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WAGING A WAR ON DRUGS:
ADMINISTERING A LETHAL DOSE TO KENDRA'S LAW

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INTRODUCTION

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

Does this sound incredulous? Hardly.

People often fear what they do not understand, and for many individuals, mental illness falls into this category. This fear is amplified by highly publicized incidents of violent acts committed by people with mental illnesses. The New York legislature was propelled into action recently when, on two separate occasions, unmedicated mental patients violently assaulted innocent bystanders. On January 3, 1999, after terminating his medication, Andrew Goldstein, a diagnosed schizophrenic, pushed thirty-two-year-old

2. See American Psychiatric Association, Public Information: Violence and Mental Illness (visited Jan. 22, 2000) <http://www.psych.org/psych/htdocs/public_info/violent-1.htm>. This fear is embellished by movies like "Psycho!" or "splashy news accounts of serial killer trials where the word 'insane'... is heard often." Id.
4. See Anderson, supra note 3.
Kendra Webdale to her death in front of a subway train.⁶ Three months later, on April 28, a similar episode took place when thirty-seven-year-old Edgar Rivera was abruptly pushed in front of an oncoming train by a schizophrenic assailant who had also terminated his medication.⁷ Though Mr. Rivera survived the event, his legs were severed.⁸ What could be more frightening than a precipitous, unanticipated act of violence by a perfect stranger?

These cases roused concern for public safety⁹ and prompted the New York legislature to facilitate the outpatient commitment of the mentally ill.¹⁰ Outpatient commitment involves court-ordered involuntary treatment for mentally ill individuals in community settings, rather than in conventional inpatient hospitals.¹¹ In response to the public outcry over these incidents, on August 9, 1999, New York passed “Kendra’s Law,”¹² which permits state courts to order “assisted outpatient treatment”¹³ for patients deemed mentally ill. Before outpatient laws were established, persons suffering from mental illnesses could be involuntarily hospitalized as inpatients only after a court determined that they were a danger to themselves or others.¹⁴ Those individuals who were ineligible for inpatient

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⁶ See, e.g., Nina Bernstein, Hospitals Face Lawsuit by Kin of Victim in Subway Push, N.Y. Times, May 25, 1999, at B1 (describing the incident and developments in New York’s outpatient commitment law in response to Kendra Webdale’s tragic death); see also supra note 3 (listing articles that describe the horrific death of Kendra Webdale). In March, 2000, Andrew Goldstein was found guilty of second-degree murder for killing Kendra Webdale and was sentenced to 25-years-to-life in state prison. See Guilty—and Insane, N.Y. Daily News, March 24, 2000, at 54; Pushing the Insane into Jail, N.Y. Post, March 24, 2000, at 28. The jury refused to accept an insanity plea for the schizophrenic assailant. See id.


⁸ See id.

⁹ Although these “headline grabbing” incidents were committed by mentally ill individuals, such random acts of violence do not occur very often. Only about “4% of all violence is committed by mentally ill people, and much of it is against family members.” Julie Marquis & Dan Morain, The Broken Contract: Rights of Mentally Ill Pitted Against Public, Patient Safety Debate, L.A. Times, Nov. 23, 1999, at A1. Furthermore, research has shown no direct correlation between violence and mental disorder. See APA, supra note 2.

¹⁰ See infra notes 56-59 and accompanying text.

¹¹ These programs seek to “coordinate care and provide as many services as possible in the consumer’s own environment.” Jeffrey Draine, Conceptualizing Services Research on Outpatient Commitment, 24 J. of Behav. Health Services & Res. 306, 306 (1997).

¹² N.Y. Mental Hyg. Law § 9.60 (McKinney 1999); infra Part I.B. (describing outpatient commitment laws, with a concentration on Kendra’s Law).

¹³ N.Y. Mental Hyg. Law § 9.60(a)(1). Assisted outpatient treatment” in New York is a form of coercive, involuntary commitment whereby mentally ill individuals are ordered to comply with psychiatric and medical treatment in outpatient settings. See Group for the Advancement of Psychiatry (“GAP”), Forced Into Treatment: The Role of Coercion in Clinical Practice 65 (1994).

¹⁴ See, e.g., Julian E. Barnes & Susan Sachs, Man Shot by Police Told Hospital Staff of Violent Impulses, N.Y. Times, Sept. 3, 1999, at A1 (referring to commitment
commitment were left without any form of treatment or care. Kendra’s Law, a newly amended version of Mental Hygiene Law § 9.61, makes it easier to compel non-dangerous mental patients into involuntary treatment on an outpatient basis. Depending on the needs of a particular patient, outpatient commitment may include many different categories of services, such as case management, mandatory medication, therapy, counseling, and/or supervision within community settings rather than in an institution. Although outpatient commitment laws are of recent vintage, they are emerging as a significant force in the mental health arena. Since Kendra’s Law was enacted, only nine states lack some form of involuntary outpatient treatment.

This Note argues against the implementation of Kendra’s Law because it infringes on the constitutional rights of the mentally ill and fails to address their mental health needs. Undeniably, the bill was enacted to provide the mentally ill with access to a variety of services and to eliminate the legal and clinical barriers to timely treatment. The freedom to refuse unwanted treatment, however, is a fundamental right rooted in the constitutional protections of liberty, expression, and the right to privacy. The murky standards of Kendra’s Law allow psychiatrists and judges to curtail basic freedoms procedures in New York prior to Kendra’s Law). Today, in order for an inpatient to be civilly committed in New York, an application for admission must be executed by a roommate, relative, director, or officer, and must be accompanied by certificates of two examining physicians maintaining that the patient is mentally ill and in need of immediate inpatient treatment to prevent a dangerous situation. See N.Y. Mental Hgy. Law § 9.27 (McKinney 1994). If an individual can live safely outside an institution, and is not dangerous to herself or others, due process will not tolerate her involuntary inpatient commitment irrespective of whether treatment may be beneficial. See O’Connor v. Donaldson, 422 U.S. 563, 576 (1975); In re Harry M., 468 N.Y.S.2d 359, 363-64 (App. Div. 2d Dep’t 1983). Moreover, the danger that a mentally ill individual poses to herself or others must be a “substantial threat to [her] physical well-being to justify [inpatient] commitment.” In re Harry M., 468 N.Y.S.2d at 364.

16. See Guastaferro, supra note 3 (describing the facets of Kendra’s Law and involuntary outpatient commitment in general).
18. See Guastaferro, supra note 3 ("What makes a difference is the scope, flexibility, responsiveness and coordination of community-based psychiatric treatment and rehabilitation services.").
19. See infra Part II.A. (focusing on significant Supreme Court and lower court decisions recognizing an individual’s constitutional right to refuse psychotropic medication).
based on subjective impressions and biases. Furthermore, as critics of outpatient laws have demonstrated, coercive treatment does not work. Patient rights groups insist that outpatient commitment is merely a “knee-jerk reaction” that fails to resolve larger societal problems, including a shortage of community services, crisis prevention, and treatment facilities.

Part I of this Note explores the history of involuntary civil commitment of the mentally ill. This part also discusses the development of outpatient laws in general, with a concentration on the enactment of Kendra’s Law in New York. Part II examines pertinent Supreme Court and lower court decisions addressing an individual’s constitutional right to refuse involuntary medication. It then scrutinizes New York courts’ stance on the issue of forcible medication. Finally, this part discusses the right of the state to authorize involuntary medication in two situations: (1) as a result of an “emergency” and (2) after an individual is deemed “incompetent.” Part III analyzes the arguments both in favor of and against Kendra’s Law. This part then demonstrates that Kendra’s Law impermissibly infringes on an individual’s right to liberty, privacy, and freedom from bodily harm. The Note concludes that the most appropriate way to treat individuals before they become severely mentally ill is through an array of voluntary services, rather than coercive therapies.

I. THE CIVIL COMMITMENT PROCESS

This part discusses the history and background of civil commitment and the treatment of mentally ill individuals, examining how the advent of antipsychotic medication led to the deinstitutionalization movement and the emergence of outpatient commitment laws. This part also scrutinizes the features of outpatient treatment, focusing on New York’s outpatient commitment statute, Kendra’s Law.


22. See, e.g., Bruce J. Winick, The Right to Refuse Mental Health Treatment 333-37 (1997) [hereinafter Winick, Mental Health Treatment]. Professor Winick states that: “the potential for successful treatment in many contexts would appear to increase when individuals choose treatment voluntarily rather than through coercion. … Indeed, such coercion may backfire, producing a negative ‘psychological reactance’ that sets up oppositional behavior leading to failure.” Id. at 337.

23. Anderson, supra note 3. Coercive treatment is not effective, whether it is imposed on inpatients or outpatients. For example, “[r]esearch shows that those subjected to forced treatment are at increased risk of drug dependence, disabling side effects of medication and … [i]t can result in damage to self-esteem and motivation for recovery.” Edward S. Kramer, Don’t Force Patients into Mental Health Programs, Hartford Courant, Sept. 25, 1999, at A14.

24. See, e.g., Guastaferro, supra note 3 (“The primary barrier to community-based mental-health care has always been inadequate funding.”).
A. History of Treatment for the Mentally Ill

Laws relating to the mentally ill in America have been in existence since colonial times. Initially, states failed to distinguish between mental patients and simple criminals and provided both groups with the same institutional treatment. The protocol of this era was "a one size fits all solution...[to] put 'em all in an institution." For more than two centuries, the fundamental objective of the government was to expel the mentally ill from society, rather than undertake their rehabilitation and release them into communities. During the mid-nineteenth century, however, as prisons became overcrowded and increasingly jeopardous, reformers crusaded for superior civil commitment laws and the "asylum movement" originated.

In the early stages of the movement, the process of committing patients to an insane asylum was extremely informal and was consummated by any number of persons simply applying for admission. In fact, "friends or relatives...would apply to the superintendent for admission without legal procedures or the direct involvement of judicial officials." Moreover, psychiatrists in these insane asylums possessed virtually unencumbered discretion concerning the treatment of mental patients. In the name of science, they administered radical and often misguided treatments, including lobotomies, sterilization, clitoridectomies, and psychotherapies.

Before the advent of psychotropic medication, the focus of

28. See Weiner & Wettstein, supra note 25, at 42.
29. Miller, supra note 26, at 5. Reformers such as Dorothea Dix and Mrs. E.P.W. Packard revolutionized the care of the mentally ill during the nineteenth century. See id. They "not only shifted the burden of caring for the mentally disabled from the family to the state but also changed the community's attitude, to expand their concern from one of self-protection from the mentally ill, to concern for the disabled members of the community." Weiner & Wettstein, supra note 25, at 42.
30. See Miller, supra note 26, at 5.
31. Id. During this time, there were few procedural protections against wrongful commitments. See id.
33. See Marquis & Morain, supra note 9.
34. The term "psychotropic medication" or "antipsychotic medication" refers to drugs such as Thorazine and Lithium, which are used to treat numerous psychotic illnesses, especially schizophrenia. See Winick, Mental Health Treatment, supra note 22, at 61-68; see also Mills v. Rogers, 457 U.S. 291, 293 n.1 (1982) (describing classes of antipsychotic medication and their side effects); Rogers v. Okin, 478 F. Supp. 1342, 1359-60 (D. Mass. 1979), aff'd in part, rev'd in part, 634 F.2d 650 (1st Cir. 1980)
institutionalization was on confinement rather than treatment. 35 Patients afflicted with illnesses, such as schizophrenia or related psychoses, 36 required long-term hospitalization in facilities that primarily rendered custodial care. 37 After antipsychotic medications were introduced in the 1950s, the treatment of mental patients underwent a great transformation. 38 With the growing availability of effective medication, reformers and advocates concerned with patients' civil rights began working for the deinstitutionalization of hospitalized patients. 39 The availability of psychotropic medication led to a massive depopulation of the mental hospital system. 40 Today, medication constitutes a fundamental component of treatment for the mentally ill. 41

Medication fostered the deinstitutionalization movement because it was able to control the more deviant symptoms of psychotic illnesses, abating the need for long-term hospitalization. 42 Deinstitutionalization is the public policy initiative underscoring short-term and community-based treatment. 43 Its premise is based on the notion that once effective treatment is readily available in communities, there will no longer be a need for involuntary commitment. 44 The foremost objective of deinstitutionalization is to

(same).

35. See Miller, supra note 26, at 101.
36. Other types of psychotic illnesses include manic-depressive illness, psychotic depressive reaction, paranoia, neuroses, obsessive-compulsive disorders, and psychosis. See Beis, supra note 25, at 363-64.
37. See Winick, Mental Health Treatment, supra note 22, at 68. Before the advent of antipsychotic medication, psychotic patients were often delusional, violent, and extremely withdrawn, and had poor prognoses for returning to society. See id.
38. See id. at 68. Widespread use of these drugs has been cited as the major reason for the dramatic decrease of the population of mental hospitals. See id. at 69.
39. See Miller, supra note 26, at 209; Winick, Mental Health Treatment, supra note 22, at 9-11. Professor Winick states:
Rather than a long-term custodial facility, the hospital has become essentially a short-term medical facility designed to deal with patients in crisis, to diagnose and stabilize them on a course of medication to be continued after discharge, and then to discharge them into the community where their continued medical and social needs would be met in community-based facilities.
Winick, Mental Health Treatment, supra note 22, at 68.
40. See Miller, supra note 26, at 209.
41. See Winick, Mental Health Treatment, supra note 22, at 69.
42. See Bruce A. Arrigo, The Contours of Psychiatric Justice: A Postmodern Critique of Mental Illness, Criminal Insanity, and the Law 80 (1996). Drugs such as Thorazine and Lithium relieve psychotic symptoms, including hallucinations, delusions, paranoia, and withdrawal, which eventually leads to the decrease of violent or destructive outbursts. See id.
43. See Miller, supra note 26, at 116-17.
44. See id. at 233. In addition, "[l]egislators were attracted to the movement by the prospect of saving money by closing hospitals and providing less expensive treatment in the community." Id. at 209. By releasing the mentally ill from hospitals, "[t]he patients, and the money, could all be diverted to community mental health centers." Id. at 233.
identify patients who can be treated in less formal settings and release them from psychiatric hospitals into a network of community care.\(^\text{45}\)

The "least restrictive alternative"\(^\text{46}\) doctrine quickly became one of the "chief slogans" of the deinstitutionalization movement.\(^\text{47}\) This doctrine provides an analytical guideline in ascertaining whether the government has prudently selected the appropriate means to accomplish a legitimate end.\(^\text{48}\) The monumental decision of *Shelton v. Tucker*\(^\text{49}\) first articulated this principle when it proposed:

> [E]ven though the governmental purpose be legitimate and substantial, that purpose cannot be pursued by means that broadly stifle fundamental personal liberties when the end can be more narrowly achieved. The breadth of legislative abridgment must be viewed in the light of less drastic means for achieving the same basic purpose.\(^\text{50}\)

Since the late 1960s, courts have applied the least restrictive alternative principle to civil commitment cases.\(^\text{51}\) In the mental health arena, this doctrine is activated by courts deciding where a patient should receive treatment and what form of medical treatment is least intrusive.\(^\text{52}\) Because state hospitals are deemed to be "antiquated, overcrowded, and underfunded,"\(^\text{53}\) courts frequently order the mentally ill to participate in alternative treatment regimens.\(^\text{54}\) These types of alternatives include outpatient programs and community support services.\(^\text{55}\)

Outpatient commitment is a legal scheme that employs court orders

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\(^\text{45. See A New Look at Treating the Mentally Ill, Buffalo News, Nov. 16, 1999, at B2.}\)

\(^\text{46. The "least restrictive environment" or "least restrictive alternative" doctrine requires the government to pursue its ends by means narrowly tailored so as not to unnecessarily encroach on important competing interests, such as the constitutional rights to liberty and privacy. See Beis, supra note 25, at 193 (citation omitted).}\)

\(^\text{47. Miller, supra note 26, at 116.}\)

\(^\text{48. See Cichon, supra note 5, at 355; Douglas S. Stransky, Comment, Civil Commitment and the Right to Refuse Treatment: Resolving Disputes from a Due Process Perspective, 50 U. Miami L. Rev. 413, 437 (1996). The Supreme Court has invoked this doctrine in a number of contexts where government action has unnecessarily restricted individual liberties, such as the right to association, privacy, and freedom from bodily restraint. See O'Connor v. Donaldson, 422 U.S. 563, 580 (1975) (bodily restraint); Griswold v. Connecticut, 381 U.S. 479, 485 (1965) (privacy); Shelton v. Tucker, 364 U.S. 479, 488 (1960) (association).}\)

\(^\text{49. 364 U.S. 479 (1960).}\)

\(^\text{50. Id. at 488.}\)

\(^\text{51. See Beis, supra note 25, at 195. The first case in the mental health arena to apply this doctrine was *Lake v. Cameron*, 364 F.2d 657 (D.C. Cir. 1966) (en banc). In this civil commitment case, Chief Judge Bazelon held that the government has an affirmative duty to explore all treatment options so that "[d]eprivations of liberty . . . [do] not go beyond what is necessary for [the patient's] protection." Id. at 660.}\)

\(^\text{52. See Beis, supra note 25, at 193.}\)

\(^\text{53. Miller, supra note 26, at 233.}\)

\(^\text{54. See id. at 209-10.}\)

\(^\text{55. See id. at 233; Beis, supra note 25, at 193.}\)
and other means\textsuperscript{56} to involuntarily compel mentally ill individuals to participate in community treatment.\textsuperscript{57} The tenets underlying this form of treatment are that patients are better served in community facilities, and states can reduce the ponderous costs of long-term care by discharging patients from hospitals.\textsuperscript{58} Outpatient commitment strives to provide patients with a copious array of community treatment programs, including therapy and/or medication, thereby reducing the likelihood of mental deterioration and preventing a relapse that may later require hospitalization.\textsuperscript{59}

Forty-one states currently have outpatient commitment statutes.\textsuperscript{60} However, the classes of people affected by these laws, the conditions under which they are treated, and the consequences for not adhering to mandatory treatment vary from state to state.\textsuperscript{61} In some states, outpatient care is utilized as an alternative to inpatient hospitalization, and is designed for severely mentally ill patients who pose an immediate danger to society.\textsuperscript{62} In contrast, other states use outpatient commitment to treat individuals who are not presently dangerous and do not meet the criteria for inpatient care.\textsuperscript{63} New York's outpatient

\textsuperscript{56} These “other means” include expanding the responsibilities of local police, peace officers, and sheriff's departments to include the apprehending and transporting of individuals with serious mental illnesses to local hospitals for psychiatric evaluations. See, e.g., N.Y. Mental Hyg. Law § 9.60(h)(3), (n) (McKinney 1999) (detailing the extended responsibilities of police officers and members of the sheriff's department).

\textsuperscript{57} See Elizabeth Dickinson Furlong, Coercion in the Community: The Application of Rogers Guardianship to Outpatient Commitment, 21 New Eng. J. on Crim. & Civ. Confinement 485, 486 (1995); MadNation, Replacing Outpatient Commitment Initiatives with Strategies that Work to Engage People in Need (visited Jan. 21, 2000) \textless\texttt{http://www.madnation.org/news/kendra/strategiesshatwork.htm}\textgreater [hereinafter Strategies that Work]. Such outpatient treatment may consist of rehabilitation programs and therapy, as well as medication. See supra note 17 and accompanying text.

\textsuperscript{58} See, e.g., A New Look at Treating the Mentally Ill, supra note 45 (discussing the goals of the deinstitutionalization movement and community treatment).

\textsuperscript{59} See Bruce D. Sales & Daniel W. Shuman, Law, Mental Health and Mental Disorder 233 (1996); Weiner & Wettstein, supra note 25, at 59; see also N.Y. Mental Hyg. Law § 9.60(a)(1) (describing categories of outpatient services that may be ordered, such as medication, therapy, and/or case management).

\textsuperscript{60} See Health Policy Tracking Service, supra note 18 (summarizing states’ use of outpatient commitment laws).

\textsuperscript{61} Compare N.C. Gen. Stat. § 122C-265 (1998) (“In no event may a respondent . . . meet[ing] the outpatient commitment criteria be physically forced to take medication or forcibly detained for treatment pending a district court hearing.”), with N.Y. Mental Hyg. Law § 9.60(n) (“[I]f such assisted outpatient refuses to take medications as required by the court order . . . the director . . . may direct peace officers . . . or police officers . . . to take into custody” such person).


\textsuperscript{63} See Ala. Code § 22-52-10.2 (1975) (maintaining that an individual may be
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commitment statute, Kendra's Law, is among the most extreme in the nation and carries the potential to reach practically any mentally ill individual, regardless of whether she presents an immediate threat to society.  

B. Assisted Outpatient Treatment in New York

Outpatient commitment, as a legal mechanism, forces the mentally ill to comply with community treatment or face involuntary hospitalization. In the 1980s, New York was the only state that explicitly prohibited outpatient commitment. While other states permitted involuntary outpatient care, few provided express statutory procedures to govern such commitment. Rather, the decision-making power to commit an individual to outpatient treatment was left to the unregulated and subjective judgment of physicians and courts.

By 1988, almost every state had enacted laws authorizing outpatient commitment for the mentally ill. Most states established conditional release, a statutory procedure sanctioning outpatient commitment as a condition of discharge from inpatient facilities. Typically, if a patient failed to adhere to treatment in this capacity, she would once again become subject to involuntary hospitalization. Other states elected

committed on an outpatient basis if she is not dangerous, but rather “will, if not treated . . . continue to experience deterioration”); Haw. Rev. Stat. Ann. § 334-121 (Michie 1993) (prescribing involuntary outpatient commitment for patients necessitating treatment in order to prevent a relapse or deterioration); N.Y. Mental Hyg. Law § 9.60(c) (describing outpatient commitment and the criteria for court-ordered treatment for individuals who are not imminently dangerous).


65. See MadNation, Strategies that Work, supra note 57.

66. See GAP, supra note 13, at 65; Miller, supra note 26, at 211 (citing I. Keilitz & T. Hall, State Statutes Governing Involuntary Outpatient Civil Commitment, 9 Mental & Physical Disability L. Rep. 378-97 (1985)). While New York was the only state that prohibited outpatient commitment, “only 26 states and the District of Columbia made explicit provisions for it. The remaining 24 states neither explicitly prohibited nor established procedures for outpatient commitments.” Miller, supra note 26, at 211.

67. See Miller, supra note 26, at 210.

68. See id. at 210-11.

69. See Sales & Shuman, supra note 59, at 233.


71. See Marvin S. Swartz et al., New Directions in Research on Involuntary Outpatient Commitment, 46 Psychiatric Services, 381, 382 (1995). However, “[o]utpatient commitment differs from conditional release in that the court, rather than treatment personnel, authorize[s] the commitment [procedure].” Weiner & Wettstein, supra note 25, at 59. Furthermore, outpatient commitment is determined
to use outpatient commitment in conjunction with, or as an alternative to, inpatient commitment.\textsuperscript{72} In recent years, several states have significantly revised their statutes by establishing less stringent criteria for compulsory outpatient commitment.\textsuperscript{73} These modifications ultimately subject a greater number of non-dangerous people who are psychologically "deteriorating" to the treatment discretion of clinicians and courts.\textsuperscript{74} Many states have created a separate statutory framework empowering courts to order outpatient commitment for individuals who may not meet strict inpatient standards, but who, in the court's view, still require community care.\textsuperscript{75} Such laws target the large numbers of mentally ill patients "cycling in and out of hospitals, living day to day on the streets, or otherwise surviving on the social margin."\textsuperscript{76}

In 1994, New York enacted section 9.61 of the Mental Hygiene Law, which established a pilot program for outpatient commitment of the mentally ill.\textsuperscript{77} This enactment was based on the recognition that "[s]uch [a] program shall serve those patients who can benefit from involuntary outpatient treatment"\textsuperscript{78} and "to assist the person in living and functioning in the community."\textsuperscript{79} Under this program, hospitalized individuals appeared before a judge to determine whether they met the statutory criteria for court-ordered outpatient commitment,\textsuperscript{80} which included a variety of services, such as case

\textsuperscript{73} Id. at 210.
\textsuperscript{74} Id. supra note 26, at 217-18 (discussing outpatient commitment statutes in North Carolina, Hawaii, and Arizona). These laws authorize outpatient commitment for individuals who are not presently violent or imminently dangerous, but are merely mentally ill and psychologically deteriorating. See id. at 218.
\textsuperscript{76} Arrigo, supra note 42, at 209.
\textsuperscript{77} See N.Y. Mental Hyg. Law § 9.61 (McKinney 1994).
\textsuperscript{78} Id. § 9.61(b).
\textsuperscript{79} Id. § 9.61(a).
\textsuperscript{80} See id. § 9.61(d-f) (detailing the procedure for involuntary outpatient
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management, therapy, and medication.\textsuperscript{81}

New York devised its pilot program to obviate the deterioration of mentally ill individuals who were capable of surviving in the community.\textsuperscript{82} This law set stringent and well-defined standards establishing who was eligible for outpatient care, and under what circumstances the involuntary administration of psychotropic drugs was authorized.\textsuperscript{83} For example, only those individuals currently hospitalized and approaching release were eligible for outpatient commitment.\textsuperscript{84} An application to obtain an order authorizing involuntary outpatient treatment was to be initiated by the director of the hospital in which the patient resided.\textsuperscript{85} This application was to set forth the criteria for outpatient treatment as delineated in the statute, the facts that supported the director's belief that the patient met the relevant criteria, and an affirmation by an examining physician corroborating the need for outpatient commitment.\textsuperscript{86} An outpatient who failed to comply with such commitment, and required immediate medical assistance, could ultimately be re-hospitalized.\textsuperscript{87}

Moreover, with regard to patients who met the specified outpatient criteria, only those individuals clearly incapable of making treatment decisions on their own were subjected to involuntary psychotropic medication.\textsuperscript{88} The program required courts to balance the interests of

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\textsuperscript{81} See id. § 9.61(a).

\textsuperscript{82} See id.

\textsuperscript{83} Section 9.61(c) of the Mental Hygiene Law set out the criteria for involuntary outpatient treatment:

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

\textit{Id.} § 9.61(c)(1) (emphasis added).

\textsuperscript{84} See id. § 9.61(c)(1)(iv).

\textsuperscript{85} See id. § 9.61(d)(1).

\textsuperscript{86} See id. § 9.61(c).

\textsuperscript{87} See id. § 9.61(d)(2)-(3).

\textsuperscript{88} See id. § 9.61(k).

\textsuperscript{89} See id. § 9.61(c)(2). This section stated:

A court may order the involuntary administration of psychotropic drugs as

the individual with those of the state before ordering such intrusive medical treatment.\textsuperscript{90} In addition, medication was to be administered only after a judge had contemplated all relevant factors, including the beneficial and detrimental effects of the drugs, and the dignity and privacy rights of the patient.\textsuperscript{91}

Despite its apparent utility, however, the pilot program was applied infrequently, and by January 1999, only 198 patients received court orders for outpatient commitment.\textsuperscript{92} Furthermore, research studies showed no difference in treatment outcomes between the recipients of involuntary outpatient commitment and a control group that received assistance on a voluntary basis.\textsuperscript{93}

In response to several high-profile crimes committed by the mentally ill,\textsuperscript{94} the New York legislature amended the pilot program in 1999, and passed Chapter 408 of the Mental Hygiene Law,\textsuperscript{95} commonly referred to as Kendra’s Law. While the 1994 pilot program allowed only hospital directors to petition the court for outpatient commitment,\textsuperscript{96} Kendra’s Law broadens this authority to include family members, roommates, caregivers, local mental health officials and qualified psychiatrists.\textsuperscript{97} The petition must be accompanied by an affidavit from an examining physician attesting to the severe nature of the mental illness.\textsuperscript{98} If patients fail to comply with outpatient treatment, they can be transported to psychiatric hospitals for part of an involuntary outpatient treatment program if the court finds the hospital has shown by clear and convincing evidence that the patient lacks the capacity to make a treatment decision as a result of mental illness and the proposed treatment is narrowly tailored to give substantive effect to the patient’s liberty interest in refusing medication, taking into consideration all relevant circumstances, including the patient’s best interest, the benefits to be gained from the treatment, the adverse side effects associated with the treatment and any less intrusive alternative treatments.

\textit{Id.} § 9.61(c)(2) (emphasis added).

\textsuperscript{90} See id.

\textsuperscript{91} See id. § 9.61(f)(2), (k)(2).

\textsuperscript{92} See Torrey & Zdanowicz, supra note 18, at 3.

\textsuperscript{93} See, e.g., Kramer, supra note 23 (maintaining that “[o]utpatient commitment simply does not work”).

\textsuperscript{94} See, e.g., Anderson, supra note 3 (describing incidents where individuals were injured by schizophrenics who refused to take medication); Fredric U. Dicker, \textit{State Law Can Force Mentally Ill Into Hospital}, N.Y. Post, Nov. 20, 1999, at 3 (same). For other examples of these tragic incidents, see Lynn Hicks, \textit{Critics: Commitment law leaves some mentally ill untreated}, Des Moines Reg., Oct. 19, 1999, at 1A. See also supra note 3 and accompanying text (describing recent violent acts committed by mentally ill individuals).

\textsuperscript{95} See N.Y. Mental Hyg. Law § 9.60 (McKinney 1999).

\textsuperscript{96} See id. § 9.61(d) (McKinney 1994).

\textsuperscript{97} See id. § 9.60(e) (McKinney 1999). These informalities are quite similar to the colloquial procedures of the mid-nineteenth century, which existed prior to the deinstitutionalization movement. \textit{See supra} notes 30-32 and accompanying text for comparison.

\textsuperscript{98} See N.Y. Mental Hyg. Law § 9.60(e)(3).
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evaluation and subsequently hospitalized against their will.99

Under Kendra's Law, individuals may be committed to outpatient treatment if they meet all of the following criteria: (1) are eighteen years of age or older; (2) have a mental illness; (3) are unlikely to survive safely in the community without supervision; (4) have a history of noncompliance with treatment (have been hospitalized or violent in the past); (5) are unlikely to voluntarily participate in treatment; (6) are in need of outpatient treatment to prevent relapse or deterioration; and (7) are likely to benefit from outpatient therapy.100

Kendra's Law thus lowers the standard of eligibility for outpatient commitment.101 New York's 1994 pilot program applied only to individuals who were "incapable" of surviving in the community without supervision.102 Furthermore, "capacity" was statutorily defined as the "patient's ability to factually and rationally understand and appreciate the nature and consequences of proposed treatment."103 Kendra's Law has lessened this criterion from "incapable" of surviving to "unlikely" to survive without supervision.104 Unfortunately for many persons affected by this distinction, the term "unlikely" is not defined anywhere in the statute. Similarly, while the 1994 pilot program reached only those patients currently hospitalized, Kendra's Law has the potential to affect all individuals suffering from severe mental illnesses, whether or not they

99. See id. § 9.60(n).
100. See id. § 9.60(c)(1)-(7).
101. Kendra's Law gives psychiatrists greater latitude in their subjective determinations of persons eligible for outpatient treatment. Section 9.60(c) lists the criteria for outpatient commitment. See id. Many of section 9.60's criteria for outpatient commitment are identical to those listed in the 1994 pilot program statute. However, there are a number of criteria that are different from those listed in the previous pilot program, such as:

(3) The patient is unlikely to survive safely in the community without supervision . . .

(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;

(ii) resulted in one or more acts of serious violent behavior toward self or others . . . .

Id. § 9.60(c)(3)-(4) (emphasis added).
102. Id. § 9.61(c)(iii) (McKinney 1994).
103. N.Y. Comp. Codes R. & Regs. tit. 14, § 527.8(a)(2) (1995). While the legislature is responsible for enacting general laws in New York State, it often delegates rule-making powers to the state's administrative departments and agencies. See id. at UG 1 (User's Guide). These agencies are then empowered to develop and enforce the rules and regulations they find necessary to implement the broad policies adopted by the legislature. See id. The Codes, Rules and Regulations of the State of New York (NYCRR) is the official compilation of these rules, and courts must abide by these policies. See id.
104. N.Y. Mental Hyg. Law § 9.60(c)(3) (McKinney 1999).
have been previously institutionalized.\textsuperscript{105} Despite the relative infrequency with which the 1994 pilot program was used and the lack of research assessing its effectiveness,\textsuperscript{106} Kendra’s Law will be enforced on a much larger segment of the population.

Kendra’s Law is most controversial for its failure to delineate the circumstances under which an outpatient can be involuntarily medicated.\textsuperscript{107} New York courts require an adjudication of incompetency before forcibly medicating an individual.\textsuperscript{108} The 1994 pilot program included such a standard in its text and clearly established the conditions under which medication could be dispensed.\textsuperscript{109} Kendra’s Law, however, does not explicitly require an adjudication of incompetency before ordering involuntary medication. A statute containing such nebulous standards leaves the mental health care system open to inconsistent and arbitrary enforcement. Moreover, without proper guidelines, Kendra’s Law may curtail a mental patient’s constitutionally protected liberty and privacy interests in making treatment decisions.\textsuperscript{110} The next part examines the constitutional issues underlying forced outpatient treatment laws and their implications for patients’ fundamental rights.

II. MENTALLY ILL INDIVIDUALS AND THE RIGHT TO REFUSE PSYCHOTROPIC MEDICATION

When antipsychotic drugs were introduced, they seemed to eliminate many of the symptoms of psychoses. They were found to abate hallucinations, agitation, delusions, and other psychotic symptoms.\textsuperscript{111} Not only did these drugs enable patients to live outside hospital confines, but physicians also alleged that the drugs reduced incidents of violence and disruption among patients who remained

\textsuperscript{105} See \textit{id.} § 9.60(c)(4)(i)-(ii). Under Kendra’s Law, an individual may be ordered to undergo outpatient commitment if she has either been previously institutionalized at least twice within the last thirty-six months or has engaged in serious violent behavior within the past two years. \textit{See id.}

\textsuperscript{106} See \textit{supra} notes 92-93 and accompanying text.

\textsuperscript{107} Kendra’s Law specifies only that medication is an acceptable mode of treatment and that physicians must describe “the beneficial and detrimental physical and mental effects of such medication.” N.Y. Mental Hyg. Law § 9.60(h)(4). Moreover, if medication is authorized, the examining physician “shall recommend whether such medication should be self-administered or administered by authorized personnel.” \textit{Id.}

\textsuperscript{108} See \textit{infra} notes 246-48 and accompanying text.

\textsuperscript{109} See \textit{supra} note 89 and accompanying text.

\textsuperscript{110} See, e.g., Mills \textit{v. Rogers}, 457 U.S. 291, 298-300 (1982) (recognizing a mental patient’s constitutional right to avoid the unwanted administration of psychotropic drugs).

\textsuperscript{111} See Cichon, \textit{supra} note 5, at 293. The decrease in the average length of hospitalization has been attributed to the effectiveness of psychotropic drugs in reducing the severity of psychotic incidents and elongating the interval between relapses. \textit{See id.}
institutionalized.\textsuperscript{112}

However, "a dark side to these medications surfaced in the 1960s and 1970s."\textsuperscript{113} Physicians quickly learned that antipsychotic drugs do not cure mental illnesses, but rather alleviate and mask psychotic symptoms, which usually return once the treatment is discontinued.\textsuperscript{114} In addition, these drugs plague a substantial number of patients with a myriad of side effects, some of which are minimal and others that are debilitating and occasionally fatal.\textsuperscript{115} While certain adverse effects are apparent instantaneously, others arise only after prolonged administration.\textsuperscript{116} In fact, scientific evidence suggests that "drug therapy fosters hospital dependency and thus serves to increase the likelihood of rehospitalization."\textsuperscript{117} Amidst this climate of uncertainty regarding the efficacy of antipsychotic drugs, advocates and reformers began exploring the constitutional right of patients to refuse involuntary medication.\textsuperscript{118}

The legal controversy underlying a law such as Kendra's Law reflects a balancing of the state's interest in protecting the public from harm with an individual's interest in refusing involuntary medication. This part begins by discussing the constitutionally protected rights of individuals to remain free from unwarranted governmental intrusions in the area of forced medication. It then examines the two categories of state interests at stake: the parens patriae authority and police powers. This part concludes by demonstrating how courts have balanced the interests of the individual against those of the state, with an emphasis on New York procedures.

A. Court Decisions Establishing the Right to Refuse Medication

One of the earliest legal arguments addressing the right to refuse medical treatment was derived from the common law recognition of individual freedom from "intentional [bodily] contacts."\textsuperscript{119} The common law action of battery developed out of the law's protection of personal autonomy and bodily integrity.\textsuperscript{120} Regulation of treatment on this basis was historically consummated in two ways: criminal

\textsuperscript{112} See id.
\textsuperscript{113} Arrigo, supra note 42, at 80.
\textsuperscript{115} Side effects include: drowsiness, seizures, cardiac irregularities, extrapyramidal symptoms, akinesia (physical mobility), dyskinesia, tardive dyskinesia (irreversible neurological disorder), and akathisia (motor restlessness). See id. at 30; Doudera & Swazey, supra note 5, at 16; see also Rivers v. Katz, 67 N.Y.2d 485, 490 n.1 (1986) (describing the most common side effects of antipsychotic drugs).
\textsuperscript{116} See Doudera & Swazey, supra note 5, at 13.
\textsuperscript{117} Cichon, supra note 5, at 295.
\textsuperscript{118} See Arrigo, supra note 42, at 80-83.
\textsuperscript{119} People v. Medina, 705 P.2d 961, 968 (Colo. 1985).
\textsuperscript{120} See id.
prosecutions for battery and civil proceedings for malpractice. The majority of effective legal attempts to combat forced medication have utilized either state or federal constitutional arguments. A number of litigants have relied upon such constitutional protections as sources for the right to refuse involuntary medication, including the First Amendment's guarantees of freedom of thought and expression. More frequently, however, courts recognize an individual's right to refuse medication on the basis of the due process clauses of the Fifth and Fourteenth Amendments. This part will discuss these constitutional protections in turn.

1. The First Amendment

The First Amendment's guarantee of free speech has provided a foundation for challenging involuntary medication. Although the amendment expressly insulates "freedom of speech," the Supreme Court has construed this clause to include other rights deemed essential to free speech, such as "freedom of belief," "freedom of the mind," or "freedom of thought." While the Supreme Court has yet to consider the application of the First Amendment with regard to the administration of psychotropic medication, several lower court decisions "provide ample support for construing the First Amendment to place limits on ... the more intrusive therapies."

121. See Miller, supra note 26, at 138.
122. See Cichon, supra note 5, at 314-15. These values of bodily integrity and self-determination are embedded in the "philosophy of Western Civilization." Id. at 314.
123. See Miller, supra note 26, at 138-39.
124. See infra Part II.A.1.
125. See infra Part II.A.2.
126. See infra Part II.A.1.
127. Id.
128. Winick, Mental Health Treatment, supra note 22, at 135; see, e.g., Stanley v. Georgia, 394 U.S. 557, 565 (1969) (holding that "[o]ur whole constitutional heritage rebels at the thought of giving government the power to control men's minds").
129. Winick, Mental Health Treatment, supra note 22, at 135. Professor Winick convincingly argues that "[m]ental processes must remain presumptively immune from governmental control in a system committed to the values of the First Amendment." Id. at 164. He points out that there is no definitive method for "distinguishing 'normal from abnormal'... or 'sane from disordered thought.'" Id. (internal quotations omitted). Therefore, subjecting involuntary medication to First Amendment scrutiny "erects a presumption against forced governmental intrusion into the mind, one that may be overcome only on a showing of compelling necessity."
Significantly, some lower courts have recognized a First Amendment basis for refusing antipsychotic medication. These courts have held that the First Amendment protects the communication of ideas, which itself implies protection of the capacity to produce ideas.\textsuperscript{130} Antipsychotic medication severely affects an individual's ability to think and communicate, and thus hampers a patient's exercise of her First Amendment rights.\textsuperscript{131} Because these medications directly alter mental capabilities, courts have maintained that individuals have a First Amendment interest in avoiding unwanted treatment with antipsychotic drugs.\textsuperscript{132}

Despite this reasoning, however, many courts hesitate to extend First Amendment protection to cases involving unwanted medication. For example, the district court in \textit{Rennie v. Klein}\textsuperscript{133} intimated that involuntarily administering medication would infringe upon the First Amendment, but nevertheless relied on the constitutional right to privacy as the basis for refusal.\textsuperscript{134} Because the plaintiff, a hospitalized mental patient, had asserted a desire to be cured and claimed a right to medication, the \textit{Rennie} court found that he waived any right to assert a First Amendment objection to medical treatment.\textsuperscript{135} Moreover, the court maintained that the drug's side effects were "temporary and expected to last only a few days or a couple of weeks," and therefore grounded the right to refuse medication in the due process clause, rather than the First Amendment.\textsuperscript{136} Others argue that because antipsychotic drugs are "generally incapable of creating thoughts, views, ideas... or of permanently inhibiting the process of thought generation," they do not implicate basic First Amendment values.\textsuperscript{137} Furthermore, in view of the beneficial effects that medication has on mental processes, it may be paradoxical to view such drugs as an intrusion that impels First Amendment scrutiny.\textsuperscript{138}

Finally, patients' reactions to psychotropic medication depend on

\textsuperscript{130} Id. at 165.

\textsuperscript{131} See Bee v. Greaves, 744 F.2d 1387, 1393-94 (10th Cir. 1984) (recognizing that psychotropic drugs can affect one's ability to think and communicate); Davis v. Hubbard, 506 F. Supp. 915, 933 (N.D. Ohio 1980) (noting that forced administration of medication "implicates a person's interest in being able to think and to communicate freely"); Rogers v. Okin, 478 F. Supp. 1342, 1367 (D. Mass. 1979) (maintaining that the power to produce ideas is fundamental to the right to communicate and is entitled to constitutional protection), aff'd in part, rev'd in part, 634 F.2d 650 (1st Cir. 1980).

\textsuperscript{132} See supra note 130.

\textsuperscript{133} See United States v. Brandon, 158 F.3d 947, 953 (6th Cir. 1998); Bee, 744 F.2d at 1393-94 (recognizing that the right to refuse antipsychotic medication is protected by the First Amendment, which implicitly protects the capacity to produce ideas).

\textsuperscript{134} See id. at 1144.

\textsuperscript{135} See id.

\textsuperscript{136} Id. at 1147.

\textsuperscript{137} Winick, Mental Health Treatment, supra note 22, at 174 (citation omitted).

\textsuperscript{138} See id.
their unique physical make-up, dosage, and the duration of drug use. Thus, the First Amendment's applicability will depend in part on the "evidentiary showing of the drugs' potential side effects" in each individual case. Being entirely fact-specific, courts prefer to apply a due process analysis, which focuses on the general intrusiveness of treatment, rather than on the specific reactions of a particular patient.

2. Due Process and the Right to Refuse Medication

The Supreme Court has never specifically explicated the extent of due process protection for mental patients who wish to refuse antipsychotic medication. While the Court has confirmed that mentally ill individuals have a liberty interest in avoiding unwanted psychotropic drugs, the Court has left states with the responsibility of striking a balance between individual rights and the state's interest in protecting the health and safety of its citizens. As a result, the laws regarding outpatients' rights to refuse medication vary from state to state.

a. The Supreme Court and the Fourteenth Amendment

The due process clauses of the Fifth and Fourteenth Amendments prohibit the Government from depriving any person of life, liberty, or property without due process of law. In the American system of government, which embraces notions of autonomy and free choice, every individual retains a constitutionally protected right to remain free from unwanted bodily interference. This right has been cast in

139. See Cichon, supra note 5, at 326.
140. Id.
143. See infra notes 190-94 and accompanying text.
144. See U.S. Const. amend. V, XIV, § 1. In the early 1800s, due process was viewed primarily as procedural, and its implications were rather limited in scope. See Winick, Mental Health Treatment, supra note 22, at 189-90. Substantive due process theory began to develop prior to the Civil War with the rise of natural rights philosophy. See id. at 190. After the Fourteenth Amendment was ratified in 1868, the notion that the due process clauses imposed both substantive and procedural limits on the government was widely accepted by courts. See id. at 191.
145. See Youngberg v. Romeo, 457 U.S. 307, 315-16 (1982) (holding that the residents of mental retardation facilities have a liberty interest in personal security and reasonably safe conditions of confinement); Mills, 457 U.S. at 299 (maintaining that both voluntary and involuntary mental hospital patients have a constitutionally recognized liberty interest in avoiding the unwanted administration of antipsychotic
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variegated terms, often depending on the type of proposed governmental action at issue, but includes a liberty interest in bodily integrity,\textsuperscript{146} freedom from restraint,\textsuperscript{147} and the right to privacy.\textsuperscript{148} Furthermore, this right extends uniformly to all individuals,\textsuperscript{149} including those suffering from mental illnesses.

Due process challenges may be scrutinized under either a strict scrutiny,\textsuperscript{150} intermediate tier,\textsuperscript{151} or rational basis\textsuperscript{152} standard of review. In the context of involuntary medication, as the intrusiveness of the government’s action rises, the stronger the justification must be to override that interest.\textsuperscript{153} Deciding the appropriate standard of review

medication); Vitek v. Jones, 445 U.S. 480, 494 (1980) (implicating a liberty interest by transferring prisoner to a mental hospital for psychiatric treatment, including psychotropic drugs).

146. See, e.g., Schmerber v. California, 384 U.S. 757, 771-72 (1966) (upholding a compelled blood test of a suspected intoxicated driver against constitutional attack, but recognizing that more substantial intrusions may be treated differently).

147. See, e.g., Youngberg, 457 U.S. at 316 (holding that the “core of the liberty protected by the due process clause” is implicated by subjecting residents of mental retardation facilities to physical restraints (citation omitted)).

148. See, e.g., Winston v. Lee, 470 U.S. 753, 766 (1985) (maintaining that an involuntary surgical operation to remove a bullet from a suspect charged with attempted robbery entailed a severe intrusion on that individual’s sense of personal privacy). But see Cruzan v. Director, Missouri Dep’t of Health, 497 U.S. 261, 279 n.7 (1990) (“Although many state courts have held that a right to refuse treatment is encompassed by a generalized constitutional right of privacy, we have never so held. We believe this issue is more properly analyzed in terms of a Fourteenth Amendment liberty interest.”). Such classification suggests that the Court is unwilling to grant “fundamental” status to the right to refuse medication, because while the rights encompassed within the privacy doctrine are “fundamental,” certain liberty interests may be outweighed by a mere rational governmental interest.

149. See Union Pacific Ry. Co. v. Botsford, 141 U.S. 250, 251 (1891) (deciding that plaintiffs in civil injury suits may not be forced to submit to surgical examinations and that “[n]o right is held more sacred... than the right of every individual to the possession and control of his own person, free from all restraint or interference with others” (emphasis added)).

150. Government action that implicates a fundamental right, including rights to reproduction, marriage, contraception, and abortion, must be narrowly tailored to further a compelling governmental interest. See generally Roe v. Wade, 410 U.S. 113 (1973) (abortion); Griswold v. Connecticut, 381 U.S. 479 (1965) (contraception); see also 3 Ronald D. Rotunda & John E. Nowak, Treatise on Constitutional Law: Substance and Procedure § 18.3, at 216-21 (3d ed. 1999) (analyzing the standards of review that courts apply to due process challenges).

151. The Supreme Court has adopted an intermediate standard of review that is not as onerous as the strict scrutiny test, but which involves less deference to the legislature than does rational basis review. See Rotunda & Nowak, supra note 150, § 18.3, at 218-21.

152. Government action that does not burden a fundamental right will survive a due process challenge if the government can prove that it rationally relates to a legitimate governmental interest. See United States v. Brandon, 158 F.3d 947, 957 (6th Cir. 1998).

153. See Cichon, supra note 5, at 331-32; see also Winick, Mental Health Treatment, supra note 22, at 284 (“In scrutinizing governmental interests asserted to justify involuntary treatment, courts inevitably engage in a balancing of the interests of the state and of the individual, and the balance is struck differently in different
is crucial, because the ultimate disposition in a case is often shaped by the standard applied.

As of yet, the Supreme Court has not held that the right to refuse involuntary medication is "fundamental,"\textsuperscript{154} which would thereby subject the state to a "strict scrutiny" standard of review. The Court has instead adopted manifold levels of review, depending on the context in which the due process challenge is brought.\textsuperscript{155} In \textit{Washington v. Harper},\textsuperscript{156} the Court held that under the Fourteenth Amendment, a convicted prisoner has a significant liberty interest in avoiding involuntary psychotropic medication; however, it determined that this due process right is not absolute.\textsuperscript{157} This constitutional right may be infringed upon by the state when a mentally ill inmate poses a substantial threat to herself or others.\textsuperscript{158} The Supreme Court adopted a low standard of review and maintained that an invasion of constitutional rights pursuant to prison regulations may be justified if "reasonably related" to a legitimate penological objective.\textsuperscript{159} In reaching its decision, the Court emphasized that prisons must be able to ensure safety and order within the facility.

The implications of the \textit{Harper} decision were colossal. First, \textit{Harper} rejected the supposition that the right of prison inmates to refuse treatment was "fundamental."\textsuperscript{160} Rather, the Court applied a "standard of reasonableness" in evaluating the constitutionality of a prison policy which authorized the involuntary medicating of dangerous inmates.\textsuperscript{161} Second, by applying a less rigid "reasonableness" test, the Court rejected the least restrictive alternative principle,\textsuperscript{162} which would have required a showing that the particular therapy in question was necessary to accomplish a

\textsuperscript{154} See Riggins v. Nevada, 504 U.S. 127, 135 (1992) (deciding that the Fourteenth Amendment affords pre-trial detainees at least as much protection as the "reasonableness" standard); Washington v. Harper, 494 U.S. 210, 224 (1990) (noting that a prisoner's right to avoid unwanted medication is judged "under a 'reasonableness' test less restrictive than that ordinarily applied to alleged infringements of fundamental constitutional rights." (quoting O'Lone v. Estate of Shabazz, 482 U.S. 342, 349 (1987))).

\textsuperscript{155} See Winick, Mental Health Treatment, supra note 22, at 284. "The level of scrutiny to be applied in the circumstances—strict, intermediate, or low level—tells courts performing this constitutional balancing how to weigh the competing state and individual interests." Id.

\textsuperscript{156} 494 U.S. 210 (1990).

\textsuperscript{157} See id. at 221-22, 228.

\textsuperscript{158} See id. at 221-22. If a prisoner is not an imminent threat, however, the right to refuse medication may not be infringed. See id.

\textsuperscript{159} Id. at 223 (emphasis added). The Court adopted a deferential approach to reviewing the discretion of prison authorities in dealing with problems of institutional security. See id. at 223-24.

\textsuperscript{160} See id.

\textsuperscript{161} Id.

\textsuperscript{162} See supra notes 46-52 and accompanying text. If the rights were deemed "fundamental," the Court would have applied a more stringent standard of review.
compelling governmental interest. Whether this lower level of scrutiny would apply beyond the prison context to include all cases involving involuntary medication remained unclear after Harper. The Court's decision in Riggins v. Nevada, however, dissipated the notion that Harper would be construed broadly.

Riggins involved a dangerous pretrial detainee—an unconvicted individual held in prison while awaiting trial. Although the Court again resisted adopting a strict scrutiny standard of review, it did indicate that the state must make a "compelling" showing that the medication is both necessary to prevent an imminent threat and is the least restrictive means to accomplish its objective. The Court thus tempered the Harper decision by suggesting that outside the context of convicted prisoners, the right to refuse medical treatment will be accorded more leeway.

Harper and Riggins leave the constitutional issues raised by involuntary medical treatment outside the prison realm substantially unresolved, and provide little guidance as to how to analyze an asserted right to refuse treatment. Because the right to refuse medication in an outpatient setting has not yet been examined by the Supreme Court, the status of persons ordered into outpatient treatment, who are neither prisoners nor pretrial detainees, remains unclear. As such, outpatients undergoing involuntary medication should at least be afforded the equivalent level of protection as the defendants in Riggins, which would require the state to demonstrate a compelling interest and the least restrictive means of fulfilling that interest.

163. See supra notes 46-52 and accompanying text.
164. See Winick, Mental Health Treatment, supra note 22, at 272.
166. See id. at 129-30.
167. See id. at 136. "Contrary to the dissent's understanding, we do not 'adopt a standard of strict scrutiny.'" Id. (emphasis added).
168. See id. at 135-36; see also Sales & Shuman, supra note 59, at 264 (discussing the standards proposed by the Supreme Court in "right-to-refuse" medication cases); White, supra note 114, at 16 n.80 (same).
169. See Winick, Mental Health Treatment, supra note 22, at 278-79. The Supreme Court in Mills v. Rogers also expressed its assumption that involuntarily administered antipsychotic drugs intrude on a liberty interest protected by the due process clause of the Fourteenth Amendment. See 457 U.S. 291, 299 (1982). In Mills, the Supreme Court granted certiorari to consider the involuntary use of psychotropic drugs for civil patients at the Boston State Hospital. See id. at 293-94. After briefing and oral argument, however, the Supreme Court vacated and remanded the case for reconsideration in light of an intervening decision of the Supreme Judicial Court of Massachusetts that recognized a right to refuse medication on state law grounds. See id. at 303, 306 (remanding the case in the wake of In re Guardianship of Roe, 421 N.E.2d 40 (Mass. 1981), and therefore failing to determine which level of scrutiny is appropriate in involuntary commitment cases).
170. See White, supra note 114, at 16 n.80. The author argues that because these individuals are not criminals, they should be entitled to "at least as much protection as that accorded pretrial detainees." Id.
Moreover, mentally ill outpatients may be deserving of an even higher level of scrutiny. Under liberal statutes such as Kendra’s Law, participants in outpatient commitment programs are neither imminently dangerous nor incapable of making informed decisions to refuse medication. Arguably, the exigencies invoked by the Harper Court to justify deference in the forcible administration of medication to control violence are often not present in the community setting. Therefore, outpatients would appear to be entitled to the most exacting standard of review, and are thus deserving of strict judicial scrutiny.

In addition, since the reform movement of the mid-1960s, courts have repeatedly distinguished between the rights of criminals and the mentally ill. This criminal-civil distinction suggests that the limitations placed on a prisoner’s right to refuse medication are not automatically applicable to civil patients. As the Court in Harper emphasized, “[t]here are few cases in which the State’s interest in combating the danger posed by a person to both himself and others is greater than in a prison environment,” and the state “under other circumstances would have been required to satisfy a more rigorous standard of review.” This reasoning leads to the belief that the interest of a mental patient is at least as great, and in fact greater, than a prisoner’s right to avoid antipsychotic medication.

b. Lower Courts and the Right to Refuse Medication

Lower courts have recognized the right to refuse antipsychotic medication on the basis of both federal and state constitutional due process clauses. Because outpatient commitment laws are of recent vintage, there exists little case law addressing the extent of due process protections for civilly committed outpatients. However, lower court decisions in the area of inpatient commitment indicate a growing trend toward greater individual autonomy and more stringent limitations on governmental intrusions. The first two landmark cases implicating the right to refuse treatment in an inpatient context arose in the federal courts of New Jersey and Massachusetts. These cases

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171. See N.Y. Mental Hyg. Law § 9.60(c), (o) (McKinney 1999).
172. See Stransky, supra note 48, at 432.
173. See id.
175. Id. at 223.
relied solely upon the substantive liberty interests provided by the federal constitution. While in juxtaposition these cases differ significantly in their facts and holdings, both courts recognized a constitutional right to refuse involuntary medication.\textsuperscript{177}

In the first of these landmark decisions, the district court in \textit{Rogers v. Okin}\textsuperscript{178} recognized a state police power justification for the involuntary administration of antipsychotic medication.\textsuperscript{179} The \textit{Rogers} court held that involuntarily committed patients may be forcibly medicated in emergency situations "in which a failure to do so would result in a substantial likelihood of physical harm."\textsuperscript{180} On appeal, the First Circuit broadened the definition of "emergency" to include predictions of future violence and possible psychological deterioration.\textsuperscript{181}

\textit{Rennie v. Klein},\textsuperscript{182} which arose in the same period as \textit{Rogers}, was the first case to address the issue of a patient's right to refuse psychotropic drugs in a non-emergency situation. In \textit{Rennie}, the court examined New Jersey's administrative regulations governing medication refusals by hospitalized patients.\textsuperscript{183} The Third Circuit maintained that forcibly medicating a patient over her objection in a non-emergency situation infringes on that patient's liberty interest.\textsuperscript{184} However, the court held that antipsychotic drugs could be administered "whenever, in the exercise of [a treating clinician's] professional judgment, such an action is deemed necessary to prevent the patient from endangering himself or others."\textsuperscript{185}

Both \textit{Rogers} and \textit{Rennie} have served as models for other state and federal courts ordering involuntary medication of hospitalized patients.\textsuperscript{186} Subsequent cases have uniformly held that patients have a protected liberty interest in deciding whether to take antipsychotic medication.\textsuperscript{187} This liberty interest has been defined as a substantial

\begin{itemize}
\item \textsuperscript{177} See \textit{Rennie}, 653 F.2d at 838; \textit{Rogers}, 478 F. Supp. at 1365.
\item \textsuperscript{178} 478 F. Supp. 1342 (D. Mass. 1979).
\item \textsuperscript{179} See \textit{id}. at 1365.
\item \textsuperscript{180} \textit{id}.
\item \textsuperscript{181} See \textit{Rogers}, 634 F.2d at 654-56.
\item \textsuperscript{182} 653 F.2d 836 (3d Cir. 1981) (en banc).
\item \textsuperscript{183} See \textit{id}. at 840.
\item \textsuperscript{184} See \textit{Rennie}, 720 F.2d 266, 269 (3d Cir. 1983).
\item \textsuperscript{185} \textit{id}.
\item \textsuperscript{186} See Weiner & Wettstein, supra note 25, at 125. These decisions provide two models of the right of civilly committed patients to refuse antipsychotic medication in both emergency and non-emergency situations.
\item \textsuperscript{187} See, e.g., \textit{Large v. Superior Ct.}, 714 P.2d 399, 407 (Ariz. 1986) (maintaining that competent adult cannot be involuntarily medicated in a non-emergency situation); \textit{Anderson v. State}, 663 P.2d 570, 571 (Ariz. Ct. App. 1983) (same); \textit{People v. Medina}, 705 P.2d 961, 963-64 (Colo. 1985) (declaring that even incompetent persons do not automatically lose their right to refuse medication, but rather a judge weighs various factors to make that determination); \textit{Superintendent of Belchertown v. SaiKewicz}, 370 N.E.2d 417, 427 (Mass. 1977) (grounding the right to refuse medication
right to be free from unwarranted intrusions upon an individual's personal security.\(^{188}\) In the United States, notions of liberty are inextricably intertwined with the idea of physical freedom and self-determination, and therefore, courts have often deemed state incursions into the body repugnant to the interests protected by the due process clause.\(^{189}\)

Moreover, it is a well-established principle that substantive rights provided by the federal constitution define only minimum protections that individuals must be afforded.\(^{190}\) Thus, states are free to extend greater protections when they so desire. As one commentator notes: "federal courts appear[] to be moving away from the extension of individual rights based on the federal constitution, and toward a federalist policy of permitting states to set their own courses in the area of such rights."\(^{191}\) Similar to the federal constitution, state constitutional due process clauses have been held to afford a right to refuse medication.\(^{192}\) State law may also recognize liberty interests more extensively than does the federal constitution,\(^{193}\) and ultimately state law will be applied to ensure the fullest protection of individual autonomy and freedom from governmental interference.\(^{194}\)

States not only recognize individual liberty interests, but have also surpassed the Supreme Court\(^{195}\) and have grounded the right to refuse medication in their state constitutions' right to privacy.\(^{196}\) In

\(^{188}\) See, e.g., Opinion of the Justices, 465 A.2d 484, 488-89 (N.H. 1983) (holding that because antipsychotic drugs have drastic effects upon one's physical well-being, they significantly intrude upon an individual's security and liberty interests).

\(^{189}\) See supra note 187.


\(^{191}\) Miller, supra note 26, at 144-45.

\(^{192}\) See Large, 714 P.2d at 406; In re Guardianship of Roe, 421 N.E.2d 40, 51 n.9 (Mass. 1981); Opinion of the Justices, 465 A.2d at 488; Rivers, 67 N.Y.2d at 492-93.

\(^{193}\) See Mills, 457 U.S. at 300. "If the state interest is broader, the substantive protection that the Constitution affords against the involuntary administration of antipsychotic drugs would not determine the actual substantive rights and duties of persons in the State of Massachusetts." Id. at 303 (emphasis omitted).

\(^{194}\) See, e.g., In re Gordon, 619 N.Y.S.2d 235, 236 (Sup. Ct. 1994) (applying New York's due process clause (rather than the federal due process clause), which insures greater protection to an individual's "furtherance of his own desires"); Weiner & Wettstein, supra note 25, at 47.

\(^{195}\) See supra note 148 (citing the Supreme Court's decision in Cruzan v. Director, Missouri Department of Health, which limited the scope of the privacy doctrine in the right-to-refuse treatment context).

\(^{196}\) See Davis v. Hubbard, 506 F. Supp 915, 932-33 (N.D. Ohio 1980); Hondroulis v. Schuhmacher, 553 So. 2d 398, 415 (La. 1989) (maintaining that the state constitution expressly guarantees that each individual has an affirmative 'right to privacy'); In re Guardianship of Roe, 421 N.E.2d 40, 51 n.9 (Mass. 1981) (same); Saikewicz, 370 N.E.2d at 426-27 (same); see also Souder v. McGuire, 423 F. Supp. 830, 832 (E.D. Pa. 1976) (finding that involuntary administration of psychotropic
Hondroulis v. Schuhmacher, for example, the Louisiana court maintained that its state constitution “expressly guarantees that every person shall be secure... against unreasonable ‘invasions of privacy.’” Treatment with psychotropic drugs not only impacts the patient’s bodily integrity, but also the individual’s mind, which is the “quintessential zone of human privacy.” Furthermore, psychotropic medication is a direct governmental intrusion into mental processes and “[i]nvasive the innermost privacy of the individual and cuts off the right of expression at its source.” Because psychotropic medication by its very nature alters mental processes, both in its primary effects and in certain side effects, these drugs are deemed to implicate the right to mental privacy. Thus, both the Supreme Court and lower courts, while not always agreeing on the source or extent of the constitutional right to avoid involuntary medication, have established a mentally ill patient’s right to refuse antipsychotic drugs in certain contexts. The next section discusses how courts balance the constitutional rights of mentally ill individuals against the government’s interests in protecting society at large.

B. Balancing an Individual’s Constitutionally Protected Interest with the Government’s Reasons for Infringement

Even when a constitutional source is relied upon to support a patient’s refusal of antipsychotic medication, there is no guarantee that the refusal will be upheld. Constitutional rights are not absolute, but rather are balanced against the government’s interests in protecting and caring for individuals. Courts have identified two governmental interests which, under appropriate circumstances, justify the involuntary administration of antipsychotic medication. The first is the government’s police power interest in preventing medication amounts to an unwarranted governmental intrusion and is in violation of an individual’s privacy rights.

197. 553 So. 2d 398.
198. Id. at 415.
200. Winick, Mental Health Treatment, supra note 22, at 144 (quoting T. Emerson, Toward a General Theory of the First Amendment 64 (Random House ed. 1966)).
201. Psychotropic medication seeks to influence psychological conditions through the use of chemical interventions that affect the mind, behavior, and intellectual functions. See Winick, Mental Health Treatment, supra note 22, at 61 n.3; supra notes 111-17 and accompanying text.
202. See Cichon, supra note 5, at 331-45.
204. See infra notes 214-27 and accompanying text.
patients from endangering themselves or others. The second is the state's parens patriae authority205 to care for citizens who are unable to care for themselves. Because these powers are deemed inherent in the rights of sovereignty, "courts and clinicolegal tribunals invoke the doctrine of paternalism to justify the 'massive deprivation of liberty' which affects the lives of mentally disordered persons."206

When scrutinizing the governmental interests asserted to justify involuntary medication, courts inevitably balance the interests of the state with those of the individual. At a minimum, governmental infringement of an individual’s protected liberty or privacy interest must be “reasonably related to legitimate government objectives.”207 Highly intrusive conduct must be supported by a compelling governmental interest and a showing that there are no less intrusive means available to accomplish the state’s objective.208 Courts have placed even further limitations on governmental authority in the context of involuntary medical treatment of hospitalized patients.209 Today, states can authorize the forcible administration of medication to inpatients in only two situations: (i) during an emergency, and (ii) when an individual lacks the capacity to control her treatment regimen. Logically, these same limitations should also extend to protect outpatients from unwarranted medication.

1. Emergency Situations Where the State’s Police Power Interest Is Authorized

Every individual “of adult years and sound mind has the right to determine what shall be done with his own body... and to control the course of his medical treatment.”210 Recognition of this right to
refuse medication is consistent with existing medical mores and philosophies.211 The right to reject medical treatment, however, is not absolute and must occasionally yield to compelling state interests.212

Governmental officials exercise broad discretion through their police powers to protect public health, safety, welfare, and moral behavior.213 In certain situations, the state may utilize this police power authority to involuntarily restrain mentally ill patients in hospital settings.214 The state’s police power stems from its legitimate interest in preventing the mentally ill from harming themselves or others.215 This principle of “societal self-defense” has been applied ubiquitously to restrain any person who endangers the safety of others.216

After hospitalization, however, courts have set limits on a state’s ability to involuntarily medicate a patient under its police power authority.217 The scope of the government’s police power has been defined in terms of either an “emergency” or “dangerousness” standard, or both.218 While courts apply these labels interchangeably,

211. See Superintendent of Belchertown v. Saikewicz, 370 N.E.2d 417, 424 (Mass. 1977). “[S]uch a doctrine does not threaten either the integrity of the medical profession, the proper role of hospitals in caring for such patients or the State’s interest in protecting the same.” Id. at 426-27.
212. See Rivers, 67 N.Y.2d at 495; see also In re Storar, 52 N.Y.2d 363, 377 (1981) (“The State has a legitimate interest in protecting the lives of its citizens. It may require that they submit to medical procedures in order to eliminate a health threat to the community.”).
213. See Cornwall, supra note 203, at 390.
214. See id. States have exercised police powers since the colonial period to protect the community from the violent tendencies of the mentally ill. See id. at 389.
215. See id.
216. See id. at 390. For example, courts have distinctly recognized the Government’s authority to enact quarantine laws, and “health laws of every description,” which relate to the protection of public safety. See, e.g., Jacobson v. Massachusetts, 197 U.S. 11, 25 (1905) (“According to settled principles the police power of a State must be held to embrace, at least, such reasonable regulations established directly by legislative enactment as will protect the public health and the public safety.”).
217. In New York, for example, the state can only use its police power to medicate an individual who is imminently dangerous. See Rivers, 67 N.Y.2d at 495-96. When the only indication of dangerousness is the commission of a nonviolent or minor crime that does not place the individual or others in immediate danger, the individual’s constitutional right to refuse medication outweighs the state’s interest.
218. See Cichon, supra note 5, at 337; cf. O’Connor v. Donaldson, 422 U.S. 563, 575 (1975) (finding that a patient cannot be involuntarily committed if she is nondangerous, but failing to directly address whether “dangerousness” is a prerequisite for civil commitment). In this case, the Court balanced the patient’s interest in refusing medication against the state’s parens patriae authority, rather than its police power. The Court held that a “State cannot constitutionally confine without more a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends.” Id. at 576. Although the Supreme Court did not acknowledge that “dangerousness” is a prerequisite for commitment, virtually all states statutorily require that an individual be either a danger to himself or to others as a necessary criterion for
there is a "major difference in scope between the[se] underlying standards." There is a major difference in scope between the underlying standards. Emergency authority is limited to situations in which the threat of physical violence is immediate. A "dangerousness" standard authorizes involuntary drugging on the prediction that a patient will deteriorate and present a future threat of violence if not medicated.

The majority of courts, including New York, apply the "emergency" standard, and require that the harm to be prevented have a high degree of imminence before forcibly medicating involuntary patients. In an emergency, the state may thus be empowered in the exercise of its police power to involuntarily administer psychotropic medication to patients until the emergency subsides. New York courts have recognized the need for emergency medical treatment of a competent individual who is "presently dangerous." This state exists when a mentally ill individual engages in conduct or is imminently likely to engage in conduct that poses a risk of physical harm to herself or others. Unlike other jurisdictions, New York does not require that an individual commit a "recent overt act" as evidence of imminence. Rather, for medication to be ordered, the court need only find that an individual is "substantially likely" to cause injury or bodily harm.

2. Incompetent Patients and the State's Parens Patriae Authority To Order Involuntary Medication

Parens patriae, which literally means "parent of the country,"
KENDRA'S LAW refers to the role of the state as a sovereign and guardian of persons legally incapable of caring for themselves.230 Grounded in principles of beneficence, the parens patriae authority permits states to provide treatment to citizens who are unable to make their own decisions due to their mental illnesses.231 As the Supreme Court has stated, "[t]he classic example of this role is when a State undertakes to act as 'the general guardian of all infants, idiots, and lunatics.'"232 This capacious philosophy historically served as a justification for expeditious commitment and treatment, a goal consistent with the pre-deinstitutionalization belief that hospitals were best able to manage the mentally ill.233 Thus, in order to administer medication by force, an individual must be found to be incompetent to function or unable to make medical decisions.

Prior to the civil rights movement, psychiatric patients were deemed "globally incompetent by virtue of their hospitalizations."234 Today, however, both clinicians and courts maintain that mental illness strikes only limited areas of functioning, leaving other regions of the mind unimpaired.235 Moreover, the Supreme Court in Mills v. Rogers236 found a distinction between the standards governing involuntary commitment and those applying to incompetency.237 Thus, it is now acknowledged that many mentally ill individuals retain the capacity to function in a competent manner and to control their treatment regimens.238

230. See Winick, Mental Health Treatment, supra note 22, at 289; see also Black's Law Dictionary 1114 (6th ed. 1991) (defining "parens patriae").
231. See Cornell, supra note 203, at 377.
233. See Cornell, supra note 203, at 381.
234. Miller, supra note 26, at 138.
235. See Rivers v. Katz, 67 N.Y.2d 485, 494 (1986); see also N.Y. Mental Hyg. Law § 9.60(o) (McKinney 1999) ("The determination by a court that a patient is in need of assisted outpatient treatment under this section shall not be construed as or deemed to be a determination that such patient is incapacitated [for purposes of guardianship appointment]"). The appointment of a guardian is necessary to provide for the personal needs of that person, "including food, clothing, shelter, health care, or safety and/or to manage the property and financial affairs of that person." N.Y. Mental Hyg. Law § 81.02(a) (McKinney 1996). "Incapacity" is determined by the person's inability to provide for his personal needs and/or property management and inability to understand and appreciate the consequences of such inability. See id. § 81.02(b). The fact that an outpatient under Kendra's Law need not be deemed "incapacitated" reflects an understanding that mental illness is not synonymous with incompetency.
237. See id. at 297. The Court of Appeals for the Second Circuit has likewise held that civil commitment fails to raise a presumption of incompetence. See Winters v. Miller, 446 F.2d 65, 68 (2d Cir. 1971).
238. Under New York law, "mental illness" is defined as "an affliction with a mental disease or mental condition which is manifested by a disorder or disturbance in behavior, feeling, thinking, or judgment to such an extent that the person afflicted requires care, treatment and rehabilitation." N.Y. Mental Hyg. Law § 1.03(20). This definition in no way implies that a mentally ill person is also incapacitated. The clear
Today, courts consistently maintain that psychiatric patients are entitled to the same protections as other individuals when seeking or refusing medical treatment. New York courts, in particular, have held that a finding of mental illness does not raise a presumption that a patient is incompetent to make decisions regarding medical treatment. Hence, absent a determination of incompetency, the forcible administration of medication to a competent individual in a non-emergency situation violates her liberty interests in bodily integrity, personal security, and the right to privacy. On balance, the right to self-determination generally outweighs any countervailing state interests, and competent individuals are permitted to refuse medication, even at the risk of death.

While the parens patriae philosophy purports to be in the best interests of the individual and society as a whole, such coercive treatment raises fundamental questions of liberty, dignity, and justice that may override the state's interest. The court in Project Release v. Prevost held that diminished mental capacity alone cannot undermine the due process protections afforded to individuals. In order to justify treatment that invades fundamental constitutional rights, the patient's incompetency must be separately demonstrated in a manner that meets the requirements of procedural due process.

Trend in the law is to distinguish between mental illness and incapacity. See infra note 246 for examples of courts that require a separate adjudication of incompetency before ordering involuntary commitment.

239. See, e.g., Kulak v. City of New York, 88 F.3d 63, 74 (2d Cir. 1996) (detailing the rights of involuntary committed patients to refuse medication); Rivers, 67 N.Y.2d at 492 (finding that every individual has the right to control the course of her medical treatment); Superintendent of Belchertown v. Saikewicz, 370 N.E.2d 417, 428 (Mass. 1977) (maintaining that individual autonomy applies equally to mentally ill patients who should not be treated with less dignity or status due to their illnesses).

240. See Winters, 446 F.2d at 70-71; see also Rivers, 67 N.Y.2d at 495 (“[T]here is ample evidence that many patients, despite their mental illness are capable of making rational and knowledgeable decisions about medications. The fact that a mental patient may disagree with the psychiatrist’s judgment about the benefit of medication outweighing the cost does not make the patient’s decision incompetent.” (internal quotations omitted)).

241. See Project Release v. Prevost, 722 F.2d 960, 977-79 (2d Cir. 1983). Absent an overwhelming state interest, such as an emergency, a competent person has the right to refuse such treatment. See In re Guardianship of Roe, 421 N.E.2d 40, 51 (Mass. 1981). “To deny this right to persons who are incapable . . . is to degrade those whose disabilities make them wholly reliant on other, more fortunate, individuals.” Id.

242. See Arrigo, supra note 42, at 139. The author points to three paternalistic values underscoring institutionalization: social control, custody, and treatment. See id. at 139-43.

243. See, e.g., Swartz et al., The Ethical Challenges, supra note 206, at 37 (discussing the ethical implications of coercion with respect to mental health).

244. 722 F.2d 960 (2d Cir. 1983).

245. See id. at 971.

Moreover, even after a person is deemed incompetent, she does not forfeit her protected liberty interest to refuse unwanted medication. Rather, the individual remains entitled to have her "substituted judgment" exercised on her behalf. The substituted judgment standard is premised on the notion that the freedom of self-determination should not be lost merely because an individual is incompetent. The standard thus requires courts to draw two conclusions before forcibly administering medication. First, the party seeking the treatment order must demonstrate by clear and convincing evidence that the patient is incompetent. Second, the court must determine whether the proposed treatment is narrowly tailored to give substantive effect to a patient's liberty interest. Therefore, even when a person is deemed incompetent, the judge is required to weigh relevant factors before determining if medication is in the best interests of the ward.

Undoubtedly, institutionalized mental patients retain constitutional liberty and privacy rights to refuse antipsychotic medication. Furthermore, the government may infringe upon these rights only in an emergency or when the mental patient is deemed incompetent. The next part examines how these interests should be balanced in the

1982); People v. Medina, 705 P.2d 961, 973 (Colo. 1985).

247. Under the "substituted judgment" standard, courts weigh the individual's values and preferences to determine whether she would choose treatment if competent. See Beis, supra note 25, at 157. "[T]he doctrine in its original inception called on the court to 'don the mental mantle of the incompetent.'" Superintendent of Belchertown v. Saikewicz, 370 N.E.2d 417, 431 (Mass. 1977) (citation omitted).

248. See Mills, 457 U.S. at 301-02 (requiring that a court take into consideration a variety of factors before administering psychotropic drugs). These factors include: (1) the ward's expressed preferences regarding treatment; (2) her religious beliefs; (3) the impact upon the ward's family; (4) the probability of adverse side effects; (5) the consequences if treatment is refused; and (6) the prognosis with treatment. See id. at 302 n.19 (citing In re Guardianship of Roe, 421 N.E.2d 40, 57 (Mass. 1981)).

249. See Cruzan v. Director, Missouri Dep't of Health, 497 U.S. 261, 273 (1990); Saikewicz, 370 N.E.2d at 431; Winick, Mental Health Treatment, supra note 22, at 347 n.10.


251. See id.; see also Medina, 705 P.2d at 973 (maintaining that the patient's incompetency must be established before the state can administer antipsychotic medication to a nonconsenting mental patient.); Opinion of the Justices, 465 A.2d 484, 489 (N.H. 1983) (same).

252. See Rivers, 67 N.Y.2d at 497. This includes taking into consideration the patient's best interests, benefits and detriments from treatment, and less intrusive alternatives. See id. at 497-98.

253. See In re Guardianship of Roe, 421 N.E.2d at 56-57. Another court also maintained:

[I]t cannot be said that it is always in the 'best interests' of the ward to require submission to such treatment. . . . To presume that the incompetent person must always be subjected to what many rational and intelligent persons may decline is to downgrade the status of the incompetent person by placing a lesser value on his intrinsic human worth and vitality. Saikowicz, 370 N.E.2d. at 428.
context of involuntary outpatient commitment.

III. THE CONTROVERSY OVER KENDRA'S LAW

This part presents the arguments in support of and in opposition to involuntary outpatient commitment, with a concentration on New York's outpatient treatment statute, Kendra's Law. This part argues that as enacted, Kendra's Law violates both federal and state constitutional liberty interests, freedom of expression, and the individual right to privacy. Kendra's Law is also irreconcilable with the least restrictive alternative principle. Furthermore, this part concludes that such overinclusive outpatient laws are unsuitable means for treating mentally ill individuals. Given the coercive and intrusive characteristics of these statutes, this Note proposes that states also focus on voluntary programs and recovery-oriented services based on choice in treating the mentally ill.

A. Proponents of Kendra's Law

Proponents of Kendra's Law maintain that assisted outpatient commitment effectively ensures that severely mentally ill individuals will receive much-needed community treatment. The basis of this contention stems from the theory of deinstitutionalization and the accessibility of treatment facilities in the community. Proponents maintain that in outpatient programs, "patients [will] be better served, since they [can] have a more normal life, while the state [can] reduce the significant costs of long-term, round-the-clock care." Moreover, this intervention will treat mentally ill patients who are not presently dangerous, but who may become violent in the future, thereby reducing the risk of future tragedies similar to the death of Kendra Weidale.

The understanding of mental illness has progressed significantly in the past thirty years, and advocates of assisted outpatient laws believe that legislation, the judicial system, and public awareness must advance as well. Proponents maintain that outpatient commitment promotes these goals by enabling judges to order a "less restrictive, less expensive, [and] often [a] more beneficial option" to inpatient hospitalization. They argue that nearly half of those suffering from psychotic diseases do not realize they are sick and in need of

255. See Miller, supra note 26, at 209; supra notes 43-45 and accompanying text (describing the deinstitutionalization movement).
256. A New Look at Treating the Mentally Ill, supra note 45.
257. See Health Policy Tracking Service, supra note 18.
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This is because psychotic illnesses affect the brain’s self-evaluation function and patients' ability to give informed consent. Under Kendra's Law, professionals will monitor each individual's treatment program and intervene if the individual becomes non-compliant. Proponents contend that these services will ultimately "prevent violence, reduce hospital readmission rates, and save [the state] money."

Supporters of Kendra's Law acknowledge that individuals have certain constitutional rights to refuse medical treatment, including a right to liberty and privacy. However, they also note that such interests are not absolute. Courts have consistently held that the individual right to refuse antipsychotic drugs may be overcome by the state in the event of an emergency or when an individual is deemed incompetent. Advocates of Kendra's Law seemingly assume that the statute is consistent with both prongs of this constitutional mandate.

Supporters of outpatient protection have found that in recent years courts have relaxed the strictness of the “dangerousness” standard in determining the state’s ability to medicate civilly committed patients, and are statutorily defining the term “emergency” in a broader manner. In the Massachusetts case of Rogers v. Commissioner of Mental Health, for example, the court expanded the definition of “emergency” to prevent “immediate, substantial, and irreversible deterioration of a serious mental illness.” The justification for this expansion was to prevent future violence, rather than focusing solely upon the elimination of immediate societal threats. Advocates argue that Kendra’s Law is consistent with this definition because it authorizes involuntary medication “in order to prevent a relapse or deterioration which would be likely to result in serious harm to the patient or others.”

In the absence of an emergency, proponents of Kendra’s Law contend that the statute is also constitutional under the parens patriae doctrine. The parens patriae authority applies when an individual

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259. See Marquis & Morain, supra note 9.
260. For a more detailed analysis of schizophrenia and neuroleptic drugs, see Doudera & Swazey, supra note 5, at 1-18.
261. See N.Y. Mental Hyg. Law § 9.48 (a), (b) (McKinney 1999).
263. See supra Part II.B.
264. See Weiner & Wettstein, supra note 25, at 130. Some examples of states that ubiquitously define “emergency” are New Jersey and Massachusetts. See id. at 123.
266. Id. at 322 (quoting In re Guardianship of Roe, 421 N.E.2d 40, 55 (Mass. 1981)).
267. See id.
268. N.Y. Mental Hyg. Law § 9.60(c)(6) (McKinney 1999).
cannot care for herself or is unable to participate in treatment decisions. In such situations, the government intervenes to protect the well being of individuals deemed incompetent. Kendra’s Law authorizes involuntary psychotropic medication for individuals “unlikely to survive safely in the community without supervision,” and who are “unlikely to voluntarily participate in the recommended treatment . . . .” Advocates maintain that in the name of public and patient protection, this language meets the standard of “incompetency” that is necessary to compel mental patients into treatment.

Finally, Kendra’s Law supporters assert that the statute is consistent with the least restrictive alternative doctrine. Without community treatment, the only alternatives for the mentally ill are hospitalization and imprisonment, both of which are more intrusive than outpatient commitment. Mental hospitals “[bear] some similarities to prisons” and confine individuals for extended periods of time. Advocates of outpatient commitment argue that community treatment, by contrast, protects mental health consumers from becoming disenfranchised, facilitates a process of stable rehabilitation, and avoids the “crisis-oriented approach” that governs many mental hospital systems.

B. Arguments Against Outpatient Commitment

Civil libertarians and patients’ rights advocates vigorously oppose outpatient statutes, such as Kendra’s Law, as “harsh quick fix[es] that [do] little to address the system’s underlying problems” of inadequate funding and services for the mentally ill. They fear that such legislation is nebulous because it fails to delineate clear criteria

269. See supra notes 235-53 and accompanying text.
270. See supra notes 235-53 and accompanying text.
271. N.Y. Mental Hyg. Law § 9.60(c)(3).
272. Id. § 9.60(c)(5).
273. See, e.g., Sally Kalson, Mental Health Expert to Share Experiences, Insights, Pittsburgh Post-Gazette, Sept. 28, 1999, at A11 (“Kendra’s Law . . . makes it easier . . . to compel seriously mentally ill patients . . . to receive medication and treatment, as long as the treatment has been shown to help them and they are judged unable to make informed decisions themselves.” (emphasis added)).
274. See Beis, supra note 25, at 193. “In the mental health area, the doctrine of least restrictive alternative is a major factor in the decision of where a patient should be treated as an alternative to hospitalization.” Id.; see supra notes 46-55 and accompanying text.
275. See Winick, Mental Health Treatment, supra note 22, at 27.
276. Id.
277. Arrigo, supra note 42, at 85. Advocates maintain that “psychosocial treatment in the community introduces the patient to the experiences of living . . . in a nonpsychotic state.” Id. (internal quotations omitted).
for outpatient commitment, and will ultimately restore high rates of inpatient commitment.\footnote{280}

Opponents of Kendra’s Law maintain that the refusal of psychotropic medication is a fundamental right rooted in New York’s constitutional protections of liberty, expression, and the right to privacy.\footnote{281} New York courts have found that “[f]orçible medication can alter mental processes and limit physical movement, and therefore is analogous to bodily restraint.”\footnote{282} Bodily invasions, such as involuntary medication, implicate due process rights, which require some governmental justification.\footnote{283} The precise level of state scrutiny will in turn depend upon the seriousness of the intrusion.\footnote{284} Courts have maintained that these rights are abrogated in only two situations: (1) during an emergency or (2) when an individual is deemed incompetent.\footnote{285} Opponents assert that Kendra’s Law is unconstitutional because it infringes on individual rights without a determination of either.

New York courts have indubitably established that an “emergency” exists only when there is an \textit{imminent} danger to a patient or the community.\footnote{286} Furthermore, a “dangerous” person is defined as one who “engages in conduct or is \textit{imminently} likely to engage in conduct posing a risk of physical harm.”\footnote{287} Kendra’s Law, however, authorizes medical treatment to prevent a relapse or subsequent mental deterioration rather than when an individual poses an imminent threat to society.\footnote{288} The purpose of the law is to intervene “before the individual becomes dangerous.”\footnote{289} Thus, without meeting the requirement of imminence, the state’s police power interest is not sufficiently compelling to justify forcible intrusive treatment.

Some states, such as Arizona, use outpatient commitment as an alternative to hospitalization and apply inpatient criteria prior to

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\item[280] See Hicks, supra note 94.
\item[281] See Marquis & Morain, supra note 9; supra notes 190-94 and accompanying text.
\item[283] See supra notes 145-53 and accompanying text.
\item[284] See supra notes 207-08 and accompanying text.
\item[285] See supra notes 210-53 and accompanying text.
\item[287] N.Y. Comp. Codes R. & Regs. tit. 14, § 527.8(a)(4) (emphasis added).
\item[288] See N.Y. Mental Hyg. Law § 9.60(c)(6) (McKinney 1999). Even organizations dedicated to educating communities on the benefits of assisted outpatient treatment, such as the Treatment Advocacy Center, maintain that Kendra’s Law is preventative in nature. See Zdanowicz, supra note 254.
\item[289] See Zdanowicz, supra note 254.
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By utilizing outpatient statutes in this capacity, Arizona courts are ensuring that only severely mentally ill individuals will be involuntarily medicated. However, under Kendra’s Law, an individual can be forced into outpatient commitment despite the fact that she is not dangerous and does not meet the requirements for inpatient care. Rather, this law purportedly treats individuals before they become an imminent threat to themselves or others. Allowing forced treatment for non-dangerous reasons—including speculation of future deterioration or a history of refusing medication—will inevitably violate both the federal and state constitutions by involuntarily medicating competent individuals.

Critics also argue that Kendra’s Law does not explicitly require an adjudication of incompetency before authorizing forced medication. Courts have consistently held that competent patients have the constitutional right to refuse medical treatment. Competency is treated as a prerequisite to informed consent, and its absence must be established in order for the state to invoke its parens patriae power. Kendra’s Law states that:

If the recommended assisted outpatient treatment includes medication, such physician’s testimony shall describe the types or classes of medication which should be authorized, shall describe the beneficial and detrimental physical and mental effects of such medication, and shall recommend whether such medication should be self-administered or administered by authorized personnel.

Because the statute fails to indicate whether the patient must be “incompetent” prior to the authorization of medication, the state cannot constitutionally invoke its parens patriae authority. The failure of Kendra’s Law to make incompetency an explicit prerequisite to forced medication violates the principles of autonomy, liberty, and the constitutional right to privacy, by limiting a functional person’s ability to make informed decisions without governmental

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291. In New York, current inpatient commitment laws apply to persons who are regarded to be a danger to themselves or others. See N.Y. Mental Hyg. Law §§ 9.39, 9.40 (McKinney 1994). However, for one to be eligible for outpatient commitment, Kendra’s Law establishes a different set of criteria that must first be met. See N.Y. Mental Hyg. Law § 9.60(c) (McKinney 1999).

292. See Commitment Violates Basic Constitutional Rights, supra note 262.

293. See id. ("Allowing forced medication of nondangerous persons would mean that persons with psychiatric diagnoses would lose their right to give informed consent to treatment and their right to refuse unwanted treatment.")

294. See supra notes 210-11 and accompanying text.

295. See supra notes 239-46 and accompanying text.

296. N.Y. Mental Hyg. Law § 9.60(h)(4).

297. See supra notes 234-46 and accompanying text.
Moreover, Kendra’s Law prescribes that an outpatient must be "unlikely" to survive in the community sans supervision. It is unclear, however, what the legislature meant by the term "unlikely." Did they intend for it to have the same implications as "incompetency"? Although the competency question is of critical importance, there is no general consensus among states concerning the appropriate legal standard for ascertaining competency.

Various tests have been applied (sometimes in combination) to determine "[a] patient’s ability (a) to make and express a decision; (b) to actually understand the information disclosed about the treatment and alternatives to treatment; (c) to engage in decision making in a rational manner . . . ; and (d) to make a reasonable treatment decision." If the standards used to define legal "competency" vary considerably, then it will be even more arduous for courts to decipher the meaning of the term "unlikely." As one commentator notes, "[b]elief of intent, the subjective interpretation of language or acts, and even personal bias, may come into play under these criteria." The stigmatizing tendency to disbelieve people with mental disorders may also affect court decisions. Opponents maintain that without more clarity, this law will "give psychiatrists far greater latitude in their subjective determinations of persons considered to meet vague standards of being ‘unlikely’ . . . to ‘survive in the community’" and will ultimately infringe on the constitutional rights of competent and functional patients.

In addition, opponents of Kendra’s Law challenge whether the statute is actually the "least restrictive alternative." Because of the law’s arbitrary standards, competent patients may be compelled to take their medication or risk involuntary hospitalization. Undeniably, involuntary treatment is one of the most severe actions a government can impose on an individual, short of a criminal charge. Coercive treatment has many negative effects on individuals, undermining their "motivation, learning and general sense of organismic well-being." Moreover, psychotropic medication is

298. See supra Part II.B.2.
299. See N.Y. Mental Hyg. Law § 9.60(c)(3).
300. See Winick, Mental Health Treatment, supra note 22, at 349.
301. Id.
302. MadNation, Seven Misconceptions, supra note 64.
303. See id.
305. See supra notes 46-52 and accompanying text.
307. See Winick, Mental Health Treatment, supra note 22, at 85.
308. Id. at 336 (citation omitted). Institutionalized patients coerced into accepting
distressing and may present a variety of unwelcome side effects.\footnote{309} As compared to other forms of treatment, including verbal psychotherapy, behavior therapy, and voluntary services, psychotropic medication is the most intrusive and hazardous form of therapy.\footnote{310}

Aside from constitutional implications, opponents contend that outpatient laws are faulty in many other respects. First, basing involuntary treatment decisions on the guesswork of physicians and psychiatrists is problematic. As to the speculation of future violence, the medical professional's ability to predict dangerous behavior remains unclear.\footnote{311} The American Psychiatric Association has stated that "psychiatrists have no special knowledge or ability with which to predict dangerous behavior."\footnote{312} Physicians also recognize that there is a tendency to overestimate the "curative" effects and to underestimate the less desirable effects of antipsychotic medication.\footnote{313} Moreover, it is difficult for psychiatrists to offer definitive conclusions about the effectiveness of treatment on any particular patient.\footnote{314} One of the most persuasive criterion for courts ordering outpatient medical treatment under Kendra's Law is the examining physician's determination that "the patient will benefit from assisted outpatient treatment."\footnote{315} Because the efficacy of such medication is not always apparent, the language of Kendra's Law may lead a greater number of mentally ill persons into unwarranted coercive treatment.

Second, while psychotropic drugs are efficacious in the treatment of many mental patients, for some, they present unacceptably high risks of toxicity and unpropitious side effects.\footnote{316} These risks can be eliminated only by closely monitoring patients and carefully

\footnote{309}{See supra notes 113-16 and accompanying text.}
\footnote{310}{See Winick, Mental Health Treatment, supra note 22, at 42. "Behavior therapy postulates that maladaptive behaviors are learned and reinforced by the same principles of conditioning as 'normal' responses and... may be altered through the systematic application of principles of learning theory." Id. Verbal psychotherapy seeks to ameliorate mental symptoms in the context of a patient-therapist relationship. See id. at 30. Recent research supports the superiority of these approaches and maintains that such interventions have more lasting effects than pharmacological approaches. See id. at 50. Moreover, psychotropic medication presents a greater potential for misuse and abuse than these other treatment methods. See id. at 85.}
\footnote{311}{See Project Release v. Prevost, 722 F.2d 960, 973 (2d Cir. 1983); Miller, supra note 26, at 21.}
\footnote{312}{APA, supra note 2.}
\footnote{313}{See Doudera & Swazy, supra note 5, at 11-13; see also Addington v. Texas, 441 U.S. 418, 430 (1979) ("Psychiatric diagnosis... is to a large extent based on medical 'impressions' drawn from subjective analysis and filtered through the experience of the diagnostician.").}
\footnote{314}{See Doudera & Swazy, supra note 5, at 11-13.}
\footnote{315}{N.Y. Mental Hyg. Law § 9.60(c)(7) (McKinney 1999).}
\footnote{316}{See supra notes 114-16 and accompanying text.}
controlling dosages. This practice is difficult in understaffed mental hospitals and may be nearly impossible in outpatient programs, where patients are unmonitored and unregulated. Moreover, Kendra’s Law gives courts permission to order outpatients to self-administer psychotropic medication as part of their treatment regimens. Without direct supervision, patients are left vulnerable to serious abuses, misuse, and hazardous risks.

Finally, opponents maintain that Kendra’s Law would not have prevented the death of victims such as Kendra Webdale. The law attempts to make involuntary commitment easier. Kendra Webdale’s assailant, Andrew Goldstein, voluntarily sought commitment or supervised living thirteen times prior to his horrific outburst. However, he was repeatedly discharged and denied assistance because of an underfunded mental health system. While Kendra’s Law attempts to assist individuals who are “unlikely to voluntarily participate” in treatment programs, it provides no safeguards for the mentally ill who recognize their illnesses and seek help voluntarily. Only additional funding and services can aid these individuals.

C. The Resolution: Kendra’s Law Is Overbroad and Violates Basic Constitutional Rights

There is a tremendous need for an environment in which the mentally ill have widespread access to recovery-oriented rehabilitation and self-help services. New York has responded to this need by enacting Kendra’s Law, which is intended to enhance compliance with community treatment, improve functioning, and reduce hospital recidivism. However, this statute is a “dreadful ‘knee-jerk’ political [reaction]” to the tragically violent death of Kendra Webdale.

Not only is Kendra’s Law facially unconstitutional, but involuntary outpatient commitment laws in general are improper means of treating those suffering from psychiatric illnesses. Courts have consistently held that mentally ill prisoners, detainees, and inpatients retain constitutional liberty and privacy interests in refusing unwanted

317. See Winick, Mental Health Treatment, supra note 22, at 83.
318. See id. at 79-85.
320. See Bernstein, supra note 6.
321. See id. (describing the “long waiting lists” for admittance into state-financed mental institutions).
322. N.Y. Mental Hyg. Law § 9.60(c)(5) (McKinney 1999).
323. See generally Swartz et al., The Ethical Challenges, supra note 206, at 35 (discussing the goals of outpatient laws in general).
324. MadNation, Replacing Outpatient Commitment, supra note 57.
medication. Outpatients are logically entitled to similar, or even greater, constitutional protections. Because outpatients by definition are not imminently dangerous to society and retain some degree of functional capacity, they are deserving of the most strict level of scrutiny before involuntary medication is authorized.

The arguments opposing Kendra’s Law are a step in the right direction. Critics properly maintain that the statute is an infringement on an individual’s liberty interest, freedom of expression, and right to privacy. Kendra’s Law is preventative in nature rather than a mechanism for impeding immediate danger, and therefore does not invoke the government’s police power authority. Furthermore, because the law does not provide a constitutionally adequate procedure for determining whether an outpatient is incompetent, the state cannot authorize involuntary medication under the parens patriae doctrine.

When examining New York’s involuntary outpatient statute prior to Kendra’s Law, one discovers section 9.61(c)(2) of the 1994 pilot program, which authorized psychotropic medication for individuals incapable of making treatment decisions on their own. Kendra’s Law likewise contained a similar provision when it was first introduced to the Senate on June 3, 1999. The proposed statute stated:

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

This section, however, was eliminated from Kendra’s Law as enacted in August 1999. A logical explanation for this purposeful omission is that the New York legislature wished to enact a sweeping law that would embrace a large number of mentally ill individuals, rather than limiting involuntary medication to those severely ill. The lax criteria under the enacted statute inevitably violate both the

325. See supra notes 278-322 and accompanying text.
326. See supra notes 286-92 and accompanying text.
327. See supra notes 293-97 and accompanying text.
328. See N.Y. Mental Hyg. Law § 9.61(c)(2) (McKinney 1994).
329. See S. 5762, 222d Leg. Sess. (N.Y. 1999) (describing the first version of Kendra’s Law as it was introduced to the Senate on June 3, 1999).
330. Id. (emphasis added).
331. See generally N.Y. Mental Hyg. Law § 9.60(c) (omitting any reference to the kinds of circumstances that warrant involuntary medication).
procedural and substantive due process rights of nonviolent, competent patients and result in a blanket infringement of individual civil rights.

The legislature can address the flaws in Kendra’s Law in a number of ways. One alternative is to reinstate a provision specifying that antipsychotic medication may be involuntarily administered only upon a finding of legal incompetence. Many other states include such standards in their outpatient commitment laws, and authorize medication only after a determination that an individual is incapable of making medical decisions on her own. For example, Wyoming recently enacted a new mental health bill that allows courts to prescribe psychotropic medication only when individuals are “incompetent to make an informed decision.” Such provisions set explicit standards, thereby reducing the potential for constitutional infringements.

A second solution would be to statutorily encourage patients to engage in advance planning in order to express their desires about future treatment. Advance health care proxies bear a strong resemblance to a will and allow individuals to make future treatment decisions while they are still competent. Under Kendra's Law, courts are required to consider whether a patient has created a health care proxy before authorizing outpatient commitment. However, this is only one factor weighed against the other listed criteria.

In its landmark “right-to-die” case, Cruzan v. Director, Missouri Department of Health, the Supreme Court recognized that a patient enjoys a constitutionally protected liberty interest in making future health care decisions. Although Cruzan involved the right of a terminally ill patient to discontinue life-prolonging treatment, the Court’s language logically extends to both medical and mental health treatment that is not life-prolonging. If a patient possesses a due process right to accept or refuse medication, then “a competent expression of the patient’s desires should be respected” even if, at a

334. See Winick, Mental Health Treatment, supra note 22, at 392-93. Under this theory, patients are empowered to make decisions in advance (while competent) concerning future health care needs arising at a time when they may later be incapacitated. See id. at 392.
335. See Winick, Mental Health Treatment, supra note 22, at 393. “Just as individuals have the ability to dispose of their property upon death by expressing their intentions in a will, patients may control future health treatment through the use of advance directive instruments.” Id.
338. See id. at 278-79.
later date, the patient is incapacitated. The New York legislature should therefore give bolder force and effect to an outpatient’s health care proxy in order to preserve her constitutional right to refuse involuntary medication.

Although the former solution would likely render Kendra’s Law constitutional on its face, and the latter would ensure that it is constitutionally applied, both fail to resolve the law’s larger problems. While forty-one states have outpatient commitment laws, most of these states refuse to enforce them. In fact, “judges in many states are not familiar or comfortable with the laws and are reluctant to use them.” Thus, despite the fact that these laws are enacted out of concern for public safety, in actuality they protect neither the public nor the mentally ill when they remain underutilized.

Moreover, a recently completed study in New York City found that involuntary outpatient commitment was ineffective in reducing hospital re-admissions and patient dangerousness. Studies have concluded that there are no significant differences in the treatment outcomes of recipients of involuntary outpatient treatment and those who do not receive such services. Furthermore, research shows that coercion undermines patient confidence, deters individuals from seeking voluntary treatment, and increases the risk of “drug dependence, disabling side effects of medication and suicide.” Finally, involuntary outpatient commitment has not been demonstrated to have a positive impact upon mental health or on a patient’s quality of life.

Overly broad outpatient commitment laws, such as Kendra’s Law, are simply “quick-fix[es]” that fail to address the mental health system’s underlying problems, such as lack of services, funding, and programs. In this age of managed health care policies, hospitals are provided with financial incentives to discharge patients promptly. Kendra’s Law will not change this “calculus of financial, political and legal pressures” to release patients from mental hospitals. Even under Kendra’s Law, “[d]ownsizing of psychiatric hospitals will continue . . . [and] the billions of dollars saved will continue to go to

339. Winick, Mental Health Treatment, supra note 22, at 392.
340. See Health Policy Tracking Service, supra note 18.
341. Id.
343. See id at 3. However, the Treatment Advocacy Center also notes that the PRA itself acknowledged flaws in its study due to the small sample size. See id.
344. See MadNation, Replacing Outpatient Commitment, supra note 57.
346. See id.
347. Fields, supra note 278.
348. See Bernstein, supra note 6.
the state’s General Fund, rather than to community facilities. Moreover, establishing a system in which large categories of individuals can petition the already overcrowded courts to order an individual into outpatient commitment opens the floodgates of litigation and subjects those displaying signs of mental illness to a deprivation of their constitutional rights.

While outpatient commitment may be appropriate for those severely mentally ill, in that it acts as a mechanism that allows such individuals to live in the community rather than in a hospital, a more appropriate solution for less severely afflicted individuals is to shift focus away from coercive therapies and toward rehabilitative services based on choice. Undoubtedly, many mentally ill individuals require medication to function in society. However, enacting involuntary outpatient laws as broad as Kendra’s Law are not necessarily the proper way to meet this need. City and state governments should expand the availability of effective individual-based rehabilitation and recovery-oriented services for patients who are not deemed incompetent and therefore are not eligible for outpatient commitment. These services should include crisis prevention, management services, and plans that promote wellness, independence, and personal responsibility. An extensive body of psychological literature points to the positive value of allowing individuals to exercise choice concerning a variety of matters affecting them. Patient choice in treatment decisions, for example, is an important determinant of treatment success:

Choice . . . may bring a degree of commitment that mobilizes the self-evaluative and self-reinforcing mechanisms that facilitate goal achievement. To the extent that patients’ agreements to accept a course of treatment recommended by therapists constitutes an affirmative expression of patient choice of treatment, such choice itself may be therapeutic.

Rather than broadening involuntary outpatient commitment laws to include virtually all mentally ill patients, governments must create a spectrum of humane and attainable voluntary services that offer a broad range of choices and respect patients’ dignity. Involuntary

350. MadNation, Seven Misconceptions, supra note 64.
351. See N.Y. Mental Hyg. Law § 9.60(e) (McKinney 1999); supra note 97 and accompanying text.
352. See supra notes 56-59 and accompanying text.
355. Winick, Mental Health Treatment, supra note 22, at 329.
commitment statutes and consequent forced medication should be correspondingly limited in scope and applied only to patients who present an emergency or are deemed incompetent. Only then will the constitutional rights of mentally ill individuals be preserved.

CONCLUSION

Kendra’s Law, adopted in the aftermath of Kendra Webdale’s death at the hands of a schizophrenic assailant, was undoubtedly enacted with the best of intentions. Such headline-grabbing acts of violence set the stage for outpatient commitment laws aimed at lowering the standards for involuntary treatment in order to reach a larger portion of the mentally ill community. However, outpatient commitment is only one part of a much larger set of issues that ultimately determines whether mentally ill individuals have access to appropriate treatment and services. If community treatment resources are unavailable, outpatient commitment laws will ultimately fail.

This Note argues that Kendra’s Law, which provides for involuntary medication absent an emergency or a declaration of incompetence, is unconstitutionally vague. Although New York courts have established that forcible medication of a competent patient is unethical and in violation of the First and Fourteenth Amendments, Kendra’s Law allows for such an act on its face. Furthermore, the law does not provide a constitutionally adequate procedure to determine a patient’s competency prior to ordering psychotropic medication. No legal basis exists to support the involuntary administration of antipsychotic drugs to a competent, non-dangerous mentally ill outpatient.

Infringing upon the rights of individuals merely because they are mentally ill is both unconstitutional and culturally loathsome. Kendra’s Law should be amended and reconciled with both federal and state constitutional mandates. In addition, the legislature should make voluntary support services and programs based on patient choice and medically-monitored recovery widely available to mentally ill individuals. Only then will tragedies such as the death of Kendra Webdale be prevented.