

January 2008

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Recommended Citation

Henry A. Dlugacz, *Involuntary Outpatient Commitment: Some Thoughts on Promoting a Meaningful Dialogue Between Mental Health Advocates and Lawmakers*, 53 N.Y.L. SCH. L. REV. 79 (2008-2009).

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Involuntary Outpatient Commitment:
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Meaningful Dialogue Between Mental
Health Advocates and Lawmakers

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I. INTRODUCTION

Far-reaching are the effects of the events of January 3, 1999, when Andrew Goldstein, a young man diagnosed with a severe mental illness, pushed Kendra Webdale on to the subway tracks where she was tragically killed by an oncoming train.¹ Obscured by the saturation of media coverage that followed this painful incident² was the fact that Goldstein had previously been rebuffed by the mental health system in his efforts to obtain treatment.³ From this tragic event came New York's adoption of Kendra's Law,⁴ a comprehensive statute establishing procedures for obtaining court orders mandating outpatient mental health treatment for those found by clear and convincing evidence to meet its criteria.

Much has been written about involuntary outpatient commitment ("OPC"). It is not the purpose of this essay to fully explore OPC in general or New York's version of such a law in particular, nor will I attempt to cover in depth the complex state of research related to OPC's effectiveness. I will, instead, put forth some thoughts to

1. See Julian E. Barnes, *Insanity Defense Fails for Man Who Threw Woman onto Track*, N.Y. TIMES, Mar. 24, 2000, available at <http://query.nytimes.com/gst/fullpage.html?res=9C05EFD6173DF930A15750C0A9669C8B63>.

2. See, e.g., Michael L. Perlin, *Therapeutic Jurisprudence and Outpatient Commitment: Kendra's Law as Case Study*, 9 PSYCHOL. PUB. POL'Y & L. 183, 184 (2003) [hereinafter *Case Study*]. Professor Perlin noted:

[B]ecause of the sensational series of events that led to the introduction and passage of the law—the vivid and horrifying facts of Kendra Webdale's death, the tortured life of her killer Andrew Goldstein, the saturation publicity given to the case and the way it became the focal point for so much political maneuvering in Albany—it has developed a public "following" that none of its predecessors shared.

Id.

3. See Margo Flug, *No Commitment: Kendra's Law Makes No Promise of Adequate Mental Health Treatment*, 10 GEO. J. ON POVERTY L. & POL'Y 105, 105 (2003); Peter A. Briss et al., *Strengthening Legal and Scientific Framework: Science and Public Health Policy Makers*, 33 J. L. MED. & ETHICS 89, 92 (2005) (statement of Richard N. Gottfried, Assemblyman, N.Y. State Assembly) ("Labels put on proposals, such as the names of victims put on laws . . . tend to obscure the real issues or crimes. . . . [I]n New York State, we have Kendra's Law named after a woman who was pushed onto the train tracks in New York City by a person with a history of mental illness. The aftermath of this included the passing of a law mandating court ordered assisted outpatient treatment. The truth is that the man in Kendra's case had not refused treatment; he had actually been banging on the doors of the system seeking help and getting turned away. The facts in Kendra's case had nothing to do with Kendra's Law but once her name was affixed to it, it drove the bill to enactment."). This is not to say that people with mental disabilities do not at times refuse offers of assistance, even in cases where it seems clear to the outside observer that such refusal is not in the person's best interest. This is typically ascribed to a lack of insight on the part of the patient. But, Tanya Marie Luhrmann found that:

[H]omeless women who could get housing based on a psychiatric diagnosis but who reject it with the assertion that they are not "crazy" are making . . . a costly signal. The signal is indeed expensive to them. The choice to forgo housing exposes them to considerable danger and discomfort. But it is a signal that asserts competence and strength in a social setting in which those attributes are highly valued.

Tanya Marie Luhrmann, *"The Streets Will Drive You Crazy": Why Homeless Psychotic Women in the Institutional Circuit in the United States Often Say No to Offers of Help*, 165 AM. J. PSYCHIATRY 15, 15 (2008). I wonder if the primary insight here is that people, including those diagnosed with mental disabilities, are, to a sometimes surprising degree, willing to go to great lengths to maintain a sense of dignity and autonomy.

4. Diane D. Denish, *City's Kendra's Law an Empty Promise*, ALBUQUERQUE J., Apr. 21, 2006, at A13.

prompt further inquiry and, I hope, provoke some thinking about an issue that has engendered more vitriol than rational discourse. As I delineate some thoughts on this topic, I will note a series of what I refer to as dialogue points, the good-faith discussion of which I suggest would help law-makers, advocates, and clinicians reach a socially constructive and ethically sound solution to the “incredible dilemmas”⁵ that OPC brings into stark relief whenever and wherever it is proposed.⁶ The primary goal is to add, in some modest fashion, to the “national dialogue [which] is taking place on the legality and morality of allowing deprivations, such as jail or hospitalization to be avoided, and rewards, such as money or housing to be obtained, based on adherence to treatment.”⁷ In this context, OPC is but one manifestation of

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5. As discussed by the Supreme Court in a different context, “[t]he law should not, and in our judgment does not, place the defendant in such an incredible dilemma.” *Green v. United States*, 355 U.S. 184, 193 (1957). The dilemma in *Green* was that, in the words of the court, “[the defendant] must be willing to barter his constitutional protection against a second prosecution for an offense punishable by death as the price of a successful appeal from an erroneous conviction of another offense for which he has been sentenced to five to twenty years’ imprisonment.” Although *Green* presented this concept in a distinct context, the notion that some situations present seemingly impossible to reconcile interests is apropos to this discussion. As in other areas of current national significance, I would argue that it is not constructive to prematurely frame the debate as one of safety vs. civil liberties, a truly incredible dilemma if ever there was one—at least when not fairly presented. See Michael L. Perlin, *Hospitalized Patients and the Right to Sexual Interaction: Beyond the Last Frontier?*, 20 N.Y.U. REV. L. & SOC. CHANGE 517, 540 n.142 (citing Peter Westen, *Incredible Dilemmas: Conditioning One Constitutional Right on the Forfeiture of Another*, 66 IOWA L. REV. 741, 742 (1981)).
 6. As I will discuss what I consider to be some underlying assumptions held by some of the participants in the controversy concerning OPC, it seems only fair that I state some of my core beliefs about this important area. On a meta-level, I am deeply concerned about a growing trend away from a respect for the inherent right of self-determination possessed by all human beings—a principle which I believe is at the core of American values. I personally believe we are all, collectively and individually, in trouble if this does not remain a bedrock, commonly-shared value in our society. See generally Dora W. Klein, *Involuntary Treatment of the Mentally Ill: Autonomy Is Asking the Wrong Question*, 27 VT. L. REV. 649 (2003), for an interesting discussion of this question. If improperly implemented, OPC could certainly be one part of this troubling trajectory. At the same time, I have seen in individual instances beneficial results from its application—people who stabilize and lead more productive lives as a result of this intervention. There are times when I wonder if these two observations can be reconciled. There are times when deeply flawed solutions to large-scale social, ethical, and public health problems can still be the humane and safest thing to do in specific, individual cases. The problem, I think, comes from the fact that this is only true if we acquiesce to our avoidance of systemic solutions to these problems. More specifically, given our inability as a society to truly deal with the need for universal access to quality healthcare, the dwindling public health care system and the over-representation of disenfranchised groups among those who rely on this scarce resource, and the large-scale incarceration of the mentally ill in our criminal justice system, perhaps OPC is, in any particular instance, the most practicable tool available to those on the ground at any given point in time. That does not mean that taken from the public health or public policy perspectives this is the best we as a society can do. Nor, therefore, should enactment of an OPC statute end the discussion in any particular jurisdiction. As Justice Brandeis said, “Experience should teach us to be most on our guard to protect liberty when the government’s purposes are beneficent. . . . The greatest dangers to liberty lurk in insidious encroachment by men of zeal, well-meaning but without understanding.” *Olmstead v. United States*, 277 U.S. 438, 479 (1928) (Brandeis, J., dissenting).
 7. John Monahan, *Mandated Treatment: Applying Leverage to Achieve Adherence*, 36 J. AM. PSYCHIATRY L. 282, 284 (2008).

INVOLUNTARY OUTPATIENT COMMITMENT

the coercion applied to people with mental disabilities living in the community, aimed at increasing adherence to prescribed treatment regimens.

II. BACKGROUND: INVOLUNTARY OUTPATIENT COMMITMENT

Involuntary Outpatient Commitment, or OPC, is also known in some jurisdictions as “assisted outpatient treatment,”⁸ and in some commonwealth jurisdictions as “community treatment orders.”⁹ Psychiatrist Marvin Swartz and psychologist Jeffrey Swanson suggest that: “[OPC] is a legal intervention designed to benefit persons with serious mental illness . . . who need ongoing psychiatric care and support to prevent relapse, hospital readmissions, homelessness, or incarceration, but have difficulty following through with community-based treatment.”¹⁰ In all forms of OPC, a judge orders a person who resides in the community and meets certain statutorily defined criteria, to follow a prescribed course of treatment related to a diagnosed mental health condition.¹¹

We do not venture far into what would appear to be a fairly straightforward definitional matter before we are confronted with core assumptions underlying much of the debate about OPC. Swartz’s and Swanson’s definition seemingly works off of the assumptions that the target population is ill, that the population is in need of treatment that its members are incapable of seeking on their own, and that the proposed services will ameliorate a wide range of medical and social ills.

Consider, however, the following definition: OPC is a legal intervention designed to disproportionately coerce into treatment members of racial minority groups who are labeled as having psychiatric disorders or are victims of a variety of social conditions, notwithstanding the fact that they wish to resist this unwanted treatment which generally includes forced drugging.¹² This definition emphasizes the coercive and unwanted nature of the so-called treatment. Additionally, there is the clear implication that OPC is primarily an agent of social control, targeting segments of society already subjected to destructive, disparate treatment.

What if, however, the following definition were tendered: OPC is a legally sanctioned method of ensuring that people meeting statutorily defined criteria are given priority in securing scarce mental health treatment and social service resources. Furthermore, OPC is designed to ensure that the treatment system provides the identified and needed services. This definition emphasizes yet another aspect of OPC—the statutory schema is designed to move to the front of the line those who

8. See, e.g., Laura’s Law, CAL. WELF. & INST. CODE § 5345 (West 2008).

9. See, e.g., Mental Health Act, R.S.O., ch. M7, s. 33.1 (West 2008).

10. Marvin S. Swartz & Jeffrey W. Swanson, *Involuntary Outpatient Commitment, Community Treatment Orders, and Assisted Outpatient Treatment: What’s in the Data?*, 49 CAN. J. PSYCHIATRY 585, 585 (2004).

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

12. See generally N.Y. LAWYERS FOR PUB. INTEREST, IMPLEMENTATION OF “KENDRA’S LAW” IS SEVERELY BIASED, (Apr. 7, 2005), [hereinafter IMPLEMENTATION OF “KENDRA’S LAW”] available at http://nylpi.org/pub/Kendras_Law_04-07-05.pdf.

are the subject of court-ordered outpatient treatment,¹³ holding the system as well as the subjects accountable for treatment.¹⁴

Scholars Jennifer Honig and Susan Stefan offer a credibly neutral definition:

OPC . . . is a court order compelling the compliance of an individual living outside of an institution with a treatment regimen or other aspects of community life. The order generally mandates acceptance of psychiatric medication and may mandate receipt of other services, such as individual or group therapy, participation in educational or vocation programs, and supervised living arrangements.¹⁵

With this general background in mind, we turn to several dialogue points.

III. DISCUSSION

Dialogue Point 1: Multiple assumptions and values fuel OPC definitions.

Any comprehensive approach to the issue of OPC must be cognizant and respectful of the range of assumptions and values concerning OPC, and must recognize that certain aspects of OPC will be afforded different weights depending upon the outlook of the person creating the definition. A careful analysis of the underlying assumptions of each stakeholder to the OPC dialogue helps us to examine how the interests related to those assumptions are vindicated (or not vindicated) in any proposed or existing OPC legislation.

The prototypical OPC law was developed in North Carolina in 1985.¹⁶ At present, most states have statutes providing for some type of OPC.¹⁷ Some states, however, make more active use of OPC than others.¹⁸ In recent years, a trend toward enactment of OPC statutes has gained international momentum—reaching Israel,

13. While surely made by others, I first made this point in a presentation on OPC at the Twenty-fifth International Congress on Law and Mental Health in Siena, Italy: if nothing else, OPC is at heart a rationing statute. In many ways, this point is made by the question posed by the very title of the paper referenced *infra* note 14, *Outpatient Commitment in Mental Health: Is Coercion the Price of Community Services?*

14. See, e.g., *Outpatient Commitment in Mental Health: Is Coercion the Price of Community Services?*, 757 ISSUE BRIEF (Nat'l. Health Policy Forum of George Washington Univ., Washington, D.C.), July 11, 2000, at 5 (quoting an anonymous policy advisor: "A lot of providers don't want to treat the people who are at higher risk for relapsing [those that would be subject to outpatient treatment orders] because they are the most difficult to treat We now have the ability to encourage accountability among providers.").

15. Jennifer Honig & Susan Stefan, *New Research Continues to Challenge the Need for Outpatient Commitment*, 31 NEW ENG. J. ON CRIM. & CIV. CONFINEMENT 109, 110 (2005).

16. See N.C. GEN. STAT. § 122C-2 (2008).

17. See, e.g., N.C. GEN. STAT. § 122C-2 (2008); ARIZ. REV. STAT. ANN. § 36-540 (2008).

18. See, e.g., Paul S. Appelbaum, *Assessing Kendra's Law: Five Years of Outpatient Commitment in New York*, 56 PSYCHIATRIC SERVICES 791, 791 (2005) ("Forty-two states now have some form of statutory authorization for involuntary outpatient treatment, although surveys suggest that only a minority actively implement such laws.").

INVOLUNTARY OUTPATIENT COMMITMENT

Canada, the United Kingdom, Australia, and New Zealand.¹⁹ In a mutually reinforcing phenomenon, this has added to the sense of inevitability of these statutes in the United States.

New York enacted Kendra's Law²⁰ in 1999 and was among the last states to adopt an explicit OPC statute. Nonetheless, my experience, both nationally and internationally, has been that many knowledgeable people discuss the issue of OPC as if it began with New York's adoption of Kendra's Law.²¹ One need look no further than the recent attempt to adopt OPC in New Mexico for a striking example of this phenomenon: the defeated proposal for an OPC law was actually entitled *Kendra's Law*.²² Thus, as a practical matter, much of the deliberation concerning the efficacy of OPC and the wisdom of enacting OPC statutes in other jurisdictions centers on an analysis of Kendra's Law.²³

19. See, e.g., Swartz & Swanson, *supra* note 10, at 585. Recently, scholars from Australia, Canada, New Zealand, the United Kingdom, and the United States were brought to the same podium to partake in a panel entitled *The Role of Political Perceptions in the Development of Mental Health Legislation* at the 30th International Congress on Law and Mental Health in Padua, Italy. The panel focused on involuntary outpatient commitment. My role was to discuss the New York experience.

20. N.Y. MENTAL HYG. L. § 9.60 (McKinney 1999).

21. See, e.g., Joel A. Dvoskin & Erin M. Spiers, *Commentary: In Search of Common Ground*, 31 J. AM. ACAD. PSYCHIATRY L. 184, 185 (2003) (discussing the universal debate regarding problems associated with OPC, the article uses Kendra's Law as an identifying tool for the general pitfalls of OPC legislation).

22. See, e.g., Denish, *supra* note 4.

23. See, e.g., Perlin, *Case Study*, *supra* note 2, at 184. Professor Perlin wrote:

Kendra's Law is one of those state-specific statutes whose impact will inevitably extend beyond the one jurisdiction in which it is law. New York is far from the first state to experiment with an [OPC] law (although that is something that the unsuspecting reader would not know from the press coverage).

Id. Under the New York Mental Hygiene laws, a court may order a person to OPC if the court finds that the patient meets the following criteria: is at least eighteen years of age; suffers from a mental illness and is unlikely to survive safely in the community without supervision, as deemed by a clinical determination; has a history of noncompliance with treatments that has resulted in one or more seriously violent acts, threats of violence, or attempted violence toward self or others within the last forty-eight months, or which has resulted in a hospitalization or receipt of mental health services at a correctional facility at least twice within the last thirty-six months—excluding the period of hospitalization or incarceration immediately prior to the filing of the petition; is unlikely to voluntarily participate in treatment; and will likely benefit from treatment and needs such treatment in order to prevent behavior likely to result in serious harm to the patient or others. N.Y. MENTAL HYG. LAW § 9.60(c) (McKinney 1999). Court proceedings are initiated by petitions. Potential petitioners include parents, spouses, persons with whom the subject resides, children, siblings, a qualified treating psychiatrist, or a probation or parole officer charged with supervising the individual. N.Y. MENTAL HYG. LAW § 9.60(e)(1)(i–vii). The petition must be accompanied by an affidavit of a physician (not the petitioner) who attests either that he or she has examined the patient within ten days and recommends OPC, or that the physician has been unable to examine the patient because of non-cooperation by the patient and that “such physician has reason to suspect that the subject of the petition meets the criteria for assisted outpatient treatment.” N.Y. MENTAL HYG. LAW § 9.60(e)(3)(ii).

Dialogue Point 2: The mass media has reduced the ability for rational discourse about OPC.

Media portrayals of the mentally ill, as well as the tragic nature of specific cases where a person with a mental disability kills or harms another person, color our thinking, making difficult a dispassionate discussion of the facts of specific cases and reducing the likelihood of a response that is rationally related to the provoking incident.²⁴ One question which should inform an analysis of any such situation is: to what extent does a vivid, horrible event create pressure for a solution to a perceived problem that incorrectly equates mental illness with dangerousness, and/or creates a solution not reflective of the underlying problem?

After Kendra Webdale's death, calls came from many corners for legislation aimed at dealing with mentally ill people who resist treatment in the community, and thus endanger society.²⁵ Much of the coverage was seemingly unaware of the fact that Goldstein had previously sought treatment voluntarily.²⁶ This is not particularly surprising when one examines the portrayal of people with mental illness in the media and popular culture, where they are typically portrayed in unfavorable ways. A comprehensive summary of these media portrayals by Professors Patricia Stout, Jorge Villegas, and Nancy Jennings found that:

[s]pecifically, the media tended to present severe, psychotic disorders. Persons with mental illness were depicted as being inadequate, unlikable, and dangerous and as lacking social identity. Characters with mental illness were portrayed as unemployable—they were less likely to be employed outside the home and more likely to be seen as failures when employed. Even more consistent were depictions of violence and dangerousness associated with media images of mental illness. Signorielli found that 72 percent of characters with mental illness portrayed in prime-time television dramas were violent.²⁷

Professor Elaine Sieff reviewed the specific case of the portrayal of Andrew Goldstein in this light and found that he was referred to, for example, as a “ticking time bomb.”²⁸ In this way, in the New York public's mind the Webdale case was connected with its modern antecedent—the case of Larry Hogue.²⁹ Mr. Hogue,

24. See Elaine Sieff, *Media Frames of Mental Illness: The Potential Impact of Negative Frames*, 12 J. MENTAL HEALTH 259 (2003) (describing how the mentally disabled are portrayed in the media and the power of that portrayal in shaping public opinion regarding this group of citizens).

25. See Appelbaum, *supra* note 18, at 791 (“[T]he attack [on Kendra Webdale] galvanized the public and lawmakers in support of the proposed legislation.”).

26. Michael Cooper, *Suspect Has a History of Mental Illness, but Not of Violence*, N.Y. TIMES, Jan. 5, 1999, at B6.

27. Patricia Stout et al., *Images of Mental Illness in the Media: Identifying Gaps in the Research*, 30 SCHIZOPHRENIA BULLETIN 543, 545–51 (2004) (citations omitted).

28. Sieff, *supra* note 24, at 264.

29. *Seltzer v. Hogue*, 594 N.Y.S.2d 781 (2d Dep't 1993).

INVOLUNTARY OUTPATIENT COMMITMENT

labeled in the media as the “wild man of 96th street,”³⁰ was described by a resident of the Manhattan area where he spent much of his time while living in the community in the following way:

Hogue appeared to be merely a harmless homeless man to whom she [Lehr] used to bring food and clothing. However, over the years Hogue’s behavior turned violent and erratic. Specifically, Lehr observed Hogue on numerous occasions jumping into moving traffic from crouched positions between cars. She also observed Hogue siphoning gasoline out of parked cars at 2:00 or 3:00 A.M., igniting newspapers with the gasoline, and then stuffing the newspapers into other cars, and assaulting and injuring an old woman. Lehr further testified that on one occasion Hogue carried a marble bench weighing approximately 150 pounds from a building adjacent to her own, and crashed it with “great fury” through the window of her car, bending the frame and breaking the steering wheel. Hogue also frequently exposed himself in the middle of the street and masturbated. Finally, Lehr testified that at another, earlier hearing involving Hogue, he had threatened her by saying: “You’re dead, bitch.”³¹

Because his criminal offenses were minor and his mental status would typically clear rapidly following a brief period off of drugs, he was not retained in either the criminal justice or mental health systems for any significant period of time. This case heightened the sense that these systems overemphasized individual rights to the detriment of community safety.

The connection between mental illness and dangerousness is the subject of much popular and scholarly exploration, and is beyond the scope of this essay.³² But no discussion of OPC can be complete without acknowledging that an important per-

30. See, e.g., Editorial, *The “Wild Man” and the Law*, N.Y. TIMES, Aug. 29, 1992, at 18, available at <http://query.nytimes.com/gst/fullpage.html?res=9E0CE1D8113FF93AA1575BC0A964958260>.

31. *Seltzer*, 594 N.Y.S.2d at 782.

32. For a good starting point in understanding this topic, see generally the United States Department of Health and Human Service Substance Abuse and Mental Health Services Administration, *Understanding Mental Illness: Factsheet*, http://www.samhsa.gov/MentalHealth/understanding_MentalIllness_Factsheet.aspx.

Research has shown that the vast majority of people who are violent do not suffer from mental illnesses. Clearly, mental health status makes at best a trivial contribution to the overall level of violence in society. [T]he absolute risk of violence among the mentally ill as a group is still very small and . . . only a small proportion of the violence in our society can be attributed to persons who are mentally ill. Most people who suffer from a mental disorder are not violent—there is no need to fear them. Embrace them for who they are—normal human beings experiencing a difficult time, who need your open mind, caring attitude, and helpful support. Compared with the risk associated with the combination of male gender, young age, and lower socioeconomic status, the risk of violence presented by mental disorder is modest. People with psychiatric disabilities are far more likely to be victims than perpetrators of violent crime. A new study by researchers at North Carolina State University and Duke University has found that people with severe mental illness—schizophrenia, bipolar disorder or psychosis—are 2 1/2 times more likely to be attacked, raped or mugged than the general population.

Id. (formatting and citations omitted).

ception concerning OPC is that it protects the public.³³ Indeed, one might ask if outpatient commitment statutes are enacted primarily as a transitional step toward a person's independent and fully integrated community functioning, or if their bedrock purpose is to enhance monitoring and treatment of such individuals to promote public safety. Are these goals mutually exclusive? I would assert that they are not. In fact, I would argue that people with mental illness who are offered treatment and services which address their needs in a manner that engages their desires for dignity and independence (the goal of which is to assist them in maintaining the greatest degree of autonomy and community integration reasonably possible) will be more likely to accept such offers of assistance, and as a result may pose a reduced public safety risk.

Dialogue Point 3: Where you stand on OPC depends upon where you sit.

Early reference to OPC schema can be found in the landmark patient-rights case of *Lessard v. Schmidt*, which mentioned OPC as an alternative to the more restrictive involuntary hospitalization.³⁴ Initial OPC efforts can be seen as attempts to reduce the degree of coercion employed on people already subjected to some degree of involuntary psychiatric oversight, making these efforts consistent with the least restrictive alternative principle.³⁵ In contrast, later iterations of OPC are seen by some as efforts

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33. If we required any reminder of this, we need look no further than the recent events at Virginia Tech, when, on April 16, 2007, a student with a previously identified mental illness opened fire at the school, killing thirty-two people before committing suicide. The horrific event reinvigorated the discussion concerning privacy laws, but also brought additional attention to the question of whether OPC can assist in preventing such tragedies. See, e.g., Aaron Levin, *Va. Tech Tragedy Spurs Examination of Commitment, Campus MH*, PSYCHIATRIC NEWS, June 1, 2007, at 1, available at <http://pn.psychiatryonline.org/cgi/content/full/42/11/1-a?etoc>. Even since that unsettling event last year, there have been at least two, recent, high-profile crimes allegedly committed by people with mental disabilities. It will be instructive to follow media portrayals of these horrific events and compare and contrast them to the manner in which the media dealt with Andrew Goldstein's murder of Kendra Webdale some nine years ago. See Monica Davey, *Gunman Showed Few Hints of Trouble*, N.Y. TIMES, Feb. 16, 2008, at A1, available at <http://www.nytimes.com/2008/02/16/us/16gunman.html?scp=3&sq=mental+gun&st=nyt> (reporting the instance of a twenty-seven-year-old man who had apparently stopped taking his psychiatric medications prior to opening fire and killing five students and himself on an Illinois campus); Daryl Khan & Fernanda Santos, *Bizarre Turn at Hearing for Suspect in Stabbing*, N.Y. TIMES, Feb. 17, 2008, at A1, available at <http://www.nytimes.com/2008/02/17/nyregion/17cnd-murder.html?x=1203915600&en=17a02b3e3c1d4307&ei=5070&emc=eta1> (describing a case involving a thirty-year-old man with an apparent psychiatric history accused of stabbing to death a Manhattan psychologist and injuring another psychologist who had been involved in his prior civil commitment proceedings).
34. 349 F. Supp. 1078, 1096 (E.D. Wis. 1972) (Harlan, J., concurring) ("These alternatives [to inpatient commitment] include voluntary or court-ordered out-patient treatment, day treatment in a hospital, night treatment in a hospital, placement in the custody of a friend or relative, placement in a nursing home, referral to a community mental health clinic, and home health aide services.").
35. See *Olmstead v. L.C. ex rel Zimring*, 527 U.S. 581, 587 (1999).
 [W]e confront the question whether the proscription of discrimination may require placement of persons with mental disabilities in community settings rather than in institutions. The answer, we hold, is a qualified yes. Such action is in order when the State's treatment professionals have determined that community placement is appropriate,

INVOLUNTARY OUTPATIENT COMMITMENT

to widen the net, placing a larger group of people within the coerced treatment system.³⁶

Dialogue Point 3a: Examining OPC as an alternative to inpatient commitment focuses on fundamentally different aspects of its effects than does an analysis viewing OPC as an autonomy reducing statute.

OPC looks quite different if viewed as an autonomy-enhancing, community-based alternative to inpatient commitment, than if viewed from the point of view of the person already living in the community who wishes to retain the right to make fundamental choices concerning medical treatment. Therefore, it is reasonable to ask: what is the goal of any proposed OPC statute, and what is the target population—people living inside of institutions or those living in the community? Another fair question is: who is viewed as the primary beneficiary of the OPC order—the individual or society?

The degree to which OPC is seen as an intrusion on civil liberties depends not only on whether it is contrasted to being confined to a hospital or to living freely in the community, but also on how one perceives the restrictions of the court order itself. Like most OPC statutes, New York's law does not have contempt provisions, so while a person is ordered to follow a certain course of treatment, there are few consequences attached to noncompliance. In New York, a subject who violates an OPC order (or, as it would be called in New York, an AOT order) can be brought to an emergency room for a period of observation not to exceed seventy-two hours, after which time a person not found to meet ordinary civil commitment criteria must be released.³⁷

This situation may have narrative and factual truths (the subjective experience of someone that cannot be quantified versus objective facts) that are difficult to reconcile. A person may feel the coercion associated with a judicial decree that he or she must comply with a prescribed course of treatment. Further, while OPC is certainly less intrusive than involuntary inpatient commitment, being forcibly brought to an emergency room and held in the hospital for seventy-two hours without the option of leaving is still a considerable intrusion on liberty.

the transfer from institutional care to a less restrictive setting is not opposed by the affected individual, and the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities.

Id.

36. *But see* Perlin, *Case Study*, *supra* note 2, at 187–88; Jeffrey L. Geller et al., *Involuntary Outpatient Treatment as “Deinstitutionalized Coercion”: The Net-Widening Concerns*, 29 INT'L J. L. & PSYCHIATRY 551 (2006) (reporting the findings of a naturalistic experiment in Massachusetts which revealed that net-widening did not occur, despite an environment strongly conducive to that expansion).
37. *See, e.g.*, Ilissa L. Watnik, Comment, *A Constitutional Analysis of Kendra's Law: New York's Solution for Treatment of the Chronically Mental Ill*, 149 U. PA. L. REV. 1181, 1200 (2001) (“[M]edication may not be administered over the individual’s objection. In cases of noncompliance, a physician may recommend that the patient be taken to a hospital and be retained there for up to seventy-two hours to determine if a need exists for inpatient treatment.”) (citation omitted).

Dialogue Point 3b: Depending upon one's viewpoint, OPC's impact reflects either its lack of consequences for noncompliance or its coercive nature.

OPC statutes can be seen as having “no teeth” or as being unnervingly intrusive. The lack of contempt provisions in such laws does not negate what may be a narrative truth reflecting a considerable sense of coercion and loss of personal dignity.

Dialogue Point 3c: Judges, like the rest of us, may be influenced by paternalism and a desire to see good outcomes.

Judicial paternalism manifests itself either in the sense of wishing to see an individual do well, or as conservatism in judicial decision-making based upon a desire to avoid spectacular failures.³⁸ The same it-depends-upon-your-perspective phenomenon concerning the statute itself is relevant to judicial decision-making regarding renewals of existing OPC orders. I have personally witnessed many such hearings where the testimonies of both the physician and OPC subject are factually consistent.³⁹ For example, the patient is taking medications, attending group therapy, and has remained out of the hospital during the pendency of the OPC order. Yet each draws opposite conclusions from this set of essentially stipulated facts.

The physician sees OPC as an effective intervention as demonstrated by improved functioning of the patient. Why, the doctors posit, would the patient not continue such a beneficial treatment regime? In contrast, the subject of the OPC order may, in these same factual circumstances, see a disparate, yet equally obvious conclusion: he is doing better and no longer requires an intrusive interference with his autonomy. How a judge reconciles these opposing presentations will often depend upon the degree of paternalism he or she is comfortable with. From my experience, the pull toward the “better safe than sorry” approach often proves irresistible, leading judges to renew orders in circumstances such as the one described above. Again, where you stand depends upon where you sit. This is no less true for a person sitting upon the bench as it is for the rest of us.

These divergent perspectives on OPC engender difficult and often contradictory pulls in many of those who examine it.⁴⁰ This makes OPC stand out from other forms of coercion used to promote adherence to socially-desirable behaviors among people with mental disabilities. As Professor John Monahan and his colleagues

38. In my experience, judges may err on the side of caution to avoid being responsible for releasing someone who then causes harm.

39. I have represented various New York City area hospitals in a variety of mental hygiene hearings over the past decade.

40. See Flug, *supra* note 3, at 108–09.

[T]he central characteristic of Kendra's Law, and possibly the biggest reason for its popularity, is that it is based on the belief that coercion is necessary to successfully treat severe mental illnesses in an outpatient setting. The Law's strongest critics counter, however, that most people with severe mental illnesses would accept treatment voluntarily if the State offered more comprehensive and more flexible services.

Id.

INVOLUNTARY OUTPATIENT COMMITMENT

pointed out in 2001, leverage is employed in many situations affecting this group, including the withholding or providing of welfare benefits, representative payees, subsidized housing, and, increasingly for those arrested, sentencing considerations in exchange for compliance with OPC treatment requirements.⁴¹

Dialogue Point 4: OPC statutes cause visceral, polarizing reactions among many stakeholders on all sides of the issue.

In that same article, Monahan makes a point which, sadly, cannot be taken for granted: “an evidence-based approach must rapidly come to replace the ideologic posturing that currently characterizes the field [referring to OPC].”⁴² This informal essay does not attempt to comprehensively review the evidence which is available in the field. Rather, I submit that there exist some empirical questions which must first be asked, and then answered objectively if we are to move beyond the “ideologic posturing” Monahan so aptly describes.⁴³

In 2004, Swartz and Swanson conducted a comprehensive literature review asking the question: what’s in the data concerning OPC?⁴⁴ They conclude that OPC appears to be most effective when sustained for six months or more, and is most effective for people with psychotic disorders.⁴⁵ The study further notes that “OPC is not a substitute for comprehensive services; in fact, it is only effective if combined with frequent services.”⁴⁶ It is the latter of these findings that has the greatest implications for this discussion because, I think, it shows the way for both advocacy and science in this area. OPC is only helpful with sustained treatment. Advocacy should be aimed toward obtaining better treatment for the mentally disabled client.

Dialogue Point 5: Advocates in OPC proceedings significantly influence the outcomes.

Early advocacy concerning OPC, particularly in New York, focused on constitutional attacks. In 1986, the New York Court of Appeals decided the ground-breaking case of *Rivers v. Katz*, holding, on strictly state constitutional grounds, that an involuntarily committed patient in a psychiatric hospital could not be medicated over his or her objection absent an emergency, unless the hospital proved by clear and convincing evidence that the person: (1) suffered from a mental illness; (2) lacked the capacity to make a reasoned decision; and, those threshold findings being made; (3) that the proposed treatment was the least restrictive way of treating the illness; and (4) was in the patient’s best interest.⁴⁷

41. See, e.g., John Monahan et al., *Mandated Community Treatment: Beyond Outpatient Commitment*, 52 PSYCHIATRIC SERVICES 1198 (2001).

42. *Id.* at 1204.

43. *Id.*

44. Swartz & Swanson, *supra* note 10.

45. *Id.* at 585.

46. *Id.*

47. *Rivers v. Katz*, 67 N.Y.2d 485, 497–98 (1986).

When confronted with Kendra's Law petitions, attorneys representing the mentally ill focused on the threshold requirement in *Rivers*—that the person subjected to involuntary medication had to lack the capacity to make a reasoned decision—prior to moving on with the inquiry as to whether medication over objection could be judicially sanctioned.⁴⁸ Surely, they reasoned, if such a requirement attached to forced drugging within a hospital (presumably focusing on a more incapacitated cohort), then the New York State constitution would require the same finding prior to mandated medication in outpatient treatment. How, it was asked, could it be that a person confined to a hospital could be afforded a greater bundle of rights than a person living within the community?

Such were the constitutional questions presented to the New York Court of Appeals in *In re K.L.*,⁴⁹ a case involving a man with a diagnosis of schizoaffective disorder who did not comply regularly with his medications and, at times, became aggressive. He challenged Kendra's Law on equal protection grounds because it failed to require the threshold finding that he lacked the capacity to make his own treatment decisions.⁵⁰ The New York Court of Appeals, however, did not agree that such a threshold finding was required for OPC orders. The court held that Kendra's Law did not

violate equal protection by failing to require a finding of incapacity before a patient can be subjected to an [OPC] order. Although persons subject to guardianship proceedings and involuntarily committed psychiatric patients must be found incapacitated before they can be forcibly medicated against their will, a court-ordered assisted outpatient treatment plan simply does not authorize forcible medical treatment—nor, of course, could it, absent incapacity. The statute thus in no way treats similarly situated persons differently.⁵¹

No forced medication could occur under Kendra's Law; thus no prior finding of lack of capacity was constitutionally required.⁵²

As a matter of law, it seems settled that Kendra's Law and other similar schema will pass constitutional muster.⁵³ Where does that leave an advocate? One obvious answer is that an individual subject to an OPC order must still meet the statutory criteria. As a result, there are always fact-specific arguments in any given case for

48. See, e.g., *In re K.L.*, 1 N.Y.3d 362, 369 (2004).

49. See *id.*

50. *Id.* at 482–83.

51. *Id.* at 486.

52. *Id.*

53. See, e.g., *Moore v. Wyo. Med. Ctr.*, 825 F. Supp. 1531, 1536–39 (D. Wyo. 1993) (noting that a state statute allowing an officer or medical examiner to detain a mentally ill person with a threshold standard of “substantial probability” of causing themselves or others harm did not deprive the individual of their liberty interest and therefore the standard need not be the more vigorous “imminent threat of physical harm” to pass “constitutional muster”); *Suzuki v. Quisenberry*, 411 F. Supp. 1113 (D. Haw. 1976) (holding that a state's interest in emergency intervention is sufficient to justify the temporary deprivation of a mentally ill patient's liberty interest, and in such a case, no prior notice or hearing is necessary).

INVOLUNTARY OUTPATIENT COMMITMENT

why a client is not a suitable candidate. Non-constitutional arguments may be put forth to defeat OPC laws as well. In addition, other courts in jurisdictions where OPC statutes have not yet been challenged might be more sympathetic to constitutional arguments.

I would suggest an additional possibility—that OPC statutes might be used by advocates as a vehicle to secure needed services for their clients. Note that Kendra’s Law brought with it a considerable increase in funding for short-in-supply, yet needed services such as medications and case management services.⁵⁴

One early case, *Arden Hill Hospital v. Daniel W.*, held that, except in instances where the respondent had sufficient resources, the county was the party responsible for financing court-ordered services.⁵⁵ It is the treatment provider who brings the petition to which a specific treatment plan must be appended.⁵⁶ But should not the advocate with a willing client, instead of the treatment provider, examine with great scrutiny the services offered in the plan? Whether the services are suitable? Whether they are sufficient? Do they meet with the client’s approval? Does an independent expert agree? Why would an advocate not consider bringing a contempt motion against a provider that secured a court order mandating a certain type of treatment and then subsequently failed to provide it properly? Is this not an appropriate form of advocacy in a post-*In re K.L.* world?

Acceptance of this proposed approach in some (*not all*) circumstances leads to an important empirical question: what do the data tell us about what types of services⁵⁷ are useful to the group subjected to the restrictions associated with treatment provider prescribed treatment plans? Perhaps one of reasons that the discussion of OPC has evolved as it has is the over-reliance on medication as the sole or primary form of assistance.⁵⁸

Indeed, attendant questions arise: Would subjects of OPC orders be more amenable to the treatment plan provided if they had a more meaningful opportunity to participate in its creation? Is this an appropriate consideration for counsel representing subjects of OPC orders? In OPC, even more so than in other areas of mental disability law, outcomes and the very nature of the proceedings are intensely depen-

54. The statute introduced considerable funding for transitional medications and case management services. See Erin O’Connor, Note and Comment, *Is Kendra’s Law a Keeper? How Kendra’s Law Erodes Fundamental Rights of the Mentally Ill*, 11 J.L. & POL’Y 313, 364 n.255 (“To implement the law, the state has allocated more funding for community programs and discharge planning.”).

55. 703 N.Y.S.2d 902, 906 (Sup. Ct. Orange County 2000).

56. N.Y. MENTAL HYG. LAW § 960 (McKinney 2008).

57. I use the word *services* knowingly as it is meant to encompass housing, financial support, integrated mental health, and substance abuse treatment when indicated, in addition to medication when warranted.

58. See Rachel A. Scherer, Note, *Toward a Twenty-First Century Civil Commitment Statute: A Legal, Medical, and Policy Analysis of Preventative Outpatient Treatment*, 4 IND. HEALTH L. REV 361, 369 (2007).

dent upon the role of counsel. To some extent, whether OPC petitions are contested “appears to be a function of venue.”⁵⁹

Should the proper role of the advocate in an OPC proceeding be to secure more or different services for the client? If so, what services would be useful to, and accepted by, any given client, and how would greater consumer participation in the development of treatment plans improve adherence to treatment with or without a court order?⁶⁰

Dialogue Point 6: OPC criteria mandate the inclusion of specifically defined people.

It is beyond question that, as a matter of public policy, OPC laws are, at heart, rationing statutes. OPC statutes give certain groups of people priority in securing

59. Perlin, *Case Study*, *supra* note 2, at n.156 (emphasis omitted). In his analysis, Perlin notes that one unit of lawyers representing people in Kendra’s Law petitions (attorneys in the Second Department) contests these petitions disproportionately. Perlin further notes that “sources in that office” informed him “that their primary concern is the way the law has been implemented: that it may potentially undermine the therapeutic alliance (by undermining individuals’ sense of self-esteem and self-importance).” *Id.* It is interesting to consider this point in conjunction with the insights provided by Luhrmann’s study, *supra* note 3, which notes that some people will reject assistance in order to project a sense of strength and competence, even when these actions appear to those of us outside of the milieu to be irrational.

60. For an advocate to answer this requires the examination of some tricky questions. One is foundational—what is the role of an advocate in the representation of the mentally disabled? But, given the number of jurisdictions nationally and internationally which have adopted OPC schema, a second could be characterized as strategic—has the battle engaged in by some to defeat the advance of OPC statutes been lost? If so, should the focus shift toward ensuring adequate representation of subjects of OPC proceedings and toward using OPC orders as leverage to secure scarce services for clients? Or, for example, does the recent rejection of an OPC statute in New Mexico, and the New York State legislature’s unwillingness to make Kendra’s Law permanent, suggest that the call for surrender is premature? I have argued the former, but understand that others may see this differently. Further, the ground may have shifted somewhat since I first proposed this idea. On August 5, 2008, the New Mexico Court of Appeals upheld the lower court’s decision to strike down New Mexico’s version of Kendra’s Law. While the court based its opinion on a number of grounds related to a city’s lack of authority to preempt by ordinance a state code and statute, it also distinguished New York cases upholding that state’s OPC on due process grounds:

[E]ven, for the purpose of argument, were we to read the Ordinance to be consistent with the New York statute as to the absence of a sanction, for two reasons we conclude that the reasoning behind the New York court’s due process holding cannot be applied in the context of the preemption analysis at issue in this case. First, the New York court was faced with a state statute that addressed assisted outpatient treatment, not an ordinance. Consequently, the due process discussion in *In re K.L.* is not particularly helpful to our consideration of the separate issue of preemption, especially because the New York legislature had incorporated other, related mental health statutes into its assisted outpatient treatment statute. When considering preemption, we must, above all, follow our Legislature’s intent, which, as we discussed earlier in this opinion, is clearly that no person with capacity be treated without consent. Second, unlike the New York statute, the Ordinance does not state that the failure to comply with a court order will not result in sanctions.

Protection and Advocacy System, *Jane Does 1–3 and John Doe 1 v. City of Albuquerque*, No. 27-199, slip op. at 47 (N.M. Ct. App. Aug. 5, 2008) (citations omitted), *cert. denied*, No. 31-301 (N.M. Sept. 22, 2008).

INVOLUNTARY OUTPATIENT COMMITMENT

scarce or at least finite mental health services.⁶¹ In New York's case, this group is defined according to the criteria set forth in Kendra's Law.⁶² In other jurisdictions the specific criteria will vary, but in all instances some statutorily defined group of people is given higher priority for mental health services than others.

Do OPC statutory definitions envelope the group most in need of the services it prescribes? Would a greater public health or public safety benefit be garnered by changing the criteria such as to capture within the ambit of the OPC schema a distinct cohort?

Dialogue Point 7: OPC statutes do not stand alone in the public mental health system.

Swartz and Swanson's review of the data indicates that OPC only appears to be effective if combined with frequent services.⁶³ How, then, can a discussion of OPC be conducted meaningfully outside of a thorough review of a jurisdiction's public mental health system? If OPC is only one point in a continuum of measures that society routinely applies to people with serious, chronic mental illness,⁶⁴ how can the services that form the mandated treatment plan associated with OPC be separated from other public mental health services available within any given jurisdiction? Again, it is worth recalling that Andrew Goldstein killed Kendra Webdale after knocking on the doors of multiple mental health providers in New York City.⁶⁵

Questions to be considered include: How do current or proposed statutes providing for OPC fit into the larger public mental health system? Are adequate services available to effectuate well-designed treatment plans with services of sufficient quality and quantity useful to the consumer? If the answer is no, what additional funds, if any, would be required to change this? Is OPC envisioned as part of a continuum of adequate public mental health services ranging from community-based, non-coercive services to those provided within hospitals and correctional facilities? Or, in contrast, is the implementation of a proposed or existing schema more fairly seen as a Band-Aid placed on a severely wounded public mental health system?

Assuming that an adequate array of public mental health services is available in sufficient quantity to ensure reasonable access to care for those who need and/or want it, an important, and yet unanswered, empirical question remains: is the coercive aspect of OPC orders a necessary component of the successful outcomes associated with these orders? Or, are adequate, individualized services in which consumers are treated with respect and afforded dignity sufficient to obtain a reasonable

61. See Scherer, *supra* note 58, at 369.

62. See N.Y. MENTAL HYG. L. § 9.60(c) (McKinney 1999).

63. Swartz & Swanson, *supra* note 10.

64. See John Monahan et al., *Use of Leverage to Improve Adherence to Psychiatric Treatment in the Community*, 56 PSYCHIATRIC SERVICES 37, 37 (2005) ("Debates on current policy emphasize only one form of leverage, outpatient commitment, which is much too narrow a focus. Attempts to leverage treatment are ubiquitous in serving traditional public-sector patients."). Other forms of leverage include money, housing, sentence mitigation, and the threat of further incarceration, as well as outpatient orders.

65. Cooper, *supra* note 26.

degree of treatment adherence? In other words, is the coercive aspect an essential part of positive outcomes that may be obtained, or is it merely a politically palatable way to allocate needed dollars to public mental health services?

Dialogue Point 8: The racial disparity in the application of OPC statutes is one of the more troubling aspects of the debate concerning the desirability of such laws.

New York Lawyers for the Public Interest analyze the data from the New York OPC experience and assert that

[t]here are major racial, ethnic, and geographic disparities throughout New York State in the implementation of “Kendra’s Law.” Black people are almost five times as likely as White people to be subjected to this law—which dramatically reduces freedom of choice over their treatment and their lives—and Hispanic people are two and a half times as likely as non-Hispanic White [sic] people. People who live in New York City are more than four times as likely to be subjected to orders as people living in the rest of the state. Also, contrary to how it has been sold, the law is used mainly on people with multiple psychiatric hospitalizations but no histories of hurting others.⁶⁶

Such findings are serious and should not be lightly dismissed. They require an unflinching examination of their veracity, causes, and implications, as they have social justice, public policy, and equal protection clause implications. First, I would suggest that the issue should be made more precise: Is the assertion that, in specific instances, the provisions of Kendra’s Law are applied disproportionately to people of color because of their membership in racial groups? Or is the suggestion that, like other putatively neutral laws or social policies, the statute’s negative, disparate impact on racial minorities is reflective of broader social inequities? If an examination were to reveal the former, the issue does not warrant status as a dialogue point, but rather should be dealt with promptly and robustly under existing civil rights statutes.

However, if at heart, the suggestion is really the latter, we are once again confronted with a legally, morally, and socially complex matter ripe for good-faith discussion. Could the following findings account for the over-representation of people of color as subjects of Kendra’s Law: (1) members of racial minorities are disproportionately represented in the public mental health system; (2) this system is inadequate to meet the demonstrated needs of public mental health patients; and (3) there is a disparity between the results of treatment for those involved with the public rather than private mental health system? What if an empirical examination were to find that people of color disproportionately lack the means to acquire services independently of OPC orders? Could that also account for the over-representation of people of color as subjects of Kendra’s Law? The basis for the aforementioned possible conclusions could be the result of years of *institutionalized* racism. This, in turn, could be seen as the cause for the disparate utilization associated with Kendra’s Law petitions. Is it necessary to distinguish between root and proximate causes

66. IMPLEMENTATION OF “KENDRA’S LAW”, *supra* note 12, at 1.

INVOLUNTARY OUTPATIENT COMMITMENT

when conducting this analysis, or is that irrelevant so long as the outcome is disparate?

At which point of this complex web does one intervene, and what would be an appropriate response? What if, as the experts suggest, petitions are utilized primarily for people who have multiple hospitalizations rather than histories of dangerousness, and, hypothetically, these multiple hospitalizations could be traced to inadequate access to community-based treatment in certain communities? Where would that lead us?

What does the empirical evidence regarding the representation of people of color as subjects of OPC petitions demonstrate? How, if at all, do these data connect with other indicia of inequalities in terms of access to treatment, penetration in the public mental health and correctional systems, and other relevant factors? What further study is needed to answer these questions, and where does the data lead us in terms of intervention?

IV. CONCLUSION

Paul Appelbaum notes that just because Kendra's Law is found to be constitutional "does not necessarily mean that it represents good policy."⁶⁷ This essay proposes some empirical questions, answers to which would assist lawmakers in New York (and elsewhere) in deciding whether OPC is indeed good policy. It is my hope that the thoughts put forth in this essay promote some much-needed, rational dialogue about the wisdom of enacting OPC statutes, or once the decision to enact an OPC statute is made, the form it should take. I expect, at the least, that I have suggested some useful questions that must be addressed—some are philosophical, but others can only be answered by empirical research and legal analysis. I hope that we move in the direction of thoughtful examination and reform.

67. See Appelbaum, *supra* note 18, at 792.