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IS KENDRA'S LAW A KEEPER? HOW KENDRA'S LAW ERODES FUNDAMENTAL RIGHTS OF THE MENTALLY ILL

*Erin O'Connor**

INTRODUCTION

In 1999, New York enacted legislation mandating involuntary outpatient commitment for mentally ill individuals with a history of noncompliance with treatment who are “unlikely to survive safely in the community without supervision.”¹ Outlining an Assisted Outpatient Treatment (AOT) program that includes intensive community-based treatment under the court-ordered supervision of a team of mental health professionals, the law, commonly known as “Kendra’s Law,” was passed in response to the tragic death of Kendra Webdale.² Ms. Webdale was killed when an individual with a long history of mental illness pushed her onto the New York City subway tracks in front of an oncoming train.³ Her death raised questions about the efficacy of

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¹ N.Y. MENTAL HYG. LAW § 9.60 (McKinney 2002). *See also infra* Part I.B (discussing Kendra’s Law and outlining additional eligibility requirements).

² § 9.60. *See also* discussion *infra* Part I.B (describing AOT in detail).

³ *See, e.g.*, Maggie Haberman et al., *Woman, 32, Is Pushed to Her Death in Subway Horror*, N.Y. POST, Jan. 4, 1999, at 4; Bill Sanderson, *Horror on the Tracks: Woman Killed in Subway Nightmare, Pushed from Platform by*

the mental health system, and public outrage spurred the law into effect.⁴

Legislators designed Kendra's Law to prevent future, similar tragedies involving individuals with mental illness who are noncompliant with treatment.⁵ Despite this effort, another woman was seriously injured in 2001 when a severely mentally ill individual pushed her onto the subway tracks in New York City's Grand Central Station.⁶ This incident, given the factual similarities with Ms. Webdale's death, naturally and justifiably

Man who had 'Urge,' N.Y. POST, Jan. 4, 1999, at 2. Ms. Webdale was dragged under the train and decapitated. *Id.* She died instantly. *Id.* A witness reported that Goldstein said afterward, "Take me to the hospital. I'm crazy." K.C. Baker et al., *Pushed to Her Death, Straphanger Shoved to Tracks*, N.Y. DAILY NEWS, Jan. 4, 1999, at 3. Goldstein then waited quietly on the platform for the police to arrive. *Id.* He did not resist arrest. *Id.*

⁴ Richard Lezin Jones, *Suspect in Subway Attack Has a History of Violence*, N.Y. TIMES, Nov. 17, 2001, at D1 (recalling incidents of subway riders pushed to their deaths by individuals with mental illness, most notably the death of Ms. Webdale, which led to Kendra's Law).

⁵ See Press Release, Office of New York State Attorney General Eliot Spitzer, Speaker Silver Joins Attorney General Spitzer in Calling for Passage of Kendra's Law (May 19, 1999), http://www.oag.state.ny.us/press/1999/may/may19c_99.html. Assembly Speaker Sheldon Silver stated that "the specific incident that inspired Kendra's Law accurately depicts this as a public safety issue," but additionally the bill will assist "the thousand of families who have nowhere to turn when a loved one is refusing to participate in medical treatment plans." *Id.* Attorney General Eliot Spitzer added, "[t]he way things stand now, we must wait for a tragedy to take place before we can get the mentally ill the help they need." *Id.* Kendra's mother, Patricia Webdale, emphatically urged the Legislature to enact Kendra's Law to "reduc[e] the number of potential victims" of the mentally ill. *Id.*

⁶ Jones, *supra* note 4. On November 15, 2001, Jackson Roman pushed Latchmie Ramsamy into the path of an oncoming train at Grand Central Station. *Id.* Ms. Ramsamy lost a foot and suffered other injuries. *Id.* Mr. Roman had been released in October 2001 from a psychiatric hospital after a yearlong stay. *Id.* It is unknown if he was under an AOT order at the time of this incident. *Id.* He was supposed to be in a supervised outpatient mental health program, but he had left it without authorization. *Id.* The directors of the program had been looking for him but had not yet contacted the police. *Id.* See also discussion *infra* Part III.C (examining the effectiveness of Kendra's Law).

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implicated the effectiveness of Kendra's Law and New York's AOT program.⁷

Although beneficial to many individuals with mental illness, New York's AOT provision extends beyond protecting society from dangerous mentally ill individuals to infringing upon the rights of those with mental illness who pose no threat. Although Kendra's Law provides legal representation for all individuals at hearings, the right to counsel is diminished by other aspects of the law.⁸ By subjecting an individual who refuses treatment to serious consequences, including arrest and hospitalization, the law infringes on an individual's right to determine his own course of treatment, particularly the right to refuse medication.⁹

⁷ See Sean Gardiner, *Psychiatric Motive? Subway Suspect Tells Cops He Pushed Woman to Get Mental Help*, NEWSDAY, Nov. 17, 2001, at A7 (stating that Mr. Roman told investigators that he pushed Ms. Ramsamy because he was desperate for psychiatric help); Patricia Hurtado, *History of Convictions, Treatment: Subway Suspect Had Been in Jail, Also Spent Time in Mental Facilities*, NEWSDAY, Nov. 17, 2001, at A26 (comparing the history of Mr. Roman and Mr. Goldstein and suggesting that, despite Kendra's Law, hospitals discharge dangerous patients without court orders); see also Robert Kolker, *Diagnosis: Insanity*, CITY LIMITS, May 2000 (arguing that the mentally ill want to go to jail in order to receive mental health services), <http://www.citylimits.org/content/articles/articleView.cfm?articlenumber=824>.

⁸ N.Y. MENTAL HYG. LAW § 9.60(g) (McKinney 2002). See also discussion *infra* Part II.B (discussing how the right to counsel is eroded by the limitations placed on the ability of counsel to effectively represent the interest of patients).

⁹ § 9.60(n).

Where in the clinical judgment of a physician, the patient has failed or has refused to comply . . . such physician may request the director . . . to direct the removal of such patient to an appropriate hospital [I]f such assisted outpatient refuses to take medications as required by the court order, . . . such physician may consider such refusal or failure when determining whether the assisted outpatient is in need of an examination to determine whether . . . hospitalization is necessary. Upon the request of such physician, the director . . . may direct peace officers . . . or police officers . . . to take into custody and transport any such person to the hospital

Id. See also discussion *infra* Part II.C (explaining the right to determine the course of one's own treatment).

Moreover, the law abridges the physician-patient privilege by allowing treating psychiatrists to testify at AOT hearings.¹⁰ Additionally, studies suggest Kendra's Law is not only ineffective but also counterproductive.¹¹

This note provides a critical analysis of Kendra's Law and suggests areas for careful scrutiny and possible reform. Part I provides a brief history of involuntary treatment of the mentally ill through the use of outpatient commitment. Next, it explains the development of New York's AOT law.¹² Part II discusses both the minimal protections Kendra's Law provides and the various infringements the law imposes on the rights of mentally ill people. Specifically it discusses how Kendra's Law erodes the right to counsel, the right to refuse treatment and the right to privileged, confidential treatment. Part III discusses the general effectiveness of involuntary outpatient commitment and the effectiveness of New York's AOT law. Finally, this note concludes that if Kendra's Law is to survive past 2005, when the sunset provision takes effect, the law's impact on fundamental rights as well as its effectiveness need to be considered prior to its renewal.¹³

I. INVOLUNTARY MENTAL HEALTH TREATMENT

Involuntary outpatient commitment refers to the use of court orders to compel mentally ill individuals to participate in community treatment.¹⁴ Involuntary outpatient commitment takes

¹⁰ § 9.60(e)(3). "The petition shall be accompanied by an affirmation or affidavit of a physician, who shall not be the petitioner, and shall state . . . [that] he or she is willing and able to testify at the hearing on the petition" *Id.* See also discussion *infra* Part II.D (describing the physician-patient and psychotherapist privileges).

¹¹ See discussion *infra* Part III (examining the effectiveness of outpatient commitment generally and Kendra's Law in particular).

¹² § 9.60.

¹³ § 9.60. Kendra's Law expires in 2005 if the legislature fails to renew it. *Id.*

¹⁴ Jennifer Gutterman, Note, *Waging a War on Drugs: Administering a Lethal Dose to Kendra's Law*, 68 FORDHAM L. REV. 2401 (2000) (arguing

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one of three forms: (1) conditional release from inpatient hospitalization; (2) outpatient treatment as a less restrictive alternative to hospitalization; or (3) preventive commitment.¹⁵ With the passage of Kendra's Law, New York began to utilize the third type—preventive commitment. Although this method presents more constitutional issues than the alternatives, Kendra's Law has survived equal protection and due process challenges in the lower courts.¹⁶

that Kendra's Law "impermissibly infringes upon an individual's right to liberty, privacy, and freedom from bodily harm" and that it fails to address mentally ill individuals' mental health needs). One criticism of outpatient commitment laws is that rehospitalization is often the only sanction available when patients refuse to comply with treatment. Ronald L. Wisor, Jr., *Community Care, Competition, and Coercion: A Legal Perspective on Privatized Mental Health Care*, 19 AM. J.L. & MED. 145, 165 (1993) (arguing that current outpatient commitment statutes are ineffective in reducing hospital readmissions); *see also* Jillane T. Hinds, *Involuntary Outpatient Commitment for the Chronically Mentally Ill*, 69 NEB. L. REV. 346, 358 (1990) (discussing the development of and need for involuntary outpatient commitment). The failure of the deinstitutionalization movement, a public policy initiative developed in the 1960s to transfer less severely mentally ill individuals from state psychiatric hospitals to the community, led to the trend of involuntary outpatient treatment. *Id.* Deinstitutionalization's failure also led to a phenomenon known as the "transinstitutionalization" of the mentally ill, meaning that the majority of the mentally ill are now housed and treated in jails, prisons, and homeless shelters as opposed to being treated by state psychiatric hospitals or community mental health programs. Ilissa L. Watnik, 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, 1186 (2001); *see also* Kolker, *supra* note 7 (discussing the revolving door syndrome in New York City).

¹⁵ *See* Geraldine A. McCafferty & Jeanne Dooley, *Involuntary Outpatient Commitment: An Update*, 14 MENT. & PHYSICAL DISABILITY L. REP. 277 (1990) (providing an in-depth discussion on the three types of outpatient commitment and the status of outpatient commitment as of 1990).

¹⁶ *See In re Martin*, 225 N.Y.L.J. 6, Jan. 9, 2001, at 31 (N.Y. Sup. Ct. Jan. 8, 2001) (holding Kendra's Law constitutional, as well as finding an additional hearing is not required prior to arrest or hospitalization in order to satisfy due process); *In re Urcuyo*, 714 N.Y.S.2d 862 (N.Y. Sup. Ct. 2000) (holding that Kendra's Law does not violate the fundamental right to choose the course of one's own medical treatment under the due process and equal protection clauses of state's constitution); *see also infra* Part I.B.3 (discussing

A. Outpatient Commitment

The state-imposed treatment of individuals with mental illness is justified by the state's police power to protect its citizens from harm and the state's *parens patriae* power to protect those who cannot help themselves.¹⁷ Police power relates to a state's duty to protect its citizens' health, safety and general welfare.¹⁸ Recognizing that some mentally ill individuals pose a danger to themselves or others in society, states justify involuntary inpatient commitment through their police powers.¹⁹ *Parens patriae* power, however, is derived from the state's paternalistic responsibility to care and protect those that it deems unable to care for themselves.²⁰ The different rationales lead to different standards for forced medication.²¹ With regard to the state's police power, the state has the authority to forcibly medicate when an individual poses a danger to himself or others.²² The state's *parens patriae* power, on the other hand, justifies forceful administration of medication for individuals that lack the capacity

how Kendra's Law has withstood constitutional challenges in the lower courts thus far); *infra* Part II (discussing how Kendra's Law infringes on various rights of those with mental illness).

¹⁷ Watnik, *supra* note 14, at 1187 (concluding that the state's police power and *parens patriae* power outweigh the patient's liberty and autonomy interests and arguing that Kendra's Law does not violate substantive and procedural due process). *See also* Rivers v. Katz, 495 N.E.2d 337 (N.Y. 1986) (discussing the state's police and *parens patriae* powers and involuntary treatment and ultimately concluding that involuntarily committed mentally ill individuals have a fundamental right to refuse anti-psychotic medication under the Due Process clause of the state constitution). *Parens patriae* literally means "parent of the country." BLACK'S LAW DICTIONARY 712 (6th ed. 1996).

¹⁸ Watnik, *supra* note 14, at 1187.

¹⁹ *See Rivers*, 495 N.E.2d at 343.

²⁰ Watnik, *supra* note 14, at 1187.

²¹ *Rivers*, 495 N.E.2d at 495-96.

²² *Id.* at 495. "Where the patient presents a danger to himself or other members of society or engages in dangerous or potentially destructive conduct within the institution, the State may be warranted, in the exercise of its police power, in administering antipsychotic medication over the patient's objection." *Id.*

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to decide for themselves.²³

Conditional release is a type of outpatient commitment that requires an individual to follow the hospital's treatment plan upon discharge from involuntary civil commitment.²⁴ Conditional release is hospital-oriented and often without judicial proceedings.²⁵ When an individual's condition improves and hospitalization is no longer necessary, the hospital may place conditions on the discharge prior to the release.²⁶ Under conditional release, the hospital or physician generally determines the terms of the release.²⁷ If the individual does not comply with the terms of the release, the doctor decides whether

²³ *Id.* at 496.

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 the drugs.

Id.

²⁴ Hinds, *supra* note 14, at 356-58; McCafferty & Dooley, *supra* note 15, at 279. In some jurisdictions, such as Georgia, the court may require conditional release as part of the initial involuntary commitment order. *Id.* at 279. The dynamics of conditional release vary from state to state. *Id.*

²⁵ Hinds, *supra* note 14, at 358 (comparing the differences between conditional release and other forms of outpatient commitment and finding that the decision to place an individual on conditional release is solely the discretion of the inpatient facility or treating physician). Generally, the treatment facility or the treating physician also creates the terms of the release and courts are notified after the fact. McCafferty & Dooley, *supra* note 15, at 279.

²⁶ McCafferty & Dooley, *supra* note 15, at 279. "Typical conditions include periodic reporting [follow-up care]; continuation of medication and submission to testing; and restrictions on travel, consumption of liquor or drugs, associations with others, and the incurrence of debts and other obligations." *Id.* The length of time on conditional release varies among the states. *Id.*

²⁷ *Id.*; Hinds, *supra* note 14, at 356. When the hospital or physician, as opposed to the court, creates the plan, the hospital or physician can create an individualized treatment plan geared towards the best interests of the patient, for whom the hospital or physician may have previously provided help. Hinds, *supra* note 14, at 356.

rehospitalization is appropriate.²⁸ Most states, including New York, authorize conditional release.²⁹

As a dispositional alternative, outpatient commitment allows a court discretion to order outpatient commitment in lieu of hospitalization after finding that the standard for involuntary inpatient commitment is met.³⁰ Most states authorize outpatient

²⁸ McCafferty & Dooley, *supra* note 15, at 279.

²⁹ N.Y. MENTAL HYG. LAW § 29.15 (McKinney 2002). “A patient may be conditionally released, rather than discharged, when in the opinion of staff familiar with the patient’s case history, the clinical needs of such patient warrant this more restrictive placement” *Id.* As of 1990, forty-three states authorized conditional release. McCafferty & Dooley, *supra* note 15, at 279 n.41; *see also* ALA. CODE § 22-52-57 (2001); ALASKA STAT. § 47.30.795 (Michie 2001); ARIZ. REV. STAT. ANN. § 36-540.01 (West 2002); CAL. WELF. & INST. CODE § 5305 (West 2002); CONN. GEN. STAT. ANN. § 17a-509 (West 2002); DEL. CODE ANN. tit. 16, § 5131 (2001); FLA. STAT. ANN. § 394.469 (West 2002); GA. CODE ANN. § 37-3-85 (2002); HAW. REV. STAT. § 334-75 (2001); IDAHO CODE § 66-338 (Michie 2002); 20 ILL. COMP. STAT. ANN. 1705/15 (West 2002); IND. CODE § 12-26-14-7 (2002); IOWA CODE ANN. § 229.15(4) (West 2002); KY. REV. STAT. § 202A.181 (Banks-Baldwin 2002); LA. REV. STAT. ANN. § 28:56(G) (West 2002); ME. REV. STAT. ANN. tit. 34-B, § 3870 (West 2002); MD. CODE ANN., HEALTH-GEN. § 10-806 (2002); MASS. GEN. LAWS ANN. ch. 123 § 4 (West 2002); MINN. STAT. ANN. § 235B.15 (West 2002); MISS. CODE ANN. § 41-21-87 (2002); MO. ANN. STAT. § 632.385 (West 2002); MONT. CODE ANN. § 53-21-183 (2002); NEB. REV. STAT. § 83-1046 (2002); NEV. REV. STAT. 433A.380 (2002); N.H. REV. STAT. ANN. § 135-C:49 (2002); N.J. STAT. ANN. § 30:4-27.15(c) (West 2002); N.M. STAT. ANN. § 43-1-21 (Michie 2002); N.Y. MENTAL HYG. LAW § 29.15 (McKinney 2002); N.C. GEN. STAT. § 122C-277(a) (2002); N.D. CENT. CODE § 25-03.1-30 (2001); OHIO REV. CODE ANN. § 5122.20 (West 2002); OKLA. STAT. ANN. tit. 43A, § 7-101 (West 2002); OR. REV. STAT. §§ 426.130, 426.126 (2001); 50 PA. CONS. STAT. ANN. § 7304 (West 2002); S.C. CODE ANN. § 44-22-210 (Law Co-op. 2002); TENN. CODE ANN. § 33-6-202 (2002); TEX. HEALTH & SAFETY CODE ANN. §§ 574.061, 574.082, 574.086 (2001); UTAH CODE ANN. § 62A-15-637 (2002); VT. STAT. ANN. tit. 18, § 8007 (2002); VA. CODE ANN. § 37.1-98 (Michie 2002); WASH. REV. CODE ANN. § 71.05.340 (West 2002); W. VA. CODE § 27-7-2 (2002); WIS. STAT. ANN. § 51.35 (West 2002). Some states refer to conditional release as “convalescent status.” *See, e.g.*, KY. REV. STAT. § 202A.181 (Banks-Baldwin 2002); ME. REV. STAT. ANN. tit. 34-B, § 3870 (West 2002); N.M. STAT. ANN. § 43-1-21 (Michie 2002).

³⁰ McCafferty & Dooley, *supra* note 15, at 279-80.

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treatment as a less restrictive alternative to inpatient hospitalization.³¹ After a finding that the individual meets the requirement for civil inpatient commitment, some courts have the discretion to opt for outpatient treatment.³²

Preventive commitment is a type of outpatient commitment that does not require a finding of dangerousness in order to

³¹ See ALA. CODE § 22-52-10.1 (2001); ALASKA STAT. §§ 47.30.735, 47.30.755 (Michie 2001); ARIZ. REV. STAT. ANN. § 36-540 (West 2002); ARK. CODE ANN. § 20-47-214(c) (Michie 2001); COLO. REV. STAT. § 27-10-107(6) (West 2002); CONN. GEN. STAT. ANN. § 17a-498 (West 2002); DEL. CODE ANN. tit. 16, § 5010(2) (2001); D.C. CODE ANN. § 21-545(b) (2002); FLA. STAT. ANN. § 394.467(6)(b) (West 2002); IDAHO CODE § 66-329(k) (Michie 2002); 405 ILL. COMP. STAT. ANN. 5/3-812 (West 2002); IND. CODE § 12-26-6-8 (2002); IOWA CODE ANN. § 229.14 (West 2002); KAN. STAT. ANN. § 59-2967 (2001); KY. REV. STAT. ANN. § 202A.081 (Banks-Baldwin 2002); LA. REV. STAT. ANN. § 28:55(E) (West 2002); MICH. COMP. LAWS ANN. § 330.1468 (West 2002); MINN. STAT. ANN. § 235B.09 (West 2002); MISS. CODE ANN. § 41-21-73(4) (2002); MONT. CODE ANN. § 53-21-127 (2002); NEB. REV. STAT. § 83-1038 (2002); N.H. REV. STAT. ANN. § 135-C:45 (2002); N.M. STAT. ANN. § 43-1-11 (Michie 2002); N.D. CENT. CODE § 25-03.1-21 (2001); OHIO REV. CODE ANN. § 5122.15 (West 2002); OKLA. STAT. ANN. tit. 43A, § 5-405 (West 2002); OR. REV. STAT. § 426.130(1) (2001); 50 PA. CONS. STAT. ANN. § 4406 (2002); R.I. GEN. LAWS § 40.1-5-8(j) (2001); S.C. CODE ANN. § 44-17-580 (Law. Co-op. 2002); S.D. Codified Laws § 27A-10-9 (Michie 2002); TEX. HEALTH & SAFETY CODE ANN. §§ 574.012, 574.036 (2001); VT. STAT. ANN. tit. 18, §§ 7617, 7618 (2002); VA. CODE ANN. § 37.1-67.3 (Michie 2002); WASH. REV. CODE ANN. § 71.05.240 (West 2002); W. VA. CODE § 27-5-4(o) (2002); WIS. STAT. ANN. § 51-20(13) (West 2002); WYO. STAT. ANN. § 25-10-110(j) (Michie 2002). New York does not authorize this form of outpatient commitment. See N.Y. MENTAL HYG. LAW § 9.37 (McKinney 2002). In Arizona, once the court finds by clear and convincing evidence that an individual meets the criteria for court-ordered treatment, “the court shall order the patient to undergo one of the following: 1. Treatment in a program of outpatient treatment[;] 2. Treatment in a program consisting of combined inpatient and outpatient treatment[; or] 3. Inpatient treatment” ARIZ. REV. STAT. ANN. § 36-540 (West 2002). Some states authorize the “least restrictive” court-ordered treatment, which is included as a form of outpatient treatment as a dispositional alternative. See, e.g., TEX. HEALTH & SAFETY CODE ANN. §§ 574.012, 574.036 (2001); WYO. STAT. ANN. § 25-10-110(j) (Michie 2002).

³² McCafferty & Dooley, *supra* note 15, at 279-80.

commit involuntarily an individual to treatment.³³ As of 1990, only three states authorized preventive commitment.³⁴ Preventive commitment statutes mandate treatment for individuals who do not meet the high standards for inpatient commitment but who are likely to face inpatient commitment in the near future if they do not receive immediate treatment.³⁵ Preventive commitment is an attempt to remedy the problem of “revolving door” patients, i.e., patients who, after being released from a hospital, subsequently stop taking medications, deteriorate and are

³³ Mark Moran, *Coercion or Caring?*, AM. MED. NEWS (Apr. 17, 2000) (debating whether outpatient commitment benefits the severely mentally ill or whether it is a “cop-out” for a failed mental health system), available at http://www.ama-assn.org/sci-pubs/amnews/pick_00/hlsa0417.htm. North Carolina is considered a pioneer in outpatient preventive commitment because it was the first state to enact an involuntary outpatient treatment statute in 1983. Wisor, Jr., *supra* note 14.

³⁴ McCafferty & Dooley, *supra* note 15; see also GA. CODE ANN. §§ 37-3-90, 37-3-1 (Supp. 1989); HAW. REV. STAT. § 334-127 (1985); N.C. GEN. STAT. § 122C-263 (1989). According to a more recent survey, the following ten states allow outpatient commitment without a finding of dangerousness: Alabama, Georgia, Hawaii, Mississippi, Montana, New York, North Carolina, Oregon, South Carolina and Texas. Moran, *supra* note 33.

³⁵ § 9.37. Preventive commitment statutes often apply a “grave disability” standard, which is a major shift in focus from commitment laws that require a standard of current dangerous behavior. M. SUSAN RIDGELY ET AL., RAND ORG., THE EFFECTIVENESS OF INVOLUNTARY OUTPATIENT TREATMENT: EMPIRICAL EVIDENCE AND THE EXPERIENCE OF EIGHT STATES (2001) (providing a comprehensive analysis of state outpatient commitment statutes), at <http://www.rand.org/publications/MR/MR1340/>. A grave disability standard requires only that an individual is dangerous because of an inability to care adequately for himself. *Id.* at 2. Current dangerousness, which is frequently the standard for inpatient hospitalization, requires a finding that an individual is overtly dangerous to himself or others. *Id.* Under North Carolina’s statute, for example, an individual is eligible for outpatient commitment if, “[b]ased on the respondent’s psychiatric history, the respondent is in need of treatment in order to prevent further disability or deterioration that would predictably result in dangerousness” N.C. GEN. STAT. § 122C-263(d)(1) (1989). See also Nisha C. Wagle et al., *Outpatient Civil Commitment Laws: An Overview*, 26 MENT. AND PHYSICAL DISABILITY L. REP. 179 (2002) (discussing the similarities and differences between the New York and North Carolina statutes).

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rehospitalized.³⁶ It is also a reflection of the state's *parens patriae* powers and the conflict between medical paternalism and individual autonomy.³⁷ Coerced medication compliance is the most important factor in preventive commitment.³⁸ Preventive commitment, however, has been criticized as simply a "form of judicial intimidation [because] [c]ompliance is achieved only if the person fears rehospitalization or mistakenly believes that the court's order must be obeyed."³⁹ As one commentator noted, "[p]reventive commitment is a backlash to the gains in mental patient autonomy over the past two decades."⁴⁰ Another critic noted that:

[T]he courts [now] 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 . . . which medications a patient must take to whether they spend their days learning word processing or taking pottery classes. Even such basic decisions as where to live and work can now be controlled by the courts.⁴¹

³⁶ Wisor, *supra* note 14, at 159-60 (discussing the "revolving door" dilemma and appropriate community responses to stop it).

³⁷ *Id.* at 168-69. One commentator has described medical paternalism as "the caring parent who nurtures and protects a child without waiting for permission." Mark J. Hauser & Archie Brodsky, *Paternalism in Mental Health Facilities: Resolving Conflicts over Telephone Access, Mail, and Visits*, at <http://www.psychiatry.com/advocacy/paternalism.html> (last visited Nov. 5, 2002). Medical paternalism refers to the notion that doctors can make decisions for their patients. *Id.*

³⁸ Wisor, *supra* note 14, at 161, 169.

³⁹ *Id.* at 171.

⁴⁰ *Id.* at 166.

⁴¹ Wendy Davis, *Insanity Pleas*, CITY LIMITS, May 2000 (arguing that Kendra's Law and mental hygiene courts generally have significant power, including the power to erode the rights of the mentally ill, especially the right to refuse medication), <http://www.citylimits.org/content/articles/articleView.cfm?articlenumber=326>. Davis discusses the example of John Sharpe, who has a psychotic disorder and history of numerous hospitalizations and, at the time Davis wrote her article, was a patient at Kingsboro Psychiatric Hospital. *Id.* Mr. Sharpe told the judge that he refused the medication because of the severe side effects, such as twitching. *Id.* The judge authorized the forcible

B. New York's Response—Kendra's Law

New York's support of outpatient commitment is a recent development.⁴² Prior to the 1990s, New York was the only state with a law that explicitly prohibited outpatient commitment.⁴³ One purpose of New York's shift was to close the loophole of lack of services to the mentally ill due to the high standard of dangerousness required for involuntary inpatient commitment.⁴⁴ Without involuntary outpatient treatment, the only mandated treatment available, inpatient hospitalization, required a finding by two physicians that the individual was currently a danger to himself or others, a difficult standard to meet.⁴⁵ Unlike statutes that utilize a grave disability standard, New York's pilot project

administration of the medication anyway, and Mr. Sharpe was then injected with Prolixin, an anti-psychotic that can cause muscle spasms, eye paralysis and permanent neurological damage. *Id.*

⁴² Watnik, *supra* note 14, at 1191. New York does not authorize outpatient commitment as an alternative if an individual meets the criteria for civil inpatient commitment. N.Y. MENTAL HYG. LAW § 9.37 (McKinney 2002). Before Kendra's Law, New York required a finding of immediate danger of serious harm to oneself or others prior to initiating commitment proceedings. *Id.* Involuntary inpatient hospitalization requires a finding that an individual "has a mental illness for which immediate inpatient care and treatment in a hospital is appropriate and which is likely to result in serious harm to himself or herself or others The need for immediate hospitalization shall be confirmed by a staff physician of the hospital prior to admission." *Id.* If the patient is to be retained involuntarily beyond seventy-two hours, the certificate of another examining physician concluding that the patient is in need of involuntary care and treatment must be filed. *Id.* If a New York court determines that an individual meets the civil inpatient commitment criteria, the individual must be hospitalized. *Id.* See also McCafferty & Dooley, *supra* note 15, at 279 n.70 (listing states which do authorize outpatient treatment as an alternative to inpatient hospitalization).

⁴³ See Gutterman, *supra* note 14, at 2409; Watnik, *supra* note 14, at 1191.

⁴⁴ § 9.37. Inpatient hospitalization is only appropriate when two physicians find an individual is likely to commit serious harm to himself or others if not committed. *Id.*

⁴⁵ See discussion *supra* note 42 (explaining the requirements of involuntary inpatient hospitalization).

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and Kendra's Law employ the "likelihood of physical harm to self or others" standard.⁴⁶ This lower standard is easier to meet, thus leading to a greater number of individuals eligible for involuntary commitment.

1. Origins of Kendra's Law: The Bellevue Pilot Project

In 1994, New York enacted legislation that created an outpatient commitment program at Bellevue Hospital in New York City—the Bellevue Pilot Project.⁴⁷ Only those who met nine criteria were eligible for involuntary outpatient treatment under the project, which was the precursor to Kendra's Law:

- (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 [Bellevue] . . . ; 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

⁴⁶ RIDGELY, *supra* note 35, at 33, 37-38.

⁴⁷ N.Y. MENTAL HYG. LAW § 9.61 (repealed 1999). Opponents of New York's outpatient commitment statute argued that section 9.61 was a "political maneuver intended to appease a frightened and frustrated public." POLICY RESEARCH ASSOCIATES, INC., FINAL REPORT: RESEARCH STUDY OF THE NEW YORK CITY INVOLUNTARY OUTPATIENT COMMITMENT PILOT PROGRAM 16 (1998) [hereinafter PRA REPORT]. The Legislature enacted section 9.61 after a decade-long effort to extend the state's *parens patriae* power to include "gravely disabled" mentally ill individuals living on the street. *Id.* The majority of these individuals were more dangerous to themselves due to their environmental circumstances, but occasionally they became a public nuisance and received media attention. *Id.* For example, Larry Hogue was cited as a prime example of the necessity for outpatient commitment. *Id.* Hogue was "a homeless veteran who was both actively psychotic and a crack cocaine addict" and who allegedly terrorized the Upper West Side of Manhattan. *Id.* Neither police nor the mental health system were able to help him or the neighborhood. *Id.* Hogue, ironically, would most likely not have been eligible for services under the pilot project due to concerns regarding liability for his dangerousness. *Id.*

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 treatment program of such hospital is willing and able to provide the involuntary outpatient treatment ordered.⁴⁸

Interestingly, studies of the Bellevue Pilot Project showed that mandatory treatment did not make a significant difference in a patient's recovery.⁴⁹ Two groups of researchers studied the project: Policy Research Associates (PRA) and Bellevue Hospital.⁵⁰ The PRA study assigned individuals randomly to either the control group or the experimental court-ordered group.⁵¹ Researchers interviewed subjects prior to discharge from the hospital and in the community at one, five and eleven months.⁵² The key findings of the PRA study are:

[1.] No statistically significant differences were found between the experimental and control groups for acute or state rehospitalizations in terms of the proportion rehospitalized or the amount of days spent hospitalized in the 11-month follow-up. [2.] For both the experimental

⁴⁸ § 9.61(c). The eligibility criteria did not focus on patients with a documented history of violence, the supposed targets of the legislation. PRA REPORT, *supra* note 47, at 47.

⁴⁹ PRA REPORT, *supra* note 47. *See also* Michael A. Riccardi, *Courts Make Kendra's Law Work*, N.Y.L.J., May 7, 2001, at 1.

⁵⁰ PRA REPORT, *supra* note 47; HOWARD TELSON ET AL., REPORT OF THE BELLEVUE HOSPITAL CENTER OUTPATIENT COMMITMENT PILOT PROGRAM (1999), available at <http://www.psychlaws.org/MedicalResources>.

⁵¹ *See* TELSON, *supra* note 50. Those in the control group received outpatient treatment as part of their discharge plans. *Id.* at 12. The study consisted of 78 patients under an AOT and 64 control patients. PRA REPORT, *supra* note 47, at i.

⁵² PRA REPORT, *supra* note 47, at i.

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and control subjects, a statistically significantly smaller proportion were rehospitalized during the 11 month follow-up in OCP as compared to the year preceding the target admission. [3.] Arrests during the follow-up period revealed no violence against persons for either group and relatively few subjects arrested overall, 16% for controls and 18% for experimentals. There were no differences between the control and experimental group on indicators for any arrest, multiple arrests, number of arrests, or most serious charge. [4.] The control and experimental groups overall were not significantly different on any quality of life or symptomatology outcome measures. [5.] There were no significant differences in the number of clients in the two groups who discontinued treatment—27% for the experimental group and 26% for the control group.⁵³

Notably, the researchers found “[t]here is no indication that, overall, the court order for outpatient commitment produces better outcomes for clients of the community than enhanced services alone. However, both groups appeared to profit from the enhanced services”⁵⁴

While New York’s legislature was still exploring the issue, Kendra Webdale’s death occurred, spurring the state to expedite the implementation of outpatient commitment throughout the state

⁵³ PRA REPORT, *supra* note 47, at ii (references to Tables omitted). “For the experimental subjects the proportion went from 87.1% to 51.4% and for the controls from 80% to 41.6% with a hospitalization.” *Id.* at ii. Critics have argued that the PRA study has its limitations as well. RIDGELY, *supra* note 35, at 26. For example, providers were unclear as to who was under an AOT order and therefore did not consistently enforce the orders. *Id.* Also, more individuals under a court order also suffered from substance abuse as compared to the control group (56% and 39% respectively). *Id.* Critics additionally assert that the study suffers from small sample size. *Id.* PRA acknowledges that the pilot project “never reached the fully executed, clinicians-working-with-law-enforcement-officers, preventive detention version intended by the legislature.” PRA REPORT, *supra* note 47, at 46.

⁵⁴ PRA REPORT, *supra* note 47, at ii.

in only eight months.⁵⁵ In enacting Kendra's Law, the legislature found:

there are mentally ill persons who are capable of living in the community with the help of family, friends, and mental health professionals, but who, without routine care and treatment, may relapse and become violent or suicidal, or require hospitalization The legislature further finds that some mentally ill persons, because of their illness, have great difficulty taking responsibility for their own care, and often reject the outpatient treatment offered them on a voluntary basis.⁵⁶

This legislative finding particularly reflects the state's assertion of its paternalistic *parens patriae* power.⁵⁷

Prior to Kendra's Law, the real problem was lack of available treatment for individuals with mental illness. For example,

⁵⁵ Jones, *supra* note 4. In addition to Kendra's death in January of 1999, other similar incidents occurred that same year. See Nisha C. Wagle et al., *Outpatient Civil Commitment Laws: An Overview*, 26 MENT. AND PHYSICAL DISABILITY L. REP. 179 (2002). In April 1999 two incidents of violence by men with mental illness occurred: a man swung a sword on the Long Island Rail Road and a man pushed another man into an oncoming subway train. *Id.* at 179. Tragically, subway pushing is not a new phenomenon since similar incidents occurred in prior years. Kirsten Danis, *Horror on the Tracks: Flashback to Terror of Days Gone By*, N.Y. POST, Jan. 4, 1999, at 4. In February of 1996 a teen with mental illness pushed a young woman to her death from a train. See *id.* In January of 1995, an escaped mental patient pushed an elderly woman in front of a train, causing her death. *Id.* New York adopted Kendra's Law on August 9, 1999. S. 5762-A, 222d Sess. (N.Y. 1999). Kendra's Law passed both houses of the legislature by an overwhelming majority: 49 to 2 in the Senate and 142 to 4 in the Assembly. Jonathan Stanley, *Getting Care to Those Most in Need* (Jan. 2000) (describing the large support for Kendra's Law by both houses), at <http://www.naswnyc.org/mhs4.html>.

⁵⁶ 1999 N.Y. Laws 408, § 2. "Effective mechanisms for accomplishing these ends include[] the establishment of assisted outpatient treatment" *Id.* "The legislature further finds that if such court-ordered treatment is to achieve its goals, it must be linked to a system of comprehensive care" *Id.*

⁵⁷ See *supra* Part I.A (discussing the state's *parens patriae* power in outpatient commitment).

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Andrew Goldstein, the man who pushed Kendra Webdale in front of the train, ironically, would not likely have been subject to an AOT order, which is limited to individuals who are noncompliant with treatment.⁵⁸ In fact, Mr. Goldstein had sought commitment or supervised living no fewer than thirteen times.⁵⁹ Each time, he was discharged and denied help due to a lack of funding.⁶⁰ In reality, “the contemporary problem [in mental health treatment] is obtaining treatment, not refusing its imposition.”⁶¹

The Legislature enacted Kendra's Law, disregarding the significant research findings from the Bellevue Pilot Project suggesting that court orders are ineffective.⁶² Additionally, research shows that only a small number of people with severe and persistent mental illness are at risk of becoming violent.⁶³ Kendra's Law is, therefore, a hasty enactment that is unresponsive to the real problem of providing community treatment to individuals with mental illness.

2. Kendra's Law in a Nutshell

Kendra's Law authorizes an AOT program,⁶⁴ which provides case management services or assertive community treatment to an individual with mental illness and may include other services ordered by the court.⁶⁵ Case management is a method of

⁵⁸ Moran, *supra* note 33; *see* N.Y. MENTAL HYG. LAW § 9.60 (McKinney 2002).

⁵⁹ Gutterman, *supra* note 14, at 2439.

⁶⁰ *Id.*

⁶¹ Paul F. Stavis, *The George Mason University First Annual Forum on Mental Illness and the Law*, 11 GEO. MASON U. CIV. RTS. L.J. 1, 7 (Winter 2000) (describing the history of mental health treatment and changes in law and policies).

⁶² Moran, *supra* note 33; RIDGELY, *supra* note 35. *See supra* text accompanying notes 49-54 (discussing the findings of the researchers who studied the Bellevue Pilot Project).

⁶³ American Psychiatric Association, *Fact Sheet: Violence and Mental Illness* (1998), available at http://www.psych.org/public_info/violence.pdf.

⁶⁴ N.Y. MENTAL HYG. LAW § 9.60 (McKinney 2002).

⁶⁵ Moran, *supra* note 33. Other services that the court may include in an AOT order are:

coordinating treatment and care in the community. It entails a case manager “develop[ing] care plans, arrang[ing] for services to be provided, monitor[ing] the care provided, and maintain[ing] contact with the individual.”⁶⁶ Aimed at keeping individuals in contact with a variety of services, assertive community treatment (“ACT”) is a model of treatment that uses a team approach to provide comprehensive, community-based psychiatric treatment, rehabilitation, and support.⁶⁷

In order to obtain an AOT order in New York, an individual authorized by the statute to file a petition must state the facts that support the belief that a patient meets all of the criteria.⁶⁸

medication; periodic blood tests or urinalysis to determine compliance with prescribed medications; individual or group therapy; day or partial day programming activities; educational and vocational training or activities; alcohol or substance abuse treatment and counseling and periodic tests for the presence of alcohol or illegal drugs for a person with a history of alcohol or substance abuse; supervision of living arrangements; and any other services . . . 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.

N.Y. MENTAL HYG. LAW § 9.60(a)(1) (McKinney 2002).

⁶⁶ RIDGELY, *supra* note 35, at 29.

⁶⁷ *Id.* at 28. An ACT team typically includes psychiatrists, nurses, social workers, peer advocates, and other professionals working together. *Id.*

⁶⁸ N.Y. MENTAL HYG. LAW § 9.60(e) (McKinney 2002). Under Kendra’s Law, a petition may be initiated by:

(i) any person eighteen years of age or older with whom the subject of the petition resides; or (ii) the parent, spouse, sibling eighteen years of age or older, or child eighteen years of age or older of the subject of the petition; or (iii) the director of a hospital in which the subject of the petition is hospitalized; or (iv) the director of any public or charitable organization, agency or home providing mental health services to the subject of the petition in whose institution the subject of the petition resides; or (v) a qualified psychiatrist who is either supervising the treatment of or treating the subject of the petition for a mental illness; or (vi) the director of community services, or his or her designee, or the social services official, as defined in the social services law, of the city or county in which the subject of the petition is present or reasonably believed to be present;

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Whereas the Bellevue Pilot Project established nine criteria for determining the eligibility of a patient,⁶⁹ under Kendra's Law a patient qualifies for an AOT order if seven criteria are met:⁷⁰

(1)[T]he patient is eighteen years of age or older; (2) the patient is suffering from a mental illness; (3) the patient is unlikely to survive safely in the community without supervision, based on a clinical determination; (4) the patient has a history of lack of compliance with treatment for mental illness that has: (i) at least twice within the last thirty-six months been a significant factor in necessitating hospitalization . . . or receipt of services in a . . . mental health unit of a correctional facility . . . or; (ii) resulted in one or more acts of serious violent behavior toward self or others or threats of, or attempts at, serious physical harm to self or others within the last forty-eight months . . . ; and (5) the patient is, as a result of his or her mental illness, unlikely to voluntarily participate in the recommended treatment; and (6) 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.⁷¹

A physician's affirmation or affidavit must accompany the

or (vii) a parole officer or probation officer assigned to supervise the subject of the petition.

§ 9.60(e)(1). "A petition . . . may be filed in the supreme or county court in the county in which the subject . . . is present." § 9.60(e)(1). In addition to each criterion, the petitioner must state the facts which support the petitioner's belief that the subject meets each criterion and the subject is present within the county. § 9.60(e)(2).

⁶⁹ See *supra* text accompanying note 48 (listing the Bellevue Pilot Project criteria).

⁷⁰ § 9.60(c).

⁷¹ *Id.* Some of these eligibility requirements, such as (3) and (5), require a physician to make predictions, which is not possible in psychiatry or psychology. TELSON, *supra* note 50, at 15. "Many factors influence a patient's clinical course in the community." *Id.* at 22.

petition.⁷² At the hearing, the examining physician must then testify and provide the court with a proposed written treatment plan.⁷³ A court may then order assisted outpatient treatment only if the court finds by clear and convincing evidence that a patient meets the criteria, but it must dismiss the petition if any one of the criteria is not met.⁷⁴

Once ordered, a patient must accept the treatment.⁷⁵ Failure to comply with an AOT order may lead to involuntary hospital admission for up to seventy-two hours for observation, care and treatment.⁷⁶ Efforts must first be made to solicit compliance, though.⁷⁷ And, involuntary retention beyond seventy-two hours is

⁷² § 9.60(e)(3). If the petitioner is the treating physician, the affirmation must be from a different physician. *Id.* “The petition shall be accompanied by an affirmation or affidavit of a physician, who shall not be the petitioner” *Id.*

⁷³ § 9.60(h)(2). “The court shall not order assisted outpatient treatment unless an examining physician . . . testifies in person at the hearing.” *Id.* “The court shall not order assisted outpatient treatment unless an examining physician . . . develops and provides to the court a proposed written treatment plan.” § 9.60(i)(1).

⁷⁴ § 9.60(j). “If after hearing all relevant evidence, the court finds that the subject of the petition does not meet the criteria for assisted outpatient treatment, the court shall dismiss the petition.” § 9.60(j)(1). If the court “finds by clear and convincing evidence that the subject of the petition meets the criteria . . . , and there is no appropriate and feasible less restrictive alternative,” the court shall authorize AOT. § 9.60(j)(2); *see also infra* Part I.B.4 and accompanying notes (discussing the court’s authority to dismiss the petition or order alternatives).

⁷⁵ Watnik, *supra* note 14, at 1199.

⁷⁶ § 9.60(n):

Where in the clinical judgment of a physician, the patient has failed or has refused to comply with the treatment ordered by the court, and in the physician’s clinical judgment, efforts were made to solicit compliance, and, in the clinical judgment of such physician, such patient may be in need of involuntary admission to a hospital . . . , or for whom immediate observation, care and treatment may be necessary . . . such physician may request . . . the removal of such patient to an appropriate hospital

Id.

⁷⁷ *Id.*

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permissible only when the individual meets the grounds for involuntary civil commitment.⁷⁸

Kendra's Law takes away some of the procedural safeguards and protection of rights that were in place under the Bellevue Pilot Project.⁷⁹ These differences effectively increase the number of individuals eligible for AOT.⁸⁰ Additionally, under the pilot project, the proposed written treatment plan was part of the application.⁸¹ Kendra's Law requires only that the treatment plan be submitted before the court can order AOT, which means that the individual who is the subject of the petition and his lawyer may not learn about the plan before the hearing.⁸² This change

⁷⁸ § 9.60(n). Involuntary civil commitment requires a finding by two physicians that a person "has a mental illness for which immediate inpatient care and treatment in a hospital is appropriate and which is likely to result in serious harm to himself or herself or others." N.Y. MENTAL HYG. LAW § 9.37 (McKinney 2002).

⁷⁹ Compare N.Y. MENTAL HYG. LAW § 9.61 (repealed 1999) with § 9.60. One of the differences is in the fourth criteria. Compare § 9.61 with § 9.60. The pilot project required that a subject be currently hospitalized; under Kendra's Law, the subject may now be in the community. Compare § 9.61 with § 9.60. The third criteria also changed. Compare § 9.61 with § 9.60. The pilot project required a finding that the "patient is incapable of surviving safely in the community"; Kendra's Law lowered the standard to a finding of "unlikely to survive safely in the community." Compare § 9.61 with § 9.60. Additionally, the hospitalization "lookback period," the length of time that the court may consider prior acts of noncompliance, increased. Compare § 9.61 with § 9.60. Under the pilot project, the lookback period was only eighteen months; Kendra's Law extends the period to thirty-six. Compare § 9.61 with § 9.60. Also Kendra's Law offers an alternative avenue—not available under the pilot project—for a finding of lack of compliance if the subject does not meet the hospitalization requirement: violent behavior within the last forty-eight months. Compare § 9.61 with § 9.60. Lastly, under the pilot project, only the director of a hospital could petition for an AOT order, but Kendra's Law authorizes petitions from a number of different individuals. Compare § 9.61 with § 9.60; see also Kristina M. Campbell, Note, *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) (discussing the differences between sections 9.60 and 9.61).

⁸⁰ Compare § 9.61 with § 9.60; see also Campbell, *supra* note 79.

⁸¹ § 9.61(d)(2)(iii).

⁸² § 9.60(i).

significantly limits the ability of the individual to contest any aspects of the treatment plan. Furthermore, Kendra's Law narrows the time frame for a hearing from five days to three.⁸³ These changes seriously limit a respondent's ability to challenge an AOT petition, thereby lessening substantive due process protections.

3. *Constitutional Challenges to Kendra's Law*

Thus far, Kendra's Law has withstood constitutional challenges in the lower state courts.⁸⁴ The first case to challenge the constitutionality of the law was *In re Urcuyo*, in which the respondents argued that Kendra's Law violated both the Due Process Clause of the New York Constitution and the Equal Protection Clause of the New York and United States constitutions.⁸⁵ Relying on the fact that patients have the capacity to participate actively in the treatment plan, the court held that the law did not violate a patient's fundamental constitutional due process right to choose the course of his treatment.⁸⁶ Specifically, the court noted that, under Kendra's Law, "there is no forcible

⁸³ Compare § 9.61(f)(1) with § 9.60(h).

⁸⁴ See *In re Urcuyo*, 714 N.Y.S.2d 862, 865 (N.Y. Sup. Ct. 2000); *In re Martin*, N.Y.L.J., Jan. 9, 2001, at 31 (N.Y. Sup. Ct. Jan. 8, 2001).

⁸⁵ 714 N.Y.S.2d 862, 865 (N.Y. Sup. Ct. 2000). Outpatient mental health treatment providers sought declaratory relief regarding the constitutionality of Kendra's Law. *Id.* The court rejected arguments that Kendra's Law violates an individual's due process rights without a finding that an individual lacks the capacity to make a reasoned treatment decision. *Id.* The court also rejected the argument that it violates equal protection because it treats AOT subjects differently from individuals subject to guardianship proceedings and involuntary inpatients. *Id.*

⁸⁶ *Id.* The court drew on its own experience in presiding over Kendra's Law hearings in Brooklyn, stating specifically that individuals facing an AOT order usually have the capacity to make treatment decisions. *Id.* The court noted "[t]he practical result of requiring a lack of capacity component to be added to the statutory scheme would be to eliminate the option of an Assisted Outpatient Treatment order for many patients." *Id.* at 869. See also discussion *infra* Part II.C (discussing the right to determine one's own course of treatment).

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administration of medication and the patient will suffer no punitive measures for failing to comply.”⁸⁷ The court further explained that failure to comply only leads to heightened scrutiny by the physician as to whether or not the patient may be in need of inpatient hospitalization.⁸⁸ The petitions in *In re Urcuyo* were ultimately withdrawn, making it impossible to appeal and obtain a higher court ruling on the law.⁸⁹

In January 2001, *In re Martin* again challenged the constitutionality of Kendra's Law.⁹⁰ In *In re Martin*, respondents argued that due process and equal protection require a finding of incapacity before forcing an individual to undergo treatment.⁹¹ The court again concluded that Kendra's Law was constitutional, finding that “the patient is invited to participate in the formulation of his treatment plan” and that “no drugs or treatment will be forced upon him if he fails to comply with the treatment plan.”⁹² Similar to the court in *In re Urcuyo*, the court

⁸⁷ *In re Urcuyo*, 714 N.Y.S.2d at 868.

⁸⁸ *Id.* at 869-70.

⁸⁹ *In re Martin*, N.Y.L.J., Jan. 9, 2001, at 31 (N.Y. Sup. Ct. Jan. 8, 2001); Fred Cohen, *Assisted Outpatient Treatment: Review of New York Case Law—And Beyond*, 3 CORRECTIONAL MENT. HEALTH REP. 1, (July/Aug. 2001) (arguing that the expectation is that *Martin* petition, unlike the *Urcuyo* petition, will remain viable and appealable so long as the petitions are not withdrawn), available at <http://www.psychlaws.org/generalresources/article48.htm>.

⁹⁰ N.Y.L.J., Jan. 9, 2001, at 31 (N.Y. Sup. Ct. Jan. 8, 2001). The director of a psychiatric hospital sought an AOT order against respondent patient, who opposed it on the ground that it was unconstitutional. *Id.* The court rejected the respondent's argument that due process and equal protection require a finding of incapacity before an AOT petition may be granted. *Id.* The court also denied respondent's argument that notice and a hearing should be required prior to being arrested and detained for alleged failure to comply. *Id.* The court was deferential to the legislature: “[I]t is presumed that the Legislature has investigated and found facts necessary to support the legislation.” *Id.* In its conclusion, the court stated, “Kendra's Law is a carefully crafted, well drawn and narrowly tailored enactment specifically directed toward the solution of serious problems faced by society and mentally ill persons.” *Id.*

⁹¹ *Id.*

⁹² *Id.* The court also concluded that the finding that the individual is

in *In re Martin* reasoned that failure to comply only leads to heightened scrutiny from a physician regarding the need for hospitalization and that re-confinement is far from automatic.⁹³ The court also held that Kendra's Law complied with due process requirements even though it does not require a pre-revocation hearing prior to arrest or hospitalization because the existence of a potential emergency supports the important governmental interest of protecting the individual and society.⁹⁴

The courts are correct that, on its face, the statute requires participation and proscribes forcibly medicating an individual.⁹⁵ In practice, however, the application of Kendra's Law may be less protective of an individual's interests.⁹⁶ Neither the courts nor the legislature have defined the meaning and level of participation sufficient to protect due process.⁹⁷

4. Judicial Restraint

Kendra's Law has also been challenged on non-constitutional

unlikely to participate voluntarily in treatment is "analogous to the finding of lack of capacity necessary for the forcible administration of medication." *Id.*

⁹³ *Id.*

⁹⁴ *Id.* A review of due process challenges in other states that allow revocation of outpatient commitment status and hospitalization of an individual suggests that respondents are unlikely to win on this issue if appealed. *See, e.g., In re K.B.*, 562 N.W.2d 208, 211 (Mich. Ct. App. 1997) (holding that statutory procedures that do not include a revocation hearing did not violate due process because of the due process protections in the original commitment proceeding); *In re True*, 645 P.2d 891 (Idaho 1982) (holding that due process requires prompt written notice and a revocation hearing as soon as reasonably possible following the patient's rehospitalization). *But see State v. Bryant*, 871 P.2d 129, 132 (Or. Ct. App. 1994) (allowing for a revocation hearing prior to hospitalization but finding that due process does not require the state to prove that the person remains mentally ill in order to revoke outpatient commitment).

⁹⁵ N.Y. MENTAL HYG. LAW § 9.60 (McKinney 2002).

⁹⁶ *See* discussion *infra* Part II.C (examining how Kendra's Law erodes the right to determine the course of own's treatment which includes the right to refuse medication).

⁹⁷ *See In re Martin*, N.Y.L.J., Jan. 9, 2001, at 31; *In re Urcuyo*, 714 N.Y.S.2d 862 (N.Y. Sup. Ct. 2000); § 9.60.

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grounds. For example, Kendra's Law severely restricts judicial discretion when reviewing petitions.⁹⁸ Specifically, a court "may not order treatment that has not been recommended by the examining physician and included in the written treatment plan."⁹⁹ This judicial restraint limits the judge's inquiry solely to the question of whether an individual meets all of the criteria for AOT.¹⁰⁰

In a recent decision, the Appellate Division, First Department, found that, when deciding whether to grant an AOT petition, a court does not have the authority to decide if a patient should be released from a hospital.¹⁰¹ The First Department reasoned that the hospital must already have considered releasing the patient and have concluded that AOT is a viable alternative to hospitalization if it is seeking an AOT order.¹⁰² The court clearly stated that a patient may not be hospitalized simply because an AOT petition was denied.¹⁰³

Another court found it had no choice but to approve a "woefully inadequate" treatment plan for an individual the court

⁹⁸ § 9.60(j). Under Kendra's Law, a court must dismiss the petition if all of the criteria are not met. *Id.* A court, however, is not required to order AOT even if all of the criteria are satisfied. *Id.*

⁹⁹ § 9.60(j)(2).

¹⁰⁰ *Id.*

¹⁰¹ *In re Manhattan Psychiatric Ctr.*, 728 N.Y.S.2d 37 (N.Y. App. Div. 2001). The psychiatric hospital petitioned for an AOT order against respondent in March 2000, but the court held the order "in abeyance subject to independent psychiatrist concurring in release." *Id.* Counsel for the hospital subsequently argued that it may have no legal means to retain the patient until the independent examination. *Id.* The Appellate Division concurred with the hospital's counsel that "while it is within the discretion of the hospital director to determine whether to apply for an order, it is for the court to determine whether the director's petition meets the statutory prerequisites" *Id.* The hospital has already decided that release is appropriate, and "that decision is not at issue in the AOT proceeding." *Id.*

¹⁰² *Id.*

¹⁰³ *Id.* Specifically, the court stated that "[f]or a person residing in the community, the alternative to dismissal of a petition because the criteria for AOT are not met is not admission to a hospital" *Id.*

felt should not be released under any circumstances.¹⁰⁴ The court concluded that it does not appear from the statute, and in light of the Appellate Division decision, that “the court can scrutinize the plan and require improvements in it. Thus the court must either accept or reject this plan.”¹⁰⁵ Thus, Kendra’s Law effectively shuts down judicial review regarding the wisdom or propriety of AOT petitions.

Although courts may not agree with the strict requirements, the Legislature may have desired to keep power out of the courts.¹⁰⁶ One possible reason for the lack of discretion is that the Legislature may believe that doctors and hospitals are in a better position to decide when to release a patient and when he is in need of AOT. Lack of discretion, furthermore, protects an individual from arbitrary decisions regarding the need for an AOT order. The legislature, however, should consider allowing judges some discretion, or at least allowing judges to suggest improvements in the treatment plan, as an alternative.

¹⁰⁴ *In re Endress*, 732 N.Y.S.2d 549 (N.Y. Sup. Ct. 2001). Barry H. had a long history of numerous psychiatric hospitalizations and criminal justice contacts due to his schizophrenia. *Id.* The proposed treatment plan included living in a rooming house, supervision during the day, medication and supervised employment. *Id.* Mr. H. explicitly told the court that he was unwilling to comply with any long-term outpatient treatment. *Id.* At the hearing, hospital doctors expressed a concern that he was still a danger to himself or others. *Id.* The court did not want to discharge him from the hospital but felt it had no alternative. *Id.*; see also Tom Perrotta, *Judge Frustrated by Flaws in Kendra’s Law*, N.Y.L.J., Oct. 18, 2001, at 1.

¹⁰⁵ *In re Endress*, 732 N.Y.S.2d at 554. Another Judge, Norman C. Ryp, Supreme Court, New York County, who presided over the first jury trial appeal, has also spoken out about the lack of judicial discretion under Kendra’s Law. Norman C. Ryp, Letter to the Editor, *Kendra’s Law Needs Review*, N.Y.L.J., Oct. 30, 2001, at 2 (calling for legislative review and evaluation).

¹⁰⁶ During the pilot project, individuals lodged complaints regarding the role of judges. TELSON, *supra* note 50, at 18. Specifically, complaints arose when judges limited testimony that doctors or patients wanted to introduce, relying instead on the physician’s affidavit, or when judges failed to review the entire treatment plan. *Id.*

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II. PROTECTION AND INFRINGEMENT OF RIGHTS

Although the Legislature specifically found that Kendra's Law was "compassionate, not punitive, [and] will restore patients' dignity," certain aspects of the law do not respect a patient's rights to due process, autonomy, liberty and privacy.¹⁰⁷ Specifically, Kendra's Law infringes on the necessary right to counsel, the fundamental right to refuse treatment and privileges necessary for confidential treatment.

A. Protection of Due Process

Kendra's Law has a high standard for eligibility.¹⁰⁸ One of the first reported cases, *In re Sullivan*, found that the "specificity in pleading required under Kendra's Law is not to be taken lightly."¹⁰⁹ In fact, the court held that specificity was necessary to protect a respondent's due process rights, enable a respondent to prepare a defense and permit the court to make an informed decision regarding the need for AOT.¹¹⁰ The court also found the physician's supplemental affirmation insufficient because it "neither state[d] that the allegations [were] based upon the

¹⁰⁷ 1999 N.Y. Laws 408, § 2.

¹⁰⁸ N.Y. MENTAL HYG. LAW § 9.60 (McKinney 2002); *see also In re Martin*, N.Y.L.J., Jan. 9, 2001, at 31 (N.Y. Sup. Ct. Jan. 8, 2001) (discussing procedural due process protections provided for in Kendra's Law).

¹⁰⁹ 710 N.Y.S.2d 853, 856 (2000).

¹¹⁰ *Id.* In this case, the physician submitted an affidavit that made conclusory statements rather than citing specific facts. *Id.* The doctor stated in his affirmation, "without any supporting documentation or specification, that the respondent 'has a long history of noncompliance with aftercare followup [sic] and medications which has led to physically violent behavior resulting in hospitalizations and criminal incarcerations.'" *Id.* at 856-57. He further states that respondent "has a 'previous history of homelessness that has led to incarcerations and hospitalizations for dangerous behavior.'" *Id.* at 857. Then he stated that respondent "has a history of lack of compliance with treatment that has resulted in one or more acts of serious violent behavior toward self or others" *Id.* The court concluded that the language of the doctor's statements suggested that he tailored his statements to satisfy the statutory language. *Id.*

personal knowledge of [the doctor] nor identifie[d] the source of such information.”¹¹¹ Heightened specificity ensures procedural due process, which in turn ensures that only individuals appropriate for AOT will be correctly found eligible.¹¹² One court expressed concern, however, that judges, “motivated more by protecting the public rather than compelling patients to get needed treatment[,] may decide to err on the side of caution.”¹¹³

B. Right to Counsel

The right to counsel is a fundamental protection against the risk of erroneous deprivation of liberty.¹¹⁴ Kendra’s Law safeguards this right by providing for representation by Mental Hygiene Legal Services (“MHLS”), lawyers who represent respondent outpatients at all stages of a proceeding.¹¹⁵ The law, however, does not specify when the proceedings begin and, thus, when the right to counsel attaches.¹¹⁶ MHLS has argued that the

¹¹¹ *Id.* at 857.

¹¹² *Id.*

¹¹³ Yael Schacher, *Experts Disagree Over the Success of Kendra’s Law*, N.Y.L.J., June 30, 2000, at 1 (quoting Justice DiBlasi, Westchester County Supreme Court).

¹¹⁴ Watnik, *supra* note 14. *See also* *Lassiter v. Dept. of Soc. Services of Durham County, N.C.*, 452 U.S. 18 (1981) (finding a right to counsel for parents whose rights are subject to termination in certain circumstances); *In re Gault*, 387 U.S. 1 (1967) (finding a right to counsel in juvenile delinquent proceedings); *Rivers v. Katz*, 495 N.E.2d 337 (N.Y. 1986) (finding a right to counsel for an involuntarily committed inpatient at a hearing where the state wants to administer antipsychotic medication against the individual’s wishes); *People ex rel. Rogers v. Stanley*, 17 N.Y.2d 256 (1966) (finding a right to counsel for individuals in involuntary commitment proceedings). “[T]here is a right to appointed counsel only where the indigent, if he is unsuccessful, may lose his personal freedom.” *Lassiter*, 452 U.S. at 20. *See also* *Matthews v. Eldridge*, 424 U.S. 319 (1976) (outlining three elements to be balanced when deciding what due process requires).

¹¹⁵ N.Y. MENTAL HYG. LAW § 9.60(g) (McKinney 2002); *see also* N.Y. MENTAL HYG. LAW § 47.03(c) (McKinney 2002) (describing the functions of MHLS with respect to AOT).

¹¹⁶ § 9.60(g). “The subject of the petition shall have the right to be represented by [MHLS], or other counsel . . . at all stages of a proceeding

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right to counsel begins when the individual is being examined.¹¹⁷ If the right attaches at the time of the examination, counsel could ensure 'participation' in the treatment plan.¹¹⁸ Attaching the right prior to the filing of the petition, though, is more costly and could overwhelm MHLS.¹¹⁹ The courts or the legislature should clarify when the right to counsel attaches.

While providing for legal representation may give the appearance that Kendra's Law protects procedural due process rights, the right to counsel under Kendra's Law is less meaningful given some other aspects of the law.¹²⁰ For example, Kendra's Law requires a court hearing within three days after the petition is filed.¹²¹ This brief period provides insufficient time for MHLS to prepare a case or even meet the client,¹²² especially considering that MHLS often does not receive the petition containing the doctor's findings until the day after filing.¹²³ As a result, MHLS attorneys often do not have the opportunity to see their clients prior to their hearings.¹²⁴ Additionally, the law allows for the treatment plan to be submitted at the time of the

commenced under this section." *Id.*; see also D.J. Jaffe, *Report on the New York City Bar's Forum on Kendra's Law*, at <http://www.psychlaws.org/StateActivity/NewYork/NYCBBarForum.htm> (last visited Nov. 5, 2002).

¹¹⁷ Jaffe, *supra* note 116.

¹¹⁸ *Id.*

¹¹⁹ See Watnik, *supra* note 14, at 1209. Critics "expressed concern that MHLS is underfunded and is often unable to provide attorneys." *Id.* "[T]he [legal] system could become overburdened as the demand for lawyers increases." *Id.* at 1218. Wisconsin provides legal counsel once the petition is filed. WIS. ST. ANN. § 51.20(3) (West 2002) (assigning legal counsel at the time of the filing of the petition).

¹²⁰ N.Y. MENTAL HYG. LAW § 9.60(g) (McKinney 2002).

¹²¹ § 9.60(h). The requirement that the hearing be held three days after the filing of the petition is, on its face, insufficient for any attorney to adequately defend a client. The issue is beyond the scope of this note.

¹²² Watnik, *supra* note 14, at 1209.

¹²³ Jaffe, *supra* note 116.

¹²⁴ Michael A. Riccardi, *Courts Make Kendra's Law Work*, N.Y.L.J., May 7, 2001, at 1. Judges, however, have been receptive to granting extensions. Jaffe, *supra* note 116.

hearing.¹²⁵ This does not provide sufficient time for an attorney to rebut the plan.¹²⁶ Also, the law does not require that the defending attorney be notified when a warrant has been issued for a client's alleged failure to comply.¹²⁷ Attorneys with MHLS have thus requested that the court include on the AOT order mandatory notification when allegations of noncompliance spark the issuance of a warrant.¹²⁸ Some lower courts have added attorney notification provisos to AOT orders, but other judges will not add the requirement since the law does not require it.¹²⁹ Patients' lawyers should be notified so they can intervene and prepare for a hearing. There would be little detriment to the state to include these safeguards in the law. The lack of these safeguards in the law makes Kendra's Law defective in fully protecting the right of the mentally ill to effective representation.

C. Right to Determine the Course of One's Own Treatment

New York courts have long recognized that every individual "of adult years and sound mind has a right to determine what shall be done with his own body" and, therefore, to determine the course of his own medical treatment.¹³⁰ Kendra's Law

¹²⁵ N.Y. MENTAL HYG. LAW § 9.60(i) (McKinney 2002).

¹²⁶ Watnik, *supra* note 14, at 1210.

¹²⁷ § 9.60.

¹²⁸ Riccardi, *supra* note 124.

¹²⁹ *Id.* at 1.

¹³⁰ Schloendorff v. Soc'y of N.Y. Hosp., 105 N.E. 92, 93 (N.Y. 1914). *See, e.g.*, Rivers v. Katz, 495 N.E.2d 337 (N.Y. 1986) (finding a trend in law and psychiatry to give mentally ill individuals an increasing amount of control over their treatment decisions).

In our system of a free government, where notions of individual autonomy and free choice are cherished, it 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.

Id. at 341; *See also In re Storar*, 420 N.E.2d 64 (N.Y. 1981) (recognizing the right to choose one's own medical treatment even if the treatment is necessary to preserve one's life); *see also O'Connor v. Donaldson*, 422 U.S. 563 (1975)

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infringes upon this right due to the consequences of failure to comply with an AOT order and by coercing a mentally ill individual to comply with treatment.¹³¹ Although the law clearly states that “[f]ailure to comply with an order of assisted outpatient treatment shall not be grounds for involuntary civil commitment or a finding of contempt of court,”¹³² Kendra’s Law authorizes physicians to “direct the removal of such [noncompliant] patient[s] to an appropriate hospital for examination to determine” whether hospitalization is necessary.¹³³ Furthermore, the law allows the physician to direct police officers to “take into custody and transport” the noncompliant patient.¹³⁴ These consequences severely impinge upon an individual’s right to freely choose the course of his treatment. An individual has little choice if the only options are to follow the treatment plan or face arrest and hospitalization for failure to comply.¹³⁵ Given that “[t]he right to refuse treatment is perhaps the ultimate expression of mental patient autonomy,” this right

(holding that the state must have a compelling interest to justify the deprivation of a mentally ill person’s liberty interest).

¹³¹ See § 9.60(n). Failure to comply with an AOT order may lead to arrest, hospitalization, or both. *Id.* Psychiatrists recognize that noncompliance is a “complex phenomenon, which may have many causes” with many factors to consider. TELSON, *supra* note 50, at 11. For example, patients frequently rejected supported housing because they objected to structure, curfews, and other requirements. *Id.* at 17. Additionally, noncompliance is a clinical judgment—some physicians may find noncompliance only if a patient refuses all services; other physicians may deem noncompliance to mean a refusal of some services; and others may find noncompliance for failure to attend a single treatment session. *Id.* at 14. Additionally, New York’s Mental Hygiene Law requires that an individual with mental illness “receive care and treatment that is suited to his needs and skillfully, safely, and humanely administered *with full respect for his dignity and personal integrity.*” § 33.03 (emphasis added).

¹³² N.Y. MENTAL HYG. LAW § 9.60(n) (McKinney 2002).

¹³³ *Id.*

¹³⁴ § 9.60(n).

¹³⁵ Moran, *supra* note 33. “In theory, if a person doesn’t comply with the judge’s ruling, that patient can be sent to the inpatient ward.” *Id.* (quoting Harvey Bluestone, M.D., director of the Dept. of Psychiatry at Bronx-Lebanon Hospital Center in New York).

should be better protected.¹³⁶

One aspect of the right to refuse treatment, the right to refuse medication, is particularly controversial.¹³⁷ The right to refuse medication is well-established in New York courts.¹³⁸ In *Rivers v. Katz*, the New York Court of Appeals held that the state can administer medications over a patient's objections only where the patient presents a danger to himself or others or where the individual lacks the capacity to decide for himself.¹³⁹ The court found "the due process clause of the New York State Constitution (art. I, § 6) affords involuntarily committed mental patients a fundamental right to refuse antipsychotic medication."¹⁴⁰ Under *Rivers*, the court must conduct an individual assessment of an individual's incompetency or dangerousness before allowing forced medication.¹⁴¹ The *Rivers* court found that "[t]he fact that a mental patient may disagree

¹³⁶ Wisor, *supra* note 14, at 162.

¹³⁷ See Campbell, *supra* note 79 (arguing that Kendra's Law is overbroad and unconstitutional, particularly with respect to the right to refuse treatment).

¹³⁸ 495 N.E.2d 337 (N.Y. 1986).

¹³⁹ *Id.* at 343-44. Rivers, and others similarly situated, were involuntarily committed and refused medication. *Id.* Following administrative review procedures, their objections were overruled and they were then medicated. *Id.*

¹⁴⁰ *Id.* at 492. Traditional antipsychotic medications, such as Thorazine, Mellaril, Prolixin, Stelazine, and Haldol, commonly cause dry mouth, blurred vision, constipation, impotence, weight gain and severe neurological adverse effects, such as parkinsonism (muscle stiffness and rigidity) and tardive dyskinesia ("abnormal, involuntary, irregular" muscle movements). HAROLD I. KAPLAN & BENJAMIN J. SADOCK, SYNOPSIS OF PSYCHIATRY (8th ed. 1998). Dry mouth is a "troubling symptom" for individuals and often leads to discontinuation of medications. *Id.* at 1030. Newer anti-psychotic medications, such as Risperdal and Zyprexa, do not cause the debilitating neurologic effects, but still cause problematic adverse effects, such as drowsiness, dizziness, weight gain, constipation, erectile dysfunction and nausea. *Id.* at 1075-77. For a thorough discussion of antipsychotic medications and the right of mentally ill patients to refuse these medications, see William M. Brooks, *Reevaluating Substantive Due Process as a Source of Protection for Psychiatric Patients to Refuse Drugs*, 31 IND. L. REV. 937 (1998) (providing an in-depth discussion of effects of psychotropic medication as well as the right to refuse).

¹⁴¹ 495 N.E.2d 337, 344.

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with the psychiatrist's judgment about the benefit of medication outweighing the cost does not make the patient's decision incompetent."¹⁴² The court understood that "mental illness often strikes only limited areas of functioning, leaving other areas unimpaired, and consequently, that many mentally ill persons retain the capacity to function in a competent manner."¹⁴³ A recent study supports this finding and the holding in *Rivers*.¹⁴⁴

It should be noted that, when interpreting the right to refuse treatment, courts generally treat mentally ill individuals differently than medically ill individuals.¹⁴⁵ The differential approach and response is based on the assumption that mental illness impairs an individual's decision-making capacity and thus prevents a mentally ill individual from meeting the requirements

¹⁴² *Id.* at 342 (citation omitted). "For many, a medication refusal is not a rejection of all treatment, but a protest against the current dosage or side effects" Wisor, *supra* note 14, at 172.

¹⁴³ *Id.* at 342.

¹⁴⁴ *Id.*

¹⁴⁵ William M. Brooks, *A Comparison of a Mentally Ill Individual's Right to Refuse Medication under the United States and the New York State Constitutions*, 8 TOURO L. REV. 1 (1991) (arguing that mentally ill individuals should have the same right to refuse medication as healthy citizens and advocating the *Rivers* approach, which requires a finding of incompetence before administering psychotropic drugs against an individual's wishes). In *Griswold v. Connecticut*, the Supreme Court recognized the right to privacy as a constitutional right. 381 U.S. 479 (1965). The right to privacy has been extended to include the right to refuse medical treatment. *In re Quinlan*, 355 A.2d 647 (N.J. 1976), *cert. denied*, 429 U.S. 922 (1976) (finding a right to refuse treatment for comatose patient). The Supreme Court concluded in *Cruzan v. Director, Missouri Dept. of Health* that a constitutionally protected interest exists in the right to refuse unwanted medical treatment. 497 U.S. 261 (1990). As to mental health treatment, the Supreme Court in *Washington v. Harper* recognized a "significant" liberty interest in the right to refuse antipsychotic medication under the Fourteenth Amendment. 494 U.S. 210 (1990). Nevertheless, the court held that treatment with antipsychotic medication of a mentally ill prisoner against his will did not violate substantive due process when the prisoner was found to be dangerous to himself or others and treatment was in prisoner's medical interest. *Id.* The broader impact of *Harper* is unclear because it occurred in the context of a prison where the state's interest may be greater. Brooks, *supra*, at 22-23.

of informed consent.¹⁴⁶ A recent study shows, however, that mentally ill individuals are not always incompetent to make rational treatment decisions, despite the fact that impairment in decision-making is a symptom of mental illness.¹⁴⁷ The study concluded that there was a “need for individualized determinations of the competency question rather than across-the-board assumptions that mental illness equates with impaired ability to make treatment decisions.”¹⁴⁸ This finding echoes the New York Court of Appeals holding in *Rivers*.¹⁴⁹

Interestingly, under the precursor to Kendra’s Law, a court could order “involuntary administration of psychotropic drugs” only if the court found by “clear and convincing evidence that the patient lack[ed] the capacity to make a treatment decision . . . and the proposed treatment [wa]s narrowly tailored”¹⁵⁰ The

¹⁴⁶ Bruce J. Winick, *The MacArthur Treatment Competence Study: Legal and Therapeutic Implications*, 2 PSYCHOL. PUB. POL.’Y & L. 137 (1996) (assessing the legal and public policy implications of involuntary hospitalizations and informed consent after the MacArthur Treatment Competence Study and arguing for a presumption of competence).

¹⁴⁷ *Id.* at 140. In an attempt to assess different abilities related to treatment decision-making, the MacArthur study researchers administered three separate tests to six groups of patients and three groups of well persons in the community matched on key demographic variables. *Id.* The tests used cannot be directly equated with legal standards relating to competency. *Id.* Although the study found that patients with mental illness as a group more often manifested deficits on the measures of understanding, appreciation, and reasoning, it also found that “on any given measure of decisional abilities, the majority of patients with schizophrenia did not perform more poorly” than other groups. *Id.* A minority of individuals with schizophrenia brought down the mean. *Id.* at 142. Notably, “nearly half of the schizophrenia group and 76% of the depression group were found to perform in the ‘adequate range . . . across all decision-making measures,’ and a significant portion performed at or above the mean for persons without mental illness.” *Id.* at 144.

¹⁴⁸ *Id.*

¹⁴⁹ 495 N.E.2d 337 (N.Y. 1986).

¹⁵⁰ § 9.61(c)(2). The statute further stated that the proposed treatment must “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

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Legislature deleted this provision from Kendra's Law and failed to include an alternative.¹⁵¹ Under Kendra's Law, the court may order an individual to take a prescribed medication as part of a treatment plan.¹⁵²

Although Kendra's Law does not allow the "forcible administration of medication,"¹⁵³ an individual may be "ordered" to take prescribed medication with severe consequences if he fails to do so.¹⁵⁴ The issue is one of semantics—a difference in interpretation of "forcible administration" versus "ordered self-administration." Practically speaking, the patient has little choice in deciding whether to take prescribed medication since noncompliance may lead to arrest, involuntary hospitalization, or both.¹⁵⁵ Even some proponents of preventive commitment admit that outpatient commitment statutes are "designed to circumvent the rights of competent persons to refuse treatment."¹⁵⁶

Two lower court decisions have upheld the practice of ordering patients to take prescribed medication under Kendra's Law.¹⁵⁷ Specifically the courts found Kendra's Law requires the physician creating the treatment plan to provide the subject of the

side effects associated with the treatment and any less intrusive alternative treatments." *Id.* The legislature, however, did not detail how the medication order would work in practice. TELSON, *supra* note 50, at 19. Alarming, researchers of the Bellevue Pilot Project found few thorough capacity hearings, even though almost two-thirds of the initial orders included medication provisions. *Id.* at 18, 19. Researchers were not aware, however, of any incidences of medication being forcibly administered in the community. *Id.* at 19.

¹⁵¹ § 9.60.

¹⁵² § 9.60(j)(4).

¹⁵³ *In re Urcuyo*, 714 N.Y.S.2d 862, 868 (N.Y. Sup. Ct. 2000).

¹⁵⁴ § 9.60(j)(4). "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." *Id.*

¹⁵⁵ § 9.60(n). "The right to reject the treatment may be more of an empty right than an actual one." Watnik, *supra* note 14, at 1205.

¹⁵⁶ Wisor, *supra* note 14, at 170.

¹⁵⁷ *In re Urcuyo*, 714 N.Y.S.2d 862 (N.Y. Sup. Ct. 2000); *In re Martin*, N.Y.L.J., Jan. 9, 2001, at 31 (N.Y. Sup. Ct. Jan. 8, 2001). *See also* discussion *supra* Part I.B.3 (discussing the holdings of these two cases).

petition “an opportunity to actively participate in the development of such plan”¹⁵⁸ and precludes forcing “drugs or treatment . . . upon [an outpatient] if he fails to comply with the treatment plan.”¹⁵⁹ These findings, however, ignore the fact that the doctor creates the treatment plan and the court makes the final decision as to the plan.¹⁶⁰ Both the physician and the court may even disregard the patient’s wishes.¹⁶¹ Ultimately, the cases fail to define the parameters of “opportunity to actively participate.”¹⁶² Although this oversight needs to be addressed, even if the patient does participate, the court may still order forcible medication against his wishes.¹⁶³

The lower courts’ interpretations of the right to refuse medication under Kendra’s Law do not protect an individual’s right to the same extent as the Court of Appeals required in *Rivers*.¹⁶⁴ Although the lower courts interpret Kendra’s Law as providing an opportunity to participate in treatment planning to prevent an individual from being ‘forcibly medicated,’ they disregard the fact that an individual has a greater right to refuse

¹⁵⁸ 714 N.Y.S.2d at 868 (quoting § 9.60(i)(1)).

¹⁵⁹ *In re Martin*, N.Y.L.J., Jan. 9, 2001, at 31.

¹⁶⁰ *See generally In re Urcuyo*, 714 N.Y.S.2d 862; *In re Martin*, N.Y.L.J., Jan. 9, 2001, at 31.

¹⁶¹ § 9.60(c)(8). “[A]ny directions included in [a health care] proxy shall be taken into account by the court in determining the written treatment plan.” *Id.* “Nothing herein shall preclude a person with a health care proxy from being subject to a petition” § 9.60(d). A health care proxy is a document that authorizes the power of another individual to make health care decisions for or states the preferred treatment of an incompetent or incapacitated individual. *See* N.Y. MENTAL HYG. LAW § 2980(8) (McKinney 2002).

¹⁶² *In re Urcuyo*, 714 N.Y.S.2d 862 (N.Y. Sup. Ct. 2000); *In re Martin*, N.Y.L.J., Jan. 9, 2001, at 31.

¹⁶³ *Hinds*, *supra* note 14. “If forcible medication [i.e., an enforceable court order requiring a patient to medicate himself] is permitted during outpatient treatment, with fewer patient safeguards than are required for [forcible medication, i.e., physically-forced administration of medication to an unwilling patient, during] inpatient treatment . . . , outpatient commitment loses much of its attractiveness as a less restrictive alternative to inpatient hospitalization.” *Id.* at 371.

¹⁶⁴ *Rivers v. Katz*, 495 N.E.2d 337 (N.Y. 1986).

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medication when involuntarily hospitalized under *Rivers*.¹⁶⁵ Medication orders should not be part of an AOT order. If the legislature and the courts continue to allow medication orders as part of AOT orders, they should require a finding of dangerousness or incapacity before allowing a medication order to protect an individual's right to refuse medication, thus following *Rivers*.¹⁶⁶

D. Physician-Patient and Psychotherapist Privileges

The Supreme Court has recognized the importance of confidentiality in mental health treatment, finding that effective therapy “depends upon an atmosphere of confidence and trust in which the patient is willing to make a frank and complete disclosure of facts, emotions, memories, and fears. The mere possibility of disclosure may impede the development of the confidential relationship necessary for successful treatment.”¹⁶⁷ Recognizing the significant public policy interests in protecting the psychotherapist privilege, the Supreme Court stated that the privilege “serves the public interest by facilitating the provision of appropriate treatment for individuals suffering the effects of a mental or emotional problem. The mental health of our citizenry, no less than its physical health, is a public good of transcendent

¹⁶⁵ 495 N.E.2d 337, 344; *see also supra* text accompanying notes 145-48 (discussing the ability of the mentally ill to make medication decisions).

¹⁶⁶ *Rivers*, 495 N.E.2d at 344; *see, e.g.*, WIS. STAT. ANN. § 51.20 (West 2002) (requiring a finding of dangerousness or incompetency before allowing medication to be part of an outpatient commitment order).

¹⁶⁷ *Jaffee v. Redmond*, 518 U.S. 1, 10 (1996). In *Jaffee*, an administrator of Ricky Allen's estate brought a federal civil suit against Mary Lu Redmond, a police officer, who had shot and killed Allen. *Id.* at 1. The court ordered a social worker to give the administrator her notes from counseling sessions with Redmond after the shooting. *Id.* Neither the social worker nor Redmond complied. *Id.* The jury found for the plaintiff after being instructed that it could “presume that the notes would have been unfavorable to respondents.” *Id.* The Supreme Court ultimately held that rule 501 of the Federal Rules of Evidence compels recognition of the psychotherapist privilege; therefore, the privileged notes were protected from compelled disclosure. *Id.*; *see also* FED. R. EVID. 501.

importance.”¹⁶⁸ Other reasons for the privilege of confidentiality include reducing the stigma and discrimination that attaches with certain mental illnesses, fostering trust in the therapeutic relationship and ensuring privacy.¹⁶⁹

The majority of states have adopted the psychotherapist-patient privilege as well as the physician-patient privilege, which developed in the early nineteenth century.¹⁷⁰ Although no privilege exists in federal common law, federal courts recognize state privilege laws if applicable to the proceedings.¹⁷¹ In the civil

¹⁶⁸ *Jaffee*, 518 U.S. at 2.

¹⁶⁹ See U.S. SURGEON GENERAL, MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL 8 (1999), at <http://www.surgeongeneral.gov/library/mentalhealth/home.html>; see also THE PRINCIPLES OF MEDICAL ETHICS WITH ANNOTATIONS ESPECIALLY APPLICABLE TO PSYCHIATRY § 4 annots. (Am. Psychiatric Assoc. 2001), available at http://www.psych.org/apa_members/medicalethics2001_42001.cfm.

1. Psychiatric records, including even the identification of a person as a patient, must be protected with extreme care. Confidentiality is essential to psychiatric treatment. This is based in part on the special nature of psychiatric therapy as well as on the traditional ethical relationship between physician and patient 5. Ethically, the psychiatrist may disclose only that information which is relevant to a given situation. He/she should avoid offering speculation as fact.

Id.

¹⁷⁰ *Developments in the Law—Privileged Communications*, 98 HARV. L. REV. 1530 (1985) [hereinafter *Privileged Communications*] (discussing in-depth the medical and counseling privileges, their history and recent changes). States originally created the privilege to foster public health by encouraging people to seek medical treatment. *Id.* at 1532. Later, legislatures justified the privilege to encourage patients to fully disclose all necessary information for treatment. *Id.* at 1532-33. Beginning in the 1950s, when psychology and psychotherapy gained legitimacy, legislatures extended the privilege to include counselors, such as psychologists, social workers, school guidance counselors and family therapists. *Id.* at 1540.

¹⁷¹ FED. R. EVID. 501. Privileges “shall be governed by principles of the common law . . . in the light of reason and experience.” *Id.* When state law applies, privileges “shall be determined in accordance with State law.” *Id.* See, e.g., *Jaffee*, 518 U.S. at 2 (recognizing the state psychotherapist-patient privilege in a federal civil action). “That it is appropriate for the federal courts to recognize a psychotherapist privilege is confirmed by the fact that all 50 states and the District of Columbia have enacted into law some form of the

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commitment context, though, the general view is that the physician-patient privilege is not applicable because it would undermine the purpose of the hearings.¹⁷² Some jurisdictions, however, have retained the right to raise the privilege.¹⁷³

New York adopted the physician-patient privilege “on the belief that fear of embarrassment or disgrace flowing from disclosure of communications made to a physician would deter people from seeking medical help and securing adequate diagnosis and treatment.”¹⁷⁴ New York, which in 1828 became the first state to adopt the common law physician-patient privilege, has a long history of upholding the privilege.¹⁷⁵ New

privilege” *Id.*

¹⁷² See, e.g., *In re T.C.F.*, 400 N.W.2d 544 (Iowa 1987) (holding the privilege inapplicable in a commitment proceeding after finding a waiver by respondent who introduced portions of his doctor’s records at the hearing); *In re Farrow*, 255 S.E.2d 777 (N.C. App. 1979) (holding the privilege inapplicable in a commitment proceeding); see also 53 AM. JUR. 2D *Mentally Impaired Persons* § 55 (1996) (providing an overview of the privilege and its application in commitment proceedings). Some states argue that privilege is inapplicable because it would undermine the purpose of commitment, because individuals raise their mental status as a defense, and because a physician’s affidavit is not testimony. *Id.*

¹⁷³ See, e.g., *In re Kathleen M.*, 493 A.2d 472 (N.H. 1985) (holding that the privilege applies in commitment proceedings, but the privilege may be overcome for compelling reasons); *C.V. v. State*, 616 S.W.2d 441 (Tex. Civ. App. 1987) (holding that trial court erred in admitting treating psychiatrist’s testimony in commitment proceeding); see also 53 AM. JUR. 2D *Mentally Impaired Persons* § 55 (1996) (arguing that privilege should be retained particularly when an individual voluntarily commits himself to a hospital or when a physician is a “treating” doctor). Some jurisdictions retain the privilege but make narrow exceptions in cases where it would be unreasonably difficult to obtain an evaluation by another physician or where the treating doctor is the only source available to testify. *Id.*

¹⁷⁴ *Williams v. Roosevelt Hosp.*, 488 N.E.2d 94, 96 (N.Y. 1985); see also RICHARD T. FARRELL, PRINCE, RICHARDSON ON EVIDENCE (11th ed. 1995) (discussing the history of the privilege and its application, particularly in New York).

¹⁷⁵ *Amin v. Rose F.*, N.Y.L.J., Dec. 7, 2000, at 31 (N.Y. Sup. Ct. Dec. 6, 2000); *Dillenbeck v. Hess*, 536 N.E.2d 1126 (N.Y. 1989). In 1835, the Court for the Correction of Errors recognized that the physician-patient privilege barred a treating physician from testifying in a divorce proceeding.

York's Civil Practice Laws and Rules 4504(a) states that "[u]nless the patient waives the privilege, a person authorized to practice medicine . . . shall not be allowed to disclose any information which he acquired in attending a patient in a professional capacity, and which was necessary to enable him to act in that capacity."¹⁷⁶ New York has codified separate privileges to cover therapeutic relationships with registered psychologists and certified social workers, who are often mental health treatment providers.¹⁷⁷

Limited exceptions to the physician-patient privilege exist for specific purposes. The CPLR, for example, sets out two exceptions to the privilege: 1) "[a] dentist shall be required to disclose information necessary for identification of a patient;" and 2) specified medical personnel "shall be required to disclose information indicating that a patient" under sixteen years old "has been the victim of a crime."¹⁷⁸ The Legislature has also limited the privilege in other statutes.¹⁷⁹ Additionally, in Article 81 guardianship proceedings, the legislature made a specific exception to the privilege—the court may authorize the court

Johnson v. Johnson, Lock. Rev. Cas. 141 (N.Y. Sup. Ct. 1835); *see also* Reinhan v. Dennin, 9 N.E. 320 (N.Y. 1886) (applying the privilege in testamentary cases).

¹⁷⁶ N.Y. C.P.L.R. 4504 (McKinney 2002).

¹⁷⁷ N.Y. C.P.L.R. 4507, 4508 (McKinney 2002).

¹⁷⁸ N.Y. C.P.L.R. 4504(b) (McKinney 2002).

¹⁷⁹ *See* N.Y. FAM. CT. ACT § 1046(a)(vii) (McKinney 2002) (stating that no privilege exists in proceedings for child abuse or neglect); N.Y. SOC. SERV. LAW §§ 413, 415 (McKinney 2002) (stating that no privilege exists in cases of suspected abuse or neglect); N.Y. PUB. HEALTH LAW § 2101(1) (McKinney 2002) (stating that no privilege exists in cases of communicable diseases for public health reasons); N.Y. PUB. HEALTH LAW § 3373 (McKinney 2002) (stating that no privilege exists in cases of narcotic addictions); N.Y. PENAL LAW § 265.25 (McKinney 2002) (stating that no privilege exists in cases of firearm or deadly knife wounds for penal reasons); N.Y. MENTAL HYG. LAW § 33.13 (McKinney 2002) (stating that no privilege exists for psychiatric records to enumerated individuals or agencies for specific purposes); N.Y. MENTAL HYG. LAW § 33.13(c)(1) (McKinney 2002) (stating that no privilege exists in cases of court orders where the interests of justice significantly outweigh the need for confidentiality).

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evaluator to inspect medical, psychological and psychiatric records “notwithstanding the physician-patient privilege.”¹⁸⁰ In addition, courts have also recognized implied waivers of the privilege in certain circumstances.¹⁸¹ The express “exceptions to the privilege make clear the legislative concept that exceptions to the statutorily enacted physician-patient privilege are for the Legislature to declare.”¹⁸²

New York courts have differed in determining whether the statutory physician-patient privilege should bar treating physicians from testifying in involuntary hospitalization commitment proceedings. New York's lower courts have concluded that the privilege does not apply in commitment proceedings.¹⁸³ The Appellate Division, Third Department, however, concluded that it was error to allow a patient's personal physician to testify in civil commitment proceedings.¹⁸⁴

In enacting Kendra's Law, the Legislature did not include an exception to the privilege.¹⁸⁵ The Legislature could easily have provided an alternative by simply requiring an evaluation by a court-ordered doctor as opposed to relying on an evaluation by the treating physician. The Legislature did find that “[e]ffective mechanisms for accomplishing [the goals of Kendra's Law]

¹⁸⁰ N.Y. MENTAL HYG. LAW § 81.09(d) (McKinney 2002). Similarly, the Legislature made a specific exception to the physician-patient privilege in certain guardianship and custody proceedings. N.Y. SOC. SERV. LAW 384-b(3)(h) (McKinney 2002).

¹⁸¹ *In re Urcuyo*, 714 N.Y.S.2d 862 (N.Y. Sup. Ct. 2000). Implied waivers occur when a party affirmatively places his condition in controversy, such as when a defendant pleads insanity in a criminal case. *See* N.Y. C.P.L.R. 4504 (McKinney 2002).

¹⁸² *In re Grand Jury Investigation of Onondaga County*, 450 N.E.2d 678, 679 (N.Y. 1983) (holding that public interest in homicide case is not sufficient to override statutory physician-patient privilege).

¹⁸³ *In re Benson*, 16 N.Y.S. 111 (N.Y. County Ct. 1891); *In re Allen*, 204 N.Y.S.2d 876 (N.Y. Sup. Ct. 1960). *But see In re Barbara W.*, 537 N.Y.S.2d 427 (N.Y. Sup. Ct. 1988) (holding that the privilege, as to communications made prior to admission, is not waived when an involuntarily admitted inpatient challenges a retention hearing).

¹⁸⁴ *In re Gates*, 170 A.D. 921 (1915).

¹⁸⁵ *See* N.Y. MENTAL HYG. LAW § 9.60 (McKinney 2002).

include . . . the improved dissemination of information between and among mental health providers and general hospital emergency rooms.”¹⁸⁶ To meet this goal, the Legislature amended the confidentiality provision of the Mental Hygiene Law, but the change does not appear to have had any significant impact.¹⁸⁷

Despite New York’s long-standing reverence for the physician-patient privilege, Kendra’s Law infringes upon the right of the mentally ill to a confidential relationship with their physicians by permitting their treating physicians to testify at their court hearings.¹⁸⁸ Patients and their advocates have argued that the physician-patient privilege should bar the treating physician from testifying.¹⁸⁹ Given New York’s history regarding the privilege, courts should not conclude that the Legislature desired an implied waiver in Kendra’s Law.¹⁹⁰

The lower courts, however, have determined that the privilege does not apply to AOT hearings.¹⁹¹ In *Amin v. Rose F.*, the court concluded that there is an implied waiver of the privilege, finding that the Legislature “intended and desired” the treating psychiatrist to be “intimately involved.”¹⁹² The court

¹⁸⁶ 1999 N.Y. Laws 408, § 2.

¹⁸⁷ See N.Y. MENTAL HYG. LAW § 33.13(d) (McKinney 2002) (allowing patient clinical information to be exchanged between and among licensed mental health facilities and hospital emergency rooms throughout the state). Surprisingly, there have been no challenges to the amended law.

¹⁸⁸ N.Y. MENTAL HYG. LAW § 9.60(h)(2) (McKinney 2002). “The court shall not order assisted outpatient treatment unless an examining physician . . . testifies in person at the hearing.” *Id.* The testifying physician must state “the facts which support the allegation that the subject meets each of the criteria for assisted outpatient treatment, and the treatment is the least restrictive alternative, the recommended assisted outpatient treatment, and the rationale for the recommended assisted outpatient treatment.” § 9.60(h)(4).

¹⁸⁹ See *Amin v. Rose F.*, N.Y.L.J., Dec. 7, 2000, at 31 (N.Y. Sup. Ct. Dec. 6, 2000); *In re Sullivan*, 710 N.Y.S.2d 804 (N.Y. Sup. Ct. 2000).

¹⁹⁰ See *supra* note 181 (discussing implied waivers).

¹⁹¹ See *Amin v. Rose F.*, N.Y.L.J., Dec. 7, 2000, at 31; *In re Sullivan*, 710 N.Y.S.2d 804.

¹⁹² N.Y.L.J., Dec. 7, 2000, at 31. Rather than upholding the sanctity of the privilege and its tradition, the court viewed the privilege negatively,

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held that the Legislature must have intended to waive the privilege in Kendra's Law.¹⁹³ The court also analogized the AOT hearing to a retention hearing, where physicians are allowed to testify, to justify the waiver.¹⁹⁴

In *In re Sullivan*, however, the court reached a different conclusion, limiting the testimony of a treating physician.¹⁹⁵ The court in *In re Sullivan* found that "[t]he protection of the physician-patient privilege extends only to communications and not to facts. A fact is one thing and a communication concerning that fact is an entirely different thing."¹⁹⁶ What information a physician may reveal is unclear due to the complexity of distinguishing "facts" from "communications." The privilege under C.P.L.R. 4504 covers not only "communications" but also "any information . . . acquired" in attending a patient.¹⁹⁷ The court in *In re Sullivan* evaded the serious questions of privilege and confidentiality because the respondent failed to specify what information should be characterized as protected by the privilege.¹⁹⁸ Furthermore, the court held that the patient had the

finding that it is used as a "tactical maneuver . . . to suppress facts that are injurious to the legal position of the person who seeks its protection." *Id.*

¹⁹³ *Id.* Furthermore, the court concluded, "[O]nce the privilege is waived, it is waived for all purposes." *Id.*

¹⁹⁴ *Id.* See also N.Y. MENTAL HYG. LAW § 9.31 (McKinney 2002) (explaining the rules in a situation where a psychiatric inpatient is seeking release, yet the hospital is seeking involuntary retention); *In re Barbara W.*, 537 N.Y.S.2d 427 (N.Y. Sup. Ct. 1988) (holding that the privilege, as to communications made prior to admission, is not waived when an involuntarily admitted inpatient challenges a retention hearing). In a retention hearing, "any physician-patient privilege . . . which [the patient] has does not extend to communications with the physicians responsible for her involuntary admission . . ." *Id.*

¹⁹⁵ 710 N.Y.S.2d 804, 805 (N.Y. Sup. Ct. 2000).

¹⁹⁶ *Id.*

¹⁹⁷ N.Y. C.P.L.R. 4504 (McKinney 2002); see also Michael Martin, *The Patient's Privilege of Confidential Communication*, N.Y.L.J., Feb. 14, 1997, at 3.

¹⁹⁸ *Sullivan*, 710 N.Y.S.2d at 805-06. See also Cohen, *supra* note 89 (providing a brief overview of *In re Sullivan* and other early cases that challenge Kendra's Law). "[T]he privilege question remains clouded and undecided." *Id.* at 4.

burden of showing that the circumstances justified invoking the privilege.¹⁹⁹ Given the court's ambiguous statement regarding "facts" and "communications," it is unclear what information a physician may provide when testifying and what information remains privileged.²⁰⁰

Similarly, Kendra's Law creates confidentiality concerns for community mental health providers—the treating psychiatrists, psychologists, social workers, physicians and case managers—regarding reporting noncompliance to the AOT case manager.²⁰¹ According to a recent report on mental health by the Surgeon General, confidentiality is a core ethical principle for all mental health professionals.²⁰² The New York state chapter of the National Association of Social Workers warned that Kendra's Law violated social worker-client confidentiality, undermined the treatment plan and prevented effective treatment by imposing mandatory treatment, violating civil liberties.²⁰³ Involuntary outpatient treatment providers have expressed concern with the required "police" role, which conflicts with the therapeutic role.²⁰⁴ If the provider must report noncompliance, a patient may not be honest with his provider out of fear of repercussions.²⁰⁵

¹⁹⁹ *Sullivan*, 710 N.Y.S.2d at 805.

²⁰⁰ *Sullivan*, 710 N.Y.S.2d at 805.

²⁰¹ Lawrence K.W. Berg, Ph.D., Esq., Presentation Before the Coalition of Voluntary Mental Health Agencies, Inc., *Assisted Out-Patient Treatment: (Kendra's Law) Implications for Community Mental Health Providers' Responsibilities & Liabilities* (n.d.) (on file with the author).

²⁰² U.S. SURGEON GENERAL, *supra* note 169, at ch. 7.

²⁰³ Harvey Rosenthal, *A Misguided Alternative to Fixing Our Mental Health System* (Jan. 2000) (arguing that involuntary outpatient commitment, and Kendra's Law in particular, are "false solutions and misguided public policies borne out of fear and frustration with failure" of the mental health system), at <http://www.naswnyc.org/mhs5.html>.

²⁰⁴ McCafferty & Dooley, *supra* note 15. New York's civil practice rule 4504, which requires certain medical professionals to disclose certain patient information relating to a crime, governs treatment providers as well since it refers to any and all "person[s] authorized to practice medicine . . . attending a patient in a professional capacity." N.Y. C.P.L.R. 4504 (McKinney 2002).

²⁰⁵ See *Privileged Communications*, *supra* note 170 (stating that some individuals forego treatment to avoid the risk of stigma that follows from

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Dishonesty will not benefit a patient's treatment.²⁰⁶ Clients may fear the repercussion of hospitalization if they inform their treatment provider that they did not take their medicine or otherwise comply.²⁰⁷ "The preservation of confidentiality of communications between therapist and patient may be a crucial factor in the successful treatment of psychiatric problems."²⁰⁸ Some patients might forego treatment entirely rather than risk disclosure.²⁰⁹

To continue to protect the privilege, then, the treating physician should not be the examining physician. The treating physician should also not provide an affidavit or testimony containing confidential information.²¹⁰ The Legislature should consider adding a provision to the statute that requires an independent examiner.²¹¹ Although an independent examiner is more costly in terms of time and money, an independent

public disclosure). Because information divulged to a therapist is so personal and because of the social stigma attached to those seeking mental health counseling, individuals might hesitate to seek treatment or disclose information if any possibility of subsequent disclosure exists. *Id.* at 1543. For example, when New York required doctors to report to the government the names of those prescribed narcotics, some individuals discontinued use of the medications or obtained them in other states. *Id.* at 1543.

²⁰⁶ U.S. SURGEON GENERAL, *supra* note 169. The Surgeon General's report noted that a 1995 study found that "as persons perceived themselves at risk for serious sociolegal consequences, being informed that certain disclosures would result in mandatory reporting, did limit self-disclosing." *Id.*

²⁰⁷ See N.Y. MENTAL HYG. LAW § 9.60(n) (McKinney's 2002) (discussing the implications of failure to comply with an AOT order).

²⁰⁸ 53 AM. JUR. 2D *Mentally Impaired Persons* § 55 (1996).

²⁰⁹ See *supra* note 205 (discussing why patients might sacrifice treatment altogether without assurances of confidentiality). Interestingly, proposed AOT bills required community providers to report AOT noncompliance and provided reporting providers with immunity from civil liability; the provision was deleted from Kendra's Law. Berg, *supra* note 201, at 11.

²¹⁰ Cohen, *supra* note 89.

²¹¹ See *Privileged Communications*, *supra* note 170. To preserve the privilege, "when an important issue at trial requires information regarding an individual's physical or emotional condition, that information should be obtained through a court-ordered examination whenever possible." *Id.*

examiner could provide important protection to the privilege.²¹² Lastly, the Legislature should consider adding a provision that clearly protects the privilege between treatment providers and their patients to ensure patients provide full disclosure.

III. EFFECTIVENESS

Although forty states, not including New York, and the District of Columbia currently have outpatient commitment laws of various forms, twenty-three states rarely use them to order treatment.²¹³ Studies on outpatient commitment and the Bellevue Pilot Project have had inconclusive findings.²¹⁴ Although Kendra's Law has not been fully studied, statistics regarding Kendra's Law provide some insight into the law's effectiveness.²¹⁵

A. Research and Statistics on Outpatient Commitment

Researchers have not found conclusive evidence that

²¹² *Id.*

²¹³ See National Conference of State Legislatures, *Health Policy Tracking Service: Fact Sheet: Outpatient Civil Commitment* (July 14, 1999), at <http://www.ncsl.org/programs/health/hpts.commit.htm>. The researchers surveyed the states' use of outpatient commitment by self-report. *Id.* Six states reported very common use; seven states reported common use; three states reported occasional use; fourteen states reported rare use; and nine states reported very rare use. *Id.* See also RIDGELY, *supra* note 35, at 15.

²¹⁴ See discussion *supra* Part I.B.1 (discussing the findings of the Bellevue Pilot Project studies); see also RIDGELY, *supra* note 35 (analyzing the empirical evidence of various state studies on the effectiveness of involuntary outpatient treatment). No studies exist on the cost-effectiveness of involuntary outpatient treatment. RIDGELY, *supra* note 35.

²¹⁵ N.Y. STATE OFFICE OF MENTAL HEALTH, STATUS REPORTS FOR ASSISTED OUTPATIENT TREATMENT (2001) [hereinafter STATUS REPORTS], at http://www.omh.state.ny.us/omhweb/Kendra_web/kstatus_rpts/statewide.htm. Every month the New York State Office of Mental Health updates the information on the website to reflect current data. *Id.*; see also discussion *infra* Part III.B (providing statistics and analysis of the effectiveness of Kendra's Law).

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treatment is as effective when forced by court order as opposed to non-mandated treatment.²¹⁶ Advocates for the mentally ill assert that individuals who might otherwise voluntarily participate in treatment avoid such services out of fear of the possibility of forced treatment later.²¹⁷ One must question whether court-ordered coercion will ever work for those mentally ill individuals who simply refuse treatment.²¹⁸ Coercion may actually prevent a patient from participating in community treatment.²¹⁹ Studies have shown that individuals sometimes avoid treatment due to the fear of commitment.²²⁰ "Patients are more likely to willingly participate in a program when they believe that they are viewed as equal partners with the professional staff" as opposed to being viewed as individuals in need of treatment.²²¹ The therapeutic

²¹⁶ See John Monahan et al., *Mandated Community Treatment: Beyond Outpatient Commitment*, PSYCHIATRIC SERVICES, Sept. 2001, at 1198 (discussing the findings of the Duke and Bellevue outpatient commitment studies), available at <http://macarthur.virginia.edu/article.pdf>; RIDGELY, *supra* note 35. Early studies finding limited positive results suffered from significant methodological problems. *Id.* at xvi. Only two randomized clinical trials of involuntary outpatient treatment exist—the Bellevue Pilot Project and the Duke mental health study, but these studies had conflicting results. *Id.* at xvii. Both studies suggest that improving the availability and quality of mental health services leads to positive outcomes, but differ regarding the effect of court mandates. Monahan, *supra*.

²¹⁷ Monahan, *supra* note 216.

²¹⁸ See, e.g., *In re Endress*, 732 N.Y.S.2d 549, 553 (N.Y. Sup. Ct. 2001). Despite the fact that the respondent stated he would refuse to comply long-term with any outpatient treatment plan or court order, the court ordered AOT anyway. *Id.*

²¹⁹ Wisor, *supra* note 14, at 172.

²²⁰ MadNation, *Replacing Outpatient Commitment Initiatives with Strategies that Work to Engage People in Need*, at <http://www.networksplus.net/fhp/madnation/news/kendra/strategiesthatwork.htm> (last visited Nov. 5, 2002). One study found that fifty-five percent of patients reported avoiding mental health services because of their prior experiences of being involuntarily committed. *Id.* Another study found that forty-seven percent of patients discharged from a hospital stated that the fear of being involuntarily committed has caused them to avoid treatment on prior occasions. Monahan, *supra* note 216.

²²¹ Wisor, *supra* note 14, at 172. See also Monahan, *supra* note 216

relationship is unlikely to develop in a system based on compulsion.²²²

A 1984 study of North Carolina's outpatient commitment statute found that success did not relate to coercion but rather to staff dedication.²²³ Similar to the Bellevue Pilot Project study, the North Carolina study found that those under outpatient commitment did not fare significantly better on outcome measures of living situation, rehospitalization, number of hospital days, social contacts, employment, dangerousness and arrest as compared to the control group.²²⁴ The study did find, however, that those on outpatient commitment had lower rates of medication refusal and treatment noncompliance.²²⁵ In addition, they tended to stay in treatment longer.²²⁶

A more recent study of North Carolina's outpatient commitment statute, conducted by Duke University researchers, found no significant differences regarding hospital use between those on outpatient commitment and the control group at first glance.²²⁷ The Duke Study did show, however, that extended outpatient commitment—greater than 180 days—with intensive outpatient services of three or more visits per month was effective in reducing hospital admissions, lengths of stay, arrest rates and violence.²²⁸

(discussing various studies on coercion and its negative effect on patients).

²²² Wisor, *supra* note 14.

²²³ *Id.* at 172.

²²⁴ RIDGELY, *supra* note 35 (detailing studies on the effectiveness of outpatient commitment in different states). The authors noted a number of limitations of the Duke study: the length of time on outpatient commitment was not randomly assigned; an adherence protocol ensured that enforcement provisions were applied when applicable; and the study was limited to patients discharged from hospitals. *Id.* at 25.

²²⁵ *Id.*

²²⁶ *Id.*

²²⁷ *Id.* at 23. The 331 participants were randomly assigned to one of the two groups—outpatient commitment order or no order. *Id.* Individuals in both groups, however, were assigned a case manager and received outpatient treatment. *Id.*

²²⁸ *Id.* The average intensity of the outpatient services was seven services per month. *Id.*

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A study of Tennessee's outpatient commitment law had a somewhat different outcome.²²⁹ The researchers found that outpatient commitment was ineffective in reducing admission rates among revolving door patients, which is often the cited goal of preventive commitment.²³⁰ Other studies of various forms of outpatient commitment in other states suggest a positive effect of court orders in reducing hospital rates and length of stays.²³¹ These studies, though, suffer from small sample size and other limitations that restrict the validity and reliability of the studies.²³² The empirical evidence is, thus, at best inconclusive.²³³

Even if mandated treatment is effective, the detrimental impact on patients' rights suggests that states should consider other equally-effective voluntary methods.²³⁴ While court orders act as leverage for some individuals, "the best studies suggest that the effectiveness of outpatient commitment is linked to the provision of intensive services. Whether court orders have any effect at all in the absence of intensive treatment is an unanswered question."²³⁵ Further research is clearly needed, however, in order to fully assess the law's effectiveness.

B. Statistical Analysis of Kendra's Law

According to the New York State Office of Mental Health

²²⁹ *Id.*

²³⁰ *Id.* at 22. In the Tennessee study, researchers conducted a retrospective review of medical records of seventy-eight individuals discharged with an outpatient commitment order compared to a match group not under court orders. *Id.*

²³¹ *Id.* at 19-21.

²³² *Id.* Sample sizes included nineteen in a Massachusetts study, twenty in an Ohio study, twenty-six in a New Hampshire study, and forty-two in a D.C. study. *Id.*

²³³ See RIDGELY, *supra* note 35; BAZELON CENTER, POSITION STATEMENT ON INVOLUNTARY COMMITMENT (documenting further studies regarding the effectiveness of outpatient civil commitment), at <http://www.bazelon.org/opcstud.html> (last visited Mar. 16, 2001).

²³⁴ See discussion *supra* Part III.A (comparing findings on the effectiveness of voluntary and involuntary programs).

²³⁵ RIDGELY, *supra* note 35, at 27.

(“OMH”), 7,157 AOT investigations were conducted from November 1999 to August 2002.²³⁶ Of those cases, 3,166 were closed with no action taken.²³⁷ For the same period, merely 2,135 court orders were issued.²³⁸ Only 843 renewed orders have been issued.²³⁹ During the same two and a half years, more than half of the AOT petitions in New York City were dismissed.²⁴⁰ The high number of dismissals of AOT petitions may be due to the need to ration limited mental health services.²⁴¹ The high number of dismissals also suggests that too many individuals are inappropriately referred for AOT. Another possible reason for dismissal is that courts may be requiring the high level of specificity as called for in the statute.²⁴² In either case, Kendra’s Law wastes expensive investigative and judicial resources, especially if only about one of every four result in an order.²⁴³

²³⁶ STATUS REPORTS, *supra* note 215. OMH oversees the state’s mental health system, including operating psychiatric centers and regulating and certifying various mental health programs operated by local governments and non-profit agencies. New York State Office of Mental Health, *About OMH*, at <http://www.omh.state.ny.us/> (last visited Nov. 5, 2002). OMH is the state agency with oversight of the state’s AOT program. *Id.*

²³⁷ STATUS REPORTS, *supra* note 215.

²³⁸ STATUS REPORTS, *supra* note 215.

²³⁹ *Id.* The Office of Mental Health does not provide statistics regarding compliance with AOT orders. *Id.*

²⁴⁰ N.Y. STATE OFFICE OF MENTAL HEALTH, STATUS REPORTS FOR ASSISTED OUTPATIENT TREATMENT—NEW YORK CITY (2001), at http://www.omh.state.ny.us/ohmweb/Kendra_web/kstatus_rpts/nyc.htm. Specifically, 2,143 out of 4,472 investigations were dismissed. *Id.* These reports, unfortunately, do not state reasons for dismissal of petitions. STATUS REPORTS, *supra* note 215.

²⁴¹ Schacher, *supra* note 113, at 1.

²⁴² N.Y. MENTAL HYG. LAW § 9.60. *See also In re Sullivan*, 710 N.Y.S.2d 853 (2000) (discussing the specificity needed).

²⁴³ *See* STATUS REPORTS, *supra* note 215. OMH, however, believes that Kendra’s Law has been effective in meeting its goals. N.Y. STATE OFFICE OF MENTAL HEALTH, PROGRESS REPORT ON NEW YORK STATE’S PUBLIC MENTAL HEALTH SYSTEM (2001) [hereinafter PROGRESS REPORT], available at <http://www.omh.state.ny.us>. An evaluation of the first three months and the first 141 individuals in AOT found that case management increased by 194%, housing services increased by 107%, Mentally Ill-Chemically Addicted

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Another indication of Kendra's Law's ineffectiveness is the state's lack of use.²⁴⁴ As of June 2000, forty-five of the sixty-two counties in New York had not used Kendra's Law.²⁴⁵ As of September 2002, three years after the law went into effect, twenty-one counties have still not issued a single court order.²⁴⁶ Another twenty-three counties have issued orders in less than five cases.²⁴⁷ For example, and not surprisingly, in the two and a half years that Kendra's Law has been in effect, Niagara and Onondaga counties combined have only used court orders for two people.²⁴⁸ The law cannot be effective if it is not used. Even those counties that utilize Kendra's Law do not obtain court orders with any degree of frequency. Erie County, for example, has created 168 agreements with patients to undergo outpatient treatment voluntarily in lieu of AOT and sought only thirteen court orders during the first year the law was in effect.²⁴⁹ When the law initially went into effect, New York City estimated that

(MICA) services increased by 79%, medication management services increased by 67% and therapy increased by 50%. *Id.* Additionally, the study found that medication compliance increased by 129%, while harmful behavior decreased by 26% and homelessness decreased by 100%. *Id.* at 18. This study, however, suffers from small sample size and short-term effects, since it was so early after the law went into effect. Additionally it suffers from potential bias, since OMH conducted the study and oversees the AOT programs. This study, therefore, should be critically examined.

²⁴⁴ See STATUS REPORTS, *supra* note 215 (providing monthly updates regarding the use of Kendra's Law across the state). Overall, an overwhelming majority of the statewide investigations and court orders occurred in New York City, which has taken individuals to court to force an AOT order in 1,813 cases out of 7,360 statewide investigations. *Id.* New York City also has a higher ratio of court orders to voluntary treatment agreements than anywhere else in the state. *Id.*

²⁴⁵ Jaffe, *supra* note 116.

²⁴⁶ STATUS REPORTS, *supra* note 215.

²⁴⁷ *Id.*

²⁴⁸ E. Fuller Torrey & Mary T. Zdanowicz, *Kendra's Law Could Help Mentally Ill Inmates*, BUFFALO NEWS, July 28, 2002, at H5.

²⁴⁹ Gene Warner, *Helping or Hurting?*, BUFFALO NEWS, Jan. 30, 2001, at A1. As of September, 2002, Erie County has drafted 222 voluntary agreements and only sought court orders in thirty-seven cases. STATUS REPORTS, *supra* note 215.

7,000 individuals would be eligible for AOT,²⁵⁰ yet less than 2,000 court orders have been issued in the city since Kendra's Law's inception.²⁵¹

C. Additional Factors

Other less coercive methods may be equally effective as AOT in accomplishing the stated goals of Kendra's Law—stopping revolving door patients and protecting society from the dangerously mentally ill.²⁵² The most successful community programs ensure a wide array of services.²⁵³ Indeed, OMH recently acknowledged the effectiveness of intensive case management in reducing inpatient hospital days.²⁵⁴ Additionally, the money may be better spent on community resources rather than court intervention.²⁵⁵ Lastly, education to increase a patient's understanding of his mental illness is a key factor in successful treatment.²⁵⁶ A voluntary community program offering intensive case management, psycho-education and respect for the individual may be as effective as Kendra's Law in reducing the rates of hospitalization, arrest, homelessness and violence.

Moreover, many individuals with mental illness feel further

²⁵⁰ Jaffe, *supra* note 116.

²⁵¹ STATUS REPORTS, *supra* note 215.

²⁵² See Monahan, *supra* note 216.

²⁵³ Wisor, *supra* note 14, at 172.

²⁵⁴ PROGRESS REPORT, *supra* note 243. Intensive case management (ICM) means that a case manager is assigned only a small number of cases in order to ensure individuals receive an intensive level of services. According to the report, ICM clients had a decline in inpatient days by twenty-three days as compared to a control group that had eleven fewer days. *Id.* at 8.

²⁵⁵ Moran, *supra* note 33. To implement the law, the state has allocated more funding for community programs and discharge planning. Schacher, *supra* note 113. Although some have praised the New York Legislature for its funding of community services at a high level after the passage of Kendra's Law, others have expressed concern about future funding because of the need to maintain a high level of spending in order for the law to be successful. RIDGELY, *supra* note 35.

²⁵⁶ Winick, *supra* note 146.

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stigmatized by the AOT proceedings.²⁵⁷ Additionally Kendra's Law fails to consider that an individual's treating therapist or physician is in the best position to determine a client's treatment needs.²⁵⁸ AOT orders also displace individuals who voluntarily seek treatment and for whom treatment may be more beneficial.²⁵⁹ These non-economic costs of AOT suggest voluntary treatment is a better alternative.

Lastly, Kendra's Law does not effectively protect society from violent, mentally ill individuals.²⁶⁰ Two recent examples demonstrate that New York continues to be plagued by incidences of violence caused by individuals with mental illness. In November 2001, a severely mentally ill man, Jackson Roman, pushed a woman in front of a moving subway train.²⁶¹ Roman told investigators he pushed her because he was desperate for psychiatric help.²⁶² Although it is unknown whether Roman was under an AOT order, either way, the mental health system, including Kendra's Law, failed to serve Roman and to protect society.²⁶³ If he was under an AOT order, he should have been picked up and hospitalized for failure to comply after he left his program. If he was not under an AOT order, one must ask how

²⁵⁷ June M. Briese, *Treat Mentally Ill with Dignity*, N.Y.L.J., May 1, 2002, at § 5. Many "feel as if they are being treated like criminals in the [m]ental [h]ealth [s]ystem when they appear for their court proceedings." *Id.*

²⁵⁸ See Hinds, *supra* note 14.

²⁵⁹ McCafferty & Dooley, *supra* note 15.

²⁶⁰ See *supra* text accompanying note 56 (discussing the legislative findings and purpose of Kendra's Law).

²⁶¹ Jones, *supra* note 4. In August of 2002, Roman was sentenced to twenty-two years for the incident after pleading guilty. Dareh Gregorian, *Grand Central Subway Pusher Gets 22 Years*, N.Y. POST, Aug. 22, 2002; Barbara Ross, *22 Years in Subway Push*, N.Y. DAILY NEWS, Aug. 22, 2002. See also Editorial, *Is Kendra's Law Enough?*, N.Y. POST, Nov. 24, 2001, at 20 (arguing that Kendra's Law failed since Jackson Roman was able to do what he did).

²⁶² Sean Gardiner, *Psychiatric Motive? Subway Suspect Tells Cops He Pushed Woman to Get Mental Help*, NEWSDAY, Nov. 17, 2001, at A7. A police officer recalled taking Roman to a local psychiatric hospital recently for an evaluation because of his strange behavior in the subway. *Id.*

²⁶³ *Id.*

he was overlooked. In March 2002, Peter Troy, who suffers from paranoid schizophrenia, shot and killed a priest and parishioner in the middle of mass in Long Island.²⁶⁴ His case raises even more alarming questions regarding the effectiveness of Kendra's Law because the Nassau County Department of Mental Health Commissioner acknowledged that Troy's AOT case simply fell through the cracks.²⁶⁵ Hospital doctors referred Troy's case to the county for AOT.²⁶⁶ Insufficient staffing, large caseloads, and the inability to locate Troy forced his case to be closed without any investigation or hearing.²⁶⁷ Although the Legislature hoped to end these types of violent incidences by individuals with mental illness through enactment of Kendra's Law, the continuation of the problem demonstrates its ineffectiveness.²⁶⁸

²⁶⁴ Lauren Terrazzano & Roni Rabin, *Warnings Unheeded: County was Unable to Monitor Violent Patient Because He Could Not Be Found*, NEWSDAY, Mar. 20, 2002, at A5. Peter Troy was arrested three times since 2000 for bizarre behavior. *Id.* The year before the incident, he was hospitalized at Bellevue for a month. *Id.* Bellevue told Nassau County Department of Mental Health about Troy. *Id.* After his discharge, he was arrested the same month, again due to bizarre behavior, and taken to a hospital on Long Island. *Id.* See also Kieran Crowley & Andy Geller, *How Law Failed Slain Priest*, N.Y. POST, Mar. 21, 2002, at 8; Peter C. Campanelli et al., *Job Vacancies at Fault*, NEWSDAY, Mar. 29, 2002, at A41. "As a psychiatric patient with a long, documented history of violence, Troy did not receive the services and follow-up that were to be assured by the passage of the well-funded 1999 legislation, Kendra's Law, which mandates outpatient treatment for people whose histories are similar to Troy's." *Id.*

²⁶⁵ Terrazzano & Rabin, *supra* note 264.

²⁶⁶ *Id.*

²⁶⁷ *Id.*

²⁶⁸ See *supra* notes 260-67 and accompanying text (noting the continuing problem of violence by the mentally ill despite Kendra's Law). Additionally, the story of Rosemary Murray suggests the law's ineffectiveness. Rocco Parascandola, *Help for Ill Restricted By Standards*, NEWSDAY, Mar. 31, 2002, at A28. Murray's family was shocked when doctors who cared for Murray, a paranoid schizophrenic, said she could not be forced into treatment or an institution because she was not considered dangerous. *Id.* At times, Murray was a productive member of society, but then she would stop taking medication and deteriorate. *Id.* There was no "catastrophic moment" that

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CONCLUSION

As one commentator stated, Kendra's Law is "neither a boon nor a bust," concluding that "[l]egislators, lawyers, the judiciary, and mental health professionals must continue to analyze the effects of Kendra's Law to determine, ultimately, whether it helped to remedy some of the problems it was created to remedy, or if it created intractable problems for mentally ill individuals and for society."²⁶⁹ Despite research regarding the lack of effectiveness of involuntary outpatient commitment generally, New York passed Kendra's Law as an emotional response to a tragedy caused by an individual with mental illness. Although the Legislature carefully crafted Kendra's Law to narrowly define those eligible for AOT, it did not go far enough in crafting procedural safeguards to protect the rights of those who suffer from a mental illness. Given the findings that involuntary outpatient commitment has little effect, money may be better spent on enhancing mental health services for those who want treatment, which would also allow individuals to retain their invaluable rights.

Kendra's Law automatically expires in 2005, according to the sunset provision, unless the legislature acts to renew it.²⁷⁰ Before renewing the law, however, the legislature should clarify the problematic elements discussed in this note and provide funding and resources for further research on the efficacy of the law and the treatment programs. Some recommendations for the legislature to consider include (1) requiring the treatment plan to

would have led to commitment. *Id.* Murray's sister stated she was told "they can't commit her unless she commits a crime, or tries to kill herself or somebody else." It is unclear if the family pursued an AOT order, but Murray was recently found dead in a lake in Central Park. *Id.* Although the events leading to Murray's death are unknown, her mother believes that voices in Murray's head were responsible. Rocco Parascandola, *End of a Lifelong Battle*, *NEWSDAY*, Mar. 31, 2002, at A06. Apparently, those same voices had caused Murray "to drink water from the curb." *Id.*

²⁶⁹ Susan L. Pollet, *Has Kendra's Law Been a Boon or a Bust?*, *N.Y.L.J.*, Oct. 23, 2000, at 1.

²⁷⁰ N.Y. MENTAL HYG. LAW § 9.60 (McKinney's 2002).

be submitted with the petition, (2) extending the time before the hearing, (3) allowing individuals the right to refuse medication without consequence, and (4) requiring an independent examiner as opposed to allowing the patient's current treating physician to be an examiner. Only a proper balancing of an individual's autonomy and privacy with the state's interest will provide due respect for individuals with mental illness, ensure effective treatment, and protect society from those who need more intensive treatment.