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Settling the Doubts About the Constitutionality of Outpatient Commitment

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I. INTRODUCTION

The salient issue for the proponents, opponents, and undecided on involuntary outpatient treatment ("IOT") (involuntary outpatient commitment ("IOC")); Assisted Outpatient Treatment ("AOT") should be a straight forward, case-by-case risk-benefit analysis. Simply, do the clinical, vocational, safety, and quality of life gains accrued to the beneficiary of IOT outweigh any abrogations of autonomy and freedom experienced by the particular individual from IOT? Unfortunately, to date, this has not been the predominant approach. Rather, IOT has been the center of a cacophonous political debate devoid of evidence-based practices. Although almost every clinical examination of IOT has found at least one statistically significant and salutary effect of the treatment mechanism,¹ the research is

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1. E.g., Marvin S. Swartz et al., *Can Involuntary Outpatient Commitment Reduce Hospital Recidivism?*, 156 AM. J. PSYCHIATRY 1968, 1973 (1999) (AOT reduced hospital admissions by fifty-seven percent when used for at least six months and combined with routine mental health services); Jeffrey W. Swanson et al., *Involuntary Out-Patient Commitment and Reduction of Violent Behaviour in Persons With Severe Mental Illness*, 176 BRIT. J. PSYCHIATRY 224, 228-29 (2000) (incidences of violence halved when AOT used for at least six months and combined with routine mental health services); Jeffrey W. Swanson et al., *Can Involuntary Outpatient Commitment Reduce Arrests Among Persons with Severe Mental Illness?*, 28 CRIM. JUST. & BEHAV. 156, 182-83 (2001) (among those with history of multiple hospitalizations and arrests or violence, median re-arrest rate of those under AOT was approximately one-quarter (twelve versus forty-seven percent) of

such that many studies have been used to vociferously support any of the three positions: for, against, and undecided.

Before clinicians and researchers can get to the point of the examination of the efficacy and effectiveness of IOT, the issue of IOC's constitutionality needs to be put to rest. Contrary to repeated assertions in the opposition, the choice by states to legislate measures authorizing IOC, or of state political subdivisions to make greater use of existing statutes for IOT, should not be seen as one of permissibility but rather of sound policy.

The legal foundation upon which IOT rests has been validated by a number of courts. As it has long been conclusively settled that courts can be empowered to commit some individuals with psychiatric disorders to the generally more restrictive setting of a hospital, judicial orders requiring compliance with treatment in the more integrated outpatient setting would seem to be permissible.² Constitutional challenges and arguments of constitutional invalidity, capable of negating entire outpatient commitment measures, have instead focused on the progressive eligibility standards incorporated in most of the more recent statutes.³

Pursuant to the law of every state, and firmly recognized by the case law of the United States Supreme Court, people who become a danger to themselves or others due to the symptoms of mental illness, may be involuntarily placed in inpatient treatment.⁴ Debated is whether there are

those who were not under AOT); Virginia A. Hiday et al., *Impact of Outpatient Commitment on Victimization of People With Severe Mental Illness*, 159 AM. J. PSYCHIATRY 1403, 1411 (2002) (in one year, forty-two percent of those in the control group were victims of crimes such as rape, theft, mugging, or burglary, versus only twenty-four percent of those who were in assisted outpatient treatment for six months or more with routine services); Gustavo A. Fernandez & Sylvia Nygard, *Impact of Involuntary Outpatient Commitment on the Revolving-Door Syndrome in North Carolina*, 41 HOSP. & CMTY. PSYCHIATRY 1001, 1003 (1990) (median readmissions decrease from 3.7 to 0.7 per 1,000 days); Virginia A. Hiday & Teresa L. Scheid-Cook, *The North Carolina Experience with Outpatient Commitment: A Critical Appraisal*, 10 INT'L J.L. & PSYCHIATRY 215, 229 (1987) (over six months, thirty percent medication refusal versus sixty-six percent absent orders); Robert A. Van Putten et al., *Involuntary Outpatient Commitment in Arizona: A Retrospective Study*, 39 HOSP. & CMTY. PSYCHIATRY 953, 957 (1988) ("[A]lmost no patient[s]" without an order voluntarily maintain treatment in mental health system versus seventy-one percent who receive such an order); Guido Zanni & Leslie deVeau, *Inpatient Stays Before and After Outpatient Commitment*, 37 HOSP. & CMTY. PSYCHIATRY 941, 942 (1986) (readmissions decrease from 1.81 to 0.95 per year).

2. *E.g.*, *O'Connor v. Donaldson*, 422 U.S. 563 (1975).

3. *In re K.L.*, 806 N.E.2d 480 (N.Y. 2004); *In re Urcuyo*, 714 N.Y.S.2d 862, 871-72 (Sup. Ct. 2000).

4. *O'Connor*, 422 U.S. at 575; see also Floyd L. Jennings, *Current Status of Mental Health Commitments*, 35 THE HOUSTON LAWYER 40, 40 (noting that discussion over past two decades has focused not on whether state can commit an individual with mental illness, but rather what procedural and substantive due process are necessary).

other constitutionally sufficient justifications for the court-ordered treatment of individuals with mental illness.⁵ As judges are understandably hesitant to find individuals to be an imminent danger to themselves or others and then order their release to the community at the same hearing, an effective outpatient commitment statute must include a non-danger based eligibility standard, or at least a dangerous standard more broadly defined than the inpatient standard.

Examination of the history of involuntary psychiatric treatment in the United States reveals that a dramatic heightening of the statutory threshold for the initiation of involuntary treatment began in the late 1960s.⁶ For decades before that, essentially anyone who was adjudged suffering from a mental illness could be involuntarily placed in treatment, often with no more than two physicians signing a certificate.⁷ This lax standard resulted in many commitments deemed, in retrospect, to be arbitrary, discriminatory, and clinically unnecessary.

In reaction to such abuses, revisions in mental health laws led to virtually every state restricting court-ordered treatment to only those found a danger to him or herself or to others, typically an imminent or immediate one.⁸ Further, inspiring this marked reconfiguration of involuntary treatment laws was an erroneous, but prevailing, belief that the only constitutionally acceptable justification for commitment was imminent

5. See Brief for the Appellant at 12, *Department Of Treasury v. Galioto*, 477 U.S. 556 (1986) (commitment may be ordered only in the presence of clear and convincing evidence that the individual presents a danger to himself or others (citing *O'Connor*, 422 U.S. at 575)); GENERAL ACCOUNTING OFFICE, MENTAL HEALTH: COMMUNITY-BASED INCREASES FOR PEOPLE WITH SERIOUS MENTAL ILLNESS 6 (2000) (stating "In 1975, the Supreme Court found held that mentally ill individuals could not be committed unless they were found to be dangerous to themselves or others." (citing *O'Connor*, 422 U.S. at 575)); NEW YORK CIVIL LIBERTIES UNION, STATEMENT OF NORMAN SIEGEL, EXEC. DIR. CONCERNING "KENDRA'S LAW," available at <http://www.nyclu.org/kendrastrmnt.html> (last visited Nov. 30, 2004); (BAZELON CENTER FOR MENTAL HEALTH LAW, POSITION ON INVOLUNTARY COMMITMENT, available at <http://www.bazelon.org/issues/commitment/bazelonposition.htm> (last visited Nov. 30, 2004) (various bases currently used for outpatient commitment "are not legally permissible" because the individual does not "constitute imminent, significant physical harm to self or others.").

6. See Steven B. Datlof, *The Law of Civil Commitment in Pennsylvania: Towards a Consistent Interpretation of the Mental Health Procedures Act*, 38 DUQ. L. REV. 1, 7 (1999); Donald H.J. Hermann, *Barriers to Providing Effective Treatment: A Critique of Revisions in Procedural, Substantive, and Dispositional Criteria in Involuntary Civil Commitment*, 39 VAND L. REV. 83, 94-95 (1986); Grant H. Morris, *Defining Dangerousness: Risking a Dangerous Definition*, 10 J. CONTEMP. LEGAL ISSUES 61, 65-66 (1999); Darold A. Treffert, *The MacArthur Coercion Studies: A Wisconsin Perspective*, 82 MARQ. L. REV. 759, 768-69 (1999).

7. Datlof, *supra* note 6, at 5; Treffert, *supra* note 6, at 764.

8. E.g., VA. CODE ANN. § 37.1-67.3 (1998).

dangerousness combined with mental illness (grave disability also being considered an imminent danger).⁹

The adoption of imminent danger as the sole standard for involuntary placement in psychiatric treatment soon left hundreds of thousands of others incapacitated by illnesses for which effective treatments were available. Many states subsequently adopted involuntary treatment standards based on criteria other than simple dangerousness. These standards encompass factors such as deteriorating condition, need for treatment, inability to make informed treatment decisions, likelihood of becoming dangerous absent treatment, and the capability of independent functioning.¹⁰ There is no single standard phraseology, but each allows for the involuntary treatment of some persons impaired by the symptoms of mental illness without requiring them to be immediately dangerous.

The existence of these newer involuntary treatment standards, some in effect for more than two decades, is a seeming paradox. If dangerousness is an indispensable predicate to involuntary commitment, how can states pass statutes that seem to defy the United States Constitution? And how is it that this new breed of standards has not been struck down?

The most enlightened explanation is that people who refuse treatment *because* of their symptoms of mental illness need not be dangerous before they can be helped. And indeed, the belief that dangerousness is the only justification for involuntary treatment is waning. Some still cling to the dangerousness credo,¹¹ but, with progressively greater frequency, there is the recognition that a more flexible interpretation of dangerousness, and the legitimacy of a state acting in the *parens patriae* ("parent of the country") role to help individuals who have been rendered incapable of rational decision making or self-preservation by the effects of mental illness, is persuasive.¹²

9. *E.g.*, *Lessard v. Schmidt*, 349 F. Supp. 1078, 1093-94 (E.D. Wis. 1972), *vacated* by 414 U.S. 473 (1974).

10. *E.g.*, ARIZ. REV. STAT. § 36-540 (A) (1999) (need for treatment); IDAHO CODE § 66-339A(2) (1999) (likelihood of becoming dangerous without treatment); S.C. CODE ANN. § 44-17-580 (1976) (incapacity to make responsible decisions with respect to treatment); WASH. REV. CODE ANN. § 71.05.020(14) (1998) (severe and escalating deterioration in routine functioning); WIS. STAT. ANN. § 51.20(1)(a)(2) (2003) (will result in the loss of ability to function in community).

11. *See supra* text accompanying note 5.

12. John K. Cornwell, *Preventative Outpatient Commitment for People with Serious Mental Illness: Exposing Myths Surrounding Preventative Outpatient Commitment for Individuals with Chronic Mental Illness*, 9 PSYCHIATRY PUB. POL'Y & L. 209, 221 (2003) (challenges to preventative outpatient commitment standards on substantive due process grounds will prove unavailing); Hermann, *supra* note 6, at 94-95 (*O'Connor* suggests that alleviating or curing illness is constitutional grounds for commitment).

A conclusive determination concerning states' use of their *parens patriae* powers to aid those burdened by mental illness has not come from the Supreme Court.¹³ To the authors' knowledge, neither has any other federal court ruled against the constitutionality of the new breed of *parens patriae*-based inpatient commitment criteria. Such standards have, however, been upheld by the high courts of three states: Washington (1989), Wisconsin (2002) and New York (2004).¹⁴ Nor has there been a successful challenge to an outpatient commitment law or its standard despite such laws being in place in over forty states,¹⁵ and some of these for nearly two decades.¹⁶

To establish the constitutionality of OPC, we analyze the pertinent portions of the Supreme Court opinions most often claimed as establishing imminent dangerousness as the exclusive grounds for commitment, and then we look at the holdings of the three state supreme court cases clearly demonstrating that involuntary treatment need not be restricted to a finding of imminent dangerousness on the basis of mental illness.

II. UNITED STATES SUPREME COURT

A. *O'Connor v. Donaldson*

The Supreme Court in *O'Connor* considered the continued detention of Kenneth Donaldson, who had been confined to a Florida psychiatric hospital for fifteen years. He had mental illness but was neither receiving treatment nor considered dangerous.¹⁷ The opinion in this case, written by Justice Stewart, has been the foundation for those who contend that the Supreme Court has found dangerousness to be the only possible Constitutional basis for the involuntary hospitalization of a person suffering from mental illness.¹⁸

In support of this contention, those against OPC often quote this

13. Cornwell, *supra* note 12, at 221.

14. *In re Detention of LaBelle*, 728 P.2d 138 (Wash. 1986); *State of Wisconsin v. Dennis H.*, 647 N.W.2d 851 (Wisc. 2002); *In re K.L.*, 806 N.E.2d 480 (N.Y. 2004).

15. See Kenneth J. Kress, *An Argument for Assisted Outpatient Treatment for Persons with Serious Mental Illness Illustrated with Reference to a Proposed Statute for Iowa*, 85 IOWA L. REV. 1269, 1290 (2000) (While the precise number depends on the definitional criteria adopted, over forty states have statutory provisions for outpatient commitment); TREATMENT ADVOCACY CENTER, STANDARDS FOR ASSISTED TREATMENT: STATE BY STATE SUMMARY, available at <http://www.psychlaws.org/LegalResources/statechart.htm> (last visited Nov. 30, 2004) (listing forty-two states as having AOT).

16. The Mental Health, Developmental Disabilities, and Substance Abuse Act of 1985, N.C. GEN. STAT. §§ 122C, 1-433 (1985) (enacting AOT).

17. *O'Connor*, 422 U.S. at 568-69 (1975).

18. *Doremus v. Farrell*, 407 F. Supp. 509, 524-25 (D. Neb. 1975).

passage:

In short, a State cannot constitutionally confine without more a non-dangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends.¹⁹

There has been considerable discourse over the phrase "without more" because it implies that there are grounds other than dangerousness sufficient to justify the involuntary hospitalization of an individual. The most plausible interpretation is that a person with mental illness cannot be involuntarily placed in a psychiatric facility "without" treatment. However, there is no need to do more than pause on the meaning of those two words because the Court in *O'Connor* excluded standards based on *parens patriae* from its consideration in the case:

Specifically, there is no reason now to decide whether mentally ill persons dangerous to themselves or to others have a right to treatment upon compulsory confinement by the State, or whether the State may compulsorily confine a non-dangerous, mentally ill individual for the purpose of treatment.²⁰

Further, Stewart opined:

There is, accordingly, no occasion in this case to decide whether the provision of treatment, standing alone, can ever constitutionally justify involuntary confinement or In its present posture this case involves not involuntary treatment but simply involuntary custodial confinement.²¹

The Court twice explicitly states that it is not reaching any conclusion as to whether an individual may be hospitalized for the purposes of treatment. Thus, the language from the focal case often proffered as proof that dangerousness is the only justification for involuntarily placing a person in treatment is not pertinent to such an assertion.

B. *Foucha v. Louisiana*

In his opinion in *Foucha*, Justice White seems to settle the issue that keeping a person "against his will in a mental institution is improper absent a determination in civil commitment proceedings of current mental illness and dangerousness."²² Relying on *O'Connor* and *Addington v. Texas*,

19. *O'Connor*, 422 U.S. at 576.

20. *Id.* at 573.

21. *Id.* at 574 n.10.

22. *Foucha v. Louisiana*, 504 U.S. 71, 78 (1992).

Justice White provides variations of this assertion through his opinion.²³ Even though the case fails to reconcile, or even address *O'Connor's* "without more," it is tempting to take *Foucha* as an authoritative statement that only dangerousness can justify court-ordered treatment. However, Justice White's assertions are dicta. Moreover, they do not speak with the voice of the Supreme Court.

Louisiana's justification for confining Terry Foucha, the petitioner, was that he was dangerous, a determination that was undisputed. The Supreme Court ruled this detention unconstitutional because Foucha did not have a mental illness.²⁴ There was thus, no reason for the Court to entertain on what grounds a person with mental illness can be placed in involuntary treatment. The scope of the Court's decision is limited to when someone without mental illness and who constitutes a danger may be held. Any tangential contemplation is dicta.

Even if Justice White was trying to render dangerousness the sole permissible reason for involuntary treatment, he did not speak for a majority of the Court. Only Justices Blackmun, Stevens, and Souter joined in White's opinion. Four others (Rehnquist, Kennedy, Scalia and Thomas) dissented from the Court's ruling. Tipping the scales was, not surprisingly, Justice O'Connor, who concurred in part and in the judgment. Writing separately, she made clear her view of the ruling's appropriate scope:

I write separately, however, to emphasize that the Court's opinion addresses only the specific statutory scheme before us, which broadly permits indefinite confinement of sane insanity acquittees in psychiatric facilities.²⁵

Any ramifications of Justice White's opinion in *Foucha* on the use of the state's *parens patriae* power to justify treatment placement were endorsed by only four of the Court's justices. As a historical footnote, two of those four have since left the bench, while Justice O'Connor and the four dissenting members remain on the high bench.²⁶

C. *Addington v. Texas*

In *Foucha*, Justice White cited *Addington* in support of dangerousness being the sole grounds for commitment of someone with mental illness.²⁷ Yet Chief Justice Burger wrote for a unanimous Court in *Addington* that:

23. *Id.* at 75, 77.

24. *Id.* at 79, 86.

25. *Id.* at 86-87.

26. Justices White and Blackmun have left the bench, Justices Souter and Stevens remain.

27. *Foucha*, 504 U.S. at 75-76.

The state has a legitimate interest under its *parens patriae* powers in providing care to its citizens who are unable because of emotional disorders to care for themselves; the state also has authority under its police power to protect the community from the dangerous tendencies of some who are mentally ill. Under the Texas Mental Health Code, however, the State has no interest in confining individuals involuntarily if they are not mentally ill or if they do not pose some danger to themselves or others.²⁸

The consideration in *Addington* is thus limited to dangerousness not by the United States Constitution, but by Texas law (although it has since been reformed to also include need for treatment based criteria).²⁹ Furthermore, the Court explicitly states that involuntary treatment may be premised on the *parens patriae* power. And significantly, this declaration in *Addington* is made four years after the alleged prohibition of such commitments in *O'Connor*.

III. STATE SUPREME COURTS

A. *In re* Detention of LaBelle

This case is one of the three instances in which a state supreme court has ruled on the constitutionality of a standard that allows for a person with mental illness to be placed in treatment for reasons other than dangerousness.

After thrice recognizing the *O'Connor* decision, the *en banc* Washington Supreme Court found constitutional placement criteria that hinged on whether a person with mental illness "manifests severe deterioration in routine functioning evidenced by repeated and escalating loss of cognitive or volitional control over his or her actions and is not receiving such care as is essential for his or her health or safety."³⁰

In applying this standard, the unanimous court approved the continued hospitalization of one of the petitioners because, although his "condition was in the process of stabilizing," he was likely to be medication non-compliant and consequently deteriorate if released.³¹ While setting out the controlling law, the court notes, "it is clear that the State has a legitimate interest under its police and *parens patriae* powers in protecting the community from the dangerously mentally ill and in providing care to those

28. *Addington v. Texas*, 441 U.S. 418, 426 (1979).

29. TEX. HEALTH & SAFETY CODE ANN. § 574.035(a)(2)(C) (1997).

30. *In re* Detention of LaBelle, 728 P.2d at 143, 146 (en banc) (quoting WASH. REV. CODE. § 71.05.020 (1)(b) (1998)).

31. *In re* Detention of LaBelle, 728 P.2d at 149.

who are unable to care for themselves”³²

B. *State of Wisconsin v. Dennis H.*

In this case, the Wisconsin Supreme Court rebuffed a constitutional challenge to that state’s “Fifth Standard,” which contains some of the nation’s broadest eligibility criteria for the court-ordered treatment of people with psychiatric disorders. In *Dennis H.*, the unanimous court found that those who meet the Fifth Standard are in a condition that constitutes “dangerousness” under both the United States and Wisconsin Constitutions, but the court’s definition of what is dangerous was what most would call “need for treatment.”³³

The Fifth Standard, enacted in 1995, allows a person rendered incapable of making informed medical decisions to be placed in treatment on the finding of a substantial probability that “if left untreated” he or she will “lack services necessary for his or her health or safety and suffer severe mental, emotional or physical harm that will result in the loss of the individual’s ability to function independently in the community or the loss of cognitive or volitional control over his or her thoughts or actions.”³⁴ The standard essentially permits the placement in psychiatric care of a person who is unable to make rational treatment decisions and likely to seriously suffer as a consequence.

The central assertion of the opposing attorneys in *Dennis H.* indicated the statute is unconstitutional because it lacks a requirement for imminent danger to self or others.³⁵ That argument was premised on the U.S. Supreme Court’s decision in *O’Connor v. Donaldson*.³⁶

The Wisconsin Supreme Court instead ruled unanimously that:

The fifth standard thus fits easily within the *O’Connor* formulation: even absent a requirement of obvious physical harm such as self-injury or suicide, a person may still be “dangerous to himself” if “he is helpless to avoid the hazards of freedom either through his own efforts or with the aid of willing family members or friends.”³⁷

The court further explained:

Mentally ill persons who meet the fifth standard’s definition are clearly dangerous to themselves because their incapacity to make informed medication or treatment decisions makes them more vulnerable to

32. *Id.* at 143.

33. *Dennis H.*, 647 N.W.2d at 863.

34. *Id.* at 851 (quoting WIS. STAT. § 51.20(1)(a)(2)(e) (2003)).

35. *Id.* at 854-55.

36. *Id.* at 862.

37. *Id.* at 863.

severely harmful deterioration than those who are competent to make such decisions. The state has a strong interest in providing care and treatment before that incapacity results in a loss of ability to function.³⁸

Rather than using *O'Connor* to strike down the Fifth Standard, the court used *O'Connor* to justify its ruling while presenting the *parens patriae* power in the clothing of dangerousness.

C. *In re K.L.*

New York State passed statutorily-based IOT, which the state statute refers to as AOT. The 1999 measure, known as Kendra's Law, has withstood a string of challenges in New York courts,³⁹ most recently culminating in the state's Court of Appeals unanimously rejecting an attack on the law's progressive eligibility standard.⁴⁰

Rather than being triggered by immediate dangerousness, the critical conditional requirement in New York is that the person with mental illness be in need of AOT in order to prevent a relapse or deterioration likely to result in harm to self or others; this is a proactive rather than reactive criterion.⁴¹ Among the other central elements of the AOT standard is a provision limiting the scope of the law's application to persons who must have either been institutionalized for mental health treatment twice in the previous three years, or committed one or more acts, attempts or threats of serious violent behavior toward self or others in the last four years.⁴² These alternative historical predicates tailor the law to the state's use of its *parens*

38. *Dennis H.*, 647 N.W.2d at 862.

39. *In re K.L.*, 806 N.E.2d 480; *In re Urcuyo*, 714 N.Y.S.2d at 871-72.

40. N.Y. MENTAL HYGIENE LAW § 9.60(C)-(D) (2004). The statutorily-defined eligibility criteria for AOT are: (1) be eighteen years of age or older; (2) suffer from a mental illness; (3) be unlikely to survive safely in the community without supervision, based on a clinical determination; (4) have a history of non-adherence with treatment that has (a) been a significant factor in his or her being in a hospital, prison or jail at least twice within the last thirty-six months; or (b) resulted in one or more acts, attempts or threats of serious violent behavior toward self or others within the last forty-eight months; (5) be unlikely to voluntarily participate in treatment; (6) be, in view of his or her treatment history and current behavior, in need of AOT in order to prevent a relapse or deterioration which would be likely to result in: (a) a substantial risk of physical harm to the individual as manifested by threats of or attempts at suicide or serious bodily harm or conduct demonstrating that the individual is dangerous to himself or herself, or (b) a substantial risk of physical harm to other persons as manifested by homicidal or other violent behavior by which others are placed in reasonable fear of serious physical harm; (7) be likely to benefit from AOT; and (8) if the consumer has a health care proxy, any directions in it will be taken into account by the court in determining the written treatment plan. Nothing, however, precludes a person with a health care proxy from being eligible for AOT. *Id.*

41. N.Y. MENTAL HYGIENE LAW § 9.60(C)(6) (2004).

42. *Id.* § 9.60(c)(4).

patriae power to aid those consistently incapable of maintaining needed treatment in the community and the invocation of its police powers in the instance of an individual who has previously been dangerous as a result of non-compliance with treatment, particularly prescribed medications. While the law does not include specific enforcement provisions, non-compliance is a factor in a physician's consideration of an evaluation for involuntary hospitalization.⁴³

New York courts have conclusively upheld the constitutionality of the standard for Kendra's Law. Less than a year after New York's AOT law became effective, a trial court in Kings County categorically rejected substantive due process and equal protection challenges to the eligibility criteria in the case *In re Urcuyo*.⁴⁴ The court recognized the substantial interest that a government has in providing treatment to those incapacitated by severe psychiatric disorders, pronouncing, "Kendra's Law provides the means by which society does not have to sit idly by and watch the cycle of decompensation, dangerousness and hospitalization continually repeat itself."⁴⁵

On February 17, 2004, a unanimous ruling from New York's highest court definitively established the constitutionality of the state's AOT standard in *In re K.L.*⁴⁶ The Court of Appeals found that the criteria triggering Kendra's Law satisfied constitutional requirements for substantive due process, as justified by "the state's compelling interest in both its police and *parens patriae* power" in the instance of an individual meeting each criterion of the standard.⁴⁷

With *In re K.L.*, seventeen high justices on the highest courts of three states have, without a single dissent, voted to affirm the constitutionality of the progressive eligibility criteria integral to an effective AOT framework.⁴⁸

IV. CONCLUSIONS

Rebuffing the constitutional challenge to IOT is the beginning. It is time to move on to the challenging tasks of determining for whom IOC is the appropriate clinical tool. Statutes are permissive; statutes inform the psychiatrist who that psychiatrist *can* treat under an IOC. Statutes neither inform the psychiatrist for what type of patient IOC is an efficacious tool,

43. *Id.* § 9.60(n).

44. *In re Urcuyo*, 714 N.Y.S. 2d at 871-72 (emphasis added).

45. *Id.* at 873.

46. *In re K.L.*, 806 N.E.2d at 477.

47. *In re K.L.*, 806 N.E.2d at 485.

48. *In re Detention of LaBelle*, 728 P.2d 138 (8-0 decision); *Dennis H.*, 647 N.W.2d 851 (4-0 decision); *In re K.L.*, 806 N.E.2d 480 (5-0 decision).

nor is there an expectation that IOC will be an effective augmentation to treatment. We need to address these issues now.

This is an opportune time for members of the legal advocacy community to move on to the task of tackling important, discriminatory mental health policy issues, e.g., parity, the IMD exclusion rule, overly restrictive Medicare formularies, inadequate inpatient and outpatient settings for individuals whose health insurance is attached to federal entitlement programs,

etc., and to leave the fine-tuning of IOT to those whose professional lives are devoted to treating people with serious mental illnesses. Perhaps it is time to recognize that the abrogation of the opportunity for treatment is a much greater impediment to autonomy and self determination than is the denial of treatment in the name of sustaining the faux liberty of a psychotic state.