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STATEWIDE POLICIES RELATING TO PRE-ARREST DIVERSION AND CRISIS RESPONSE

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INTRODUCTION

Handcuffs close about a person's wrists and the few, simple words "you are under arrest" are spoken as the individual is placed in the back of a police car. It is a scene that plays out once every three seconds in the United States and sets into motion a criminal process that exhibits at times all of the control and potential for damage of a runaway locomotive.[1] Indeed, regardless of whether a murder indictment or an ordinance violation spurred the arrest, the immediate aftermath is the same. The individual loses their freedom and gains a new entry in their criminal history, while the officer must spend hours transporting and processing the individual with the specter of additional court time hanging over the future. And, while arrest is warranted for many of the more serious transgressions, it is an ill-fitting and disproportionate response to myriad other situations. Yet, traditionally, the only other option officially available to officers is to do nothing.

The shortcomings of this approach have not been lost on many law enforcement leaders and other crisis first responders, and in recent years, police departments from Seattle, Washington to Gloucester, Massachusetts have instituted new strategies and initiatives meant to break this old paradigm and present their officers with options beyond the binary choice to arrest or take no action. Operating under a variety of labels that usually reference 'diversion' in some form,[2] these efforts have ranged from actively searching out vulnerable members of the community and connecting them with services to de-escalating potentially criminal encounters through citations or treatment opportunities. Often, it has meant law enforcement officers working in concert with other first responders; in some instances, non-law enforcement personnel may direct a response themselves—indeed, for crises without a criminal justice component, this can represent the optimal response. It has also involved turning to a set of independent crisis response procedures, such as protective custody or citations in lieu of arrest, that entail a noncriminal or deescalated enforcement response and can operate as part—or instead—of a more comprehensive diversion program.

Although these strategies are often locally designed and implemented, they do not operate in a legal or political vacuum. Instead, localities are subject to a web of state laws and regulations that directly bear on their ability to institute pre-arrest diversion and other crisis response strategies effectively. Laws that grant local officials noncriminal responses to crises can propel diversion efforts or provide

1. Rebecca Neusteter and Megan O'Toole, "Every Three Seconds," Vera Institute of Justice, January 2019. https://www.vera.org/publications/arrest-trends-every-three-seconds-landing/arrest-trends-every-three-seconds/overview.

2. These efforts have been called deflection, pre-arrest diversion, police led diversion and pre-booking diversion, among other terms.

alternative, supplemental crisis responses. Laws that require criminal responses or otherwise circumscribe when and how non-law enforcement responders are able to intervene can impede them.

In light of this, the present study dives into these problems by reviewing and analyzing the primary statewide barriers to and accelerants of pre-arrest diversion and crisis response strategies. It begins by providing an overview of pre-arrest diversion strategies. It then delves into five categories of law or regulation that most directly affect these strategies and often serve as the basis of fully-fledged crisis responses in their own right: emergency mental health hold laws, protective custody statutes, citation authority, substance abuse Good Samaritan laws and ambulance transport destination rules.

TABLE I: STATEWIDE POLICIES RELATING TO PRE-ARREST DIVERSION AND CRISIS RESPONSE

Emergency Mental Health Hold	Emergency mental health hold laws authorize certain first responders to take an individual experiencing a mental health crisis into a form of civil custody in order for them to be evaluated by appropriate mental health or medical personnel.
Protective Custody	Protective custody procedures operate as the substance abuse analog to emergency mental health holds by authorizing first responders to place an individual experiencing an acute substance abuse episode in temporary civil custody.
Citation Authority	Citation authority statutes permit or require law enforcement officers to issue a citation to individuals alleged to have committed certain specified offenses, instead of placing them under arrest, booking or detaining them.
Substance Abuse Good Samaritan	Substance abuse Good Samaritan laws offer immunity from arrest, criminal charges, prosecution or conviction for limited, drug-related offenses as an incentive for individuals to call for assistance for someone experiencing a suspected overdose.
Ambulance Transport Destination	Ambulance transport laws and regulations can influence where emergency medical services may take an individual experiencing a crisis, potentially by requiring transport to a hospital emergency department or otherwise discouraging the use of alternative destinations.

For each category, the report outlines the results of a fifty-state review of the current legal status quo and then uses recent legislative action to highlight the areas of the law advocates are attempting to alter.[3] Finally, it provides an analysis of these legal frameworks and legislative developments, and suggests avenues for future action.

3. Each survey also includes the District of Columbia.

PRE-ARREST DIVERSION AND CRISIS RESPONSE STRATEGIES

The primary purpose of pre-arrest diversion and related crisis response strategies is to address underlying problematic or troubling behavior—before it potentially causes serious harm—through noncriminal or deescalated criminal responses that are more effective and appropriate in certain situations.[4] At the preventative end of the crisis continuum, programs shield individuals from arrest so that they can seek out law enforcement or social service providers for treatment assistance or alternatively, so that those officers and providers can reach out to them. At the other end of the spectrum—during and immediately following an acute mental health, substance abuse or other crisis—officials work to resolve the crisis and start the process of addressing the underlying issues. If the crisis involves potentially criminal behavior, officials might hold off on filing charges, downgrade the criminal reaction involved or remove the individual from the auspices of the criminal system altogether in order to facilitate treatment.

Although the appetite for pre-arrest diversion programs that incorporate these strategies has grown in recent years, their more widespread adoption and implementation still represent a developing phenomenon. As late as 2014, a survey of municipal and county law enforcement agencies found that only 34 percent of responding agencies utilized police-led diversionary practices.[5] Further, of that group, a mere 27 percent determined an individual's eligibility for diversion prior to an arrest and 28 percent did so at the point of arrest, with the remainder doing so at booking or even later in the process.[6] While crisis intervention teams can trace their history to the late 1980s,[7] two of the other leading programs—Law Enforcement Assisted Diversion (LEAD) and the Police Assisted Addiction and Recovery Initiative (PAARI)—began in 2011[8] and 2015,[9] respectively. Notably, however, the LEAD and PAARI networks already boast hundreds of affiliated jurisdictions that are considering or actively utilizing ver-

4. Although an overreliance on law enforcement to handle even non-criminal crisis response in many situations leads many jurisdictions to merge pre-arrest diversion and crisis response strategies, theoretically the two are distinct. Indeed, greater investments in behavioral health systems may allow a jurisdiction to more effectively differentiate the two and permit law enforcement to scale-back its own crisis response role to a more traditional, criminal justice-oriented one.

5. Jennifer A. Tallon et al., "Creating Off-Ramps: A National Review of Police Led Diversion Programs," Center for Court Innovation, 2018, p. 15. https://www.courtinnovation.org/sites/default/files/media/document/2018/Creating_Off_Ramps.pdf.

6. Ibid., p. 17.

7. Amy C. Watson and Anjali J. Fulambarker, "The Crisis Intervention Team Model of Police Response to Mental Health Crises: A Primer for Mental Health Practitioners," *Best Practices in Mental Health* 8:2 (December 2012), p. 71. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3769782.

8. "What is LEAD?" LEAD National Support Bureau, accessed July 11, 2019. https://www.leadbureau.org/about-lead.

9. "About Us," The Police Assisted Addiction and Recovery Initiative, accessed July 11, 2019. https://paariusa.org/about-us.

sions of these strategies.[10] This is evidence of the rising popularity of these types of strategies more generally. Further, a host of local efforts, such as Tucson, Arizona's opioid deflection pilot program and Mental Health Support Teams,[11] often operate without garnering the same degree of national attention or following.

The relative novelty of many of the leading approaches has meant that research on these strategies is still in its infancy. Many of the early outcomes, however, have been positive. A review of Seattle, Washington's LEAD program, for example, found that compared to a control group, LEAD's participants were 60 percent less likely to be arrested during the six months following their entry into the program. Extending this comparison window out by a couple of years found similar results, with LEAD participants still 58 percent less likely to be arrested and 39 percent less likely to be charged with a felony during that period than the control group.[12] An analysis of Leon County, Florida's Pre-Arrest Diversion/ Adult Civil Citation program found even better outcomes: an 80 percent reduction in the re-arrest rate for individuals who successfully completed the program.[13] This is a promising early indicator, which additional research should examine further.

The contours of programs such as these can depend on a collection of noncriminal and deescalated criminal response authorities that jurisdictions vest to varying degrees in law enforcement officers and other first responders. It would be quite difficult, for example, for Leon County, Florida to run a successful Pre-Arrest Diversion/ Adult Civil Citation program if its officers did not have the relevant authority to issue citations. At the same time, the presence of tools, such as protective custody for substance abuse crises or emergency holds for acute mental health episodes, means that a response outside of the criminal justice system may be possible even without a formal pre-arrest diversion program. Indeed, these legal mechanisms are employed frequently as crisis responses in their own right, sometimes with the intent of providing additional separation from the criminal justice system in order to reduce stigma for those involved. As such, these legal tools serve as both components of and alternatives to pre-arrest diversion programs.

Whether law enforcement or other first responders are able to employ any of these tools may turn on a couple of other legal areas: substance abuse Good Samaritan laws and ambulance transport destination rules. By removing criminal liability for individuals at the scene of a suspected overdose, a substance abuse Good Samaritan law can make noncriminal responses a possibility in situations in which they might not otherwise be. Likewise, ambulance transport regulations that allow EMS personnel to transport an individual in crisis to a wider range of destinations, rather than solely to hospitals with an emergency department, can facilitate additional noncriminal pathways.

Systemic data revealing the extent to which law enforcement and other first responders rely on these tools does not exist, but studies examining particular jurisdictions hint at their prevalence. For example, in Alameda County, California, which has roughly 1.6 million residents, researchers found that 26,283 people had at least one emergency mental health hold placed on them over a five-year period.[14] Similarly, in Fairbanks, Alaska, a metropolitan area with just under 100,000 residents, the Community Service Patrol reported 4,464 protective custody transports in a single year.[15] Likewise, Maryland has one of the more limited citation authority statutes,[16] yet its law enforcement officers still issue about 20,000 criminal citations each year.[17] Finally, with over 70,000 drug overdoses[18] and 18 million patients receiving care from emergency medical services each year,[19] the potential for Good Samaritan laws and ambulance transport regulations to affect crisis responses remains enormous.

10. See "What is LEAD?", LEAD National Support Bureau, accessed Oct. 25, 2019. https://www.leadbureau.org/about-lead; and "Our Partners," The Police Assisted Addiction and Recovery Initiative, accessed July 11, 2019. https://paariusa.org/about-us.

11. See Caitlin Schmidt, "Pima County leading the state in criminal justice reform efforts," Arizona Daily Star, March 23, 2019. https://tucson.com/news/local/pima-county-leading-the-state-in-criminal-justice-reform-efforts/article_8f6f1125-79c0-55a0-93d3-dd3b417228da.html.

12. Susan E. Collins et al., "Seattle's Law Enforcement Assisted Diversion (LEAD): Program Effects on Recidivism Outcomes," *Evaluation and Program Planning* 64 (2017), pp. 52-53. https://www.researchgate.net/publication/316863460_Seattle's_Law_Enforcement_Assisted_Diversion_LEAD_Program_Effects_on_Recidivism_Outcomes.

13. "Leon County/Tallahassee Pre-Arrest Diversion – Adult Civil Citation Program – A Model Program With National Implications," Civil Citation Network, 2017, p. 1. https://university.pretrial.org/HigherLogic/System/DownloadDocumentFile.ashx?DocumentFileKey=4250408e-c6c7-766f-2aa8-419fd31d05ad&forceDialog=0.

14. Tarak K. Trivedi et al., "Emergency Medical Services Use Among Patients Receiving Involuntary Psychiatric Holds and the Safety of an Out-of-Hospital Screening Protocol to 'Medically Clear' Psychiatric Emergencies in the Field, 2011 to 2016," *Annals of Emergency Medicine* 73:1 (January 2019), pp. 42-51. https://www.annemergmed.com/article/S0196-0644(18)31158-2/fulltext.

15. "Community Service Patrol," Downtown Association of Fairbanks, accessed July 25, 2019. https://www.downtownfairbanks.com/?page_id=1624.

16. The Maryland rule (Md. Crim. Pro. Code 4-101) limits citations to misdemeanors carrying a penalty of 90 days or less in jail—a category that excludes most offenses—and a handful of other enumerated low-level misdemeanors. It also lays out a series of exclusionary conditions.

17. "2017 Criminal Citations Data Analysis Final Report to the State of Maryland," Governor's Office of Crime Control and Prevention, Oct. 1, 2018, p. 3. https://goccp.maryland.gov/wp-content/uploads/criminal-citations-report-2018.pdf.

18. "Overdose Death Rates," National Institute on Drug Abuse, accessed July 25, 2019. https://www.drugabuse.gov/related-topics/trends-statistics/overdose-death-rates.

19. Zachary F. Meisel et al., "Variations in Ambulance Use in the United States: the Role of Health Insurance," *Academic Emergency Medicine* 18:10 (2011), p. 1036-44. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3196627.

Emergency Mental Health Hold Laws

TABLE 2: CHARACTERISTICS OF EMERGENCY MENTAL HEALTH HOLD LAWS

Who can initiate?	Law enforcement officers and, in some jurisdictions, other first responders, behavioral health or medical professionals.
When can a hold be initiated?	The exact standard varies considerably, but usually an official can initiate a hold if an individual is experiencing an acute mental health episode and is a danger to themselves or others or, in some jurisdictions, is gravely disabled.
Discretion of Officials	A jurisdiction may require that officials take all qualifying individuals into custody or it may be up to their discretion.
Eligible Destinations	Eligible destinations frequently include hospital emergency departments, psychiatric facilities, crisis centers and, in some jurisdictions, jails.
Duration	The maximum period that a hold can persist without a court order can range from a handful of hours to over a week. Often regular medical evaluations are required during and to prolong this period.

Alongside, and often in tandem with, substance abuse crises, acute mental health episodes present one of the more frequent emergency situations encountered by law enforcement officers and other first responders. Intervention may be necessary in these scenarios to prevent harm to the individual in question or others. The criminal justice system, however, may be unavailable (if there is no criminal conduct involved) or unsuited to address the conduct (even if there is something potentially criminal about it). Forty-nine states and the District of Columbia have responded to this reality by authorizing certain officials to institute short, civil detentions outside of a hospital setting and without a court order to provide for the emergency evaluation and possible treatment of an individual.[20] Although these holds are often colloquially known as "72-hour holds," the actual maximum permitted duration can range from as little as six hours to as long as ten days without a court order.

While the existence of these emergency holds is practically universal, they do not have a uniform influence on local pre-arrest diversion and crisis response strategies. To begin with, jurisdictions authorize different groups of officials to initiate proceedings. For example, in 17 jurisdictions, only law enforcement officers can unilaterally begin these holds. In another 29, they share this power with a collection of medical and social service professionals, including physicians, social workers and mental health officers. The remaining four states require law enforcement and other crisis responders to work together; usually, a law enforcement officer initiates the proceedings but consultation with another professional with a mental health or medical background is required for the hold to proceed. Who is able to initiate a hold may determine whether an emergency hold is possible at all. It may also influence whether officials choose to utilize the process, since this decision will naturally be influenced by each official's own set of experiences and expertise.

Whether officials initiate an emergency hold may also turn on the discretion entrusted to them, specifically whether they have a choice in the matter at all. While 43 jurisdictions allow the officials on-scene to make the determination of whether it is appropriate in a particular case, the other seven require officials to take all qualifying individuals into custody. Such an absence of discretion is likely well intentioned—to ensure the well-being of all individuals in crisis—and will increase the use of this particular crisis response, but this may come at the cost of an alternative option that might be more appropriate. It likewise forfeits the judgment of the responder in the field to tailor the response to the individual and the situation at-hand.

The preconditions necessary to initiate a hold will, of course, have a strong bearing on its availability in a given situation, as will the manner in which officials interpret relevant statutory language. There is relatively little agreement among jurisdictions about what exactly these preconditions should be. The majority of statutes reference danger to oneself or others, with seven requiring that danger to be "imminent;" another 11 use terms suggesting it need only be "immediate" or in the "near future;" and a further 14 state that "immediate confinement" must be necessary to prevent some form of danger. The remaining 14 jurisdictions use thresholds of danger that are even lower or more vague, failing to specify just how impending these risks might be. Finally, in addition to these danger-related requirements, 15 states allow officials to initiate a hold in response to an individual who is gravely disabled.

Two other essentially procedural attributes of emergency hold laws are likely to have a strong bearing on pre-arrest diversion and crisis response. First, a significant number of jurisdictions state that a mental health hold can only be initiated based on the law enforcement officer's personal observations of the individual's conduct or condition. Presumably meant as a due process protection, this could unintentionally hamstring efforts in which a mental health provider on-scene has already made a careful professional judgment, yet crisis responders cannot proceed until an untrained law enforcement officer reaches the same conclusion. Second, the burden of proof on these officials ranges across language such as "reasonable cause" to "probable cause" to "reason to believe" that a hold is required. The height of this threshold will naturally affect the range of situations that potentially qualify for such a hold.

20. The remaining state, West Virginia, requires an initial court order to begin the emergency hold process.

The list of acceptable facilities may go a long way to determining the availability and effectiveness of an emergency hold. Depending on the jurisdiction, an individual might find himself or herself transported to a mental health facility, hospital or other treatment facility. In six states, the list of possible locations includes a jail or other correctional facility, albeit usually only either as a last resort or in other limited circumstances.[21] This final piece speaks to the impact that legally acceptable locations have on the use of emergency holds: if a particular jurisdiction lacks available beds in the prescribed facilities, then an emergency hold may not be possible. Then again, expanding the list of potential facilities to include those that lack adequate ability to evaluate or treat an individual in crisis may undermine the effectiveness of that hold. This creates a difficult balancing act for jurisdictions with limited budgets and treatment capacity.

Legislative Action—The need to provide meaningful access to appropriate treatment has animated recent legislative discussions about how to update mental health emergency hold laws to serve individuals in crisis better. This issue has largely manifested as a complex debate over where to take individuals experiencing acute mental health crises and how long a detention must be to facilitate treatment. It has also included questions surrounding the appropriate circumstances required to initiate a hold. The result has been a steady, albeit occasionally halting, move to broaden the scope and use of emergency holds.

Legislative deliberations on these topics have been remarkably free of partisan rancor, though not procedural drama. Sponsors and widespread support from both parties, for example, did not prevent a bill in Colorado from receiving the governor's veto in 2016 over policy concerns.[22] In an even more noteworthy display of bipartisanship, an updated version of that bill in 2017—which made the dramatic swing from potentially expanding jail-based mental health detention to eliminating it altogether in favor of other facilities—also received bipartisan sponsorship and deep support on its way to becoming law. Likewise, in neighboring Kansas, legislation altering the state's emergency hold law garnered bipartisan support in both 2016 and 2017, once again in spite of significant alterations to the underlying text in the interim.

In 2013, a bill adding "gravely disabled" as a possible basis for an emergency hold easily passed in Indiana with only a single senator voting against the measure.[23] A similar piece of legislation that year in Montana represents one of the more partisan votes on the topic. The bill passed both houses of the legislature by around a two-to-one margin, yet only garnered the support of roughly two in five Republicans.[24] However, even of those bills that failed to make it out of committee, let alone into law, most appear to have been consumed by policy rather than political opposition.[25]

Like most of the politicians involved, the law enforcement community has been largely supportive of legislation aiming to expand emergency mental health holds. This has included measures relating to the use of crisis centers in Kansas,[26] and sharing emergency hold authority with behavioral health professionals in Nebraska.[27] It has also meant participating in the debate surrounding both Colorado bills relating to jails. Sheriffs' concerns about treatment for rural emergency hold patients helped spur the original expansion of jail-based detention,[28] while sheriffs and other law enforcement members helped devise the recommendations that eliminated their use. These experiences suggest that law enforcement, as the individuals in the field handling these crises firsthand, is perhaps more results- than process-oriented when it comes to legislation to aid their efforts.

Organizations representing criminal defense lawyers and mental health advocates have not always shared law enforcement's enthusiasm for many of these suggested policy changes. In Kansas, the heartland chapter of Mental Health America vigorously opposed efforts to make it easier to hold individuals against their will based on mental illness.[29] The Kansas Association of Criminal Defense Lawyers likewise weighed in with their own concerns about a possible extension of mental health holds from 24 to 72 hours; three days without a court appearance struck them as too long.[30] The Kansas chapter of the National Alliance on Mental Illness

21. This includes Nebraska, which very narrowly limits the use of jails, reserving them solely for individuals previously convicted of a sex crime.

22. Yesenia Robles, "Gov. Hickenlooper vetoes bill on mental health holds," *The Denver Post* (June 9, 2016). https://www.denverpost.com/2016/06/09/gov-hickenlooper-vetoes-bill-on-mental-health-holds.

23. H.B. 1130, 1st Reg. Sess., 118th Gen. Assembly (Ind. 2013). http://archive.iga.in.gov/2013/bills/PDF/HE/HE1130.1.pdf.

24. H.B. 16, 2013 Reg. Sess., 63rd Leg. (Mont. 2013). https://legiscan.com/MT/rollcall/HB16/id/224931.

25. See, e.g., Electa Draper, "Debate rages in Colorado over involuntary holds for mental illness," *The Denver Post*, May 24, 2014. https://www.denverpost.com/2014/05/24/debate-rages-in-colorado-over-involuntary-holds-for-mental-illness; and Joe Duggan, "Bill would let mental health professionals in Nebraska put people in emergency protective custody," *Omaha World-Herald*, Feb. 15, 2018. https://www.omaha.com/news/legislature/bill-would-let-mental-health-professionals-in-nebraska-put-people/article_8ad2370b-18c2-51e8-b244-ae740cbd1e5c.html.

26. Meg Wingerter, "House Committee Oks Involuntary Hold Plan For Kansans in Mental Health Crises," *KCUR*, Feb. 16, 2017. https://www.kcur.org/post/house-committee-oks-involuntary-hold-plan-kansans-mental-health-crisis#stream/0.

27. Duggan. https://www.omaha.com/news/legislature/bill-would-let-mental-health-professionals-in-nebraska-put-people/article_8ad2370b-18c2-51e8-b244-ae740cbd1e5c.html.

28. Brandon Rittiman, "Debate rages over holding mentally ill patients," *9News*, May 3, 2016. https://www.9news.com/article/news/local/politics/debate-rages-over-holding-mentally-ill-patients/167367683?fb_comment_id=1014381021990027_10144367186511 24?fb_comment_id=1014381021990027_10144367186511 24.

29. Tammy Worth, "Proposal Aims to Keep Kansas Mental Patients Out of Jail, Courts and Emergency Rooms," *KCUR*, Feb. 9, 2016. https://www.kcur.org/post/proposal-aims-keep-kansas-mental-patients-out-jail-courts-and-emergency-rooms#stream/0.

30. Wingerter. https://www.kcur.org/post/house-committee-oks-involuntary-hold-plan-kansans-mental-health-crisis#stream/0.

took a more equivocal stance on the establishment of crisis centers for these holds, expressing concerns about the proposal drawing funding from voluntary treatments, but accepting that it could be a valuable last resort.[31] In Colorado, legislation that would have altered the standard for the initiation of an emergency hold split the mental health community. Mental health providers were favorably inclined toward the move to lower it from "imminent" to "immediate" danger, while those representing mental health services consumers expressed opposition.[32]

The ultimate success of the second iterations of expansion bills in Colorado and Kansas in 2017 is attributable, in part, to the establishment of committees with diverse membership to assess the problem. In Colorado, after vetoing the original emergency hold expansion bill, the governor directed the creation of a task force, which was composed of members of the executive branch and legislature, law enforcement representatives and individuals from various behavioral health, civil liberties and disability rights organizations.[33] Likewise, in Kansas, after legislative setbacks in 2016, supporters of the emergency hold expansion convened six meetings to discuss the proposal with stakeholders, including representatives from law enforcement, treatment providers and mental health advocates.[34]

In both states, the involvement of outside organizations representing various interested constituencies provided valuable perspective to lawmakers. This inclusive approach allowed for the development of more nuanced proposals able to survive the legislative process. The statement of Mike Burgess, director of policy and outreach for the Disability Rights Center of Kansas, exemplified the dramatic reversals made possible by the process: "To say I was opposed would not do it justice. Now, I return as a supporter."[35]

The experiences of these working groups highlight the fact that advancing crisis response strategies through emergency hold policies is not a straightforward endeavor. Even well intentioned measures—such as preventing time-consuming trips to far away detention sites by allowing for additional local ones—can have unintended consequences that have to be considered—for example, in the case of additional local sites, the fact that many would end up being correctional facilities.[36] At the same time, the dramatic legislative swings in Colorado and—to a lesser extent—Kansas suggest that a deliberate, inclusive policymaking process can help unravel many of these thornier issues.

Recommendations—One of the clearest areas of emergency hold laws in need of reform is the continued use of correctional facilities in a handful of states, though eliminating the use of correctional facilities is inevitably more complicated than simply writing their ineligibility into law. Jails are correctional environments not suited for a health-related crisis, and thus they are generally poor destinations for an individual experiencing a mental health emergency. Indeed, the Substance Abuse and Mental Health Agency itself has stated that no individual should be detained in a correctional setting pending commitment.[37] Yet, there may be no reasonably available alternatives, especially in jurisdictions that are more rural. This can force officials to either not seek treatment or detain individuals longer in order to transport them to facilities that are far away.

The issue is therefore inseparable from that of capacity and related problems around insufficient resources. Colorado suggests, however, that although increased funding may be an especially difficult political issue, it is surmountable with the right coalition behind it. The last six states still using jails should therefore convene their own stakeholder groups to evaluate an appropriate path forward. While drawing on a marijuana tax fund, as Colorado did, is not an option for these jurisdictions, cost-conscious legislators in these states could, for example, incorporate into their analysis the cost-savings that would accrue from officer hours recovered and future interventions averted by the use of appropriate care in the first instance. Advancing pre-arrest diversion and crisis response strategies in this manner may entail some up-front costs, but in the long term, the budget impact may be more positive.

The civil liberties implications of emergency holds mean that any potential expansion of these authorities must also attempt to mitigate the risks of their misuse or overuse. Kansas provides an interesting example of one way in which to safeguard individual rights while advancing this critical crisis response strategy. The Kansas bill gained the support necessary to become law in part because of a compromise that paired a longer period of detention—72 instead of 24 hours—with regular medical evaluations at four, 23 and 48 hours to determine whether an individual should be

31. Worth. https://www.kcur.org/post/proposal-aims-keep-kansas-mental-patients-out-jail-courts-and-emergency-rooms#stream/0.

32. Draper. https://www.denverpost.com/2014/05/24/debate-rages-in-colorado-over-involuntary-holds-for-mental-illness.

33. "Colorado Mental Health Hold Task Force Final Report and Recommendations," Colorado Mental Health Hold Task Force, Dec. 31, 2016. https://cdpsdocs.state.co.us/ccij/meetings/2017/2017-01-13_MMHTF-Rpt-Rec-2016-12-31.pdf.

34. Wingerter. https://www.kcur.org/post/house-committee-oks-involuntary-hold-plan-kansans-mental-health-crisis#stream/0.

35. Ibid.

36. Robles. https://www.denverpost.com/2016/06/09/gov-hickenlooper-vetoes-bill-on-mental-health-holds.

37. Substance Abuse and Mental Health Administration, "Civil Commitment and the Mental Health Care Continuum: Historical Trends and Principles for Law and Practice," U.S. Dept. of Health and Human Services, 2019, p. 33. https://www.samhsa.gov/sites/default/files/civil-commitment-continuum-of-care.pdf.

released.[38] Regardless of which aspect of emergency holds are addressed, policymakers should consider this kind of coupling of new authorities with additional protections; this will ensure that pre-arrest diversion is not just more popular, but fairer and more effective, as well.

Finally, states without a strong role for medical and behavioral health personnel during the initiation phase of these holds should consider how to include them. Whether an emergency hold is appropriate is ultimately a mental health question, which many members of law enforcement may not have adequate training to answer correctly and with consistency. Yet, in 17 states, law enforcement officers have sole discretion to initiate holds and in two of these, the law actually requires that officers take all eligible individuals into custody. This appears to be a recipe for ill-conceived holds and missed opportunities. At the same time, it may well be an unnecessary restriction, as research suggests that emergency medical services personnel can effectively screen patients in the field for potential diversion to psychiatric emergency services.[39] Although the direct, on-scene participation of behavioral health professionals should likely be an ultimate goal for jurisdictions, using technology to connect law enforcement officers with these individuals for live consultations could serve as a valuable interim step.

Protective Custody Statutes

TABLE 3: CHARACTERISTICS OF PROTECTIVE CUSTODY STATUTES

Who can initiate?	Law enforcement officers and, in some jurisdictions, certain other first responders or behavioral health personnel.
Substances Covered	Officials can initiate protective custody for individuals impaired or incapacitated by alcohol and, in some jurisdictions, other drugs.
Discretion of Officials	A jurisdiction may require that officials take all qualifying individuals into custody, it may be entirely up to the discretion of those officials, or it may condition the availability of discretion on whether the individual in question is impaired or incapacitated.
Eligible Destinations	Common eligible destinations include jails and police stations, hospital emergency rooms, behavioral health facilities and other crisis centers.
Duration	Protective custody can last anywhere from eight hours to five days, depending on the jurisdiction; generally, a person must also be released as soon as they are no longer impaired or incapacitated.
Criminal Charges	In most jurisdictions, no criminal charges related to the individual's intoxication are possible if the individual is placed in protective custody, however, a handful of jurisdictions still allow an individual in protective custody to be criminally charged.

One of the more common emergencies that law enforcement officers and other first responders encounter is an individual who is intoxicated or otherwise impaired by the use of substances. Officials faced with this scenario generally feel a strong imperative to act, given the propensity of these individuals to harm themselves or others, or for others to take advantage of them. Historically, the official response to such an individual in need was an arrest, a stint in jail and a possible misdemeanor conviction. In two states, this remains the only approach recognized at the state level, while another seven only supplement this option by allowing officials to begin a long-term, court-sanctioned involuntary commitment for substance abuse treatment. Neither response, however, is particularly well designed to deal with an acute substance use crisis. In fact, criminal charges can distract from and exacerbate health issues, while a potentially months-long commitment may be inappropriate for many individuals who only need temporary assistance.

In the remaining forty-one states and the District of Columbia, law enforcement officers have an alternative option available aimed specifically at acute crises: protective custody. Although the details of the authorizing statutes vary considerably, these laws generally authorize law enforcement officers and, in some places, other first responders to place an individual temporarily in a form of civil custody. Unlike involuntary commitment statutes, chronic substance abuse or dependence is not required. Instead, officials invoke these laws in response to a specific instance of intoxication, impairment or incapacitation due to substance use. Even though many offer potential pathways to further treatment, the overriding objective is to ensure that the individual is safe and attended to medically in the short term, if necessary. Depending on the jurisdiction, this temporary custody can last anywhere from eight hours to five days.[40]

Whether an official actually utilizes protective custody may depend, in part, on the level of discretion afforded to them. The elimination of official discretion for protective custody can push toward its increased use, though at the risk of requiring its use in situations for which an alternative pre-arrest diversion or crisis response strategy may be more appropriate. Six jurisdictions require that authorized officials utilize protective custody for all qualifying individuals, another six require its use for incapacitated individuals, but allow officers discretion in cases involving simple impairment. Thirty grant these officials complete discretion to determine whether to use it.

Thirty-five states further accentuate the health focus of protective custody by explicitly stating that it does not qualify

38. Senate Substitute for H.B. 2053, 2017-2018 Biennium Session (Kan. 2017-2018). http://kslegislature.org/li_2018/b2017_18/measures/documents/hb2053_enrolled.pdf.

39. Trivedi et al. https://www.annemergmed.com/article/S0196-0644(18)31158-2/fulltext.

40. These numbers do not reflect a handful of states that do not specify the maximum period of protective custody. Furthermore, nearly every jurisdiction includes some variation of a provision that states an individual must be released once they are no longer intoxicated, incapacitated or a danger to themselves or others.

as an arrest or serve to commence criminal process. In the remaining seven jurisdictions, criminal charges relating to public intoxication may still be possible despite the use of protective custody. Usually, however, these statutes still encourage officers to either use protective custody as a substitute for criminal process or at least to downgrade an arrest to a citation. The decriminalization of protective custody can decrease the officer time required to utilize the procedure, thereby incentivizing its use as part of a pre-arrest diversion and crisis response scheme.

The degree to which states have leaned into the idea of protective custody as primarily a public health tool is reflected in their treatment of who can initiate the procedure. All jurisdictions with a protective custody law authorize law enforcement officers to begin protective custody procedures. Only 10 extend this authority to other first responders which, in various jurisdictions, includes positions such as members of the emergency patrol, health officers and designated crisis responders. Given that research suggests non-law enforcement first responders can effectively triage intoxicated individuals,[41] failing to empower these personnel may represent an unnecessary restriction on the reach and utility of pre-arrest diversion and crisis response strategies.

The number and type of available custody locations can similarly affect the use and efficacy of protective custody. Nineteen jurisdictions allow an individual to be held in a jail or police station as a location of first resort; fourteen do so only after other health or crisis facilities have been determined to be unavailable. In the remaining 23, officials are required instead to take individuals to an assortment of non-correctional facilities, including detoxification centers, hospitals and other treatment facilities. While the availability of any facility will govern whether protective custody is possible at all, the existence of an appropriate facility may determine its usefulness. For example, a sobering center may offer referral to services, which can disrupt the cycle of substance abuse in a way not generally possible at a jail or emergency room.[42]

One of the more critical distinctions between protective custody statutes is their treatment of non-alcoholic intoxicating substances. All 41 protective custody statutes cover alcohol intoxication, yet only 27 open the door to other drugs. Most of these jurisdictions simply extend the same alcohol-related procedure to other drugs, but a handful have different procedures and protections for other substances, which include elements such as shorter periods of detention or the possibility of criminal charges. Although how protective custody procedures are adapted to non-alcoholic substances may prove important, jurisdictions that create some pathway for doing so will be able to use noncriminal responses to engage with a wider range of individuals in crisis.

A couple of other statutory quirks stand out as interesting approaches to protective custody, which could merit further examination by more jurisdictions. Minnesota, for example, attempts to demonstrate the noncriminal nature of protective custody even further through language stating that police, "as far as is practicable," should not wear a uniform or use a marked police car when transporting an individual under protective custody. In a handful of states, including North Carolina and Texas, officials can take an individual in protective custody to that person's home or place them under the supervision of another adult. Both approaches facilitate the wider use of protective custody by reducing the disruption that it causes. The latter method could be especially helpful for more marginal cases in which a person may not be safe on their own, yet transport to a hospital or other treatment facility may not be appropriate either.

Legislative Action—Long a backdrop to policing efforts, protective custody procedures have captured legislative attention in recent years in large part due to the ongoing opioid crisis. States have increasingly considered whether and how to apply protective custody tools to individuals who are impaired or incapacitated by non-alcoholic drugs. The extension of this tool to drugs, however, has proven more complicated than for alcohol. Whereas alcohol use is itself legal (at least without additional factors), the same is generally not true for many other drugs. Likewise, the necessity for and content of follow-up treatment for a potential substance use disorder can vary based on the substance or substances in question. As a result, states have considered two possible models to develop temporary civil detention for drugs: the relatively straightforward adaptation of existing procedures for alcohol and the extension of involuntary emergency mental health holds.

For the most part, those states embarking on the first of these approaches – looking to alcohol protective custody for guidance – have found broad, bipartisan support for the endeavor. In Massachusetts, for example, a Democratic legislature worked with a Republican governor to pass an extension in 2016 with overwhelming support on both sides of the aisle. Likewise, in Wisconsin, an updated protective custody law sailed through the Republican-controlled legislature with unanimous approval in 2017.

Many outside groups have been equally enthusiastic about expanding alcohol-based protective custody procedures to include other drugs. In Massachusetts, the Massachusetts Chiefs of Police Association was one of the leading

41. David W. Ross et al., "EMS Triage and Transport of Intoxicated Individuals to a Detoxification Facility Instead of an Emergency Department," Annals of Emergency Medicine 61:2 (February 2013). https://www.sciencedirect.com/science/article/abs/pii/S0196064412015090.

42. See Suzanne V. Jarvis et al., "Public Intoxication: Sobering Centers as an Alternative to Incarceration, Houston, 2010-2017," *American Journal of Public Health* (March 13, 2019). https://ajph.aphapublications.org/doi/full/10.2105/AJPH.2018.304907.

organizations rallying behind the law, with individual police chiefs speaking in its favor.[43] Wisconsin similarly saw lobbying in favor of its bill by groups such as the City of Milwaukee and the Wisconsin Medical Society.[44]

The handful of interested parties that have expressed reservations about these bills generally have not allowed their concerns to rise to the level of outright opposition. In Massachusetts, for example, the Speaker of the House supported the new protective custody law, but also stated concerns that the law could overtax limited treatment capacity.[45] In Wisconsin, a couple of outside groups had similar hesitations. The Wisconsin Association for Marriage and Family Therapy and Mental Health America of Wisconsin both raised fears about treatment funding and the latter added that the expansion of outpatient service options would be more desirable than commitment.

In addition to the capacity issue, the role of treatment has served as the primary substantive point of disagreement in states considering whether to expand their protective custody law. In Massachusetts, this manifested as a veto of the original text of the protective custody bill over language that permitted officials to take the incapacitated individual to that person's residence.[46] Despite this section mirroring the procedure for alcohol incapacitation, with the notable difference that the police station had been removed as a possible destination, the governor pushed back against the inclusion of destinations without the capacity for medical treatment. He stated that with such language, the bill did "not reflect the urgency of the health risks associated with incapacitation resulting from a controlled substance or toxic vapor."[47] He ultimately only signed the bill after the legislature amended it to limit acceptable transport locations to those able to provide medical treatment.[48]

The utilization of the emergency mental health hold as the model for drug-related protective custody has proven significantly more controversial than the extension of the procedures governing individuals incapacitated by alcohol. In 2015, the Massachusetts governor floated the idea of permitting physicians, or police officers in the alternative, to authorize the detention and involuntary treatment of an individual experiencing a substance abuse crisis for up to 72 hours. The Speaker of the House and members of the medical community quickly rebuffed this proposal because of concerns about the due process implications and effectiveness of forced treatment.[49] The provision was eliminated from the 2016 bill and ultimately downgraded in 2018 from a new section of law to the subject of study by a special committee after Democrats in the legislature defeated unanimous, albeit limited, Republican support of the measure.

Similar setbacks initially beset legislators pushing for these kinds of changes in Washington State. As in Massachusetts, the issue became a partisan one, albeit with the roles reversed—Democrats led the charge with a portion of Republicans resisting.[50] Although the bill passed the House in 2015, budget concerns caused it to falter in the Senate.[51] Renewed efforts the following year proved more successful, and the measure became law, overcoming reduced Republican opposition.

A new debate in Washington State in 2019 focused on whether to extend the detention period from 72 hours to five days; whether to allow for the involuntary administration of medication similarly divided the policy community.[52] This proposal quickly drew opposition from Disability Rights Washington and the state public defenders' group, which stated that the 2016 law already held individuals for long periods and that these individuals should "see a judge in a timely manner."[53] On the other hand, two national groups, the National Alliance on Mental Illness and the Treatment Advocacy Center, lent their support for the measure, citing the treatment benefits of holding patients for longer periods of time.[54] Notably, the involvement of these two national groups represents some of the only national attention paid to legislation relating to protective custody procedures.

Recommendations—More research is necessary to parse out which protective custody procedures are most desirable, yet a handful of recommendations are already actionable. The first is the inclusion of all drugs, not just alcohol,

43. Bob Salsberg, "Protective Custody Rules Extended to Drug Overdose Cases," *WBUR*, July 22, 2016. https://www.wbur.org/news/2016/07/22/protective-custody-drug-overdose-cases.

44. "January 2017 Special Session Assembly Bill 5," Wisconsin Ethics Commission, accessed July 11, 2019. https://lobbying.wi.gov/What/BillInformation/2017REG/Information/13818?tab=Principals.

45. Salsberg. https://www.wbur.org/news/2016/07/22/protective-custody-drug-overdose-cases.

46. H.4490, 189th Reg. Sess. (Mass. 2015-2016). https://malegislature.gov/Bills/189/H4490/House/Bill/Text.

47. Charlie Baker, "Letter to the Senate and House of Representatives," General Court of Massachusetts, July 8, 2016. https://www.mass.gov/files/documents/2016/07/ws/attach-i.doc.

48. Mass. Gen. Laws ch. 111E, § 9A. https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXVI/Chapter111E/Section9A.

49. Shira Schoenberg, "Massachusetts House Speaker Robert DeLeo concerned about 72-hour opioid prescription limit," *Masslive*, Oct. 16, 2015. https://www.masslive.com/politics/2015/10/house_speaker_robert_deleo_con.html.

50. H.B. 1713, 2015-2016 Reg. Sess. (Wash. 2015-2016). https://app.leg.wa.gov/billsummary?BillNumber=1713&Year=2015.

51. Rachel Alexander, "Heroin epidemic in Washington: Father wants state to help parents confront addiction," *The Spokesman-Review*, Feb. 21, 2016. https://www.spokesman.com/stories/2016/feb/21/as-state-deals-with-heroin-epidemic-an-anguished-f.

52. Tom James, "New rules would allow longer forced holds," *The Spokesman-Review*, April 5, 2019. https://www.spokesman.com/stories/2019/apr/05/new-rules-would-allow-longer-forced-holds.

53. Ibid.

54. Ibid.

within the ambit of protective custody laws. It is somewhat arbitrary and counterproductive to pre-arrest diversion and crisis response strategies to have protective custody apply to only one potential intoxicant rather than the dozens of others that regularly result in health emergencies—especially when multiple substances may be at the root of a given crisis. If jurisdictions are serious about protective custody serving as a noncriminal public health response, then the source of impairment should not serve as a bar to protective custody, even if it is an otherwise illicit one. Further, a debate about the best way to use protective custody to address drugs is one likely to find legislative enthusiasm as long as the opioid crisis remains front and center.

Another area of potential statutory improvement, just as pressing but practically more difficult, is the elimination of jails and other correctional institutions as possible detention sites whenever feasible. An individual in protective custody is suffering from a health crisis, not a criminal one; many jurisdictions already implicitly acknowledge this fact through statutory disclaimers about how protective custody does not qualify as an arrest. Placing those same individuals alongside alleged criminals is therefore illogical. It is also potentially harmful, given that most jail facilities and police stations are not well equipped to provide adequate medical treatment to an individual in crisis. Taking individuals to facilities that are more appropriate can reduce the odds that crisis responders will simply have to pick up the same individual repeatedly in quick succession.

Wider reforms in this regard are, of course, heavily dependent upon resources and raise the question: if not jail, then where? As such, any movement in this direction would likely require an accompanying increase in treatment capacity. This necessitates additional funding, which is why this likely amounts to a more difficult political task. For this reason, as an interim measure, jurisdictions could consider restricting the use of jails or other correctional locations to only those with medical facilities and capabilities that meet certain minimum standards.

Citation Authority

TABLE 4: CHARACTERISTICS OF CITATION AUTHORITY

Eligible Offenses	Citation eligible offenses vary considerably by jurisdiction. Most permit citations for at least some misdemeanors, though a couple limit this to traffic violations, while others include some felonies or even all offenses subject to warrantless arrest.
Exclusionary Conditions	Jurisdictions often include a list of exclusionary conditions that make an offense ineligible for a citation or remove the presumption one. This can include conditions such as a lack of sufficient identification, prior criminal history and a risk of continued criminal conduct.
Discretion of Officials	Law enforcement officers usually have the discretion to determine whether to cite, though some jurisdictions may make citations mandatory, particularly for traffic or especially low-level offenses.

While serious felonies may dominate many of the headlines, misdemeanors prevail in the arrest and court statistics.[55] At the same time, the moral opprobrium associated with many of these offenses—such as disturbing the peace, drug possession or shoplifting—is generally quite low, as is the risk to the public presented by the offender. Put simply, an arrest may be a disproportionate and unnecessary act that takes up a lot of officer time. This recognition has propelled every jurisdiction in the nation to permit citations in lieu of arrests in certain instances.[56]

The breadth of this citation authority and the discretion of officers to issue these citations, however, is quite varied. Although all but two states permit the issuance of citations for at least some non-traffic misdemeanors, only 12 states extend this citation authority to include at least one felony offense. The majority of jurisdictions—28 to be exact—grant officers the discretion whether to utilize citations in lieu of arrest in all instances, while 14 condition it on the type of offense at issue, and nine require citations for all eligible offenses.

While the expansion of eligible offenses and removal of officer discretion may both appear to favor the increased use of pre-arrest diversion, the actual impact of such moves may not be so straightforward. For example, an officer may believe that a particular situation does not merit a citation and, if one is required for low-level charges, may simply seek an enhanced charge. Certain procedural safety valves, which allow for arrest in limited circumstances otherwise requiring a citation, might thus be necessary for officer buy-in and successful implementation of expanded citation authority.

Many jurisdictions have sought to make their citation authority more nuanced and effective in this manner

55. Alexandra Natapoff, "Criminal Misdemeanor Theory and Practice," *Oxford Handbooks Online* (October 2016). https://www.oxfordhandbooks.com/view/10.1093/oxfordhb/9780199935352.001.0001/oxfordhb-9780199935352-e-9.

56. Although these citations usually represent the initiation of criminal process, in some jurisdictions, civil citations may be available for certain offenses.

through exclusionary conditions that prohibit or discourage the use of citations in certain situations. Most places limit citation authority through blanket bars on certain subcategories of otherwise eligible offenses; usually this manifests as a disqualification of domestic violence-related offenses and potentially other types of assaultive behavior. Other conditions require an officer to make a judgment about the defendant rather than the conduct at issue. These include factors such as the prior issuance of a citation or a criminal record more generally, lack of identification, the individual's intoxication, the individual's ties to the jurisdiction, the risk that the offensive conduct would continue and the cooperativeness of the individual. Conditions that prohibit the issuance of a citation, rather than simply removing the presumption that one will issue, may impede pre-arrest diversion efforts by precluding this valuable deescalated criminal response. Likewise, conditions that are potentially applicable to too many individuals may quickly undercut the value of the citation authority itself.

While citation authority largely boils down to where a jurisdiction's law falls on the spectrum of restrained or expansive authority, a few statutory outliers provide a little more complexity, as well as additional potential benefits. One such approach is to provide for additional layers of review in order to reduce further the odds that a citation will lead to formal criminal proceedings. In California, this means that a prosecutor must file additional paperwork post-citation or the case never makes it to the docket,[57] while in Arkansas, police supervisors and prosecutors have the authority to override an arrest and issue a citation instead.[58] In addition, although a large number of states allow individuals to pay fines by mail in response to citations, this generally requires a guilty plea as well. In the District of Columbia, however, the "post-and-forfeit" procedure allows the record to remain clear in these instances.[59] Finally, Vermont and Nebraska reduce the number of warrants issued by granting prosecutors and, in the case of Nebraska, judges the authority to utilize citations instead of arrest warrants.

Legislative Action—In recent years, citation authority within law enforcement has been a relatively popular criminal justice reform topic. In particular, legislation has sought to either increase the types of eligible offenses or to reduce the breadth of exclusionary conditions. Support for these measures has often been widespread, but their advancement has not always represented a priority. Expanded citation authority has been included, relatively unremarkably, into more comprehensive criminal justice overhauls enacted into law, while standalone legislation has, at times, failed to advance, even without vocal opposition. The legislative struggle thus tends to be one of prioritization, not support.

As with protective custody and emergency hold legislation, it is hard to define partisan positions on citation authority. Much of the legislative action has occurred in conservative states under the leadership of Republican legislators. Nevertheless, Democrats have joined in these efforts in Tennessee, Alabama, Georgia and Alaska, ensuring bipartisan endeavors that could command overwhelming support across party lines. However, the developments have not all occurred in conservative locations. In 2013, Maryland Democrats led a successful bipartisan push to expand citation authority in their state.[60]

The advocacy community has been similarly united behind expansion efforts, often bringing together otherwise strange bedfellows. Both the American Civil Liberties Union[61] and Americans for Prosperity,[62] for example, endorsed Tennessee's 2019 downgrading of a couple of exclusionary conditions. Likewise, that bill earned the support of nonpartisan groups, including the Nashville Area Chamber of Commerce and the Tennessee Association of Goodwills.[63] In both Tennessee[64] and Alabama, law enforcement officers publicly supported bills to increase the use of citations.

This widespread support has not always translated into legislative success, however, as bills addressing citation authority often struggle to find legislative momentum on their own. Thus, while Georgia and Alaska[65] were able to pass citation authority reforms as part of comprehensive criminal justice bills in 2018 and 2016 respectively, Tennessee's 2019 update of its citation statute represents the rare recent success of a more limited bill.[66] More frequently, bills solely concerned with citation authority have stalled. In the recent 2018 legislative sessions, for example, citation legislation was intro-

57. Cal. Pen. Code § 853.6 (2018). https://law.justia.com/codes/california/2018/code-pen/part-2/title-3/chapter-5c/section-853.6.

58. Ark. Jud. Rule 5.2. https://www.arcourts.gov/printpdf/198620.

59. Under "post-and-forfeit," an individual "charged with certain misdemeanor crimes may post and simultaneously forfeit an amount of money and thereby obtain a full and final resolution of the criminal charge" that does not involve a guilty plea. See: D.C. Code § 5-335.01.

60. H.B. 742, 2013 Reg. Sess. (Md. 2013). https://legiscan.com/MD/bill/HB742/2013.

61. "Updates from the Legislature," American Civil Liberties Union - Tennessee, accessed July 11, 2019. https://www.aclu-tn.org/2019-tga-legislative-review.

62. "AFP – Tennessee has most productive session ever!" Americans for Prosperity, accessed July 11, 2019. https://americansforprosperity.org/afp-tennessee-has-most-productive-session-ever.

63. "Our Agenda," Tennessee Coalition for Sensible Justice, accessed July 11, 2019. http://tnsensiblejustice.com/our-agenda.

64. Ben Stickle, "A Conservative Cop's Take on Criminal Justice Reform: Citation in Lieu of Arrest," Beacon Center of Tennessee, April 4, 2019. https://www.beacontn.org/a-conservative-cops-take-on-criminal-justice-reform-citation-in-lieu-of-arrest.

65. S.B. 407, 2017-2018 Reg. Sess. (Ga. 2017-2018). http://www.legis.ga.gov/Legislation/en-US/display/20172018/SB/407; S.B. 91, 29th Leg. (Alaska 2015-2016). http://www.akleg.gov/basis/Bill/Detail/29?Root=SB%20%2091.

66. S.B. 0587, 111th Gen. Assembly (Tenn. 2019). https://wapp.capitol.tn.gov/apps/billinfo/default.aspx?BillNumber=SB0587.

duced but never advanced in Kentucky[67] and Maryland,[68] and an effort in Alabama managed to pass the Senate unanimously before quietly receiving dust in the House.[69]

Although a handful of bills have made targeted restrictions to citation authority—usually relating to crimes of domestic violence—the majority attempt to increase its use. Most do so by expanding the list of eligible offenses by including additional categories—such as Alaska allowing citations for class C felonies[70] or Georgia enumerating a few additional eligible misdemeanors.[71] A couple of states, however, have taken a slightly different tack. Tennessee downgraded two exclusionary conditions—whether there was a reasonable likelihood the individual would appear in court and whether the prosecution of an offense might be jeopardized—that were hampering the ability of officers to use the citation authority they otherwise possessed effectively.[72] Instead of prohibiting citations in these instances, the law affords them the discretion to cite or arrest. In 2018, Florida likewise enacted a law to encourage jurisdictions to create programs that use the citation authority already available under current law.[73]

Recommendations—The recent hurdles to citation authority legislation appear to be more related to procedure or passion than they do policy. As such, one of the first recommendations for supportive lawmakers is to consider whether a standalone piece of legislation is the best vehicle for statutory changes. To the extent there is a wider criminal justice package under consideration, this may represent the best placement for new citation authorities. Especially if this is not possible, legislators would do well to harness the energy and advocacy of outside groups, such as in Tennessee, to support, lobby and otherwise raise the profile of the issue.

Although the most straightforward method of expanding citation authority may simply be to add to the list of citable offenses, legislators should also look at ways to make existing authorities more useful. In particular, jurisdictions should consider how exclusionary conditions might prove to be unintended and unnecessary barriers to implementation. For instance, although a prior failure to appear or other entry on a criminal history may serve as an indicator of that individual's likelihood of appearing in court, it may not always be the best one. Prohibiting the use of a citation and thereby curtailing an officer's judgment that the individual is otherwise appropriate for a citation in some of these instances can be costly and counterproductive.

Similarly, legislators should view citation authority as a possible complement to other pre-arrest diversion statutory authorities. For example, while in the abstract a bar to citations in cases involving an intoxicated individual may make sense—for example, in cases wherein an arrest prevents the individual from befalling harm while unattended—it is not necessary in places with a robust protective custody statute. Likewise, a prohibition on the citation and release of an individual who presents a danger to themselves or others is, on its face, logical. Yet, if that requires the arrest and jailing of an individual experiencing a mental health crisis, the condition becomes counterproductive. Ensuring that each of these different pre-arrest diversion authorities works together seamlessly should thus be a priority for jurisdictions. In many instances, altering exclusionary conditions from serving as mandatory bars to citations to mere potential bars to them—thereby preserving officer discretion—may be enough to achieve this goal.

Substance Abuse Good Samaritan Laws

TABLE 5: CHARACTERISTICS OF SUBSTANCE ABUSE GOOD SAMARITAN LAWS

Eligible Offenses	Immunity covers the use or possession of illegal substances and, in some jurisdictions, the possession of drug paraphernalia. It may also cover violations of community supervision.
When Immunity Commences	Depending on the jurisdiction, immunity may prevent an arrest, booking, the issuance of criminal charges or the conviction of an individual for a covered offense.
Immunity for the Individual Experiencing the Overdose	The individual experiencing an overdose may also be immune from prosecution. Depending on the jurisdiction, they may qualify if they were themselves the Good Samaritan caller, were the subject of a Good Samaritan call or irrespective of whether any call was placed at all.
Additional Conditions	Some jurisdictions place additional conditions on whether an individual can receive immunity, such as limiting it to the first caller or requiring cooperation with first responders.

A drug overdose represents an all-too-common crisis for crisis responders, as well as an especially dangerous one requiring a prompt response. Of course, a crisis response requires responders to know that there is an individual in crisis. Yet, the presence of illegal substances or paraphernalia can make the decision to call for help a complicated one in an overdose situation. For example, one study of substance users in Baltimore, Maryland found that only 23 percent called for an ambulance during the last overdose they witnessed, in large

67. Two bills failed in the Kentucky House: H.B. 102, 2018 Reg. Sess. (Ky. 2018). https://legiscan.com/KY/bill/HB102/2018; and H.B. 226, 2018 Reg. Sess. (Ky. 2018). https://legiscan.com/KY/bill/HB226/2018.

68. S.B. 248, 2018 Reg. Sess. (Md. 2018). https://legiscan.com/MD/bill/SB248/2018 (Senate version); H.B. 323, 2018 Reg. Sess. (Md. 2018). https://legiscan.com/MD/bill/HB323/2018 (House version).

69. S.B. 154, 2018 Reg. Sess. (Ala. 2018). https://legiscan.com/AL/bill/SB154/2018.

70. S.B. 91, 29th Leg. (Alaska 2015-2016). http://www.akleg.gov/basis/Bill/Detail/29?Root=SB%20%2091.

71. S.B. 407, 2017-2018 Reg. Sess. (Ga. 2017-2018). http://www.legis.ga.gov/Legislation/en-US/display/20172018/SB/407.

72. S.B. 0587, 111th Gen. Assembly (Tenn. 2019). https://wapp.capitol.tn.gov/apps/billinfo/default.aspx?BillNumber=SB0587.

73. S.B. 1392, 2018 Reg. Sess. (Fla. 2018). https://www.flsenate.gov/Session/Bill/2018/1392/BillText/er/PDF.

part due to a fear of police involvement.[74] Forty-seven states and the District of Columbia have responded to this fear by enacting a Good Samaritan law.

These laws provide some measure of immunity from criminal process as an incentive to call for help for an individual experiencing an overdose. Studies have suggested that these laws have been effective in this initial mission, increasing the likelihood that an individual who was aware of the law would call for assistance,[75] as well as the rate at which individuals who experience an overdose receive emergency room care.[76] Although research has not generally been able to show any significant relationship with overdose deaths,[77] this kind of outcome measurement fails to account for the incredible variation between these laws. Differences in who they cover, for which offenses and under which circumstances likely have a strong bearing on how individuals utilize these laws and what their overall effect is.

One of the more fundamental differences between Good Samaritan laws is which types of criminal offenses are covered. Although all laws apply some level of protection to the possession or use of a controlled substance, only 35 extend these protections to the possession of drug paraphernalia. Given the likelihood that paraphernalia will be present at the scene of an overdose, this disparity may undercut a Good Samaritan law. Likewise, while the dividing line between mere possession and possession with the intent to distribute may be a fine one for many substance users, the latter category of crimes is generally not included within the auspices of Good Samaritan laws. The notable exceptions are Vermont, which covers all potential violations of its chapter on controlled substances, and New York, which extends coverage to distribution of small quantities of marijuana. Finally, 23 states protect individuals from probation, parole or pretrial supervision violations. Fear of arrest on these grounds may similarly deter erstwhile Good Samaritans.

The nature of the immunity itself—where on the continuum of criminal process it arises—can likewise alter the options available at the scene of an overdose. Only immunity from arrest truly forecloses any criminal response on-scene, thereby freeing law enforcement to consider alternative interventions. In 27 jurisdictions, this is the law. In the other 21, however, immunity only prevents a charge from issuing, a prosecution from proceeding or a conviction from entering, meaning that an individual could still be arrested, booked and potentially compelled to attend a court date.

Jurisdictions have likewise diverged on which parties can qualify for Good Samaritan immunity. In particular, while all laws specify immunity for individuals who initiate assistance for another individual who is experiencing an overdose, the same is not true for that individual requiring assistance. In 15 jurisdictions, individuals experiencing an overdose only receive Good Samaritan protections if they placed the call for assistance. Another 18 grant them immunity as the subject of a call for assistance. Thirteen jurisdictions go further, however, with the individual experiencing an overdose receiving immunity by virtue of the overdose and need for medical attention itself, regardless of whether or not anyone even made a Good Samaritan call. Finally, Alabama and Indiana's statutes do not appear to contemplate protections for the individual experiencing the overdose at all.

In some jurisdictions, making a call for help or being the subject of one is not enough, on its own, to garner protection from criminal liability. Fifteen states require individuals to remain on-scene, 12 require some level of cooperation with law enforcement or medical authorities and four provide immunity only to the first person who calls for assistance. In addition, in Ohio and Wisconsin, individuals must enter substance abuse treatment to ensure immunity. Intended to increase the odds of a successful medical intervention, the actual impact of these conditions is less clear given that they may deter potential callers or otherwise alter the relationship between responders and substance users.

Two other statutory conditions appear especially unhelpful to diversionary efforts and Good Samaritan laws. The first restricts immunity to a onetime offer, a restriction embraced by four states. Likely stemming from a fear that a Good Samaritan law will encourage greater drug use, this requirement neglects research suggesting that these laws do not encourage drug use,[78] as well as the realities of substance abuse in which an individual may experience multiple relapses and overdoses on the road to recovery. The second problematic restriction limits Good Samaritan protections to situations in which the Good Samaritan used naloxone. This provision—only present in Indiana—essentially merges Good Samaritan call protections with those meant to facilitate the wider use of naloxone, but does so in a manner that undermines both.

74. See, e.g., K.E. Tobin et al., "Calling emergency medical services during drug overdose: an examination of individual, social and setting correlates," Addiction 100:3 (2005), pp. 397-404. https://www.ncbi.nlm.nih.gov/pubmed/15733253.

75. See C.J. Banta-Green et al., "Washington's 911 Good Samaritan Drug Overdose Law: Initial Evaluation Results," University of Washington, November 2011. http://adai.uw.edu/pubs/infobriefs/adai-ib-2011-05.pdf; and A. Jakubowski et al., "Knowledge of the 911 Good Samaritan Law and 911-calling behavior of overdose witnesses," *Substance Abuse* 39:2 (2018). https://www.ncbi.nlm.nih.gov/pubmed/28972445.

76. H. Nguyen and B.R. Parker, "Assessing the effectiveness of New York's 911 Good Samaritan Law-Evidence from a natural experiment," *The International Journal on Drug Policy* 58 (August 2018), pp. 149-56. https://www.ncbi.nlm.nih.gov/pubmed/29966919.

77. Danielle N. Atkins et al., "Good Samaritan harm reduction policy and drug overdose deaths," *Health Services Research* 54:2 (Feb. 11, 2019), pp. 407-16. https://onlinelibrary.wiley.com/doi/abs/10.1111/1475-6773.13119; and Daniel I. Rees et al., "With a Little Help From my Friends: The Effects of Naloxone Access and Good Samaritan Laws on Opioid-Related Deaths," National Bureau of Economic Research, Working Paper, February 2017, p. 2. https://www.nber.org/papers/w23171.pdf.

78. See Rees et al., p. 3. https://www.nber.org/papers/w23171.pdf.

Legislative Action—Since New Mexico enacted the first Good Samaritan law in 2007, the level of legislative action on the subject across the United States has been extraordinary. In little over a decade, forty-seven states and the District of Columbia have enacted a law, while the remaining three states have vigorously debated it. This represents a level of legislative attention far exceeding the other policy areas in this paper and, indeed, a good many other policy areas as well. The near universal adoption of these laws in so short a period, however, should not be confused with unanimity of support. An ardent resistance in many states has managed to delay or obstruct the passage of Good Samaritan laws or otherwise water them down.

The heart of this opposition movement has been a nucleus of conservative politicians who continue to espouse beliefs reminiscent of the tough-on-crime mantras and policies of prior decades. In Maine, for example, Republican Governor Paul LePage vetoed a Good Samaritan bill in 2013 and 2017,[79] stating that he believed it would encourage drug use. It was only after he left office in 2019 that Maine managed to enact a Good Samaritan law.[80] Similarly, Republican Governor Greg Abbott has unilaterally held up Good Samaritan efforts in Texas, despite bipartisan legislative support for the measures.[81] In 2015, for example, he vetoed a bill because he did not believe it did enough to prevent misuse by habitual drug users and drug dealers.[82] Similar vetoes from Republican governors in California and New Jersey delayed implementation in those states.[83] Recalcitrant governors have not been the only source of political opposition, however. In Wyoming, for example, conservative legislators have balked at Good Samaritan bills, helping ensure it is one of the three states without a law on the books.[84]

The concerns of some members of the law enforcement and prosecutorial communities are instructive not only for the procedural hurdles that they can raise, but also for their potential influence on the legislative text itself. For example, to some members of law enforcement, the ability to arrest an individual who experiences an overdose is preferable to potentially allowing them to walk away without any required interventions.[85] These concerns may help explain why Ohio and Wisconsin require treatment in order to receive Good Samaritan protections. Likewise, the requirement that individuals cooperate with law enforcement may represent an accommodation of another law enforcement concern that Good Samaritan laws could interfere with the prosecution of drug dealers by removing cooperation incentives for low-level substance users.[86]

In Washington State, better education about the intent and details of the law proved sufficient to overcome law enforcement and prosecutorial skepticism. The Washington Association of Sheriffs and Police Chiefs as well as the Washington Association of Prosecuting Attorneys originally opposed a Good Samaritan bill, helping lead to its initial demise.[87] Advocates, however, met with representatives from these organizations and after discussions about the intent and details of the bill were able to convince the Washington Association of Sheriffs and Police Chiefs to reverse their opposition and the Washington Association of Prosecuting Attorneys to alter their stance to neutrality. The bill became law shortly thereafter.[88]

As the case of Washington State highlights, the push for Good Samaritan laws has been fueled in large part by the advocacy of a diverse set of organizations. At the forefront, the Drug Policy Alliance has helped educate policymakers about these statutes, with local chapters getting involved at the state legislative level.[89] Similarly, the ACLU and its state chapters have advocated on behalf of Good Samaritan legislation.[90] The American Medical Association, the National Association of Drug Diversion Investigators, the U.S. Conference of Mayors and the American Public Health Association

79. See, e.g., Tessie Castillo, "Governor LePage of Maine Joins Christie and Schwarzenegger on Wall of Shame: Vetoes Life-Saving Bill," *Huffpost*, June 15, 2013. https://www.huffpost.com/entry/governor-lepage-of-maine_b_3446756; and Kevin Miller, "House upholds LePage veto of bill to shield those who report drug overdoses," *Portland Press Herald*, June 19, 2017. https://www.pressherald.com/2017/06/19/house-upholds-lepage-veto-of-bill-to-shield-those-who-report-drug-overdoses.

80. Chloe Teboe, "Governor signs 'Good Samaritan' bill into law," *News Center Maine*, May 2, 2019. https://www.newscentermaine.com/article/news/local/governor-signs-good-samaritan-bill-into-law/97-23e18de1-76ce-4891-9266-5a12f7fc194e.

81. Carlos Tirado, "Texas misses chance to prevent overdose deaths," *TribTalk*, June 7, 2019. https://www.tribtalk.org/2019/06/07/texas-misses-chance-to-prevent-overdose-deaths.

82. Mary Huber, "Bills would protect Texas drug users who report overdoses," *Austin American-Statesman*, March 25, 2019. https://www.statesman.com/news/20190325/bills-would-protect-texas-drug-users-who-report-overdoses.

83. "Governor LePage of Maine Joins Christie and Schwarzenegger on Wall of Shame." https://www.huffpost.com/entry/governor-lepage-of-maine_b_3446756.

84. Seth Klamann, "Senate advances bill to give immunity to people reporting drug overdose," *Casper Star Tribune*, Feb. 26, 2017. https://trib.com/news/state-and-regional/govt-and-politics/senate-advances-bill-to-give-immunity-to-people-reporting-drug/article_102e5778-e3fa-5931-a2c2-18c2b776c02f.html.

85. See, e.g., Jana Benscoter, "Law enforcement to lawmakers: Revisit 'Good Samaritan' overdose law," *York Dispatch*, Sept. 8, 2017. https://www.yorkdispatch.com/story/news/politics/2017/09/08/law-enforcement-lawmakers-revisit-good-samaritan-overdose-law/521231001.

86. See, e.g., Jo Ciavaglia, "Do overdose immunity laws save lives or delay deaths? Police, lawyers, lawmakers disagree," *Bucks County Courier Times*, July 24, 2017. https://www.buckscountycouriertimes.com/7dbea598-5128-11e7-9999-7b149502975b.html.

87. Tessie Castillo, "What Do Prosecutors and District Attorneys Say About 911 Good Samaritan Laws?", *HuffPost*, Nov. 30, 2015. https://www.huffpost.com/entry/what-do-prosecutors-and-d_b_5159938.

88. Ibid.

89. See, e.g., Matt Sledge, "Chris Christie Comes Out For Good Samaritan Drug-Overdose Bill," *HuffPost*, April 30, 2013. https://www.huffpost.com/entry/chris-christie-drug-good-samaritan_n_3185688.

90. See, e.g., Chloe Cockburn, "Criminalizing Drug Users Is Killing People," American Civil Liberties Union, Feb. 12, 2014. https://www.aclu.org/blog/smart-justice/sentencing-reform/criminalizing-drug-users-killing-people; and Frank Knaack, "Rethinking Virginia's Drug Policy," American Civil Liberties Union - Virginia, Jan. 20, 2015. https://acluva.org/en/news/rethinking-virginias-drug-policy.

have likewise given Good Samaritan laws their endorsement.[91]

Policymakers looking to tackle the opioid epidemic have also shown an increasing appetite for laws that allow the prosecution of an individual who distributed a fatal dose of drugs.[92] These drug-induced homicide laws have the potential to undermine Good Samaritan laws by deterring individuals from calling for assistance. As such, the steady uptick in legislative attention for these laws has caused consternation among Good Samaritan advocates.[93] Future legislative updates to Good Samaritan laws may therefore have to also deal with these provisions and the political pressures they represent.

Recommendations—The two major benefits of a Good Samaritan law are the incentive to call for assistance during a suspected overdose and the fact that they free law enforcement to pursue non-criminal responses to those they find at the scene of the overdose. The most straightforward statutory way to pursue both is to ensure that Good Samaritan protections commence at the very beginning of the criminal justice process, prior to an arrest. Waiting until after law enforcement have already arrested, booked and potentially even charged an individual with a crime is an inefficient means to the same end: no prosecution. This approach wastes officer time and can fray an already fragile relationship between law enforcement and substance abusers. Only removing the specter of criminal justice involvement entirely allows both officers and substance abusers to focus their attention and energies on non-criminal methods of addressing the substance abuse issue.

This rationale similarly motivates the need to expand the coverage of most Good Samaritan laws. Failing to provide immunity for drug paraphernalia possession or other low-level, substance abuse-related offenses undermines these laws, while providing little conceivable benefit. Likewise, providing immunity for new criminal charges but not for potential violations of pretrial release, probation or parole creates a legal distinction that is largely unwarranted. While individuals under community supervision rightly have smaller margin for error, the transgressions forgiven under a Good Samaritan law remain relatively minor and pale in comparison to the potential consequences of an untreated overdose. Including some form of community supervision protections within the ambit of a Good Samaritan law is therefore entirely in keeping with the law's overarching purpose of placing harm reduction before punishment. Although some kind of response by supervisory authorities may be necessary and appropriate—such as placing a notation in an individual's file—at a minimum, immunity would likely need to protect against arrest and potential revocation in order to be effective.

Good Samaritan laws should likewise extend broader protections to individuals who experience an overdose. Providing immunity to these individuals eliminates the possibility of a criminal response and frees first responders to consider other, more suitable actions. As a possible half measure for jurisdictions unwilling to entirely forego the leverage that a criminal charge can provide, policymakers might consider ensuring that citations are used in overdose situations. While this would not remove the specter of justice system involvement entirely, it would at least ensure that no arrest is made, and that the individual who experienced an overdose does not have to recover in a jail cell.

Although every Good Samaritan law on the books has room for improvement, in most jurisdictions, one of the most pressing needs does not even require an alteration to the statute: education. Very few states dedicate funding to their Good Samaritan laws, even if they require official agencies to educate relevant portions of the public about their protections.[94] This, of course, undermines the effectiveness of the laws. After all, if individuals are unaware of or confused about their immunity from prosecution, they will be no more likely to call for assistance. Equally important, law enforcement must be aware of the exact contours of the law so that there are no unnecessary arrests and officers can effectively integrate Good Samaritan protections into their post-overdose response plans.

91. "States use Good Samaritan laws, Narcan, to fight drug overdoses," *The Denver Post*, Feb. 20, 2014. https://www.denverpost.com/2014/02/20/states-use-good-samaritan-laws-narcan-to-fight-drug-overdoses.

92. Lindsay LaSalle, "An Overdose Death Is Not Murder: Why Drug-Induced Homicide Laws Are Counterproductive and Inhumane," Drug Policy Alliance, November 2017, p. 15. http://www.drugpolicy.org/sites/default/files/dpa_drug_induced_homicide_report_0.pdf.

93. Ibid.

94. Jess Aloe, "Few call 911 for an overdose despite immunity law," *Associated Press*, June 18, 2018. https://www.apnews.com/e0d14b6eccc64ae185a9da954682ea68.

Ambulance Transport Destination Rules

TABLE 6: CHARACTERISTICS OF AMBULANCE TRANSPORT DESTINATION RULES

Alternative Destinations	"Alternative destinations" is a term that collectively refers to a host of facilities other than a hospital emergency department. It includes behavioral health facilities, crisis centers, detoxification centers and other community-based resources.
Source of Authority	Jurisdictions split on whether to permit alternative destinations, either expressly permitting or prohibiting them in statute or delegating that decision to executive agencies or local authorities.
Community Paramedicine	Community paramedicine programs permit Emergency Medical Services and other first responders or medical personnel to provide community-based health services in an attempt to increase access and reduce strain on hospital emergency departments. Many of these programs include transport to alternative destinations.

Individuals experiencing an acute mental health or substance abuse crisis frequently find themselves in a hospital emergency department. Indeed, roughly one in eight emergency department visits involves a diagnosis relating to a mental health or substance abuse condition,[95] and data from 2007-2011 showed the number of these behavioral health visits increasing by 15 percent during that period.[96] Further, wait times for acute substance abuse or mental health patients can last days, and are often longer for these patients than others.[97] Long wait times can exacerbate the symptoms of an individual experiencing a behavioral health issue, and some hospitals that lack available beds have to refer patients to other facilities, increasing this wait time even further. The opportunity costs of these visits are significant. Specialized treatment centers—such as sobering centers and mental health facilities—are more likely to accept these patients, offer shorter wait times and are often better suited to deal with the individual's needs in the first place.

Yet, in 14 jurisdictions, statutes nevertheless require Emergency Medical Services (EMS) to transport all patients to a hospital emergency department and forego alternative destinations.[98] Some states do so in relatively explicit terms by referring exclusively to hospital emergency departments in statutes defining acceptable EMS practices or eligible transport destinations. For example, the relevant California statute reads: "Any local EMS agency may authorize an advanced life support program [...] for the delivery of emergency medical care [...] during transport to a general acute care hospital, during interfacility transfer, or while in the emergency department of a general acute care hospital."[99] Other states are more circumspect, often appearing to allow for alternative transport initially, but precluding it in other parts of the law. For instance, Massachusetts law includes treatment during transport to "appropriate healthcare facilities" in its definition of EMS, but the Department of Public Health rules define "appropriate healthcare facility"[100] as "an emergency department, either physically located within an acute care hospital licensed by the Department [...] or in a satellite emergency facility approved by the Department."[101]

Another 14 jurisdictions take the opposite approach to ambulance transport destination policy, allowing in statute for ambulance transport to facilities other than hospital emergency departments. Of these jurisdictions, three—Louisiana, Hawaii and Washington State—specifically refer to and allow for "alternative destinations" in statute. The remaining states permit alternative destinations through the definitions of certain terms—similar to the model for restricting destinations. For example, Illinois, allows alternative destinations by permissively defining "appropriate destinations" as a hospital or "other fixed location at which medical and health care services are performed."[102] Arizona is more explicit in its legal provisions and defines "health care institutions" as "every place, institution, building or agency [...] with medical services, nursing services, behavioral health services, health screening services, other health-related services, supervisory care services, personal care services [...] outdoor behavioral health care programs and hospice service agencies."[103]

The remaining 23 jurisdictions, however, do not resolve the destination issue directly in statute. Instead, they opt to delegate authority on authorized destinations to state and local EMS boards or lack any clear language on the issue at all. Of these jurisdictions, eight explicitly delegate authority to state and local bodies in charge of EMS procedures. Oregon, as an example, grants EMS medical directors some discretion to determine where to transport a patient.[104] The State Health Authority works with these medical directors and local EMS personnel to set medical control protocols,

95. Pamela Owens et al., "Mental Health and Substance Abuse-Related Emergency Department Visits among Adults, 2007," Agency for Healthcare Research and Quality, July 2010, p. 1. https://archive.ahrq.gov/research/findings/nhqrdr/2014chartbooks/index.html.

96. "2014 National Healthcare Quality and Disparities Report: Chartbook on Care Coordination," Agency for Healthcare Research and Quality, May 2015, p. 9. https://archive.ahrq.gov/research/findings/nhqrdr/2014chartbooks/index.html.

97. Jay Greene, "Emergency rooms fill up with psych patients — and then they wait," *Crain's Detroit*, Jan. 27, 2019. https://www.crainsdetroit.com/health-care/emergency-rooms-fill-psych-patients-and-then-they-wait.

98. "Alternative destination" is shorthand in this paper for all specialized treatment centers not located inside of a hospital emergency department.

99. Cal. Code Reg. tit. 22, §§ 100063, 100146(c). https://emsa.ca.gov/wp-content/uploads/sites/71/2019/02/EMSA-Regulations-all.pdf.

100. Mass. Gen. Laws ch. 111C § 1. https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXVI/Chapter111C/Section1.

101. 105 C.M.R. §170.020. https://www.mass.gov/files/documents/2017/09/11/105cmr170.pdf.

102. 210 Ill. Comp. Stat. 50/3.5. http://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=1226&ChapterID=21.

103. Ariz. Rev. Stat. 36-401. https://www.azleg.gov/ars/36/00401.htm.

104. Or. Rev. Stat. 682.025. https://www.oregonlaws.org/ors/682.025.

which establish guidelines for appropriate locations.[105] The remaining 13 jurisdictions do not have any guiding language permitting or forbidding transport to alternative destinations, or even text directing state and local boards to make this determination. As a result, the potential use of alternative destinations may be under the de facto control of each local EMS board or provider.

The emergence of community paramedicine programs has provided another means by which local EMS providers can transport patients to alternative destinations, potentially despite state policies otherwise to the contrary. The term "community paramedicine"[106] encompasses a variety of innovative healthcare delivery programs, all of which aim to reduce unnecessary emergency calls for populations that lack access to specialized treatment or primary care and, as a result, call emergency services.[107] At least 33 states now operate at least one community paramedicine program,[108] with alternative destination programs comprising half of these programs. These include states that do not allow alternative destinations according to state law. In California, for example, the state has accepted 20 community paramedicine pilot projects since 2014—including multiple alternative destination projects, notwithstanding the state's statutory mandate to transport patients to emergency departments.[109]

These community paramedicine programs thus further muddy the waters on the statewide legal status of alternative destinations. Indeed, one survey found that roughly 10 percent of directors operating community paramedicine programs were uncertain of their program's legal status.[110] At the same time, however, these programs may also provide local communities with one more potential avenue to pursue a crisis response strategy that includes alternative destinations.

Legislative Action—Policy fights over alternative destinations are relatively rare and meaningful public attention to them even more so. This is partly due to the niche nature of the policy, but also because alternative destination provisions are frequently included in broader bills authorizing community paramedicine programs rather than serving as standalone pieces of legislation. Not all community paramedicine bills include language on alternative destinations, but generally legislation addressing alternative destinations also involves community paramedicine.

California's active legislature and robust media markets help it provide the most illuminating example of the forces that can get involved when alternative destinations capture legislative attention. In 2018, three bills emerged that would have allowed for alternative destinations.[111] The first bill exclusively addressed them, while the subsequent two bills authorized them as part of a broader package of community paramedicine legislation. Each received some measure of bipartisan support, with Democratic legislators nearly unanimously backing all three, and a significant minority of Republicans supporting each. Yet, despite each successive bill moving progressively further through the legislative process, none managed to make it into law. In fact, the additions and compromises made to ensure legislative passage appear to have helped doom the whole endeavor; in the face of unanimous Democratic support, the Democratic governor nevertheless vetoed the final bill, citing a handful of provisions.[112]

The shifting opinion of outside organizations on these successive bills, which moved from widespread to more mixed support, may explain some of the governor's reluctance to sign the final bill. The first bill received the backing of EMS stakeholders, such as the California Hospital Association, the California Ambulance Association, the Emergency Medical Services Administrators' Association of California, the California District Attorneys' Association, as well as multiple cities, counties and associations of fire and police chiefs.[113] It likewise drew support from an ideologically diverse group of civil society groups, including the California Chamber of Commerce, the ACLU of California, the Depression and Bipolar Support Alliance, the National Sobering Collaborative and the National Alliance on Mental Illness. The bill was

105. OAR 333-200-0080. https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=255958.

106. "Community Paramedicine," Rural Health Information Hub, accessed July 17, 2019. https://www.ruralhealthinfo.org/topics/community-paramedicine.

107. These programs use specially trained community paramedics to conduct out-of-hospital visits with frequent 9-1-1 callers and use emergency medical services for non-emergency issues because they lack access to appropriate care. Examples of these programs include: following up with patients after ER visits to connect them with appropriate services in the community, treating patients or administering medication at in-home visits, as well as assessing emergency callers on scene for possible referral to an alternative destination. The term "mobile integrated healthcare" is used interchangeably with community paramedicine.

108. This survey did not receive responses from every state, meaning that some states may have community paramedicine programs but were not captured. "Mobile Integrated Healthcare and Community Paramedicine (MIH-CP): 2nd National Survey," National Association of Emergency Medical Technicians, April 2018, pp. 4, and 11. http://www.naemt.org/docs/default-source/2017-publication-docs/mih-cp-survey-2018-04-12-2018-web-links-1.pdf?Status=Temp&sfvrsn=a741cb92_2.

109. Karen Shore, "Community Paramedicine in California: Overview of Pilot Projects," Golden State Health Policy, May 2018, p. 1. https://www.chcf.org/publication/community-paramedicine-california-overview-pilot-projects.

110. "Mobile Integrated Healthcare and Community Paramedicine (MIH-CP)," p. 25. http://www.naemt.org/docs/default-source/2017-publication-docs/mih-cp-survey-2018-04-12-2018-web-links-1.pdf?Status=Temp&sfvrsn=a741cb92_2.

111. AB 1795, 2018 Gen. Sess. (Cal. 2018). https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201720180AB1795; SB 944, 2018 Gen. Sess. (Cal. 2018). https://leginfo.legislature.ca.gov/faces/billAnalysisClient.xhtml?bill_id=201720180SB944; AB 3115, 2018 Gen. Sess. (Cal. 2018). https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201720180AB3115.

112. Office of the Governor of California, "AB 3115 Veto Message," Sept. 30, 2018. http://www.naemt.org/docs/default-source/home-page-docs/ca-ab-3115-veto-message-from-the-governor.pdf?sfvrsn=9168c892_0.

113. "Leading the Way Legislative Tracking – Identified Bills," California Hospital Association, April 16, 2018. https://www.calhospital.org/sites/main/files/file-attachments/ab_1795.pdf.

so popular it even garnered the support of the *Los Angeles Times* editorial board.[114]

The incorporation of additional provisions into the two later bills, however, helped to swell the ranks of opposition. The California Nurses Association and California chapter of the American College of Emergency Physicians led the opposition to all three bills, claiming it would be dangerous to allow EMTs to make triage and destination assessments on the scene.[115] Even a handful of supporters of the first bill, including local jurisdictions, EMS groups and the California Hospital Association, joined the opposition for the two later bills.[116] These groups criticized a right-of-first-refusal provision for unfairly privileging public entities over private ones—such as private ambulance companies that service 71 percent of community paramedicine patients statewide[117]—and saw a state-level oversight committee as an unnecessary layer of review that would inhibit innovation. Additional opposition centered on the firefighter groups' attempt to gain additional seats on the state's EMS Commission, as well as the proposed requirement that alternative destinations be designated as federally qualified health centers, which one article claimed would be "cost-prohibitive."[118]

Successful legislation in Washington State and Louisiana also received bipartisan political support, though dramatically less media attention. In 2015, the Washington State legislature overwhelmingly passed a bill that authorized alternative destinations and Medicaid reimbursement for these transports; the measure received unanimous support in the House and only two votes in opposition by Republicans in the Senate.[119] In 2018, a Louisiana bill with similar provisions passed the Senate with only one vote against it and the House with over a two-thirds majority.[120] In a reversal of the California and Washington State political experiences, however, a Republican sponsored the measure in Louisiana and the majority of the opposition came from Democrats. Unlike in California, neither bill gained significant media coverage,[121] perhaps due to their seemingly technical and bipartisan nature.

Although the availability of alternative destinations has occasionally occupied legislative focus directly, community paramedicine consistently claims the lion's share of legislative attention. Many of the states where community paramedicine programs exist have passed specific authorizing legislation, while in others, such as Wyoming, EMS groups have worked with executive branch agencies to formulate rules for these programs.[122] States that have passed community paramedicine laws include reliably conservative ones such as Idaho and Tennessee,[123] as well as more liberal ones such as Colorado and Maine.[124] While not all of these programs involve alternative destinations, this trend demonstrates a widespread amenability to experimenting with innovative EMS models. Notably, the majority of these programs have only been implemented in the past few years,[125] which suggests a growing interest.

Recently, the federal government has also taken action that signals support for alternative destination transport. In 2019, the Centers for Medicare and Medicaid Services (CMS) announced the rollout of its Emergency Triage, Treat and Transport (ET3) Model.[126] This model will allow states to submit applications for its programs to receive reimbursement through Medicare for alternative destinations. The program is still in its infancy, but the Director of CMS' Innovation Center made a promising statement when he described his reaction to discovering Medicare has only reimbursed trips to hospital emergency departments: "I thought that was

114. The Times Editorial Board, "Give paramedics the power to make better choices on behalf of vulnerable people," *Los Angeles Times*, April 24, 2018. https://www.latimes.com/opinion/editorials/la-ed-paramedics-sobering-center-law-20180423-story.html.

115. "California Nurses Oppose Bills That Threaten Patient Safety & Lower Care Standards for Medi-Cal Patients," California Nurses Association, April 30, 2018. https://www.nationalnursesunited.org/press/california-nurses-oppose-bills-threaten-patient-safety-lower-care-standards-medi-cal-patients.

116. Farrah McDaid Ting et al., "Counties Ask Governor to Veto AB 3115," California State Association of Counties, Sept. 6, 2018. https://www.counties.org/csac-bulletin-article/counties-ask-governor-veto-ab-3115. See also, Dennis Rowe, "Comment to SB 944," National Association of Emergency Medical Technicians, June 28, 2018. http://www.naemt.org/docs/default-source/advocacy-documents/letters-and-comments/comment-to-sb944-6-26-18.pdf?Status=Temp&sfvrsn=dee2cb92_2.

117. Chris Mitchell, "Why the Governor Should Veto AB 3115," *Fox & Hounds Daily*, Sept. 20, 2018. http://www.foxandhoundsdaily.com/2018/09/governor-veto-ab-3115.

118. John Ehrhart, "Governor Brown Vetoes AB3115 Community Paramedicine Bill," California Paramedic Foundation, Oct. 9, 2018. https://caparamedic.org/news-and-events/governor-brown-vetoes-ab3115-community-paramedicine-bill.

119. H.B. 1721, 2015 Reg. Sess. (Wash. 2015). https://app.leg.wa.gov/billsummary?BillNumber=1721&Year=2015&Initiative=False.

120. S.B. 414, 2018 Reg. Sess. (La. 2018). http://www.legis.la.gov/legis/BillInfo.aspx?s=18RS&b=SB414&sbi=y.

121. The Washington State bill received some attention due, in part, to its link to community paramedicine provisions. See Shaughn Maxwell, "Washington State Passes Bill Supporting Public EMS and Fire Agencies," *Journal of Emergency Medical Services*, May 11, 2017. https://www.jems.com/articles/2017/05/washington-state-passes-bill-supporting-public-ems-and-fire-agencies.html.

122. "Mobile Integrated Healthcare and Community Paramedicine (MIH-CP)," p. 25. http://www.naemt.org/docs/default-source/2017-publication-docs/mih-cp-survey-2018-04-12-2018-web-links-1.pdf?Status=Temp&sfvrsn=a741cb92_2.

123. See, e.g., H.B. 153, 2015 Reg. Sess. (Idaho 2015). https://legislature.idaho.gov/sessioninfo/2015/legislation/h0153; and

H.B. 1271, 2017 Reg. Sess. (Tenn. 2017). https://trackbill.com/bill/tennessee-house-bill-1271-health-care-as-enacted-requires-the-emergency-medical-services-board-to-establish-standards-for-a-community-paramedic-through-promulgation-of-rules-amends-tca-title-68-chapter-140-part-3/1384650.

124. See, e.g., S.B. 16-069, 2016 Reg. Sess. (Colo. 2016). https://openstates.org/co/bills/2016A/SB16-069; and H.P. 0981, 128th Leg. (Me. 2017). https://legislature.maine.gov/legis/bills/bills_128th/billtexts/HP098101.asp.

125. "Mobile Integrated Healthcare and Community Paramedicine (MIH-CP)," p. 7. https://www.naemt.org/docs/default-source/community-paramedicine/naemt-mih-cp-report.pdf?sfvrsn=df32c792_4.

126. "HHS launches innovative payment model with new treatment and transport options to more appropriately and effectively meet beneficiaries' emergency needs," *CMS Newsroom*, Feb. 14, 2019. https://www.cms.gov/newsroom/press-releases/hhs-launches-innovative-payment-model-new-treatment-and-transport-options-more-appropriately-and.

a joke. I had to verify it multiple times [...] What a ridiculous incentive."[127]

Recommendations—Alternative destinations will not always be the appropriate destination—often that will remain a hospital emergency room—but especially for situations involving simpler cases and non-medically emergent issues, they can represent a potentially valuable tool for crisis responders. In particular, policies that prohibit or discourage alternative destination transport by EMS can inhibit pre-arrest diversion and undercut crisis response by forcing law enforcement to serve as the only possible transporters to these alternative destinations. If law enforcement is unable or unwilling to take the time to transport an individual to an alternative destination, the only remaining options may be transport to an emergency department or a police station. In either instance, the effectiveness of the crisis response may suffer. As such, jurisdictions should adopt policies that allow for the considered and appropriate use of alternative destination transport by EMS.[128]

Although prescriptive language is the most straightforward way for policymakers to expand the availability of alternative destinations, additional clarity is also important. As this survey shows, a failure to address destinations clearly—or at all—in statute, as well as a delegation of the issue to local authorities, can leave the legal status of alternative destinations unclear. For example, one study that interviewed EMS directors and representatives in all fifty states on their perceptions of their legal prerogatives found only 40 percent concordance between the researchers' findings on EMS boards' ability to expand alternative destinations and what EMS representatives believed was permissible.[129] The remedy to this problem is twofold: legislators should work to ensure the law directly and clearly permits alternative destinations, and authorities should work to resolve ambiguities in current law and educate relevant stakeholders about the potential availability of alternative destinations.

Finally, ensuring that alternative destinations are not only legally permissible but also actually used requires addressing the collateral issue of costs. Ambulance providers are unlikely to utilize alternative destinations—at least with any degree of frequency—unless they receive reimbursement for the trip.[130] Yet, while alternative destination programs could result in significant healthcare cost reductions, these programs face their own set of financial obstacles. In many states, ambulances are reimbursed through specific grants from the state set aside for the purpose of keeping these programs afloat, but that model may not be scalable.[131] Likewise, many programs involving alternative destinations run through earmarked grants from the state for pilot programs available to select localities, and only a handful of states, such as Minnesota and Georgia, have extended Medicaid reimbursement. Although there are many ways in which jurisdictions could resolve these cost concerns, expanding reimbursement through federal programs may be an especially effective means of addressing the cost issue. Medicaid remains the most common payer type of all emergency department visits,[132] and private insurers often follow the lead of Medicare and Medicaid reimbursement policies.

CONCLUSION

For the five policies examined in this paper, there is no 'typical' statute. Each area exhibits a stunning variety of statutory permutations across a handful of key legislative lines. A protective custody procedure, for example, in one state may look wildly different from that of a neighboring one, and the complete package of protective custody, emergency holds, citation authority, Good Samaritan laws and ambulance regulations can result in a pre-arrest diversion and crisis response landscape that is fundamentally and critically different. At the same time, continued legislative attention in recent years that generally attempts to expand the reach of these policies means that they are only more likely to affect future pre-arrest diversion and crisis response strategies.

The depth of relevant research has generally not matched the complexity or popularity of these policy areas. For instance, while the mental health community has largely rallied behind the idea that jail is no place for the mentally ill, there is no similar consensus or research base on how to structure an emergency hold to facilitate productive outcomes. Likewise, research on Good Samaritan laws is rel-

127. Hilary Gates, "Medicare Announces Payment Model To Reimburse for On-Scene Treatment, Alternative Destinations," *EMSWorld*, Feb. 14, 2019. https://www.emsworld.com/article/1222205/medicare-announces-payment-model-reimburse-scene-treatment-alternative-destinations.

128. These policies may also need to include some form of liability protection to ensure that the transport of an individual to an alternative destination that is reasonable under the circumstances, but ultimately results in complications, does not subject the first responder in question to undue legal action, which could have the further effect of disincentivizing future alternative destination use.

129. Melody Glenn et al., "State Regulation of Community Paramedicine Programs: A National Analysis," *Prehospital Emergency Care* 22:2 (2018), p. 250. https://www.tandfonline.com/doi/10.1080/10903127.2017.1371260.

130. Similarly, one study surveyed the heads of community paramedicine programs across the country, and 86 percent agreed that funding or reimbursement was a primary obstacle. "Mobile Integrated Healthcare and Community Paramedicine (MIH-CP)," p. 17. http://www.naemt.org/docs/default-source/2017-publication-docs/mih-cp-survey-2018-04-12-2018-web-links-1.pdf?Status=Temp&sfvrsn=a741cb92_2.

131. See "Final Report on the Community Paramedic Mobile Crisis Management Pilot Program: Report to the Joint Legislative Oversight Committee on Health and Human Services," North Carolina Dept. of Health and Human Services, Nov. 1, 2016. https://files.nc.gov/ncdhhs/SL%202015-241%20Section%2012F%208%20d%20Community%20Paramedicine.pdf; and Arthur Hsieh, "Without insurance changes, CP programs will be on life support," *EMS1*, March 17, 2015. https://www.ems1.com/community-paramedicine/articles/2137687-Without-insurance-changes-CP-programs-will-be-on-life-support.

132. Ruirui Sun et al., "Trends in Hospital Emergency Department Visits by Age and Payer, 2006–2015," Agency for Healthcare Research and Quality: Healthcare Cost and Utilization Project, March 2018, p. 1. https://www.hcup-us.ahrq.gov/reports/statbriefs/sb238-Emergency-Department-Age-Payer-2006-2015.pdf.

atively robust compared to some of the other policy areas, yet it still generally does not distinguish between—let alone investigate—the various versions of these laws. Thus, most of the assumptions and logical arguments about these policy areas remain untested.

As such, future research should attempt to parse out the relative strengths of some of the more prevalent and compelling statutory configurations. This would have a twofold impact on pre-arrest diversion and crisis response strategies. In the short run, programs could take advantage of whatever flexibility exists in current law to accentuate the stronger aspects of these policies and educate law enforcement and other first responders on available legal authorities and best practices. With time, legislators could redesign the legal regimes themselves to reflect the research better.

Pre-arrest diversion and crisis response strategies are inherently local in nature. Yet, as this paper shows, state policymakers often get to dictate which tools are available to these programs and can influence the conditions under which they operate. This means that individuals seeking to maximize the potential of pre-arrest diversion and crisis response strategies cannot ignore developments at the state level. Further, the surveys within this study shatter any notion of any of these policy areas as some sort of monolith. Incredible variation occurs across each, and the survey contained herein should therefore be viewed as a map of areas of improvement as well as a source of inspiration. No state may have yet figured out how to create the most conducive environment possible for pre-arrest diversion and crisis response, but in their divergent approaches they present a wealth of promising options.

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APPENDIX I: SURVEY RESULTS OF STATEWIDE POLICIES RELATING TO PRE-ARREST DIVERSION AND CRISIS RESPONSE

Emergency Holds

Jurisdiction	Statute	Preconditions for a Hold	Who can Initiate	Discretion of Officials	Eligible Destinations	Maximum Duration
Alabama	Ala. Code § 22-52-91	Reasonable cause to believe individual is mentally ill and likely to be immediate danger to self/others	Law enforcement officer in concert with community mental health officer	Mandatory custody of eligible individuals	Designated mental health facility	7 days
Alaska	Alaska Stat. § 47.30.705	Probable cause to believe individual is gravely disabled or likely to cause serious harm to self/others	Peace officer; psychiatrist; physician; clinical psychologist	Complete discretion	Nearest evaluation facility	72 hours
Arizona	Ariz. Rev. Stat. § 36-525	Probable cause to believe individual is danger to self/others and likely to suffer/ inflict serious harm	Peace officer	Complete discretion	Screening agency; evaluation agency (if transport to screening agency impractical)	24 hours (excluding weekends/ holidays)
Arkansas	Ark. Code § 20-47-210	If it appears individual is danger to self/ others and immediate confinement necessary to avoid harm	Interested citizen (law enforcement obligated to transport)	Complete discretion	Hospital; receiving facility or program	72 hours (excluding weekends/ holidays)
California	Cal. Welf. & Inst. Code § 5150	Probable cause to believe individual is danger to self/others, or gravely disabled	Peace officer; treatment facility staff; mobile crisis team member	Complete discretion	Treatment facility	72 hours (excluding weekends/ holidays)
Colorado	Colo. Rev. Stat. § 27-65-105	Probably cause to believe individual is imminent danger to self/others, or gravely disabled	Peace officer; professional person; nurse; therapist/ counselor; social worker	Complete discretion	Treatment facility; emergency medical services facility (last resort)	72 hours (excluding weekends/ holidays)
Connecticut	Conn. Gen. Stat. § 17a-503	Reasonable cause to believe individual is dangerous to self/others, or gravely disabled and in need of immediate care	Peace officer	Complete discretion	Hospital	72 hours
Delaware	Del. Code tit. 16 § 5004	Individual likely is danger to self/others	Peace officer; mental health screener	Mandatory detention	Treatment facility	24 hours; 72 hours (juveniles with parental consent)
District of Columbia	D.C. Code § 21-521	Reason to believe individual is likely danger to self/others if not immediately detained	Peace officer; agent of Department of Mental Health; physician; psychologist	Complete discretion	Hospital; Department of Mental Health	48 hours
Florida	Fla. Stat. § 394.463	Reason to believe there is substantial likelihood person is danger to self/others in near future, or gravely disabled	Peace officer; physician; psychologist; nurse; mental health counselor; therapist; social worker	Complete discretion	Hospital; crisis stabilization unit; addictions receiving facility	72 hours
Georgia	Ga. Code Ann. §§ 37-3-41; 37-3-42	Based on personal examination, believes individual is mentally ill and in need of treatment	Physician; peace officer (only until individual transported to physician)	Complete discretion	Emergency receiving facility	48 hours
Hawaii	Haw. Rev. Stat. § 334-59	Reason to believe that person imminently dangerous to self/others; person is suicidal	Peace officer in concert with mental health emergency worker	Mandatory discretion	Psychiatric facility	48 hours
Idaho	Idaho Code Ann. § 66-326	Reason to believe individual is imminent danger to self/others, or gravely disabled	Peace officer; physician; physician's assistant; nurse	Complete discretion	Hospital; sanitarium; institution; mental health facility	24 hours
Illinois	405 Ill. Comp. Stat. 5/3-600	Reasonable grounds to believe individual is in need of detention to protect self/others	Peace officer; any adult (via petition to mental health facility director)	Complete discretion	Mental health facility	24 hours

Indiana	Ind. Code § 12-26-4-1	Reasonable grounds to believe individual is in need of detention to protect self/others	Peace officer	Complete discretion	Nearest appropriate facility	24 hours
Iowa	Iowa Code § 229.22	Reasonable grounds to believe individual is in need of detention to protect self/others	Peace officer	Complete discretion	Hospital; mental health or substance abuse treatment facility	48 hours (following magisterial authorization)
Kansas	Kan. Sta. Ann. § 59-2953	Reasonable belief that person is likely danger to self/others	Peace officer; any individual (at crisis intervention facility)	Complete discretion	Crisis intervention facility; treatment facility (last resort)	Next business day; 72 hours (crisis intervention facilitys)
Kentucky	Ky. Rev. Stat. Ann. § 202A.041	Reasonable grounds to believe individual danger to self/others if not restrained	Peace officer	Mandatory custody	Hospital; psychiatric facility	18 hours
Louisiana	La. Stat. Ann. § 28-53	Reasonable grounds to believe person is danger to self/others or gravely disabled and in need of immediate detention	Peace officer; peace officer accompanied by emergency medical technician	Complete discretion	Hospital; retreat; institution; mental health facility; treatment facility	72 hours
Maine	Me. Stat. tit. 34-B, § 3862	Probable cause to believe person is imminent danger to self/others or gravely disabled	Peace officer	Complete discretion	Psychiatric hospital	18 hours
Maryland	Md. Code, Health § 10-622	Reason to believe individual is danger to self/others	Peace officer; physician; psychologist; social worker; nurse; therapist; health officer; any other interested person	Complete discretion	Nearest emergency facility	30 hours
Massachusetts	Mass. Gen. Laws ch. 123, §12	Reason to believe there is likelihood individual is danger to self/others	Physician; nurse; psychologist; social worker; peace officer (last resort)	Complete discretion	Treatment facility	3 days
Michigan	Mich. Comp. Laws §330.1427	Reason to believe individual requires treatment	Peace officer	Complete discretion	Preadmission screening unit designated by a community mental health services program	24 hours
Minnesota	Minn. Stat. § 253B.05	Reason to believe individual danger to self/others if not immediately detained	Peace officer; health officer	Complete discretion	Physician; treatment facility	72 hours (excluding weekends/ holidays)
Mississippi	Miss. Code Ann. §§ 41-21-139; 42-21-67	Substantial likelihood of serious harm, and medical personnel find person immediate danger to self/others or gravely disabled	Crisis intervention trained peace officer	Complete discretion	"Designated single point of entry" for catchment area	72 hours
Missouri	Mo. Rev. Stat. § 632-305	Reasonable cause to believe that individual is imminent danger to self/others	Peace officer; mental health coordinator	Complete discretion	Mental health facility	96 hours
Montana	Mont. Code Ann. § 53-21-139	Appears to present imminent danger to self/others or gravely disabled	Peace officer	Complete discretion	Mental health facility; state hospital (last resort); behavioral health inpatient facility (last resort)	Next regular business day
Nebraska	Neb. Rev. Stat. § 71-919	Probable cause to believe individual is danger to self/others and harm occurs before regular proceedings can occur	Peace officer; mental health professional (can detain until peace officer arrives)	Complete discretion	Medical facility; detention facility (convicted sex offenders)	36 hours
Nevada	Nev. Rev. Stat. § 433A.160	Probable cause to believe individual is likely danger to self/others	Peace officer; physician; physician's assistant; psychologist; therapist; counselor; social worker; nurse	Complete discretion	Mental health facility; hospital	72 hours (including weekends/ holidays)
New Hampshire	N.H. Rev. Stat. Ann. § 135-C:28	Probable cause to believe that person is danger to self/others if not placed in custody	Peace officer	Complete discretion	Hospital emergency room; site designated by community mental health program	6 hours

New Jersey	N.J. Rev. Stat. § 30:4-27.6	Reasonable cause to believe individual in need of involuntary commitment	Peace officer	Mandatory detention	Ambulatory care service that provides mental health services	24 hours
New Mexico	N.M. Stat. § 43-1-10	Individual otherwise subject to arrest; reasonable grounds to believe individual presents likelihood of danger to self/others without immediate detention	Peace officer	Complete discretion	Evaluation facility; detention facility (last resort)	7 days (evaluation facility); 24 hours (detention facility)
New York	Ny. Mental Hyg. Law §§ 9.39; 9.41	Appears individual is likely danger to self/others	Peace officer	Complete discretion	Hospital; other safe/comfortable place (temporarily)	15 days (once individual is at a hospital); 48 hours (without 2nd physician confirming) – right to hearing within 5 days
North Carolina	N.C. Gen. Stat. §§ 122C-262; 122C-263	Requires immediate hospitalization to prevent harm to self/others	"Anyone, including a law enforcement officer"	Complete discretion	Area facility; home or hospital (temporarily)	10 days (examination within 24 hours)
North Dakota	N.D.C.C. § 25-03.1-25	Reasonable cause to believe individual is serious, immediate danger to self/others	Peace officer; physician; psychiatrist; physician's assistant; psychologist; nurse; mental health professional	Complete discretion	Treatment facility; detention facility (last resort)	4 days (after initial evaluation); 24 hours (detention facility)
Ohio	Ohio Rev. Code § 5122.10	Reason to believe individual is substantial risk of danger to self/others	Peace officer; psychiatrist; physician; psychologist; nurse; health officer	Complete discretion	Hospital	3 days (following initial examination, conducted within 24 hours)
Oklahoma	Okla. Stat. §§ 43A-5-207; 43A-5-208	Reason to believe individual poses substantial risk of immediate danger to self/others	Peace officer	Mandatory detention	Nearest facility designated by the Commissioner of Mental Health and Substance Abuse Services	120 hours
Oregon	Or. Rev. Stat. § 426.228	Probable cause to believe individual is danger to self/others and in need of immediate care	Peace officer; community mental health director	Complete discretion	Hospital; nonhospital facility approved by the Oregon Health Authority	5 judicial days
Pennsylvania	Pa. Mental Health Code § 50-7302	Reasonable grounds to believe individual is clear and present danger to self/others	Peace officer; physician; anyone authorized by county administrator	Complete discretion	Facility approved by county administrator	120 hours
Rhode Island	R.I. Gen. Laws §§ 40.1-5-7; 40.1-5-7.1	Reason to believe individual imminent danger to self/others	Peace officer (initial custody); medical director; physician; mental health professional (last resort)	Complete discretion	Hospital emergency room	10 days
South Carolina	S.C. Code Ann. § 44-13-05	Reason to believe individual likelihood of serious danger to self/others or has committed offense with penalty of 1 year or less	Peace officer	Complete discretion	Mental health center; crisis stabilization program	24 hours
South Dakota	S.D. Codified Laws §§ 27A-10-1; 27A-10-3	Probable cause to believe individual is danger to self/others requiring immediate intervention	Peace officer	Complete discretion	Appropriate facility designated by the Department of Social Services; detention facility (last resort)	5 days; 24 hours (detention facility)
Tennessee	Tenn. Code Ann. §§ 33-6-401; 33-6-402	Reason to believe individual is immediate, substantial danger to self/others	Peace officer; physician; psychologist	Complete discretion	Hospital; treatment resource	24 hours
Texas	Tex. Health & Safety Code § 573.001	Reason to believe individual is substantial danger to self/others and no time for court order	Peace officer	Complete discretion	Appropriate mental health facility; detention facility (last resort)	48 hours (if this time ends on weekend/holiday, then next business day)

Utah	Utah Code § 62A-15-629	Probable cause to believe individual is substantial danger to self/others	Peace officer; mental health officer	Mandatory detention	Local mental health authority	24 hours (excluding weekends/ holidays)
Vermont	18 V.S.A. 7505	Reasonable grounds to believe individual is immediate danger to self/others	Peace officer; mental health professional	Complete discretion	Hospital	Must seek court warrant without delay (then 24 hours; 72 hours after 2nd certification)
Virginia	Va. Code Ann. § 37.2-808	Probable cause to believe substantial likelihood individual is danger to self/ others in near future, or gravely disabled	Peace officer	Complete discretion	Appropriate location to assess need for hospitalization and treatment	8 hours
Washington	RCW § 71.05.153	Information that individual is imminent danger to self/others, or gravely disabled	Designated crisis responder; peace officer (limited custodial powers)	Complete discretion	Evaluation and treatment facility; triage facility/ crisis stabilization unit/ treatment facility/ detoxification facility/ hospital (peace officer)	72 hours (crisis responders); 12 hours (peace officer)
West Virginia	None	N/A	N/A	N/A	N/A	N/A
Wisconsin	Wis. Stat. § 51.15	Cause to believe substantial probability individual is danger to self/others, or gravely disabled	Peace officer; person authorized to take a child into custody	Complete discretion	Treatment facility	72 hours (excluding weekends/ holidays)
Wyoming	Wyo. Stat. Ann. §§ 25-10-101; 25-10-109	Reasonable cause to believe individual is danger to self/others	Peace officer; examiner	Complete discretion	Hospital; detention facility (last resort)	72 hours (excluding weekends/ holidays); 24 hours (if not examined by examiner)

Protective Custody

Jurisdiction	Statute	Substances Covered	Who can Initiate	Discretion of Officials	Eligible Destinations	Criminal Charges	Maximum Duration
Alabama	None	N/A	N/A	N/A	N/A	N/A	N/A
Alaska	Alaska Stat. § 47.37.170	Alcohol & Drugs	Peace officer; member of emergency service patrol	Discretion for intoxication; mandatory custody for incapacitation	Home; treatment facility; another appropriate health facility or service; detention facility (last resort)	No charges with protective custody	48 hours; 12 hours (detention facility)
Arizona	Ariz. Rev. Stat. § 36-2026	Alcohol	Peace officer	Complete discretion	Local alcoholism reception facility; detention facility (last resort)	No charges with protective custody	24 hours (excluding weekends/ holidays); 12 hours (detention facility)
Arkansas	None	N/A	N/A	N/A	N/A	N/A	N/A
California	Cal. Pen. Code § 647	Alcohol	Peace officer	Mandatory protective custody	Treatment facility	No charges with protective custody	72 hours
Colorado	Colo. Rev. Stat. §§ 27-81-11; 27-82-107	Alcohol & Drugs	Peace officer; member of emergency service patrol	Mandatory protective custody	Treatment facility; detention facility (last resort)	No charges with protective custody	As long as necessary to prevent injury or breach of peace
Connecticut	Conn. Gen. Stat. § 17a-683	Alcohol & Drugs	Peace officer	Discretion for intoxication; mandatory custody for incapacitation	Treatment facility; hospital	No charges with protective custody	48 hours
Delaware	None	N/A	N/A	N/A	N/A	N/A	N/A
District of Columbia	D.C. Code § 24-604	Alcohol	Designees of the mayor	Complete discretion	Home; health facility; detoxification facility	Charges possible	Until danger has passed
Florida	Fla. Stat. §§ 397.677-397.6775	Alcohol & Drugs	Peace officer	Complete discretion	Hospital; detoxification or addictions facility; detention facility (last resort)	No charges with protective custody	72 hours

Georgia	None	N/A	N/A	N/A	N/A	N/A	N/A
Hawaii	None	N/A	N/A	N/A	N/A	N/A	N/A
Idaho	Idaho Code Ann. § 39-307A	Alcohol & Drugs	Peace officer	Mandatory protective custody	Treatment facility; detention facility (last resort)	No charges with protective custody	72 hours; 24 hours (detention facility)
Illinois	20 Ill. Comp. Stat. 301/25-15	Alcohol & Drugs	Peace officer	Complete discretion	Emergency medical service; facility for withdrawal management	No charges with protective custody	Unspecified
Indiana	Ind. Code § 12-23-15-1	Alcohol	Peace officer	Complete discretion	Home; relative's home; responsible person; treatment facility; detention facility (last resort)	Charges possible	Unspecified
Iowa	Iowa Code §§ 125.34; 125.91	Alcohol & Drugs	Peace officer	Complete discretion	Hospital; facility for mental health or substance abuse; emergency medical service (last resort)	No charges with protective custody	48 hours
Kansas	None	N/A	N/A	N/A	N/A	N/A	N/A
Kentucky	Ky. Rev. Stat. Ann. § 222.203	Alcohol	Peace officer	Complete discretion	Authorized facility	Charges possible	8 hours
Louisiana	La. Stat. Ann. § 28-53	Alcohol & Drugs	Peace officer; peace officer accompanied by emergency medical service technician		Treatment facility (includes hospital, retreat, institution, mental health facility); detention facility (last resort)	No charges with protective custody	72 hours
Maine	None	N/A	N/A	N/A	N/A	N/A	N/A
Maryland	Md. Code, Health § 8-501	Alcohol & Drugs	Peace officer; others authorized by regulation	Complete discretion	Home; detoxification facility; other appropriate health care facility	No charges with protective custody	72 hours
Massachusetts	Mass. Gen. Laws ch. 11B, § 8; ch. 11E, § 9A	Alcohol & Drugs	Peace officer	Complete discretion	For alcohol: home; treatment facility; police station. For drugs: hospital; emergency facility	No charges with protective custody	48 hours; 12 hours (police station); no detention (drugs)
Michigan	Mi. Mental Health Code § 330.1276	Alcohol & Drugs	Peace officer	Mandatory protective custody	Emergency medical service; approved service program	No charges with protective custody	72 hours (excluding weekends/ holidays)
Minnesota	Minn. Stat. § 253B.05	Alcohol & Drugs	Peace officer	Complete discretion	Home; treatment facility	No charges with protective custody	72 hours (excluding weekends/ holidays)
Mississippi	Miss. Code Ann. § 41-21-139	Alcohol & Drugs	Crisis intervention trained peace officer	Complete discretion	Designated "single point of entry" for catchment area	Charges possible	Until impairment resolved and any danger has passed
Missouri	Mo. Rev. Stat. § 67.315	Alcohol & Drugs	Peace officer	Complete discretion	Home; treatment service; other appropriate facility; detention facility	No charges with protective custody	12 hours
Montana	Mont. Code Ann. §§ 53-24-301; 53-24-303	Alcohol	Peace officer	Complete discretion	Home; treatment facility; other health care facility; detention facility (last resort)	No charges with protective custody	Until danger has passed
Nebraska	Neb. Rev. Stat. § 53-1.121	Alcohol	Peace officer	Complete discretion	Home; hospital; clinic; alcoholism facility; with a medical doctor; detention facility (last resort)	No charges with protective custody	24 hours
Nevada	Nev. Rev. Stat. § 458-270	Alcohol & Drugs	Peace officer	Mandatory protective custody	Treatment facility; detention facility (last resort)	No charges with protective custody	48 hours; until impairement resolved (detention facility)

New Hampshire	N.H. Rev. Stat. Ann. § 172-B:3	Alcohol	Peace officer	Complete discretion	Home; alcohol treatment program; other appropriate location; responsible person; detention facility; hospital emergency room (incapacitation)	No charges with protective custody	24 hours
New Jersey	N.J. Rev. Stat. §§ 26-2B-15; 26-2B-16	Alcohol	Peace officer; emergency medical services personnel	Discretion for intoxication; mandatory custody for incapacitation	Home (intoxication only); treatment facility	No charges with protective custody	48 hours
New Mexico	N.M. Stat. § 43-2-8	Alcohol & Drugs	Peace officer; physician	Complete discretion	Treatment facility	No charges with protective custody	72 hours
New York	N.Y. Ment. Health Laws § 22.09	Alcohol & Drugs	Peace officer; designee of director of community services	Complete discretion	Home; treatment facility; other authorized facility for emergency services	Charges possible	72 hours
North Carolina	N.C. Gen. Stat. §§ 122C-301; 122C-302; 122C-303	Alcohol & Drugs	Peace officer; local intoxication officers	Complete discretion	Home; another's home; shelter facility; hospital; physician's office; other health care facility; detention facility (last resort)	Charges possible	24 hours
North Dakota	N.D.C.C. § 5-01-05.1	Alcohol	Peace officer	Complete discretion	Home; hospital; detoxification facility; detention facility (if danger)	No charges with protective custody	72 hours; 24 hours (detention facility)
Ohio	Ohio Rev. Code § 2935.33	Alcohol	Peace officer	Complete discretion	Community addiction services provider	No charges with protective custody	48 hours
Oklahoma	Okla. Stat. § 43A-3-428	Alcohol & Drugs	Peace officer; member of emergency services patrol	Complete discretion	Treatment facility	No charges with protective custody	12 hours (excluding weekends/ holidays)
Oregon	Or. Rev. Stat. § 430.399	Alcohol & Drugs	Peace officer	Discretion for intoxication; mandatory custody for incapacitation	Sobering facility; treatment facility; detention facility (last resort)	No charges with protective custody	24 hours (sobering facility); 48 hours (treatment facility); until intoxication resolves (detention facility)
Pennsylvania	None	N/A	N/A	N/A	N/A	N/A	N/A
Rhode Island	R.I. Gen. Laws § 23-1.10-10	Alcohol	Peace officer	Discretion for intoxication; mandatory custody for incapacitation	Home; treatment facility; health facility; detention facility (last resort)	No charges with protective custody	5 days
South Carolina	S.C. Code Ann. § 44-13-05	Alcohol & Drugs	Peace officer	Complete discretion	Mental health facility; crisis stabilization program	No charges with protective custody	24 hours
South Dakota	S.D. Codified Laws § 34-20A-55	Alcohol & Drugs	Peace officer	Complete discretion	Treatment facility; detention facility (last resort)	No charges with protective custody	48 hours (facility); until danger has passed (detention facility)
Tennessee	Tenn. Code Ann. § 33-10-407	Alcohol	Peace officer; custodial health officer	Complete discretion	Treatment facility; social services facility	No charges with protective custody	Unspecified
Texas	Tex. Code Crim. Pro. § 14-031	Alcohol	Peace officer	Complete discretion	Responsible adult; treatment facility	No charges with protective custody	Unspecified
Utah	Utah Code § 76-9-701	Alcohol & Drugs	Peace officer	Complete discretion	Detoxification facility; other special facility	No charges with protective custody	Unspecified
Vermont	18 V.S.A. 4808	Alcohol & Drugs	Peace officer	Discretion for intoxication; mandatory custody for incapacitation	Substance abuse treatment program; hospital emergency room; secure facility not operated by department of corrections	No charges with protective custody	24 hours

Virginia	Va. Code Ann. § 18.2-388	Alcohol & Drugs	Peace officer	Complete discretion	Detoxification facility	No charges with protective custody	Unspecified
Washington	RCW §71.05.153	Alcohol & Drugs	Peace officer; designated crisis responder	Complete discretion	Triage facility; crisis stabilization unit; evaluation and treatment facility; detoxification facility; substance abuse treatment facility; hospital	No charges with protective custody	12 hours (peace officer); 72 hours (crisis responder)
West Virginia	W.Va. Code § 60-6-9	Alcohol	Peace officer	Complete discretion	Responsible adult; home; judicial officer; hospital emergency room	Charges possible	Unspecified
Wisconsin	Wis. Stat. §51-45	Alcohol & Drugs	Peace officer	Mandatory protective custody	Treatment facility; emergency medical facility (last resort)	No charges with protective custody	72 hours
Wyoming	None	N/A	N/A	N/A	N/A	N/A	N/A

Citation Authority

Jurisdiction	Statute	Eligible Offenses	Exclusionary Conditions	Discretion of Officials
Alabama	Ala. Code §§ 11-45-9.1 and 32-1-4	Class C misdemeanors not involving violence, threat of violence or alcohol or drugs; or littering or animals running at large ordinances (Ala. Code 11-45-9.1); traffic misdemeanors except those causing or contributing to an accident resulting in injury or death, and DUIs (Ala. Code 32-1-4)	Refusal to sign the summons and complaint	Municipality may authorize officer discretion under 11-45-9.1; officers shall issue citation under 32-1-4
Alaska	Alaska Stat. § 12.25.180	Misdemeanors and violations of a municipal ordinance (except for domestic violence) or Class C felony; when a person is stopped for an infraction or violation	Failure to furnish ID; individual is danger to self/others; crime involves harm to another person/property; individual requests appearance before judge/magistrate. For infractions and violations, conditions are: failure to furnish ID; failure to accept citation or promise to appear.	Officer discretion for misdemeanor/ordinances; mandatory citations for infractions/ violations
Arizona	Ariz. Rev. Stat. § 13-3903	Misdemeanors and petty offenses (except certain domestic violence offenses involving injury/firearms, DUI)	Refusal to sign the notice and complaint	Officer discretion
Arkansas	Ark. Code § 27-50-603; Court Rule 5.2	Traffic misdemeanors (except involving accident involving injury/death, negligent homicide, DUI, or failure to stop in accident with injury or property damage); any misdemeanor	Failure to furnish ID; refusal to sign a promise to appear; individual is danger to self/others; lack of ties to jurisdiction; previous failure to appear on citation	Officer discretion
California	Cal. Penal Code §§ 853.5; 835.6	Infractions; misdemeanors (except most domestic violence situations and offenses requiring a bail hearing)	Individual is intoxicated and danger to self/others; individual requires medical attention; prior arrest for certain vehicular violations; outstanding warrants or failure to appear; failure to furnish ID; would jeopardize a prosecution; likelihood offenses/harm would continue; individual requests appearance before magistrate; refusal to sign notice to appear; reason to believe individual will not appear; individual cited/arrested/convicted for felony theft in prior six months; probable cause individual committed organized retail theft	Mandatory citations
Colorado	Colo. Rev. Stat. §§ 16-3-105; 42-4-1705	Misdemeanors (except domestic violence); petty offenses; traffic misdemeanors (except DUIs, failure to stop causing death/injury/property damage, offense causing injury/death)	None	Officer discretion
Connecticut	Conn. Gen. Stat. § 54-1h	Misdemeanors (including those subject to an arrest warrant; excluding domestic violence); offenses punishable by 1 year or less imprisonment or $1,000 or less fine; traffic violations (except DUI, use w/o permission, leaving the scene, involves injury/death)	None	Officer discretion
Delaware	Del. Code tit. 11 §§ 1907; 1908	Misdemeanor (except protective order violations); traffic violations	Lack of state residency; officer not satisfied individual will appear in court	Officer discretion

District of Columbia	D.C. Code § 23-584	Misdemeanors deemed eligible by the Attorney General and Chief of Police (cannot include crimes of violence, dangerous crimes, domestic violence)	Individual is danger to self/others; insufficient evidence of ID; active violation of court order; violation of condition of release of prior citation; failure to cooperate with booking	Officer discretion
Florida	Fla. R. Crim. Proc. 3.125	Misdemeanors of the 1st or 2nd degree; violations; municipal/county ordinance; traffic violations	Failure to furnish ID; refusal to sign notice to appear; lack of ties to jurisdiction; officer suspects active warrants; prior failure to appear on notice/summons; prior pretrial release violation	Officer discretion
Georgia	Ga. Code Ann. § 17-4-23	Traffic infractions (except vehicular homicide; leaving the scene; racing; fleeing an officer; operating with bad vehicle registration); underage purchase of alcohol; trespass; shoplifting; theft by refund fraud; some drug possession	None	Officer discretion
Hawaii	Haw. Rev. Stat. § 803-6	Misdemeanors; petty misdemeanor or violation; traffic violations (except those with mandatory arrest)	Officer has reason to believe person will not appear in court; active warrants that would justify detention; risk of ongoing danger or criminal activity	Officer discretion for non-traffic offenses; mandatory citations for traffic offenses
Idaho	Idaho Code Ann. § 19-3901	Misdemeanors or infractions triable to a magistrate; misdemeanor traffic violations (except serious offenses)	None	Officer discretion
Illinois	725 Ill. Comp. Stat. 5/107-2	Offense subject to warrantless arrest	None	Officer discretion
Indiana	Ind. Code § 35-33-4-1	Misdemeanors committed in an officer's presence; traffic offenses (except DUI, offense causing injury/death; suspended license)	For traffic: individual requests appearance before a magistrate; refusal to sign promise to appear	Officer discretion for misdemeanors; mandatory citations for traffic offenses
Iowa	Iowa Code § 805.1	Offenses subject to warrantless arrest (except those ineligible for bail, stalking, domestic violence involving injury/weapons)	Failure to furnish ID; refusal to sign citation; ongoing risk of harm; individual is intoxicated and nobody else can take custody; insufficient ties to jurisdiction	Officer discretion for misdemeanors; mandatory citations for traffic offenses
Kansas	Kan. Sta. Ann. § 22-2408	Misdemeanors (except domestic violence); traffic offenses (except DUI, leaving the scene, felonies)	None	Officer discretion
Kentucky	Ky. Rev. Stat. Ann. § 431-.015	Misdemeanors (except protective order violations)	Officer does not believe individual will appear (only for offenses committed outside the officer's presence)	Mandatory citations (if offense committed in officer's presence; except if defendant poses danger, refuses to follow instructions, or committed certain serious offenses); officer discretion (if offense committed outside officer's presence)
Louisiana	La. Code Crim. Pro. § 211	Misdemeanors subject to warrantless arrest; felony theft or possession of stolen goods $500-1,000; warrants for misdemeanors or violations (except for DUI, offenses involving weapons, violent crimes; child support)	Officer lacks reasonable grounds to believe individual will appear; individual is danger to self/others; no prior convictions (only applicable to felony offenses)	Officer discretion (except for driving without a license in possession, then it is mandatory citation)
Maine	Me. Stat. tit. 17-A, § 15-A	Any offense (except protective order violations and domestic violence)	None	Officer discretion
Maryland	Md. Code, Crim. Pro. 4-101	Misdemeanors or local ordinance violations with a maximum penalty of 90-days imprisonment or less (except protective order violations, violation of conditions of release on sex crime against minor, animal abuse); marijuana possession; misdemeanor theft; malicious destruction of property under $500	Failure to furnish ID; officer does not believe individual will comply with citation; danger to self/others;	Mandatory citations for most offenses
Massachusetts	Mass. Gen. Laws ch. 90C, § 3	Traffic offenses	None	Officer discretion
Michigan	Mich. Comp. Laws § 764.9c	Misdemeanors and ordinances violations with a maximum penalty of 93 days in jail or less or a fine (except domestic violence, violation of protective orders, offenses with mandatory confinement or bail)	None	Officer discretion
Minnesota	Minn. Rule Crim. Pro. 6.01	Misdemeanors; gross misdemeanors; felonies	Individual is danger to self/others; risk of further criminal conduct; substantial likelihood individual will not respond to a citation	Mandatory citations (misdemeanors); Officer discretion (gross misdemeanors; felonies)

Mississippi	Miss. Code Ann. §§ 99-3-18; 63-9-21	Misdemeanors (except domestic violence); traffic violations	None	Officer discretion
Missouri	Mo. Rev. Stat. § 300.580	Traffic violations	None	Mandatory citations
Montana	Mont. Code Ann. § 46-6-310	Offenses subject to warrantless arrest	None	Officer discretion
Nebraska	Neb. Rev. Stat. § 29-422	Misdemeanors; (except protective order violations) ordinance violations; infractions; traffic infractions	None	Officer discretion (misdemeanors); mandatory citations (traffic infractions)
Nevada	Nev. Rev. Stat. § 171.177	Misdemeanors (except domestic violence and nonbailable offenses); ordinance violations; misdemeanor warrants; traffic misdemeanors	Individual requests appearance before magistrate; refusal to sign notice to appear. For warrants: prior failure to appear; failure to furnish ID; refusal to sign notice to appear; reasonable grounds to believe individual will not appear in court	Officer discretion
New Hampshire	N.H. Rev. Stat. Ann. § 594.14	Misdemeanor or violation subject to warrantless arrest	None	Officer discretion
New Jersey	N.J. Crim. Pro. R. 4:4-1; N.J. Rev. Stat. § 2B:12-21	Offenses committed in officer's presence (except for certain serious felonies and domestic violence)	Prior failure to appear; individual is danger to self/others; active warrants; failure to furnish ID; would jeopardize a prosecution; reason to believe defendant will not appear; reason to believe pretrial monitoring is necessary	Mandatory citations
New Mexico	N.M. Stat §§ 31-1-6; 66-8-123	Petty misdemeanors subject to warrantless arrest; traffic misdemeanors (except DUI; failure to stop causing injury; reckless driving; driving w/ suspended license)	For traffic: individual requests appearance before magistrate; individual has committed a felony; refusal to sign notice to appear	Officer discretion
New York	N.Y. Crim. Pro. Law § 150.20	Offenses subject to warrantless arrest (except A, B, C, or D felonies, certain domestic violence or sexual assault)	Active warrants; prior failure to appear in previous two years; failure to furnish ID; individual requires medical attention	Mandatory citations
North Carolina	N.C. Gen. Stat. § 15A-302	Misdemeanors; infractions	None	Officer discretion
North Dakota	N.D. Crim. Pro. R. 5	Offenses committed in officer's presence; traffic offenses; game and fish offenses	None	Officer discretion
Ohio	Ohio Rev. Code § 2935.26	Misdemeanors subject to warrantless arrest; minor misdemeanors	Individual requires medical attention; failure to furnish ID; refusal to sign notice to appear; prior failure to appear on citation for that misdemeanor	Officer discretion (misdemeanors); mandatory citations (minor misdemeanors)
Oklahoma	Okla. Stat. § 22-209	Misdemeanors or ordinance violations subject to warrantless arrest (except protective order violations)	None	Officer discretion
Oregon	Or. Rev. Stat. § 133.055	Misdemeanors and felonies reducible to misdemeanors by the court (except domestic violence); ordinance violations; traffic violations	None	Officer discretion
Pennsylvania	234 Pa. Crim. Pro. R. 519; 410	Misdemeanors of the 2nd degree or less; misdemeanors of the 1st degree for DUI; summary offenses	Individual danger to self/others; reasonable grounds to believe individual will not appear in court	Officer discretion (misdemeanors); mandatory citations (summary offenses)
Rhode Island	R.I. Gen. Laws §§ 12-7-11; 31-27-12	Misdemeanors (except domestic violence or crimes against the elderly); traffic violations	None	Officer discretion; mandatory citation (traffic and possession of marijuana under 1 oz.)
South Carolina	S.C. Code Ann. § 56-7-10	Certain enumerated low-level misdemeanors; misdemeanors subject to a magistrate committed freshly or in presence of officer; traffic violations	None	Officer discretion (misdemeanors); mandatory citations (enumerated misdemeanors and traffic violations)
South Dakota	S.D. Codified Laws §§ 23-1A-1; 23-1A-2	Petty offenses (except domestic violence)	None	Mandatory citations

Tennessee	Tenn. Code Ann. § 40-7-118	Misdemeanors committed in officer's presence or involving a citizen's arrest (except DUIs, various shoplifting offenses; driving w/o license; assault & battery if individual danger to others; prostitution if prior prostitution)	Individual requires medical attention; danger to self/others; continued criminal conduct; would jeopardize a prosecution; reasonable likelihood individual will fail to appear in court; individual requests appearance before magistrate; individual intoxicated and is danger to self/others; active warrants	Mandatory citations; officer discretion (for limited, enumerated offenses)
Texas	Tex. Code Crim. Pro. § 14.06	Class C misdemeanors (except public intoxication); Class A or B misdemeanors (if individual resides in county and offense is theft, graffiti, mischief, driving w/o license, contraband in correctional facility, or certain drug possession offenses); misdemeanor traffic violations	None	Officer discretion
Utah	Utah Code § 77-7-18	Misdemeanors, infractions	Probable cause to believe continued violence against victim; perpetrator used a weapon or caused injury in violent domestic violence offense	Officer discretion
Vermont	Vt. Crim. Pro. R. 3	Misdemeanors	Failure to furnish ID; arrest necessary to secure nontestimonial evidence; risk of continuing criminal conduct; individual is danger to self/others; lack of jurisdictional ties; likelihood individual will fail to appear in court; prior failure to appear; prior violation of court order	Mandatory citations
Virginia	Va. Code Ann. §§ 19.2-74; 46.2-936	Jailable misdemeanors; Class 1 or 2 misdemeanors committed in officer's presence (except DUI); Class 3 or 4 misdemeanors; non-jailable misdemeanors; ordinances; traffic misdemeanors. Exceptions for protective order violations and domestic assault	Risk of continuing criminal conduct; reason to believe individual will fail to appear in court; individual is danger to self/others	Mandatory citations
Washington	Wa. Crim. R. for Courts of Lim. Jur. R. 2.1; RCW 46.64.015	Misdemeanors and gross misdemeanors (except domestic violence and protective order violations); traffic violations	Failure to furnish ID; individual is danger to self/others; lack of jurisdictional ties; reason to believe individual will fail to appear in court; prior failure to appear on citation	Officer discretion
West Virginia	W.Va. Code § 62-1-5A	Misdemeanors not involving injury to a person committed in an officer's presence (except domestic violence); traffic misdemeanors (except DUI, negligent homicide, failure to stop involving injury)	Individual is danger to self/others	Officer discretion
Wisconsin	Wis. Stat. §§ 968.085; 345.23	Misdemeanors (except domestic violence); traffic violations	Failure to furnish ID; refusal to sign notice to appear; individual is danger to self/ others; lack of jurisdictional ties; prior failure to appear on citation; would jeopardize a prosecution	Officer discretion (misdemeanors); mandatory citations (traffic)
Wyoming	Wyo. Stat. Ann. §§ 7-2-103; 31-5-1205	Misdemeanors; traffic misdemeanors (except DUI)	Individual is danger to self/others; reason to believe individual will fail to appear in court; refusal to sign notice to appear	Officer discretion

GOOD SAMARITAN LAWS

Jurisdiction	Statute	When Immunity Arises	Eligible Offenses	Coverage of Individual Experiencing an Overdose	Conditions for Immunity
Alabama	Ala. Code § 20-2-281	Prosecution	Possession/use; paraphernalia	None	First caller only (good faith belief)
Alaska	Alaska Stat. § 11.71.311	Prosecution	Possession/use; (paraphernalia not illegal)	Individual can be Good Samaritan	Remain on scene; cooperate with officials
Arizona	Ariz. Rev. Stat. § 13-3423	Charge	Possession/use; paraphernalia	Individual can be Good Samaritan	None
Arkansas	Ark. Code § 20-13-1701 et. seq.	Arrest	Possession/use; paraphernalia; community supervision violations	Individual can be Good Samaritan	None
California	Cal. Health & Safety Code § 11376.5	Arrest	Possession/use; paraphernalia	Individual can be Good Samaritan	Cannot obstruct officials
Colorado	Colo. Rev. Stat. § 18-1-711	Arrest	Possession/use; paraphernalia	Individual protected as subject of call	Remain at scene; furnish ID; cooperate
Connecticut	Conn. Gen. Stat. §§ 21a-267(e); 21a-279(d)	Arrest	Possession/use; paraphernalia	Individual can be Good Samaritan	None

Delaware	Del. Code tit. 16 § 4769	Arrest	Possession/use; paraphernalia; community supervision violations	Individual can be Good Samaritan	Cooperate
District of Columbia	D.C. Code § 7-403	Arrest	Possession/use; paraphernalia; community supervision violations	Individual can be Good Samaritan; individual protected as subject of call	None
Florida	Fla. Stat. § 893.21	Arrest	Possession/use; paraphernalia	Individual protected because of overdose	None
Georgia	Ga. Code Ann. § 16-13-5	Arrest	Possession/use; paraphernalia	Individual can be Good Samaritan; individual protected as subject of call	None
Hawaii	Haw. Rev. Stat. § 329-43.6	Arrest	Possession/use; paraphernalia; community supervision violations	Individual can be Good Samaritan; individual protected as subject of call	None
Idaho	Idaho Code Ann. § 37-2739C	Charge	Possession/use; paraphernalia	Individual protected because of overdose	None
Illinois	720 Ill. Comp. Stat. 570/414	Charge	Possession/use	Individual protected because of overdose	None
Indiana	Ind. Code § 35-38-1-7.1	Arrest	Possession/use; paraphernalia	None	Must administer naloxone
Iowa	Iowa Code § 124.418	Arrest	Possession/use; paraphernalia	Individual can be Good Samaritan	First caller; furnish name; remain on scene; cooperate; no active warrants
Kansas	None	N/A	N/A	N/A	N/A
Kentucky	Ky. Rev. Stat. § 218A.133	Charge	Possession/use; paraphernalia	Individual can be Good Samaritan; individual protected as subject of call	Remain on scene
Louisiana	La. Stat. Ann. § 14:403.10	Charge	Possession/use	Individual protected because of overdose	None
Maine	Me. Stat. tit. 17-A, § 1111-B	Charge	Possession/use; paraphernalia; community supervision violations	Individual protected because of overdose	None
Maryland	Md. Code, Crim. Pro. § 1-210	Arrest	Possession/use; paraphernalia; community supervision violations	Individual protected because of overdose	None
Massachusetts	Mass. Gen. Laws ch. 94C, § 34A	Charge	Possession/use; community supervision violations	Individual can be Good Samaritan; individual protected as subject of call	None
Michigan	Mich. Comp. Laws § 333.7403	Arrest	Possession/use	Individual can be Good Samaritan; individual protected because of overdose (if incapacitated)	None
Minnesota	Minn. Stat. § 604A.05	Charge	Possession/use; paraphernalia; community supervision violations	Individual protected because of overdose	First caller; furnish name; cooperate; remain on scene
Mississippi	Miss. Code Ann. § 41-29-149.1	Arrest	Possession/use; paraphernalia; community supervision violations	Individual can be Good Samaritan; individual protected as subject of call	None
Missouri	Mo. Rev. Stat. § 195.205	Arrest	Possession/use; paraphernalia; community supervision violations	Individual can be Good Samaritan	None
Montana	Mont. Code Ann. § 50-32-609	Arrest	Possession/use; paraphernalia	Individual protected because of overdose	None
Nebraska	Neb. Rev. Stat. § 28-472	Arrest	Possession/use; paraphernalia	Individual can be Good Samaritan	Call as soon as overdose is apparent; remain on scene; cooperate
Nevada	Nev. Rev. Stat. § 453C.150	Arrest	Possession/use; paraphernalia; community supervision violations	Individual can be Good Samaritan; individual protected as subject of call	None
New Hampshire	N.H. Rev. Stat. Ann. § 318-B:28-b	Arrest	Possession/use	Individual can be Good Samaritan; individual protected as subject of call	None
New Jersey	N.J. Rev. Stat. § 2C:35-30	Arrest	Possession/use; paraphernalia; community supervision violations	Individual can be Good Samaritan	None

New Mexico	N.M. Stat. § 30-31-27.1	Charge	Possession/use	Individual protected because of overdose	None
New York	N.Y. Pen. Law §§ 220.03; 220.78	Arrest	Possession/use; distribution (small quantities of marijuana)	Individual can be Good Samaritan; individual protected as subject of call	None
North Carolina	N.C. Gen. Stat. § 90-96.2	Prosecution	Possession/use; paraphernalia; community supervision violations	Individual protected as subject of call	First caller; furnish name
North Dakota	N.D.C.C. § 19-03.1-23.4	Charge	Possession/use; paraphernalia	Individual protected as subject of call	Remain on scene; cooperate
Ohio	Ohio Rev. Code § 2925.11	Arrest	Possession/use	Individual can be Good Samaritan; individual as subject of call	Referral to treatment
Oklahoma	Okla. Stat. § 63-2-413.1	Prosecution	Possession/use; paraphernalia	Individual can be Good Samaritan	Furnish name; remain on scene; cooperate
Oregon	Or. Rev. Stat. § 475.898	Arrest	Possession/use; paraphernalia; community supervision violations	Individual protected as subject of call	None
Pennsylvania	35 Pa. Cons. Stat. § 780-113.7	Charge	Possession/use; paraphernalia; community supervision violations	Individual protected as subject of call	Furnish name; remain on scene; cooperate
Rhode Island	R.I. Gen. Laws § 21-28.9-4	Charge	Possession/use; paraphernalia; community supervision violations	Individual protected because of overdose	None
South Carolina	S.C. Code Ann. § 44-53-1910	Prosecution	Possession/use; paraphernalia	Individual protected because of overdose	Furnish name; cooperate; one-time immunity
South Dakota	S.D. Codified Laws § 34-20A-110	Arrest	Possession/use	Individual can be Good Samaritan	Remain on scene; cooperate; one-time immunity
Tennessee	Tenn. Code Ann. § 63-1-156	Arrest	Possession/use; paraphernalia; community supervision violations	Individual can be Good Samaritan; individual protected as subject of call	One-time immunity
Texas	None	N/A	N/A	N/A	N/A
Utah	Utah Code § 58-37-8	Conviction	Possession/use; paraphernalia	Individual can be Good Samaritan	Remain on scene; cooperate; committed offense in same course of conduct as overdose
Vermont	18 V.S.A. § 4254	Arrest	Possession/use; (paraphernalia not illegal); distribution; community supervision violations	Individual can be Good Samaritan; individual as subject of call	None
Virginia	Va. Code Ann. § 18.2-251.03	Conviction	Possession/use; paraphernalia	Individual can be Good Samaritan	Remain on scene
Washington	RCW § 69.50.315	Charge	Possession/use	Individual protected because of overdose	None
West Virginia	W.Va. Code § 16-47-4	Charge	Possession/use	Individual can be Good Samaritan	Remain on scene; cooperate
Wisconsin	Wis. Stat. § 961.443	Prosecution	Possession/use; paraphernalia; community supervision violations	Individual protected as subject of call	Completion of treatment
Wyoming	None	N/A	N/A	N/A	N/A

AMBULANCE TRANSPORT RULES

Jurisdiction	Statute/Rule	Ambulance Destination Policy	Active Community Paramedicine Program	Community Paramedicine Program(s) Include Alternative Destinations
Alabama	Ala. Code § 22-18-1-8; Ala. Board of Health Admin. Code § 420-2-1	Hospital emergency department	Yes	No
Alaska	Alaska Stat. §§ 18.08.010; 18.08.200; 7 A.A.C. 26.240	Executive discretion	Yes	No
Arizona	Ariz. Rev. Stat. §§ 36-2232; 41-1831; A.A.R. R9-25-504	Alternative destinations permitted	Yes	No
Arkansas	Ark. Code §§ 20-13-202; 20-13-1003	Alternative destinations permitted	Yes	No

California	Cal. Health & Safety Code §§ 1797.52; 1797.218; 128125	Hospital emergency department	Yes	Yes
Colorado	Colo. Rev. Stat. §§ 25-3.5-103; 25-3.5-1203; 6 C.C.R. 1015-3	Executive discretion	Yes	No
Connecticut	Conn. Gen. Stat. § 19a-177; 19a-175-197c	Executive discretion	No	No
Delaware	Del. Code § 16-9802; Del. Admin. Code 1-710	Alternative destinations permitted	No	No
District of Columbia	D.C. Code § 7-2341.01	Alternative destinations permitted	Yes	Yes
Florida	Fla. Stat. § 395.4001; Fla. Admin. Code § 64J-2.004	Executive discretion	Yes	No
Georgia	Ga. Code Ann. §§ 31-11-2; 31-11-81; Ga. Reg. 511-9-2	Executive discretion	Yes	No
Hawaii	Haw. Rev. Stat. §§ 321-221; 321-222; H.A.R. § 11-72-1	Alternative destinations permitted	Yes	No
Idaho	Idaho Code Ann. § 39-1301; IDAPA 16.01.02	Executive discretion	Yes	No
Illinois	210 Ill. Comp. Stat. 50/3.5; Ill. Admin. Code 77-515.100	Alternative destinations permitted	Yes	No
Indiana	Ind. Code §§ 16-28-13-0.5; 16-31-2-7	Executive discretion	Yes	No
Iowa	Iowa Code § 147A.5; IAC 641.134.1	Alternative destinations permitted	No	No
Kansas	Kan. Sta. Ann. §§ 65-425; 65-6112	Hospital emergency department	Yes	No
Kentucky	Ky. Rev. Stat. Ann. § 311A.010	Alternative destinations permitted	Yes	No
Louisiana	La. Stat. Ann. § 40:1131.3	Alternative destinations permitted	Yes	No
Maine	Me. Stat. tit. 32, § 84; Me. Reg. 16.163.3-1	Executive discretion	Yes	No
Maryland	Md. Code, Health § 19-301; Md. Reg. 30.08.01.02	Hospital emergency department	Yes	No
Massachusetts	Mass. Gen. Laws ch. 111C, § 1; 105 Mass. Code Reg. § 170.020	Hospital emergency department	Yes	No
Michigan	Mich. Comp. Laws § 333.20115; Mi. Admin. Code Reg. 325.22112	Hospital emergency department	Yes	No
Minnesota	Minn. Stat. §§ 144E.001; 256B.0625; Minn. Reg. 4690.0100	Executive discretion	Yes	No
Mississippi	Miss. Code Ann. § 41-59-3; Miss. EMS Laws, Rules and Reg. Appendix 4	Hospital emergency department	Yes	No
Missouri	Mo. Rev. Stat. § 190.100; 19 C.S.R. 30-40	Alternative destinations permitted	Yes	Yes
Montana	Mont. Code Ann. § 50-6-302; Montana EMS Protocols	Executive discretion	Yes	No
Nebraska	Neb. Rev. Stat. § 38-1208.02; 172 Neb. Admin. Code 12-002	Executive discretion	Yes	No
Nevada	Nev. Rev. Stat. §§ 449.0151; 450B.1993; NAC 450B.105	Alternative destinations permitted	Yes	Yes
New Hampshire	N.H. Rev. Stat. Ann. §§ 151:2; 153-A:1-2; Saf-C 5901.38	Alternative destinations permitted	Yes	No
New Jersey	N.J. Rev. Stat. § 26:2K-7; N.J.A.C. 8:40A-1.3	Hospital emergency department	Yes	No
New Mexico	N.M. Stat. §§ 24-10B-3; 24-10B-4; 7.27.11.18 NMAC	Executive discretion	Yes	Yes
New York	N.Y. Pub. Health Laws § 3001; Bureau of EMS Policy Statement	Executive discretion	Yes	No
North Carolina	N.C. Gen. Stat. § 143-507; 10A NCAC 13P.0102	Executive discretion	Yes	Yes
North Dakota	N.D.C.C. §§ 23-27-02; 23-40; N.D.A.C. § 33-11-01.2	Hospital emergency department	Yes	No
Ohio	Ohio Rev. Code § 4765.01; State EMS Protocols	Executive discretion	Yes	No
Oklahoma	Okla. Stat. § 63-1-2503v2; OAC 317:30-5-336.3; State EMS Protocols	Hospital emergency department	Yes	No
Oregon	Or. Rev. Stat. §§ 682.027; 682.062; Or. Admin. Reg. 333-200-0080	Executive discretion	Yes	No

Pennsylvania	35 Pa. Cons. Stat. § 8128; 28 Pa. Cons. Stat. § 117.12; State EMS Protocols	Hospital emergency department	Yes	No
Rhode Island	R.I. Gen. Laws § 23-4.1; State EMS Protocols	Executive discretion	Yes	No
South Carolina	S.C. Code Ann. § 44-61-30; SCR 61-7.200	Executive discretion	Yes	No
South Dakota	S.D. Codified Laws § 34-11-2; ARSD 44:75:01:01	Hospital emergency department	No	No
Tennessee	Tenn. Code Ann. § 68-140-302; Tenn. Dept. of Health R. 1200-12-01-.21	Executive discretion	Yes	No
Texas	Tex. Health & Safety Code § 9B-773; TAC 25:157A-157.2	Executive discretion	Yes	Yes
Utah	Utah Code § 26-8a-102; UAC R426-1-20	Alternative destinations permitted	No	No
Vermont	18 V.S.A. §§ 901-909; 9432; CVR 13-140-013	Hospital emergency department	Yes	No
Virginia	12 VAC 5-31-10	Hospital emergency department	Yes	No
Washington	RCW 70.168.170; State EMS Protocols; Washington Health Care Authority Billing Guide	Alternative destinations permitted	Yes	Yes
West Virginia	W.Va. Code § 7-15-3	Executive discretion	No	No
Wisconsin	Wis. Stat. § 256.205; Wis. Admin. Code DHS 110	Executive discretion	Yes	No
Wyoming	Wyo. Code § 33-36; Department of Health Rules; State Medicaid Reimbursement Rules	Executive discretion	Yes	Yes