NO-ONE RECEIVES PSYCHIATRIC TREATMENT IN A SQUAD CAR

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> *"Since when did we consider the idea, even with the best intentions, that placing someone in need of psychiatric care in the back of a squad car is a good thing?"*[1]

I. INTRODUCTION

With state-of-the-art facilities and cutting-edge research, modern medicine offers quality care for individuals with serious mental illness (SMI) defined as bipolar disorder, major depressive disorder, schizophrenia, or schizoaffective disorder.[2] Yet, those individuals must accept treatment, and public or private resources must offer facilities in which to provide treatment. Poverty is not the primary reason that so many individuals with SMI are homeless or incarcerated.[3] Lack of psychiatric care cannot be blamed primarily on lack of funding. Two issues prevent many individuals with SMI from accessing treatment.

First, SMI often causes the afflicted individual to refuse treatment.[4] The illness impedes capacity, producing treatment refusals (illness-induced treatment refusal).[5] Second, reforms in the twentieth century closed state-funded psychiatric hospitals, while preventing treatment against the patient's will, even if that *will* was illness-induced treatment refusal.[6] To secure involuntary treatment, the person's behavior must meet criteria revealing dangerousness to self or others.[7] Even people in psychosis may not meet such

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1. *See* TREATMENT ADVOC. CTR. ET AL., ROAD RUNNERS: THE ROLE AND IMPACT OF LAW ENFORCEMENT IN TRANSPORTING INDIVIDUALS WITH SEVERE MENTAL ILLNESS, A NATIONAL SURVEY, at 15 (2019), https://www.treatmentadvocacycenter.org/storage/documents/Road-Runners.pdf (quoting an Illinois respondent to the survey).

2. *What is Serious Mental Illness?*, SMIADVISER, https://smiadviser.org/about/serious-mental-illness (last visited Apr. 8, 2022).

3. *Homelessness and Mental Illness: A Challenge to Our Society*, BRAIN & BEHAV. RSCH. FOUND. (Nov. 19, 2018), https://www.bbrfoundation.org/blog/homelessness-and-mental-illness-challenge-our-society.

4. *See* Judy Ann Clausen, *An Americans with Disabilities Act Critique of Advance Directive Override Provisions*, 71 N.Y.U. ANN. SURV. AM. L. 25, 35 (2015) (defining illness-induced treatment refusal as how a "mental illness can prevent a patient from recognizing that she is sick and cause her to refuse treatment to which she would otherwise consent").

5. *See id.* at 32.

6. Daniel Yohanna, MD, *Deinstitutionalization of People with Mental Illness: Causes and Consequences*, AMA J. OF ETHICS (Oct. 2013), https://journalofethics.ama-assn.org/article/deinstitutionalization-people-mental-illness-causes-and-consequences/2013-10 (describing the twentieth-century reforms that led to the closing of state-funded psychiatric hospitals).

7. *See* Simei Zhang et al., *Involuntary Admission and Treatment of Patients with Mental Disorder*, 31 NEUROSCIENCE BULL. 99, 100–04 (2015), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5562644/

criteria. Thus, despite resources, many individuals with SMI, with illness-induced treatment refusals, suffer, surrounded by a patchwork system that fails to address the symptomology of SMI.[8] Tragically, treatment would work for many and ease suffering if they could only obtain intervention.

This Article explores tragedies caused by our current system for responding to mental health emergencies: homelessness, institutionalization, criminalization, harm to self, harm to others, and harm by police. In the wake of the George Floyd murder, there has been increased attention on our response to mental health emergencies and an outcry to reduce the role of police. This Article analyzes reforms from California, Colorado, Eugene, Oregon, the federal government, Dallas, and Nebraska. This Article posits that any reform that focuses only on first responders will not fix our system. Harm by police is only one of the tragedies suffered by people with SMI.[9] It is dangerous to myopically focus on preventing interaction with police without addressing what transpires after interactions with first responders and whether there is adequate intervention, care, and stabilization.

This Article recommends the Nebraska and Dallas approaches with added improvements. In Nebraska, people can form Ulysses arrangements, a mental health advance directive empowering a person to obtain treatment during an episode because the person has learned that episodes cause treatment refusals.[10] The person enters the arrangement when she has capacity.[11] The arrangement authorizes doctors to treat the person during a future episode when the person lacks capacity, even if the episode causes refusals and the person does not meet involuntary treatment criteria.[12] The arrangement derives its name from Homer's epic, the *Odyssey*.[13] Ulysses was afraid the Sirens' song would lead him into danger, so he directed his shipmates to tie him to the mast of his ship and keep him there, even if the Sirens' song made him demand to be set free.[14]

Also, jurisdictions should adopt the Dallas approach, which dispatches three-person teams consisting of a specially trained officer, a paramedic, and a mental health professional to mental health emergency calls. This innovation brought results. Plus, this Article adds procedures (1) to secure involuntary transportation to a hospital pursuant to a Ulysses arrangement,

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pdf/12264_2014_Article_1493.pdf.

8. *See generally* Clausen, *supra* note 4 (describing how illness-induced treatment refusals can cause individuals with SMI to suffer).

9. *See generally* BRAIN & BEHAV. RSCH. FOUND., *supra* note 3 (illustrating how homelessness is also a tragedy suffered by people with SMI).

10. *See* NEB. REV. STAT. § 30-4403 (2020) (laying out procedural protections for an advance mental health directive); *see also* Judy A. Clausen, *Making the Case for a Model Mental Health Advance Directive Statute*, 14 YALE J. HEALTH POL'Y, L., & ETHICS 1, 61 (2015).

11. Clausen, *supra* note 10, at 31–33, 59.

12. *Id.*

13. Theo Van Willigenburg & Patrick J. J. Delaere, *Protecting Autonomy as Authenticity Using Ulysses Contracts*, 30 J. MED. & PHIL. 395, 396 (2005).

14. *Id.*

(2) for first responder access to Ulysses arrangements, and (3) for continuity of care. Lastly, this Article proposes that these reforms be implemented in a Department of Veterans Affairs (VA) pilot program because veterans often have free care, removing obstacles to third-party reimbursement.

II. TRAGEDIES CAUSED BY OUR RESPONSE TO MENTAL HEALTH EMERGENCIES

In designing a system for responding to mental health calls, one must consider situations in which calls result in tragedy. This Part explores America's deinstitutionalization history and identifies the movement's unintended consequences of homelessness and incarceration. Drawing from lessons learned, this Part cautions policymakers to consider the identified tragedies and predict unintended consequences. Next, through real-life scenarios, this Part identifies tragedies resulting from our response to mental health emergencies: criminalization, institutionalization, homelessness, harm to others, harm by police, and harm to self.

A. Unintended Consequences

The road to today's dismal treatment of individuals with SMI was paved with good intentions.[15] Aspirational dreams led to unintended consequences. Nowhere is that clearer than in the plight of individuals with SMI who live on American streets, receive little care, become crime victims, or are killed during police interventions.[16] Historically, people suffering from SMI were warehoused in jails or poorhouses.[17] Beginning in the mid-1800s, state-run psychiatric hospitals were established, designed to remove people from jails and provide care, typically in pastoral settings.[18] State-run psychiatric hospitals were heralded as replacing the brutal abuse suffered by people with SMI in jails and poorhouses.[19]

However, by the middle of the twentieth-century, overcrowding, neglect, and lack of effective treatment undermined this approach.[20] After

15. *See generally* Yohanna, *supra* note 6 (describing how the twentieth-century reforms that led to the closing of state-funded psychiatric hospitals were influenced by those who desired better treatment for people suffering from SMI).

16. *See generally* TREATMENT ADVOC. CTR. ET AL., *supra* note 1; BRAIN & BEHAV. RSCH. FOUND., *supra* note 3.

17. *See* Joanmarie Ilaria Davoli, *No Room at the Inn: How the Federal Medicaid Program Created Inequities in Psychiatric Hospital Access for the Indigent Mentally Ill*, 29 AM. J. L. & MED. 159, 166 n.37 (2003).

18. *See generally id.* (detailing how and why state-run psychiatric hospitals were established).

19. *See id.* at 167–68.

20. *See id.* at 168–69.

World War II, miserable conditions in psychiatric hospitals were exposed.[21] The deinstitutionalization movement began with the intention to abolish "warehousing" and move people back into the community to receive treatment in outpatient settings.[22] Those good intentions led to abandonment of people to the "open-air [insane] asylum[s]"[23] seen in every American city.

Simultaneously, the federal government enacted Medicaid with the intention to provide care to the poor.[24] However, Medicaid exempted payment of care received in inpatient psychiatric hospitals. Known as the Institution for Mental Diseases (IMD) exclusion, Congress intended states to fund necessary inpatient treatment.[25]

> While the IMD Exclusion is poorly conceived and effectively facilitated the dramatic rise in the incarceration of the mentally ill, the provision was originally the lynchpin of an earnest movement to reform a deteriorating public mental healthcare system. This movement, known as "deinstitutionalization" represented a critical component to the U.S. government's evolving view on how to best provide treatment for low income Americans suffering from mental disease. Medical experts and politicians in favor of deinstitutionalization desired to shift several long-lasting features of the public mental health system. First, stakeholders wanted to transition the basic model for mental healthcare from a predominantly inpatient-centric service treating large populations to a more decentralized system of smaller, outpatient-centric service facilities. Second, proponents of deinstitutionalization wanted to shift the treatment venue from state hospitals to private community centers.[26]

These good intentions prompted the closing of state-funded psychiatric hospitals, beginning in the 1960s and accelerated until today.[27] States shifted the cost of psychiatric hospitalizations to the federal government,[28] but there

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21. *See generally* MARY JANE WARD, THE SNAKE PIT (1946) (fictionalizing Ward's experiences in a psychiatric hospital); Joseph Shapiro, *WWII Pacifists Exposed Mental Ward Horrors*, NPR (Dec. 30, 2009, 2:00 PM), https://www.npr.org/templates/story/story.php?storyId=122017757 (discussing pacifist Warren Sawyer's quest to expose unbearable conditions in mental health hospitals); Aeron S. Lloyd, Mental Health for the Everyman: World War II's Impact on American Psychology, at 6 (Aug. 5, 2015) (B.A. thesis, University of Washington Tacoma) (on file with UW Tacoma Digital Commons, University of Washington Tacoma) (stating that World War II "has shaped American culture in turn, with the average person's psychological and emotional needs achieving a validity in the context of American social life that still shapes our society today").

22. Yohanna, *supra* note 6 (describing how the deinstitutionalization movement began).

23. Davoli, *supra* note 17, at 159 n.1.

24. *Id.* at 163.

25. *See* Michael E. Onah, *The Patient-to-Prisoner Pipeline: The IMD Exclusion's Adverse Impact on Mass Incarceration in United States*, 44 AM. J. L. & MED. 119, 123–26 (2018) (describing how the purpose of deinstitutionalization was to make the federal government the source of funding for low-income patient treatment).

26. *Id.* at 123.

27. *See* Davoli, *supra* note 17, at 159–70.

28. *See* Onah, *supra* note 25, at 123.

was no corresponding shift of treatment, and inpatient hospital care remains a vital aspect of psychiatric treatment for individuals with SMI.[29] Tragically, the vast majority of homeless people with SMI receive no treatment.

> Congress created the IMD exclusion to incentivize community-based treatment and prevent unnecessarily restrictive hospital stays. Community-based treatment is a vital part of treating any brain disease, but people with the most severe cases of mental illness—such as schizophrenia, bipolar disorder, schizoaffective disorder[,] and other psychotic disorders—still need some inpatient care to be stable and thrive.[30]

The majority of inpatient state-run psychiatric hospitals have closed, while the intention of developing "community care" has failed. The lack of funding is blamed for the failure of outpatient community care centers and subsequent crisis of untreated mental illness.[31] However, public funding remains available for psychiatric treatment with the exception for stays in long-term psychiatric hospitals.[32] Yet, psychiatric hospitals remain necessary for many individuals. Without inpatient hospitalization, it is impossible to receive treatment when a patient voices illness-induced treatment refusals.[33]

Thus, the noble intention to close psychiatric hospitals to improve care has resulted in obstruction to access to care. American jails, streets, and shelters are now filled with people with untreated SMI.[34] Abandoning individuals suffering from SMI to become victims of their own illness-induced treatment refusals is cruel. Reforms tore down the institutions for people with mental illness.[35] Treatments improved, but people suffering from SMI, whose illnesses induce them to refuse treatment, do not get the benefit of progress in medicine.[36] Therefore, when fixing the system for responding to mental health emergencies, unintended consequences must be avoided.

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29. Joanmarie Ilaria Davoli, *Still Stuck in the Cuckoo's Nest: Why Do Courts Continue to Rely on Antiquated Mental Illness Research?*, 69 TENN. L. REV. 987, 1034 (2002).

30. Michael Gray, *States Need Congress' Help Repealing a Law That Hinders Treatment for Mental Illness*, THE HILL (Jan. 13, 2022, 7:30 PM), https://thehill.com/blogs/congress-blog/politics/589703-states-need-congress-help-repealing-a-law-that-hinders-treatment/.

31. *See* Samantha Raphelson, *How the Loss of U.S. Psychiatric Hospitals Led to a Mental Health Crisis*, NPR (Nov. 30, 2017, 1:15 PM), https://www.npr.org/2017/11/30/567477160/how-the-loss-of-u-s-psychiatric-hospitals-led-to-a-mental-health-crisis (discussing the disappearance of long-term care facilities and psychiatric beds).

32. *Id.*

33. Clausen, *supra* note 4, at 35.

34. *See* TREATMENT ADVOC. CTR. ET AL., *supra* note 1, at 1;BRAIN & BEHAV. RSCH. FOUND., *supra* note 3.

35. Although the full history of the IMD exclusion is outside the scope of this Article, there have been recent attempts to alleviate the problems caused by the IMD exclusion. Gray, *supra* note 30. President Trump offered IMD exclusion waivers. *Id.* So far, only eight states have accepted. *Id.*

36. Clausen, *supra* note 4, 35–40 (describing how illness-induced treatment refusals can cause individuals with SMI to suffer).

The movement to address the harms caused by police responding to psychiatric crisis calls must avoid inadvertently creating a *solution* that makes the lives of people with SMI, their loved ones, and first responders more painful. It would be dangerous to myopically focus on preventing interaction with police without addressing what transpires after interactions with first responders, and whether there is adequate intervention, care, and stabilization. Any reform should be designed to prevent the tragedies identified below. A new model should ensure follow-up, continuity of care, timely intervention, and access to care in contravention of illness-induced treatment refusals.

B. Criminalization and Institutionalization

This case study, inspired by real cases, underscores the criminalization and institutionalization tragedies. Jane Doe was diagnosed with Bipolar I Disorder in college when she experienced her first manic episode. Since her diagnosis, Jane takes daily medication. However, Jane broke her arm, and the resulting pain caused insomnia. The insomnia caused her to lose insight about her need for medication, resulting in her illness-induced treatment refusal.[37] Hypomanic, she slept only a few hours a night. Weeks of insufficient sleep caused psychosis. As with her previous episode, she was under the delusion that she was the star of a movie. She staged episodes for the movie, culminating in her stripping off her clothing and running through a farmer's backyard.

The farmer called 911 and the police arrived with no background on Jane. She struggled when they handcuffed her. Police brought her to the jail, failing to recognize that Jane's behavior was symptomatic of SMI. Jane did not sleep in jail and was given no evaluation or treatment. When taken before the judge, Jane continued to harbor the delusion that she was starring in a movie, so she spoke inappropriately to the judge, thinking doing so would make a great scene. This behavior made the judge question her competence to stand trial on charges of resisting arrest, indecent exposure, and criminal trespass. Jane remained in jail for months while awaiting competency evaluations. Finally, evaluators found that she was incompetent to stand trial, and the judge adjudicated her incompetent and ordered that she be sent to a state psychiatric facility for restoration of competency. Because of lack of funding, that facility had no beds, so Jane remained in jail for months. A bed finally became available, and Jane began to take lithium and started competency restoration classes. Ultimately, Jane accepted a plea offer. Losing over a year incarcerated and institutionalized, Jane now has a criminal

37. *See id.* at 35 (defining illness-induced treatment refusal as how a "mental illness can prevent a patient from recognizing that she is sick and cause her to refuse treatment to which she would otherwise consent").

record. If, at the outset of the mania, she had been medicated, she would have stabilized, avoiding psychosis, incarceration, institutionalization, and a criminal record. Plus, having experienced psychosis, she is more likely to slip into psychosis again.[38]

1. Criminalization

Approximately one-third of people with SMI have their first contact with treatment through a law enforcement encounter.[39] Almost half of the 8.3 million people in the United States who suffer from SMI are untreated.[40] Individuals with SMI are more likely to be arrested for symptoms of their SMI if they live in parts of the United States where there are limited treatment options, resulting in "mercy bookings"—a process of using low-level misdemeanor charges to facilitate treatment.[41] In some areas, treatment is more accessible in jail than in the community.[42] In police encounters, people with SMI are often arrested for misdemeanors and are four times more likely to be incarcerated for low-level offenses than others.[43] About 383,000 people with SMI are incarcerated—ten times the number of patients residing in state mental health hospitals.[44]

Not only does criminalizing SMI dehumanize people, but it also deprives society of such individuals' potential. Plus, criminalizing SMI squanders law enforcement resources.[45] Law enforcement encounters with people with SMI use at least 90% more resources than encounters with people

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38. *See* Tom Ehmann, *When Psychosis Comes Back*, 15 VISIONS J. 31, 31–33 (2019), https://www.heretohelp.bc.ca/visions/blips-and-dips-vol15/when-psychosis-comes-back.

39. TREATMENT ADVOC. CTR. ET AL., *supra* note 1, at 1 (citing JUDITH ADELMAN, STUDY IN BLUE AND GREY 23 (2003)).

40. *Id.* (citing TREATMENT ADVOC. CTR., SERIOUS MENTAL ILLNESS AND TREATMENT PREVALENCE, at 1–2 (2017), https://www.treatmentadvocacycenter.org/key-issues/anosognosia/3638-serious-mental-illness-and-treatment-prevalence).

41. *Id.* (citing Amy C. Watson et al., *Outcomes of Police Contacts with Persons with Mental Illness: The Impact of CIT*, 37 ADMIN. & POL'Y MENTAL HEALTH & MENTAL HEALTH SERVS. RSCH. 302, 302–17 (2009); Mary A. Finn & Loretta J. Stalans, *Police Handling of the Mentally Ill in Domestic Violence Situations*, 29 CRIM. JUST. & BEHAV. 278, 278–307 (2002); William H. Fisher et al., *Beyond Criminalization: Toward a Criminologically Informed Framework for Mental Health Policy and Services Research*, 33 ADMIN. & POL'Y MENTAL HEALTH & MENTAL HEALTH RSCH. 544, 544–57 (2006); *see generally* E. FULLER TORREY ET AL., CRIMINALIZING THE SERIOUSLY MENTALLY ILL: THE ABUSE OF JAILS AS MENTAL HOSPITALS (1992).

42. TREATMENT ADVOC. CTR. ET AL., *supra* note 1, at 1 (citing Richard Lamb et al., *The Police and Mental Health*, 53 PSYCHIATRIC SERVS. 1266, 1266–71 (2002)).

43. *Id.* at 1 (citing William H. Fisher et al., *Risk of Arrest Among Public Mental Health Services Recipients and the General Public*, 62 PSYCHIATRIC SERVS. 67, 67–72 (2011)).

44. *Id.* at 5 (citing *Serious Mental Illness (SMI) Prevalence in Jails and Prisons*, TREATMENT ADVOC. CTR., at 1–4 (2016) https://www.treatmentadvocacycenter.org/storage/documents/backgrounders/smi-in-jails-and-prisons.pdf).

45. *See id.*

without SMI.[46] In 2017, 10% of law enforcement agencies' annual budgets were spent responding to mental health emergencies, resulting in spending $918 million transporting people with SMI.[47]

Law enforcement officers are the first responders to mental health emergencies; in these responses, 70% of officers are dispatched because of an emergency call, and 30% result from an officer encountering a crisis while on patrol.[48] In 2017, law enforcement transported people with SMI in crises approximately 10 million times, equaling approximately eighteen years of law enforcement time.[49] Law enforcement departments find it challenging to allocate staff to cover all of their public safety concerns because of the unpredictable nature of mental health emergencies.[50] Mental health crises take enormous time because law enforcement must (1) respond to the call, (2) take custody of the individual, (3) transport the individual to a facility or jail, and (4) wait for transfer of custody.[51] Officers typically wait 2.5 hours longer if they drop off the person at a medical facility than if they drop off at a jail.[52] Officers reported waiting for seventy-two hours or more at the hospital until a bed became available.[53] Often, officers transport the person to a facility only to have the person denied admission or prematurely discharged, so the person in crisis walks out the front door as the officer drives away.[54]

2. Institutionalization

The primary way a person obtains intervention when an episode causes treatment refusals is through institutionalization.[55] But institutionalization, a massive deprivation of liberty, is dangerous, ineffective, traumatic, untimely, and expensive.[56] First, institutionalized patients risk abuse from other patients

46. *Id.* at 1 (citing Yanick Charette et al., *Police Encounters Involving Citizens with Mental Illness: Use of Resources and Outcomes*, 65 PSYCHIATRIC SERVS. 511, 511–16 (2014)).

47. *Id.* at 7 (citing U.S. DEP'T OF JUST., LAW ENF'T AGENCY ROSTER (LEAR), 2016 (ICPSR 36697) (2017)).

48. TREATMENT ADVOC. CTR. ET AL., *supra* note 1, at 28.

49. *Id.* at 18–19.

50. *Id.* at 3.

51. *Id.*

52. *See id.* at 3.

53. *Id.* at 20.

54. *Id.* at 10.

55. Clausen, *supra* note 4, at 35.

56. Judy A. Clausen, *Bring Ulysses to Florida: Proposed Legislative Relief for Mental Health Patients*, 16 MARQ. ELDER'S ADVISOR 1, 13 (2014); FLA. STAT. §§ 394.4655, 394.467 (2013); Breanne M. Sheetz, Comment, *The Choice to Limit Choice: Using Psychiatric Advance Directives to Manage the Effects of Mental Illness and Support Self-Responsibility*, 40 U. MICH. J. L. REFORM 401, 415 (2007).

and staff.[57] For example, in 2013, a witness told reporters that staff in a state mental health state hospital abused patients.[58]

Second, even if the patient manages to avoid abuse, institutionalization is ineffective and intrusive.[59] One advocate said about a state hospital: "People there are not getting any treatment. They smoke and they eat. It's ridiculous."[60] As one court acknowledged, "[i]t has been recognized that mental illness may be caused or intensified by institutionalizing mental patients."[61] Institutionalized patients suffer sleep deprivation and stress caused by noise and disruptive behaviors of patients and staff.[62] Third, institutionalization is not therapeutic because patients have no self-determination.[63] Patients with SMI who have self-determination over their treatment have better outcomes.[64]

Fourth, institutionalization provides intervention too late. Time is of the essence because allowing cognitive functions to deteriorate to such an extent undermines chances of returning to full functioning.[65] Early intervention

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57. *Preventing Patient Abuse: Why Abuse Happens and How to Stop It*, IAHSS FOUND., https://iahssf.org/research/preventing-patient-abuse-why-abuse-happens-and-how-to-stop-it/ (last visited Apr. 8, 2022).

58. Britney Jones, *Exclusive: Witness Speaks Out About Abuse at Fla. State Hospital*, WTXL (Sept. 4, 2013, 7:44 PM), https://www.wtxl.com/news/exclusive-witness-speaks-out-about-abuse-at-fla-state-hospital/article_e8a80a84-15bd-11e3-8e6d-0019bb30f31a.html.

59. Clausen, *supra* note 56, at 4.

60. *See* Jenni Bergal, *Mental Hospital's Cost Per Patient Leads State*, SUN SENTINEL (Feb. 27, 1990), https://www.sun-sentinel.com/news/fl-xpm-1990-02-27-9001260683-story.html.

61. Tuten v. Fariborzian, 84 So.3d 1063, 1067 (Fla. Dist. Ct. App. 2012).

62. *Developments in the Law: Civil Commitment of the Mentally Ill*, 87 HARV. L. REV. 1190, 1195–97 (1974) ("[H]ospitalization itself interferes with privacy, since the patient cannot shield himself from constant observation by both his fellow patients and the staff . . . ."); Morgan C. Shields et al., *Patient Safety in Inpatient Psychiatry: A Remaining Frontier for Health Policy*, 37 HEALTH AFFS. 1853, 1854 (2018) (explaining statistics of lack of patient safety in psychiatric care leading to "cascading consequences on a person's health"); Neil Bedi, *How One Florida Psychiatric Hospital Makes Millions Off Patients Who Have No Choice*, TAMPA BAY TIMES (Sept. 18, 2019), https://projects.tampabay.com/projects/2019/investigations/north-tampa-behavioral-health/ (describing a Florida psychiatric hospital that took advantage of patients and gave "virtually no psychiatric treatment"); Lucas Manfield, *Killing of Patient, Allegations of Dangerous Care Haunt South L.A. Psychiatric Hospital, Investigation Finds*, L.A. TIMES (Oct. 9, 2019, 5:00 AM), https://www.latimes.com/california/story/2019-10-09/kedren-psychiatric-hospital-murder-investigation (describing "serious failures of oversight in the care of patients" in psychiatric hospital including sexual assault, choking, and murder); Daniel Gilbert, *Public Crisis, Private Toll: Key Findings of the Seattle Times' Investigation of Private Psychiatric Hospitals in Washington*, SEATTLE TIMES (Oct. 6, 2019, 6:00 AM), https://www.seattletimes.com/seattle-news/times-watchdog/public-crisis-private-toll-major-findings-of-the-seattle-times-investigation/ (explaining inadequate staffing, inaccurate patient records, and failed hospital inspections, to name a few issues).

63. Ryan Petros & Phyllis Solomon, *How Adults with Serious Mental Illness Learn and Use Wellness Recovery Action Plan's Recovery Framework*, 31 QUALITATIVE HEALTH RSCH. 631, 633 (2020).

64. Clausen, *supra* note 56, at 46; Willigenburg & Delaere, *supra* note 13, at 396; *see generally* Clausen, *supra* note 10; Eric B. Elbogen et al., *Effectively Implementing Psychiatric Advance Directives to Promote Self-Determination of Treatment Among People with Mental Illness*, 13 PSYCH. PUB. POL'Y & L. 273, 275, 285 (2007); R. Henry Olaisen et al., *Assessing the Longitudinal Impact of Physician-Patient Relationship on Functional Health*, 18 ANNALS FAM. MED. 422, 422 (2020) ("The quality of the physician-patient relationship is positively associated with functional health.").

65. Clausen, *supra* note 56, at 26.

brings the patient back to capacity sooner.[66] Because of strict commitment criteria, the person's cognitive functions must deteriorate to such an extent as to be dangerous.[67] Waiting for intervention until the episode is sufficiently severe requires the person to allow the SMI to damage or destroy her life.[68] Fifth, institutionalization squanders years and is a massive deprivation of liberty. The average length of stay in a state facility is 1.7 years.[69] Sixth, institutionalized patients are rarely treated by their doctors, undermining the quality of care and the prognosis for long-term recovery. People have the best chance for positive outcomes when they are treated by doctors who have treated them in the past.[70]

Seventh, institutionalization is not a viable option because there are insufficient psychiatric beds.[71] State hospitals are closing, producing a shortage of beds.[72] Even if there are beds, they are usually not for therapeutic intervention, but for individuals awaiting competency determinations.[73] Eighth, commitment and guardianship proceedings required for institutionalization are dehumanizing.[74] At guardianship proceedings, patients must witness people describing their embarrassing behaviors.[75] Incompetency adjudications required for guardianship proceedings cause psychological damage to the ward.[76] Finally, institutionalization is

66. *Id.* at 30; Davoli, *supra* note 29, at 1045.

67. RALPH REISNER ET AL., LAW AND THE MENTAL HEALTH SYSTEM: CIVIL AND CRIMINAL ASPECTS 704–05 (2006).

68. Anika Reichert & Rowena Jacobs, *The Impact of Waiting Time on Patient Outcomes: Evidence from Early Intervention in Psychosis Services in England*, 27 HEALTH ECON. 1772, 1772 (2018) ("We find that longer waiting time is significantly associated with a deterioration in patient outcomes 12 months after acceptance for treatment for patients that are still in [early intervention in psychosis] care."); MENTAL HEALTH EVALUATION & CMTY. CONSULTING UNIT, EARLY IDENTIFICATION OF PSYCHOSIS 7, https://www.health.gov.bc.ca/library/publications/year/misc/Psychosis_Identification.pdf (last visited Apr. 8, 2022) ("It has been found that delays in receiving treatment are associated with slower and less complete recovery and that long duration of psychotic symptoms before treatment appears to contribute to poorer prognosis and a greater chance of early relapse."); Heather Stringer, *Catching Psychosis Early*, 47 AM. PSYCH. ASS'N 36 (2016) (explaining how treating someone before psychosis promotes better long term outcomes).

69. Clausen, *supra* note 56, at 26.

70. Bruce J. Winick, *Advance Directive Instruments for Those with Mental Illness*, 51 U. MIA. L. REV. 57, 72 (1996); Jemimah Ride et al., *Impact of Family Practice Continuity of Care on Unplanned Hospital Use for People With Serious Mental Illness*, 54 HEALTH SERVS. RSCH. 1316, 1320 (explaining that a care plan can reduce hospitalization for individuals with serious mental health illness conditions by nearly 40%); Eva Biringer et al., *Continuity of Care as Experienced by Mental Health Service Users – A Qualitative Study*, 17 BMC HEALTH SERVS. RSCH. 1, 1 (2017) (dividing the importance of continuity of care into five critical themes for those with mental health conditions: relationship, timeliness, mutuality, choice, and knowledge).

71. Sheetz, *supra* note 56, at 415.

72. Paul S. Appelbaum, *The 'Quiet' Crisis in Mental Health Services*, 22 HEALTH AFFS. 110, 115 (2003).

73. Clausen, *supra* note 56, at 26.

74. *Id.* at 1, 4.

75. *Id.* at 33; FLA. STAT. § 394.4655(6)(a) (2013).

76. Robert D. Miller, *Advance Directives for Psychiatric Treatment: A View from the Trenches*, 4 PSYCH. PUB. POL'Y & L. 728, 736 (1998).

time-consuming and expensive for overburdened state budgets, squandering judicial and public defender resources.[77]

C. Homelessness

While poverty may cause homelessness, resources are available for people struggling from homelessness because of acute financial or personal crises.[78] However, SMI is chronic and episodic.[79] The United States homeless population consists primarily of people suffering from SMI and those suffering from substance abuse.[80] The combined forces of deinstitutionalization, strict criteria for involuntary treatment, and the illness-induced treatment refusal phenomenon results in homelessness.[81]

Not only are people with SMI abandoned, roaming the streets, and suffering from symptoms, but they are at risk of becoming victims of crime, hunger, and exposure.[82] And many of the homeless population served their country.[83] For example, Iraq War Veteran Vance Perry died of hypothermia in Madison, Wisconsin, after spending the night in a parking garage wearing only a light jacket. Perry had been picked up by a "Veteran Affairs van for a routine appointment at the Madison [VA] hospital for paranoid schizophrenia. He was then admitted for mental instability."[84] However, once Perry wanted to leave, there was no ability to hold him in the hospital against his will, despite his obvious need for treatment.[85] The VA Hospital released a statement: "[We] are terribly saddened to learn of the loss of this veteran. Prior to his death, he voluntarily checked out of our facility, which had no grounds to prevent him forcibly from doing so."[86] As an Iraqi War Veteran, Perry had veterans' benefits and had been in a treatment facility when his illness led him back onto the streets.[87] His homelessness was not produced

77. Clausen, *supra* note 56, at 33–34.; FLA STAT. §§ 394.4655(6), .467(6) (2013); Clausen, *supra* note 10, at 61.

78. *See generally* U.S. DEP'T HEALTH & HUM. SERVS., https://www.hhs.gov (last visited Apr. 8, 2022).

79. Rayan K. AI Jurdi et al., *Aging with Serious Mental Illness: An Overview and Implications for Service Delivery*, 38 ASPECTS MENTAL HEALTH & AGING 14, 14 (2014).

80. *The Connection Between Homelessness and Addiction*, ADDICTION CTR., https://www.addictioncenter.com/addiction/homelessness (last visited Apr. 8, 2022).

81. Clausen, *supra* note 56, at 4; REISNER ET AL., *supra* note 67, at 704–05.

82. Molly Meinbresse et al., *Exploring the Experiences of Violence Among Individuals Who Are Homeless Using a Consumer-Led Approach*, 29 VIOLENCE & VICTIMS 122, 123 (2014).

83. *See generally* NAT'L COALITION FOR HOMELESS VETERANS, https://nchv.org/veteran-homelessness/ (last visited Apr. 8, 2022).

84. *Army Veteran Freezes to Death After Being Released from VA Hospital*, 11ALIVE (Jan. 5, 2018, 2:31 AM), https://www.11alive.com/article/news/local/army-veteran-freezes-to-death-after-being-released-from-va-hospital/85-504901459.

85. *Id.*

86. *Id.*

87. *Id.*

by poverty, nor was his death.[88] Both were produced by his untreated SMI that caused illness induced treatment refusals that he had no mechanism to override.[89]

D. Harm by Police

Some officers are trained to respond to an individual suffering from a psychiatric crisis.[90] Such training includes recognizing psychosis as well as de-escalation tactics.[91] However, many officers are untrained, and those who are trained might not respond appropriately.[92] Sometimes, officers misinterpret symptoms of a psychiatric crisis as malingering or worse.[93]

In 2016, when Tony Timpa called 911, he explained that he had schizophrenia and had not taken his medicine.[94] When officers arrived, they found Mr. Timpa agitated and handcuffed by security guards.[95] The officers restrained Mr. Timpa by kneeling on him while he was on the ground.[96]

> The video footage shows how responding officers restrained Mr. Timpa as he pleaded for them to let him go.
>
> . . . .
>
> The officers pinned Mr. Timpa facedown on a patch of grass . . . for more than 13 minutes. They joked and laughed, with one officer suggesting a "Greek Oaks cocktail," a reference to a local psychiatric facility. Their laughter continued after he stopped moving or making any sounds.
>
> "Back to school! Come on, wake up!" one officer quipped as they tried to rouse him.
>
> After Mr. Timpa was loaded into an ambulance, the officers grew concerned about whether he was breathing.
>
> "I hope I didn't kill him," one officer says, as his colleagues continue to laugh. The paramedics were unable to revive Mr. Timpa. An autopsy classified his death as a homicide, a victim of sudden cardiac death due to "the toxic effects of cocaine and the stress associated with physical restraint."[97]

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88. *Id.*
89. *Id.*
90. Zoe R. Fiske et al., *A National Survey of Police Mental Health Training*, 36 J. POLICE & CRIM. PSYCH. 236, 236–37 (2021).
91. *Id.*
92. *Id.*
93. Karen Zraick, *Dallas Officers Pinned Tony Timpa and Joked During Fatal Encounter, Video Shows*, N.Y. TIMES (Aug. 1, 2019), https://www.nytimes.com/2019/08/01/us/tony-timpa-dallas-police-body-cam.html.
94. *Id.*
95. *Id.*
96. *Id.*
97. *Id.*

One in five people killed by police has mental illness.[98] When race intersects with SMI, the person may be at increased risk of police harm.[99] People with SMI are almost half of the victims in fatal police encounters.[100] Untreated SMI results in people being sixteen times more likely to die in a police encounter.[101]

Police detain and transport people who are in an episode to a facility for involuntary evaluation, an exam conducted without the patient's consent.[102] Criteria for an involuntary exam requires that, due to mental illness, there is a substantial likelihood that, without treatment, the person will cause serious bodily harm, evidenced by recent behavior.[103] Law enforcement can detain and transport a person who meets criteria, based on (1) recorded observations of dangerous behavior, or (2) a court order authorizing involuntary transportation to a facility, based on the court's determination that the person meets criteria.[104]

For example, police may detain and transport a person after officers receive a call from a family member stating that the person is in an episode. In response, the officer will check on the individual. Only if the officer observed and documented that the person's behaviors met the criteria could the officer detain and transport the person. As another example, officers on patrol could happen upon a person in an episode and observe that behaviors met criteria, document behaviors, and detain and transport the individual to a facility. Typically, officers have no discretion to refuse to detain and transport a person if the officers are given a facially valid certificate to do so.[105]

As a result of cases in which police have killed individuals with SMI, there is an outcry to change the system for responding to mental health emergencies, reducing law enforcement's role.[106]

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98. Minyvonne Burke, *Policing Mental Health: Recent Deaths Highlight Concerns Over Officer Response*, NBC NEWS (May 16, 2022), https://www.nbcnews.com/news/us-news/policing-mental-health-recent-deaths-highlight-concerns-over-officer-response-n1266935.

99. Ayana Jordan et al., *Decriminalising Being Black with Mental Illness*, 8 LANCET PSYCHIATRY 8, 8–9 (2021).

100. Tim Murphy, *Addressing the Link Between Violence, Serious Mental Illness*, PITTSBURGH POST-GAZETTE (May 10, 2021, 9:25 AM), https://www.post-gazette.com/news/insight/2021/05/10/Addressing-the-link-between-violence-serious-mental-illness/stories/202105090022.

101. *Id.*

102. Clausen, *supra* note 56, at 6.

103. *See, e.g.*, FLA. STAT. § 394.462(1)(a) (2013).

104. *Id.*

105. *See, e.g.*, Pruessman v. Dr. John T. MacDonald Found., 589 So.2d 948, 949 (Fla. Dist. Ct. App. 1991) (holding county was not liable for police detaining and transporting patient to mental health facility based on facially valid Baker Act—Florida law concerning involuntary commitment—certificate executed by physician because police had no discretion to refuse to detain and transport patient upon presentation of facially valid certificate); Clausen, *supra* note 56, at 7.

106. *See* Rachel Treisman, *13-Year-Old Boy With Autism Disorder Shot By Salt Lake City Police*, NPR (Sept. 9, 2020, 5:00 PM), https://www.npr.org/2020/09/09/910975499/autistic-13-year-old-boy-shot-by-salt-lake-city-police (explaining how a police officer shot and severely injured a young boy

E. Harm to Others

Tuten v. Fariborzian reveals how our system for responding to mental health emergencies harms others.[107] Mr. Tuten admitted himself to a facility after he attempted suicide.[108] After a couple of days, unable to recognize his need for treatment, he requested discharge.[109] The law required doctors to honor his request because, even though he was not stabilized, Mr. Tuten did not meet involuntary hospitalization criteria.[110] Still in an episode, Mr. Tuten could not be treated involuntarily because his recently documented behavior failed to clearly evidence that he was an imminent danger.[111] Without treatment, his cognitive functions deteriorated.[112] Two months later, he attempted suicide and was admitted to a facility.[113] After a few days, his episode caused him to refuse treatment.[114] He demanded discharge.[115] This time, his doctor denied his request, believing Mr. Tuten met involuntary placement criteria.[116] The facility administrator filed petitions for involuntary placement and adjudication of incompetence to consent to treatment.[117] Before the hearing on the petitions, Mr. Tuten, in the midst of an episode, requested discharge.[118] Recognizing that state law prohibited involuntary retention, hospitalization, and treatment, the doctor honored his discharge request.[119] The day after discharge, Mr. Tuten shot his wife and fatally shot himself.[120]

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experiencing a "mental breakdown"); Maki Becker, *Dispatch Records, Video Show Tense 15 Minutes That Led to Police Shooting Man*, BUFFALO NEWS (Mar. 23, 2022), https://buffalonews.com/news/local/dispatch-records-video-show-tense-15-minutes-that-led-to-police-shooting-man/article_0175cf78-f901-11ea-bc6c-d7ce5a6267c4.html#tracking-source=home-top-story-1 (telling the story of police officer responding to a call regarding a "man having a mental health crisis" ultimately leading to a shooting); Eric Westervelt, *Mental Health and Police Violence: How Crisis Intervention Teams Are Failing*, NPR (Sept. 18, 2020, 5:00 AM), https://www.npr.org/2020/09/18/913229469/mental-health-and-police-violence-how-crisis-intervention-teams-are-failing ("Many are calling for removing or dramatically reducing law enforcement's role in responding to [mental health] crisis calls unless absolutely necessary.").

107. Tuten v. Fariborzian, 84 So.3d 1063, 1065 (Fla. Dist. Ct. App. 2012).
108. *Id.*
109. *Id.*
110. *Id.*
111. *Id.*
112. *Id.*
113. *Id.*
114. *Id.*
115. *Id.*
116. *Id.*
117. *Id.*
118. *Id.*
119. *Id.* at 1065–67.
120. *Id.* at 1065.

F. Harm to Self

Paddock v. Chaco exemplifies the harm to self-tragedy.[121] In *Paddock*, the husband of the woman drove her to the hospital where she stayed for two days following her suicide attempt.[122] The treating psychiatrist determined she was suffering from psychosis, causing her suicide attempt.[123] The psychiatrist recommended she be hospitalized because she was at risk for another suicide attempt and was unable to appreciate her need for treatment.[124] However, she refused to stay because her episode prevented her from recognizing her need for treatment, and the strict criteria prohibited the psychiatrist from involuntarily hospitalizing her.[125]

Even though she initially met criteria for an involuntary exam, the state law only allowed the hospital to retain her for seventy-two hours after she was hospitalized for a mental health evaluation.[126] After that time, criteria required that she be released upon her request, even if discharge was unwise, and even if she was still experiencing psychosis.[127] According to the state law, she could only be retained in the hospital if she met criteria for involuntary placement.[128] In Florida, as in most states, to meet criteria, the person must be mentally ill; because of mental illness, must refuse voluntary admission or be unable to determine whether admission is necessary; and, without treatment, present a serious danger, as evidenced by recent behavior.[129] But with seventy-two hours of treatment and sleep in the hospital, she no longer met criteria; she was still experiencing psychosis, but sleep had calmed the episode, and she was no longer clearly dangerous, as evidenced by recent behavior.[130] Because her episode prevented her from recognizing her need for treatment, she rejected her psychiatrist's advice, demanding discharge.[131] As the law required, the hospital discharged her against her psychiatrist's advice.[132] Within a month, she attempted suicide, sustaining life-altering injuries.[133]

Inadequate intervention, resulting from strict criteria obstructing intervention despite illness-induced treatment refusals, often kills people who are at risk of suicide and often have other health issues.[134] Half of people with

121. *See generally* Paddock v. Chacko, 522 So.2d 410 (Fla. Dist. Ct. App. 1988).
122. *Id.* at 412.
123. *Id.*
124. *Id.*
125. *Id.*
126. FLA. STAT. § 394.463(2)(g) (2021).
127. *Paddock*, 522 So.2d at 412.
128. *Id.* at 414.
129. FLA. STAT. § 394.463(1) (2021).
130. *Paddock*, 522 So.2d at 413.
131. *Id.*
132. *Id.*
133. *Id.*
134. *See Consequences of Non-Treatment*, TREATMENT ADVOC. CTR., https://www.treatmentadvoca

SMI attempt suicide.[135] Three out of four people with SMI have at least one chronic illness, such as cardiovascular disease or diabetes, contributing to their ten to fifteen years shorter lifespan.[136]

SMI episodes destroy capacity to provide informed consent, preventing individuals from recognizing they are sick.[137] Even in an acute episode which has altered behavior, many people do not meet criteria for involuntary treatment.[138] Once an episode has caused illness-induced treatment refusals, people cannot get treatment.[139] The only hope for intervention is through involuntary evaluation, hospitalization, and treatment. This is initiated through an involuntary exam.[140] Physicians cannot involuntarily examine a person unless they meet the dangerousness criteria.[141] Even psychosis, observed by the physician, often does not meet criteria.[142]

As in *Paddock*, even if the person meets criteria, the typical statute requires discharge after a seventy-two hour observation if the patient demands discharge—even if the patient is experiencing psychosis—and the patient does not meet criteria for involuntary treatment.[143] If the hospital retains a person after seventy-two hours who does not meet criteria, the doctor and the hospital are exposed to liability.[144] Healthcare professionals involuntarily holding a patient without compliance with mental health statutes constitutes false imprisonment.[145] Wrongfully initiating and maintaining civil proceedings resulting in involuntary examination and detention constitutes malicious prosecution.[146] Plus, even if the physician or the facility fall short of flagrantly disregarding the law but negligently retain a patient involuntarily, and a court later determines the patient did not meet criteria, the physician or hospital could be liable for medical negligence for wrongful diagnosis resulting in improper detention.[147] Moreover, patients have federal civil rights claims for due process violations if a facility admits the patient without obtaining informed consent or following involuntary

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cycenter.org/key-issues/consequences-of-non-treatment (last visited Apr. 8, 2022).

135. *Id.*

136. Murphy, *supra* note 100.

137. *Id.*

138. *Id.*

139. *Id.*

140. Stephen A. Colucciello, *Civil Commitment: Medical, Legal, and Ethical Considerations*, RELIAS MEDIA (Mar. 16, 1997), https://www.reliasmedia.com/articles/37351-civil-commitment-medical-legal-and-ethical-considerations.

141. *Id.*

142. *Id.*

143. Paddock v. Chacko, 522 So.2d 410, 412 (Fla. Dist. Ct. App. 1988).

144. Dan Ketchum, *Laws on 72 Hours of Mental Observation*, LEGAL BEAGLE (Dec. 4, 2018), https://legalbeagle.com/8696682-laws-72-hours-mental-observation.html.

145. Everett v. Fla. Inst. of Tech., 503 So.2d 1382, 1383 (Fla. Dist. Ct. App. 1987); Liles v. P.I.A. Medfield, Inc., 681 So.2d 711, 712 (Fla. Dist. Ct. App. 1995).

146. Pellegrini v. Winter, 476 So.2d 1363, 1366 (Fla. Dist. Ct. App. 1985).

147. Blom v. Adventist Health Sys./Sunbelt, Inc., 911 So.2d 211, 215 (Fla. Dist. Ct. App. 2005).

placement procedures.[148] The typical state statutory scheme incentivizes doctors to discharge patients in episodes that cause refusals of treatment, deterring intervention.[149] The typical statute for involuntary exam, hospitalization, and treatment postpones intervention until the person meets dangerousness criteria, requiring murderous or suicidal behavior observed by others.[150]

III. NEW AND PROPOSED LAWS TO IMPROVE AMERICA'S RESPONSE

As described in Part I, individuals suffering from SMI are an afterthought in the criminal justice system.[151] Historically, there was a sense that this issue had already been resolved when psychiatric hospitals were built in the late 1800s.[152] Then, as now, medical experts agreed that individuals suffering from SMI who commit crimes need treatment, not punishment.[153] However, the deinstitutionalization described in Part I demonstrates that both the state and federal governments have abandoned a therapeutic approach and abdicated responsibility to the jail and prison systems.[154] Media coverage of the deaths occurring during police encounters with individuals in psychiatric crises generated interest in fixing the system.[155] Part II surveys these reforms and suggests the necessary attributes for preventing the tragedies described in Part I.

A. Federal Proposals

As seen in Part I, federal government policies have had negative consequences for individuals suffering from SMI.[156] The federal government now attempts to fund solutions without focusing on the needs of the

148. Zinermon v. Burch, 494 U.S. 113, 138–39 (1990).

149. *See* FLA. STAT. § 394.463(2) (2021).

150. For example, in Florida, there must be a "substantial likelihood that without . . . treatment the person will cause serious bodily harm to . . . [self] or others in the near future, as evidenced by recent behavior." *Id.* § 394.463(1)(b)(2).

151. Janet Golden, *Prisons and Jails Are Not a Mental Health System*, PHILA. INQUIRER (Apr. 2, 2018), https://www.inquirer.com/philly/health/prisons-and-jails-are-not-a-mental-health-system-20180402.html ("But, tragically, prisons and jails do have the responsibility of caring for a large population in need of mental health services and it is a costly one for patients and for society.").

152. *Id.*; Manon S. Perry, *"I Tell What I Have Seen" – The Reports of Asylum Reformer Dorthea Dix*, 96 AM. J. PUB. HEALTH 622, 624 (explaining how Dorthea Dix was the leading figure to promote hospital treatment to help mentally ill individuals in the early 1800s).

153. Christine Montross, *We Must Change How Our Criminal Justice System Treats People with Mental Illness*, TIME (Aug. 5, 2020, 3:44 PM), https://time.com/5876045/we-must-change-how-our-criminal-justice-system-treats-people-with-mental-illness/ (describing punishment to those who need mental health treatment as "unjust and cruel").

154. Davoli, *supra* note 17, at 169.

155. *Id.* at 160.

156. *See supra* Part I (outlining the negative consequences that individuals with SMI have suffered due to federal government policies).

individual.[157] The best response to a psychiatric crisis would allow for safe transportation to a hospital. Of course, when appropriate, a mobile team can defuse the crisis at the scene. However, the escalation is often such that the person needs to be hospitalized.[158] Currently, police transport people to treatment facilities or jails in response to an emergency.[159] Whether police or other individuals transport the person to a hospital, the identified tragedies will still occur if the person cannot obtain effective intervention.[160]

1. The 988 Hotline

In 2020, President Trump signed into law the creation of a three-digit number for mental health emergencies.[161] The new 988 hotline replaces the ten-digit suicide prevention hotline.[162] By July 2022, all phone carriers will redirect calls from the ten-digit number to the 988 hotline.[163] The new hotline will respond to requests for help received as texts as well as calls.[164] As most Americans are accustomed to using the three-digit 911 number for emergencies, the 988 number builds on that familiarity.

Making a nationally recognized number, similar to 911, will increase ease and accessibility so those considering suicide or self-harm receive help more efficiently. This transition will also ensure that more mental health crisis calls go to the lifeline, rather than 911, as the lifeline call centers have advanced training in helping someone experiencing a mental health emergency.[165]

Thus, the 988 lifeline streamlines assistance by connecting suffering individuals with psychiatric professionals.[166]

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157. Stuart M. Butler & Nehath Sheriff, *Innovative Solutions to Address the Mental Health Crisis: Shifting Away from Police as First Responders*, BROOKINGS (Nov. 23, 2020), https://www.brookings.edu/research/innovative-solutions-to-address-the-mental-health-crisis-shifting-away-from-police-as-first-responders/.

158. *Id.*

159. *Id.*

160. *Id.*

161. Rhitu Chatterjee, *New Law Creates 988 Hotline for Mental Health Emergencies*, NPR (Oct. 19, 2020, 6:18 PM), https://www.npr.org/sections/health-shots/2020/10/19/925447354/new-law-creates-988-hotline-for-mental-health-emergencies.

> President Trump has signed into law a bipartisan bill to create a three-digit number for mental health emergencies. The Federal Communications Commission had already picked 988 as the number for this hotline and aims to have it up and running by July 2022. The new law paves the way to make that a reality.

Id.

162. *Id.*

163. *Suicide Prevention Hotline*, FED. COMMC'N COMM'N, https://www.fcc.gov/suicide-prevention-hotline (last updated Jan. 5, 2022).

164. *Id.*

165. *What You Need to Know About the Suicide Prevention Hotline Changing to 988*, KVC HEALTH SYS. (Sept. 22, 2021), https://www.kvc.org/blog/what-you-need-to-know-about-the-suicide-prevention-hotline-changing-to-988/.

166. *Id.*

2. Covid Relief Legislation

a. Mobile Crisis Units

In March 2021, President Biden signed into law the American Rescue Plan Act of 2021.[167] The law expands Medicaid coverage for a five-year period, allowing states to "cover mobile crisis intervention services for individuals experiencing a mental health or substance use . . . crisis. The law provides $15 million for planning grant funds for states to develop a mobile crisis service program . . . ."[168] The funding requires that the Mobile Crisis Units meet criteria, including de-escalation training of the staff and twenty-four hour-a-day, seven days-a-week response availability.[169]

b. Certified Community Behavioral Health Clinics

The American Rescue Plan Act of 2021 granted funds to expand Certified Community Behavioral Health Clinics (CCBHC).[170] First established in 2014,[171] there are now over four hundred CCBHCs in over forty states.[172] Each CCBHC must meet certain criteria, requiring that it "provide a comprehensive range of addiction and mental health services to

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167. *Summary of American Rescue Plan Act of 2021 and Provisions Affecting Hospitals and Health Systems*, AM. HOSP. ASS'N (Mar. 17, 2021), https://www.aha.org/advisory/2021-03-17-summary-american-rescue-plan-act-2021-and-provisions-affecting-hospitals-and.

168. *Id.*

169. American Rescue Plan Act of 2021, Pub. L. No. 117-2, § 9813, 135 Stat. 4, 213–14 (2021). Mobile crisis services must meet certain criteria to qualify for Medicaid funding under the new program. *Id.* § 9811.

170. American Rescue Plan Act of 2021, Pub. L. No. 117-2, § 2713, 135 Stat. 4, 48–49 (2021); *SAMHSA Awards $250 Million to 100 Certified Community Behavioral Health Centers to Improve Community Substance Use Disorder and Mental Health Treatment Services*, U.S. DEP'T OF HEALTH & HUM. SERVS. (July 29, 2021), https://www.hhs.gov/about/news/2021/07/29/samhsa-awards-250-million-to-100-certified-community-behavioral-health-centers.html.

> The Substance Abuse and Mental Health Services Administration (SAMHSA) has awarded 100 grants to increase access to facilities throughout the nation that provide community-based support for Americans in need of substance use disorder and mental health treatment services. Totaling $250 million, including $77 million from the American Rescue Plan (ARP), the grants support the Biden-Harris Administration's priority of addressing the behavioral health needs of Americans—particularly those impacted by the COVID-19 pandemic.
>
> *Id.*

171. Protecting Access to Medicare Act of 2014, Pub. L. No. 113–93, § 223, 128 Stat. 1040, 1077–78 (2014); *CCBHC Demonstration*, NAT'L COUNCIL FOR BEHAV. HEALTH (Nov. 28, 2017), https://www.thenationalcouncil.org/wp-content/uploads/2017/11/National-CCBHC-survey-write-up-FINAL-11-28-17.pdf?daf=375ateTbd56 ("Section 223 of the Protecting Access to Medicare Act of 2014 established a federal definition and criteria for Certified Community Behavioral Health Clinics (CCBHCs).").

172. *Integrated Care & Law Enforcement: Lessons Learned from Certified Community Behavioral Health Clinics (CCBHCs)*, NAT'L COUNCIL FOR MENTAL WELLBEING (July 20, 2021), https://www.thenationalcouncil.org/wp-content/uploads/2022/01/CoE-Webinar_Integrated-Care-Law-Enforcement_7.20.21_final-slides-1.pdf.

vulnerable individuals while meeting additional requirements related to staffing, governance, data and quality reporting and more."[173] Funding for each CCBHC depends upon compliance with regulations.[174]

Designed to increase access to treatment, CCBHCs strive to serve underserved populations.[175] Situated within communities to make access easier, the CCBHCs strive to provide coordination of care.[176] Regulations require that patient history be shared among all participants concerned with a patient's care "to achieve safer and more effective care. This means the patient's needs and preferences are known ahead of time and communicated at the right time to the right people, and this information is used to provide safe, appropriate, and effective care to the patient."[177]

Shared medical history improves patient care and eliminates the need to subject patients to repetitive questioning by multiple caregivers, thus treating the whole patient.

Strengths:

The national 988 system provides an easy-to-remember number that connects those in need with someone who can assist or access resources. Increased funding for CCBHCs should expand access to care. Additionally, funding allows current CCBHCs to increase services while expanding the number of CCBHCs.

Weaknesses:

The 988 system relies upon matching state funds and has a deadline of July 2022.[178] The cumbersome federal legislation might inhibit otherwise qualified caregivers from accessing CCBHC funds.[179] The controlling manner in which the federal money is allocated raises questions about the cost of paperwork and compliance outweighing the cost of clinical benefits to patients.

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173. NAT'L COUNCIL FOR BEHAV. HEALTH, *supra* note 171.

174. *See generally Criteria for the Demonstration Program to Improve Community Mental Health Centers and to Establish Certified Community Behavioral Health Clinics*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., https://www.samhsa.gov/sites/default/files/programs_campaigns/ccbhc-criteria.pdf (last visited Apr. 8, 2022).

175. *Id.* at 2.

176. *Id.* at 16.

177. *Id.* at 3–4.

178. 47 C.F.R. § 52.200 (2022); Julianne Hill, *The 988 Crisis Hotline Is Coming. Will States Answer the Call?*, MINDSITENEWS (Sept. 29, 2021), https://mindsitenews.org/2021/09/29/the-9-8-8-crisis-hotline-is-coming-will-states-answer-the-call/ ("But with the deadline for launching the 988 line just 9 months away, only a few states have enacted legislation to create and fund call centers and other services.").

178. *See* Hill, *supra* note 178.

B. State and Municipal Improvements

1. Virginia

In 2020, Virginia amended its code by adding sections "relating to response to mental health crises; establishment of the mental health awareness response and community understanding services (Marcus) alert system."[180] Prompting this law was the tragic death of Marcus-David Peters, a twenty-four-year-old teacher who was fatally shot by police.[181] On May 14, 2018, Peters arrived at a hotel where he worked part-time.[182] After removing his shirt, Peters appeared naked in the hotel's surveillance footage.[183] Peters drove away and hit another car.[184] Police officer Michael Nyantakyi witnessed the hit-and-run and followed Peters, activating his blue lights.[185] "The officer, who thought he was pursuing a felony hit-and-run suspect, only learned of Mr. Peters mental condition . . . when Mr. Peters stopped his car in the grass next to the Belvidere Street entry ramp to Interstate 95 after hitting two other cars."[186] Mr. Peters jumped out of his car naked and ran into traffic.[187]

The officer's bodycam footage revealed[188] that a van travelling on Interstate 95 hit Peters who fell to the ground and spun on his back, summersaulted and tumbled, finally laying on his back and making snow angels.[189] Cars in the far-right lane, where Peters had been hit, came to a standstill. However, the middle lane and far-left lane of traffic kept moving, oblivious to the naked man lying in the road.[190]

> The officer further explained that he holstered his firearm and drew his yellow Taser as he moved closer to observe and check on Mr. Peters. Suddenly, Mr. Peters stood and faced the officer who was standing some feet away. He appeared agitated and yelled at the officer to "[b]ack the fuck up." The officer backed up as Mr. Peters advanced. He explained to us that he was

180. H. 5043, Va. Acts, 1st Spec. Sess. (Va. 2020).

181. *Marcus Alert*, CITY OF VA. BEACH, https://www.vbgov.com/government/departments/human-services/behavioral-health/Pages/marcus-alert.aspx (last visited Apr. 8, 2022).

182. Jeremy M. Lazarus, *New Review of Marcus-David Peters Case Finds Shooting Justified*, RICHMOND FREE PRESS (Nov. 12, 2020, 6:00 PM), https://richmondfreepress.com/news/2020/nov/12/new-review-marcus-david-peters-case-findsshooting/.

183. *Id.*

184. *Id.*

185. *Id.*

186. *Id.*

187. *Id.*

188. Kate Albright & Kelly Avellino, *Police Release Body Cam Footage of I-95 Shooting Death*, NBC12 (June 2, 2018, 7:28 PM), https://www.nbc12.com/story/38277351/watch-police-to-release-body-cam-footage-of-i-95-shooting-death/ (providing bodycam video released by Richmond police for viewing).

189. Lazarus, *supra* note 182.

190. Albright & Avellino, *supra* note 188.

> attempting to maintain distance between them and to stall in hopes that other units would arrive. Mr. Peters then yelled "Put that [t]aser down or I'll kill you." The officer warned that he would deploy the [t]aser, but Mr. Peters continued to advance on the officer while yelling, "[d]ie motherfucker." The officer deployed his [t]aser striking Peters with one prong, but it had no effect.
>
> Nude and unarmed, Mr. Peters advanced closer and lunged at the officer with his arms extended in what appeared to be an effort to grab him. In his interview, the officer acknowledged that Mr. Peters was unarmed, but he indicated that by this point, it was "an all-out fight between the two" of them to gain control over his firearm. The officer further explained that he was wary of engaging hand to hand with Mr. Peters because of his erratic behavior, his unresponsiveness to pain, and fear that Mr. Peters might land on top of him. Using his left arm to repel him, the officer explained that he "bladed" his body to shield his firearm from Mr. Peters. As Mr. Peters continued to charge in apparent attack, the officer fired at least twice. It is unclear whether Mr. Peters actually made contact before the shots were fired; although, in the footage he was certainly well within arm's length.[191]

Mr. Peters was transported to a hospital where he died later that evening; his death received national attention.[192] "While the number of mental health-related calls in Virginia is low, they account for one in four officer-involved fatalities."[193] The death of Mr. Peters prompted a push for reforms that led to the passage of the Marcus Alert system.[194] The law provides a "comprehensive crisis system, with such funds as may be appropriated . . . , based on national best practice models and composed of a crisis call center, community care and mobile crisis teams, crisis stabilization centers, and the Marcus Alert system."[195] The Marcus Alert system provides for trained assessment of psychiatric crisis calls with the operator directing the call to the appropriate responder, including mobile crisis teams and

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191. Colette Wallace McEachin, *Marcus-David Peters Shooting: Review of Use of Force Investigation by Richmond Commonwealth's Attorney*, CBS 6 NEWS RICHMOND (Nov. 6, 2020), wtvr.com /news/local-news/marcus-david-peters-shooting-review-of-use-of-force-investigation-by-richmond-com monwealths-attorney.

192. "The case is somewhat different than other police shootings that have gained widespread national attention. Mr. Peters, Officer Nyantakyi and the city's prosecutor all are Black. Still, many people protesting racial injustice and police brutality in Richmond consider Mr. Peters a martyr . . . ." Lazarus, *supra* note 182.

193. Caroline Kealy & Christina Thompson, *Police React to Va. Bill Calling for Counselors to Respond to Mental Health 911 Calls*, ABC 13 NEWS (Oct. 13, 2020), https://wset.com/news/local/police-react-to-va-bills-calling-for-counselors-to-respond-to-mental-health-911-calls.

194. The Act modifies Code of Virginia to add § 9.1-193. VA. DEP'T OF BEHAV. HEALTH & DEV. SERVS., SUMMARY: STATE PLAN FOR THE IMPLEMENTATION OF THE MARCUS-DAVID PETERS ACT 1, https://www.dbhds.virginia.gov/assets/doc/hr/Health-Equity/mdpa/mdp_act_state-plan-july-2021.pdf (last visited Apr. 8, 2022).

195. VA. CODE ANN. § 37.2-311.1 (West 2021).

police.[196] The Marcus Alert system further provides for specialized training for officers who respond to psychiatric crisis calls.[197] Plus, the legislation requires consideration of whether a plain-clothes officer arriving in an unmarked car would de-escalate the situation.[198]

Strengths:

The Marcus Alert system provides a database in which anyone can upload information to be available to first responders who respond to emergency calls.[199] "Residents are encouraged to create a free emergency health profile at https://www.emergencyprofile.org/. Here, they can enter any health information of their choosing, such as mental health issues, developmental disabilities, pre-existing conditions, allergies, emergency contacts and more into the voluntary database."[200] The database is available to police and first responders.[201] Empowering people with SMI to provide this information to first responders helps prevent the identified tragedies because first responders will better understand the person's behaviors when they arrive, protecting the safety of first responders, others on the scene, and the person in crisis.

Weaknesses:

a. Intervention Occurs Too Late

Even if the Marcus Alert system were in place, it is unlikely that it would have helped Peters or others with SMI experiencing a violent psychiatric crisis for the first time, before a pattern has emerged in the person's illness. There was no time for intervention prior to the incident on the highway. No one at the hotel in which he disrobed contacted authorities.[202] Mr. Peters'

196. "The regional crisis call center staff are trained to assess calls for what type of intervention is needed. They offer services ranging from over the phone de-escalation to mobile crisis dispatch. In more severe cases, they will also coordinate with law enforcement to arrive on the scene." *The Marcus-David Peters Act*, VA. DEP'T OF BEHAV. HEALTH & DEV. SERVS., https://dbhds.virginia.gov/human-resource-development-and-management/health-equity/mdpa/ (last visited Apr. 8, 2022).

197. VA. CODE ANN. § 9.1-193 (West 2020).

198. "Specialized response protocols and training by law enforcement shall consider the impact to care that the presence of an officer in uniform or a marked vehicle at a response has and shall mitigate such impact when feasible through the use of plain clothes and unmarked vehicles." *Id.*

199. VA. DEP'T OF BEHAV. HEALTH & DEV. SERVS., *supra* note 194, at 12.

200. *Emergency Health Profile*, CITY OF RICH., https://www.rva.gov/911/healthprofile (last visited Apr. 8, 2022) (explaining that residents can include mental health issues amongst other health issues that will be available to the Richmond Department of Emergency Communications and first responders).

201. VA. DEP'T OF BEHAV. HEALTH & DEV. SERVS., *supra* note 194, at 12.

202. The review of the shooting examined this issue:

> The Coordinator opined that a successful intervention might have been possible if Mr. Peters' decompensation had been able to be psychologically addressed while he was at the Jefferson Hotel. Even at that point, his behavior appeared so disordered that it is unlikely that

behavior was out of character for him.[203] His sister "reiterated that Peters, the youngest of a dozen siblings, exhibited no signs in the days or hours before his death that something was amiss, and the behavior exhibited in the now-public videos 'has never been seen by me or my family before[—]ever.'"[204] There is no evidence that he was afflicted with a mental illness prior to this event.[205]

After stripping, Peters drove into another car and kept going.[206] Officer Nyantakyi witnessed the hit-and-run but had no way to know that Peters was in a psychiatric crisis.[207] Not until Mr. Peters emerged from his vehicle on the side of 95, naked, did the officer become aware of his psychiatric condition.[208] "Only 76 seconds elapsed between Mr. Peters exiting his car and the shooting . . . ."[209] When Mr. Peters emerged from his car, Officer Nyantakyi recognized that he needed care and requested back up.[210] Additional officers did not arrive until after Peters was shot.[211]

Officer Nyantakyi had previously received crisis intervention training.[212] He recognized that Mr. Peters was suffering.[213] However, because of Mr. Peters's dangerous behavior of running onto Interstate Highway 95 and being hit by a car, the situation unfolded so rapidly that there was nothing anyone could have done to de-escalate the situation.[214] The officer tried to contain Peters until help could arrive. Mental illness led him to threaten and attack the officer.[215]

Two separate investigations came to the same conclusion: Officer Nyantakyi acted appropriately.[216] One expert, Kelly Furgurson, is a

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> communication could have been established with him. Ideally, the "intervenor," at that point would have been a licensed and experienced mental health professional with a Master's degree level of education. The intervenor would also have had training in crisis intervention, de-escalation and the civil commitment process. Unfortunately, the authorities were not aware of Mr. Peters' irrational behavior until the officer observed Mr. Peters hit a car on N. Belvidere Street and leave the scene.

McEachin, *supra* note 191.

203. Sarah King, *Video Shows Fatal I-95 Shooting at Close Range*, RICHMONDMAG (May 25, 2018, 7:08 PM), https://richmondmagazine.com/news/news/police-video-shows/.

204. *Id.*

> The circumstances surrounding Peters' final hours are unclear, even to his closest friends and family. After finishing his work day teaching in Essex County, he briefly stopped at his home in Henrico County, where he lived with his girlfriend. He took off his school badge, said he needed to go to a meeting at the hotel and told his girlfriend he loved her.
>
> *Id.*

206. Lazarus, *supra* note 182.

207. *Id.*

208. *Id.*

209. McEachin, *supra* note 191.

210. *Id.*

211. *Id.*

212. *Id.*

213. Lazarus, *supra* note 182.

214. *See id.*

215. *Id.*

216. *Id.*

Richmond Behavioral Health Authority staff member.[217] Mr. Furgurson directs emergency services for people with mental illness and coordinates RBHA's crisis intervention training for officers on dealing with people with mental illness.[218] Officer Nyantakyi had taken the course, and according to his findings: [219]

> Mr. Furgurson reported that Officer Nyantakyi used the crisis intervention training appropriately, recognized that Mr. Peters was "mentally unstable" and called for assistance.
>
> [However,] Mr. Furgurson also found "there was no time when both the officer and Mr. Peters were in a safe position to make communication and de-escalation possible."
>
> He found the officer "did not yell at Mr. Peters or attempt to touch Mr. Peters," both of which are considered key to de-escalation. He also found the officer sought to keep a safe distance between himself and Mr. Peters as the officer awaited assistance.
>
> Mr. Furgurson also noted that Mr. Peters appeared to have been "incapable of rational communication," which means that de-escalation techniques were useless. As Mr. Furgurson pointed out, "de-escalation can only be attempted once all parties are able to communicate from a safe position that is free from the threat of injury or death to either party."[220]

Thus, the Virginia law likely would not have helped Peters, even though it makes strides for people with SMI. Allowing first responders access to information about the person's history, diagnosis, symptoms, and behaviors promotes safety. First responders can better understand the behaviors of the person, making the situation less likely to end in violence.[221] However, the Virginia law only helps people who have experienced acute episodes in the past because their information is already entered into the database.[222] Mr. Peters was experiencing his first episode, so he would not have benefited from the law's database.[223]

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217. *Id.*
218. *Id.*
219. *Id.*
220. *Id.*
221. VA. DEP'T OF BEHAV. HEALTH & DEV. SERVS., STATE PLAN FOR THE IMPLEMENTATION OF THE MARCUS-DAVID PETERS ACT 81 (2021), https://www.dbhds.virginia.gov/assets/doc/hr/Health-Equity/mdpa/mdp_act_state-plan-july-2021.pdf.
222. *See id.* at 11–12; VA. CODE ANN. § 9.1-193 (West 2020).
223. *See* King, *supra* note 203.

b. Virginia Fails to Empower People to Secure Intervention

The Marcus Alert system received criticism from Peters' family, including his sister Princess Blanding.[224] At the signing ceremony of the bill, Blanding said:

> Please take a moment to pat yourselves on the back for doing exactly what this racist, corrupt, and broken, may I also add, system expected you all to do: make the Marcus Alert bill a watered[-]down, ineffective bill that will continue to ensure that having a mental health crisis results in a death sentence.[225]

Blanding argues that the Marcus Alert system does not go far enough and objects to "the discretionary role of police, the timeline for implementation and the potentially disjointed application of the system across the state."[226] Essentially, the political movement that supported passing the Marcus Alert system was propelled by the desire to remove police from responding to individuals suffering from psychiatric crisis, but it fails to empower individuals suffering from a crisis to secure safe and effective intervention.[227] Focusing only on the first responders and only on that first interaction with the person in crisis is misguided. Whether healthcare professionals or police arrive on the scene of a mental health emergency will not determine the ability of the person in crisis to avoid the identified tragedies. Rather, people in crisis need access to care, even in contravention of illness induced treatment refusals, for sufficient time to regain stability and capacity.

2. California

> "He broke our sliding glass window. He's threatening us. He has this long pole. He needs to be apprehended. He cannot be in our house."[228]

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224. Ali Rockett, *Peters' Sister Blasts Legislators and Gov. Northam as He Ceremonially Signs 'Marcus Alert' Bill*, RICHMOND TIMES-DISPATCH (Dec. 15, 2020), https://richmond.com/news/local/govt-and-politics/peters-sister-blasts-legislators-and-gov-northam-as-he-ceremonially-signs-marcus-alert-bill/article_6542c0d6-40a7-5f97-b5f1-cba11413c1fd.html.

225. *Id.*

226. *Id.*

227. *Mental Health Crises Response in Richmond Will Change in December with Introduction of Marcus Alert*, RICHMOND TIMES-DISPATCH (Sept. 22, 2021), https://richmond.com/news/local/article_edbc7084-1ac3-57b9-9407-c6f6a7f76e15.html.

228. Kris Reyes, *Miles Hall Death: Family Says $4M Settlement With Walnut Creek Doesn't Do 'Justice,' Demands Non-Police Responses to Mental Crisis Calls*, ABC7 NEWS (Sept. 21, 2020), https://abc7news.com/miles-hall-death-walnut-creek-settlement/6488760/ (providing footage of bodycam video and 9-1-1 calls).

On June 2, 2019, the family of Miles Hall called police because Mr. Hall was threatening and violent.[229] Police responded and tried to subdue Mr. Hall.[230] The police were aware that Mr. Hall suffered from schizoaffective disorder with hallucinations and had previously worked with the family.[231] The family expected the officers to assist.[232]

> [His mother] said her son was holding a gardening tool when he started running in officers' direction. He was shot and killed. She said police were aware of her son's mental health problems before arriving on the scene.
>
> "We even had a mental health officer that was established that knew our family," Hall said. "So, we were feeling like, okay. They're coming to help him with care and compassion and unfortunately, that day they came and he was shot four times.[233]

The death of Miles Hall led to an investigation that cleared the police but led to a $4 million settlement from the City of Walnut Grove to the Hall family, inspiring legislation to eliminate police response to psychiatric crisis.[234] The proposed legislation promotes the goal that mental health experts, rather than police, respond to individuals in psychiatric crisis.[235]

Callers who dial or text 988 would be connected with counselors and assisted by mobile crisis support teams staffed with mental health professionals.[236] Backers say this proposal offers a better option than calling 911 where police are the first responders, and they advocate that too often involving police make situations turn violent.[237] Those who still call the emergency line but report a mental health crisis would be transferred to 988, and dispatchers for both lines would be able to decide if police, fire, or medical responders are needed.[238]

The Miles Hall bill builds on federal law establishing a new suicide prevention hotline. "This bill would require 988 centers, as defined, to, by July 16, 2022, provide a person experiencing a behavioral health crisis access

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229. *Walnut Creek Police Release Body Cam Footage From Fatal Encounter, Family Files Wrongful Death Claim*, ABC7 NEWS (June 25, 2019), https://abc7news.com/walnut-creek-police-department-body-camera-footage-video/5364279/.

230. *Id.*

231. Melissa Mecija, *AB 988: New Mental Health Legislation and a Mother's Crusade to Honor Her Son*, ABC10 NEWS SAN DIEGO (Apr. 22, 2021, 12:02 AM), https://www.10news.com/news/local-news/ab-988-new-mental-health-legislation-and-a-mothers-crusade-to-honor-her-son.

232. *Id.*

233. *Id.*

234. *See id.*; Leslie Brinkely, *No Charges Filed Against Officers in Fatal Shooting of Walnut Creek Man Having Mental Health Crisis*, ABC7 NEWS (May 7, 2021), https://abc7news.com/miles-hall-death-walnut-creek-police-shooting-officers-shoot-man-in/10594049/.

235. *See* Mecija, *supra* note 231.

236. *See* Assemb. Bill No. 988, Sec. 3, art. 6.1, 2021 Cal. Stat. 1.

237. *See, e.g.*, Mecija, *supra* note 231.

238. Assemb. Bill No. 988, Sec. 3, 5312(b)(2), 2021 Cal. Stat. 1.

to a trained counselor by call and, by January 1, 2027, provide access to a trained counselor by call, text, and chat."[239] By providing access to a counselor, the bill attempts to facilitate a therapeutic approach while allowing the operator to determine the best response.[240]

The proposal presupposes that the majority of psychiatric crisis calls do not require a police presence.[241] "This bill can save lives that we are losing to suicide and shootings by police, said Krystal LoPilato, volunteer leader with California Moms Demand Action."[242] The reasoning underlying removal of police assumes that, but for police, the individual in crisis would not have become violent.[243]

Additionally, the California bill would change the way authorities respond to psychiatric emergencies routed through the 988 hotline:[244]

> The bill would require mobile crisis teams, as defined, to respond to any individual in need of immediate suicidal or behavioral health crisis intervention in a timely manner in all jurisdictions, and would require any call made to 911 pertaining to a clearly articulated suicidal or behavioral health crisis to be transferred to a 988 center, except under specified circumstances. The bill would require 988 centers to provide follow-up services to individuals accessing 988 consistent with guidance and policies established by the National Suicide Prevention Lifeline and within specified timelines.[245]

Under the proposed law, mobile crisis teams may include:

> (1) Teams that include both medical professionals and a team of behavioral health professionals that are embedded in emergency medical services.
> (2) Specialized teams that can provide coordinated care for individuals experiencing chronic homelessness.

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239. Assemb. B. 988, 2021 Cal. Stat. 2.

240. *See, e.g.*, Mecija, *supra* note 231.

241. *Id.*

242. *California Bill Seeks to Create Hotline that Would Have Counselors, Not Police, Respond to Mental Health Calls*, KTLA, https://ktla.com/news/california/california-bill-seeks-to-create-hotline-that-would-have-counselors-rather-than-police-respond-to-mental-health-calls/ (last updated Mar. 8, 2021, 5:03 PM).

243. *See* Mecija, *supra* note 231.

244. *See* Assemb. B. No. 988, 2021 Cal. Stat. 2.

245. *See also id.* at sec. 3, § 53123.1(f). "Mobile crisis team" means a jurisdiction-based behavioral health team, as defined in the American Rescue Plan Act of 2021 (Section 1947(b)(2) of Public Law 117-2.); "Qualifying community-based mobile crisis intervention services are defined as services provided by a multidisciplinary mobile crisis team to a Medicaid-eligible individual experiencing a mental health or substance use disorder crisis outside of a hospital or other facility setting. The multidisciplinary team must include at least one behavioral health care professional who meets specified qualifications." ALISON MITCHELL ET AL., CONG. RSCH. SERV., R46777, AMERICAN RESCUE PLAN ACT OF 2021 (P.L. 117-2): PRIVATE HEALTH INSURANCE, MEDICAID, CHIP, AND MEDICARE PROVISIONS (2021).

> (g) "Coresponder teams" means a jurisdiction-based behavioral health team in which a trained mental health professional and law enforcement officer jointly respond to a suicidal or mental health crisis. Coresponder mobile crisis teams shall include at least one mental health professional and officers shall dress in plain clothes and travel in unmarked vehicles.[246]

Thus, any time police are involved in psychiatric crisis intervention pursuant to a 988 call, the officer must not be in uniform and must be in an unmarked car.[247]

Strengths:

The focus on continuation of care in the California proposal is long overdue. SMIs are a long-term diagnosis.[248] One visit with a mental health expert will not cure the patient. Instead, there needs to be the follow-up. Among other goals, the bill states:

> (d) It is the intent of the Legislature that . . . to provide the most appropriate level of care that the 988 system provides a continuum of crisis services, including high-quality crisis counseling, in-person intervention by trained mental health professionals as an alternative to law enforcement, and linking individuals with crisis and ongoing services.[249]

Thus, this bill both acknowledges that ongoing care is needed and envisions a process for ensuring services.[250] Such a point might seem obvious, but one of the failures of deinstitutionalization was a false belief that SMI would easily be cured and did not require hospitalization.[251]

Weaknesses:

There is no way to know if the bill proposed in his name would have changed the tragic outcome for Mr. Hall. Underlying the proposed law's minimization of the role of police is the assumption that the presence of police in response to mental health emergencies causes violence, and without

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246. Assemb. B. No. 988, 2021 Cal. Stat. 2.

247. Assemb. B. No. 988, sec. 3, art. 6.1, Miles Hall Lifeline and Suicide Prevention Act, § 53123.1(g), 2021 Cal. Stat. 10.

248. *See generally Living Well with Serious Mental Illness*, SAMHSA, https://www.samhsa.gov/serious-mental-illness (last updated Mar. 3, 2022).

249. Assemb. Bill No. 988, § 1(d), 2021 Cal. Stat. 7.

250. *See id.*

251. *See, e.g.*, Alisa Roth, *The Truth About Deinstitutionalization*, THE ATLANTIC (May 25, 2021), https://www.theatlantic.com/health/archive/2021/05/truth-about-deinstitutionalization/618986/.

police there would be no violence. However, the actual event of the Miles Hall death does not support that assumption.[252]

Miles Hall was violent prior to arrival of police.[253] Without police response, his violence may have escalated and harmed others or himself. His family called the police because Mr. Hall was violent, and neighbors called 911, frightened by Mr. Hall's behavior.[254]

Thus, the criteria for many 911 mental health emergency calls includes risk of violence. The criteria for involuntary detention, transportation, evaluation, and treatment for a person in mental health crisis is dangerousness.[255] Therefore, the nature of these situations involves threat of violence. The fact that these emergencies may turn violent means responders must be trained in preventing violence. Who knows if the California solution would have promoted safety and de-escalated violence in the Hall situation? An undercover officer arriving in an unmarked car might confuse or escalate, instead of diffuse, a violent situation.

When an individual has broken a window, tries to break into a home, and is in possession of a sharp metal pole, the situation is so volatile that there is no guarantee de-escalation techniques would resolve the event. Four out of five officers who arrived had crisis intervention training that included de-escalation techniques.[256] Non-lethal force was used against Mr. Hall, but to no avail. The bodycam video does not show him lunging at the officers, just running with a weapon.[257] A violent individual running with a weapon presents a concern for public safety.[258] Thus, the Hall Law does not adequately address a volatile situation in which an individual's mental illness produces violence to his family and danger to the community. The need for a police officer, or some other professional adequately trained in preventing and responding to violence, as a member of a response team, remains vital to public safety.[259]

Additionally, Mr. Hall was known to police; his family knew about his SMI and need for treatment.[260] The Hall Law does not address the

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252. *See generally Officer Involved Shooting: June 2, 2019*, WALNUT CREEK POLICE DEP'T, https://www.walnut-creek.org/departments/public-safety/police/policies-and-transparency/officer-involved-shootings/june-2-2019 (last visited Apr. 8, 2022).

253. *See id.*

254. *Id.*

255. *See generally* CAL. DEP'T OF STATE HOSP., POLICY 408 MENTAL ILLNESS COMMITMENTS (2020), https://www.dsh.ca.gov/Law_Enforcement/docs/Policies_Procedures/Mental_Illness_Commitments.pdf.

256. Haven Orecchio-Egresitz, *Miles Hall's Mother Did Everything She Could to Protect Her Son with Schizoaffective Disorder. Police Still Killed Him*, INSIDER (Jan. 27, 2021, 10:31 AM), https://www.insider.com/miles-halls-killed-by-police-california-2020-11.

257. *See id.*

258. *See* WALNUT CREEK POLICE DEP'T, *supra* note 252.

259. Assemb. B. 988 2021–2022 Leg., Reg. Sess. (Cal. 2021).

260. *See* Orecchio-Egresitz, *supra* note 256.

illness-induced treatment refusal phenomenon.[261] People with SMI are still left victims of their illnesses, unable to secure intervention to which they would have consented if they were not under the influence of an acute episode. Intervention must arrive sooner, prior to crisis, and the California solution does not offer this hope.

A third weakness in the California bill occurs when only the medical health professional team, or the homeless crisis team, responds to a situation that first appears nonviolent to the 988 dispatchers, but then becomes violent on the scene.[262] The California-proposed process poses a risk of serious injury or death to responders, who lack the ability to defend themselves. In Mr. Hall's situation, if verbal de-escalation techniques did not work, there was little first responders could have done to stop Mr. Hall, who was armed with a sharp metal rod. By intervening, the responders themselves might have been injured.

The California bill echoes antiquated language that undermines successful psychiatric treatment.[263] For example, "(c) It is the intent of the Legislature that the 988 system be designed to provide individuals with the least restrictive care necessary to stabilize an individual in crisis and to set them up for success on their recovery and wellness journey."[264] This language harmfully shifts the focus away from long-term solutions. Short-term "stabilization" of an individual suffering from a psychotic event, the "least restrictive care necessary," simply perpetrates a seventy-two-hour revolving door imposed by current commitment laws that require doctors to heed the illness-induced treatment refusals of people in crisis, even when those people desperately need care.[265]

3. Colorado

On June 27, 2021, the Governor of Colorado signed two laws to improve responses to psychiatric crisis.[266] The first law[267] expands funding for co-responder programs and counseling services for officers involved in a shooting or fatal use of force. The Colorado legislature referenced the intention to avoid continued overuse of the criminal justice system for

261. *See generally* Assemb. B. 988 2021–2022 Leg., Reg. Sess. (Cal. 2021).

262. *Id.*

263. This topic is too broad to cover in this Article, but the antiquated Supreme Court decisions that focus on "least restrictive environment" display a stunning lack of knowledge about the etiology and treatment of serious mental illnesses. *See id.*

264. *Id.*

265. *See id.*

266. *See generally* H.B. 21-1030, 73rd Gen. Assemb., Reg. Sess. (Colo. 2021); H.B. 21-1085, 73rd Gen. Assemb., Reg. Sess. (Colo. 2021).

267. H.B. 21-1030, 73rd Gen. Assemb., Reg. Sess. (Colo. 2021).

societal problems including psychiatric crises.[268] The second law[269] enables counties to issue licenses for alternative transportation for individuals suffering from psychiatric crises. Both laws received widespread police support.[270]

Both laws expand community-based public safety partnerships and encompass a wide variety of issues.[271] "Community-based alternative response means a person-centered crisis response to community members who are experiencing problems related to poverty, homelessness, behavioral health, food insecurity, and other social issues, that directs certain calls for police service to more appropriate support providers in lieu of a police response."[272] The transportation law sets out specific regulations that are to be developed by the State Board of Health prior to implementation in July 2022.[273] Some Colorado counties have established programs that will benefit from the new laws:

> Summit County has previously made use of the grant program, which helped to set up the county's Systemwide Mental Assessment Response Team (SMART), a program housed under the Summit County Sheriff's

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268. *Id.*

> (c) Locally driven and innovative programs that leverage partnerships between safety net care providers and first responders are effective and critical strategies for bolstering overall community resilience, connecting people to care, and preventing criminal justice involvement and recidivism; and (d) With the current public health crisis exacerbating existing systemic inequities, we must pivot away from overutilizing the criminal justice system for what are public health and social determinants of health needs and utilize other community resources in a richer way to be leaders in the solution to these challenges.
>
> *Id.*

269. H.B. 21-1085, 73rd Gen. Assemb., Reg. Sess. (Colo. 2021).

270. Douglas County Deputy Dan Brite testified on behalf of the Colorado Fraternal Order of Police. Deborah Takahara, *New Bill Would Expand Programs Allowing Mental Health Counselors to Work with Police Officers*, FOX31 NEWS (Mar. 2, 2021, 7:30 PM), https://kdvr.com/news/politics/new-bill-would-expand-programs-allowing-mental-health-counselors-to-work-with-police-officers/.

> He said, "Law enforcement is not designed to handle the enormous amount of mental health calls that we get and so it's time we create these co-responder programs to help combat mental health in a much more effective way, give them direct access to resources." He has first-hand experience. Five years ago, he responded to a suicidal man with a gun that ended in a gunfight. "Had a program like this existed 5 years ago, there's a really good chance he would've got more appropriate mental health resources and he'd be alive with his family and I would be not living in a wheelchair and not having experienced such a traumatic event," Brite said. He is supporting community-based public safety partnerships that will provide more tools for those responding to calls for help and hopefully better outcomes.
>
> *Id.*

271. *See generally* H.B. 21-1085; H.B. 21-1030. "Therefore, the general assembly finds and declares that investing in community-based public safety partnerships will allow for a wider spectrum of responses to calls for service by fostering coordination with behavioral health clinicians, emergency medical service providers, community resource and housing navigators, and others." H.B. 21-1030, at 2.

272. H.B. 21-1030, at 7.

273. *See generally* COLO. REV. STAT. § 25-3.5-311 (2021). "(1) On or before July 1, 2022, the state board of health shall adopt rules establishing the minimum requirements for secure transportation services licensing . . . ." *Id.*

> Office since January last year. The initiative provides a plain-clothed deputy and clinician to respond to mental health[-]related calls in hopes of stabilizing someone rather than falling back on arrests or emergency room visits. Individuals the team contacts can later work with a case manager to facilitate additional mental health treatment or connect with other community resources.[274]

The SMART system's focus on continuity of care will be enhanced by expanded transportation options and can serve as a model for other counties in Colorado.

Strengths:

The new Colorado law is designed to minimize the trauma for the individual being transported for psychiatric treatment.[275] Allowing counties to provide alternative vehicles for transportation to mental health facilities eliminates wait time for ambulances and frees up ambulances for medical emergencies requiring specialized equipment such as obstetrical kits, defibrillators, and immobilization devices for spinal injuries.[276]

While ambulances in Colorado may still transport an individual in a mental health crisis, this law gives more flexibility to experts on the scene. The transportation itself becomes less traumatic, helping to calm an agitated individual.[277] Additionally, alternative transportations are likely less costly and may offer more flexibility.[278] Transportation also resolves the issue of an individual who wants to access treatment but cannot reach the appropriate facility.[279] By providing funds and increasing transportation opportunities, the new law eliminates a common barrier—transportation—to receiving psychiatric treatment.

Weaknesses:

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274. Sawyer D'Argonne, *Gov. Polis Signs Mental Health, Law Enforcement Bills in Silverthorne*, SUMMITDAILY (June 27, 2021), https://www.summitdaily.com/news/local/gov-polis-signs-mental-health-law-enforcement-bills-in-silverthorne/.

275. *See id.*

276. *See id.*

277. *Id.*

278. *See id.*

> Not only is an ambulance somewhat dramatic and traumatic for somebody in a mental health crisis, with all the sirens and the hardcore medical equipment, but it also happens to cost an awful lot,' Polis said. '. . . If it's a behavioral health crisis, there's a way that a county can create a secure transportation service that has the necessary pieces to it—not all the bells and whistles an ambulance would have—but it's lower cost and a lot less traumatic for the person who needs to be transported.
>
> *Id*.

279. *See id.*

a. Lack of Focus

These laws are quite broad, and the breadth of focus prevents the Colorado solution from being practical and effective. Although poverty, homelessness, behavioral health, food insecurity, and other social issues are included, specific problems related to a psychiatric crisis are not meaningfully addressed. All of these issues are critical to those personally impacted—people with SMI and their loved ones. However, resolving tragic encounters between the police and individuals suffering from a psychiatric crisis requires a completely different solution than does resolving food insecurity.

b. Funding

Funding remains a problem in Colorado.[280] The lofty goals of the laws may be undermined by the lack of consistent, adequate funding. Unfortunately, "funding requests from communities around the state have already pushed the program beyond its limits. There were about $6 million in grant requests this year and only $2 million to go around . . . ."[281] Additionally, funding from other sources had already been cut before these laws were passed.[282] "Of note, funding from the grant program for Summit's SMART team was cut by almost $250,000 this year, a significant loss as officials began allocating additional money from the Strong Futures initiative and county reserves to bring 24/7 responses to the county."[283] Even the Governor, who signed the legislation into law, admits that without adequate funding, such programs are not sustainable.[284]

c. Failure to Facilitate Intervention

Any proposal, such as Colorado's, which focuses only on facilitating alternative transportation options and reconfiguring the appearance, training, and identities of the first responders is wholly inadequate. Such proposals merely address one problem in America's broken system for responding to

280. *See id.*
281. *Id.*
282. *See id.*
283. *Id.*
284. *Id.*
"I think it's more of a short-term solution," Polis said. "We need to figure out a better funding source in the long run. It absolutely can help. Frankly, many communities don't even have these kinds of programs like Summit County has. So first of all, we want to model the success of the program and bring better support into communities that have very little that they can offer their officers of the peace. But secondly, we need to have a serious statewide discussion about the sustainable funding."
Id.

mental health emergencies.[285] No matter who picks up the person in crisis, Colorado state law still requires healthcare providers to heed the person's illness-induced treatment refusals, even if the person is experiencing psychosis and needs treatment.[286] Colorado law still requires the hospital who receives the person in crisis to release the person upon her illness-induced discharge demands.[287] The person in crisis still suffers from the seventy-two-hour state law mandated revolving door.[288] Even if the person avoids harm by police, she will suffer the other tragedies. The state involuntary treatment laws will still require following her illness-induced treatment refusals, even if when she had capacity, she would have wanted such intervention.[289] Plus, even if a person in crisis has alternative transportation options, if her illness induces her to refuse transportation, and state law requires first responders to honor her illness-induced refusals, she will not obtain intervention but will continue to decompensate and may ultimately suffer institutionalization, criminalization, homelessness, and self-harm.[290]

4. Eugene, Oregon

In Eugene, Oregon, mobile crisis units have responded to mental health emergencies for over thirty years. Known as CAHOOTS (Crisis Assistance Helping Out On The Streets), each mobile crisis unit "consists of a medic (either a nurse or an EMT) [and] a crisis worker (who has at least several years' experience in the mental health field)."[291] Emergency calls are evaluated by the operator to determine whether police should respond.[292] "911 dispatchers filter calls they receive—if they're violent or criminal, they're sent to police. If they're within CAHOOTS' purview, the van-bound staff will take the call. They prep what equipment they'll need, drive to the scene and go from there."[293] Essentially, CAHOOTS partners with the police and responds to nonviolent calls which may include psychiatric crises.

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285. *See generally* Thy Vo, *A Mental Health Hold Can Help Coloradans in Crisis. But For Many Who Are Seriously Ill, That's Where the Help Stops*, THE COLO. SUN (Jan. 14, 2022, 4:28 AM), https://coloradosun.com/2022/01/14/72-hour-mental-health-holds-colorado/.

286. *See generally* COLO. REV. STAT. §§ 27-65-101 to -131 (2017); *Colorado's Involuntary Mental Health Treatment System Explained*, COLO. DEP'T OF HUM. SERVS., https://cdhs.colorado.gov/behavioral-health/involuntary-mental-health-treatment (last visited Apr. 8, 2022).

287. *See generally* COLO. REV. STAT. §§ 27-65-101 to -131 (2017).

288. *Id.*

289. *Id.*

290. *See id.*

291. *CAHOOTS: Crisis Assistance Helping Out on the Streets*, WHITE BIRD CLINIC, https://whitebirdclinic.org/cahoots/ (last visited Apr. 8, 2022).

292. *See id.*

293. Scottie Andrew, *This Town of 170,000 Replaced Some Cops with Medics and Mental Health Workers. It's Worked for Over 30 Years*, CNN (July 5, 2020, 10:10 PM), https://www.cnn.com/2020/07/05/us/cahoots-replace-police-mental-health-trnd/index.html.

CAHOOTS offers many services to individuals suffering from psychiatric crisis such as crisis counseling, suicide prevention, assessment, and intervention, grief and loss, and substance abuse. CAHOOTS also offers "Transportation to Services."[294] However, this is voluntary transportation service for individuals requesting or in agreement.[295] The staffing, response, and follow-through of CAHOOTS results in improved outcomes for individuals suffering from mental illness. Working together, the medic and the crisis worker recognize the relevant medical situation and respond appropriately.[296] Stocked with appropriate first aid and medicine, the units can begin treatment on the scene.[297] Additionally, the mobile crisis units make follow-through decisions about next steps, allowing continuation of care.[298]

However, CAHOOTS does not respond to events involving potential violence, limiting any impact in defusing potentially violent encounters with police. "CAHOOTS workers are not trained in law enforcement and do not have the same authority as police. We are a mobile crisis intervention team, designed as an alternative to police response for non-violent crises."[299] In volatile situations, CAHOOTS may respond in conjunction with police or may defer to the police.[300] "Any person who reports a crime in progress, violence, or a life-threatening emergency may receive a response from the police or emergency medical services instead of or in addition to CAHOOTS."[301] While CAHOOTS has been widely touted by national media as a solution to harm created by police action,[302] it is unlikely that CAHOOTS would have been called to any of the high-profile cases described in this Article due to the violence that preceded the police presence.

Strengths:

a. Longevity & Partnerships

Being in existence for over thirty years, CAHOOTS has integrated into the community.[303] CAHOOTS is well-known and respected in Eugene. It

294. However, some of the services offered are more social work type: conflict resolution and mediation, housing crisis, first aid and non-emergency medical care, and resource connection and referrals. WHITE BIRD CLINIC, *supra* note 291.

295. *See generally* Andrew, *supra* note 293.

296. *See id.*

297. *See* WHITE BIRD CLINIC, *supra* note 291.

298. *See id.*

299. *Id.*

300. *See* Andrew, *supra* note 293.

301. WHITE BIRD CLINIC, *supra* note 291.

302. *See generally id.*; Rowan Moore Gerety, *An Alternative to Police that Police Can Get Behind*, THE ATLANTIC (Dec. 28, 2020), https://www.theatlantic.com/politics/archive/2020/12/cahoots-program-may-reduce-likelihood-of-police-violence/617477/; Andrew, *supra* note 293.

303. *See* Andrew, *supra* note 293.

partners with the police and has connections with many other services available in the community.

> CAHOOTS is a partner organization with the City of Eugene and is run through the White Bird Clinic. It is currently dispatched via the same system as EPD and Eugene Springfield Fire (ESF) to a variety of calls diverting some from EPD and other emergency services, as well as handling a subset of unique calls that would [not] normally be responded to by law enforcement.[304]

CAHOOTS supplements the police, as noted by a report by the Eugene Police Department. "CAHOOTS is a valued partner within the city of Eugene and provides a needed service within the community. EPD and CAHOOTS are partner organizations that both meet specific and unique needs."[305] By providing welfare checks and assisting individuals with non-emergency needs, CAHOOTS partners with the local government and the community to reduce the need for police intervention in situations that include psychiatric crises.[306]

b. Transportation

Along with other services,[307] CAHOOTS offers transportation for individuals they serve.[308] The transportation services are broad and not limited by regulations. A 2020 Eugene police department crime analysis reported:

> TRANSPORT (3,712 dispatched): A CAHOOTS transport call generally involves moving an individual, often unhoused and in need, or dealing with mental health issues, from one location to another for non-emergency services. For example: an individual may need to get from a dusk-to-dawn site to a hospital for non-emergency issues. CAHOOTS arrived at 3,303 of the Transport calls. Transport calls make up 24% of the total call volume CAHOOTS is dispatched to.[309]

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304. EUGENE POLICE CRIME ANALYSIS UNIT, CAHOOTS PROGRAM ANALYSIS 2 (2020), https://www.eugene-or.gov/DocumentCenter/View/56717/CAHOOTS-Program-Analysis.

305. *Id.* at 8.

306. *See What is CAHOOTS?*, WHITE BIRD CLINIC (Oct. 29, 2020), https://whitebirdclinic.org/what-is-cahoots/.

307. WHITE BIRD CLINIC, *supra* note 291 (listing other services including crisis counseling, suicide prevention, assessment, and intervention, conflict resolution and mediation, grief and loss, substance abuse, housing crisis, first aid and non-emergency medical care, resource connection and referrals, transportation to services).

308. *Id. But see* Gerety, *supra* note 302.

309. EUGENE POLICE CRIME ANALYSIS UNIT, *supra* note 304, at 6.

Overall, the CAHOOTS response team focuses on solving the problem of the individual in crisis including transportation to appointments, shelters, or elsewhere.

Weaknesses:

c. Narrow Options

Even if CAHOOTS responds and finds a cooperative individual in crisis, there are no easy resolutions. While CAHOOTS provides transport to clinics or shelters, for many individuals suffering from SMI, there is nowhere to go.[310]

> At last, Maker and Troutz succeeded in leading the woman to the van. They'd avoided an arrest [for trespass], but it was a temporary victory. The woman had only just gotten out of jail. Before that, she'd been in and out of the state mental hospital for years. Space constraints, insurance issues, and time limits on residential programs all contributed to the difficulty of finding a place where she could receive long-term mental-health services and drug treatment . . . .
>
> "This is one of those cases where there is no perfect place to take her, but it's better to take her out of the part of town where she's been causing some trouble," Maker said. The van stopped, and the woman got out and took a seat on a discarded couch in the parking lot.[311]

CAHOOTS works well in a limited scope and in limited situations, but it depends upon the availability of services and locations.

> "You can call someone for the crisis, but what are they supposed to do for it—where can they take them except for jail?" she said. "That doesn't necessarily provide much treatment."
>
> They're better equipped than police to care for the people she serves, she said. But if there isn't space in affordable housing, Eugene's detoxing center or mental health facilities, those clients will turn into regulars.[312]

Thus, CAHOOTS lacks the ability to provide long-term, successful follow-up care for individuals suffering from chronic conditions that need stability and continuity of care. Additionally, while CAHOOTS provides

310. Christina Jedra, *Here's What Happens When Social Workers, Not Police, Respond to Mental Health Crises*, HONOLULU CIV. BEAT (Mar. 1, 2021), https://www.civilbeat.org/2021/03/heres-what-happens-when-social-workers-not-police-respond-to-mental-health-crises/.

311. Gerety, *supra* note 302.

312. Andrew, *supra* note 293.

transportation options, the individual transported must be a willing participant.[313] However, individuals whose illness induces them to refuse psychiatric treatment are unlikely to accept transportation to mental health facilities. CAHOOTS does not transport individuals involuntarily and would need to refer these situations to police.[314]

d. Violence

The biggest weakness with CAHOOTS is the inability to respond and assist in de-escalating violent situations created by an individual suffering from psychiatric crisis. CAHOOTS do not respond to situations involving actual or potential violence.

> CAHOOTS is still limited by the rules that govern its role in crisis response. Its teams are not permitted to respond when there [is] "any indication of violence or weapons," or to handle calls involving "a crime, a potentially hostile person, a potentially dangerous situation . . . or an emergency medical problem."[315]

Many psychiatric crises involve potential violence. Individuals suffering from SMI may be armed, unpredictable, agitated, and aggressive.[316] While CAHOOTS employees are trained in de-escalation techniques, they do not respond to violent emergency calls.[317] Thus, CAHOOTS does not respond to a large number of psychiatric crises. Much of its work focuses on homelessness and drug addiction.[318]

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313. NAT'L ALL. ON MENTAL ILLNESS, CAHOOTS – CRISIS ASSISTANCE HELPING OUT ON THE STREETS, at 1–10 (2021), https://www.nami.org/NAMI/media/NAMI-Media/Images/Ask%20the%20Expert/FAQ_NAMI-Ask-The-Expert_Help-Not-Handcuffs-Part-2_3-25-21.pdf.

314. *Id.* (discussing frequently asked questions about CAHOOTS).

> CAHOOTS cannot do anything without a client's consent. The teams' role is to assess the goals of the client and help them achieve those. CAHOOTS can provide counseling and information to empower the client to make informed decisions about what care to engage in. If someone must go somewhere against their will, that is a law enforcement responsibility, and a CAHOOTS team may request them at that time.

Id. at 5.

315. Gerety, *supra* note 302.

316. *See* IACP L. ENF'T POL'Y CTR., RESPONDING TO PERSONS EXPERIENCING A MENTAL HEALTH CRISIS, at 1–11 (2018), https://www.theiacp.org/sites/default/files/2021-07/Mental%20Health%20Crisis%20Response%20FULL%20-%2006292020.pdf.

317. WHITE BIRD CLINIC, CAHOOTS CONSULTING GUIDE 4 (2020), https://whitebirdclinic.org/wp-content/uploads/2020/07/CAHOOTS-Consulting.pdf.

318. *See* Troy Brynelson, *'You Want a Resolution as Much as Possible': Six Hours with Eugene's Mobile Crisis Intervention Team*, SALEM REP. (Dec. 9, 2019, 1:27 PM), https://www.salemreporter.com/posts/1584/you-want-a-resolution-as-much-as-possible-six-hours-with-eugenes-mobile-crisis-intervention-team ("About 60% of their calls last year were tied directly to people experiencing homelessness.").

> Many of the park's visitors are part of Eugene's unhoused population, which accounts for about 60 percent of CAHOOTS calls . . . . One man had woken up shivering on the grass before dawn, after the park's sprinklers had soaked him through; CAHOOTS gave him dry clothes

5. Nebraska's Solution—Empower Patients to Form Ulysses Arrangements

In 2020, Nebraska enacted the Advance Mental Health Care Directives Act, empowering people with SMI to prevent homelessness, incarceration, harm to self, and institutionalization.[319] It started with a University of Nebraska law student who wrote a paper positing why Nebraska needed a mental health advance directive statute, highlighting a model mental health advance directive statute set forth in a previous article written by one of this Article's authors.[320] Ulysses arrangements are a special type of mental health advance directive that authorizes a doctor to administer treatment during a future episode, even if the episode causes the individual to refuse care, and even if the individual does not meet involuntary placement criteria.[321] The student sent her paper to Nebraska State Senator Kate Bolz who enthusiastically supported the concept, drafted a bill, and garnered bipartisan support, which ended with enactment of the law.[322]

The new Nebraska statute empowers patients to form self-binding instruments to obtain up to twenty-one days of inpatient mental health treatment, including pharmacological treatment, even in contravention of their illness-induced treatment refusals, and even if they do not meet Nebraska's standards for involuntary treatment and commitment.[323] In doing this, Nebraska is the first state to empower people to form true Ulysses arrangements so that they can maintain autonomy over their treatment and crisis intervention plans, even when acute episodes induce them to refuse care to which they consented when they had capacity.[324]

> and a ride to the hospital to make sure he didn't have hypothermia. A woman had received first aid after getting a spider bite on her face while sleeping on the ground. Another man hadn't had a place to stay since he got out of prison more than a year ago. When he had a stroke in the park earlier this summer, a friend called CAHOOTS. "If you go with the ambulance, it will cost you big money, so a lot of people go the CAHOOTS route," the man explained.

Gerety, *supra* note 302.

319. Advance Mental Health Care Directives Act, NEB. REV. STAT. §§ 30-4401 to -4415 (2020).

320. *See generally* Clausen, *supra* note 10. That law student was Shannon Seim.

321. *See* Chrisoula Andreou, *Making a Clean Break: Addiction and Ulysses Contracts*, 22 BIOETHICS 1 (2008); Elizabeth M. Gallagher, *Advance Directives for Psychiatric Care: A Theoretical and Practical Overview for Legal Professionals*, 4 PSYCHOL. PUB. POL'Y & L. 746 (1998); Theo Van Willigenburg & Patrick J.J. Delaere, *Protecting Autonomy as Authenticity Using Ulysses Contracts*, 30 J. MED. & PHIL. 395, 397 (2005).

322. Doug Kennedy, *Nebraska Lawmakers Advance Mental Health Care Directives Bill*, NEWS CHANNEL NEB. CENT. (Mar. 5, 2020, 6:14 AM), https://www.newschannelnebraska.com/story/41856561/nebraska-lawmakers-advance-mental-health-care-directives-bill (quoting Senator Bolz discussing the bill: "In other words, colleagues, we can relieve pressure on our hospitals, jails and institutional settings, by giving people the tools they need to continue to receive mental health care, when they have a mental health crisis. As opposed to getting sicker, and making poor and even criminal decisions.").

323. NEB. REV. STAT. § 30-4408 (2020).

324. Clausen, *supra* note 10, at 31–33, 59 (footnotes omitted) (citations omitted) ("Washington's approach is touted as being at the forefront of patient empowerment. However, even Washington prohibits Ulysses arrangements by requiring discharge of an incapacitated patient who demands discharge even when releasing the patient contravenes her irrevocable directive.").

First, the Nebraska statute sets the stage for authorizing Ulysses arrangements with legislative findings.[325] The statute recognizes that mental illness is often episodic, and periods of incapacity obstruct a person's capacity to give informed consent and impede the individual from recognizing her need for treatment.[326] Nebraska defines capacity as a person's ability to understand and appreciate the nature and consequences of mental health care decisions, including their benefits, risks, alternatives, and the ability to provide informed consent.[327] Additionally, capacity is evaluated in relation to the specific health care decision at issue.[328] Next, the statute recognizes that an acute episode can induce the person to refuse treatment to which the person would have consented if her judgment were not altered.[329] Plus, the Nebraska statute proclaims that empowering individuals to create self-binding mental health care directives enabling them to secure treatment in contravention of illness-induced refusals protects patient safety, health, and autonomy.[330] Importantly, Nebraska recognizes that a person can lose capacity due to an acute episode and still not be eligible for civil commitment.[331] In these instances, people, in the midst of an episode causing them to refuse intervention, cannot obtain access to care.[332] Finally, the statute recognizes that a person should have the same right of advance healthcare planning for mental illness as an individual planning for end-of-life care.[333] Then, the Nebraska Ulysses statute posits that an advance mental health care plan can accomplish these goals and sets forth procedural protections for formation, activation, revocation, and administration of treatment.[334]

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325. NEB. REV. STAT. § 30-4402 (2020).

326. *Id.*; Clausen, *supra* note 10 (providing under "Legislative Findings" that "[m]ental illness is often episodic. Periods of incapacity obstruct the individual's ability to give informed consent and impede the individual's access to mental health care.").

327. NEB. REV. STAT. § 30-4402 (2020).

328. Clausen, *supra* note 10 (stating under "Legislative Findings" that "[a]n individual with capacity has the right to control decisions relating to her mental health care.").

329. *Id.* (stating under "Legislative Findings" that "[a]n acute episode can induce an individual to refuse treatment when the individual would consent to treatment if the individual's judgment were unimpaired.").

330. *Id.* (stating under "Legislative Findings" that advance planning "improve[s] care and enable[s] patients to exercise control over their treatment.").

331. *Id.* at 9–12.

332. *Id.* at 61 ("Periods of incapacity obstruct the individual's ability to give informed consent and impede the individual's access to mental health care.").

333. NEB. REV. STAT. § 30-4402(1)(e) (2020); Clausen, *supra* note 10 (providing under "Legislative Findings" that "[i]ndividuals with mental illness have the same rights to plan in advance for treatment as individuals planning for end-of-life care.").

334. NEB. REV. STAT. § 30-4403 (2020) (laying out procedural protections for an advance mental health care directive); Clausen, *supra* note 10.

a. Formation

Nebraska gives patients the right to form instructions for mental health care and provide advance informed consent to inpatient treatment, psychotropic medication, and electroconvulsive therapy.[335] But Nebraska does not empower patients to provide advance informed consent to psychosurgery.[336] In their directives, principals (the person with capacity who forms a directive) may designate an agent to make mental health care decisions for them.[337] Agents may consent to mental health treatment, psychotropic medication, and electroconvulsive therapy but not psychosurgery.[338] Authority must be expressed for the agent to consent to electroconvulsive therapy and need not be expressed for the agent to consent to inpatient mental health treatment or psychotropic medication.[339] Agents' decisions must be in good faith and follow the principal's instructions and, if no instructions are known about an issue, must be in the best interests of the principal.[340] Agents' decisions are effective without judicial approval.[341]

Patients may list all individuals with whom providers may communicate if the patient loses capacity.[342] In Nebraska, advance mental health care directives shall be in writing, dated, and signed by the principal or her representative if she is unable to sign, state whether the principal wishes to be able to revoke the directive at any time, or whether the directive should remain irrevocable during periods of incapacity.[343] If the directive fails to clarify whether it is revocable, the directive is still enforceable, but the principal may revoke it at any time.[344] Directives must be witnessed in writing by at least two disinterested adults, and they are valid upon

335. Clausen, *supra* note 10. While it is true that the Nebraska statute provides for electroconvulsive therapy, the author does not recommend Ulysses arrangements for electroconvulsive therapy. *Id.* at 44 ("[T]he community is not in unanimous agreement with critics saying that ECT is ineffective and can damage the brain."); *see also* Helia Garrido Hull, *Electroconvulsive Therapy: Baby Boomers May Be in for the Shock of Their Lives*, 47 U. LOUISVILLE L. REV. 241, 251 (2008).

336. NEB. REV. STAT. § 30-4406(2) (2020); Clausen, *supra* note 10 ("Principals may not consent to or authorize agents to consent to psychosurgery in a directive."); Clausen, *supra* note 56, at 55–58 ("Ulysses arrangements are inappropriate for psychosurgery and unwise for ECT.").

337. NEB. REV. STAT. § 30-4404(2) (2020); Clausen, *supra* note 10 ("Designate an agent to make health care decisions for the patient.").

338. NEB. REV. STAT. §§ 30-4406(1)(a)–(2) (2020); Clausen, *supra* note 10.

339. NEB. REV. STAT. §§ 30-4406(1)(a)–(2) (2020); Clausen, *supra* note 10, at 44, 62–63.

340. NEB. REV. STAT. § 30-4410(3) (2020); Clausen, *supra* note 10, at 63 ("An agent's decisions for the principal must be in good faith and consistent with the principal's instructions expressed in the principal's directive.").

341. Clausen, *supra* note 10, at 63.

342. NEB. REV. STAT. § 30-4405(6) (2020).

343. *Id.* §§ 30-4405(1)(a)–(e); Clausen, *supra* note 10, at 61–62.

344. NEB. REV. STAT. § 30-4405(1)(c) (2020); Clausen, *supra* note 10, at 62 ("If the directive fails to state whether it is revocable, the principal may revoke it at any time."); *id.* at 22 ("A patient with capacity should always be able to revoke her Ulysses arrangement.").

execution.[345] The statute gives patients the right to form Ulysses arrangements, but directives must state that they remain irrevocable during periods of incapacity.[346] Witnesses shall attest that (1) they were present when the principal signed, (2) the principal did not appear incapacitated or under undue influence or duress, (3) and the principal presented ID or was known to the witness.[347]

b. Activation

Unless the principal specifies otherwise, the directive becomes active when the principal loses capacity.[348] Nebraska defines activation as the point at which the directive is the basis for health care decision-making and dictates treatment.[349] Patients may choose the standard by which their directives become active.[350] Nebraska empowers the principal to designate an activation standard other than incapacity by describing that standard in the directive, clarifying that even if the directive is activated, it does not prevail over contemporaneous preferences expressed by a principal with capacity.[351]

c. Revocation

Patients may dictate whether the directive is revocable during periods of incapacity.[352] A directive shall remain effective until it expires by its terms or until it is revoked by the principal.[353] Principals may revoke directives by writing, destruction, or subsequent directive, even during periods of incapacity, unless they make their directives irrevocable.[354]

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345. NEB. REV. STAT. § 30-4405(1)(c)(ii) (2020); Clausen, *supra* note 10, at 55–56, 62 ("The model execution provision contains safeguards the Uniform Act eliminates such as the requirement of a signed writing witnessed by two disinterested people who attest that the principal presented identification and did not appear coerced.").

346. NEB. REV. STAT. § 30-4405(3) (2020); Clausen, *supra* note 10, at 28, 64.

347. NEB. REV. STAT. §§ 30-4405(5)(a)–(c) (2020); Clausen, *supra* note 10, at 35–36, 62 (stating that (1) witnesses shall attest that they were present when the principal signed, (2) the principal didn't appear incapacitated or under undue influence or duress, and (3) the principal presented identification or the witness personally knows the principal).

348. NEB. REV. STAT. § 30-4409(1) (2020); Clausen, *supra* note 10, at 38–41, 62 ("Unless the principal otherwise designates in the directive, a directive becomes active when the principal loses capacity.").

349. *See* Clausen, *supra* note 10, at 62.

350. NEB. REV. STAT. § 30-4409(2) (2020); Clausen, *supra* note 10, at 62 ("The principal may designate an activation standard other than incapacity by describing the circumstances under which the directive becomes active.").

351. NEB. REV. STAT. § 30-4411 (2020); Clausen, *supra* note 10, at 62 ("Despite activation, a directive does not prevail over contemporaneous preferences expressed by a principal who has capacity.").

352. NEB. REV. STAT. § 30-4405(1)(c) (2020); Clausen, *supra* note 10, at 64.

353. NEB. REV. STAT. § 30-4407(1) (2020); Clausen, *supra* note 10, at 42–43, 64–65 (recommending automatic expiration of Ulysses arrangements *only*).

354. NEB. REV. STAT. §§ 30-4407(3)(a)–(b) (2020); Clausen, *supra* note 10, at 42–43, 63–65.

d. Implementation of Ulysses Arrangements

People may secure intervention through Ulysses arrangements, even if their behavior and symptoms do not meet commitment criteria and even in contravention of illness-induced treatment refusals.[355] When an incapacitated principal refuses inpatient mental health treatment or psychotropic medication, the person's agent may consent to such treatments if the irrevocable directive authorizes the agent to consent to the treatments.[356] Procedures for forming and implementing a self-binding arrangement are (1) making the directive expressly irrevocable and (2) consenting to inpatient treatment.[357] If the principal desires psychotropic medication, in contravention of illness-induced refusals, the principal must consent to such medication in the directive.[358] If the patient has a Ulysses arrangement and refuses admission, despite the directive's instructions, the principal's statements in the directive requesting inpatient treatment, activation of the directive, and contemporaneous treatment refusals create a rebuttable presumption that the principal lacks capacity.[359] The treatment facility shall respond by (1) obtaining informed consent from the agent, if one is designated, (2) within twenty-four hours after arrival, a mental health professional evaluating the principal to determine whether the principal has capacity and documenting findings and recommendations; and (3) admitting the principal if the principal is found to lack capacity.[360]

Then, all treatment administered pursuant to the directive should be documented in the patient's records.[361] Inpatient treatment pursuant to the Ulysses arrangement shall only happen for up to twenty-one days.[362] After twenty-one days from the date of admission, if the principal has not regained capacity or has regained capacity but refuses to consent to remain for treatment, the facility shall discharge the principal during daylight hours, unless the principal is detained pursuant to involuntary commitment procedures.[363] A principal who has been determined to lack capacity who continues to refuse inpatient treatment may seek injunctive relief for release.[364]

If a principal with a Ulysses arrangement consenting to inpatient treatment refuses psychotropic treatment through words or actions, only a licensed psychiatrist may administer the medication, and only if (1) the

355. Clausen, *supra* note 10, at 63.
356. *Id.* at 63–64
357. *Id.*
358. *Id.*
359. *Id.*
360. *Id.* at 65.
361. *Id.*
362. *Id.*
363. *Id.*
364. *Id.*

principal consented to the medication in her Ulysses arrangement; (2) the agent, if one was designated, consented to the medication; and (3) a licensed healthcare provider recommended in writing the specific treatment.[365]

e. Strengths

The Nebraska statute provides people with SMI a powerful tool to prevent the identified tragedies. First, allowing patients to set forth instructions and designate agents allows them to craft intervention plans that are flexible and responsive during emergencies.[366] No patient can predict every turn of events that will occur during an episode, so the combination of instructions and an agent to make decisions in the patient's best interests when there are unforeseen circumstances is the optimum approach.[367] Second, allowing patients to secure treatment, despite illness-induced refusals, even if they fail to meet strict commitment criteria is a potential lifesaver.[368] The Ulysses arrangement empowers people to end the pipeline from squad car to jail or emergency room, with the revolving seventy-two hour door, in which they are released from the hospital only to decompensate.

Third, the statute recognizes that self-binding care does not have normal due process protections of involuntary commitment, so there should be safeguards against abuse, fraud, coercion, and undue influence.[369] The statute provides protections such as formation requirements of a signed writing, multiple witnesses, and a witness attestation of capacity.[370] And it provides protections against fraud in the implementation of Ulysses arrangements because only psychiatrists can administer psychotropic medication in contravention of illness-induced refusals, after documenting reasons for recommending the specific treatment.[371] Finally, only twenty-one days of treatment are authorized pursuant to a Ulysses arrangement.[372] After that, long-term inpatient treatment would have to follow involuntary placement procedures.[373]

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365. *Id.* at 65.

366. *Id.*

367. *Id.* (recommending an "ongoing dialogue" between patient and medical staff to update the directive for unforeseen circumstances); *see also* Bruce J. Winick, *Advance Directive Instruments for Those with Mental Illness*, 51 U. MIAMI L. REV. 57, 81–86 (1996); NAT'L ETHICS COMM. U.S. DEP'T OF VETERANS AFFS., ADVANCE DIRECTIVES FOR MENTAL HEALTH: AN ETHICAL ANALYSIS OF STATE LAWS & IMPLICATIONS FOR VHA POLICY 8 (2008), https://www.ethics.va.gov/pubs/necreports.asp; Clausen, *supra* note 56, at 70.

368. Clausen, *supra* note 56, at 66.

369. *Id.*

370. *Id.* at 18.

371. *See* NEB. REV. STAT. § 30-4413 (2020).

372. *See id.* § 30-4412(2).

373. *See id.*

f. Areas for Improvement

i. No Pickup and Transportation Option

The new Nebraska law removes obstacles to care, but patients who refuse care because of an episode will also refuse transportation to a facility.[374] How is the patient in the midst of an episode causing treatment refusals going to arrive at the hospital? It would be dangerous for a family member to drive a psychotic loved one to the hospital.[375] Therefore, one area of improvement would be for Nebraska to empower people to secure involuntary, safe transportation to a treatment facility, in contravention of illness-induced refusals, pursuant to their Ulysses arrangements.[376]

ii. Does Not Improve the Composition of First Responder Team

Because the new Nebraska law does not change the composition or training of first responders to mental health emergencies, there is a missed opportunity to prevent harm by police or harm to others.[377] Many involuntary mental health evaluations begin because police arrive at a scene in which a person is in the midst of a mental health crisis.[378] Often, the police respond

374. Clausen, *supra* note 56, at 7 (footnote omitted) ("Patients whose illnesses cause them to refuse treatment will also refuse transportation to a hospital.").

375. *Id.* at 62–63 ("It would be illegal for a private person, such as a family member, to transport a refusing patient pursuant to the patient's Ulysses arrangement."); *see also* Retreat Hosp. v. Johnson, 660 So. 2d 333, 340 (Fla. Dist. Ct. App. 1995) (holding that only an officer and transportation contractor may transport a patient under the Baker Act).

376. Clausen, *supra* note 56, at 16–17 (discussing a Florida case, *Preussman v. Dr. John T. McDonald Foundation*, 589 So. 2d 948 (Fla. Dist. Ct. App. 1991), where transportation pursuant to state Baker Act was inadequate).

377. Westervelt, *supra* note 106 ("Since 2015, nearly a quarter of all people killed by police officers in America have had a known mental illness."); *People with Untreated Mental Illness 16 Times More Likely to Be Killed by Law Enforcement*, TREATMENT ADVOC. CTR., https://www.treatmentadvocacycenter.org/key-issues/criminalization-of-mental-illness/2976-people-with-untreated-mental-illness-16-times-more-likely-to-be-killed-by-law-enforcement- (last visited Apr. 8, 2022) ("People with untreated mental illness are 16 times more likely to be killed during a police encounter than other civilians approached or stopped by law enforcement . . . ."); *Cities Aim to Remove Police from Most Psychiatric, Substance Abuse Calls*, NPR (Oct. 15, 2020, 7:09 AM), https://www.npr.org/2020/10/15/923885799/cities-aim-to-remove-police-from-most-psychiatric-substance-abuse-calls (explaining the mobile unit to include a paramedic, psychologist or social worker, and a peer support specialist).

378. *See* Drummond *ex rel.* Drummond v. City of Anaheim, 343 F.3d 1052, 1054–55 (9th Cir. 2003) (discussing police responding to mental health call ultimately leading to police brutality); Clausen, *supra* note 56, at 14 (discussing involuntary examination criteria in which police officers can detain and transport an individual); DEP'T OF CHILD & FAMS., FLORIDA'S BAKER ACT: 2013 FACT SHEET, https://www.yumpu.com/en/document/read/51770825/floridas-baker-act-2013-fact-sheet-florida-department-of- (stating that law enforcement initiated approximately 49% of involuntary detentions for involuntary examinations in 2013); Jack Evans, *Plan to Fix Florida's Baker Act Would Make it More Powerful, Raising Alarms*, TAMPA BAY TIMES (Mar. 26, 2021), https://www.tampabay.com/news/florida

to a 911 emergency call from family members or happen upon the situation on patrol.[379] Plus, even if there is a court order to initiate an involuntary evaluation, typically police pick up and transport the person.[380] Then, the state involuntary detention, evaluation, and treatment laws require police to bring the person whose behavior illustrates dangerousness to a treatment facility.[381] Police bring the person to jail because they often have to wait for hours at the hospital.

There should be a mechanism for officers, or other first responders, to search a database and find the Ulysses arrangement of a person in crisis. Such a database would help prevent harm to others and harm by police because police or other first responders could learn the person's (1) chosen facility to receive treatment; (2) contact information of healthcare agent or other family members who should be notified; (3) diagnosis and history, especially if there has been no history of violence—this could calm the situation, protecting everyone's safety; and (4) typical symptoms so that first responders can understand the episode they are witnessing and respond appropriately.[382] Without access to the Ulysses arrangement, first responders who arrive at a mental health crisis may misunderstand symptoms and interpret them as criminal behavior. This lack of transparency to the first responders threatens the safety of police or other first responders, others on the scene, and the individual in crisis. Moreover, as many jurisdictions have recognized, unaccompanied and untrained police are not the appropriate first responders to mental health crisis situations.[383] The new Nebraska law does not change the training or composition of first responders who arrive on the scene of a mental health crisis.[384] In this way, the new Nebraska law misses an opportunity to prevent harm by police and harm to others.

iii. No System to Ensure First Responders and Facilities Learn of Ulysses Arrangement, and People Who Do Not Have Them Are Not Helped

Finally, most people with SMI do not have mental health advance directives. For the majority of people with SMI, until Ulysses arrangements become ubiquitous, the new Nebraska law misses opportunities to prevent

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/2021/03/26/plan-to-fix-floridas-baker-act-would-make-it-more-powerful-raising-alarms/ ("But more than half of all Baker Act cases are initiated by law enforcement officers. So the majority of those forced to undergo a mental health exam are likely taken there by police, possibly in handcuffs.").

379. Clausen, *supra* note 56, at 15 ("A common scenario involves a concerned family member who contacts law enforcement to report a loved one is in the midst of an episode.").

380. *Id.* at 14.

381. *Id.* at 14–19; *see* FLA. STAT. § 394.463 (2016) (providing on example of a state law regarding involuntary examination); *id.* § 394.455 (defining involuntary examination); *id.* § 344. 462 (designating a receiving system for individuals subject to involuntary examination).

382. *See infra* Section III.A.2 (discussing the database that should be implemented).

383. *See supra* Section I.D (highlighting police officer's lack of training).

384. *See* NEB. REV. STAT. §§ 30-4401 to -4415 (2020).

the identified tragedies. Unless the person has a Ulysses arrangement, the new Nebraska law does not help. Even if an individual has a Ulysses arrangement, the new Nebraska law could be improved by adding a database accessible to first responders and healthcare providers.[385] The Ulysses arrangement will not be effective in securing necessary intervention in a crisis if first responders and treatment providers do not know about it.

6. Dallas

Since 2018, Dallas, Texas has implemented emergency response protocols for psychiatric crises. The Rapid Integrated Group Healthcare Team (RIGHT) was developed to improve outcomes in police encounters:

> A RIGHT Care team consists of a community paramedic, licensed mental health clinician, and specially trained police officer. This integrated team responds to mental health calls placed through 911. The team is skilled in de-escalating a crisis while assuring public safety and can assess both physical and mental health needs on the scene. The team also is linked to community treatment resources, including same-day prescriber access, so the person does not have to be taken to a jail or emergency room.[386]

In its first two years, the RIGHT Care team approach has vastly reduced the number of people being admitted to psychiatric emergency rooms.[387]

When responding to emergency calls, the RIGHT Care Team follows a protocol:

> 1. A call center clinician from Parkland Hospital is physically present at the 911 call center dispatch to field calls and assist with questioning. Trained clinicians can help prioritize calls, assess if the RIGHT Care Program team should be dispatched, and communicate to the team in the field with important details about the specifics of the call.

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385. *See* NEB. REV. STAT. § 30-4403 (2020); *Medical Alert Bracelets for Mental Illness*, AM. MED. ID, https://www.americanmedical-id.com/mental-health (last visited Apr. 8, 2022) ("Wearing a medical alert bracelet for mental illness or medical ID jewelry can let first responders know about a person's mental health condition.").

386. *Transforming Police Responses to Mental Health Emergencies: Rapid Integrated Group Healthcare Team (RIGHT Care)*, MEADOWS MENTAL HEALTH POL'Y INST., https://mmhpi.org/project/right-care/ (last visited Apr. 8, 2022).

387. Michael Murney, *Should Cops Be Involved in Dallas' Mental Health Crisis Response Teams?*, DALL. OBSERVER (Aug. 24, 2021, 4:00 AM), https://www.dallasobserver.com/news/dallas-right-care-program-includes-cops-in-mental-health-response-some-say-it-shouldnt-12254373 ("Officials pegged the pilot's success to a 20% reduction in admissions to Parkland's psychiatric emergency rooms within that district over a two-year period . . . .").

2. Upon arrival, first, law enforcement officers engage and establish if the situation is safe for the rest of the team. If the situation is deemed unsafe, the clinician and paramedic will not engage with the individual.

3. If the situation is deemed safe, then a DFR paramedic evaluates the patient to determine if there are acute medical issues which might manifest as a behavioral health issue.

4. If no medical exclusionary criteria are identified, then the mental health clinician enters to determine the patient's needs and where they will best be served in the community.

5. Finally, as a team, the group determines the most appropriate course of action. If possible, the primary choice is to assist the patient with securing treatment from a community-based mental health provider. Each team member has an equal say in the final decision.[388]

In addition to decreased emergency room admissions, the RIGHT Care team response has resulted in decreased arrests and improved continuation of care.[389] Dallas recently received additional funds to expand call center availability twenty-four hours a day.[390]

a. Strengths: Team Approach

By responding as a team that includes a paramedic, mental health counselor, and a specially trained officer, the RIGHT Care team provides for every eventuality. The officer ensures that the location is safe.[391] The paramedic can provide emergency medical care if there are injuries or other physical needs.[392] A mental health counselor can provide critical intervention and treatment.[393] Working together, they determine the optimum outcome for the individual.

388. MAIA JACHIMOWICZ ET AL., DALLAS FORMS MULTIDISCIPLINARY TEAM TO RESPOND TO MENTAL HEALTH 911 CALLS 5 (2018), https://results4america.org/wp-content/uploads/2018/12/Dallas CaseStudy_FINAL-1.pdf.

389. *Id.* at 1.

390. Everton Bailey Jr., *Dallas to Expand RIGHT Care to Cover Overnight Shifts*, DALL. MORNING NEWS (Feb. 23, 2022, 4:27 PM), https://www.dallasnews.com/news/politics/2022/02/23/dallas-to-expand-right-care-to-cover-overnight-shifts/.

391. JACHIMOWICZ ET AL., *supra* note 388, at 5.

392. *Id.*

393. *Id.*

b. Transportation

Transportation of the individual in crisis to the correct facility is a critical step in resolving the crisis. While police officers are able to transport, the RIGHT Care team focus on treatment allows more flexibility. Many studies demonstrate that it is less time-consuming and involves less paperwork to book a person into jail rather than wait at a care facility for an assessment.[394] The Dallas team approach essentially provides for the assessment that streamlines the admission process for medical and psychiatric needs.

c. Weaknesses

The weakness in the Dallas approach is that it fails to empower patients to secure intervention in contravention of illness-induced treatment refusals. Admittedly, in Dallas people in mental health crisis will be safer because first responders will better understand their illnesses, symptoms, and behaviors. However, even in Dallas when the person arrives at the facility, if the episode causes treatment refusals, the hospital will be precluded from admitting the patient unless the patient meets strict criteria for involuntary admission.[395] Even psychotic patients may not meet such criteria. Plus, if the RIGHT Care team responds to a call and does not observe behaviors revealing dangerousness, the team must leave the patient, even if the patient is in crisis, if the patient refuses to be transported to a hospital.[396] Even if the hospital is able to admit the patient against his illness-induced refusals because the patient demonstrates behaviors revealing dangerousness, after seventy-two hours of observation, if the patient's episode calms and the patient demands discharge, the facility must discharge the patient.[397] This patient, still in crisis, will continue to decompensate. Dallas improves the composition and training of first responders. But this does not fix the problem of our broken system.

C. Towards a Patient-Directed & Community-Protected System

Overall, these solutions to tragic encounters between the police and individuals suffering from a psychiatric crisis demonstrate a commitment to protect everyone involved. Yet, despite their individual strengths, each process except Nebraska's lacks the one component that would practically guarantee nonviolent resolutions to psychiatric crises—Ulysses

394. *See supra* notes 17–22 and accompanying text (booking to facilitate treatment).

395. *See generally RIGHT Care Team Responds to Mental Health Crisis Calls*, PARKLAND (Feb. 18, 2019), https://www.parklandhealth.org/news-and-updates/right-care-team-responds-to-mental-health-crisis-c-1488.

396. *See generally id.*

397. *See generally id.*

Arrangements. Part IV takes the strongest components of the various federal and state schemes to develop a proposed system combining the Dallas and Nebraska approaches. The strength of this proposal lies in its acknowledgment of the etiology of SMI, the abuses of previous civil commitment systems, the dignity of the individual, and an understanding of police procedure.

IV. MODEL SYSTEM FOR RESPONDING TO MENTAL HEALTH EMERGENCY CALLS

This Part articulates a blueprint for responding to mental health emergencies, drawing from reforms from Nebraska and Dallas. Even these reforms could be improved, so this Part allows patients to arrange for involuntary transportation to a hospital, in contravention of illness-induced refusals, outlining how that transportation will work through Dallas's three-person first responder team. SMI episodes, inducing treatment refusals, cause patients to refuse transportation to a hospital.[398] If a patient is unable to be transported in contravention of her illness-induced refusals, she cannot secure intervention.[399] Plus, first responders must know about the arrangement, so this Part recommends a database. Finally, this Part recommends that these reforms should start with VA.[400]

A. Adopt and Improve Reforms from Nebraska and Dallas

1. Follow Dallas: Change the First Responders

At its core, this Article's proposed system offers Ulysses arrangements, empowering people to be the architects of their own crisis intervention plans. However, few people form mental health directives, so it will take time for Ulysses arrangements to become the norm. Plus, Ulysses arrangements are only appropriate for people who recognize that they have SMI and have the resources to form a Ulysses arrangement.[401] For the first episode, no person will have a Ulysses arrangement because that person could not have predicted the episode. For many, SMI does not begin until adulthood.[402] Moreover, it may take a pattern of episodes for the person to gain the insight that she would benefit from a Ulysses arrangement.[403]

Thus, to prevent tragedy, reform must not rely only on Ulysses arrangements but must improve mental health emergency response for every

398. Clausen, *supra* note 56, at 7.
399. *See id.*
400. *See infra* Section IV.B (introducing a VA pilot program).
401. *See generally* Clausen, *supra* note 56, at 5–6.
402. *See, e.g.*, ALIVE, *supra* note 84 (describing the story of a veteran who suffered from SMI).
403. *See* Clausen, *supra* note 56, at 5–6.

person facing mental illness. State legislatures should adopt the Dallas RIGHT Care approach, dispatching one paramedic, one behavioral health specialist, and one specially trained officer to respond to 911 mental health emergency calls.

If the jurisdiction determines that having an officer on the team imposes too great a risk, the jurisdiction should not simply dispatch mental health professionals. Doing this, as proposed in California, endangers the person in crisis, first responders, and others.[404] Rather, the legislature should require at least one member of the first responder team be trained and equipped to de-escalate emergencies that could end in violence. The Dallas approach has proven to prevent the identified tragedies.[405]

A solution that protects against harm by police addresses only one of the identified tragedies. The person who arrives at the hospital and cannot obtain treatment, in contravention of illness-induced refusals, will still suffer. In Mr. Tuten's case, tragedy occurred, not because police responded, but because strict involuntary hospitalization criteria forced doctors to heed his illness-induced discharge demand, even though he was in crisis.[406] After discharge, he shot his wife and himself because the law prevented him from obtaining intervention.[407]

2. Follow Nebraska and Add Improvements

Jurisdictions should adopt the Nebraska approach. Patients can obtain twenty-one days of inpatient treatment pursuant to their Ulysses arrangements, even if they do not meet commitment criteria. Formation requirements such as the requirement of a signed, witnessed writing protect against fraud, misinterpretation, undue influence, abuse, and coercion should be adopted.[408] Nebraska empowers patients to create flexible crisis intervention plans because they can appoint agents to make their healthcare decisions when they lack capacity.[409] Plus, Nebraska allows patients to choose the activation standard for their directives.[410] Most importantly, the Nebraska solution provides a process with safeguards for admitting and treating patients, in contravention of contemporaneous illness-induced treatment refusals.[411] This Part perfects the Nebraska innovation.

404. *See supra* Section III.B.2 (discussing California's proposed legislation).
405. *See supra* Section III.C.4 (outlining the Dallas approach).
406. *See* Tuten v. Fariborzian, 84 So.3d 1063, 1065–67 (Fla. Dist. Ct. App. 2012).
407. *See id.*
408. *See* NEB. REV. STAT. § 30-4405 (2020).
409. *See id.*
410. *See* NEB. REV. STAT. § 30-4406 (2020).
411. *See id.* § 30-4402.

a. Add Process for Involuntary Transportation and Access of First Responders

Legislatures should improve upon the new Nebraska law by laying out a process for patients to arrange for involuntary transportation to a facility and for dissemination of Ulysses arrangements in case Ulysses arrangement activation, pursuant to its terms, is not possible. Patients, in the midst of an episode, cannot obtain intervention unless they can obtain transportation to a facility, in contravention of illness-induced refusals.[412] States should enable patients to form Ulysses arrangements that secure involuntary transportation to a hospital to effectuate the arrangement. Involuntary transportation could be subject to abuse, so there should be safeguards. Only patients who request involuntary transportation in their arrangements should be subject to it, unless those patients meet involuntary exam criteria.

The statute should clarify that a patient desiring to arrange for involuntary transportation when the arrangement becomes active must designate a surrogate and grant that surrogate authority to consent to the patient's involuntary transportation once the arrangement becomes activated. The statute should clarify activation procedures. Under these procedures, the surrogate can execute a written, sworn affidavit stating that the arrangement has become activated and disclose the basis upon which the surrogate has made that conclusion. Then, the Ulysses statute should set forth a process whereby the surrogate can petition the court for an ex parte order authorizing involuntary transportation, with an attached affidavit and the Ulysses arrangement. The court shall review the petition within forty-eight hours. Within that timeframe, the court shall issue an ex parte order for transportation if it finds by clear and convincing evidence that the Ulysses arrangement has become active and that the patient has requested involuntary transportation in the arrangement.

Typically, police transport people to jail or a hospital based on a court order authorizing an involuntary exam. States should safeguard against tragedies of harm by police and harm to others by adopting the Dallas RIGHT Care program. Therefore, when a court issues an order to pick up a patient and transport her to the hospital based on an activated Ulysses arrangement, the three-person first responder team should respond.

This helps prevent harm by police, harm to others, criminalization, and institutionalization because the response to an emergency is no longer a criminal response but a healthcare response.[413] These trained professionals

412. *See* Samina T. Syed et al., *Traveling Towards Disease: Transportation Barriers to Health Care Access*, NAT'L LIBR. OF MED., https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4265215/ (last visited Apr. 8, 2022) (discussing the need for transportation to access intervention in a crisis).

413. Tamar Ezer & Denise Tomasini-Joshi, *First Responders with a Rights-Based Approach to Mental Health Crises*, HEALTH & HUM. RTS. J. (Oct. 10, 2021), https://www.hhrjournal.org/2021/10/first-responders-with-a-rights-based-approach-to-mental-health-crises/.

will be better able to identify symptoms and calm the situation than police. Plus, under this proposal, this team will have read the Ulysses arrangement and will know more about the situation they are called to address.[414] For example, the patient could state in her Ulysses arrangement (1) she has never been violent, (2) she owns no weapons, (3) she has no dangerous animals, (4) her diagnosis and symptoms, and (5) effective treatments and her chosen hospital. This information will help prevent harm to first responders, the patient, and others because the response team will arrive informed. Because this team will have training in mental health, emergency response, de-escalation, and be privy to the patient's history, everyone on the scene will be safer.[415]

Requirements for a surrogate affidavit and petition and court order may result in small delays in intervention. Those delays are minimal because the court must make its decision within forty-eight hours.[416] Plus, the delays are warranted because the safeguards of a court order and petition protect against abuse.[417] The surrogate affidavit requirement ensures involuntary transportation is what the patient chose.[418] The patient has the power to choose a person she trusts to follow her instructions. Moreover, the patient chooses the activation standard for her arrangement, maintaining autonomy over how she is transported.[419] Furthermore, the court order requirement protects against abuse by requiring the court to review the Ulysses arrangement and affidavit to determine whether there is clear and convincing evidence of Ulysses arrangement activation and that the patient has requested involuntary transportation.[420]

However, Ulysses arrangement activation as described in the arrangement with a resulting court order might not occur in time. Some emergencies are initiated when police find people in crisis.[421] Consider the situation of a person who forms a Ulysses arrangement and is suffering from an episode. An officer happens upon the person exhibiting psychosis but not meeting strict involuntary detention criteria. To address such situations, the legislature should empower patients to maintain Ulysses arrangements in an electronic database accessible by law enforcement and healthcare facilities, facilitating crisis intervention through Ulysses arrangements even if it was not possible to formally activate the arrangement.

The following illustrates a workable process for patients to activate Ulysses arrangements even when activation as the patient envisioned in the

414. *See supra* Section III.B.5 (discussing the implementation and strengths of Ulysses arrangements).

415. *See* Ezer & Tomasini-Joshi, *supra* note 413.

416. *See* Clausen, *supra* note 56, at 72.

417. *Id.* at 73.

418. *Id.*

419. *Id.* at 73–74.

420. *Id.* at 74.

421. *See generally* Ezer & Tomasini-Joshi, *supra* note 413.

arrangement is not possible. The first responder team responds to a call from a store owner reporting a woman screaming and stripping off her clothing. The team arrives and obtains the identity of the person in crisis. Another method to allow identification would be for the person who has formed a Ulysses arrangement to wear a bracelet with her identifying info for such an emergency. Then, the team searches an accessible database by entering the identification info and learns of the Ulysses arrangement. One team member reads the Ulysses arrangement, learning her diagnosis, treatments, the facility to which she would like to be transported, and typical symptoms. The team member reads this to the other team members. Another team member stabilizes the person.

Because the Ulysses arrangement consents to first responders bringing her to a designated facility because of her psychosis, even if she does not meet dangerousness criteria and there has been no opportunity for formal Ulysses arrangement activation, the team can detain her and transport her to her chosen facility.[422] Technically, she has been brought to the facility for treatment in contravention of illness-induced refusals.[423] But her refusals are not truly her will; she has no capacity. She has provided her clear consent in her Ulysses arrangement when she had capacity: to be transported in such a crisis to a facility.

b. Add Process for Transfer, Discharge, Follow-Up, and Continuity of Care

The new Nebraska law lays out a process for treatment over contemporaneous objections and for admission over contemporaneous objections pursuant to a Ulysses arrangement.[424] States should adopt that process. However, because the new Nebraska law does not address pickup, transportation, and transfer to a facility pursuant to a Ulysses arrangement, this Part does.

c. Transfer

The legislature should layout the process for transfer of custody from first responders to the facility. First, the Ulysses arrangement enables the patient to designate and effectuate where she would like to be transported to receive treatment and by which providers. The team shall transport the person to the facility she has chosen. That facility shall notify the person's physician as requested in her arrangement. The statute should require healthcare facilities to maintain access to Ulysses arrangements so that when the first responder team delivers a person, providers can learn the person's

422. Clausen, *supra* note 56, at 82.
423. *Id.* at 6.
424. *See supra* Section III.B.5 (discussing Nebraska's implementation of Ulysses arrangements).

(1) medical history, including other illnesses impacting treatment; (2) refusals, informed consent, and side effects to treatments; (3) diagnosis; and (4) contact info for surrogates and loved ones who should be notified.

This Article's system serves people with SMI, their loved ones, first responders, and the state better than the current system that squanders law enforcement resources because, after police respond to emergency calls, they must wait in emergency rooms and jails for hours to transfer custody. Moreover, delays in intervention harm the person, exposing her to the trauma of waiting for treatment, further decompensation of her cognitive functions, and obstructing her long-term recovery by forcing the patient to endure hours of a psychotic episode.[425] This Article's reform, involving a three-person first responder team, two of whom are medical professionals, facilitates effective transfer.

For example, the mental health provider team member can communicate to the receiving providers symptoms observed during pickup and transportation or any communication from people on the scene. In the current system, no one in the receiving facility knows about the person's medical history.[426] This proposal benefits the patient because transfer is made to the chosen facility and physician and is made from a team including a mental health professional and paramedic, instead of from an officer unfamiliar with symptoms, diagnoses, and behaviors.

d. Follow-Up and Continuity of Care

The new Nebraska law provides a process for admission, retention, and treatment for up to twenty-one days pursuant to a Ulysses arrangement.[427] People in Nebraska with SMI can now exercise autonomy over their illness-induced treatment refusals. States should adopt the Nebraska statute. But the new Nebraska law does yet not adequately address follow-up and continuity of care,[428] and this Part does. The statute should ensure the facility does not simply discharge the patient at the end of the requested care and cease follow-up. Rather, the legislature should require follow-up and continuity of care. Because illness-induced refusals are part of SMI, the legislature should require visits from providers. Home-health workers should make weekly visits for the first few months and monthly visits for the remainder of the year. Status checks ensure compliance with treatment. Plus, visits should be done in-person or by Zoom so that providers can observe behaviors to assess stability. Without continuity of care, patients may slip back into crisis.

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425. Clausen, *supra* note 56, at 34.

426. *See supra* Section III.C.2 (discussing lack of knowledge of patient's medical history).

427. *See supra* Section II.B.5 (discussing Nebraska's implementation of Ulysses arrangements).

428. *See* Advance Mental Health Care Directives Act, NEB. REV. STAT. §§ 30-4401 to -4415 (2020). The Nebraska law does anticipate creation of regulations governing continuity of care.

B. VA Pilot

Congress should enact legislation authorizing VA to implement this Article's reforms. The overhaul of America's system for responding to mental health emergencies should start at VA for the following reasons.

1. Veterans Have Increased Risk of Mental Illness. The Nation Owes a Debt

First, society owes a debt to veterans, so fixing the broken system of mental health emergency response should start with this population. Plus, veterans have an increased risk of mental illness, producing an increased risk of suicide and homelessness.[429] Society owes a debt to these heroes, so fixing America's system for responding to mental health emergencies should begin at VA, especially considering that veterans' struggles are often connected to the sacrifices they made.[430]

2. Veterans Often Have Free Healthcare, Removing Obstacles of Reimbursement for Care Provided Under Ulysses Arrangements

Second, VA is a practical place to begin implementing these reforms because healthcare through VA is, many times, free for the veteran.[431] Starting with VA helps to address the biggest challenge to securing inpatient treatment pursuant to a Ulysses arrangement: funding.[432] For example, a person with health insurance who has endured several manic episodes may want to form a Ulysses arrangement to secure weeks of inpatient care at the beginning of an episode. However, three weeks of inpatient treatment would be extremely expensive.[433] Without legislative reform, insurance providers will contend they do not have to reimburse for care pursuant to Ulysses arrangement when the person did not meet criteria for involuntary placement.[434] Once Congress requires VA to provide Ulysses arrangement intervention services, up to twenty-one days of inpatient care would be free to qualified veterans.

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429. *See generally Office of Research & Development*, U.S. DEP'T OF VETERANS AFFS., https://www.research.va.gov/topics/mental_health.cfm (last visited Apr. 8, 2022).

430. Melissa M. Thomas et al., *Mental and Physical Health Conditions in U.S. Combat Veterans: Results from the National Health and Resilience in Veterans Study*, CME INST., https://www.psychiatrist.com/pcc/mental/veteran/mental-and-physical-health-conditions-in-combat-veterans (last visited Apr. 8, 2022).

431. *See generally Military and Veteran Benefits*, MILITARY.COM, www.military.com/benefits (last visited Apr. 8, 2022).

432. *See supra* Section III.B.3 (discussing lack of funding as an issue).

433. Clausen, *supra* note 56, at 33.

434. *Id.* at 34.

3. VA Is a Nationwide System and Could Teach Others

Third, beginning with VA would spark reform nationwide, exposing the players (judges, lawyers, doctors, nurses, and social workers) in jurisdictions everywhere to this Article's reforms. VA hospitals are in every state and major city.[435] VA physicians, nurses, social workers, paramedics, behavioral health specialists, law enforcement, and other professionals who implement these reforms are integrated with professionals outside of VA in their communities.[436] For example, VA hospitals are often connected to university medical schools.[437] Therefore, implementing this Article's fixes in VA would allow VA healthcare workers to teach healthcare providers all over the country about how to implement these reforms. As VA works through implementing these reforms, there will be lessons learned shared in conferences and other settings. VA employees can share insights with professionals relevant to implementing Ulysses arrangements. Simply put, starting with VA is the best first step of national reform.

4. VA Possesses Expertise

Veterans who use VA services are more likely to have advance directives than others.[438] Advance directives are more common in VA because VA has made efforts to ensure patients have advance directives for end-of-life care.[439] Plus, VA performed a study on mental health advance directives.[440] VA personnel created the infrastructure to ensure veterans formed advance directives, learned issues implicated in advance healthcare planning, and crafted a template, providing valuable experience for implementing this proposal.[441]

5. Law School Veterans Clinics Can Help

Fifth, there is a supportive community of law school veterans clinics across the country.[442] Pro bono attorneys and supervised law students could

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435. *See Locations*, U.S. DEP'T OF VETERANS AFFS., https://www.va.gov/directory/guide/allstate.asp (last visited Apr. 8, 2022).

436. *See generally Helping Our Nation's Veterans*, AAMC, https://www.aamc.org/what-we-do/mission-areas/health-care/veterans-affairs (last visited Apr. 8, 2022).

437. *See id.*

438. *See Geriatrics and Extended Care*, U.S. DEP'T OF VETERANS AFF., https://www.va.gov/geriatrics/pages/advance_care_planning_advance_directives.asp (last visited Apr. 8, 2022).

439. *Id.*

440. NAT'L ETHICS COMM. U.S. DEP'T OF VETERANS AFFS., *supra* note 367 (requested access necessary via email to vhaethics@va.gov).

441. *See id.*

442. *See The National Law School Veterans Clinic Consortium*, NAT'L L. SCH. VETERANS CLINIC, https://nlsvcc.org/ (last visited Apr. 8, 2022).

partner with veterans to empower veterans to create crisis intervention plans. A template might work for general advance healthcare planning for the end-of-life decision-making. But each Ulysses arrangement must be tailored to a person's treatment instructions, history, and diagnosis. Supervised law students could ensure that the veteran understands the nature of a self-binding arrangement and could help ensure the veteran enters the arrangement knowingly, free from duress, coercion, undue influence, or fraud.

6. VA Has the Necessary Personnel, Facilitating Uniform Implementation and Dissemination of Lessons Learned

Sixth, VA has the personnel required to implement these reforms, even a police force.[443] As the largest healthcare entity in the United States,[444] VA has behavioral health specialists, paramedics, nurses, psychiatric nurse practitioners, psychologists, psychiatrists, and social workers.[445] All of these personnel work for the same employer.[446] Training first responder teams could be uniform, and the professionals required for the teams already work for VA. Specialty training for VA law enforcement officers to respond to emergency calls could happen uniformly with oversight of Congress and the President. Inevitably, there will be lessons learned, and because VA is one organization led by a cabinet member,[447] dissemination of lessons learned can happen uniformly and effectively.

7. VA Has Electronic Records; Using Artificial Intelligence to Offer Ulysses Arrangements Is Practicable

Seventh, identifying and communicating with veterans with SMI to offer them Ulysses arrangements and explain how the process will work if they have an episode in the future should be doable because VA is one network. VA could use artificial intelligence to identify veterans with SMI receiving VA healthcare and offer them a Ulysses arrangement.[448] VA could create uniform messaging, explaining to veterans what a Ulysses arrangement is and how it might benefit the veteran. Uniform messaging and procedures could help protect against forcing a Ulysses arrangement on any veteran.

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443. *Office of Rural Health*, U.S. DEP'T OF VETERANS AFFS., https://www.ruralhealth.va.gov/about us/index.asp (last visited Apr. 8, 2022).

444. *Veterans Health Administration*, U.S. DEP'T OF VETERANS AFFS., https://www.va.gov/health/ (last visited Apr. 8, 2022).

445. *Id.*

446. *Id.*

447. *Id.*

448. *Office of Public and Intergovernmental Affairs*, U.S. DEP'T OF VETERANS AFFS., https://www.va .gov/opa/pressrel/pressrelease.cfm?id=5729 (last visited Apr. 8, 2022).

8. Congress Enacted Reforms for VA Police, so There Is a Place to Start

Eighth, Congress implemented reforms for VA police,[449] so this statutory language might be a place to start to expand authorization and implement these reforms. The key to the statutory authorization would be to require VA to allow veterans to form Ulysses arrangements. Plus, the legislation should empower veterans to form Ulysses arrangements requesting an emergency response team to transport the veteran in crisis to a VA hospital even in contravention of illness-induced objections and even if the veteran does not meet criteria for involuntary placement. Moreover, the legislation should require VA to create a database of Ulysses arrangements available to VA law enforcement and law enforcement across the country so that if an officer happens upon a veteran in crisis, the officer can search the database, find and read the Ulysses arrangement, and transport the veteran to a VA hospital pursuant to the arrangement or contact VA so that VA can dispatch an emergency response team to bring the veteran to the VA hospital.

9. Veterans' Treatment Courts May Prove Useful

Jurisdictions across the country have veterans' treatment courts.[450] These problem-solving courts could be used to implement these proposals. These courts are diversionary programs for veterans who have committed minor offenses, such as drug offenses, and have mental illness symptoms and behaviors.[451] These courts provide mentors to the veterans, oversee compliance with rehabilitation programs, do status checks, and facilitate the transition back into civilian life rather than focusing on punishment.[452] These courts might be useful in implementing this pilot and may be the courts to issue orders authorizing first responder teams to pick up and transport the veteran to a VA hospital pursuant to a Ulysses arrangement.

V. CONCLUSION

Merely changing the composition of the first responder team will not fix our system. A holistic approach, combining Dallas and Nebraska reforms, will offer the best hope for people battling SMI. Nebraska is the first state to truly empower people to escape the cruel consequences of strict involuntary treatment criteria, requiring decompensation to dangerousness. Illness-induced treatment refusals are a component of SMI. Ulysses arrangements offer hope to obtain intervention despite this symptom.

449. Police Improvement and Accountability Act, H.R. 2429-VA, 117th Cong. (2021).

450. *What Is a Veterans Treatment Court?*, JUST. FOR VETS, https://justiceforvets.org/what-is-a-veterans-treatment-court/ (last visited Apr. 8, 2022).

451. *Id.*

452. *Id.*

Nebraska has the necessary procedures to secure admission, hospitalization, treatment, and stabilization through a Ulysses arrangement even if the person does not meet commitment criteria and voices illness-induced treatment refusals.

However, the new Nebraska law fails to build a process for detention and transportation to a hospital. Plus, the new Nebraska law fails to address situations in which first responders happen upon a crisis and have no way to know about the Ulysses arrangement. This Article fills those gaps. First, a first responder team of a medic, mental health professional, and specially trained officer have access to Ulysses arrangements through a database. First responders can be summoned through formal Ulysses arrangement activation or could happen upon a crisis and learn of the arrangement by searching the database. Then, first responders transport the individual to the hospital, pursuant to the Ulysses arrangement. These interactions will be safer because medically trained first responders, having read the Ulysses arrangement, will know about the person's history and desired interventions. Then, pursuant to the Ulysses arrangement, the person can obtain twenty-one days of inpatient treatment, enough to stabilize many with SMI, offering a better chance for long-term recovery than the seventy-two-hour revolving door of the current system. Finally, the model secures follow-up. A VA pilot makes sense because there are typically no third-party reimbursement issues.