

**POLICY ANALYSIS OF
INVOLUNTARY PSYCHIATRIC
HOSPITAL ADMISSION IN
NEW YORK**

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BIO

Stephanie Cheng is an alumna of the Columbia School of Social Work, with experience in both an inpatient psychiatric unit and a mobile crisis team. She has a keen interest in research and practices that advance mental health systems and promote trauma-informed, person-centered care.

INSPIRATION

I was inspired to write this piece after my experience in the inpatient psychiatric unit, where I interacted with patients and gained insight into their experiences in the hospital. Involuntary hospitalization presents a complex ethical dilemma, and for this vulnerable population, questions remain as to whether current policies are sufficient to protect their safety and dignity. In this paper, I aim to explore these challenges and the evolution in policies and practices related to involuntary hospitalization. I also aim to highlight the importance of fostering sustainable recovery in the community and minimizing reliance on institutionalized care.

ABSTRACT

Involuntary hospitalization is used when an individual with serious mental illness is at imminent risk of harming themselves or others. Homelessness and racial disparities in mental health care can contribute to higher risks of involuntary hospitalization. Since 2023, former New York City Mayor Eric Adams proposed the Supportive Interventions Act, which would lower the criteria for transporting to hospitals and involuntarily admitting those who are unable to maintain their basic needs, even with no recent act of harm to self or others. The proposal sparked debate: Some groups believe that involuntary admission is necessary to preserve safety, while others believe it can cause more harm by infringing on the individual's well-being, autonomy, and dignity. Accordingly, recommendations follow for alternative proposals to provide sustainable care to individuals with serious mental illness. Social workers should advocate for the expansion of community-based programs, provide compassionate and holistic care, and advocate for more research and policy changes to examine biases in mental health care and advance legal rights for people with severe mental health challenges.

Keywords: involuntary hospitalization, mental health, serious mental illness

POLICY ANALYSIS OF INVOLUNTARY PSYCHIATRIC HOSPITAL ADMISSION IN NEW YORK

In 2021–2022, an estimated 3.2 million adults in New York state were living with mental illness, while 783,000 adults had serious mental conditions (DiNapoli, 2024). Serious mental illness, such as schizophrenia, bipolar disorder, and recurrent major depression, causes significant and long-term

psychosocial impairments (Maura & Weisman de Mamani, 2017). Social determinants of health, including discrimination, racism, and poor living conditions, can also contribute to poor mental health (Mayor's Office of Community Mental Health, n.d.). People with serious mental health challenges, especially those who are racially marginalized and homeless, are vulnerable to civil commitment to involuntary inpatient hospitalization. While involuntary inpatient civil commitment policies aim to preserve the safety of the individual and the public, these policies can also result in unintended harmful consequences (McCall, 2023).

HISTORICAL CONTEXT

Before the 1970s, all psychiatric hospital admissions were involuntary, as people who were mentally ill were presumed to be incapable of making decisions and had little autonomy to decide their treatment and commitment process (Substance Abuse and Mental Health Services Administration [SAMHSA], 2019).

The first hospitals in the United States that acknowledged the need to address mental health began operating in the 1700s and early 1800s. However, by the mid-1800s, the number of mental hospitals was so small that it was common to put mentally ill people into almshouses, where they were "tossed together" with people who were physically disabled, had alcohol use disorder, were developmentally disabled, or were elderly (SAMHSA, 2019). Dorothea Dix was one of the reformers in the mid-1800s who addressed the poor living conditions at almshouses and advocated for residential care facilities for people with mental illness, leading to the expansion of state-run asylums across the United States at that time. The admission criteria were simply that the patient

would benefit from treatment due to mental illness. Admission was often proposed by family members, and physicians would certify an indefinite stay in the institution (SAMHSA, 2019).

By the 1960s, the deinstitutionalization movement had shifted focus from long-term stays at state facilities to short-term stays or community-based care (Edwards & Morris, 2024). In 1963, the Community Mental Health Act was enacted to allocate federal funding to community-based mental health programs and to prohibit payment for institutional care (Saunders & Rudowitz, 2025). In 1964, through the federal Ervin Act, the required criteria for admission were narrowed to "dangerousness." Congress also recognized a preference for less restrictive treatment, as the Ervin Act expanded options for alternative, less restrictive treatment outside hospitals (SAMHSA, 2019). In 1975, the U.S. Supreme Court ruled that a state could not confine a person solely on the basis that they had a mental illness and that to be involuntarily committed, an individual must present a danger to the public or self (McCall, 2023).

MENTAL HYGIENE LAW

According to the 2014 U.S. federal data on psychiatric inpatient admissions, 46% were voluntary admissions, 34% were involuntary and nonforensic admissions (the person was civilly committed), and 19% were involuntary and forensic admissions (the person was ordered by a criminal court to be evaluated and treated; Lutterman et al., 2017). From 2011 to 2018, among 25 states with publicly available data, the all-age emergency involuntary detention rate in hospitals per 100,000 people ranged from 29 in Connecticut to 966 in Florida (Lee & Cohen, 2020).

The New York State Office of Mental Health (NYSOMH)
Mental Hygiene Law Article 9, Hospitalization of Persons With

a Mental Illness, outlines definitions, criteria, and processes for such hospitalizations (New York State Senate, 2021a). Within Article 9, Section 9.13 explains that voluntary admission means that the patient requests evaluation and admission to the hospital, and that the patient must notify the hospital in writing prior to leaving (New York State Senate, 2014b). Section 9.27, Involuntary admission on medical certification, is used in psychiatric hospital settings, accompanied by an application for admission by a family member or relative, officer, director of community services or facilities, director of a hospital, or qualified psychiatrist (New York State Senate, 2025). Two medical doctors of a hospital must certify that the person requires involuntary admission because they have a mental health concern that poses a “substantial” risk of harm to themselves or others, that the treatment is essential to their welfare, and that their judgment is too impaired for them to seek care and treatment on their own (Sullivan & Smith, 2022).

Section 9.39 explains the guidelines for emergency admission at a hospital for people who need immediate observation and care. If the patient is discharged before they are admitted to an inpatient psychiatric center, appropriate referrals and discharge care should be provided (New York State Senate, 2014a). The patient can be held up to 15 days under emergency admission; after that, they must be discharged if they no longer have a likelihood of risk of harm (New York State Senate, 2014a). If the patient continues to show high risks of harm to self or others and needs to stay at the hospital for more than 15 days, the patient has to be converted to either voluntary legal status if they agree to remain in the hospital for treatment, or involuntary legal status through 2PC if they do not agree to remain in the hospital (New York State Senate, 2024).

Sections 9.41 and 9.58 state that a mobile crisis team member, peace officer, or police officer may direct or initiate a mentally ill person's removal and transportation to a facility for a psychiatric evaluation (New York State Senate, 2021b, 2024). NYSOMH outlines legal rights for patients staying at an OMH state psychiatric facility, including the right to privacy, the right to refuse treatment, and the right to be legally represented (NYSOMH, 2022).

PSYCHOSOCIAL FACTORS THAT CONTRIBUTE TO INVOLUNTARY HOSPITALIZATION

HOMELESSNESS

The relationship between homelessness and serious mental illness is complex and bidirectional. Predisposed factors for homelessness can include psychiatric issues, poverty, and substance use disorders, while some suggest that homelessness is a vulnerability that may lead to mental illness (Castellow et al., 2015).

The social disadvantages that unhoused individuals face make mental health access difficult. Unhoused individuals face day-to-day challenges to meet basic needs, such as access to food, water, and shelter, which take priority over psychiatric needs until a crisis occurs (Balasuriya et al., 2020). Unhoused individuals may have difficulty accessing transportation to attend regular mental health visits or to pick up medication (Balasuriya et al., 2020). Additionally, they may not attend treatment consistently due to past negative experiences with mental health care, and their mental health condition itself may decrease their motivation to seek care (Balasuriya et al., 2020).

Studies demonstrate that people with untreated severe mental illness have higher mortality rates due to increased risks of

suicide and exposure to violence (Balasuriya et al., 2020; Jain et al., 2022). Experiences of trauma, substance use, and unstable social environments associated with being homeless can heighten the risk of harm. Being unhoused for longer is associated with more difficulty sustaining mental health recovery to maintain optimal functioning, and psychiatric problems and substance use issues can persist even after the person becomes stably housed (Balasuriya et al., 2020; Castellow et al., 2015). These psychosocial vulnerabilities place unhoused individuals at higher risk for involuntary hospital admission and readmissions (Banerjee et al., 2023; Jain et al., 2022).

RACIAL DISPARITIES

People of color are more likely to be involuntarily admitted to inpatient psychiatric settings than white patients. This may be explained in part by the overdiagnosis of psychotic disorders in people of color and lack of access to culturally sensitive mental health care (Shea et al., 2022). A study found that among a sample of people admitted to a hospital's psychiatry unit, a higher percentage of people of color (41% to 58%) had been diagnosed with psychotic disorders compared to white patients (25%). Black Americans are diagnosed with schizophrenia three to four times more than white Americans, while Latinx Americans are three times more likely than white Americans to be diagnosed with schizophrenia (Schwartz & Blankenship, 2014). Misdiagnosis can occur due to clinician bias, stereotyping, lack of attention to cultural contexts that shape behaviors, and interpretation of culturally normative behaviors as psychopathology, leading to ineffective pharmaceutical interventions and inequities in mental health treatment (Maura & Weisman de Mamani, 2017; Schwartz & Blankenship, 2014; Shim, 2021).

Additionally, people of color have less access to healthcare, lower quality of care, less trust in mental health professionals, and heightened social stigma for seeking mental health care (Maura & Weisman de Mamani, 2017). In medical settings, people of color are more likely to use psychiatric emergency services than community mental health services and are more likely to be hospitalized when seeking care (Maura & Weisman de Mamani, 2017). In 2018, data from the Substance Abuse and Mental Health Services Administration showed that 69% of Black adults and 67% of Latinx adults did not receive treatment for mental health issues (Shim, 2021). For those with serious mental illness, 42% of Black adults and 44% of Latinx adults did not receive treatment (Shim, 2021).

One study followed individuals with serious mental illness one year after discharge from a psychiatric hospital. Black patients had less improvement in psychotic symptoms, a lower likelihood of returning to work, and less improvement in functioning compared to white patients, even after controlling for socioeconomic status, gender, and diagnosis (Maura & Weisman de Mamani, 2017). These social factors lead to psychiatric vulnerabilities and increase the risk of involuntary hospitalization.

NEW PROPOSALS ON INVOLUNTARY HOSPITALIZATION

Unhoused individuals in New York City have increased vulnerability to serious mental illness, which has become a public health concern. In 2022, about 3,400 people in New York City lived in the streets and subway systems, and one-third of them had serious mental health issues (Newman & Fitzsimmons, 2022).

In 2024, former New York City Mayor Eric Adams focused efforts on people experiencing homelessness and having severe mental health issues. He cited a 2022 NYSOMH

memorandum, clarifying that people who are unable to “meet basic living needs, even when there is no recent dangerous act” could legally be involuntarily admitted. He claimed that removing these vulnerable individuals would provide them with an opportunity for assessment and treatment, and would enhance public safety (Sullivan & Smith, 2022, p. 1). The former mayor advocated to expand police officers’ authority to remove and involuntarily commit people who cannot care for their basic needs to prevent future harm to themselves or others (Lewis, 2024; Newman & Fitzsimmons, 2022; Rajamani, 2023). The former mayor cited an incident in 2023 in which a homeless man with schizophrenia, Jordan Neely, was murdered by a former Marine (Rajamani, 2023). Neely was said to have cycled in and out of hospitals and jails before he was murdered. The former mayor also cited an incident in 2024 in which Ramon Rivera, a homeless man who had several interactions with the justice system, went on a stabbing spree that resulted in three deaths (Lewis, 2024).

The former mayor proposed the Supportive Interventions Act to codify and clarify involuntary commitment guidelines in the law, address gaps in the current Mental Hygiene Law, and make it legal for people who are unable to meet their basic needs to be transported and admitted to a hospital (Blau, 2024; Kerman et al., 2023; Lewis, 2024; Newman & Fitzsimmons, 2022; Rajamani, 2023). Following the former mayor’s proposal, New York State Governor Kathy Hochul announced a \$1 billion plan to expand mental health services by adding 850 psychiatric beds to public and private hospitals to reach pre-COVID numbers in an effort to enable a higher level of care for those affected by homelessness and severe mental health issues (Blau, 2024; DiNapoli, 2024).

In July 2025, President Donald Trump signed Executive Order 14321, aiming to broaden the use of involuntary

civil commitment for unhoused adults with serious mental illness by putting individuals into long-term institutions and assisted outpatient treatment programs to preserve public safety (Exec. Order No. 14321, 2025). Trump highlighted the increasing number of people living on the streets, saying the majority are affected by mental health conditions and substance use issues. He described this as a threat to order and as promoting violence. Trump also announced plans for the National Guard to clear homeless encampments in the capital to relocate unhoused individuals and use involuntary commitment to move individuals to institutions (Saunders & Rudowitz, 2025).

FINANCIAL EXPENDITURES ON INVOLUNTARY HOSPITALIZATION

Involuntary psychiatric stays in the U.S. can cost an average of just over \$7,000 for 6.4 days (Morris & Kleinman, 2020). Among the 2 million inpatient hospitalizations in 2016, public programs like Medicaid and Medicare covered 60% of the stays; private insurance covered 27%; and 10% were either self-paid or free of charge (Morris & Kleinman, 2020). New York City reported that from January to October of 2024, an average of 126 people per week were involuntarily taken to the hospital, with Medicaid as the primary insurance provider (DiNapoli, 2024; Lewis, 2024). Billing for involuntary psychiatric admission requires close attention because while patients are evaluated and detained against their will, the incurred cost may be passed to them. This further infringes on their rights by forcing them to assume financial responsibility (Morris & Kleinman, 2020).

There are questions about which party should bear the cost of involuntary admission. Some argue that the patient should bear the financial cost for receiving treatment and

benefits; others argue that the public should contribute to the cost, as involuntary psychiatric admission is part of the legal framework enforced by the government, and the public benefits from the policies. Any decision to admit a patient involuntarily needs to be made carefully due to the financial burden it imposes on the patient or the public.

It is also important for hospitals' finances and billing to be scrutinized to preserve patients' best interests. This is especially true because patients with mental health issues are vulnerable to financial exploitation (Morris & Kleinman, 2020). Involuntary hospitalization requires additional financial oversight, as the patient is billed for care that they did not agree to; they are thus vulnerable to surprise medical bills, or unexpected out-of-pocket costs for hospital care (Morris & Kleinman, 2020). One organization that financially exploited patients was Acacia Healthcare, which made a profit by holding patients involuntarily without medical necessity while maximizing payout from their insurance (Lindner, 2024).

THE BENEFITS OF INVOLUNTARY HOSPITALIZATION

Involuntary hospitalization is a necessary last resort for individuals at imminent risk of harm to themselves or others, to preserve safety and prevent further decompensation (Danzer & Wilkus-Stone, 2015). Hospital units provide a structured and social support system where patients can be stabilized by receiving supervision, appropriate medication, and intensive therapy (Danzer & Wilkus-Stone, 2015; Wilkes, 2019). Even if the patient may not have insight into their mental health condition and refused help when they were first admitted, they may shift their initial negative attitude about "confinement" to accepting their illness and focusing on recovery (Danzer & Wilkus-Stone, 2015). Involuntary hospitalization may especially lead to positive outcomes for

patients in an active psychotic or manic episode who refused medication in the community because their psychiatric symptoms inhibited their ability to make informed decisions (Danzer & Wilkus-Stone, 2015).

THE CHALLENGES AND HARM OF INVOLUNTARY HOSPITALIZATION

Despite the potential benefits of involuntary hospitalization, the goal of reducing the risk of harm is not always met. Initial coercion by law enforcement and healthcare providers may lead to disengagement, poor clinical rapport, and lower chances of recovery, resulting in future dissatisfaction with care (Corderoy et al., 2025; Danzer & Wilkus-Stone, 2015). Perceived coercion, such as seclusion, restraint, and lack of decision-making power, could increase patients' suicide attempts on the unit and heighten their post-discharge suicide risk (Corderoy et al., 2025; Gerlach, 2024).

Hospitals often implement safety measures that restrict patients' freedom, such as locked doors, 15-minute security checks, limitations on visits, and limited access to personal belongings (Edwards & Morris, 2024; Gerlach, 2024). In one study, patients noted that during their stay, they were treated as objects and disrespected by staff. Patients also reported a lack of communication regarding their hospitalization, treatment plan, side effects of medications, and legal rights (Shields & Davis, 2024). Patients can experience a loss of autonomy, self-esteem, and self-control, and diminished hope for recovery (Danzer & Wilkus-Stone, 2015). Adverse events such as self-harm, violence, and breach of confidentiality can happen in inpatient care, even though the goal of hospitalization is to preserve patients' safety (Edwards & Morris, 2024).

Additionally, patient outcomes are affected by incomplete discharge planning. Patients may have difficulties accessing outpatient treatment or lack social support in treatment after discharge, resulting in repeated hospitalizations (Gerlach, 2024). Some patients are discharged from the hospital before they are stable, and some do not have adequate aftercare programs when discharged, which can lead to poor outcomes in the community (Newman & Fitzsimmons, 2022). A tragic incident occurred in 2022 in which a woman, Michelle Go, was killed when Simon Martin, a man who had schizophrenia and was unhoused, pushed her onto the subway tracks (Newman et al., 2022). He had been hospitalized multiple times, and there were indications that he had been discharged before he was fully stabilized (Newman et al., 2022). The incident serves as an example that simply forcing people into the hospital without addressing aftercare means they could be unsafe in the long run.

The determination of involuntary hospitalization is nuanced. Psychiatrists have different training on how to assess immediate danger, which means they may make varied judgments on whether to hospitalize a patient (Richmond, 2025). Some patients fall into a gray area because clinicians may have different interpretations of "imminent harm," which determines whether the patient would be admitted as an inpatient (Richmond, 2025). For patients who were admitted as inpatients but were considered to be in a gray area, involuntary hospitalization did not lower the risk of danger but actually doubled their risk of violent crime charges or dying by suicide in the next months (Richmond, 2025).

One study showed that one in five patients involuntarily admitted died within five years (Richmond, 2025). Involuntarily admitted patients are also no more likely to attend outpatient mental health care than those who were evaluated and not

held (Richmond, 2025). Patients can be trapped in a revolving door, where they are frequently readmitted with no effective long-term treatment (Alliance for Rights and Recovery, 2025). Defaulting to involuntary hospitalization is ineffective and unsustainable. Instead, it can worsen long-term outcomes, increase trauma, reinforce stigma, and increase expenditure (Alliance for Rights and Recovery, 2025; Eastgate, 2025).

PUBLIC OPINION ON THE POLICY

The public has mixed attitudes toward involuntary inpatient commitment and the former mayor's push to reform the Mental Hygiene Law. Advocates for involuntary hospitalization agree that some people living with serious mental illness may not be aware that they need treatment due to their illness, and many end up in the streets or in prison (Gerlach, 2024). For example, a person in active psychosis who is experiencing a disoriented reality may decline treatment due to their mental state. Some clinicians question whether not treating people who do not consent would truly advance civil liberties, considering that not treating them could risk further harm to them (Gerlach, 2024). In *Psychiatric Times*, Daniel Morehead argued that the public has an inaccurate image of involuntary admission and framed psychiatrists as the representatives of social control (Morehead, 2023). Morehead stated that involuntary treatment is common across medical care and is essential to preserving the life and well-being of individuals, where the individual still preserves the right to accept or reject treatment within the facility (Morehead, 2023).

Sullivan et al. (2024) suggested that involuntary hospitalization is a necessary option even when the act can infringe on a patient's autonomy. The authors drew a comparison to epilepsy, noting that medical providers do not withhold antiepileptic medication for a person in active

seizure just because they cannot provide consent. They suggested that people with serious mental illness should similarly be provided with care even when unable to consent (Sullivan et al., 2024). As psychiatrists working in inpatient units, they observed patients who were involuntarily admitted showing improvement in functioning: Patients with catatonia began to walk and talk, or patients were relieved of auditory hallucination after treatment on the unit (Sullivan et al., 2024). Sullivan et al. also suggested that involuntary hospitalization and commitment are necessary tools to provide lifesaving care in a situation where withholding treatment would endanger individuals.

Advocates against the expansion of involuntary hospitalization are concerned about the unclear guidance on removal and transport to the hospital (Newman & Fitzsimmons, 2022). Some members of public defender organizations, including the Legal Aid Society, stated that the former mayor's announcement leaves too much uncertainty about implementation and intentions (Newman & Fitzsimmons, 2022). The chief executive of the New York Association of Psychiatric Rehabilitation Services, Harvey Rosenthal, believes that the former mayor's proposal would traumatize individuals by forcing them into an overburdened and failed system (Newman & Fitzsimmons, 2022).

Representatives of the New York Civil Liberties Union (NYCLU) believe that expanding involuntary hospitalization violates the individual's civil rights, worsens the stigma around people who are unhoused with a mental illness, and may lead to abuses of power (Gerlach, 2024; Lewis, 2024). They believe that increasing involuntary commitment does not address the chronic issues of homelessness and lack of access to mental health care (Rajamani, 2023). They also believe that people on the streets have more medical needs

than psychiatric needs and that the administration should focus on funding supportive housing, mobile treatment teams, and street psychiatry (Lewis, 2024). Psychiatrists advocating for reform in inpatient psychiatric settings added that hospitals can resemble the carceral system, as racially marginalized people are more likely to be subjected to coerced healthcare systems such as involuntary psychiatric admission and restraints (Edwards & Morris, 2024).

RECOMMENDATIONS

Expanding involuntary hospitalization is not sufficient to support long-term treatment for people with severe mental health issues. This paper advocates for alternative proposals, including allocating funding for Assertive Community Treatment programs, strengthening cultural competency in mental health care, providing complete discharge planning and continuity of care, and improving the quality of care at inpatient psychiatric hospitals.

ALLOCATE FUNDING FOR ASSERTIVE COMMUNITY TREATMENT PROGRAMS

Evidence-based community mental health treatments are more cost-effective and can reduce acute care and hospital stays (Saunders & Rudowitz, 2025). Assertive Community Treatment (ACT) is an accessible form of treatment that can effectively address psychosocial complexities and improve social determinants of health (Balasuriya et al., 2020). ACT involves mobile, evidence-based, intensive, multidisciplinary teams that deliver 24/7 care for people with serious mental illness at risk of psychiatric crisis and hospitalization (Duch et al., 2025). ACT services include psychiatric evaluation, medication management, therapy, supported employment, supported housing, case management, and peer support (Duch et al., 2025).

Though ACT is considered an alternative to decrease inpatient care costs, the cost can still be substantial due to its intensive nature, costing an average of \$21,481 per person per year, which can limit the extent of its usage (Duch et al., 2025). But these costs will be offset and will decrease in the long term, as inpatient admissions and criminal justice system–related expenses will decrease and use of regular outpatient care will increase (Duch et al., 2025). Value-based payment based on provider performance has been shown to decrease expenditures for ACT and shift high-cost inpatient expenditures to community-based care (Duch et al., 2025).

STRENGTHEN CULTURAL COMPETENCY IN MENTAL HEALTH CARE

Increased diversity and collaborative care can foster trust in mental health services for people of color with severe mental illness (Maura & Weisman de Mamani, 2017). Integrating cultural perspectives and increasing patients' involvement in treatment decisions can improve treatment engagement. This can include asking patients about their preferences on treatment and providing options (Maura & Weisman de Mamani, 2017). Cultural competency training can strengthen communication with patients and avoid stigmatizing them (McGregor et al., 2019).

Care providers need to maintain cultural humility through ongoing self-reflection and adaptation, and reflect on their own biases and cultural identities, which can affect how they interact with patients (Delfish & Chadha, 2025). Providers can limit implicit bias by attending workshops or seminars to broaden their knowledge about cultural diversity in mental health care (Delfish & Chadha, 2025). Mental health providers need to recognize the intersection of race, gender, and socioeconomic status, and how identities can shape a person's mental health experience (Delfish & Chadha, 2025).

In response, the provider should tailor treatment based on the individual's culture and perspective (Delfish & Chadha, 2025). Mental health providers are also encouraged to challenge existing discriminatory practices and advocate for policy reform (Delfish & Chadha, 2025).

PROVIDE COMPLETE DISCHARGE PLANNING AND ENSURE CONTINUITY OF CARE

Prior to discharge, the patient should be assessed for previous and future barriers to maintaining treatment in the community. Inpatient clinicians need to ensure that patients maintain continuity of care by linking them to appropriate community mental health care. This linkage is essential because individuals who do not attend an aftercare appointment are associated with increased risk of relapse, homelessness, suicide, and criminal justice involvement (Smith et al., 2019). Communication between inpatient hospital staff and outpatient mental health providers should be the standard practice to maintain continuity of care (Smith et al., 2019). Inpatient staff can provide details on the patient's treatment plan and the circumstances around the inpatient admission to better inform outpatient treatment (Smith et al., 2019). Among patients who were not engaged in outpatient mental health services prior to inpatient admission, those who have an outpatient appointment scheduled prior to discharge are three times more likely to attend a follow-up psychiatric visit within seven days (Smith et al., 2022).

Additionally, broadening the use of Critical Time Intervention (CTI) can support patients' transition out of inpatient care. CTI is a time-limited case management model for individuals who require support in "critical time" transitions (NYSOMH, n.d.). CTI teams help individuals transition from an inpatient hospital to their community and to long-term providers (NYSOMH,

n.d.). Prior to discharge, the CTI team meets the individual at the inpatient psychiatric unit to build rapport with them (NYSOMH, n.d.). After discharge, the CTI team conducts visits to support the connection between the individual and the long-term community provider (NYSOMH, n.d.). CTI teams continue to monitor the individual's support networks before they fully transition out of care (NYSOMH, n.d.).

IMPROVE QUALITY OF CARE AT INPATIENT PSYCHIATRIC HOSPITALS

It is important to improve the overall quality of care in inpatient hospital settings. For inpatient admission to achieve the goal of reducing harm, hospital staff need to be transparent about patients' rights and use trauma-informed and person-centered care. The hospital should be a healing setting where the patient can use the time and space to focus on their mental health.

Instead of using a "zero-risk" approach, hospitals can consider using a new safety paradigm to promote safety and equity in inpatient care (Slemon & Dhari, 2024). Mental health professionals should decrease the power imbalance between staff and patient, decrease the use of chemical and physical restraints, and promote a collaborative approach (Slemon & Dhari, 2024). The design of inpatient units should foster autonomy and promote safety and social interactions (Bodryzlova et al., 2024). Colorful spaces and home-like design can reduce stress and stigma (Bodryzlova et al., 2024; Slemon & Dhari, 2024). Inpatient mental health staff can incorporate individual or group outdoor activities to promote social interactions (Bodryzlova et al., 2024; Slemon & Dhari, 2024).

CONCLUSION

It is complex to achieve long-term safety for people with severe mental health issues. While people at imminent risk can benefit from involuntary hospitalization as a necessary last resort, the criteria for admission need to be closely examined. Simply moving unhoused people who have mental health issues to an inpatient hospital involuntarily is not an effective solution to address the root cause and will result in readmissions and add financial burden to the public.

Social workers should advocate to expand community-based programs to prevent individuals from getting to the point of hospitalization and institutionalization. Social workers in practice should work alongside other mental health professionals to provide compassionate and holistic care, whether in the setting of community programs or at inpatient institutions. More qualitative research is needed on patients' perspective of their experiences in involuntary admission and hospital stays. Social workers must be aware of structural discrimination in mental health care and advocate for more research and policy changes to examine biases in mental health care and to advance legal rights for people with severe mental health challenges. Policies and practices involving involuntary hospitalization must be continuously reviewed and revised.

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