

Kendra's Law and the Rights of the Mentally Ill: An Empirical Peek Behind the Courts' Legal Analysis and a Suggested Template for the New York State Legislature's Reconsideration for Renewal in 2010

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Worthington, Kathryn A. (2009) "Kendra's Law and the Rights of the Mentally Ill: An Empirical Peek Behind the Courts' Legal Analysis and a Suggested Template for the New York State Legislature's Reconsideration for Renewal in 2010," *Cornell Journal of Law and Public Policy*: Vol. 19: Iss. 1, Article 6.

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NOTE

KENDRA'S LAW AND THE RIGHTS OF THE MENTALLY ILL: AN EMPIRICAL PEEK BEHIND THE COURTS' LEGAL ANALYSIS AND A SUGGESTED TEMPLATE FOR THE NEW YORK STATE LEGISLATURE'S RECONSIDERATION FOR RENEWAL IN 2010

*Kathryn A. Worthington**

This Note explores the relationship between the empirical results of New York's outpatient commitment law and the strict scrutiny legal test that New York courts have applied to evaluate the law's constitutionality. The Note includes a brief review of current mental health law, the nature of mental illness, and the civil liberties concerns associated with outpatient treatment. It also outlines the details of Kendra's Law, New York's own outpatient commitment statute. With this background, the Note then proceeds to put Kendra's Law under a legal microscope, establishing why the New York courts have evaluated the constitutionality of Kendra's Law with a qualified strict scrutiny analysis under the New York State Constitution's due process clause. The Note then proceeds to examine empirical social science research concerning the effectiveness of assisted outpatient treatment in New York, and recommends a methodology for how lingering questions about the constitutionality of Kendra's Law could ultimately be resolved. By simply isolating the test courts have articulated for determining the constitutionality of Kendra's Law, and applying it to the process of conducting social science research into the effectiveness of the law, empirical evidence can be gathered to either satisfy the strict scrutiny test, or demonstrate that court-ordered outpatient commitment is not the least restrictive means for achieving the state's interests in both patient and community safety.

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INTRODUCTION

The most recent study by the Bureau of Justice Statistics at the U.S. Department of Justice shows that sixty-four percent of local jail prisoners, fifty-six percent of state prisoners, and forty-five percent of federal prisoners have symptoms of mental illness.¹ Beyond increasing costs in the penal system and compromising prison security, the staggering number of mentally ill individuals in American jails implies that prison wardens are becoming the de facto care providers for our nation's mentally ill.

As a special advisor on criminal justice and mental health for the Florida Supreme Court cogently observed, "It's the one area in civil rights that we've gone backwards on."² The advisor lamented that with nearly half of the nine floors in the Miami-Dade County Jail demarcated as de facto mental health wards, it seems our society is reverting to the nineteenth century practice of simply imprisoning our mentally ill rather than treating them.³ Even putting aside ethical considerations, the current status quo defeats the purposes of the justice system itself. Imprisoning sick people and allowing their diseases to fester is an ineffective way to deter and prevent crime committed by the mentally ill. Addressing this problem requires input from across several disciplines, as the plight of the mentally ill implicates interests in health care, the criminal

¹ See Doris J. James & Lauren E. Glaze, Special Report: Mental Health Problems of Prison and Jail Inmates (2006), available at <http://www.ojp.usdoj.gov/bjs/pub/pdf/mhppji.pdf>.

² M.J. Stephey, *De-Criminalizing Mental Illness*, TIME, Aug. 8, 2007, <http://www.time.com/time/health/article/0,8599,1651002,00.html>.

³ See *id.*

justice system, and public safety, and raises significant welfare and civil liberties concerns.

In 2000, the New York state legislature attempted to address this problem by passing § 9.60 of the New York Mental Hygiene Law. Known as "Kendra's Law," § 9.60 is a comprehensive provision that authorizes court-mandated treatment plans for mentally ill individuals in New York.⁴ Kendra's Law has remained on the books for nine years, but has proven to be highly controversial because it raises significant civil liberties issues.⁵ While there has been a host of academic work both supporting and decrying Kendra's Law from an ideological standpoint, very little empirical research has been conducted to determine whether the coercive means authorized by the law are actually needed to achieve the benefits that are claimed to justify them.

This Note attempts to deconstruct the debate by analyzing the supposed link between deinstitutionalization of the mentally ill and crime, the nature of mental illness and its treatment, and whether empirical evidence can substantiate the findings that have served as the legal justification for Kendra's Law. Part I places policy considerations in context by providing a brief review of current mental health law and the nature of mental illness. While dispelling the strong link that is often perceived between mental illness and violence, the discussion provides alternative explanations for the disproportionate numbers of mentally ill in the criminal justice system.

Part I provides the background leading up the development of Kendra's Law, details its provisions, and outlines the issues surrounding outpatient commitment in general, including its legal origins and common criticisms.

Part II outlines a sound methodology for how the constitutionality of Kendra's Law could ultimately be determined in the face of heated controversy surrounding Kendra's Law and court-ordered outpatient commitment. By simply isolating the test that courts have articulated for determining the constitutionality of Kendra's Law and applying it to the process of conducting social science research into the effectiveness of the law, empirical evidence can be gathered to either substantiate or sound the death knell for Kendra's Law. Part II thus places Kendra's Law under the legal microscope. Beginning with a brief overview of the constitutional analysis, it establishes why the New York courts use a qualified strict scrutiny analysis under the New York State Constitution's due process clause.

⁴ See N.Y. MENTAL HYGIENE LAW (Kendra's Law) § 9.60 (McKinney 2006).

⁵ See E. Fuller Torrey & Robert J. Kaplan, *A National Survey of the Use of Outpatient Commitment*, 46 *PSYCHIATRIC SERVICES* 778, 778 (1995).

The analysis then proceeds to examine what other ideological critiques of Kendra's Law have neglected to take into account—empirical social science research concerning the effectiveness of assisted outpatient treatment. Only if empirical social science research demonstrates that the court order is itself *necessary*, and that increased funding for treatment alone will not achieve the same improvements Kendra's Law has elicited with its court-ordered treatment, does the law truly withstand the strict scrutiny test articulated by the courts.

Ultimately, this Note determines that while Kendra's Law passes the constitutional test because New York courts have determined its provisions to be the "least restrictive means" towards securing a compelling interest in patient and public safety, empirical review of the law shows it is unclear whether the coercive aspects of Kendra's Law are truly necessary or effective in preventing dangerousness. However, it must be cautioned that no study has directly compared patient outcomes under Kendra's Law court orders to results for patients who received enhanced treatment services without the coercive order. This is a crucial comparison for determining if the measures promulgated by Kendra's Law are truly the "least restrictive means."

A sunset provision is written into Kendra's Law, and in 2010 the New York state legislature will determine whether Kendra's Law will become permanent or will be allowed to expire as a flawed experimental policy.⁶ This Note argues that the New York state legislature would be wise to cast aside the ideologically-driven or selective statistics presented by lobbyists when reconsidering Kendra's Law in 2010. Instead, adopting the analysis of this Note, and ordering a comprehensive study that directly compares patient outcomes under Kendra's Law court orders to patients who did not receive the benefits of the law's accompanying enhanced treatment programs, the legislature could empirically vindicate the law under the legal test already articulated by the courts. Such a legislative resolution would provide a nonpartisan and unbiased method to determine whether the coercive treatment methods imposed by court order under Kendra's Law truly pass the strict scrutiny test applied by the courts.

I. REFORM AND DEINSTITUTIONALIZATION, OR FROM INSTITUTIONS TO PRISONS?: WHAT HAS BECOME OF THE MENTALLY ILL IN THE AFTERMATH OF DEINSTITUTIONALIZATION?

Beginning in the 1950s, reports of widespread maltreatment and mismanagement in many state-run mental health institutions turned public opinion against the institutionalization model for government-pro-

⁶ See *id.*

vided mental health treatment.⁷ This shift away from the traditional model was dramatic—while 559,000 people resided in state psychiatric hospitals in 1955, by 1982 that number had dwindled to less than 83,320.⁸ There is a strong argument that advances in mental health care, such as the development of neuroleptic medications and community-based programs, have replaced the need for placing the mentally ill in restrictive environments.⁹ According to some estimates, there are approximately 750,000 individuals now living in the community who would likely have been inpatients in state psychiatric hospitals forty years ago.¹⁰

Outpatient treatment has become the dominant delivery vehicle for services to individuals who, in another time, might have faced forced confinement by the state. Those with schizophrenia and others who can function at a high level but remain in need of intensive mental health care are most frequently treated as outpatients.¹¹ However, evaluation of the nature of the many types of mental illness highlights a key weakness of this treatment model.

The National Institute of Mental Health counsels families of schizophrenic individuals that one of the characteristics inherent in the disease is that schizophrenics often resist treatment, believing their delusions or hallucinations are real, and that psychiatric help is not required.¹² There has been “an emerging consensus” regarding the percentage of individuals with schizophrenia who demonstrate an unawareness of their disease, with one study reporting that sixty percent of patients with schizophrenia had moderate to severe unawareness of having any type of mental disorder.¹³

This lack of insight and awareness is biologically correlated with a frontal lobe dysfunction associated with the disease, as intact prefrontal function is required for an individual to maintain many aspects of per-

⁷ See David A. Rochefort, *Origins of the “Third Psychiatric Revolution”: The Community Mental Health Centers Act of 1963*, 9 J. HEALTH POL. POL'Y & L. 1, 4–6 (1984).

⁸ See Torrey & Kaplan, *supra* note 5, at 778.

⁹ See, e.g., Gary Collins, *Court-Mandated Psychiatric Outpatient Treatment in New York—Doesn't This Process Invoke More Care than Controversy?*, 15 CRIM. BEHAV. & MENTAL HEALTH 214, 214 (2005).

¹⁰ See Torrey & Kaplan, *supra* note 5, at 778.

¹¹ See Gustavo A. Fernandez & Sylvia Nygard, *Impact of Involuntary Outpatient Commitment on the Revolving-Door Syndrome in North Carolina*, 41 HOSP. & COMMUNITY PSYCHIATRY 1001, 1003 (1990).

¹² National Institute of Mental Health, *What is the Role of the Patient's Support System?*, <http://www.nimh.nih.gov/health/publications/schizophrenia/what-is-the-role-of-the-patients-support-system.shtml> (last visited Sept. 9, 2009).

¹³ Brief of the Treatment Advocacy Center as Amicus Curiae in Support of Neither Party at 14, *Clark v. Arizona*, 548 U.S. 735 (2006) (No. 05-5966) (citing Xavier Amador et al., *Awareness of Illness in Schizophrenia and Schizoaffective and Mood Disorders*, 51 Archives Gen. Psychiatry 826, 828–29 (1994)).

sonal self-awareness.¹⁴ Known as anosognosia, this condition is characterized by an individual's inability to be self-monitoring or self-correcting, and has also been linked to right hemispheric involvement and a disconnection from awareness of body scheme or image representation.¹⁵ Keeping track of individuals who are not proactive about their own care is further complicated by the fact that the facilities tasked with providing outpatient care are all too often disorganized and poorly funded.¹⁶ By the 1980s, this treatment delivery system for the chronically mentally ill became known to many as a "revolving door syndrome" consisting of brief inpatient hospitalization for acute stabilization, discharge into the community, subsequent deterioration, dangerous acts, and rehospitalization.¹⁷ Unfortunately, those caught in this syndrome did not just cycle back and forth between hospital and outpatient status. A study conducted in 1985, the height of deinstitutionalization, showed that within six months of release from state psychiatric hospitals, sixty-four percent of individuals with chronic mental illness in the study group came within the purview of the criminal justice system.¹⁸

It does not come as a surprise then that many individuals have significant concerns about the viability of outpatient treatment programs. One such skeptic, a psychiatrist who runs an advocacy center endorsing more coercive methods of outpatient care, cites a study of schizophrenic individuals in outpatient treatment indicating that "at any given follow-up interval, thirty to forty percent of the subjects were shown to be noncompliant [with their treatment program]," and that medication non-compliance may be as high as sixty-three percent in some instances of outpatient treatment programs.¹⁹ Thus, while institutionalization failed for a lack of flexibility and personalized patient care, outpatient treatment falls short because it lacks an effective enforcement mechanism to ensure that individuals remain compliant with their treatment programs.

The idea of non-compliant mentally ill patients being "out on the streets" is disconcerting to many individuals, as most societies associate mental illness with violence.²⁰ Empirical findings and literature reviews indicate that the general public view individuals with severe mental ill-

¹⁴ Xavier F. Amador et al., *Awareness of Illness in Schizophrenia*, 17 OXFORD J. OF MED. 113, 123 (1991).

¹⁵ See *id.*

¹⁶ See Torrey & Kaplan, *supra* note 5, at 779.

¹⁷ See *id.*

¹⁸ See John R. Belcher, *Are Jails Replacing the Mental Health System for the Homeless Mentally Ill?*, 24 COMMUNITY MENTAL HEALTH J. 185, 190 (1988).

¹⁹ See Torrey & Kaplan, *supra* note 5, at 778-79.

²⁰ John Monahan, *Mental Illness and Violent Crime*, Summary of Presentation before the National Institute of Justice, U.S. Department of Justice I (October 1996), available at <http://www.ncjrs.gov/pdffiles/mentilln.pdf>.

ness as “extremely dangerous.”²¹ However, the reality is that the risk of these individuals committing serious, violent crime is minimal compared to the general population. Dr. Richard Friedman of Weill Cornell Medical College notes that only three to five percent of violence in the general population is attributable to individuals with serious mental illnesses, such as schizophrenia, major depression, or bipolar disorder.²² His estimate is buttressed by a comprehensive Swedish study on the correlation between crime and mental illness, which showed that approximately one in twenty of all violent crimes committed in Sweden over the course of a thirteen year period could be attributed to mentally ill individuals.²³ Indeed, such statistics are “probably lower than most people would imagine,” as “[m]any see those with serious psychiatric disorders as significantly contributing to the amount of violent crime in society.”²⁴

Furthermore, the same characteristics that make mentally ill individuals more prone to commit violence in the general community also inhibit their ability to perceive risks and protect themselves. Mentally ill individuals are fifteen times more likely to be assaulted, twenty-three times more likely to be raped, and one hundred forty times more likely to experience property theft than the general population.²⁵ The mentally ill also face a disproportionate number of confrontations with law enforcement. When a mentally ill individual's condition destabilizes outside a hospital or institutional setting, police, who lack the training to know how to interpret or react to the behaviors of the mentally ill, are often the first responders.²⁶ Amnesty International reports incidences of police using excessive deadly force against mentally ill or disturbed people who

²¹ David L. Penn & James Martin, *The Stigma of Severe Mental Illness: Some Potential Solutions for a Recalcitrant Problem*, 69 PSYCHIATRIC QUARTERLY 235, 237 (1998).

²² Richard A. Friedman, *Violence and Mental Illness—How Strong is the Link?*, 355 NEW ENG. J. MED. 2064, 2065 (2006).

²³ Seena Fazel & Martin Grann, *The Population Impact of Severe Mental Illness on Violent Crime*, 163 AM. J. PSYCHIATRY 1397, 1400 (2006) (noting that the study shows the rates of crime vary by the offense the mentally ill persons are found responsible for—specifically 18.2% of homicides and attempted homicides, 15.7% of arsons, 7.5% of threats and harassment, 6.8% of cases of assaulting an officer, 6.3% of aggravated assaults, 4.9% of sexual offences, 3.6% of robberies, and 3.1% of common assaults).

²⁴ *One in 20 violent crimes committed by people with severe mental illness*, University of Oxford News, July 28, 2006, available at <http://www.admin.ox.ac.uk/po/060728.shtml> (noting that Sweden is one of the very few countries in the world where this type of precise research is possible because all residents, including immigrants on arrival to the country, are provided a 12-digit ID number that tracks an individual's health care use, as well as any involvement in crime, making Sweden's population the largest hospital register in the world).

²⁵ Aaron Levin, *People with Mental Illness More Often Crime Victims*, 40 PSYCHIATRIC NEWS 16, 16 (2005) (reporting on a study by researchers at Northwestern University), available at <http://pn.psychiatryonline.org/cgi/content/full/40/17/16>.

²⁶ See Stephey, *supra* note 2.

could have been subdued through less extreme measures.²⁷ These tragedies often occur when police unknowingly act in a way that escalates the situation.²⁸

Thus, contrary to the general perception that the mentally ill are unpredictable and violent, they are in fact more likely to be victims of crime than to commit it. In fact, almost half of the mentally ill individuals in the penal system have been incarcerated for nonviolent crimes.²⁹ When one considers that nearly three-quarters of inmates with mental illness have a co-occurring substance abuse problem, it is not difficult to imagine how the mentally ill wound up incarcerated by committing vagrancy, property, and drug offenses.³⁰

The disproportionate number of mentally ill in the U.S. prison population thus represents a two-part problem. The failures of current treatment models have adversely affected the rights of the mentally ill by leaving them more susceptible to crime and an overall deterioration in their mental state. These inadequate measures for handling the mentally ill also impose monetary costs on society and sometimes cause mentally ill individuals to become violent and potentially harm others. Although the risk of violent crime being committed by mentally ill individuals does not seem to depart substantially from that of the general population, there is a fundamental difference between the crimes perpetrated by the mentally ill and those by the general population. While other types of crime are multifactorial, and extraordinarily difficult to predict or combat prophylactically, the risk of crime resulting from mental illness can be greatly diminished if the individual receives proper treatment. Although mentally ill individuals perpetrate only three to five percent of violent crime, this is still three to five percent of violent crime that does not need to happen, three to five percent of crime victims who did not need to suffer, and three to five percent of incarcerated violent criminals who need treatment, not punishment.

Understanding the background of deinstitutionalization, the nature of some mental illnesses, the “revolving door” of outpatient commit-

²⁷ National Association For Rights Protection And Advocacy, *Mentally Ill or Homeless: Vulnerable to Police Abuse*, <http://www.narpa.org/amnesty%20international.htm> (last visited Aug. 31, 2009) (citing AMNESTY INTERNATIONAL, UNITED STATES OF AMERICA: RIGHTS FOR ALL; RACE, RIGHTS, AND POLICE BRUTALITY (1999)).

²⁸ See *id.*

²⁹ CRIMINAL JUSTICE/MENTAL HEALTH CONSENSUS PROJECT, PEOPLE WITH MENTAL ILLNESS IN THE CRIMINAL JUSTICE SYSTEM: ABOUT THE PROBLEM, http://consensusproject.org/downloads/fact_about-the-problem.pdf (last visited Aug. 31, 2009) (citing PAULA M. DITTON, MENTAL HEALTH TREATMENT OF INMATES AND PROBATIONERS, U.S. DEPARTMENT OF JUSTICE, OFFICE OF JUSTICE PROGRAMS, BUREAU OF JUSTICE STATISTICS (July 1999)).

³⁰ See *id.* (citing Linda Teplin and Karen Abram, *Co-Occurring Disorders Among Mentally Ill Jail Detainees: Implications for Public Policy*, *Am. Psychologist*, 46:10 at 1036–45 (Oct. 1991)).

ment, and the relationship of the criminal justice system with the mentally ill, as well as the correlation between mental illness and violence, provides context for appreciating the circumstances that gave rise to the rare bipartisan effort of New York politicians to pass Kendra's Law, and the start of a controversial program facilitating *involuntary* outpatient commitment in New York.

II. KENDRA'S LAW

A. *Background*

Kendra's Law was passed in reaction to a dramatic incident occurring in a New York City subway station in January 1999. Kendra Webdale, a thirty-one year old aspiring writer, became one of the three to five percent of victims of violent crime who were targeted by a mentally ill individual, as she was tragically pushed to her death under an oncoming train by a schizophrenic man with a record of psychiatric hospitalization.³¹ The perpetrator's first words when he was arrested were allegedly, "Take me to a hospital."³² As the media latched onto the story of the sympathetic victim and the perpetrator's history of mental illness, violent behavior, and non-compliance with treatment, the incident escalated into a topic of controversy.

The perpetrator was caught in the "revolving door" of inpatient psychiatric hospitalization—he had been stabilized, only to decompensate and become dangerous once released.³³ The media frenzy and degree of public outrage led to a rare instance of swift and bipartisan action in the New York state legislature, and "Kendra's Law" was incorporated into the state's Mental Hygiene Law by the year's end.³⁴

B. *The Provisions of Kendra's Law*

Kendra's Law became effective on a provisional basis as Mental Hygiene Law § 9.60 in August 1999, and required renewal in 2005.³⁵ Initial results after implementation of the law were sufficiently promising that it was extended for another five years in 2005.³⁶ In 2010, the New York state legislature will decide whether or not to renew the law; it may

³¹ See Collins, *supra* note 9, at 215.

³² *Id.*

³³ See *Dateline: A Deadly Encounter* (MSNBC television broadcast Jan. 20, 2007), available at <http://www.msnbc.msn.com/id/16713078>.

³⁴ See Collins, *supra* note 9, at 215.

³⁵ See 1999 N.Y. Laws 408 (codified at N.Y. MENTAL HYG. LAW § 9.60 (McKinney 2006)).

³⁶ See 2005 N.Y. Laws 158.

also choose to make the law permanent.³⁷ Kendra's Law was designed to provide outpatient treatment for mentally ill individuals who respond well to treatment when hospitalized, but struggled to maintain their recovery once they are released into the community.³⁸ The text of the legislation notes that "some mentally ill persons, because of their illness, have great difficulty taking responsibility for their own care, and often reject the outpatient treatment offered to them."³⁹ Kendra's Law thus provides for an Assisted Outpatient Treatment Program (AOT) for a small, target population of "mentally ill people who are capable of living in the community with the help of family, friends, and mental health professionals, but who, without routine care and treatment, may relapse and become violent or suicidal, or require hospitalization."⁴⁰ The law lays out several programs to improve community-based psychiatric care, including improved implementation of mental health care, expansion of conditional release in psychiatric hospitals, improved coordination of information among mental health providers and general hospital emergency rooms, as well as the hallmark establishment—the development of AOT as a delivery method of services.⁴¹

The AOT provisions of Mental Hygiene Law § 9.60 outline the procedure required to obtain a court order that would compel a mentally ill individual to comply with a treatment program.⁴² The standard required to receive this court order is substantially easier to meet than that used for inpatient hospitalization. While inpatient hospitalization requires a finding of current "substantial risk of physical harm" to self or others,⁴³ a general review of the provisions of Kendra's Law demonstrates that an outpatient commitment order may be predicated upon a lack of compliance with treatment that has resulted in two episodes of treatment in a psychiatric inpatient, forensic, or other mental health unit in the last three years; or at least one act of serious violent behavior towards self or others, or threats or attempts of causing harm within the past four years.⁴⁴

The petition process to obtain this court order is also open not only to doctors or mental health professionals, but also family members over

³⁷ See 1999 N.Y. Laws 408 (as amended by 2005 N.Y. Laws 158, § 9); Press Release, NYCLU.org, State Lawmakers Extend "Kendra's Law" For 5 Years, Despite Concerns That It Targets Men of Color (June 23, 2005), available at <http://www.nyclu.org/node/203>.

³⁸ John Kip Cornwell & Raymond Deeney, *Exposing the Myths Surrounding Preventive Outpatient Commitment for Individuals with Chronic Mental Illness*, 9 PSYCHOL. PUB. POL'Y & L. 209, 226 (2003).

³⁹ N.Y. MENTAL HYG. LAW § 9.60.

⁴⁰ Collins, *supra* note 9, at 215.

⁴¹ See N.Y. MENTAL HYG. LAW § 9.60(a)(1) (McKinney 2006).

⁴² See Cornwell & Deeney, *supra* note 38, at 226.

⁴³ N.Y. MENTAL HYG. LAW § 9.37(a)(1-2).

⁴⁴ See *id.* § 9.60(c)(4)(i).

eighteen, as well as any adult who lives with the subject of the petition.⁴⁵ Although this standard might seem overly lax considering its implications for the subject's civil liberties, safeguards for the patient have been written into the law. In addition to prior commitment requirements, a licensed psychiatrist must examine the individual and testify before the judge considering the petition. The psychiatrist must testify that the patient is unlikely to survive safely in the community without supervision, would be unlikely to voluntarily participate in a treatment plan, and, based on history and current behavior, is in need of AOT in order to prevent relapse or deterioration that would likely result in serious harm to the individual or others.⁴⁶ The law then requires that a hearing be held, where the court hears all evidence, including testimony from both the examining physician and the individual being recommended for treatment.⁴⁷ The examining physician must testify and explain each aspect of the proposed treatment plan that the court order would enforce.⁴⁸ The patient is also ensured the right to free representation by an attorney from the Mental Hygiene Legal Service, who can cross-examine the physician, and supply separate witnesses and experts for the defense.⁴⁹ If the judge concurs with the petitioner's assertions against the patient-defendant, and believes that the physician's plan is justified, the patient is referred to either a hospital or a community mental health services program, which is then charged with overseeing and administering the recommended treatment plan.⁵⁰ The hallmark requirement of AOT under Kendra's Law, which distinguishes it from most other analogous laws, rests in that if the patient fails to comply with this recommended treatment plan in the

⁴⁵ See New York State Office of Mental Health: About AOT, <http://bi.omh.state.ny.us/aot/about?p=kl-faq> (last visited August 31, 2009).

⁴⁶ See N.Y. MENTAL HYG. LAW § 9.60(i)(1). Note also that § 9.60(4)(i) requires that either mental illness be a significant factor leading to hospitalization at least twice over the three-year period prior to filing an AOT petition, or that the subject of the petition has received psychiatric services in a mental health unit of a correctional facility. Additionally, § 9.60(4)(ii) requires that the mental illness precipitate one or more threats, attempts, or acts of seriously violent behavior toward oneself or others within four years prior to filing an AOT petition, withstanding any period in which the individual was hospitalized or incarcerated.

⁴⁷ See N.Y. MENTAL HYG. LAW § 9.60(h) (McKinney 2006); see also Cornwell and Deeney, *supra* note 38, at 209 (noting that patients have the right to cross-examine any adverse witness including their physicians, to call their own witnesses, and to present any other admissible evidence for the court's consideration).

⁴⁸ See N.Y. MENTAL HYG. LAW § 9.60(i)(1); see also Ilissa Watnick, Comment, *A Constitutional Analysis of Kendra's Law: New York's Solution for Treatment of the Chronically Mentally Ill*, 149 U. PA. L. REV. 1181, 1209 (2001) (explaining the due process protections required by Kendra's Law).

⁴⁹ Watnick, *supra* note 48, at 1208.

⁵⁰ See N.Y. MENTAL HYG. LAW § 9.60(j)(5); *id.* § 9.60(a)(1) (indicating that the treatment plan may include medications, periodic blood tests or urinalysis to determine compliance with prescribed medications, individual or group therapy, day or partial day programming activities, educational or vocational training or activities, alcohol or substance abuse treatment, or supervision of living arrangements).

“clinical judgment” of a physician, the patient will be directed by the county director of mental health to be involuntarily admitted to a hospital for a seventy-two hour evaluation period.⁵¹ Patients are then monitored for the seventy-two hours to see if they meet the separate requirement for involuntary inpatient commitment.⁵²

C. *Outpatient Commitment in General*

Although Kendra’s Law broke new ground in New York’s Mental Hygiene Law, outpatient commitment laws are common. At the time New York passed Kendra’s Law, forty states already had some form of AOT.⁵³ Thus, it is helpful to look at the system of outpatient treatment from a general perspective before honing in on Kendra’s Law in particular.

Outpatient commitment is the least restrictive form of commitment for a mentally ill individual, whereby the individual is free to live in the community, provided he is subject to close monitoring by a physician or agency. The other alternatives include inpatient commitment in a hospital or institution, or criminal commitment—where an individual is either found not guilty of criminal responsibility, yet mentally ill and in need of care and treatment, or found guilty and mentally ill—wherein the individual will receive psychiatric services in a prison.⁵⁴ The theory behind the state’s exertion of such authority over the mentally ill extends as far back as antiquity. According to Aristotle, government has two basic powers—a police power, to protect citizens from harm, and a *parens patriae* power, which embodies the state’s authority to help those in need with a paternal-type care that includes nurturing individuals not capable of caring for themselves.⁵⁵

The principles of police power and *parens patriae* authority provide a justification for the state’s authority to impose general outpatient commitment laws on mentally ill individuals. Many conditions associated with mental illness, such as impaired reality testing, disorganized thought

⁵¹ New York State Office of Mental Health, *supra* note 45.

⁵² *Id.*; see also N.Y. MENTAL HYG. LAW § 9.37(a)(1-2) (requiring either a showing of substantial risk of physical harm to the patient’s self through threatened or attempted suicide, serious bodily harm, or other conduct demonstrating this risk, or a showing of substantial risk of physical harm to other persons through homicidal or other violent behavior by which others reasonably fear serious physical harm).

⁵³ See Fred Cohen, *Assisted Outpatient Treatment: Review of New York’s Case Law—And Beyond*, 3 CORRECTIONAL MENTAL HEALTH REP. 1 (July/August 2001), available at http://www.treatmentadvocacycenter.org/index.php?option=com_content&task=view&id=356.

⁵⁴ Paul F. Stavis, Esq., Civil Commitment: Past, Present, and Future, Address at the National Conference of the National Alliance for the Mentally Ill (July 21, 1995), in QUALITY OF CARE NEWSL. (Int’l Planned Parenthood Fed’n, London, U.K.), Aug./Sept. 1995, available at http://www.cqc.state.ny.us/counsels_corner/cc64.htm#1.

⁵⁵ Stavis, *supra* note 54.

processes, impulsivity, poor planning and problem solving⁵⁶—and in rare cases, hallucinations and compulsions—suggest that mentally ill individuals have characteristics that would make it reasonable for the state to approach the mentally ill with an extra degree of caution when seeking to enforce its police powers. Even assuming *ad arguendo* that the mildly increased risk of violent crime among mentally ill individuals could not justify a higher level of state regulation based on the police powers, the state simultaneously has a police power interest in protecting the mentally ill from the increased rate of violent crime perpetrated against them.⁵⁷ This is in addition to its *parens patriae* interest in preventing the mentally ill from falling out of treatment and suffering a deterioration in their mental health.

D. *Concerns About Outpatient Commitment*

Although outpatient commitment laws might squarely draw from the state's police and *parens patriae* powers, they tread very fine lines under the United States Constitution and its concepts of due process and equal protection. Outpatient commitment laws are often the subject of contention within the mental health care community, as opponents of outpatient commitment claim it is at best a form of "thinly veiled benevolent coercion, which . . . undermines the therapeutic relationship, and has broad potential for abuse."⁵⁸ Indeed, even though Kendra's Law does seem logical given the nature of many mental illnesses and the state's need to monitor mentally ill individuals who could potentially endanger themselves or society, it is important to keep in mind that legislators are prone to develop laws in reaction to public sentiment and generalities. These laws have the potential to cross the boundaries of constitutional safeguards, and may be counterproductive when analyzed scientifically, even if they make for effective or popular policy. Considering that the provisions of Kendra's Law empower the state to deprive an individual of intimate rights of personhood—including the freedom of the person, and the right to make treatment decisions that bear on one's own mental state—a careful review of Kendra's Law and its place under current constitutional doctrine is necessary.

III. KENDRA'S LAW UNDER THE LEGAL MICROSCOPE

A. *A Constitutional Analysis*

The bulk of the legal objections to Kendra's Law lie in concerns that it infringes constitutional due process and equal protection rights.

⁵⁶ See Levin, *supra* note 25.

⁵⁷ See *id.*

⁵⁸ Torrey & Kaplan, *supra* note 5, at 778.

Particularly, concerns arise from the fact that the law uses a lower standard for involuntary outpatient commitment than for inpatient commitment, has an abridged procedure for placing an individual in an inpatient commitment status during the seventy-two hour confinement period, and can authorize compelled medication with psychotropic drugs if such medication is found necessary in the outpatient commitment treatment plan.⁵⁹

As with any constitutional question, the first step in the analysis is to establish an appropriate level of scrutiny to evaluate the law's constitutionality.⁶⁰ In *United States v. Carolene Products*, the Supreme Court established that it would conduct a rationality review of reasonableness when assessing the constitutionality of a state's social regulations.⁶¹ However, footnote four indicates that a higher standard of review will apply when the regulation involves rights covered under the first ten Amendments, or when there is a risk that there might be a distortion in the political process.⁶² Laws directed at "discrete and insular minorities" are an example of such a distortion.⁶³ These groups of people run the risk of falling through the cracks in majoritarian politics since it is impossible for them to have adequate representation in the political process, either because of their numbers or degree of agency.⁶⁴ Analysis of a law under the due process and equal protection clauses of the New York State Constitution parallels that under the analogous clauses of the U.S. Constitution.⁶⁵ Thus, when analyzing a law under either of these clauses, courts apply the strict scrutiny test if the regulation in question either affects fundamental rights (due process analysis), or disproportionately affects groups according to a suspect classification, such as race, religion, or national origin (equal protection analysis).⁶⁶ In order to pass strict scrutiny analysis, the legislature must have passed the law as a *necessary*

⁵⁹ See Cohen, *supra* note 53; see also U.S. CONST. amend. V (providing that "no person shall be . . . deprived of life, liberty, or property without due process of law . . ."); U.S. CONST. amend. XIV, § 1 (" . . . nor shall any state deprive any person of life, liberty, or property without due process of law . . .").

⁶⁰ See *United States v. Carolene Products*, 304 U.S. 144, 153–54 (1938).

⁶¹ See *id.*

⁶² See *id.* at 152 n.4.

⁶³ See *id.* (indicating that in referring to "discrete" the Court meant "visible," and in employing the term "insular," the Court was referring to individuals who might be separated from mainstream society).

⁶⁴ See *id.*

⁶⁵ See Watnick, *supra* note 48, at 1212; see also Alevy v. Downstate Med. Ctr., 39 N.Y.2d 326, 332–33 (1976) (explaining the equal protection analysis under the U.S. and New York Constitutions).

⁶⁶ See Cornell Law School Legal Information Institute, *Strict Scrutiny*, http://topics.law.cornell.edu/wex/strict_scrutiny (last visited Aug. 29, 2009).

method to achieve a *compelling* government interest, where the provisions of the law are *narrowly tailored* to achieve those ends.⁶⁷

The relevant question is therefore whether Kendra's Law triggers a heightened level of scrutiny under either equal protection or due process analysis. In *San Antonio Independent School District v. Rodriguez*, the Supreme Court spelled out criteria to ascertain whether a group falls within a suspect classification under equal protection analysis.⁶⁸ "[T]raditional indicia of suspectness" include whether the class is "saddled with disabilities," has been subjected to a history of purposeful unequal treatment, or has been relegated to a position of political powerlessness that would warrant special protections within the majoritarian process.⁶⁹ The mentally ill might appear to belong in this category, as they are a small, highly visible, and socially stigmatized group with disabilities beyond their power to overcome; they have a history of disproportionate treatment in the United States; and have an obvious lack of political agency given their weakened mental states.⁷⁰ However, the Supreme Court has authoritatively declined to apply suspect class analysis to the mentally retarded on the basis that disparate treatment for this group is often reflective of real and undeniable differences about mental capacity and decision making.⁷¹ Classification of the mentally ill is more difficult, because mental illnesses manifest in a broad range of symptoms and degrees of severity. However, because those with mental illness likewise manifest often objective and demonstrable differences in mental capacity and decision-making abilities, it is likely the Supreme Court would use a similar rationale in refusing to recognize the mentally ill as a suspect class.⁷² The Court traditionally shies away from granting suspect class status for various infirmities as it would open the door to far too many other groups also petitioning for the classification.⁷³ For instance, the Court justified its denial of suspect class status for mentally retarded citizens in part because recognition of

⁶⁷ See *Washington v. Glucksberg*, 521 U.S. 702, 721 (1997) (emphasis added); see also *Loving v. Virginia*, 388 U.S. 1, 11 (1967) (indicating that this review also applies for analysis under the Equal Protection Clause if the regulation affects fundamental rights).

⁶⁸ See *San Antonio Indep. School Dist. v. Rodriguez*, 411 U.S. 1, 29 (1973).

⁶⁹ See *id.* ("The system of alleged discrimination and the class it defines have none of the traditional indicia of suspectness: the class is not saddled with such disabilities, or subjected to such a history of purposeful unequal treatment, or relegated to such a position of political powerlessness as to command extraordinary protection from the majoritarian political process.").

⁷⁰ See THOMAS W. SIMON, *DEMOCRACY AND SOCIAL JUSTICE: LAW, POLITICS, AND PHILOSOPHY* 87 (Rowman & Littlefield Publishers, Inc. 1995).

⁷¹ See *City of Cleburne v. Cleburne Living Center*, 473 U.S. 432, 445-46 (1985) (striking down a city ordinance as discriminatory under rational basis review, but declining to rule that the mentally retarded were a quasi-suspect or suspect class); SIMON, *supra* note 70, at 87.

⁷² See SIMON, *supra* note 70, at 87.

⁷³ *Id.*

the mentally retarded as a suspect class would open the door for applying strict scrutiny analysis towards all laws that recognized “immutable disabilities” among “the aging, the disabled, the mentally ill, and the infirm” populations.⁷⁴

However, it appears that courts might apply strict scrutiny to Kendra’s Law under a due process analysis. The Supreme Court has recognized a “significant liberty interest in avoiding the unwanted administration of antipsychotic drugs rooted in the Due Process Clause of the Fourteenth Amendment.”⁷⁵ In *Washington v. Glucksberg*, the Court reaffirmed that certain liberty interests are “so deeply rooted in this Nation’s history and constitutional traditions” that due process allows their infringement only by government action narrowly tailored to the achievement of a compelling interest.⁷⁶ Issues concerning coerced medical treatment and medication fall into a zone of jurisprudence where the “Court has often deemed state incursions into the body repugnant to the interests protected by the Due Process Clause.”⁷⁷ Indeed, “the free citizen’s first and greatest right, which underlies all others [is] the right to the inviolability of his person,”⁷⁸ and “[a]lthough antipsychotic drugs are not the most invasive intervention conceivable, the methods by which they are administered to unwilling individuals go far beyond what is ‘routine in our everyday life.’”⁷⁹ The Court appears to draw a line in its due process analysis based upon whether the contested procedure is considered routine in daily life. For instance, in *Breithaupt v. Abram*, the forcible taking of blood from an individual suspected of driving while intoxicated was not considered a violation of his liberty interests because the procedure was routine, and something that “literally millions of us” have experienced.⁸⁰ However, the Court has determined that more invasive, non-routine, procedures violate due process, such as forced stomach

⁷⁴ *City of Cleburne*, 473 U.S. at 445–46.

⁷⁵ See *Cruzan v. Dir., Mo. Dep’t of Health*, 497 U.S. 261, 278 (1990) (quoting *Washington v. Harper*, 494 U.S. 210, 221–22 (1990)).

⁷⁶ *Washington v. Glucksberg*, 521 U.S. 702, 721 (1997).

⁷⁷ See *Cruzan*, 497 U.S. at 287 (O’Connor, J., concurring); see also *Rochin v. California*, 342 U.S. 165, 172 (1952) (due process violated where confession coerced by forcible administration of mind altering medication).

⁷⁸ Brief for the Drug Policy Alliance as Amicus Curiae Supporting Petitioners at 6, *Sell v. United States*, 539 U.S. 166 (2003) (No. 02–5564) [hereinafter Drug Policy Alliance Brief] (citing *Pratt v. Davis*, 118 Ill. App. 161, 166 (1905)).

⁷⁹ *Id.* at 7 (citing BRUCE J. WINICK, *THE RIGHT to Refuse Mental Health Treatment*, 103–15 (American Psychological Association 1997), *Breithaupt v. Abram*, 352 U.S. 432, 436 (1956)).

⁸⁰ See *Breithaupt*, 352 U.S. at 436; Drug Policy Alliance Brief, *supra* note 78, at 6–7.

pumping in *Rochin v. California*,⁸¹ and compelled surgical intrusion in *Winston v. Lee*.⁸²

The compulsory treatment arranged under a Kendra's Law court order is analogous to the more invasive bodily intrusions that the Supreme Court has previously determined violate due process. While "there is no accurate method of determining how a patient will respond to a particular drug," and medication and dosage levels are often determined on a "trial and error" basis by prescribing doctors.⁸³ Once injected, neuropsychiatric drugs operate directly on the brain's chemistry in ways that are not fully understood, and have been found to have a lasting effect on brain structure.⁸⁴ *Cruzan* and *Glucksberg* both recognized that the right to accept medical treatment is "firmly entrenched in American tort law," and protected under the Due Process Clause.⁸⁵

Rivers v. Katz is the seminal New York case applying due process principles in the context of outpatient commitment.⁸⁶ In *Rivers*, the New York Court of Appeals found that the right of involuntarily committed mentally ill patients to refuse medical treatment is a "fundamental right" coextensive with the patient's liberty interest protected by the due process clause of the New York State Constitution, and required strict scrutiny analysis when this interest is implicated.⁸⁷ The opinion included strong language supporting the rights of the mentally ill regarding their role in directing treatment, indicating that "mental illness [does not] result in the forfeiture of a person's civil rights, including the fundamental right to make decisions concerning one's own body."⁸⁸ The court reasoned that a patient does not lack the capacity to make a reasoned treatment decision just because he is mentally ill.⁸⁹ The court did hold, however, that the right to refuse medication is not absolute, and might have to yield to a compelling state police power interest where a patient

⁸¹ See *Rochin*, 342 U.S. 165; Drug Policy Alliance Brief, *supra* note 78, at 7.

⁸² See *Winston v. Lee*, 470 U.S. 753 (1985); Drug Policy Alliance Brief, *supra* note 78, at 7.

⁸³ Drug Policy Alliance Brief, *supra* note 78, at 7 (citing William M. Brooks, *Reevaluating Substantive Due Process as a Source of Protection for Psychiatric Patients to Refuse Drugs*, 31 IND. L. REV. 937, 946 (1998)).

⁸⁴ *Id.* (citing Paul Harrison, *Review: the Neuropathological Effects of Antipsychotic Drugs*, 40 SCHIZOPHRENIA RES. 87-89 (1999)).

⁸⁵ See *id.* at 12-13 (quoting *Cruzan v. Dir.*, Mo. Dep't of Health, 497 U.S. 261, 267 (1990)); see also *Washington v. Glucksberg*, 521 U.S. 702, 720 (1997) ("We have also assumed, and strongly suggested, that the Due Process Clause protects the traditional right to refuse unwanted lifesaving medical treatment." (citing *Cruzan*, 497 U.S. at 278-79)).

⁸⁶ See *Rivers v. Katz*, 495 N.E.2d 337 (N.Y. 1986).

⁸⁷ See *id.* at 341-43.

⁸⁸ *Id.* at 342 (citing N.Y. MENTAL HYG. LAW § 33.01 (McKinney 2006); see Eugene Z. DuBose, *Of Pariens Patriae Commitment Power and Drug Treatment of Schizophrenia: Do the Benefits to the Patient Justify Involuntary Treatment*, 60 MINN. L. REV. 1149, 1160 (1976)).

⁸⁹ See *Rivers*, at 342.

either presents a danger to himself or others, so long as the means are necessary and narrowly tailored to achieving the objective.⁹⁰

Accordingly, New York courts have applied a strict scrutiny analysis to mentally ill individuals' right to refuse medical treatment.⁹¹ In *Rivers*, the Court of Appeals found a qualified fundamental right to reject medical treatment, holding that "the right to reject treatment with antipsychotic medication is not absolute and under certain circumstances may have to yield to compelling State interests."⁹²

Under this analysis, New York courts have only found a compelling interest sufficient to outweigh a patient's right to refuse treatment on two occasions.⁹³ The state may exercise its police power to administer medication where the patient poses a danger to himself or society, or it may employ its *parens patriae* powers to order treatment where a patient is unable to care for himself because of mental illness.⁹⁴ As such, the mandatory court-ordered treatment provisions of Kendra's Law can only be maintained so long as courts deem it necessary to achieve compelling government police power and *parens patriae* interests of ensuring that both society and mentally ill patients are protected.

B. *Application to Kendra's Law*

Given the precedent that a patient is not deemed to have lost the ability to make a reasoned decision about treatment just because of his mental illness, it is unsurprising that Kendra's Law was swiftly met with a swath of criticism "ranging from attacks on the law's essence to attacks on operational detail" from New Yorkers concerned about the coercive components of the law and its implications for civil liberties.⁹⁵

In re Urcuyo, the first legal challenge to Kendra's Law, was brought by the New York Mental Hygiene Legal Service (MHLS), a public defender service run by the state for individuals with mental illness.⁹⁶ Relying on *Rivers*, the MHLS argued that Kendra's Law violated the patient's due process and equal protection rights under both the New York State and United States Constitutions because the provisions of Kendra's Law do not require a finding that the individual lacks capacity to make a reasoned treatment decision before being subjected to forced

⁹⁰ See *id.* at 343–45.

⁹¹ See, e.g., *In re K.L.*, 806 N.E.2d 480 (N.Y. 2004); *Rivers*, 495 N.E.2d 337; *In re Urcuyo*, 714 N.Y.S.2d 862 (Sup. Ct. 2000).

⁹² *Rivers v. Katz*, 495 N.E.2d 337, 343 (N.Y. 1986).

⁹³ *Watnick*, *supra* note 48, at 1213.

⁹⁴ See *id.*; *Rivers*, 495 N.E.2d at 343–44.

⁹⁵ See *Cohen*, *supra* note 53.

⁹⁶ See *In re Urcuyo*, 714 N.Y.S.2d 862; The Mental Hygiene Legal Service, http://www.courts.state.ny.us/ad4/mhls/MHLS_Default.htm (last visited Sept. 3, 2009).

medication under court-ordered treatment, as is required in *Rivers*.⁹⁷ The court held that the standard for court-ordered treatment under Kendra's Law did not violate due process rights because it required a judge to determine that, in view of the patient's history, "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."⁹⁸ The court also distinguished Kendra's Law from *Rivers* on the grounds that in *Rivers* the court was presented with a situation where medication was being involuntarily administered to civilly committed patients in hospitals without determining whether they could make reasoned choices about treatment options.⁹⁹ The court pointed out that under the provisions of Kendra's Law, a patient is only subjected to coercive treatment if they meet the *Rivers* "dangerous to self or others" standard during the time that they are kept under watch in a seventy-two hour observation period.¹⁰⁰ The observation period was thus the only coercive aspect of Kendra's Law that does not employ the *Rivers* standard, and "a patient who is determined to be in need of involuntary admission to the hospital would be protected by all of the procedural safeguards already contained within [Kendra's Law]" once within the hospital.¹⁰¹ Kendra's Law does not actually authorize involuntary medication, but rather simply prescribes a treatment plan and outlines a mechanism to bring the patient to the hospital for observation if the patient does not comply with the treatment plan.¹⁰² Once the patient arrives at the hospital, all of the *Rivers* protections and standards for involuntary inpatient commitment and medication kick-in.¹⁰³

The court thus found Kendra's Law to be narrowly tailored to the state's compelling interest in "taking measures to prevent patients who pose . . . a high risk from becoming a danger to the community and themselves."¹⁰⁴ The court also held that Kendra's Law did not violate any equal protection rights.¹⁰⁵ It noted that disparate treatment for assisted outpatients is warranted under an equal protection analysis, since the outpatient subjects affected by Kendra's Law have a history of dan-

⁹⁷ See *In re Urcuyo*, 714 N.Y.S.2d 862, 867–68 (Sup. Ct. 2000) ("The Court in *Rivers* held that an involuntarily committed psychiatric patient could not be forcibly medicated against his or her will absent a judicial determination that the patient lacked the mental capacity to make treatment decisions.").

⁹⁸ *Id.* at 870 (quoting N.Y. MENTAL HYG. LAW § 9.60(c)(6) (McKinney 2006)).

⁹⁹ See *id.* at 868.

¹⁰⁰ See *id.* at 872.

¹⁰¹ *Id.*

¹⁰² See *In re Urcuyo*, 714 N.Y.S.2d 862, 869–70 (Sup. Ct. 2000).

¹⁰³ See *id.* at 872.

¹⁰⁴ *Id.* at 873.

¹⁰⁵ See *id.*

gerousness to self or others.¹⁰⁶ The court reasoned that New York therefore has a compelling interest in preventing these high-risk individuals from becoming a danger to the community and themselves, and that “Kendra’s Law is narrowly tailored to achieve these goals.”¹⁰⁷

Thus, “*Rivers* is not sidestepped by [Kendra’s Law, rather] its application is, in effect, deferred.”¹⁰⁸ According to the *Urcuyo* court, “persons subject to Assisted Outpatient Treatment orders are not unconstitutionally deprived of their fundamental right to refuse medical treatment” given that “[t]here is no punitive remedy available to a petitioner for a patient who fails to comply with the written treatment plan.”¹⁰⁹ Instead, there is “only a constitutionally acceptable procedure to ensure that the patient is evaluated by a physician” to see if he might pose a danger to himself or others, and therefore require involuntary medication as in *Rivers*.¹¹⁰

In re K.L. also tested the constitutionality of Kendra’s Law. Again relying on *Rivers*, the respondent argued that Kendra’s Law violated his due process rights because the law called for patients to be hospitalized involuntarily during the seventy-two hour confinement period without requiring a finding of incompetency.¹¹¹ However, the New York Court of Appeals held that *Rivers* was not applicable in this situation because Kendra’s Law did not actually authorize any involuntary treatment or medication.¹¹² Noncompliance would only result in monitoring for seventy-two hours, and then the *Rivers* requirements would apply.¹¹³ The court recognized the fundamental right of patients to determine their own medical treatment.¹¹⁴ However, it noted that this right might have to yield to the compelling state interest in protecting against mentally ill individuals who may become dangerous.¹¹⁵ The court went on to explain that “[t]he restriction on the patient’s freedom effected by a court order authorizing assisted outpatient treatment is minimal . . . [as] a violation of the order, standing alone, ultimately carries no sanction.”¹¹⁶ The court found that the seventy-two hour observation period comported with constitutional notions of both equal protection and due process because the period was a “minimal” infringement of a patient’s freedom, and the assisted outpatient’s right to refuse treatment was outweighed by

¹⁰⁶ *Id.*

¹⁰⁷ *Id.*

¹⁰⁸ Cohen, *supra* note 53.

¹⁰⁹ *In re Urcuyo*, 714 N.Y.S.2d 862, 872–73 (Sup. Ct. 2000).

¹¹⁰ *See id.* at 873.

¹¹¹ *See In re K.L.*, 806 N.E.2d 480, 483–84 (N.Y. 2004).

¹¹² *See id.* at 484.

¹¹³ *See id.* at 486.

¹¹⁴ *See id.* at 484–85.

¹¹⁵ *Id.* at 485.

¹¹⁶ *Id.*

New York's compelling interests in enforcing both its police and *parens patriae* powers.¹¹⁷

The finding by New York's highest court that Kendra's Law comports with constitutional notions of due process and equal protection marked an end point in constitutional challenges to the law. However, the state prevailed in these cases only because the courts believed Kendra's Law "lacked any direct mechanisms to enforce compliance with treatment."¹¹⁸ On the one hand, the law can be heralded as a great success; the legislature succeeded in designing an effective outpatient commitment statute that comports with due process requirements. On the other hand, one can look at the provisions of Kendra's Law and ask: If the mandatory observation period is the only coercive aspect of the law, could the objective of enhanced treatment and management of mental illness be accomplished without the provision? If so, is the mandatory observation period really the "least restrictive means" for achieving the state's compelling interest in the safety of the community and the patient?

IV. MEETING THE STANDARD: IS KENDRA'S LAW EFFECTIVE ENOUGH TO LIVE UP TO ITS JUSTIFICATION?

Courts have affirmed the constitutionality of Kendra's Law on the basis that the law's enforcement mechanisms are both necessary and narrowly tailored to the compelling legislative objective.¹¹⁹ According to the courts, the state's legitimate police and *parens patriae* interests in preventing a mentally ill individual from inflicting harm upon himself or others meet the "compelling interest" requirement.¹²⁰ However, if research in psychology, psychiatry, or social sciences proves that the "means" in Kendra's Law are not "narrowly tailored," or the least restrictive method available for achieving this end, courts could no longer justify this law under strict scrutiny analysis.¹²¹ As such, research into the

¹¹⁷ *In re K.L.*, 806 N.E.2d 480, 484–88 (N.Y. 2004).

¹¹⁸ Paul S. Applebaum, *Assessing Kendra's Law: Five Years of Outpatient Commitment in New York*, PSYCHIATRIC SERVICES, July 2005, at 791, 791–92, available at <http://psychservices.psychiatryonline.org/cgi/reprint/56/7/791>.

¹¹⁹ See *In re K.L.*, 806 N.E.2d at 486–88; *In re Urcuyo*, 714 N.Y.S.2d 862, 873 (Sup. Ct. 2000).

¹²⁰ See *In re K.L.*, 806 N.E.2d at 485; *In re Urcuyo*, 714 N.Y.S.2d at 867–68.

¹²¹ See Cornell Legal Information Institute, *supra*, note 65. Strict scrutiny analysis requires that the ends employed by the government are the least restrictive, most narrowly tailored means for securing the compelling government interest. The power of social science research in legal determinations rests in the fact that empirical evidence can either confirm, or repudiate, the contention that the means are the least restrictive method available to achieve the result. If the empirical social science research demonstrates that there are in fact less invasive means of improving treatment compliance than with a court order, the courts' determinations that Kendra's Law passes strict scrutiny analysis would necessarily fail.

effectiveness of this law—specifically, whether the compulsive aspects of Kendra’s Law are the least restrictive means for achieving patient compliance with treatment—is relevant to determining whether the provisions of Kendra’s Law passing the strict scrutiny analysis can be empirically justified.

The legislature renewed Kendra’s Law for an additional five years in 2005, with the purpose of allowing further research on its efficacy before it considered the law for permanent renewal in 2010.¹²² The state’s decision to renew was no doubt attributable to striking statistics provided by the New York State Office of Mental Health, reporting seventy-four to eighty-seven percent reductions in arrest, incarceration, psychiatric hospitalization, and homelessness rates in comparison to individuals’ rates prior to their placement under AOT.¹²³ According to the 2005 renewal provision, the state Commissioner of Mental Health must submit annual reports to the governor and legislature.¹²⁴ In order to assess outcomes for AOT recipients as a group, the Office of Mental Health case managers maintain a detailed database of standardized assessments of AOT recipients’ conditions at the onset of the court order, and every six months thereafter, evaluating each AOT patient’s status in living situation, services received, adherence to medication, and incidences of homelessness, arrest, incarceration, or other harmful behaviors.¹²⁵

The most recent report of the Office of Mental Health from April 2009 shows a 58% statewide reduction in homelessness levels, a 75% decrease in incarceration, and a 57% decrease in hospitalization of individuals receiving AOT.¹²⁶ However, the state’s methodology compared the rates of homelessness, incarceration, and hospitalization to the men-

¹²² See 2005 N.Y. Laws 158, § 6.

¹²³ See SHARON E. CARPINELLO, NEW YORK STATE OFFICE OF MENTAL HEALTH, *KENDRA’S LAW: FINAL REPORT ON THE STATUS OF ASSISTED OUTPATIENT TREATMENT* (2005), http://www.omh.state.ny.us/omhweb/Kendra_web/finalreport/AOTFinal2005.pdf. The Office of Mental Health reported a 77% reduction in AOT recipients that needed psychiatric hospitalizations. See *id.* at 17–18. The study also found that AOT reduced the number of arrests of participants by 83%. *Id.* The Office of Mental Health also found a reduction in the number of AOT recipients who harmed themselves or others, or attempted suicide. *Id.* at 16; see also National Coalition for the Homeless, *Mental Illness and Homelessness*, June 2008, http://www.nationalhomeless.org/factsheets/Mental_Illness.html (last visited Sept. 9, 2009). The National Coalition for the Homeless report indicates that 20–25% of the homeless population in the United States suffers from severe mental illness. National Coalition for the Homeless, *supra*.

¹²⁴ See 2005 N.Y. Laws 158, § 7.

¹²⁵ New York State Office of Mental Health, Data Collection Methods, *available at* <http://bi.omh.state.ny.us/aot/about?p=data-collection> (last visited Sept. 29, 2009).

¹²⁶ New York State Office of Mental Health, Recipient Outcomes, <http://bi.omh.state.ny.us/aot/outcomes?p=rse-psych> (go to “Recipient Outcomes”; “Reduced Significant Events” and click on “Homelessness”; “Incarceration”; and “Psychiatric Hospitalization”) (last visited Nov. 6, 2009).

tally ill individual's *own* previous rates of incidence, not the rate of incidence of the entire statewide population.

As there are surely many contributing factors to a mentally ill individuals' decrease in incarceration and hospitalization once they begin to receive intensive treatment—namely, the treatment itself—the state needs a control group for comparison to individuals who simply benefited from the increased availability of services that also accompany an AOT order in order to test the efficacy of the coercive aspects of Kendra's Law. The statistics provided by the state leave open the question of what degree of benefit from AOT is the result of increased availability of services as opposed to the forced compliance with the court order. Indeed, the New York Civil Liberties Union (NYCLU) claims that the state's current statistics offer “no evidence that the compulsion portion of ‘Kendra's Law’ has served any purpose whatsoever,” and that improvements registered since Kendra's Law has been enacted stem only from the fact that AOT provides “preferential access to scarce mental health resources.”¹²⁷ Groups like the NYCLU and the Bazelon Group (an advocacy group for the mentally ill) point to the fact that the AOT provides patients with ready access to intensive case management services, individual and group therapy, substance abuse services, and access to housing and support services, as the key reason for improvements in AOT patients, not the compulsion or enforcement mechanisms.¹²⁸

Considering the arguments put forth by critics of Kendra's Law, judges, lawyers, and advocates are left to wonder whether the coercive provisions of the law are truly the necessary, least restrictive means for achieving the state's police and *parens patriae* objectives. The claims of both the proponents and critics of Kendra's Law require further empirical substantiation through social science research. Although there are relatively few other studies focusing on the efficacy of outpatient commitment, three studies—an investigation conducted by New York City's Bellevue Hospital, a long-term study conducted by Duke University, and an eight state survey conducted by the RAND Corporation—are recognized by both proponents and critics as, at the very least, representative of acceptable research methods.¹²⁹

¹²⁷ Beth Haroules, Statement before the New York Assembly Standing Committee on Mental Health, Mental Retardation and Developmental Disabilities, and the Assembly Standing Committee on Codes (Apr. 8, 2005), <http://www.nyclu.org/node/708> (last visited Sept. 9, 2009).

¹²⁸ See *id.*; The Bazelon Center for Mental Health Law, *Studies of Outpatient Commitment are Misused* (Jul. 3, 2001), <http://www.bazelon.org/issues/commitment/moreresources/studies.htm> (last visited Sept 20, 2009).

¹²⁹ See Statement of Beth Haroules, *supra* note 127; see also The Bazelon Center for Mental Health Law, *supra* note 128.

Critics of Kendra's Law frequently point to the Bellevue Hospital Study, which was completed in 1998 to assess a pilot outpatient commitment program run in New York City.¹³⁰ According to the Bellevue study, court orders did not lead to increased patient compliance with treatment, lower rates of hospitalizations, lower rates of arrest for violent acts, or an increase in functioning of the mentally ill.¹³¹ The study found that the coercive aspects of AOT did not improve with medication or continuation of treatment, and credited any improvements to the higher quality and coordination of services that are usually provided along with AOT.¹³² However, professors associated with the Duke study found the Bellevue study to be unreliable because it was conducted on too small a scale and too early on in the implementation of the outpatient commitment program to be conclusive because enforcement mechanisms were not fully in place during the time of the pilot program.¹³³ Indeed, the Bellevue study tracked only 142 individuals, and was a part of a three-year pilot program of AOT that was run in New York City before Kendra's Law was even passed.¹³⁴ The study compared seventy-eight patients who were hospitalized under court orders with sixty-four patients who were hospitalized without court orders, but post-hospitalization care providers did not clearly distinguish whether the patients were under court orders or not, meaning that the orders were not enforced in the early part of the program.¹³⁵ The RAND study independently evaluated the Bellevue results, and determined the study's legitimacy is weakened by the facts that: the AOT orders were inconsistently enforced throughout the study; the AOT group included more individuals with co-occurring substance abuse than the control group (fifty-six percent to thirty-nine percent); and the sample size was small.¹³⁶ Thus, the occasionally

¹³⁰ See The Bazelon Center for Mental Health Law, *supra* note 128 (indicating that "the more scientific the study, the less evidence it offers that outpatient commitment orders have any effect beyond providing increased access to effective services," and citing the Bellevue Hospital study as providing "strong evidence that outpatient commitment has no intrinsic value"); see also Statement of Beth Haroules, *supra* note 127 (claiming that "[o]ne of the most comprehensive and best-designed studies of outpatient commitment was carried out at New York City's Bellevue Hospital").

¹³¹ See H. Steadman, et. al., *Assessing the New York City Involuntary Outpatient Commitment Pilot Program*, 52 PSYCHIATRIC SERVICES 330, 335-36 (2001).

¹³² *Id.* at 335.

¹³³ See Marvin Swartz, Professor of Psychiatry, Duke University, Testimony before the Assembly Standing Committee on Mental Health, Mental Retardation and Developmental Disabilities (Apr. 8, 2005), http://www.treatmentadvocacycenter.org/index.php?option=com_content&task=view&id=1288.

¹³⁴ See Steadman, *supra* note 131 at 330.

¹³⁵ See M. SUSAN RIDGELY, RANDY BORUM & JOHN PETRILLA, THE EFFECTIVENESS OF INVOLUNTARY OUTPATIENT TREATMENT: EMPIRICAL EVIDENCE AND THE EXPERIENCE OF EIGHT STATES 25-26 (2001), available at http://www.rand.org/pubs/monograph_reports/2007/MR1340.pdf

¹³⁶ See *id.* at 26.

heavy invocation of this study's results by critics of Kendra's Law¹³⁷ ought to be taken with a grain of salt, as the general consensus on the Bellevue study from the academic community is that the "results of the study were compromised by problems in implementing the law, essentially leaving the question of effectiveness unanswered."¹³⁸

A second study, run by Duke University over the course of fifteen years, examined a similar North Carolina AOT law, and is considered "the better of the two" when examined against the Bellevue study.¹³⁹ It is interesting to note that while critics have portrayed the results of the Duke study to "support the New York finding that outpatient commitment has no effect on hospital use,"¹⁴⁰ it is characterized very differently by the professors who actually conducted the study, such as Professor Marvin Swartz.¹⁴¹ Professor Swartz indicated that while his study showed no improvements for AOT orders for less than six months, long-term AOT, with orders lasting more than six months, proved to be effective when combined with intensive mental health services.¹⁴² While RAND generally approved of the methodology used in the Duke study, it did find possible limitations, including that it used an "adherence protocol" to ensure that enforcement provisions of the law were implemented whenever applicable for study participants (but enforcement mechanisms might not be that widely used in actual community practice), as well as the fact that the study tracked people who had AOT orders subsequent to discharge from a hospital (meaning they might be more serious cases than those who were simply given a court order, and coercive aspects might not be as effective for people with less acute symptoms).¹⁴³

The RAND study is an independent report conducted in 2001 at the request of the California state legislature, which, in an effort to shape its own policy on outpatient commitment, hired the firm to conduct an impartial, empirical study on the experiences of the eight states with involuntary outpatient commitment laws, including New York's Kendra's Law, along with the Bellevue and Duke studies.¹⁴⁴ The RAND study probes the issue of AOT more deeply than the other studies, specifically honing into the concern of whether a court order for an intensive mental health treatment program significantly improves the outcome over intensive treatment itself, without the court order. Specifically, the RAND

¹³⁷ See, e.g., The Bazelon Center for Mental Health Law, *supra* note 128.

¹³⁸ Applebaum, *supra* note 118, at 792.

¹³⁹ Testimony of Marvin Swartz, *supra* note 133, at par. 2; Ridgely, et al., *supra* note 135, at xv.

¹⁴⁰ The Bazelon Center for Mental Health Law, *supra* note 128.

¹⁴¹ See Testimony of Marvin Swartz, *supra* note 133.

¹⁴² See *id.* at par. 6

¹⁴³ See RIDGELY ET AL., *supra* note 135, at 25.

¹⁴⁴ See *id.*; The Bazelon Center for Mental Health Law, *supra* note 128, at par. 2.

study asks “whether involuntary outpatient treatment and voluntary alternatives produce equally good outcomes.”¹⁴⁵ This issue strikes at the heart of the legal determination that justifies Kendra’s Law. If a voluntary alternative to Kendra’s Law that provided the enhanced treatment services, but not the court order, was equally effective in advancing the state’s police and *parens patriae* interests, then the law’s coercive court order would not be the least restrictive means necessary to achieving the state’s compelling interests, and the court order provision of Kendra’s Law would fail the constitutional test. Unfortunately, although the RAND study provides the most comprehensive analysis available, because of the limited empirical research that has been done on this specifically focused issue, the RAND study found that “there is no empirical data that will allow us to assess the policy tradeoffs between involuntary outpatient treatment and alternatives such as assertive community treatment,” which would include assessment of the results generated under more enhanced treatment services provided under AOT, without the presence of coercion.¹⁴⁶ Thus, although the RAND study essentially announces that there is no answer for this specific question, it does indicate that research on court-ordered mental health treatment suggests that the two most salient factors in reducing recidivism and problematic behavior among people with mental illness are enhanced services and monitoring, which would suggest that some form of coercive element is necessary.¹⁴⁷

Given this current state of affairs, critics of Kendra’s Law focus on the fact that to date there is no evidence that the coercive aspect of the law has any correlation with successful treatment.¹⁴⁸ They claim coercion is instead counterproductive because it erodes patient trust,¹⁴⁹ and that the investment in enforcement diverts resources away from other treatment initiatives.¹⁵⁰ According to the NYCLU:

The obligation to find services for those who are compelled to have them acts as a rationing device. There are already some areas in the State that are seeing critical shortages of intensive case managers because they are available only to people in outpatient commitment programs, and not to other people in the community who need them.¹⁵¹

¹⁴⁵ RIDGELY ET AL., *supra* note 135, at xvi.

¹⁴⁶ *See id.* at xvii.

¹⁴⁷ *See id.* at xv.

¹⁴⁸ *See* Statement of Beth Haroules, *supra* note 127.

¹⁴⁹ *See id.*

¹⁵⁰ *See* WINICK, *supra* note 79, at 210.

¹⁵¹ Statement of Beth Haroules, *supra* note 127.

However, even if this assertion is true, the worst-case scenario is that New York is concentrating resources on the most needy, which suggests a need for more funding for mental health services in general rather than a disassembly of Kendra's Law. Nevertheless, it is understandable that "[m]ost community-based providers of mental health services do not relish the role of 'parole agent,'" and the enforcement mechanisms might themselves be a distraction from the more critical role of providing acute care to the large number of people tasked to mental health services.¹⁵²

However, the most concerning aspect of the coercive component of AOT derives from the workability of the outpatient commitment standard itself. The power of the state to limit individuals' personal liberty is a result of the state's "compelling interest in taking measures to prevent these patients who pose such a high risk from becoming a danger to the community and themselves."¹⁵³ Therefore, the decision to require outpatient commitment is predicated upon a physician's assessment of whether the individual poses a danger to himself or others.

Unfortunately, predicting violence is perhaps the most difficult aspect of a mental health care provider's evaluation, and "despite widespread application of dangerousness in criminal and civil law standards, the ability of trained clinicians, much less judges and juries, to assess dangerousness—particularly future violence—accurately and reliably for legal purposes is controversial, and without convincing empirical support."¹⁵⁴ The issue of liability magnifies this concern. Could a care provider be found liable for the crimes committed by an AOT patient, if the provider determined the individual did not pose a threat to the community? Even if providers are given immunity from suit, their professional reputation faces serious scrutiny if one of their patients becomes unpredictably violent. Thus, even the most responsible mental health service provider is under pressure to protect his or her own professional reputation and err on the side of caution when assessing "dangerousness" for an AOT order or involuntary commitment.

The coercive component of Kendra's Law is designed to address the fact that at times the nature of a mental illness itself makes the patient noncompliant, and has been legitimated on the grounds of the state's police power and its compelling interest in preventing violence. However, if even some supporters of Kendra's Law believe "difficulties in predicting and preventing violence—especially the uncommon acts of brutality that galvanize the media and the public—make outpatient com-

¹⁵² Torrey & Kaplan, *supra* note 5, at 782.

¹⁵³ *In re Urcuyo*, 714 N.Y.S.2d 862, 873 (Sup. Ct. 2000).

¹⁵⁴ JOHN PARRY & ERIC Y. DROGIN, *MENTAL DISABILITY LAW, EVIDENCE AND TESTIMONY: A COMPREHENSIVE REFERENCE MANUAL FOR LAWYERS, JUDGES AND MENTAL DISABILITY PROFESSIONALS* 13 (American Bar Association 2007).

mitment a mediocre tool for the purpose of preventing violence,” then perhaps the legal justification that Kendra’s Law is “necessary” to achieve these police power interests needs to be revisited.¹⁵⁵

Ultimately, the precedent that Kendra’s Law sets for depriving individuals of their liberty by building neuropsychiatric findings into court orders is one that ought to be handled thoughtfully and with extreme caution. While incorporation of neuroscience and empirical research has great potential for focusing the law and improving public policy, it is a process that ought to be approached judiciously. Although the law operates normatively, as of now, a hard line is drawn at the sanctity of an individual’s thoughts, and psychiatric treatment is imposed on an individual only when deemed necessary to protect himself and others.

However, as neuroscience and empirical definitions of mind, brain, and behavior inevitably become more accepted and woven into how society approaches problems and views aberrant behavior in general, such an increased confidence could turn into hubris. It might eventually seem possible to “fix” an individual by bringing him back within the normative standards embodied by the law. Further neuro-scientific analysis of AOT will be invaluable in proving whether the coercive elements of Kendra’s Law are truly necessary to provide effective treatment to the mentally ill and whether the “dangerousness” standard is itself workable. However, it is important to keep in mind that the standard should never be expanded beyond the *Rivers* “dangerousness” criterion for involuntary treatment. No matter how advanced neuroscience and medicine become, the slippery slope of determining what is and is not “normal” within our society is dangerous and should not be experimented with.

CONCLUSION

Legal analysis reveals that Kendra’s Law passes strict scrutiny because its provisions provide the least restrictive means necessary to secure the state’s compelling interest in preventing patients from posing a high risk of danger to the community and themselves. However, scientific analysis shows that it is unclear whether the coercive aspects of Kendra’s Law are necessary. If new research demonstrates that outpatient commitment is not an accurate or effective means of preventing violence over simply enhanced treatment services alone, then the justification for Kendra’s Law would be obviated.

When the legislature reconsiders Kendra’s Law in 2010, it will be faced with a great deal of pressure from lobbyists and anecdotal testimony, and each legislator will approach the issue with the background of

¹⁵⁵ Paul S. Applebaum, *Ambivalence Codified: California’s New Outpatient Commitment Statute*, 54 *PSYCHIATRIC SERVICES* 26, 28 (2003).

their own biases and ideological perspectives on due process, equal protection, and the law's relative merits. However, for a truly disciplined analysis, legislators would be wise to focus the debate and pair the results of social science research into the effectiveness of outpatient commitment with the legal standard by which the law is constitutionally justified. Just as the California legislature ordered a study to assess the effects of outpatient commitment, the New York legislature would also be wise to temporarily renew Kendra's Law and order a study that specifically addressed whether the coercive aspects of the law are truly necessary to address its efficacy. Kendra's Law could then either be made permanent or suspended, based upon how these findings compared with the narrow strict scrutiny legal test justifying the law's constitutionality.

An analysis based on these considerations would provide a beautiful illustration of how public policy can be advanced through a multidisciplinary approach based on rigorous legal review and neuro-scientific and psychological study. If the need for the coercive component of the law cannot be proven necessary to the overall treatment scheme, it seems very likely that holes will be poked in the current constitutional justification for Kendra's Law, and it will fail the strict scrutiny test of constitutionality. Conversely, if further research does prove that the enforcement powers facilitated by the court order provision are essential to treatment success, then it will place Kendra's Law on firmer constitutional footing.

However, until such a study is conducted and its results are received, it is worthwhile to take a step back and consider the perspective of Dr. Gary Collins, who formerly served as the director of the New York County Assisted Outpatient Treatment Program. Dr. Collins raises the point that "while assisted outpatient treatment is no panacea, what in medicine or psychiatry is?"¹⁵⁶ He suggests that it is time to realign our focus from controversy to a dedication to improving the level of care available to the mentally ill.¹⁵⁷ Indeed, while infringements of constitutional rights of any kind should never be accepted lightly, policy towards outpatient commitment could be materially improved if there was a focal shift of the type Dr. Collins suggests. While there is extensive literature, material from advocacy centers, and litigation surrounding the controversy of Kendra's Law, outpatient commitment law policy remains unclear and contentious because very few people have approached the issue without an agenda to see if the policies currently in place actually work.

Since the final analysis on Kendra's Law cannot be undertaken until the results of an empirical study comparing the results of patients who have received enhanced treatment services without a court order to those that have received the enhanced treatment with a court order become

¹⁵⁶ Collins, *supra* note 9, at 219.

¹⁵⁷ *See id.*

available, analysis of Kendra's Law must focus on what determinative information is available now. Thus, while it is clear that Kendra's Law is certainly far from a panacea, it is a prime example of what is needed at the intersection of law and psychiatry. No truly innovative policy is going to be effective on the first try. What is important here is that New Yorkers engaged in a bipartisan effort to take a proactive, assertive step to address a legitimate problem in the mental health system. Although this Note recognizes that the coercive provisions of the law pass a strict scrutiny review for constitutionality based on currently available evidence, the sunset clauses written into the legislation in 1999 and 2005 reflect that the legislature at least recognized that these provisions of the law might require adjustment. Indeed, it is rare for legislation to be sensitive towards empirical research, and such "a salutary approach to public policy is all too infrequently observed at either the state or local level."¹⁵⁸ In this modern age where psychology and psychiatry can truly inform our decisions on public policy and criminal law, designing laws that are both responsive, and adjustable, to the findings of science is key.

By placing sunset clauses on the legislation, the New York legislature was in effect recognizing that Kendra's Law was not a cure-all, and therein provided opportunities for the future legislatures to respond and adjust to how the law worked in practice, as well as to future findings from empirical research. While there are indeed no panaceas in science, medicine, politics, or law, our democratic system provides the best chance of achieving one.

Opinions on Kendra's Law will always be split between those who take a utilitarian approach and would rather err on the side of providing the most benefit and potential security for society at the sacrifice of some individual rights, and others, who would choose to hedge on the side of individual rights and ascribe to the philosophy that they would rather see ten guilty men go free rather than one case of wrongful deprivation of liberty. Hopefully through the friction between these two groups, and the guiding hand of empirical scientific research, the effectiveness and composition of Kendra's Law will ultimately be meted out in a way that achieves the broadest possible protection for society while still safeguarding individual constitutional rights of due process and equal protection.

¹⁵⁸ See Applebaum, *supra* note 155, at 791.