ALTERNATIVES TO THE SQUAD CAR: A STRATEGY PROVIDING HOPE FOR PEOPLE WITH MENTAL ILLNESS

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INTRODUCTION[1]

> *"The voices of those who believe that . . . severely mentally ill people should be able to refuse the treatment that they don't know they need have always been louder than those of the family members watching their loved ones die from lack of care."*[2]
>
> – Melinda Henneberger

The return to sanity has begun as the psychiatric crisis and

[1] This Article is a follow-up to the authors' recent publication *No-one Receives Psychiatric Treatment in a Squad Car*, 54 TEXAS TECH. L. REV. 645 (2022), which undertook a review of the mental health crisis taking place in the United States, and described how the responsibility for that crisis falls largely in the lap of first responders, who, through little fault of their own, are ill-equipped to handle such situations, causing unnecessary violent escalations and police killings. The article surveyed national, state, and local attempts to ameliorate the causes of both long-term untreated mental illness and police violence against mentally-ill individuals, and determined that successful models would need to address timely intervention, train mental health dispatchers to respond to emergency calls, ensure care in contravention of illness-induced treatment refusals, and facilitate follow-up and continuity of care. Based on that determination, the article proposed that legislation should blend slightly modified models instituted in Nebraska and Dallas, Texas.

[2] Melinda Henneberger, Opinion, *'We' Let Blind, Mentally Ill, Homeless Mark Rippee Die in Vacaville. But Let's Name Names*, SACRAMENTO BEE (Dec. 1, 2022, 7:24 AM), https://www.sacbee.com/opinion/article269419817.html [https://perma.cc/5UP4-PWAZ].

its links with lost potential,[3] ruined lives,[4] and violence[5] has finally moved from societal denial[6] to frontline action.[7] Over the past twenty years, many scholars have noted the negative impact of legal decisions[8] that were historically viewed as rescuing victims of the Cuckoo's Nest, the Snake Pit and Bedlam.[9] Such scholars concluded that a series of Supreme Court decisions regarding civil liberties unintentionally abandoned individuals suffering from mental illness to the streets, the criminal justice system, and the

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[3] COUNS. OF ECON. ADVISERS, EXEC. OFF. OF THE PRESIDENT, REDUCING THE ECONOMIC BURDEN OF UNMET MENTAL HEALTH NEEDS (2022), https://www.whitehouse.gov/cea/written-materials/2022/05/31/reducing-the-economic-burden-of-unmet-mental-health-needs/ [https://perma.cc/9ZFX-XXBP] (describing the effects of long-term mental health crises to include homelessness; increased instance of substance abuse, suicide, and incarceration; worse educational outcomes; significant earning loss; and further describing how mental health issues in one generation often cause trauma and mental health issues in the next generation); Seth A. Seabury et al., *Measuring the Lifetime Costs of Serious Mental Illness and the Mitigating Effects of Educational Attainment*, 38 HEALTH AFFILIATE 652, 652 (2019) ("We estimated that the per patient lifetime burden of SMI [Serious Mental Illness] is $1.85 million.").

[4] AM. PSYCHIATRIC ASS'N, SUICIDE AND SERIOUS MENTAL ILLNESS: AN OVERVIEW OF CONSIDERATIONS, ASSESSMENTS, AND SAFETY PLANNING 2 (2020), https://smiadviser.org/wp-content/uploads/2020/12/Guide-to-Suicide-and-SMI-vFINAL-05182021.pdf [https://perma.cc/9EDB-YRH3] ("The rate of death by suicide for people with mood disorders–such as depression or bipolar disorder-is estimated to be 25 times higher than the general population. Among adults diagnosed with schizophrenia, 1 in 20 dies by suicide, a rate that is 20 times higher than the general population.").

[5] *See, e.g.*, Neil Osterweil, *Virginia Tech Missed 'Clear Warnings' of Shooter's Mental* Instability, MEDPAGE TODAY (Aug. 30, 2007), https://www.medpagetoday.com/psychiatry/anxietystress/6546 [https://perma.cc/LFA3-D9JZ].

[6] *See infra*, note 21.

[7] *See* discussion *infra* Section I.

[8] *See, e.g.*, Olmstead v. L.C., 527 U.S. 581, 592 (1999); O'Connor v. Donaldson, 422 U.S. 563 (1975); Lake v. Cameron, 364 F.2d 657, 659 (D.C. Cir. 1966).

[9] President Robert F. Kennedy used the term "snake pit" to describe the abysmal conditions of a mental health institution he visited unannounced when he was the Senator of New York. Aryeh Neier, *Cleaning Up the Snake Pit*, ACLU (Nov. 8, 2019), https://www.aclu.org/issues/disability-rights/cleaning-snake-pit [https://perma.cc/NM8B-9T73]. Similar cultural references developed soon thereafter. *See, e.g.*, KEN KESEY, ONE FLEW OVER THE CUCKOO'S NEST (1963).

morgue.[10] Additionally, media attention highlighting the tragic results of police encounters with individuals suffering from a mental health crisis has exploded onto the national conscious.[11]

Dissent remains. Fueled by social media, some are echoing the 1960's counter-culture past claiming that mental illness is a myth. Others have joined Hearing Voices Network support groups who posit that what psychiatry calls psychosis refers only to non-consensus realities and believe that psychosis facilitates a more vivid vision of life's experiences.[12]

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[10] *See infra,* note 16; Gordon, *infra* note 214, at 660-61 ("Long-term treatment in the community is often unavailable, and without that care, many people with serious mental illness live on the streets, commit crimes for which they are sent to prison, or become victims of crime themselves."); Jessica Knowles, "*The Shameful Wall of Exclusion": How Solitary Confinement for Inmates with Mental Illness Violates the Americans with Disability Act*, 90 WASH. L. REV. 893, 908 (2015) ("[W]e seem to have reproduced some of the worst aspects of an earlier époque's snake pit mental asylums in the isolation units of our modern prisons." (quoting Terry A. Kupers, *How to Create Madness in Prison*, in HUMANE PRISONS 13 (David Jones ed., 2006)); Steven Raphael & Michael A. Stoll, *Assessing the Contribution of the Deinstitutionalization of the Mentally Ill to Growth in the U.S. Incarceration Rate*, 42 J. LEGAL STUD. 187, 187-88 (2013).

[11] *See* Judy Ann Clausen & Joanmarie Davoli, *No-one Recives Psychiatric Treatment in a Squad Car*, 54 TEXAS TECH L. REV. 645, 659 & n. 106 (2022).

[12] Daniel Bergner, *Doctors Gave Her Antipsychotics. She Decided to live with Her* Voices, N.Y. TIMES MAG. (May 22, 2022), https://www.nytimes.com/2022/05/17/magazine/antipsychotic-medications-mental-health.html [https://perma.cc/2SWT-VLPQ]. A marginal but growing portion of the mentally ill population is embracing the Hearing Voices Movement, which is attempting to recast mental illness, even those associated with hallucinations and delusions, as a normal part of the human experience to be embraced as a form of diversity and inclusion. *Id.* The movement emphasizes living with those delusions and hallucinations by discussing them with support group members rather than attempting to ameliorate hallucinations through the use of medication or treatment with trained physicians. Advocates argue that the harmful effects of psychotropic medication do more harm than good. *Id.* The group's claim regarding the harmful effects of medication, while shirked by modern medicine, has found support from a recent World Health Organization directive on human rights and mental health, which is calling for a re-evaluation of the way we treat mental health, and specifically seeking to reevaluate pharmacological treatment as the frontline and forefront response of treatment providers. *Id.*

Such alliances have created alternatives to psychiatric wards which have no clinicians on staff, no security personnel, only people who have experienced psychosis firsthand. One such alliance held a homemade banner declaring "[h]olding multiple truths. Knowing that everyone has their own accurate view of the way things are."[13] Without any scientific backing, these groups posit that maintenance on psychiatric medicine may worsen outcomes and cause brain atrophy. However, this Article posits that the idea that mental illness is merely freethinking rejection of social norms,[14] or an expression of one's own lived truth is unsupported by science and dangerous for people with serious mental illness ("SMI") and society generally.

Moreover, this thinking is merely a repeat of the tired claims that mental illness is a myth[15] rooted more in ideology, academic fantasy, and denial than anything resembling reality. Science now shows that SMI is biological, and new, promising treatments offering the hope to most individuals with SMI of ending psychosis are available. Moreover, recent research shows that leaving psychosis untreated worsens the severity of the mental illness and undermines the person's prospects for recovery.

Those on the frontline, healthcare providers and first responders have had enough of mental health care policy being rooted in ideology and utopian visions instead of the practical realities of the nature of SMI. The current system of a severe shortage of mental health beds and strict criteria for administering mental health treatment in contravention of illness-induced treatment refusals has caused the real-world preventable tragedies of mass shootings, incarceration, homelessness, victimization, and death of people suffering from untreated SMI.[16] Innovative

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[13] Bergner, *supra* note 12.

[14] *Id.*

[15] THOMAS S. SZASZ, WORDS TO THE WISE: A MEDICAL-PHILOSOPHICAL DICTIONARY 156 (2017) ("Mental illness is a myth, whose function is to disguise and thus render more palatable the bitter pill of moral conflicts in human relations.").

[16] *About Mental Health Conditions*, NAT'L ALL. OF MENTAL ILLNESS, https://namica.org/what-is-mental-illness/ [https://perma.cc/8QPJ-XXEA] (last visited Feb. 12, 2023) ("Without treatment, the consequences of mental illness for the individual and society are staggering. Untreated mental health conditions can result in unnecessary disability, unemployment, substance abuse, homelessness, inappropriate incarceration, and suicide, and poor quality of life.").

programs and long-established protocols have been profiled by the media and examined by scholars. Momentum is brewing.

Across the country, creative minds are crafting thoughtful solutions to the human suffering produced by untreated SMI. Our current failed national mental health system that prevents life-saving interventions by honoring a patient's anosognosia, a symptom of SMI that causes lack of insight, is no treatment system at all. The utopian vision of deinstitutionalization was a societal copout that resulted in trans-institutionalization of our most vulnerable citizens from substandard state psychiatric hospitals to truly traumatizing and dangerous homelessness and prisons or death.[17]

I. REAL WORLD PERSPECTIVE

From the comforts of the Ivy Tower[18] and behind the ever-glowing electronic screens, both scholars and popular media have debated issues of mental illness and deinstitutionalization, sometimes even denying the existence of the former[19] while

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[17] *See* E. FULLER TORREY, AMERICAN PSYCHOSIS: HOW THE FEDERAL GOVERNMENT DESTROYED THE MENTAL ILLNESS TREATMENT SYSTEM 95-96 (Oxford Univ. Press 2014).

[18] Many pose lofty solutions that fail to recognize homelessness and mental illness is not a choice. David Rudin, *"You Can't Be Here": The Homeless and the Right to Remain in Public Space*, 42 N.Y.U. REV. OF L. & SOC. CHANGE 309, 329 (2018):

> Applied across the general population, the pervasive control of access to public space currently imposed on homeless individuals would cause an uproar. Blanket restrictions on movement strike at the core of people's liberty to carry out their lives in the outside world and associate freely. Yet such measures would notdisrupt the average person's entire life, for a housed citizen is still free to do as she pleases inside the privacy of her home. For a subset of the population, however, there is nowhere to retreat from anti-homeless ordinances and ad hoc police directives to move along. For homeless people, the street is both the public and the private. Thus, the way these regulations of public access are applied presents a paradox. The very people who most need to remain in public space are those whose ability to do so is most under attack.

[19] SZASZ, *supra* note 15.

praising the impact of the later.[20] Lacking familiarity with the practical realities of SMI, these idealistic academics, members of the media, and governmental officials have promoted efforts that have harmed people struggling with SMI. Such efforts include: (1) defunding and closing state asylums, including denying federal funding for healthcare facilities that have "too many" mental health beds; (2) blocking treatment through strict dangerousness criteria for administering treatment in contravention of illness-induced refusals; and (3) rationalizing homelessness and incarceration of people with untreated SMI.[21] Meanwhile, narrowly interpreted rules limiting treatment have thwarted efforts of frontline healthcare workers and family members to help individuals in mental illness crisis, even when treatment is available and would

[20] Samuel R. Bagenstos, *The Past and Future of Deinstitutionalization Litigation*, 34 CARDOZO L. REV. 1, 4 (2012) ("Notwithstanding their broad pronouncements, both supporters and opponents will agree that deinstitutionalization has caused significant positive results for a large number of people who would otherwise have been set apart from their communities and denied the basic interactions of civic life."), *citing* GERALD N. GROB, THE MAD AMONG US: A HISTORY OF THE CARE OF AMERICA'S MENTALLY ILL 292 (1994) ("Whatever its contradictory and tangled origins, deinstitutionalization had positive consequences for a large part of the nation's severely and persistently mentally ill population.").

[21] *See, e.g.,* Clarence Page, *A Case That Baffles Americans Too*, CHI. TRIB. (June 5, 1988, 12:00 AM), https://www.chicagotribune.com/news/ct-xpm-1988-06-05-8801050609-story.html [https://perma.cc/M5GJ-89DT] (noting President Ronald Regan's defense of a homeless woman's right to live on the street. The President remarked: "when you have a free country, how far can we go in impinging on the freedom of someone who says this [homelessness] is the way I want to live?").

be effective.[22]

Family members, combined with frontline workers, police officers, jail guards, psychologists, psychiatrists, social workers and even politicians, have had enough.[23] Instead of accepting the status quo of a broken mental health system that blocks treatment for its most vulnerable citizens, these stakeholders are challenging long-held assumptions and proposing practical solutions to ease the suffering of people with SMI. As one family member stated:

> Rather than reform…mental health laws, mental health professionals do not want to acknowledge that they intentionally send the [untreated mentally ill] to U.S. streets. We have advocated for my brother, Mark, unsuccessfully for 34 years due to California legal blockades. He has not had mental health treatment or services in more than 3 decades. The sad truth is that there is no true mental health system in the United States for those with serious brain disorders.[24]

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[22] Linda Rippee Privatte, *I Care for my Blind & Seriously Mentally Ill Brother On The Streets: Not The Pretend Mental Health Care System: WHAT DO YOU CALL ME?*, PETE EARLEY BLOG (June 13, 2022), https://www.peteearley.com/2022/06/13/i-care-for-my-blind-seriously-mentally-ill-brother-on-the-streets-not-the-pretend-mental-health-care-system [https://perma.cc/6VUJ-BTCN]:

> I have been a caregiver on the streets of my hometown of Vacaville, California, to my brother, Mark, who is disabled, blind and has a serious brain disorder with anosognosia (lack of insight). He has been left untreated by the system and homeless for 14 years now. Lately I have been wondering what title I would be given. That is if our U.S. mental health system even acknowledged and valued the family members who go to the streets to care for their homeless untreated seriously mentally ill (SMI/SBD) loved ones? I have thought long and hard about the many things I try to be to my brother. Treatment will never be in his reach while the sickness in his brain tells him to say "no" to all offers of help. Lack of insight further complicates care given out on the streets. I take him water, food and clothing, and each time he has nothing with him again. I show him love and human kindness. I remind him about family memories and make him laugh. I hold him when he is sobbing with delusions. I try to calm him when he is raging in psychosis. I am his substitute for an In-Home Supportive Services Caregiver, nurse, therapist, and social worker.

[23] *See* discussion *infra*.

[24] Privatte, *supra* note 22.

Facing head-on various nonsensical claims, such as the Supreme Court's assertion that "psychiatrists disagree widely and frequently on what constitutes mental illness,"[25] frontline workers are leading the way to returning compassion, care and effectiveness to treatment of individuals afflicted with mental illness. As medical research continues to advance, great strides have been made in medications for mental illness. Safe, effective treatment does in fact exist.[26] Innovative, long-term administration of medications has become available and effective,[27] allowing individuals suffering from mental illness to lead productive lives freed from the tyranny of their symptoms.

In November of 2022, Mayor Eric Adams of New York City announced a comprehensive plan to tackle the chronic problem of people with SMI struggling with homelessness.[28] Mayor Adams began his message by focusing on compassion and humanity.

> As a city, we have a moral obligation to support our fellow New Yorkers and stop the decades-long practice of turning a blind eye towards those suffering from severe mental illness, especially those who pose a risk of harm to themselves.... It is not acceptable for us to see someone who clearly needs help and walk past them.[29]

Mayor Adams' humane and common-sense proposal offers hope to people with SMI and their loved ones.

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[25] Kansas v. Hendricks, 521 U.S. 346, 359 (1997) (citing Ake v. Oklahoma, 470 U.S. 68, 81 (1985)). This quote was just as questionable in 1997 as it was in 1985. *See* Joanmarie I. Davoli, *Still Stuck in the Cuckoo's Nest: Why Do Courts Continue to Rely on Antiquated Mental Illness Research*, 69 TENN. L. REV. 987, 989-90 (2002).

[26] Clausen, *supra* note 11, at 647 & n.2.

[27] *See infra* note 351 and accompanying text.

[28] *See* Press Release, Off. of the Mayor, Mayor Adams Announces Plan to Provide Care for Individuals Suffering from Untreated Severe Mental Illness Across NYC (Nov. 29, 2022), https://www.nyc.gov/office-of-the-mayor/news/870-22/mayor-adams-plan-provide-care-individuals-suffering-untreated-severe-mental [https://perma.cc/8M4D-XSY6] [hereinafter NYC Press Release].

[29] *Id.*

"The man standing all day on the street across from the building he was evicted from 25 years ago waiting to be let in; the shadow boxer on the street corner in Midtown, mumbling to himself as he jabs at an invisible adversary; the unresponsive man unable to get off the train at the end of the line without assistance from our mobile crisis team: These New Yorkers and hundreds of others like them are in urgent need of treatment and often refuse it when offered," the Mayor said.[30]

Mayor Adams thus pierces the decades long legal fiction that has turned New York City into an open-air warehouse for people with SMI.[31] Individuals who refuse housing are not expressing an interest in fresh-air camping. They are suffering from psychosis. The man with SMI who refuses housing does not want to camp in the city streets but suffers from untreated psychosis and distorted thinking. The woman with SMI standing outside the apartment from which she was evicted cannot negotiate with her landlord because she suffers from untreated delusions. The New Yorker with SMI shadow boxing on the street corner is not expressing himself but experiencing untreated hallucinations. The unresponsive woman on the subway is not enjoying liberty but is imprisoned in the misery of her untreated symptoms. Such examples underscore that untreated SMI strips people of safety, security, dignity, human potential, and happiness.

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[30] Andy Newman & Emma G. Fitzsimmons, *New York City to Involuntarily Remove Mentally Ill People From Streets*, N.Y. TIMES (Dec. 29, 2022), https://www.nytimes.com/2022/11/29/nyregion/nyc-mentally-ill-involuntary-custody.html [https://perma.cc/72YV-NXNA]; *see also* NYC Press Release, *supra* note 28.

[31] *NYPD Analysis Highlights Spike in Arrests Among Those with History of Mental Illness,* NBC N.Y. (Oct. 26, 2022, 7:28 PM), https://www.nbcnewyork.com/news/local/nypd-analysis-highlights-spike-in-arrests-among-those-with-history-of-mental-illness/3923958 [https://perma.cc/Z3UF-LNCC] (noting that with regard to major felonies such as murder, rape, and felony assault, the homeless population accounts for 23.4% of individuals arrested); *see also* Errol Louis, *The Horror that Continues to Haunt Our City*, INTELLIGENCER (Oct. 3, 2022), https://nymag.com/intelligencer/2022/10/alison-russo-elling-horror-that-continues-to-haunt-new-york-city.html [https://perma.cc/2XFH-ZUTD] (summarizing several high profile murders and assaults by the mentally ill population in New York City, including the stabbing of a 24 year veteran of NYPD, and the shoving of Michelle Go in front of a speeding train by someone hospitalized for mental treatment twenty times).

As a former police officer, Mayor Adams brings a commonsense approach to the issue of helping people struggling with SMI and homelessness. During his career in law enforcement, Mayor Adams continuously sought innovative solutions to the problems he faced and was described by one former colleague as "a thinking man's officer."[32] Additionally, as the chief executive of New York City, Mayor Adams is uniquely positioned to bring about changes at the local level. Mayor Adams proposes a holistic approach to fixing the broken mental health system by removing obstacles to effective crisis intervention and by focusing on the entire problem: legal issues, medical issues, continuity of care issues as well as the dignity inherent in every human being.

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[32] As in described by Michael Rothfeld et al., *'Keep an Eye on This Guy': Inside Eric Adams's Complicated Police Career*, N.Y. TIMES (Nov. 8, 2021), https://www.nytimes.com/2021/06/19/nyregion/eric-adams-nyc-police-mayor.html [https://perma.cc/B7PF-W4J7]:

> Mr. Adams began as a transit police officer, patrolling the subway or in a radio car, later using his associate degree in data processing to work on the department's computer programs that tracked crime . . . Randolph Blenman, who patrolled with Mr. Adams when both were transit officers, called him "a thinking man's officer," whether they were arresting someone or helping them. "He always did his best to get his point across without losing his composure," Mr. Blenman said.

Across the United States, there are echoes of movement to reform the broken mental illness system. Now is the time for society to help empower people whose untreated SMI prevent them from recognizing their need for treatment. From California's new CARE court,[33] to Nebraska's psychiatric advance directive statute,[34] to media attention on preventable tragedies,[35] legislatures, medical professionals, law enforcement and family members of people with SMI are proposing practical measures to fix the broken mental illness treatment system.

Thus, the new mental illness treatment system must prioritize helping people with SMI whose untreated symptoms too often result in incarceration, homelessness, incapacity, injury, and death. The U.S. mental illness treatment system, the most expensive in the world, too often neglects people who are most sick. There are many mental illnesses with a broad range in severity of symptoms and impact on daily functioning.[36]

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[33] California's new CARE Court empowers interested parties, including family members and first responders, to refer those with SMI to the Court, who will help design and facilitate twelve to twenty-four month programing consisting of clinical treatment and transitional housing to those suffering. The legislation further provides for state funding for such housing and enables the court to sanction local governments that are out of compliance with referral and housing provisions. Press Release, OFF. OF GOVERNOR GAVIN NEWSOME, *Governor Newsome Signs CARE Court into Law, Providing a New Path Forward for Californians Struggling with Serious Mental Illness* (Sept. 14, 2022), https://www.gov.ca.gov/2022/09/14/governor-newsom-signs-care-court-into-law-providing-a-new-path-forward-for-californians-struggling-with-serious-mental-illness/ [https://perma.cc/TNZ9-DK3J].

[34] Nebraska has enacted the Advance Mental Health Care Directives Act, which enables those with mental illness to craft a document at a time when they are competent, that authorizes care providers to administer treatment when they are incompetent and suffering symptoms of SMI, even if their illness is causing illness-induced treatment refusals, for up to twenty-one days. NEB. REV. STAT. §§ 30-4401 to -4415 (2020). For a more detailed discussion of the intricacies of the Nebraska Statute, *see* Clausen, *supra* note 11, at 686-94.

[35] Patty Wight, *Friends say Thanksgiving Day Murder Could Have Been Prevented with a Stronger Mental Health* System (Jan. 24, 2023, 4:44 PM), https://www.mainepublic.org/health/2023-01-04/friends-say-thanksgiving-day-murder-could-have-been-prevented-with-a-stronger-mental-health-system [https://perma.cc/8JSR-VR2R] (describing the mental health system's numerous points of contact with Justin Butterfield, a mentally ill individual who ultimately murdered his brother as a result of his mental illness).

[36] *Mental Illness*, NAT'L INST. OF HEALTH, https://www.nimh.nih.gov/health/statistics/mental-illness [https://perma.cc/3HZX-BLGH] (last visited Feb. 1, 2024).

Moreover, a significant percentage of the U.S. population is diagnosed with some sort of mental illness.[37] For too long, resources had been diverted from people with SMI. These factors make it crucial that mental illness treatment system reforms focus primarily on people with SMI. To prioritize reforms centered around those most impacted by mental illness, one must define SMI which is a mental illness such as bipolar disorder, major depressive disorder, schizophrenia, or schizoaffective disorder involving psychosis, which is a disconnection from reality.[38] Common psychotic symptoms include auditory and visual hallucinations and delusions.[39]

II. BOLD NEW WORLD: MAYOR ADAMS' PSYCHIATRIC CRISIS CARE LEGISLATIVE AGENDA

The announcement made by Mayor Adams in November of 2022 referenced his eleven-point legislative agenda. Focusing on the theme of compassion, Mayor Adams explained that his approach was to accept head-on the challenges of what produced the situation in the first place: legal barriers, financial barriers, and the biggest barrier of them all: the patients themselves.

> For too long, there has been a gray area where policy, law, and accountability have been unclear, and this has allowed people in desperate need to slip through the cracks. This culture of uncertainty has led to untold suffering and deep frustration, but we cannot and will not allow it to continue. Today, we are making a clear statement to our fellow New Yorkers that, by leading with compassion and care, we can

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[37] *See, e.g.*, *The State of Mental Health in America: 2023*, MENTAL HEALTH AMERICA, https://mhanational.org/sites/default/files/2023-State-of-Mental-Health-in-America-Report.pdf [https://perma.cc/Q2RD-PJTZ] (last visited Feb. 1, 2024). As of 2022, 19.86% of adults in the U.S. were experiencing mental illness which is the equivalent of 50 million Americans. *Id.* at 7. Moreover, in 2022, 4.91% of adults were experiencing severe mental illness. *Adult Ranking 2022*, MENTAL HEALTH AMERICA, https://mhanational.org/issues/2022/mental-health-america-adult-data [https://perma.cc/25W2-4MVA] (last visited Feb. 1, 2024).

[38] *What is Serious Mental Illness?,* SMI ADVISER, https://smiadviser.org/about/serious-mental-illness [https://perma.cc/L64A-E5ZE] (last visited Jan. 28, 2023).

[39] *Overview – Psychosis*, NAT. HEALTH SERV., https://www.nhs.uk/mental-health/conditions/psychosis/overview [https://perma.cc/7VKG-QUAG] (last visited Feb. 1, 2024).

> do much more to help those among us in a severe mental health crisis, even when they are unable to, by no fault of their own, recognize their own needs. This is our moral mandate as a city and we will not fail to deliver for our most vulnerable.[40]

Mayor Adams echoes the sentiments of frontline workers everywhere who have struggled to care for loved ones or strangers afflicted with mental illness.[41] Stepping over people who are trapped in delusions is not compassionate. Allowing psychotic patients to refuse treatment and safety and instead embrace illness and suffering is not moral.

[40] NYC Press Release, *supra* note 28.

[41] *See* Transcript: Mayor Eric Adams Delivers Address on Mental Health Crisis in New York City and Holds Q-and-A, Off. of the Mayor (Nov. 29, 2022), https://www.nyc.gov/office-of-the-mayor/news/871-22/transcript-mayor-eric-adams-delivers-address-mental-health-crisis-new-york-city-holds [https://perma.cc/8X5L-KJ63] ("[Frontline workers have] been relcutlant because there has not been any real clarity and we are giving them clarity with the new training that we put in place.").

Predictably, the announcement provoked controversy, with objections attacking the plan itself,[42] while also denying the problem.[43] Using the same tired arguments that brought down earlier attempts to help people struggling with SMI and homelessness in New York City,[44] the Bazelon Center for Mental Health Law ("Bazelon Center") attacked the plan as not addressing their preferred solutions,[45] while also undermining the seriousness of SMI symptomology. "The Mayor cited individuals who are 'mumbling,' 'shadow boxing,' or merely standing on the street for too long as examples of those to whom his directive would apply."[46] Reducing the symptoms of mental illness to something that everyone has experienced from time to time is a common tactic used to downplay the seriousness of mental illness while also subtly suggesting that SMIs do not exist at all.[47] Such tactics demonstrate a failure to honestly engage in the reality of psychosis.

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[42] *See, e.g.*, Brian Bushard, *Here's Why NYC Mayor Adams' Plan to Remove Mentally Ill Homeless People from Streets is Controversial*, FORBES (Nov. 30, 2022, 1:49 PM), https://www.forbes.com/sites/brianbushard/2022/11/30/heres-why-nyc-mayor-adams-plan-to-remove-mentally-ill-homeless-people-from-streets-is-controversial/?sh=444a3f817783 [https://perma.cc/RH5G-XA95] ("New York Civil Liberties Union director Donna Lieberman slammed Adams for 'playing fast and loose with the legal rights of New Yorkers.' Specifically, she said the directive could overstep state and federal law that limits the government's ability to detain people who are experiencing mental illnesses.").

[43] Some continue to claim that psychotic individuals who are living on the streets, displaying florid symptoms of mental illness are simply poor. *See, e.g.*, Emma G. Fitzsimmons & Andy Newman, *New York's Plan to Address Crisis of Mentally Ill Faces High Hurdles*, N.Y. TIMES (Nov. 30, 2022), https://www.nytimes.com/2022/11/30/nyregion/mental-health-plan-eric-adams.html [https://perma.cc/7GBX-BDLF] [hereinafter *High Hurdles*] ("Homelessness is driven by the gap between rents and income and the lack of affordable housing, and mental health challenges for both housed and unhoused people are driven by the lack of enough community-based mental health services," he [former social services commissioner under Mayor Bill DeBlasio] said in a statement.").

[44] *See infra* notes 51-59 and accompanying text.

[45] Despite this strong criticism, the Bazelon Center cited for this proposition only itself, and a report published over twenty years ago. *See* Press Release, Bazelon Center for Mental Health Law, Mayor Adams' Plan Will Not Help People With Mental Disabilities 1 & nn.2-3 (Dec. 12, 2022), https://www.bazelon.org/wp-content/uploads/2022/12/NYC-statement-final-12-12-22.pdf [https://perma.cc/426E-STH7] ("Safe, stable, and affordable housing, provided with voluntary supports, has been shown to help these individuals stabilize and avoid hospitalization and incarceration. And voluntary community-based services, such as assertive community treatment (ACT), supported employment, crisis services, and peer support services—delivered not in the hospital, but in the person's own home and community—have been shown to break the cycle of institutionalization.").

In fact, the Center and similar critics such as the New York Civil Liberties Union[48] must recognize that Mayor Adams is not proposing involuntary psychiatric treatment for people who are only mumbling. They know that he is not proposing time limits for how long individuals may stand on the street. Instead, such critics are fully aware that Mayor Adams is describing the visible symptoms of psychosis, and these critics trivialize his descriptions of the devastation and suffering caused to the minds and health of those afflicted in an attempt to undermine the legitimacy of the plan.

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[46] *See* Transcript, *supra* note 41; *see also NLIHC Joins Statement Opposing NYC Mayor Eric Adams's Plan to Increase Involuntary Hospitalization of New Yorkers with Disabilities*, NAT'L LOW INCOME HOUSING COAL. (Dec. 19, 2022), https://nlihc.org/resource/nlihc-joins-statement-opposing-nyc-mayor-eric-adamss-plan-increase-involuntary [https://perma.cc/UQY6-Z2GA].

[47] *See, e.g.*, Szasz, *supra* note 15.

[48] Bushard, *supra* note 42 ("The Civil Liberties Union's former head, Norman Siegel, also criticized the measure, saying it's likely going to be challenged in court and that 'just because someone smells, because they haven't had a shower for weeks, because they're mumbling . . . doesn't mean they're a danger to themselves or others,' the New York Times reported.").

Yet, despite controversy, there was also considerable support for Mayor Adams' plan. "The rank-and-file police union and left-wing elected officials are in rare alignment, saying police officers have enough responsibilities without confronting those in dire need of psychiatric care."[49] Former New York State Governor David Paterson praised the plan, stating that "Mayor Eric Adams' move to involuntarily commit some mentally ill homeless people is the right way to both help them and improve safety for everyone else."[50] Others support the plan because of concerns about preventing violence.[51]

[49] Emily Ngo, *Mayor Eric Adams Acknowledges Mental Health Plan Is a Work In Progress,* SPECTRUM NEWS (Dec. 5, 2022, 6:30 PM), https://www.ny1.com/nyc/all-boroughs/politics/2022/12/05/mayor-eric-adams-acknowledges-mental-health-plan-is-a-work-in-progress [https://perma.cc/THG3-CB9G].

[50] The former governor also acknowledged the specific need for inpatient psychiatric treatment. David Meyer, *Ex-Gov. David Paterson Backs Adams' Plan to Get Mentally Ill Off Streets*, N.Y. POST (Dec. 11, 2022, 2:35 PM), https://nypost.com/2022/12/11/david-paterson-backs-adams-plan-to-get-mentally-ill-off-streets/ [https://perma.cc/5UTK-N77J] (The Governor also recognized "[w]hat we need to do is what we should've been doing the last 15 or 20 years, [which] is reversing the deinstitutionalization of the late '70s that carried into the '90s that doesn't allow us to have enough beds to help these people.").

[51] *High Hurdles*, *supra* note 43 (noting that Ron Kim, a left-leaning state assemblyman, supported the proposition after meeting with the father of Michelle Go, who was pushed in front of a high-speed train by a mentally ill individual who had multiple interactions with the mental health system prior to the incident, and believes the legislation will help facilitate mental health treatment before such incidents arise).

While perhaps unimaginable today, there were relatively few chronically homeless people in large cities up until the 1970s. "Homelessness began to emerge in the late 1970s, when the presence of homeless men sleeping in the streets at night became more common."[52] New York City's current homeless crisis is directly linked to deinstitutionalization: the closing of state-run psychiatric hospitals.[53]

As the number of people struggling with homelessness increased, New York City mayors have attempted a variety of measures to assist people struggling with untreated SMI and homelessness. In 1985, Mayor Ed Koch responded to the new yet growing homeless crisis by instituting a policy to pick up and treat people struggling with SMI and homelessness whenever the temperature was below freezing. A psychiatrist would examine the individuals and make a determination as to possible treatment needs.[54]

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[52] *History of Homelessness in NYC*: *The Root of the Homeless Problem*, HOMELESSNESS & AFFORDABLE HOUS. NYC, https://eportfolios.macaulay.cuny.edu/affordablehousingnyc/homelessness-in-nyc/ [https://perma.cc/RQ4V-25NY] (last visited Feb. 12, 2023); *see also #TBT- History of Homelessness 1929-1980*, NAT'L. COAL. FOR THE HOMELESS (June 7, 2018), https://nationalhomeless.org/tbt-history-of-homelessness-1929-1980/ [https://perma.cc/HBK3-EYKP] [hereinafter *History of Homelessness*] ("Prior to the 1970s homelessness rose and fell with the economic state of the country. Starting in the 1970s policies shifted and a sharp and permeant rise in homelessness occurred.").

[53] *History of Homelessness*, *supra* note 52 ("In the 1950s, deinstitutionalization . . . affected thousands of patients who were discharged from psychiatric centers and hospitals in New York. The State adopted this policy because of the development of new medications and new mental health care treatments within the local communities . . . . As a result, the number of patients in the State psychiatric centers fell from 85,000 to 27,000 patients between 1965 and 1979.").

[54] Josh Barbanel, *Homeless in City Facing Koch Edict*, N.Y. TIMES (Nov. 14, 1985), https://www.nytimes.com/1985/11/14/nyregion/homeless-in-city-facing-koch-edict.html [https://perma.cc/AU9J-C3YW].

Mayor Koch expanded his efforts as the population facing homelessness grew, recognizing that a large percentage of people struggling with homelessness also suffered from SMI. In fact, the link between deinstitutionalization and homelessness was widely understood. In 1987, Mayor Koch instituted a comprehensive campaign that included dispatching vans staffed with psychiatrists, social workers, and nurses who would evaluate and transport individuals with mental illness to psychiatric hospitals for treatment.[55] Mayor Koch's team noted that long-term, inpatient psychiatric care is needed to care for a portion of those afflicted with SMI.

> Dr. Luis Marcos, vice president for mental hygiene in the city's hospital system, said the program could lead to the reintroduction of long-term care for some people now living on the streets [. . . .]'This is the beginning of the recognition of the need for asylums,' he said. 'The mental health care system will never be the same. For the first time there is a recognition of the patients' right to treatment, and their freedom from the prison of mental illness, rather than the freedom to die in the streets.'[56]

However, civil liberties groups quickly challenged the new law, objecting to removing people battling homelessness from the streets against their will. One of the individuals picked up in Mayor Koch's initiative was represented by the NYACLU.

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[55] Josh Barbanel, *Mentally Ill Homeless Taken Off New York Streets*, N.Y. TIMES (Oct. 29, 1987), https://www.nytimes.com/1987/10/29/us/mentally-ill-homeless-taken-off-new-york-streets.html [https://perma.cc/37SC-GNG8] [hereinafter *Taken Off Streets*].

[56] *Id.*

Joyce Brown, who when delusional, went by the name Billie Boggs,[57] challenged Mayor Koch's scheme and a civil commitment hearing was held. In a breathtakingly absurd court order demonstrating that courts apply the civil commitment criteria to block mental illness treatment paving the way for homelessness of individuals suffering from untreated symptoms, the trial court judge found that Brown failed to meet the criteria of failure to care for herself.

> The court further assessed Ms. Brown's ability to meet her basic physical needs of food, clothing, and shelter. Her need for food was satisfied by her begging for money and then buying one meal a day. While admitting that Ms. Brown lived on the street "barefooted and dressed in filthy, tattered, foul-smelling clothes," this met the basic requirement for clothes. "The legal question before me is whether Joyce Brown is mentally capable of providing herself with clothes; the question is not whether she is financially able to do so." Yet the court failed to realize that if Ms. Brown didn't tear up all paper money, she could probably afford clean, non-tattered, fresh smelling clothes. The court completely ignored the effect of her mental illness on her choice of attire.
>
> For shelter, Ms. Brown had kept "warm by lying next to an air vent that releases hot air 24 hours a day. The street is her bedroom, her toilet, her living room." Once again, the court blamed society for creating a need for Ms. Brown to reject all other options and reside next to a heating vent. Without referring to any supporting testimony, the court determined that "[h]ousing in New York is an expensive commodity, so expensive that in this rich city many no longer can afford it and are driven to live on the street."

[57] Boggs lived on the city sidewalk in NYC for more than a year where psychiatrists observed her behavior, which included tearing up paper money and being unable to maintain clean living conditions. Boggs was ultimately detained by authorities and stood trial at a civil commitment hearing where various psychiatrists testified to her competency. Joanmarie Ilaria Davoli, *Psychiatric Evidence on Trial*, 56 S.M.U. L. REV. 2191, 2205 (2003).

> There was, however, no such evidence that poverty produced Ms. Brown's homelessness.[58]

The court tragically failed to acknowledge that untreated SMI, not the price of housing, caused the individual's homelessness.[59]

While the appellate court reversed this flawed reasoning and ordered treatment, the case made Ms. Brown a heroine of the same civil liberties groups and individuals opposing Mayor Adams' current proposal. In contrast to such obstructionism, nearly every administration that came after Mayor Koch and before Mayor Adams has tried to help people with SMI and fix the so-called mental health system.[60]

Thirty-five years ago, Mayor Koch described his experience trying to help the mentally ill.

> The next month, Mayor Koch visited the woman on the street, accompanied by city mental health officials, an experience he later recalled in speeches and in broadcast interviews.
>
> "She lies there all year around, and she defecates in her clothing when she is not lucid, and when she is lucid she defecates on the sidewalk," the Mayor said later in a speech to the American Psychological Association. "I said, 'Isn't she a candidate for institutionalization in some form.' No, they said. I am thinking to myself, you are loony yourself."[61]

Understandably, this copout frustrated Mayor Koch because SMI is usually treatable, so homelessness and misery are not inevitable but preventable.

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[58] Davoli, *supra* note 57, at 2208-09.

[59] *Id.* at 2207.

[60] For a detailed account of an individual mayor's efforts to reform the mental health system, *see* Andy Newman, *35 Years of Efforts to Address Mental Illness on New York Streets,* N.Y. TIMES (Dec. 2, 2022), https://www.nytimes.com/2022/12/02/nyregion/mental-illness-homeless-streets.html [https://perma.cc/9CC3-9HT5].

[61] *Taken Off Streets*, *supra* note 55, at 6.

Thus, since the deinstitutionalization movement of the 1960s and 1970s, a large percentage of the U.S. population struggling with homelessness has untreated SMI. Although effective treatments are now available to address debilitating symptoms of most people with SMI, some portion of the population with SMI needs long-term inpatient treatment. This is because, for some people, available treatments do not adequately address psychosis and other debilitating SMI symptoms. Yet, current laws require providers to honor illness-induced treatment refusals and block intervention that could prevent incarceration, homelessness, victimization, injury, death, and violence. Mayor Adams tackles this Herculean societal problem with his comprehensive proposal analyzed below.

A. Background

In his legislative proposal, Mayor Adams first explains that the need for involuntary treatment, whether inpatient or outpatient, stems from the nature of mental illness itself. He goes on to challenge the "least restrictive alternatives"[62] mantra that has guided psychiatric treatment and contributed to drastic deinstitutionalization.

> Involuntary hospitalization and "assisted outpatient treatment" (court-ordered outpatient care, commonly known as "AOT") are essential components of a functional public mental health system. Many people with psychotic disorders experience anosognosia (lack of insight), a neurological deficit which can leave them unable to recognize their own mental illness symptoms and need for treatment – no matter how apparent these may be to observers. While voluntary care is always preferable, it is not always a realistic expectation when a person in the throes of psychosis does not believe they are ill and/or has

[62] Olmstead v. L.C., 527 U.S. 581, 609 (1999) (Kennedy, J. concurring) ("The 'least restrictive setting' frequently turns out to be a cardboard box, a jail cell, or a terror-filled existence plagued by both real and imaginary enemies").

> delusions that mental health professionals seek to harm rather than help them.[63]

By centering his proposal on the illness-induced treatment refusal phenomena, Mayor Adams casts doubt on the spurious premise that individuals whose mental illnesses induce them to refuse treatment are competently exercising their individual liberties.[64] Instead, such individuals are being tortured by their disease. As a police officer, Mayor Adams learned firsthand that the biggest obstacle to helping people with SMI is their lack of insight about their illness and their need for treatment.[65] Even worse, the disease itself tricks the diseased brain into believing that the individual is not suffering from a mental illness, which causes the individual to refuse treatment. Even critics of the plan admit that patients who refuse treatment are often in denial about their illness.[66]

When addressing issues of mental illness, the Supreme Court has consistently failed to understand this issue of psychosis.[67] The individual is not rationally weighing the pros and cons of treatment and developing a comprehensive treatment plan with a medical care provider. Instead, the individual's illness is controlling his brain, tricking the individual into denying the diagnosis.

Civil liberties rulings and laws continue to treat an afflicted individual as someone who might be making a rational choice. Instead, the delusions caused by the disease control the treatment refusal.

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[63] OFF. OF MAYOR OF NEW YORK, MAYOR ADAMS' PSYCHIATRIC CRISIS CARE LEGISLATIVE AGENDA 3 (2022) [hereinafter PSYCHIATRIC CRISIS LEGISLATIVE AGENDA].

[64] *See* Bergner, *supra* note 12.

[65] ROSENBERG, *infra* note 116, at 72 ("The experience of not knowing you are psychotic is part and parcel of SMI . . . . not knowing you're psychotic has epic consequences from inhibiting patients' cooperation with treatment to leading them to barrel full-steam ahead on irrational . . . .").

[66] Arvind Sooknanan, *Forced Treatment for Mental Illness is No Treatment At All*, SLATE (Dec. 16, 2022, 9:00 AM), https://slate.com/technology/2022/12/new-york-eric-adams-forced-hospitalization.html [https://perma.cc/483W-BAU7] (noting, from the perspective of someone with schizoaffective disorder that "[f]rom my experience, the key to anyone's recovery, regardless of their illness, is the acceptance and willingness to seek treatment.").

[67] Davoli, *supra* note 25, at 1015.

> The New York laws that facilitate treatment in these circumstances have numerous flaws and gaps, adding mightily to the City's challenges in meeting the needs of its most vulnerable residents with severe mental illness. Mayor Adams' Psychiatric Crisis Care Legislative Agenda takes aim at 11 legal barriers to psychiatric crisis care and crisis avoidance: five that prevent the timely and effective provision of hospital care, five that prevent the use of AOT with individuals stuck in the mental health system's revolving door, and one that prevents coordination of care between inpatient and outpatient providers when patients shuttle between hospitals and the community.
>
> It must be stressed that the Legislative Agenda is not intended as a cure-all to the full range of challenges facing the City's mental health system. Not all of the conspicuous holes in our safety net lend themselves to legislative patches. Some must be mended through additional investment of resources, solutions to persistent staffing challenges, and other policy reforms.
>
> As the Adams Administration continues to pursue a bold mental health reform agenda, we need our partners in Albany to pitch in with these 11 essential fixes to the state's Mental Hygiene Law. Eliminating the barriers identified below would pay immediate dividends in improved care and would enable our Administration to devote all energies to building a robust network of mental health services and supports to meet all levels of need.[68]

In this portion of his Background section, Mayor Adams offers a holistic approach to both the current problem as well as his proposed solutions. Mayor Adams demonstrates that Supreme Court decisions, federal laws, narrow interpretations of rules, and other legal barriers stand in the way of addressing this national crisis. After laying the foundation demonstrating that current rules, laws, and practices are failing to assist individuals with mental illness, Mayor Adams lists eleven (11) barriers to treatment and suggests legislative actions that should be taken to remove these barriers. Mayor Adams first addresses six (6) barriers to

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[68] PSYCHIATRIC CRISIS LEGISLATIVE AGENDA, *supra* note 63.

hospitalization and care coordination before addressing barriers to outpatient treatment.[69] Below this Article directly quotes each portion of Mayor Adams legislative proposal and then analyzes that portion. To aid the reader in identifying which segments of the article are the Adams proposal language, this Article indents the Mayor's administration proposal.

B. Barriers to Hospitalization and Care Coordination:

> **BARRIER #1:** New York's legal standard for involuntary hospitalization (mental illness "likely to result in serious harm" to self or others) is often interpreted too narrowly, denying desperately needed treatment to those who are not demonstrably violent or suicidal or engaging in blatantly dangerous conduct.
>
> When a person is experiencing psychosis and refusing care, the key determination under New York law in assessing their need for involuntary hospitalization is whether their mental illness is "likely to result in serious harm" to the person or others. This is the applicable standard in a wide range of circumstances: a mobile crisis outreach team or police officer deciding whether the person should be removed from the community and taken to an ER or CPEP; an ER physician deciding whether the person should be admitted to the hospital's inpatient psych unit; an inpatient psychiatrist deciding whether the person should be held in the unit or discharged; a judge deciding whether the person challenging their inpatient detention should be placed under civil commitment; et al.
>
> But the law provides scant guidance as to what constitutes the "serious harm" that must be found likely to result. An all-too-common interpretation is that a person must demonstrate a risk of violence, suicide or grievous bodily harm. This excludes many mentally ill individuals whose risk of "serious harm" is less overt but no less real. More specifically, a narrow interpretation of the "serious harm" standard denies care to:

[69] *See infra* Part II.C.

> - Those whose mental illness prevents them from meeting their basic survival needs of food, clothing, shelter or medical care.
>
> - Those unable to recognize their urgent need for treatment, placing them at serious risk of psychiatric deterioration. (Research tells us that in a psychiatric crisis, time is of the essence: the shorter the duration of untreated psychosis, the greater the person's prospects for recovery. Some studies have linked extended periods of untreated psychosis to physical brain damage.)
>
> There should be no question that people in these categories – even if not threatening violence or suicide or walking into traffic — are at risk of "serious harm" to themselves, in ways they would surely wish to avoid if their minds were functioning properly. But in New York, such individuals are routinely denied care by evaluators who interpret the law to require a demonstrated risk of violence, suicide or serious bodily injury.
>
> **SOLUTION:** Add language to the legal definition of "likely to result in serious harm," making it explicit and beyond debate that when untreated mental illness leaves a person unable to meet their basic survival needs and/or helpless to avoid psychiatric deterioration, involuntary hospital care is warranted.[70]

The solution of clarifying or broadening the definition for treatment criteria is a brave pushback against years of activists' arguing that mentally ill individuals suffering from psychosis are nonetheless able to make competent medical decisions.[71] The Mayor's proposal to broaden the language to include inability to care for self was met with immediate backlash. Civil liberties advocates have argued for years that a person who lacks personal

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[70] PSYCHIATRIC CRISIS LEGISLATIVE AGENDA, *supra* note 63, at 4.

[71] Such rhetoric has even swayed the Supreme Court. *See* Davoli, *supra* note 25, at 1002 ("In so holding, the Court (in Zinermon v. Burch, 494 U.S. 113, 131 (1990)) essentially decided that [the mentally ill patient] was too incompetent to volunteer for psychiatric treatment but was probably not sick enough to be involuntarily treated because he was harmless.").

hygiene, even for long periods of time, and is actively hallucinating nonetheless fails to meet the standard of being unable to care for himself.[72] Joined by other activists, the former head of the New York Civil Liberties Union and co-founder of a volunteer outreach program objected to the legality of the Mayor's plans.[73]

United States Supreme Court decisions underlie such objections. In 1975, the Court held that "a State cannot constitutionally confine, without more, a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends."[74] In subsequent years, lower courts have scrupulously upheld the first part of the holding, while seemingly ignoring the qualifiers that follow.

Thus, courts are hesitant to order involuntary psychiatric treatment for an individual unless that person is dangerous.[75] In complete disregard for common sense, civil commitment hearings typically find that a homeless person suffering from psychosis does not meet the treatment criteria because the person is not dangerous and that the person isn't starving, indicating that basic needs are met.[76] Such narrow interpretations have abandoned those suffering from mental illness to streets, prisons and the morgue.

Additionally, the standard for administering emergency treatment is not based on medical science[77] and the O'Connor decision questions the very existence of mental illness. "A finding of 'mental illness' alone cannot justify a State's locking a person up against his will and keeping him indefinitely in simple custodial

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[72] MENTAL HEALTH AMERICA, RIGHTS AND PRIVACY ISSUES: POSITION STATEMENT 22: INVOLUNTARY MENTAL HEALTH TREATMENT (2022) (specifically rejecting the National Alliance on Mental Illness for a "weaker" standard for involuntary commitment, which includes commitment for grave disability and inability to provide for basic needs and lack of capacity).

[73] Bushard, *supra* note 42.

[74] O'Connor v. Donaldson, 422 U.S. 563, 576 (1975).

[75] *See* discussion of Joyce Brown, *supra* notes 57-60 and accompanying text.

[76] *See supra* note 71.

[77] *See generally* Davoli, *supra* note 25, at 990-1002; SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, CIVIL COMMITMENT AND THE MENTAL HEALTH CARE CONTINUUM: HISTORICAL TRENDS AND PRINCIPLES FOR LAW AND PRACTICE 32 (2019) (evaluating the legal and medical framework for civil commitment hearings and recommending commitments based on an expansive view of risk for imminent harm, which is not limited to a risk of violent behavior, and includes inability to care for oneself).

confinement. Assuming that that term can be given a reasonably precise content and that the 'mentally ill' can be identified with reasonable accuracy...."[78] Perhaps originating with the Court's skepticism about mental illness, the commitment standard is not based on medical reality or therapeutic efficacy.

Instead, adhering to strict involuntary treatment rules seemed mired in an outdated notion that adhering to illness-induced treatment refusals in the midst of a mental health crisis somehow protects the person's civil liberties.[79] The proposed solution acknowledges that applying strict standards to protect "civil liberties" ignores the reality of mental illness and abandons people with mental illness, further victimizing them.[80] Additionally, the language itself needs to be abandoned and reframed based on a medical standard, instead of the current standard that suspiciously claims giving life-saving treatment to a person in mental health crisis is a deprivation of liberty.

Finally, Mayor Adams correctly recognizes the trajectory of serious mental illnesses. Time is of the essence. Effective treatment should begin as soon as possible to stop the furtherance of the disease. A brain left bathing in psychosis deteriorates and is damaged, as each subsequent psychotic event tends to become more intense and debilitating.[81] The recognition that earlier treatment prevents worse outcomes should inform any interpretation of civil commitment criteria.

> **BARRIER #2:** Hospital evaluations of whether a person's mental illness remains "likely to result in serious harm" are often based solely on how the individual presents in that moment, ignoring the broader context in which their current behavior must be understood and the risks of non-imminent serious harm.

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[78] O'Connor, 422 U.S. at 575.

[79] Davoli, *supra* note 25, at 1002-07.

[80] *Id.* at 1003 ("This all encompassing, yet unsupported conclusion had a significant impact in reducing involuntary psychiatric treatment for the mentally ill and has resulted in a large population of the mentally ill remaining untreated and abandoned to the jails and streets.").

[81] Mario Álvarez-Jiménez et al., *Preventing the Second Episode: A Systematic Review and Meta-Analysis of Psychosocial and Pharmacological Trials in First-Episode Psychosis*, 37 SCHIZOPHRENIA BULLETIN 619, 619 (2009).

Community outreach teams, shelter staff and families all report as a common frustration that even when they are successful in having a person in psychiatric crisis removed to a hospital, the person is frequently "streeted" within hours or a day or two. This is simply not a long enough period of hospitalization to fully stabilize a person with a psychotic disorder and prepare them to succeed in a community placement. Of course, if the person is unwilling to accept a voluntary admission, hospital staff cannot retain them without finding that their mental illness remains "likely to result in serious harm."

Compounding the problem of an overly narrow interpretation of "serious harm" (discussed above) is the tendency of many inpatient psychiatrists to evaluate the person's condition solely on the basis of how the person presents at the moment of evaluation, and to only consider the risk of imminent harm. A patient's symptoms may be tenuously controlled by the medication provided in the hospital such that they are no longer exhibiting the alarming behavior that led to their removal and do not appear at risk of causing or suffering harm imminently. But this does not mean the person is ready for discharge. A thorough evaluation of their condition must also take account of the available information about their recent behavior in the community, their treatment history, their readiness to adhere to the outpatient treatment they will require to avoid a quick relapse, and the risk that they will inflict serious harm upon themselves gradually over time. Mobile crisis outreach teams and shelter staff, who tend to be much more intimately familiar with the individual than the hospital doctor, are typically eager to share such information for use in evaluation. But too often such information and insight is disregarded in the hospital as irrelevant to the task of evaluating the person under the law.

SOLUTION: Require a clinician evaluating the person's need for hospitalization to take account of all relevant and credible information presented to them, as well as the

> patient's current ability to adhere to essential outpatient treatment and their risk of suffering harm over time.[82]

With this proposed solution, Mayor Adams addresses the revolving door phenomena of mental health care. As noted in his background section, individuals suffering from SMI are prone to refuse therapeutic treatment as a result of their illness. Known as illness-induced treatment refusals, the patient's illness controls the patient's decision to deny any diagnosis and refuse medication and therapy. The illness tricks a patient into believing that the patient is perfectly fine.

Thus, stabilizing a patient for a day or two and then releasing is not therapeutically or medically based. As these hospitals are often not long-term psychiatric care facilities, they are instead focusing on acute care: whether or not the patient is currently in crisis.[83] Thus, three days of emergency intervention will only briefly calm a mental health crisis but will not stabilize the person. After three days of intervention, the patient may no longer technically pose an imminent threat of serious bodily harm to self or others. But the patient will not be stabilized. After hospital discharge, due to the SMI phenomena of anosognosia, the unstable patient will fail to recognize that they are sick and need treatment, stop taking their medication, and reenter crisis. This is the revolving door of the broken mental health crisis intervention system.

Similarly, three days of emergency intervention is inadequate to allow a healthcare professional to fully evaluate, properly diagnose, and stabilize a person with SMI in crisis who has arrived at a facility pursuant to the New York Mental Hygiene Law. Instead, the hospital should be performing a competent, thorough evaluation of the patient which would include gathering

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[82] PSYCHIATRIC CRISIS LEGISLATIVE AGENDA, *supra* note 63, at 5.

[83] Author's Note: Resolving the crisis without thoroughly evaluating the patient is similar to slapping a band aid on someone who is bleeding without examining the source of the blood. The band aid might be enough, because perhaps the bleeding will stop, and the person will heal. But if the bleeding is caused by an internal injury, the band aid has temporarily covered the symptom without treating the underlying, serious medical condition.

information from other sources including family members.[84] State involuntary mental health treatment laws should empower providers who receive a patient in crisis to effectively diagnose, treat, and stabilize the patient. Such laws should not mandate providers to discharge within two to three days patients whose mental illnesses induce them to demand discharge and who have not yet been adequately diagnosed, treated, or stabilized.

> **BARRIER #3:** New York law grants authority to perform a clinical evaluation of a person's need for involuntary hospitalization or AOT exclusively to physicians (and in some circumstances specifically to psychiatrists). This prevents the system from making use of other mental health professionals who are equally qualified to perform these evaluations, exacerbates a systemic staffing shortage, and diverts physicians' time from patient care.
>
> There is nothing in the training of physicians to make them uniquely qualified to diagnose mental illness and assess whether such mental illness is likely to result in serious harm. Psychologists, psychiatric nurse practitioners and licensed clinical social workers are all adequately trained to perform this function. (In fact, these professionals are more qualified for this role than physicians who are not psychiatrists.) The same is true for determinations of eligibility for AOT.
>
> All of these professionals are authorized to bill Medicaid and Medicare for diagnosing mental illness and making (non-medical) treatment recommendations. That should be

[84] *See Psychiatric Diagnostic Evaluation and Psychotherapy Services*, CTRS. FOR MEDICARE AND & MEDICAID SERVS., https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?LCDId=33252 [https://perma.cc/X4C2-SLWS] (last visited Feb. 11, 2023) ("A psychiatric diagnostic evaluation is an integrated biopsychosocial assessment that includes the elicitation of a complete medical history (to include past, family, and social), psychiatric history, a complete mental status exam, establishment of a tentative diagnosis, and an evaluation of the patient's ability and willingness to participate in the proposed treatment plan. Information may be obtained from the patient, other physicians, other clinicians or community providers, and/or family members or other sources. There may be overlapping of the medical and psychiatric history depending upon the problem(s).").

reason enough to acknowledge their qualification to perform evaluations under the Mental Hygiene law.

SOLUTION: Authorize psychologists, psychiatric nurse practitioners, and licensed clinical social workers to evaluate an individual's need for psychiatric hospitalization or AOT.[85]

By this solution, Mayor Adams moves the conversation into the twenty-first century, where the term "health care provider" has long replaced the term "doctor."[86] As medicine has evolved and health care has changed, laws in other areas have evolved to allow medical professionals other than doctors to offer health care treatment.[87] Once again, this solution is grounded in reality and common sense.

Mayor Adams' proposal retains the expertise required to make such referrals, while recognizing that the group should include all professionals trained to diagnose and treat mental illness. This designation comports with the Supreme Court's approach to the psychotherapist/patient privilege in which the Court extended the privilege to include social workers. The Court noted that "[d]rawing a distinction between the counseling provided by costly psychotherapists and the counseling provided by more readily accessible social workers serves no discernible public purpose."[88] By focusing on the training and background of the medical provider, Mayor Adams simply recognizes the reality that patients will be better served by allowing psychologists, psychiatric nurse practitioners and licensed clinical social workers to perform evaluations.

BARRIER #4: The range of mental health professionals authorized to serve as members of mobile crisis outreach teams is too limited, making these essential teams difficult

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[85] PSYCHIATRIC CRISIS LEGISLATIVE AGENDA, *supra* note 63, at 5-6.

[86] *See Your Health Care Team*, UNIV. OF ROCHESTER MED., https://www.urmc.rochester.edu/strong-memorial/patients-families/health-care-team.aspx [https://perma.cc/KGN4-T5YN] (last visited Feb. 11, 2023).

[87] Erin Sarzynski & Henry Barry, *Current Evidence and Controversies: Advanced Practice Providers in Healthcare*, 25 AM. J. MANAGED CARE 366, 366-67 (2019).

[88] Jaffee v. Redmond, 518 U.S. 1, 9 (1996).

> to staff and reducing the number deployed in the City's streets and subways.
>
> The City urgently needs more mobile crisis outreach teams ("MCOTs") to identify individuals in the community with acute mental health needs, engage them in voluntary treatment when possible, and direct their removal to a hospital for evaluation when necessary. The challenge of meeting this demand would be greatly reduced if MCOTs could be assembled from a wider pool of mental health professionals than current law allows. Licensed mental health counselors and licensed marriage and family therapists are fully capable of doing this work but are not included in the current law's definition of "qualified mental health professional," leaving them ineligible to receive MCOT training.
>
> **SOLUTION:** Expand the range of potential MCOT members to include licensed mental health counselors and licensed marriage and family therapists.[89]

Similar to the proposal to remove Barrier #3, this commonsense proposal recognizes that medical care and the various categories of providers have evolved over the past fifty years. There are now a large number of medical professionals trained to interact with individuals suffering from mental illness. This solution modernizes the mobile crisis team while also recognizing that there is an ongoing shortage of medical professionals.[90]

> **BARRIER #5:** New York law does not authorize a mental health professional working in a homeless shelter to direct the removal of a client in psychiatric crisis to a hospital.
>
> Mental health professionals working in homeless shelters frequently encounter clients in psychiatric crisis in need of removal to a hospital. Under current law, shelter staff lack authority to direct removals, leaving them dependent upon police to exercise their own removal authority. Often, the

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[89] PSYCHIATRIC CRISIS LEGISLATIVE AGENDA, *supra* note 63, at 6.

[90] *New AAMC Report Confirms Growing Physician Shortage*, ASS'N OF AM. MED. COLLS. (June 26, 2020), https://www.aamc.org/news-insights/press-releases/new-aamc-report-confirms-growing-physician-shortage [https://perma.cc/ATS7-RYJS].

> opinion of the police officer who arrives on the scene does not align with the training-informed judgment of the shelter staff member who requested the assistance, leaving the shelter unable to effectuate the removal.
>
> **SOLUTION:** Authorize shelters and other adult care facilities to direct hospital removal of a resident in psychiatric crisis, based upon the judgment of a mental health professional on staff.[91]

While this barrier applies to specific New York City procedures, such obstacles for treatment exist throughout the United States. Whatever original purpose this rule served long ago became obsolete. A homeless shelter is not a therapeutic setting. Instead, shelters provide a place to sleep for people with nowhere else to go. If a person needs additional assistance, the mental health professionals on staff will have the best information and be in the best position to make that determination.

Transportation to a treating facility is crucial for an individual in crisis.[92] Mayor Adams brings a common-sense solution to an ongoing issue. Additionally, making the determination that someone is in crisis and needs help sometimes requires time for evaluation. The mental health professionals of the clinic should be allowed to direct the need for removal and treatment of someone staying in that facility. The professionals must care not only for that

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[91] PSYCHIATRIC CRISIS LEGISLATIVE AGENDA, *supra* note 63, at 6.

[92] *See* Judy Ann Clausen & Joanmarie Davoli, *No-one Receives Psychiatric Treatment in a Squad Car*, 54 TEXAS TECH L. REV. 645, 692, 699-701 (2022).

individual, but also for others in the shelter.[93] Thus, they need the authority to provide the best therapeutic option to each individual.

> **BARRIER #6:** New York law requires no communication or coordination of care between inpatient and outpatient providers, causing patients to lose critical connections upon moving between inpatient and outpatient treatment settings.
>
> Community providers serving clients with severe mental illness, such as ACT and IMT teams, face an immense challenge in keeping track of their clients' whereabouts and condition, especially with those who are homeless. This often becomes an impossibility when a client experiences a crisis event and is hospitalized. Current law imposes no duty on hospitals to inform outpatient providers when their clients are admitted or discharged, even when a patient's connection to an outpatient provider is readily available information in PSYCKES, the electronic database shared across the state system. Nor are hospitals required to involve the patient's community-based providers in discharge planning.
>
> Outpatient providers are frequently left to wait helplessly for their clients to re-appear on the scene. Sometimes the person is discharged to a different area of the city and connected to a new outpatient provider, forfeiting the therapeutic value of bonds forged with the former provider.

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[93] *See, e.g.*, Ari Shapiro et al., *Why Some Homeless Choose the Streets Over Shelters*, NPR (Dec. 6, 2012, 1:00 PM), https://www.npr.org/2012/12/06/166666265/why-some-homeless-choose-the-streets-over-shelters [https://perma.cc/27WM-WZC7] ("[Y]ou hear a lot of terrible things about shelters, that shelters are dangerous places, that they're full of drugs and drug dealers, that people will steal your shoes, and there's bedbugs and body lice. And yeah, unfortunately a lot of those things are true."); *Id.* ("I was a shelter director for years. . . [W]e'd make long lists of every barrier there was to those things, and there are so many. They are crowded. On a winter night you can hardly sleep because the hacking is so heavy. The smell . . ."); George Gross, *Homeless Shelters are Dangerous Places*, N.Y. TIMES (Apr. 8, 1985), https://www.nytimes.com/1985/04/08/opinion/l-homeless-shelters-are-dangerous-places-148483.html [https://perma.cc/FZ94-KKZK] ("I am the director of social services of the Hanson Place Men's Shelter in Brooklyn . . . . My colleagues from Hanson Place and many other shelters know that the shelters are dangerous for residents and staff members alike. Assaults, often with deadly weapons, are everyday occurrences.").

> This is not how a mental health system should function. Coordination of handoffs between inpatient and outpatient providers is one of the primary purposes of the PSYCKES system, but has failed to take hold as standard practice.
>
> **SOLUTION:** Require hospitals to make reasonable efforts to identify their psychiatric patients' community providers (i.e., check PSYCKES), inform providers of admission decisions and discharges, and consult providers in the development of discharge plans.[94]

Continuity of care is critical to patient treatment and recovery.[95] This solution acknowledges the enormous problem of care interruption in psychiatric cases which leads to poor and often tragic but preventable outcomes. Lack of continuity of care is a primary reason that the U.S. mental illness treatment system is broken. Continuity of care is the foundation of an effective mental illness treatment system. Applying the best practices of modern medical treatment, continuation and coordination of care is critically important.

While SMI tends to require lifelong therapeutic treatment, not every patient needs long or even short-term hospitalization. Closing the psychiatric hospitals caused the current crisis of the homeless population with a significant percentage suffering from SMI. However, a modern approach needs community-based treatment as well.

Assisted Outpatient Treatment ("AOT") is the practice of providing community-based mental health treatment under civil court commitment, as a means of: (1) motivating an adult with mental illness who struggles with voluntary treatment adherence to engage fully with their treatment plan; and (2) focusing the

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[94] PSYCHIATRIC CRISIS LEGISLATIVE AGENDA, *supra* note 63, at 7.

[95] Carol E. Adair et al., *History and Measurement of Continuity of Care in Mental Health Services and Evidence of Its Role in Outcomes*, 54 PSYCHIATRIC SERVS. 1351, 1351 ("For more than 40 years continuity of care has been considered to be crucial in the management of persons with severe and persistent mental illness."); Mohammed Alazri et al., *Continuity of Care: Literature Review and Implications,* 7 SULTAN QABOOS UNIV. MED. J. 197, 200-01 (finding that even in primary care, continuity of care increased the likelihood of engaging in healthy behaviors, yearly recommended screenings, reduce pre-natal complications, and have better overall mental health).

attention of treatment providers on the need to work diligently to keep the person engaged in effective treatment.[96]

Recognizing the need for additional treatment options, Mayor Adams sets out five (5) barriers to AOT and proposes concrete, innovative solutions.

C. Barriers to AOT

> **BARRIER #7:** Screening of psychiatric hospital patients for AOT eligibility has been inconsistent, leading to missed opportunities to utilize AOT in transitioning at-risk patients back to the community.
>
> The lifeblood of any AOT program is the flow of individuals coming directly off psychiatric hospitalizations who have been flagged as "revolving door" patients based on multiple recent hospitalizations resulting from difficulties adhering to outpatient treatment. When utilized, AOT has been remarkably successful in helping this population remain in the community and avoid repeat hospitalization and arrest. But there is good reason to wonder whether the City's AOT program is connecting with the full cohort of individuals leaving hospitals who meet the legal criteria. The program currently depends on hospitals to make AOT referrals based on their own screening procedures. There has been wide variance among City hospitals, inside and outside the H+H system, in the frequency that such referrals are made, raising concern that a significant number of AOT-eligible patients are being missed.
>
> **SOLUTION:** Make AOT-eligibility screening of psychiatric inpatients a standardized discharge planning practice for hospitals. Require submission to the NYS Office of Mental Health a report on the findings and actions taken on each AOT review.[97]

As Mayor Adams notes, AOT exists and is available, but patients are not screened for eligibility. This proposal follows from

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[96] *What is AOT?*, TREATMENT ADVOC. CTR., https://www.treatmentadvocacycenter.org/aot/what-is-aot [https://perma.cc/XEH2-TUGP] (last visited Feb. 11, 2023).

[97] PSYCHIATRIC CRISIS LEGISLATIVE AGENDA, *supra* note 63, at 8.

the lack of continuity of care noted above in Barrier #6. Since deinstitutionalization began, individuals discharged from the psychiatric hospitals were often left adrift to fend for themselves. Even if discharge plans are made and patients are expected to show up for outpatient appointments, the symptoms of SMI often interfere with the ability to think logically and follow through with appointments and other commitments. Even those who intend to show up for treatment may lack transportation.

AOT bridges the gap between full, inpatient care and complete independence. AOT screening for each patient discharged from a psychiatric hospital will "provide evidence-based treatment services focused on engagement and helping the participant maintain stability and safety in the community."[98] Nationally, family members have shouldered the burden of discharged mentally ill loved ones who do not receive adequate follow-up care.[99] People with SMI without family support have even less hope of recovery.[100] Considering AOT as an aspect of discharge planning would improve patient outcomes.

> **BARRIER #8:** A New York Court of Appeals decision (Miguel M.) requires DOHMH to obtain a person's consent before accessing the medical records it needs to establish AOT eligibility. Individuals who don't want to participate in AOT often withhold consent, making it impossible to collect the necessary evidence to support an AOT petition.
>
> While it is certainly preferable and common for a person to enter the City's AOT program willingly, AOT is an involuntary intervention by design. This is necessary because many of the individuals it seeks to help lack insight (awareness of their own mental illness and need for treatment). If AOT operates as a voluntary program, it forfeits much of its potential to achieve breakthroughs with

[98] *What is AOT*, *supra* note 96.

[99] *See, e.g.*, Privatte, *supra* note 22.

[100] Emily Hielscher et al., *For People with a Mental Illness, Loved Ones Who Care Are as Important as Formal Supports*, THE CONVERSATION (Oct. 16, 2019, 3:03 PM), https://theconversation.com/for-people-with-a-mental-illness-loved-ones-who-care-are-as-important-as-formal-supports-120344 [https://perma.cc/3M99-NQ53] ("Research has shown having a carer [family member or similar] increases the likelihood of follow-up care and better health outcomes in the short and long term.").

treatment-resistant patients by helping them over time to recognize the benefits of treatment engagement.

Regrettably, the New York Court of Appeals' 2011 decision in the Miguel M. case has effectively turned AOT into a voluntary program at the initial stage. The court ruled that when the City is conducting an AOT investigation pursuant to a referral, federal law ("the HIPAA Privacy Rule") does not allow the City to obtain hospital records without the patient's consent. In other words, a person who isn't interested in participating in AOT can simply withhold consent to release of their records and prevent the City from obtaining the evidence it needs to establish that they meet AOT criteria.

For patients coming into AOT directly from hospitals, this usually doesn't present a problem. These patients typically consent to record disclosure because they perceive that AOT will lead to an earlier hospital release. But the Miguel M. ruling has wreaked havoc on the City's ability to investigate AOT referrals for individuals currently residing in the community, including many referrals made just prior to a person's release from Rikers Island. In such cases, the person who doesn't welcome AOT has no incentive to consent to record disclosure. These referrals typically go nowhere.

A solution to this quandary lies in a federal regulation providing an exception to the HIPAA Privacy Rule for disclosures made pursuant to judicial proceedings, so long as the patient receives adequate advance notice of the disclosure request and a fair opportunity to challenge the disclosure in court. This exception was not considered by the court in Miguel M. because New York's AOT law does not include such due process prior to a disclosure of hospital records.

SOLUTION: Require hospitals to share treatment records with City health officials conducting an AOT investigation, but only after the patient has been afforded

> a reasonable opportunity to challenge the disclosure in court.[101]

The federal government created this barrier to treatment. "The Health Insurance Portability and Accountability Act of 1996 (HIPAA)[102] is a federal law that required the creation of national standards to protect sensitive patient health information from being disclosed without the patient's consent or knowledge."[103] Aside from the hypothesis that confidentially promotes patient trust in the healthcare system, nothing in HIPAA appears designed to improve patient care or patient outcomes. Instead, HIPAA focuses on protecting the patient's privacy, not the patient's health.

In SMI cases, effective treatment often requires sharing HIPAA protected information with family members and providers, and thus HIPAA can undermine effective care. Consider the following example. John Doe showed no signs of SMI before moving away for college. In college, eighteen-year-old John Doe experienced his first psychotic episode. With undiagnosed bipolar disorder, he had anosognosia and, thus, did not recognize that he was mentally ill and needed treatment. Eventually, police observed John Doe exhibiting psychotic symptoms and determined John Doe's behavior met the dangerousness criteria for three-day involuntary evaluation.

John Doe arrived psychotic at the receiving facility. After a few nights of sleep and antipsychotic medication, John Doe's mental illness crisis calmed to some extent. Thus, the evaluating physician concluded that, although John Doe remained unstable and manic, John Doe's behavior did not technically meet the strict dangerousness criteria for involuntary retention in the facility for treatment. Suffering from anosognosia from his bipolar disorder, John Doe demanded discharge from the hospital. He could not recognize he was manic and needed treatment. Suffering from bipolar disorder induced delusions, John Doe was paranoid about

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[101] PSYCHIATRIC CRISIS LEGISLATIVE AGENDA, *supra* note 63, at 8-9.

[102] Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. §§ 1301-1320d-6.

[103] *Health Insurance Portability and Accountability Act of 1996*, CDC, https://www.cdc.gov/phlp/publications/topic/hipaa.html#:~:text=The%20Health%20Insurance%20Portability%20and,the%20patient%27s%20consent%20or%20knowledge'[https://perma.cc/634Y-4KHY] (last visited Feb. 11, 2023).

his family and forbade doctors from releasing his health information to anyone. Yet at least one family member needed this information to help John Doe regain stability after his hospital discharge. Someone who received him after discharge needed to know his prescription, diagnosis, what to look for to identify if he was returning to psychosis, and how frequently he needed to take his medication. But HIPAA blocked this information flow and, thus, undermined effective treatment.

Medical professionals take HIPAA extremely seriously, especially in the area of psychiatry.[104] There are both civil and criminal penalties for violations. As an example, a tier one violation of HIPAA, the least serious level, is defined as "A violation that the covered entity was unaware of and could not have realistically avoided, had a reasonable amount of care been taken to abide by HIPAA Rules."[105] The civil penalty for a Tier 1 violation ranges from a fine of $100 up to $50,000.[106] Additionally, the criminal penalty for a Tier 1 violation is up to one year in jail. Tier 4 violations, the most severe level, include financial penalties of $50,000 per violation and ten years in jail.[107] Such an incredibly punitive system has understandably created an intense fear of sharing information as mere negligence can result in jail sentences of the medical professional.[108]

Whether patient privacy has been improved by HIPAA is beyond the focus of this Article. However, as evidenced by the example above, HIPAA can obstruct the continuity of psychiatric care. As explained in Barrier #1, individuals suffering from SMI are

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[104] Doctors' adherence to confidentiality precedes HIPAA by generations and is enshrined in the Hippocratic Oath. *See AMA Declaration of Professional Responsibility*, AM. MED. ASS'N, https://www.ama-assn.org/delivering-care/public-health/ama-declaration-professional-responsibility [https://perma.cc/4QFM-M2F7] (last visited Feb. 13, 2023) ("We, the members of the world community of physicians, solemnly commit ourselves to: . . . Protect the privacy and confidentiality of those for whom we care and breach that confidence only when keeping it would seriously threaten their health and safety or that of others.").

[105] *What Are the Penalties for HIPAA Violations*, HIPAA J. (Jan. 1, 2023), https://www.hipaajournal.com/what-are-the-penalties-for-hipaa-violations-7096/ [https://perma.cc/Y277-DGJN].

[106] *Id.*

[107] *Id.*

[108] For fines imposed *see Chiropractic HIPAA Compliance: Tales from the Dark Side*, CHIROPRACTIC ECON. (Sept. 7, 2022), https://www.chiroeco.com/chiropractic-hipaa-compliance/ [https://perma.cc/4ULX-A2XF].

often unaware of their illness and thus refuse treatment. Along with refusing treatment, such patients also tend to refuse the consent necessary to share information about their psychiatric history. Constrained by fear of HIPAA, psychiatric caretakers are prevented from aiding the very patients who critically need to have their medical information shared with someone who can help.

Additionally, HIPAA imposed extraordinary restrictions on information gathered during treatment specific to psychiatric patients. Psychotherapy notes receive special protections above and beyond the protections provided to other medical records.[109] The U.S. Department of Health & Human Services (HHS) explains that:

> The Privacy Rule defines psychotherapy notes as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of a conversation during a private counseling session or a group, joint, or family counseling session and that are separate from the rest of the patient's medical record.[110]

HHS claims that such psychotherapy notes are irrelevant for diagnosis or treatment but provides no rationale for this counterintuitive claim.[111] Instead, HHS states:

> Psychotherapy notes do not include any information about medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, or results of clinical

[109] These protections are enshrined at 45 C.F.R. §164.508(a)(2) (2023). For a summary of those protections, *see Does HIPAA Provide Extra Protections for Mental Health Information Compared with Other Health Information?,* U.S. HEALTH HUMAN SERVS., https://www.hhs.gov/hipaa/for-professionals/faq/2088/does-hipaa-provide-extra-protections-mental-health-information-compared-other-health.html [https://perma.cc/A73W-VC24] (last visited Feb. 11, 2023) [hereinafter *Extra Protections*] ("Psychotherapy notes are treated differently from other mental health information both because they contain particularly sensitive information and because they are the personal notes of the therapist that typically are not required or useful for treatment, payment, or health care operations purposes, other than by the mental health professional who created the notes. Therefore, with few exceptions, the Privacy Rule requires a covered entity to obtain a patient's authorization prior to a disclosure of psychotherapy notes for any reason, including a disclosure for treatment purposes to a health care provider other than the originator of the notes.").

[110] *Id.*

[111] *Id.*

> tests; nor do they include summaries of diagnosis, functional status, treatment plan, symptoms, prognosis, and progress to date. Psychotherapy notes also do not include any information that is maintained in a patient's medical record.[112]

Psychotherapy notes might reveal a patient's delusions, suicidal ideation, and auditory and visual hallucinations, all symptoms of SMI.[113] Thus, access to psychotherapy notes could help diagnose and treat SMI. Plus, psychotherapy notes might contain patient reports about which medications and dosages effectively treat illness symptoms and which produce side-effects, and such information is necessary for the continuity of psychiatric care. By treating psychotherapy notes as extraordinarily private, HIPAA stigmatizes mental illness because such exceptional treatment implies that mental illness symptoms are somehow more shameful and embarrassing that physical illness symptoms.

As Mayor Adams recognizes, there are exceptions allowing access to psychotherapy notes, such as a mental illness crisis. A notable exception exists for disclosures required by other law, such as for mandatory reporting of abuse, and mandatory "duty to warn" situations regarding threats of serious and imminent harm made by the patient (State laws vary as to whether such a warning is mandatory or permissible).[114] HHS indicates that state laws, such as that proposed by Mayor Adams, can allow access to records in emergency situations. However, New York courts have narrowly construed HIPAA exceptions.

Mayor Adams specifically references the 2011 case of *In re Miguel M.*[115] and its ruling that prevents lower courts from

[112] *Extra Protections*, *supra* note 109.

[113] Stephanie O. Corley, *Protection for Psychotherapy Notes Under the HIPAA Privacy Rule: As Private as a Hospital Gown*, 22 HEALTH MATRIX 489, 497-98 (2013) (noting the importance of record keeping for provider transition); *supra* note 95 and accompanying text.

[114] OFF. FOR CIV. RTS., HEALTH & HUMAN SERVS., HIPAA PRIVACY RULE AND SHARING INFORMATION RELATED TO MENTAL HEALTH 2, https://www.hhs.gov/sites/default/files/hipaa-privacy-rule-and-sharing-info-related-to-mental-health.pdf [https://perma.cc/SZF9-F6VG] (last visited Feb. 13, 2023).

[115] PSYCHIATRIC CRISIS LEGISLATIVE AGENDA, *supra* note 63, at 8-9; *see generally In re Miguel M.*, 882 N.Y.S.2d 698, 703 (N.Y. 2009) *reversed In re Miguel M.*, 17 N.Y.S.3d 37, 40 (N.Y. App. Div. 2011).

obtaining patient records during a petition for AOT. The trial court allowed the doctor access to the records to determine if the patient required AOT under the NY AOT statute of Kendra's Law.[116] The appellate court affirmed the ruling and allowed access. However, the highest court in New York reversed the decision, holding:

> We hold that the Privacy Rule adopted by the federal government pursuant to the Health Insurance Portability and Accountability Act ("HIPAA") prohibits the disclosure of a patient's medical records to a state agency that requests them for use in a proceeding to compel the patient to accept mental health treatment, where the patient has neither authorized the disclosure nor received notice of the agency's request for the records.[117]

The court almost refused to acknowledge that the notice requirement might interfere with the AOT:

> We emphasize that it is far from our purpose to make the enforcement of Kendra's Law difficult. It may often be possible to avoid all disclosure problems by getting the patient to authorize the disclosure in advance; surely many mentally ill people will, while they are under proper care, recognize that disclosure is very much in their own interest. When there is no advance authorization, patients who are given notice that their records are being sought often may not object; when they do object, their objections

[116] Kendra's Law permits courts to order assisted outpatient treatment for mentally ill individuals who would otherwise refuse treatment, in order to prevent relapses or deteriorations that could likely result in serious harm to themselves or others. N.Y. MENTAL HYGIENE LAW § 9.60 (Consol. 2023). The law was originally drafted in 1999 after a young woman, Kendra Webdale, was pushed in front of a subway train and was killed on impact by a mentally ill individual who had been in and out of treatment centers for more than a decade. In response to the media coverage that ensued, New York's Attorney General reviewed the health care laws and proposed Kendra's Law in an attempt to ensure continuity of care. After several critics came forward pointing out the flaws in the law, Edgar Rivera was pushed into a subway train by another mentally ill individual. Rivera survived and became a fierce advocate of Kendra's Law, which ensured its enactment. Nicholas Tantillo, *The Story Behind Kendra's Law*, WAMC NORTHEAST PUB. RADIO (May 21, 2017, 12:33 PM), https://www.wamc.org/wamc-news/2017-05-21/the-story-behind-kendras-law [https://perma.cc/RH74-23JK]; *See also* KENNETH PAUL ROSENBERG, BEDLAM: AN INTIMATE JOURNEY INTO AMERICA'S MENTAL HEALTH CRISIS 93 (2019).

[117] *In re Miguel M.*, 17 N.Y.3d 37, 40 (N.Y. App. Div. 2011).

> may often be overruled. We hold only that unauthorized disclosure without notice is, under circumstances like those present here, inconsistent with the Privacy Rule.[118]

Mayor Adams correctly recognized that this New York court ruling potentially harms patients with SMI by allowing the patient's lack of insight into their illness to prevent information disclosures that are "very much in their own interest."[119]

Thus, New York courts have construed HIPAA and similar state privacy laws to "stand in the way of coordinated treatment of persons with mental illness."[120] These are real fears because of HIPAA's punitive civil and criminal penalties. Fear of these penalties has universally resulted in training medical professionals across the country to default to tightly controlling patient information.[121] Such training discourages cooperation that is in the patient's best medical interests and disrupts continuity of psychiatric care for patients experiencing illness-induced treatment refusals.

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[118] *In re Miguel M.*, 17 N.Y.3d at 44.

[119] *See id.* In its opinion, the court stated that:

> We assume it is correct that, in a criminal case, a HIPAA or Privacy Rule violation does not always require the suppression of evidence.... It is one thing to allow the use of evidence resulting from an improper disclosure of information in medical records to prove that a patient has committed a crime; it is another to use the records themselves, or their contents, in a proceeding to subject to unwanted medical treatment a patient who is not accused of any wrongdoing. Using the records in that way directly impairs, without adequate justification, the interest protected by HIPAA and the Privacy Rule: the interest in keeping one's own medical condition private. We therefore hold that medical records obtained in violation of HIPAA or the Privacy Rule, and the information contained in those records, are not admissible in a proceeding to compel AOT.

Id. at 45.

[120] COMM. ON CROSSING THE QUALITY CHASM, INST. OF MED. OF THE NAT'L ACADS., IMPROVING THE QUALITY OF HEALTH CARE FOR MENTAL AND SUBSTANCE-USE CONDITIONS, app. B (2006) (noting that HIPAA and similar state level privacy laws often combine, and "in many cases stand in the way of coordinated treatment of persons with mental illness. This is an issue that the Department of Health and Human Services should consider in any revision of the HIPAA privacy regulations.").

[121] *See generally* Dana Taylor, *Special Protections and FAQ for Therapy Notes*, MAGMUTUAL, https://www.magmutual.com/learning/article/special-protections-and-frequently-asked-questions-therapy-notes/ [https://perma.cc/YB5T-NA9M] (last visited Feb. 13, 2023).

> **BARRIER #9:** Although DOHMH routinely seeks AOT court orders for a term of one year as the law allows, many judges prefer to impose shorter terms. This defies research showing that shorter periods of AOT are less effective in helping patients develop sustainable habits of treatment engagement.
>
> The original Kendra's Law in 1999 limited the maximum term of an AOT order to six months. In the New York SAFE Act of 2013, the potential order length was increased to one year, in recognition of a striking research finding that a year after graduation from the program, patients who had spent longer than six months under AOT (through renewed court orders) had generally remained successful in avoiding hospitalization and arrest, even if they had not continued under intensive case management, while those who had spent six months or less under AOT needed continued intensive case management to avoid regression. The legislative intent behind the 2013 amendment was to make one year the "default setting" for a period of AOT. It is therefore troubling that some judges have shown a consistent preference for shorter AOT periods, defying DOHMH's standard requests for year-long court orders.
>
> **SOLUTION:** Amend language on the length of an AOT order, from "not to exceed one year" to one year by default, provided that the court may shorten the order period upon a showing of good cause or the petitioner's request.[122]

Mayor Adams highlights the disconnect between laws ordering psychiatric treatment and current medical knowledge. An AOT hearing is not a criminal trial. The term of treatment is not a criminal sentence.[123] Giving a patient less treatment time does nothing to protect civil liberties. The time limitation encourages courts to treat a commitment as a punishment instead of a therapeutic option.

Instead, courts should consider the best interests of the patient. Therapeutic decisions should control the amount of time needed for treatment, including the past history of the patient,

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122 PSYCHIATRIC CRISIS LEGISLATIVE AGENDA, *supra* note 63, at 9.

123 Davoli, *supra* note 25, at 1002-04.

treatment compliance, success of treatment, and other factors that focus on helping the patient manage the SMI. Restricting the length of an AOT order when such time restriction ignores the patient's therapeutic needs undermines effective psychiatric treatment.

> **BARRIER #10:** Hospital psychiatrists are disincentivized from filing AOT petitions by the burden of having to take time away from their hospital duties to testify in person at court hearings.
>
> One of the major disincentives for hospital psychiatrists to seek AOT for their discharged patients is the burden an AOT petition places upon the psychiatrist to take time away from their hospital duties and spend at least a half-day (unbillable) traveling to court, waiting for the case to be called, and providing a few minutes of testimony at the hearing. Advances in technology since the enactment of Kendra's Law should obviate the need for a clinician to make this commitment of time and effort.
>
> Under a 2022 amendment to the AOT statute, the court is authorized to permit video testimony upon a finding of the psychiatrist's diligent efforts to appear in person or for good cause shown. But these options do not advance the goal of encouraging AOT referrals from doctors who would rather not make "diligent efforts" to appear and who could not be confident in advance that the court would find "good cause" for video testimony.
>
> While some maintain that the Sixth Amendment establishes a respondent's right to have adverse testimony presented in person, this should be not be a concern if the potential AOT patient consents to remote testimony. Most AOT petitions are uncontested, so it is reasonable to assume that many patients would willingly waive this right. Establishing this as an option would encourage AOT referrals when a hospital psychiatrist has discussed AOT with their patient and knows that the patient is willing to participate in the program and will not contest the petition.

> **SOLUTION:** Amend the AOT law to allow clinical testimony by video link in any case where the respondent is willing to waive their right to live testimony.[124]

Hospital psychiatrists should not be required to appear in person for civil commitment hearings. Similar to setting arbitrary time limits on psychiatric treatment plans, requiring in person testimony confuses a civil commitment hearing with a criminal trial. The Sixth Amendment of the United States Constitution includes the right to confront the witnesses against a criminal defendant.[125] However, a civil commitment hearing is not a criminal trial, and a patient is not a criminal defendant. Concerns about expertise, credibility and sincerity can likely be addressed through cross-examination even when the witness testifies from another location. Additionally, there are exceptions to the requirement for in person testimony even in criminal trials.[126]

Additionally, the Covid pandemic has moved everything from court hearings[127] to medical diagnosis and treatment[128] online.

[124] PSYCHIATRIC CRISIS LEGISLATIVE AGENDA, *supra* note 63, at 9-10.

[125] *See* U.S. CONST. amend. VI.

[126] Such exceptions are narrow and rare, but nonetheless exist. *See* Maryland v. Craig, 497 U.S. 836, 850 (1990) ("[A] defendant's right to confront accusatory witnesses may be satisfied absent physical face-to-face confrontation" but "only where denial of such confrontation is necessary to further an important public policy….").

[127] The Coronavirus Economic Stabilization Act, 15 U.S.C. § 116, specifically delegated authority to the Judicial Conference to authorize the holding of even certain criminal hearings online. Just two days after the enactment of the bill, the Judicial Conference enacted that authorization broadly. Willie J. Epps Jr. & Cailynn D. Hayter, *Zoomed in to Justice: Remote Proceedings During a Pandemic*, 60 JUDGES J. 10 (2021) *reprinted at* AM. BAR ASS'N, https://www.americanbar.org/groups/gpsolo/publications/gpsolo_ereport/2021/november-2021/zoomed-to-justice-remote-proceedings-during-pandemic/ [https://perma.cc/8CSM-2RBJ] (Nov. 22, 2021) ("Following the implementation of these orders, federal trial courts almost immediately began using video teleconferencing systems to conduct court hearings virtually. All 13 federal courts of appeals also implemented live streaming of their oral arguments. And even the Supreme Court of the United States broke from its traditional practice and allowed audio broadcast of its May 2020 oral arguments, which were conducted over the phone.").

[128] *See generally Telehealth Policy Updates*, HEALTH AND HUM. SERVS., https://telehealth.hhs.gov/providers/telehealth-policy/telehealth-policy-updates [https://perma.cc/97LM-7BQG] (last visited Feb. 12, 2023) (describing generally the capability and commonplaceness of telehealth medicine in the wake of the pandemic).

Virtual meetings are now commonplace in business,[129] and the overwhelming majority of students attended school online during the pandemic.[130] Allowing hospital psychiatrists to testify remotely would not interfere with the rights of the patient as long as the testimony were live during the hearing and cross-examination was available.

> **BARRIER #11:** The provision of the AOT law allowing recent graduates to return to the program upon signs of regression is difficult to utilize.
>
> A 2022 amendment established a new procedure to obtain an AOT order for a person who was discharged from AOT within the last six months and appears to be regressing. Such person may no longer qualify for AOT under the standard eligibility criteria, if they have not been newly hospitalized, arrested or violent, and the previous such incidents which qualified them for AOT previously are now too far in the past to satisfy the statute. But ambiguity and complexity in the new language make it difficult for the City to make use of the new "return to-AOT" option, and to date no such petitions have been attempted.
>
> **SOLUTION:** Simplify the path for a recent AOT graduate to return to the program. Allow such a return upon a showing of a substantial increase in mental illness symptoms which interferes with the person's ability to maintain their health or safety.[131]

This solution recognizes the medical reality of mental illness. Generally, people can manage SMI symptoms with medication and

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[129] Claire Ballentine & Allison McNeely, *Employees Are Returning to the Office, Just to Sit on Zoom Calls*, BLOOMBERG (Apr. 1, 2022, 12:01 PM), https://www.bloomberg.com/news/articles/2022-04-01/employees-are-returning-to-office-post-covid-just-to-sit-on-zoom-calls [https://perma.cc/BM8G-J6NG].

[130] Kevin McElrath, *Nearly 93% of Households With School-Age Children Report Some Form of Distance Learning During COVID-19*, U.S. CENSUS BUREAU (Aug. 26, 2020), https://www.census.gov/library/stories/2020/08/schooling-during-the-covid-19-pandemic.html [https://perma.cc/Z6MX-5X2Z].

[131] PSYCHIATRIC CRISIS LEGISLATIVE AGENDA, *supra* note 63, at 10.

therapy to improve functioning and restore capacity.[132] Typically, there is no cure for SMI.[133] Rather, patients and providers partner to manage SMI symptoms. The trajectory of SMIs is more similar to diabetes than to a broken arm.[134] A diagnosis of SMI is a lifelong, chronic condition for most patients and should be treated as such, not just medically but also legally. Recognizing that SMI often disrupts a person's ability to recognize they are sick and need treatment, the legal framework for responding to SMI crisis situations should abandon utopian principles that have thwarted efforts to ease the suffering of people with SMI.

Thus, in reviewing the eleven (11) Barriers to Treatment and the proposed solutions, it is clear that Mayor Adams has developed a humane, comprehensive, sensitive legislative agenda that targets specific issues in New York City that have national consequences. If implemented, these solutions would significantly improve the lives of both people with SMI and the broader society. Mayor Adams' bold approach proposes to remove barriers to effective mental health treatment. However, no plan is perfect, so Part III suggests ways to strengthen Mayor Adams' proposal while empowering people with SMI.

III. IMPROVEMENTS TO THE NEW YORK CITY MAYOR'S STRATEGY TO HELP PEOPLE WITH SERIOUS MENTAL ILLNESS.

Below are recommendations to strengthen the New York City Mayor's strategy to help people with SMI and the public. Experts estimate that 4% of the US population has a SMI, and an additional

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[132] *See Mental Illness: Diagnosis & Treatment*, MAYO CLINIC, https://www.mayoclinic.org/diseases-conditions/mental-illness/diagnosis-treatment/drc-20374974 [https://perma.cc/7N2G-765X] (last visited Feb. 1, 2024).

[133] TORREY, *infra* note 209, at 146 ("[A]ntipsychotic medications help to control psychotic symptoms but do not cure the disease."); Larry Davidson & Katherine Ponte, *Serious Mental Illness Recovery: The Basics*, NAT'L ALL. ON MENTAL ILLNESS (Aug. 11, 2021), https://www.nami.org/Blogs/NAMI-Blog/August-2021/Serious-Mental-Illness-Recovery-The-Basics [https://perma.cc/BZR2-765C] ("When managing serious mental illness ("SMI"), the recovery journey can be long and challenging. It often requires creative and prolonged efforts to build and maintain a full life, but many people do reach recovery. The term 'recovery' refers to the process of learning how to minimize the symptoms associated with SMI. Note that recovery does not mean symptoms stop entirely or that deficits disappear. Ultimately, recovery is not synonymous with 'cured.' Rather, it means reaching a place where you are able to pursue a safe, dignified and meaningful life.").

[134] Davidson & Ponte, s*upra* note 133.

18% has a less serious diagnosed mental illness.[135] An even larger percentage may have poor mental health and may benefit from wellness programs.[136] Public mental health funds should be devoted primarily to the most ill, those with SMI.[137] Serious mental illnesses ("SMI") include bipolar disorder, schizoaffective disorder, schizophrenia, and severe depression with psychosis.[138] Such illnesses are biological. Generally, there are currently no cures for SMI. Typically, people do not fully recover, but they can effectively manage symptoms with medicine.

SMIs are biological illnesses of the brain and are generally best treated with pharmacological treatments.[139] People with SMI often have anosognosia (lack of insight) and therefore treatment in contravention of illness-induced treatment refusals can be necessary to return the person to capacity; delaying treatment during a psychotic episode can physically damage the brain.[140] Generally, studies have shown that alternative treatments do not work.[141] Thus, the New York City Mayor should devote funding and research to programs to help people with SMI.

Funds should not be diverted to wellness programs for the general population.[142] Instead, funding should be devoted to treatments proven to work, backed by science.[143] To determine whether a program works, Mayor Adams and his staff should assess whether empirical data shows the program prevents homelessness, incarceration, suicide, and violence.[144] These are the measures that matter; measures such as empowerment or feelings of wellness are too intangible and should not be used.[145] Below are examples of measures that could help people with SMI.

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[135] *See generally* D.J. JAFFE, INSANE CONSEQUENCES: HOW THE MENTAL HEALTH INDUSTRY FAILS THE MENTALLY ILL (2017).

[136] *Id.*

[137] *Id.*; DAVID CORN, AMERICAN PSYCHOSIS: A HISTORICAL INVESTIGATION OF HOW THE REPUBLICAN PARTY WENT CRAZY (2022).

[138] JAFFE, *supra* note 135; CORN, *supra* note 137.

[139] JAFFE, *supra* note 135.

[140] *Id.*

[141] *Id.*

[142] *Id.*

[143] *Id.*

[144] *Id.*

[145] JAFFE, *supra* note 135.

A. *Empower New Yorkers with Serious Mental Illness: Self-Binding Arrangements for Crisis Intervention.*

The New York City Mayor should encourage the New York Legislature to enact legislation clearly authorizing self-binding directives known as Ulysses arrangements.[146] New York needs specific statutory language allowing people with SMI to form self-binding advance directives to secure intervention even if they do not meet commitment criteria so that they are not left imprisoned in their mental illness by anosognosia.[147] Different issues are implicated in advance healthcare planning for end-of-life from those implicated in advance planning for SMI acute episodes.[148] For example, a general advance directive statute does not set forth the framework for a person to designate in the advance directive the mental health treatments to which the person consents in a crisis that has disrupted decision-making capacity.[149] New York's current advance directive statute is inadequate not only because it does not empower a person with SMI to plan for mental health crisis

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[146] For a detailed discussion of Ulysses arrangements and their origins, see Clausen, *supra* note 92, at 648, 686-90.

[147] *See* Judy Ann Clausen, *An Americans with Disabilities Act Critique of Advance Directive Override* Provisions, 71 N.Y.U. ANN. SURV. AM. L. 25, 33-40 (2015) [hereinafter *ADA Override*] (demonstrating through contrast the radical differences between generic health care directive statues and mental health care advance directive statutes); *see generally* Judy A. Clausen, *Making the Case for a Model Mental Health Advance Directive* Statute, 14 YALE J. OF HEALTH, POL'Y, L. & ETHICS 1, 23 (2014) [hereinafter *Model Advance Directive*] (arguing that general health directives are not created with mental health in mind, and are thus inadequate to use as mental health directives).

[148] N.Y PUB. HEALTH L. § 4306-a (Consol. 2023); *ADA Override*, *supra* note 147, at 38 ("A doctor follows a generic directive during one key time frame in a person's life: the time before death, after terminal illness or injury has destroyed the patient's capacity. Mental illness, however, is often episodic."); *Model Advance Directive*, *supra* note 147, at 25; Judy A. Clausen, *Bring Ulysses to Florida: Proposed Legislative Relief for Mental Health Patients*, 16 MARQ. BENEFITS & SOC. WELFARE L. REV. 1, 6 (2014) [hereinafter *Florida Advance Directive Relief*].

[149] N.Y. PUB. HEALTH L. § 4306-a(1) (Consol. 2023); *ADA Override*, *supra* note 147, at 33 ("In the end-of-life context, an instructional directive might state, 'If I am in a permanent vegetative state, I do not want doctors to administer artificial hydration and nutrition.' In the mental health context, an instructional directive might state, 'If an episode destroys my capacity, I consent to antipsychotic medication.'"); *Model Advance Directive*, *supra* note 147, at 25, 43-45 (detailing patient's ability to consent to intrusive but sometimes medically necessary and specialized mental health treatments); *Florida Advance Directive Relief*, *supra* note 148, at 35-38 (describing the five major components of Florida's generic health care advance directive law, none of which address mental health).

intervention, but also because it does not empower people to form Ulysses arrangements, self-binding arrangements for care in the event an acute episode causes anosognosia, destroying insight to recognize the need for intervention.[150]

Ulysses arrangements are a special type of mental health advance directive empowering a person with mental illness to obtain treatment during an episode because the person has learned that episodes cause treatment refusals or anosognosia.[151] The person enters the arrangement when the person is stable, free from the influence of an acute episode, and has decision-making capacity.[152] The arrangement authorizes providers to administer lifesaving mental health treatment during a future acute episode when the person lacks decision-making capacity to provide informed consent to treatment, even if the acute episode causes treatment refusals, and the person does not meet involuntary treatment criteria.[153] The arrangement derives its name from Homer's epic, the *Odyssey*.[154] Ulysses was afraid the Sirens' song would lead him into danger, so he directed his shipmates to tie him to the mast of his ship and keep him there, even if the Sirens' song made him demand to be set free.[155]

Arguably, treatment in contravention of illness-induced treatment refusals pursuant to an advance directive is more therapeutic than forced treatment.[156] Research indicates that forced treatment is less effective than consensual treatment.[157] The New York strategy could be improved by empowering a person to direct mental health treatment pursuant to an advance directive. If

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[150] *See, e.g.*, *Florida Advance Directive Relief*, *supra* note 148, at 38 (finding fault with Florida's generic mental health directive for, *inter alia*, its "failure to empower patients to form Ulysses arrangements.").

[151] *See* Clausen, *supra* note 92, at 648.

[152] *Id.*

[153] *Id.*

[154] *Id.*

[155] *Id.*

[156] ROSENBERG, *supra* note 116, at 109-11.

[157] Henning Hatchel et al., *Mandated Treatment and Its Impact on Therapeutic Process and Outcome Factors*, 10 FRONTIERS IN PSYCHIATRY 1, 4 (April 12, 2019) (noting that non-voluntary patients are more resistant to therapy and have less overall satisfaction with the experience); *Model Advance Directive*, *supra* note 147, at 18 ("Research indicates that mental health directives provide doctors clinically useful information that can expedite and improve care.").

New York amended its advance directive statute to address mental health advance directives, New York would promote better healthcare outcomes. Advance directives promote respect and self-determination of the patient, facilitating long-term recovery and better healthcare outcomes. Plus, empowering patients to secure crisis intervention pursuant to their own plan relieves stress. For example, through the advance directive, the person can refuse restraints. Many people with SMI have stated that restraints traumatized them making them reluctant to seek intervention in future acute episodes to avoid the trauma of restraints.[158]

Mental health advance directives facilitate better treatment because they empower people to receive treatments that have worked, in facilities of their choosing, from providers who know them and the manifestations of their mental illnesses.[159] If New York amended its advance directive statute to empower people to form mental health advance directives, people could secure care from trusted providers. Moreover, New York could empower people to receive treatment from the provider and facility of their choosing, instead of in emergency rooms or jails from providers who do not know them where most people with SMI in crisis receive treatment.

One of the most important predictors of positive healthcare outcomes and management of SMI is whether the person has a trusted relationship with one provider. Although the Mayor's strategy will improve the lives of New Yorkers with SMI, it fails to ensure a person's self-determination and that the person receives care the person wants from a provider and facility the person chooses. Typically, police pick up and transport to an emergency room or jail people with SMI in crisis who need emergency intervention. In such instances, people run a greater risk of

[158] ROSENBERG, *supra* note 116, at 133-34 (describing that certain degrading or unpleasant medical procedures can also deter individuals from seeking treatment, and detailing the story of a law professor at the University of Southern California, Elyn Saks, who was sent to the ER while experiencing an SMI episode. Professor Saks was strapped down, which traumatized her. She remarked that: "[being restrained] deterred me from ever going to an ER again . . . . It might have been useful, at times, to be able to get some care when I was really struggling, but the idea of being tied [up] again was just so horrible and traumatic that I would never, ever dream of doing it.").

[159] *See generally A Practical Guide to Psychiatric Advance Directives*, SUBSTANCE ABUSE AND MENTAL HEALTH SERVS. ADMIN. 1, 4-7 (2019), https://www.samhsa.gov/sites/default/files/practical-guide-psychiatric-advance-directives.pdf [https://perma.cc/86JM-7MZR].

receiving no intervention or intervention that is inadequate or harmful.

For example, one officer reported transferring custody of a person with SMI in an acute episode to a hospital only to see the person discharged as the officer left the hospital. Some officers have been so frustrated with the lack of inpatient beds at hospitals for people with SMI in crisis that they bring people in mental health crisis to jail for a mercy booking so that they can get some sort of intervention. If New York amended its advance directive statute to empower people to form mental health advance directives, New Yorkers with SMI would have better hope of securing intervention at the facility and provider they choose with treatments that have worked in the past.

The Ulysses arrangement empowers people to provide advance consent to effective treatments, including inpatient hospitalization, refuse treatments that have not worked, and provide other instructions that relieve stress. For example, a person can use the advance directive to instruct loved ones on how to care for their pets during their hospitalization.

Although the New York City Mayor removed one barrier to treatment by declaring that criteria for treatment in contravention of illness-induced treatment refusals should be more flexible to facilitate treatment to an individual with SMI who is decompensating, a more therapeutic approach empowers the person to obtain treatment through the person's own direction. The treatment will be more effective because it will be provided by a doctor who knows the person and their medical history, instead of being provided by an ER physician who has no knowledge of the person.

New York City should consider the mental health advance directive statute in Nebraska for a model system to ensure that a person can obtain intervention during a crisis pursuant to that person's instructions when the person had capacity with improvements specified below.[160] Under the Nebraska statute, people can obtain 21 days of inpatient treatment pursuant to their Ulysses arrangement even if they do not meet commitment criteria

[160] NEB. REV. STAT. §30-4415 (2023).

and even in contravention of illness-induced treatment refusals.[161] Formation requirements such as a writing requirement protect against fraud, misinterpretation, undue influence, and abuse.[162]

Nebraska eliminated the requirement for a mental health care provider's capacity assessment and attestation of individuals forming Ulysses arrangements featured in the model statute in the law review article that inspired the Nebraska mental health advance directive law.[163] New York should go a different direction and require a capacity assessment when the individual forms a Ulysses arrangement.[164] In such an arrangement an individual may secure up to three weeks of hospitalization and pharmacological treatment even if the person does not meet dangerousness criteria for involuntary treatment, and even in contravention of illness-induced treatment refusals.[165] Such a right to obtain earlier intervention before tragedy ensues is vital to prevent homelessness, incarceration, violence, and suicide. A mental health professional's capacity assessment and attestation of the individual helps ensure the individual forms the arrangement voluntarily and knowingly and will make the Ulysses arrangement less vulnerable to attack.[166] Such a capacity assessment and attestation need not be required when the individual forms a revocable mental health advance directive.[167]

New York should adopt Nebraska's approach and empower patients to create flexible crisis intervention plans where they can appoint agents to make their healthcare decisions when they lack decision-making capacity.[168] This allows for ultimate flexibility by empowering the person to determine the intervention they will receive in a future episode and to designate a person they trust to make healthcare decisions in the event of unanticipated contingencies. Mental illness episodes are unpredictable by nature.

New York should follow Nebraska's lead and empower people with mental illness to designate the activation standard for the

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[161] NEB. REV. STAT. §30-4415(1) (2023).
[162] *See* NEB. REV. STAT. §30-4405 (2020).
[163] *See* NEB. REV. STAT. §30-4415 (2023); *Model Advance Directive, supra* note 147.
[164] *See Model Advance Directive, supra* note 147, at 59.
[165] *Id.* at 56.
[166] *Id.* at 57.
[167] *See Model Advance Directive, supra* note 147, at 57-59.
[168] NEB. REV. STAT. §30-4404(2) (2020).

mental health advance directives. In Nebraska, unless the principal specifies otherwise, the directive becomes active when the principal loses capacity.[169] Nebraska empowers people to designate an activation standard other than incapacity by describing that standard in the directive, clarifying that even if the directive is activated, it does not prevail over contemporaneous preferences expressed by a principal with capacity.[170] Allowing the person to designate the activation standard facilitates early intervention, on the individual's terms. For example, a principal could specify in the advance directive that the principal wants it to become active, and thus determine care, even if the principal is not yet experiencing psychosis, if both the principal's children execute affidavits and file them with the court indicating that they have observed symptoms of mania.

This person could obtain pharmacological inpatient treatment for three weeks, despite illness-induced treatment refusals, and even though she does not yet meet dangerousness criteria for involuntary treatment. The Ulysses arrangement option empowers the person to prevent devastation that would have resulted from a mental health system that requires complying with psychosis induced treatment refusals of lifesaving treatments. Our current involuntary treatment system requires tragedy before treatment when mental illness induces treatment refusal. The current standard to administer involuntary treatment discriminates against people with SMI that cause anosognosia. People with SMI causing treatment refusals cannot obtain lifesaving mental health care until they have decompensated to such an extent that they are dangerous; the Ulysses arrangement offers them hope for intervention.[171]

Moreover, New York should adopt Nebraska's solution and provide a process with safeguards for admitting and treating people in contravention of contemporaneous illness-induced treatment refusals.[172] In Nebraska, people may secure intervention through Ulysses arrangements, even if their behavior and symptoms do not meet commitment criteria and even in contravention of illness-

[169] NEB. REV. STAT. §30-4409(1) (2020).
[170] NEB. REV. STAT. §30-4411 (2020).
[171] *See* JAFFE, *supra* note 135.
[172] Clausen, *supra* note 92, at 698.

induced treatment refusals.[173] When an incapacitated principal refuses inpatient mental health treatment or psychotropic medication, the person's agent may consent to such treatments if the irrevocable directive authorizes the agent to consent to the treatments.[174]

Procedures for forming and implementing a self-binding arrangement are (1) making the directive expressly irrevocable and (2) consenting to inpatient treatment.[175] If the principal desires psychotropic medication, in contravention of illness-induced treatment refusals, the principal must consent to such medication in the directive.[176] If the patient has a Ulysses arrangement and refuses admission, despite the directive's instructions, the principal's statements in the directive requesting inpatient treatment, activation of the directive, and contemporaneous treatment refusals create a rebuttable presumption that the principal lacks capacity.[177]

Nebraska eliminated this rebuttable presumption requirement recommended in the law review article that inspired the Nebraska mental health advance directive law.[178] But New York should maintain the requirement to ensure people with SMI are truly empowered to form self-binding treatment arrangements to override anosognosia.[179] For example, a person with bipolar disorder with psychotic features could arrive at the hospital in a manic episode exhibiting psychosis. Even if the hospital maintained a copy of the person's Ulysses arrangement requesting three weeks of self-binding treatment, if the person then refused treatment, the doctor might determine that the person had decision-making capacity to refuse treatment even though she was experiencing full-blown mania with psychosis.[180] The rebuttable presumption that

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[173] Clausen, *supra* note 92, at 690.

[174] *Id.*

[175] *Id.*

[176] *Id.*

[177] *Id.*

[178] *See* NEB. REV. STAT. §30-4408(2020); *Model Advance Directive*, *supra* note 147, at 56.

[179] *Model Advance Directive*, *supra* note 147, at 56.

[180] *Id.* (discussing how the concern for liability will cause doctors to likely adjudge patients as possessing capacity who are experiencing episodes that cause them to refuse the treatment they requested in their directives and that this caution harms these patients in the long run because it wholly prevents intervention).

the principal lacks capacity incentivizes the receiving physician to treat pursuant to the instructions in the Ulysses arrangement.[181] The New York Ulysses arrangement statute should clarify that no provider or facility would be subject to criminal or civil liability or adverse actions from professional licensure boards for treating pursuant to the Ulysses arrangement or for the capacity determination itself.[182]

Then, under the Nebraska statute, the treatment facility shall respond as follows.[183] First, the facility shall obtain the informed consent of the agent if an agent is designated.[184] Second, within 24 hours of the principal's arrival at the facility, one of the facility's mental health professionals shall evaluate the principle to determine whether the principal has capacity and document their findings and recommendations.[185] Third, the facility shall admit the principal if the principal is determined to lack capacity.[186] Here, the New York statute should contain language urging providers to determine that a principal who arrives at a facility in the midst of an acute episode refusing care requested by the Ulysses arrangement lacks capacity.[187] This is because if the mental health professional determines the individual has capacity, the individual will not be able to secure intervention before further decompensation and even tragedy ensues.[188] She must rather wait until she is observed being dangerous before she can secure treatment.[189]

All treatment administered pursuant to the directive should be documented in the individual's records.[190] Inpatient treatment under the Ulysses arrangement shall only happen for up to twenty-one days.[191] After twenty-one days from the date of admission, if the principal has not yet regained capacity or has regained capacity

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181 *Model Advance Directive*, *supra* note 147, at 56.

182 *Id.*

183 *See* NEB. REV. STAT. §30-4403 (2020) (laying out procedural protections for an advance mental health directive); *Model Advance Directive*, *supra* note 147, at 61.

184 *Model Advance Directive*, *supra* note 147, at 61.

185 *Id.*

186 *Id.*

187 *Id.* at 56.

188 *Id.*

189 *See id.*

190 Clausen, *supra* note 92, at 690.

191 *Id.*

but refuses to consent to further treatment, the facility shall discharge the principal during daylight hours, unless the principal is detained under involuntary commitment procedures.[192] A principal who has been found to lack capacity and who continues to refuse inpatient treatment may seek injunctive relief or release.[193] Again, during the timeframe in which the principal is hospitalized pursuant to her request in the Ulysses arrangement, mental health professionals should be urged to err on the side of determining that she lacks capacity.[194] Following this approach honors the individual's self-determination. When she was free from the influence of an acute mental illness episode, she chose this intervention of medicine and hospitalization.[195] The New York statute should articulate a rebuttable presumption that the principal lacks capacity for as long as her Ulysses arrangement directs her hospitalization [up to twenty-one days or as long as the New York Legislature determines to authorize self-binding intervention] to incentivize providers to honor the Ulysses arrangement instead of illness-induced treatment refusals.[196]

Moreover, when one of the authors of this Article presented the Ulysses arrangement concept to psychiatrists, one psychiatrist supported the prospect of empowering people with SMI with anosognosia to obtain intervention before dangerousness. But she stated that three weeks might be an insufficient timeframe to stabilize a patient in crisis. The psychiatrist stated that one month would be far better. The psychiatrist explained that it takes time for the medicines to take effect, for doctors to determine the appropriate dosing and medicines themselves, and for patients to be free from the influence of an acute episode so that they can recognize their need for treatment and have a better hope of staying on their medicine upon discharge. Therefore, New York should consult psychiatrists about the optimum length of time of hospitalization to empower people with SMI to secure through their Ulysses arrangement inpatient intervention during an episode that has caused anosognosia.

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[192] Clausen, *supra* note 92, at 690.

[193] *Id.*

[194] *See Model Advance Directive*, *supra* note 147, at 56.

[195] *See id.*

[196] *See id.*

> If a principal with the Ulysses arrangement consenting to inpatient treatment refuses psychotropic treatment through words or actions, only a licensed psychiatrist may administer the medication, and only if (1) the principal consented to the medication in her Ulysses arrangement; (2) the agent, if one was designated, consented to the medication; and (3) a licensed healthcare provider recommended in writing the specific treatment.[197]

New York should adopt this Nebraska approach because it ensures self-binding care includes safeguards against abuse, fraud, coercion, and undue influence.[198] New York should follow Nebraska by empowering people with SMI suffering from anosognosia to secure intervention without waiting for decompensation of cognitive functions to such an extent that they meet dangerousness criteria.[199] Individuals with SMI will finally be able to obtain early intervention and avoid tragedies caused by acute mental illness episodes and protect their brains from the damage wrought by untreated psychosis.[200] Nebraska has provided hope by enacting a statute that accounts for anosognosia, an attribute of SMI recognized by New York Mayor Adams.[201] Adding Ulysses arrangements would improve Mayor Adams' strategy.

B. Lobby the New York Legislature to Change Statutory Criteria for Treatment in Contravention of Illness-Induced Treatment Refusals; Grant Immunity to Doctors Applying the Criteria.

Self-determined inpatient pharmacological treatment pursuant to a Ulysses arrangement is optimum to promote crisis intervention before tragedy ensues and to allow the individual to determine the treatment plan to overcome anosognosia. But what about people with SMI who do not have Ulysses arrangements or individuals unable or unwilling to form them?

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[197] Judy Ann Clausen & Joanmarie Davoli, *No-one Receives Psychiatric Treatment in a Squad Car*, 54 TEXAS TECH L. REV. 645, 690-91 (2022).

[198] *Id.* at 691, 698. *See* NEB. REV. STAT. §30-4405 (2020).

[199] *See Model Advance Directive*, *supra* note 147, at 39, 55.

[200] *Id.*

[201] NEB. REV. STAT. §30-4401-4415 (2020).

Mayor Adams calls for broad interpretation of New York's statutory dangerousness criteria for administering mental health treatment during a crisis in contravention of illness-induced treatment refusals.[202] His call for broader interpretation provides hope to society, people with SMI, and their families. The dangerousness criteria combined with closing of state psychiatric hospitals and defunding of the nation's inpatient mental health treatment system resulted in incarceration, homelessness, victimization, and death of millions of untreated people with SMI.[203] Experts posit that deinstitutionalization was trans-institutionalization from hospitals to prisons and the streets.[204]

The Mayor's staff should draft new statutory criteria for treatment in contravention of illness-induced treatment refusals that account for developments that occurred in the decades after dangerousness criteria for involuntary treatment became the norm. First, we now know that delaying treatment of psychosis harms the brain and worsens SMI.[205] Second, the dangerousness standard was created when inpatient asylums offered little hope of successful pharmacological intervention.[206] Third, we now understand the phenomenon of SMI of anosognosia, and we recognize that SMI induces the person to refuse treatment to which she would

[202] PSYCHIATRIC CRISIS LEGISLATIVE AGENDA, *supra* note 63, at 1; *supra* notes 70-81 and accompanying text.

[203] *See* Gordon, *supra* note 214, at 691-98.

[204] TORREY, *supra* note 17, at 95-96. *See also*, Henry J. Steadman et al., *The Impact of State Mental Hospital Deinstitutionalization on United States Prison Populations 1968-1978*, 75 J. CRIM. L. & CRIMINOLOGY 474, 475 (1984).

[205] Kwame J. McKenzie, M.D., *How Does Untreated Psychosis Lead to Neurological Damage*, 59 CAN. J. OF PSYCHIATRY 511, 512 (Oct. 2014), https://journals.sagepub.com/doi/epdf/10.1177/070674371405901002 [https://perma.cc/M85A-CT8B] (noting that the longer the pathological process of psychosis goes unchecked the more damage that is done and the more complex the illness becomes thereby making it more difficult to treat).

[206] *See generally* M.M. Large et al., *The Danger of Dangerousness: Why We Must Remove the Dangerousness Criterion from Our Mental Health Acts*, 34 J. OF MED. ETHICS 877 (Nov. 28, 2008) https://doi.org/10.1136/jme.2008.025098 [https://perma.cc/37ZB-J6HB] (discussing how the anti-psychiatry and civil rights movements planted the seed for the transition to the dangerousness standard); Megan Testa, M.D., & Sarah G. West, M.D., *Civil Commitment in the United States*, 7 PSYCHIATRY 30, 32-35 (Oct. 2010), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3392176/pdf/PE_7_10_30.pdf [https://perma.cc/CXW8-AZ8N] (noting that when many people were released from asylums, they had lost many of their civil rights which contributed to the shift away from the need-for-treatment standard towards the dangerousness standard).

otherwise consent, because it destroys insight.[207] We now understand that viewing the only liberty to protect as the right to refuse life-saving treatment so that one can remain psychotic may be ill-conceived.

The 1960's utopian ideal for large scale closure of state psychiatric hospitals to move care to community-based centers resulted in the eventual defunding of those centers, essentially leaving inpatient care to jails and prisons and outpatient care to courts and police.[208] The dangerousness standard was penned in an era when society did not understand that SMI was biological. Many state statutes go far beyond what the Supreme Court demands in blocking lifesaving mental health treatment during a crisis that has caused illness-induced treatment refusals.[209] Architects of the federal government's plan to close state psychiatric hospitals had the euphoric, unrealistic vision that society would cure SMI by ending income disparity, and that people would be released from state hospitals into the bosom of family and society; obviously, they were wrong.[210] Medical science has since learned that Sigmund

[207] *See Model Advance Directive*, *supra* note 147, at 7-8.

[208] Jails are already the country's largest psychiatric providers. *See* Alisa Chang, '*Insane': America's 3 Largest Psychiatric Facilities are Jails*, NPR (Apr. 25, 2018, 4:56 PM), https://www.npr.org/sections/health-shots/2018/04/25/605666107/insane-americas-3-largest-psychiatric-facilities-are-jails [https://perma.cc/LRG7-DN4T]. *See also supra* note 10 and accompanying text.

[209] E. FULLER TORREY, AMERICAN PSYCHOSIS: HOW THE FEDERAL GOVERNMENT DESTROYED THE MENTAL ILLNESS TREATMENT SYSTEM 141 (Oxford Univ. Press 2014) (describing that even today, many people believe that mental illness is of a psychological, and not biological, nature); *see also supra* notes 74-81 and accompanying text.

[210] TORREY, *supra* note 209, at 75-80 (describing the surge of anti-communist rhetoric under President Nixon, a staunch opponent of communism, who had helped spearhead McCarthyism and the Committee on Un-American Activities. The John Birch Society and the Daughters of the American Revolution exploited this rhetoric and began connecting communism with federal mental health hospitals. This rhetoric resonated with President Nixon, who was already suspicious of the mental health community due to their low Republican voter rates and tendency to publicly label him a "narcissist" and "paranoid." As a result of these tensions, President Nixon, in concert with the National Institute of Mental Health, began discharging seriously ill patients from mental hospitals, believing such patients to simply be members of the "worried well," and that involvement in the community with supportive care from a Community Mental Health Center ("CMHC") would enable these individuals to transition seamlessly back into society. In reality, economic tensions between psychiatric hospitals and CMCH's prevented many seriously ill patients from transitioning into these facilities, discharged psychiatric hospital patients made up just 3.6 to 6.5% of CHMC patients, while many of those deinstitutionalized were left on the streets without care).

Freud was wrong when he believed that SMI could be cured with psychotherapy to reorder a disordered mind.[211]

The dangerousness criteria requiring tragedy before treatment developed when psychiatric pharmacological treatment was not as effective as it is today.[212] There is now a single injection that can effectively treat psychosis for three months.[213] The concept of "forced treatment" embedded in state statutes came about before such medical advances.[214] If allowed to obtain treatment despite their illness-induced treatment refusals, many people with SMI could return to home, family, employment, safety, and health. But the dangerousness criteria for treating in contravention of illness-induced treatment refusals has resulted in untreated people with SMI who roam our streets and reside in our prisons with "the most dreaded of confinements": "the imprisonment inflicted by [their] own mind[s], which shuts reality out and subjects [them] to the torment of voices and images beyond our own powers to describe."[215]

Dangerousness criteria developed in the courts before medical science understood what it understands clearly now – SMI is biological. And SMI causes anosognosia, so treatment refusals are the person's symptoms instead of an expression of constitutional rights.[216] Before the current dangerousness standard that developed in the courts in the 1960s and 1970s, the criteria for

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[211] TORREY, *supra* note 209, at 141-42 (describing the mentally ill's inability to recognize the need to treat their own illness and expressing dismay on how Freud's hold on public opinion on mental illness affects how people think it is not necessary to treat and underplay or ignore its magnitude); *Id.* at 32-33 (explaining the profound positive impact of antipsychotics on the mentally ill and how that can cause long-term deinstitutionalization).

[212] *See generally* Large, *supra* note 206.

[213] *See* Johnathan Block, *FDA Approves First Three-Month-Long Injectable Antipsychotic*, PSYCHIATRY ADVISOR (May 21, 2015), https://www.psychiatryadvisor.com/home/topics/schizophrenia-and-psychoses/fda-approves-first-three-month-long-injectable-antipsychotic/ [https://perma.cc/AF3K-NKZ2].

[214] *See generally* Sara Gordon, *The Danger Zone: How the Dangerousness Standard in Civil Commitment Proceedings Harms People with Serious Mental Illness,* 66 CASE W. RES. L. REV. 657, 662-68 (2016).

[215] *Id.* (quoting Olmstead v. L.C. *ex rel* Zimring, 527 U.S. 581, 609-10 (1999) (Kennedy, J., concurring)).

[216] *See id.* at 659.

administering treatment despite illness-induced treatment refusals was the therapeutic need for treatment.[217]

The Mayor should hold public hearings to brainstorm about ideas about crafting optimum criteria for treatment in contravention of illness-induced treatment refusals. He should invite all the knowledgeable players: psychiatrists and ER physicians who treat people with SMI in crisis, people with SMI and their family members who have lived experiences, and law enforcement officers, prison guards, public defenders, social workers, and judges who work cases involving people with SMI. Also, the Mayor should task his staff to survey statutory standards for administering mental health treatment in contravention of illness-induced treatment refusals in all 50 states as well as other nations with strong reputations for protecting human rights. Many states have crafted frameworks that allow earlier and longer intervention to prevent further decompensation of an individual suffering from psychosis so that they do not require tragedy before treatment.

New York's revised involuntary treatment criteria should not be based on outdated images of the Snake Pit or the Cuckoo's Nest but should be based on modern medicine – what we now know about damage to the brain from untreated psychosis and anosognosia. Psychosis, rather than the immediate threats of violence exhibited by recent behaviors, should be at the center of the standard. The strictest current state standards requiring observed recent behaviors of suicidality or threats of serious violence unnecessarily and cruelly block treatment to individuals suffering psychosis, wreaking havoc on society. The new statutory standard should protect the civil liberties of the person in crisis and facilitate medical intervention. It should be designed to protect patient safety, public safety, prevent deterioration of the brain and worsening of the illness, and prevent homelessness and incarceration of people with SMI. The new standard should not be based on the flawed narrative that mental health treatment of a person experiencing psychosis is a massive deprivation of "liberty." Such a narrative myopically focuses only on the side effects of

[217] Gordon, *supra* note 214, at 664 ("[T]he standard for civil commitment continued to loosen and, by 1970, thirty-one states had statutes that allowed commitment upon a finding by a physician that the person was mentally ill and was in need of treatment.").

treatment and not the risks to the person and society caused by blocking treatment of psychosis.

To frame the question is to answer the question. New York should frame the question of how to treat a person with SMI in crisis involving psychosis who suffers from anosognosia more humanely and practically. In many states, the law of involuntary treatment only myopically safeguards the right to be psychotic. But the law of involuntary treatment should also recognize that blocking treatment during psychosis, only to honor illness-induced treatment refusals results in a massive deprivation of liberty – incarceration and homelessness.[218] Without treatment, people with SMI in a psychotic episode inducing treatment refusal are often arrested and incarcerated because of conduct that is symptomatic of their illness.[219] People with SMI should be free from societal discrimination based on their illness. Requiring tragedy before treatment discriminates against people with SMI. They are the only people in society required to forgo lifesaving medical intervention until they meet dangerousness criteria; they are the only people forced to suffer devastation before they can obtain treatment.[220] Our current system blocks treatment for illnesses that cause the brain to lose insight.[221]

For example, in one case, an Ivy League graduate developed schizophrenia in his mid-20s.[222] This resulted in him losing his job, refusing to take medicine that effectively treated his psychosis, moving to the streets, despite his parents urging him to live at home, and being arrested for behaviors symptomatic of psychosis.[223] His parents tried to convince him to take his medicine.[224] His illness made him refuse treatment that would have worked, resent his parents, and he suffered in paranoid

[218] *See* Gordon, *supra* note 214*,* at 691-98

[219] *See, e.g.*, *Florida Advance Directive Relief*, *supra* note 148, at 12 ("Untreated episodes may destroy the patient's career, relationships, and financial stability; lead to incarceration and a criminal record; and risk the patient's and others' health and safety.").

[220] *Id.* at 24 (discussing how Florida law "makes patients victims of their own illnesses" because they cannot obtain intervention once an episode destroys their insight, but rather must wait until the episode produces violence or grave disability).

[221] *Id.*

[222] ROSENBERG, *supra* note 116, at 102-03.

[223] *Id.* at 102-07.

[224] *Id.* at 104.

psychosis[225]. In his psychosis, he believed his parents were out to get him.[226] Though he was psychotic, the statutory dangerousness criteria thwarted treatment and required honoring his illness-induced treatment refusals.[227] He suffered alone in paranoid psychosis.[228] Before the onset of schizophrenia, he enjoyed the outdoors and camping.[229] Angry because his parents had petitioned the courts to allow for involuntary treatment of him, he moved into a hotel room.[230] In his psychosis, he believed he was camping in the wilderness.[231] He fell asleep while the camping gas lamp burned, caught fire, and burned him to death.[232] His parents arrived and found him dead.[233] In reference to the court's failure to order involuntary psychiatric treatment, his mother remarked, "my son died with his civil liberties intact."[234]

In many states, the current dangerousness standard requires evidence of threats of suicide or violence to others.[235] This is not a medical standard, and it is difficult for psychiatrists to apply. Psychiatrists cannot predict the future. Verbal threats of suicide are often not predictive of suicide. The dangerousness standard does not adequately account for the way medical providers diagnose and treat SMI. The focus of the criteria should be on clinical symptoms that indicate that the person with SMI involving psychosis in crisis needs treatment to prevent further decompensation of cognitive functions, worsening of SMI, and

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[225] ROSENBERG, *supra* note 116, at 104-06.

[226] *Id.* at 106-07.

[227] *Id.* at 106.

[228] *Id.* at 106-07.

[229] *Id.* at 107.

[230] *Id.*

[231] ROSENBERG, *supra* note 116, at 107.

[232] *Id.* at 108.

[233] *Id.* at 107-08.

[234] *Id.* at 108. Similarly, in *Lake v. Cameron*, 364 F.2d 657 (D.C. Cir. 1966), a policeman found a woman wandering the streets and took her to a hospital. The patient was transferred to a psychiatric facility for treatment and was detained on the basis of her mental illness, specifically, her poor memory. *Id.* She occasionally wandered away from the facility. *Id.* The patient sought and received her "freedom" on the grounds that there were less restrictive alternatives. *Id.* The patient ultimately died in a hospital five years later. TORREY, *supra* note 209, at 71-72.

[235] *E.g.,* Gordon, *supra* note 214, at 669-71. For example, the author discussed how a Washington statute provides that a person presents a likelihood of serious harm to themselves if there is a substantial risk that physical harm will by inflicted by the person on their own self as evidenced by threats or attempts to commit suicide. *Id.* at 683.

whose illness renders him unable to recognize the need for treatment. The standard should incorporate clinical symptoms and facilitate crisis intervention as well as provide adequate due process protections because treating in contravention of patient refusals implicates constitutionally protected rights. That is why the Mayor should look to other states to find ways that other states have facilitated intervention of SMI crisis situations involving psychosis while also complying with the mandates from the US Supreme Court case law concerning involuntary treatment.

In many states, the current dangerousness standard exposes medical providers who administer treatment or hospitalize patients in contravention of illness-induced treatment refusals to liability for administering treatment without informed consent, false imprisonment, battery, and, if the provider is an employee of a state facility, 1983 civil rights violations.[236] Mayor Adams should support legislation that protects doctors who in good faith try to save the lives of people with SMI in crisis. A revised statutory framework governing administration of mental health treatment should incentivize medical practitioners to follow best practices for the person's health.

Deinstitutionalization, defunding inpatient mental health treatment for SMI, closing state hospitals to release untreated severely mentally ill people to the streets, leaving mental health care to police, jails, and prisons has devastated people with SMI, their families, and society.[237] It is time for a new vision that more honestly respects the rights and lives of people with SMI. This will not mean a return to warehousing people with SMI for years in asylums. Rather, bringing experts together to draft statutory criteria for treatment in contravention of illness-induced treatment

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[236] 42 U.S.C. § 1983:

> Every person who, under color of [the law of any state] . . . subjects, or causes to be subjected, any citizen of the United States to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law . . . .

[237] *See supra* notes 3, and accompanying text (discussing the importance of early treatment, long-term nontreatment, and current attempts at prevention); *supra* notes 10, 208 and accompanying text (discussing how mental health treatments for severe mental health issues takes place primarily in jail or not at all); *supra* note 210 (discussing failed historical attempts to deinstitutionalize mental illness, and how that left, and continues to leave, people without care).

refusals that accounts for the progress in medicine and science's understanding of mental illness for the last several decades would go a long way to improving the lives of people with SMI, protecting society from violence caused by untreated SMI, and mercifully treating people with SMI instead of incarcerating them and forcing them into homelessness.

Judging from his courageous and practical legislative agenda, Mayor Adams is the right person to ignite the movement to holistically address the gargantuan problem of the "lobotomized" American mental health system.[238]

> Civil libertarians say no [–] that it is our right to commit crimes that land us in prison, that it is our choice to be so ill that we prefer to forage through garbage and live on the streets, that it is our prerogative to let voices in our heads torment us into sleepless nights. But something tells me that the people locked up in San Quentin with a mental illness, and the people roving the back alleys of Skid Row, are not singing 'God Bless America.'[239]

It is past time to stop pretending that it honors the freedom of people with SMI to force them to be victims of an attribute of their illnesses, anosognosia, so that they are forced into homelessness, incarceration, suicide, and worsening of their illnesses.

C. Adopt the Dallas Approach of the Three-Person First Responder Team

New York City instituted a new program to dispatch healthcare professionals without police to mental health

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[238] TORREY, *supra* note 209, at 115. E. Fuller Torrey used this phrase to describe the new mental health care system ushered in by President John F. Kennedy, who had a particular interest in the issue because of the institutionalization of his sister Rosemary who had a lobotomy. *Id.* The operation left Rosemary with severe brain damage. *Id.* The author posits that with this background, President Kennedy was vulnerable to pressures to overhaul the nation's mental health treatment system. *Id.* The author ultimately opined that the new system "lobotomized both the existing and the emerging state mental health programs." *Id.*

[239] Gordon, *supra* note 214, at 657-58.

emergencies that do not pose a risk of violence.[240] The program relies too heavily on dispatchers to determine whether there is violence potential.[241] Episodes of untreated SMI are unpredictable, so this imposes an unsurmountable burden on dispatchers.[242] In New York, police operating alone still respond to the vast majority of mental health emergencies.[243] New York should adopt the Dallas approach that dispatches a three-person team to mental health emergency calls consisting of a medic, a mental health professional, and a specially trained police officer.[244]

In June 2021, New York City developed a pilot, Behavioral Health Emergency Assistance Response Division ("B-HEARD"), in Harlem to reduce police involvement in responding to mental health emergency 911 calls.[245] Under B-HEARD, instead of dispatching police to respond to certain mental health emergency calls that dispatchers determine do not pose a risk of violence, New York City dispatches teams of EMTs and social workers trained in de-escalation procedures.[246] Mayor Adams announced plans to expand B-HEARD to other boroughs.[247] B-HEARD critics argued B-HEARD has not helped the problem of the criminalization of mental illness because dispatchers continue to send over three fourths of mental health 911 calls to police for a police or law enforcement

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[240] *See generally* Greg B. Smith, *Non-Cop Response Teams Handled Just 16% of 911 Mental Health Crisis Calls*, THE CITY (July 18, 2022, 4:01 AM), https://www.thecity.nyc/2022/7/18/23267193/mental-health-911-b-heard-teams [https://perma.cc/7NV2-85VC].

[241] *See* Smith, *supra* note 240 (noting that, despite the initiative, 911 dispatchers continue to route approximately seventy-five to seventy-eight percent of mental health calls straight to NYPD).

[242] *Id.* (describing how the program prohibition on sending the B-HEARD team to any place there might be violence deters 911 dispatchers from sending the team, and also noting that even if the dispatcher refers the team, the call gets a second level of review before the team is sent).

[243] *Id.* ("As a result, although they fielded 23% of the [911 dispatch] calls, the teams actually handled only 16% of them (383 of 2,400) [due to, *inter alia,* inadequate staffing] . . . . The NYPD handled the vast majority — 84%.").

[244] Clausen, *supra* note 197, at 694-96 (describing the Dallas RIGHT initiative, and assessing its strengths and weaknesses).

[245] Smith, *supra* note 240.

[246] *Id.* ("Instead of cops, teams of EMT and social workers trained to de-escalate these interactions would show up instead.").

[247] *Id.* (describing the Mayor's intent to expand the program from four Harlem precincts to eleven precincts in Manhattan and The Bronx).

response.[248] Moreover, according to B-HEARD's critics, since its inception, B-HEARD's response rate has dropped.[249] In June 2021, B-HEARD teams responded to about 20% of mental health calls in the covered area, but, later, B-HEARD teams responded to slightly less than 16% of 911 mental health calls.[250]

B-HEARD began as Mayor de Blasio's response to public outcry caused by nineteen New York City deaths in the previous six years resulting from police responding to mental health emergency calls.[251] Mayor de Blasio strove to ensure mental health professionals, not police responded to mental health crises.[252] B-HEARD started in Harlem and handled only cases where dispatchers determined there was no risk of violence to self or others.[253] Mayor de Blasio promised B-HEARD teams would eventually respond to 70% of 911 mental health emergency calls.[254] B-HEARD is nowhere near that goal with dispatchers routing only about 20% of mental health emergency calls to B-HEARD teams.[255]

Critics argued B-HEARD teams did not keep up with the calls dispatchers routed to them.[256] Rather, B- HEARD teams responded to less than 70% of the calls routed to them; in these instances, B-HEARD teams were unavailable because they were responding to other calls.[257] Therefore, police responded to many mental health emergencies originally routed to B-HEARD.[258] The Mayor's staff defended the program, asserting that when B-HEARD responds,

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[248] *See* Smith, *supra* note 240 and accompanying text.

[249] *Id.* "(In fact, in its first 10 months, B-HEARD's response rate has actually dropped, THE CITY found.").

[250] *See* Smith, *supra* note 240.

[251] *Id.*

[252] *Id.* (describing that the B-HEARD initiative was inspired by the program in Eugene, Oregon that wanted to remove police from response to mental health calls, in response to a string of police related killings in New York when responding to mental health calls); Clausen, *supra* note 197, at 681-85 (describing the Eugene initiative, and assessing its strengths and weaknesses).

[253] *See* Smith, *supra* note 240.

[254] *Id.* ("[Mayor] de Blasio . . . vowed that when the program was up and running, 70% of 911 mental health calls would be handled by the no-cop teams.").

[255] *Id.* (describing the continued decline in response rate of the B-HEARD team).

[256] *Id.* (quoting a critic who stated "[h]ow is it that you are referred [to a reduced number of] the calls and you can't even handle that tiny number that you are referred?").

[257] *Id.* ("In June 2021, B-HEARD responded to 80% of the mental health calls routed to them by 911 dispatchers. In the January through March 2022 report, the teams were responding to 68% of those calls.").

[258] *See* Smith, *supra* note 240.

the person in crisis is more likely to accept treatment, compared to the traditional police response.[259] Plus, when the B-HEARD teams respond, more people are treated in their communities than are with the traditional police response.[260] Critics responded B-HEARD only has on duty teams 16 hours per day, and 24 hour a day coverage is necessary because mental health emergencies are unpredictable.[261] B-HEARD teams are not keeping up with the demand because of staffing shortages.[262] Critics also argued B-HEARD failed to address the problem of police picking up people with SMI and dropping them off at the hospital emergency rooms only to have them discharged within 72 hours, allowing them to decompensate further.[263] Defenders of B-HEARD responded with a commitment to open a center staffed by mental health care professionals to which people in crisis can be brought, instead of hospital emergency rooms.[264]

Critics also assert B-HEARD wrongfully relies on unqualified dispatchers to decide whether B-HEARD should respond based on quick assessment of whether there is a threat of harm to self or others.[265] Critics assert these dispatchers may not have appropriate training or orientation to enable them to predict.[266] B-HEARD's goal is to provide people with SMI access to a therapeutic instead of law enforcement response.[267] City officials responded they are working to hire more B-HEARD team members to facilitate a therapeutic response in more situations.[268] Plus, New York City

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[259] *See* Smith, *supra* note 240 (The Mayor's spokesperson stated that "[t]he success of the B-HEARD pilot program is demonstrated by more people — over 90% — accepting help from B-HEARD teams compared to a traditional response . . . .").

[260] *Id.* (The Mayor's spokesperson further noted that thirty percent of individuals who interact with the team ultimately receive treatment in their community).

[261] *Id.* (quoting a critic who stated that "[e]mergencies don't conform to a clock . . . .").

[262] *Id.* (explaining that people are leaving emergency response in droves and causing staffing shortages).

[263] *Id.* (explaining that, despite the program, police continue to use emergency rooms to treat the mentally ill, knowing they will be discharged back to the streets within a few days).

[264] *Id.*

[265] *See* Smith, *supra* note 240.

[266] *Id.*

[267] *See Id.*

[268] *Id.* (describing hiring efforts, including assigning additional staff and encouraging EMTs to get mental health training).

officials spread the word about B-HEARD so that police responding to mental health emergencies knew about the B-HEARD option.[269]

New York City officials should consider incorporating the Dallas solution.[270] Police untrained in SMI and how to de-escalate crises involving SMI,[271] combined with the erratic behavior of an individual with SMI induced psychosis, often predictably results in a dangerous situation.[272] For example, fatal violence erupted to the person in crisis and others on the scene in New York City after the city instituted B-HEARD.[273] A Harlem resident in 2021 called for B-HEARD help because her son with SMI was in crisis involving psychosis.[274] Dispatchers determined there was a threat of violence, so they dispatched police instead of B-HEARD team members.[275] Police arrived, and the person with untreated SMI, in psychotic crisis, shot and killed NYPD officers Wilbert Mora and Justin Rivera.[276] Then, police shot the person in crisis.[277]

Although B-HEARD critics have argued dispatchers inappropriately sent police instead of B-HEARD team members, the dispatchers made the best choice given less than optimum choices. Clearly, there was a risk of violence. Having only two responder teams – one with no law enforcement and only healthcare professionals and the other with only law enforcement

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[269] *See* Smith, *supra* note 240 (describing more police referrals to B-HEALTH for mental health calls as a result of more awareness efforts about B-HEARD within the police department).

[270] For a detailed discussion of the Dallas program, including its strengths and weaknesses, see Clausen, *supra* note 197, at 694-96.

[271] Often, officers are untrained, or fail to correctly institute training they do have. *Id.* at 658 (citing Zoe R. Fiske et al., *A National Survey of Police Mental Health Training*, 36 J. POLICE & CRIM. PSYCH. 236, 236-37 (2021)).

[272] In fact, individuals with SMI make up almost half of the victims of fatal police encounters. *Id.* at 659 (citing Tim Murphy, *Addressing the Link Between Violence, Serious Mental Illness*, PITTSBURGH POST GAZETTE (May 10, 2021, 9:25 AM), https://www.post-gazette.com/news/insight/2021/05/10/Addressing-the-link-between-violence-serious-mental-illness/stories/202105090022 [https://perma.cc/M9PD-H68A].

[273] Greg B. Smith, *Non-Cop Response Teams Handled Just 16% of 911 Mental Health Crisis Calls*, THE CITY (July 18, 2022, 4:01 AM), https://www.thecity.nyc/2022/7/18/23267193/mental-health-911-b-heard-teams [https://perma.cc/7NV2-85VC].

[274] *Id.*

[275] *Id.*

[276] *Id.* (describing how Mora and Rivera, the responding NYPD officers, died in a hail of bullets fired by the individual with untreated SMI).

[277] *Id.*

with no mental health professionals – does not adequately protect safety. New York City should look to Dallas.[278]

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

> A RIGHT Care team consists of a community paramedic, licensed mental health clinician, and specially trained police officer. This integrated team responds to mental health calls placed through 911. The team is skilled in de-escalating a crisis while assuring public safety and can assess both physical and mental health needs on the scene. The team also is linked to community treatment resources, including same-day prescriber access, so the person does not have to be taken to a jail or emergency room.[279]

In its first two years, the RIGHT Care team approach has vastly reduced the number of people being admitted to psychiatric emergency rooms.When responding to emergency calls, the RIGHT Care Team follows a protocol:

> 1. A call center clinician from Parkland Hospital is physically present at the 911 call center dispatch to field calls and assist with questioning. Trained clinicians can help prioritize calls, assess if the RIGHT Care Program team should be dispatched, and communicate to the team in the field with important details about the specifics of the call.
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> 2. Upon arrival, first, law enforcement officers engage and establish if the situation is safe for the rest of the team. If the situation is deemed unsafe, the clinician and paramedic will not engage with the individual.
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> 3. If the situation is deemed safe, then a paramedic evaluates the patient to determine if there are acute

[278] Judy Ann Clausen & Joanmarie Davoli, *No-one Receives Psychiatric Treatment in a Squad Car*, 54 TEXAS TECH L. REV. 645, 694-96 (2022).

[279] *Transforming Police Responses to Mental Health Emergencies: Rapid Integrated Group Healthcare Team (RIGHT Care)*, MEDOWS MENTAL HEALTH POLICY INSTITUTE, https://mmhpi.org/project/right-care/ [https://perma.cc/87HW-PTHD] (last visited May 5, 2024).

> medical issues which might manifest as a behavioral health issue.
>
> 4. If no medical exclusionary criteria are identified, then the mental health clinician enters to determine the patient's needs and where they will best be served in the community.
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> 5. Finally, as a team, the group determines the most appropriate course of action. If possible, the primary choice is to assist the patient with securing treatment from a community-based mental health provider. Each team member has an equal say in the final decision.[280]

In addition to decreased emergency room admissions, the RIGHT Care team response has resulted in decreased arrests and improved continuation of care. Dallas recently received additional funds to expand call center availability twenty-four hours a day.[281]

This three-person team "provides for every eventuality."[282] "The officer ensures that the location is safe."[283] The paramedic provides "emergency medical care if there are injuries or other physical needs."[284] "A mental health counselor can provide critical intervention . . . ."[285] Working together, they determine the optimal course of action.[286]

Dallas's approach better protects safety than New York's current approach. First, in the Dallas approach, one member of the team, the police officer, is trained and equipped to respond appropriately to violence that may erupt on the scene.[287] It is nearly impossible to predict from scant information collected in a brief 911 call whether there is a potential for violence. By their nature, episodes resulting from untreated SMI are unpredictable and involve risk of harm to self or others.[288] New York's overreliance on

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[280] Clausen, *supra* note 278, at 695.
[281] *Id.* at 694-95 (internal citations omitted).
[282] *Id.* at 695.
[283] *Id.*
[284] *Id.*
[285] Clausen, *supra* note 278, at 695.
[286] *Id.*
[287] *Id.* at 694.
[288] *See id.* at 687 (discussing how many mental health crises involve violence and how individuals with SMI can be unpredictable, aggressive, and easily agitated).

the dispatcher to decide whether to dispatch only healthcare workers or only police is ill-advised because the dispatcher cannot accurately predict the situation.[289] Therefore, the current New York City approach endangers the person in crisis, others on the scene, and first responders.[290] In Dallas, the dispatcher would have had a better choice, the three-person first responder team.[291]

Additionally, first responders will be better able to respond to a SMI crisis if they can access the medical history of the person with SMI who is in crisis. Therefore, New York should encourage its citizens with SMI to form mental health advance directives that they then consent to be stored in a database accessible to first responders. First responders would better understand the diagnosis, typically experienced SMI symptoms and illness-induced behaviors, whether the person with SMI owns or carries a weapon or has ever been violent, where the person would like to be transported for treatment, and whom to notify.

The New York Mayor should lobby the state legislature to enact a Ulysses enabling statute, as described previously, that empowers people with SMI to arrange for self-binding transportation to a treatment center.[292] The legislation should also set forth the process for people with SMI to arrange for pickup and transportation to a facility in case Ulysses arrangement activation, pursuant to its terms, is not possible.[293] People with SMI, under the influence of an episode cannot obtain intervention unless they can be picked up and transported to a treatment facility despite their illness-induced refusals.[294] It would be unsafe for a family member to transport the person with SMI experiencing psychosis to a facility for treatment. "Involuntary transportation could be subject

[289] *See* Greg B. Smith, *Non-Cop Response Teams Handled Just 16% of 911 Mental Health Crisis Calls*, THE CITY (July 18, 2022, 4:01 AM), https://www.thecity.nyc/2022/7/18/23267193/mental-health-911-b-heard-teams [https://perma.cc/7NV2-85VC].

[290] *See* Smith, *supra* note 289.

[291] Clausen, *supra* note 278, at 694-96.

[292] For a detailed discussion of Ulysses arrangements, and recommended improvements upon them, see *id.* at 648, 696-97, 697-702.

[293] *Id.* at 700.

[294] *Id.* at 699 (citing Samina T. Syed et al., *Traveling Towards Disease: Transportation Barriers to Health Care Access*, NAT'L LIBR. OF MED., https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4265215/ [https://perma.cc/TW33-L4MV] (last visited Apr. 8, 2022)).

to abuse, so there should be safeguards."[295] Only people who request transportation in contravention of illness-induced refusals in their Ulysses arrangements should be subject to such transportation unless the person meets New York's statutory criteria for involuntary detention and transportation.[296]

The New York Ulysses enabling statute "should clarify that a patient desiring to arrange for involuntary transportation when the [Ulysses arrangement activates] must designate a surrogate and grant that surrogate authority to consent to the [individual's] transportation once the arrangement [activates]."[297] The New York statute should articulate Ulysses arrangement activation procedures.[298] "Under these procedures, the surrogate [should be able to] execute a written, sworn affidavit stating that the arrangement has become activated and disclose the basis upon which the surrogate has made that conclusion."[299] The Ulysses enabling New York statute "should set forth a process [allowing] the surrogate [to] petition the court for an *ex parte* order authorizing . . . transportation, with an attached affidavit and the Ulysses arrangement" requesting transportation.[300] "The court shall review the petition within forty-eight hours," and, "[w]ithin that timeframe, the court shall issue an *ex parte* order for transportation if it finds by clear and convincing evidence that the Ulysses arrangement has [activated] and [the individual] has requested involuntary transportation in the arrangement."[301]

To prevent tragedies that result from interaction between police untrained in SMI and a person with untreated SMI, New York should adopt the Dallas approach.[302] When the "court issues an order to pick up a [person with SMI in crisis] and transport [the person] to the hospital based on an activated Ulysses arrangement, the three-person first responder team should respond."[303] This will

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[295] Clausen, *supra* note 278, at 699.
[296] *Id.*
[297] *Id.*
[298] *Id.*
[299] *Id.*
[300] *Id.* (emphasis added).
[301] *Id.* (emphasis added).
[302] Clausen, *supra* note 278, at 658-59, 699; *supra* notes 271-272 and accompanying text.
[303] *Id.* at 699.

help prevent predictable tragedies that occur with interaction between police untrained in SMI and people suffering from psychosis.[304] The three-person team "will be better able to identify symptoms and calm the situation than police" acting alone and will have advance access to the individual's background through the individual's Ulysses arrangement stored in a database accessible to first responders.[305]

Police initiate most mental health emergency detentions and transportations to treatment facilities or jails when they happen upon a person with SMI in crisis.[306] Therefore, even when the Ulysses arrangement has not been activated by court order pursuant to the Ulysses arrangement terms, if the Ulysses arrangement is in a first responder accessible database, first responders who happen upon a person in crisis will better understand the situation.[307] First responders can read about symptoms and the individual's medical history and treatment instructions. First responder understanding of the nature of the person's illness, symptoms, and measures that tended to calm the situation in the past will protect other first responders, surrounding people, and the person in crisis.[308]

Undoubtedly, it will take time for New York to launch a large-scale effort to offer Ulysses arrangements to its most vulnerable citizens with SMI. New York should follow Nebraska's approach.[309] After enactment of the mental health advance directive statute empowering people to form Ulysses arrangements, the Nebraska Bar Association created a program pairing pro bono attorneys with people with SMI battling homelessness.[310] The Nebraska Bar Association held a CLE teaching pro bono attorneys about SMI, the

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[304] *See supra* notes 271-272 and accompanying text.

[305] Clausen, *supra* note 278, at 700.

[306] *Id.* at 659, 692-93 & nn.377-82.

[307] *Id.* at 700.

[308] *Id.* at 700-01.

[309] NEB. REV. STAT. § 30-4403 (2020); Clausen, *supra* note 278, at 686-93; Judy Clausen & Joanmarie Davoli, *Mental Health Advance Directives in Nebraska: A statutory Deep Dive*, NEB. BAR ASS'N (Nov. 8, 2022), https://mcle.wcc.ne.gov/ext/law/ViewCleEvent.do?id=237691 [https://perma.cc/56F3-KMX9] (Click "CLE MHAD Submission Form.docx").

[310] *See generally Tenant Assistance Project,* VOLUNTEER LAWYERS PROJECT: HELPING LAWYERS HELP PEOPLE, https://www.nevlp.org/tenant-assistant-project.html [https://perma.cc/8B47-K328] (last visited Feb. 13, 2023).

plight of incarceration, homelessness, and suicide for people with untreated SMI, and Nebraska's solution of offering pro bono legal representation to create mental health advance directives for people battling SMI and homelessness.[311]

D. Lobby the New York State Legislature and Congress for Publicly Funded Free to the Patient Mental Health Hospitals.

Many people with SMI will calm SMI symptoms and return to their communities after short-term inpatient treatment combined with pharmacological therapy. If these people with SMI remain treated, they stand the best change of avoiding psychosis and the homelessness, incarceration, and violence that often results from psychosis. However, some people with SMI do not respond to pharmacological treatment and therefore currently have no remedy for psychosis – they should not be forced into incarceration and homelessness.[312] Some people with SMI need long-term inpatient treatment.[313] Others need publicly funded inpatient treatment for weeks or months to regain stability and return to their lives. Although in the 60s policymakers had the utopian vision that society would cure SMI and that all people could live safely in their

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[311] Clausen & Davoli, *supra* note 309; *Tenant Assistance Project, supra* note 310.

[312] Oliver D. Howes et al., *Treatment Resistance in Psychiatry: State of the Art and New Directions*, 27 MOLECULAR PSYCHIATRY 58, 58 (2022) (describing how treatment resistance was not a focus of psychiatric drug development and further noting that only one drug, clozapine is approved for treatment of resistant psychiatric disorders, but offering hope that drug companies are turning their attention to this need); ROSENBERG, *supra* note 116, at 44-46, 50-53 (describing pharmaceutical companies' risk-aversion to developing new drugs, opting instead to simply slightly modify available drugs to ameliorate known side effects and also describing doctors aversion to prescribing clozapine, the only known drug for treatment of averse psychological conditions due to the risk of malpractice and the high maintenance it entails); *Id.* at 46-53 (describing the despair a family member feels at not being able to control the condition of her loved one having her despite adherence to medication).

[313] Dominic A. Sisti, *Improving Long-Term Psychiatric Care: Bringing Back the Asylum*, 313 JAMA 243, 244 (2015) ("For severely and chronically mentally ill persons, the optimal option is long-term care in a psychiatric hospital. . . ."); TORREY, *supra* note 209, at 146, 148 (summarizing statistics that illustrate that a small portion of the mentally ill population are permanently not able to care for themselves through less restrictive means, and that in any case transitionary care is often needed to combat the phenomena known as anosognosia, where people are unable to recognize their illness, and as a result stop taking medication).

communities, this vision has not come to fruition.[314] Rather, many people with untreated SMI live in our streets where they risk exposure to violence and inclement weather or are incarcerated in jails and prisons, again exposed to violence and death.[315] America closed the asylums and did not offer viable alternatives for long-term or even shorter term SMI treatment.[316] Therefore, this population of people with untreated or treatment resistant SMI shuttle between jail, the streets, prison, nursing homes, boarding houses, and emergency rooms.[317] When they do receive care, it is fragmented, disjointed, and ineffective, provided by different healthcare professionals who do not know the patient in jails, prisons, and emergency rooms.[318] A society that claims to be humane and to promote liberty can no longer deny that long-term

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[314] The enactment of this legislation had less than noble intentions. TORREY, *supra* note 209, at 17-35. The initiator of the idea, Robert Felix, wanted to destroy the state mental hospitals and transition people to community care centers. *Id.* at 26. To this end, he helped form a committee to research and write broad legislation. *Id.* One influential member was Mike Gorman, a known communist, who leveraged the opportunity to centralize power in the federal government. *Id.* at 27-29. The ultimate legislation and report Felix and Gorman devised was reported as "largely" an ideological document," but through intense PR campaigns, had garnered significant public support. *Id.* at 31. Ironically, anti-communist rhetoric would also serve as the impetus for the death of the federal control this committee had worked so hard to build. *See supra* note 210, at 75-76.

[315] *See, e.g.*, TREATMENT ADVOC. CTR., ROAD RUNNERS: THE ROLE AND IMPACT OF LAW ENFORCEMENT IN TRANSPORTING INDIVIDUALS WITH SEVERE MENTAL ILLNESS, A NATIONAL SURVEY, 1 (2019), https://www.treatmentadvocacycenter.org/reports_publications/road-runners-the-role-and-impact-of-law-enforcement-in-transporting-individuals-with-severe-mental-illness/ [https://perma.cc/TL2L-2FPJ]; Peter Tarr, Ph.D., *Homelessness and Mental Illness: A Challenge to Our Society*, BRAIN & BEHAV. MAG. (Nov. 19, 2018), https://www.bbrfoundation.org/blog/homelessness-and-mental-illness-challenge-oursociety [https://perma.cc/T9KT-Z8LB].

[316] *See, e.g.*, *supra* note 315.

[317] *See supra* notes 3, 10, 208.

[318] ROSENBERG, *supra* note 116, at 105; (describing the importance of continuity of care and telling the story of one mentally ill individual who finally found a doctor he bonded with, but after the doctor's death, the patient was unable to find a treatment provider he could bond with again); *supra* note 95; as put by Gordon, *supra* note 214, at 660:

> Instead, many of these people have become "revolving-door patients"; they have a serious mental disorder, do not voluntarily comply with treatment, and are unable to live successfully in the community without treatment. They often cycle in and out of hospital emergency rooms, where they receive the minimum amount of care necessary to stabilize them, and are discharged.

or even shorter-term for up to six months inpatient treatment is necessary for some people suffering from SMI.[319] Because of the impact untreated SMI has on employability, many people with untreated SMI lack healthcare coverage, except for Medicaid which excludes coverage for inpatient mental health treatment in hospitals that treat primarily mental health patients.[320]

Treating SMI episodes is generally not profitable, and the responsibility of caring for this population must be appropriately placed on healthcare professionals rather than police and the courts who now shoulder the responsibility. Short and long-term inpatient treatment should be publicly and or donor funded and free to the patient.[321] Even if only for a small percentage of the population with SMI, it is time to bring back state psychiatric hospitals.[322] Unlike the Snake Pits of the past, modern psychiatric hospitals should be a place for state-of-the-art evidence-based treatment, respite,

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[319] In some instances, "civil liberties" dominate so strongly that death ensues. Surely, allowing someone to suffer to the point of death is neither moral nor free. Gordon, *supra* note 214, at 661:

> Although most states have statutes that ostensibly allow for commitment when a person is not dangerous to herself or others but is nevertheless unable meet her basic needs for food and shelter, these standards are often interpreted strictly to require dangerousness. In these cases, the individual's lack of ability to meet her basic needs must be so grave that death is likely to result.

[320] COUNS. OF ECON. ADVISERS, *supra* note 3 (describing the impacts of long-term untreated mental illness); *Psychiatric Diagnostic Evaluation*, *supra* note 84 and accompanying text (noting the Medicaid exclusion).

[321] TORREY, *supra* note 209, at 159-61 ("For-profit funding of public mental illness services has been tried and does not work."); *id.* (citing studies and Medicaid data to demonstrate that furnishing costs of the few for consistent treatment would reduce overall expenditures and reduce crime and the number of individuals in prison. In one particularly egregious incident, one mentally ill man, Murray Barr, due to inconsistent treatment, cost a city at least $1 million in just six months).

[322] Sisti, *supra* note 313, at 244 ("For persons with severe and treatment-resistant psychotic disorders, who are too unstable or unsafe for community-based treatment, the choice is between the prison–homelessness–acute hospitalization–prison cycle or long-term psychiatric institutionalization. The financially sensible and morally appropriate way forward includes a return to psychiatric asylums that are safe, modern, and humane.").

kindness, understanding, and healing.[323] Such inpatient mental health treatment hospitals should not be the Cuckoo's Nests that led to deinstitutionalization.[324] Deinstitutionalization occurred before major advances in mental health pharmacological treatment.[325] There should be robust governmental oversight of mental health hospitals to protect against fraud and abuse and to ensure excellent treatment.[326]

The healthcare system provided by the Department of Veterans Affairs provides high-quality care, so America can do this.[327] VA hospitals can form the model for either state, municipal, federal government, or a combination mental health hospital system. But until there is an adequate number of mental health beds for those with SMI, which experts estimate to be about 50 per 100,000 people,[328] our society will continue to cruelly abandon its citizens with SMI to jails and prisons, the streets, victimization,

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[323] Dorthea Dix stumbled across abysmal conditions for the mentally ill while volunteering to teach Sunday school at the Massachusetts East Cambridge Jail. RON POWERS, NO ONE CARES ABOUT CRAZY PEOPLE 70-73 (2017). When she inquired as to their conditions, being cramped in an ice-cold cell, and housed with criminals, the jailer famously told her that the insane could not feel cold or heat. *Id.* Impassioned about the injustice, Dix embarked on what is estimated to be a thirty-thousand-mile inter-continental tour of the conditions of the imprisoned mentally ill. *Id.* Her knowledge led her to give a speech to the Legislature of Massachusetts, where she was successful in securing funding to build humane housing for 150 patients. *Id.* Her passions continued until her death, but at that time the building could not keep up with the population explosion, which reverted the institutions back to inhumane conditions. *Id.*

[324] *Supra* note 9; MARY JANE WARD, THE SNAKE PIT (1946); POWERS, *supra* note 323, at 169 (describing how the novel by Ken Kesey, ONE FLEW OVER THE CUCKOO'S NEST, which described the abysmal conditions at an Oregon insane asylum, turned public opinion against institutionalization and served as an impetus for its demise).

[325] *See infra* note 351.

[326] *See supra* notes 104-108 and accompanying text; TORREY, *supra* note 209, at 156 ("The most effective way to counteract the natural tendency for staff to dehumanize mentally ill residents in total institutions such as nursing homes and board-and-care homes is through aggressive oversight and inspections.").

[327] Rebecca Anhang Price et al., *Comparing Quality of Care in Veterans Affairs and Non-Veterans Affairs Settings*, 33 J. GEN. INTERNAL MED. 1631, 1637 (2018) ("In conclusion, in 2013-2014, on most publicly reported measures, on average, the quality of VA inpatient care was the same as or better than the quality of non-VA inpatient care and, on average, the quality of VA outpatient care was better than the quality of non-VA outpatient care.").

[328] TORREY, *supra* note 209, at 146 (citing E. FULLER TORREY ET AL., THE SHORTAGE OF PUBLIC HOSPITAL BEDS FOR MENTALLY ILL PERSONS, https://www.treatmentadvocacycenter.org/storage/documents/the_shortage_of_publichospital_beds.pdf [https://perma.cc/TL2L-2FPJ] (last visited Feb. 13, 2023)).

neglect, tortured untreated psychosis, abuse, and subject society to violence that can result from untreated psychosis.[329] We must learn from history and properly care for our most vulnerable citizens.

Even though these hospitals will incur taxpayer and philanthropic expense, in the end, they will save money for society overall.[330] The federal government releases abundant funds each year to mental health organizations that is earmarked to address the needs of people with SMI. But too large a portion of these funds is used for programs that are not evidence-based and fail to address the needs of people with SMI. For one poignant example, after 9/11, mental health workers who typically treated people with SMI were diverted from that role so that they could provide therapy to people in the general public who were traumatized from the attacks, even if they had no diagnosis.[331]

Mayor Adams should ensure that funds given to New York are first used to expand the number of mental health inpatient beds for people with SMI, and he should lobby to end the IMD exclusion to allow Medicaid reimbursement for inpatient treatment for people with SMI. Imprisoning people with SMI is far more expensive than paying for publicly funded beds to allow for treatment. Generally, in prison, people with SMI receive no treatment, so there is little

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[329] *See supra* notes 3, 10, 208 and accompanying text.

[330] *Supra* notes 321-322 and accompanying text.

[331] *See* Erica Goode & Emily Eakin, *Threats and Responses: The Doctors; Mental Health: The Profession Test Its Limits*, N.Y. TIMES. (Sept. 11, 2002), https://www.nytimes.com/2002/09/11/us/threats-and-responses-the-doctors-mental-health-the-profession-tests-its-limits.html [https://perma.cc/8QKY-KEUU] ("But in the midst of the crisis, the city's abundance of mental health professionals turned out to be a mixed blessing. There was no shortage of help, but few practitioners were trained in disaster response. The trauma treatments with the most evidence behind them were also the least available. City officials and agencies like the Red Cross had little control over therapists who wandered into firehouses, made their way to ground zero or stopped people on the street to offer counseling.").

hope they can return to society to contribute.[332] Moreover, arresting and processing through the courts people with SMI whose "criminal" conduct is essentially untreated symptomology is enormously expensive and diverts public resources from intended criminal justice roles.[333] For example, one police officer had to wait nine days in an emergency room with a detainee with untreated SMI before transferring custody to a hospital for inpatient treatment because there were no available mental health beds.[334]

Not only will investing in high quality inpatient public mental health hospitals save money, such investment prevents tragedies such as people with untreated SMI dying in the streets of exposure or as victims of murder.[335] It will prevent tragedies such as people with untreated SMI being injured and murdered by other detainees, abused by prison or jail staff, or harming themselves because of a lack of treatment.[336] For example, one firefighter who had been a lifesaver in his community and a loving husband and father, in a manic episode, was incarcerated for nonviolent behaviors symptomatic of psychosis.[337] He was held in jail instead of a hospital.[338] The jail staff placed him in solitary confinement as punishment for behaviors symptomatic of psychosis.[339] In solitary confinement, he gouged out his eyes because there was no

[332] Clausen, *supra* note 278, at 653 & n.41 (describing mercy bookings——a process of using low-level misdemeanor charges to facilitate treatment); COUNS. OF ECON. ADVISERS, *supra* note 3 (describing the impacts of long-term untreated mental illness);

> In Florida's Broward County Jail in 2007, the difference was $130 versus $80 per day. In Texas prisons in 2003, mentally ill prisoners cost $30,000 to $50,000 per year, compared to $22,000 for other prisoners. In Washington State prisons in 2009, the most seriously mentally ill prisoners cost $101,653 each, compared to approximately $30,000 per year for other prisoners. And these costs do not include the costs of lawsuits being increasingly brought against county jails . . . .

See TORREY, *supra* note 209, at 119.

[333] *See supra* note 332 and accompanying text; TORREY, *supra* note 209, at 121.

[334] TORREY, *supra* note 209, at 121.

[335] *Supra* notes 10, 321-322.

[336] *See generally* TORREY, *supra* note 17, at 103-13.

[337] ALISA ROTH, INSANE: AMERICA'S CRIMINAL TREATMENT OF MENTAL ILLNESS 35-38 (2018).

[338] *Id.*

[339] *Id.*

treatment available in jail to address psychosis.[340] His delusions told him to rip out his eyeballs, leaving him blind.[341]

Moreover, investing in public mental health hospitals will prevent violence to the public caused by untreated SMI.[342] Examples include: the Aurora Colorado massacre where a man with untreated schizophrenia killed many, Virginia Tech where a man with untreated SMI killed many, and the massacre by a man with untreated schizophrenia of children and staff of an a Connecticut elementary school.[343] In each of these and countless other tragedies, people who knew the individual with SMI in crisis had tried to obtain mental health treatment but were thwarted by the combination of strict criteria for involuntary treatment, the illness-induced treatment refusal phenomena, and a shortage of beds in mental health treatment facilities.[344]

One expert estimated in 2013 that our nation's "lobotomized" mental health treatment system that has failed society and people with SMI cost $140 billion every year.[345] That does not include the lost productivity of people with SMI trapped in psychosis by their illnesses combined with the shortage of inpatient beds and strict criteria for involuntary treatment.[346] Excellent publicly funded mental health hospitals will be far less expensive and more humane and therapeutic to people with SMI than abandoning this

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[340] ROTH, *supra* note 337, at 35-38.

[341] *Id.*

[342] Public hospitals will ensure that those in most need of help, and those who most pose a threat to themselves or otherwise will be receiving supervised treatment, reducing their interactions with law enforcement and their access to weapons. TORREY, *supra* note 209, at 157-58, 160-61; *supra* notes 271-272 (explaining that nearly half of all people killed by police have a serious mental illness).

[343] *See* Rachel Bozek, *The Aurora Theater Shooter: Insights from a Psychiatrist Who Interviewed Mass Murderer James Holmes,* A&E TRUE CRIME BLOG: STORIES & NEWS (July 20, 2018), https://www.aetv.com/real-crime/james-holmes-aurora-colorado-theater-mass-shootings-psychiatrist-reid [https://perma.cc/UQF7-FB6T]; *Va. Tech Killer Ruled Mentally Ill by Court; Let Go After Hospital Visit,* ABC NEWS (Apr. 18, 2007, 7:47 AM), https://abcnews.go.com/US/story?id=3052278&page=1 [https://perma.cc/RL5S-CH3R].

[344] *See supra* notes 328-329, 343 and accompanying text.

[345] *See* TORREY, *supra* note 17, at 138.

[346] *See supra* note 238 and accompanying text.

vulnerable population to prisons, jails, the courts, the streets, sickness, exposure, illness, victimization, and death.[347]

These inpatient mental health hospitals should offer state-of-the-art evidence-based treatment and promote healthy living, including recreational and physical education activities, religious practice opportunities, opportunities for community, healthy food, a regular sleep schedule, enriching cultural opportunities and entertainment, opportunities to commune with nature, and vocational training and educational opportunities. Even the most state-of-the-art mental health hospitals will be far less expensive than the current toll the so-called mental health system has caused people with SMI, their families, and society.[348] Many patients of these hospitals will receive SMI treatments that will abate symptoms allowing them to live in the community and lead productive lives.[349]

However, some patients with SMI whose illnesses are resistant to treatment may not be able to return to their communities.[350] But there is hope; SMI treatments are advancing all the time.[351] As discussed previously, patients with SMI whose illnesses induce them to refuse treatment can receive antipsychotics by shot, every three months.[352] This medical advance holds the promise of addressing the most difficult aspect of

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[347] *See supra* notes 3, 10, 208 (describing the devastating impacts, including the high victimization and jail rates of the mentally ill); *supra* notes 271-272, 342 (describing the high cost of the failure to have free healthcare available to the mentally ill).

[348] *Id.*

[349] *See supra* note 311-313 and accompanying text; POWERS, *supra* note 323, at xiv-xxi, 27 (describing the story of the author's son, who was schizophrenic, ultimately killing himself, and explaining the benefits of scarcely used immunization shot that medicates the individual for up to three months, which may combat the phenomenon whereby people fail to medicate because they are unable to recognize that they are sick, and positing whether his son would still be alive if he had access to such a medication).

[350] *Supra* notes 312-313, 322 and accompanying text.

[351] *See, e.g.*, Nick Zagorski, *Studies Point to Benefits of Early Treatment with Long-Acting* Antipsychotics, PSYCHIATRIC NEWS (Nov. 23, 2022), https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2022.12.10.39 [https://perma.cc/UJM2-XX7U] ("Numerous studies have pointed to the benefits of long-acting injectable antipsychotics [] at reducing the risk of symptom relapse, hospitalizations, and other adverse outcomes in patients with schizophrenia."); POWERS, *supra* note 323, at xiv-xxi, 27 (demonstrating the potential usefulness of long-lasting medications).

[352] *See supra* notes 349-351.

SMI, that it causes people to fail to recognize they are sick.[353]The data suggests that 57% to 98% percent of patients with schizophrenia struggle with poor insight.[354] Poor insight means that the individual either lacks awareness of their condition or fails to understand the need for treatment.[355] The data shows that one third of homeless people suffer from untreated SMI.[356] Plus, it is estimated that 44% of individuals in jail and 37% of individuals in prison suffer from mental illness.[357] There is now uncontroverted evidence that untreated SMI is heavily linked to violence.[358] But there is no evidence that treated psychosis is linked to violence.[359] In fact, people with schizophrenia are more likely to be the victims

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[353] ROSENBERG, *supra* note 116, at 72 ("The experience of not knowing you're psychotic is part and parcel of SMI [. . . .] [N]ot knowing you're psychotic has epic consequences, from inhibiting patients' cooperation with treatment to leading them to barrel full-steam-ahead on irrational, often perilous journeys."); POWERS, *supra* note 323, at xiv-xxi, 27-29 (detailing how this shot may permit a better lifestyle).

[354] Douglas S. Lehrer & Jennifer Lorenz, *Anosognosia in Schizophrenia: Hidden in Plain Sight*, 11 INNOVATIONS IN CLINICAL NEUROSCIENCE 10, 11 (2014) (citing P.F. Buckey et al., *Lack of Insight in Schizophrenia: Impact on Treatment Adherence*, 21 CNS DRUGS 129 (2007)); POWERS, *supra* note 323, at 27 (indicating that lack of recognition of need for treatment occurs in approximately 50% of schizophrenia cases) ("Poor insight is a core attribute of schizophrenia that is highly prevalent, occurring in 57 to 98 percent of patients with schizophrenia.").

[355] *See* Powers, *supra* note 323, at 7.

[356] TREATMENT ADVOC. CTR. OFF. OF RSCH. & PUB. AFFS., *Serious Mental Illness and Homelessness*, TREATMENT ADVOC. CTR. (Sept. 2016), https://www.treatmentadvocacy center.org/evidence-and-research/learn-more-about/3629-serious-mental-illness-and-ho melessness [https://perma.cc/54EA-YXGV] ("People with untreated serious mental illness comprise an estimated one-third of the total homeless population in the United States and an even higher percentage of women and individuals who are chronically homeless.").

[357] *About Criminal and Juvenile Justice*, SUBSTANCE ABUSE AND MENTAL HEALTH SERVS. ADMIN., https://www.samhsa.gov/criminal-juvenile-justice/about [https://perma.cc/KVL5-LLXL] (last visited Feb. 1, 2024); TORREY, *supra* note 209, at 152.

[358] TORREY, *supra* note 209, at 111 (quoting John Monahan, *Mental Disorder and Violent Behavior*, 47 AM. PSYCH. 511 (1992)) ("The data . . . suggest the one conclusion I did not want to reach . . . . [N]o matter how many social or demographic factors are statistically taken into account, there appears to be a relationship between mental disorder and violent behavior.").

[359] *Mental Illness and Violence,* BETTERHEALTH CHANNEL, https://www.betterhealth.vic.gov.au/health/conditionsandtreatments/mental-illness-and-violence [https://perma.cc/F4HY-XN68] (last visited Feb. 13, 2023) ("But people living with a mental illness and receiving effective treatment are no more violent or dangerous than the rest of the population.").

of violence than to perpetrate violence.[360] Creating public mental health hospitals that provide excellent short-term SMI treatment so that people with SMI can return to their communities, or long-term SMI treatment and residency for people whose illnesses require long-term treatment: (1) gives people with SMI the best chance of leading healthy lives, (2) helps prevent violence caused by untreated SMI, and (3) protects people with SMI from homelessness, incarceration, victimization, exposure, and self-harm.

E. Ensure Continuity of Care by Making Assertive Community Treatment Teams Accessible to all New Yorkers with SMI.

Continuity of care is key to long-term stability and illness management for people suffering from SMI.[361] However, people with SMI too often receive substandard treatment from providers who do not know their medical history in ERs, jails, prisons, board and care homes, nursing homes, and homeless shelters.[362] Without knowing the person's medical history, the provider cannot know which medicines and dosages effectively treated SMI symptoms and which medicines caused unbearable side effects.[363] People with SMI stand the best chance of relieving psychosis if they have continuity of care.[364]

In the 1970s, as patients were increasingly discharged en masse from closing state psychiatric hospitals, Assertive Community Treatment ("ACT") teams were established.[365] These ACT teams consist of 100 to 120 patients who are assigned to approximately 10 mental health professionals, including

[360] John S. Brekke et al., *Risks for Individuals with Schizophrenia Who are Living in the Community*, 52 PSYCHIATRIC SERVS. 1358, 1365 (2001) ("Individuals in the community who have schizophrenia are at least 14 time more likely to be a victim of a violent crime than to be arrested for one.").

[361] TORREY, *supra* note 209, at 152.

[362] *See supra* note 318 (noting the importance of relying on a single provider and telling the story of one mentally ill individual who finally found a doctor he bonded with, but after the doctor's death, the patient was unable to find a treatment provider he could bond with again).

[363] *Id.*

[364] TORREY, *supra* note 209, at 153 (noting that, pursuant to extensive research, "ACT teams have been adopted in 38 states as the best model for treating people with serious mental illness.").

[365] *Id.* at 152-53.

psychiatrists, psychologists, psychiatric nurse practitioners, therapists, and others.[366] The ACT model is founded on the importance of accountability and continuity of care to long-term patient success.[367] The assigned ACT healthcare professional team is responsible for the patient's total well-being.[368] ACT team members visit patients with SMI in nursing homes, board and care homes, prisons, jails, emergency rooms, or wherever patients reside.[369] ACT team members work to ensure patients continue taking prescribed antipsychotic medications, and ACT team members respond to crises situations that arise.[370] ACT team members work on a call schedule, 24 hours a day, every day of the year for assigned patients.[371] Therefore, patients with SMI get optimum care because they receive care from providers who understand the patient's symptoms, medications, side effects, life situation, diagnosis, and previous episodes.[372] Plus, the ACT team members coordinate for their patients' nonmedical issues such as housing, educational, vocational, recreational, and cultural and entertainment needs.[373]

ACT team members do not transfer their responsibilities to others.[374] Rather, "the buck stops with the team . . . . The [ACT] team remains responsible for the client no matter what his or her behavior is."[375] This mental health provider accountability can be extremely important to long-term patient success; providers often grow frustrated with patients with SMI because of the nature of SMI causing illness-induced treatment refusals, paranoia, and resentment even against providers who are trying to help.[376] Consequently, problems arise with providers prematurely

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[366] TORREY, *supra* note 209, at 153.
[367] *Id.* at 152-153.
[368] *Id.* at 153.
[369] *Id.*
[370] *Id.*
[371] TORREY, *supra* note 209, at 153.
[372] *Id.*
[373] *Id.*
[374] *Id.*
[375] *Id.*
[376] *See, e.g.*, *supra* note 303-305 and accompanying text.

discharging or not accepting patients who present such challenges.[377]

Research shows that ACT teams reduce rehospitalization, relapse, and incarceration.[378] Plus, ACT team care tends to increase patient access to educational, housing, and vocational opportunities.[379] This is done through leveraged care; patients obtain access to housing and other services if they comply with their treatment regimen.[380] ACT teams have been highly effective in treating and improving the lives of people with SMI.[381] However, research shows that, in 2013, only approximately one percent of the population with SMI is being served by ACT teams because of the way mental health care is funded in America.[382] "ACT teams do not fit well with the traditional categories of funding created for Medicare reimbursement, and because they produce less federal Medicaid revenue for the states, they are markedly underutilized."[383]

Mayor Adams should continue New York City's commitment to ACT teams because they have a record of success for people with SMI. Plus, Mayor Adams should investigate federal legislative changes to Medicaid and Medicare required to incentivize large-scale use of ACT teams. Mayor Adams should tell success stories to the New York Legislature to ensure the legislature's commitment to providing access to ACT teams for all people with SMI.

CONCLUSION

After over fifty years of blocked efforts by executives,[384] hysteria by judges[385] and inaction by legislatures, progress toward correcting the disaster of dismantling state-run psychiatric systems

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[377] ROSENBERG, *supra* note 116, at 105 (describing the violent death of a psychiatrist at the hands of his patient, and noting how such outbursts make psychiatrists hesitant to take on patients with severe SMIs, further limiting care options).

[378] TORREY, *supra* note 209, at 153.

[379] *Id.*

[380] *Id.*

[381] *Id.*

[382] *Id.*

[383] *Id.*

[384] *See* notes 53-61 and accompanying text.

[385] *See generally* Davoli, *supra* note 25; *see also* notes 57-60 and accompanying text.

and replacing them with nothing but neglect and despair has begun.

Mayor Adams has proposed a comprehensive, compassionate agenda centered on a key attribute of SMI, anosognosia. SMI obstructs a person's ability to recognize they are sick and need treatment. Mayor Adams' plan finally offers hope to people with SMI and their loved ones. For too long, the United States has cruelly abandoned people with SMI, making them prisoners of their illnesses, and subjecting them to incarceration, homelessness, exposure, and violence based on the flawed notion that honoring their anosognosia respects their civil liberties.

No longer does anyone believe that the mentally ill homeless are simply enjoying the great outdoors, if anyone ever did. No longer does anyone observing a person with untreated SMI hallucinating in public believe that to protect the person's liberty, society should aboadon the peron whose illness causes anosognosia to jails, prisons, and homelessness. A bold new world has arrived, one in which practical proposals to ease the suffering of people with SMI replace flawed governmental policies based on outdated stereotypes of the Cuckoo's Nest, the Snake Pit, and Bedlam. Finally, sanity has returned to the national conversation about serious mental illness.