



February 2014

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Recommended Citation

Kristina M. Campbell, *Blurring the Lines of the Danger Zone: The Impact of Kendra's Law on the Rights of the Nonviolent Mentally Ill*, 16 NOTRE DAME J.L. ETHICS & PUB. POL'Y 173 (2002).

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BLURRING THE LINES OF THE DANGER ZONE: THE IMPACT OF KENDRA'S LAW ON THE RIGHTS OF THE NONVIOLENT MENTALLY ILL

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I. INTRODUCTION

When the lives of Kendra Webdale and Andrew Goldstein crossed paths in a New York City subway on January 3, 1999, no one could have predicted the tragic results of their brief encounter, nor the political and legal aftermath the events of that day would spur. According to eyewitnesses, Goldstein, a twenty-nine year old man with a long history of psychiatric illness,¹ approached Webdale, a thirty-two year old woman, to ask her the time as she waited for an uptown train. Goldstein then suddenly and inexplicably pushed Webdale in front of the approaching train; she died instantly.²

Public outrage followed Webdale's death when the press discovered that Goldstein, a diagnosed schizophrenic, had not been taking his anti-psychotic medications at the time he committed this horrific crime.³ After several other highly publicized incidents in New York City involving violent outbursts by homeless, mentally ill individuals,⁴ public support grew for a bill intro-

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1. By all accounts, Andrew Goldstein had been in and out of the New York mental health system for at least ten years. Mr. Goldstein had been hospitalized for schizophrenia no less than thirteen times in the two years before Kendra Webdale's death, with his most recent stay only two weeks prior to her murder. See, e.g., E. Fuller Torrey & Mary T. Zdanowicz, *We've Tried Mandatory Treatment—and It Works*, CITY JOURNAL, Summer 1999, at 82; Samuel Maull, *Mistrial Declared In Fatal Subway Push*, A.P. NEWSWIRE, Nov. 3, 1999, at 1.

2. The death of Kendra Webdale received much attention in both the local and national media. See, e.g., Donna De La Cruz, *New Yorkers Wary Following Subway Death*, A.P. NEWSWIRE, Jan. 5, 1999, at 1 (detailing the events of Kendra Webdale's death).

3. See, e.g., *Outpatient Commitment Bill Dedicated to Kendra Webdale*, A.P. NEWSWIRE, Feb. 19, 1999, at 1.

4. On April 28, 1999, another individual with a history of mental illness, Julio Perez, pushed Edgar Rivera in front of a subway train, severing his legs and rendering him comatose. See Nina Bernstein, *Frightening Echo in Tales of Two Subway Attacks*, N.Y. TIMES, June 28, 1999, at A1. A separate incident

duced in the New York Legislature known as "Kendra's Bill."⁵ Kendra's Bill proposed an outpatient commitment program that would require individuals with a history of mental illness to take anti-psychotic medication or face involuntary civil commitment.⁶ Kendra's Bill was passed by the New York Senate on August 9, 1999 and signed into law by New York Governor George Pataki on August 27, 1999.⁷ The bill then became known as "Kendra's Law."⁸

Since its passage, Kendra's Law has been both praised and decried by the general public, the mentally ill, social service and mental health agencies, advocates, and attorneys.⁹ Proponents of Kendra's Law argue that the law accomplishes what it was intended to do—give violent and potentially violent mentally ill individuals the care they need, thus preventing innocent bystanders from meeting the same fate as Kendra Webdale.¹⁰ Conversely, opponents of Kendra's Law contend that because the law contains a provision that allows for the potential confinement of mentally ill individuals without a history of violence,¹¹ the statute as it is currently written poses a major threat to the liberty interests of the nonviolent mentally ill.¹² This is an area fertile for debate. While there are several instances in which both the New York Court of Appeals (New York State's highest court) and the United States Supreme Court have outlined the minimum constitutional requirements for involuntary inpatient commitment,¹³

occurred on November 16, 1999, in which twenty-seven year old Nicole Barrett was struck in the head with a brick while walking to work, allegedly by a homeless man. See Larry McShane, *Transplanted Texan Fights for Life After Brick Attack in New York*, A.P. NEWSWIREs, Nov. 18, 1999, at 1.

5. 1999 N.Y. A.B. 8477 and 1999 N.Y. S.B. 5762.

6. See *id.* See also Lara Jakes, *Bills Would Mandate Care for Mentally Ill*, TIMES UNION (Albany, N.Y.), May 20, 1999, at B2.

7. See "Kendra's Law" Signed at Ceremony, 222 N.Y.L.J. 43 (1995).

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

9. There have been numerous opinions published both for and against the implementation of Kendra's Law. See, e.g., Torrey & Zdanowicz, *supra* note 1 (endorsing Kendra's Law); Joe Glazer, *Deadly Restraints*, July/August 1999, NEW YORK CITY VOICES (criticizing Kendra's Law).

10. See Torrey & Zdanowicz, *supra* note 1.

11. § 9.60(c)(4)(i) provides that an individual may be hospitalized under Kendra's Law if, in addition to meeting all other criteria of the statute, "the patient has a history of lack of compliance with treatment for mental illness that has: at least twice within the last thirty-six months been a significant factor in necessitating hospitalization in a hospital." For Kendra's Law to be applicable under this provision, no history of violence is necessary.

12. See "Position Statement on Involuntary Commitment," Bazelon Center for Mental Health Law, available at <http://www.bazelon.org/involcom.html>.

13. See *infra* Part III.

no constitutional challenge to involuntary outpatient commitment laws has yet reached the high court of either New York or the United States.¹⁴

This Note argues that Kendra's Law, which may potentially be applied to mentally ill individuals without a history of violence, is overbroad and unconstitutional because it is inconsistent with the state and federal constitutional standards for deprivation of liberty, due process, and the right to refuse treatment, as established by the New York Court of Appeals and the United States Supreme Court.

Part II of this Note examines the evolution of involuntary outpatient commitment in New York under Kendra's Law, including a comparison of how the statute differs substantially from the 1994 pilot program¹⁵ on which it was modeled. Part III will provide an overview of the federal constitutional standards under which an individual may be deprived of his or her liberty through involuntary inpatient commitment, and argue that these standards should also be applied to individuals facing involuntary outpatient commitment. It will also examine the possible conflict of Kendra's Law with New York state constitutional liberty interests, the due process right to a competency hearing, and the right to refuse treatment under *Rivers v. Katz*.¹⁶ Finally, Part IV discusses the morality, as well as the efficacy, of coercive outpatient treatment for the mentally ill in light of current public policy.

II. THE EVOLUTION OF KENDRA'S LAW IN NEW YORK

The controversy surrounding Kendra's Law is not due to an aversion to involuntary outpatient commitment laws in general, but is rather a response to the way in which the New York Legislature chose to word the statute; it potentially includes mentally ill people for whom treatment is not necessary to prevent imminent violence. New York is not unique in choosing to enact an involuntary outpatient commitment law. At the time of this writing, at least thirty-five states (and the District of Columbia) have laws

14. Although there currently is no precedent for determining the standards required for involuntary outpatient commitment under the New York State Constitution, at the time of this writing a challenge to the constitutionality of Kendra's Law is working its way through New York state courts. See *Matter of Urcuyo (James D.)*, 714 N.Y.S.2d 862 (N.Y. Sup. Ct. 2000).

15. § 9.61.

16. 495 N.E.2d 337 (N.Y. 1986).

providing for the involuntary outpatient commitment of mentally ill individuals.¹⁷

However, most of the states with involuntary outpatient commitment laws require that there be a finding of dangerousness for an individual to be civilly committed under such a statute.¹⁸ The reason Kendra's Law has received so much criticism is due, in large part, to the fact that New York, along with a minority of the states having involuntary outpatient commitment laws, does not require a finding of dangerousness to self or others for an individual to be civilly committed.¹⁹ A close examination of the elements of New York Mental Hygiene Law § 9.60²⁰ reveals how the wording of Kendra's Law allows it to be potentially applied to mentally ill individuals without a history of violence, and why this particular outpatient commitment law presents the greatest threat of all outpatient commitment laws to the liberty interests of nonviolent mentally ill citizens.²¹

A. *The 1994 Pilot Program*

Before the tragic meeting of Webdale and Goldstein in 1999, the idea of an involuntary outpatient commitment program had already begun to take shape in the New York Legislature. In response to the recognition that many patients hospitalized for mental illness are capable of leading normal, productive lives outside of an inpatient setting, the state enacted New York Mental Hygiene Law § 9.61 in 1994.²² The stated pur-

17. See Mark Moran, *Coercion or Caring? Kendra's Law is the Flash Point in a Debate About Whether Outpatient Commitment Laws are Effective*, AMERICAN MEDICAL NEWS, Apr. 17, 2000, at 1.

18. See *id.* The following states require a finding of dangerousness for involuntary outpatient commitment: Alaska, Arizona, Arkansas, Colorado, Delaware, District of Columbia, Illinois, Indiana, Iowa, Kansas, Louisiana, Michigan, Minnesota, Nebraska, New Hampshire, North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Dakota, Utah, Vermont, Virginia, Washington, and West Virginia.

19. See *id.* The states that do not require dangerousness as an element of involuntary outpatient commitment are: Alabama, Georgia, Hawaii, Mississippi, Montana, New York, North Carolina, Oregon, South Carolina, and Texas. See *id.*

20. McKinney 1999.

21. See, e.g., Wendy Davis, *Insanity Pleas: With Kendra's Law, Mental Hygiene Courts Now Have Unprecedented Powers Over the Lives of the Mentally Ill—And a Long Track Record of Shutting Them Out*, CITY LIMITS MAGAZINE, May 1999, available at <http://www.citylimits.org/mag/0005.davis.htm>. "Contrary to tabloid opinion, 'dangerous' does not always mean violent. In particular, perfectly peaceful homeless patients may be considered dangerous to themselves, because if they are released they face the very real threat of victimization on the streets." *Id.*

22. McKinney 1994.

pose of the pilot program was “to treat the person’s mental illness and to assist the person in living and functioning in the community,”²³ and was only available to individuals “who have been hospitalized at a hospital.”²⁴

The criteria for involuntary outpatient commitment under the pilot program were quite different than the current specifications set forth under Kendra’s Law. The pilot program’s criteria for involuntary outpatient commitment are set forth in New York Mental Hygiene Law § 9.61(c), which reads as follows:

- (1) A patient may be ordered to obtain involuntary outpatient treatment if the court finds that:
 - (i) the patient is eighteen years of age or older; and
 - (ii) the patient is suffering from a mental illness; and
 - (iii) the patient is incapable of surviving safely in the community without supervision, based on a clinical determination; and
 - (iv) the patient is hospitalized at the hospital designated . . . to take part in the pilot project . . . ; and
 - (v) the patient has a history of lack of compliance with treatment that has necessitated involuntary hospitalization at least twice within the last eighteen months; and
 - (vi) the patient is, as a result of his or her mental illness, unlikely to voluntarily participate in the recommended treatment pursuant to the treatment plan; and
 - (vii) in view of the patient’s treatment history and current behavior, the patient is in need of involuntary outpatient treatment in order to prevent a relapse or deterioration which would be likely to result in serious harm to the patient or others . . . ; and
 - (viii) it is likely that the patient will benefit from involuntary outpatient treatment; and
 - (ix) the involuntary outpatient treatment program of such hospital is willing and able to provide the involuntary outpatient treatment ordered.²⁵

23. § 9.61(a).

24. *See id.* § 9.61(b).

25. § 9.61(c).

Another restriction on the implementation of the outpatient commitment pilot program was the stipulation that the court may only order a mentally ill patient to take psychotropic drugs if it was shown that the individual was not competent to make his or her own treatment decisions, and that there were no less intrusive means available:

A court may order the involuntary administration of psychotropic drugs as part of an involuntary outpatient treatment program if the court finds the hospital has shown by clear and convincing evidence that the patient lacks the capacity to make a treatment decision as a result of mental illness and the proposed treatment is narrowly tailored to give substantive effect to the patient's liberty interest in refusing medication, taking into consideration all relevant circumstances, including the patient's best interest, the benefits to be gained from the treatment, the adverse side effects associated with the treatment and any less intrusive alternative treatments.²⁶

By recognizing the liberty interest of competent mentally ill individuals to refuse treatment, the pilot program demonstrates that an effort was made to take into consideration the capacity of the mentally ill individual to make his or her own treatment decisions.

Although there is no dangerousness requirement other than the speculative component regarding prediction of future violence contained in § 9.61(1)(c)(vii),²⁷ the desire to preserve the liberty interests of the mentally ill is expressed in the statutory language and commitment criteria of the pilot program. The pilot program reflects an understanding that not all those suffering from mental illness—even those who have been hospitalized—are necessarily incompetent, and therefore incapable of making rational decisions regarding their treatment.

B. *New York Mental Hygiene Law § 9.60: Kendra's Law*

One of the main criticisms of the 1994 pilot program was that while it failed to reach a significant proportion of the mentally ill population in the first place, too few of those eligible were actually receiving the assistance the program was designed to

26. § 9.61(c)(2).

27. See AMERICAN PSYCHIATRIC ASSOCIATION, *infra* note 30 (citing APA *Statement on Prediction of Dangerousness*). "Psychiatrists have no special knowledge or ability with which to predict dangerous behavior. Studies have shown that even with patients in which there is a history of violent acts, predictions of future violence will be wrong for two out of every three patients." *Id.*

provide.²⁸ The hysteria generated by the death of Webdale and other isolated incidents of violence perpetrated by mentally ill individuals²⁹ contributed to the general public's perception that mentally ill people were roaming the streets searching for victims.³⁰ This hysteria led the New York Legislature to determine that not enough was being done to control the violent mentally ill. Therefore, when State Attorney General Eliot Spitzer proposed legislation in honor of Kendra Webdale, ostensibly to prevent a similar tragedy from occurring, the legislature concluded that the pilot program was a failure and adopted the more stringent New York Mental Hygiene Law § 9.60, also known as Kendra's Law.

Kendra's Law, signed into law in August 1999, differs from the 1994 pilot program in that it gives less recognition to the liberty interests of the non-violent, competent mentally ill individual. Unlike the pilot program, which specifically mentions the importance of an individual's right to refuse treatment and the exploration of less intrusive means,³¹ Kendra's Law fails to mention these very important constitutional protections at all.³² The elimination of such safeguards makes Kendra's Law a substantial revision of the pilot program that potentially impinges on the liberty interests of the nonviolent mentally ill.

The basic criteria of the pilot program and Kendra's Law are similar. However, the elimination of the protective language present in the pilot program is problematic.

The criteria for assisted outpatient treatment under Kendra's Law, codified in New York Mental Hygiene Law § 9.60(c), read as follows:

A patient may be ordered to obtain assisted outpatient treatment if the court finds that:

28. By January 1999, only 198 patients had received orders for outpatient commitment. See Jennifer Gutterman, Note, *Waging a War on Drugs: Administering a Lethal Dose to Kendra's Law*, 68 FORDHAM L. REV. 2401, 2412 (2000) (citing E. Fuller Torrey & Mary T. Zdanowicz, *Kendra's Law—The Culmination of a 10-Year Battle For Assisted Outpatient Treatment in New York*, CATALYST: TREATMENT ADVOCACY CENTER, Nov./Dec. 1999, at 3).

29. See Bernstein and McShane, *supra* note 4.

30. While the majority of people who commit violent acts are not mentally ill, and while most mentally ill people are not violent, there is the perception that most or all mentally ill people are violent. This belief is reinforced through violent acts in movies and television committed by "insane" people, and by fear and lack of knowledge about mental illness. See AMERICAN PSYCHIATRIC ASSOCIATION FACTSHEET, *Violence and Mental Illness*, available at <http://www.psych.org> (accessible in pdf file under "Public Information").

31. See § 9.60(c)(2).

32. See § 9.60.

- (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:
- (5) 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 . . . or;
 - (i) 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 . . . ; and
 - (ii) the patient is, as a result of his or her mental illness, unlikely to voluntarily participate in the recommended treatment pursuant to the treatment plan; and
- (6) in view of the patient's treatment history and current behavior, the patient is in need of assisted outpatient treatment in order to prevent a relapse or deterioration which would be likely to result in serious harm to the patient or others . . . ; and
- (7) it is likely that the patient will benefit from assisted outpatient treatment; and
- (8) if the patient has executed a health care proxy . . . that any directions included in such proxy shall be taken into account by the court in determining the written treatment plan.³³

The criteria for involuntary outpatient commitment under Kendra's Law are more specific than the pilot program regarding dangerousness,³⁴ which admittedly may offer more protection to the nonviolent mentally ill in assessing whether an individual qualifies for involuntary treatment. However, the absence of any language acknowledging the mentally ill individual's right to refuse treatment and access to less restrictive alternatives in the text of Kendra's Law creates the potential for infringement on their constitutional liberty interests.

In addition to the absence of language recognizing mentally ill individuals' liberty interests in Kendra's Law, the incorpora-

33. § 9.60(c).

34. See § 9.61(c).

tion of ambiguous language in the statute defining who is eligible for involuntary outpatient treatment has the potential to be applied in an overbroad and indiscriminate manner. For example, under the pilot program, a showing that the individual being subjected to outpatient commitment “is incapable of surviving safely in the community without supervision” was required.³⁵ By contrast, under Kendra’s Law, it need only be shown that the individual “is *unlikely* to survive safely in the community without supervision.”³⁶ While the distinction is subtle, the possible ramifications are great. Though both statutes require a “clinical determination” of the individual’s survival in the community,³⁷ the distinction between whether an individual is *actually* unable to survive safely, or is merely *unlikely* to, can mean the difference between civilly committing someone who is clearly incompetent versus committing someone who may be deemed competent in the subjective judgment of another.³⁸

Another difference between the pilot program and Kendra’s Law is the expansion of the time frame during which an individual who has previously been hospitalized is eligible for outpatient commitment. Under the pilot program, the individual’s failure to comply with treatment for mental illness “has necessitated involuntary hospitalization at least twice within the last *eighteen months*.”³⁹ Kendra’s Law mandates that an individual’s lack of compliance with treatment for mental illness may subject him or her to outpatient commitment if such noncompliance has “at least twice within the last *thirty-six months* been a *significant factor* in necessitating hospitalization.”⁴⁰ By doubling the time frame during which a mentally ill individual may be subject to a petition for outpatient commitment, and by making mental illness merely a significant factor in necessitating hospitalization rather than the primary cause, Kendra’s Law continues to blur the line between those who truly require outpatient commitment and those who do not.

35. See § 9.61(c)(1)(iii) (emphasis added).

36. See § 9.60(c)(3) (emphasis added).

37. See *id.* and § 9.61(c)(1)(iii).

38. One of the problems cited by opponents of Kendra’s Law is the level of subjectivity used to determine whether an individual is competent or not. Under the statute as it is currently drafted, there is no objective test used to determine competency. Supporters of the law argue that the statute itself serves as an objective test. See, e.g., Eve Kupersanin, *Outpatient Commitment Law Becomes N.Y. Battleground*, PSYCHIATRIC NEWS, Aug. 18, 2000, available at <http://www.psych.org/pnews/00-08-18/outpatient.html>.

39. See § 9.61(c)(1)(v) (emphasis added).

40. See § 9.60(c)(4)(i) (emphasis added).

While Kendra's Law contains the same speculative clause regarding predictions of future violence outlined in the pilot program,⁴¹ it also contains a provision that would allow for the commitment of an individual whose lack of compliance with treatment has resulted in violence or "threats of, or attempts at, serious physical harm to self or others within the last forty-eight months."⁴² This expansive time frame—four years—and the loose criteria for potential involuntary outpatient commitment that include "threats" and "attempts" of violence, make it easy for such a provision to be abused. As a result, a generally nonviolent, competent person may therefore face a substantial restriction on his or her liberty if subjected to involuntary outpatient commitment as codified in Kendra's Law.⁴³

The potential for abuse is made all the more likely because of the many individuals who may, under Kendra's Law, petition for the involuntary outpatient commitment of a mentally ill person. While the pilot program specified that "an application to obtain an order authorizing involuntary outpatient treatment may be initiated *only* by the director of the hospital in which the patient is hospitalized,"⁴⁴ Kendra's Law provides that petitions may be made by just about anyone involved in the mentally ill person's private life.⁴⁵

41. See § 9.60(c)(6) and § 9.61(c)(1)(viii).

42. See § 9.60(c)(4)(ii).

43. The following is an example of such a restriction:

Imagine that you are sitting home watching television with your family. You hear a knock at your door and think it is odd that someone is knocking this late at night. You answer the door and it's a police officer coming to take you to a psychiatric hospital. You have not hurt anyone. Your family is safe and happy. The only "crime" you committed was that you did not want to live with the side effects of Lithium and you chose to stop taking the drug prescribed for your bi-polar disorder.

Guterman, *supra* note 28 at 2401 (citing Elaine Sutton Mbionwu, *Involuntary Outpatient Commitment: If It Isn't Voluntary . . . Maybe It Isn't Treatment*, 4 PROTECTION & ADVOCACY SYSTEM NEWS 1, 1 (Winter 1999)). While such a scenario may seem a bit paranoid to some, if such an encounter were to occur and was preceded by a domestic dispute in which "threats" were communicated (which may or may not be the result of a "failure to comply with treatment"), under statutes such as Kendra's Law, the situation at hand might seem less Orwellian than we are first inclined to believe. See *id.*

44. See § 9.61(d)(1) (emphasis added).

45. See § 9.60(e) (Detailing the persons who may petition for involuntary outpatient commitment of a mentally ill person. The list includes: adult roommates; parents, spouses, adult children and siblings; hospital directors; directors of mental health organizations and charitable agencies; psychiatrists and others supervising mental health care; the director of community services of the city or

Since rational minds often disagree, it is highly likely that someone close to a mentally ill individual might believe, for example, that her decision to reduce her anti-depressant medication constitutes non-compliance when, for the patient herself, such a choice is liberating. Allowing so many people to have a potential say in intimate treatment decisions potentially threatens the liberty interests and due process concerns of competent, nonviolent persons who have a history of mental illness. If an individual is faced with the possibility of having his or her right to refuse medication taken away, there needs to be substantial protection given to that person's liberty interest in being free from unwanted psychotropic medication.⁴⁶ A law such as Kendra's Law, which seeks to substantially limit the autonomy of an individual to make his or her own treatment decisions, must also include a safeguard to protect the due process rights of competent individuals who may be subject to involuntary treatment at the request of a third party.⁴⁷

The goal of allowing so many people to petition for the involuntary outpatient commitment of a mentally ill individual is a noble one: to prevent anyone else from becoming seriously injured at the hands of a person in the grip of psychosis. However, Kendra's Law in its current form is fatally flawed because the overbroad statutory language makes it applicable to a class of mentally ill people for whom it should not apply. Kendra's Law should focus on the population it was intended to address—the mentally ill with a demonstrated history of consistent violence and refusal to seek and/or maintain treatment—and should be narrowly tailored to suit this end.⁴⁸

county in which the petitioned individual resides; and the individual's parole or probation officer.).

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

47. See *id.*

Under liberal statutes such as Kendra's Law, participants in outpatient commitment programs are neither imminently dangerous nor incapable of making informed decisions to refuse medication. Arguably, the exigencies invoked by the Harper Court to justify deference in the forcible administration of medication to control violence are often not present in the community setting. Therefore, outpatients would appear to be entitled to the most exacting standard of review, and are thus deserving of strict judicial scrutiny.

See Gutterman, *supra* note 28, at 2422.

48. See *Matter of Sullivan (Jesus A.)*, in which the trial judge held that "the specificity in pleading required under Kendra's Law is not to be taken lightly." 710 N.Y.S.2d 853, 856 (N.Y. Sup. Ct. 2000) The judge held that an affidavit by the patient's physician, stating that the patient "has a long history of noncompliance with aftercare, follow-up, and medications which has led to physically

III. KENDRA'S LAW AND THE CONSTITUTIONAL STANDARDS GOVERNING INVOLUNTARY INPATIENT COMMITMENT

Kendra's Law, as stated before, is not unique because of its nature as an involuntary outpatient commitment statute.⁴⁹ What makes Kendra's Law particularly troublesome is its statutory language. The Fourteenth Amendment of the United States Constitution, through the Due Process Clause, requires the states to recognize an individual's liberty interest to be free from the arbitrary administration of psychotropic medication.⁵⁰ However, the states are given the power to administer the laws as they see fit through their legislative bodies.⁵¹

Despite the lack of a clear federal constitutional standard governing involuntary outpatient commitment, many state legislatures have chosen to model their outpatient commitment statutes on their inpatient commitment statutes.⁵² By applying the same criteria to involuntary outpatient commitment as the state does to inpatient commitment, the goal of providing an alternative treatment through less restrictive means than hospitalization is offered for the same class of people.⁵³ Since such dispositional alternative⁵⁴ approaches to involuntary outpatient commitment usually mirror the state involuntary inpatient commitment statute, there are generally no substantive challenges made to the constitutionality of such laws since the due process requirements are almost always satisfied under such an analysis.

Kendra's Law, however, is not a dispositional alternative to hospitalization. Rather, Kendra's Law is the type of involuntary outpatient commitment law that would best be categorized as a preventive commitment law.⁵⁵ Preventive commitment laws generally apply a lower standard to involuntary outpatient commit-

violent behavior resulting in hospitalizations and criminal incarcerations" were merely "broad, simple, conclusory statements." *Id.* at 857.

49. See *supra* notes 19 and 20.

50. See U.S. CONST. amend. XIV, § 1; See *Washington v. Harper*, 494 U.S. 210 (1990).

51. As stated in *Addington v. Texas*, 441 U.S. 418, 431 (1979), "The essence of federalism is that states must be free to develop a variety of solutions to problems and not be forced into a common, uniform mold. As the substantive standards for civil commitment may vary from state to state, procedures must be allowed to vary so long as they meet the constitutional minimum."

52. See Geraldine A. McCafferty & Jeanne Dooley, *Involuntary Outpatient Commitment: An Update*, 14 MENTAL & PHYSICAL DISABILITY L. REP. 277, 280 (1990).

53. *Id.*

54. *Id.*

55. *Id.* at 281.

ment than is required for involuntary inpatient commitment.⁵⁶ As is the case in Kendra's Law, preventive commitment laws often give the courts the power to civilly commit an individual who is not currently dangerous, but whom the court believes could become dangerous without treatment.⁵⁷

Such a speculative standard of dangerousness for outpatient commitment raises serious questions regarding liberty and due process.⁵⁸ Until the United States Supreme Court rules on the constitutional parameters governing involuntary outpatient treatment, the same rights guaranteed to those facing involuntary inpatient commitment should be given to those facing involuntary outpatient commitment because of the substantial liberty interests involved in the forced administration of medication to nonviolent individuals who are competent to make their own treatment decisions.

A. *Due Process Concerns Arising Under Kendra's Law*

1. The Right to Refuse Treatment

In *Mills v. Rogers*,⁵⁹ the United States Supreme Court held that the Constitution "recognizes a liberty interest in avoiding the unwanted administration of antipsychotic drugs."⁶⁰ Although the holding in *Mills* only extends specifically to mentally ill inpatients,⁶¹ a strong argument can be made that the due process protections given to inpatients should be extended to outpatients as well. Since the liberty interest of an outpatient is at least equal to, if not greater than, that of an inpatient, statutes such as Kendra's Law should be required to protect an individual's right to refuse treatment.

The Due Process Clause of the Fourteenth Amendment of the United States Constitution prohibits the government from depriving a person of life, liberty, or property without due process of law.⁶² In *Washington v. Harper*,⁶³ the United States Supreme Court held that inmates "possess a significant liberty interest in avoiding the unwanted administration of antipsychotic

56. *Id.*

57. *Id.* "This approach is particularly dependent on the assumption that dangerousness can be reliably predicted." *Id.*

58. The United States Supreme Court has held that in order for an individual to be subject to involuntary inpatient commitment, there must be a finding of *both* mental illness and dangerousness. *See infra* Part III.A.1.

59. 457 U.S. 291 (1982).

60. *Id.* at 299.

61. *See id.* at 298-99.

62. *See* U.S. CONST. amend. XIV, § 1.

63. 494 U.S. 210 (1990).

drugs under the Due Process Clause of the Fourteenth Amendment."⁶⁴ However, as long as the methods used by the State to administer the antipsychotic drugs meet the demands of the Due Process Clause, the federal Constitution provides "no greater right than that recognized under state law."⁶⁵

The Court in *Harper* found that the procedures established by the State of Washington for administering medication without consent of an inmate were consistent with the Due Process Clause.⁶⁶ The Court held that the procedures established by the State were constitutional because they permitted a psychiatrist to treat an inmate with antipsychotic drugs against his wishes only if he is found to be both mentally ill and gravely disabled or dangerous.⁶⁷ In the Court's opinion, this policy "creates a justifiable expectation on the part of the inmate that the drugs will not be administered unless those conditions are met,"⁶⁸ and that requiring the state to prove both of these conditions before forcibly administering antipsychotic medication "is a rational means of furthering the State's legitimate objectives."⁶⁹ Therefore, although an inmate's due process right to refuse medication is not absolute, the state must show that it has an obligation—not merely an interest—in administering medication to justify depriving a person of his or her liberty.⁷⁰

In *Youngberg v. Romeo*,⁷¹ the Court held that "liberty from bodily restraint has always been recognized as the core of the liberty protected by the Due Process Clause from arbitrary governmental action This interest survives criminal conviction and incarceration. Similarly, it must also survive involuntary commitment."⁷² Kendra's Law is troubling when viewed in light of the due process standards set forth by the Court for several reasons. First, the *Youngberg* decision makes it clear that even those who have suffered a substantial deprivation of liberty—incarcerated criminals—still have a liberty interest in avoiding the unwanted administration of antipsychotic drugs.⁷³ A strong argument can be made that if such a liberty interest exists for an

64. *Id.* at 221–22.

65. *Id.* at 222.

66. *See id.* at 222–23 ("These standards, which recognize both the prisoner's medical interests and the State's interests, meet the demands of the Due Process Clause.")

67. *Id.* at 220 (citing *Vitek*, 445 U.S. at 488–91).

68. *Id.*

69. *Id.* at 226.

70. *See id.* at 225.

71. 457 U.S. 307 (1982).

72. *Id.* at 316.

73. *See id.*

individual who is imprisoned or involuntarily committed, then certainly individuals who are not incarcerated should enjoy at least as much due process when faced with forced administration of psychotropic drugs. Kendra's Law falls short of adequately addressing such liberty interests because even though it provides for administrative procedures before an individual may be forcibly medicated, its text fails to even mention the individual's right to refuse treatment.

Of course, the liberty interest in refusing antipsychotic drugs is not absolute, and can be overridden if the state can satisfy *Harper's* twin tests of: 1) dangerousness, and 2) compelling state interest necessitating the forced administration of drugs.⁷⁴ Kendra's Law is problematic in light of these tests because it does not set forth rigid enough standards by which dangerousness should be measured, and it likewise fails to enumerate what standard must be met for the state to meet the level of "compelling State interest." In *Harper*, the Court held that "the extent of a prisoner's right under the Clause to avoid the unwanted administration of antipsychotic drugs must be defined within the context of the inmate's confinement."⁷⁵ When analyzed under this standard, Kendra's Law fails to provide adequate due process protection to individuals facing involuntary outpatient commitment.

Additionally, the criteria established in Kendra's Law for determining dangerousness for those facing involuntary outpatient commitment—whether an individual has been hospitalized in the recent past—falls far short of the type of inquiry that should be mandated when the liberty and autonomy of an individual is at stake. At a minimum, Kendra's Law should be rewritten to ensure that the standards for involuntary administration of psychotropic drugs in *Harper* are met.

B. Federal Constitutional Standards Governing Involuntary Inpatient Commitment Laws

1. O'Connor v. Donaldson

Due process requires that states not allow mentally ill individuals to be involuntarily committed in an inpatient facility without a finding of dangerousness.⁷⁶ In *O'Connor v. Donaldson*,⁷⁷ the United States Supreme Court held that "[a] finding of mental illness alone cannot justify locking a person up against his will . . . [;] there is . . . no constitutional basis for confining such persons

74. See *Harper*, 494 U.S. at 220.

75. *Id.* at 222.

76. *O'Connor v. Donaldson*, 422 U.S. 563 (1975).

77. *Id.*

involuntarily if they are dangerous to no one and can live safely in freedom."⁷⁸ *O'Connor* was a watershed case in affirming the rights of the mentally ill to be treated with fairness and dignity. Recognizing the tremendous liberty interests at stake when someone is facing involuntary commitment, the Court held that "a State cannot constitutionally confine without more a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends."⁷⁹

If this standard of dangerousness is applicable to individuals facing involuntary inpatient commitment, the same standard of dangerousness should be applied to those facing involuntary outpatient commitment. The *O'Connor* Court held that "involuntary commitment to a mental hospital, like *involuntary confinement of an individual for any reason*, is a deprivation of liberty which the State cannot accomplish without due process of law."⁸⁰ Because involuntary outpatient commitment laws such as Kendra's Law allow for the potential of forced administration of psychotropic drugs,⁸¹ due process rights come into play that require justification for state intervention.⁸²

Without a requirement of dangerousness, it is difficult for the state to justify civil commitment: "Commitment must be justified on the basis of a legitimate state interest, and the reasons for committing a particular individual must be established in an appropriate proceeding."⁸³ Simply because an individual faces commitment in an outpatient setting, rather than an inpatient setting, does not diminish his or her right to liberty under the Constitution.⁸⁴

By not including dangerousness as a prerequisite for involuntary outpatient commitment under Kendra's Law, the New York Legislature has reduced the liberty interests of the nonviolent mentally ill by potentially subjecting them to commitment in violation of *O'Connor*. Therefore, if involuntary outpatient commitment laws are to be held to the same constitutional standard

78. *Id.* at 575.

79. *Id.*

80. *Id.* at 580 (Burger, J., concurring) (emphasis added).

81. See § 9.60(j)(4) ("A court may order the patient to self-administer psychotropic drugs or accept administration of such drugs by authorized personnel as part of an assisted outpatient treatment program.")

82. See Gutterman, *supra* note 28, at 2435 ("Bodily restraints, such as involuntary medication, implicate due process rights, which require some governmental justification.")

83. 422 U.S. at 580 (Burger, J., concurring).

84. See *id.* at 586.

as involuntary inpatient commitment laws, Kendra's Law is unconstitutional because it allows for the civil commitment of mentally ill people without a finding of dangerousness.

2. *Addington v. Texas*

The next major case concerning the rights of mentally ill people facing civil commitment to come before the United States Supreme Court after *O'Connor* was *Addington v. Texas*.⁸⁵ In *Addington*, the Court held that it was necessary to apply a "clear and convincing" standard of proof that an individual is both mentally ill and dangerous for an involuntary inpatient commitment proceeding to satisfy due process under the Fourteenth Amendment.⁸⁶ While New York requires that the "clear and convincing" standard of dangerousness be employed for inpatient commitment proceedings,⁸⁷ thus meeting the constitutional burden of proof established in *Addington*, there is no such standard of proof required for an involuntary outpatient under Kendra's Law.⁸⁸

The language of *Addington* itself warns against the danger inherent in allowing individuals to face potential civil commitment without adhering to a rigorous standard of due process.⁸⁹ The *Addington* Court recognized that one of the perils of permitting individuals to be civilly committed without a "clear and convincing" standard is that a competent, nonviolent person might face a loss of liberty due to a few isolated incidents that, standing alone, would not justify involuntary inpatient commitment: "[T]here is the possible risk that the factfinder might decide to commit an individual based solely on a few isolated incidents of unusual conduct. Loss of liberty calls for a showing that the individual suffers from something more serious than is demonstrated by idiosyncratic behavior."⁹⁰

Because Kendra's Law allows the potential for involuntary hospitalization of individuals who are found to be in noncompliance with their treatment programs ordered as part of their outpatient commitment, the risk of a mentally ill person being deprived of his or her liberty due to an "isolated incident of un-

85. 441 U.S. 418 (1979).

86. *Id.* at 427.

87. *See* *Goetz v. Crosson*, 967 F.2d 29 (2d Cir. 1992).

88. *See* § 9.60(c) (outlining the requirements for determination of involuntary outpatient commitment under Kendra's Law).

89. *See* 441 U.S. at 425 ("This Court repeatedly has recognized that civil commitment for any purpose constitutes a significant deprivation of liberty that requires due process protection.")

90. *Id.* at 426-27.

sual conduct" is great.⁹¹ In addition, without the requirement of a "clear and convincing" standard of dangerousness written into the statutory language of Kendra's Law, what may be merely "idiosyncratic behavior" could be characterized as potentially violent behavior that could result in the deprivation of an individual's liberty by subjecting him or her to involuntary outpatient commitment.⁹² Thus, if involuntary outpatient commitment laws are to be held to the same constitutional standards as involuntary inpatient commitment laws, Kendra's Law is unconstitutional for its failure to apply a "clear and convincing" standard for determining both dangerousness and noncompliance.

The *Addington* Court also stated that "the State has no interest in confining individuals involuntarily if they are not mentally ill or if they do not pose some danger to themselves or others."⁹³ Although this statement appears to be dicta in the *Addington* decision, and "the State" refers specifically to Texas (the state involved in the litigation),⁹⁴ the Court in *Jones v. United States*⁹⁵ stated that the Court in *Addington* held "that the Due Process Clause requires the Government in a civil-commitment proceeding to demonstrate by clear and convincing evidence that the individual is mentally ill and dangerous,"⁹⁶ and used that as a basis for establishing the constitutional standards for civil commitment.⁹⁷

Therefore, although it is unclear whether the court in *Addington* intended to say that the standard of requiring a showing of both mental illness and dangerousness was specific to Texas or whether it applied to all civil commitment laws in general,⁹⁸ *Jones* holds that these are the requirements that must be demonstrated for involuntary inpatient commitment.⁹⁹ Since Kendra's Law fails to contain a provision in which it must be demonstrated by

91. See McCafferty & Dooley, *supra* note 52, at 278 ("Due process concerns become particularly acute in those instances where a person committed to IOC [involuntary outpatient commitment] fails to comply with the ordered treatment.").

92. See § 9.60(c) (outlining the requirements for determination of involuntary outpatient commitment under Kendra's Law).

93. 441 U.S. at 426.

94. See *id.*

95. 463 U.S. 354 (1983).

96. Katherine P. Blakey, Note, *The Indefinite Civil Commitment of Dangerous Sex Offenders is an Inappropriate Legal Compromise Between "Mad" and "Bad"—A Study of Minnesota's Sexual Psychopathic Personality Statute*, 10 NOTRE DAME J.L. ETHICS & PUB. POL'Y 227, 275 (1996) (citing *Jones*, 463 U.S. at 362) (citing *Addington*, 441 U.S. at 426-27).

97. See *id.* at n.216.

98. See *id.*

99. See *id.* at 275 (citing *Jones*, 463 U.S. at 362).

“clear and convincing” evidence that an individual facing involuntary outpatient commitment is both mentally ill and dangerous, it fails to meet the due process standards set forth by *Addington* for involuntary commitment under the federal Constitution.

Because there is currently no set of federal guidelines for determining whether state involuntary outpatient commitment laws conform with the United States Constitution, the only way to protect the liberty and due process rights of mentally ill people facing such confinement is to apply the standards governing involuntary inpatient commitment the Supreme Court gave in *O'Connor* and *Addington*. Until the Supreme Court sets forth different rules under which the mentally ill may be subjected to outpatient commitment without compromising their constitutional rights, such laws must be evaluated under the involuntary inpatient commitment standards. Kendra’s Law does not provide for the “clear and convincing” standard of mental illness and dangerousness outlined by the Supreme Court as necessary for ensuring due process and is therefore unconstitutional.

C. *New York State Constitutional Standards Governing Involuntary Inpatient Commitment*

While the constitutionality of Kendra’s Law is ambiguous when viewed in light of the federal standards for subjecting individuals to involuntary inpatient commitment, the legality of the statute is even more questionable when examined under New York state law. The New York State Constitution provides persons who are committed involuntarily the right to refuse medication unless there is a compelling state interest in using police power to force them to do so.¹⁰⁰ It is also well-established under state law that for a mentally ill person to be involuntarily civilly committed, the state bears the burden of showing, by clear and convincing evidence, that the individual poses a substantial threat of physical harm to himself or to others.¹⁰¹ When viewed in light of the language of the leading state case addressing the rights of persons who face involuntary civil commitment to refuse medication, *Rivers v. Katz*,¹⁰² the failure of Kendra’s Law to provide for a competency determination before subjecting a mentally ill person to involuntary outpatient commitment raises issues of substantive due process.

100. *Rivers v. Katz*, 495 N.E.2d 337 (1986).

101. *See generally*, *Goetz v. Crosson*, 967 F.2d 29 (2d Cir. 1992).

102. 495 N.E.2d 337 (1986).

1. *Rivers v. Katz*

The issue brought before the Court of Appeals of New York in *Rivers v. Katz* was “whether and under what circumstances the State may forcibly administer antipsychotic drugs.”¹⁰³ *Rivers* involved a challenge by several individuals who were committed, against their will, to state psychiatric hospitals for treatment of their mental illness.¹⁰⁴ After refusing to be medicated with antipsychotic drugs, the appellants sought administrative review but were overruled, and were eventually medicated against their will.¹⁰⁵ The appellants then sought to enjoin the state psychiatric hospital from administering antipsychotic drugs without their consent, based on their common law and constitutional right to refuse medication.¹⁰⁶ The complaint was dismissed on respondents’ motion for summary judgment, with the lower court holding that “involuntary retention orders necessarily determined that these patients were so impaired by their mental illness that they were unable to competently make a choice in respect to their treatment.”¹⁰⁷ The Court of Appeals reversed, holding that Article I, § 6 of the New York State Constitution¹⁰⁸ guarantees the mentally ill a fundamental right to refuse antipsychotic medication.

The holding in *Rivers* is extremely important in analyzing the substantive due process implications of Kendra’s Law on mentally ill individuals who face involuntary outpatient commitment. There are two major substantive due process rights identified in *Rivers* that should be afforded to those facing involuntary outpatient commitment as well as involuntary inpatient commitment—the right to refuse medication and the right to a determination of competency.

a. The Right to Refuse Medication

The court in *Rivers* stated that “[i]t is a firmly established principle of the common law of New York that every individual ‘of adult years and sound mind’ has a right to determine what shall be done with his own body’ and to control the course of his medical treatment.”¹⁰⁹ Although some might argue that the

103. 495 N.E.2d at 339.

104. *See id.*

105. *See id.* at 339–40.

106. *See id.* at 340.

107. *Id.*

108. N.Y. CONST. ART. I § 6.

109. 495 N.E.2d at 341 (citing *Schloendorff v. Soc’y of N.Y. Hosp.*, 105 N.E. 92 (1914)).

“sound mind” provision does not apply to the mentally ill, the court saw otherwise:

[I]t is the individual who must have the final say in respect to decisions regarding his medical treatment in order to insure that the greatest possible protection is accorded his autonomy and freedom from unwanted interference with the furtherance of his own desires This right extends equally to mentally ill persons who are not to be treated as persons of lesser status or dignity because of their illness.¹¹⁰

Therefore, the *Rivers* decision firmly establishes that the mentally ill have a right to refuse medication, and that their mental illness alone is not enough to deny them this basic constitutional right.

The court in *Rivers* did recognize, however, that “the right to reject treatment with antipsychotic medication is not absolute and under certain circumstances may have to yield to compelling State interests.”¹¹¹ Proponents of Kendra’s Law maintain that an individual who meets the qualifications for involuntary outpatient commitment under Mental Hygiene § 9.60 may be compelled to take antipsychotic medication against his or her will because the State’s interest in protecting the health and safety of the general public is greater than the individual’s right to refuse medication.¹¹² This position presupposes, presumably, that the mentally ill individual is a danger to himself or others. However, as was discussed previously,¹¹³ Kendra’s Law may potentially apply in some circumstances to the nonviolent mentally ill. Therefore, under the law as it is currently written, non-dangerous persons may be forced to take antipsychotic medication in violation of their constitutional right to refuse treatment.

Defenders of Kendra’s Law also claim that it may sometimes be necessary to medicate persons against their will because their inability to recognize their mental illness constitutes an “emergency,” and medication is the only way to prevent their condition from deteriorating.¹¹⁴ However, the *Rivers* court asserts that what constitutes an emergency must clearly demonstrate that the State’s interest is compelling enough to override the liberty interests of the individual: “[T]he most obvious example . . . is an emergency situation, such as when there is imminent danger to a

110. *Id.*

111. *Id.* at 343.

112. *See generally*, Torrey & Zdanowicz, *supra* note 1 (discussing the efficacy of coercive treatment).

113. *See supra* Part II.A.

114. *See, e.g.*, Torrey & Zdanowicz, *supra* note 1, at 3.

patient or other in the immediate vicinity. Under these circumstances, the State's police power would justify forced medication, albeit temporarily—continuing only as long as the emergency persists."¹¹⁵ The court clarified in a footnote what kinds of emergency situations generally do not constitute a compelling State interest: "[T]he State's interest in providing a therapeutic environment, in preserving the time and resources of the hospital staff, in increasing the process of deinstitutionalization and in maintaining the ethical integrity of the medical profession, while important, cannot outweigh the fundamental individual rights here asserted."¹¹⁶

One of the legislature's stated goals in the creation of Kendra's Law was to provide a mechanism for better community mental health treatment.¹¹⁷ While this is an admirable goal, and improved community mental health services will certainly benefit both the mentally ill and the general public in the long run, it is not enough on its own to justify compromising an individual's right to refuse medication.

The legislature also specifically mentions the nonviolent mentally ill in the legislative history and notes of Kendra's Law, thus eradicating any doubt as to whether or not Kendra's Law as it is currently written can apply to nonviolent persons:

The legislature further finds that many mentally ill persons are more likely to enjoy recovery from *non-dangerous, temporary episodes of mental illness* when they are engaged in planning the nature of the medications, programs or treatments for such episodes with assistance and support from family, friends, and mental health professionals.¹¹⁸

This language strongly suggests that the legislature intended Kendra's Law to apply to the nonviolent mentally ill, who, under the authority of *Rivers*, have a constitutional right to refuse medical treatment. Thus, when viewed in light of the standards governing involuntary inpatient commitment, Kendra's Law violates

115. 495 N.E. 2d at 343.

116. *Id.* at 343 n.6.

117. As stated in the Historical and Statutory Notes of § 9.60:

Effective mechanisms for accomplishing these ends include: the establishment of assisted outpatient treatment as a mode of treatment; improved coordination of care for mentally ill persons living in the community; the expansion of the use of conditional release in psychiatric hospitals; and the improved dissemination of information between and among mental health providers and general hospital emergency rooms.

118. *Id.* (emphasis added).

the liberty interests of outpatients to refuse the right to medication.

The decision in *Rivers* holds that “due process requires that a court balance the individual’s liberty interest against the State’s asserted compelling need on the facts of each case to determine whether such medication may be forcibly administered.”¹¹⁹ The court in *Rivers* refused to find that the State’s interest was compelling enough to override appellant’s right to refuse treatment when the drugs were being administered “‘in order to bring about a reintegration of [the patient’s] current psychotic disorder,’ and to ‘improve’ [the patient’s] condition and thus facilitate [the patient’s] return to the community.”¹²⁰ The court also failed to find a compelling State interest sufficient to overrule the patient’s wishes when medication is administered because the patient is “‘seriously mentally ill’ and [the patient’s] condition ‘would deteriorate if such medication were discontinued or provided in a different manner.’”¹²¹

One of the stated goals of subjecting a mentally ill individual to involuntary outpatient commitment under Kendra’s Law is: “[T]o treat the person’s mental illness and to assist the person in living and functioning in the community, or to attempt to prevent a relapse or deterioration that may reasonably be predicted to result in suicide or the need for hospitalization.”¹²²

Under the standards set forth in *Rivers*, such aspirations, while noble, are not enough to deprive mentally ill persons of their right to refuse medication. Therefore, as it is currently written, Kendra’s Law poses a serious threat to the liberty interests of the nonviolent mentally ill’s state and federal constitutional right to refuse medical treatment.

b. The Right to a Determination of Competency

In addition to its determination that the mentally ill have a right to refuse medication, the court in *Rivers* took the important step of distinguishing mental illness from incompetence. The court recognized that “many mentally ill persons retain the capacity to function in a competent manner,”¹²³ and rejected the notion that simply because one is mentally ill, a determination of incompetence must automatically follow:

119. 495 N.E.2d at 344.

120. *Id.* at 343.

121. *Id.*

122. § 9.60(a)(1).

123. 495 N.E.2d at 342.

[R]espondents . . . argue that an involuntarily committed mental patient is *presumptively incompetent* to exercise this right [to refuse medication] since in ordering involuntary retention, the court has implicitly determined that the patient's illness has so impaired his judgment as to render him incapable of making decisions regarding treatment and care. We conclude, however, 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 medication¹²⁴

Kendra's Law is flawed in light of the court's argument: it has no provision for allowing individuals facing involuntary outpatient commitment to undergo a determination of competency,¹²⁵ because it has the effect of presupposing that every mentally ill person committed under the statute is incompetent to make his or her own treatment decisions. Thus, the lack of a competency hearing raises serious issues about substantive due process for individuals facing involuntary outpatient commitment under Kendra's Law.

The decision in *Rivers* also makes the important point that simply because an individual may require hospitalization for mental illness does not mean that one is incapable of making treatment decisions, a corollary that is implicit in Kendra's Law because it allows for forced medication of involuntary outpatients.¹²⁶ The court observed that:

Although the historic view of many courts and psychiatrists was that a commitment decision necessarily includes a determination of incompetency, the nearly unanimous modern trend in the courts, and among psychiatric and

124. *Id.* at 341–42 (emphasis added).

125. Although an individual cannot be committed involuntarily under Kendra's Law without a hearing, the hearing is to determine whether the individual is mentally ill and is not a competency hearing. Therefore, it is quite possible that mentally ill individuals who are competent to make their own treatment decisions may be subjected to coercive medical treatment. See § 9.60(h)(1).

126. As stated in Kendra's Law:

A court may order the patient to self-administer psychotropic drugs or accept the administration of such drugs by authorized personnel as part of an assisted outpatient treatment program. Such order may specify the type and dosage range of such psychotropic drugs and such order shall be effective for the duration of such assisted outpatient treatment.

§ 9.60(j)(4).

legal commentators is to recognize that there is no significant relationship between the need for hospitalization of mentally ill patients and their ability to make treatment decisions. Indeed, there is considerable authority within the psychiatric community that from a medical point of view no relationship necessarily exists between the need for commitment and the capacity to make treatment decisions Professor Brooks points out that “there is ample evidence that many patients, despite their mental illness are capable of making rational and knowledgeable decisions about medications. The fact that a mental patient may disagree with the psychiatrist’s judgment about the benefit of medication outweighing the cost does not make the patient’s decision incompetent.”¹²⁷

Because Kendra’s Law merely requires a hearing to determine whether a mentally ill individual will “benefit” from involuntary outpatient commitment without also requiring a determination of competency,¹²⁸ it is very likely that Kendra’s Law will be used to force competent mentally ill individuals to be subjected to unwanted medical treatment.

The current version of Kendra’s Law also allows the State to exercise its police power and *parens patriae* power over involuntarily committed outpatients without the determination of competency required under *Rivers*.¹²⁹ The court in *Rivers* held:

127. 495 N.E.2d at 342 (citing Brooks, *Constitutional Right to Refuse Antipsychotic Medications*, 8 BULL. OF AM. ACAD. OF PSYCHIATRY & L. 179, 191).

128. See § 9.60(c)(7) (“Criteria for assisted outpatient treatment. A patient may be ordered to obtain assisted outpatient treatment if the court finds that . . . it is likely that the patient will benefit from assisted outpatient treatment.”).

129. As stated in § 9.60(h)(3):

If the subject of the petition does not consent and the court finds reasonable cause to believe that the allegations in the petition are true, the court may order peace officers, acting pursuant to their special duties, or police officers who are members of an authorized police department or force, or of a sheriff’s department to take the subject of the petition into custody and transport him or her to a hospital for examination by a physician.

§ 9.60(n) also supports this contention:

Failure to comply with assisted outpatient treatment. Where in the clinical judgment of a physician, the patient has failed or has refused to comply with the treatment ordered by the court . . . Upon the request of such physician, the director . . . may direct peace officers, when acting pursuant to their special duties, or police officers who are members of an authorized police department or force, or of a sheriff’s department to take into custody and transport any such person to the hospital operating the assisted outpatient treatment program

For the State to invoke [its *parens patriae* power], 'the individual himself must be incapable of making a competent decision concerning treatment on his own. Otherwise, the very justification for the state's purported exercise of its *parens patriae* power—its citizen's inability to care for himself . . . would be missing. Therefore, the *sine qua non* for the state's use of its *parens patriae* power as justification for the forceful administration of mind-affecting drugs is a determination that the individual to whom the drugs are to be administered lacks the capacity to decide for himself whether he should take drugs.' . . . We hold, therefore, that in situations where the State's police power is not implicated, and the patient refuses to consent to the administration of antipsychotic drugs, there must be a judicial determination of whether the patient has the capacity to make a reasoned decision with respect to proposed treatment before the drugs may be administered pursuant to the State's *parens patriae* power.¹³⁰

Although it may be argued that Kendra's Law does not violate the holding in *Rivers* that there must be a judicial determination of competency because the State's police power is lawfully invoked under the statute, it seems as if the State may have the occasion under Kendra's Law to invoke its *parens patriae* power without the requisite compelling State interest.¹³¹ Since a competency hearing is required before the State may use its police power to override the wills of involuntarily committed inpatients, it follows that protection of such liberties should also be extended to those facing involuntary outpatient commitment under Kendra's Law.

Because Kendra's Law does not provide for a competency hearing as part of the involuntary outpatient commitment procedure, there is a danger that competent individuals may have their substantive due process right to refuse treatment and right to a determination of competency compromised or taken away entirely. While the standards set forth in *Rivers* were intended for governing the procedures regarding involuntary inpatient commitment, if Kendra's Law is truly an alternative treatment offering mentally ill individuals "the least restrictive treatment appropriate,"¹³² it seems only logical that the liberties guaranteed to inpatients should be extended to outpatients as well.

130. 495 N.E.2d at 343 (citing *Rogers v. Okin*, 634 F.2d 650, 657 (1st Cir. 1980)).

131. See *supra* Part II.B.

132. See § 9.60(j) (2).

IV. THE PUBLIC POLICY IMPLICATIONS OF KENDRA'S LAW AND OTHER INVOLUNTARY OUTPATIENT COMMITMENT LAWS

Since its passage in 1999, Kendra's Law has been at the center of a heated political debate regarding not only the efficacy of involuntary outpatient commitment laws, but also whether such laws are morally and ethically proper. In addition to the legal issues discussed in this Note—whether Kendra's Law poses a threat to the constitutional liberties of the mentally ill—there is also the question of whether such laws actually assist the mentally ill in obtaining the medical attention they need, or if they only serve to further stigmatize and polarize an already marginalized and misunderstood population. This Note argues that while most, if not all, involuntary outpatient commitment laws are well-intentioned—including Kendra's Law—ultimately, they fail to assist the mentally ill in any significant manner and contribute to the stereotype that mentally ill people are violent and uncontrollable without State intervention.

Detractors of Kendra's Law and similar involuntary outpatient commitment laws argue that rather than concentrating our efforts on coercive treatment, resources should be spent on creating a wide range of services that would help prevent mentally ill individuals from "falling through the cracks." Such services might include intensive case management and outreach, rehabilitation, and vocational support, in addition to the already existing voluntary inpatient and outpatient treatment programs serving the mentally ill.¹³³ Critics of involuntary outpatient commitment programs stress the need for more of these types of community mental health resources because they believe not only that coercive treatment programs do not work, but that coercive treatment programs compromise the dignity of the mentally ill by relegating them to a less-than-human status.¹³⁴

One of the biggest problems of Kendra's Law in the eyes of some is that coercive treatment, such as the forced administration of antipsychotic drugs, is disguised as healing care for the mentally ill.¹³⁵ While the intent of State legislatures in enacting involuntary outpatient commitment laws was most likely not to cause further harm to the mentally ill—indeed, to the contrary,

133. See Elaine Sutton Mbionwu, *Involuntary Outpatient Commitment: If It Isn't Voluntary . . . Maybe It Isn't Treatment*, 4 PROTECTION & ADVOC. SYS. NEWS 1, 4 (Winter 1999).

134. *Id.* at 5 ("Peoplehood does not exist in varying degrees. Therefore, the rights of decision-making, autonomy, and human dignity must be respected and regarded as sacred at all times and void of society's definition of who is afforded personhood.")

135. See, e.g., Moran, *supra* note 17, at 1.

they are probably well-intentioned—an argument can be made that the coercive treatment of the mentally ill does more harm than good. This is not so much because of what the laws do, but rather what they fail to do.

Robert Bernstein, Ph.D., psychologist and executive director of the Bazelon Center for Mental Health Law in Washington, D.C., states that “[i]nvoluntary commitment laws are being used to compensate for the substantial holes in our public mental health system.”¹³⁶ He argues that rather than improving services for the mentally ill, “outpatient commitment laws force people to comply with and accept the inadequate services available in the community.”¹³⁷ Bernstein’s statement reflects the belief among those opposed to Kendra’s Law that outpatient commitment laws are merely “band-aids” covering up gaping wounds in the mental health system, and that such laws “are not a substitute for adequate mental health services.”¹³⁸

Another troubling aspect of Kendra’s Law, in particular, is the structure of the New York Mental Hygiene Courts, where petitions for involuntary outpatient commitment are adjudicated.¹³⁹ The Mental Hygiene Courts, which are staffed by state supreme court judges on a part-time basis,¹⁴⁰ were closed to the public until 1997.¹⁴¹ Even though the Mental Hygiene Court sessions no longer occur behind closed doors, the system still falls short of providing the type of due process that should be afforded to those facing a loss of liberty.¹⁴²

The judges in the Mental Hygiene Court have broad discretion over the lives of the mentally ill:¹⁴³

[Judges often must make their decision by] weighing the words of a psychiatric patient against the professional opinion of [a] doctor No judge or doctor wants to mistakenly free a man like Kendra Webdale’s murderer, or see a

136. *Id.* at 3.

137. *Id.*

138. *Id.* at 4.

139. *See* § 9.60(e).

140. *See* Davis, *supra* note 21.

141. *See id.*

142. *See supra* Part III.A.

143. *See* Davis, *supra* note 21:

[T]he courts have the power to decide the essential details of many mentally ill people’s lives long after they have left the hospital. A judge can now rule on many issues: from which medications a patient must take to whether they spend their days learning word processing or taking pottery classes. Even such basic decisions as to where to live and work can now be controlled by the courts.

deeply troubled patient go off medications and wind up homeless or dead. So . . . the cards are stacked against a patient's wishes. The doctor's word is almost always the law.¹⁴⁴

The result is that competent, nonviolent mentally ill persons facing involuntary outpatient commitment must navigate a system that, despite its good intentions, has the power to deprive them of their rights to refuse medication—or even commit them as inpatients.¹⁴⁵

However, the argument in favor of committing the mentally ill, in either an inpatient or outpatient setting, before they commit a crime is also a strong one—why wait until a tragedy like the one that befell Kendra Webdale to occur before taking action?¹⁴⁶ The legislative intent behind many involuntary outpatient commitment laws, including Kendra's Law, is to get the mentally ill the medical attention they need before they deteriorate to the point where they present a threat to themselves and others.¹⁴⁷ But is forcing otherwise healthy, competent adults to take unwanted medication against their will really the best way to prevent violence, homelessness, and the other social problems associated with mental illness?

The results of involuntary outpatient commitment so far, both positive and negative, seem to suggest that while preventive treatment is the ideal, it is often not the reality. A study of patients involved in the 1994 pilot program found that court orders to take medication had little or no effect on whether or not a patient was arrested or readmitted to the hospital after being discharged.¹⁴⁸ On the contrary, access to intensive case management services, day treatment programs, and therapy indicated a higher rate of mentally ill patients who complied with their treatment plan—including taking psychotropic medication.

Proponents of Kendra's Law argue that outpatient commitment laws are not only effective, but they save the government money in the process.¹⁴⁹ The National Alliance for the Mentally Ill (NAMI), which supports Kendra's Law and similar outpatient

144. *Id.*

145. *See id.* "Judges in mental hygiene cases wield a power no other judge has: the ability to imprison people who have done nothing wrong . . . 'We allow courts to commit people to psychiatric facilities if they haven't committed a crime.'" *Id.*

146. *See, e.g.,* Torrey & Zdanowicz, *supra* note 1.

147. *See* § 9.60, Historical and Statutory Notes.

148. *See* Davis, *supra* note 21.

149. *See* Martin Kohl, *New York State Moves Toward Involuntary Residential Commitment of the Mentally Ill*, *PSYCHIATRIC TIMES*, Sept. 1999, at 2.

commitment laws, has taken the position that “[c]ourt-ordered outpatient treatment should be considered as a less restrictive, more beneficial and less costly treatment alternative to involuntary inpatient treatment.”¹⁵⁰ Therefore, those in favor of outpatient commitment laws argue that while expanding community mental health services may increase the quality of life for the mentally ill, programs such as Kendra’s Law can accomplish the same goals while spending less money.

Yet, even if outpatient commitment laws are ultimately cost-saving to the mental health system, the price paid by the mentally ill may offset the apparent bargain provided by these programs. Paul Appelbaum, M.D., Vice President of the American Psychiatric Association, states that while Kendra’s Law is unlikely to cost more than expanding traditional mental health services, it is probably not a way to save a great deal of money either.¹⁵¹ He also believes that outpatient commitment laws shift the focus away from providing the mentally ill with the services they truly need by focusing on cost-cutting: “We ought to talk about these programs as ways of providing better care for people [and] ensuring that more people receive the care they need.”¹⁵²

The sentiments of Dr. Appelbaum are echoed by others in the mental health community. Jody Silver is an advocate for the mentally ill with Community Access, an organization that attempts to assist the mentally ill in leading normal, productive lives with the assistance of community-based mental health programs.¹⁵³ She is also a critic of Kendra’s Law, calling it “‘a knee-jerk response to a political and media-driven problem.’”¹⁵⁴ Silver also believes that the reason so many community mental health services fail to get the mentally ill the help they need is because of the current budget constraints on such programs.¹⁵⁵ While a new proposal by Governor George Pataki provides for an additional \$26.4 million dollars to be allocated for statewide mental health programs,¹⁵⁶ a third of that is specifically earmarked for case management services for those involuntarily committed under Kendra’s Law—while none of it is specifically

150. *Id.* (citing NAMI position statements regarding involuntary outpatient commitment laws).

151. *See id.*

152. *Id.* at 2–3.

153. *See Davis, supra* note 21.

154. *Id.*

155. *See id.*

156. *See id.*

allocated toward expanding community mental health services.¹⁵⁷

Most troubling to critics of Kendra's Law, however, is the fear that such coercive laws can inspire in mentally ill individuals. People with mental illness are often skeptical of the system to begin with, and when the state starts invoking its police power to take away their liberties, they are less likely to seek treatment voluntarily in a community mental health setting. In places like the District of Columbia, where U.S. Marshals will arrest individuals who do not comply with their outpatient commitment programs and civilly commit them as inpatients,¹⁵⁸ the mentally ill live in fear of being confined in the district mental hospital. As Silver points out, "There is a kind of terror" among the mentally ill, who often do not understand the law well enough to realize that seeking mental health treatment does not automatically mean involuntary inpatient commitment or the forced administration of drugs.¹⁵⁹ Thus, the punitive threat of statutes like Kendra's Law hang over the heads of the mentally ill and coerce them into submitting to a treatment plan that they may not believe is in their best interest.

Finally, if involuntary outpatient commitment is a step toward helping the mentally ill lead more productive lives, it is certainly not the only step that needs to be taken to prevent the mentally ill from becoming violent and/or homeless. Aside from forcibly medicating the mentally ill, what else is being done to better their lives? In particular, what is being done to help the most vulnerable and desperately ill individuals?

In New York City, where many of the mentally ill people who may be affected by Kendra's Law reside, there has not been any new housing for the mentally ill homeless built since 1997.¹⁶⁰ Before George Pataki became governor of New York, the state built supportive housing for 9,000 homeless mentally ill individuals that provided them with on-site services, access to medication, and round-the-clock staffing.¹⁶¹ The program was a success, with the majority of the residents remaining in the state-supported housing and continuing with their medication.¹⁶²

157. *See id.*

158. *See id.* at 3.

159. *See* Davis, *supra* note 21.

160. *See* Jim Dwyer, *Pataki Shut Door, Opened Streets*, NEW YORK DAILY NEWS, November 21, 1999, available at http://www.nydailynews.com/1999-11-21/News_and_VIEWS/City_Beat/a-47915.asp.

161. *See id.*

162. *See id.*

However, when the State funding ran out and Mayor Guiliani requested additional funding to build more housing for the homeless mentally ill, Pataki denied the request. At the same time his administration began to shut down state-run psychiatric hospitals.¹⁶³ The result was that more mentally ill people, like Andrew Goldstein, were left homeless and sick, with no place to go. And while the vast majority of them did not become violent, Kendra's Law was passed by the New York State Legislature in an attempt to prevent a similar tragedy from ever happening again.

So would an involuntary outpatient commitment law have prevented Kendra Webdale's death? While no one can say for sure, what is clear is that simply forcing Andrew Goldstein to take his medication, without also providing the support of community mental health services, would not have been enough. Goldstein had begged for help; he had *voluntarily* checked himself into psychiatric hospitals and asked to be given psychotropic drugs.¹⁶⁴ Being medicated and left to his own devices was simply not enough to prevent Goldstein from succumbing to the voices that plagued him—he needed the assistance of others to help him navigate through his illness.¹⁶⁵ Although Governor Pataki recently approved funding to build some additional funding for the homeless mentally ill, the proposal does not include 24-hour care and monitoring for residents.¹⁶⁶

One-third to one-half of the homeless population is chronically mentally ill.¹⁶⁷ Clearly, these are the people that Kendra's Law was meant to address. However, Kendra's Law fails to address the greater problem of the homeless mentally ill—lack of proper community mental health services—and also subjects mentally ill persons who are not at great risk for violence to undergo forced administration of medication. If we are to seriously address the issue of violence among the mentally ill, it is necessary to do more than simply drug them and put them back on the streets without any resources and support to help them get well.

163. *See id.*

164. *See id.*

165. "Practically every social worker and psychiatrist who saw [Goldstein] said he needed to live in a place where someone made sure he took the medicine that shut down his demons." *See id.*

166. *See id.*

167. *See* Dr. Stephen B. Seager, *Street Crazy: The Tragedy of the Homeless Mentally Ill*, available at <http://www.streetcrazy.com/bksmpl.html>.

V. CONCLUSION

The hard question is—are involuntary outpatient commitment laws, such as Kendra's Law, an affront to the dignity and autonomy of the mentally ill? It is a debate that is likely to last for a while, as challenges to the constitutionality of Kendra's Law make their way through the New York state court system. But as a matter of public policy, Kendra's Law is a failure not only because it is overbroad and fails to achieve its stated goals of providing the mentally ill with much-needed treatment, but because it ultimately places the nonviolent mentally ill in a position in which they must submit to the will of the State for fear of losing fundamental constitutional liberties. Unless Kendra's Law is reformed to address the due process concerns inherent in forcing the mentally ill to receive treatment, it will remain a prime example of how good intentions can easily become not only bad policy, but oppressive law.

