



ACLU of New York

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**In Opposition to GOVERNOR’S BUDGET PROPOSAL entitled  
*CONFIDENTIAL: Public Safety Package Proposals*  
9. Expand Involuntary Commitment and “Kendra’s Law”**

***March 23, 2022***

The New York Civil Liberties Union (NYCLU) is the New York affiliate of the American Civil Liberties Union and has long been devoted to the protection and enhancement of those fundamental rights and constitutional values embodied in the Bill of Rights and in the New York State Constitution. Those rights include the rights of personal liberty and bodily integrity deeply implicated by this proposal.

We write to express the NYCLU’s grave concerns regarding the proposed changes to Article 9 of the N.Y. Mental Hygiene Law, including the definitional changes proposed to § 9.01 and the changes proposed to § 9.60 (a/k/a “Kendra’s Law”) that are set forth in point 9 of the Governor’s “Public Safety Package.”

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People with mental illness are more likely to be victims of crime than perpetrators of it. But the Governor’s proposals presume that people living with mental illness are criminals. That presumption is both morally and factually wrong.<sup>1</sup> At a time when communities are demanding resources to address mental health, homelessness, and economic crises, the Governor’s plan focuses on criminalization and forced treatment.

Kendra’s Law is not some panacea for dealing with crime – not at all. The law is a civil remedy designed for only the most extreme circumstances, intended to address the so-called “merry-go-round’ of patients who would stabilize in the hospital,

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<sup>1</sup>“While the renewed focus and media attention on the importance of mental health in the aftermath of such tragedies is a positive development, the relationship between mental illness and criminality is too often conflated. The popular belief is that people with mental illness are more prone to commit acts of violence and aggression. The public perception of psychiatric patients as dangerous individuals is often rooted in the portrayal of criminals in the media as “crazy” individuals. A large body of data suggests otherwise. People with mental illness are more likely to be a victim of violent crime than the perpetrator. This bias extends all the way to the criminal justice system, where persons with mental illness get treated as criminals, arrested, charged, and jailed for a longer time in jail compared to the general population.” See Ghiasi N, Azhar Y, Singh J. *Psychiatric Illness and Criminality*. (Updated 2022 Jan 15), <https://www.ncbi.nlm.nih.gov/books/NBK537064/>.

only to decompensate because of a later failure to comply with outpatient treatment, causing rehospitalization.”<sup>2</sup> Kendra’s Law is an extraordinary use of state power and the New York Court of Appeals has held it subject to clear constitutional limits to prevent abuse – limits which the Governor’s proposed expansion is likely to violate. Expanding the standard of “harm to self” and creating a broader dragnet to force people into treatment is a provably failed strategy for connecting people to long-term effective treatment and care. In other words, the Governor’s plan would do nothing to further public safety.

New York State Office of Mental Health (“OMH”) Commissioner Ann Marie T. Sullivan and OMH Chief Medical Officer Thomas Smith have accurately explained how the Mental Hygiene Law already permits “persons who appear to be mentally ill and who display an inability to meet basic living needs” to be mandated into emergency psychiatric assessments and emergency and involuntary inpatient psychiatric admissions.<sup>3</sup> Yet the Governor inexplicably proposes an unconstitutionally broad and vague standard for involuntary admission to a psychiatric inpatient setting based on prediction of future harm to an individual who appears to be unable to “meet basic living needs.”

This language would upend a standard that New York courts have long held comports with constitutional guarantees of due process,<sup>4</sup> would undoubtedly be litigated, and would throw the entirety of the involuntary admission process into constitutional doubt. Because the § 9.01 definitional construct of “danger” to self or others is the operative standard that underpins all the provisions of the Mental Hygiene Law governing involuntary and emergency psychiatric admissions, the

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<sup>2</sup> See *In re Weinstock*, 191 Misc. 2d 143, 147, 742 N.Y.S.2d 477 (Sup. Ct. N.Y. County 2002).

<sup>3</sup> See *Interpretative Guidance for the Involuntary and Custodial Transportation of Individuals for Emergency Assessments and for Emergency and Involuntary Inpatient Psychiatric Admissions*, to: NYS Public Mental Health Providers, From: Ann Marie T. Sullivan, MD, Commissioner, NYSOMH, & Thomas Smith, MD, Chief Medical Officer, NYSOMH, Date: February 18, 2022, <https://omh.ny.gov/omhweb/guidance/interpretative-guidance-involuntary-emergency-admissions.pdf>. This document was issued by OMH, at the Governor’s behest, on February 18, 2022 (“OMH Guidance”), in connection with Governor Hochul’s and New York City Mayor Eric Adams’ unveiling of their joint plan to roust people from the New York City subway system. See *The Subway Safety Plan*, <https://www1.nyc.gov/assets/home/downloads/pdf/press-releases/2022/the-subway-safety-plan.pdf>. The Subway Safety Plan represents, for all intents and purposes, a policing response to addressing New Yorkers experiencing homelessness, mental health challenges and/or economic crises.

<sup>4</sup> See, e.g., *Project Release v. Prevost*, 722 F.2d 960 (2d Cir. 1983). In *Project Release*, the federal Second Circuit Court of Appeals upheld the constitutionality of New York’s voluntary, involuntary, and emergency commitment procedures contained in sections 9.13, 9.27, 9.37 and 9.39 of the Mental Hygiene Law. The Second Circuit concluded: “We are acutely aware of the severe curtailment of liberty which involuntary confinement in a mental institution can entail, and of the process that must be accorded to those who may be affected by such action of the state. We are also mindful of the state interests served in providing care for those in need of treatment for mental illness and in maintaining order and preventing violence to self and others. With these concerns in mind, and having considered the New York M.H.L. in its entirety, our inquiry leads us to conclude that the statute does meet the minimum facial requirements of due process — both substantive and procedural.” *Id.* at 975.

governor's proposed amendment to § 9.01 may very well result in the invalidation of all the involuntary and emergency admission provisions of Article 9 of the Mental Hygiene Law as unconstitutional violations of a person's due process rights.

The Governor also proposes fundamental and unconstitutional alterations to Kendra's Law, N.Y. Mental Hygiene Law § 9.60. By inserting the proposed standard in amended §§ 9.01 and 9.39 to a new provision of § 9.60, the Governor would apply a Kendra's order to people who appear that they cannot provide food, shelter, clothing, or medical services for themselves. By subjecting these individuals to involuntary outpatient treatment, the Governor would eliminate the Kendra's Law requirements that a person must have a "history of lack of compliance with treatment for mental illness" and that the person is "likely to benefit from assisted outpatient treatment." Mental Hygiene Law § 9.60(c)(4) and (7). Yet these two criteria that the Governor intends to strike from Kendra's Law statutory regime formed the linchpin of the New York Court of Appeals' 2004 decision upholding Kendra's Law against constitutional challenge.<sup>5</sup> Amending Kendra's Law as the Governor proposes would fundamentally and inappropriately alter the due process and equal protection rights of a recipient of a § 9.60 order, in derogation of constitutional norms and long-established New York Court of Appeals jurisprudence.

These points are discussed more fully below.

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### **Proposed Amendments to N.Y. Mental Hygiene Law §§ 9.01 and 9.39**

The Governor's proposed amendments to N.Y. Mental Hygiene Law §§ 9.01 and 9.39 rest on a redefinition of the defined term "likelihood to result in serious harm" or "likely to result in serious harm." As defined in MHL § 9.01(a), that term *currently* provides that the "risk of physical harm to the person" must be "manifested by threats of or attempts at suicide or serious bodily harm or other conduct demonstrating that the person is dangerous to himself or herself." The Governor proposes to add a new subsection (b) to § 9.01 and a new section (a)(3) to § 9.39 that provides "that as a result of a person's mental illness, a person lacks significant capacity to provide, and significant judgment to accept, provisions for food, clothing, shelter, or medical care, to the degree that there is a substantial risk of physical harm to self within the reasonably foreseeable future."

Crucially, a change to the definition of "likelihood to result in serious harm" or "likely to result in serious harm" set forth in § 9.01 actually changes multiple other

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<sup>5</sup> See *In re K.L.*, 1 N.Y.3d 362, 366, 774 N.Y.S.2d 472 (2004). You may be aware that the NYCLU was actively involved in the drafting, and passage, of "Kendra's Law". The NYCLU, with others, also challenged the constitutionality of "Kendra's Law" shortly after the law was enacted. The NYCLU participated as *amicus curiae* counsel in both the *K.L.* litigation and a predecessor litigation, *In re Urcuyo*, 185 Misc. 2d 836, 714 N.Y.S.2d 862 (Sup. Ct. N.Y. County 2000).

provision of Article 9 of the Mental Hygiene Law beyond § 9.39. This term is used in the following sections of Article 9:

- § 9.37 - Involuntary admission on certificate of a director of community services or his designee.
- § 9.39 - Emergency admissions for immediate observation, care, and treatment.
- § 9.40 - Emergency observation, care and treatment in comprehensive psychiatric emergency programs.
- § 9.41 - Emergency admissions for immediate observation, care, and treatment; powers of certain peace officers and police officers.
- § 9.43 - Emergency admissions for immediate observation, care, and treatment; powers of courts.
- § 9.45 - Emergency admissions for immediate observation, care, and treatment; powers of directors of community services.
- § 9.57 - Emergency admissions for immediate observation, care and treatment; powers of emergency room physicians.
- § 9.58 - Transport for evaluation; powers of approved mobile crisis outreach teams.

As noted above, this definitional change unnecessarily introduces an unconstitutionally vague and improperly broad standard into Article 9. But the change is more befuddling in light of the fact that OMH already interprets existing law to cover individuals struggling to meet basic needs. As Commissioner Sullivan explains in the OMH Guidance:

There is often a misconception amongst both police as well as front-line mental health crisis intervention workers that a person with mental illness must present as “imminently dangerous” in order to be removed from the community to a hospital or CPEP setting for evaluation, admission and treatment, meaning that they need to present an immediate overt risk of violence to others or an immediate overt risk of physical harm to themselves in order for removal to be implemented. This is not the case.

The Mental Hygiene Law provides authority for peace officers and law enforcement officers to take into custody for the purpose of a psychiatric evaluation those individuals who appear to be mentally ill and are conducting themselves in a manner which is likely to result in serious harm to self or others, which includes *persons who appear to be mentally ill and who display an inability to meet basic living needs, even when there is no recent dangerous act.*

Likewise, Directors of Community Services, as well as physicians or qualified mental health professional who are members of an approved mobile crisis outreach team, have the power to remove or to direct the removal of any person to a hospital for the purpose of evaluation for admission if such person appears to be mentally ill and is conducting himself or herself in a manner which is likely to result in serious harm to the person or others, which includes persons with a mental illness who displays an inability to meet basic living needs, even when there is no recent dangerous act.

Limiting the application of the Mental Hygiene Law's (MHL) removal and admission provisions to only those who present as "imminently dangerous" leaves vulnerable persons at risk in the community without an opportunity for assessment, care and treatment, and can also impact the public safety.

(Emphasis in original).<sup>6</sup>

Moreover, the Governor's proposed due process standard – "**substantial risk of physical harm to self within the reasonably foreseeable future**" – deviates significantly from the due process standard for emergency or involuntary psychiatric assessment established over decades by New York State courts. As the OMH Guidance notes, for example, *In Matter of Scopes*, the Appellate Division's Third Department ruled that in order to satisfy substantive due process requirements, "the continued confinement of an individual must be based upon a finding that the person to be committed **poses a real and present threat of substantial harm to himself or others.**"<sup>7</sup>

The Governor's proposed standard is overbroad and would result in erroneous hospitalization of non-dangerous and non-mentally ill individuals – an unconstitutional deprivation of individual liberty. The vagueness will inevitably result in the arbitrary application of the statute due to the unreliability of psychiatric prediction of "substantial risk of physical harm to self within the reasonably foreseeable future" – language which does not reflect a clinical standard. The Governor's proposed alterations to §§ 9.01 and 9.39 will inevitably open the door to significant and protracted litigations in the federal and New York State Courts.

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<sup>6</sup> See OMH Guidance, n.3 *supra*.

<sup>7</sup> *Matter of Scopes v. Shah*, 59 A.D.2d 203, 398 N.Y.S.2d 911 (3d Dep't 1977) (emphasis added). See also *Matter of Carl C.*, 126 A.D.2d 640 (2d Dept 1987) ("State must prove, by clear and convincing evidence, that the person is mentally ill and that he poses a substantial threat of physical harm to himself (resulting) from a refusal or inability to meet his essential needs for food, clothing or shelter"). The Governor's proposed standard eliminates the temporal aspect of the existing standard that requires the State to demonstrate to a court a "real and present threat of substantial harm" to an individual. Instead, the Governor's proposal improperly expands the risk standard to "the reasonably foreseeable future."

For all of these reasons, the Governor's proposed amendments to Mental Hygiene Law §§ 9.01 and 9.39 (and by extension, the entirety of Mental Hygiene Law Article 9) should be rejected.

**Proposed Amendments to N.Y. Mental Hygiene Law § 9.60, "Kendra's Law"**

In 1999, the New York legislature adopted Mental Hygiene Law § 9.60, commonly referred to as "Kendra's Law" or "AOT" (assisted outpatient treatment). "Kendra's Law" expanded the circumstances under which the State may compel persons with psychiatric disabilities to undergo treatment against their will or to participate involuntarily in mental health programs even if those individuals do not meet the criteria for involuntary hospitalization and/or medication. As noted above, in enacting "Kendra's Law", "clearly, the Legislature was concerned with the 'merry-go-round' of patients who would stabilize in the hospital, only to decompensate because of a later failure to comply with outpatient treatment, causing rehospitalization." *In re Weinstock*, 191 Misc. 2d 143, 742 N.Y.S.2d 477 (Sup. Ct. N.Y. County 2002). In justifying overriding the fundamental right of a person to determine his or her course of medical treatment,<sup>8</sup> the Legislature found:

...there are mentally ill persons who are capable of living in the community with the help of family, friends and mental health professionals, but who, without routine care and treatment, may relapse and become violent or suicidal, or require hospitalization. The legislature further finds that there are mentally ill persons who can function well and safely in the community with supervision and treatment, but who without such assistance, will relapse and require long periods of hospitalization.

The legislature further finds that some mentally ill persons, because of their illness, have great difficulty taking responsibility for their own care, and often reject the outpatient treatment offered to them on a voluntary basis. Family members and caregivers often must stand by helplessly and watch their loved ones and patients decompensate. Effective mechanisms for accomplishing these ends include: the establishment of assisted outpatient treatment as a mode of treatment;

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<sup>8</sup> The right of a person to determine his or her course of medical treatment has long been recognized as a fundamental right by the courts in this country. *In Matter of Storer*, 52 N.Y. 2d 363, 438 N.Y.S. 2d 256, 420 N.E. 2d 64 (Ct. App. 1981) the New York Court of Appeals recognized that a patient's right to choose his own medical treatment was superior to the doctor's obligation to provide care, even if the medical treatment was necessary to preserve the patient's life. And, in the seminal New York Court of Appeals' decision in *Rivers v. Katz*, 67 N.Y. 2d 483, 504 N.Y.S. 2d 74, 435 N.E. 2d 337 (1986), the Court stated that the modern trend in the legal and psychiatric fields is to give even those inpatients suffering from psychological disabilities an increasing amount of control over all of their treatment decisions -- including what medication regimes he or she follows, what therapy sessions he or she attends, and what other mental health programs he or she participates in.

improved coordination of care for mentally ill persons living in the community; the expansion of the use of conditional release in psychiatric hospitals; and the improved dissemination of information between and among mental health providers and general hospital emergency rooms.”<sup>9</sup>

Involuntary outpatient commitment orders under §9.60 (“Kendra’s orders”) typically involve judicial decrees that compel the administration of psychotropic drugs and require participation in other mental health services. These orders are intrusive invasions of personal liberty and bodily integrity. According to the New York State Office of Mental Health, § 9.60 orders determine what medications a people must take; where they receive therapy, spends much of the day (day treatment or rehabilitative programs) and lives (such as a community residence with a curfew and many rules); and whether and when they submit to blood and urine testing.<sup>10</sup> Since 1999, there have been 30,034 such intrusive orders entered statewide.<sup>11</sup>

In order to obtain a Kendra’s order, the court must first determine, by clear and convincing evidence, that:

- the individual has a history of noncompliance with treatment that has led to at least two hospitalizations or one or more acts of serious violent behavior or threats of, or attempts at, serious physical harm (§ 9.60 (c) (4));
- the individual is not likely to voluntarily comply with treatment in the absence of a Kendra’s order (§ 9.60 (c) (5));
- in view of this history, the individual “is in need of assisted outpatient treatment in order to prevent a relapse or deterioration which would be likely to result in serious harm to the patient or others” (§ 9.60 (c) (6));
- it is likely that the individual will benefit from assisted outpatient-treatment (§ 9.60 (c) (7)); and
- assisted outpatient treatment is the **least restrictive alternative** for the individual (§ 9.60 (j) (2)) (emphasis added).

As noted above, the Governor proposes expanding a Kendra’s order to include people who appear that they cannot provide food, shelter, clothing, or medical services

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<sup>9</sup> *In re Urcuyo*, 185 Misc. 2d 836, 714 N.Y.S.2d 862 (Sup. Ct. N.Y. Cty. 2000) (citing L.1999, ch. 408, § 1).

<sup>10</sup> See *Assisted Outpatient Treatment, OMH Data Analytics* dashboard Reports: *Program Statistics: Service Enhancements* and *Recipient Outcomes: Service Participation*, [https://omh.ny.gov/omhweb/kendra\\_web/khome.htm](https://omh.ny.gov/omhweb/kendra_web/khome.htm). Note all these mandated services can be viewed on both a regional basis, and, specifically, in New York City on a borough by borough basis. OMH has stopped reporting on mandated participation in individual and/or group therapy, blood or urine testing or day program services.

<sup>11</sup> See *Assisted Outpatient Treatment, OMH Data Analytics* dashboard, *Reports: Program Statistics: Petitions Filed*, [https://omh.ny.gov/omhweb/kendra\\_web/khome.htm](https://omh.ny.gov/omhweb/kendra_web/khome.htm).

for themselves. In adding this category of individuals to those who are subject to involuntary outpatient treatment, the Governor would eliminate the “Kendra’s Law” requirements that a person must have a “history of lack of compliance with treatment for mental illness” and that the person is “likely to benefit from assisted outpatient treatment.”<sup>12</sup> Yet these two criteria that the Governor intends to strike from the Kendra’s Law statutory regime underpinned the New York Court of Appeals’ 2004 decision upholding Kendra’s Law against constitutional challenge. The Governor’s proposal also adds a new subparagraph (iv) to § 9.60 (c) (4) that provides for an expired Kendra’s order to be revived on the decidedly vague basis that “the person has experienced a substantial increase in symptoms of mental illness” – language which also falls well below the very high standard for subjecting an individual to involuntary treatment.

*Constitutional Concerns: Violation of the Due Process Clause*

When the State seeks to deprive an individual of liberty, it must provide effective procedures to guard against an erroneous deprivation. A determination of the process that is constitutionally due thus requires a weighing of three factors: the private interest affected; the risk of erroneous deprivation through the procedures used and the probable value of other procedural safeguards; and the government's interest.<sup>13</sup>

In *In re K.L.*, the New York Court of Appeals determined the statute's procedure for obtaining a Kendra’s order comported with due process. In reaching its determination, the Court of Appeals reasoned that because a Kendra’s order requires a specific finding by clear and convincing evidence that an individual is in need of assisted outpatient treatment in order to prevent a relapse or deterioration which would be likely to result in serious harm to self or others, “the state's police power justified the minimal restriction on the right to refuse treatment inherent in an order that the individual comply as directed.”<sup>14</sup>

In addition, the Court of Appeals reasoned that the State's *parens patriae* interest in providing care to its citizens who are unable to care for themselves because of mental illness was properly invoked since a Kendra’s order requires “findings, by clear and convincing evidence, that an individual is unlikely to survive safely in the

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<sup>12</sup> The Governor’s proposal adds a new subparagraph (iii) to § 9.60 (c) (4) that reads as follows:

(iii) prior to the filing of petition, and **without having to prove (c) 4 of the criteria**, resulted in an inpatient psychiatric admission for a person who has a mental illness and lacks significant capacity to provide, and significant judgment to accept, provisions for food, clothing, shelter, or medical care, to the degree there is a substantial risk of physical harm to himself within the reasonably foreseeable future.

The Governor’s proposal also entirely eliminates any consideration of whether a person is likely to benefit from the assisted outpatient treatment contained in (§ 9.60 (c) (7).

<sup>13</sup> See *Mathews v. Eldridge*, 424 U.S. 319, 335, 96 S.Ct. 893, 47 L.Ed.2d 18 (1976).

<sup>14</sup> *In re K.L.*, 1 N.Y.3d 362, 366, 774 N.Y.S.2d 472 (2004).



community without supervision and, further that the individual has a history of lack of compliance with treatment that has either necessitated hospitalization or resulted in acts of serious violent behavior or threats of, or attempts at, serious physical harm.”<sup>15</sup>

Accordingly, the *K.L.* court determined that “in requiring that these findings be made by clear and convincing evidence and that the assisted outpatient treatment be the least restrictive alternative, the statute's procedure for obtaining a (Kendra's) order provides all the process that is constitutionally due.”<sup>16</sup>

The Governor's proposal inexplicably abandons the State's invocation of *parens patriae* authority by eliminating its obligation to demonstrate that a person is likely to benefit from assisted outpatient treatment. And the Governor's proposal eliminates the fundamental factual findings that must be found by clear and convincing evidence, placing this proposal's constitutionality in grave doubt. Compounding the due process insult to people living with mental illness, the Governor's language proposes that an expired Kendra's order may be revived on the vague basis that “the person has experienced a substantial increase in symptoms of mental illness” without any process at all cannot withstand constitutional scrutiny.

#### Constitutional Concerns: Violation of the Equal Protection Clause

The Equal Protection Clause enshrined in the U.S. Constitution, 14th Amendment, § 1, provides that no State shall “deny to any person within its jurisdiction the equal protection of the laws.” Equal Protection mandates that “all persons similarly situated should be treated alike.”<sup>17</sup> The Equal Protection Clause of the New York Constitution provides substantially the same rights.<sup>18</sup>

Cases involving fundamental rights (such as an autonomy right against involuntary treatment by the government) are “subjected to strict scrutiny and will be sustained only if (...) suitably tailored to serve a compelling state interest.”<sup>19</sup>

As noted above, the court in *In re Urcuyo* rejected the claim that Kendra's Law violated the Equal Protection rights of individuals subject to a Kendra's order because “assisted outpatient subjects” are not similarly situated to involuntarily committed psychiatric patients. The *Urcuyo* court reasoned that, unlike the involuntarily committed psychiatric patients, “the subjects of an assisted outpatient treatment order are persons who live in the community and have a history of dangerousness to self or others which has been satisfactorily demonstrated to the court upon clear and convincing evidence. Furthermore, it has been demonstrated that they are likely to

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<sup>15</sup> *Id.* at 366.

<sup>16</sup> *Id.* at 366.

<sup>17</sup> *City of Cleburne v Cleburne Living Ctr.*, 473 U.S. 432, 439 (1985).

<sup>18</sup> *See Alevy v Downstate Med. Ctr.*, 39 N.Y.2d 326 (1976).

<sup>19</sup> *See Heller v Doe*, 509 U.S. 312, 318-319 (1993).

decompensate and become dangerous again if they fail to follow their treatment plans.”<sup>20</sup> The New York Court of Appeals confirmed this analysis in *In re K.L.*, holding that Kendra’s Law in “no way treats similarly situated persons differently.”<sup>21</sup>

The Governor’s determination to create a new subclass of individuals subject to a Kendra’s order violates the equal protection rights of the members of that new subclass insofar as it is unfair to subject an individual *without* a proven history of non-compliance with mental health treatment to be included in the net of mandated outpatient treatment. For a person without such history of non-compliance leading to a cycling in and out of inpatient hospitalization, the solution for that individual must lie outside the of the paradigm of assisted outpatient treatment.

*In re K.L.* marked the end point in constitutional challenges to Kendra’s Law. For the reasons set forth above, the Governor’s proposed amendments to Kendra’s Law will reopen the door to new constitutional challenges. We respectfully urge you to reject these proposed significant changes to MHL § 9.60.

### **The Application of Kendra’s Law Has Revealed Racial Disparities and Systemic Lack of Health Access**

Kendra’s Law is scheduled to expire as of June 30, 2022, unless the Legislature takes further action to extend the law – something that should certainly not be part of a rushed budgetary negotiation.<sup>22</sup> Since the law was enacted in 1999, the Legislature has correctly declined to make the law permanent while mandating OMH to continue to study the efficacy of implementation of the assisted outpatient treatment regime and the potential racial biases evident in the system. Rather than expand Kendra’s Law, the legislature should be taking a critical eye to the statute’s existing use – which has produced little beyond acute racial disparities.

The information provided by the New York State Office of Mental Health in its mandated statistical public reporting continues to reveal **major racial and geographic disparities** throughout New York State, particularly in the New York City region.<sup>23</sup> In addition, there appears to be a fair amount of age and gender bias, inextricably linked to racial biases, in the implementation of Kendra’s Law.<sup>24</sup>

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<sup>20</sup> *Urcuyo*, n.9 *supra*.

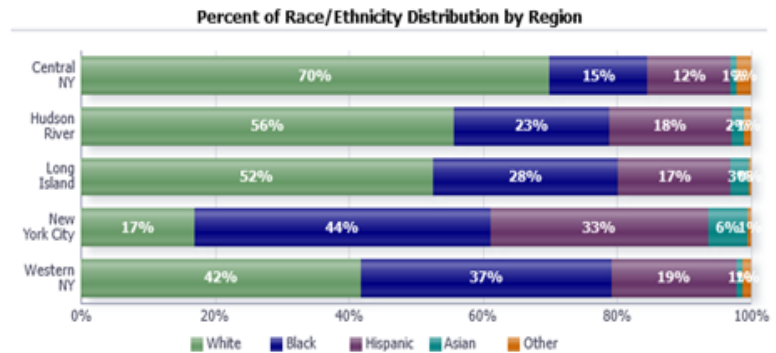
<sup>21</sup> *In re K.L.*, n.14 *supra* at 366.

<sup>22</sup> The Assembly and the Senate budget bills took differing positions on the renewal question. The Assembly proposed renewing the law for 5 years; the Senate for 1 year only.

<sup>23</sup> See *Assisted Outpatient Treatment*, OMH Data Analytics dashboard [https://omh.ny.gov/omhweb/kendra\\_web/khome.htm](https://omh.ny.gov/omhweb/kendra_web/khome.htm). New York City has the highest number of individuals in New York State under Kendra’s Order – now and since initiation in 1999, 11,835 of the statewide 19,567 Kendra’s Orders entered are in the five boroughs of New York City.

<sup>24</sup> *Id.* There continue to be extensive racial disparities in the application of Kendra’s orders. As of last month, OMH’s data showed 77% of all orders in NYC and 65% across the entire state, are entered against people of color, particularly men of color. See also, *New York Lawyers for the Public Interest Health Justice Project: IMPLEMENTATION OF “Kendra’s Law” IS SEVERELY BIASED*, dated April 7,

Region	White	Black	Hispanic	Asian	Other
Central NY	70%	15%	12%	1%	2%
Hudson River	56%	23%	18%	2%	1%
Long Island	52%	28%	17%	3%	0%
New York City	17%	44%	33%	6%	1%
Western NY	42%	37%	19%	1%	1%
Statewide	31%	38%	26%	4%	1%



We respectfully submit that the disproportionate use of Kendra’s Law court orders with communities of color, particularly in New York City, is representative of a deeper failure of our community mental health system to properly engage and serve those communities.

We also respectfully submit that the New York State Office of Mental Health has been unable, over the two decades that Kendra’s Law has been operational, to submit any evidence that the compulsion portion of Kendra’s Law has served any purpose whatsoever.<sup>25</sup> Indeed, the only benefit that a § 9.60 order appears to confer on an individual is preferential access to scarce mental health resources—access that should not require an invasive order to obtain. All research on court-ordered mental health treatment demonstrates that **the two most salient factors in reducing recidivism and problematic behavior among people with severe mental illness are access to enhanced services, and access to enhanced case management/monitoring services.**<sup>26</sup>

2005, <https://www.nympi.org/resource/implementation-of-kendras-law-is-severely-biased/>.

<sup>25</sup> OMH reports on Improved Self-Care & Social and Community Functioning, purporting to measure people’s outcomes in areas such as “Building Relationships,” “Emergency and safety skills,” “Keeping appointments,” “Managing Stressful Life Events,” “Meal Preparation,” “Meaningful activities,” “Medication management,” “Physical health,” “Self care and taking care of daily needs,” and “Transportation.” These measures purport to demonstrate “reduced difficulty in areas of Self-Care & Social and Community Functioning at six months and at most recent follow-up compared to difficulties at onset of AOT.” Yet, the OMH data shows very limited “success” in these domains. See Assisted Outpatient Treatment, OMH Data Analytics dashboard, *Reports: Recipient Outcomes: Improved Self-Care & Social and Community Functioning*, [https://omh.ny.gov/omhweb/kendra\\_web/khome.htm](https://omh.ny.gov/omhweb/kendra_web/khome.htm).

<sup>26</sup> One of the most comprehensive and best-designed studies of outpatient commitment was carried out at New York City’s Bellevue Hospital. See Steadman, H., Gounis, K., Dennis, D., Hopper, K., Swartz, M., & Robbins, P. (2001). *Assessing the New York City Involuntary Outpatient Commitment Pilot Program*. *Psychiatric Services*, 52(3), 330-336, <https://pubmed.ncbi.nlm.nih.gov/11239100/>. The Bellevue study found that court orders did not lead to increased patient compliance with treatment; did not lead to lower rates of hospitalizations; did not lead to lower rates of arrest or violent acts committed; and did not lead to reduction in symptoms or increase in functioning. Providing higher quality services and taking extra care to coordinate them was demonstrated to reduce the frequency of hospitalization.

And the Rand Corporation, in reviewing, at the request of the California State Legislature, a variety of other empirical studies as well as the experiences of several states with involuntary outpatient commitment regimes, concluded that “the research on court-ordered mental health treatment suggests

Kendra's Law ultimately poses a threat to the entire mental health system by eroding patient trust. As patients become afraid of forced treatment they are less likely to seek treatment. And, ironically, treatment is also less likely to be available to those who voluntarily seek it. In a system in which treatment services are in short supply, the obligation to find services for those who are compelled to have them acts as a rationing device – and one with an ugly racial disparity in its use. Kendra's Law must not be expanded.

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that the two most salient factors in reducing recidivism and problematic behavior among people with severe mental illness appear to be enhanced services and enhanced monitoring.”

There are no empirical data that allow us to assess the policy tradeoffs between involuntary outpatient treatment and alternatives such as assertive community treatment. However, we believe the policy question can be explicitly reframed: “Does adding a court order to the provision of intensive treatment significantly improve outcomes over and above the intensive treatment itself?” and, if so, “Is the addition of such orders cost-effective?” Unfortunately, the existing empirical studies do not provide a definitive answer to these questions either ... (but) the results of the second generation of research on outpatient commitment are consistent in supporting the need for intensive community-based services to prevent relapse, violent behavior, and criminal recidivism among people with severe mental illness. They are less consistent, however, in providing clear and convincing evidence concerning the importance of the court mandate per se ... **In conclusion, the research on court-ordered mental health treatment suggests that the two most salient factors in reducing recidivism and problematic behavior among people with severe mental illness appear to be enhanced services and enhanced monitoring.**

See M. Susan Ridgely, Randy Borum and John Petrila, *The Effectiveness of Involuntary Outpatient Treatment*, Rand Corporation, 2001, at pp. xix, 26-27, <http://www.rand.org/publications/MR/MR1340/>.