

Position Statement on Involuntary Commitment

Inpatient Commitment

The United States Supreme Court has termed involuntary civil commitment to a psychiatric hospital "a massive curtailment of liberty."¹ The court has also emphasized that "involuntary commitment to a mental hospital, like involuntary confinement of an individual for any reason, is a deprivation of liberty which the State cannot accomplish without due process of law."² Moreover, the court has found "no Constitutional basis for confining such persons involuntarily if they are dangerous to no one and can live safely in freedom."³ "[T]he mere presence of mental illness," the court held, "does not disqualify a person from preferring his home to the comforts of an institution."⁴

Opposing unnecessary coercion is a key focus of the Bazelon Center's work to protect the rights of people with mental illnesses. We believe that the vast majority of individuals with mental illnesses are better served by access to appropriate voluntary services in the community.

The Bazelon Center opposes involuntary inpatient civil commitment except in response to an emergency, and then only when based on a standard of imminent danger of significant physical harm to self or others and when there is no less restrictive alternative. Civil commitment requires a meaningful judicial process to protect the individual's rights.

Outpatient Commitment

The Bazelon Center also opposes all involuntary *outpatient* commitment⁵ as an infringement of an individual's constitutional rights. Outpatient commitment is especially problematic when based on:

- a prediction that an individual may become violent at an indefinite time in the future;
- supposed "lack of insight" on the part of the individual, which is often no more than disagreement with the treating professional;
- the potential for deterioration in the individual's condition or mental status without treatment;
- an assessment that the individual is "gravely disabled."

The above criteria are not meaningful. They cannot be accurately assessed on an individual basis, and are improperly rooted in speculation. Neither do they constitute imminent, significant physical harm to self or others—the only standard found constitutional by the Supreme Court. As a consequence, these are not legally permissible measures of the need for involuntary civil commitment—whether inpatient or outpatient—of any individual.

The Bazelon Center supports the right of each individual to fully participate in, and approve, a treatment plan and to decide which services to accept. The Bazelon Center encourages the articulation of treatment preferences in advance through the use of advance directives and/or a legally recognized health care agent.

Outpatient commitment is a dangerous formalization of coercion within the community mental health system. Such coercion undermines consumer confidence and causes many consumers to avoid contact with the mental health system altogether. Furthermore:

- Outpatient commitment is a simplistic response that cannot compensate for a lack of appropriate and effective services in the community. In fact, the enforcement demands of outpatient commitment will divert resources away from treatment.
- Data on outpatient commitment show it confers no additional benefit above access to effective community services. (In one of only two controlled studies, individuals given the option of

enhanced community services did just as well as those under commitment orders who had access to the same services.)⁶

- There are enormous practical problems in implementation of outpatient commitment, and potentially high costs for law enforcement.
- The threat of forced treatment, with medication that has harmful side effects, often deters individuals from voluntarily seeking treatment. At best, outpatient commitment undermines the therapeutic alliance between the provider and consumer of mental health services. Greater sensitivity is needed on the part of mental health professionals in working with consumers to find the most effective and acceptable treatment.

In short, outpatient commitment penalizes the individual for what is essentially a systems problem. Lack of appropriate and acceptable community mental health services is the issue.

1999, updated 4/2000

Notes

¹ *Humphrey v. Cady*, 405 U.S. 504, 509 (1972).

² *Specht v. Patterson*, 386 U.S. 605, 608 (1967).

³ *O'Connor v. Donaldson*, 422 U.S. 563, 574 (1975).

⁴ *Id.*

⁵ The term "outpatient commitment" when used in this document refers to procedures for (a) involuntary commitment to outpatient treatment and (2) hospital release conditioned on treatment compliance.

⁶ For more information on this study, conducted by the Bellevue program in New York City, contact Policy Research Associates, online. The findings of a North Carolina study confirmed the New York study in finding that overall outpatient commitment conferred no additional benefits for individuals receiving enhanced services. This study did, however, find that a small group of patients who were under commitment orders for six months or longer, and who also actually received more services, did better than those not under outpatient commitment.

DRC Will Challenge California's Outpatient Committal Laws in Court

madinamerica.com/2014/09/drc-will-challenge-californias-outpatient-committal-laws-court/

Rob Wipond

Disability Rights California will challenge Los Angeles County's Assisted Outpatient Treatment program in court as early as this fall, DRC staff attorney Pamela Cohen has announced. DRC, the federally mandated Protection and Advocacy agency in California, has notified the government of its intentions, and plans to follow up with legal challenges to similar ordinances in Orange County and San Francisco next.

Cohen was speaking at the National Association for Rights Protection and Advocacy conference in Seattle on September 5th. She said the agency has been studying the legislation in collaboration with experts from the Bazelon Center for Mental Health Law and the American Civil Liberties Union. She described the Assisted Outpatient Treatment (AOT) program as "a bad investment in a broken promise." AOT diverts desperately needed dollars away from community mental health services and towards police, administrators and courts, doesn't reach the people it purports to be trying to help, and violates people's civil rights, she said.

Also known as "Laura's Law," California's *AB-1421* allows the government to force people who've been diagnosed with mental illnesses into treatment programs even though they are living in the community and do not require hospitalization. Though the law doesn't specifically mandate involuntary drugging, said Cohen, it allows people to be forced into capacity hearings where drugging could be mandated, and non-compliance with treatment is a central criterion for being put in the program in the first place. Furthermore, medication regimes can be written into a person's AOT plan, and then non-compliance with the plan may be considered a breach of the law. She also said there would likely be a "black robe" effect, where at AOT hearings people would be persuaded by judges to take medications for fear of potentially facing more serious legal consequences later. The overarching state law *AB-1421* authorizes AOT, and so far 6 of California's 58 counties have begun AOT initiatives. With expanded funding now available Cohen said she expects more AOT programs to be "popping up" in other counties. But many people have been deeply misled about whom the AOT programs target and how well they work, she said.

Pamela Cohen

"At [County] Board of Supervisor hearings people are always testifying that these laws are for people who don't know they have a mental illness and have no insight and can't make their own decisions," said Cohen. "[They testify that] this law provides services for people who would otherwise slip through the cracks, who can't get services because they're dangerous and lack capacity to make their own decisions."

Cohen said those assertions are mere myth, and that in fact *AB-1421* expands the criteria for forced treatment to a much broader segment of the population. "The standard [for being forced into the AOT program] is that someone thinks you might be dangerous," said Cohen. "Not that you are dangerous." Meanwhile, California already has laws addressing circumstances where people may be losing their decision-making capacity, so the AOT laws do not even mention questions of capacity. "People are very misled about that."

Cohen outlined DRC's three main legal arguments against California's AOT programs in her presentation.

First, she noted that AOT is designed to provide people with a diverse range of individualized services, such as housing assistance, employment training, family support, medication co-ordination, mobile multi-disciplinary mental health teams using high staff-to-client ratios, and culturally sensitive psychosocial and psychotherapeutic options. However, *AB-1421* also stipulates that people cannot be forced to participate in an AOT program unless they've already been offered this same range of services on a voluntary basis. "We don't believe that any county is actually

offering that range of services" to the many people who want them, said Cohen. And the fact that no county is actually following the law by providing these services to everyone to access



on a voluntary basis is extremely relevant, she said, because it's these services that truly help people, not the use of force.

"The Treatment Advocacy Center and [National Alliance on Mental Illness] have all kinds of studies that they talk about that they say show benefits from these [court ordered outpatient forced treatment] programs," said Cohen. "But there are only three studies in the whole world that have controls, where they actually offered the same services to people on a voluntary basis. Any other study is meaningless... These three studies all show that there's no benefit to the court order."

"These are very broad criteria," said Cohen. "It's unconstitutionally vague and overbroad."

The second major problem with the legislation, said Cohen, is that people can become subject to an AOT order if they've threatened to commit suicide even once in the past four years, or if they are "substantially deteriorating" or are "unlikely to survive safely in the community without supervision."

"These are very broad criteria," said Cohen. "It's unconstitutionally vague and overbroad."

A third problem, said Cohen, is that *AB-1421* violates the federal *Health Information Protection Act* (HIPA), because anyone merely coming under consideration for the program is forced to divulge their mental health records. "Starting from this investigation stage going forward there are all kinds of disclosures happening without consent," she said.

Meanwhile, people only get five days to prepare their defense against an AOT order, said Cohen. "We know that the Los Angeles public defenders are concerned about this. They don't think they can adequately represent their clients when they're only given five days notice."

In an interview with *Mad In America*, Cohen said that DRC's court challenge may involve representing someone who has been put under an AOT order, or representing a taxpayer and arguing that AOTs are an illegal use of state funding. "Our view is that this is an illegal program," said Cohen.

...e the AOT programs dismantled. We'd like to see the range of services that are offered by AOT
to people on a voluntary basis," Cohen told *Mad In America*. "We should not be using coercion to provide
services that should be provided on a voluntary basis."

Rob Wipond is *Mad In America's* News Editor. This week he has been reporting on the National
Association for Rights Protection and Advocacy conference in Seattle.

For more information:

AB-1421 Mental health: involuntary treatment (California Legislative Information)

Disability Rights California

National Association for Rights Protection and Advocacy



UPDATE: Los Angeles Postpones Implementation of Outpatient Committal (Mad In America, October 13, 2014)



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Can Laura's Law help the mentally ill? Researcher Tom Burns' surprising conclusion.



PATT MORRISON

PATT MORRISON ASKS

Recent Columns

July 22, 2014, 5:51 p.m.

Laura's Law has been an option for counties in California since 2003, but only in recent weeks have three of the most populous ones — Los Angeles, Orange and San Francisco — voted to implement it. The law — like another one in New York, Kendra's Law — allows families or officials to ask the courts to order outpatient treatment for the seriously mentally ill.

Will it help? A decade ago, Tom Burns, a psychiatrist and professor of social psychiatry at Oxford University, was among those arguing ardently for the British version of Laura's Law — "community treatment orders," or CTOs. Now, he says, the most thorough research including his own — shows these laws don't accomplish much: Compulsion added to otherwise decent care makes no difference. But note the qualification: "otherwise decent care."

You say the best research shows that legally forcing the mentally ill to get outpatient treatment doesn't change overall outcomes. That would indicate that Laura's Law won't do much good.

You've got three [randomized] trials in the world on CTOs; two are in America, and there's our study. All three have the same results: CTOs don't make a difference.

We looked at two groups of similarly ill people in the British healthcare system who'd been judged by their psychiatrists to need CTOs. One group received CTOs and one not, and we found that there was absolutely no difference in the outcome, with or without compulsory treatment. About a third of both groups relapsed and required hospitalization over the fol-

lowing 12 months.

I was depressed by those results. I worked for more than 20 years to get the CTO law passed. I thought such laws were going to make a difference, but they don't.

Why not?

I don't know the answer, but they don't. We know what does keep patients well, and our experience is that adding compulsion does not appear to make it work better. Care is better than no care; it doesn't say care with compulsion is better than care.

What does work?

The long-term treatment of very severely mentally ill people consistent, steady, low-grade outreach which is flexible and which goes on for months and years and which is based on ensuring the person gets their medicine, ensuring their social life is stabilized as best we can that reduces the rate of relapse substantially. We've now tried to add compulsion to it and it hasn't improved the outcome. So I think the effort should go into making sure that everybody gets access to basic treatment.

So you found CTOs don't prevent the mentally ill from getting worse as a group, but are there any good outcomes from them?

If you look at high-quality research evidence, you could say there is no evidence patients are benefited by CTOs if they are getting decent care otherwise. We were careful in our Lancet article to say that in well-coordinated mental health services, compulsory treatment has nothing to offer. If you have semi- to nonexistent services, then you don't know whether compulsion is helping the patient or whether treatment is helping the patient. I think treatment helps patients.

It may be that getting the care you are describing would require, in this country, compulsion.

I don't think it does. One of a doctor's biggest skills is in forming a trusting relationship with scared, frightened, shy, anxious individuals, and through that encourage them, nag them, to get them to treatment. I'm shameless at it! And most of my colleagues are too. I had hoped that adding compulsion would move the proportion who do well up, but the evidence is stubbornly consistent that it doesn't.

It sounds as if Britain has better basic mental health services than the United States.

Even in impoverished bits of Europe like Portugal, any psychotic patient will be able to see

a psychiatrist and psychiatric nurse ad infinitum. Someone will go see them at home, make sure they get their meds, etc. [If] with Kendra's Law in New York, or Laura's Law in California, most disabled patients will get treatment because the law allows us to force services or at least pay services to give that treatment, I can see something beneficent about that. At least let's try to target the few resources we've got on the most at-risk.

The United States is one of the richest countries in the world, it's not short of trained mental health staff, there's no shortage of resources. There's no political will to deploy them. You could argue that selecting out some very high-profile patients to give what by most international standards is fairly average treatment is not a benign advance but a sort of fig leaf to let politicians off the hook.

Many families of the mentally ill support Laura's Law because they are desperate for some recourse. In California, involuntary hospitalization requires that a patient be dangerous or "gravely disabled." Laura's Law is seen as a way to help, short of that standard and short of hospitalization. Patients must recently have been violent, hospitalized or jailed, among other criteria.

That's utterly understandable. Seeing young people's lives ruined by mental illness is very difficult to watch. And most families like this law because it makes them feel safer, just as you could argue it makes [medical] staff feel safer. [Laura's Law was named for Laura Wilcox; she and another mental health clinic staffer were killed by a man whose family had tried and failed to force him to be treated.] I think there's an ethical issue. If you're going to use compulsion to make me feel better about my job, the compulsion should be on me, not the patient.

There's a profound conceptual difference in the approach to mental health care between America and Europe. European laws often state "danger to self or others," but danger in Europe is almost always interpreted very broadly and you might think paternalistically to include the patient's mental health. If I have a seriously ill schizophrenic patient who is neglecting himself, not taking his medicine, and I know he's going to get worse, I can say that's a "danger" to his health. My understanding is that in many states in America, it's got to be an imminent physical risk. People who are actively and immediately dangerous they probably shouldn't be out of hospital.

As Laura's Law takes effect, what would you tell us to look for?

Don't expect it to make a big difference. If people are going to evaluate it, then evaluate it in a way that's sufficiently rigorous to distinguish differences in access to better treatment from the effects of compulsion.

This interview has been edited and condensed.

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'Psychiatric Asbos' were an error says key advisor

Former champion says public safety fears led to adoption of measures that seriously curtailed patients' freedoms

Sanchez Manning

Sunday, 14 April 2013

Controversial powers to treat mental health patients in the community while seriously curtailing their freedoms have been criticised by one of their strongest supporters.

Popularly known as "psychiatric Asbos", Community Treatment Orders (CTOs) were introduced five years ago after a series of high-profile cases that involved mentally ill people attacking members of the public. The draconian measures have now been shown to make no clinical difference – and the psychiatrist who championed them is calling for their immediate suspension.

CTOs gave doctors legal authority to impose conditions on their patients after they are released from hospital such as where they must live, what drugs they must take and even how much alcohol they could consume.

If they broke any of these stipulations they could be immediately recalled and sectioned to a psychiatric unit.

It was hoped that the orders would strengthen psychiatrists' ability to ensure patients stuck to their treatment programmes after being discharged.

According to NHS figures, the number of people placed on CTOs has risen steadily since they were first brought in five years ago. The latest statistics show that in 2012 there were 4,764 people subject to orders – 473 more than in 2011, which amounts to an 11 per cent rise.

Now Tom Burns, the psychiatrist who originally advised the government on CTOs, has also come to the conclusion they are ineffective and unnecessary. Professor Burns, once a strong supporter of the new powers, said he has been forced to change his mind after a study he conducted proved the orders "don't work".

CTOs were introduced with the aim of reducing the number of readmissions of patients who were regularly in and out of hospital by compelling them to take their medication.

But after leading the UK's largest randomised trial of CTOs, Professor Burns has discovered that they made absolutely no difference to these so-called "revolving door" patients.

"The evidence is now strong that the use of CTOs does not confer early patient benefits despite substantial curtailment of individual freedoms," said Professor Burns, who is head of the social psychiatry department at Oxford University.

"Their current high usage should be urgently reviewed. I think there should be a moratorium

stay well in the community. "For one or two people, it may actually be doing the job it's meant to do, which is to keep them well, help them recover, help them have a social life, get into training and employment," he said.

A Department of Health spokesman said they welcomed the Burns report. He said: "We will consider the implications of this report carefully."

'My Community Treatment Order was the mental health equivalent of having a tag'

Paul Chapman had just got married when he was first placed on a Community Treatment Order (CTO) in 2009. He had a history of mental illness and had been admitted to hospital some 25 times since first being diagnosed with bipolar disorder and other forms of psychosis in 1991.

On this occasion, he had been sectioned to a psychiatric ward after he began hearing voices and his psychotic episodes re-ignited. After he absconded from the ward, his wife persuaded the hospital that he would be better cared for at home, so he was discharged on the CTO.

However, Paul, from Brigg in Lincolnshire, says what had first seemed like an attractive option turned into something less positive. The 46-year-old describes how being put on a CTO changed his relationship with his family and carer: rather than being based on empathy, it became a much more legalistic arrangement.

"Instead of them being concerned out of care and compassion for the problem I was having, there was reason for them to be responsible and have authority over me," he says.

"I think I had to be seen by my specialist care worker once a fortnight and there was a lockdown on medication – there was no messing with my medication. It was the mental health equivalent of having a tag. If I became unwell again or stopped taking my medication – like re-offending – I would have gone straight back into hospital."

After a few months, he inquired about being taken off the CTO but was turned down: "I felt stigmatised by it. Because of the nature of my condition, I felt other people might know and think, 'He must be bad, he's on a CTO'."

Paul was readmitted to a hospital last June after his psychosis returned.

Sanchez Manning

The Double Standard of Forced Treatment

Forced treatment for people with mental illness has had a long and abusive history, both here in the United States and throughout the world. No other medical specialty has the rights psychiatry and psychology do to take away a person's freedom in order to help "treat" that person.

Historically, the profession has suffered from abusing this right — so much so that reform laws in the 1970s and 1980s took the profession's right away from them to confine people against their will. Such forced treatment now requires a judge's signature.

But over time, that judicial oversight — which is supposed to be the check in our checks-and-balance system — has largely become a rubber stamp to whatever the doctor thinks is best. The patient's voice once again threatens to become silenced, now under the guise of "assisted outpatient treatment" (just a modern, different term for **forced treatment**).

This double standard needs to end. If we don't require forced treatment for cancer patients who could be cured by chemotherapy, there's little justification for keeping it around for mental illness.

Charles H. Kellner, MD unintentionally provides a perfect example of this double-standard in this article about why he believes electroconvulsive therapy (ECT, also known as shock therapy) shouldn't be held to the same standards as FDA-approved drugs or other medical devices:

Yes, ECT has adverse effects, including memory loss for some recent events, but all medical procedures for life-threatening diseases have adverse effects and risks. Severe depression is every bit as lethal as cancer or heart disease. It is inappropriate to allow public opinion to determine medical practice for a psychiatric illness; this would never happen for an equally serious nonpsychiatric illness.

And yet, strangely enough, if someone were dying from cancer or heart disease, they have an absolute right to refuse medical treatment for their ailment. So why is it that people with mental disorders can have that similar right taken away from them?

People who've just been told they have cancer are often not in their "right" minds. Many people never recover from that information. Some rally, undergo treatment, and live a long and happy life. Others feel like they've been given a death sentence, resign themselves to the disease, and refuse medical treatment.

As long as they do it in the quiet of their home, nobody seems to much care.

Not so with mental disorders. No matter what the concern — depression, schizophrenia, bipolar disorder, heck, even ADHD — you could be forced into treatment against your will if a doctor thinks it may help you.



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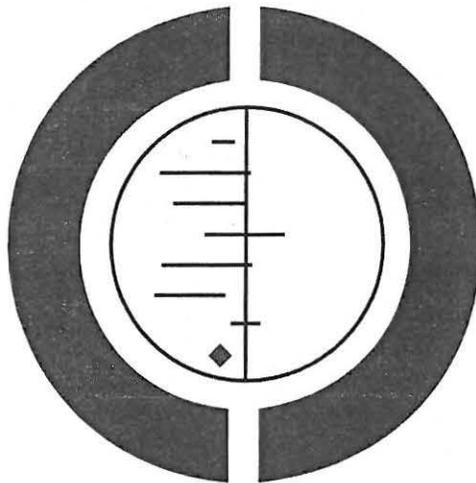
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Compulsory community and involuntary outpatient treatment for people with severe mental disorders (Review)

Kisely SR, Campbell LA, Preston NJ



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WILEY

[Intervention Review]

Compulsory community and involuntary outpatient treatment for people with severe mental disorders

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ABSTRACT

Background

There is controversy as to whether compulsory community treatment for people with severe mental illnesses reduces health service use, or improves clinical outcome and social functioning. Given the widespread use of such powers it is important to assess the effects of this type of legislation.

Objectives

To examine the clinical and cost effectiveness of compulsory community treatment for people with severe mental illness.

Search methods

We undertook searches of the Cochrane Schizophrenia Group Register 2003, 2008, and Science Citation Index. We obtained all references of identified studies and contacted authors of each included study.

We updated this search July 2012, five new studies added to awaiting classification section.

Selection criteria

All relevant randomised controlled clinical trials of compulsory community treatment compared with standard care for people with severe mental illness.

Data collection and analysis

We reliably selected and quality assessed studies and extracted data. For binary outcomes, we calculated a fixed effects risk ratio (RR), its 95% confidence interval (CI) and, where possible, the weighted number needed to treat/harm statistic (NNT/H).

Main results

We identified two randomised clinical trials (total n = 416) of court-ordered 'Outpatient Commitment' (OPC) from the USA. We found little evidence that compulsory community treatment was effective in any of the main outcome indices: health service use (2 RCTs, n = 416, RR for readmission to hospital by 11-12 months 0.98 CI 0.79 to 1.2); social functioning (2 RCTs, n = 416, RR for arrested at least once by 11-12 months 0.97 CI 0.62 to 1.52); mental state; quality of life (2 RCTs, n = 416, RR for homelessness

Compulsory community and involuntary outpatient treatment for people with severe mental disorders (Review)

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0.67 CI 0.39 to 1.15) or satisfaction with care (2 RCTs, n = 416, RR for perceived coercion 1.36 CI 0.97 to 1.89). However, risk of victimisation may decrease with OPC (1 RCT, n = 264, RR 0.5 CI 0.31 to 0.8). In terms of numbers needed to treat (NNT), it would take 85 OPC orders to prevent one readmission, 27 to prevent one episode of homelessness and 238 to prevent one arrest. The NNT for the reduction of victimisation was lower at six (CI 6 to 6.5). A new search for trials in 2008 did not find any new trials that were relevant to this review.

Authors' conclusions

Compulsory community treatment results in no significant difference in service use, social functioning or quality of life compared with standard care. People receiving compulsory community treatment were, however, less likely to be victims of violent or non-violent crime. It is unclear whether this benefit is due to the intensity of treatment or its compulsory nature. Evaluation of a wide range of outcomes should be considered when this type of legislation is introduced.

[Note: the five citations in the awaiting classification section of the review may alter the conclusions of the review once assessed.]

PLAIN LANGUAGE SUMMARY

Compulsory community and involuntary outpatient treatment for people with severe mental disorders

The evidence found in this review suggests that compulsory community treatment may not be an effective alternative to standard care.

We examined the effectiveness of compulsory community treatment for people with severe mental illness through a systematic review of all relevant randomised controlled clinical trials. Only two relevant trials were found and these provided little evidence of efficacy on any outcomes such as health service use, social functioning, mental state, quality of life or satisfaction with care. No data were available for cost and unclear presentation of data made it impossible to assess the effect on mental state and most aspects of satisfaction with care. In terms of numbers needed to treat, it would take 85 outpatient commitment orders to prevent one readmission, 27 to prevent one episode of homelessness and 238 to prevent one arrest.

HENRY A. DLUGACZ

Involuntary Outpatient Commitment:
Some Thoughts on Promoting a
Meaningful Dialogue Between Mental
Health Advocates and Lawmakers

ABOUT THE AUTHOR: Henry A. Dlugacz is an adjunct professor of law at New York Law School and at St. John's University School of Law, an assistant clinical professor of psychiatry and behavioral sciences at New York Medical College, and the former founding co-chair of the New York State Bar Association's Health Law Section's Mental Health Committee. The author would like to thank Susan Moser and Courtney Killelea, J.D. candidates at New York Law School, for their excellent research assistance.

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).

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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.").

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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(c)(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).

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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_MentallIllness_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

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?ex=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,

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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.

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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).

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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).

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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 to 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.

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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.

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