IMPLEMENTATION OF KENDRA'S LAW CONTINUES TO BE SEVERELY BIASED

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EXECUTIVE SUMMARY

Since 1999, Kendra's Law – also referred to as Assisted Outpatient Treatment or Involuntary Outpatient Commitment[1] – has authorized New York courts to mandate that people with mental illness, who have a history of hospitalizations or violence, receive outpatient mental health services *over their objection*, thereby greatly reducing their freedom to make decisions about the most important aspects of their lives. As of February 25, 2025, there were 3,674 people under an active Involuntary Outpatient Commitment order statewide, including 1,684 in New York City.[2]

This report highlights that:

- There is no proof that Involuntary Outpatient Commitment is more effective than voluntary treatment and there is extensive literature pointing to the harms of treating individuals over objection.

- Twenty years after New York Lawyers for the Public Interest first reported on the bias of the law's implementation,[3] Black people continue to be far more likely than white and Hispanic[4] people to be subjected to Involuntary Outpatient Commitment orders,[5] and Hispanic people are more likely to be subjected to the law than white people.[6]

- The State's own data indicate that 38% of current Involuntary Outpatient Commitment orders involve Black individuals, despite the fact that Black individuals make up only 17.7% of the population,[7] 26% of the orders involve Hispanic individuals, who make up only 19.8% of the populations,[8] while 31% of the orders involve white people, although white individuals make up 54% of the population.[9] These disparities have existed for at least the past twenty years.

- The racial disparities in Involuntary Outpatient Commitment orders cannot be attributed to Black and Hispanic individuals having a higher rate of serious mental illness.

- There are significant geographic disparities in the implementation of Kendra's Law, with individuals who live in New York City being nearly three times more likely to be subjected to the law than people living in the rest of the state,[10] and counties with majority Black and Hispanic populations employing Kendra's Law more than five times more often than majority white counties.

- Rather than foster a supportive environment for recovery, Kendra's Law strips individuals of their autonomy, stigmatizes mental illness, and potentially worsens mental health conditions.

- There is no statistically significant difference in the rates of rehospitalization, quality of life, or arrests between those under Involuntary Outpatient Commitment orders and those engaging in voluntary treatment, according to at least one study.

Based on these findings, this report recommends that New York State:

- Discontinue use of Kendra's Law and in no event expand its scope or reach.

- In the interim, take proactive measures to eliminate racial bias from Involuntary Outpatient Commitment by mandating racial bias training for all those involved in the implementation of Kendra's Law, conduct outreach to underserved communities of color, and offer a diverse range of services, support, and engagement in mental health care.

- Decouple Kendra's Law "Enhanced Service Packages"[11] from Kendra's Law orders, and make them available to persons with mental health diagnoses without the requirement of Involuntary Outpatient Commitment.

- Shift funding from Kendra's Law to affordable, culturally competent,[12] and evidence-based[13] voluntary mental health treatment and social services, that provide both prevention and early intervention, including: peer[14] support, mental health urgent care centers, peer-led mental health crisis response teams, supportive housing, respite centers, and social services.

WHAT IS KENDRA'S LAW?

Kendra's Law, which took effect in November 1999, and is set forth in Section 9.60 of New York's Mental Hygiene Law, authorizes a court to order people with mental illness to accept outpatient "treatment" for their illnesses, over their objection. The law was never made permanent, and is reviewed for continuation every five years by the Legislature, which is charged with evaluating the impact of Kendra's Law on individuals with mental disabilities.[15]

The State Legislature and then-Governor George Pataki hurriedly approved Kendra's Law following a blitz of publicity over a horrific tragedy in a New York City subway. Andrew Goldstein, a man with schizophrenia who was unable to secure the mental health services he needed to stay well, pushed a young woman, Kendra Webdale, into the path of an oncoming train, killing her.[16] Goldstein's mental disabilities and his thirteen psychiatric hospital admissions were well documented.[17] All of Goldstein's hospital admissions were voluntary, and when he asked for additional help and services, he was denied them.[18]

By naming the law after Kendra Webdale, lawmakers suggested that the law deals primarily with people who commit violence against others – which is far from the case. The name also suggests that

Ms. Webdale might be alive today had her attacker been compelled to accept treatment – whereas in fact, Mr. Goldstein was trying to obtain services but could not because they were expensive and in short supply.[19] Thus, from its inception, Kendra's Law was not an appropriate response to this tragedy by New York lawmakers, who should instead have focused on addressing the well-known, long-standing, and persistent lack of mental health services in the state.

Tragic incidents involving individuals with mental illness, and violence in New York's subways and elsewhere, are terrifying for the community at large. Thus, it is critical to address root causes of these incidents so that all community members feel safe. While these tragedies draw mass attention, it is crucial to note that most people with mental health illnesses are no more likely to be violent than anyone else.[20] Further, studies show that "a mere 3%–5% of violent acts occurring in the community are attributable to mental illness,"[21] and that "[e]ven if serious mental illnesses were to be cured altogether, more than nine out of ten violent acts would still occur."[22] In fact, individuals with mental illness are much more likely to become victims of violent acts, rather than perpetrators.[23] Many with mental illness, like Goldstein, often report that treatment is unavailable or unaffordable, or that they lack information as to where to find services.[24] To appropriately address the small percentage of individuals with mental illness who are violent, investment in affordable, culturally competent, and evidence-based voluntary mental health treatment, that provides both prevention and early intervention, is critical.[25]

Involuntary Outpatient Commitment orders are intrusive and take away freedom of choice in many fundamental aspects of people's lives. These orders typically compel the taking of medications that have serious side-effects, participation in individual or group therapy at a specified clinic and at a specified time, participation in day treatment or rehabilitation programs that take up a majority of the individual's daytime hours, residence in a particular place which may have

extensive rules like curfews, and blood or urine testing to determine whether the individual is taking medication and/or abstaining from alcohol or street drugs.[26] In other words, Involuntary Outpatient Commitment orders control how, where, and from whom one receives services, with whom one must discuss deeply personal matters, and with whom one lives – wholly stripping away decision-making abilities.

One of the most important criteria for an Involuntary Outpatient Commitment order is that one must have either a) been hospitalized or received services in a mental health unit in a correctional facility twice in the prior three years, or, b) in the prior four years, have performed, attempted, or threatened some act of serious violent behavior towards oneself or someone else (not including any time the individual was hospitalized or incarcerated in the past six months) as a result of "non-compliance" with recommended treatment – an extremely subjective criterion.[27] The hospitalizations need not even have been involuntary, and the act, attempt, or threat need not even have been taken seriously enough to lead to arrest or commitment to a hospital. At a minimum, including voluntary hospitalizations in this standard is wholly counterproductive, as it penalizes individuals who are *voluntarily* seeking treatment, and runs the risk of discouraging them from actively pursuing care.

Each Kendra's Law order includes case management, which requires a case manager to report to mental health officials on the individual's compliance with the order.[28] While case management is important because it provides specialized support to individuals, and ensures they receive appropriate care and services in a timely manner, it can become problematic when coercion is introduced.

Under a Kendra's Law order, if a physician determines that the individual failed to comply with some aspect(s) of the order, and also determines that the person may need involuntary admission to a hospital, the physician may recommend, and the county director may then order, the person to be transported to a hospital and detained for up to 72 hours to determine if an involuntary inpatient hospital commitment is necessary.[29] The individual can be restrained while the 72-hour evaluation is in process.[30] The physician may consider any refusal of the person to take prescribed medication, failure to comply with services, or any test result which finds either medication non-compliance or alcohol or street drug use, in reaching the clinical determination regarding involuntary inpatient commitment.[31]

Passage of Kendra's Law brought profound changes to New York's mental health system. Never before had a New York court been authorized to force people with mental illnesses to take medications and accept services when not committed to a hospital. In addition, for the first time, outpatient treatment providers were made part of a system of monitoring compliance with mandated services – similar to probation officers – a task at great odds with their obligation to treat the individual's acceptance or non-acceptance of services as part of their confidential relationship with the individual.[32]

Moreover, for the first time, an enormous impediment to voluntary care stood in the way of treatment for the majority of individuals with mental health diagnoses who were pushed to the bottom of the waitlist for services, while only those potentially subject to Involuntary Outpatient Commitment orders could go to the head of the line to access services that were already in extremely short supply. In other words, the Office of Mental Health (OMH) tied the opportunity to receive critical mental health services to potential eligibility for a Kendra's Law order. However, there is no reason why these services could not simply be offered to high-needs individuals without a tie-in to Kendra's Law.

Specifically, under Kendra's Law, OMH authorizes counties to provide "Enhanced Service Packages" or "Voluntary Agreements"[33] to individuals who meet most of Kendra's Law criteria, but have never previously received care management or services.[34] The Enhanced Services Packages, in theory, allow people to access services without the compulsion of a court order.[35] However, if an individual fails to comply, they may be subject to a full Involuntary Outpatient Commitment order (if a judge concludes that the person meets each of the Kendra's Law court order criteria).[36]

By decoupling Enhanced Service Packages from coercive Kendra's Law orders, individuals can receive truly voluntary treatment that does not suffer from the moral and legal concerns created by Kendra's Law, particularly in view of its racially, ethnically, and geographically biased application.

Additionally, during the 2022-2023 legislative session, state lawmakers amended Kendra's Law to make it even more restrictive of the rights of individuals with mental disabilities. Kendra's Law now allows an order to be renewed within 30 days before the initial order expires.[37] Additionally, if an order has expired within the prior six months, the procedure for obtaining a new order is significantly less protective of the individual's rights than is the procedure for obtaining an initial order. The individual does not have to meet the criteria regarding

previous hospitalizations or acts of violence toward self or others. Rather, a renewal can now be accomplished if a person's mental illness "substantially interferes with or limits one or more major life activities."[38] This automatically equates the inability of a person to meet basic needs for food, clothing, shelter, or medical care with the "likely to result in serious harm to self or others" standard. It puts individuals diagnosed with mental health challenges at risk for Involuntary Outpatient Commitment, even if they are not violent or threatening.

The amendment also requires hospitals to share confidential patient records with county officials managing Involuntary Outpatient Commitment orders, and it allows doctors to merely make virtual court appearances.[39]

In 2025, Governor Kathy Hochul proposed further expanding Kendra's Law as well as New York's involuntary inpatient commitment laws.[40]

INVOLUNTARY TREATMENT IS NO MORE EFFECTIVE THAN VOLUNTARY TREATMENT

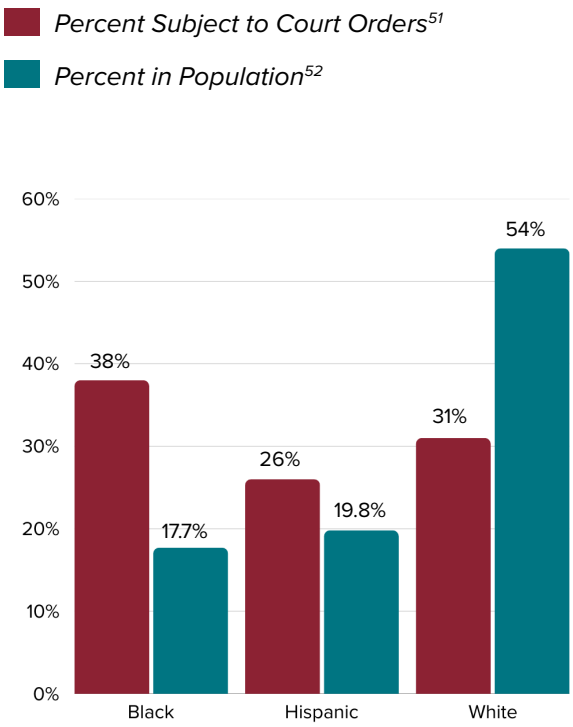
Voluntary mental health treatment is strongly encouraged by both health professionals and the courts because it respects individual autonomy and increases patient engagement.[41] Further, voluntary treatment bolsters the therapeutic alliance critical to recovery from mental health conditions.[42] Involuntary treatment, on the other hand, can undermine long-term patient independence and prevent the individual from seeking out voluntary treatment after a court order expires.[43] Moreover, most individuals report that they did not find their Involuntary Outpatient Commitment beneficial.[44] The United Nations Human Rights Council condemned coercive mental health treatment, stating that "[c]oercion in psychiatry perpetuates power imbalances in care relationships, causes mistrust, exacerbates stigma and discrimination and has made many turn away, fearful of seeking help within mainstream mental health services" and "immediate action is required to radically reduce medical coercion and facilitate the move towards an end to all forced psychiatric treatment and confinement."[45] Yet, Kendra's Law which mandates such involuntary commitment, has been repeatedly renewed since 1999, and the Governor intends to further expand the law in 2025.[46]

While the State claims benefits and positive outcomes for those subjected to Involuntary Outpatient Commitment orders, it is impossible to tell from its data what is accomplished by compulsion and what by enhanced access to the services that Kendra's Law provides.[47] By simply looking at the current data provided by OMH, it would appear that Kendra's Law is effective because those subject to it have a 66% reduction in psychiatric hospitalizations, a 73% decrease in incarcerations, and a 64% reduction in homelessness, compared to any time before they were subject to the order.[48] However, OMH does not provide any information to show that these outcomes are a result of, or can only result from, forced commitment.[49]

To the contrary, a study conducted at Bellevue Hospital that compared the effectiveness of voluntary and involuntary outpatient treatment, found that there was no statistically significant difference between the two groups' rates of rehospitalization, quality of life, or arrests.[50]

RACIAL BIAS IN THE IMPLEMENTATION OF KENDRA'S LAW

From November 1999 to February 25, 2025, there were 35,218 Kendra's Law petitions approved statewide, with disaggregation by race and ethnicity showing vast disparities:



These disparities have existed for at least the last 20 years.[53] Proponents of coercion argue that some people with mental illness do not appreciate their illness or their need for treatment and so must be coerced for their own good.[54] Even if this is true, it is very difficult to understand why Black and Hispanic people would be far more likely to fail to appreciate their need for treatment.

The National Institute of Mental Health (NIMH), among other prominent public and private mental health entities, offers several possible explanations of why implementation of Involuntary Outpatient Commitment laws are so skewed racially and ethnically:

- ***Unequal access to mental health treatment***
  Unequal access to mental health treatment occurs because Black and Hispanic people often receive poorer quality of care and lack access to culturally competent and evidence-based care due to systemic oppression.[55] This has also been underscored by the Surgeon General.[56]

- ***Poverty and high cost of treatment***
  Cost also presents a major barrier for communities of color, due at least in part to lack of insurance or underinsurance.[57]

- ***People selected from already biased pools***
  Black and Hispanic people are often selected from biased pools, like psychiatric hospitals and prisons, where factors such as historical adversity, racism, and lower access to services already exist.[58]

- ***Lack of suitable treatment to meet needs***
  Black and Hispanic people find services less suited to their needs because of mistrust, fear, racism, and discrimination in treatment, along with language and communication barriers.[59]

- ***Overdiagnosis of serious mental illness***
  Black and Hispanic people are more frequently diagnosed with severe conditions like schizophrenia, while white people are more often diagnosed with mood disorders, despite exhibiting similar symptoms.[60]

- ***Greater service usage from public providers***
  Individuals of color with mental disabilities are more likely to seek care from public providers who refer patients for involuntary treatment more often than private providers do.[61]

- ***Conscious or implicit bias on the part of those involved in referring and selecting people to whom to apply the law***
  Conscious or implicit biases related to race often manifest in the form of negative stereotypes about Black and Hispanic people, particularly regarding behaviors or mental health conditions.[62] For example, Black and Hispanic people are more likely to be perceived as "aggressive," "dangerous," or "non-compliant," even when they are not.[63] These biases can influence mental health professionals or law enforcement officers when deciding to refer someone for an Involuntary Outpatient Commitment order, leading to over-referrals of Black and Hispanic people, compared to white people who might exhibit similar symptoms or behaviors.[64]

- ***All or some combination of the above***[65]

A report of the New York State Bar Association Task Force on Mental Health and Trauma Informed Representation, which highlighted the racial disparities in the implementation of Kendra's Law, stated that the disparities are "disturbing indicators of continued disparities in resources and disengagement with health care systems."[66]

Similarly, researchers at the Duke University School of Medicine, who also highlighted the racial disparities in the implementation of Kendra's Law, found that "the overrepresentation of African Americans" is "a function of African Americans' higher likelihood of being poor, [and] uninsured, [having a] higher likelihood of being treated by the public mental health system (rather than by private mental health professionals), and [having a] higher likelihood of having a history of psychiatric hospitalization."[67] Duke's evaluation also notes that when considering only the seriously mentally ill population in New York – as opposed to the population at large – the disparity between Black and white people slightly decreases, but Black individuals remain three times more likely to be subject to Kendra's Law orders, showing that the rates of serious mental illness among Black individuals is not the cause of the gross racial disparity in Involuntary Outpatient Commitment orders.[68]

Despite these extensive findings of racial disparities in the implementation of Kendra's Law, New York has neither further studied the issue beyond the lone Duke study, nor, most critically, taken steps to rectify the injustice. Action to address these racial disparities is long overdue.

Notably, under N.Y. Mental Hyg. Law § 9.60(r), OMH must provide education and training materials to court personnel, local governmental units (LGUs), and the general public, on the use of Kendra's Law. The materials OMH makes publicly available on their website are largely designed to establish consistency in the forms and procedures used to execute Involuntary Outpatient Commitment

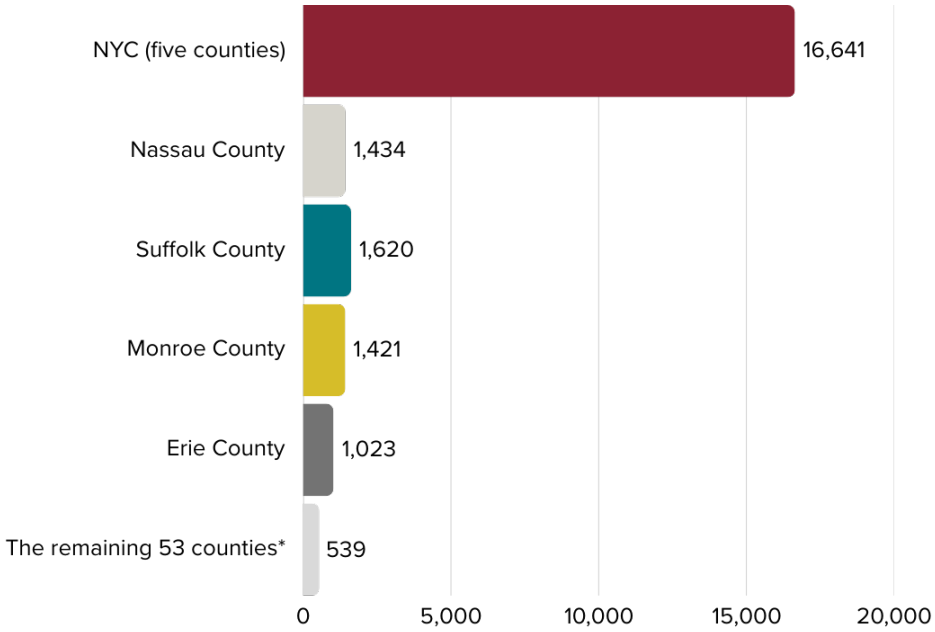
orders. However, the law further requires OMH to collaborate with the Office of Court Administration to train judges and court personnel, not just on procedure, but to establish a training program that will "address issues relating to mental illness and mental health treatment."[69] Critically, such training programs must include how to eliminate racial bias in mental healthcare, as this is an integral part of mental health service delivery. In addition, these training programs must be made publicly available to ensure greater accountability.

Outreach to Black and Hispanic individuals is also critical to eliminate racial bias in involuntary outpatient commitment as it ensures that racial minorities are informed, engaged, and supported in accessing and benefiting from voluntary mental health services, in lieu of coercion.[70] This outreach requires sufficient funding to effectively reach communities of color who can be understandably skeptical of the State's mental health system. A diverse range of services, support, and engagement designed to increase awareness of mental illness must also be tailored to the unique experiences of racial and ethnic minority communities, in order to address issues of shame, stigma, discrimination, and distrust.[71] This approach ensures that these communities receive relevant support while breaking down barriers to seeking help.[72]

Without comprehensive training and outreach on racial bias, and without offering a diverse range of services, support, and engagement in mental health care, Involuntary Outpatient Commitment orders will continue to disproportionately impact Black and Hispanic communities, perpetuating existing inequities.

THE GEOGRAPHICAL DISPARITIES IN THE IMPLEMENTATION OF KENDRA'S LAW FURTHER UNDERSCORE THE RACIAL DISPARITIES

By far, the largest number of Involuntary Outpatient Commitment orders in New York State exist in New York City, followed by Nassau, Suffolk, Monroe, and Erie Counties:

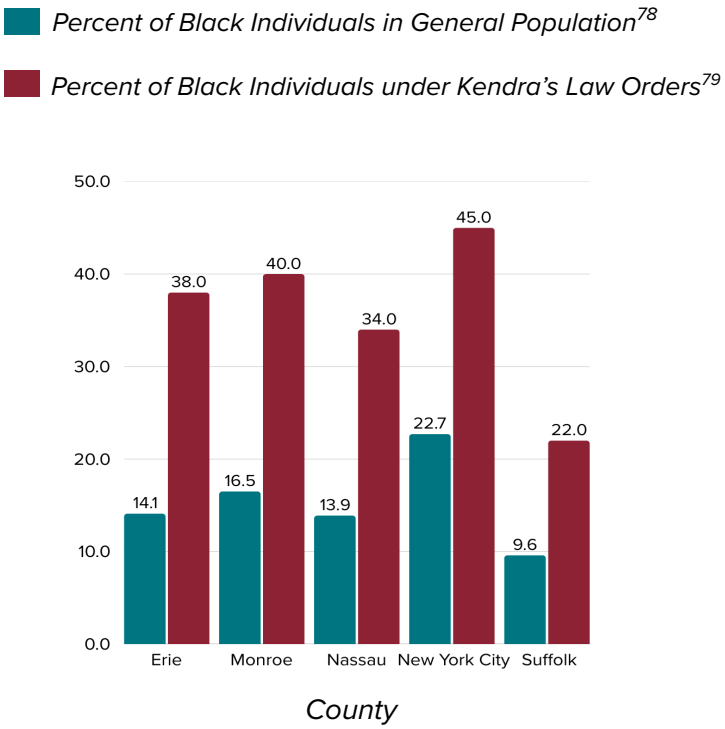


**combined (with Schuyler and Hamilton Counties) which have no orders*

And the racial disparities discussed above are not confined to state averages; they are also visible at the county level.

For example, counties like the Bronx, where there is a high percentage of people of color, have a dramatically disproportionate number of Involuntary Outpatient Commitment orders compared to predominately white counties like Oswego and Clinton. Bronx County, where only 9% of residents were white in 2023, had 33 orders per 100,000 residents.[75] In contrast, Oswego County, where 92.6% of residents were white in 2023, had only 4 orders per 100,000 residents.[76] Similarly, Clinton County, where 90.1% of residents were white in 2023, had only 6 orders per 100,000 residents.[77] The Bronx employed Kendra's Law more than five times more often than Oswego and Clinton Counties.

Notably, people of color face the highest number of court orders not only in counties where they make up a large percentage of the population, but also in some counties where they represent a smaller percentage, such as in Nassau and Suffolk counties, indicating bias across diverse communities:



The disproportionate issuance of Involuntary Outpatient Commitment orders in certain New York counties, and in majority Black and Hispanic counties, reflects a bias based on geographical location, with Black and Hispanic individuals being subjected to these orders at rates far exceeding their percentage in the population.

OTHER WAYS IN WHICH KENDRA'S LAW FALLS SHORT OF ITS MISSION

Kendra's Law, which was designed to ensure court-ordered treatment for individuals with severe mental illness and violent tendencies, is falling short of its mission in significant ways. An audit conducted by OMH from April 2019 to September 2023 revealed serious gaps in the implementation and monitoring of Involuntary Outpatient Commitment orders.[81] Despite a framework intended to connect recipients with timely treatment, the audit found that many LGUs failed to investigate referrals within a reasonable timeframe, and nearly half of the cases reviewed took over six months to address, with some delays stretching nearly two and a half years.[82] Delays often go unreported until significant incidents occur.[83] Further, many LGUs perform inadequate evaluations prior to order expirations, resulting in lapses in services.[84] With many LGUs neglecting proper protocols, the current structure of Kendra's Law does not ensure that individuals receive the treatment they require, ultimately undermining its intended purpose of promoting public safety and mental health.[85]

The deficiencies in the implementation of Kendra's Law subject individuals to unnecessary court orders and coercive treatment without cause. When evaluations are lacking, and timely investigations are not conducted, many people are forced into a system that does not address their actual needs or circumstances.
This results in individuals being subjected to Involuntary Outpatient

Commitment, despite not posing a genuine threat or lacking the necessary ability to engage meaningfully in treatment. Rather than fostering a supportive environment for recovery, the law's current implementation leads to excessive compulsory measures, stripping individuals of their autonomy and potentially worsening their mental health conditions.

EFFECTIVE VOLUNTARY MENTAL HEALTH SERVICES

Prioritizing prevention and early intervention, as well as access to affordable, culturally competent, and evidence-based voluntary practices, is key.[86] By significantly improving long-term outcomes, reducing symptoms, and preventing complications like substance use or self-harm,[87] prevention and early intervention measures will ultimately reduce the need for laws like Kendra's Law and the disparities that exist with its implementation. Prevention and early intervention also enhance emotional and social development in children, promote family well-being, and support healthier lifestyles by addressing mental health concerns early.[88]

Rather than invest in Involuntary Outpatient Commitment, New York must support evidence-based voluntary alternatives, many of which already exist in the State:

Peer support services, which are mental health services provided by peers,[89] allow individuals to be supported by those who draw from their personal experiences with mental health problems, including their recovery journey, to provide help and support to those in similar circumstances.[90] Along with support, peers offer hope, and they have substantially contributed to decreased hospitalization rates.[91]
New York must make peer support services an accessible treatment option for individuals with mental health conditions.

Mental health urgent care centers – such as the recently opened Support and Connection Centers in East Harlem and the Bronx[92] – provide short-term treatment and immediate access to services for those with mental health concerns.[93] ***New York must invest in more centers across the state and provide updates regarding outcomes and availability of these centers.***

Peer-led mental health crisis response teams, consisting of peers and emergency medical technicians, will address the current situation where police officers are the primary responders to emergency mental health calls. Sending police officers as first responders to mental health emergencies is counterproductive to the goal of providing adequate health care, and it far too frequently results in death for individuals experiencing mental health emergencies.[94] Police officers, whose expertise is in public safety and who are not healthcare providers, are not capable of de-escalating mental health crises.[95] ***Daniel's Law (S3670/A4617)[96] will establish precisely such a system statewide, and must be passed and signed into legislation forthwith.***

Supportive housing – a combination of affordable housing and support services designed to help individuals and families use housing as a platform for health and recovery[97] – will help address the fact that many individuals subjected to Involuntary Outpatient Commitment orders face homelessness.[98] Homelessness has been associated with mental health and substance use, and often triggers or exacerbates those illnesses.[99] ***Supportive housing must be expanded across the state.***

Respite centers provide an alternative to hospitalization for people experiencing mental health crises by offering services, including 24-hour peer support, self-advocacy education, social support groups, and psychoeducation.[100] ***New York must increase the number of respite centers to serve its community members in need.***

Social services, including ***food aid and employment skills training,*** must be made available to people with severe mental illness and limited income in order to promote mental wellness and stability. Increasing social services will improve the living conditions of all New Yorkers and address the social determinants of health like poverty, unemployment, and food insecurity that contribute to mental illness.[101] Food insecurity increases symptoms of anxiety and depression,[102] and employment is critical to mental health,[103] with individuals with serious mental illness reporting better quality of life and fewer psychiatric symptoms when employed.[104] ***New York must develop social services programs with significant input from peers, and substantially invest in them.***

Increasing access to voluntary mental health services gives individuals with mental disabilities a feeling of control over their treatment and trust in their providers.[105] True progress in mental health treatment relies on fostering an environment where individuals feel safe and empowered.[106] Ensuring appropriate service provision also requires that the service provider considers the person's culture, ethnicity, race, and beliefs when deciding the best way to care for, and interact with, that person.[107] Rather than use duress and coercive tactics, voluntary, culturally competent treatment is essential for increasing the likelihood that patients will seek care in the future and improve overall well-being.

RECOMMENDATIONS[108]

- ***New York State must discontinue use of Kendra's Law, and in no event expand its scope or reach.***

  A system that relies heavily on involuntary treatment and compulsion is fundamentally flawed and short-sighted. Certainly, Kendra's Law should not be expanded until the racial disparities are appropriately addressed and a study conclusively determines that involuntary treatment is more effective than voluntary treatment.

- ***New York State must eliminate racial bias in Involuntary Outpatient Commitment.***

  In the interim, New York State must take proactive measures to ensure that racial bias, whether conscious or implicit, does not influence the Involuntary Outpatient Commitment selection process.

  While the nation still has a long way to go in addressing racial disparities in mental health, the State must implement and

execute comprehensive training on racial bias pursuant to N.Y. Mental Hyg. Law § 9.60(r). Mental health professionals, county officials, court personnel, and law enforcement officers involved in the implementation of Kendra's Law must receive training to understand diverse cultural backgrounds and challenge stereotypes and implicit biases associated with race, in order to support appropriate decision making and actions, particularly for individuals from marginalized communities.

Eliminating the racial bias evident in the implementation of Kendra's Law also requires adequately funding and conducting outreach to communities of color that can be justifiably skeptical of engaging with the State's mental health system.

In addition, offering a diverse range of services, support, and engagement in mental health care ensures that individuals from all racial backgrounds have access to care tailored to their unique needs and cultural contexts. This approach fosters trust, reduces disparities in treatment outcomes, and helps dismantle racial biases by promoting inclusivity and ensuring that all patients feel heard, respected, and supported throughout their treatment.

- ***New York State must decouple Kendra's Law "Enhanced Service Packages" from Kendra's Law orders, and make them available to persons with mental health diagnoses without the requirement of Involuntary Outpatient Commitment.***

  New York State must separate "Enhanced Service Packages" from Kendra's Law orders to ensure that individuals have access to voluntary services that adequately meet their needs. Tying "Enhanced Service Packages" to Kendra's Law orders perpetuates the dangers of coercion highlighted in this report.

- ***New York State must increase access to affordable, culturally competent, and evidence-based mental health services, that provide prevention and early intervention, on a truly voluntary basis.***

  New York State must prioritize voluntary mental health services for individuals in highest need by increasing its funding for affordable, culturally competent, evidence-based, and truly voluntary mental health services, that include prevention and early intervention, including:

  - Peer Support Services
  - Mental Health Urgent Care Centers
  - Peer-led Mental Health Crisis Response Teams
  - Permanent Supportive Housing
  - Respite Centers
  - Social Services that provide access to food and employment skills training

CONCLUSION

The goal of New York's mental health service delivery must be to provide affordable, culturally competent, and evidence-based mental health services to everyone in need, on a genuinely voluntary basis.

The coercive nature of Involuntary Outpatient Commitment results in a loss of autonomy, including significant limitations on personal decision-making, a lack of engagement in services, decreased treatment satisfaction, a loss of confidentiality, and distrust in the system. Yet, there is no factual evidence that Involuntary Outpatient Commitment is more effective than voluntary treatment. Moreover, with its primary focus on psychiatric care, Involuntary Outpatient Commitment often neglects broader social needs that are crucial for an individual's recovery and stability, including food, shelter, and employment skills.

Critically, Black and Hispanic individuals, especially those residing in New York City, are disproportionately subjected to Involuntary Outpatient Commitment orders. These disparities cannot be justified by the prevalence of serious mental illness, and this raises serious concerns about the overall efficacy of our mental health system. Addressing these disparities is vital to more equitably implementing mental health policies and ensuring that all individuals receive the care and support they need, regardless of race or geographic location.

Kendra's Law must be discontinued, and in any event not expanded in any manner. Mental health services must be guaranteed without the threat of a court order, and New York must invest in voluntary services to meet the needs of all its community members.

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The authors also want to thank report reviewers William Brooks, Beth Haroules, Sadie Ishee, and Harvey Rosenthal.

ENDNOTES

1 This report uses the term “Involuntary Outpatient Commitment” rather than the more commonly used “Assisted Outpatient Treatment,” as “Involuntary Outpatient Commitment” more accurately reflects the involuntary nature of these programs, and also recognizes that services received under duress cannot constitute “treatment.”

2 N.Y. Off. of Mental Health, Reports – Program Statistics: Recipients under Court Order, https://my.omh.ny.gov/analytics/saw.dll?dashboard#reports (click on “Recipients under Court Order”) (last visited February 25, 2025).

3 NYLPI, Implementation of “Kendra’s Law” is Severely Biased (2005), https://www.nylpi.org/resource/implementation-of-kendras-law-is-severely-biased/.

4 This report uses the term “Hispanic” to reflect the language the New York Office of Mental Health includes in its statistics regarding Kendra’s Law.

5 N.Y. Off. of Mental Health, Reports – Characteristics of Recipients: Demographics, https://my.omh.ny.gov/analytics/saw.dll?dashboard#reports (click on “Race/Ethnicity”) (last visited February 25, 2025). It is unclear from the Office of Mental Health’s reporting whether these statistics reflect the percentage of individuals in each race that have been subject to Kendra’s Law since 1999, or if they reflect the current racial breakdown of Involuntary
Outpatient Commitment Orders.

6 Id.

7 Reports – Characteristics of Recipients: Demographics, supra note 5; U.S. Census Bureau, QuickFacts: New York (July 1, 2023), https://www.census.gov/quickfacts/fact/table/NY/PST045223.

8 Id.

9 Id.

10 Reports - Program Statistics: Recipients under Court Order, supra note 2.

11 “Enhanced Service Packages,” also known as “voluntary agreements” or “enhanced services” are used when an individual meets most of Kendra’s Law criteria, but has never previously received care management or services. See N.Y. Off. of Mental Health, Assisted Outpatient Treatment Frequently Asked Questions, https://my.omh.ny.gov/analytics/saw.dll?Dashboard&PortalPath=%2Fshared%2FAOTLP%2F_portal%2FAssisted%20Outpatient%20Treatment%20Reports&Page=home#faq (last visited Jan. 15, 2025).

12 See, e.g., Fountain House, Why is Cultural Competence Important in Mental Health Care? (Feb. 8, 2022), https://fountainhouse.org/news/why-is-cultural-competence-important-in-mental-health-care.

13 Evidence-based practice in mental health is "the integration of the best available scientific research from laboratory and field settings with clinical expertise so as to provide effective psychological services that are responsive to a patient's culture, preferences, and characteristics." Am. Psych. Ass'n, APA Dictionary of Psych. – Evidence-based Practice (Apr. 19, 2018), https://dictionary.apa.org/evidence-based-practice.

14 Peers are individuals with lived mental health or substance use experience. Substance Abuse and Mental Health Servs. Admin., Peer Support (2017), https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tacs/peer-support-2017.pdf.

15 N.Y. Off. of Mental Health, Assisted Outpatient Treatment, https://my.omh.ny.gov/analytics/saw.dll?Dashboard&PortalPath=%2Fshared%2FAOTLP%2F_portal%2FAssisted%20Outpatient%20Treatment%20Reports&Page=home#home (last visited Feb. 25, 2025).

16 Edie Magnus, A Deadly Encounter, NBC News (Jan. 20, 2007), https://www.nbcnews.com/id/wbna16713078.

17 Michael Winerip, Bedlam in the Streets, The N.Y. Times Magazine (May 23, 1999), https://www.nytimes.com/1999/05/23/magazine/bedlam-on-the-streets.html.

18 Id.

19 Id.

20 Substance Abuse and Mental Health Servs. Admin., Mental Health: Get the Facts (Apr. 24, 2023), https://www.samhsa.gov/mental-health/what-is-mental-health/facts.

21 Jeffery Swanson, Introduction: Violence and Mental Illness, 29 Harv. Rev. Psychiatry 1 (2021), https://psycnet.apa.org/record/2021-17250-001.

22 Id.

23 Norman Ghiasi et al., Psychiatric Illness and Criminality, StatPearls (Mar. 30, 2023), https://www.ncbi.nlm.nih.gov/books/NBK537064/; Heather Stuart, Violence and Mental Illness: An Overview, World Psychiatry (June 2023), https://pmc.ncbi.nlm.nih.gov/articles/PMC1525086/pdf/wpa020121.pdf.

24 Emilee Green, Mental Illness and Violence: Il. Crim. Just. Info. Auth. (May 4, 2020), https://icjia.illinois.gov/researchhub/articles/mental-illness-and-violence-is-there-a-link/.

25 Id.

26 N.Y. Mental Hyg. Law § 9.60(a)(1).

27 N.Y. Mental Hyg. Law § 9.60(c). One of the criteria about which the testifying psychiatrist must persuade the judge to obtain a Kendra's Law order is that the person is unlikely to participate in recommended treatment because of his or her illness. N.Y. Mental Hyg. Law § 9.60(c)(5) (Appendix A).

28 N.Y. Mental Hyg. Law § 9.60(i)(1).

29 N.Y. Mental Hyg. Law § 9.60(n)(iii).

30 Id.

31 N.Y. Mental Hyg. Law § 9.60(n)(i)-(iii).

32 N.Y. Mental Hyg. Law § 9.60(s).

33 N.Y. Off. of Mental Health, Assisted Outpatient Treatment Frequently Asked Questions, https://my.omh.ny.gov/analytics/saw.dll?Dashboard&PortalPath=%2Fshared%2FAOTLP%2F_portal%2FAssisted%20Outpatient%20Treatment%20Reports&Page=home#faq (last visited Jan. 15, 2025).

34 Id.

35 Id.

36 Marvin Swartz et al., N.Y. Assisted Outpatient Treatment Program Evaluation, Duke Univ. Sch. of Med., 5-6 (June 30, 2009), https://my.omh.ny.gov/analyticsRes1/files/aot/aot-2009-report.pdf.

37 N.Y. Mental Hyg. Law § 9.60(k)(1).

38 N.Y. Mental Hyg. Law § 9.60(c)(4)(iii).

39 In Miguel M. v. Barron, 17 N.Y.3d 37 (2011), New York's Court of Appeals ruled that the privacy rule under the Health Insurance Portability and Accountability Act (HIPAA), 42 U.S.C. § 1320d–9, prohibited disclosing a patient's medical records to a state agency for a Kendra's Law proceeding without the patient's authorization or notice of the agency's request or court order. The 2023 amendment thus potentially invites a host of legal challenges and litigation.

40 The Governor's FY26 budget proposes to amend the standard for likelihood of serious harm to include attenuated claims of a person's inability or refusal to provide for their basic needs in N.Y. Mental Hyg. Law § 9.60(c)(6). The Governor also now proposes to further amend the completely vague standard for reinstatement of an expired Kendra's Law order in § 9.60 (c)(4)(iii), a change that introduces the unconstitutionally vague and improperly broad standard that the person has experienced a substantial increase in symptoms that substantially interfere or limit the person's "ability to maintain their health or safety." https://www.budget.ny.gov/pubs/archive/fy26/ex/artvii/hmh-bill.pdf. Passage of these provisions will be

determined post-publication of this report.

41 Donald Stone, The Benefits of Voluntary Inpatient Psychiatric Hospitalization: Myth or Reality?, 9 B.U. Pub. Int. L. J. 25, 27 (1999) https://pubmed.ncbi.nlm.nih.gov/16506327/.

42 Id.

43 Michael Allen and Vicki Fox Smith, Opening Pandora's Box: The Practical and Legal Dangers of Involuntary Outpatient Commitment, 52 Am. Psychiatric Publ'g 342, 344 (2001), https://pubmed.ncbi.nlm.nih.gov/11239102/.

44 Martin Swartz et al., Endorsement of Personal Benefit of Outpatient Commitment among Persons with Severe Mental Illness, 9 Psych., Pub. Policy, and L. 70, 87 (2003), https://pubmed.ncbi.nlm.nih.gov/16700137/.

45 United Nations Human Rights Council, Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health (June 23, 2017), https://digitallibrary.un.org/record/1298436?v=pdf.

46 See supra note 40.

47 M. Susan Ridgely et al., The Effectiveness of Involuntary Outpatient Treatment, Rand Inst. for Civ. Just., xix (2001), http://www.rand.org/publications/MR/MR1340/mr1340.sum.pdf.

48 N.Y. Off. of Mental Health, Reports - AOT Recipient Outcomes, https://my.omh.ny.gov/analytics/saw.dll?Dashboard&PortalPath=%2Fshared%2FAOT%2F_portal%2FAssisted%20Outpatient%20Treatment%20Reports&Page=Recipient%20Outcomes (last visited Feb. 25, 2025).

49 See, e.g., Steve Kisely et al., Compulsory Community and Involuntary Outpatient Treatment for People with Severe Mental Disorders, Cochrane Database of Systematic Revs, 24 (Mar. 17, 2017) https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD004408.pub5/full; The Effectiveness of Involuntary Outpatient Treatment, supra note 47. Some argue that other studies have shown that Involuntary Outpatient Commitment can be effective; however, critically, those studies have not determined that the perceived successful outcomes cannot be achieved through voluntary treatment. See Swartz, supra note 36 at 53-54.

In 2023, OMH awarded $1 million to the Human Services Research Institute ("HSRI") to conduct a two-year review of its Involuntary Outpatient Commitment program starting in 2024. The evaluation "will compare the treatment and health outcomes for individuals who have received court ordered community-based services with the treatment of those who receive a comprehensive package of voluntary services." N.Y. Off. of Mental Health, N.Y. State Awards Contract to Evaluate Assisted Outpatient Treatment Program (Oct. 2, 2023), https://apps.cio.ny.gov/apps/mediacontact/public/view.cfm?parm=A878D280-BAA7-631A-6DE23D52D61F3E71. It should also examine

whether the lack of access to mental health and culturally competent services relate to the disproportionate use of Involuntary Outpatient Commitment orders on Black and Hispanic people; whether study participants were diagnosed with serious mental illnesses and/or if participants have a history of substance use; and whether individuals are housed or homeless at the time of receiving services.

50 Henry Steadman et al., Assessing the N.Y.C. Involuntary Outpatient Commitment Pilot Program, 52 Psychiatric Servs. 330, 333 (2001), https://pubmed.ncbi.nlm.nih.gov/11239100/.

51 Reports – Characteristics of Recipients: Demographics, supra note 5.

52 U.S. Census Bureau, QuickFacts: New York (July 1, 2023), https://www.census.gov/quickfacts/fact/table/NY/PST045223.

53 Implementation of "Kendra's Law" is Severely Biased, supra note 3. In 2005, NYLPI reported that 42% of Involuntary Outpatient Commitment orders in New York at that time were issued to Black individuals, despite Black people comprising only 16% of the population. Additionally, 21% of the orders involved Hispanic individuals, who made up just 15% of the population, while 34% were directed at white individuals, who accounted for 62% of the population. Thus, the racial disparities have remained largely unchanged.

54 Celia Quayum, Ethical Considerations of Involuntary Psychiatric Treatment, Psychiatric Times (Oct. 31, 2024), https://www.psychiatrictimes.com/view/ethical-considerations-of-involuntary-psychiatric-treatment.

55 U.S. Dep't of Health and Human Services, Mental Health: Culture, Race, and Ethnicity, 164 (2001), https://www.ncbi.nlm.nih.gov/books/NBK44243/pdf/Bookshelf_NBK44243.pdf.

56 Id.

57 Am. Psych. Ass'n, Mental Health Disparities: African Americans (Dec. 19, 2017), https://www.psychiatry.org/File%20Library/Psychiatrists/Cultural-Competency/Mental-Health-Disparities/Mental-Health-Facts-for-African-Americans.pdf.

58 See Mental Health: Culture, Race, and Ethnicity, supra note 55, at 53-58, 146, 163.

59 Id.

60 Mental Health Am., Black and African American Cmtys. and Mental Health (2021), https://africanamericanbehavioralhealth.org/ResourceMaterials/Black%20and%20African%20American%20Communities%20and%20Mental%20Health%20_%20Mental%20Health%20America.pdf; Mental Health: Culture, Race, and Ethnicity, supra note 55, at 145.

61 Julian Chun-Chung Chow et al., Racial/Ethnic Disparities in the Use of Mental Health Servs. in Poverty Areas, 93 Am. J. Pub. Health 792, 796 (2003), https://pubmed.ncbi.nlm.nih.gov/12721146/.

62 “Stereotypes” are fixed, general images or sets of characteristics that a large number of people believe represent a particular type of person or thing. Collins Dictionary, https://www.collinsdictionary.com/us/dictionary/english/stereotype (last visited Jan. 2, 2025); “Implicit Biases” are preferences or prejudices of which people holding them are not aware. Collins Dictionary, https://www.collinsdictionary.com/us/dictionary/english/implicit-bias (last visited Jan. 2, 2025).

63 Adrienne N. Milner et al., Black and Hispanic Men Perceived to Be Large Are at Increased Risk for Police Frisk, Search, and Force, PLOS.1, 10 (Jan. 19, 2016), https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0147158.

64 Stereotypes and implicit bias may also drive diagnostic errors. Psychiatrists may even conduct their patient evaluations in a more cursory fashion based on bias. Elizabeth Chapman et al., Physicians and Implicit Bias: How Doctors May Unwittingly Perpetuate Health Care Disparities, 28 J. of Gen. Internal Med. 1504, 1505 (2013), https://pubmed.ncbi.nlm.nih.gov/23576243/. One study found that physicians with greater bias spent less time on patient interaction, and that the patients picked up on that, describing those doctors as being “less patient-centered.” Louis Penner et al., The Effects of Oncologist Implicit Racial Bias in Racially Discordant Oncology Interactions, 34 J. of Clinical Oncology 2874, 2877 (2016), https://pubmed.ncbi.nlm.nih.gov/27325865/.

Based on stereotypes, psychiatrists are also likely to over-diagnose psychiatric disorders in patients who are part of historically marginalized groups. Yesenia Merino et al., Implicit Bias and Mental Health Professionals: Priorities and Directions for Research, 69 Psychiatric Services 723, 724 (2018), https://pubmed.ncbi.nlm.nih.gov/29493411/. Women and other minorities are “20% to 30% more likely than white men to experience a misdiagnosis” with respect to a mental disability. Liz Szabo, Med. Mistakes are More Likely in Women and Minorities, NBC News (Jan. 15, 2024), https://www.nbcnews.com/health/health-news/medical-mistakes-are-likely-women-minorities-rcna133726.

65 Mental Health: Culture, Race, and Ethnicity, supra note 55.

66 N.Y. State Bar Ass’n, Rep. and Recommendations of the N.Y. State Bar Ass’n Task Force on Mental Health and Trauma Informed Representation (June 2023), final-report-Task-Force-on-Mental-Health-and-Trauma-Informed-Representation-June-2023.pdf.

Racial bias is not confined to Involuntary Outpatient Commitment. In New York City, there is also evident racial disparity in those involuntarily transported to a hospital for psychiatric care. Only 23% of New York City’s population is Black, while Black individuals made up 54% of involuntary transports in 2024. N.Y.C. Mayor’s Off. of Cmty. Mental Health, 2024 Annual Rep. of Involuntary Transports (Jan. 31, 2025), https://mentalhealth.cityofnewyork.us/sdm_downloads/2024-involuntary-transports-annual-report.

67 Swartz, supra note 36, at 53. The report acknowledged that candidates for Involuntary Outpatient Commitment orders are "largely drawn from a population where Blacks are overrepresented: psychiatric patients with multiple involuntary hospitalizations in public facilities." Selecting Involuntary Outpatient Commitment orders from this pool perpetuates systemic bias as there is historical institutional racism in the U.S. mental health care system. While the Involuntary Outpatient Commitment system may not be intentionally racially biased, the numbers show that it is an inherently racially biased structure.

68 Swartz, supra note 36, at 53. NYLPI attempted to update these statistics by submitting a Freedom of Information Law request to the New York State Office of Mental Health (OMH) for the current racial breakdown of New Yorkers with serious mental illness. Unfortunately, OMH denied the request, erroneously stating that this information could be found on its website.

69 N.Y. Mental Hyg. Law § 9.60(r).

70 See Mental Health: Culture, Race, and Ethnicity, supra note 55, at 165-68.

71 Id.

72 Id.

73 Reports - Program Statistics: Recipients under Court Order, supra note 2.

74 Bronx: 4,002; Kings: 3,088; New York: 5,525; Queens: 3,222; Richmond: 804.

75 U.S. Census Bureau, QuickFacts: Bronx Cnty., N.Y. (July 1, 2023), https://www.census.gov/quickfacts/fact/table/bronxcountynewyork/PST045223; Reports - Program Statistics: Recipients under Court Order, supra note 2.

76 U.S. Census Bureau, QuickFacts: Oswego Cnty., N.Y. (July 1, 2023), https://www.census.gov/quickfacts/fact/table/oswegocountynewyork/PST045223; Reports - Program Statistics: Recipients under Court Order, supra note 2.
Note that OMH redacts the number of orders in a county if there are fewer than five orders. Reports - Program Statistics: Recipients under Court Order, supra note 2. OMH reported that Oswego had zero orders in 2023, meaning the true value was between 0 and 5. To account for this discrepancy, the calculation in this report assumes that Oswego County had a minimum of five orders in 2023.

77 U.S. Census Bureau, QuickFacts: Clinton Cnty., N.Y. (July 1, 2023), https://www.census.gov/quickfacts/fact/table/clintoncountynewyork/PST045223; Reports - Program Statistics: Recipients under Court Order, supra note 2.

78 U.S. Census Bureau, QuickFacts: Erie Cnty., N.Y., Nassau Cnty., N.Y., Suffolk Cnty., N.Y., Monroe Cnty. N.Y., N.Y.C., N.Y. (July 1, 2023), https://www.census.gov/quickfacts/fact/table/newyorkcitynewyork,nassaucountynewyork,monroecountynewyork,suffolkcountynewyork,eriecountynewyork/PST045223.

79 Reports – Characteristics of Recipients: Demographics, supra note 5.

80 The New York City county breakdown for Black individuals is as follows: Bronx: 48% of orders and 45.1% of population; Kings: 51% of orders and 32.8% of population; New York: 43% of orders and 18.4% of population; Queens: 38% of orders and 20.7% of the population; and Richmond: 33% of orders and 11.5% of the population. Although the Bronx alone of the New York counties shows little disparity between percent of orders for Black people and percent of Black people in the population, it nonetheless is among the counties with the highest percentage of Black people subject to Kendra's Law orders, since Black individuals make up a very large portion of the population (45.1%).

81 Andrea C. Miller et al., Oversight of Kendra's Law, Report 2022-S-43, N.Y. Off. of Mental Health (2024), https://www.osc.ny.gov/files/state-agencies/audits/pdf/sga-2024-22s43.pdf.

82 Id. at 12–13.

83 Id. at 14–15.

84 Id. at 2.

85 Id. at 18.

86 Behavioral Health Network, Evidence-Based Practice in Mental Health (May 2, 2023), https://www.bhninc.org/evp#:~:text=Evidence%2Dbased%20practice%20(EBP)%20in%20mental%20health%20is,through%20research%20studies%2C%20clinical%20trials%2C%20and%20meta%2Danalyses.

87 Pa. State Psychiatric Inst., The Power of Early Intervention in Mental Health: A Pathway to Wellness and Recovery, https://ppimhs.org/newspost/the-power-of-early-intervention-in-mental-health-a-pathway-to-wellness-and-recovery/#:~:text=Early%20detection%20and%20intervention%20for,term%20disability%20or%20chronic%20illness (last visited Feb. 12, 2025).

88 Id.

89 Substance Abuse and Mental Health Servs. Admin., Peers Supporting Recovery from Mental Health Conditions (2017), https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tacs/peers-supporting-recovery-mental-health-conditions-2017.pdf.

90 Id.

91 Larry Davidson et al., Peer Support among Persons with Severe Mental Illnesses: A Rev. of Evidence and Experience, 11 World Psychiatry 123, 125 (2012), https://pmc.ncbi.nlm.nih.gov/articles/PMC3363389/.

92 N.Y.C, Mayor Adams Opens New, Innovative Behavioral Health Facility for New Yorkers Experiencing Mental Illness (July 13, 2022), https://www.nyc.gov/office-of-the-mayor/news/499-22/mayor-adams-opens-new-innovative-behavioral-health-facility-new-yorkers-experiencing-mental#/0.

93 Jumaane D. Williams, Improving New York City's Responses to Individuals in Mental Health Crisis: 2022 Update, New York City Off. of the Pub. Advoc. (Nov. 16, 2022), https://advocate.nyc.gov/reports/improving-new-york-citys-responses-mental-health-crisis-2022/.

94 Christina Maxouris, These Mental Health Crises Ended in Fatal Police Encounters. Now, Some Communities are Trying a New Approach, CNN (Oct. 10, 2020), https://www.cnn.com/2020/10/10/us/police-mental-health-emergencies/index.html; Correct Crisis Intervention Today, See Their Faces. Say Their Names, https://www.ccitnyc.org/general-8 (last visited Feb. 24, 2025).

95 Chris James, There's a New Approach to Police Response to Mental Health Emergencies. Taking the Police Out of It, CNN (Apr. 2, 2021), https://www.cnn.com/2021/04/02/us/mental-health-police-response-go-there/index.html; see also N.Y. Off. Mental Health, Daniel's Law Task Force New York State Behavioral Health Crisis Response Rep. (2024), https://omh.ny.gov/omhweb/daniels-law-task-force/dltf-final-report.pdf.

96 Daniel's Law (S3670/A4617), https://www.nysenate.gov/legislation/bills/2025/A4617 (last visited Feb. 24, 2025).

97 N.Y.C. Dep't of Health, Housing Services (Supportive Housing), https://www.nyc.gov/site/doh/health/health-topics/housing-services-supportive-housing.page (last visited Dec. 30, 2024).

98 N.Y. Off. of Mental Health, Reports - Characteristics of Recipients: Significant Events, https://my.omh.ny.gov/analytics/saw.dll?Dashboard (last visited Feb. 25, 2025).

99 Lilanthi Balasuriya et al., The Never-Ending Loop: Homelessness, Psychiatric Disorder, and Mortality, 37 Psychiatric Times (May 29, 2020), https://www.psychiatrictimes.com/view/never-ending-loop-homelessness-psychiatric-disorder-and-mortality.

100 N.Y.C. Dep't of Health, Crisis Services/Mental Health: Residential Crisis Support and Respite Ctrs., https://www.nyc.gov/site/doh/health/health-topics/crisis-emergency-services-respite-centers.page (last visited Jan. 17, 2025).

101 See Ctrs. for Disease Control, Addressing Soc. Determinants of Health and Chronic Diseases (Aug. 14, 2024), https://www.cdc.gov/health-equity-chronic-disease/social-determinants-of-health-and-chronic-disease/index.html.

102 Ovinuchi Ejiohuo et al., Nourishing the Mind: How Food Insecurity Influences Mental Wellbeing, 16 Nutrients 4, 6 (2024), https://pmc.ncbi.nlm.nih.gov/articles/PMC10893396/.

103 Robert Drake and Michael Wallach, Employment is a Critical Mental Health Intervention, 29 Epidemiology and Psychiatric Sciences 1 (2020), https://pmc.ncbi.nlm.nih.gov/articles/PMC7681163/pdf/S2045796020000906a.pdf.

104 See Id.

105 Jason Craws and Michael Compton, Characteristics Associated with Involuntary Versus Voluntary Legal Status at Admission and Discharge among Psychiatric Inpatients, 41 Soc. Psychiatry and Psychiatric Epidemiology 981, 981 (Oct. 11, 2006), https://pubmed.ncbi.nlm.nih.gov/17041737/; Stone, supra note 41, at 27.

106 Why is Cultural Competence Important in Mental Health Care?, supra note 12.

107 Id.

108 NYLPI endorses the recommendations in the March 4, 2025 Community Access report, “Community Access’ Position Paper on Assisted Outpatient Treatment / Involuntary Outpatient Commitment.”

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