

ASSISTED OUTPATIENT TREATMENT: AN UNCONSTITUTIONAL INVASION OF PROTECTED RIGHTS OR A NECESSARY GOVERNMENT SAFEGUARD?

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I. INTRODUCTION

Kendra Webdale never saw it coming. As she stood along the train tracks among countless other New York City commuters, she suddenly felt a shove in her back, and before she knew what happened, she landed face first in the subway tracks before her. Within seconds she was crushed by an approaching train and died shortly thereafter. Her attacker was Andrew Goldstein, a lifelong paranoid schizophrenic who had been in and out of psychiatric treatment. While undergoing regular medical treatment as an inpatient, Goldstein was under control. Every time he was released, however, Goldstein would fail to take his medication, and consequently he would decompensate and his mental illness would re-emerge, characterized by unpredictable and violent behavior.¹ Kendra Webdale's death was followed three months later by the dismemberment of Edgar Rivera, who lost both of his legs after being pushed in front of an oncoming train by another schizophrenic assailant who had terminated his medication.²

These tragedies touched off a flurry of publicity and community outrage, which led to the passage of New York's Mental Health Law § 9.60, popularly called "Kendra's Law."³ The focus behind New York's new law was to prevent mentally-ill patients from decompensating to the point of violence.⁴ While many states have passed similar legislation providing for the mandatory treatment of mentally-ill citizens who pose a danger to society, New York's law went further than most. Those who support the law insist that it is sufficiently narrowly tailored to protect the interests of the mentally ill, but there are many who fear that Kendra's Law unconstitutionally infringes on the rights of all citizens to refuse medical treatment and to be free from unwanted physical restraint.⁵

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1. See Maggie Haberman et al., *Woman, 32, Is Pushed to her Death in Subway Horror*, N.Y. POST, Jan. 4, 1999, at 4.

2. See Bill Egbert et al., *Pushed Man Loses Legs, Suspect's Nabbed at Lex. Ave. Station*, N.Y. DAILY NEWS, April 29, 1999, at 5.

3. See John Caher, *Panel Explores Uncertainties In Early Days of Kendra's Law*, N.Y. LAW JOURNAL, Jan. 28, 2000, at 20.

4. See Erin O'Connor, Note, *Is Kendra's Law a Keeper? How Kendra's Law Erodes Fundamental Rights of the Mentally Ill*, 11 J.L. & POL'Y 313, 314 (2002).

5. See *Id.* See also Watnik, *infra* note 12; Gutterman, *infra* note 53; Perlin, *infra* note 113; Winnick, *infra* note 128, articulating arguments against the constitutionality of Kendra's Law.

Further criticism is levied at the procedure itself, including allegations that the statute does not afford sufficient due process protection for the rights of the mentally ill, and in particular infringes on the rights of those who have not been formally determined to be incompetent. These arguments will be considered in greater depth below.

This Note is organized as follows: Part II analyzes the text of New York's Kendra's Law. In Part III, this Note compares the chief provisions of Kendra's Law with outpatient treatment laws enacted in other states. Part IV examines the U.S. Supreme Court's and lower courts' treatment of the constitutional questions implicated by the statute. This section also explores recent New York case law interpreting Kendra's Law and discusses the policy arguments both in favor of and in opposition to the law. Finally, this Note concludes by suggesting that the New York legislature consider a compromise position regarding the imposition of psychological treatment on mental patients who have not been adjudged incompetent. This compromise would include a revision to the current text of Kendra's Law to incorporate a provision requiring a finding of incompetence, or at minimum a formal diagnosis of mental illness, before an assisted outpatient treatment order under Kendra's Law could issue.

II. KENDRA'S LAW: A STATUTORY ANALYSIS

Kendra's Law provides in relevant part:

(c) Criteria for assisted outpatient treatment. A patient may be ordered to obtain assisted outpatient treatment if the court finds that:

- (1) the patient is eighteen years of age or older; and
- (2) the patient is suffering from a mental illness; and
- (3) the patient is unlikely to survive safely in the community without supervision, based on a clinical determination; and
- (4) the patient has a history of lack of compliance with treatment for mental illness that has:

- (i) at least twice within the last thirty-six months been a significant factor in necessitating hospitalization in a hospital, or receipt of services in a forensic or other mental health unit of a correctional facility or a local correctional facility, not including any period during which the person was hospitalized or incarcerated immediately preceding the filing of the petition; or
- (ii) resulted in one or more acts of serious violent behavior toward self or others or threats of, or attempts at, serious physical harm to self or others within the last forty-eight months, not including any period in which the person was hospitalized or incarcerated immediately preceding the filing of the petition.⁶

Several of the above provisions of Kendra's Law have since become highly controversial and thus warrant careful consideration. In particular, the requirement that the patient be "unlikely to survive safely in the community" has been criticized as unduly restrictive as many other similar statutes use a higher standard to measure survival in the community than New York's low threshold of "unlikely to survive."⁷ The New York

6. N.Y. MENTAL HYG. LAW § 9.60(c) (McKinney 1999).

7. See, e.g., HAW. REV. STAT. ANN. § 334-121 (Michie 1984); VA. CODE ANN. § 37.1-67.3 (Michie

standard is important because it may serve to impermissibly restrict the rights of competent, yet mentally-ill individuals, based purely on the opinion of physicians or psychiatrists. Additionally, much has been made of the provisions allowing assisted outpatient treatment (AOT) on the basis of either a "history of a lack of compliance" with medical treatment or threats of violence, presumably under the belief that these prongs constitute guesswork and are not necessarily rooted in provable fact.⁸

Kendra's Law also provides an expansive list of potential petitioners, including: anyone over eighteen with whom the mentally ill individual resides; the individual's parent, spouse, sibling, or child eighteen years or older; the director of a hospital in which the individual resides; and a qualified psychiatrist who is treating the individual, among others.⁹ This list arguably provides for petitions by those in a position to responsibly assess the mental health of the individual under consideration and the potential threat he or she presents, but may simultaneously confer too much authority on the medical profession.¹⁰

Kendra's Law also provides a right to counsel for the subject of the petition as well as a hearing, which is to be held within three days of the filing of the petition.¹¹ If the subject of the petition fails to appear for the hearing, it is conducted in his or her absence. However, critics of the statute point to the short time period for securing counsel and the provision for a hearing in absentia as indicia of a failure of due process.¹² Further, critics point to the statute's provision for a treatment plan as questionable grounds upon which to base a coercive course of treatment, which, they claim, amounts to forcible medication.¹³ The physician who performed the examination to support the initial petition is also the one to devise the subject's court-ordered treatment plan.¹⁴ The plan is to be developed in consultation with the subject of the petition, the subject's treating physician, and upon the subject's request, an individual significant to him or her.¹⁵ Again, however, critics argue that this amounts to coerced compliance as AOTs only issue pursuant to court order, effectively leaving patients no choice but to comply.¹⁶ Under such a coercive scheme, then, the patient's participation in crafting the treatment plan is no more than a formality and fails to provide any substantive protection for the mentally-ill individual.

Another aspect of Kendra's Law that has received significant criticism is its reliance on physician testimony alone as the basis for outpatient commitment. According to the

1976); WYO. STAT. ANN. § 25-10-110 (Michie 1977).

8. *Id.* § 9.60(c)(4).

9. *Id.* § 9.60(e).

10. This is in contrast to other state outpatient commitment statutes that provide either multiple physician examinations to form the basis for a petition for outpatient treatment or provide the patient with the opportunity to present his own medical evidence. *See, e.g.,* VA CODE ANN. § 37.1-67.3 (Michie 1976).

11. N.Y. MENTAL HYG. LAW § 9.60(h).

12. *See* Ilissa L. Watnik, Comment, *A Constitutional Analysis of Kendra's Law: New York's Solution for the Treatment of the Chronically Mentally Ill*, 149 U. PA. L. REV. 1181, 1186 (2001).

13. *See* O'Connor, *supra* note 4, at 343.

14. N.Y. MENTAL HYG. LAW § 9.60(h)-(i). The provision allowing the examining physician and the testifying physician to be the same individual, as well as the fact that only one physician is required to commit a mental patient under Kendra's Law is a significant change from New York's prior mental patient commitment laws which required at minimum two examining physicians and one concurring physician for commitment of a mental patient. *See* Project Release v. Prevost, 722 F.2d 960, 965-967 (2d. Cir 1983).

15. N.Y. MENTAL HYG. LAW § 9.60(i)(1).

16. *See* Fred Fusco, *Kendra's Law is "Patriot Act for Mental Patients,"* POST STANDARD/HERALD JOURNAL, March 17, 2004.

statute, the court must hear testimony from the examining physician explaining the terms of the proposed plan prior to its acceptance by the court.¹⁷ The physician's report must include the categories of assisted outpatient treatment, the rationale for each category, facts that establish that the proposed plan is the least restrictive alternative, and if the plan includes medication, the report must explain the classes of medication recommended, the beneficial and detrimental physical and mental effects of the medicine, and whether the medication should be self-administered or administered by a physician.¹⁸ However, physician predictions of violence are unreliable and cannot justify even minimal psychological side effects to a patient who has not chosen to submit to medication in the first place.

Finally, the statute also provides for appropriate action in the event that the subject refuses to comply with the treatment plan. If the subject refuses to take his or her prescribed medication, and efforts were made to solicit the subject's compliance, the examining physician is authorized to request the detention of the subject for a seventy-two hour period of observation to make a determination regarding whether involuntary inpatient commitment is warranted.¹⁹ However, if at any time during the detention there is a determination that the subject does not meet the involuntary admission and retention requirements under New York law, the subject must be released.²⁰

Significant to the following analysis is the language of the statute, which expressly states that "[a] determination by a court that a patient is in need of assisted outpatient treatment under this section shall not be construed as or deemed to be a determination that such patient is incapacitated."²¹ This is particularly significant due to the heightened protection that is due to all citizens who have not been determined to be incompetent,²² a concern that figures prominently among the critiques of Kendra's Law.

III. OTHER STATE ASSISTED OUTPATIENT TREATMENT LAWS

A. *Arizona's Conditional Outpatient Treatment Law*

Arizona's AOT law provides for written treatment plans, issued by the hospital medical director and staff most familiar with the offending patient.²³ The plan must include requirements such as medication and supervision and may include periodic reporting requirements, as well as travel and behavioral restrictions.²⁴ While the patient is provided copies of the document, he or she has no right to contribute to the formation of the plan.²⁵ Further, the medical director administering the plan is authorized to make

17. N.Y. MENTAL HYG. LAW § 9.60(j).

18. *Id.* § 9.60(j)(1)–(2).

19. *Id.* § 9.60(n).

20. *See id.*

21. *Id.* § 9.60(o).

22. *See Rivers v. Katz*, 495 N.E.2d 437, 494 (N.Y. 1986) (stating that "neither the fact that appellants are mentally ill nor that they have been involuntarily committed, without more, constitutes a sufficient basis to conclude that they lack the mental capacity to comprehend the consequences of their decision to refuse medication that poses a significant risk to their physical well-being").

23. ARIZ. REV. STAT. § 36-450.01 (2003).

24. *Id.* § 36-450.01(B)(4).

25. *Id.* § 36-450.01(A)(3).

alterations at any time as he or she sees fit.²⁶ Finally, the plan can be rescinded at any time and the patient subsequently returned to an inpatient mental health facility.²⁷

While Arizona's AOT law may seem significantly more restrictive than Kendra's Law at first glance, a key difference makes the Arizona statute far less intrusive. The statute applies only to patients who are being conditionally released from an inpatient treatment program, and thus necessarily they have already had a formal incompetence determination. Kendra's Law, by contrast, gives significant power to medical professionals to restrict the life activities of individuals who have merely been shown to present a potential threat of harm due to mental illness, but have not been determined to be mentally incompetent. Consequently, Arizona's conditional outpatient statute is actually less restrictive and more protective of the rights of mentally-ill individuals than the current AOT statute of New York.

B. New Hampshire's Conditions of Conditional Discharge Statute

Unlike Arizona's AOT statute, New Hampshire's law²⁸ only grants conditional discharge upon informed consent of the mentally-ill individual and pursuant to his or her agreement to participate in "continuing treatment on an outpatient basis."²⁹ Pursuant to the program, the patient agrees to any rules adopted by the commissioner and the treatment plan is to last for the duration of the patient's involuntary admission order.³⁰ Thus, like Arizona's AOT law, New Hampshire's statute only applies to mentally-ill individuals who have been committed to inpatient facilities. Commitment to an inpatient facility necessitates a formal determination of mental incompetence. Therefore, despite New Hampshire's grant of broad authority to physicians to craft treatment plans without substantial oversight, New Hampshire's law is actually more protective of patients rights because it requires an incompetence ruling, while Kendra's Law permits treatment based on evidence that the patient is suffering from mental illness alone.

C. Alabama's Commitment of Mentally Ill Persons Statute

According to Alabama's statute, an individual can be committed for outpatient treatment if the probate court finds based on clear and convincing evidence that:

- (1) the individual is mentally ill; (2) as a result of the mental illness the respondent will, if not treated, continue to suffer mental distress and will continue to experience deterioration of the ability to function independently; and (3) the respondent is unable to make a rational and informed decision as to whether or not treatment for mental illness would be desirable.³¹

Alabama's commitment procedure is somewhat similar to New York's because it addresses mentally-ill individuals who reside in the community and potentially pose a

26. *Id.* § 36-450.01(H).

27. *See id.*

28. N.H. REV. STAT. ANN. § 135-C:50 (1986).

29. *Id.*

30. *See id.*

31. ALA. CODE § 22-52-10.2 (1991).

safety threat. However, the key difference between Alabama's statute and Kendra's Law is found in the third requirement under the Alabama statute, which mandates a pre-commitment finding of incompetence before a judge. This requirement adds a layer of protection for the mentally ill in Alabama that is missing under Kendra's Law, namely a safeguard for individuals who are mentally ill but not incompetent or unable to "make a rational and informed decision."³²

D. Hawaii's Criteria for Involuntary Outpatient Treatment

Hawaii's Involuntary Outpatient Treatment statute³³ mirrors Kendra's Law in many respects. Hawaii requires that the subject of the order be suffering from a severe mental disorder; that the individual have received inpatient treatment or presented a threat of imminent danger to self or others in the recent past; that the subject be currently in need of medical treatment to prevent a relapse or deterioration; and that the person be capable of surviving safely in the community under the treatment plan.³⁴ However, Hawaii's law additionally requires that "the person's mental status or the nature of the person's disorder limits or negates the person's ability to make an informed decision."³⁵ Much like the Alabama statute, Hawaii's minimum threshold requirement of a finding of compromised mental competence prior to the issuance of AOT orders provides a safeguard against violations of the rights of the competent but mentally ill—a protection that is missing from Kendra's Law.

E. California's Assisted Outpatient Treatment Statute

California's AOT statute³⁶ is strikingly similar to Kendra's Law in several aspects, but its divergences are far more significant. Among the elements required for an AOT order to issue in California, the subject of the order must: (1) be eighteen years or older; (2) be suffering from a mental illness; and (3) have been subject to a clinical determination that he or she is unlikely to survive safely in the community without supervision.³⁷ Additionally, the patient must have a history of lack of compliance with treatment and a mental illness that has either (a) resulted in necessary hospitalization or treatment at least twice within the last thirty-six months or (b) resulted in one or more acts of serious and violent behavior toward himself or others, or threats or attempts at such acts, within the last forty-eight months.³⁸ California's AOT statute also requires that the patient have been offered the opportunity to participate in a voluntary treatment plan and currently have a condition that is substantially deteriorating.³⁹ Further, the AOT order must be judicially-determined to be the least restrictive alternative available, the subject must be in need of the AOT to prevent serious harm, and the court must determine that the subject will likely benefit from the AOT order before it issues.⁴⁰

32. *See id.*

33. HAW. REV. STAT. ANN. § 334-121 (Michie 1984).

34. *See id.*

35. *Id.*

36. CAL. WEL & INST. CODE § 5346 (West 2002).

37. *Id.* at § 5346 (a)(1)-(3).

38. *Id.* at § 5346 (a)(4).

39. *See id.* § 5346(a)(1)-(6).

40. *Id.* § 5346(a)(7)-(9).

Although California's AOT law contains several provisions that are nearly identical to Kendra's Law—such as the determination that the subject is “unlikely to survive” in the community, the required history of lack of compliance, and the demonstrated threat of harm posed by the subject—California's law provides a safeguard that is lacking in New York's version. California explicitly requires that the AOT be the least-restrictive alternative available to aid the subject of an order, while New York's AOT orders can issue regardless of other options at the disposal of the courts.

F. Virginia's Involuntary Admission and Treatment Law Center

As an initial matter, Virginia's involuntary admission statute⁴¹ requires that the judge provide the subject of a petition the opportunity to enter voluntary treatment and works with the mentally-ill individual to craft a suitable treatment plan.⁴² However, if the subject refuses, the court must advise him or her of the right to counsel and to a hearing, for which counsel may be appointed. Further, unlike Kendra's Law, Virginia's statute allows the subject to present his or her own expert testimony and evidence of mental competence.⁴³ Following a court-ordered examination by a licensed psychologist or psychiatrist, the examiner must then testify as to whether the subject: (1) is or is not mentally ill; (2) presents an imminent danger to himself or herself or others; and (3) requires either involuntary treatment or hospitalization.⁴⁴ Further, prior to issuing an order for inpatient commitment, the judge must request a certification from the community board where the subject resides indicating that the subject presents a threat to the safety of the community or is unable to care for him or herself, that involuntary commitment is the least-restrictive alternative available, and that the recommendations are made solely for the care of the mentally-ill individual.⁴⁵ Finally, the judge must then issue findings that the subject (1) presents an imminent danger to him or herself or the community due to mental illness or is so mentally-ill that he or she cannot care for him or herself; and (2) that alternatives to involuntary commitment have been explored and that no less restrictive alternative exists before the judge may enter the order for involuntary commitment.⁴⁶

Virginia's statute thus has three separate layers of review, all three of which require an independent finding of mental illness and also require that involuntary commitment be the least-restrictive alternative available to the mentally-ill individual. Kendra's Law, by contrast, has no real least-restrictive alternative requirement because it merely requires that during the proceeding, a physician testify to his opinion that the subject of a petition is “suffering from a mental illness.”⁴⁷

41. VA. CODE ANN. § 37.1-67.3 (Michie 1976).

42. *Id.*

43. *Id.*

44. *See id.*

45. *Id.*

46. *Id.*

47. N.Y. MENTAL HYG. LAW § 9.60(c)(2) (McKinney 1999).

G. Wyoming's Statute Governing Involuntary Hospitalization Proceedings⁴⁸

Among the existing involuntary commitment statutes, Wyoming's statute provides the greatest discretion to the judge to determine the appropriate course of action for involuntary treatment of mentally-ill individuals. Wyoming's statute assumes involuntary hospitalization as the default treatment for patients who have been examined by a physician within the fifteen days preceding the court hearing and who have been determined to be mentally ill.⁴⁹ While this seems to confer significant power on the judge, there is a safeguard inherent in the language of the statute that is not present in Kendra's Law. Wyoming requires that the subject of a commitment hearing have been determined to be mentally ill prior to the hearing.⁵⁰ This requirement protects those whose mental status is questionable or undetermined from ever being the subject of a commitment proceeding unless they are adjudged mentally ill. Kendra's Law, by contrast, allows outpatient commitment proceedings against persons who pose a potential threat to themselves or others or who are "unlikely to survive" in the community,⁵¹ but does not require an actual finding of mental incompetence.⁵²

Based on the analysis of other states' AOT statutes, Kendra's Law seems to be somewhat of an anomaly among AOT statutes due to its failure to require a finding of incompetence prior to the issuance of a commitment order. As discussed below, New York's decision to omit the incompetence requirement has been the source of much debate regarding the constitutionality of Kendra's Law.

IV. CONSTITUTIONAL ANALYSIS

A. Due Process and Kendra's Law

1. The Supreme Court's Due Process Analysis of the Right to Refuse Medical Treatment

Much of the recent debate surrounding outpatient treatment laws has focused on the due process rights of those subject to the orders.⁵³ To better understand this line of argument, it is necessary to take a closer look at how the Due Process Clause applies to the right to refuse medical treatment. The Due Process Clause of the Fourteenth Amendment guarantees that the government will not deprive any person of life, liberty, or property without due process of law.⁵⁴ Although the Supreme Court has never really clarified the extent of due process protection for the mentally ill, as discussed below, the Court has confirmed that the mentally ill have a liberty interest in refusing unwanted psychotropic medication.⁵⁵ However, the Court has left the determination of the proper

48. WYO. STAT. ANN. § 25-10-110 (Michie 1977).

49. See *id.* § 25-10-110(a)(i)(A).

50. *Id.* § 25-10-110(a)(i)(C).

51. N.Y. MENTAL HYG. LAW § 9.60 (c)(3) (McKinney 1999).

52. *Id.*

53. See Jennifer Gutterman, Note, *Waging a War On Drugs: Administering a Lethal Dose to Kendra's Law*, 68 FORDHAM L. REV. 2401, 2418 (2000).

54. U.S. CONST. amend XIV, § 1.

55. *Mills v. Rogers*, 457 U.S. 291, 299 (1982).

balance between individual liberty interests and competing government interests to the states.⁵⁶

The bulk of the successful challenges to AOT laws across the country have come under the Due Process Clause, particularly focusing on the right of all individuals to refuse unwanted medical treatment. The right to refuse medical treatment was solidified in *Cruzan v. Director, Missouri Dep't of Health*,⁵⁷ in which a patient living in a persistent vegetative state was removed from life support pursuant to the substituted judgment test accepted by the Missouri Supreme Court below.⁵⁸ In *Cruzan*, the Supreme Court accepted the application of the substituted judgment test to cases involving incompetent patients, requiring proof of the incompetent patient's desires regarding his or her own medical treatment by clear and convincing evidence prior to imposing treatment.⁵⁹ While in *Cruzan* the patient's choice concerned a refusal of medication to prolong the life of a woman living in a persistent vegetative state, the *Cruzan* substituted judgment standard should be extended to protect mentally incompetent patients who face involuntary outpatient commitment under Kendra's Law.⁶⁰

The first Supreme Court case to deal with the specific issue of refusal of medication by a mentally-ill patient was *Washington v. Harper*, in which a prisoner challenged mandatory medication.⁶¹ In *Harper*, the Court established that a prisoner has a liberty interest in avoiding psychotropic drugs, but that his right is tempered by the state's interest in protecting the inmate and others from harm.⁶² Therefore, the Court adopted a lowered standard of review, which only requires that the prison's reasons for invading the prisoner's constitutional rights and for forcibly administering drugs be "reasonably related" to a legitimate penological objective.⁶³

The Court later extended its holding in *Harper* to dangerous individuals in pre-trial detention in *Riggins v. Nevada*.⁶⁴ In *Riggins*, a criminal defendant on trial for murder was forcibly administered psychotropic drugs without any prior finding that medication was the least restrictive alternative or even the medically-appropriate course of action.⁶⁵ The *Riggins* Court employed a higher level of scrutiny than that used in *Harper* by requiring a "compelling" showing of the need for the administration of psychotropic drugs to a dangerous pre-trial detainee.⁶⁶ Thus, although the *Riggins* Court clearly articulated that the right to refuse medical treatment does not rise to the level of a fundamental right, it did leave the door open for interpretation, according greater protection to those

56. *Id.*

57. *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261 (1990) (upholding the Missouri Supreme Court's requirement of proof by clear and convincing evidence of the treatment preference of an incompetent patient under the substituted judgment standard for medical treatment).

58. *Id.* at 273. The substituted judgment test requires that the party seeking treatment demonstrate by clear and convincing evidence that the patient is incompetent and that the court determine whether the proposed treatment is narrowly tailored to give effect to the patient's liberty interest.

59. *Id.*

60. Note, however, that extension of the *Cruzan* holding to cases involving mentally-ill patients subject to medical treatment for which they cannot choose their preferred course, would require that the New York legislature adopt a provision requiring a formal adjudication of mental incompetence prior to the issuance of an AOT order.

61. *Washington v. Harper*, 494 U.S. 210 (1990).

62. *See id.* at 223.

63. *Id.*

64. *Riggins v. Nevada*, 504 U.S. 127 (1992).

65. *Id.* at 127-28.

66. *Id.*

who are not yet formally incarcerated.⁶⁷ But, because the Court has yet to directly address the issue in the context of mentally-ill individuals living in the community, the standard of protection and whether the “least restrictive alternative” test must be employed remain open questions. Further complicating the analysis is the potential for a situation to arise in which the dangerous individual falls somewhere between detention in state custody and fully-integrated citizen.⁶⁸ Again, the Court has yet to address the protection that would be due a mentally-ill citizen who is deemed likely to commit a crime or cause harm to himself or another. However, given the earlier cases dealing with individuals already in state custody, it is likely that the Court would resolve such cases based on the degree of severity of the threat posed by the mentally-ill individual.

2. The Right to Refuse Medical Treatment in the Lower Courts

While the Supreme Court has yet to weigh in with particular regard to mentally-ill individuals residing in the community at large, several lower courts have issued decisions addressing the right to refuse medication in this context.⁶⁹ In *Rogers v. Okin*, the District Court of Massachusetts recognized a police power explanation for the forcible administration of psychotropic medication in emergency situations.⁷⁰ In *Rogers*, the court determined that forcible medication of involuntarily-committed patients is permissible in “emergency situations in which a failure to do so would result in a substantial likelihood of physical harm.”⁷¹ Emergency situations were defined to include predictions of future violence and psychological deterioration.⁷² However, the power to coerce medication was expressly limited to emergency situations, preserving the basic right of mental patients to refuse medication in non-emergency conditions.⁷³

Also of relevance is a Third Circuit case, *Rennie v. Klein*, which addressed the right to refuse medication in a non-emergency context under New Jersey’s administrative regulations.⁷⁴ In *Rennie*, the court held that forcible medication in a non-emergency context infringes on the protesting patient’s liberty interest.⁷⁵ However, the court also included a caveat, allowing for forcible medication when the physician judged that the medication was necessary to prevent the patient from endangering himself or others.⁷⁶ Subsequent cases have followed *Rennie* in upholding the patient’s protected liberty interest in freedom from unwarranted intrusions on individual liberty.⁷⁷ Further, courts must recognize that the protections afforded mentally-ill patients under the federal constitution are merely minimum requirements; states are free to afford greater liberty protections to their citizens. In this vein, critics of AOT laws argue that “treatment with

67. See Gutterman, *supra* note 53, at 2421.

68. *Id.*

69. See *id.* at 2422. See also, *Rogers v. Okin*, 478 F. Supp. 1342 (D. Mass. 1979); *Rennie v. Klein*, 653 F.2d 836 (3d Cir. 1981) (en banc) (recognizing the right of the state to forcibly medicate mentally-ill patients in cases of emergency when the patient poses a risk of harm to himself or others around him).

70. *Rogers v. Okin*, 478 F. Supp. 1342 (D. Mass. 1979).

71. *Id.* at 1365.

72. *Id.* at 1364.

73. *Id.* at 1361.

74. *Rennie v. Klein*, 653 F.2d 836 (3d Cir. 1981) (en banc).

75. *Id.* at 838.

76. See Gutterman, *supra* note 53, at 2423.

77. See, e.g., *Osgood v. District of Columbia*, 567 F.Supp. 1026, 1030 (D.D.C. 1983); *Project Release v. Prevost*, 722 F.2d 960, 974 (2d Cir. 1983); *White v. Napoleon*, 897 F.2d 103, 111 (3d Cir. 1990).

psychotropic drugs not only impacts the patient's bodily integrity, but also the individual's mind, which is the 'quintessential zone of human privacy.'"⁷⁸

3. Due Process and the Government's Interest Versus Individual Rights

Generally speaking, individual rights are paramount to competing government interests, even with regard to the privacy and liberty interests of the mentally ill. However, the Supreme Court has articulated two conditions under which government interests may supersede those of individuals: (1) in emergency situations;⁷⁹ and (2) in situations in which the individual is unable to care for or control him or herself.⁸⁰ These conditions thus correspond to the familiar government police and *parens patriae* powers.⁸¹

Under some states' police power, the government is authorized to abrogate the rights of mentally-ill individuals when there is an immediate threat of physical violence.⁸² Therefore, in the context of the forcible administration of medication, "dangerousness" allows involuntary drugging based on a prediction that the patient will deteriorate and thus presents a threat of future violence.⁸³ Put another way, an emergency exists when the mentally-ill individual engages in conduct, or is imminently likely to engage in conduct, that poses a risk of harm to the patient or to others. This standard was first articulated in *Rivers v. Katz*⁸⁴ and has since been expounded by the New York courts.⁸⁵

In addition to acting pursuant to the police power, the government is also authorized to act under its *parens patriae* power, which in this context refers to the state's power to act on behalf and for the protection of its citizens. The standard delineating the scope of the *parens patriae* power in the context of forcible medication was enunciated in *Project Release v. Prevost*.⁸⁶ In *Prevost*, the court held that a finding of mental illness did not create a presumption of incompetence.⁸⁷ Generally, the individual's right to self-determination outweighs contradictory government aims absent a showing of a compelling

78. See *Hondroulis v. Schumacher*, 553 So.2d 398, 415 (La. 1989) (articulating concerns that forcible medication constitutes an impermissible invasion of privacy).

79. See *Addington v. Texas*, 441 U.S. 418, 426 (1979) (holding that "[t]he state has a legitimate interest under its *parens patriae* powers in providing care to its citizens who are unable because of emotional disorders to care for themselves; the state also has authority under its police power to protect the community from the dangerous tendencies of some who are mentally ill").

80. *Id.*

81. See John Kip Cornwell, *Understanding the Role of the Police and Parens Patriae Powers in Involuntary Civil Commitment Before and After Hendricks*, 4 PSYCHOL. PUB. POL'Y. & L. 377 (1998).

82. See Gutterman, *supra* note 53, at 2427 ("Government officials exercise broad discretion through their police powers to protect public health, safety, welfare, and moral behavior. In certain situations, the state may utilize this police power authority to involuntarily restrain mentally ill patients in hospital settings. The state's police power stems from its legitimate interest in preventing the mentally ill from harming themselves or others. This principle of 'societal self defense' has been applied ubiquitously to restrain any person who endangers the safety of others.").

83. See Dennis E. Cichon, *The Right to "Just Say No": A History and Analysis of the Right to Refuse Antipsychotic Drugs*, 53 LA. L.REV. 283, 338 (1992).

84. *Rivers v. Katz*, 495 N.E.2d 437, 496 (N.Y. 1986).

85. In re K.L., 2004 WL 303202 (N.Y. Feb. 17, 2004) at *3; In re Urcuyo, 714 N.Y.S. 862, 840 (N.Y. Sup. Ct. 2000).

86. *Project Release v. Prevost*, 722 F.2d 960 (2d Cir. 1983).

87. See *id.* at 971.

government interest.⁸⁸ Therefore, diminished mental capacity without a finding of incompetence does not necessarily undermine an individual's due process rights.

To preserve the liberty rights of the mentally ill, the Supreme Court devised the substituted judgment standard in *Cruzan*.⁸⁹ Under the substituted judgment test, two conditions must be satisfied. First, the proponent of forcible medication must show that the patient is conclusively incompetent by clear and convincing evidence.⁹⁰ Note that this requires actual proof of incompetence, as *Project Release* clearly established that proof of mental illness does not constitute proof of mental incompetence.⁹¹ Second, the court must decide whether the proposed treatment is narrowly tailored to promote the liberty interest at stake, here the right to refuse unwanted medication.⁹² This standard requires the judge to weigh the relevant factors adduced at trial to determine whether the patient will be best served by a course of treatment that requires forcible medication.⁹³ While this test seemingly provides a significant amount of discretion to the judge, it also provides a safeguard against arbitrary decision-making by requiring a showing of incompetence by clear and convincing evidence prior to forcible treatment.⁹⁴

B. Recent New York Case Law

The body of New York case law interpreting Kendra's Law is sparse at best, largely due to the recent enactment of the law. However, several challenges to Kendra's Law were recently decided—all of which upheld the constitutionality of New York's AOT law.

1. *In re K.L.*

In February of 2004, the New York Court of Appeals upheld the constitutionality of Kendra's Law against several due process challenges in *In re K.L.*⁹⁵ This case involved a petition for outpatient commitment of a mentally-ill individual diagnosed with schizoaffective disorder, bipolar type, and a history of psychiatric hospitalization and noncompliance with prescribed medication and treatment, as well as aggressiveness toward family members during periods of decompensation. The court first dismissed respondent's argument that Kendra's Law is unconstitutional because it fails to provide a judicial incompetence determination. Distinguishing this case from its holding in *Rivers*, the court held that Kendra's Law was a valid regulation because it "neither authorizes forcible medical treatment in the first instance nor permits it as a consequence of noncompliance with court-ordered AOT."⁹⁶ The *K.L.* court then went on to reject respondent's argument that Kendra's Law violated due process because it provided for extended detention of a mental patient without notice or hearing. While the court agreed

88. See *id.* at 977–79.

89. See *Cruzan*, 497 U.S. at 273.

90. *Id.*

91. See *Project Release*, 722 F.2d at 971.

92. *Cruzan*, 497 U.S. at 273.

93. See Gutterman, *supra* note 53, at 2431.

94. See *Cruzan*, 497 U.S. at 273.

95. *In re K.L.*, 2004 WL 303202 (N.Y. Feb. 17, 2004). In particular, respondent challenged the statute's failure to require a finding of incompetence, as well as the statute's provision for a seventy-two hour removal and detention without notice or hearing. The court rejected respondent's arguments on both challenges. See *id.*

96. *Id.* at *4.

that the extended detention of a mental patient under Kendra's Law constitutes a significant deprivation of the patient's protected liberty interest, the court found that the state's interest in protecting its citizens against dangerous non-compliant mental patients outweighed the risk of erroneous intrusion into the patient's liberty rights.⁹⁷ The holding in *In re K.L.* is consistent with all prior challenges to the constitutionality of Kendra's Law, and suggests that the New York courts will continue their pattern of deference to the New York legislature.

2. *In re Martin*

In re Martin also presented a challenge to the constitutionality of Kendra's Law, and in particular to the provision allowing for involuntary commitment of mental patients without a prior finding of mental incompetence.⁹⁸ Much like the respondent in *In re K.L.*, the patient in *In re Martin* sought to challenge the AOT order obtained by the director of a psychiatric hospital, ordering respondent's involuntary commitment.⁹⁹ The court ultimately rejected the respondent's due process argument, showing great deference to the law as enacted, holding that because the patient may participate in forming his own treatment plan, the statute did not deprive the mental patient of his due process rights.¹⁰⁰ The court was further persuaded by the fact that under Kendra's Law, no treatment can be forced upon a mental patient for failure to comply with his prescribed treatment plan, which led the court to conclude that the statute is a valid exercise of the state's emergency powers.¹⁰¹

3. *In re Urcuyo*

In re Urcuyo involved a constitutional challenge to forcible treatment under Kendra's Law.¹⁰² The respondent argued that the court is required to find by clear and convincing evidence that a respondent lacks the capacity to make a reasoned treatment decision regarding his or her own treatment plan.¹⁰³ The respondent further argued that enforcing a treatment plan without a finding of incapacity violates the individual's right to make his or her own medical decisions.¹⁰⁴ The petitioners in *Urcuyo*, however, responded that the law was not unconstitutional because "there is no forcible administration of medication [under Kendra's Law] and the patient will suffer no punitive measure

97. *Id.* at *6-7. The court relied on the three-factor balancing test established in *Mathews v. Eldridge*, 424 U.S. 319, 335 (1976), to determine that the state's compelling interest in protecting the community outweighed the risk of an erroneous deprivation of the mental patient's rights during detention. The court was particularly persuaded of this balance in light of safeguards such as the requirement of judicial review as to the threat posed by the individual, the requirement that extensive medical history be presented, and the necessity of a physician's testimony that the patient poses a threat to himself or the community prior to the issuance of an AOT order. *Id.*

98. Court Decisions, Second Judicial Department, Supreme Court, Queens County, 225 N.Y.L.J., Jan. 9, 2001, at 31 (citing slip opinion in *In re Martin*).

99. *Id.*

100. *Id.*

101. *Id.* at 31.

102. *In re Urcuyo*, 714 N.Y.S.2d 862 (N.Y. Sup. Ct. 2000).

103. *See id.* at 865.

104. *See id.* at 841-42. *See also Project Release*, 722 F.2d at 971 (holding that a finding of mental illness does not establish a presumption of mental incompetence).

for failing to comply with the treatment plan.”¹⁰⁵ It was this distinction that the court found persuasive, holding that Kendra’s Law was constitutional because it did not require the forcible administration of medication.¹⁰⁶ The court also rejected the respondent’s equal protection challenge reasoning that the “different treatment for assisted outpatient subjects as opposed to [alleged incapacitated subjects] and involuntarily committed psychiatric patients is warranted.”¹⁰⁷ Consequently, the court determined that Kendra’s Law was not unconstitutional even though it did not include “a requirement that a respondent lacks the capacity to make a reasoned treatment decision before an AOT order can be granted.”¹⁰⁸

4. *In re Conticchio*

Although not the primary focus of the litigation, Kendra’s Law was addressed in dicta in *In re Conticchio*¹⁰⁹ in which the court sought to reconcile Kendra’s Law with the New York Court of Appeals decision in *Rivers*. The tension between the *Rivers* holding and Kendra’s Law had been mounting, centering on the fact that Kendra’s Law did not require a finding of incompetence prior to issuance of an AOT order. Critics argued that this provision of Kendra’s Law was unconstitutional because in *Rivers v. Katz* the New York Court of Appeals determined that the right for a competent individual to determine the course of his medical treatment was a fundamental right.¹¹⁰ Further, this right was subject only to police power and *parens patriae* exceptions, which had to be based on a compelling state interest or alternatively an immediate threat to the community.¹¹¹ The court in *In re Conticchio* attempted to resolve the dissonance between Kendra’s Law and *Rivers*, stating:

The recently passed legislation known as Kendra’s law is based on the dangers that can arise from schizophrenics and other mentally disturbed persons who cease or refuse to take their necessary medication. While said law is apparently based more on the State’s police power, it reemphasizes the importance of not permitting interruptions in the treatment of such individuals.¹¹²

While the court attempted to reconcile the need to protect the community with the parallel requirement that the state recognize the rights of the mentally ill, the court was unable to offer to any substantive solution to resolve the competing concerns. The court thus set a precedent tending to support the state’s protective powers over the individual rights of mental patients that has been narrowly followed in subsequent New York case law. As evidenced by the recent holding in *In re K.L.* and the continuity in the jurisprudence of New York AOT challenges, it seems unlikely that Kendra’s Law will succumb

105. *Id.* at 868.

106. *Id.* (holding that “Kendra’s Law contemplates treatment of patients who have been discharged from the hospital. These patients do not require forcible administration of medication”).

107. *Id.* at 849. The court ultimately concluded, “Kendra’s Law provides the means by which society does not have to sit idly by and watch the cycle of decompensation, dangerousness and hospitalization continually repeat itself.” *Id.*

108. *Id.*

109. *In re Conticchio*, 696 N.Y.S.2d 769 (N.Y. Sup. Ct. 1999).

110. *See Rivers*, 495 N.E.2d at 496.

111. *Id.*

112. *Id.* at 774 (citations omitted).

to a constitutional challenge in the near future. However, this trend may change as the sting of the recent slate of tragic deaths in New York dissipates and the state legislature begins to consider the wide-ranging effect of eliminating the liberty and privacy interests of the mentally-ill without a formal incompetence determination.

V. POLICY ARGUMENTS

As this Note has repeatedly discussed, Kendra's Law has created significant controversy in New York and throughout the country regarding the constitutionality of the AOT laws and their ramifications for the mentally-ill individuals within their ambit. Some of the most common arguments both in support of and against Kendra's Law are examined below.

A. Opponents of Preventive Outpatient Commitment Laws

1. Constitutional Deficiencies of Kendra's Law

First and foremost, opponents of Kendra's Law are troubled by the provision for forcible medical treatment without a finding of patient incompetence.¹¹³ The statute does not require a formal adjudication of incompetence prior to the administration of medication, allowing the state to forcibly medicate allegedly under the *parens patriae* power without a showing of a compelling state interest.¹¹⁴ Further, if the subject of the treatment plan fails to comply at any point, he or she can be forcibly detained and examined for mental illness and violent proclivities without the protections of state law requirements for inpatient commitment.¹¹⁵ Hospitalization can occur on the basis of physician recommendation, and in spite of the patient's fundamental liberty interests.

Further, the statutory language only requires a finding that the patient is "unlikely" to survive in the community, leaving unclear its relevance to a finding of incompetence.¹¹⁶ Opponents of the statute are left to wonder whether this provision is to serve as an implicit requirement for an incompetence finding, and to fear that this statute sanctions psychiatric treatment without any determination regarding competency.¹¹⁷ There is a real concern, therefore, that Kendra's Law impermissibly broadens the category of persons eligible for forcible treatment, and provides a state-sanctioned means to circum-

113. See Gutterman, *supra* note 53, at 2436. See also Michael Perlin, *Preventive Outpatient Commitment for Persons with Serious Mental Illness: Therapeutic Jurisprudence and Outpatient Commitment Law: Kendra's Law as a Case Study*, 9 PSYCHOL. PUB. POL'Y. & L. 183, 193 (2003) (stating that "[o]ne of the implicit 'givens' of the contemporary OPC debates is that persons with mental illness are not competent—in a lay sense, if not in a legal sense—to decide whether to self-medicate in a community setting").

114. See Gutterman, *supra* note 53, at 2434 (arguing that Kendra's Law is unduly intrusive because it infringes on individual liberties without a determination by the state that an emergency exists or a determination that the individual in question is mentally incompetent).

115. Further, this detention may be preventive in nature, as Kendra's Law only requires that the subject pose an imminent threat to society before he or she may be taken into preventive detention. This standard is significantly lower than that required for the state to declare an emergency, which mandates that the subject be a dangerous person or one who "engages in conduct or is imminently likely to engage in conduct posing a risk of physical harm." See N.Y. COMP. CODES R. & REGS. tit. 14, § 27.8(a)(4) (2003).

116. N.Y. MENTAL HYG. LAW § 9.60(c).

117. See Perlin, *supra* note 113, at 193–94 (discussing concerns that all outpatient treatment laws implicitly assume that those who are mentally ill are thereby also mentally incompetent, which he disputes).

vent the constitutional protection of liberty and self-determination for those whose incompetence has not been determined but is only suspected.¹¹⁸

Under New York law, the right to refuse treatment is fundamental, protected under the right to liberty, freedom of expression, and as a right to privacy. Kendra's Law does not require proof of either an emergency or a determination of incompetence.¹¹⁹ In New York, the proof required for a showing of an emergency is imminent danger which necessitates a significantly higher amount of proof than that contained in the history of violence provisions under Kendra's Law.¹²⁰ The minimal evidence of a threat of violence required to invoke the statute is insufficient to amount to a compelling state interest that overcomes individual rights; rather, it is an unconstitutional preventive measure. Thus Kendra's Law is an impermissible exercise of the state's police power authority and violates the rights of the mentally ill who are subject to its constrictions without adequate proof animating its authority.

2. Procedural Failings of Kendra's Law

Opponents of Kendra's Law take issue with the contention that it presents the least-restrictive means available to reduce the threat to the community posed by potentially violent mentally-ill citizens.¹²¹ As a threshold matter, they argue that because Kendra's law does not provide clear criteria for assisted outpatient treatment will ultimately lead to higher inpatient commitment rates.¹²² The significant discretion reserved to medical professionals essentially obscures from public view the process by which patients are committed. Further, the lack of transparency for commitment review, should the patient fail to adhere to his or her treatment plan, will lead to arbitrary and increased inpatient commitment orders. Opponents of Kendra's Law also point to the narrow three day window between examination and hearing, which severely limits the opportunity for the subject of a petition to secure counsel and mount a defense to charges of mental illness and posing a threat of danger to the community.¹²³ Therefore, Kendra's Law reduces the safeguards established in *Rivers* and poses a severe threat to the liberty of any citizen who shows features of mental illness and for whom evidence of the threat of potential violence can be shown.

Tied to the arbitrary and secretive nature of the patient review process is the unreliability of psychiatric assessment.¹²⁴ To date the research on the accuracy of psychiatric predictions shows significant unreliability, and therefore should not be used as the basis for assisted outpatient treatment and its resultant restraints on individual rights. The

118. *Id.* at 196–97 (discussing what Perlin calls “widening the net”). By this, Perlin refers to the broadened reach of AOT laws, both in terms of their effect on the individual liberties of those subject to them as well as the burden imposed on the states who must administer the hearings and oversee the resulting treatment plans of those subject to them.

119. See Gutterman, *supra* note 53, at 2435.

120. *Kulak v. City of New York*, 88 F.3d 63 (2d Cir. 1996). See also *supra* note 82 (containing a discussion of the requirements for exercising emergency powers under New York state law).

121. See Gutterman, *supra* note 53, at 2437–38.

122. See Mind Freedom Online, *NY State Set to Pass Law Today Allowing Involuntary Psychiatric Drug-ing of People Living In Their Own Homes, Out In The Community*, at <http://www.mindfreedom.org/mindfreedom/news/99084.shtml>. (last visited April 13, 2004).

123. See Perlin, *supra* note 113, at 196 (arguing that “vigorous advocacy” under the three day window for the subject to mount a defense is all but impossible, particularly because it deals with the mentally ill who are not in hospitals, and therefore have fewer resources at their disposal).

124. See Gutterman, *supra* note 53, at 2438.

restrictive consequences of Kendra's Law far outweigh its potential beneficial effects, leading to a statute that is fueled by fear and consequently results in an unconstitutional intrusion on individual rights without proof of any measurable resulting social benefit.¹²⁵

Others point to the serious dangers posed by psychotropic drugs and the possible consequences of their side effects.¹²⁶ While the statute does provide for elucidation of the primary risks and benefits of medication, it relies on the medical profession to provide unbiased information to the court and then further relies on a non-medical expert (i.e. the judge) to weigh the risks and to issue a decision as to what course of treatment the patient should follow. This, they argue, presents an unacceptable risk to the health of mentally-ill patients who are afforded little say over the medications that will enter their bodies, and more importantly over the risks to their health that will ensue.¹²⁷ Further, the imposition of mandatory treatment plans along with forced medication may leave many mentally-ill individuals resentful and defiant.¹²⁸ This is particularly true of those who find themselves subject to a petition under Kendra's Law despite minimal mental health history and little indication of imminent danger posed to their community.

Coupled with concerns regarding the elimination of fundamental rights of the mentally ill are those regarding the lack of independent expert medical evidence required at a hearing under Kendra's Law. Under the current structure of Kendra's Law, the treating physician is responsible for presenting his professional opinion regarding mental illness, as well as for presenting all of the medical evidence in support of the patient's outpatient commitment. Those who oppose this structure argue that the subject of a petition under Kendra's Law should be able to present independent expert evidence in support of their mental health.¹²⁹ Further, this dual role for the examining physician could result in a conflict of interest or perhaps merely excessive discretion, leading to a compromised evaluation of the best interests of the mentally-ill individual.

Finally, questions of funding and liability surface.¹³⁰ The statutory scheme under Kendra's Law requires extensive physician diagnosis, research, and treatment but does not disclose the source of its funding. If the bulk of the funds will come from state sources, the heavy burden required by the statute should be reviewed and approved by the citizens of New York first. Additionally, questions of liability will become significant should the program result in unfounded treatment or commitments.¹³¹ Again, who will be liable under this scheme and should citizens who oppose the law in the first place

125. See *id.* at 2437 (noting that opponents of Kendra's Law challenge whether the statute is actually the "least-restrictive alternative").

126. See *id.* at 2435 (explaining that "New York courts have found that 'forcible medication can alter mental processes and limit physical movement, and therefore is analogous to bodily restraint.' Bodily invasions, such as involuntary medication, implicate due process rights, which require some governmental justification").

127. See O'Connor, *supra* note 4, at 343.

128. See Bruce Winnick et al., *Exposing The Myths Surrounding Preventive Outpatient Commitment for Individuals with Chronic Mental Illness*, 9 PSYCHOL. PUB. POL'Y. & L. 209, 229-30 (2003) (responding to findings in a longitudinal study of coercion in mental hospital admissions performed by the John D. and Catherine T. MacArthur Foundation, finding that procedural justice was one of the most significant factors to eliminate feelings of anger and helplessness among mental patients) [hereinafter Winnick, *Exposing the Myths*].

129. See VA CODE ANN. § 37.1-67.3 (Michie 1976) (providing the mentally-ill individual who is subject to an outpatient commitment order an opportunity to present her own medical history and expert testimony in her defense).

130. See Perlin, *supra* note 113, at 199-200.

131. *Id.*

then be responsible for making amends to victims of the law? The answers to these questions so far have been unavailing.

B. Arguments In Support of Assisted Outpatient Treatment Laws

1. Kendra's Law Protects Both The Community and The Mentally Ill

The primary foundation for those who support AOT laws such as Kendra's Law is a concern for the threat to safety posed by mentally-ill individuals who sometimes terrorize the communities in which they live.¹³² Unlike the fear associated with stereotypical inner-city criminals, citizens of communities threatened by the mentally ill feel empowered by AOT laws that allow residents to identify and target future offenders before they have the chance to harm their communities and neighbors.¹³³ Thus, AOT laws provide the rest of the community with a stronger sense of security, ostensibly pursuant to the state's police power duty to safeguard the security and wellbeing of its citizens.¹³⁴

The sense of empowerment to fight crime is coupled with a concern to help those who do not know, or prefer not to recognize, that they are mentally ill and in need of medical treatment. In addition to providing needed medical treatment, AOT laws also help depress historical readmission rates for those mentally ill individuals who seem to float in and out of treatment in perpetuity.¹³⁵ The power to impose treatment upon the mentally ill also could potentially save the state significant funds as the unending cycle of treatment and decompensation will, at least theoretically, come to an end under Kendra's Law.¹³⁶

2. Kendra's Law Provides the Least-Restrictive Means Available

Those who support AOT laws also argue that the structure of Kendra's Law is consistent with the least restrictive means principle.¹³⁷ They point to the fact that it allows for safe rehabilitation and minimizes a "crisis approach" by relying on medical expertise

132. Gutterman, *supra* note 53, at 2432.

133. See Bruce Winnick et al., *Involuntary Outpatient Commitment*, 9 PSYCHOL. PUB. POL'Y & L. 94, 98 (2003). [hereinafter Winnick, *Involuntary Outpatient Commitment*]. "With the psychiatric patient . . . we may eventually require hospitalization [of the patient] because the patient becomes dangerous. So we, the community, have an interest in making sure the patient does not devolve into needing involuntary inpatient treatment. . . . If the psychiatric patient needs involuntary inpatient treatment it generally means that he has become a danger; and that is putting ourselves at risk."

134. But see Winnick, *Exposing the Myths*, *supra* note 128, at 218–19. Winnick argues that current AOT laws are not strict enough and that "chronically mentally ill individuals who do not presently pose a danger due to their compliance with medication are not subject to a commitment order in these jurisdictions [with AOT laws]. This requirement of imminent dangerousness which the petitioner often must demonstrate by proffering evidence of a recent overt act, risks releasing potentially dangerous, mentally disordered individuals into the community without appropriate monitoring of their mental health." *Id.*

135. *Id.* at 228 (citing the results of studies showing that "sustained outpatient commitment, when combined with a high intensity of outpatient services, reduced hospital readmissions and helped prevent re-hospitalization").

136. But see *Use or Lose Kendra's Law*, N.Y. DAILY NEWS, Feb. 7, 2000, at 32 (reporting that while officials had initially projected that Kendra's Law would cover up to 7,000 mental patients in the state of New York, as of four months after the passage of Kendra's Law in November 1999, only nine mental patients had been committed pursuant to its assisted outpatient treatment plan).

137. See Winnick, *Exposing the Myths*, *supra* note 128, at 218–19 (discussing different state approaches to the least restrictive alternative principle and advocating a heightened standard for outpatients, similar to the standard used to assess the rights of inpatients, particularly in light of recent incidents of violence by mentally-ill persons who live in the community under low-restriction treatment plans).

to fashion a treatment plan that requires the least amount of restriction possible while narrowly addressing the affected individual's mental illness.¹³⁸ This, supporters argue, is a sufficient safeguard. It ensures that involuntary medication will only be introduced if the patient refuses to comply with the approved treatment plan—and responds to a clear need for additional treatment to protect the community.¹³⁹

Further, Kendra's Law allows the mentally-ill individual to participate in the formation of the plan, even allowing significant others in his or her life to provide input into the plan's formation. Finally, AOT plans are the least-restrictive alternative because they avoid treatment through institutionalization; they allow the mentally-ill individual to retain his or her physical liberty while simultaneously protecting the community from uncontrolled behavior. Certainly, the argument goes, a mentally-ill patient will be more likely to comply with a treatment plan that preserves some modicum of physical freedom and in which the patient him or herself participated in the planning.

3. Kendra's Law Provides Sufficient Procedural Safeguards

Proponents of Kendra's Law point to several structural components of the law itself to highlight safeguards that were built in to the law. As a threshold matter, many argue that the requirement of a history of violence or threats, most often documented due to hospital stays, is a sufficient safeguard against the potential unreliability of a physician's diagnosis.¹⁴⁰ The argument is based on the idea that if the patient has demonstrated a documented history of violence, the basis for the physician's recommendation for AOT is bolstered, and the danger to the community is further proved.¹⁴¹

As a procedural matter, during the initial evaluation phase the evaluating psychiatrist or physician is required to detail his or her recommendations for medication, explaining both the benefits and the potential side effects and risks of the recommended medication for approval by the court.¹⁴² This safeguard was designed to act as a control on the recommending physician and to provide a balancing assessment to protect the mentally-ill individual from excessively risky medication treatment plans.

Kendra's Law supporters also point to the fact that the statute only provides for confinement if the patient fails to adhere to the treatment plan and the patient's physician finds him or her to be in need of involuntary admission to an institution. The law provides no other enforcement mechanism for those who fail to comply with their court-ordered treatment and is replete with protections for the mentally-ill individual throughout the evaluation process. While a non-compliant AOT patient may be held involuntarily for up to seventy-two hours for evaluation by a physician, if at any time the physician determines that the patient does not qualify for admission, the patient must be re-

138. See also Winnick, *Exposing the Myths*, *supra* note 128, at 225 (arguing that the requirement of an adversarial proceeding in outpatient treatment laws such as Kendra's Law, including the right to secure counsel and provide evidence of mental competence, is sufficient to guarantee the due process rights of the mentally ill).

139. See *In re K.L.*, 2004 WL 303202 at *4.

140. *Id.*

141. See Winnick, *Exposing the Myths*, *supra* note 128, at 222 (arguing that AOT laws require "proof of more than some free-floating tendency toward aggression; the petitioner must present evidence of mental illness coupled with prior inpatient hospitalization or violent behavior linked to medication noncompliance such that, without court-ordered treatment, the individual will 'predictably' become dangerous").

142. See N.Y. MENTAL HYG. LAW § 9.60(j)(1)–(2) (McKinney 1999).

leased immediately.¹⁴³ Further, the physician must provide a supportable evaluation and prove that the patient qualifies for institutionalization which requires a finding of incompetence in order to meet the *Rivers* standard for inpatient treatment. Thus, the AOT order issued under Kendra's Law itself cannot be the grounds for inpatient treatment, and consequently does not constitute an impermissible restriction of liberty.

Finally, supporters of Kendra's Law point to the provision for the mentally-ill individual's right to counsel and the guarantee of a hearing before the court as safeguards against arbitrary medical treatment and medical provider discretion.¹⁴⁴ The statute requires significant documentation and the presentation of extensive evidence by the treating psychiatrist or physician. These requirements, coupled with the detached review of a state judge and the provision for an advocate to exclusively represent the mentally-ill individual, combine to provide sufficient protection for the interests of mentally-ill citizens while protecting the community in which they reside.¹⁴⁵

VI. CONCLUSION

The New York legislature enacted Kendra's Law following a series of tragic events, and the law was designed to address the threats to community safety posed by mentally-ill citizens. Kendra's Law, however, overshoots its mark and consequently creates a scheme for outpatient treatment that impermissibly intrudes on the privacy and liberty rights of the mentally ill. Much of Kendra's Law does withstand constitutional scrutiny—perhaps even those provisions that confer open-ended authority and discretion on medical personnel to issue evaluations, treatment plans, and non-compliance review. Where Kendra's Law runs afoul of the constitution is in its omission of a requirement that mental patients subject to AOT orders first be declared mentally incompetent.¹⁴⁶ The omission of an incompetence finding prior to the issuance of an AOT order is significant not so much for the threat it poses to compliant mental patients, but rather to those who fail to adhere to their prescribed treatment regimen, and thus risk conversion of their treatment under outpatient status to that of permanent inpatient.¹⁴⁷

While there are compelling arguments in support of Kendra's Law, its failure to provide for an incompetency determination is its primary flaw. Although Kendra's Law does provide substantial procedural safeguards and, at least textually, requires a finding that the proposed treatment be the least restrictive alternative, New York's grant of authority to treat those suffering from a mental illness without a formal finding of mental incompetence, or even a diagnosis of mental illness, renders the statute as a whole

143. *Id.* § 9.60(n). The standards necessary to qualify for admission as an inpatient necessarily include a finding of mental incompetence. *See also Rivers*, 67 N.Y. 2d 485, 494 (1986).

144. *See* Perlin, *supra* note 113, at 206. *See also* Winnick, *supra* note 128, at 225.

145. *See* Perlin, *supra* note 113, at 206.

146. This Note does recognize that the weight of authority in New York is to the contrary, having resolved all similar constitutional challenges in favor of the state's protective interest. Nevertheless, the omission of an incompetence requirement under Kendra's Law renders the statute significantly more restrictive than its counterpart in most states and unnecessarily infringes on the rights of the mentally ill to be free from forcible medication and involuntary confinement.

147. *See* N.Y. MENTAL HYG. LAW § 9.60(n) (McKinney 1999) (providing for a seventy-two hour detention period during which the noncompliant patient's physician may "determine whether such person has a mental illness and is in need of involuntary care and treatment in a hospital"). The statute does not define what constitutes noncompliance. Therefore, noncompliance could conceivably lead to the involuntary inpatient confinement of a mental patient for mere superficial violations of the treatment plan, as the statute does not protect against this eventuality.

overly intrusive. New York would do well to look to the statutory language contained in Alabama and Hawaii's outpatient treatment statutes. Both states require a formal adjudication of mental incompetence prior to authorizing the involuntary treatment and medication of mental patients.¹⁴⁸ By requiring a formal incompetence determination, those states ensure that in cases of involuntary treatment, the state has legitimate *parens patriae* authority to act in the best interests of both the mental patient—through the provision of needed mental health assistance—and the community in which he or she lives—in the form of protection against violent or threatening decompensated mental patients.

In the alternative, New York should at least adopt a requirement that the court determine that the subject of an involuntary outpatient treatment order is "mentally ill" as codified under the Virginia and Wyoming statutes.¹⁴⁹ While Kendra's Law currently requires that the patient be "suffering from a mental illness,"¹⁵⁰ this standard is not the same as a formal diagnosis that the patient is mentally ill.¹⁵¹ The distinction between "suffering from mental illness" and "mentally ill" is clear through the plain text of the statute. The provisions governing the failure to comply with AOT orders explicitly provide for the involuntary inpatient commitment of a noncompliant patient on the basis that the patient is "mentally ill." This necessarily means, then, that under Kendra's Law, a patient who is diagnosed as mentally ill is in need of greater medical treatment or inpatient commitment than one who is merely "suffering from a mental illness." Thus, a patient who started out as merely "suffering from a mental illness" can be involuntarily institutionalized on the basis of an analysis by the same physician who first placed him or her under the AOT and without further judicial review. Therefore, although Kendra's Law seems to mirror many of the substantive provisions of other states' assisted outpatient treatment laws, the depressed standard for mental-illness assessment renders the New York statute impermissibly intrusive and denies mental patients in New York their right to freedom from invasive and involuntary medical treatment.

As it stands today, Kendra's Law constitutes an unacceptable burden on the rights of the mentally ill and poses a serious threat to the future treatment of New York's mental patient population. The New York legislature must amend Kendra's Law to include a provision for a judicial determination of mental incompetence, or at the very least a formal diagnosis of mental illness, before it can claim constitutional integrity.

148. See HAW. REV. STAT. ANN. § 334-121 (Michie 1984); ALA. CODE § 22-52-10.2 (1991) (both requiring that the court enter a formal adjudication of mental incompetence before the state can compel the subject of a petition to submit to involuntary outpatient treatment).

149. See VA. CODE ANN. § 37.1-67.3 (Michie 1976); WYO. STAT. ANN. § 25-10-110 (Michie 1977).

150. See N.Y. MENTAL HYG. LAW § 9.60(c)(2) (McKinney 1999).

151. See *id.* § 9.60(n).

