New York's Directive for Mental Health Involuntary Removals:

The Intersectional Risk for Unhoused New Yorkers with a Serious Mental Illness

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ABSTRACT

Behavioral health care, more commonly known as psychiatric care, has been a longstanding and complex issue, especially for marginalized New Yorkers. Healthcare policy addressing and caring for people diagnosed with a serious mental illness is fundamental to basic human rights; at the same time, it is a nuanced matter. Policies surrounding economic issues of poverty and housing instability are inextricably linked to social issues of mental and physical healthcare.

Healthcare policy and the experience of homelessness are closely linked for two reasons: first, the high cost of healthcare contributes to poverty for many Americans; and second, the poor and the aging are the most likely to suffer from illness and high medical expenses (Martin, 2015). This paper will consider the intersectional risk for unhoused New York City residents with a serious mental illness in light of Mayor Eric Adams' recent directive for Mental Health Involuntary Removals. This new directive enables authorities to forcibly transport unhoused New Yorkers to hospitals to remove them from public areas. Although the current mayoral administration frames this as a moral obligation to act on behalf of New Yorkers with a serious mental illness, it is far from an effort to ensure that everyone has housing and receives basic healthcare. Adams' misguided policy is a veiled attempt to make the city appear safer while doing little to assist those who are suffering and fails to address interventions for the real issue at hand: housing.

On the morning of January 15, 2022, Michelle Go, a 40-year-old Chinese-American, was fatally pushed onto the subway tracks at Times Square. Martial Simon, the individual who committed this unprovoked act, emigrated to New York from Haiti in his teens and had been experiencing homelessness for the past 18 years. He also has a longstanding history of schizophrenia, including approximately 20 prior hospitalizations. Go's death is sadly not the first of its kind. New York has struggled to enact effective legislation governing the treatment of individuals with a chronic serious mental illness (SMI) and, as a result, thousands of New Yorkers like Simon elude treatment (Diven, 2022). A SMI is defined by the National Institute for Mental Health (NIMH) as a mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities (Mental Illness, n.d.).

The timing of this violence impacted the political response. This tragedy occurred when hate crimes targeting Asian Americans were on the rise, and although police concluded that this particular incident was not racially motivated and there was no known prior connection between Go and Simon, the larger sociopolitical context may have fueled the administration's need to respond, in order to ensure public support. This particular incident happened following a slew of incidents in which people were pushed onto subway tracks, though none of the previous had been fatal. As of mid-March 2022, transit crime was up 80.3% compared with the same period in 2021, though this number may be skewed because of decreased subway ridership during the first year of the Covid-19 pandemic (Gelinas, 2022). It also occurred during Eric Adams' first week as mayor. This timing amplified issues of racially driven hate crimes, random acts of violence, and a perceived surge in subway crime, and it provided linkage to the deep-seated issues of unhoused New Yorkers with mental illness, specifically those with persistent and often treatment-resistant SMI.

Leaders in the public and private sectors have worked for decades to propose policies for those who struggle with homelessness and mental illness. Hospitalization rates for New Yorkers living with a SMI are consistently higher than the national average (Heun-Johnson et al., 2018). While the percentage of people with a SMI is a much smaller subset than those living with any mental illness, New York City has a disproportionately higher number of its population diagnosed with a SMI compared to the national average and fewer resources to treat those needing inpatient psychiatric care.

Go's death garnered widespread media attention and was the catalyst for The Subway Safety Plan, a reaction outlined by the Adams administration the month after the incident. This was followed by the Mental Health Involuntary Removal (MHIR) policy directive, announced later in 2022.

Multifaceted sociopolitical issues in which mental health is just one dimension enable politicians to cite mental health as an oversimplified justification while omitting other contributing factors that are not as politically compelling. Adams' MHIR response to the issues at the forefront, who it affects, and how it will be implemented amount to nothing more than compassionate window dressing in an effort to appear tough on crime. Using public safety as justification, it points the finger at unhoused individuals who may have an untreated mental illness. If, as Adams says, preventing unhoused New Yorkers from living on city streets or in subway stations and "helping them heal" is the city's objective, forcibly transporting them to an Emergency Department (ED) does little to solve the issue of housing (Adams, 2022, 16:45).

MENTAL HEALTH INVOLUNTARY REMOVALS (MHIR)

Racial and ethnic minorities and immigrant populations in New York City have significantly less access to stable housing, livable wages, and physical and mental health resources compared to majority groups, putting them at a higher risk for adverse mental health consequences in the wake of traumatic experiences (Rudenstine et al., 2020). On

November 28, 2022, Adams announced his directive to remove unhoused individuals from the street and treat their SMI. What was omitted in both Adams' speech and the policy is that not all unhoused individuals have a SMI and there are often co-occurring determinants that negatively impact the population of individuals with SMI: racial discrimination, employment status, familial or community support systems, comorbidities, co-occurring psychological disorders, and a person's health insurance or lack thereof. These are in addition to housing, the social determinant most closely linked to the MHIR policy directive.

For context, one must first understand the existing New York State Mental Hygiene Laws. Article 9 of the Mental Hygiene Law (MHL) is legislation from the New York State Senate (2021) that sets forth standards and procedures for patients who require inpatient hospitalization for a mental illness. The policy outlines emergency assessment for immediate observation, care, and treatment, powers of certain peace officers and police officers, transport for evaluation, and powers of approved mobile crisis outreach teams (Mental Health Involuntary Removals [MHIR], 2022).

The directive for MHIRs augments Article 9 of the MHL by outlining roles and responsibilities for involuntary removals. According to the Office of Mental Health's (OMH) directive, sections 9.41 and 9.59 of the MHL authorize the removal of a person who appears to be mentally ill and displays an inability to meet their basic living needs (MHIR, 2022). The relaxed language of the MHIR authorizes the removal of a person by force and involuntary transport to the closest hospital for a psychiatric evaluation, "even when no recent dangerous act has been observed" (MHIR, 2022, p. 1). The five-page MHIR policy ends after outlining vague protocols for involuntary hospital transfers with respect to different agencies tasked with enforcing this directive. The scant guidelines are expressed with over-simplified language compared to what has always been standard ED or Comprehensive Psychiatric Emergency Program (CPEP) procedure for receiving healthcare facilities: take responsibility

for the individual in the hospital, obtain collateral information, complete a comprehensive psychiatric evaluation for the removed individual, and a psychiatrist evaluates the individual for admission (MHIR, 2022).

There is no outline in the MHIR for how a person, once removed from public areas and taken to a hospital, would receive long-term treatment for an ongoing SMI or related social determinants. Nor is there any guidance or resources if they are not admitted to the hospital and return to the streets. For individuals who meet the criteria to receive treatment through inpatient hospitalization, the MHIR fails to address what happens once a person is discharged. The crisis of care—as in the case of Mr. Simon, who, according to Kaufman (2023), received five months of inpatient treatment at the Bronx Psychiatric Center before discharge in July of 2021— is not an issue of whether New York hospital systems can compassionately treat someone experiencing a SMI. Medical facilities can and do stabilize hundreds of psychiatric patients every day. The gaping hole is an omission of policy that should but does not address the continuum of care, including effective housing solutions for New Yorkers with a SMI.

INSTITUTIONS AFFECTED BY THE MHIR DIRECTIVE

Hospital-based emergency care is the only medical treatment to which Americans have a legal right regardless of their ability to pay (Barish et al., 2012). Whether a particular hospital operates under public or private auspices is of critical importance in determining who receives psychiatric services and how those services are financed. Hospitalization rates for New Yorkers living with a SMI are consistently higher than the national average (Heun-Johnson et al., 2018). It is widely accepted that psychiatric units generate less revenue for healthcare systems compared to surgical units; thus, in consideration of financial pressures, private hospitals divert psychiatric patients to city public hospitals (Mueller, 2017). Unhoused New Yorkers are more likely to receive treatment through the city's public hospital systems.

OTHER RELEVANT PUBLIC POLICIES
THE SUBWAY SAFETY PLAN

The MHIR is an extension of the memorandum published on February 18, 2022 by the OMH known as the Subway Safety Plan. This was the first directive from the Adams administration for police and other officials to remove any person with a mental illness or any person who appears to be mentally ill, even when there is no recent dangerous act, and transport them to a hospital for a psychiatric evaluation. This lengthier policy qualifies the rationale for enforcement, stating that "homelessness in NYC has reached the highest levels since the Great Depression" (Office of Mental Health [OMH] et al., 2022, p. 2). What is conspicuous is the city's rationale for why this population is at risk: "chronically homeless individuals with SMI often have symptoms and cognitive difficulties that contribute to difficulties accessing treatment and housing resources" (OMH et al., 2022, p. 2). Furthermore, the alternative agenda here is hiding in plain sight. Adams justified this aggressive language to augment existing sections of the MHL under the guise of a moral obligation to help unhoused New Yorkers in need of mental healthcare, while simultaneously using it to quell public safety concerns about crime on the street and in the subway system.

MHL SECTION 9.60, KNOWN AS KENDRA'S LAW

After Go's death, Adams pointed to New York MHL section 9.60, better known as Kendra's Law, which assertively connects New Yorkers experiencing a mental health emergency to medical treatment. Section 9.60 was named after Kendra Webdale, who died in January 1999 when she was pushed in front of a NYC subway train by a person with untreated schizophrenia (Pataki et al., 2005). Similar to Go's case, the man who pushed Webdale had just been released from a psychiatric hospital, and his actions resulted from medication non-compliance (Diven, 2022). Soon thereafter, in 1999, New York passed legislation to provide court-mandated Assisted Outpatient Treatment (AOT). This is a more humane and less restrictive alternative to inpatient commitment for

those who are unlikely to survive safely in the community without court-mandated supervision (Pataki et al., 2005). Per the U.S. Department of Justice (2022), AOT programs are also responsible for the oversight and monitoring of service providers, including case management services or Assertive Community Treatment (ACT) team services. Case managers and ACT team members follow an AOT recipient's level of compliance and delivery of services by other providers pursuant to the court order (U.S. Department of Justice [DOJ], 2020).

ASSISTED OUTPATIENT TREATMENT (AOT) EVALUATION

More than two decades have passed since the enactment of section 9.60 under New York's MHL. Critics of AOT argue that court mandated medical compliance infringes on civil liberties and disproportionately targets people of color. Others have studied the results and praised its effectiveness in reducing harm to individuals and communities. Appelbaum (2005) reviewed more than 10,000 New Yorkers who were referred to AOT during the five-year span after it was first enacted. Of the referrals, 93% of cases were granted court-ordered AOT. In evaluating participation, Appelbaum's (2005) study examined the history of the individuals granted AOT for three years prior to their court-ordered AOT. It found that 97% had been previously hospitalized, 30% were arrested, 23% were incarcerated, and 19% were unhoused. Even more encouraging were outcomes assessed over five years after mandated treatment, which showed a 44% decrease in general harmful behaviors, including a 47% decrease in physical harm to others (Appelbaum, 2005). Furthermore, arrests, incarceration, psychiatric hospitalization, and homelessness collectively dropped by 74 to 87% (Appelbaum, 2005).

AOT CRITICISM

Kaufman (2023) notes that when Simon left the hospital in July of 2021, social workers escorted him to a supportive housing apartment building in the Bronx, where he could live with on-site services. They left him with a 30-day supply of medication and a next-day appointment with a psychiatrist. Mr. Simon never showed up to his outpatient psychiatry

appointment and is believed to have spent no more than two hours in his new home where he left only a trace of his presence: a brown paper bag stuffed with the supply of medications (Kaufman, 2023). AOT is not a life sentence; court orders can lapse after six months. The most frequently cited reason for non-renewal of court orders, according to the NYS-OMH, is that the individual has improved and is no longer in need of court-ordered services. The paradox is that people likely improved because they were mandated to comply with medication, as was the case for Simon. According to Simon's sister, treatment and medicine kept him going, and once he no longer posed a threat to himself or others, the court no longer required him to take his medicine (Diven, 2022). Left to his own devices, he stopped taking his medication and his delusions resumed.

Racial disparities pervade New York's AOT program, with Black and Hispanic people disproportionately subjected to its court orders. Because of this, AOT programs have arguably further marginalized and discriminated against New Yorkers of color (Rodríguez-Roldán, 2020). During Adams' 2022 announcement, he called to make it easier to enforce Kendra's Law as a means to improve ongoing mental health outpatient treatment compliance for those who cannot meet their needs outside of institutions. New York MHL 9.60, outlined by Jaffe (2019), stipulates that once a patient meets the threshold for AOT eligibility, almost any person associated with that individual can petition for court-ordered treatment. While hospital providers can and do apply for AOT, Adams' statement is misleading, as it suggests Kendra's Law can only be mandated through hospitalization. In fact, the petition can be initiated by any mental health providers, directors of community programs, supportive housing directors, parole or probation officers, or any social service designee working with the individual. Furthermore, AOT is not an under-utilized resource as Adams also infers. According to Rascoe and Lewis (2022), as of October, there was an 800-person waiting list for those eligible for AOT. Without additional funding for this supportive service, forcing AOT creates a bottleneck for outpatient behavioral healthcare supportive services in the community.

While Kendra's Law can be beneficial for those who do receive AOT, Diven (2022) outlines its pitfalls. It fails to address the population at large, because it does not account for those who are not a threat to themselves or others. Furthermore, the legal statute for obtaining a court order is based on prior acts demonstrating dangerousness and treatment non-compliance, which imposes a high burden of proof. A widespread misconception is that people who are hospitalized for psychiatric stabilization are simply discharged to the streets without shelter, follow-up outpatient care, medications, or other supportive services. According to a study of psychiatric inpatient discharge practices and aftercare appointments in New York State, Smith et al. (2017) concluded that hospital providers, including social workers, reported having scheduled appointments for ongoing follow-up treatment for 85% of patients prior to discharge. The percentage of those found not to have psychiatric outpatient services were patients associated with having a co-occurring substance use disorder or other comorbid condition that took priority. This does not account for other social services secured for these patients in discharge planning. This study examined associations between routine discharge planning practices and time to treatment follow-up after discharge, finding that 45% of adults did not attend an initial aftercare appointment within 30 days of discharge (Smith et al., 2017). The data illustrates a void in the continuum of care needed for outpatient support, such as intensive case management and services through ACT teams, during the transition from the inpatient setting to supportive housing.

STAKEHOLDERS

For the MIHR directive, stakeholders include community members, law enforcement officials, healthcare workers and administrators, lawmakers, and New York City residents. New Yorkers with a SMI are primary stakeholders, considering this policy directly affects their social welfare. At present, it is estimated that 250,000 adults have a SMI, or 3% of the total population in New York City. Among the unhoused population, which totals about 60,000 living in city shelters or on the

streets, the NIMH's New York chapter estimates that one in five to one in six people live with a SMI (Kaufman, 2023). While the percentage of people with a SMI is significantly smaller than those living with other mental illnesses, New Yorkers with a SMI are disproportionately visible in the community given the longstanding systemic failures and lack of continuity in care.

SOCIAL DETERMINANTS FOR PRIMARY STAKEHOLDERS

In addition to the linkage between poverty and housing insecurities, it should also be noted that much of the population in need of urgent psychiatric care already face racial stigma, injustice, and other oppressive systemic forces. This population may suffer for years without being treated, and then often do not have affordable follow-up care or access to costly prescriptions. Many unhoused patients with a SMI also suffer from comorbidities such as substance abuse, which is to say that even if medication and therapeutic treatments are to stabilize the mental illness, these New Yorkers still face afflicting headwinds. Longstanding failures to address oppressive social determinants are why people often end up back in the ED or CPEPs mere days after discharge from inpatient care. The lack of funding and resources for the continuum of care including housing—that is not predicated on drug testing, curfews, or a lapse in mental health care—exacerbates the syndemics of homelessness and mental illness.

THE PROBLEM: NEW YORK CITY'S CURRENT MAYORAL STANCE

New York City is facing a crisis as those in power are using people experiencing homelessness, more specifically those with a SMI or, now, even a perceived mental illness, as a means to ensure public safety. Politicians like Adams, a former NYPD Captain, turn to policing as a means to remove the unhoused from the streets. Friedman (2022) argues that politicians conflate issues of homelessness and the need for public safety, utilizing law enforcement to unfairly target people

who are unhoused to ensure public safety. He points to how laws, particularly those in urban areas that wrest the "out of sight, out of mind" mantra, lessen public concerns for safety. There is an exhaustive list of legislation to keep those experiencing homelessness out of sight, including laws against living in public spaces, camping in cities, vagrancy and loitering, begging and panhandling, and sleeping in public.

In the policy's original version, Adams claimed people with mental illness were largely responsible for an increase in subway crime, despite data suggesting most crimes were not committed by unhoused or mentally ill New Yorkers (Fitzsimmons & Newman, 2022). The only qualification for removal, according to the MHIR directive, is that the person in question cannot meet their basic needs, a judgment entirely subjective and in the hands of those tasked with the person's removal.

CRITIQUES AND CONSIDERATIONS

The MHIR is an attempt to outstrip laws that already exist for people experiencing a psychiatric emergency in public, through its directive that police and emergency responders simply remove individuals from the streets and transport them to a hospital, whether or not the individual poses a danger to themselves or to others. Superficially, this implies that all people without permanent housing must suffer from an untreated mental illness and are violent individuals. In addition to this flawed presumption, politicians such as Adams cite morality and responsibility to disguise policing as a means of confronting longstanding problems, instead of addressing the root causes of homelessness through substantive policy changes. The New York City Civil Liberties Union (NYCLU) has been a vocal critic of MHIR and believes this directive violates fundamental legal rights for people living with any mental illness. The National Alliance on Mental Health (NAMI) has been critical, too, suggesting involuntary detention does not solve the issue of supportive housing for those with any mental health crisis. Adams points to court ordered AOT as a successful law that should be enforced, yet is misleading regarding how this essential component of a functional

public mental health system can be implemented and to whom it applies (Subway Safety Plan, 2022).

Admittedly, the 2019 NYS-OMH data for all inpatient New York City psychiatric facilities show that one in five (20%) patients were readmitted within 30 days, and nearly one in three (33%) were readmitted within 90 days. At five city hospitals, the 90-day psychiatric readmission rates were significantly higher, ranging from 53% to 64%. Similar rates exist for those presenting to EDs departments for psychiatric symptoms soon after inpatient discharge. On the surface, it is easy for politicians to point the finger at healthcare systems, when in actuality the data points to a system that relies on short-term treatment of psychiatric symptoms rather than adequately addressing long-term supportive care and social determinants for people with a SMI (Nortz, 2021). There is no formal healthcare policy, much less detailed plans or proposed guidance for actual treatment in the MHIR other than a psychiatric evaluation. This policy does not acknowledge, let alone propose, solutions that largely contribute to why unhoused people do not have access to healthcare. And for those who do receive some inpatient treatment through hospitalization, there are inadequate resources for the post-discharge continuum of care, which is essential for sustaining remission from chronic illness.

Opponents of the mayor's MHIR policy say not enough attention is directed towards accessible and affordable housing and healthcare. For decades, unhoused New Yorkers have been brought to EDs by NYPD and EMS every night. In response to Adams' plan, many psychiatrists say this will not come close to solving the problem of untreated mental illness among those living on society's margins (Goldstein, 2022). Hospitals are not a place to forcibly transport and offload people simply to remove them from the streets. Adams fails to acknowledge the long-term resources needed to address the interconnected medical and housing issues this policy directive purports to solve. When treating someone with a SMI there is a disproportionate emphasis on symptom reduction using drug therapies and psychotherapy and not enough

attention and resources for the continuum of care that is practical and affordable. The mental health crisis cited by politicians is not strictly medical; the path to healing also involves interventions to address the social determinants. Without ongoing follow-up appointments, supportive care, and rehabilitative services including housing, several days or even a few weeks of psychiatric hospitalization do little to break the cycle of chronic homelessness and SMI.

SOLUTION: HOUSING REFORM

The solution to the issue at the core of this crisis is to reform housing policies. Social workers join other providers and advocates in lamenting the lack of service integration and the scarcity of resources available for adults who are experiencing comorbidities of homelessness and mental illness (Padgett et al., 2006). However, studies have consistently found that only about 25%–30% of unhoused people have a SMI (Padgett, 2020). In just a handful of days, if a person receives proper nutrition, sleep regulation, social support, and consistent medication, their behavior changes and psychiatric symptoms diminish. During the public announcement for the Subway Safety Plan, Adams said, "It is cruel and inhumane to allow unhoused people to live on the subway, and unfair to paying passengers and transit workers who deserve a clean, orderly, and safe environment" (2022, February 18). If the mayor believes this, then the administration should consider redirecting resources toward policies that connect people with community-based systems such as ACT teams and adopt Housing First (HF) policies.

New York City relies on an overcrowded shelter system and a treatment-first approach, which requires unhoused individuals with a SMI to complete a sequence of steps to demonstrate readiness for supportive housing. HF is a departure from this linear continuum of care model by providing immediate access to housing in independent apartments. This evidence-based housing policy offers tenants an array of services through interdisciplinary ACT teams consisting of social workers, psychiatrists, vocational trainers, and substance

abuse counselors (Padgett et al., 2006). HF does not require people experiencing homelessness to address their behavioral health or substance use before providing housing. The policy is predicated on the philosophy that housing is the foundation on which people can recover. Additionally, studies have consistently shown access to housing generally results in cost savings for communities because housed people are less likely to use emergency services such as hospitals, jails, and emergency shelters (National Alliance to End Homelessness [NAEH], 2022). Waiting for individuals to receive and comply with medical treatment for a SMI, then rewarding them with housing, perpetuates the never-ending cycle of homelessness, institutionalization, and incarceration. In short, it solves neither the housing nor the mental health crisis.

During his MHIR address, Adams said his administration had a moral obligation to help [New Yorkers] who "cycle in and out of hospitals and jails, and New Yorkers rightly expect our city to help them and help them we will" (Adams, 2022, 1:47). Ironically, a mere three weeks before this speech, data was released showing that nearly 2,600 supportive housing apartments were vacant, which is enough to house the estimated 3,400 people living in streets or subways (Newman, 2022). According to Brand (2022), the city launched a new pilot program in early September of 2022, moving 80 formerly unhoused New Yorkers into vacant supportive housing units in single-room occupancy (SRO) buildings in Brooklyn and Manhattan. This pilot program, based on the HF model, enables residents to bypass the bureaucratic hurdles necessary to obtain supportive housing. While a start, the 80 units represent a paltry 3% of NYC's empty units. Furthermore, the program is being run by the nonprofit volunteers, rather than by the city. If the Adams administration truly wanted to solve the issue of housing and provide compassionate care for those in need, it might consider adopting the evidence-based HF policies citywide in the other 97% of reportedly empty apartments.

CONCLUSION

Adams' MHIR policy takes a page out of the political playbook that conflates issues of public safety with those of mental health. If, as the MHIR directive states, the only qualification for removal from public areas is that a person cannot meet their basic needs, then perhaps a more compassionate and effective way to solve the problem at hand would be to pivot from "mental health" and reform current housing policies that enable individuals to meet these basic needs. Policing unhoused New Yorkers with a SMI and forcibly transporting them to overcrowded healthcare systems in NYC do little to reduce the intersectional risks for this population. Without reforming policies that address long-term care, namely social determinants and housing policies, forcibly hospitalizing unhoused New Yorkers in need of psychiatric treatment is not only ineffective, but perpetuates this cycle. Thus, it is reasonable to conclude that Adams' MHIR directive is largely symbolic—optics for being tough on crime—while doing little to implement policy that provides actual relief and support to New Yorkers who are unhoused and living with a chronic SMI.

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