so many aspects of federal policy in that decade, the shift came not from Congress, and not only from state and local groundswells, but from within the administrations of Presidents John F. Kennedy and Lyndon Johnson.[13] President Kennedy's younger sister, Rosemary Kennedy, suffered from an intellectual disability and likely had a severe mental illness.[14] She was lobotomized at age twenty-three in a misguided attempt to treat her symptoms.[15] Joseph Kennedy Sr., the patriarch of the Kennedy dynasty, made that decision unilaterally and, in the aftermath that included Rosemary's descent into a state where she could not communicate coherently, he forbade any family from visiting her.[16]

This ordeal left a lasting impact on her siblings and played a part in the last piece of major legislation signed by President Kennedy, the Mental Retardation and Community Mental Health Centers Construction Act of 1963, or "Community Mental Health Act."[17] Intended to deinstitutionalize the mental healthcare system and shift treatment towards less-restrictive community-based services, it had two major flaws—it relied on large and continuous sums of federal funding for community-based services, and it failed to take into account the fact that there are people with mental illness

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10. Miguel A. Faria, Jr., *Violence, Mental Illness, and the Brain-A Brief History of Psychosurgery: Part 1-From Trephination to Lobotomy*, SURGICAL NEUROLOGY INT'L (Apr. 5, 2013), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3640229/.

11. *See Mental Health Treatment: Then and Now*, LUMEN, https://courses.lumenlearning.com/wmopen-psychology/chapter/introduction-to-mental-health/ (last visited June 12, 2021).

12. *A Brief History of Mental Illness and the U.S. Mental Health Care System*, UNITE FOR SIGHT, https://www.uniteforsight.org/mental-health/module2 (last visited June 12, 2021).

13. This is not to say that Congress was without power or influence. In fact, the Southern Democrat_dominated congresses of the 1960s were an integral part in both progressive and conservative policy shifts of the era. Julian Zelizer provides a political history of one example of the dynamics at work between the Executive and Legislative branches during the Johnson administration. *See* Julian E. Zelizer, *The Contentious Origins of Medicare and Medicaid*, *in* COHEN ET AL., MEDICARE AND MEDICAID AT 50: AMERICA'S ENTITLEMENT PROGRAMS IN THE AGE OF AFFORDABLE CARE (2015).

14. ROSE F. KENNEDY, TIMES TO REMEMBER 286 (1974); Interview by John F. Stewart with Bertram S. Brown, former director, Nat'l Inst. of Mental Health (Aug. 6, 1968); E. FULLER TORREY, MD, AMERICAN PSYCHOSIS: HOW THE FEDERAL GOVERNMENT DESTROYED THE MENTAL ILLNESS TREATMENT SYSTEM 10 (2014).

15. KENNEDY, *supra* note 14, at 11.

16. LARRY TYE, BOBBY KENNEDY: THE MAKING OF A LIBERAL ICON 220–21 (2016); *see also* TORREY, *supra* note 14, at 11–15 (discussing how the federal government's approach to mental health policy shifted).

17. Community Mental Health Act, Pub. L. No. 88-164, 77 Stat. 282 (1963) (codified as amended in sections of 42 U.S.C. §§ 2661–2698b).

whose symptoms are so severe that during acute episodes community services alone are inadequate.[18]

The result of the Community Mental Health Act and the policy shift it represented has been a set of state laws and locally-delivered psychiatric, housing, transportation, education, and other services trying to patch together the myriad of resources needed to treat psychiatric illnesses from public and private funding.[19] Services for people with the most severe forms of mental illness—schizophrenia, schizoaffective disorder, bipolar disorder, major depression, and other psychotic disorders—suffered from underfunding and lack of physical resources, like fully-staffed inpatient beds.[20] As it became harder to find inpatient and residential facilities for people living with severe mental illness, the need for those services far outpaced their availability.[21]

The lack of federal support for inpatient facilities left state governments as the major funding source for inpatient psychiatric institutions.[22] Private institutions also exist and full service hospitals provide some psychiatric

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18. *See generally* HENRY A. FOLEY & STEVEN S. SHARFSTEIN, MADNESS AND GOVERNMENT: WHO CARES FOR THE MENTALLY ILL? (1983); TORREY, *supra* note 14, at 61–92.

19. Community Mental Health Act, Pub. L. No. 88-164, 77 Stat. 282 (1963) (codified as amended in sections of 42 U.S.C. §§ 2661–2698b).

20. Two major results of the policy shift are the institutions for mental diseases (IMD) exclusion to Medicaid and the 190-day lifetime limit on inpatient psychiatric care through Medicare. *See* 42 U.S.C. § 1396d(a)(30)(B) (omitting Medicaid reimbursement for medical services rendered in an IMD); 42 C.F.R. § 409.62 (requiring a Medicare lifetime limit of 190 days of inpatient psychiatric services). Both federal programs were products of the 89th Congress and priorities of the Johnson administration. *See id.* In the spirit of deinstitutionalization, federal Medicaid funds may not be used to reimburse for medical services provided in mental health treatment facilities with more than sixteen inpatient beds absent a waiver to the contrary. *See* 42 U.S.C. § 1396d(a)(30)(B). This is a significant obstacle for people with severe mental illness in need of psychiatric treatment because Medicaid inherently provides coverage for low-income individuals and people with debilitating mental illness symptoms often live in poverty. Additionally, Medicare will not pay for more than 190 days of psychiatric treatment for a Medicare enrollee, which was less relevant to SMI in the 1960s, but created a major barrier to care in the subsequent decade when Congress extended Medicare eligibility to Social Security Disability Income (SSDI) recipients. *See* 42 C.F.R. § 409.62. Federal policy aimed at preventing overuse of inpatient treatment facilities has created bed shortages for patients needing more than just community-based services to be stable. *See* 42 U.S.C. § 1396d(a)(30)(B) (omitting Medicaid reimbursement for medical services rendered in an IMD); 42 U.S.C. § 1396d(i) (defining IMDs as a psychiatric facility of more than sixteen inpatient beds); 42 C.F.R. § 409.62 (requiring a Medicare lifetime limit of 190 days of inpatient psychiatric services).

21. *See, e.g.*, Doris A Fuller et al., *Going, Going, Gone: Trends and Consequences of Eliminating State Psychiatric Beds*, TREATMENT ADVOC. CTR. 2 (2016), https://www.treatmentadvocacycenter.org/storage/documents/going-going-gone.pdf. One example of limited resources is the national bed shortage:

> [A] majority of states maintain wait lists for their forensic beds, and some lists are months long. As more beds are diverted to the forensic population, fewer beds are left for people who haven't committed crimes. "Boarding" patients in mental health crisis to wait in loud, chaotic hospital emergency rooms has become virtually universal as the number of beds for non-offenders has shrunk. A growing number of states are resorting to hospital beds behind bars for criminal offenders—psychiatric treatment facilities operated by corrections systems instead of mental health departments. New Hampshire even sends selected civil patients there.

Id.

22. *See id.* at 29 (discussing issues state governments face as the major funding source for these institutions and calling for federal action).

care.[23] Regardless of the type of treatment facilities available in a local area, people with severe mental illness that present psychosis periodically need inpatient care.[24] Consistently accessing that care is difficult enough if the patient voluntarily seeks treatment, but delusions, hallucinations, and a condition called anosognosia often rob individuals with SMI of the self-awareness necessary to seek treatment on their own.[25]

When someone lacks insight into their own condition but is psychotic or has otherwise deteriorated to the point of posing a harm to themselves or others, mechanisms within the laws of every state allow involuntary commitment to an inpatient treatment facility.[26] Each state's set of involuntary commitment laws are different and, as the main symptom of federalism, they are guided only by a loose framework of tangentially related federal law.[27]

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23. Psychiatric beds have low financial returns in full-service hospitals, disincentivizing those facilities from providing enough inpatient psychiatric beds to meet demand. *See* Paul Sisson, *Hospitals Lose Money Caring for Mental Health Patients; Is there a Better Way?*, SAN DIEGO UNION-TRIBUNE (July 1, 2019), https://www.sandiegouniontribune.com/news/health/story/2019-07-01/hospitals-lose-money-caring-for-mental-health-patients-is-there-a-better-way.

24. *See generally* FOLEY & SHARFSTEIN, *supra* note 18 (identifying the individuals who care for people who need inpatient care and the systems flaws).

25. Anosognosia is a condition when a patient has "no awareness of their own illness or need to take medication." TORREY, *supra* note 14, at 95. Torrey elaborates that anosognosia can happen "when specific areas of the brain are damaged, as also occurs in Alzheimer's disease and some individuals with strokes. Individuals with serious mental illness who are unaware of their own illness usually do not take medication voluntarily and thus have a high relapse rate when living in the community." *Id*. The effects of anosognosia are a driving factor behind involuntary civil commitment in the United States. At times, controversial as a symptom of SMI, at least two hundred studies have documented the lack of insight in some patients. Treatment Advoc. Ctr., *Anosognosia 1 of 2*, YOUTUBE (July 7, 2010), https://www.youtube.com/watch?v=88kG8Qx2Xs8&feature=emb_logo; DJ JAFFE, INSANE CONSEQUENCES: HOW THE MENTAL HEALTH INDUSTRY FAILS THE MENTALLY ILL 253–55 (2017). Furthermore, physical indicators of anosognosia are detectable in some patients' brains via computerized tomography (CT) scans. *See* F. Laroi et al., *Unawareness of Illness in Chronic Schizophrenia and Its Relationship to Structural Brain Measures and Neuropsychological Tests*, 100 PSYCHIATRY RSCH: NEUROIMAGING 49–58 (Aug. 21, 2000).

26. *See generally* Dailey et al., *Grading the States: An Analysis of U.S. Psychiatric Treatment Laws*, TREATMENT ADVOC. CTR. (Sept. 2020), https://www.treatmentadvocacycenter.org/storage/documents/grading-the-states.pdf (introducing a state-by-state survey of involuntary treatment laws with criteria-based evaluations of the effectiveness of each state's statutory language).

27. Federal law played a limited role in regulating involuntary commitment—other than the funding constraints of Medicaid and Medicare. *See* 42 U.S.C. § 1396d(i). This was the reality until the landmark case of *Olmstead v. L.C.*, 527 U.S. 581 (1999), in which the Supreme Court ruled that mental illness is a disability subject to the Americans with Disabilities Act (ADA), 42 U.S.C. ch. 126 § 12101 et seq. Regarding involuntary inpatient commitment, the Court held that "unjustified isolation" constitutes discrimination under Title II of the ADA. *See Olmstead*, 527 U.S. at 597. *Olmstead* aimed to prevent institutionalization in a way that avoided "unwarranted assumptions" that people with mental diseases are "unworthy of participating in community life" and also to prevent decreased quality of life for people with SMI. *See id.* at 584. *Olmstead* has since become the cornerstone of advocates who do not believe in the benefits of civil commitment, but those voices tend to ignore vital pieces of the majority opinion. For example, the majority opinion states:

> [P]lacement outside the institution [*i.e.*, outpatient treatment as opposed to inpatient commitment] may [n]ever be appropriate . . . 'Some individuals, whether mentally retarded or mentally ill, are not prepared at particular times—perhaps in the short run, perhaps in the long run—for the risks and exposure of the less protective environment of community settings' . . .

Statutes defining the process for civilly committing a person to psychiatric treatment over the person's objection are a function of a state legislature's *parens patriae* powers and, although the crucial details of state laws vary widely, most states follow a basic process.[28] First, a person who is experiencing a psychiatric crisis may be removed from the community under a temporary emergency hold so that mental health professionals can evaluate their condition and determine what type of treatment is appropriate but least restrictive.[29] Then, if the patient meets the state's criteria for commitment, a court may initiate a statutorily defined process for longer term inpatient treatment.[30]

One element that the inpatient commitment process has in common in all fifty states and the District of Columbia is that law enforcement officers are permitted to transport someone in need of an emergency evaluation to an appropriate facility.[31] A vital part to understanding the uniqueness of civil commitment for mental illness is that it is civil and not criminal in nature.[32] A person need not, in theory, commit a crime in order to be taken into custody for the purposes of transportation to a treatment facility for evaluation.[33] However, the inadequacies and inconsistencies in civil commitment laws mean that the person who is seeking to get another person (often a close relative) committed has to wait in a delicate space between the time when the person with SMI may meet the commitment criteria and an impending time in which they may either harm themselves or criminally harm someone else.[34] Either way, there will be law enforcement officers involved.[35]

II. FAMILIES

People who are responsible for the health and well-being of an adult relative with severe mental illness navigate a complex and often inadequate

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'institutional settings are needed and must remain available.'

Id. at 606 (quoting Brief for American Psychiatric Association et al. as *Amicus Curiae* 22–23). This is a long running debate with opponents of involuntary commitment laws believing that civil commitment is a violation of civil liberties and proponents of involuntary commitment, when it is the least restrictive means of accessing treatment, believing that anosognosia and other elements of SMI necessitate and prove *Olmstead*'s reasoning that, for some people, "no placement outside the institution may ever be appropriate." *Id.* at 606. The proponents of involuntary commitment believe that this is especially the case for a limited amount of time until an individual is stable enough for community based treatment.

28. *See generally* Dailey et al., *supra* note 26 (analyzing states' involuntary treatment laws).

29. *See Olmstead*, 527 U.S. at 599 (citing 89 Stat. 502, 42 U.S.C. § 6010(2) (1976 ed.)) (noting that a key component of civil commitment is that it must be the "least restrictive" means of obtaining appropriate treatment).

30. *See* Dailey et al., *supra* note 26, at 14.

31. *Id.*

32. *Id.*

33. *Id.*

34. *Id.* at 15.

35. *See id.* at 12–16.

system of treatment.[36] These caregivers, known simply but accurately as "family members" within the loosely-knit community of advocates for mental illness treatment reform, live an onerous life that is hard for non-family members to appreciate.[37] One of the most difficult but common aspects of these caregivers' struggle is weighing the decision to involve law enforcement officers in a situation that is not criminal, but clinical in nature.[38]

Law enforcement officers respond to calls from family members when a relative with SMI poses a dangerous threat to themselves or others.[39] Police would also respond to a situation in which a person without SMI poses danger, but a person without mental illness or some other behavioral health disorder only poses danger if the person possess the *mens rea* to cause harm by committing a crime.[40] The struggle for family members compelled to call the police is that they know the person with SMI lacks the necessary *mens rea* to be legally culpable for a crime.[41] Family members know that the requisite *mens rea* is missing, and yet they still involve law enforcement.[42] The family members do so because calling the police is the only option to prevent harm.[43]

In some states, calling the police is the only way to access involuntary care.[44] Calling law enforcement would not be the only option if involuntary commitment laws allowed clinical intervention at an earlier and more appropriate part of a person's digression into dangerous behavior.[45]

Civil commitment for mental illness treatment is governed by state laws that provide involuntary treatment for psychiatric illness.[46] Each state has its own legal mechanisms for committing an individual to treatment that rely on criteria that must be met in court as a part of the petition process.[47] In an ideal system, those criteria would allow for families to successfully petition for involuntary treatment prior to an individual's SMI symptoms reaching the level of severity that they are near the point of criminal or imminent harm.[48]

Poorly written, seldom used, or otherwise insufficient civil commitment laws make it difficult for family members to get a person with SMI into

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36. For a comprehensive analysis of the difficulties families face when seeking treatment for a relative's severe mental illness, see PETE EARLEY, CRAZY: A FATHER'S SEARCH THROUGH AMERICA'S MENTAL HEALTH MADNESS (2007).

37. *See* Dailey et al., *supra* note 26, at 18 (discussing the difficulties of mental illness on others in the community).

38. *See* EARLEY, *supra* note 36, at 424.

39. *Id.* at 418.

40. *See id.* at 423–24.

41. *See id.* at 424.

42. *See id.*

43. *See id.*

44. *See id.* at 423–24.

45. *See id.*

46. *See generally* Dailey et al., *supra* note 26 (providing a state-by-state survey of involuntary treatment laws with criteria-based evaluations of the effectiveness of each state's statutory language).

47. *See id.* at 9.

48. *See id.* at 17–18.

treatment, even when the person with the illness is incapable of helping themselves[49] and the family knows that effective courses of treatment exist. Absent adequate civil commitment laws, families must wait until their relative's behavior reaches the level of potential criminal activity or imminent self-harm and are then forced to invite law enforcement officers into their homes.[50]

III. THE UNTENABLE SPACE: RACE, MENTAL ILLNESS, AND LAW ENFORCEMENT

Recent events in the United States have publicly re-exposed the longstanding troubles between law enforcement and Black Americans.[51] For Black people with a mentally ill family member living in their home, they are caught in an especially difficult space created by both the realities that all families face when seeking treatment for a loved one and the added tension of being Black and making the decision to invite law enforcement into their homes.

The apprehension that Black family members feel toward involving law enforcement—a feeling of added risk to everyone in the household but particularly a relative with SMI in the home—is not built on mere assumption or anecdote.[52] While all family members experience the aforementioned risks to their relatives when law enforcement officers respond to their homes, the risk of death to a person with mental illness when confronted by police is 30.8% higher if the person is Black as opposed to White.[53]

Several studies have examined police use of force with the mentally ill and Black people, and looked for overlapping propensity of officers to use deadly force and the public's perception of such uses of force.[54] They found results that give credence to Black family members' reluctance to involve law enforcement even though their loved one with SMI poses a risk of harm

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49. *See supra* note 25 (discussing anosognosia).

50. *See* Dailey et al., *supra* note 26, at 17–18, 21–22.

51. Sabah Muhammad, *Daniel Prude's Death is a Nightmare Scenario for Black Families Like Mine*, WASH. POST (Sept. 7, 2020), https://wwwwashingtonpost.com/opinions/2020/09/07/daniel-prude-death-policing-mental-illness/.

52. *See generally* Saleh et al., *supra* note 1, at 110, 112 (examining death rates based on mental illness status, race, and other variables and found that Black people with SMI experience higher death rates than Whites in law enforcement interactions); Camille A. Nelson, *Racializing Disability, Disabling Race: Policing Race and Mental Status*, 15 BERKELEY J. CRIM. L. 1–64 (2010) (finding that police routinely used excessive force against persons of color that have a mental illness); Hyun-Jin Jun et al., *Police Violence among Adults Diagnosed with Mental Disorders*, 45 HEALTH & SOC. WORK 81–89 (2020) (showing that people with mental illness are more likely to experience violence in police encounters, regardless of whether they are involved in actual criminal activity).

53. *See* Saleh et al., *supra* note 1, at 110, 112 (using data from police interactions with civilians in 2015, the death rate per million of White people with SMI was 19.6. For Black people with SMI, it was 25.63).

54. *Id.*

to themselves or others in the home.[55] Not only is a Black individual with SMI more likely to experience deadly force in police encounters, but according to one troubling result found by Drs. Kimberly Barsamian Kahn, Melissa Thompson, and Jean M. McMachon, the public's support for use of force with such individuals is higher compared to the use of force with White mentally ill individuals:

> Mental illness may signal to the public that police officers should take into account this condition as a mitigating factor, potentially by approaching with different de-escalation tactics, and ultimately avoid escalating to force. However, Black suspects did not receive the same level of public protection regarding mental illness status, with mental illness histories instead *increasing public support for police force*, although the levels of support were still low overall. That is, individuals were relatively more supportive of force toward Black suspects when mental illness was involved.[56]

Therefore, not only does objective data show a higher likelihood of a mentally ill Black suspect being killed by law enforcement, but public opinion itself necessitates a Black family exercising a higher level of scrutiny on their own pending decision when there is a psychiatric crisis in the home.[57] Black families have good reason to hesitate in calling law enforcement, even when they know it is the only viable option. It is this hesitation—that rational reluctance to invite law enforcement into the home—that puts Black families in an even more difficult position than other families struggling with a relative in need of immediate treatment for SMI. Civil commitment laws deny most Texas families the chance to obtain treatment for a relative before SMI symptoms reach the point of crisis.[58] They must wait until a deeply personal crisis necessitates law enforcement involvement. For Black families, that time of waiting constitutes living in an untenable space.

IV. STATUTORY CHANGES

Limitations and insufficiencies in Texas law create the untenable space occupied by Black families.[59] Statutory changes can put an end to the untenable space by addressing the lack of more timely access to treatment through involuntary commitment before a Black person with SMI engages in

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55. *See id.* at 114–15.

56. Kimberly Barsamian Kahn et al., *Privileged Protection? Effects of Suspect Race and Mental Illness Status on Public Perceptions of Police Use of Force*, 13 J. EXPERIMENTAL CRIMINOLOGY 171, 183 (2017) (emphasis added).

57. *See id.* at 183–84.

58. *See* Dailey et al., *supra* note 26, at 130 (analyzing whether an individual who needs involuntary evaluation or treatment can receive it in a timely fashion, for sufficient duration, and in a manner that enables and promotes long-term wellbeing. Texas received a C+.).

59. *See id.*

the *actus reus* of a crime, or otherwise rises to the level necessitating law enforcement involvement.[60]

A. Clearly Define Dangerousness

The untenable space families are forced to navigate is marked by periods of waiting for a loved one to reach crisis level before they can access treatment. This means daily crises like paranoia, which evokes fight or flight, or starvation and homelessness become commonplace living conditions for families until the behavior of their loved ones inevitably rises to a legally sufficient level of dangerousness.[61] The Texas criteria for dangerousness in the context of involuntary commitment is statutorily defined but only vaguely, and a more clearly worded definition would allow family members to access mental illness treatment through the judicial system at an earlier stage of their relative's symptoms.[62]

Dangerousness is the core concept of determining eligibility for involuntary commitment. As Dailey et al. explains: "[S]tates have the authority to intervene and provide involuntary care if an individual poses a danger to self or to other people. Any basis for involuntary treatment fits within one of these two overarching categories."[63] An effective dangerousness standard should be worded in such a way that a court can apply it to anyone who, because of mental illness, poses a threat of harm to self or others.[64] Texas's dangerousness standard is too vague to be effective.[65]

Under current law, the court must determine whether someone is "likely to cause serious harm to [themselves]" or "likely to cause serious harm to

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60. Michelle Raji, *Why is APD Responding to Mental Health Crises Like Violent Crimes?*, TEX. OBSERVER (June 4, 2020), https://www.texasobserver.org/mauris-desilva-austin-protests-police/ (explaining that all individuals diagnosed with SMI risk having a deadly encounter with police officers, however Black families experience the added element of racism and often experience different outcomes. Morgan Rankins, a thirty-year-old Black woman diagnosed with bipolar disorder, was killed by an Austin police officer while holding a knife during an episode of psychosis, and Maurius DeSilva, a neuroscientist and person of color battling severe depression, was killed for allegedly wielding a knife at officers Joseph Cast and Karl Kyrcia. Nine months prior to DeSilva's death, officers Cast and Kyrcia confronted a knife-wielding Caucasian woman during an episode of psychosis and were able to tase and arrest her. It was reported that the woman yelled threats and refused to drop the knife).

61. *See Civil Commitment and the Mental Health Care Continuum: Historical Trends and Principles for Law and Practice*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN. 4 (2019) [hereinafter SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN], https://www.samhsa.gov/sites/default/files/civil-commitment-continuum-of-care.pdf.

62. *See* TEX. HEALTH & SAFETY CODE ANN. § 574.034.

63. Dailey et al., *supra* note 26, at 13.

64. HEALTH & SAFETY § 574.034(a)(2); *see* Dailey et al., *supra* note 26, at 21.

65. Texas does not include any requirement of "imminent" harm, which is one strength of the state's dangerousness standard. *See* HEALTH & SAFETY § 574.034(a)(2). Texas's dangerousness standard is in fact stronger and more effective than many states' standards, but still needs improvement to quell the untenable space. *See id.* The inclusion of specific criteria, as well as the lack of a requirement that the harm be imminent, makes the Texas statutory language more effective than several states, including Texas's neighboring state of Oklahoma. *See* Dailey et al., *supra* note 26, at 21.

others."[66] The ambiguity of the language is problematic. The court must determine what exactly it means for "serious harm" to be "likely."[67] Too much is left for interpretation in what should be a relatively straightforward analysis of an individual's state of mind. By contrast, Mississippi's dangerousness standard provides guidance to the court that helps determine whether someone has met the criterion: "[Any person who] poses a substantial likelihood of physical harm to himself or others in that there has been (A) a recent attempt or threat to physically harm himself or others, or (B) a failure and inability to provide necessary food, clothing, shelter, safety, or medical care for himself."[68]

Arkansas's legislative guidance is even stronger:

> "[A] clear and present danger to himself or herself" is established by demonstrating that:
>
> (A) The person has inflicted serious bodily injury on himself or herself or has attempted suicide or serious self-injury, and there is a reasonable probability that the conduct will be repeated if admission is not ordered;
>
> (B) The person has threatened to inflict serious bodily injury on himself or herself, and there is a reasonable probability that the conduct will occur if admission is not ordered; or
>
> (C) The person's recent behavior or behavior history demonstrates that he or she so lacks the capacity to care for his or her own welfare that there is a reasonable probability of death, serious bodily injury, or serious physical or mental debilitation if admission is not ordered . . . .[69]

Mississippi's and Arkansas's dangerousness standards are written to allow families access to the legal mechanisms of involuntary commitment and shorten the waiting period between the time that their mentally ill relative's symptoms are present and their ability to get that relative into treatment.[70] Compared to Texas law, Mississippi and Arkansas courts are not left to interpret the meaning of "likely serious harm,"[71] but rather are given direction, *i.e.*, "has attempted suicide or serious self-injury," or "has threatened to inflict serious bodily injury on himself or herself."[72] In the latter (Arkansas) example, the court is even directed to determine whether, "there

66. HEALTH & SAFETY § 574.034(a)(2).

67. *See id.*

68. *See* MISS. CODE ANN. § 41-21-61(g) (2019). Inability to provide for one's own basic needs is an aspect of grave disability discussed in the preceding section of this Article. *See id.*

69. ARK. CODE ANN. §§ 20-47-207(c)(2)(A)–(C) (2009).

70. *See* SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., *supra* note 61, at 11–13.

71. *See* HEALTH & SAFETY §§ 574.034(a)(2)(A)–(B).

72. *See* ARK. §§ 20-47-207(c)(2)(A)–(C).

is reasonable probability" that harm will occur if the person is not committed to inpatient psychiatric care.[73] Similar clarification to Texas's dangerousness standard would partially address the plight of families living in the untenable space.

B. Include a Psychiatric Deterioration Standard

In conjunction with a clearly defined dangerousness standard, effective inpatient commitment criteria should include language for grave disability and psychiatric deterioration. Both grave disability and psychiatric deterioration elaborate on ways that an individual with SMI can pose harm to himself.[74] Suicidal behavior or violent harm to one's own body should not be the only indicators of self-harm due to mental illness.[75] If a state's inpatient commitment criteria either lacks elements of grave disability and psychiatric deterioration or has weak language for either of them, it forces families to delay petitioning for inpatient commitment past the point where their mentally ill relative needs treatment.[76]

Grave disability is a condition in which a person cannot provide for his own basic needs like food, clothing, shelter, etc., due to mental illness.[77] A strong statutory definition for grave disability can also include "failure to seek needed medical treatment or an inability to protect oneself from danger."[78]

Psychiatric deterioration is a related concept that should be spelled out in a state's inpatient commitment law in order to adequately ascertain a person's need for treatment.[79] It is a recognition of "the need to prevent harm to a person arising from failure to treat a psychiatric condition."[80] A psychiatric deterioration standard allows the court to look beyond the snapshot of the person with SMI standing before them at the time of a hearing and consider the person's treatment history.[81]

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73. *See id.*

74. *See* SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., *supra* note 61, at 9–12.

75. There is no valid public policy reason to require such an extreme degree of potential harm before a person qualifies for inpatient commitment, nor does it make sense from a budgetary perspective to essentially require that all care be emergency-based, delivered in the most expensive manner, and offered at the time least likely to lead to recovery. *See* Dailey et al., *supra* note 26, at 17–18. This sort of requirement is deeply stigmatizing, as it implies a fundamental difference between psychiatric medical care and any other type of medical care, which is delivered when it is needed rather than when death or disfigurement will occur without it. *See id.*

76. *See generally* EARLEY, *supra* note 36 (discussing issues families face when attempting to petition for inpatient commitment of their SMI family members).

77. *See* Dailey et al., *supra* note 26, at 13.

78. *Id.*

79. *Id.* at 20–21.

80. *Id*. at 20.

81. *Id.* Consideration of past treatment can also be codified as part of other criteria for involuntary commitment, e.g., grave disability, suicidality, etc. *See id.*

States with strong psychiatric deterioration standards allow relevant information on recent hospitalizations; for example, if a person has recently been hospitalized multiple times due to a failure to take medication or some other symptom that the person is again exhibiting at the time of a hearing, the court may conclude that hospitalization is necessary to prevent further psychiatric deterioration.[82]

Texas has a grave disability standard but lacks a psychiatric deterioration standard.[83] Its grave disability standard is somewhat ambiguously placed within the statute such that it may not be clear to those applying the law that grave disability is a form of danger to self and not an alternative category.[84] The best practice is for the legislature to make clear that danger to self encompasses grave disability and that medical and psychiatric deterioration falls within the type of harm envisioned as a basis for intervention.[85]

The Texas Legislature should take either of two approaches for including psychiatric deterioration in the state's inpatient commitment criteria, either create a concise subsection defining the standard or incorporate it into the existing grave disability language.[86] Texas's grave disability standard is strongly worded and provides sufficient guidance to the court on a person's inability to take care of themselves through either a lack of providing basic needs or an inability to make rational decisions about his own psychiatric treatment.[87]

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82. *Id.*

83. *Id.* at 130.

84. *Id.*

85. *See id.*

86. *Id.*

87. Texas' grave disability standard states that a patient can only get inpatient mental health services if it is found that he or she is:

> [E]xperiencing substantial mental or physical deterioration of the proposed patient's ability to function independently, which is exhibited by the proposed patient's inability, except for reasons of indigence, to provide for the proposed patient's basic needs, including food, clothing, health, or safety; and . . . unable to make a rational and informed decision as to whether or not to submit to treatment.

TEX. HEALTH & SAFETY CODE ANN. §§ 574.034(a)(2)(C)(ii)–(iii). Subsection (iii) could even be interpreted to include the symptom of anosognosia as a basis for court ordered hospitalization. *See id.* § 574.034(a)(2)(C)(iii). For a definition of anosognosia and discussion of its relevance in involuntary commitment criteria, see *supra* note 25 (discussing anosognosia). Colorado has a strong grave disability standard, and that state has incorporated psychiatric deterioration language into its grave disability language:

> "Gravely disabled" means a condition in which a person, as a result of a mental health disorder, is incapable of making informed decisions about or providing for his or her essential needs without significant supervision and assistance from other people. As a result of being incapable of making these informed decisions, a person who is gravely disabled is at risk of substantial bodily harm, dangerous worsening of any concomitant serious physical illness, significant psychiatric deterioration, or mismanagement of his or her essential needs that could result in substantial bodily harm.

COLO. REV. STAT. § 27-65-102(9).

The Texas Legislature could take a similar approach or insert a subsection below its current grave disability standard.[88] Either approach would facilitate more timely access to inpatient care for Texas families needing to prevent deterioration to the point of crisis and law enforcement involvement.[89]

C. Extend the Duration of the Emergency Hold Period to at Least 72 Hours

Every state allows law enforcement to transport a person in psychiatric crisis to a healthcare facility where a qualified mental health professional can make a determination whether that person needs inpatient treatment, outpatient treatment, discharge, or some type of longer-term care plan.[90] That custodial process—the emergency hold period—may not exceed a statutorily determined length of time necessary for observation and evaluation.[91] The forty-eight hour period specified in Texas law[92] is too short to adequately assess a person's condition and plan for their immediate treatment.

The length of time allowed for an emergency hold is a practical issue of allowing mental health service-providers to do their jobs while respecting the rights of the patient subject to the temporary custody of a treatment facility. It is also a practical issue that a family must consider when deciding whether to call law enforcement to their home. Research shows that insufficient durations for emergency holds lead to negative outcomes—most commonly readmission for mental illness treatment in a short period of time—and higher suicide rates among individuals released before healthcare providers could make accurate determinations of their need for further treatment.[93]

Families—many of whom have been through the revolving door of mental health services with their mentally ill relative for years—are aware of

88. Alaska took the latter approach by including the following psychiatric deterioration language: "[A person] will, if not treated, suffer or continue to suffer severe and abnormal mental, emotional, or physical distress, and this distress is associated with significant impairment of judgment, reason, or behavior causing a substantial deterioration of the person's previous ability to function independently." ALASKA STAT. § 47.30.915(9)(B).

89. *See id.*; COLO. REV. STAT. § 27–65–102(9) (2018).

90. *See* Dailey et al., *supra* note 26, at 14.

91. *See generally id.* (evaluating the emergency hold periods required by state laws).

92. HEALTH & SAFETY § 573.021(b).

93. *See generally* Debra A. Pinals, M.D. & Doris A. Fuller, M.F.A., *Beyond Beds: The Vital Role of a Full Continuum of Psychiatric Care*, TREATMENT ADVOC. CTR. (Oct. 2017), https://www.treatmentadvocacycenter.org/storage/documents/beyond-beds.pdf (examining the lack of a robust system of mental illness care, including the outcomes when patients in need of inpatient psychiatric care are released too quickly); Leslie C. Hedman et al., *State Laws on Emergency Holds for Mental Health Stabilization*, 67 PSYCHIATRIC SERVS. 529–35 (2016) (examining the wide variation in state emergency hold laws); Harrick Bickley et al., *Suicide Within Two Weeks of Discharge from Psychiatric Inpatient Care: A Case-Control Study*, 64 PSYCHIATRIC SERVS. 653–59 (2013) (finding, inter alia, that discharged patients need immediate community follow-up).

the issues relating to shorter lengths of emergency evaluation periods.[94] The knowledge that, even after they make the difficult decision to call law enforcement, the officers will take their loved one to a facility where the person will be released long before the process benefits them in any way exacerbates their dilemma of knowing if and when to make that call.[95]

To support long-term outcomes, emergency hold periods should be at least seventy-two hours.[96] In Texas, healthcare providers have no more than forty-eight hours to determine the best course of treatment for someone with SMI in a psychiatric crisis.[97] That time frame constriction is at best impractical and at worst impossible. Thirty-five states have emergency hold durations of at least seventy-two hours.[98] As long as the rights of the individual subject to the hold are respected as much as practical, the longer the duration, the better. Texas is one of only sixteen states with custody periods of forty-eight hours or less.[99] Neighboring Oklahoma has a duration of 120 hours,[100] New Mexico has a duration of seven days,[101] and in Louisiana the duration is fifteen days.[102] Expanding the emergency hold duration, contained in Texas Health & Safety Code § 573.021(b), to at least seventy-two hours would alleviate this one important part of the struggle to access mental illness treatment services for families in crisis.[103]

V. CONCLUSION

The complex and barely workable "system" of mental healthcare in the United States makes it difficult for anyone to help a loved one with SMI access treatment. That difficulty is compounded by factors of race and insufficient statutory criteria. Relatively simple, straightforward changes by the Texas Legislature could do much to address those issues. Clearly defined dangerousness language, inclusion of a psychiatric deterioration standard, and an emergency hold period of at least seventy-two hours would be major steps in the direction of increased access to care for families living in an

94. *See* sources cited *supra* note 93 and accompanying text (discussing the negative effects of incomplete evaluation and rushed release of patients).

95. *See id.*

96. Seventy-two hours should be the minimum amount of time to both evaluate whether a patient meets the criteria for inpatient commitment and to plan accordingly. A shorter period of time for those crucial steps is inadequate and leads to the negative outcomes described herein.

97. HEALTH & SAFETY § 573.021(b).

98. Hedman et al., *supra* note 93, at 530.

99. *Id.*

100. OKLA. STAT. tit. 43A, § 5-208(A)(3) (1986). Oklahoma further elaborates that the evaluation must be in the first twelve hours but the hold itself is up to 120 hours. This is not ideal but allowing up to 108 hours to plan for the next steps in the patient's treatment is still more practical than a total hold time of forty-eight hours.

101. N.M. STAT. ANN. § 43-1-11(a) (2009).

102. LA. STAT. ANN. § 28:53(A)(1) (2020).

103. *See generally* Pinals & Fuller, *supra* note 93 (explaining steps that states can take in order to improve access to mental health treatment for those with SMI).

untenable space between crises. With changes to the law, Texans experiencing psychosis, like Mauris DeSilva and Morgan Rankins,[104] who were both killed by police officers while at their most vulnerable, would be able to get treatment when they need it, not after it is too late. With changes to the law, family members would not be forced to watch while their loved ones deteriorate in that untenable space while waiting for a crisis. Changing the laws to limit police encounters with individuals with SMI will save many lives, but especially Black lives.

104. Raji, *supra* note 60.