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ANNALS OF HEALTH LAW
Advance Directive

Editors' Note

The *Annals of Health Law and Life Sciences* is proud to present the second issue of the thirty-first volume of our online, student-written publication, *Advance Directive*. This *Spring 2022 Advance Directive* Issue focuses on mental health in the ever-evolving health care landscape.

The Issue dives into the broad spectrum of topics within the current conversation taking place in the United States surrounding the multi-faceted effects of modern technology, innovation, and the COVID-19 pandemic on the provision of mental health care services.

The articles in this Issue not only analyze the current mental health care environment from both the provider and patient perspective, but also from that of technology providers and marketers. Although the articles acknowledge the positive impact of technological and other advancements in the mental health care field, they also endeavor to identify the gaps created thereby, and, importantly, propose legal and regulatory solutions to fill the recognized gaps.

The *Annals of Health Law* members deserve special recognition for their hard work and dedication to the well-thought articles included in this Issue. We would also like to thank Meera Patel, our *Annals* Editor-in-Chief, for her leadership and support. We would also like to thank and acknowledge our *Annals* Executive Board Members: Edwin Caro, Josh Wiedner, and Abby Higgins for their efforts in producing this Issue. Lastly, we must thank the Beazley Institute for Health Law and Policy and our faculty advisors, Professors Sawicki and Paradise and Kristin Finn for their guidance and support.

We hope you enjoy this Issue of *Advance Directive*.

Sincerely,

Sarah Ryan
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ANNALS OF HEALTH LAW
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THE *STUDENT* HEALTH POLICY AND LAW REVIEW OF LOYOLA UNIVERSITY CHICAGO SCHOOL OF LAW

BRINGING YOU THE LATEST DEVELOPMENTS IN HEALTH LAW

Beazley Institute for Health Law and Policy

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Should AI Psychotherapy App Marketers Have a *Tarasoff* Duty?

Matt Brown

I. PSYCHOTHERAPY AND COVID-19

The COVID-19 pandemic has both revealed[1] and exacerbated[2] the general public's demand for psychotherapy.[3] Before the pandemic, psychotherapy was established as an effective treatment for certain mental health needs,[4] but some patients faced barriers to accessing psychotherapy resources.[5] The scarcity of mental health resources has an equity dimension: "people with the highest level of mental health needs often have the least access to services."[6] This scarcity may be in part due to a chronic shortage of psychotherapists in the United States.[7] Since the onset of the COVID-19 pandemic, that shortage has become more acute as demand for psychotherapy has increased.[8]

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[1] Christina Caron, *'Nobody Has Openings': Mental Health Providers Struggle to Meet Demand*, N.Y. TIMES (Sep. 14, 2021), https://www.nytimes.com/2021/02/17/well/mind/therapy-appointments-shortages-pandemic.html ("'There's always been more demand for services than there are mental health providers to provide them,' Dr. Wright said. 'I think what the pandemic has done is really laid bare that discrepancy.'").

[2] Holly A. Swartz, *The Role of Psychotherapy During the COVID-19 Pandemic*, 73 AM. J. PSYCHOTHERAPY 41, 41 (2020).

[3] Psychotherapy, or talk therapy, is the treatment of "mental health problems by talking with a psychiatrist, psychologist or other mental health provider." *Psychotherapy*, MAYO CLINIC, (last visited Feb. 3, 2022).

[4] *Research Shows Psychotherapy Is Effective but Underutilized*, AM. PSYCH. ASS'N (Aug. 2012), https://www.apa.org/news/press/releases/2012/08/psychotherapy-effective.

[5] Caron, *supra* note 1 (noting the more pronounced lack of practitioners in rural counties); *See* Tonya Mosley et al., *'Critical' Need for Mental Health Counselors Grows as Pandemic Takes a Toll*, WBUR (Mar. 5, 2021), https://www.wbur.org/hereandnow/2021/03/05/mental-health-therapists-pandemic (noting that there were "disproportionately fewer Black counselors before the pandemic").

[6] Ramyadarshni Vadivel et al., *Mental Health in the Post-COVID-19 Era: Challenges and the Way Forward*, 34 GEN. PSYCHIATRY 1, 2 (2021), https://gpsych.bmj.com/content/gpsych/34/1/e100424.full.pdf.

[7] Caron, *supra* note 1; Ganes Kesari, *AI Can Now Detect Depression From Your Voice, And It's Twice As Accurate As Human Practitioners*, FORBES (May 24, 2021, 6:50 AM), https://www.forbes.com/sites/ganeskesari/2021/05/24/ai-can-now-detect-depression-from-just-your-voice/.

[8] Caron, *supra* note 1; *see also Worsening mental health crisis pressures psychologist workforce: 2021 COVID-19 Practitioner Survey*, AM. PSYCH. ASS'N (Oct. 19, 2021), https://www.apa.org/pubs/reports/practitioner/covid-19-2021 (detailing continued increase in demand for treatment since 2020); Zoë Read, *'It's OK to not be OK': For clients' mental*

In response, the remote delivery of mental health care increased to meet this newfound demand[9] with the explosion of virtual and online therapy platforms.[10] These platforms allow many Americans to access therapy without leaving home.[11] Empirically, virtual delivery of psychotherapy is a promising evolution in mental health care: research shows that it can be as effective as in-person psychotherapy for certain conditions.[12] However, it is not free; its cost to consumers may be slightly less than in-person therapy, but virtual psychotherapy may nevertheless be prohibitively expensive for some.[13]

II. THE PROMISE AND PERIL OF AI

As useful as remote psychotherapy has proven to be during the COVID-19 pandemic, technology has long promised an even more advanced option:

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health, and their own, therapists managed intense new demands, WHYY (Apr. 2, 2021), https://whyy.org/articles/its-ok-to-not-be-ok-for-clients-mental-health-and-their-own-therapists-managed-intense-new-demands/ (illustrating increased requests to psychotherapists for therapy appointments).

[9] Nicole Owings-Fonner, *Telepsychology expands to meet demand*, AM. PSYCH. ASS'N (June 1, 2020), https://www.apa.org/monitor/2020/06/covid-telepsychology; Claudia Wallis, *The Pandemic Has Created a 'Zoom Boom' in Remote Psychotherapy*, SCI. AM. (Jan. 1, 2022), https://www.scientificamerican.com/article/the-pandemic-has-created-a-zoom-boom-in-remote-psychotherapy/.

[10] *See, e.g.*, Samantha Vincenty, *10 of the Best Online Therapy Platforms*, OPRAH DAILY (Mar. 3, 2021), https://www.oprahdaily.com/life/health/a35631973/best-online-therapy-platforms/ ("[B]oth new and established services rose to meet a rising need in treatment for depression and anxiety."); *see also* Nancy Redd & Shannon Palus, *The Online Therapy Services We'd Use*, N.Y. TIMES: WIRECUTTER, https://www.nytimes.com/wirecutter/reviews/online-therapy-services/ (last updated June 17, 2021) (emphasizing the similarity between virtual and in-person therapy).

[11] Redd & Palus, *supra* note 10.

[12] *See* Per Carlbring et al., *Internet-based vs. face-to-face cognitive behavior therapy for psychiatric and somatic disorders: an updated systematic review and meta-analysis*, 47 COGNITIVE BEHAV. THERAPY 1, 9-11 (2017) (displaying a lack of disparate effect between virtual and face-to-face cognitive behavioral therapy among various mental disorders or symptoms).

[13] *See* MS Broudy, *How Much Should You Expect to Pay for Online Therapy?*, ECOUNSELING.COM (Feb. 14, 2021), https://www.e-counseling.com/online-therapy-guide/how-much-should-you-expect-to-pay-for-online-therapy/ (estimating the cost of the two most popular live online therapy platforms at about $400 per month and about $360 per month).

the development of artificial intelligence (AI)-enabled programs and apps to deliver psychotherapy.[14] Instead of participating in a session with a live therapist, those seeking therapy can use their smartphones or tablets to speak with a computer program designed to converse with them as a "patient."[15] That technology is, in a sense, already here: apps like Woebot have already begun to fill the demand for cheap, widely-available psychotherapy.[16] Woebot is a "chatbot" program that uses AI to analyze the content of text messages and respond appropriately to it.[17] Chatbots are not yet substitutes for humans[18]—AI technology has not advanced to the point that such programs are fully able to pass the Turing Test[19]—but the day is coming

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[14] AI-based psychotherapy is not a new concept: in 1966, MIT professor and computer scientist Joseph Weizenbaum created ELIZA, a computer program designed to respond in the manner of a Rogerian psychotherapist to typed inputs. Evgeniya Panova, *Which AI Has Come Closest to Passing the Turing Test?*, DATACONOMY (Mar. 9, 2021), https://dataconomy.com/2021/03/which-ai-closest-passing-turing-test/.

[15] This paper will use the term "patient" to refer to the consumer or user of an AI-enabled psychotherapy app. "Patient" is shorthand; the psychotherapist's duty to third parties does not require that the psychotherapist be a medical doctor. *See* Tarasoff v. Regents of the University of California, 551 P.2d 334, 345 (1976) ("The role of the psychiatrist, who is indeed a practitioner of medicine, and that of the psychologist who performs an allied function, are like that of the physician who must conform to the standards of the profession …").

[16] *See* Eileen Bendig et al., *The Next Generation: Chatbots in Clinical Psychology and Psychotherapy to Foster Mental Health – A Scoping Review*, VERHALTENSTHERAPIE 1, 8 (Aug. 20, 2019), https://www.karger.com/Article/Fulltext/501812 ("The Woebot chatbot offers a self-help program to reduce anxiety and depression with a script based on cognitive-behavioral principles.").

[17] Karen Brown, *Something Bothering You? Tell It to Woebot*, N.Y. TIMES (June 1, 2021), https://www.nytimes.com/2021/06/01/health/artificial-intelligence-therapy-woebot.html.

[18] James Dinneen, *I Chatted with a Therapy Bot to Ease my Covid Fears. It Was Bizarre.*, ONEZERO (Jul. 8, 2020), https://onezero.medium.com/i-chatted-with-a-therapy-bot-to-ease-my-covid-fears-it-was-bizarre-ccd908264660 ("There were…times when the bots made obvious errors, exposing the rigidity of their scripts and their essential non-personness.").

[19] The Turing Test is the common name for the thought experiment constructed by British computer scientist Alan Turing to determine a machine's ability to "think." Turing proposed that a computer could be constructed to play the "imitation game," in which an interrogator asks questions of a human and a computer, neither of which the interrogator can see. The interrogator must, by reference only to the written responses she receives and within a limited time frame, determine which interlocutor is the human and which is the computer. A computer that can convince the interrogator it is the human is said to pass the Turing Test. Alan Turing, *Computing Machinery and Intelligence*, 59 MIND: Q. REV. PSYCH. & PHIL. 433, 433-34, 442 (1950) (describing the imitation game and the possibility that a computer could

when people will talk to an AI psychotherapist whose responses are indistinguishable from a human psychotherapist's.

Indeed, AI carries an even greater promise: in time, AI programs may perform a psychotherapist's job better than a human ever could.[20] Whereas human psychotherapists are susceptible to fatigue, limited perception, and faulty or biased analysis, AI promises 24/7 access to a psychotherapist with a much greater capacity for pattern recognition and unbiased analysis.[21] Just as recent AI programs have learned to play chess[22] at a much higher level than any human (and at a much higher level than more antiquated AI programs, like IBM's Deep Blue),[23] so too can we imagine AI providing constructive psychotherapy at a higher level than humans—and at lower financial cost.[24]

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take part in it; predicting that, by the year 2000, a computer would be able to play the imitation game well enough that a human interlocutor would have no better than a seventy percent chance of correctly identifying it); Stephen Johnson, *The Turing test: AI still hasn't passed the "imitation game,"* BIG THINK (Oct. 12, 2021), https://bigthink.com/the-future/turing-test-imitation-game/ (synopsizing the test and reporting that no computer has yet passed it).

[20] As with any other human endeavor subject to encroachment by AI, human psychotherapists will likely resist being replaced by apps. *See* Katharine Miller, *Augmenting Psychotherapy with AI*, STAN. UNIV. INST. FOR HUM.-CENTERED A.I. (Jan. 14, 2021), https://hai.stanford.edu/news/augmenting-psychotherapy-ai ("Some reasonable clinical psychologists might insist that artificial intelligence should play no role in mental health care — that the psychotherapeutic relationship is sacrosanct, and AI shouldn't even be in the room.").

[21] *See id.* (describing uses of AI in psychotherapy, including using natural language processing to identify what makes the best psychotherapists effective and to identify changes in speech patterns that human psychotherapists would miss); *see* Kesari, *supra* note 7 (describing current use of AI in identifying depression through vocal biomarkers).

[22] The ability to play chess has long been considered the sort of task a machine could do in a human-like way. *See* Turing, *supra* note 19, at 434-35 (giving an elementary chess problem as one example of a question suitable for the imitation game).

[23] *See, e.g.*, Will Knight, *Defeated Chess Champ Garry Kasparov Has Made Peace With AI*, WIRED (Feb. 21, 2020, 7:00 AM), https://www.wired.com/story/defeated-chess-champ-garry-kasparov-made-peace-ai/ (detailing the development of chess-playing AI).

[24] Whether AI-enabled psychotherapy apps charge a one-time fee to access the AI's services, a periodic subscription fee, or a per-session fee, their value will derive from their lower cost relative to the cost of paying for a human psychotherapist's time. *See* Broudy, *supra* note 13 (estimating cost of live virtual therapy); *see FAQ*, WOEBOT HEALTH, https://woebothealth.com/faq/ (last visited Apr. 10, 2022) (noting that Woebot is free of charge but may change to a paid service as its business grows).

Although increased access to psychotherapy brings hope in the COVID-19 world, it also brings moral and legal peril to providers in the tension between patient confidentiality and the need to protect third parties from harm. Confidentiality, a practical and legal concept, is crucial to psychotherapy's success: those seeking mental health treatment must feel safe to tell their psychotherapists their innermost thoughts.[25] However, confidentiality conflicts with psychotherapists' duties to third parties, as illustrated in the seminal case, *Tarasoff v. Regents of the University of California*.[26] When a patient indicates that she may pose a danger to a third party, a human psychotherapist must judge whether the third party is identifiable and whether the patient poses a sufficiently severe threat to justify breaking their patient's confidence to warn the threatened third party.[27] But when a patient confides in an AI-enabled program and indicates that she may be a danger to a third party, who must warn the third party, and how?

In the AI-enabled future of psychotherapy, clear legal duties must attach to app marketers to ensure that threats do not go unheeded. Since consumers will consider the app marketers, whose name is on the app, in deciding to use AI-based psychotherapy apps, marketers should be primarily responsible for warning third parties. To the extent that failures to warn stem from faulty design, marketers should be allowed to seek contribution from the designer(s) of faulty apps. This paper argues for state legislatures to establish a three-part duty to be upheld by marketers attempting to capitalize on AI-enabled psychotherapy apps: 1) a duty to design an AI-enabled psychotherapy app to accurately and reliably flag a potential threat to a third party; 2) a duty to maintain human oversight of the app so that when certain

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[25] *Protecting your privacy: Understanding confidentiality*, AM. PSYCH. ASS'N (Oct. 19, 2019), https://www.apa.org/topics/ethics/confidentiality.
[26] Tarasoff v. Regents of Univ. of Cal., 551 P.2d 334 (Cal. 1976).
[27] *Id.* at 345 (recognizing the judgment of psychotherapists in forecasting the danger a patient poses).

speech is flagged as containing a threat, a human can intervene and warn the third party of the threat; and 3) a duty to warn the third party, according to the holding and rationale of *Tarasoff*. Because the potential societal benefit of widely-available AI-enabled psychotherapy is so great, legislatures establishing this duty should, as a matter of public policy, cap damages recoverable for a breach of these duties. But, just as physicians do not escape tort liability despite the benefits they render to society, so should AI marketers be required to internalize the societal costs of their technology, however beneficial they may be.

III. EXTENDING THE DUTY TO WARN TO AI

The duty of psychotherapists to warn third parties of dangers posed by their patients originates with the *Tarasoff* case.[28] In *Tarasoff*, Prosenjit Poddar, a University of California graduate student, killed Tatiana Tarasoff, an undergraduate student he had briefly dated.[29] During therapy sessions, Poddar admitted to thoughts of harming a girl identifiable as Tatiana.[30] The therapist notified campus police but did not notify Tatiana or her family; Poddar killed Tatiana two months later.[31] Subsequently, Tatiana's parents brought a wrongful death suit for the psychotherapist's failure to warn Tatiana or her family of the danger Poddar posed.[32]

The California Supreme Court held that, "once a therapist does in fact determine, or under applicable professional standards reasonably should have determined, that a patient poses a serious danger of violence to others,

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[28] *Id.* at 344 (cataloguing cases from other jurisdictions that approximate, but do not speak directly to, the issue presented in the case).
[29] Kenneth Kipnis, *In Defense of Absolute Confidentiality*, 5 VIRTUAL MENTOR 337, 337 (2003), https://journalofethics.ama-assn.org/sites/journalofethics.ama-assn.org/files/2018-07/hlaw2-0310.pdf.
[30] *Tarasoff*, 551 P.2d at 341.
[31] Kipnis, *supra* note 29, at 337.
[32] *Tarasoff*, 551 P.2d at 341-42.

he bears a duty to exercise reasonable care to protect[33] the foreseeable victim of that danger."[34] The fulfillment of this duty necessarily entails violating the patient confidence that effective therapy relies upon;[35] the *Tarasoff* court held that the law must weigh the patient's interest in confidentiality against the public's interest in being safe from harm.[36] The court concluded, in language presaging the advent of AI and COVID-19,[37] that, in a "crowded and computerized society compel[ling] the interdependence of its members," "[t]he protective privilege ends where the public peril begins."[38]

In the future of AI psychotherapy, the public peril can be expected to expand. When AI-based apps provide psychotherapy services, patients will, in due course, reveal violent thoughts to their nonhuman therapists. Indeed, since many dynamics of in-person therapy that cause patients to feel uncomfortable are absent from the patient-app interaction, the patient may reveal his innermost thoughts, including violent intent, to the AI-based app even more readily than he does to a human psychotherapist.[39] Perhaps even more importantly, AI-based apps may be better able to identify threats than human psychotherapists can—speech analysis and pattern detection is one of

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[33] The duty to protect is often fulfilled through "adequate warnings." Regents of Univ. of Cal. v. Super. Ct., 413 P.3d 656, 663 n.3 (Cal. 2018).
[34] *Tarasoff*, 551 P.2d at 345.
[35] The court circumscribed the therapist's duty by requiring that the therapist breach the patient's confidence only when it is "necessary to avert danger to others" and only in such a way as to preserve as much of the patient's privacy as possible while protecting or warning the third party. *Id.* at 347.
[36] *Id.* at 346-47.
[37] The court, looking to other jurisdictions for support, cited cases imposing liability to infected third parties on doctors who "negligently [fail] to diagnose a contagious disease or, having diagnosed [it], [fail] to warn members of the patient's family." *Id.* at 344 (citations omitted).
[38] *Id.* at 347.
[39] *See 10 Ways Therapists Can Strengthen the Therapeutic Relationship*, GOODTHERAPY (Oct. 1, 2019), https://www.goodtherapy.org/for-professionals/marketing/customer-experience/article/10-ways-therapists-can-strengthen-the-therapeutic-relationship (listing barriers causing patients not to "open up" in in-person therapy, including anxiety and lack of experience of the therapist, the patient's fear that the therapist will judge him, discomfort in the space designated for therapy, the therapist's body language, and a mismatch between the personalities of the client and the therapist—barriers absent from human-AI interaction).

the current uses of AI in the mental health context.[40] Those factors, combined with the sheer number of people that may gain access to AI-based psychotherapy, may produce a surge in detected threats to third parties. The removal of the human psychotherapist from the equation does not remove the danger; the marketers of AI-enabled psychotherapy apps should be required to fulfill the duty to protect or warn identifiable third parties.

It may be safely assumed that marketers of AI-enabled psychotherapy apps will try to escape liability for harm patients using their products do to themselves or others: legal liability is a cost all profit-seeking companies aim to avoid if they can.[41] Thus, these tech companies will likely claim that they owe no duty to third parties (indeed, they may claim they owe no duty to their users).[42] But, just as the *Tarasoff* court found that human psychotherapists have duties to third parties, the same public policy principle—weighing the interests of patient confidence and public safety—applies in the AI context. In fact, it applies even more forcefully, as the introduction of AI means the possibility of greater success identifying and averting threats.

Tarasoff liability hinges on the existence of a "special relationship" between the therapist and either the patient or the third party.[43] The *Tarasoff* court paid homage to the common-law rule that, under ordinary circumstances, citizens do not owe a duty to protect or to warn others of dangers they perceive.[44] It departed from that rule, however, when there is a

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[40] Kesari, *supra* note 7.
[41] *Simple Ways a Business Owner Can Reduce Tort Liability*, EHLINE LAW FIRM, https://ehlinelaw.com/blog/simple-ways-for-business-owners-to-reduce-liability (last visited Feb. 6, 2022) ("Intelligent business owners must reduce their liability.").
[42] Software developers, who, like app marketers, fall under the umbrella of tech companies, have argued that they do not owe a duty of care to their users. *See* Richard Lee et al., *Understanding Software Developer Liability and Mitigating Legal Risk*, BLOOMBERG L. at 2 (Sep. 2019), https://www.icemiller.com/MediaLibraries/icemiller.com/IceMiller/PDFs/SoftwareDeveloperRisk.pdf ("Courts that have considered the issue have typically held that software developers … are not 'professionals' who owe an enhanced duty of care under the law.").
[43] *Tarasoff*, 551 P.2d at 343.
[44] *Id.*

"special relationship" between the defendant who has failed to warn and either a dangerous person or the possible victim.[45] In *Tarasoff*, the special relationship was between the therapist and Poddar, his patient; that relationship was sufficient for the court to find that the therapist owed a duty to warn Tatiana of Poddar's danger.[46] The "special relationship" requirement has been interpreted differently by courts around the country,[47] and some commentators have called into question the idea that the psychotherapeutic relationship is of the sort that should subject therapists to liability to third parties.[48]

Nevertheless, the law should recognize a "special relationship" between a patient and an AI-based psychotherapist. Indeed, patients can develop a "human-like connection" with AI, so a "special relationship" with an AI-enabled psychotherapist is just as possible as with a human psychotherapist.[49] The defining features of the "special" psychotherapist-patient relationship are its confidentiality and vulnerability: patients bare their souls to their therapists, and therapists safeguard their patients' confidences and respond

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[45] *Id.*
[46] *Id.* at 343 n.6 (finding the "requisite relationship between Poddar and both Dr. Moore, [Poddar's therapist], and Dr. Powelson, who supervised the treatment").
[47] *See, e.g.*, Eckhardt v. Kirts, 534 N.E.2d 1339, 1344-45 (Ill. App. 1989) (holding that a third party must prove either a physician-patient relationship between a "doctor" and an injured third party or a "special relationship between the patient and the [injured third party]" to hold the doctor liable).
[48] *E.g.,* Robert Schopp & Michael Quattrocchi, *Tarasoff, the Doctrine of Special Relationships, and the Psychotherapist's Duty to Warn*, 12 J. PSYCHIATRY & L. 13, 21-27 (1984) (using formalistic analysis to determine that psychotherapy does not fit a principled definition of special relationship).
[49] *See* Michael Holohan & Amelia Fiske, *"Like I'm Talking to a Real Person": Exploring the Meaning of Transference for the Use and Design of AI-Based Applications in Psychotherapy*, 12 FRONTIERS IN PSYCH. 1, 4 (Sep. 27, 2021), https://www.frontiersin.org/articles/10.3389/fpsyg.2021.720476/full ("[S]tudies of specific chatbots demonstrate anecdotal evidence that some users develop a human-like connection with the chatbot that can be seen as suggestive of the kind of personal relationship out of which transference can develop.").

constructively, for the patient's benefit.[50] These characteristics are present in the patient's relationship with an AI-enabled psychotherapist.[51] Just as patients speak frankly and openly to their human therapists, so would they speak frankly and openly to their AI-based apps that mimic human therapists.[52] And, just as patients can expect human therapists to safeguard their confidences, so would patients expect to enjoy privacy and constructive dialogue from an AI therapist.[53] As AI-enabled psychotherapists are increasingly able to mimic the responses of human psychotherapists, patients can be expected to be just as open with AI as with a human.[54]

Public policy dictates that AI-based psychotherapy app marketers should be required to protect third parties.[55] That requirement should have three components: first, the app marketer must ensure that its app has been constructed to detect and flag speech evidencing violent intent, just as a

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[50] *The Client-Therapist Relationship Is Unique*, ONE THERAPY BRIGHTON (Mar. 19, 2018), https://www.onetherapybrighton.com/client-therapist-relationship-unique/; Elisia Klinka, *It's Been a Privilege: Advising Patients of the* Tarasoff *Duty and its Legal Consequences for the Federal Psychotherapist-Patient Privilege*, 78 FORDHAM L. REV. 863, 874-75 (2009).

[51] *See* Holohan & Fiske, *supra* note 49, at 3 (describing apps' aim to "mimic a human therapist" and projecting apps' therapeutic role independent of human therapists).

[52] *See* Elisabeth Hildt, *What Sort of Robots Do We Want to Interact With? Reflecting on the Human Side of Human-Artificial Intelligence Interaction*, FRONTIERS COMPUT. SCI. 2 (July 5, 2021), https://www.frontiersin.org/articles/10.3389/fcomp.2021.671012/full ("Humans tend to react to [the] simulated behavior [of robots] in similar ways as they react to human behavior.").

[53] *See id.* at 2 (humans react similarly to robots as they do to humans). Indeed, the very promise of the AI-enabled psychotherapist is the close approximation of human intentionality, understanding, and interaction that AI can emulate. *See* Eva Wiese et al., *Robots as Intentional Agents: Using Neuroscientific Methods to Make Robots Appear More Social*, FRONTIERS IN PSYCH. 1, 2-4 (Oct. 4, 2017), https://www.frontiersin.org/articles/10.3389/fpsyg.2017.01663/full (positing that robot behavior is the most important factor in human social acceptance of robots and that the most important component of robot behavior is the appearance of intentionality).

[54] *See* Adnan Asar, *Opening Up To A Robot? How Mental Health Tech Can Help Patients*, FORBES (Apr. 2, 2021, 7:30 AM), https://www.forbes.com/sites/forbestechcouncil/2021/04/02/opening-up-to-a-robot-how-mental-health-tech-can-help-patients ("[AI] tools will be particularly useful for patients who are more likely to be held back by stigma or fear of judgement…").

[55] *See, e.g.,* McIntosh v. Milano, 403 A.2d 500, 510 (N.J. Super. Ct. 1979) (following *Tarasoff* based, in part, on common-law public policy principle that "for every wrong there should be a remedy," quoting Lambert v. Brewster, 125 S.E. 244, 249 (W. Va. 1924)).

human psychotherapist is required under *Tarasoff* to detect violent intent.[56] Second, the app marketer must ensure that, when speech is flagged, a human can review the speech and decide whether circumstances warrant warning the third party. Third, the app marketer must have protocols in place to warn and take any other steps reasonably necessary to protect the third party.[57] Failure to carry out any of these three components may lead to liability.

The first component is analogous to strict products liability. Under the Restatement of Torts and the law of several states, those in the business of distributing products are liable to anyone, including foreseeable third parties, harmed by a defectively designed product.[58] The design of AI-enabled psychotherapy apps should include a mechanism for flagging speech that evidences a danger to third parties or else be subject to strict liability, just as other medical apps can be subject to strict liability for their design defects.[59] If a patient harms a third party after revealing to the AI-enabled app a credible danger to that third party and the AI failed to flag the speech revealing the

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[56] *Cf.* Tarasoff v. Regents of Univ. of Cal., 551 P.2d 334, 345 (Cal. 1976) (requiring human psychotherapists to detect danger to third parties in their interactions with patients).

[57] Such steps might include warnings by phone call, text message, or email; face-to-face contact by an agent of the app marketer; similar attempts to contact household members, if the identifiable third party cannot be reached; and contact with local law enforcement to bring the situation to light. Reasonableness would dictate the bounds of the steps to be taken, just as a human psychotherapist is not required to take unreasonably extensive steps to protect identifiable third parties. *See* Regents of Univ. of Cal. v. Super. Ct., 413 P.3d 656, 663 n.3 (Cal. 2018) (discussing that duty may be discharged through "adequate warnings").

[58] RESTATEMENT (THIRD) OF TORTS: PRODS. LIAB. § 1 (AM. L. INST. 1998); Eugene Volokh, *Tort Law vs. Privacy*, 114 COLUM. L. REV. 879, 900 ("[D]esign defect liability can be based on foreseeable risks of harm to third parties, not just to the buyers."); Berrier v. Simplicity Mfg., 563 F.3d 38, 54 (3d. Cir. 2009) (listing states allowing for liability to third parties ("bystander liability") for defective products).

[59] *See* Vernessa Pollard & Kevin Henley, *Navigating Litigation and Tort Liability Risks for Mobile Health and Health IT Applications*, ARNOLD & PORTER, LLP 5-6 (Feb. 2015), https://www.arnoldporter.com/-/media/files/perspectives/publications/2015/02/navigating-litigation-and-tort-liability-risks-f__/files/newsletter-item/fileattachment/adv022015navigatinglitigationandtortliabilityris__.pdf? (including strict products liability as part of a list of theories of liability for medical apps).

danger, the AI-based app should be deemed defectively designed.[60] The marketer of the app should be held liable to the third party, with the possibility of contribution from the app designer if the designer and marketer are different entities.

The second component gives rise to ordinary negligence liability.[61] Under the Restatement, when an actor's conduct creates a risk of physical harm, he must exercise reasonable care to avoid the harm.[62] Here, the *Tarasoff* duty to use human judgment collides with the app marketer's role. A human psychotherapist performs all the aspects of the *Tarasoff* duty: she identifies a potential danger in her interaction with a patient; she judges whether the circumstances require reasonable efforts to protect a third party; and she undertakes to warn or protect the third party.[63] In contrast, an app, no matter how advanced its AI, cannot perform the latter two functions—human involvement is necessary. The app marketer must provide that human involvement. If the AI flags speech as evidencing a danger to a third party, but the app marketer does not use reasonable care in providing for human review of the speech to determine whether to act on it, the app marketer is liable for negligence.

The third component gives rise to *respondeat superior* liability, which subjects an employer to liability for the negligent acts of an employee within the scope of his employment.[64] Because a human act is required to protect a

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[60] Proof of defectiveness would necessarily be result-oriented, since the "dynamic inscrutability" ("black-box nature") of AI programs precludes an inquiry into their inner workings to examine the process by which they do or do not flag certain speech. Charlotte Tschider, *Medical Device Artificial Intelligence: The New Tort Frontier*, 46 B.Y.U. L. REV. 1551, 1555 (2021).

[61] *See* Pollard & Henley*, supra* note 59, at 6 (including ordinary negligence in the same list).

[62] RESTATEMENT (THIRD) OF TORTS: LIAB. FOR PHYS. & EMOTIONAL HARM § 7 (AM. L. INST. 2010).

[63] Tarasoff v. Regents of Univ. of Cal., 551 P.2d 334, 345 (Cal. 1976) (establishing that a therapist must use reasonable judgment in predicting harm and, if warranted, reasonable care in protecting the third party).

[64] RESTATEMENT (THIRD) OF AGENCY § 7.07 (AM. L. INST. 2006).

third party from harm, app marketers must designate an employee to carry out that duty.[65] If the app flags the speech and a human reviews it and judges that the circumstances warrant action, but the employee tasked with warning or protecting the third party does not take reasonable care to warn or protect,[66] the app marketer (employer) would be liable for the employee's negligence.

Negligence liability is not, however, automatic. For negligence liability to attach, a plaintiff must show a breach of the duty to warn[67] and a causal link—both factual and proximate—to the third party's injuries.[68] Limitations of time and circumstance will preclude liability in some cases; one can imagine a case in which a patient harms a third party before the app marketer's warning system has a reasonable chance to work (no breach), or a case in which an app marketer exercises a lack of care, but the patient harms the third party after years have passed, during which time the foreseeable risk of harm attributable to the breach has dissipated (no proximate causation).[69]

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[65] *See supra* note 57.
[66] *Cf. Tarasoff*, 551 P.2d at 345 (plaintiffs alleged that therapists judged that Poddar was a danger but did not take adequate steps to protect Tatiana).
[67] *See, e.g.*, Marshall v. Burger King Corp., 856 N.E.2d 1048, 1061 (guarding against conflating the concepts of duty and breach).
[68] The requisite factual causal link is established when a plaintiff shows that "the harm would not have occurred absent the conduct"—here, the failure to protect. RESTATEMENT (THIRD) OF TORTS: LIAB. FOR PHYS. & EMOTIONAL HARM § 26 (AM. L. INST. 2010); *see, e.g.*, Ross v. Ctrl. La. St. Hosp., 392 So. 2d 698, 699 (La. Ct. App. 1980) (finding no liability where defendant doctor's failure to warn of patient's failure to take medication did not cause harm suffered; no evidence that patient was off medication when she attacked family members). Proximate cause is established by showing that the harm done is consistent with the risk foreseeably created by the tortfeasor's conduct or is traceable to the tortfeasor's conduct. Mark A. Geistfeld, *Proximate Cause Untangled*, 80 MD. L. REV. 420, 422-23 (2021).
[69] *See, e.g.*, Wofford v. E. State Hosp., 795 P.2d 516, 520-21 (Okla. 1990) (holding that Oklahoma law recognizes the *Tarasoff* duty but that a harm occurring over two years after the patient's release from the hospital was "too remote to have been legally foreseeable").

IV. OBJECTIONS TO AI MARKETER LIABILITY

Tarasoff's holding and rationale have been far from universally accepted.[70] Courts have disagreed about the extent of psychotherapist liability to third parties.[71] The California legislature enacted California Civil Code § 43.92 in response to *Tarasoff*, clarifying the criteria for holding a psychotherapist liable to a third party: psychotherapists are not liable to third parties, "except if the patient has communicated to the psychotherapist a *serious* threat of *physical* violence against a *reasonably identifiable* victim or victims."[72] The general objections to *Tarasoff*-esque liability for psychotherapists fall into two categories: concerns about 1) the uncertainty of the application of the therapist's duty[73] and 2) the societal cost of jeopardizing patient confidence in psychotherapy.[74] Both objections will likely be raised against the imposition of a *Tarasoff*-like duty to warn on AI app marketers.

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[70] Douglas Mossman, *Critique of Pure Risk Assessment or, Kant meets* Tarasoff, 75 U. CIN. L. REV. 523, 529 (2006) ("*Tarasoff* in California and its progeny in other states have resulted in action by many state legislatures to define and limit duty-to-protect obligations only to situations where patients have made explicit threats.").

[71] Fleming v. Vest, 475 S.W.3d 576, 584 (Ark. App. 2015) (J. Harrison, concurring).

[72] CAL. CIV. CODE § 43.92(a) (Deering 2021) (emphasis added). Thus, under California law, threats that are idle, vague, musing, or unspecific; threats to inflict psychological, rather than physical, harm; or threats against unidentifiable or indeterminate victims are insufficient to give rise to liability.

[73] *See, e.g.*, Michael Perlin, *"You Got No Secrets to Conceal": Considering the Application of the* Tarasoff *Doctrine Abroad*, 75 U. CIN. L. REV. 611, 615-16 (2006) (listing academic objections to *Tarasoff*, including therapists becoming oversensitive to potential threats to third parties and the mistaken assumption that therapists would be required to predict threats with certainty); *see also* Michael Thomas, *Expanded Liability for Psychiatrists: Tarasoff Gone Crazy?*, J. MENTAL HEALTH L. 45, 52-56 (2009) (describing difficulty confining bounds of *Tarasoff* liability and arguing that the United Kingdom should not adopt a rule of liability similar to *Tarasoff*).

[74] *See, e.g.*, Perlin, *supra* note 73, at 615-16 (including in a list of objections to *Tarasoff* that the decision prioritized the needs of the public over the needs of patients and that the disclosure of patient confidences would dissuade patients from revealing violent thoughts or from seeking treatment altogether).

As for the first concern, *Tarasoff* provides a sufficient answer: app marketers do not need to perform perfectly; they must act reasonably.[75] The combination of AI and human backup will likely produce better results than humans alone,[76] but the AI-and-human-backup system will inevitably be imperfect. It will sometimes fail to identify true threats and, on the other hand, produce some false positives (flag patients that do not in fact pose a threat). This imperfection underscores the need for the courts to sort out meritorious claims from ones lacking merit—that is, to determine when an app marketer has failed to act reasonably to flag, judge, and warn of threats.

As for the second concern, privacy in app design is crucial in today's technology-dependent world.[77] Since there is a possible correlation between privacy protections and patient trust, privacy protections can combat the possible loss of trust inherent in a duty to divulge confidential information when AI flags patients as a threat.[78] Patients must be confident when they use an AI-based app that their sensitive information is not improperly jeopardized or used against them. The possibility that the app's warning system will divulge sensitive information to third parties could be seen to compound the risk that sensitive information is subject to unauthorized

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[75] Tarasoff v. Regents of Univ. of Cal., 551 P.2d 334, 344-45 (Cal. 1976) ("Obviously, we do not require that the therapist … render a perfect performance; the therapist need only [fulfill her duty of care].").

[76] *See* David De Cremer & Garry Kasparov, *AI Should Augment Human Intelligence, Not Replace It*, HARV. BUS. REV. (Mar. 18, 2021), https://hbr.org/2021/03/ai-should-augment-human-intelligence-not-replace-it (explaining that less-skilled humans, using powerful AI and—crucially—an effective system for integrating the complementary strengths of humans and AI, can outperform highly-skilled humans).

[77] Sam Rehman & Boris Khazin, *Why mobile app developers need to prioritize user data privacy and security—and what they can do to ensure it*, SECURITY (Oct. 13, 2021), https://www.securitymagazine.com/articles/96296-why-mobile-app-developers-need-to-prioritize-user-data-privacy-and-security-and-what-they-can-do-to-ensure-it ("[U]ser privacy, particularly Personally Identifiable Information (PII) and other sensitive data, is increasingly becoming a top consideration for ethical app developers during the construction of apps and all throughout the development lifecycle.").

[78] CJ Wolf, *The Surprising Link Between Patient Outcomes and HIPAA*, HEALTHICITY (Feb. 1, 2022), https://www.healthicity.com/blog/surprising-link-between-patient-outcomes-hipaa ("[T]his study ... suggest[s] our HIPAA compliance efforts could lead to more trust from our patients, leading to better care.").

access or interception.[79] Therefore, marketers of AI-based apps should be required by statute to protect users' privacy, both against cyber-threats that could expose private information[80] and against discriminatory use of patient information (i.e., "algorithmic bias").[81] The need for privacy protection in AI-based psychotherapy is particularly salient, but solid privacy protections are good for business for any health app marketer: app marketers can market their privacy features as selling points for their products.[82]

Companies profiting from health care must be required to internalize the costs their business models entail.[83] One of the costs of psychotherapy is the risks patients pose to third parties when patients reveal that risk to their therapists.[84] Though cost internalization necessitates imposing liability, legislatures have, in other contexts, seen fit to limit or "cap" the monetary

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[79] *See* Apurva Mohan, *Cyber Security for Personal Medical Devices Internet of Things*, INST. ELECTRICAL & ELECTRONICS ENG'RS 372, 373 (2014) (In the context of personal medical devices, "[s]ensitive patient data with limited encryption travels through trusted and untrusted networks, which can be intercepted by adversaries leading to [patient] privacy loss…through direct disclosure or inference attacks.").

[80] *See id.* (describing the threats to patient data).

[81] Patients must be confident that their personal attributes—notably their race or gender identity—are not either explicitly or implicitly built into an AI's algorithm as factors used to flag them as dangerous. *See* Cameron Kerry, *Protecting Privacy in an AI-Driven World*, BROOKINGS (Feb. 10, 2020), https://www.brookings.edu/research/protecting-privacy-in-an-ai-driven-world/ (describing the privacy risks of combining AI with "big data," identifying the possibility of "algorithmic discrimination," and articulating the legislative challenge "to pass privacy legislation that protects individuals against any adverse effects from the use of personal information in AI").

[82] *Privacy is Good Business: A Case for Privacy By Design in App Development*, AMA at 9, https://www.ama-assn.org/system/files/privacy-principles-by-design.pdf (last visited May 1, 2022) ("Adopting these guidelines [for improving app privacy protections] can help bolster understanding of and trust in your company's data privacy practices [and thus] make your apps more appealing to patients and physicians.").

[83] Omer Pelled, *The Proportional Internalization Principle in Private Law*, 11 J. LEGAL ANALYSIS 160, 160-61 (2019) (stating that a basic principle of economic legal theory is that the law should require actors to internalize the costs of their actions).

[84] *See* Brian Ginsberg, *Therapists Behaving Badly: Why the Tarasoff Duty Is Not Always Economically Efficient*, 43 WILLAMETTE L. REV. 31, 41, 51-63 (2006) (describing the basic theory of assigning tort liability according to social cost and analyzing how the *Tarasoff* duty to warn accords with mathematical models of tort liability).

damages recoverable from tortfeasors.[85] Because the societal benefit of cheap, widely-available psychotherapy has been made abundantly clear in the COVID-19 era,[86] the liability of AI app developers may be limited by statute. This limitation would lower the barrier to market entry and allow marketers and investors to factor the cost of fulfilling the duty to warn third parties into their business decisions, including the decision to insure against liability for failure to warn,[87] without barring injured third parties from recovery entirely. A cap on damages in this context makes sense, since injured third parties will have separate causes of action against the patients who injure them and will not be limited to their claim against the app marketer.

V. CONCLUSION

AI promises to expand the availability of psychotherapy to more Americans, but the law must preserve the protection of third parties from foreseeable harm. The duty of psychotherapists to protect third parties from the harm posed by patients should be extended to the marketers of AI-enabled psychotherapy apps.

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[85] *See, e.g.*, VA. CODE ANN. § 8.01-581.15 (2022) (capping total recovery amount in medical malpractice cases to fixed amounts, increasing year by year through 2031); *see also* IND. CODE ANN. § 34-18-14-3 (LexisNexis 2022) (capping total recovery amount for in medical malpractice cases to fixed amounts, increasing periodically; limiting liability of healthcare providers to amounts lower than the recovery cap and providing that any amount awarded in excess of the provider cap is to be paid from the state's patient compensation fund).

[86] *See supra* Part 2.

[87] *See* Michelle Mello & Allen Kachalia, *Medical Malpractice: Evidence on Reform Alternatives and Claims Involving Elderly Patients*, MEDPAC 39 (July 29, 2016), https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/dec16_medicalmalpractice_medpac contractor.pdf (concluding that state noneconomic damage caps lower the cost of malpractice insurance premiums and raise the supply of physicians in those states).

Legislative Barriers and the Study of the Efficacy of Marijuana in Mental Health Care Treatment

Julian Caruso

I. INTRODUCTION

Health experts speculate that the country's next pandemic will comprise of mental health disorders, especially given the ongoing uncertainties and isolation individuals are experiencing during both the COVID-19 pandemic and its aftermath.[1] Specifically, the manifestations of anxiety and depression over the past two years of the pandemic may change the culture of humankind more than COVID-19 has.[2] Since the beginning of the pandemic, the number of people taking prescription medication for various mental health conditions has steadily increased to roughly one out of every four people.[3] Furthermore, twenty-eight states nationwide have seen a ten to fifty percent increase in the number of people taking prescription mental health medication within the last year, suggesting that the pandemic is having a severe impact on Americans' mental health.[4]

Numerous traditional prescription options are currently available on the market to address mental health conditions and treatment, including antidepressants, anti-anxiety medications, stimulants, and antipsychotics.[5]

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[1] Jim Clifton, *The Next Global Pandemic: Mental Health*, GALLUP (Dec. 3, 2021), https://www.gallup.com/workplace/357710/next-global-pandemic-mental-health.aspx.
[2] *See id.* (highlighting the fact that pandemic anxiety and depression has already changed American culture more than COVID-19. This spike does not make the news because the definition and measurement of anxiety and depression have very fuzzy edges compared with the absolute diagnosis of COVID-19).
[3] Nick VinZant, *Pandemic Fuels Rise in Mental Health Prescriptions*, QUOTE WIZARD (Jan. 6, 2022), https://quotewizard.com/news/posts/mental-health-prescriptions.; *see also Mental Health Care Household Pulse Survey*, CTRS. FOR DISEASE CONTROL & PREVENTION [CDC] (2021), https://www.cdc.gov/nchs/covid19/pulse/mental-health-care.htm (monitoring the most recent changes in mental health care, including the impact of the COVID-19 pandemic for mental health. This is broken down by age, sex, gender identity, sexual orientation, race, education, disability status, and state).
[4] *Id.*
[5] *Mental Health Medications*, NAT'L INST. OF MENTAL HEALTH, https://www.nimh.nih.gov/health/topics/mental-health-medications (last revised Oct. 2016).

There are few options, however, for safe, effective, and well-understood alternative treatment routes for a physician to prescribe, like medical marijuana.[6] In fact, health care providers are not legally allowed to prescribe medical marijuana due to its federal classification, and insurance companies do not cover it as a form of treatment.[7] Even assuming a provider recommends marijuana use for a patient, there is a staunch lack of necessary clinical trials and research evaluating the safety and efficacy of marijuana for mental health treatment.[8] For marijuana to be seen as a trusted treatment form, or rather, not one, clinical trials and research on its safety and efficacy are vital to this assessment.

Given the increasing number of individuals struggling with mental health disorders[9] and continuing state legalization of marijuana,[10] the Federal Government must alleviate the burdens and difficulties that prevent researchers from conducting robust clinical trials that evaluate the effectiveness of medical marijuana as a treatment option for various mental health conditions. Alleviating these hindrances is critical because doing so will (1) create more trusted treatment options for patients,[11] and (2) provide

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[6] *See generally* Kamaron McNair, *66% of Americans Want Health Insurance Companies to Cover Alternative Medicine*, VALUEPENGUIN (June 21, 2021), https://www.valuepenguin.com/alternative-medicine-survey (describing how many health care consumers have recently turned to natural remedies instead of prescription methods which is largely attributed to the opioid epidemic in this country. However, the consumers often do not receive a "prescription" for alternative care from their provider, and many insurance companies do not cover this care as an accepted form of treatment).

[7] Michaela D. Poizner, *Provider Concerns when Recommending Medical Marijuana*, BAKER DONELSON (June 22, 2017), https://www.bakerdonelson.com/provider-concerns-when-recommending-medical-marijuana.

[8] Jay Ripton, *CBD Oil and Physician Liability*, PHYSICIANS PRAC. (Aug. 4, 2020), https://www.physicianspractice.com/view/cbd-oil-and-physician-liability.

[9] VinZant, *supra* note 3.

[10] Michael Hartman, *Cannabis Overview*, NAT'L CONF. OF STATE LEGISLATURES [NCSL] (June 6, 2021), https://www.ncsl.org/research/civil-and-criminal-justice/marijuana-overview.aspx.

[11] *See generally* Theresa Kane et al., Expanding Legal Treatment Options for Medical Marijuana in the State of Louisiana, 11 J. CMTY. HOSP. INTERN MED. PERSP. 343, 343–344 (2021) (discussing the fact that cannabis for "medical" purposes has expanded throughout

more flexibility for physicians wishing to prescribe marijuana for treatment purposes.[12]

This article will first differentiate between marijuana and hemp, as both are part of the same plant species of cannabis yet have different legal classifications under federal law. It will then describe marijuana's current classification under federal law and its historical significance in medicine. Next, this article will discuss the potential benefits and risks of using marijuana to treat mental health conditions, followed by a brief overview of how funding is secured for clinical trials in the United States. Finally, it will illustrate the main impediments to researching the relationship between marijuana and mental health disorders and argue that the Federal Government must decriminalize and reclassify marijuana from its current Schedule I classification to help meet the need for more mental health treatment options.

II. MARIJUANA VS. HEMP

Marijuana and hemp are two varieties of the same plant species, *Cannabis sativa*.[13] Many individuals attribute the term cannabis to the plant commonly known as marijuana, which contains compounds delta-9 tetrahydrocannabinol (THC) and cannabidiol (CBD).[14] Hemp-derived CBD products contain less than 0.3% THC and became federally legal in 2018

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the US, but the ability for an individual patient to receive this is very limited and can only be used for limited medical disorders. While this article specifically looks at the State of Louisiana, however, the sentiments are generally the same throughout the country).

[12] Poizner, *supra* note 7.

[13] Dana Murray, *CBD Oil vs. Hempseed Oil: How to Know What You're Paying For*, HEALTHLINE (Apr. 3, 2020), https://www.healthline.com/health/hemp-vs-cbd-oil.

[14] *What You Need to Know (And What We're Working to Find Out) About Products Containing Cannabis or Cannabis-Derived Compounds, Including CBD*, U.S. FOOD & DRUG ADMINISTRATION [FDA], https://www.fda.gov/consumers/consumer-updates/what-you-need-know-and-what-were-working-find-out-about-products-containing-cannabis-or-cannabis (last visited Jan. 19, 2022) [hereinafter FDA on Cannabis].

under the Farm Bill.[15] Nevertheless, hemp products remain illegal under some state laws.[16] Due to hemp's legal classification under federal law, however, hemp products do not face tremendous barriers when researchers apply for clinical trials, physicians opt to prescribe it, and consumers opt for public access.[17] In contrast, marijuana-derived CBD products are currently federally illegal yet are legal under some state laws.[18] This article will focus on the marijuana-derived CBD product and the barriers surrounding its research.

III. THE FEDERAL COMPREHENSIVE DRUG ABUSE PREVENTION AND CONTROL ACT OF 1970

During the late 1960s, recreational drug use became relatively common in the United States.[19] In an effort to combat this, Congress passed the Comprehensive Drug Abuse Prevention and Control Act in 1970, which includes two parts, Title II and Title III.[20] Title II contains the Controlled Substances Act ("CSA"), which consolidates laws on manufacturing and distributing drugs of all kinds.[21] Under the CSA, marijuana is classified as a Schedule I drug, meaning it is one of the most dangerous drugs, has no mainstream accepted medical uses, and has a high potential for abuse.[22]

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[15] Murray, *supra* note 13; *see also* Farm Bill, *U.S. Dep't of Agric.* [USDA] https://www.usda.gov/farmbill (Jan. 14, 2022) (describing the Farm Bill and its implementation process).
[16] Murray, *supra* note 13.
[17] *Id.*
[18] *Id.*
[19] *Comprehensive Drug Abuse Prevention and Control Act of 1970*, FINDLAW (last updated Feb. 4, 2019), https://www.findlaw.com/criminal/criminal-charges/comprehensive-drug-abuse-prevention-and-control-act-of-1970.html#:~ (Feb. 4, 2019).
[20] *Id.*; *see also* 21 U.S.C. ch. 13 § 801 et seq. (1970) (detailing the act itself).
[21] *Comprehensive Drug Abuse Prevention and Control Act of 1970*, *supra* note 19.
[22] *Id.*

Other drugs classified in this category include heroin, ecstasy, LSD, bath salts, and MDMA.[23]

Despite its federal classification, individual states have been legalizing medicinal and recreational marijuana for several years.[24] An abundance of reasons exist as to why states choose to legalize marijuana, including the economic benefits of the regulated commercial availability of marijuana, such as tax revenues, job growth, and investment opportunities.[25] Currently, thirty-seven states, including the District of Columbia, Guam, Puerto Rico, and the U.S. Virgin Islands, have approved comprehensive, publicly available medical marijuana programs.[26] Of those thirty-seven states, eighteen have legalized adult recreational usage.[27]

IV. HISTORICAL SIGNIFICANCE OF MARIJUANA IN MEDICINE

Only within the past 100 years has marijuana shifted into the illicit classification it has today.[28] Marijuana has a long-standing history of global usage, dating back to before 3000 B.C., with the first recorded uses in China before expanding into the Americas in the 1600s.[29] During the 19th and early 20th centuries, marijuana was widely utilized as a patent medicine in the

[23] *List of Schedule 1 Drugs*, DRUGS.COM, https://www.drugs.com/article/csa-schedule-1.html (June 26, 2020).
[24] Hartman, *supra* note 10.
[25] Mrinalini Krishna, *The Economic Benefits of Legalizing Weed*, INVESTOPEDIA (Apr. 29, 2021), https://www.investopedia.com/articles/insights/110916/economic-benefits-legalizing-weed.asp.
[26] *State Medical Cannabis Laws*, NAT'L CONF. OF STATE LEGISLATURES [NCSL], https://www.ncsl.org/research/health/state-medical-marijuana-laws.aspx#:~ (Feb. 3, 2022).
[27] *Id.*
[28] Patricia Atkins, *Everything Old is New Again: Cannabis Returns to USP*, 3 CANNABIS SCI. & TECH. J. 17 (2020).
[29] *Id.*

United States.[30] In fact, the *United States Pharmacopeia* described marijuana as a therapeutic option in 1850.[31]

Federal restriction of marijuana usage and sale first occurred in 1937 with the passage of the Marijuana Tax Act.[32] The Marijuana Tax Act essentially made marijuana illegal by imposing a tax on its usage with hefty fines and possible prison time for failure to pay.[33] The Federal Government enacted this law mainly in response to political pressures from enforcement agencies who feared the use and spread of marijuana by "Mexicans" throughout the country.[34] Subsequently, the *United States Pharmacopeia* dropped marijuana as a patent medicine in 1942.[35] Legal penalties for possession followed in 1951 and 1956 with the enactment of the Boggs and Narcotic Control Acts.[36] Ultimately, these restrictions led to the Federal Government outright prohibiting marijuana in 1970 with the CSA.[37]

V. LIMITED DATA FROM INITIAL STUDIES

The field of cannabinoid therapeutics in psychiatry currently provides no convincing evidentiary support for its usage in any mental health

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[30] Mary Barna Bridgeman & Daniel T. Abazia, *Medical Cannabis: History, Pharmacology, and Implications for the Acute Care Setting*, 42 PHARMACY AND THERAPEUTICS J. 180, 180 (Mar. 2017), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5312634/.
[31] *Id.*; *see also FAQs: USP and its Standards*, U.S. PHARMACOPEIA, https://www.usp.org/frequently-asked-questions/usp-and-its-standards (last visited Mar. 20, 2022) (the *United States Pharmacopeia* is a nonprofit scientific organization founded in 1820 that develops and disseminates public compendial quality standards for medicine).
[32] *Comprehensive Drug Abuse Prevention and Control Act of 1970*, *supra* note 19.
[33] *Marijuana Tax Act of 1937 and Federal Prohibition*, DRUG POL'Y FACTS, https://www.drugpolicyfacts.org/node/2478 (last visited Mar. 20. 2022).
[34] David F. Musto, *The Marijuana Tax Act of 1937 Abstract*, JAMA NETWORK (Feb. 1972), https://jamanetwork.com/journals/jamapsychiatry/article-abstract/490581.
[35] Bridgeman & Abazia, *supra* note 30.
[36] *Id.*
[37] *Id.*

application.[38] More research is urgently needed on this front, as some psychiatric disorders like post-traumatic stress disorder (PTSD), depression, anxiety, insomnia, schizophrenia, bipolar disorder, and ADHD have very little sound empirical data exploring the effects of medicinal marijuana on these conditions.[39]

Although governing bodies do not commonly recognize anxiety and other mood disorders as valid health conditions for physicians to recommend medical marijuana, anxiety ranks among the top five medical symptoms Americans report using marijuana for self-help treatment.[40] The usage is noted to be frequently driven by the desire for stress management and the general sense of relaxation that marijuana provides users.[41] Despite its frequent use by individuals, the anxiolytic effects of marijuana in clinical populations are not well-documented.[42]

Aside from its anxiolytic abilities, marijuana has been associated with feelings of euphoria, and many people report that they began using it during depressive episodes.[43] A 2017 report notes that improvements from depressive symptoms were described among a small group of individuals who had a history of marijuana usage.[44] Four out of five patients reported that the efficacy of marijuana superseded the benefits of past treatment trials of antidepressants.[45] Additionally, anecdotal reports suggest that some bipolar patients use marijuana to relieve depressive and manic symptoms.[46]

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[38] Jerome Sarris et al., *Medicinal Cannabis for Psychiatric Disorders: A Clinically-Focused Systematic Review*, BMC PSYCHIATRY (2020), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6966847/.
[39] *Id.*
[40] Jasmine Turna et al., *Is Cannabis Treatment for Anxiety, Mood, and Related Disorders Ready for Prime Time?*, 34 DEPRESS ANXIETY 1006, 1008 (June 1, 2017).
[41] *Id.*
[42] *Id.*
[43] *Id.*
[44] *Id.*
[45] *Id.*
[46] *Id.*

Anecdotal survey evidence shows that individuals with insomnia may also benefit from marijuana usage.[47] For example, seventy-two adults in a retrospective case series received marijuana-derived CBD for anxiety and sleep complaints in conjunction with their usual treatment.[48] Seventy-nine percent of these adults saw decreased anxiety scores within the first month, which lasted throughout the duration of the 12-week study and subsequently improved their sleep.[49] Unfortunately, without more in-depth research, the best evidence for marijuana's effectiveness on mental health conditions is primarily anecdotal.[50]

VI. POSITIVE AND NEGATIVE EFFECTS OF MARIJUANA USAGE

In general, the beneficial effects of marijuana are well known, including the relaxant/sedative and mood-elevating effects and an increase in appetite.[51] Conversely, potential adverse effects may include dizziness, paranoia, anxiety, fatigue, nausea, and impaired mental functions.[52] It is important to recognize that the cannabis plant contains a complex range of natural chemicals and ratios that create 'medicinal marijuana' varieties targeted at certain health conditions.[53] This indicates that what is recommended for one condition may not benefit another.[54] Regarding both the positive and negative effects of medicinal marijuana on psychiatric disorders, the research is nascent, and the overall evidence is relatively weak.[55] However, one privately funded study called "Marijuana

[47] Sarris et al., *supra* note 38.
[48] *Id.*
[49] *Id.*
[50] *Id.*
[51] *Id.*
[52] *Id.*
[53] *Id.*
[54] *Id.*
[55] *Id.*

Investigations for Neuroscience Discovery" found that patients who used marijuana to treat a range of mental health conditions, including anxiety, had improved cognitive performance, reduced clinical and anxiety-related symptoms, and reduced the rate of conventional medications usage, such as antidepressants.[56]

When specifically analyzing anxiety, marijuana appears to have mixed effects.[57] On one end, it seems that the elements of marijuana may have the potential to modify anxiety levels.[58] On the other end, marijuana has also been associated with adverse effects, including anxiety, psychosis, neurocognitive impairment, and addictions, which may present significant limitations to its use as a treatment method unless further investigations prove otherwise.[59] Marijuana use has not necessarily been associated with an increased risk for developing depression, anxiety, or PTSD, yet a frequently cited concern is the increased risk of psychosis in those with a preexisting genetic vulnerability to schizophrenia.[60]

VII. SECURING FUNDING FOR CLINICAL TRIALS

In the U.S., clinical trials are the primary tool for researchers to determine if a new treatment is safe and effective.[61] Before it is eligible to enter the market, the treatment must undergo a relatively extensive approval process under the U.S. Food and Drug Administration (FDA).[62] To conduct clinical research that can lead to a new drug's approval for market distribution,

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[56] Sara Zaske, *Can Marijuana Ease Mental Health Conditions?*, AM. PSYCH. ASS'N (Dec. 2018), https://www.apa.org/monitor/2018/12/marijuana.
[57] Turna et al., *supra* note 40 at 1010.
[58] *Id.* at 1011.
[59] *Id.*
[60] *Id.*
[61] *What are Clinical Trials and Studies?*, NAT'L INST. OF HEALTH [NIH] (last reviewed Apr. 9, 2020), https://www.nia.nih.gov/health/what-are-clinical-trials-and-studies.
[62] *Id.*

researchers must first work with the FDA and submit an investigational new drug application to the FDA Center for Drug Evaluation and Research.[63] Once approved, researchers can begin the four clinical trial research stages.[64]

Regarding the actual funding of clinical trials in the United States, the drug and device industry now funds six times more clinical trials than the Federal Government.[65] Despite this additional funding, obtaining funding to research the potential therapeutic benefits of marijuana has historically been difficult.[66] Much of the allocated funding, albeit limited, goes towards research on marijuana's illicit use and its harmful effects.[67] Furthermore, for a researcher to successfully apply for and obtain a Schedule I license necessary for beginning marijuana research, the researcher must demonstrate experience in the field with extensive support— creating a problematic cycle.[68]

VIII. THE IMPEDIMENT OF THE FEDERAL CLASSIFICATION

As more states continue to legalize marijuana, it further exacerbates the existing confusion surrounding its legality.[69] According to the FDA, it is not

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[63] *FDA and Cannabis: Research and Drug Approval Process*, U.S. FOOD & DRUG ADMIN. [FDA], https://www.fda.gov/news-events/public-health-focus/fda-and-cannabis-research-and-drug-approval-process (Oct. 1, 2020).
[64] *Step 3: Clinical Research*, U.S. FOOD & DRUG ADMIN. [FDA], https://www.fda.gov/patients/drug-development-process/step-3-clinical-research (Jan. 04, 2018).
[65] Meredith Cohn, *Industry Funds Six Time More Clinical Trials than Feds, Research Shows*, THE BALTIMORE SUN (Dec. 15, 2015), https://www.baltimoresun.com/health/bs-hs-trial-funding-20151214-story.html.
[66] Cathleen O'Grady, *Cannabis Research Database Shows how U.S. Funding Focuses on Harms of the Drug*, SCI. (Aug. 27, 2020), https://www.science.org/content/article/cannabis-research-database-shows-how-us-funding-focuses-harms-drug.
[67] *Id.*
[68] Ziva D Cooper et al., *Challenges for Clinical Cannabis and Cannabinoid Research in the United States*, 2021 JNCI MONOGRAPHS 114, 119 (Dec. 2021), https://academic.oup.com/jncimono/article/2021/58/114/6446199.
[69] Travis McDermott, *U.S. Supreme Court Justice Says Current Federal Cannabis Prohibition is "Contradictory and Unstable*," JD SUPRA (July 30, 2021), https://www.jdsupra.com/legalnews/u-s-supreme-court-justice-says-current-8562095/.

easy to conduct streamlined clinical research using marijuana-derived substances that are considered controlled substances under the CSA.[70] Conducting these trials often involves interactions with several federal agencies, including the Drug Enforcement Agency (DEA) and the Drug Supply Program of the National Institute on Drug Abuse (NIDA).[71] The NIDA Drug Supply Program specifically funds research in drug abuse, addiction, prevention, and treatment.[72] In total, there are currently seven steps to getting approval for marijuana-related research, compared to only five steps for hemp-related research.[73] Consequently, because of marijuana's Stage I federal classification, researchers wishing to study its effects must obtain a particular Schedule I license through the DEA before conducting any related research.[74]

In addition to the burdensome process of applying for and obtaining a license to begin research on marijuana, clinical researchers in the United States cannot study the safety and efficacy of marijuana products purchased from legal, state-authorized dispensaries.[75] Historically, researchers in the United States have only been able to study the effects of marijuana using plant material grown by a single grower, the University of Mississippi, under an exclusive contract with NIDA.[76]

Obtaining marijuana from a single grower is an issue, and numerous researchers have complained about the quality and potency of the marijuana

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[70] *FDA and Cannabis: Research and Drug Approval Process*, *supra* note 63.
[71] *Id.*
[72] *NIDA Drug Supply Program*, NAT'L INST. ON DRUG ABUSE (May 10, 2021), https://nida.nih.gov/research/research-data-measures-resources/nida-drug-supply-program.
[73] *Id.*
[74] *DEA Form 225–New Application for Registration*, DEA DIVERSION CONTROL DIV., https://www.deadiversion.usdoj.gov/drugreg/reg_apps/225/225_instruct.htm (last visited Mar. 22, 2022).
[75] Britt E. Erickson, *Cannabis Research Stalled by Federal Inaction*, C&EN (June 29, 2020), https://cen.acs.org/biological-chemistry/natural-products/Cannabis-research-stalled-federal-inaction/98/i25.
[76] *Id.*

grown by the University of Mississippi.[77] In general, the marijuana produced by the University has lower levels of THC than products available in legal state markets.[78] It also appears to be of poor quality because it is highly processed and dried immediately after harvesting.[79] The harvesting process provides a powder-like texture inconsistent with what is legally distributed to consumers in the state markets.[80] Moreover, even the DEA acknowledges that the quality and potency of the University's marijuana are not representative of the marijuana that consumers purchase in the state marketplaces.[81]

On May 14, 2021, the DEA took a small step towards increasing medical and scientific marijuana research opportunities.[82] The DEA approved specific marijuana grower applications outside of the University of Mississippi and soon will allow the registration of other entities authorized to produce marijuana for research purposes so long as the research is consistent with applicable legal standards and relevant laws.[83] However, these entities will continue to be under strict monitoring.[84] Furthermore, the number of entities eligible to produce marijuana must be pre-approved by the DEA, which still constrains researchers from purchasing marijuana from state-authorized dispensaries.[85]

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[77] *Id.*
[78] *Id.*
[79] *Id.*
[80] *Id.*
[81] *Id.*
[82] *DEA Continues to Prioritize Efforts to Expand Access to Marijuana for Research in the United States*, DRUG ENF'T AGENCY [DEA] (May 14, 2021), https://www.dea.gov/stories/2021/2021-05/2021-05-14/dea-continues-prioritize-efforts-expand-access-marijuana-research.
[83] *Id.*
[84] *Id.*
[85] *Id.*

These impediments all implicate the same issue—the federal classification of marijuana.[86]

IX. CHANGING THE LAW

The FDA highlights that it recognizes the significant public interest in marijuana and cannabis-derived compounds, particularly CBD, yet there remain many unanswered questions about these products' science, quality, and safety.[87] These unanswered questions create significant barriers to fully understanding the benefits of marijuana in mental health care. Currently, it is estimated that more than 3.6 million people in the United States are using marijuana as a form of medicine.[88] As many states continue to legalize medical marijuana, clinical trials on therapeutic effects on mental health conditions *need* to be conducted as soon as possible. In conjunction with the states' legalization of medical marijuana, there is a strong societal push toward adult recreational usage, which has resulted in many states legalizing marijuana recreationally.[89]

According to a Gallup poll conducted in 2021, more than two out of every three Americans support the legalization of marijuana.[90] Understanding this social push, a diverse range of federal political figures have proposed decriminalizing marijuana, which entails reduced penalties for users and

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[86] *See Medical Marijuana FAQ*, WEBMD (Dec. 18, 2021), https://www.webmd.com/a-to-z-guides/medical-marijuana-faq (noting that one reason why more research has not been done is because of marijuana's current Schedule I classification).
[87] FDA on Cannabis, *supra* note 14.
[88] Martha S. Rosenthal & R. Nathan Pipitone, *Demographics, Perceptions, and Use of Medical Marijuana Among Patients in Florida*, KARGER (Dec. 22, 2020), https://www.karger.com/Article/Pdf/512342.
[89] *Alice Wallace, Cannabis is One Industry that's Actually Coming out of Covid Stronger*, CNN BUS. (Oct. 28, 2021), https://www.cnn.com/2021/10/28/business/cannabis-booming-industry-mjbizcon/index.html.
[90] *Supports for Legal Marijuana Holds at Record High of 68%*, GALLUP (Nov. 4, 2021), https://news.gallup.com/poll/356939/support-legal-marijuana-holds-record-high.aspx.

prevents people from being incarcerated for possession.[91] This, in fact, is an area where confusion arises from the juxtaposition between state and federal law.[92] Specifically, states have already begun to decriminalize and reduce incarceration rates for marijuana-related crimes.[93] These actions by the states have been driven by a public desire for marijuana reform, as many of the decisions were enacted after appearing on state ballots for an individual to vote.[94] At the federal level, however, interstate commerce still regulates marijuana possession meaning criminal penalties may still arise for possession.[95]

Combined with state legalization and staunch public support, the speculation of a "mental health pandemic" heavily supports the need for more research conducted on medical marijuana's treatment efficacy for various mental health conditions. To ensure that researchers conduct clinical trials researching this relationship, the Federal Government must decriminalize and reclassify marijuana from its Schedule I status. If the Government decriminalizes and removes marijuana's current classification, it will open the door for more extensive and specialized research on the relationship between marijuana and mental health disorders. Additionally, if this occurs, marijuana research may be conducted under the same process as hemp because the hurdles of its classification would no longer be an impediment. The Biden campaign underscored this point by stating that decriminalizing

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[91] Alex Leary, *Pushing to Relax Marijuana Laws Hits Roadblocks*, THE WALL STREET J. [WSJ] (Feb. 22, 2022), https://www.wsj.com/articles/push-to-relax-marijuana-laws-hits-roadblocks-11645525980.
[92] Rebecca Pirius, *Marijuana Possession: Laws & Penalties*, CRIM. DEFENSE LAW., https://www.criminaldefenselawyer.com/crime-penalties/federal/Marijuana-Possession.htm (last visited Mar. 20, 2022).
[93] Kyle Jaeger, *Voters Across the U.S. Will Decide on Marijuana and Psychedelics Ballot Measures Next Month*, MARIJUANA MOMENT (Oct. 13, 2021), https://www.marijuanamoment.net/voters-across-the-u-s-will-decide-on-marijuana-and-psychedelics-ballot-measures-next-month/.
[94] *Id.*
[95] *Id.*

and reclassifying marijuana as a Schedule II drug, like cocaine or fentanyl, would make it easier for researchers to study it.[96] Unfortunately, despite dozens of bills being introduced since the 1970s to decriminalize marijuana, none have yet to become law.[97]

If the Federal Government does not opt to decriminalize marijuana nor reconsider its federal classification, it must still create a more straightforward process for researchers to obtain approval to conduct clinical trials. This would involve expanding researchers' access to marijuana from state-authorized dispensaries and increasing funding opportunities for researching the therapeutic benefits, not just marijuana's harmful effects. Options for this method include recognizing the legality of marijuana in numerous states and using that subset of legalization to justify a broader approval process for clinical studies and funding allocations.

X. BENEFITS OF DECRIMINALIZATION & RECLASSIFICATION

Many practical benefits can be attributed to conducting more clinical studies for both patients and providers. On the patient's end, obtaining more research involving marijuana's therapeutic effects may allow them to deviate from traditional prescription medications, providing them with a greater number of treatment options. Conventional mental health prescriptions often invoke numerous undesirable side effects for the patient.[98] The side effects of marijuana may be less severe for the patient, potentially leading to better

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[96] Leary, *supra* note 91.

[97] *See* Chelsey Cox, *'A Matter of Justice': Congress Moves Closer to Decriminalizing Marijuana with House MORE Act*, USA TODAY (Apr. 1, 2022), https://www.usatoday.com/story/news/politics/2022/04/01/congress-decriminalize-marijuana-more-act/7206098001/?gnt-cfr=1 (discussing the MORE Act, which will decriminalize marijuana and open up the opportunity to tax the drug, and noting that the bill is expected to pass in the House of Representatives, but not the Senate due to political divide).

[98] *Drugs to Treat Mental Illness*, WEBMD (Nov. 4, 2021), https://www.webmd.com/mental-health/medications-treat-disorders.

overall holistic treatment.[99] Moreover, reclassifying marijuana from its current Schedule I status would potentially allow for insurance coverage for the patient, as it would no longer be considered a drug with no currently accepted medical use.[100]

Looking to the provider, additional research may allow for more flexibility for physicians wishing to prescribe medicinal marijuana treatment. Even in states where marijuana is legal, most medical marijuana laws only allow physicians to "recommend" marijuana to patients with no authority to prescribe it.[101] Because of such restrictions, physicians have some fear regarding liability concerns.[102] These liability concerns depend on the state, yet there can be varying levels of malpractice liability risk depending on what standard of care the state courts apply.[103] Decriminalizing and reclassifying marijuana from its current Schedule I status could solve this issue by potentially motivating states to amend their prescription laws, giving physicians the authority to prescribe it to their patients without fear of liability. Additionally, similar to insurance coverage for the patient, insurance reimbursement options may become available for providers.

XI. CONCLUSION

High-quality, rigorous, and well-funded empirical studies on the effects and interactions of marijuana-related products with mental health disorders need to be conducted. The Federal Government must decriminalize and

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[99] *See generally* Sinikka L. Kvamme et al., *Exploring the Use of Cannabis as a Substitute for Prescription Drugs in a Convenience Sample*, 18 HARM REDUCTION J. 1, 2-3 (2021) (describing that cannabis may be a good substitute for opioid usage with fewer side effects. However, more studies need to be conducted on this relationship).
[100] Elizabeth Davis, *Why Health Insurance Won't Pay for Medical Marijuana*, VERYWELL HEALTH (Jan. 10, 2022), https://www.verywellhealth.com/why-health-insurance-wont-pay-for-medical-marijuana-1738421.
[101] Poizner, *supra* note 7.
[102] *Id.*
[103] *Id.*

reclassify marijuana from its current Schedule I status to ensure such research is undertaken adequately. Should it choose not to do this, it must still eliminate the onerous barriers currently in place to allow researchers to conduct marijuana research more efficiently, despite its stringent classification. Conducting more research involving the relationship between marijuana and mental health disorders is beneficial not only because it will provide more treatment options for patients, but it will create more security and flexibility for the prescribing providers. As more states continue to legalize medical marijuana and the rate of mental health conditions continue to rise across the country, there is an immediate need for sound data on the safety and efficacy of the drug's relationship to mental health conditions.

Using Crisis Stabilization Models to Improve Mental Health Care: Proposed Changes to State and Federal Law

Micaela Enger

I. INTRODUCTION

The emergency department in a hospital is cold, loud, bright, and busy with employees, patients, visitors, emergency responders, and even law enforcement.[1] For individuals experiencing a mental health crisis, the emergency department can exacerbate their situation, triggering an increased stress response and additional symptoms.[2] In response to this issue, a small number of communities have implemented crisis stabilization models to shift mental health care away from institutionalized care and towards community-based care.[3] Generally, crisis stabilization models provide an alternative to emergency department or inpatient psychiatric admission by providing short-term interdisciplinary care to rapidly stabilize the patient, reduce symptoms, and prevent the need for further hospitalization.[4] Crisis stabilization models are appealing to many communities because they can improve treatment and care for individuals experiencing a mental health crisis while also decreasing healthcare costs.[5] However, many state laws impede the implementation of crisis stabilization models due to complexities around licensing, scope of practice, transportation, and more.

Amending state laws to address the factors that impede crisis stabilization models will allow for an increase in crisis stabilization models around the country, thereby decreasing healthcare costs, reducing racial and socioeconomic inequities in care, and providing for better quality mental

[1] Linda Picone, *EMPATH A New Approach to Mental Health Crisis*, 104 MINN. MED. 8, 8 (2021).
[2] Verletta Saxon et al., *Behavioral Health Crisis Stabilization Centers: A New Normal*, 2 J. OF MENTAL HEALTH AND CLINICAL PSYCH. 23, 24 (2018).
[3] *Id.*
[4] *Id.*
[5] *Id.*

health care services.[6] This article will first provide an overview of the shift towards community-based care, how crisis stabilization models work, and why they are important. Next, this article will examine how the Emergency Medical Treatment and Labor Act ("EMTALA") and different state laws impede crisis stabilization models. Finally, this article will propose necessary amendments to state laws for the successful implementation of these models.

II. THE SHIFT TOWARDS COMMUNITY-BASED CARE FOR MENTAL HEALTH SERVICES

In 1963, President John F. Kennedy signed the Community Mental Health Act ("CMHA"), the first federal policy that "shifted funding and services from institutionalized care to community-based mental health services."[7] However, historically, states have struggled to provide sufficient resources and alternatives to inpatient psychiatric hospitalization.[8] Almost forty years after President Kennedy signed the CMHA, the Substance Abuse and Mental Health Services Administration ("SAMHSA") awarded a grant to create a network of crisis centers that would respond to crisis calls from the community.[9] Out of that funding came the National Suicide Prevention

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[6] *Id.*; Ruth S. Shim et al., *Improving Behavioral Health Services in the Time of Covid-19 and Racial Inequities*, NAT'L ACAD. OF MED. (Nov. 1, 2021), https://nam.edu/improving-behavioral-health-services-in-the-time-of-covid-19-and-racial-inequities/ (noting that "…problems within the behavioral health care system in the United States must be reimagined with equity at the forefront."); Verletta Saxon, *Psychiatric Boarding: Evolving Models for Community Crisis Centers*, OPEN MINDS (Apr. 28, 2015), https://openminds.com/market-intelligence/editorials/psychiatric-boarding-evolving-models-community-crisis-centers/ (stating that EMTALA, transportation, and funding are some of the barriers to mental health treatment; however, some of these barriers are beyond the scope of this article).

[7] Saxon et al., *supra* note 2, at 23.

[8] *Id.*

[9] Anita Everett, *Groundbreaking Developments in Suicide Prevention and Mental Health Crisis Service Provision*, SUBSTANCE ABUSE AND MENTAL HEALTH SERV. ADMIN. (May 14, 2021), https://www.samhsa.gov/blog/groundbreaking-developments-suicide-prevention-mental-health-crisis-service-provision.

Lifeline, a single national number that received more than 2.1 million calls during the 2020 fiscal year.[10] Between 1999 and 2018, suicide rates in the United States rose thirty-five percent.[11] Overdoses as a result of synthetic opioids, cocaine, and psychostimulants also increased at an alarming rate.[12] Advocates pushed for more legislation to address mental health services, and Congress enacted the National Suicide Hotline Improvement Act in 2018.[13] Finally, the National Suicide Hotline Designation Act of 2020 ("988 Designation Act"), enacted in October of 2020, incorporated the 988 three-digit crisis prevention number into statute.[14] The 988 Designation Act, which will go into effect in July of 2022, will allow for more people to access help and support and more effectively triage crisis situations, while bringing more attention and providing additional funding to crisis stabilization services.[15]

In addition, the impact of COVID-19 on mental health and the spike in overdose deaths during the pandemic exposed existing gaps in care.[16] As a result, Congress increased funding for mental health federal block grants.[17] Further, recent social unrest and high-profile, tragic incidents have led to increased recognition of alternatives to law enforcement responses to mental health crises, especially in minority and underserved communities.[18] In 2020 and 2021, Congress added new funding into the Mental Health Block Grant ("MHBG") and Substance Abuse Prevention and Treatment Block Grant ("SAPTBG") as part of the Consolidated Appropriations Act of 2021

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[10] *Id.*
[11] Kristin K. Beronio, *Funding Opportunities for Expanding Crisis Stabilization Systems and Services*, NAT'L ASS'N OF ST. MENTAL HEALTH PROGRAM DIR. 1, 4 (Sept. 2021), https://www.nasmhpd.org/sites/default/files/8_FundingCrisisServices_508.pdf.
[12] *Id.*
[13] Everett, *supra* note 9.
[14] *Id.*
[15] *Id;* Beronio, *supra* note 11, at 5 (noting, for example, the 988 Designation Act included a provision that allows states to enact fees on telephone services as a way to further finance crisis outreach and crisis stabilization).
[16] Beronio, *supra* note 11, at 4.
[17] *Id.* at 6.
[18] *Id.* at 4.

("CAA") and through the American Rescue Plan Act ("ARPA").[19] Congress also set aside thirty-five million dollars of the regular 2021 fiscal year MHBG appropriation to fund crisis stabilization programs.[20] The House Appropriations Committee report specifically directed SAMHSA to use the new five percent set-aside to fund "short-term residential crisis stabilization beds" along with other mental health services.[21]

In addition to increased funding for block grants, opportunities for Medicaid innovation and expanded telehealth coverage have also contributed to a recent shift toward community-based care for mental health services.[22] In 2018, the Centers for Medicare and Medicaid Services ("CMS") issued guidance related to innovative delivery systems for mental health services.[23] This guidance provided that states "may be able to access administrative match" for crisis services, meaning states could receive federal Medicaid reimbursement for fifty percent of the proportion of costs that are attributable to serving Medicaid beneficiaries.[24] Finally, through the 2022 Physician Fee Schedule, CMS announced plans to permanently expand telehealth services used in the treatment of mental health and substance abuse issues.[25]

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[19] *Id.* at 6.
[20] *Id*. at 7.
[21] *Id.*; H.R. REP. NO. 116-450 (2021).
[22] Beronio, *supra* note 11, at 22-23.
[23] Mary C. Mayhew, Deputy Administrator and Director, *Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance. State Medicaid Directors Letter # 18-011*, CTR. FOR MEDICARE & MEDICAID SERV. (Nov. 13, 2018), https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf.
[24] Beronio, *supra* note 11, at 13; Mayhew, *supra* note 23.
[25] Eric Wicklund, *CMS Expands Coverage for Telehealth in Mental Health Care*, HEALTHLEADERS (Nov. 5, 2021), https://www.healthleadersmedia.com/technology/cms-expands-coverage-telehealth-mental-health-care.

III. CRISIS STABILIZATION MODELS

Typically, when individuals experience mental health crises, they are either taken to the emergency department ("ED") or jail.[26] In 2016, forty-one percent of all state and federal prisoners had a self-reported history of a mental health problem.[27] Further, nearly two million people experiencing mental illness are booked into jails each year.[28] The National Alliance on Mental Illness estimates that between twenty-five and forty percent of Americans experiencing mental illness will be jailed or incarcerated in their lives.[29] Once in the criminal justice system, individuals lack access to benefits, treatment relationships, or any other sources of support or stability.[30] As a result, law enforcement and the justice system dedicate a disproportionate amount of resources to address issues resulting from untreated mental health crises.[31]

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[26] Lindsay Kalter, *Treating Mental Illness in the ED*, AAMC (Sept. 3, 2019), https://www.aamc.org/news-insights/treating-mental-illness-ed (noting that patients experiencing a mental health crisis often do not have anywhere to go, so they flood EDs); *See also Jailing People with Mental Illness*, NAT'L ALL. ON MENTAL ILLNESS, https://namibuckspa.org/about-nami-bucks-county/public-policy/jailing-people-with-mental-illness/ (last visited Jan. 28, 2022) (stating that people experiencing a mental health crisis are "more likely to encounter police than get medical help").

[27] U.S. DEP'T OF JUST., INDICATORS OF MENTAL HEALTH PROBLEMS REPORTED BY PRISONERS, 1 (2021), https://bjs.ojp.gov/sites/g/files/xyckuh236/files/media/document/imhprpspi16st.pdf.

[28] NAT'L ALL. ON MENTAL ILLNESS, *supra* note 26.

[29] Matt Ford, *America's Largest Mental Hospital is a Jail*, THE ATLANTIC (June 8, 2015), https://www.theatlantic.com/politics/archive/2015/06/americas-largest-mental-hospital-is-a-jail/395012/.

[30] *See generally National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit*, SUBSTANCE ABUSE AND MENTAL HEALTH SERV. ADMIN. (2020), https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf [hereinafter SAMHSA Toolkit] (noting that "you can't keep people out of the Emergency Department and jail without these relationships" when referring to the relationships between the community, behavioral health workers, and law enforcement); NAT'L ALL. ON MENTAL ILLNESS, *supra* note 26.

[31] SAMHSA Toolkit, *supra* note 30, at 10; *see also* Theresa Nguyen & Kelly Davis, *The State of Mental Health in America 2017*, MENTAL HEALTH AM. 5 (2017), https://www.mhanational.org/sites/default/files/2017%20MH%20in%20America%20Compressed.pdf (noting that despite more Americans having health insurance in the wake of the Patient Protection and Affordable Care Act, most Americans still lack adequate access to care).

Similarly, individuals seeking treatment in an ED do not always receive adequate care or have proper access to services.[32] Between 2006 and 2014, ED visits for all reasons increased by 14.8% in the United States, while mental health and substance abuse related ED visits increased by 44.1% over the same time period.[33] When individuals are taken to the ED, they often wait hours before being evaluated by a healthcare professional.[34] The wait in the busy, loud, and bright emergency department might intensify their condition or symptoms.[35] When mental health patients enter the ED, they are forty percent more likely to be admitted for inpatient care than someone with an acute medical condition.[36] When hospital beds are full, patients can end up in the hallways with someone supervising them.[37] The lack of inpatient beds has led to the common practice of "boarding" mental health patients in the ED, where hospital staff "board" them as a way to stall until they find additional resources.[38] This experience can infuse more stress and anxiety into an already difficult situation for the patient.[39] Moreover, ED staff may become frustrated with certain patients as individuals with mental illness are often stereotyped to be disruptive or dangerous.[40] Additionally, a 2016 survey found that only approximately seventeen percent of EDs had an on-

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[32] Michelle Heyland et al., *The Living Room, a Community Crisis Respite Program: Offering People in Crisis an Alternative to Emergency Departments*, 4 GLOB. J. OF CMTY PSYCH. PRAC. 1, 6 (2013).
[33] Brian J. Moore et al., *Trends in Emergency Department Visits, 2006-2014*, AGENCY FOR HEALTHCARE RSCH. AND QUALITY 1, 1 (Sept. 2017), https://www.hcup-us.ahrq.gov/reports/statbriefs/sb227-Emergency-Department-Visit-Trends.pdf.
[34] Heyland et al., *supra* note 32, at 6.
[35] Saxon et al., *supra* note 2, at 24.
[36] Jeff Goodale & Virginia Pankey, *Addressing Mental Health Needs With Crisis Stabilization Units*, HOK, https://www.hok.com/ideas/publications/addressing-mental-health-needs-with-crisis-stabilization-units/ (last visited Jan. 28, 2022).
[37] Kalter, *supra* note 26.
[38] *Id.*
[39] *Id.*
[40] Heyland et al., *supra* note 32, at 6.

call psychiatrist.[41] Because of these factors, mental health patients in crisis may not only feel additional stress in the ED setting, but also might not receive proper care.[42]

There are several different models for crisis stabilization services, and each serves as a cost-effective alternative to improve care compared to EDs and jails.[43] Three prevalent models are: the 23-hour crisis stabilization model; the living room model; and the crisis stabilization center model, also known as short-term crisis residential stabilization service or community-based behavioral health stabilization.[44] The 23-hour crisis stabilization model is the most short-term option, providing rapid stabilization by determining what care is necessary to avoid higher levels of care, such as psychiatric hospitalization.[45] The living room model differs from the 23-hour short-term model in that it serves patients that might need more than 23 hours to resolve the issues associated with their mental health crisis.[46] Further, the living room model setting reflects the name in that it is set up to provide a warm and comfortable space for patients where they receive care from either a psychiatric registered nurse or counselor.[47] Finally, the crisis stabilization center model builds on the two previous models in that the amount of time a patient can stay varies depending on community needs, but this model

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[41] Am. College of Emergency Physicians, *Waits for Care and Hospital Beds Growing Dramatically for Psychiatric Emergency Patients*, CISION PR NEWSWIRE (Oct. 17, 2016, 12:30 PM), https://www.prnewswire.com/news-releases/waits-for-care-and-hospital-beds-growing-dramatically-for-psychiatric-emergency-patients-300345668.html.
[42] Heyland et al., *supra* note 32, at 6.
[43] Saxon et al., *supra* note 2, at 24; SUBSTANCE ABUSE AND MENTAL HEALTH SERV. ADMIN., EXECUTIVE ORDER SAVING LIVES THROUGH INCREASED SUPPORT FOR MENTAL AND BEHAVIORAL HEALTH NEEDS REPORT, (Dec. 2020), https://www.samhsa.gov/sites/default/files/saving-lives-mental-behavioral-health-needs.pdf.
[44] Saxon et al., *supra* note 2, at 24.
[45] Paulette M. Gillig et al., *The Psychiatric Emergency Service Holding Area: Effect on Utilization of Inpatient Resources*, 146 AM. J OF PSYCHIATRY 369, 371 (1989) (discussing how the rate of hospitalization with an extended evaluation unit, the short-term crisis stabilization model, decreased by sixteen percent).
[46] Saxon et al., *supra* note 2, at 24.
[47] Heyland et al., *supra* note 32, at 4.

provides more expansive care in terms of monitoring the patient for twenty-four hours, prescribing medication, and creating a plan to address future crises.[48]

Studies on crisis stabilization models have shown that better management of patients through these models reduces unnecessary hospitalization, and as a result, reduces healthcare costs.[49] For example, a facility based on the living room model, located in Skokie, Illinois, saved the state of Illinois $550,000 in just two years after deflecting ninety-three percent of mental health patients away from the ED.[50] Crisis stabilization models also improve care for individuals experiencing a mental health crisis because of the multi-disciplinary and interdisciplinary approach to care.[51] Care coordination can exist between hospitals, nurses, emergency medical services, first responders, law enforcement, peer counselors, and mental and behavioral health professionals.[52] In addition, crisis stabilization models aim to ensure that patients do not owe any out-of-pocket costs for their care by utilizing state grants and donations, such that patients are not saddled with the high costs of inpatient hospitalization.[53] Many mental health professionals do not participate in insurance plans, and there is a mental health provider shortage,

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[48] Saxon et al., *supra* note 2, at 24-25.
[49] Daw San San Thinn et al., *The 23-Hour Observation Unit Admissions Within the Emergency Service at a National Tertiary Psychiatric Hospital: Clarifying Clinical Profiles, Outcomes, and Predictors of Subsequent Hospitalization*, 17 THE PRIMARY CARE COMPANION FOR CNS DISORDERS 1, 11 (2015).
[50] Heyland et al., *supra* note 32, at 5; Lauren Carrane, *Turning Point Hosts Open house of Living Room Facility March 9*, PATCH (Feb. 27, 2015, 3:59 PM), https://patch.com/illinois/skokie/turning-point-hosts-open-house-living-room-facility-march-9-0.
[51] Saxon et al., *supra* note 2, at 25.
[52] *Id.*
[53] Heyland et al., *supra* note 32, at 5 (stating that community crisis respite centers such as The Living Room represent important alternatives to EDs by remedying many of the issues accompanying EDs, including providing cost-effective care); Saxon et al., *supra* note 2, at 26 (stating that "models such as 23-hour stabilization, the Living Room Model and Crisis Stabilization Centers have been shown to be effective at treating individuals in crisis and are cost-effective").

meaning it is of utmost importance for crisis stabilization models to ensure patients are not at risk of out-of-pocket costs because a crisis stabilization facility might be a patient's last hope.[54] Ultimately, crisis stabilization models expand community-based care to improve mental healthcare by providing a broader range of treatment, increased care coordination, and decreased costs.[55] Despite the advantages of crisis stabilization models, there are federal and state laws that impede the implementation of these services, which are examined in the following sections.[56]

IV. EMTALA AS A BARRIER TO CRISIS STABILIZATION MODELS

Congress enacted the Emergency Medical Treatment and Labor Act in 1986 to require Medicare-participating hospitals with emergency departments to treat patients with emergency medical conditions in a non-discriminatory manner.[57] Current EMTALA obligations make it difficult to effectively provide care for mental or behavioral health patients beyond the inpatient setting.[58] When an individual experiencing a mental health crisis presents at a hospital ED, the hospital must screen and examine the patient, and, if they find an emergency medical condition, must provide further treatment until the condition is stabilized, which often includes admitting the

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[54] *Out-of-Network, Out-of-Pocket, Out-of-Options: The Unfulfilled Promise of Parity*, NAT'L ALL. ON MENTAL ILLNESS, https://www.nami.org/Support-Education/Publications-Reports/Public-Policy-Reports/Out-of-Network-Out-of-Pocket-Out-of-Options-The (last visited March 11, 2022) (discussing that after a majority of states expanded Medicaid, "Americans should have better access to mental health care than any time in history;" however, this is not necessarily the case).

[55] Heyland et al., *supra* note 32, at 5.

[56] Saxon, *supra* note 6 (noting EMTALA is a federal barrier to implementing the Centerstone Crisis Center; however, the author does not cite state laws or other legal barriers that impede crisis stabilization facilities as this article aims to).

[57] *EMTALA Fact Sheet*, AM. COLL. OF EMERGENCY PHYSICIANS, https://www.acep.org/life-as-a-physician/ethics--legal/emtala/emtala-fact-sheet/ (last visited Feb. 2, 2022).

[58] Catherine Greaves & Kristin Roshelli, *EMTALA and the Challenges of Treating Behavioral Health Patients in Crisis*, COSMOS (Feb. 2018), https://compliancecosmos.org/emtala-and-challenges-treating-behavioral-health-patients-crisis.

patient for inpatient services.[59] An emergency medical condition is one "manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in . . . serious jeopardy, impairment or dysfunction of a bodily organ or part."[60] Because an individual facing a mental health crisis might not know about a crisis stabilization model in their area, they might seek care in the ED first. Moreover, because of EMTALA, the hospital may not be able to immediately transfer the individual to a community-based center if it is determined that they are experiencing an emergency medical condition.[61] The patient cannot be transferred until they are determined to be stable, at which point the patient has already waited in the ED, potentially been "boarded," and potentially received inadequate care, thereby escalating stress and anxiety.[62]

Therefore, EMTALA should include additional language to guide physicians when treating patients experiencing a mental health crisis so that transfer can be arranged, or first responders can be routed to community-based crisis stabilization services, before the patient is subjected to the stressful environment of the ED. This is possible because it is within the scope of practice for ED physicians to evaluate patients with mental health conditions.[63] Part (C) of EMTALA ("Restricting transfers until individual stabilized") should include an additional subsection for patients seeking psychiatric care that would read,

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[59] *Id.*
[60] 42 U.S.C. § 1395dd(e)(1).
[61] Greaves & Roshelli, *supra* note 58.
[62] *Id.*
[63] Karen Tritz, Acting Director of Quality, Safety & Oversight Group, *Frequently Asked Questions on the Emergency Medical Treatment and Labor Act (EMTALA) and Psychiatric Hospitals*, Ref: QSO-19-15-EMTALA, CENTERS FOR MEDICARE & MEDICAID SERV. (July 2, 2019), https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/QSO-19-15-EMTALA.pdf.

> "The term 'stabilized' in the context of a psychiatric patient that could benefit from community-based crisis stabilization services means, with respect to an emergency medical condition described in paragraph (e)(1)(A), that transfer will not cause deterioration of the condition, or the benefits associated with community-based care outweigh the potential for material deterioration if the condition can be successfully treated in a more comfortable and less costly setting for the patient."

This language would provide greater guidance and lessen the threat of liability in terms of EMTALA obligations for providers encouraging patients to seek care through a crisis stabilization model in the community. However, it is critical that the crisis stabilization facility has the ability to stabilize the emergency medical condition, otherwise it would be inconsistent with the purpose of EMTALA.[64] Thus, hospitals should evaluate and assess the capabilities of any crisis stabilization models in the community before transferring patients for stabilizing treatment.[65]

Currently, crisis stabilization models are not subject to EMTALA unless they are Medicare certified and function as an ED, which they generally do not.[66] This poses a problem for crisis stabilization facilities whose goal is to encourage law enforcement to refer or bring individuals in that are experiencing a mental health crisis.[67] If crisis stabilization facilities were subject to EMTALA, they would have to accept anyone that law enforcement brings.[68] This would create a need for crisis stabilization facilities to incorporate law enforcement trainings into their practice. In return, law enforcement might be more likely to utilize crisis stabilization facilities as

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[64] Alicia Macklin, *EMTALA in the Psychiatric Environment*, CAL. HOSP ASS'N, https://www.calhospital.org/sites/main/files/file-attachments/emtala_1_up.pdf (last visited March 11, 2022).
[65] *Id.*
[66] *Id.*
[67] SAMHSA Toolkit, *supra* note 30, at 73 (discussing an interview with a retired detective in Memphis who described his experience with crisis stabilization services and the need for a better relationship with law enforcement after a tragic incident led to the death a 27-year-old man experiencing Paranoid Schizophrenia).
[68] *Id.* at 74.

opposed to hospital EDs or local jails.[69] Some crisis stabilization facilities require law enforcement who accompany individuals to the facility to go through the process of obtaining medical clearance to enter the facility, only to ultimately deny the patient admittance into the facility, resulting in the officer taking the individual to the ED or jail.[70]

If EMTALA applied, these facilities would have to accept all individuals and be able to provide services. Such an approach is a clear benefit for individuals facing a mental health crisis as opposed to only having the ED as an option, or in some cases jail. Ultimately, this could create a shift in how law enforcement responds to individuals with mental health issues by giving them more options to ensure effective care for the individual.[71] While this cultural shift could have advantageous implications in many communities, especially minority and underserved communities, an EMTALA obligation could prevent the implementation of crisis stabilization facilities where the community lacks funding, support, and staff. However, as our society promotes mental health and we continue to see a shift towards community-based care, federal block grants and additional legislation, as mentioned earlier in this article, could begin to solve the more logistical and practical issues involved in establishing a crisis stabilization facility.

V. STATE LAW BARRIERS TO CRISIS STABILIZATION MODELS

In addition to EMTALA creating a federal barrier to the implementation of crisis stabilization models, some states have enacted laws that impede the success of these models.[72] While there are three general models for

[69] *Id.*
[70] *Id.*
[71] *Id.* (quoting a retired police officer who stated that "police officers believe that drop-offs [at behavioral health facilities] allow them to do their job better and help people").
[72] Ill. Admin. Code tit. 77 § 380.310(e)(2) (2021) (for example, this article will expand on an Illinois law that doesn't allow crisis stabilization units to accept anyone who is intoxicated);

community-based crisis stabilization facilities, in practice, the specific service and staffing regulations vary greatly between different states.[73] Under Illinois statute, crisis stabilization units may not accept anyone who is intoxicated for admission.[74] However, community services should reflect community need, and many communities in Illinois face substance abuse issues.[75] Illinois, like many other midwestern states, is at the center of the opioid crisis.[76] Additionally, the majority of intoxicated people do not require medical intervention to become sober in a safe manner.[77] Many intoxicated individuals may end up in either the ED or jail, and the current Illinois law does not allow for individuals who may be struggling with substance abuse to seek care through crisis stabilization.[78]

Perhaps Illinois legislators were concerned that the crisis stabilization staff would find it challenging to distinguish between comorbid mental health issues or that intoxicated individuals would overwhelm these facilities. While valid, these concerns can be addressed through additional training or EMS assessments so that they can better triage multiple mental health

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Cal. Code Regs. tit. 9 § 1840.348 (this article will also discuss the California statute that requires a physician to be on call at all times at a crisis stabilization facility).

[73] Saxon et al., *supra* note 2, at 25; SAMSHA Toolkit, *supra* note 30, at 10 (suggesting that fragmented crisis care would benefit from more uniform national best practice guidelines).

[74] Ill. Admin. Code tit. 77 § 380.310(e)(2) (2021).

[75] *Drug Abuse Statistics in Illinois*, N. ILL. RECOVERY CTR. (Jan. 13, 2021), https://www.northernillinoisrecovery.com/drug-abuse-statistics-in-illinois/.

[76] *See id.* (stating that the Illinois death rate due to opioid overdose is "almost 20% higher than the national opioid overdose death rate").

[77] The Comm. on Psychiatry & the Cmty. for the Group for the Advancement of Psychiatry, *Roadmap to the Ideal Crisis System*, GROUP FOR THE ADVANCEMENT OF PSYCHIATRY NAT'L COUNCIL FOR BEHAV. HEALTH 74 (2021), https://www.thenationalcouncil.org/wp-content/uploads/2021/03/031121_GAP_Crisis-Report_Final.pdf?daf=375ateTbd56.

[78] Kelsy Schlotthauer, *What to Expect After a Public Intoxication Arrest*, THE O'COLLY (Apr. 27, 2017), https://www.ocolly.com/news/what-to-expect-after-a-public-intoxication-arrest/article_2e1ac542-2baa-11e7-9bf6-c7e6d4d851c0.html (discussing the experience of an individual that spent time in jail after a public intoxication arrest); Robert Donovan, *Jail or ER: An Easy Choice for Drunks*, EMS 1 (Apr. 10, 2010), https://www.ems1.com/medical-clinical/articles/jail-or-er-an-easy-choice-for-drunks-YOet2ZBe9NwuLqxH/ (discussing the struggle that EMS and law enforcement face for certain individuals that appear to be intoxicated and where the best place for them is).

concerns and decide whether the individual needs the ED or can receive care through crisis stabilization.[79] In terms of capacity issues, diverting some of the load from the ED or jail could improve some patient experiences until the crisis stabilization facility can grow to accommodate more people. Also, while it might be a concern that patients with a substance abuse issue will not be able to recover in a short-term facility, there are a large number of substances that can be detoxed within twenty-four hours and up to a week.[80] These shorter timeframes give the facility the ability to provide care for more individuals relatively quickly.[81] Therefore, Illinois, and states with similar laws, should eliminate any provisions that require facilities to turn away intoxicated individuals in order for crisis stabilization centers to better serve the needs of the community.

In addition to laws that prohibit certain types of individuals from receiving care, some states have requirements that make it difficult for crisis stabilization facilities to operate. In California, each crisis stabilization facility, regardless of the model, must have a physician on call at all times.[82] Initially, this might appear beneficial because it allows the facility to increase its scope of practice; however, current mental health provider and psychiatrist shortages might limit the establishment of crisis stabilization facilities because of this physician staffing requirement.[83] In twenty-two

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[79] *Reinventing EMS Response to Substance Abuse, Mental Health Emergencies*, PRIORITY AMBULANCE LEADERSHIP FOUND. (Sept. 24, 2020), https://www.ems1.com/mental-health/articles/reinventing-ems-response-to-substance-abuse-mental-health-emergencies-OkqYPJQfgWccx28r/.

[80] *How Long Does Detox Take?*, ADDICTION CTR., https://www.addictioncenter.com/rehab-questions/how-long-does-detox/ (last visited Feb. 6, 2022) (discussing the length of detoxification for different substances and noting that many substances can be detoxed from the system in 24 hours).

[81] *Id.* (making the connection that individuals that can detox more quickly allow the crisis stabilization facility to treat more individuals).

[82] Cal. Code Regs. tit. 9 § 1840.348.

[83] Andy Smith, *Shortage of Psychiatrists & Mental Health Providers Projected to Rise*, INSYNCHCS, https://www.insynchcs.com/blog/rising-shortage-mental-health-providers (last visited Feb. 6, 2022).

states, nurse practitioners have full practice authority without physician oversight, with more states expanding this authority every year.[84] Further, employment of nurse practitioners is projected to grow fifty-four percent over the next decade, a much faster rate than the average for all occupations.[85] States should take advantage of this growing trend as it may be easier to staff crisis stabilization centers with nurse practitioners as the trend for community-based care expands. Some states, like Tennessee, provide for more flexibility by requiring "at least one registered nurse, nurse practitioner or physician assistant" to be on duty at all times in crisis stabilization facilities.[86] As a result, the twenty-two states that can utilize nurse practitioners should, and states like California, with pending grants of authority for nurse practitioners to expand their scope of practice, should reassess the medical staffing requirements for crisis stabilization facilities or provide for greater flexibility.

Moreover, there are a few provisions regarding crisis stabilization services that each state should include in its laws. Similar to the above Tennessee statute, states should allow for medical staffing flexibility as long as at least one provider has prescribing authority and the crisis stabilization facility's scope of practice can serve the needs of the community.[87] Additionally, because collaboration with law enforcement and EMS is essential to effective

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[84] *The Differences Between a Nurse Practitioner and Doctor*, UNIV. OF ST. AUGUSTINE FOR HEALTH SCI. (July 2020), https://www.usa.edu/blog/nurse-practitioner-vs-doctor (explaining that 'full practice authority' means the ability to "evaluate patients, order and interpret diagnostic tests, create and manage treatment plans, and prescribe medications"); Chaunie Brusie, *California Grants Nurse Practitioners Full Practice Authority by 2023*, NURSE.ORG (Oct. 20, 2020), https://nurse.org/articles/california-nurse-practitioners-full-practice/.

[85] *Nurse Anesthetists, Nurse Midwives, and Nurse Practitioners*, U.S. BUREAU OF LAB. STAT. (Dec. 7, 2021), https://www.bls.gov/ooh/healthcare/nurse-anesthetists-nurse-midwives-and-nurse-practitioners.htm (noting that "nurse practitioners work in a variety of healthcare settings"); Andrea Mosher, *Nurse Practitioner Job Outlook By State*, NURSINGPROCESS.ORG (2022), https://www.nursingprocess.org/nurse-practitioner-job-outlook.html (stating that nurse practitioners "are one of the fastest-growing careers in the United States").

[86] Tenn. Comp. R. & Regs. 0940-05-18.04.

[87] *Id.* (noting that Tennessee has an example of this type of medical staffing flexibility).

community response, states must allow both law enforcement and EMS to refer patients to crisis stabilization facilities.[88] Finally, states should allow for crisis stabilization facilities to accept minors, or for the establishment of minor-specific facilities.[89] For example, Illinois does not allow minors to be admitted to a crisis stabilization facility, but Colorado has crisis stabilization services specifically for individuals under eighteen years old.[90] Ultimately, communities should conduct surveys and evaluate local demographics to determine what types of services are necessary and could best serve the area, and state law should provide flexibility for communities to serve that purpose.[91]

VI. CONCLUSION

Crisis stabilization models provide states with an alternative approach to acute psychiatric care by promoting care coordination between multidisciplinary staff.[92] This approach provides better treatment and care while also reducing the number of individuals experiencing a mental health

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[88] SAMHSA Toolkit, *supra* note 30, at 34; Katie McKeller, *State Poised for 'Monumental' Shift in the Handling of Mentally Ill, Lawmakers Say*, DESERET NEWS (Mar. 14, 2020, 8:44 PM), https://www.deseret.com/utah/2020/3/14/21178368/utah-crisis-centers-suicide-prevention-mental-health-funded (describing an example of crisis centers in Utah making "a difference in communities and to the lives of people experiencing mental illness, their families, and local law enforcement agencies").

[89] *See* M. Reinert et al., *The State of Mental Health in America 2021*, MENTAL HEALTH AM. 29 (2020), https://mhanational.org/sites/default/files/2021%20State%20of%20Mental%20Health%20in%20America_0.pdf (reporting that "less than 1 in 3 youth with severe depression" receive some consistent treatment); *see also Workforce Issues*, AM. ACAD. OF CHILD AND ADOLESCENT PSYCHIATRY (Apr. 2019), https://www.aacap.org//aacap/resources_for_primary_care/Workforce_Issues.aspx (stating that "there are approximately 8,300 practicing child and adolescent psychiatrists in the US and over 15 million children and adolescents in need of the special expertise of a child and adolescent psychiatrist" as of 2019, indicating a lack of access and resources for minors experiencing mental health issues).

[90] Ill. Admin. Code tit. 77 § 380.310(e)(1) (2021); *Meeting the Need Through Creativity and Growth*, JEFFERSON HILLS, https://jeffersonhills.org/About (last visited Feb. 8, 2022) (providing an example of a youth crisis stabilization center in Colorado).

[91] SAMSHA Toolkit, *supra* note 30, at 13.

[92] Saxon et al., *supra* note 2, at 23-25.

crisis in the ED or criminal justice system.[93] Amending federal and state laws that impede crisis stabilization models will increase access to crisis stabilization services, decrease healthcare costs for the patient and federal healthcare spending, and reduce disparities in mental healthcare.[94] Federal law can better accommodate crisis stabilization services through the amendment of EMTALA to recognize the benefits of community-based mental health care. Across the U.S., states should amend or ratify laws that address current statutory barriers to crisis stabilization, including admission of intoxicated individuals and minors, more practical staff requirements, expanded nurse practitioner scope of practice, and improved collaboration with EMS and law enforcement. Expanding access and service availability through crisis stabilization models can benefit both individuals in the midst of a mental health crisis and the community as a whole.

[93] *Id.*
[94] Saxon et al., *supra* note 2, at 24; Shim et al., *supra* note 6.

Telemental Health Care and Data Privacy: Current HIPAA Privacy Pitfalls and a Proposed Solution

Charlotte Kurzweil

I. INTRODUCTION

Telehealth and home-based care have existed in some form or another for much longer than many people suspect.[1] One of the earliest mentions of home-based care that we today might define as telehealth or telemedicine appeared in an 1879 article discussing "using the telephone to reduce unnecessary office visits."[2] Other historical evidence points to a decades-long practice of community health aides in Alaska performing tests and sending away the results to specialists to determine whether specialist treatment is needed.[3] There are numerous other examples, but the result is that with advances in technology, telemedicine will continue to afford opportunities for better, more efficient and effective care.[4] For purposes of this article, "telemedicine" is defined as remote clinical services. "Telehealth" encompasses remote healthcare initiatives, including administrative activities and continuing medical education, as well as remote clinical services.

The growth in use of telehealth has led to an increase in telemental health services, though its incorporation into health care practices was not truly accepted until the COVID-19 pandemic.[5] "Telemental health" in this article means remote clinical services for mental health treatment. To illustrate such growth, consider usage of telemental health care which increased among

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[1] *See* TRACY A. LUSTIG, THE ROLE OF TELEHEALTH IN AN EVOLVING HEALTH CARE ENVIRONMENT: WORKSHOP SUMMARY 11 (2012) (describing the history and evolution of home-based care and how it has expanded to include telehealth).
[2] *Id.*
[3] *Id.* at 12–13.
[4] *Id.* at 9.
[5] Samantha L. Connolly et al., *Rapid Increase in Telemental Health Within the Department of Veterans Affairs During the COVID-19 Pandemic*, 27 TELEMEDICINE AND E-HEALTH 454, 455 (Apr. 2021) (examining the VA's early response to the COVID-19 pandemic and the 556% growth in telemental health visits between March 11, 2020, and April 22, 2020).

rural Medicare beneficiaries with mental illnesses between 2004 and 2014.[6] However, even with the expansion occurring, up until recently psychotherapists spent only an estimated ten percent of their time on telemental health.[7] Experts remain unclear as to the primary factors driving growth, but some trends show that age, income, geography, and state payment parity laws may affect telemental health use.[8] The COVID-19 pandemic tremendously accelerated growth.[9]

As a response to the COVID-19 pandemic, many disciplines of the healthcare system found themselves moving in-person patient visits to a remote format as a means of facilitating social distancing.[10] One of those disciplines was mental health.[11] Although telemental health is beneficial for patients due to the ease of access and ability to see providers even when out of state, its expansion raises serious questions regarding patient and data privacy under the Health Insurance Portability and Accountability Act (HIPAA).[12] HIPAA seeks to protect patients' privacy by regulating paper, electronic, and oral forms of patients' protected health information (PHI).[13] The federal government temporarily relaxed its enforcement of HIPAA in use of

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[6] Ateev Mehrotra, et al., *Rapid Growth In Mental Health Telemedicine Use Among Rural Medicare Beneficiaries, Wide Variation Across States*, 36 HEALTH AFFS. 909, 914 (May 2017).
[7] Emil Chiauzzi, et al., *Videoconferencing-Based Telemental Health: Important Questions for the COVID-19 Era from Clinical and Patient-Centered Perspectives*, 2 JMIR MENTAL HEALTH (Dec. 2020).
[8] Mehrotra, *supra* note 6, at 912–13.
[9] H. Paul Chin & Guillermo Palchik, *Telepsychiatry in the Age of COVID: Some Ethical Considerations*, 30 CAMBRIDGE Q. OF HEALTHCARE ETHICS 37, 37 (2021).
[10] Chiauzzi et al., *supra* note 7.
[11] Connolly et al., *supra* note 5, at 454.
[12] Timothy M. Hale & Joseph C. Kvedar, *Privacy and Security Concerns in Telehealth*, 16 AMA J. OF ETHICS 981, 982 (Dec. 2014).
[13] OCR, *Summary of the HIPAA Privacy Rule*, U.S. DEPT. OF HEALTH & HUM. SERVS. (July 26, 2013) https://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html.

telemental health platforms in an effort to encourage participation in virtual care.[14] However, more clarity for providers and for patients regarding HIPAA enforcement is necessary when the government reinstates regulations. Such guidance will prove instrumental to navigating the evolving health care landscape.

This article will explore the nature of patient and provider interactions with remote video and audio providers such as FaceTime®, Zoom®, Skype™, and other platforms commonly used for telemental health services during the pandemic. It will argue that, under HIPAA, companies who provide remote video and audio communication services between HIPAA covered providers and patients for telemental health care purposes must be considered business associates and therefore be required under HIPAA to sign a business associate agreement (hereinafter a "BAA") with privacy and notification of breach provisions. Second, it will explore new legislation enacted in several states and the European Union to protect personal data and how that legislation may guide amendments to the HIPAA Privacy and Security Rules. Finally, the article will propose that the HIPAA Privacy and Security Rules be expanded to provide increased privacy and security protections while maintaining the increased access to telemental health achieved during the pandemic and will put forward three provisions for expansion.

[14] Chiauzzi et al., *supra* note 7.

II. PRIVACY AND SECURITY RISKS UNIQUE TO TELEMENTAL HEALTH

Communication technologies such as FaceTime®, Zoom®, and Skype™ become telehealth devices when they are used to communicate health care information from a patient's phone or computer over a network to a provider.[15] Current HIPAA regulations and other laws do not provide enough privacy coverage for patients relying on telehealth, especially those accessing telemental health services via videoconferencing platforms.[16] Nor do patients have any right or capabilities to access information stored by apps they use for telemental health services.[17] Further, "[s]martphone apps may share sensitive data—such as sensor data on location—with advertisers and other third parties in ways not anticipated by users" which poses problems for telemental health patients who expect confidentiality.[18] Currently, there is little to stop platforms used for telemental health care from using health information that would ordinarily come under protection during in-person visits to, for example, generate revenue from targeted ads.[19] The only measure HIPAA currently takes to prevent security and privacy issues in telemental health is requiring that "identifiable health information be encrypted."[20] Even that regulation is limited, though, as HIPAA applies only to covered

[15] Joseph L. Hall & Devin McGraw, *For Telehealth to Succeed, Privacy and Security Risks Must Be Identified and Addressed*, 33 HEALTH AFFS. 216, 216 (Feb. 2014).
[16] *Id.* at 217.
[17] *Id.*
[18] Hale & Kvedar, *supra* note 12, at 981.
[19] Hall & McGraw, *supra* note 15, at 217.
[20] *Id.*

entities and their business associates.[21] That means that any telemental health encounter not using a platform hosted by an entity that is considered a business associate is missing even the protection offered by HIPAA's encryption requirement.

The COVID-19 pandemic further complicated matters regarding telemental health privacy and security. The Office of Civil Rights (OCR), within the Department of Health and Human Services (HHS), is responsible for enforcing the HIPAA Privacy, Security, and Breach Notification Rules (the "HIPAA Rules").[22] During the pandemic, the OCR is exercising its "enforcement discretion and will not impose penalties for noncompliance with the regulatory requirements under the HIPAA Rules against covered health care providers in connection with the good faith provision of telehealth."[23] By declining to enforce the HIPAA Rules, though, the OCR is removing even the narrow protection given by the encryption requirement.[24] While this rule may have originally encouraged the

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[21] *Id.* at 218; *see generally* OCR, *Covered Entities and Business Associates*, U.S. DEPT. OF HEALTH & HUM. SERVS., (June 16, 2017), https://www.hhs.gov/hipaa/for-professionals/covered-entities/index.html (defining that for HIPAA purposes, covered entities include health care providers, health plans, and health care clearinghouses. Business associates are engaged to help covered entities carry out health care activities and functions).
[22] OCR, *Notification of Enforcement Discretion for Telehealth Remote Communications During the COVID-19 Nationwide Public Health Emergency*, U.S. DEPT. OF HEALTH & HUM. SERVS. (Jan. 20, 2021), https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html; *see generally* OCR, *Summary of the HIPAA Privacy Rule*, U.S. DEPT. OF HEALTH & HUM. SERVS. (July 26, 2013), https://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html (stating some requirements the Privacy Rules impose include, but are not limited to: developing and implementing written policies and procedures consistent with the Privacy Rule, designating privacy personnel, training management and workforce personnel on privacy policies and procedures, development and maintenance of safeguards to prevent misuse or improper disclosure of PHI, and mitigation of harmful effects of violations of the Privacy Rules).
[23] OCR, *Notification of Enforcement Discretion for Telehealth Remote Communications During the COVID-19 Nationwide Public Health Emergency*, *supra* note 22.
[24] *See* Chiauzzi et al., *supra* note 7 (discussing the privacy implications of loosening federal and state regulations on videoconferencing-based telemental health post-COVID-19).

widespread use of telemental health as an alternative to in-person care at the beginning of the pandemic, continued non-enforcement leaves patients vulnerable and gives no guidance to providers on privacy and security expectations once the pandemic ends.[25]

Ensuring privacy in telemental health is arguably even more important because of the historical stigma surrounding mental illness.[26] That stigma is present and often reinforced through patients' daily lives, including the devices they turned to during the pandemic to receive treatment.[27] Working around the stigma and protecting patients' privacy so as not to worsen its effects requires facing challenges regarding "informed consent, confidentiality, technological and clinical competence" and will require coordination across jurisdictions.[28] It is therefore necessary for HHS to expand the scope of HIPAA to cover companies that provide videoconferencing platforms used for telemental health treatment.

III. PROPOSAL TO CONSIDER COMPANIES PROVIDING VIDEO- AND AUDIO-CONFERENCING PLATFORMS USED BY MENTAL HEALTH PROVIDERS BUSINESS ASSOCIATES UNDER HIPAA

The Department of Health and Human Services defines a "business associate" as an entity that "[c]reates, receives, maintains, or transmits protected health information" to perform certain functions or activities on behalf of a covered entity or provides "legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or

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[25] *Id.*
[26] Jennifer R. Flynn, *Break the Internet, Break the Stigma: The Promise of Emerging Technology & Media in Mental Health*, 20 QUINNIPIAC HEATH L. J. 1, 11 (2017).
[27] *See id.* at 17, 23–25 (discussing the potential for positive impact of developing technology and the legal and ethical pitfalls of mismanaging the incorporation of advancing technology when considered in conjunction with the prevalence of the internet and investment by the media in that technology).
[28] *Id.* at 24.

financial services to or for" a covered entity.[29] Business associates are required to sign a BAA with the covered entity with which they are associated.[30] Such agreements address the scope of protected health information the business associate can access, what to do in the event of a breach, required employee training, et cetera.[31] Currently, whether an entity that provides telemental health technology is a business associate under HIPAA "depends on whose interests are being served by the technology."[32] That consideration triggers a number of different questions, but continues to leave patients vulnerable should the platform they use avoid classification as a business associate.[33]

As a case study, consider Apple and Skype (both consumer Skype and Skype for Business – now Microsoft Teams) as examples of companies whose technology saw increased usage during the pandemic for telemental health purposes.[34] Both companies spark debate about qualification as a HIPAA business associate "due to the 'mere conduit' rule, which states that a company is exempt from being a business associate if: It only transmits PHI

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[29] 45 CFR § 160.103; *see also* Center for Connected Health Policy, *HIPAA and Telehealth*, THE NAT'L TELEHEALTH POL'Y RESOURCE CTR., (accessed Apr. 12, 2022), https://cdn.cchpca.org/files/2018-09/HIPAA%20and%20Telehealth.pdf (providing an overview of covered entities and business associates).

[30] Center for Connected Health Policy, *HIPAA and Telehealth*, THE NAT'L TELEHEALTH POL'Y RESOURCE CTR., (accessed Apr. 12, 2022), https://cdn.cchpca.org/files/2018-09/HIPAA%20and%20Telehealth.pdf.

[31] *What is a HIPAA Business Associate? Partners in Compliance*, ACCOUNTABLE (July 6, 2020) https://www.accountablehq.com/post/what-is-a-business-associate.

[32] *See* Hall & McGraw, *supra* note 15, at 218 (explaining that whose interests are served by technology requires asking questions such as who benefits from the technology, who provides the technology to a patient, who benefits, and who controls the information generated by the technology).

[33] *Id.*

[34] Kirsty Watson, *Is Apple Facetime a HIPAA Compliant Telehealth Software Platform?*, BRIDGE (Sept. 30, 2020) https://www.bridgepatientportal.com/blog/Is-Apple-FaceTime-a-HIPAA-Compliant-Telehealth-Software-Platform/; Blake Rodocker, *Is Skype HIPAA Compliant?*, BRIDGE (July 12, 2017) https://www.bridgepatientportal.com/blog/skype-hipaa-compliant/.

in an encrypted format [and] it never has access to the encryption key."[35] Apple currently refuses to sign a BAA,[36] though it should be considered a business associate.[37] As a cloud service provider ("CSP"), Apple and FaceTime provide cloud services to covered entities as business associates when patients use FaceTime to connect for telemental health services.[38] Those services involve "creating, receiving, or maintaining ePHI" and meet the "definition of a business associate, even if the CSP cannot view the ePHI."[39] Skype and Microsoft Teams offer two different security standards, and only Microsoft Teams includes a BAA as one of those elements.[40]

Allowing CSPs and other software providers to escape HIPAA compliance through the "conduit rule" poses two problems unless the HIPAA Rules are amended to consider them business associates. First, in the telemental health care field it will mean a downgrade in privacy for telemental health treatment compared to in-office visits because CSPs do not store PHI in a manner that is "transient."[41] Second, it may pose access issues for those who can't afford technology that supports software to integrate a HIPAA compliant conferencing option and therefore forego mental health treatment out of fear for their health information privacy.[42] "Options for

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[35] Blake Rodocker, *supra* note 34.
[36] Steve Alder, *Is FaceTime HIPAA Compliant?*, HIPAA J. (Sept. 19, 2021) https://www.hipaajournal.com/facetime-hipaa-compliant/ (following an extensive search of Apple's website reveals no indication that it is willing to sign a BAA, and in fact advises that services like iCloud should not be used for activities involving PHI).
[37] Kirsty Watson, *supra* note 34.
[38] *Id.*
[39] *Id.*
[40] Rodocker, *supra* note 34.
[41] *See* Steve Alder, *supra* note 36 (explaining that the OCR has specified on its website that CSPs are not generally considered conduits because, regardless of whether the CSP can access the PHI, it is not merely transmitting the information, but storing it).
[42] *See HIPAA Guidelines on Telemedicine*, HIPAA J. (last visited Apr. 12, 2022) https://www.hipaajournal.com/hipaa-guidelines-on-telemedicine/ (explaining that, if patients and providers want a HIPAA compliant telehealth service, access issues include price of

physicians who want to provide a HIPAA compliant telehealth service for patients . . . tend to be both complicated and expensive."[43] Microsoft Teams, for example, requires that both patient and provider have a Microsoft Office365 account to access the service and charges a monthly fee.[44] Less expensive options offer poorer quality, which affects providers' ability to diagnose without an in-person visit.[45]

Therefore, HHS should amend HIPAA (and its accompanying act, Health Information Technology for Economic and Clinical Health Act – HITECH, enforced by the Federal Trade Commission) to create a mandatory business associate designation for CSPs and software providers commonly used for telemental health and telehealth services. HITECH gives HHS "authority to establish programs to improve health care quality, safety, and efficiency through the promotion of health IT, including electronic health records and private and secure electronic health information exchange."[46] A business associate designation would require those companies to implement universal business associate agreements providing, among other things, (1) enhanced compliance officer responsibilities, (2) a procedure for patients to inspect or request a copy of the information or records created and/or stored by the business associate during a session, and (3) procedures to allow patients greater control over the use of their health data.

compliant services, quality, and broadband bandwidth issues if other applications are running in the background).

[43] *Id.*

[44] *Id.*

[45] *Id.*

[46] *Health IT Legislation*, OFF. OF THE NAT'L COORDINATOR FOR HEALTH INFO. TECH., (June 8, 2021), https://www.healthit.gov/topic/laws-regulation-and-policy/health-it-legislation.

IV. JURISDICTIONS WITH STRICTER PRIVACY AND SECURITY LAWS AS A MODEL FOR HIPAA/HITECH AMENDMENT

A few states have passed enhanced protection laws beyond HIPAA, including California, Colorado, and Virginia,[47] which should stand as models for a HIPAA/HITECH amendment. Those laws provide additional provisions for protections including "opt-out options for consumers who do not wish for their information to be sold to third parties as well as more detailed disclosure of how consumer data is used to promote transparency and understanding by consumers," vastly broader definitions of who is a covered entity, and more strict timeframes for breach notifications.[48] Looking farther afield, the European Union recently implemented the EU General Data Protection Regulation ("GDPR"), similar to HIPAA but with a focus on "data, technology, cloud-based applications and third-party access to data."[49] The GDPR covers all organizations that target or collect the data of individuals in the EU, regardless of where the organization is located.[50]

The California Consumer Privacy Act (CCPA) sets out four new rights for residents of California; the right to (1) know about personal information a business collects, (2) delete personal information collected, (3) opt out of sale of personal information, and (4) nondiscrimination for using rights under the CCPA.[51] Unfortunately, the CCPA only applies to for-profit businesses with

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[47] Kim Theodos & Scott Sittig, *Health Information Privacy Laws in the Digital Age: HIPAA Doesn't Apply*, 18 PERSPECT. HEALTH INF. MANAG. (2021).
[48] *Id.*
[49] *Id.* at 5.
[50] Ben Wolford, *What is GDPR, the EU's new data protection law?*, GDPR.EU, (last visited Apr. 12, 2022), https://gdpr.eu/what-is-gdpr/.
[51] Rob Bonta, *California Consumer Privacy Act (CCPA)*, STATE OF CA DEPT. OF JUST., (last visited Apr. 12, 2022), https://oag.ca.gov/privacy/ccpa.

a certain minimum yearly revenue and that receive at least fifty percent of annual revenue from selling personal information.[52]

The Colorado Privacy Act (CPA) passed in July 2021 and will take effect in 2023.[53] The Act borrows from the CCPA, Virginia's Consumer Data Protection Act ("VCDPA"), and the GDPR.[54] It contains similar measures for residents of Colorado to (1) opt out of personal data processing, (2) control who has access to their data and to access said data themselves, (3) facilitate deletion of their data or correct inaccuracies, and (4) obtain copies of their data in portable format to send to other entities.[55] The CPA has similar thresholds for applicability as seen in the CCPA, but does not have a minimum revenue threshold at all.[56] Among the CCPA, CPA, VCDPA, and GDPR, only the GDPR provides a provision for citizens to recover damages.[57] Unfortunately, none of the privacy laws passed in California, Colorado, or Virginia apply to protected health information or other health care information.[58]

The GDPR provides more comprehensive protection compared to the above state laws, prohibiting processing of special categories of personal data, and includes health data as a special category of personal data.[59] Data subjects may still give explicit consent for health data processing unless a

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[52] *Id.*
[53] Cynthia J. Larose & Christopher J. Buontempo, *And Now There are Three …. The Colorado Privacy Act*, NAT'L L. REV., (July 16, 2021), https://www.natlawreview.com/article/and-now-there-are-three-colorado-privacy-act.
[54] *Id.*
[55] *Id.*
[56] *Id.*
[57] Wolford, *supra* note 50.
[58] *Id.*
[59] *Art. 9 GDPR Processing of Special Categories of Personal Data*, GDPR.EU, (last visited Apr. 12, 2022), https://gdpr.eu/article-9-processing-special-categories-of-personal-data-prohibited/.

Member State or Union law otherwise prohibits lifting such protection.[60] The GDPR also requires those entities that focus on data processing as a core activity for a special category, like health data, to appoint a Data Protection Officer ("DPO") whose job tasks are set forth by the GDPR, not the organization for which the DPO works.[61]

A Data Protection Officer's primary duty is to use specialized knowledge of data and privacy practices to involve themselves in all issues of data protection.[62] This means the DPO must have expert knowledge of privacy laws in every jurisdiction in which the organization operates, as well.[63] In contrast, while HIPAA requires that covered entities appoint a Compliance Officer, HIPAA leaves the decision of job duties to the individual covered entity or business associate.[64] Additionally, there are no specific qualifications listed for a Compliance Officer's level of education or experience, and the Officer does not have the same protection from organizational oversight or interference afforded to a DPO.[65] In light of the benefits for patients that come with stricter privacy protection laws, an amendment to the HIPAA Privacy and Security Rules and HITECH should take guidance from the new legislation discussed above.

V. PROPOSAL FOR EXPANDING HIPAA RULES

If the proposal to expand the definition of business associate is to have any meaningful effect, HHS must also expand the HIPAA Privacy, Security, and

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[60] *Id*.
[61] Wolford, *supra* note 50.
[62] Ben Wolford, *Everything You Need to Know About the GPDR Data Protection Officer (DPO)*, GDPR.EU (last visited Apr. 12, 2022), https://gdpr.eu/data-protection-officer/.
[63] *Id.*
[64] *What are the Duties of a HIPAA Compliance Officer?*, HIPAA J. (last visited Apr. 12, 2022), https://www.hipaajournal.com/duties-of-a-hipaa-compliance-officer/.
[65] *Id.*

Breach Notification Rules using similar methods utilized in the CCPA, CPA, VCDPA, and the GDPR. Specifically, HHS must enact provisions to (1) allow patients greater control of PHI transferred using telemental health software, including requiring business associates to allow patients to opt-out of any data sales, even if that information is de-identified; (2) require business associates which provide video- or audio-conferencing platforms for telemental health services to send breach notifications directly to affected patients within the same sixty-day period already required for the business associate to notify covered entities;[66] and (3) establish a concrete list of duties for organizational Compliance Officers, including recommendations for education and experience, and mandating that the Officer is protected from employer interference in the execution of their job.

Allowing patients greater control over how their health information is used provides (1) increased trust and confidence in the covered entities and business associates which provide telemental health services, and (2) a step toward addressing the privacy concerns over the lack of controls or limits on how patients' sensitive information is used.[67] Without both of these benefits for patients, the health care system will have greater difficulty realizing telehealth and telemental health's true positive potential post-COVID-19.[68]

Requiring business associates who provide audio- and video-conferencing platforms to provide notice of security breaches directly to patients as well as to the covered entities with which they have BAAs will give patients more control over their health information. This is important because unlike some other business associates that provide services only to the covered entity,

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[66] *See* OCR, *Breach Notification Rule*, U.S. DEPT. OF HEALTH & HUM. SERVS. (July 26, 2013) https://www.hhs.gov/hipaa/for-professionals/breach-notification/index.html (defining breach notification and explaining HIPAA requirements and guidance); 45 CFR §§ 164.400–414.
[67] Hall & McGraw, *supra* note 15 at 216–17.
[68] *Id.*

those that provide conferencing platforms are in direct contact with the patients themselves. Finally, this requirement helps close the gap between HIPAA/HITECH and the FTC's Health Breach Notification Rule, which governs only non-HIPAA third party service providers.[69]

Indeed, while HIPAA does require that organizations have a Compliance Officer, the job designation falls short compared to the DPO appointment required by the GDPR. Instituting the recommendations above for the Compliance Officer position increases the level of expertise the officer must have regarding both state privacy laws and HIPAA. Granting independence from the organization's control over job duties shifts the Compliance Officer's focus from protecting just the organization against liability to protecting both the organization *and* the patients whose information the organization handles.

In summary, these three expansion provisions will make progress toward addressing privacy concerns associated with telemental health care in the months and years following the COVID-19 pandemic and a continuously evolving health care landscape. The provisions will reduce uncertainty for providers, covered entities, and business associates when dealing with telemental health privacy related questions in the future, and can be adapted to account for new types of technology, software, and other patient-facing modalities. Patients will feel more comfortable accessing mental health care through virtual visits knowing they have greater control over their personal health information and data.[70]

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[69] Health Breach Notification Rule, 16 C.F.R. pt. 318 (2009).

[70] *See generally* Sharyl J. Nass et al., *Beyond the HIPAA Privacy Rule: Enhancing Privacy, Improving Health Through Research*, NAT'L ACADS. PRESS 75–104, (2009) (discussing studies regarding patient access to their medical records after HIPAA, continued concerns over the improvement of their access, and benefits of access such as better doctor-patient coordination, patient empowerment, and patient education).

VI. CONCLUSION

With advances in technology and increased use of telemental health services resulting from the COVID-19 pandemic,[71] new solutions are necessary to ensure that patients and providers feel comfortable continuing to use telemental health as an equally viable treatment option in addition to in-person visits. To facilitate access, confidentiality, and continued patient-provider relationships, HHS must expand its definition of business associate to include cloud service providers and software providers whose products are commonly used in telemental health treatment. HHS must also amend current regulatory laws to include provisions that give patients greater control over their health data, expand the role and independence of HIPAA Compliance Officers, and expand security breach notification requirements. Making these changes to better protect patients' privacy will better prepare the United States to successfully adapt to an evolving health care system.

[71] Chiauzzi et al., *supra* note 7.

The Pressing Need for Mental Health Parity Law Reform Amid the COVID-19 Pandemic

Elliana Lenz

I. INTRODUCTION

The COVID-19 pandemic and resulting economic recession adversely impacted many individuals' mental health.[1] In January 2019, prior to the pandemic, one in ten adults reported symptoms of depression and anxiety.[2] During the pandemic, however, mental health concerns have grown significantly, and this statistic has jumped to four in ten people reporting the same or worsened symptoms.[3] Since history has shown that the mental health impact of disasters outlasts its physical impact, these COVID-19-related mental health issues may carry long-term, deleterious repercussions.[4]

Although mental health care would traditionally serve as an effective solution to treat these mental health issues, inadequate health insurance is often cited as a top barrier that individuals face when trying to obtain mental health care.[5] Health insurance companies, however, possess immense control over the adequacy of health insurance because many insurers are not legally obligated to cover mental health care,[6] and those that do provide such care can set restrictive "medical necessity" standards that limit the types of

[1] *See* Chris Berdik, *Shock to the System*, HARV. PUB. HEALTH (2021), https://www.hsph.harvard.edu/magazine/magazine_article/shock-to-the-system/ (describing emerging research that displays an alarming uptick in self-reported depression symptoms compared to before the pandemic).
[2] Nirmita Panchal et al., *The Implications of COVID-19 for Mental Health and Substance Use*, KFF (Feb. 10, 2021), https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/.
[3] *Id.*
[4] *Id.*
[5] Kathleen Rowan et al., *Access and Cost Barriers to Mental Health Care by Insurance Status, 1999-2010*, 32 HEALTH AFFAIRS (Oct. 2013).
[6] *Does Your Insurance Cover Mental Health Services?*, AM. PSYCH. ASS'N, https://www.apa.org/topics/managed-care-insurance/parity-guide (Oct. 10, 2019) (explaining how pertinent federal parity laws only apply to large group health plans and insurers that choose to include mental health and substance use disorder benefits in their packages).

mental health care services that are reimbursed.[7] Therefore, the health insurance industry has a critical role to play in combating the mental health issues that plague millions of Americans today by helping the United States achieve mental health parity. When a health insurance plan has mental health parity, "conditions that share the same characteristics are treated in the same way."[8]

Mental health parity is particularly observed through both coverage and reimbursement (also known as "payment") parity. Coverage parity exists when health insurers cover the same amount of mental health care as the plan provides for medical and surgical care.[9] Similarly, reimbursement parity occurs when health insurance plans compensate health care professionals at the same rate for the same service irrespective of whether the service was performed remotely or in-person.[10] Therefore, to achieve mental health parity, state and federal actors should amend existing mental health parity laws to include more mental health services and in-network providers, fairly compensate mental health professionals, and impose effective parity law enforcement mechanisms.

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[7] *See* '*Mental Health Parity' Is Still An Elusive Goal In U.S. Insurance Coverage*, NPR.ORG (June 7, 2019), https://www.npr.org/sections/health-shots/2019/06/07/730404539/mental-health-parity-is-still-an-elusive-goal-in-u-s-insurance-coverage (describing how insurance companies interpret mental health claims more stringently than those for physical illness and circumvent mental health parity mandates by imposing restrictive standards of medical necessity, and in observed in cases like the U.S. District Court for the Northern District of California's ruling that United Behavioral Health wrote its guidelines for treatment more narrowly than common medical standards to only cover enough care to stabilize patients).
[8] MEGAN DOUGLAS, ET AL., WHAT IS MENTAL HEALTH PARITY? A CONSUMER GUIDE TO THE EVALUATING STATE MENTAL HEALTH ADDICTION AND PARITY STATUTES REPORT 1 (2018).
[9] *See The Mental Health Parity and Addiction Equity Act (MHPAEA)*, CMS.GOV, https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet (last visited Feb. 9, 2022) (explaining that if a health insurance coverage includes physical health benefits and mental health benefits, the financial requirements that apply to mental health benefits must be no more restrictive than the predominant financial requirements that apply to substantially all physical health benefits) [hereinafter "CMS.GOV"].
[10] *Parity*, CCHP, https://www.cchpca.org/topic/parity/ (last visited Feb. 9, 2022).

First, this paper will explore the nature of health insurance and the different types of public and private health insurance offered in the United States. Next, this paper will address federal and state parity laws and areas for reform including mandated network adequacy standards, coverage and reimbursement parity, and stronger enforcement mechanisms. Finally, this paper will posit that to ameliorate the mental health issues exacerbated by the COVID-19 pandemic, state and federal actors must hold the United States health insurance sector accountable by amending present parity laws via the proposed areas for reform.

II. THE EVOLUTION OF HEALTH INSURANCE

A. What is Health Insurance?

Health insurance is a contract between an insurer and policyholder that requires an insurer to pay for some or all of an individual's health care costs in exchange for a set premium.[11] The amount the insurer pays typically depends on how much the policyholder pays via a monthly premium and other costs set within the policy, including copays, deductibles, or coinsurance.[12] Health insurance covers various health care services, including medical procedures, treatments, surgeries, and prescription drugs.[13] Health insurance also protects individuals from high, unexpected costs by providing financial protection when illness ensues.[14] In particular, by collecting premiums from various enrollees—most of which are healthy and typically maintain low health care expenses—health insurance companies

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[11] Julia Kagan, *What is Health Insurance?* INVESTOPEDIA, https://www.investopedia.com/terms/h/healthinsurance.asp (Mar. 6, 2022).
[12] *What is Health Insurance*? HEALTHINSURANCE.ORG, https://www.healthinsurance.org/glossary/health-insurance/ (last visited Feb. 9, 2022).
[13] Kagan, *supra* note 11.
[14] *3 Reasons to Enroll in 2019 Marketplace Coverage*, HEALTHCARE.GOV BLOG (Nov. 21, 2018), https://www.healthcare.gov/blog/reasons-to-enroll-2019-health-insurance/.

share the risk by covering health care costs for sick individuals.[15] Although this reduces health care costs for individuals, it also gives insurance companies immense bargaining power with providers.[16]

B. Types of Public and Private Health Insurance

In the United States, individuals have different public and private health insurance options. Public health insurance plans include Medicare, which is the federal health insurance program for individuals that are sixty-five or older, certain younger individuals with disabilities, and those with end-stage renal disease.[17] Medicaid is another type of public health insurance that provides coverage to eligible low-income adults, children, pregnant women, and individuals with disabilities.[18] CHIP—the State Children's Health Insurance Program—stands as another dominant public health insurance plan that provides low-cost health coverage to children whose families earn too much money to qualify for Medicaid, but not enough to afford private health insurance.[19] Conversely, private health insurance is offered to individuals for purchase by private health insurance companies.[20] Dominant private health insurance companies include Aetna, Anthem, Blue Cross Blue Shield, CIGNA, Humana, and United Health.[21] Private health insurance also

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[15] *How U.S. Health Insurance Works*, STANFORD VADEN HEALTH SERVS., https://vaden.stanford.edu/insurance/health-insurance-overview/how-us-health-insurance-works (last visited Feb. 9, 2022).
[16] Eric T. Roberts et al., *Market Share Matters: Evidence of Insurer and Provider Bargaining Over Prices*, *36* HEALTHAFFAIRS 141, 146 (2017).
[17] *What's Medicare?*, MEDICARE.GOV, https://www.medicare.gov/what-medicare-covers/your-medicare-coverage-choices/whats-medicare (last visited Feb. 9, 2022).
[18] *Medicaid*, MEDICAID.GOV, https://www.medicaid.gov/medicaid/index.html (last visited Feb. 9, 2022).
[19] Children's Health Insurance Program (CHIP), HEALTHCARE.GOV, https://www.healthcare.gov/glossary/childrens-health-insurance-program-chip/ (last visited Feb. 9, 2022).
[20] *Id*.
[21] Elizabeth Walker, *Top 25 Health Insurance Companies in the U.S.*, PEOPLEKEEP. (Sept. 27, 2021), https://www.peoplekeep.com/blog/top-25-health-insurance-companies-in-the-u.s.

includes health plans provided through an employer or union, some of which may be negotiated with the aforementioned private insurance companies.[22]

III. HEALTH INSURANCE: MENTAL HEALTH COVERAGE

A. Federal and State Parity Laws

Historically, many insurance companies provided more comprehensive coverage for physical, rather than mental, illness.[23] Although this issue still exists, the enactment of two federal laws—namely, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (herein "the MHPAEA"), and the Patient Protection and Affordable Care Act (herein "the ACA")—attempted to confront this problem.[24] First, the MHPAEA requires insurance companies to provide comparable mental and physical health coverage.[25] This means that insurance companies must treat financial requirements for mental and physical health services equally, and insurers cannot impose annual or lifetime dollar limits on mental health benefits that are less favorable than any limits imposed upon medical and surgical benefits.[26] However, the MHPAEA only applies to large group health plans (companies with 50+ employees, Children's Health Insurance Program, most Medicaid programs, and coverage purchased through health insurance exchanges) and insurers that choose to include mental health and substance use disorder benefits in their packages.[27]

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[22] *Health Insurance Glossary*, U.S. CENSUS BUREAU, https://www.census.gov/topics/health/health-insurance/about/glossary.html (last visited Feb. 9, 2022).
[23] AM. PSYCH. ASS'N, *supra* note 6.
[24] *Id*.
[25] *Id*.
[26] *See* CMS.GOV, *supra* note 9.
[27] *Id*.; AM. PSYCH. ASS'N, *supra* note 6.

Subsequently, the ACA built upon the MHPAEA and expanded mental health coverage.[28] As of 2014, all new small group and individual market plans had to cover mental health services at parity with medical and surgical benefits.[29] Under the statute, mental health care qualifies as part of the "Essential Health Benefits" available to individuals via individual and small group markets.[30] However, some states—like Colorado and Illinois—have imposed more comprehensive and demanding parity laws.[31] For example: Colorado expanded federal parity law protections via Senate Bill 21-266, which requires health insurers to cover an annual mental health wellness examination performed by a qualified provider, comparable coverage to that of a physical examination, and not require any deductibles, copayments, or coinsurance.[32] Illinois also expanded federal parity law protections via Public Act 99-480 (herein "the Act"), which requires small employer fully insured plans and state government plans, in addition to the insurance plans covered by federal parity laws, to also offer coverage for reasonable and necessary treatment and services for mental, emotional, or nervous disorders or conditions.[33]

Moreover, for the disorders and conditions covered by these insurance policies, the Act stipulates that the insurer must pay the charges of any professional that the insured individual chooses as long as the professional is licensed pursuant to the Illinois Alcoholism and Other Drug Abuse and

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[28] Kirsten Beronio et al., *Affordable Care Act Expands Mental Health and Substance Use Disorder Benefits and Federal Parity Protections for 62 Million Americans*, ASPE (Feb. 19, 2013), https://aspe.hhs.gov/reports/affordable-care-act-expands-mental-health-substance-use-disorder-benefits-federal-parity-protections-0.
[29] *Id*.
[30] *Id*.
[31] *Mental Health and Addiction Parity in Illinois*, THE KENNEDY FORUM, https://thekennedyforumillinois.org/wp-content/uploads/2015/12/Summary-of-HB-1-Parity-Provisions.pdf (last visited Feb. 9, 2022); *Colorado Statutes: Parity Report*, PARITYTRACK, https://www.paritytrack.org/reports/colorado/statutes/ (last visited May 1, 2022).
[32] PARITYTRACK, *supra* note 31.
[33] THE KENNEDY FORUM, *supra* note 31.

Dependency Act and is authorized to provide said service.[34] Recognizing that compliance must be monitored in order to achieve true parity, the Act also requires the Department of Insurance to enforce state and federal parity law requirements and coordinate with mental health advocacy groups, healthcare insurance carriers, and mental health physician groups for the purpose of discussing treatment and coverage issues.[35]

IV. AREAS FOR REFORM

A. Redefine and Mandate Network Adequacy Standards

Although existing parity laws have made significant strides by broadening the coverage offered to policyholders, such laws still fail to account for issues surrounding network adequacy. Defined as "whether a plan has enough network providers to meet the needs of the plan's members in a geographic area,"[36] health insurance plans with inadequate provider networks render many MHPAEA and ACA benefits obsolete. Inadequate provider networks force plan members to travel far distances to see in-network providers, wait extensive periods of time before receiving necessary care, and pay high out-of-pocket costs to see professionals outside of their network.[37] For many individuals, in-network care is their only option since many health insurance plans come at the cost of high deductibles and premiums.

To participate in the Federally-facilitated Exchange as a qualified health plan (herein "QHP"), health insurance plans that use a provider network must

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[34] 215 ILCS 5/370c.1 (2021 State Bar Edition).
[35] THE KENNEDY FORUM, *supra* note 31.
[36] Guin Becker Bogusz, *Health Insurers Still Don't Adequately Cover Mental Health Treatment*, NAT'L ALL. ON MENTAL ILLNESS (Mar. 13, 2020), https://www.nami.org/Blogs/NAMI-Blog/March-2020/Health-Insurers-Still-Don-t-Adequately-Cover-Mental-Health-Treatment.
[37] *Id.*

satisfy minimum network adequacy standards.[38] The ACA requires each QHP to ensure that its provider network "maintains a network that is sufficient in number and types of providers, including providers that specialize in mental health…services, to assure all services will be accessible without delay.[39] However, the ACA does not expressly define the terms "sufficient" or "without delay."[40] Instead, guidance issued by the Centers for Medicare & Medicaid Services (herein "CMS") indicates that QHPs satisfy this requirement by simply contracting with at least thirty-five percent of available essential community providers (herein "ECPs") in each plan's service area to participate in the plan's provider network.[41] Accordingly, states maintain considerable flexibility to establish their own network adequacy standards.[42]

First, to account for these network inadequacies, the ACA should provide a numeric threshold for the terms "sufficient" or "without delay" by establishing empirically-based time, distance, and quality metrics that account for resource and other state-specific constraints. The ACA should also raise the percentage of ECPs that each health plan must contract with and mandate the inclusion of mental health treatment as an ECP category. Lastly, because these network adequacy requirements only apply to non-grandfathered health plans in the individual and small group markets,[43]

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[38] *Essential Community Providers and Network Adequacy,* CMS.GOV, https://www.qhpcertification.cms.gov/s/ECP%20and%20Network%20Adequacy (last visited Mar. 16, 2022).
[39] 45 C.F.R §156.230(a)(2) (2021).
[40] CMS.GOV, *supra* note 38.
[41] *Id*.
[42] *Network Adequacy: What Advocates Need to Know*, CMTY. CATALYST (Mar. 2016), https://www.communitycatalyst.org/resources/publications/document/Network-Adequacy_what-advocates-need-to-know_Update-in-process-FINAL-4-21-16.pdf.
[43] *Information on Essential Health Benefits (EHB) Benchmark Plans*, CMS.GOV, https://www.cms.gov/CCIIO/Resources/Data-Resources/ehb (last visited Feb. 9, 2022).

existing ACA network adequacy standards should be amended to include all health insurance plans that receive federal funding.

B. Coverage and Reimbursement Parity

State and federal actors should amend existing laws to mandate both coverage and provider reimbursement parity. Specifically, coverage parity requires insurers to cover the same amount of mental health care as the health plan provides for medical and surgical care.[44] Presently, parity laws do not require all health insurers to provide mental health benefits, so many insurers exclude certain mental illness diagnoses from health insurance coverage and refuse to cover additional treatments that do not fit within their definition of a "medically necessary" treatment or procedure.[45] Health insurance plans that fall within the scope of the ACA, however, must provide health insurance for all "essential health benefits," which includes mental health coverage.[46] Specifically, these plans must cover behavioral health treatment, such as psychotherapy and counseling, as well as mental and behavioral health inpatient services.[47]

Therefore, to move toward complete coverage parity, federal legislators must amend the ACA to broaden the range of mental health treatments that constitute "essential health benefits" and specifically include outpatient services. Government actors also must amend existing parity laws to expand the definition of "medically necessary" to include more empirically-based mental health treatment options, such as psychotherapy, cognitive behavioral group therapy, and other services. Additionally, state parity laws should

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[44] *See* CMS.GOV, *supra* note 9.
[45] AM. PSYCH. ASS'N, *supra* note 6.
[46] Beronio et al., *supra* note 28.
[47] *Mental Health & Substance Abuse Coverage*, HEALTHCARE.GOV, https://www.healthcare.gov/coverage/mental-health-substance-abuse-coverage/ (last visited Feb. 9, 2022).

require all health insurance plans to include mental health benefits and specify particular mental health treatment options that must be covered. If imposing the aforementioned mandates is infeasible, federal and state governments could incentivize the presently excluded health insurance plans to provide broader mental health service coverage via subsidization.

Reimbursement parity, however, traditionally focuses on payment disparities between health care services—predominantly, mental health care—rendered remotely versus in-person at a hospital, clinic, or office.[48] Since federal laws do not require reimbursement parity, mental health care professionals that provide remote services often are reimbursed at a lesser rate.[49] In addition to these reimbursement disparities, many insurance companies also have not increased reimbursement rates for psychologists.[50] Accordingly, since psychologists and other mental health providers maintain the autonomy to choose whether to accept a particular insurance, if they are not being appropriately reimbursed, many mental health professionals will refuse to accept such health insurance plans.[51] This issue, exacerbated by the existing mental health professional shortage,[52] has serious implications on mental health care accessibility in the United States. To address this problem, health insurers should increase mental health professional reimbursement rates and also compensate these providers at the same rate irrespective of whether the service is provided remotely or in-person.

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[48] *Parity*, *supra* note 10.
[49] *Mental Health Parity*, NAT'L ALL. ON MENTAL ILLNESS, https://www.nami.org/Advocacy/Policy-Priorities/Improving-Health/Mental-Health-Parity (last visited Apr. 9, 2022).
[50] AM. PSYCH. ASS'N, *supra* note 23.
[51] *Id*.
[52] Kaia Hubbard, *Many States Face Shortage of Mental Health Providers*, U.S. NEWS (June 10, 2021, 4:46 PM), https://www.usnews.com/news/best-states/articles/2021-06-10/northeastern-states-have-fewest-mental-health-provider-shortages.

Therefore, by amending parity laws to mandate mental health coverage, include more mental health conditions and treatments, and compensate mental healthcare providers at an appropriate rate, state and federal actors can make significant strides toward achieving coverage and reimbursement parity.

C. Implement Stronger Enforcement Mechanisms

In 2020, private health insurance was more prevalent than public health insurance.[53] Particularly, employment-based insurance was the most common subtype of private health insurance, covering 54.4% of the population.[54] In terms of parity law enforcement, this is problematic because the Department of Labor maintains no enforcement mechanisms against insurance companies that offer plans to employers that violate the MHPAEA.[55] To ensure compliance with coverage parity laws, Congressman Norcross sponsored the Parity Enforcement Act of 2021, which would amend the Employee Retirement Income Security Act (herein "ERISA") and give the Department of Labor the authority to investigate and levy monetary penalties against health insurers.[56] Although it was introduced in 2021, it has not been passed by the respective committee, so it has yet to advance to the House or Senate. [57] To push for this enforcement mechanism and legislative amendment, state actors should vocalize their support for this bill, and, if able, federal legislators should join as co-sponsors.

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[53] *Health Insurance Coverage in the United States: 2020*, U.S. CENSUS BUREAU (Sept. 14, 2021), https://www.census.gov/library/publications/2021/demo/p60-274.html.
[54] *Id*.
[55] *The Parity Enforcement Act of 2021*, U.S. CONGRESSMAN DONALD NORCROSS, https://norcross.house.gov/sites/norcross.house.gov/files/Parity%20Enforcement%20Act%20of%202021%20-one-pager.pdf (last visited Feb. 9, 2022).
[56] *Id*.
[57] *H.R. 1364: Parity Enforcement Act of 2021*, GOVTRACK (Feb. 25, 2021), https://www.govtrack.us/congress/bills/117/hr1364.

Because the MHPAEA allowed insurers that provided mental health coverage to not cover additional treatment that it did not find "medically necessary," in 2021, the Consolidated Appropriations Act amended the MHPAEA and imposed stricter "non-qualitative treatment limitations" ("NQTL").[58] In particular, it holds that a group health plan or health insurance issuer cannot impose NQTLs with respect to mental health benefits unless it can demonstrate that the underlying processes and standards are in parity with those used to determine the benefits provided for medical and surgical care.[59] Pursuant to the Department of Labor's discretion and supervision, the Employee Benefits Security Administration supervises and enforces group plan compliance with both Title I of ERISA and the MHPAEA.[60] Additionally, CMS monitors and enforces compliance with non-Federal governmental group health plans, such as those for employees of state and local governments.[61] For states that do not enforce the MHPAEA, CMS reviews health insurance policy forms prior to individual and group market products being offered for sale.[62] Considering the fiscal, resource, and time constraints that both the Employee Benefits Security Administration and CMS maintain, the federal government should allocate more funding to hire on and train more individuals tasked with auditing and

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[58] *Consolidated Appropriations Act of 2021, Division BB, Title II, Section 203- Mental Health Parity and Substance Use Disorder Benefits*, BLUE SHIELD OF CA, https://www.blueshieldca.com/bsca/bsc/public/broker/PortalComponents/StreamDocumentServlet?fileName=MHPAEA_FAQs_External.pdf (last visited Apr. 10, 2022).
[59] *FAQs About Mental Health and Substance Use Disorder Parity Implementation and the Consolidated Appropriations Act, 2021 Part 45*, U.S. DEPT. OF LABOR (Apr. 2, 2021), https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-45.pdf.
[60] *FY 2021 MHPAEA Enforcement*, U.S. DEPT. OF LABOR, https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/mhpaea-enforcement-2021.pdf (last visited Mar. 16, 2022).
[61] *Id*.
[62] *Id*.

enforcing such standards to ensure effective mental health parity-related compliance.

The Department of Labor also produced a self-compliance tool to assist administrators, group and individual market health insurance issuers, state regulators, and other parties to determine whether a plan complies with the MHPAEA amongst other Consolidated Appropriations Act requirements.[63] The self-compliance tool provides definitions of language within parity-related laws and regulations; outlines the classification applicability and financial and disclosure requirements; and provides examples of provider reimbursement rate warning signs.[64] Since some states have more expansive parity laws, and as other states implement more rigorous parity laws and regulations, producing similar self-compliance tools and guides for state-level laws and regulations would stand as a more passive, yet beneficial way to enforce such laws.

V. CONCLUSION

To ameliorate the mental health issues exacerbated by the COVID-19 pandemic, state and federal actors should amend present parity laws and mandate coverage parity via broader mental health services and more in-network providers, reimbursement parity via fair compensation for mental health professionals, and more effective parity law enforcement mechanisms. The social and economic reverberations that accompany the COVID-19 pandemic have produced serious mental health issues in the United States. There is uncertainty regarding when the pandemic will end, and irrespective of any purported timeline, the pandemic is bound to have a long-term impact

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[63] *Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (MHPAEA)*, U.S. DEPT. OF LABOR, https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/self-compliance-tool.pdf (last visited Feb. 9, 2022).
[64] *Id.*

on the mental health of many Americans. Accordingly, it is critical to respond to the mental illness issues plaguing the United States and ensure accessible health care. The health insurance industry historically and presently continues to levy its bargaining power in favor of its own financial success at the cost of many Americans receiving inadequate or no mental health coverage. Therefore, state and federal legislators should utilize their authority to hold such insurers accountable by imposing more stringent parity laws and regulations.

Mental Health Days for Students in Michigan Needed Now More than Ever

Ibtesam Mustafa

I. INTRODUCTION

The COVID-19 pandemic has affected many areas of life from public health and food systems to the workforce.[1] The pandemic has also adversely impacted the lives of students.[2] In an effort to reduce the spread of the virus, schools across the United States transitioned from in-person instruction to remote instruction.[3] By August 2020, nearly 93% of U.S. households with school-aged children engaged in distance learning due to the pandemic.[4] The disruptions to learning have caused students to fall behind.[5] According to a survey conducted by consulting firm McKinsey & Company, the pandemic has led K-12 students to fall four to five months behind in math and reading.[6] Statistics are not only showing students' academics falling behind, but they indicate that student mental health is on the decline as well. A Gallup poll conducted in May 2020 found that three in ten parents said social distancing and closures caused their child to experience harm to their emotional and

[1] Joint statement by Int'l Labor Org. [ILO], Food & Agric. Org. [FAO], Int'l Fund for Agric. Dev. [IFAD], & World Health Org. [WHO], *Impact of COVID-19 on people's livelihoods, their health and our food systems*, WHO (Oct. 13, 2020), https://www.who.int/news/item/13-10-2020-impact-of-covid-19-on-people%27s-livelihoods-their-health-and-our-food-systems.
[2] *Education in a Pandemic: The Disparate Impacts of COVID-19 on America's Students (2021)*, U.S. DEPT. OF EDUC., https://www2.ed.gov/about/offices/list/ocr/docs/20210608-impacts-of-covid19.pdf.
[3] Stacey Decker et al., *The Coronavirus Spring: The Historic Closing of U.S. Schools (A Timeline)*, EDUCATIONWEEK (Jul. 1, 2020), https://www.edweek.org/leadership/the-coronavirus-spring-the-historic-closing-of-u-s-schools-a-timeline/2020/07.
[4] Kevin McElrath, *Nearly 93% of Households With School-Age Children Report Some Form of Distance Learning During COVID-19*, U.S. CENSUS BUREAU, (Aug. 26, 2020), https://www.census.gov/library/ stories/2020/08/schooling-during-the-covid-19-pandemic.html.
[5] Emma Dorn et al., *COVID-19 and education: The lingering effects of unfinished learning*, MCKINSEY & CO. (Jul. 27, 2021), https://www.mckinsey.com/industries/education/our-insights/covid-19-and-education-the-lingering-effects-of-unfinished-learning.
[6] *Id.*

mental health.[7] According to the Centers for Disease Control and Prevention, compared to 2019, 2020 saw a "31% increase in the proportion of mental health–related emergency department visits that occurred among adolescents aged 12–17 years."[8] Although in the spring of 2020 the number of visits for suicide attempts for those aged 12–17 decreased, as the pandemic continued, the numbers started to rise.[9] In the winter of 2021, suspected suicide attempts were up 50.6% for females and up 3.7% among males compared to the same time period in 2019.[10] Such statistics indicate that measures need to be taken to mitigate the adverse impact the pandemic has had on students' mental health.

States in the U.S. have implemented various measures to improve the mental health of their students, including implementing suicide prevention programs, conducting mental health screenings, and training staff on how to support the emotional well-being of students.[11] The Education Commission of the States has tracked more than 600 bills related to student mental and behavioral health since 2019 and at least thirty states have enacted seventy-two of those bills.[12] Michigan is one of these states.[13] Michigan has enacted several bills relating to student mental and behavioral health since 2019, such as Senate Bill 154, which allocates funds for health-related services in

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[7] Valerie J. Calderon, *U.S. Parents Say COVID-19 Harming Child's Mental Health,* GALLUP (June 16, 2020), https://news.gallup.com/poll/312605/parents-say-covid-harming-child-mental-health.aspx.
[8] Ellen Yard et al., *Emergency Dept. Visits for Suspected Suicide Attempts Among Persons Aged 12-25 Years Before and During the COVID-19 Pandemic*, CDC: MORB. MORTAL WKLY (June 18, 2021), https://www.cdc.gov/mmwr/volumes/70/wr/mm7024e1.htm.
[9] *Id.*
[10] *Id.*
[11] *See* Mary Fulton et al., *State Approaches to Addressing Student Mental Health*, EDUC. COMM'N OF THE STATES (May 4, 2021), https://www.ecs.org/state-approaches-to-addressing-student-mental-health/ (discussing the numbers of bills related to student mental and behavioral health passed by states in the U.S.).
[12] *Id.*
[13] *See* Alyssa Evans et al., *State Funding for Student Mental Health*, EDUC. COMM'N OF THE STATES (Mar. 2, 2021), https://www.ecs.org/state-funding-for-student-mental-health/ (discussing states using funding for students' mental health).

schools.[14] In September 2021, Michigan's Governor, Gretchen Whitmer, signed the Fiscal Year 2022 budget bill which included $240 million to hire more school psychologists, school social workers, school counselors, and school nurses.[15] Governor Whitmer acknowledged the importance of student mental health stating, "[t]he pandemic reminded us that school-based mental and physical health professionals are not luxuries. Healthy students—physically, mentally, and social-emotionally—are better learners. Having skilled professionals in school buildings helps our kids get the supports they need so they can thrive in the classroom and beyond."[16] Although Michigan has made efforts to provide mental health benefits to its approximately 1.4 million students, more can and needs to be done.[17] One of the ways Michigan can further support the mental health of its students is by passing legislation allowing the students to take excused mental health days.

This article will first discuss what mental health days are as well as their benefits. It will then discuss various laws other states have passed that allow their students mental health days. Finally, this article will advocate for the passing of similar legislation in Michigan and propose additional specific elements the legislation should include.

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[14] S.B. No. 0154, 100th Reg. Sess. (Mich., 2019), http://legislature.mi.gov/doc.aspx?2019-SB-0154.

[15] Press Release, Michigan Schools Use New State Grant to Invest in Students' Mental and Physical Health, Recruit 560+ Nurses, Social Workers, Counselors (Dec. 28, 2021), https://www.michigan.gov/whitmer/0,9309,7-387-90499_90640-574659--,00.html.

[16] *Id.*

[17] MI SCHOOL DATA, https://www.mischooldata.org/student-enrollment-counts-report/ (last visited Mar. 24, 2022).

II. MENTAL HEALTH DAYS FOR STUDENTS

One way some states are trying to help their students is by allowing the students to take "mental health days."[18] Merriam-Webster defines a "mental health day" as "a day that an employee takes off from work in order to relieve stress or renew vitality."[19] For students, a mental health day is a day off to "relieve stress or renew vitality," as well as a day to take off for reasons related to mental or behavioral health.[20] One expert stated that mental health days empower students to take care of their mental health.[21] A teenager from Maryland stated that he and his classmates were struggling with the pressure of school and in an effort to improve their mental health began advocating for mental health days, and a student from Oregon, a state that has passed legislation allowing for student mental health days, called the ability to take a day off for mental health, "life-changing."[22]

Some parents oppose bills allowing students mental health days under the premise that students can take mental health days by "pretending to be sick."[23] However, if students pretend to be sick to get out of school instead of being honest about their need for a mental health day, there could be a missed opportunity to have a conversation with the student about their mental

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[18] Derrick Byson Taylor, *Need a Mental Health Day? Some States Give Students the Option*, N.Y. TIMES (July 24, 2019), https://www.nytimes.com/2019/07/24/health/need-a-mental-health-day-some-states-give-students-the-option.html.
[19] *Mental Health Day*, Merriam-Webster.com, https://www.merriam-webster.com/dictionary/mentalhealthday (last visited Feb. 13, 2022).
[20] *See id.*; Rae Jacobson, *Should Kids Take Mental Health Days?*, CHILD MIND INST., https://childmind.org/article/should-kids-take-mental-health-days/ (last visited Mar. 24, 2022); *see generally* Christina Caron, *Teens Are Advocating for Mental Health Days Off School*, N.Y. TIMES, (Oct. 14, 2021), https://www.nytimes.com/2021/08/23/well/mind/mental-health-day-laws-kids.html (discussing reasons cited by teens for taking mental health days off of school).
[21] Taylor, *supra* note 18.
[22] *Id.*; Caron, *supra* note 20.
[23] Taylor, *supra* note 18.

health and a missed opportunity to provide additional steps that can be taken such as getting professional help.[24]

Creating laws allowing students mental health days is also a step towards decreasing the stigmas associated with mental health.[25] According to the American Psychiatric Association, more than fifty percent of people with a mental illness do not receive help for their illness.[26] The Association states that this is often the case because the stigma against people with mental illnesses is a prevalent problem.[27] Giving students the opportunity to take mental health days will help students feel more comfortable asking for help and receiving help before mental health problems worsen or reach a point of crisis.[28]

Mental health days can help students improve their mental health and reduce the stigma surrounding mental health moving forward. It is evident that the mental health of students is declining and passing legislation that grants students mental health days is a step that states in the U.S. have begun to take to halt this decline.

III. STATES THAT HAVE PASSED MENTAL HEALTH DAY LEGISLATION

States that have already passed legislation allowing their students to take mental health days are Arizona, Colorado, Connecticut, Illinois, Maine,

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[24] *See id.* (discussing statement made by parents of a daughter that committed suicide stating that their daughter struggled with bullying and pretended to be sick, therefore not allowing the parents to have conversations about mental health with her).
[25] Lois M. Collins, *Why schools increasingly offer mental health days for students*, DESERETNEWS, (Oct. 16, 2021), https://www.deseret.com/2021/10/16/22726285/why-schools-increasingly-offer-students-mental-health-days-children-anxiety-depression-state-laws.
[26] AM. PSYCHIATRIC ASS'N, *Stigma, Prejudice and Discrimination Against People with Mental Illness*, https://www.psychiatry.org/patients-families/stigma-and-discrimination (last visited Feb. 13, 2022).
[27] *Id.*
[28] Collins, *supra* note 25.

Nevada, Oregon, Utah, and Virginia.[29] Each state's statutes share similarities but there are also differences among them.

Arizona bill SB1097 states that "the department of education shall identify an absence due to the mental or behavioral health of a pupil as an excused absence."[30] Arizona's bill does not state the number of days allocated to students or what constitutes mental or behavioral health.[31] Specific policies regarding the mental health days are left to the discretion of each school district.[32]

Colorado's bill, SB20-014, amends the old language of its statute concerning excused absences in public schools from "physical, mental or emotional disability" to "physical disability or a mental or behavioral health disorder."[33] The bill further amends the statute to state that the Board of Education must provide for excused absences, "as well as temporary absences due to behavioral health concerns."[34] According to the Substance Abuse and Mental Health Services Administration, "behavioral health" is a term that includes the promotion of mental health.[35] Similar to Arizona, the Colorado statute does not specify the number of mental health days available for students and instead requires each school district to adopt a policy for attendance requirements, and include absences for behavioral health concerns in that policy.[36]

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[29] Jonathan Franklin, *Kids In Illinois Will Soon Be Able To Take 5 Mental Health Days From School*, NPR (Sept. 2, 2021), https://www.npr.org/sections/back-to-school-live-updates/2021/09/02/1033605650/illinois-children-mental-health-days-schools-coronavirus.
[30] S.B. No. 1097, 55th Reg. Sess. (Ariz. 2021).
[31] *Id*.
[32] Jennifer Martinez, *Proposed Arizona State Senate bill will give students mental health days*, FOX10 PHOENIX (Feb 1, 2021), https://www.fox10phoenix.com/news/proposed-arizona-state-senate-bill-will-give-students-mental-health-days.
[33] S.B. No. 20-014, 2d Reg. Sess. (Colo. 2020).
[34] *Id*.
[35] U.S. Dept. of Health & Hum. Servs., Substance Abuse & Mental Health Servs. Admin. [SAMSHA], Behavioral Health Integration, https://www.samhsa.gov/sites/default/files/samhsa-behavioral-health-integration.pdf.
[36] Colo. S.B. No. 20-014.

Connecticut's legislation, SB2, is part of a larger public act, "An Act Concerning Social Equity And The Health, Safety And Education Of Children."[37] In regard to mental health days specifically, the act uses the term "mental health wellness day."[38] Unlike other legislation, the act goes on to describe what the term means, stating that it is, "a school day during which a student attends to such student's emotional and psychological well-being in lieu of attending school."[39] The act also sets specific requirements for school boards to follow: the boards must permit students in grades kindergarten to grade twelve to take two mental health wellness days per school year, and the mental health wellness days cannot be taken consecutively.[40]

Illinois is the most recent state to pass legislation for student mental health days.[41] Illinois' SB1577 amends Illinois Compiled Statute 26-1 by adding that absences caused by illness include the mental or behavioral health of the child.[42] The statute permits students to take up to five days and a medical note does not need to be provided.[43] The statute also specifically states that students will have the opportunity to make up the school work that they miss during the absence.[44] A unique aspect of the bill is that after the second mental health day is used, students "may be referred to the appropriate school support personnel."[45] Co-sponsor of the bill, State Representative Barbara Hernandez, provided justification for the provision, stating, "after students take their second mental health day, they should understand that a

[37] S.B. No. 2, 2021, Reg. Sess. (Conn. 2021).
[38] *Id*.
[39] *Id.*
[40] *Id.*
[41] Franklin, *supra* note 29.
[42] S.B. No. 1577, 102d Gen. Assemb. (Ill. 2021).
[43] *Id.*
[44] *Id*.
[45] *Id.*

conversation with an adult is needed about whatever it is they're going through."[46]

Maine's legislation for student mental health days, H.P. 1326 - L.D. 1855, is not as detailed as Illinois' legislation.[47] The Maine Act amends the state's legislation for excusable absences which originally excused absences for "personal illness" to now excuse absences for "personal health, including the person's physical, mental and behavioral health."[48]

Nevada's law, SB249, allows students to take excused absences for "physical or mental condition or behavioral health," however, a certificate in writing from "any qualified physician, mental health professional or behavioral health professional" is required.[49] The bill also states that the excusal of students from attendance cannot negatively impact a school's rating based on the state's Department of Education's system of accountability.[50]

Oregon's legislation, HB2191, allows for excused absences for "the mental or behavioral health of the pupil."[51] It specifies that students are permitted to take up to five excused absences within a three-month period.[52] The five excused absence limitation includes all excused absences, not just those taken for mental health.[53] Further, an excused absence requires a letter to the principal of the school the student attends.[54]

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[46] Franklin, *supra* note 29.
[47] Ill. S.B. No. 1577; *compare with* H.P. No. 1326 - L.D. No. 1855 (Me. 2020), http://www.mainelegislature.org/legis/bills/getPDF.asp?paper=HP1326&item=3&snum=129 (Maine's legislation does not state a specific amount of excused days allotted for mental health, the ability for students to make up work, and does not have a provision stating students will be contacted by school support personnel).
[48] H.P. No. 1326 - L.D. No. 1855 (Me. 2020).
[49] S.B. No. 249, 81st Session (Nev. 2021).
[50] *Id.*
[51] H.B. No. 2191, 80th Reg. Session (Or. 2019).
[52] *Id.*
[53] *Id.*
[54] *Id.*

Utah originally passed HB0081 in March of 2021, making mental or behavioral health a valid excuse for missing school.[55] The bill was modeled after Oregon's bill regarding mental health days for students.[56] Under Utah's bill, the excused absence still required a diagnosis from a doctor.[57] This was similar to Oregon's requirement that a letter must be provided to the school's principal for an absence to be excused.[58] However, a few days after Utah's Governor signed the HB0081, he signed a second bill, HB0116, which adds that mental and behavioral health is a valid excuse with the language "regardless of whether the school-age child or parent provides documentation from a medical professional."[59] The bill's sponsor, Representative Adam Robertson, stated that removing the need for a doctor's note was done so that families can avoid unnecessary medical expenses which could be a burden on families and students, leading to students not staying home when not feeling well.[60]

Virginia's HB308, requires the Department of Education to establish guidelines for school boards to follow that grant excused absences to students for mental or behavioral health.[61] On June 12, 2020, the Virginia Department of Education issued guidelines in response to the bill.[62] The memorandum goes into detail as to what mental and behavioral health is and then grants local school divisions the authority to determine whether an absence is mental or behavioral health related.[63] The memorandum then gives examples

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[55] H.B. No. 0081, Gen. Sess. (Utah 2021).
[56] Taylor Stevens, *Utah students could miss school for a mental health day under a bill that passed through the Senate*, SALT LAKE CITY TRIB. (Feb. 17, 2021), https://www.sltrib.com/news/politics/2021/02/18/utah-students-could-miss/.
[57] I*d*.
[58] Or. H.B. No. 2191.
[59] H.B. No. 0116, Gen. Sess. (Utah 2021).
[60] Stevens, *supra* note 56.
[61] H.B. No. 308, 2020 Sess. (Va. 2020).
[62] Superintendent's Memo 142-20 (Va. 2020), https://www.doe.virginia.gov/administrators/superintendents_memos/2020/142-20.docx.
[63] *Id.*

of criteria that may be established by the local divisions such as requiring doctor's notes after a certain number of absences is reached.[64]

The legislation regarding mental health days in each state have similarities as well as differences, but the basis of all are the same – students should be able to be excused from school for matters related to their mental health and well-being.

IV. PROPOSAL FOR MICHIGAN'S STUDENT MENTAL HEALTH DAY LEGISLATION

On October 28, 2021, Representative Sarah Anthony introduced legislation that would allow Michigan students to take five mental health days as excused absences—HB5497.[65] The absences do not require a medical note, the student must be given the opportunity to make up the school work they miss, and similar to Illinois, if a student is absent for two or more days, a school official may "refer the pupil to the appropriate school personnel."[66] HB5497 already has elements that make it a strong bill for helping the mental health of students. By not requiring a medical note, like Illinois and Utah, the bill mitigates the risk of students being dissuaded from taking a mental health day due to medical costs or stigma in seeing a mental health professional. Allowing students to make up the work they miss could reassure parents that their student taking the day off will not negatively impact their education or grades. Further, the provision that requires school personnel to reach out after a second absence will allow schools to assist students before the student's mental health problems are exacerbated.[67]

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[64] *Id*.
[65] H.B. No. 5497 (Mich. 2021).
[66] *Id.*
[67] Alison DeNisco, *Student mental health days reduce stigma,* DIST.ADMIN. (Sept. 12, 2019), https://districtadministration.com/student-mental-health-days-reduce-stigma/ (stating that mental health days flag issues for schools and parents allowing the students to get treatment sooner).

Despite the positive aspects of Michigan's bill, there are additional provisions that Michigan should incorporate to strengthen the effectiveness of the bill. Like Connecticut, Michigan should add language to the bill allowing for an absence to be taken for a "mental wellness day."[68] By only relating the absence to "an illness" that impacts mental or behavioral health, the bill implies that the standard for what constitutes the need for a mental health day is higher. Michigan, like Connecticut, should add the term, "mental wellness day" and issue a memorandum similar to Connecticut in which the definition of a "mental wellness day" is outlined. The memorandum should also contain information similar to the memorandum issued by Virginia in which examples of mental and behavioral health issues are given, such as anxiety disorders, mood disorders, eating disorders and others.[69] Michigan should also add a provision similar to Nevada's stating that the excusal of students from attendance cannot negatively impact a school's rating.[70] If school districts fear their ratings will be affected by students using their five absences, it is possible the districts and their schools will not be as encouraging of students using the absences as they would be if there was no consequence to the school. Adding the provision that the absence will not impact any ratings eliminates the fear of consequences to the school.

As mentioned, the stigma surrounding mental health is prevalent. The language selected for the bill can play a part in reducing the stigma. A school board in Maryland created a resolution for the district to change its definition of an excusable absence from "student illness" to "student illness and well-being."[71] The board's selection of words was intentional and it stated the

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[68] Conn. S.B. No. 2.
[69] Va. H.B. No. 308.
[70] Nev. S.B. No. 249.
[71] Catherine Gewertz, *Why More Schools Are Excusing Student Absences for Mental Health*, EDUCATIONWEEK (Jun. 21, 2021) https://www.edweek.org/leadership/why-more-schools-are-excusing-student-absences-for-mental-health/2021/06 (discussing how follow-up days in

reason for not referring to the absence as a "mental health day" was due to the stigma, as well as parents' and students' possible apprehension in self-identifying their need for a mental health day.[72] The "mental wellness day" language used in the Connecticut statute aligns with this approach and Michigan should follow suit to allow its students and parents to feel more comfortable using the excused absences.

Additionally, adding the term "mental wellness" in addition to "mental illness" could further encourage students and parents to use the excused absences. According to the American Psychiatric Association, a mental illness "refers collectively to all diagnosable mental disorders — health conditions involving: significant changes in thinking, emotion and/or behavior and distress and/or problems functioning in social, work or family activities."[73] Even if someone does not suffer from a mental illness, it does not mean they do not need a mental health day. According to the Global Wellness Institute, an organization that conducts research regarding preventative health and wellness, even those without a mental illness can feel as though they are not functioning or feeling well.[74] The Institute states, "a lack of mental illness does not equate to mental wellness."[75] Similarly, just because a student does not have a mental illness does not mean they do not need a mental health day. The addition of the term "mental wellness" will lower the barrier as to what is acceptable under the mental health day excused absence because it will allow students that do not suffer from a diagnosed

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an Ohio school district allowed the school to "find students we wouldn't otherwise know are struggling.").

[72] *Id.*

[73] AM. PSYCHIATRIC ASS'N, *What is Mental Illness?*, https://www.psychiatry.org/patients-families/what-is-mental-illness (last visited Mar. 24, 2022).

[74] Beth McGroarty, *Industry Research: Defining "Mental Wellness" vs. "Mental Health"*, GLOBAL WELLNESS INSTITUTE (Feb. 23, 2021), https://globalwellnessinstitute.org/global-wellness-institute-blog/2021/02/23/industry-research-defining-mental-wellness-vs-mental-health/; GLOB. WELLNESS INST., https://globalwellnessinstitute.org/about-us/ (last visited Mar. 24, 2022).

[75] McGroarty, *supra* note 74.

mental illness but are still not feeling mentally healthy to take a day or days off.

In addition to using language that makes mental health days more accessible, Michigan, like Connecticut and Virginia, should issue memoranda that accompany the bill and provide more information for what a mental health and/or mental wellness day is. There are discrepancies in the mental health knowledge of Americans.[76] By issuing a memorandum that gives details and explanations of what the bill's purpose is and what can constitute an excusable absence, the discrepancy in knowledge can be mitigated and students and their parents can be better informed. Further, schools are a popular avenue for spreading information regarding mental health, and improving the mental health literacy of the students and their caretakers can facilitate better outcomes for those with mental disorders.[77]

In addition to students and parents understanding what a mental health day is and that they should feel comfortable taking one, schools need to be supportive of their students using the excused absences. Michigan adding a provision that school ratings will not be affected is one way it can make sure schools are supportive. Michigan issues grades to its schools pursuant to state-required school accountability measures.[78] Among the indicators that comprise a school's grade is attendance.[79] If schools are, or believe their grades will be, impacted due to students using their mental health days, there is a chance schools will not encourage their students to use the days as needed. Michigan should therefore add a provision to the bill that the

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[76] Mark Skidmore et al., *National mental-health survey finds widespread ignorance, stigma*, MSUTODAY (Apr. 27, 2017), https://msutoday.msu.edu/news/2017/national-mental-health-survey-finds-widespread-ignorance-stigma? (discussing a mental health literacy survey conducted by Michigan State University).
[77] Claire M Kelly et al., Improving Mental Health Literacy as a Strategy to Facilitate Early Intervention for Mental Disorders, 187 MED. J. OF AUSTL. 26, 26, 29 (2007).
[78] MI SCHOOL DATA, *School Grades*, https://www.mischooldata.org/school-grades/ (last visited Mar. 24, 2022).
[79] *Id.*

excused absences for mental health days will not impact the grades of Michigan schools.

Adding the above provisions will make Michigan's bill stronger and help the State better aid the mental health of its students.

V. CONCLUSION

Mental health problems for students existed well before the COVID-19 pandemic, but the pandemic has greatly exacerbated the problem.[80] States and school districts have taken various steps to try to improve the mental health of students, one of which is the allowance of excused absences for mental and behavioral health. Arizona, Colorado, Connecticut, Illinois, Maine, Nevada, Oregon, Utah, and Virginia have already passed legislation allowing for mental health days and Michigan is following close behind.[81] The proposed legislation in Michigan will allow students to take a break when they need it and address their mental health problems while reducing the stigma that surrounds them. Thus, Michigan should strengthen this pending legislation to continue to improve the mental and behavioral health of its students.

The current legislation proposed by Representative Sarah Anthony is a step in the right direction, but Michigan can do even more to benefit the mental health of its students. Michigan can do so by implementing the best elements of other states' legislation regarding mental health day laws for students. Adding the provisions outlined above will strengthen the Michigan

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[80] *See generally* Christine Vestal, *COVID Harmed Kids' Mental Health—And Schools Are Feeling It*, PEW (Nov. 9, 2021), https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2021/11/08/covid-harmed-kids-mental-health-and-schools-are-feeling-it (discussing increased mental health issues for children during the COVID-19 pandemic).

[81] Franklin, *supra* note 29; H.B. No. 5497, *supra* note 65.

bill’s impact and will bring the State closer to addressing and improving the mental health of its almost 1.4 million students.

Mental Health Care Policing in Illinois: Ensuring Safety for Individuals Suffering from Mental Health Crises Through Mandatory Police Training

Joshua Neumann

I. INTRODUCTION

Over the last few years, it has become clear that there is a mental health crisis in the United States.[1] Individuals with untreated mental illness are sixteen times more likely to be killed during a police encounter than other civilians stopped by law enforcement, and despite numbering fewer than one in fifty adults, individuals with untreated severe mental illness are involved in at least a quarter, and as many as half, of all fatal police shootings.[2] In response to this crisis, several cities throughout the United States have begun to deploy mental health professionals on specified 911 calls that relate to mental health crisis scenarios.[3]

In the 1990s, Eugene, Oregon began to institute a co-responder method that allows mental health professionals to aid in 911 calls related to a mental health crisis; this joint initiative is called Crisis Assistance Helping Out On The Streets or "CAHOOTS."[4] This CAHOOTS model has been a catalyst for other cities, like Chicago, to begin implementing their own forms of co-responder models.[5] In January of 2022, the Illinois General Assembly passed House Bill 2784 ("Bill 2784"), which will ensure that the appropriate mobile response, between mental health professionals and police officers, is

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[1] *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 Feb. 2, 2021).
[2] *Id.*
[3] Julianne Hill, *Redefining Justice: Calls for Help: Police Are Often First Responders to Mental Health Crises, but Tragedies Are Prompting Change*, 107 A.B.A. J. 46, 48 (2021).
[4] 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), https://www.cnn.com/2020/07/05/us/cahoots-replace-police-mental-health-trnd/index.html.
[5] Heather Cherone, *Chicago Starts Sending Mental Health Professionals to Some 911 Calls for Help*, WTTW (Sept. 1, 2021, 9:33 PM), https://news.wttw.com/2021/09/01/chicago-starts-sending-mental-health-professionals-some-911-calls-help.

available.[6] Bill 2784 also vaguely establishes new mental health training for responders.[7] Although this is a crucial first step, Bill 2784 lacks the appropriate guidance to ensure that both police officers and mental health professionals receive the proper training that will keep both responders and citizens safe during these unpredictable situations.[8]

This article will first provide background information on mental health crisis interactions with police. Next, it will describe the CAHOOTS model and its applications, and analyze the details of Bill 2784. Then, the article will compare the CAHOOTS model with the Chicago model and will analyze how Bill 2784, which employs similar tactics to the CAHOOTS model, lacks the appropriate detail to ensure adequate responder training. Lastly, this article will propose that Illinois pass an additional bill, in tandem with Bill 2784, that sets forth a more detailed and wholistic training program required for both mental health professionals and police to ensure the safety of all individuals involved in mental health crisis scenarios.

II. BACKGROUND

It is estimated that at least twenty percent of police calls involve some form of mental health or substance abuse crisis.[9] A nationwide survey of more than 2,400 senior law enforcement official respondents revealed that approximately eighty-four percent of officers believe that mental health-related calls are increasing, and sixty-three percent said their respective departments have increased the amount of time they spend on mental illness

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[6] Press Release, J.B. Pritzker, Governor, Illinois House of Representatives, Gov. Pritzker Signs Nation-Leading Legislation Expanding Access to Mental Healthcare (Aug. 25, 2021), https://www.illinois.gov/news/press-release.23805.html [hereinafter "Press Release"].
[7] *Id.*
[8] *Id.*
[9] Ashley Abramson, *Building mental health into emergency responses*, AM. PSYCH. ASS'N (July 1, 2021), https://www.apa.org/monitor/2021/07/emergency-responses.

calls.[10] Given this increase in mental health-related crisis situations, the statistic that more than one in five people fatally shot by police have some form of mental illness is, sadly, not surprising. Consequently, there has been a national outcry for state and local governments to improve their first-response protocols for these mental health situations.[11]

A. The CAHOOTS Method

Eugene, Oregon set the standard for the co-responder model when it began the CAHOOTS program in its town of 172,000.[12] The program originated from a social services center that had operated in the town since the 1960s.[13] The program works by filtering the 911 calls the town receives to determine whether the call is "violent/criminal," or if it involves a mental health scenario.[14] If it is the former, 911 dispatchers send the police, but if it is the latter, a van of mental health professional staff, who are skilled in counseling and de-escalation techniques, responds to the call.[15] The program's initial goal was to reduce the city's suicide rate, which was approximately seventeen deaths per 100,000 individuals, about forty percent higher than the national average.[16] The mental health staff that are employed arrive at the scene unarmed, do not force the individual to accept their aid, and are unable to arrest the individual.[17]

Although this model has proven successful in Eugene, Oregon, there are concerns that this form of emergency response may not be effective in other

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[10] *Id.*
[11] Minyvonne Burke, *Policing mental health: Recent deaths highlight concerns over officer response*, NBC NEWS (May 16, 2021, 4:30 AM), https://www.nbcnews.com/news/us-news/policing-mental-health-recent-deaths-highlight-concerns-over-officer-response-n1266935.
[12] Scottie Andrew, *supra* note 4.
[13] *Id.*
[14] *Id.*
[15] *Id.*
[16] *Id.*
[17] *Id.*

portions of the country.[18] Eugene has a population that is eighty percent white, and the CAHOOTS program recognizes that Eugene residents historically have a healthy relationship with the police.[19] This fact is in contrast to cities like Chicago, which have much more diverse populations and where civilian-police relationships are more tenuous.[20] Only nineteen percent of the African American population nationally is confident in the police force's ability to protect them.[21] Differences in populations and perspectives on policing might drastically affect how individuals engage with those responding to 911 calls.[22]

Individuals who perceive that they have received "procedural justice," which is the idea of fairness in the processes that resolve disputes in situations such as police interactions, are more likely to comply with police and other public service members in the future.[23] However, citizens who live in high-crime areas, such as Chicago, and regularly hear others talk about misconduct among the police, will perceive "procedural justice" as uncommon in their respective area.[24] This distrust of the police that occurs in high-crime areas can lead to serious consequences because it undermines the legitimacy of law

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[18] Navish Dholakia & Daniela Gilbert, *What Happens When We Send Mental Health Providers Instead of Police*, FORBES (Nov. 1, 2021, 10:00AM), https://www.forbes.com/sites/forbeseq/2021/11/01/what-happens-when-we-send-mental-health-providers-instead-of-police/?sh=c1d16f57a416; *see also* Scottie Andrew, *supra* note 4 (stating that CAHOOTS workers responded to 24,000 calls in 2019, which is about twenty percent of total dispatches, and has saved the city $8.5 million in public safety costs every year, plus another $14 million in ambulance trips and ER costs).
[19] *Id.*
[20] Aimee Ortiz, *Confidence in Police Is at Record Low, Gallup Survey Finds*, N.Y. TIMES (Aug. 12, 2020), https://www.nytimes.com/2020/08/12/us/gallup-poll-police.html.
[21] *Id.*
[22] Andrew Sheldon Franklin et al., *The Influence of Police Related Media, Victimization, and Satisfaction on African American College Students' Perceptions of Police,* 4 FRONTIERS IN SOCIO. (2019), https://www.frontiersin.org/articles/10.3389/fsoc.2019.00065/full.
[23] *Perceptions of Treatment by Police: Impacts of Personal Interactions and the Media*, NAT. INST. OF JUST. (Mar. 17, 2014), https://nij.ojp.gov/topics/articles/perceptions-treatment-police-impacts-personal-interactions-and-media.; *Procedural Justice*, U.S. DEPT. OF JUST., https://cops.usdoj.gov/prodceduraljustice.
[24] *See id.* (noting that individuals form opinions surrounding police based on experiences they hear about from friends and family).

enforcement, and, without legitimacy, the police lose their authority and ability to work effectively.[25] Research finds that when there is a lack of legitimacy associated with the police in a local area, compliance and cooperation with the police is deterred.[26]

When the CAHOOTS model is employed in a city where there are high levels of trust in the police, it reinforces the legitimacy of law enforcement and in turn increases the likelihood of compliance during police interactions.[27] In Chicago, where police mistrust is high, non-compliance during police encounters can lead to officers being more suspicious, perceiving danger where there is none, and experiencing antagonistic emotions such as frustration, anger, and annoyance.[28] This heightened level of emotion in police officers can lead to the officers conducting searches or detaining individuals, sometimes under non-legal circumstances.[29] The differences between the Eugene and Chicago populations might lead to very different results in first responder encounters, and therefore, the CAHOOTS model may not be the best choice for a city like Chicago that has a much different perception of police and other responders.[30]

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[25] *Race, Trust and Police Legitimacy*, NAT. INST. OF JUST. (Jan. 9, 2013), https://nij.ojp.gov/topics/articles/race-trust-and-police-legitimacy.
[26] EMILY EKINS, POLICING IN AMERICA: UNDERSTANDING PUBLIC ATTITUDES TOWARD THE POLICE. RESULTS FROM A NATIONAL SURVEY, 14 CATO INST. (2016), https://www.cato.org/survey-reports/policing-america-understanding-public-attitudes-toward-police-results-national#americans-are-not-anti-cop.
[27] *See id.* (noting that legitimacy allows for more compliance in police interactions); Navish Dholkia and Daniela Gilbert, *supra* note 18.
[28] Justin Nix et al., *Compliance, noncompliance, and the in-between: casual effects of civilian demeanor on police officers' cognitions and emotions*, 15 J. OF EXPERIMENTAL CRIMINOLOGY 611, 615 (2019), https://link.springer.com/article/10.1007/s11292-019-09363-4#Sec13.
[29] *Id.* at 616.
[30] *See* Navish Dholakia & Daniela Gilbert, *What Happens When We Send Mental Health Providers Instead of Police*, FORBES (Nov. 1, 2021), https://www.forbes.com/sites/forbeseq/2021/11/01/what-happens-when-we-send-mental-health-providers-instead-of-police/?sh=c1d16f57a416 (noting that every community is different, so a one-size-fits-all approach such as the CAHOOTS program will not work everywhere in the United States).

To answer for its current mental health crisis, Chicago is implementing its own CAHOOTS-like mental health responder program, which was approved through Illinois House Bill 2784.[31]

B. Illinois House Bill 2784

On August 25, 2021, the Illinois House of Representatives passed House Bill 2784 ("the Bill") which established a statewide protocol for responding to mental health crises.[32] The Bill states that every 911 dispatcher and provider of emergency services, dispatched through a 911 system, must coordinate with:

> "…the mobile mental and behavioral health services established by the Division of Mental Health so that the following State goals and State prohibitions are met whenever a person interacts with one of these entities for the purpose of seeking emergency mental and behavioral health care or when one of these entities recognizes the appropriateness of providing mobile mental or behavioral health care to an individual whom they have engaged."[33]

This portion of the Bill mandates that 911 dispatchers must now work with mental health professionals to determine the correct team to send into mental health crisis scenarios, to assure a safer response for individuals experiencing a mental health crisis.[34] The Bill adds the force of law to the co-responder pilot program that Chicago has instituted, which sends teams consisting of police officers with crisis-intervention-training, EMTs, and professional crisis counselors.[35]

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[31] Press Release, *supra* note 6.
[32] *Id.*
[33] H.B. 2784, 102nd Gen. Assemb., Reg. Sess. 1, 4 (Il. 2021).
[34] *Id.*
[35] *Id.*; Allison Schatz, *Chicago pilots mental health co-responder model, critics say armed officers should not be present*, MEDILL REPORTS CHICAGO (Dec. 7, 2020), https://news.medill.northwestern.edu/chicago/chicago-pilots-mental-health-co-responder-model-critics-say-armed-officers-should-not-be-present/.

The Bill further states that a "regional advisory committee" will determine the appropriate credentials for the mental health providers responding to the calls, however, the Bill fails to specify what category of officers is subject to the trainings and what the trainings would specifically entail. A later section of the Bill denotes training requirements for all responders dispatched through 911 calls, which include de-escalation techniques, knowledge of local community services and supports, and training in respectful interaction with people experiencing mental or behavioral health crises.[36] But the Bill fails to specifically state any mandatory or optional training for the officers and mental health professionals that will be responding to these mental health crisis 911 calls.[37]

Although the Bill is an excellent start to enforcing a mental health emergency response, there are still major gaps within the training requirements. The Bill does not describe exactly who will receive training and what specifically that training will entail. In order for the Bill to be more effective, the Illinois House of Representatives should pass an additional Bill that directly describes the mandatory trainings and defines which responders are required to undergo such training. This will in turn allow for easier implementation of these changes into Illinois first responder scenarios.

III. ANALYSIS

The Bill creates a solid foundation for emergency responders in the State of Illinois to begin accurately determining which 911 calls require mental health care assistance, but it may not be as applicable in cities like Chicago, where the crime rate is more than twice as high as the rest of the state and where mental health crises could be more dangerous to the mental health

[36] H.B. 2784, *supra* note 33 at 6–7.
[37] *Id.*

responders.[38] The Bill may not adequately instruct police and other first responders on how to deal with possibly dangerous interactions with civilians that can occur during a call that was originally thought to just be a mental-health crisis scenario.[39]

As previously noted,[40] the Bill requires some forms of training for mental health crisis responders, but this list is both vague and lacking strict enforcement mechanisms.[41] For the Bill to be more impactful for its desired effect in cities like Chicago, it must explicitly require the following trainings for both police officers and mental health professionals: Crisis Intervention Training, Managing Mental Health Crisis Training, and Mental Health First Aid Training. This will ensure that responders not only protect themselves, but that they also protect those experiencing a mental health crisis.

A. Required Trainings for Police Officers

The first proposed amendment to the Bill is mandatory mental health training for police officers. In Michigan, the Michigan Mental Health Diversion Council (MMHDC) created a comprehensive list of recommended trainings for law enforcement to enhance their mental health knowledge and de-escalation skills.[42] The MMHDC has been proven to successfully divert individuals with mental health issues to sources of treatment and care in place of incarceration.[43]

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[38] *Id.*; *Chicago, IL Crime Rates*, NEIGHBORHOOD SCOUT, https://www.neighborhoodscout.com/il/chicago/crime (last visited Mar. 11, 2021).
[39] Denise Craig, *How does crime in Illinois compare to national crime rate?*, WGNTV (Oct. 3, 2021), https://wgntv.com/news/chicagocrime/how-does-crime-in-illinois-compare-to-national-crime-rate/.
[40] *Infra* Background(b) at 5.
[41] H.B. 2784, *supra* note 33 at 6–7.
[42] *Behavioral Health and Crisis Response Trainings for Law Enforcement Officers*, WAYNE STATE UNIV. (Mar. 2020), https://behaviorhealthjustice.wayne.edu/resource/recommended-best-practices/law-enforcement-training.
[43] Colin Merry, *Michigan achieving positive outcomes diverting individuals with mental health issues from incarceration*, THE RECORD PATRIOT (Jan. 25, 2018),

The first training recommended is Crisis Intervention Team (CIT) Training, which has been the standard for behavioral health and law enforcement collaboration.[44] This training involves 40 hours of instruction from community mental health workers, individuals with mental illness and their families, and police officers that are currently familiar with CIT.[45] The second portion of CIT includes training and special coding for dispatch operators to enable them to more easily recognize community reports with a high probability of involving individuals with mental illnesses.[46] CIT training creates a personal and grounded approach, allowing officers to do their jobs safely and effectively, which reduces the number of arrests of individuals with mental illness.[47] Overall, CIT training allows police officers to learn from individuals with mental illness in order to recognize when these crises occur and how to safely manage them.[48]

The next form of training that MMHDC recommends is Managing Mental Health Crisis ("MHHC") training.[49] MMHC training is a two-day curriculum taught by both law enforcement and mental health professionals who prepare the officers in the field to safely respond to mental health crises and learn about safer options for the affected individuals, such as mental-health care, instead of jail.[50] The training utilizes case-based video scenario reviews, role play, and de-escalation scenarios in order for the officers to learn how to

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https://www.recordpatriot.com/local-news/article/Michigan-achieving-positive-outcomes-diverting-14320039.php.

[44] *Behavioral Health and Crisis Response Trainings for Law Enforcement Officers*, *supra* note 42.

[45] Michael S. Rogers et al., *Effectiveness of Police Crisis Intervention Training Programs,* 49 THE J. OF THE AM. ACAD. OF PSYCH. AND THE L. 4 (Dec. 1, 2021), http://jaapl.org/content/early/2019/09/24/JAAPL.003863-19.

[46] *Id.*

[47] Alex Oliver, *Crisis Intervention Training Simulator*, APEX OFFICER (Mar. 4, 2022), https://www.apexofficer.com/resources/crisis-intervention.

[48] *Behavioral Health and Crisis Response Trainings for Law Enforcement Officers*, *supra* note 42.

[49] *Id.*

[50] *Id.*

recognize the signs of mental illness and become familiar with how to properly handle these scenarios.[51]

The last important training that MMHDC recommends is Mental Health First Aid ("MHFA").[52] This training focuses on teaching individuals how to identify, understand and respond to signs of mental illnesses.[53] Peer-reviewed studies have found that individuals who participate in MHFA training not only grow their knowledge of the symptoms, signs, and risk factors of mental illness, but also gain confidence and effectiveness in aiding individuals in distress.[54]

Although this is not a fully comprehensive list of recommended mental health trainings for police officers, these specific trainings have been proven in Michigan by the MMHDC to effectively direct individuals to mental health care options instead of incarceration.[55] By requiring these trainings through an amendment to the Bill, the State will see improvements in the way officers interact with individuals with mental health problems.[56] There is a consensus from police personnel who have received training, such as CIT, that they have seen success in diverting from arrests to providing mental health services to those in need.[57] Currently, CIT training has been implemented partially in Chicago, and reports from the field demonstrate that there has been success in properly handling mental health crises in urban settings.[58]

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[51] *Course Agenda*, MANAGING MENTAL HEALTH CRISIS, https://managingmentalhealthcrisis.com/course-agenda/ (last visited Feb. 4, 2021).
[52] *Behavioral Health and Crisis Response Trainings for Law Enforcement Officers,* WAYNE STATE UNIV. (Mar. 2020), https://behaviorhealthjustice.wayne.edu/resource/recommended-best-practices/law-enforcement-training.
[53] *About MHFA*, MENTAL HEALTH FIRST AID, https://www.mentalhealthfirstaid.org/about/ (last visited Feb. 4, 2021).
[54] *Research and Evidence Base*, MENTAL HEALTH FIRST AID, https://www.mentalhealthfirstaid.org/about/research/ (last visited Feb. 4, 2021).
[55] Colin Merry, *supra* note 43.
[56] Kelli E. Canada et al., *Crisis Intervention Teams in Chicago: Successes on the Ground*, J. POLICE CRISIS NEGOT. 1, 5 (2010).
[57] *Id.*
[58] *Id.* at 9.

Coordination between police officers that are effectively trained for mental health scenarios and mental health professionals may prove to be the most safe and effective format for both the individuals facing a mental health crisis and the first responders.[59]

B. The Co-Responder Model

The Bill currently institutes a co-responder model in which police and mental health professionals determine which 911 calls require mental health professionals, and which calls require police.[60] In early September 2021, the city of Chicago began to implement co-responder teams in which Chicagoans who call 911 while experiencing a mental health crisis will receive help from not only a police officer, but also paramedics and mental health professionals.[61] These teams are responsible for de-escalating tense situations which, in turn, prevents individuals suffering from mental illness from being arrested and/or jailed.[62]

In 2018, a systematic review found evidence that co-responder models are more successful in providing a timely linkage with behavioral health services than just a police response.[63] Although this co-responder method can prove to be successful, there is still trepidation among individuals that having police answer these calls, alongside mental health professionals, will not produce better outcomes than the police-only method that has been previously used.[64]

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[59] Ashley Krider et al., *Responding to Individuals in Behavioral Health Crisis Via Co-Responder Models: The Roles of Cities, Counties, Law Enforcement, and Providers*, POL'Y RSCH., INC. 1, 1 (Jan, 2020), https://www.prainc.com/wp-content/uploads/2020/03/RespondingtoBHCrisisviaCRModels.pdf.
[60] H.B. 2784, *supra* note 33 at 4.
[61] Heather Cherone, *Chicago Starts Sending Mental Health Professionals to Some 911 Calls for Help*, WTTW (Sept. 1, 2021, 9:33PM), https://news.wttw.com/2021/09/01/chicago-starts-sending-mental-health-professionals-some-911-calls-help.
[62] *Id.*
[63] Taleed El-Sabawi & Jennifer J. Carroll, *A Model for Defunding: An Evidence-Based Statute for Behavioral Health Crisis Response,* 94 TEMP. L. REV. 1, 17 (2021).
[64] *Id.*

However, by requiring police officers that partake in the co-responder method to be effectively trained in handling mental health crises, it is more likely that these co-responder encounters will have safer outcomes than the previous police-only encounters.[65] A study performed on CIT training for police officers concluded that the training had an immediate influence on officers' perceptions of the "dangerousness of emotionally and mentally disturbed individuals."[66] As a result of the trainings, officers are better able to listen and talk to individuals who may appear to be erratic or violent during a mental health crisis.[67]

The co-responder method is effective in assuring the safety of both the mental health professional and the individual suffering from a mental illness, but without the appropriate training for law enforcement we may not see a change in the police's treatment of these individuals.[68]

IV. CONCLUSION

The Illinois House of Representatives has made excellent strides in aiding those dealing with mental health issues by passing Bill 2784. However, the Bill falls short without specific mandatory training for law enforcement and responders. The Illinois House needs to amend the Bill to incorporate mandatory CIT, MHHC, and MHFA training for all police officers in the state. By making an amendment to the Bill that will incorporate these mandatory trainings, there will likely be greater success in assuring that Chicago's co-responder model will result in safer police interactions, while

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[65] Kimberly D. Hassell, *The Impact of Crisis Intervention Team Training for Police,* 22(2) INT'L J. OF POLICE SCI. & MGMT. 159, 161 (May 26, 2020), https://journals.sagepub.com/doi/full/10.1177/1461355720909404.
[66] *Id.* at 164.
[67] *Id.*
[68] *See* Ashley Krider et al., *supra* note 59 at 3 (noting that the co-responder model has positive effects that include the necessary training to better de-escalate intense or emotional crisis situations without the use of force).

also ensuring that individuals dealing with mental health crises have a greater likelihood of avoiding unnecessary arrests or even death.

Instituting mandatory training for police officers will ensure a more comprehensive understanding of how to handle these unpredictable situations, and it should be an important goal for the State of Illinois to take the necessary steps to guarantee that individuals needing mental health services receive safe and effective aid.

The Cause and the Effect: How Covid-19 Spurred a Mental Health Crisis Necessitating Significant Improvements in Telemedicine Services

Riley Olson

I. INTRODUCTION

Nearly one in five Americans have a mental health condition,[1] and during the COVID-19 pandemic, approximately four in ten adults have reported anxiety or depressive disorder symptoms.[2] In contrast, approximately only one in ten adults reported symptoms of anxiety or depressive disorder in 2019 prior to the pandemic.[3] As healthcare providers look for ways to safely expand access and deliver healthcare, the mental health crisis spurred by the COVID-19 pandemic has prompted the increased use of telemedicine services.[4]

Telemedicine policy varies amongst the states, with no two states possessing the same standard in how telehealth is defined, regulated, or reimbursed.[5] Even amidst the COVID-19 pandemic, this trend has continued.[6] The vast variability of telemedicine policies produces widespread ambiguity in how laws and regulations of telemedicine services are executed, which creates barriers that can hinder patient access.[7] For this

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[1] Megan Leonhardt, *What you need to know about the coast and accessibility of mental health care in America,* CNBC MAKE IT (May 10, 2021), https://www.cnbc.com/2021/05/10/cost-and-accessibility-of-mental-health-care-in-america.html.
[2] Nirmita Panchal et al., *The Implications of COVID-19 for Mental Health and Substance Use*, KAISER FAMILY FOUND. (Feb. 10, 2021), https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/.
[3] *Id.*
[4] Oleg Bestsennyy et al., *Telehealth: A quarter-trillion-dollar post-COVID-19 reality?* MCKINSEY & CO. HEALTHCARE SYS. & SERV. (July 9, 2021), https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/telehealth-a-quarter-trillion-dollar-post-covid-19-reality.
[5] Center for Connected Health Policy, *State Telehealth Laws and Reimbursement Policies*, THE NAT'L TELEHEALTH POL'Y RES. CTR. (2021), https://www.cchpca.org/2021/10/Fall2021_Infographic_FINAL.pdf.
[6] *Id.*
[7] Samantha Achenbach, *Telemedicine: Benefits, Challenges, and Its Great Potential,* 14 HEALTH L. & POL'Y BRIEF 1 (2020).

reason, nearly every state may benefit from altering the scope of telemedicine restrictions they have in place. This article will focus on Illinois; specifically, it aims to pinpoint the gaps in Illinois' telemedicine laws and regulations and propose optimal legislative and policy changes that should be made to expand healthcare coverage, thereby remedying the ambiguity problem and increasing patient access through convenient and accessible care.[8]

The allowances and restrictions that govern telemedicine practice will continue to change as states adapt to the evolving COVID-19 pandemic.[9] As of January 5, 2022, only three states—Arizona, Florida, and Indiana—allow all providers to practice telehealth across state lines effectively.[10] These three states have a straightforward licensing process for all healthcare providers to practice within their state, regardless of whether the provider is in-state or out-of-state.[11] Illinois, on the other hand, does not have a clear telemedicine licensing process, which creates a barrier for Illinois patients seeking care through telemedicine or from an out-of-state provider.[12] Such issues, concerning unclear health care provider licensure processes and jurisdictional boundaries, are sometimes considered to be the unanticipated consequences of telehealth expansion. [13]

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[8] Carrie Macmillan, *Why Telehealth for Mental Health Care is Working*, YALE MED. (Sept. 16, 2021), https://www.yalemedicine.org/news/telehealth-for-mental-health.
[9] *Telehealth licensing requirements and interstate compacts*, HRSA (Sept. 8, 2021), https://telehealth.hhs.gov/providers/policy-changes-during-the-covid-19-public-health-emergency/telehealth-licensing-requirements-and-interstate-compacts/.
[10] Anuja Vaidya, *Many States Hit Hard by COVID-19 Limit Telehealth Practice, Report Finds*, MHEALTH INTELLIGENCE (Jan. 5, 2022), https://mhealthintelligence.com/news/many-states-hit-hard-by-covid-19-limit-telehealth-practice-report-finds.
[11] *Telehealth Laws Across the U.S. in 2022: How Each State Measures Up*, MEDLINK, https://medlinkstaffing.com/telehealth-laws-across-the-u-s-in-2022-how-each-state-measures-up-%ef%bf%bc/.
[12] *Id.* (explaining how Illinois has barriers to patient access in comparison to Arizona, Florida, and Indiana which allow all providers to practice telehealth across state lines).
[13] Mitchell Panter, *Potential Legal Implications of Telemedicine and Telehealth*, LAW TECH. TODAY (Jan. 25, 2021), https://www.lawtechnologytoday.org/2021/01/implications-of-telemedicine-and-telehealth/.

This article will first address the background of telemedicine service: what it is, where it is used, and how it is implemented. Next, this article will advocate for the use of telemedicine services to mitigate the mental health crisis in the United States by providing patients with greater access to healthcare and will explain why Illinois should maximize access to these services. Then, this article will detail the current Illinois telemedicine regulations and compare how such regulations vary from state to state. Finally, the article will describe Illinois' parity law and look to it as a model for recommending policy enforcement that Illinois should adopt while also acknowledging and addressing potential pitfalls.

II. THE BACKGROUND OF TELEMEDICINE SERVICES

The terms "telehealth" and "telemedicine" tend to be used interchangeably.[14] Telehealth is generally used to describe healthcare diagnosis, management, and education.[15] Telemedicine is usually defined as the remote delivery of healthcare services and clinical information using telecommunications technology.[16] Telemedicine involves clinical services, such as a mobile app that allows physicians to video-conference with their patients, or a software solution that allows a primary care physician to communicate with another physician to aid in a patients' diagnosis.[17] However, the definitions of these terms vary from state to state.[18] These platforms are used by a variety of healthcare providers, including hospitals, clinics, and physicians, to interact with patients and other providers.[19] For

[14] *The Ultimate Telemedicine Guide: What is Telemedicine?*, EVIST (May 25, 2018), https://evisit.com/resources/what-is-telemedicine/#2.
[15] *About Telehealth*, CTR. FOR CONNECTED HEALTH POL'Y, https://www.cchpca.org/about/about-telehealth (last visited Feb 2, 2022).
[16] Panter, *supra* note 13.
[17] EVisit, *supra* note 14.
[18] *Id.*
[19] *Id.*

the purposes of this article, the term "telemedicine services" means both telemedicine and telemedicine platforms that are delivering services to patients.

Telemedicine services play a crucial role in the effort to increase health care affordability and value.[20] This is because "virtual care technology saves patients time and money, reduces patient transfers, emergency department and urgent care center visits, and delivers savings to payers."[21] Additionally, telemedicine services allow patients to be seen by healthcare providers regardless of their physical location,[22] eliminating "waiting times, travel times, and travel expenses that occur when seeking face-to-face health consultation."[23] Hence, patients have greater access to health care specialists and can choose when and how they want to see their provider.[24] Because the cost and accessibility to mental health care are prohibitive for many Americans, telemedicine within the healthcare system is vital to alleviate the mental health care crisis in the United States.[25]

Despite technological advancements that have prompted the use of telemedicine services across the country, implementation varies across states.[26] In addition, there are currently no uniform telemedicine laws or regulations among states.[27] Research supports the idea that telemedicine

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[20] *Fact Sheet: Telehealth*, AM. HOSP. ASS'N (Feb. 2019), https://www.aha.org/system/files/2019-02/fact-sheet-telehealth-2-4-19.pdf.
[21] *Id.*
[22] EVisit, *supra* note 14.
[23] Hassan Khader Y Almathami et al., *Barriers and Facilitators That Influence Telemedicine-Based, Real-Time, Online Consultation at Patients' Homes: Systematic Literature Review*, 22 J. OF MED. INTERNET RSCH. (Feb. 2020), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7059083/.
[24] *Id.*
[25] Leonhardt, *supra* note 1.
[26] *State Telehealth Laws and Reimbursement Policies*, CTR. FOR CONNECTED HEALTH POL'Y, (Oct. 2021), https://www.cchpca.org/resources/state-telehealth-laws-and-reimbursement-policies-report-fall-2021/.
[27] Jayme Matchinski, *Telehealth and telemedicine: Surveying the regulatory landscape*, WESTLAW (Oct. 2018),

services improve health outcomes by providing greater access to healthcare needs, while enhancing cost reductions and patient satisfaction efficiencies.[28] This suggests that increased use of telemedicine services benefits patients and will help meet the ever-increasing need for mental health care services. This is why Illinois should adopt laws and regulations that increase patients' access to telemedicine services and eliminate the ambiguities associated with these services that create barriers to patient access.

III. CURRENT TELEHEALTH SERVICES LAWS AND REGULATIONS

The use of telemedicine services is "thirty-eight times higher" than before the start of COVID-19.[29] This growth "was enabled by these factors: 1) increased consumer willingness to use telehealth, 2) increased provider willingness to use telehealth, 3) regulatory changes enabling greater access and reimbursement."[30] The remainder of this article will focus on the impact of regulatory changes on access and reimbursement. There are two crucial aspects of telemedicine-related laws and regulations that create barriers to patient access to mental health care: licensure requirements for providers and the definition of a provider's "standard of care."[31] Gaps exist in Illinois' telemedicine laws and regulations regarding state licensure requirements for physicians. Illinois' parity law and the federal 2005 Public Readiness and Emergency Preparedness Act (PREP Act) should be used as models for other Illinois legislation to address the state licensure requirements and thereby alleviate barriers to patient access to care.

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https://www.greensfelder.com/media/publication/333_Matchinski_telehealth-telemedicine_Oct2018.pdf.

[28] *Top 3 Ways Telehealth is Impacting Health Care,* TEX. WOMAN'S UNIV. (Feb. 1, 2021), https://onlinenursing.twu.edu/blog/top-3-ways-telehealth-impacting-health-care.

[29] *Bestsennyy* et al., *supra* note 4.

[30] *Id.*

[31] Achenbach, *supra* note 7.

IV. CURRENT TELEMEDICINE LAWS IMPACTING ILLINOIS

A. The 2005 Public Readiness and Emergency Preparedness Act

The PREP Act[32] authorizes the Secretary of the Department of Health and Human Services (HHS) to make declarations that provide physicians with protection from liability (except for willful misconduct) in certain emergency situations.[33] On December 9, 2020, HHS published Amendment 4 to the Act, which allows for the interstate practice of telemedicine to improve public health outcomes in an emergency by permitting providers to provide care under specified covered countermeasures.[34] In 2021, HHS ratified Amendment 8, which determined that the state's laws where the provider is licensed apply when they provide covered COVID-19 countermeasures to a qualified patient in another state.[35]

Currently, the PREP Act only allows exemptions from state licensure to providers that order or administer their services under the specifically covered countermeasures.[36] However, the list of covered countermeasures is relatively selective and thus excludes a vast majority of patients who would benefit from providers receiving the exception and liability protection.[37] The legislature should amend the PREP Act to expand its coverage to individuals seeking mental health services; in instances where liability issues arise, the

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[32] The PREP Act is a federal law but applies to the states and therefore will impact patient access in Illinois.
[33] Fourth Amendment to the Declaration Under the Public Readiness and Emergency Preparedness Act for Medical Countermeasures Against COVID-19 and Republication of the Declaration, 85 FED. REG. 79191 (Dec. 9, 2020).
[34] *Id.* at 79192.
[35] HRSA, *supra* note 9.
[36] *Id.*
[37] *Id.* (explaining that because the covered countermeasures list only includes qualified products used to treat, diagnose, cure, prevent, or mitigate COVID-19; drugs, biological products, or devices authorized for COVID-19 emergency use; and respiratory-protective devices approved by the National Institute for Occupational Safety and Health that many patients will be excluded from access because their physician does not have state licensure and liability protection).

state's laws where the provider is licensed will govern.[38] Additionally, the legislature should amend the PREP Act's list of covered countermeasures, thereby expanding its authority to include mental health services, which in turn would create more coverage for individuals seeking these services.

B. Illinois' Parity Law

Previously, Illinois had no mental health parity law.[39] Mental health parity law "requires insurers to provide the same level of benefits for mental illness, serious mental illness or substance abuse as for other physical disorders and diseases."[40] Currently, Illinois has adopted a law that establishes payment parity for mental health and substance abuse disorders and increases access for patients by allowing patients the right to request virtual care without specifying a reason for doing so.[41] This legislation was significant because Illinois became one of the first states in the United States to enact permanent legislation from an emergency pandemic response.[42] The parity bill offers increased flexibility to patients and providers using telemedicine services by detailing that insurance companies are prohibited from taking certain actions including, but not limited to: requiring in-person contact between a health care provider and patient prior to providing telemedicine services, requiring patients or providers to prove hardship or access barriers as a condition for telemedicine services, requiring "a health care professional to be physically

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[38] *Id.* (detailing how federal and state policies simplify cross-state telehealth).
[39] Nicol Turner Lee et al., *Removing regulatory barriers to telehealth before and after COVID-19*, BROOKINGS (May 6, 2020), https://www.brookings.edu/research/removing-regulatory-barriers-to-telehealth-before-and-after-covid-19/.
[40] *Mental Health Benefits: State Laws Mandating or Regulating*, NAT'L CONF. OF STATE LEG. (Dec. 2015), https://www.ncsl.org/research/health/mental-health-benefits-state-mandates.aspx.
[41] Eric Wicklund, *New Illinois Law Gives Patients the Right to Choose – or Reject – Telehealth*, MHEALTH INTEL. (July, 2021), https://mhealthintelligence.com/news/new-illinois-law-gives-patients-the-right-to-choose-or-reject-telehealth.
[42] *Id.*

present in the same room as the patient at the originating site,"[43] and creating geographic or facility restrictions for telemedicine services.[44] This type of legislation—created and implemented as a response to COVID-19—is a plausible model for the Illinois legislature to follow in an effort to expand all regulations concerning telemedicine services, and thus increase patients' access.

C. State Licensure Requirements for Physicians in Illinois

Sometimes when physicians provide telemedicine services, they practice across state lines.[45] State licensure laws typically require providers to be licensed in the state in which the patient is located.[46] In Illinois, for example, a physician treating an Illinois patient must have an Illinois medical license.[47] As a result, state licensure laws may prohibit a physician from providing care to an out-of-state patient.[48]

It is necessary to acknowledge, however, that Illinois is one of thirty-one states that has adopted a version of the Federation of State Medical Board's Interstate Licensure Compact.[49] The compact allows for an expedited

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[43] Richard L. Hindmand, *Illinois enacts telehealth parity bill*, MCDONALD HOPKINS (July 27, 2021), https://mcdonaldhopkins.com/Insights/July-2021/Illinois-enacts-telehealth-parity-bill.
[44] *Id.*
[45] HRSA, *supra* note 9.
[46] *COVID-19: State Law Telehealth Update: State Licensure Requirements Persist, Permissible Telehealth Modalities Generally Expand, and Insurance Parity Laws Ensure Reimbursement*, 12 NAT'L L. REV. 73 (Feb. 2022), https://www.natlawreview.com/article/covid-19-state-law-telehealth-update-state-licensure-requirements-persist.
[47] Federation of State Medical Boards, *U.S. States and Territories Modifying Requirements for Telehealth in Response to COVID-19*, FSMB, https://www.fsmb.org/siteassets/advocacy/pdf/states-waiving-licensure-requirements-for-telehealth-in-response-to-covid-19.pdf (last updated: Feb. 22, 2022).
[48] *Id.*
[49] Center for Connected Health Policy, *State Telehealth Laws and Reimbursement Policies*, THE NAT'L TELEHEALTH POL'Y RES. CTR. (2022), https://www.cchpca.org/illinois/?category=professional-requirements&topic=licensure-compacts.

process when physicians apply for licenses in other compact states.[50] While Illinois' participation in the compact is valuable because it improves and increases health care access across the state and other states in the compact, this alone is not enough.[51] The issue remains that licensure laws may prohibit a physician from providing care to an out-of-state patient because the compact does not abolish licensure requirements for physicians in Illinois;[52] it simply expedites the process.

Further, an out-of-state physician who provides services to a patient in Illinois through telemedicine services submits themselves to Illinois court jurisdiction.[53] This is problematic because many states define telemedicine differently.[54] Varying state requirements make it complicated and expensive for health care providers to be licensed in multiple states, and out-of-state licensing is not financially feasible for all providers.[55] Thus, barriers endure in Illinois' efforts to improve patient care.

In comparison to Illinois' processes, eleven states—Alabama, Louisiana, Nevada, New Jersey, New Mexico, Ohio, Oklahoma, Oregon, Pennsylvania, Texas, Tennessee[56]—issue a special telemedicine license that allows

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[50] *A Faster Pathway to Physician Licensure*, INTERSTATE MED. LICENSURE COMPACT (2021), https://www.imlcc.org/a-faster-pathway-to-physician-licensure/.
[51] Joseph Liss et al., *Mutual Recognition of Physician Licensure By States Would Provide For Better Patient Care*, HEALTHAFFAIRS (May 10, 2021), https://www.healthaffairs.org/do/10.1377/forefront.20210505.311262/full/.
[52] *Id.*
[53] Center for Connected Health Policy, *supra* note 49.
[54] Kimberly Lovett Rockwell, *The Promise of Telemedicine Current Landscape and Future Decisions*, MICH. B. J., 38, 39 (Feb. 2017).
[55] *Can Doctors Provide Telehealth Across State Lines?,* OMNISURE, https://www.omnisure.com/can-doctors-provide-telehealth-across-state-lines/.
[56] *Telehealth*, AM. ACADEMY OF FAMILY PHYS. (Oct. 2021), https://www.aafp.org/dam/AAFP/documents/advocacy/health_it/telehealth/BGK-Telehealth-General.pdf (explaining 12 state medical and/or osteopathic boards in 11 states issue a special telemedicine license. Nevada and New Mexico limit the license to their medical boards, Oklahoma and Tennessee limit it to their osteopathic boards, and Pennsylvania issues the license to both medical and osteopathic boards).

physicians to practice across state lines.[57] These states have professional boards that issue special licenses or certificates, or have exceptions to telehealth licensing requirements, which may include "simply registering with an in-state board rather than obtaining full licensure."[58] If Illinois adopted this special licensure model instead of the current Federation of State Medical Board's Interstate Licensure Compact, then an out-of-state provider would be permitted to administer telemedicine services in a state where they are not physically located or licensed.[59] This means that out-of-state providers would be permitted to practice telemedicine in Illinois. Furthermore, if every state implemented this special licensure policy, then providers nationwide could render telemedicine services out-of-state, thereby mitigating the barrier posed by divergent state licensing requirements.

While the Federation of State Medical Board's Interstate Licensure Compact expedites the process for physicians applying for and receiving licenses in member-states, Illinois should instead forego the full licensure requirement in favor of a special telemedicine licensure policy that would grant physicians the ability to fully maximize their access to Illinois patients, and thereby increasing patients' access to mental health care services.

D. The Definition of Standard of Care Across States

A physician's "standard of care owed to patients is the level of skill, expertise, and care possessed and practiced by physicians in the same or similar community, and under similar circumstances."[60] Standard of care is

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[57] *Id.*
[58] Center for Connected Health Policy, *State Telehealth Laws and Medicaid Program Policies*, THE NAT'L TELEHEALTH POL'Y RES. CTR. (2021), https://www.cchpca.org/2021/10/Fall2021_ExecutiveSummary_FINAL.pdf.
[59] *Id.*
[60] *Standard of Care: Treatment and Surgery*, FINDLAW, https://www.findlaw.com/injury/medical-malpractice/sub-standard-care-treatment-or-surgery.html#:~, last updated Nov. 2018).

a uniform standard that is generally established using expert testimony.[61] In the healthcare setting, the standard of care establishes a physician's duty and is sensitive to the time, place, and person involved.[62] A failure to adhere to the standard of care results in a breach of the duty a physician owes to their patient, and could potentially result in medical malpractice.[63]

Many states have not clearly defined what standard of care a physician providing telemedicine services must adhere to.[64] Thus, inconsistencies amongst states create uncertainty because the standard of care may be different for physicians who are treating patients through telemedicine versus a traditional "in-person" standard of care.[65] Moreover, by attempting to create their own state-specific regulations for the telemedicine standard of care, states are altering the way physicians interact with their patients through telemedicine.[66] Thus, state-specific regulations limit other interactions physicians have with their patients, such as how they would establish the physician-patient relationship or prescribing practices.[67]

For example, some states—New York, Alabama, California, Florida, Texas, Georgia, and North Carolina—have enacted detailed laws that provide guidance on adhering to a telemedicine-specific standard of care.[68] Even though most states assert that the standard of care for telemedicine

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[61] Robert H. Aicher, *What Standard of Care?* 36 AESTHETIC SURGERY J. 376, 377 (2016).
[62] Allison Grady, *The Importance of Standard of Care and Documentation,* 7 ETHICS J. OF THE AMA 756, 757 (Nov. 2005), https://journalofethics.ama-assn.org/sites/journalofethics.ama-assn.org/files/2018-07/hlaw1-0511.pdf.
[63] *Standard of care*, LEGALDICTIONARY.NET, https://legaldictionary.net/standard-of-care (last visited Mar. 20, 2022).
[64] Alexis Slagle Gilroy, *Telemedicine, Mobile Health and the Standards of Care - A Look at State Specific Policies Altering Traditional Standards of Care Requirements as Applied to Telemedicine and Impacting the Utilization of Mobile Technologies,* AM. ASS'N ADVANCEMENT OF SCI. 3 (2014), http://www.aaas.org/sites/default/files/Gilroy-Telemedicine%2C%20mHealth%20and%20the%20Standard%20of%20Care.pdf.
[65] *Id.* at 2-3.
[66] *Id.* at 3.
[67] *Id.*
[68] *Id.* at 4.

should be the same as it is for in-person care, those states differ in how they define a "traditional medical practice."[69] This is problematic because in order for telemedicine services to be held to the same standard as traditional in-person settings, a patient would need to have previously received an in-person exam.[70] This would effectively prohibit telemedicine for patients that are unable to meet a physician in-person.[71] Furthermore, states, such as Texas, require that the standard of care for telemedicine be the same as in-person care, but necessitates the use of a patient site presenter.[72] A patient site presenter is "an individual who facilitates the use of telemedicine equipment and the telemedicine encounter at the patient's bedside."[73] Other states, such as Illinois, allow for independent physician judgment within the bounds of established procedures and physician discretion under certain circumstances.[74] Such ambiguity and variability among and within states creates uncertainty for telemedicine providers and makes it difficult to implement regulations. Thus, it is necessary to endorse regulations that create a uniform definition of the standard of care for telemedicine.

V. CONCLUSION

Telemedicine services will continue to rapidly evolve amid the COVID-19 pandemic.[75] While Illinois' adoption of the parity law marks a significant stride in access to telemedicine services, the state still has significant barriers in place. It would be beneficial for 1) there to be a federally recognized

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[69] *Id.*
[70] *Id.* at 5.
[71] *Id.*
[72] Clay Wortham & Tesch West, *2017 Legislation Expands Telemedicine Opportunities in Texas and Ends Teladoc Dispute*, 20 J. HEALTHCARE COMPLIANCE 59 (2018).
[73] *Id.*
[74] Laura Wibberley, *Telemedicine in Illinois: Untangling the Complex Legal Threads*, 50 J. MARSHALL L. REV. 885, 891 (2017).
[75] Bestsennyy, *supra* note 4.

standard of care for telemedicine services that states such as Illinois can adopt; and 2) Illinois to adopt special licensure requirements that other states have enacted. If these federal and state changes are made, the ambiguities associated with telemedicine services will be eliminated, giving Illinois patients increased access to such services.[76]

[76] Macmillan, *supra* note 8.

Using Telehealth to Address Mental Illness in Prisons

Giovanni Padilla

I. INTRODUCTION

Nationwide, there is a mental health crisis.[1] To address this growing issue, we must first evaluate the contexts where this crisis is most prominent. No institution struggles with mental illness more than our prison system.[2] The prison system has become one of the largest providers of mental health care in the nation.[3] However, the quality-of-care prisoners receive is severely lacking.[4] Moreover, a significant number of inmates receive no mental health care while incarcerated, further contributing to the national crisis.[5] This paper proposes the expansion of telehealth services as a solution to mental health care in prisons. Part I of this paper looks at the state of healthcare in prisons across the country. Part II proposes the expansion of telehealth services as a means to address the rising need for mental health care in prisons. Finally, Part III proposes certain legal changes that must be made in order to effectively expand the use of telehealth services in prisons.

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[1] Alison M. Darcy & Timothy Mariano, *Mental Health in America: A Growing Crisis*, PSYCH. TIMES (Aug. 6, 2021) https://www.psychiatrictimes.com/view/mental-health-america-crisis.

[2] *See* Doris J. James & Lauren E. Glaze, *Bureau of Justice Statistics Special Report: Mental Health Problems of Prison and Jail Inmates*, U.S DEPT. OF JUST. (Sept. 2006), https://bjs.ojp.gov/content/pub/pdf/mhppji.pdf. (discussing mental illness across jails and prisons; Marisa Peñaloza, *America's Mental Health Crisis is Hidden Behind Bars*, NPR (Feb. 25, 2020) https://www.npr.org/2020/02/25/805469776/americas-mental-health-crisis-hidden-behind-bars (discussing the state of mental health treatment in prisons).

[3] Matt Ford, *America's Largest Mental Hospital is a Jail*, ATLANTIC (Jun. 8, 2015) https://www.theatlantic.com/politics/archive/2015/06/americas-largest-mental-hospital-is-a-jail/395012/; Ailsa Chang, *'Insane': America's 3 Largest Psychiatric Facilities Are Jails*, NPR (Apr. 25, 2018). https://www.npr.org/sections/health-shots/2018/04/25/605666107/insane-americas-3-largest-psychiatric-facilities-are-jails.

[4] Katherine Rohde et al., *Reforming Health Care for Patients in Prison*, REGUL. REV. (Feb. 12, 2022), https://www.theregreview.org/2022/02/12/saturday-seminar-reforming-health-care-patients-prison.; Chloe Hilles, *Health Care in Illinois Prisons is Deficient: Report*, INJUSTICE WATCH (Oct. 21, 2021) https://www.injusticewatch.org/news/prisons-and-jails/2021/health-care-illinois-prisons-monitor-report/.

[5] *See* Andrew P. Wilper et al., *The Health and Health Care of US Prisoners: Results of a Nationwide Survey*, 99 AM. J. PUB. HEALTH 666, 669 (2009) (detailing a lack of medical examinations and medication that prisoners receive).

II. HEALTHCARE IN PRISONS

In 1976, the United States Supreme Court in *Estelle v. Gamble* held that depriving incarcerated people of adequate medical care is a violation of the Eighth Amendment's ban on cruel and unusual punishment.[6] Thus, the only group of people in the United States with an acknowledged constitutional right to receive health care are those that are incarcerated.[7] However, "adequate medical care" has not been defined in the statute.[8] This has led to the overall poor quality of health care in prisons, with those incarcerated facing many hurdles to receiving acceptable or appropriate treatment.[9]

Three factors are the most common barriers to access care. First, understaffing continues to reduce the quality of health care in prisons across the states.[10] Budgets for the provisioning of health care services in prisons vary by state, and lower budgets usually indicate fewer available medical staff, or poorly-trained staff.[11] The lack of available or adequately-trained staff contributes to the quality of care in prisons by reducing access—one study indicated approximately sixty-eight percent of jail inmates, twenty percent of state prison inmates, and fourteen percent of federal prison inmates did not receive medical examinations.[12] Further, twenty-one percent of federal, twenty-four percent of state, and thirty-six percent of jail inmates did

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[6] Estelle v. Gamble, 429 U.S. 97, 104–05 (1976).
[7] *See* Rohde, *supra* note 4.
[8] *Id*.
[9] *Id*.
[10] Nicholas Wallace, *The Real Lethal Punishment: The Inadequacy of Prison Health Care and How it Can Be Fixed*, 4 FAULKNER L. REV. 265, 290 (2012).
[11] Arvind Dilawar, *'Cruel and Unusual Punishment': The Questionable State of Medical Care at Louisiana State Penitentiary*, PAC. STANDARD (Oct. 19, 2018), www.psmag.com/social-justice/the-questionable-state-of-medical-care-at-louisiana-state-penitentiary.
[12] *See* Wilper, *supra* note 5.

not receive the required medication they needed during their incarceration or had stopped taking medication altogether.[13]

Second, in various states, providers have shown a hesitancy to providing mental health services inside of correctional facilities due to safety concerns.[14] Providers have also cited added costs of traveling to facilities as well as the opportunity cost of not seeing more patients in their clinics as reasons for avoiding treating inmates.[15] Lack of access to care in facilities forces many prisoners to leave their facilities to seek care.[16] However, seeking care outside of correctional facilities is not easier, as some providers have also been unwilling to treat inmates in their private practices because of the perceived increased danger to both providers and their other patients.[17]

Third, increasing costs associated with health care in prisons pose a significant barrier to providing adequate care for inmates.[18] The most considerable reason behind the rise in costs is the increased overall prison population.[19] Increased population has coincided with operational costs rising on a yearly basis, with health care accounting for ten percent of increases.[20] Specifically, the increase in prisoners with mental illness has corresponded with increased costs of health care.[21] In 2000, the costs

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[13] *Id*.
[14] Stacie A. Deslish et al., *Telepsychiatry in Correctional Facilities: Using Technology to Improve Access and Decrease Costs of Mental Health Care in Underserved Populations*, 17 PERMANENTE J. 80, 80 (2013).
[15] *Id*.
[16] Alena Nikuliak, *Telemedicine for Prisons: Reduced Costs and Improved Patients' Health Outcomes*, SCIENCESOFT (May 23, 2021), https://www.scnsoft.com/blog/telemedicine-in-prisons.
[17] Deslish et al., *supra* note 14, at 81.
[18] Wallace, *supra* note 10, at 275.
[19] *Id*. at 276.
[20] *Id*.
[21] *Id*. at 277.

associated with treating mental illness amongst prisoners were estimated at $15 billion and expected to rise.[22] Another contributing factor to rising costs is the transportation costs associated with an estimated 45,000 inmates that travel outside of prison to receive health care.[23] Transporting an inmate outside of a correctional facility increases transportation and person-hour costs.[24] The cost of transporting inmates to receive such care has been cited at $90 million annually.[25] Furthermore, prisoners suffering with mental illness have higher recidivism rates and spend a longer amount of time imprisoned, which effectively contributes to rising costs.[26]

Lack of medical care is of specific concern to those with a mental illness because individuals with a mental illness typically stay imprisoned four to eight times longer, and cost states seven times more than people without mental illness.[27] Further, as stated above, addressing the issue of mental health care in prisons is of increasing importance as prisons have become some of the largest providers of mental health services in the United States.[28] Between 1880 and 1960, 0.7 to 1.5 percent of prisoners suffered from mental illness.[29] Today, statistics show that fifteen to twenty percent of prisoners

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[22] *Id*.
[23] Nikuliak, *supra* note 16.
[24] Deshlish et al., *supra* note 14, at 80-81.
[25] Joel E. Barthelemy, *Correctional Healthcare Is Changing and Here's Why*, GLOBALMED (Oct. 27, 2021) https://www.globalmed.com/correctional-healthcare-is-changing.
[26] *Ill-Equipped: U.S. Prisons and Offenders with Mental Illness*, HUM. RTS. WATCH (Oct. 21, 2003), www.hrw.org/report/2003/10/21/ill-equipped/us-prisons-and-offenders-mental-illness# [hereinafter *Human Rights Watch*].
[27] Chelsea Davis & David Cloud, *Bridging the Gap Improving the Health of Justice-Involved People through Information Technology*, VERA 1, 4 (Feb. 2015), https://www.prisonpolicy.org/scans/vera/samhsa-justice-health-information-technology.pdf.
[28] *See* Ford, *supra* note 3.
[29] Julia Schon, *Why Are California's Prisons and Streets Filled with More Mentally Ill than Its Hospitals: California's Deinstitutionalization Movement*, 59 SANTA CLARA L. REV. 269, 273 (2019).

have serious mental illnesses.[30] Lack of care or insufficient staffing of mental health professionals are factors that could distinguish a stable individual from one who experiences a poor mental health outcome.

Prisons were not intended to provide mental health care to such a large number of people.[31] Because prisons are unprepared, thousands of inmates face the potential risk of delayed diagnoses, ineffective care, and even abusive or violent care.[32] To illustrate, one study found that ninety-nine percent of mental health diagnoses in prisons are not made until twenty-nine months into a prisoner's sentence.[33] Abusive care on behalf of guards, officers, and physicians in prison may stem from a lack of awareness that a prisoner has a mental health condition to begin with.[34] Lack of proper treatment can lead mentally ill inmates to suffer from painful symptoms as their conditions worsen and as their overall health deteriorates.[35] Suffering with mental illness in prison makes it more difficult for individuals to follow prison rules.[36] Specifically, mental illness creates difficulty dealing with the

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[30] *See* E. Fuller Torrey et al., *More Mentally Ill Persons Are in Jails and Prisons Than Hospitals: A Survey of the States*, TREATMENT ADVOC. CTR. 1, 4 (2010), https://www.treatmentadvocacycenter.org/storage/documents/final_jails_v_hospitals_study.pdf. Of note, there is a distinction between mental health illnesses and 'serious' mental illness, and the full scope is not captured in this statistic.; *But see* KiDeuk Kim et al., *The Processing and Treatment of Mentally Ill Persons in the Criminal Justice System*, URBAN INST. (Mar. 2015), https://www.urban.org/sites/default/files/publication/48981/2000173-The-Processing-and-Treatment-of-Mentally-Ill-Persons-in-the-Criminal-Justice-System.pdf (an estimated 56 percent of state prisoners, forty-five percent of federal prisoners, and sixty-four percent of jail inmates have a mental health problem).
[31] *Human Rights Watch*, *supra* note 26.
[32] Maggie Puniewska, *The Prison System is Designed to Ignore Mental Health*, VICE (Jun. 1, 2017, 1:00 PM) https://www.vice.com/en/article/bj8gy4/the-prison-system-is-designed-to-ignore-mental-illness.
[33] *Id*.
[34] *Id*.
[35] *Human Rights Watch*, *supra* note 26.
[36] *Id*.

stress of prison and following a regimented daily life.[37] Those with mental illness are twice as likely to be reported for violating rules.[38] The World Health Organization Mind Project reports that twenty-four percent of inmates with a mental illness have assaulted another inmate in a correctional facility, and that they are twice as likely to be injured in a fight than inmates without a mental illness.[39] Combine poor experiences and lack of treatment, and one can understand why the mentally ill face substantially higher rates of recidivism.[40]

The impact of recidivism is the creation of a system where an individual may spend an increased amount of time in a correctional facility.[41] For those with mental illness, recidivism places them back in the same facilities that provided poor care to begin with.[42] Advocates believe recidivism rates would decrease if prisoners with mental illness had access to proper treatment and resources.[43] Prisoners not only have a right to health care, but it is in the best interest of society they are provided with adequate mental health care.[44] By providing care and lowering recidivism rates, the overall financial burden on

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[37] *Id.*
[38] *See* James & Glaze, *supra* note 2 at 4.
[39] Deslish et al., *supra* note 14, at 81.
[40] *Human Rights Watch*, *supra* note 26.
[41] Shon Hopwood, *How Atrocious Prisons Conditions Make Us All Less Safe*, BRENNAN CTR. (Aug. 9, 2021) https://www.brennancenter.org/our-work/analysis-opinion/how-atrocious-prisons-conditions-make-us-all-less-safe.
[42] *See* Ebony N. Russ et al., *Prison and Jail Reentry and Health*, HEALTH AFFS. (Oct. 28, 2021) https://www.healthaffairs.org/do/10.1377/hpb20210928.343531/ (discussing difficulty prisoners face upon reentry).
[43] Maria DiLorenzo, *Mental Illness and the Justice System*, CRIME REP. (Jan. 5, 2022) https://thecrimereport.org/2022/01/05/mental-illness-and-the-justice-system/.
[44] Hopwood, *supra* note 41.

prisons decreases.[45] To do so, we should look to increase staffing and provider participation, with a solution that lowers costs.

III. USING TELEHEALTH TO PROVIDE MENTAL HEALTH CARE IN PRISONS

The use of telehealth services would serve as a solution to the mental health crisis in prisons. Telehealth services provided by psychiatrists have proven to be very similar to in-person care.[46] Telehealth services include typical elements of in-person care such as initial diagnosis evaluations, consultations, patient education, medication management, and individual and family and group therapy sessions.[47] In addition, videoconferencing is just as reliable in diagnosing patients as is traditional care.[48] Thus, use of telehealth can address the ongoing issue of lack of proper diagnosis that inmates face.[49] Further, reports from patients indicate that they feel they can share information via telehealth in the same way they would if they were in-person.[50] Overall, the use of telepsychiatry can lead to greater access in care, positive clinical outcomes, and increased patient satisfaction.[51]

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[45] *See id*. (longer time spent incarcerated leads to the state spending more); *see also* Davis & Cloud, *supra* note 27 (those with mental illness cost the state seven times more).
[46] *What is Telepsychiatry?*, AM. PSYCHIATRIC ASS'N, (Aug. 2020) https://psychiatry.org/patients-families/telepsychiatry (last visited May 1, 2022) [hereinafter *What is Telepsychiatry?*].
[47] *Id*.
[48] *Resource Document on Telemedicine: Synchronous Video-conferencing in Psychiatry*, AM. PSYCHIATRIC ASS'N 1, 2 (2017), https://www.psychiatry.org/psychiatrists/search-directories-databases/library-and-archive/resource-documents.
[49] *See* Puniewska, *supra* note 32 (detailing that inmates often face delays in initial diagnosis of up to twenty-nine months).
[50] Carolyn Lauckner & Pamela Whitten, *The State and Sustainability of Telepsychiatry*, 43 J. BEHAV. HEALTH SERV. & RSCH. 305, 306 (2016).
[51] *Id.*

Outside of the prison system, telepsychiatry has already effectively been used to treat several mental illnesses, including panic disorders, depression, and post-traumatic stress disorder.[52] Telepsychiatry has been used among diverse populations such as children, college students, immigrants, veterans, rural residents, and inmates.[53] Using a system that works with such diverse populations is important because racial minorities are overrepresented in prisons.[54] Further, the use of such services has been approved by the American Psychiatric Association: "There is substantial evidence of the effectiveness of telepsychiatry and research has found satisfaction to be high among patients, psychiatrists and other professionals. Telepsychiatry is equivalent to in-person care in diagnostic accuracy, treatment effectiveness, quality of care and patient satisfaction. Patient privacy and confidentiality are equivalent to in-person care."[55] It should be noted that telehealth is not completely unfamiliar to prisons: a 2013 survey conducted by the Centers for Disease Control and Prevention (CDC) showed that thirty-nine out of forty-five states were already using telehealth and telepsychiatry.[56]

Telehealth can specifically address the primary concerns with providing health care in prisons. First, the use of telepsychiatry could address

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[52] *Id*.
[53] Stacie Deslich et al., *Telepsychiatry in the 21st Century: Transforming Healthcare with Technology*, 10 PERSP. HEALTH INFO. MGMT. 1, 3 (2013).
[54] Adriana Rezal, *The Racial Makeup of America's Prisons*, US NEWS (Oct. 13, 2021) https://www.usnews.com/news/best-states/articles/2021-10-13/report-highlights-staggering-racial-disparities-in-us-incarceration-rates.
[55] *What is Telepsychiatry?*, *supra* note 46.
[56] Sarah Wurzburg, *Three Things to Know About Implementing Telehealth in Correctional Facilities*, JUST. CTR. (Apr. 12, 2021), https://csgjusticecenter.org/2021/04/12/three-things-to-know-about-implementing-telehealth-in-correctional-facilities/.

understaffing and provider shortages.[57] Provider shortages are a common issue with mental health care.[58] Shortages occur nationwide, and the issue is expected to grow in the future.[59] The use of telehealth could combat these shortages as it has shown an ability to provide more accessible medical care in contexts where conditions would otherwise limit access to physicians or medical facilities.[60] One such circumstance would be in a correctional facilities where inmates are waiting to receive care.[61]

Second, telehealth is a viable solution to the increasing costs associated with providing health care to inmates. One study using a cost-benefit analysis showed that the use of telehealth could lead to a sixty-percent savings.[62] The study showed that average costs of a telemedicine consultation would be $71, compared to $173 for a traditional in person health care consultation.[63] One factor behind this reduction is the removal of transportation costs.[64] Nationally, the costs of transporting inmates to hospitals has been estimated at $90 million annually, with approximately

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[57] David Weiss, *Telepsychiatry is helping to address psychiatric shortages around the country*, MINDCARE (Oct. 16, 2020) https://www.mindcaresolutions.com/telepsychiatry-is-helping-to-address-psychiatric-shortages-around-the-country/.
[58] *New Research Shows Increasing Physician Shortages in Both Primary and Specialty Care*, ASS'N OF AM. MED. COLL. (Apr. 11, 2018), *https://www.aamc.org/news-insights/press-releases/new-research-shows-increasing-physician-shortages-both-primary-and-specialty-care.*
[59] *Id.*
[60] Peter L. Nacci et al., *Implementing Telemedicine in Correctional Facilities*, NAT'L INST. OF JUST. 1, 2 (May 2002), https://www.ojp.gov/pdffiles1/nij/190310.pdf.
[61] Christine Herman, *Most Inmates With Mental Illness Still Wait For Decent Care*, NPR (Feb. 3, 2019, 7:00 AM) https://www.npr.org/sections/health-shots/2019/02/03/690872394/most-inmates-with-mental-illness-still-wait-for-decent-care.
[62] Nacci et al., *supra* note 60.
[63] *Id*.
[64] Nikuliak, *supra* note 16.

45,000 inmates leaving their respective prisons each month for health care.[65] Telehealth can effectively lower or even remove transportation costs.[66] Further, costs related to overutilization of services, compliance with medication programs, and waiting or consultation time have all been shown to decrease with the implementation of telehealth services.[67]

Third, expansion of telepsychiatry can combat safety concerns surrounding providing care to inmates. Because prisoners would not need to leave their facilities in order to receive care, telehealth is perceived as safer by both the public and by medical staff.[68] Further, there could be increased provider participation because of the ability to examine patients without needing to feel unsafe entering a correctional facility.[69] The use of telehealth services has proven to be safer for both physicians and prison staff according to a report from the Department of Justice's Office of Justice Programs.[70]

Lastly, use of telehealth could address the issue of recidivism with mentally ill inmates. Telehealth has been shown to be beneficial for prisoners as they are able to build a relationship with a provider that can continue after release.[71] A majority of telepsychiatry services involve the use of live video

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[65] Joel E. Barthelemy, *Correctional Healthcare is Changing and Here's Why*, GLOBALMED (Oct. 27, 2021) https://www.globalmed.com/correctional-healthcare-is-changing/.
[66] *Id*.
[67] *Id*.
[68] *Id*.
[69] Michael Ollove, *State Prisons Turn to Telemedicine to Improve Health and Save Money*, PEW CHARITABLE TRUSTS (Jan. 21, 2016) https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2016/01/21/state-prisons-turn-to-telemedicine-to-improve.
[70] Nicholas John, *Telemedicine could make prisons healthier, safer, and less expensive*, RSTREET (Jun. 26, 2018) https://www.rstreet.org/2018/06/26/telemedicine-could-make-prisons-healthier-safer-and-less-expensive/.
[71] Wurzburg, *supra* note 56.

conferencing to connect providers with inmates.[72] Moreover, telepsychiatry appointments are increasingly similar to in-person care.[73] Thus, using telehealth is promising because as inmates leave their facility, they can continue to receive care from a provider that they have previously built a relationship with.[74]

It should be noted that there have been some issues with telehealth services. However, most issues associated with increased usage of telepsychiatry in correctional facilities are due to technical concerns.[75] Technical concerns include unreliable internet servers, insufficient internet service to provide quality telehealth care, or difficulty gaining access past the internet firewall utilized by correctional facilities.[76] Additional concerns relating to increased telehealth utilization in correctional facilities include the storage, maintenance, and use of prisoners health data.[77]

The hiring of additional administrative staff may be necessary with the introduction of or increased use of telehealth in prisons.[78] Prisons will need staff available to address any technical or medical issues that may arise during the sessions.[79] Further, when prisons use telehealth services, they are

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[72] *See* generally Donald M. Hilty et al., *The Effectiveness of Telemental Health: A 2013 Review*, 19 TELEMEDICINE J. & E-HEALTH 444, 444 (2013) (reviewing clinical and operational benefits of use of videoconference and telehealth mental health services, finding that additional research is needed to better evaluate outcomes).
[73] Richard O'Reilly, et al., *Is Telepsychiatry Equivalent to Face-to-Face Psychiatry? Results From a Randomized Controlled Equivalence Trial*, 58 PSYCHIATRIC SERVS. 836, 842 (2007) https://ps.psychiatryonline.org/doi/epdf/10.1176/ps.2007.58.6.836.
[74] Barthelemy, *supra* note 65, at 83.
[75] Deslish et al., *supra* note 14, at 84.
[76] *Id*.
[77] M. Mateo, et al., *Telemedicine: contributions, difficulties and key factors for implementation in the prison setting*, 21 REVISTA ESPAÑOLA DE SANIDAD PENITENCIARIA 95, 98 (Apr. 07, 2019).
[78] *Id*.
[79] *Id*.

forced to maintain separate electronic clinical history for both prisons and the health care provider.[80] Information held in the history or record can include progress reports, diagnoses, and prescriptions.[81] The need for increased availability of prison staff may be the biggest barrier to the expansion of telehealth services in prisons, as prisons already face a shortage of resources in providing health services.[82] Although they represent different challenges than the ones correctional facilities are typically accustomed to, these hurdles are not insurmountable.

IV. ADDRESSING BARRIERS TO EXPANSION OF TELEHEALTH SERVICES IN PRISONS

In order to expand telehealth services into prisons, licensing laws for psychiatrists must change.[83] The state licensure system is specifically problematic in that it counters the notable benefit of telepsychiatry—providers can more easily and conveniently reach patients through virtual means.[84] Expanding convenient access to patients is particularly important for prisoners because it would incentivize providers who are otherwise unwilling to offer care to inmates.[85] Yet, current state licensure systems limit providers to only offer psychiatric services in the state in which the provider

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[80] *Id*. at 99.
[81] *Id*.
[82] *Id*. at 98.
[83] Lisa V. Parciak, *The Future Cannot Come Soon Enough: How Federal Regulation of Telepsychiatry Is Necessary to Create Greater Access to Mental Health Services During a Time When Psychiatrists Are in Short Supply*, 122 W. VA. L. REV. 487-488 (2019). Available at: https://researchrepository.wvu.edu/wvlr/vol122/iss2/6.
[84] Jennifer M. Little, *Into the Future: The Statutory Implications of North Carolina's Telepsychiatry Program*, 93 N.C. L. REV. 863, 884–85 (2015).
[85] *See* Ollove *supra* note 69 (noting that not having to enter prisons to provide care could increase provider participation).

is licensed.[86] Under the current system only twenty-two percent of physicians have a license in more than one state.[87] The current licensing system does not encourage the provision of care across state lines.[88] Limiting psychiatrists' ability to provide mental health care is particularly problematic for prisons that already struggle with provider participation.[89]

The current legal framework makes expanding the use of telemedicine across prisons difficult as obstructive administrative burdens are placed on practitioners.[90] Some states do not have telemedicine-specific legislation which causes further complications.[91] Moreover, very few telemedicine malpractice cases have been litigated because it's a newer service.[92] Further, there is a lack of both federal and state guidance detailing what to do when a patient and provider are from different states, thus making it even less likely that a provider is willing to take on clients outside the state in which the provider is licensed.[93] As the use of telemedicine grows, there is an increased need for a more uniform regulatory framework for all to follow.[94] The legal

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[86] *See* Parciak, *supra* note 83.
[87] Amy E. Zilis, *The Doctor Will Skype You Now: How Changing Physician Licensure Requirements Would Clear the Way for Telemedicine to Achieve the Goals of the Affordable Care Act*, U. ILL. J.L. TECH. & POL'Y 193, 202 (2012).
[88] *See Id*. (because only twenty-two percent of psychiatrists choose to practice across state lines, it is arguable that the current system creates barriers).
[89] *See* Deslisch, *supra* note 14.
[90] Zilis, *supra* note 87.
[91] Tara E. Kepler & Charlene L. McGinty, *Telemedicine: How to Assess Your Risks and Develop a Program that Works*, AM. HEALTH L. ASS'N 1, 10 (Feb. 9, 2009).
[92] Bradley J. Kaspar, *Note, Legislating for a New Age in Medicine: Defining the Telemedicine Standard of Care to Improve Healthcare in Iowa*, 99 IOWA L. REV. 839, 849 (2014).
[93] *Id*.
[94] Bill Marino et al., *A Case for Federal Regulation of Telemedicine in the Wake of the Affordable Care Act*, 16 COLUM. SCI. & TECH. L. REV. 274, 282 (2015).

uncertainty that practitioners currently face may be a reason that so few practice across state lines.

The current licensing and legal framework, as described, is thus incapable of handling the changes being experienced by the healthcare industry.[95] The healthcare system is evolving past being local.[96] From a prisoner perspective, approximately sixty-three percent do not receive mental health treatment in federal and state prisons.[97] In addition, there is an outstanding shortage of mental health care providers in the United States, and this shortage is expected to increase.[98] One study indicates that as the need for mental health services increases, by 2025, 6,090 more psychiatrists will be needed to meet this increased demand.[99] Another study predicts this demand to be significantly higher, noting that 15,600 more psychiatrists will be needed to provide care.[100] Thus, in order to fully take advantage of the benefits of telehealth, as well as to address provider shortages, the state and federal legislature will need to uniformly address telemedicine licensing through a national regulatory scheme that allows providers to efficiently practice in prison systems across state lines.

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[95] *Id*.
[96] *Id*. at 405.
[97] *Mental Health Treatment While Incarcerated*, NAT'L ALL. MENTAL ILLNESS https://www.nami.org/Advocacy/Policy-Priorities/Improving-Health/Mental-Health-Treatment-While-Incarcerated (last visited May 1, 2022).
[98] NAT'L COUNCIL MED. DIR. INST., THE PSYCHIATRIC SHORTAGE: CAUSES AND SOLUTIONS 1, 12 (2018), https://www.thenationalcouncil.org/wp-content/uploads/2022/02/Revised-Final-Access-Paper.pdf.
[99] *Id*.
[100] *Id*.

V. CONCLUSION

There is a nationwide mental illness crisis.[101] Addressing the crisis should begin with the prison system as prisoners are the only group of people with a recognized right to health care,[102] and who are arguably most in need of increased access to mental health services. Expanding the use of telehealth in prisons would address the gap in mental healthcare services within the prison system. The telehealth services would not only lower costs associated with care,[103] but would also address safety concerns[104] and could lead to lower rates of recidivism.[105] However, to fully take advantage of telehealth in prisons, licensing and the overall regulatory framework must be changed nationally.

[101] Darcy & Mariano *supra* note 1.
[102] Estelle v. Gamble, 429 U.S. 97, 104–05 (1976).
[103] Nacci, *supra* note 60.
[104] John, *supra* note 70.
[105] DiLorenzo, *supra* note 43.

Ensuring Access to School Mental Health Services as Telehealth Expands

Tom Saviski

I. INTRODUCTION

The accelerated rise of telehealth during the COVID-19 pandemic has changed the way many people access healthcare generally, and particularly with respect to accessing mental health care.[1] In some communities, telehealth has become the dominant route through which mental health care can be accessed.[2] Minors are affected by this shift in a unique way which raises issues of access and confidentiality that would otherwise not exist with in-person provider services. To this end, Illinois law provides several guarantees of confidentiality and access to minors that may protect them from abusive situations at home. Ideally, this confidentiality and access allows the detection of abuse and neglect by the healthcare provider, who would then report the abuse or neglect to the Department of Children and Family Services ("DCFS") as a mandated reporter.[3] For example, minors above the age of twelve can access mental health care services without parental consent.[4] However the ability for these minors to receive mental healthcare without parental consent may be significantly impaired due to the imbalance of power a parent or guardian has over their child or ward.

Relevant is a striking drop in reports of abuse and a rise in the severity of child abuse cases arriving in emergency rooms across the nation, with the drop in cases likely due to fewer interactions between minors and mandated

[1] Mina Bakhtiar et al., Notes & Comments, *The Digital Divide: How COVID-19's telemedicine expansion could exacerbate disparities*, J. AM. ACAD. DERMATOLOGY, e1-2 (2020).
[2] *Id.*
[3] 740 ILCS 110; 405 ILCS 5; 325 ILCS 5.
[4] 405 ILCS 5/3-5A-105.

reporters during the COVID-19 pandemic.[5] To rectify this, Illinois should guarantee that services normally available to minors remain reasonably accessible during public health emergencies. Specifically, Illinois should (1) provide a space in which minors can have guaranteed access to telehealth services in privacy, and (2) increase the number of appointments a minor can receive for mental health treatment without consent, especially in situations where an appointment is forcibly cut short by parents or other circumstances.

This paper will first provide background on the intersection of mental health and public schools. It will then discuss how Illinois mental health law treats minors, particularly regarding the role of mandated reporters in detecting abuse or neglect, accommodating students with disabilities, and maintaining minor confidentiality. Next, the paper will discuss the role telehealth has played in providing mental health treatment, including how it has created certain disparities as a result of the digital divide that often exists in populations vulnerable to abuse and neglect. This paper will then argue that Illinois public schools should provide safe spaces for their students to access mental health resources via telehealth. Finally, this paper will also recommend that the limit on the number of mental health treatment sessions sessions a minor may receive be relaxed for telehealth due to the tendency of such sessions to be disrupted by forces beyond the minor's control.

II. BACKGROUND

Public health emergencies such as the COVID-19 pandemic have been found to increase the risk of abuse and neglect of children.[6] COVID-19 has

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[5] Nikita Stewart, *Child Abuse Cases Drop 51 Percent. The Authorities Are Very Worried.*, N.Y. TIMES, (last updated Aug. 7, 2020), https://www.nytimes.com/2020/06/09/nyregion/coronavirus-nyc-child-abuse.html.

[6] Elizabeth Swedo et al., *Trends in U.S. Emergency Department Visits Related to Suspected or Confirmed Child Abuse and Neglect Among Children and Adolescents Aged <18 Years Before and During the COVID-19 Pandemic – United States, January 2019-September 2020*, CDC, 1841-1847 (Dec. 11, 2020),

facilitated measures to slow the spread of the disease through reduced contact between individuals, including patient-provider and student-teacher interactions.[7] The way a school district provides mental health services to enrolled students may differ from other districts.[8] For example, students who attend one of the schools in the Chicago Public School ("CPS") system can access School Based Health Centers for medical care, including mental health care.[9] Other services can include access to school counselors and therapists.[10] Schools are a central part of public health, providing students aged six to sixteen with healthcare services that may not otherwise be easily accessible to them without the school's intervention.[11]

The principal statutes concerning this matter in Illinois are the Mental Health and Developmental Disabilities Confidentiality Act ("Confidentiality Act"), 740 ILCS 110, and the Mental Health and Developmental Disabilities Code ("Code"), 405 ILCS 5.[12] Also relevant to minors, particularly in school settings, is the Abused and Neglected Child Reporting Act ("Reporting Act"), 325 ILCS 5, which applies to mandated reporters such as school counselors and other educational personnel.[13] However the statute most relevant to minors in school settings is Illinois's School Code, 105 ILCS 5, which outlines the obligations school districts have in providing special

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https://www.cdc.gov/mmwr/volumes/69/wr/pdfs/mm6949a1-H.pdf (discussing pediatric emergency department visits due to child abuse and neglect following COVID-19 public health emergency declaration in the Southeastern United States).

[7] Sean D. Young & John Schneider, *Clinical Care, Research, and Telehealth Services in the Era of Social Distancing to Mitigate COVID-19*, AIDS BEHAV. 1, 2 (May 21, 2020), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7241061/.

[8] *School Based Mental Health*, https://youth.gov/youth-topics/youth-mental-health/school-based.

[9] Laura D. Hermer & William J. Winslade, *Access to Health Care in Texas: A Patient-Centered Perspective*, 35 TEX. TECH L. REV. 33, 90 (2004); For a map of the SBHCs in CPS, see https://schoolinfo.cps.edu/HealthCenters/.

[10] *Id.*

[11] Department of Mental Health, *School-based Mental Health*, JOHN HOPKINS BLOOMBERG SCH. OF PUB. HEALTH, https://publichealth.jhu.edu/departments/mental-health/research-and-practice/school-based-mental-health (last visited Mar. 30, 2021).

[12] 740 ILCS 110; 405 ILCS 5.

[13] 325 ILCS 5.

education services to disabled minors in accordance with federal statutes such as the Individuals with Disabilities Education Act ("IDEA"), 20 USC § 1400.[14]

a. Minors and Mental Health in Illinois

One of the most well-known roles mental health professionals and educational personnel perform is that of the mandated reporter.[15] Individuals tasked as mandated reporters have a duty to immediately report to DCFS whenever they have a reasonable cause to believe that a child known to them in their official capacity is an abused or neglected child.[16] Here, both educational personnel and mental health professionals play an important role in detecting whether a child is being abused before the child's health situation deteriorates further.[17] While the framework in which mandated reporting schemes operate is rightfully criticized for its uneven application against communities of color, it remains the primary system through which abuse is discovered.[18] Moreover, early detection of abuse is of paramount importance to the health and well-being of a child.[19] Thus, in lieu of an alternate structure to detect abuse, Illinois should take steps to ensure minors continue to have access to mandated reporters over telehealth, as access to telehealth services is necessary to guarantee access to reporters.

However, reporting abuse and neglect is far from the only function school mental health personnel serve. Particularly relevant to the mental

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[14] 105 ILCS 5; 20 USCA § 1400.
[15] 325 ILCS 5/4.
[16] 325 ILCS 5/4(a).
[17] Samantha Kleindienst Robler et al., *Telehealth: The Great Equalizer*, AUDIOLOGY TODAY, (Mar./April 2020), https://www.audiology.org/audiology-today-marchapril-2020/telehealth-great-equalizer/.
[18] Krista Ellis, *Race and Poverty Bias in the Child Welfare System: Strategies for Child Welfare Practitioners*, ABA (Dec. 17, 2019), https://www.americanbar.org/groups/public_interest/child_law/resources/child_law_practiceonline/january---december-2019/race-and-poverty-bias-in-the-child-welfare-system---strategies-f/.
[19] Marion Bailhache et al., *Is Early Detection of Abused Children Possible? A Systematic Review of the Diagnostic Accuracy of the Identification of Abused Children*, BMC PEDIATRICS (Dec. 5, 2013), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4029314/.

health of minors is the special education services Illinois schools are mandated to provide to students identified by the district to be disabled.[20] The Federal government notes that the provision of comprehensive school mental health programs help students succeed in their studies, build social skills and self-awareness, and enable connections to their greater community.[21] Under IDEA, a state is eligible for financial assistance only it provides a "free appropriate public education" to all children with disabilities, providing them with an appropriate IEP.[22] The IDEA requirements are codified into Illinois law under 5/14-4.01 of the School Code, requiring districts to "establish and maintain special educational facilities as may be needed for children with disabilities."[23] In turn, 5/14-1.08 of the School Code defines "special educational facilities and services" to include therapy, psychological services, and school social workers.[24] Thus, access to mental health services in schools is central to students' with disabilities right to receive an education.

Inside and outside the school setting, the Code and the Confidentiality Act both provide rules regulating the provision of mental health services to minors.[25] Minors over the age of twelve have a greater ability to access mental health services and maintain their confidentiality without parental consent as the minor themselves must first consent.[26] To this end, 110/4 of the Confidentiality Act entitles parents or guardians to a copy of the record when their minor child or ward is under twelve years of age, regardless of whether the minor consents to their parent or guardian accessing it.[27] Minors

[20] 20 USCA § 1400, § 1412.
[21] *Id.*
[22] 20 USCA § 1412.
[23] ILCS 5/14-4.01.
[24] ILCS 5/14-1.08.
[25] 740 ILCS 110; 405 ILCS 5.
[26] *Behavioral Health, Mental Health, and Substance Use: Parity, Confidentiality and More*, 2019 HEALTH L. HANDBOOK 8.
[27] 740 ILCS 110/4.

between the ages of twelve and eighteen, however, must give consent before parents or guardians may be permitted to access their record.[28] Minors over twelve may also receive counseling services without parental consent for no more than eight ninety-minute sessions.[29] As parents and guardians tend to have authority over the home, internet access, and means of payment, minors may be unable to safely access mental health services with their homes serving as therapeutic environments.[30] As a result, mental health services provided by schools must strategically attend to the rights of minors without invoking the wrath of their parents or guardians.

b. Telehealth in Mental Health Care

Telehealth is where medical information is exchanged using electronic communications to improve a patient's health.[31] While telehealth's application in mental health care long predates the COVID-19 pandemic, its use has been widely embraced to protect both patients and providers during the public health emergency.[32]

Of paramount importance to the application of telehealth, particularly when web-based, is addressing the disparities in internet access known as the "digital divide."[33] In Chicago alone, around 100,000 middle and high school

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[28] *Id.*
[29] 405 ILCS 5/3-5A-105.
[30] Francisco Gallego et al., *Parental monitoring and children's' internet use: The role of information, control, and cues*, VOXEU (Apr. 8, 2018), https://voxeu.org/article/parental-monitoring-and-childrens-internet-use.
[31] Kleindienst Robler et al., *supra* note 17.
[32] Press Release, U.S. Dep't of Health and Human Servs., *HHS Issues New Report Highlighting Dramatic Trends in Medicare Beneficiary Telehealth Utilization amid COVID-19*, (July 28, 2020), https://www.hhs.gov/about/news/2020/07/28/hhs-issues-new-report-highlighting-dramatic-trends-in-medicare-beneficiary-telehealth-utilization-amid-covid-19.html.
[33] Dornauer et al., *Too Many Rural Americans Are Living in the Digital Dark. The Problem Demands a New Deal Solution*, HEALTH AFFAIRS (Oct. 28, 2020), https://www.healthaffairs.org/do/10.1377/forefront.20201026.515764/full/.

age students lack access to high-speed internet.[34] Furthermore, only 75.9% of Chicago households have their own broadband internet subscription.[35] Populations affected are largely those who face disparities in access to healthcare and healthcare outcomes generally, i..e, racial minorities and lower income individuals.[36] Indeed, forty-four percent of households with an income below $30,000 a year do not have broadband service.[37] These populations are also more likely to rely on smartphones for access compared to the rest of the population, although twenty-nine percent of those with incomes below $30,000 did not have a smartphone at all.[38]

The digital divide also impacts much of Illinois's rural populations, with the Illinois Congressional Delegation stating that only "about [sixty-one] percent of rural areas in Illinois have access to fixed broadband at speeds of 25Mbps/3Mbps."[39] In turn, approximately thirty-nine percent of rural Illinoisans lack reliable access to internet with sufficient bandwidth to make use of online mental health services.[40] In 2021, only seventy-two percent of rural Americans had a home broadband internet connection; that percentage

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[34] *Providing Stable High-Speed Internet Access to Students who Need it the* Most, CHI. PUB. SCHS., (2020), https://www.cps.edu/strategic-initiatives/chicago-connected/; *QuickFacts: Chicago, IL*, U.S. CENSUS BUREAU, (July 1, 2019), https://www.census.gov/quickfacts/fact/table/chicagocityillinois/INT100218#INT100218.
[35] *Providing Stable High-Speed Internet Access to Students who Need it the* Most, *supra* note 34.
[36] Sarah Ryan, *Bridging the Digital Divide: How COVID-19's Telemedicine Expansion May Exacerbate Health Disparities for Low-Income, Urban Black Patients*, 30 ANNALS OF HEALTH L. AND LIFE SCIENCES 295, 301 (2020).
[37] Monica Anderson & Madhumitha Kumar, *Digital Divide Persists Even as Lower-income Americans Make Gains in Tech Adoption*, PEW RSCH. CTR. (2019), https://www.pewresearch.org/fact-tank/2021/06/22/digital-divide-persists-even-as-americans-with-lower-incomes-make-gains-in-tech-adoption/.
[38] *Id.*
[39] *See* Press Release, Senator Durbin, Illinois Congressional Delegation to FCC: Improve Rural Broadband Maps, (June 17, 2019), https://www.durbin.senate.gov/newsroom/press-releases/illinois-congressional-delegation-to-fcc-improve-rural-broadband-maps; *see also* Federal Communications Commission, *Section 706 Fixed Broadband Deployment Map*, https://www.fcc.gov/reports-research/maps/section-706-fixed-broadband-deployment-map/ (last updated Aug. 21, 2022).
[40] Press Release, Senator Durbin, *supra* note 39.

was even less in suburban areas.[41] Broadband stability in rural areas has also been found to be unreliable, which raises the question as to whether patients with broadband access can necessarily maintain access to the internet and online services over time.[42] Thus, the digital divide affects a significant portion of the population's ability to access telemedicine, including mental health services offered by schools.

Until recently, medical practitioners were physically located on campuses to provide care to students and their families.[43] School-based health centers have a positive impact on mental health care access and outcomes for children and adolescents.[44] The expansion of telehealth into schools provides an opportunity to improve health care access and equity to the populations most vulnerable to abuse.[45] However, the traditional legal framework of detecting abuse through mandated reporters will fall short if not revised for use in telehealth. Revision is necessary as mandated reporters in schools and day-care facilities play an outsized role in detecting abuse. For example, these same mandated reporters in schools and daycares made a third of the reports in 2019.[46] However, the number of reports of abuse have dropped significantly with the use of remote learning during the COVID-19 pandemic.[47] While this may appear to be a great development, where reported cases of child abuse have fallen, the severity of actual child abuse cases has risen over time.[48]

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[41] *Some Digital Divides Persist Between Rural, Urban, and Suburban America*, PEW RSCH. CTR. (2021), https://www.pewresearch.org/fact-tank/2021/08/19/some-digital-divides-persist-between-rural-urban-and-suburban-america/.
[42] *Id.*
[43] Love et al., *The Use of Telehealth in School-Based Health Centers*, 6 GLOB. PEDIATRIC HEALTH 1, 7-8 (Sept. 13, 2019), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6811756/.
[44] *Id.*
[45] *Id.*
[46] *Id.*
[47] *Child Abuse Cases Got More Severe During COVID-19, Could Teachers Have Prevented It?*, EDWEEK (June 1, 2021), https://www.edweek.org/leadership/child-abuse-cases-got-more-severe-during-covid-19-could-teachers-have-prevented-it/2021/06.
[48] *Id.*

Those most impacted by the digital divide are also the most vulnerable to abuse.[49] As stated earlier, students who are members of racial minorities or those who live in areas of concentrated poverty are disproportionately found to lack internet access.[50] Consequently, girls of color or those living in poverty are disproportionately found to be victims of physical, sexual, and emotional abuse.[51] Thus, the populations most impacted by the digital divide have higher incidences of reported child abuse and a greater reliance on school-based health centers, which have taken on a greater role in mental healthcare during the course of the pandemic.[52] These factors worsen disparities in access to mental health services during public health emergencies where the use of telehealth as a protective measure is prevalent.[53]

Such disparities are indicative of the social determinants of health.[54] Recent studies report that while reports of child abuse and neglect have fallen during the pandemic, the severity of child abuse cases arriving to emergency departments has significantly worsened.[55] Legislative action is required to adapt Illinois's laws and policies to better serve its minors during both a time of crisis and in the era of telehealth's ascent.

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[49] *Id.*
[50] Ryan, *supra* note 36.
[51] Jalise Burt, *From Zero-Tolerance to Compassion: Addressing the Needs of Girls Caught in the School-to-Prison Pipeline Through School-Based Mental Health Services*, 6 GEO. J.L. & MOD. CRITICAL RACE PERSP. 97 (2014).
[52] Hayley Love et al., *The Use of Telehealth in School-Based Health Centers*, GLOB. PEDIATRIC HEALTH (Oct. 23, 2019), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6811756/.
[53] *Id.*
[54] Ryan, *supra* note 36.
[55] Bullinger et al., *Pediatric emergency department visits due to child abuse and neglect following COVID-19 public health emergency declaration in the Southeastern United States*, BMC PEDIATRICS 21, 401 (Sept. 13, 2021), https://bmcpediatr.biomedcentral.com/articles/10.1186/s12887-021-02870-2.

III. ANALYSIS

Illinois must revise its laws surrounding mental health care and confidentiality for minors to ensure that services normally available to minors remain accessible during times of public health emergencies or during the use of distance education generally. These measures should look onwards to future public health emergencies to ensure there are no significant gaps in which these services are inaccessible. School districts should therefore be required to make private spaces with stable internet access available to students to ensure they can access school mental health services while maintaining confidentiality. Likewise, the legislature must revise the Mental Health Code to make minors' access to mental health care without parental consent limited solely by cumulative minutes as opposed to by the number of sessions.

A. School Districts in Illinois are obligated to maintain access to mental health services during public health emergencies.

In Illinois, school districts have an obligation to educate and accommodate children with disabilities via special education services.[56] Such services will generally include access to a school counselor, therapist, or social worker as a necessary part of the student's IEP or 504 plan.[57] Thus, access to school mental health services is a significant part of a district's obligation to accommodate students with disabilities under IDEA and Article 14 of Illinois's School Code. However, those students impacted by factors like the digital divide or unstable family situations in effect may not have access to the services guaranteed to them in situations where telehealth is the primary option. Even in instances of public health emergencies, where a

[56] 105 ILCS 5/14-1.02.
[57] 29 USC § 701 (Section 504 of the Rehabilitation Act requires all programs or activities receiving Federal financial assistance to accommodate persons with disabilities. 504 plans are what enable this accommodation at the public-school level).

district's use of telehealth is required, districts are still required to provide students with disabilities a "free appropriate education," which often requires access to district mental health resources.[58] Therefore, legislators must review and amend Illinois's laws to better accommodate these students during public health emergencies.

B. School Districts should provide private spaces for students to access mental health services.

Similar to how schools provide an important source of meals for their students through lunches, they are also an important provider of mental health services and access to mandated reporters through counselors and social workers. Just as CPS provided "Grab-and-Go Meal Sites" to maintain the provided service many families relied on for lunches, schools should also provide a site where students can securely and safely access mental health services via telehealth.[59] By providing such a space, districts can allow for students to reliably access a service guaranteed to them through stable internet access to a mandated reporter in a manner that ensures confidentiality.

Such a setup would also mitigate the effects of the digital divide in both urban and rural communities where these disparities are most common. Furthermore, it allows the school district to ensure students can receive treatment in a manner compliant with school board policy and state law. Such control over the therapeutic environment could help minimize the effect of technical issues as well. Students may also prove more willing to discuss

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[58] 20 USCA § 1400.

[59] *CPS to Provide Meals at More Than 70 Schools During Winter Break*, NBC CHICAGO NEWS, https://www.nbcchicago.com/news/local/cps-to-provide-meals-at-more-than-70-schools-during-winter-break/2711392/ (last updated Dec. 19, 2021).

sensitive issues that they are experiencing with family when they can be assured their family will not be able to eavesdrop on their conversation.[60]

As a practical matter, such a system would place the burden of maintaining confidentiality and creating a safe space for the student on the school districts obligated to accommodate them. While there is only so much a minor can do to stop a parent or guardian from intruding upon the private doctor-patient relationship during a call, school security is well-equipped to handle such situations.

This proposal is not without flaws. For example, what happens if a school does not have the physical space or resources to create such a room? How would a student access the room if buses are no longer running? What if an abusive parent or guardian notices the student has left home to go to an appointment? These questions are valid and not exhaustive.

There is only so much that can be done given the critical lack of resources many schools in Illinois face, but a lack of resources should not free a district from its duty to provide necessary mental healtj services or accommodate students with disabilities. It may be necessary under our current laws for schools to temporarily convert spaces into private telehealth rooms in addition to running a limited bus service to guarantee access. These spaces need not necessarily be on district property–they could be in community centers such as public libraries, in cooperation with municipal governments.

As for an abusive parent or guardian, any disruptions they create would likely occur under any scenario. However, as students do not need parental consent to receive mental health treatment, when a parent forcibly prevents a child from accessing treatment, the situation may give a district enough room to investigate further as may be necessary.

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[60] Shayla Love, *Parents Are Eavesdropping on Their Kids' Virtual Therapy Sessions*¸ VICE (May 14, 2020) https://www.vice.com/en/article/8899b4/parents-are-listening-to-their-kids-virtual-therapy-sessions-during-pandemic.

This proposal does not solve every problem created by a public health emergency in an already flawed system, but it would help maintain and even enhance the necessary degree of the access students are owed.

C. Illinois should relax restrictions on limits to minors receiving mental health care without parental consent during public health emergencies.

While private telehealth spaces may resolve some problems with minors' access to mental health services, students may struggle to access the physical location or may feel uncomfortable heading into a public space like a school or community center. As such, Illinois must change the limits on how many times a minor can access mental health services before parental consent is needed from a set number of sessions to cumulative minutes. This change would allow for instances where a minor is suddenly cut off from a session, whether due to technical issues or parental intervention, to not count as one of the eight guaranteed sessions. Given the history of Zoom's unreliability, this is an issue likely to repeat across many minors attempting to access online mental health services.[61]

Such a proposal is not without precedent. In 2017, the Illinois General Assembly amended section 5/301 to increase the number of sessions a minor could have without parental consent from five to eight.[62] The same amendment made it so that a service provider can continue treatment without parental consent as long as the provider determines that obtaining such consent would be detrimental to the minor's well-being.[63]

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[61] Sophia Epstein, *All the things that Zoom needs to fix right now*, WIRED (Apr. 20, 2020, 6:00AM), https://www.wired.co.uk/article/everything-zoom-needs-to-fix.
[62] Jessica Nguyen, *Changes to Illinois Mental Health and Developmental Disabilities Code Increases Amount of Counseling Services That May Be Provided to Minors Without Parental Consent*, HODGES, LOIZZI, EISENHAMMER, RODICK & KOHN LLP (Oct. 2, 2017), https://hlerk.com/changes-to-illinois-mental-health-and-developmental-disabilities-code-increases-amount-of-counseling-services-that-may-be-provided-to-minors-without-parental-consent/.
[63] *Id.*

Thus, the proposal here is a relatively minor one meant to ensure flexibility in a changing environment. The traditional imagery behind therapy is that of the therapist and patient sitting in the same room, talking face-to-face.[64] Even outside of public health emergencies, in-person therapy sessions are no longer the only means by which a patient can attend therapy as telehealth gains prominence.[65] However, electronic communications have faults that can cause interruptions in care, such as loss of signal.[66] While the statute states "limited to not more than [eight ninety-minute] sessions," the rest of the text focuses on the number of sessions without specifying if a session needs to be ninety minutes to count under the statute.[67] This ambiguity may encourage providers wary of the wrath of their patients' parents to adopt a more cautious approach by counting a partial session as a full session to avoid a costly lawsuit.

Likewise, younger minors, particularly those with developmental disabilities, may struggle to sit through a full session facilitated via telehealth.[68] As such, if a minor is only able to sit in a session for thirty minutes, they pose the risk of losing a whole hour of treatment not requiring parental consent. Such short sessions will ultimatley reduce the amount of time in which a provider can discover pertinent information as to the minor's wellbeing.

Beyond technical issues, there are also scenarios in which a minor may become unexpectedly unable to maintain confidentiality during a session.

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[64] Mostafa Langarizadeh et al., *Telemental Health Care, an Effective Alternative to Conventional Mental Care: a Systematic Review*, 25 ACTA INFORM. MED. 240, 241 (Dec. 2017), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5723163/.
[65] Hannah Calkins, *Online Therapy is Here to Stay*, 52 AM. PSYCH. ASS'N, 78, 78 (Jan. 1, 2021), https://www.apa.org/monitor/2021/01/trends-online-therapy.
[66] S.B. Gogia et al., *Unintended Consequences of Tele Health and Their Possible* Solutions, 1 YEARBOOK OF MED. INFORMATICS 41, 43 (Nov. 10, 2016) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5171569/.
[67] 405 ILCS 5/3-5A-105.
[68] *Connecting with Children and Adolescents via Telehealth During COVID-19*, AM. PSYCH. ASS'N (Apr. 2, 2020), https://www.apa.org/topics/covid-19/telehealth-children.

Where a therapist meeting with a patient can close their office door to ensure confidentiality, the home-based therapeutic environment does not guarantee sufficient privacy that would prevent a parent from listening to a session or even walking into the patient's bedroom. Attorneys should sympathize; the antics of zoom court have now become legendary.[69] In situations of potential abuse, however, breaches of confidentiality and interruptions of care are no laughing matter. A minor's ability to access mental health services should not be impaired by factors outside of their control.

Essentially, if the statute is going to allow minors eight ninety-minute sessions without notification to parents, then a minor must be able to reasonably access each minute without exposing the provider to liability. Allowing the statute to remain ambiguous as to how much treatment a provider can give to a minor before the provider must obtain parental consent will only encourage providers to give minors less than the maximum time to avoid litigation. Shifting the maximum to be based upon minute intervals would serve to eliminate this ambiguity for the benefit of all parties involved.

IV. CONCLUSION

Overall, minors must be able to access the mental health resources school districts owe them. While public health emergencies may cause difficulties in providing those resources, both school districts and the state have the obligation to overcome those difficulties. Thus, it is necessary for Illinois to adapt to the use of telemedicine by school districts while accepting the reality that not every student will have internet access at home. One means to do so is to require school districts to provide a space with reliable internet where students can access telemedicine resources. Likewise, Illinois should

[69] Kathryn Rubino, *This Judge Is Having A Particularly Stupid Run of Defendants In His Virtual Courtroom*, ABOVE THE LAW (Mar. 15, 2021), https://abovethelaw.com/2021/03/this-judge-is-having-a-particularly-stupid-run-of-defendants-in-his-virtual-courtroom/ (listing a number of known zoom antics ranging from the mid-court snack to mid-court coitus).

recognize the limitations of telemedicine and provide more flexibility to minors in accessing it without parental consent. In a therapeutic environment subject to interruptions by others and disruptions by loss of internet connection, limiting sessions undercuts the power of the statute and goes against the legislature's intent to provide telehealth services to at-risk minors.