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## Rewriting Kendra's Law: A More Ethical Approach to Mental Health Treatment

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# NOTE

## Rewriting Kendra’s Law: A More Ethical Approach to Mental Health Treatment

James Diven\*

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Michelle Go was pushed in front of a subway car by a man suffering from schizophrenia that had fallen through the cracks of New York's mental health care system. Michelle's death was imminent because the severely ill man had every right to be on the streets under present law. This note will discuss the problems with New York's mental hygiene laws that prevent courts from mandating treatment even when treatment is in the state's best interest.

Michelle's death is not unique. Historically, New York has struggled to enact effective legislation governing the treatment of mentally ill individuals. As a result, hundreds of thousands of mentally ill New Yorkers evade treatment each year. While courts mandate treatment upon individuals adjudicated to be a threat to themselves or others, this standard creates a burden that has proven too difficult to establish in a court of law. The state's mental hygiene statutes do not seek to prevent the deterioration of a person suffering from a severe mental illness. Therefore, courts lack the authority to mandate treatment even when treatment is in the patient's best interest. Amending New York's assisted outpatient statute to include a preventative standard for schizophrenia, manic depression, and bipolar disorder would allow courts to equitably protect the mentally ill population and the community at large.

## I. ROADMAP

Part II of this article will discuss the evolution of mental health treatment in the United States.<sup>1</sup> It will provide a background of how mental health treatment began, as well as the events that took place throughout history which sculpted the path to modern practice.<sup>2</sup> It will analyze civil commitment and the underlying "dangerousness standard" that led to the creation of assisted outpatient treatment.<sup>3</sup> Part III will examine New York's current assisted outpatient statute and its weaknesses.<sup>4</sup> Part IV proposes a statutory amendment that addresses the current weaknesses in New York's mental hygiene

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1. *See infra* Part II.
  2. *See infra* Part II.A.
  3. *See infra* Part II.B.
  4. *See infra* Part III.

laws.<sup>5</sup> It lays out modern justifications and how the statute should look, as well as its constitutionality. Part V will discuss financial implementation and potential expenses.<sup>6</sup> Finally, Part VI recaps the article's findings.<sup>7</sup>

## II. EVOLUTION OF MENTAL HEALTH TREATMENT IN THE UNITED STATES

To understand New York's current law, it is essential to look back at the evolution of mental health care treatment. The unethical consequences of early practitioners forced the legislature to enact law entrenched in an avoidance to overact, inadvertently leaving thousands in need of treatments on the streets.<sup>8</sup> Consequently, modern law remains premised on a standard to avoid unjust treatment at society's expense.<sup>9</sup> The result is that courts are often powerless to help mentally ill individuals until it is too late, which has further resulted in a legion of unintended negative consequences.<sup>10</sup> While six decades of medical advancements inherently provide a safeguard to the horrors that past legislature sought to prevent, recently enacted laws fail to provide the latitude to allow suffering persons to receive the benefits that modern medicine can provide.<sup>11</sup>

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5. See *infra* Part IV.

6. See *infra* Part V.

7. See *infra* Part VI.

8. See *infra* Part II.A (discussing how civil rights violations led New York to adapt a standard that resulted in a significant decrease in the involuntary treatment of the mentally ill); see also *infra* Part II.B–C (discussing how the standard prevented courts from ordering treatment upon individuals that are in dire need of treatment).

9. See *infra* Part II.A (noting that New York law remains premised on the dangerousness standard); see also *infra* Part III.B (arguing that even Kendra's law, one of New York's most recently enacted statutes covering the treatment of mental hygiene, is indirectly premised on the same dangerousness standard).

10. See discussion *infra* Part II.C and Part III.B (discussing the flaws and resulting consequences in the application New York's Mental Hygiene Laws that are premised on a finding of dangerousness).

11. See *infra* Part IV.A (discussing how modern practices and medical ethics inherently guard against the unjust treatment that the legislature seeks to avoid and how New York's laws do not accord with the benefits modern medicine can provide).

### A. Historical Influence of Court Ordered Treatment

Judicial intervention has played a significant role in preventing abuse in treatment of psychiatric disorders.<sup>12</sup> In the early 1800s, there was widespread concern that an untreated mental illness could place others in the community in danger of violent acts.<sup>13</sup> In response, countless state-run mental institutions, otherwise known as asylums, emerged across the country and began what is commonly referred to as the era of institutionalization.<sup>14</sup>

During the era of institutionalization, mentally ill individuals were involuntarily committed to mental institutions for an indefinite period based on the doctrine of *parens patriae*; the government's duty to treat the incapacitated.<sup>15</sup> The admission of these individuals is commonly known as civil commitment.<sup>16</sup>

The only proof required for civil commitment was a paternalistic recommendation for treatment by either a friend or relative.<sup>17</sup> This standard for commitment commonly led to persons

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12. See generally MICHAEL THOMPSON ET AL., COUNS. OF STATE GOV'TS JUST. CTR., IMPROVING RESPONSES TO PEOPLE WITH MENTAL ILLNESS: THE ESSENTIAL ELEMENTS OF A MENTAL HEALTH COURT (2007) (explaining the role of judicial intervention in the treatment of mental illnesses).

13. See Megan Testa & Sara G. West, *Civil Commitment in the United States*, 7 PSYCHIATRY (EDGEMONT) 30, 31–32 (2010) (discussing history of civil commitment in the United States); see also O'Connor v. Donaldson, 422 U.S. 563, 583 (1975) (discussing states' power to protect society from the dangers of untreated mental illness).

14. See Testa & West, *supra* note 13, at 32; SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., CIVIL COMMITMENT AND THE MENTAL HEALTH CARE CONTINUUM: HISTORICAL TRENDS AND PRINCIPLES FOR LAW AND PRACTICE 3 (2019).

15. See Testa & West, *supra* note 13, at 32; John Kip Cornwell, *Understanding the Role of the Police and Parens Patriae Powers in Involuntary Civil Commitment Before and After Hendricks*, 4 PSYCH. PUB. POL'Y & L. 377, 377–96 (1998) (discussing the history of the police power and the *parens patriae* doctrines); see also *Parens Patriae*, CORNELL L. SCH., LEGAL INFO. INST., [https://www.law.cornell.edu/wex/parens\\_patriae](https://www.law.cornell.edu/wex/parens_patriae) (last updated May 2022) (defining *parens patriae*: “a doctrine under which a state has third-party standing to bring a lawsuit on behalf of a citizen when the suit implicates a state's quasi-sovereign interests for the well-being of its citizens.”).

16. See *Involuntary Civil Commitment*, CORNELL L. SCH. LEGAL INFO. INST., [https://www.law.cornell.edu/wex/involuntary\\_civil\\_commitment](https://www.law.cornell.edu/wex/involuntary_civil_commitment) (last visited Jan. 3, 2023) (citation omitted).

17. See Testa & West, *supra* note 13, at 32; JOHN MONAHAN ET AL., RETHINKING RISK ASSESSMENT: THE MACARTHUR STUDY OF MENTAL HEALTH DISORDER AND VIOLENCE 3 (2001); see also *Civil Commitment*, MERRIAM-WEBSTER'S DICTIONARY OF LAW (2nd ed. 2011) (“court-ordered

being wrongfully confined.<sup>18</sup> Moreover, treatment during this era proved ineffective and had little chance of improving the patient's condition.<sup>19</sup> Most patients were restrained, sedated, and experimented on with medications and procedures that were later proven to lack medical value.<sup>20</sup>

The civil rights movement of the mid 1900s helped bring the horrors of this era to an end.<sup>21</sup> Society at large began to criticize the limited value of these state run institutions.<sup>22</sup> The public became aware that individuals were being hospitalized based on unsubstantiated allegations without an opportunity to defend their need for treatment.<sup>23</sup> The pressure of this movement led congress to pass the Ervin Act of 1964,<sup>24</sup> which was the first statute to provide for a "dangerousness standard" in civil

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institutionalization of a person suffering from mental illness, alcoholism, or drug addiction usually upon a finding that the person is dangerous to himself or herself or to others").

18. See SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., *supra* note 14, at 3.

19. See Testa & West, *supra* note 13, at 33 (discussing the 'public's' acknowledgement of ineffective treatment); John E. B. Myers, *Involuntary Civil Commitment of the Mentally Ill: A System in Need of Change*, 29 VILL. L. REV. 367, 389 (1983) ("Meaningful treatment was largely unavailable and hospitalization amounted to little more than custody.").

20. See Testa & West, *supra* note 13, at 32 (discussing the treatment of patients in asylums during the era of institutionalization); see also *The Surprising History of Mental Illness Treatment*, BATON ROUGE BEHAV. HOSP. (Jan. 13, 2022), <https://batonrougebehavioral.com/the-surprising-history-of-mental-illness-treatment/> ("When treatment did occur, it never actually helped... Exorcisms, malnutrition, and inappropriate medications all appeared as treatment methods for people with mental illnesses.").

21. See Sara Gordon, *The Danger Zone: How the Dangerousness Standard in Civil Commitment Proceedings Harms People with Serious Mental Illness*, 66 CASE W. RESV. L. REV. 657, 660 (discussing how the civil rights movement of the 1950's influenced mental health treatment).

22. See *id.* (acknowledging that long-term inpatient treatment made little difference when compared to leaving individuals in their own communities); Testa & West, *supra* note 13, at 33.

23. See Testa & West, *supra* note 13, at 33.

24. See SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., *supra* note 14, at 4 ("Dangerousness first found statutory recognition in 1964, with Congress' enactment of the Ervin Act...."); D.C. CODE ANN. §§ 21-501 to -591 (West 2001); see also Press Release, Dep't of Behav. Health, New Legislation Passes to Protect the Rights of People with Mental Illness (Dec. 17, 2002), <https://dbh.dc.gov/release/new-legislation-passes-protect-rights-people-mental-illness> (noting updates to the civil commitment procedures of the Ervin Act).

commitment.<sup>25</sup> While the Act only had the force of law in the District of Columbia, many states soon boarded the ship and adopted similar legislation.<sup>26</sup> The driving force behind this nationwide reform was to prevent the abuse of *parens patriae* powers by establishing a restrictive standard to avoid the opportunity for injustice.<sup>27</sup> This standard empowered courts to prevent unjust confinement and unilaterally circumvent overreach on an individual's constitutionally protected rights.<sup>28</sup>

In 1972, the constitutionality of civil commitment standards were examined in *Lessard v Schmidt*.<sup>29</sup> Therein, Plaintiff Alberta Lessard brought a federal class action suit alleging that Wisconsin's civil commitment law lacked a "dangerousness requirement," violative of her due process rights.<sup>30</sup> The court ruled in Lessard's favor, holding that, absent a finding of "dangerousness to self or others," civil commitment was unconstitutional.<sup>31</sup> While this was not the first opinion regarding a finding of dangerousness, it is the first case to establish modern constitutional standards that govern civil commitment.<sup>32</sup>

Soon after the *Lessard* opinion, every state adopted the constitutional standard laid out by the *Lessard* court.<sup>33</sup> To date, danger to oneself or others remains a requisite in almost all states, including New York, to involuntarily commit a mentally ill individual of adult status.<sup>34</sup>

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25. See SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., *supra* note 14, at 4; Testa & West, *supra* note 13, at 33.

26. See, e.g., CAL. WELF. & INST. CODE § 5150(f) (West 2019) (originally enacted 1969).

27. See SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., *supra* note 14, at 4.

28. See *id.*; see generally Joseph D. Bloom & Scott E. Kirkorsky, *Incompetent to Stand Trial, Not Restorable, and Dangerous*, 48 J. AM. ACAD. PSYCHIATRY & L. 1 (2020) (discussing historical justifications behind a finding of dangerousness).

29. See SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., *supra* note 14, at 4; see generally *Lessard v. Schmidt*, 349 F.Supp. 1078 (E.D. Wis. 1972) (examining the constitutionality of civil commitment standards).

30. See *Lessard*, 349 F.Supp. at 1081–82.

31. See *id.* at 1093.

32. See SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., *supra* note 14, at 4.

33. See, e.g., *Project Release v. Prevost*, 551 F.Supp. 1298, 1305 (E.D.N.Y. 1982) (citing *Lessard*, 349 F.Supp. at 1093); see also N.Y. MENTAL HYG. LAW § 9.13 (McKinney 2022).

34. See, e.g., MENTAL HYG. § 9.37.

## B. Establishing Dangerousness

For a court to mandate hospitalized treatment, it must first be determined that said persons exhibit a specified degree of danger.<sup>35</sup> Because the perception of danger is subjective, the requisite degree remains unclear.

According to most dictionaries, dangerousness is commonly defined as an ability or likelihood to cause injury or harm.<sup>36</sup> Under this broad definition, all humans are dangerous. Anyone with a conscious mind has an “ability” to cause injury or harm. Thus, in order to ethically warrant involuntary confinement of a mentally ill individual, courts had to establish a threshold degree of dangerousness.<sup>37</sup> In *Lessard*, the court established a constitutional floor stating that the danger must be immediate, evidenced by a “recent overt act, attempt or threat to do substantial harm to oneself or another.”<sup>38</sup> It further stated that degree of dangerousness must be “*great enough* to justify such a *massive curtailment* of liberty.”<sup>39</sup>

Although every state accepts that a recent overt act or attempt to inflict substantial harm constitutes a degree of dangerousness sufficient to warrant civil commitment, not all states require it.<sup>40</sup> In *People v. Sansone*, an Illinois court found that an

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35. See *Kansas v. Hendricks*, 521 U.S. 346, 352 (1997) (finding that a specified degree must be met to constitute such person as a menace to the health and safety of others); see also *In re Commitment of W.Z.*, 773 A.2d 97, 115–16 (N.J. Super. Ct. App. Div. 2001) (holding that commitment must be premised on an adequate degree of likelihood); *In re Linehan*, 594 N.W.2d 867, 872–73 (Minn. 1999) (concluding that a finding of just dangerousness, by itself is too broad to civilly commit an individual). Even dictionaries include the standard in the definition of civil commitment. See e.g., *Civil Commitment*, *supra* note 17 (“court-ordered institutionalization of a person suffering from mental illness . . . usually upon a finding that the person is dangerous to himself or herself or to others”).

36. See *Dangerous*, MERRIAM-WEBSTER DICTIONARY (2022) (“able or likely to inflict injury or harm”); *Future Dangerousness*, BLACK’S LAW DICTIONARY (11<sup>th</sup> ed. 2019) (“relative threat to others”).

37. See *Lessard v. Schmidt*, 349 F.Supp. 1078, 1093 (E.D. Wis. 1972).

38. See *id.*; see also *Warren v. Harvey*, 472 F.Supp. 1061, 1069 (D. Conn. 1979) (citing *Lessard*, 349 F.Supp. at 1093); *In re Commitment of Ali*, 698 N.W.2d 133, 133 (Wis. Ct. App. 2005) (citing *Lessard*, 349 F.Supp. at 1093).

39. *Lessard*, 349 F.Supp. at 1093 (quoting *Humphrey v. Cady*, 405 U.S. 504, 509 (1972)).

40. See, e.g., *People v. Sansone*, 309 N.E.2d 733, 741 (Ill. App. Ct. 1974) (finding a medical opinion that a person is reasonably expected to engage in dangerous conduct is sufficient for civil commitment); *In re Det. of Wygle*, 910



overt act or threat to commit harm is not necessary where “a medical opinion which clearly states that a person is reasonably expected to engage in dangerous conduct, and which is based upon the experience and studies of qualified psychiatrists.”<sup>41</sup> Although several federal courts have held that a minimal regard for the individual’s due process rights requires a recent overt act or threat,<sup>42</sup> the *Sansone* court’s decision has yet to be held unconstitutional.

While the dangerousness standard remains common in most civil commitment statutes to date,<sup>43</sup> it requires a high level of proof that almost always requires a predicate act of violence.<sup>44</sup> The justification for this heightened standard was to ensure that only those in dire need of treatment would be deprived of their liberty.<sup>45</sup> To make certain that “the massive curtailment of liberty” does not get abused once a patient is committed, this standard requires that a patient’s commitment must legally be dismissed once they cease to be dangerous or cease to suffer from a mental illness.<sup>46</sup> However, when “[l]eft to their own devices,

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N.W.2d 599, 601 (Iowa 2018) (“It is not necessary for the state to allege a recent over act.”); *In re Det. of Henrickson v. State*, 2 P.3d 473, 476 (Wash. 2000) (holding that the state was not required to prove a recent overt act).

41. See *Sansone*, 309 N.E.2d at 739.

42. See *Stamus v. Leonhardt*, 414 F.Supp. 439, 450–51 (S.D. Iowa 1976); *Doremus v. Farrell*, 407 F.Supp. 509, 514–15 (D. Neb. 1975); *Lynch v. Baxley*, 386 F.Supp. 378, 391 (M.D. Ala. 1974).

43. See SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., *supra* note 14, at 8–9; see also sources cited *supra* notes 34–35.

44. See, e.g., *In re State v. Frank P.*, 2 N.Y.S.3d 483, 492–93 (N.Y. App. Div. 2015) (holding that an individual’s mental illness, which causes him to have a propensity to commit sexual crimes, alone is not sufficient grounds to mandate involuntary hospitalization).

45. See generally *Jones v. United States*, 463 U.S. 354 (1983) (holding that civil commitment is only justified when an individual is dangerous); *Civil Commitment and Treatment*, CORNELL L. SCH. LEGAL INFO. INST., <https://www.law.cornell.edu/constitution-conan/amendment-5/civil-commitment-and-treatment> (last visited Jan. 3, 2023) (discussing the liberty rights of people who are mentally disabled).

46. See Ken 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, 1295 (2000); see also *Foucha v. Louisiana*, 504 U.S. 71, 71 (1992) (holding that Louisiana’s statute allowing continued confinement absent a threat of danger violates due process); *Foucha*, 504 U.S. at 71 (noting that a person who is “committed . . . is entitled to release when he has recovered his sanity or is no longer dangerous.”).

[patients] often relapse and become ill, dangerous, and in need of rehospitalization.”<sup>47</sup>

This statutory requirement resulted in the creation of “revolving door” patients.<sup>48</sup> “These patients would appear stable in a hospital setting but, upon discharge, would deteriorate in the community due to insufficient community resources and the patients’ own inability or unwillingness to comply with treatment.”<sup>49</sup> These individuals frequently return for “costly inpatient admissions.”<sup>50</sup> While the dangerousness standard is effective in preventing abuse of liberty, it has unintentionally created a plethora of issues.

### C. Flaws in the Dangerousness Standard

Modern civil commitment statutes inadvertently created a barrier, making it nearly impossible to treat those in severe need, but who have yet to deteriorate to a state that shows dangerous propensity.<sup>51</sup> These statutes often fail to protect the individual and the public until it is too late.<sup>52</sup>

The Virginia Tech massacre illuminates this flaw. This mental health related tragedy arose when a college student suffering from manic depression lacked the insight necessary to

47. See Kress, *supra* note 46, at 1296; see also “Revolving Door” Syndrome, CDC, [https://wwwn.cdc.gov/WPVHC/Nurses/Course/Slide/Unit3\\_11](https://wwwn.cdc.gov/WPVHC/Nurses/Course/Slide/Unit3_11) (last reviewed Feb. 7, 2020) (listing the steps that lead to rehospitalization).

48. See Kress, *supra* note 46, at 1293–99 (explaining how the revolving door patients came about); “Revolving Door” Syndrome, *supra* note 47 (explaining the revolving door cycle); Eduardo Calmon de Moura et al., “Revolving Door” In Psychiatric Units Seems To Remain a Common Phenomenon in the 21<sup>st</sup> Century, 3 J. PSYCHIATRY, DEPRESSION & ANXIETY 8, 8 (2017) (evaluating the frequency of readmissions for psychiatric patients).

49. Martin Schoenfeld, *Assisted Outpatient Treatment: May the Sun Continue to Shine on Kendra’s Law*, 82 N.Y. STATE BAR ASS’N J. 28, 29 (2010).

50. *Id.*

51. See Rachel A. Scherer, *Toward a Twenty-First Century Civil Commitment Statute: A Legal, Medical, and Policy Analysis of Preventative Outpatient Treatment*, 4 IND. HEALTH L. REV. 361, 367 (2007) (discussing flaws and effects of the dangerousness standard); George E. Dix, *Major Current Issues Concerning Civil Commitment Criteria*, 45 L. & CONTEMP. PROBS. 137, 139–43 (1982) (discussing how the dangerousness standard leaves many things unanswered).

52. See Scherer, *supra* note 51, at 367; see also *infra* Part III.B (discussing how the death of Michelle Go was the result of a flawed mental hygiene system).

recognize a need for treatment.<sup>53</sup> Although the symptoms of his disorder were observed by his professors, colleagues, and even campus authorities, a court was not able to mandate involuntary hospitalization “due to the high evidentiary requirement that he be an ‘imminent’ danger to himself or others.”<sup>54</sup> Had Virginia’s civil commitment statute contained a preventative exception for people suffering from manic depression, the lives of thirty-two victims could have been saved.

Moreover, the legislative justifications for the dangerousness requirement unethically discriminate against a class of mentally ill persons whose illness inherently prevents them from possessing the clarity to productively function in modern society.<sup>55</sup> While not all individuals suffering from a mental disorder are dangerous, this is not a direct indication that the individuals’ themselves do not need treatment.<sup>56</sup> For example, a patient suffering from grandiose delusions, who is not a clear and present danger to themselves or others, may be unable to have friends, hold a job, or even sustain a relationship with their family members. Not only does the current standard fail to protect the individuals themselves, but also fails to protect the family members who must watch the individual suffer while having no ability to prevent further deterioration.<sup>57</sup> As society began to

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53. See Scherer, *supra* note 51, at 367; see also Wei-Chin Hwang, *Mental illness, Racial Identity and the Virginia Tech Shooting*, SEATTLE TIMES (May 18, 2007, 12:00 AM), <https://www.seattletimes.com/opinion/mental-illness-racial-identity-and-the-virginia-tech-shooting/> (discussing how the Virginia Tech massacre could have been prevented by proper treatment).

54. Scherer, *supra* note 51, at 367; see also Amy Tikkanen, *Virginia Tech Shooting*, BRITANNICA (Apr. 9, 2022), <https://www.britannica.com/event/Virginia-Tech-shooting> (stating that although the shooter was once subjected to psychiatric treatment by a court, he was left to his own devices once he was no longer considered a danger and maintained no contact with any mental health services).

55. See William H. Fisher & Thomas Grisso, *Commentary: Civil Commitment Statutes—40 Years of Circumvention*, 38 J. AM. ACAD. PSYCHIATRY & L. 365, 367 (2010); Scherer, *supra* note 51, at 367 (discussing discrimination against the class of mentally ill persons who are less classically violent).

56. See DJ Jaffe, *Involuntary Treatment and Involuntary Commitment Laws: Basis in Law and History*, MENTAL ILLNESS POL’Y ORG., <https://mentalillnesspolicy.org/ivc/involuntary-commitment-concepts.html> (last visited Jan. 3, 2023) (discussing how families can approach the situation of a family member who needs help).

57. See Katherine B. Cook, *Revising Assisted Outpatient Treatment Statutes: Providing Mental Health Treatment for Those in Need*, 9 IND. HEALTH L. REV. 661, 677 (2012); see also *When a Family Member Chooses Not to Seek Help*,

acknowledge some of these flaws, it became evident that something in lieu of civil commitment had to be done.<sup>58</sup>

### III. ASSISTED OUTPATIENT TREATMENT

Assisted Outpatient Treatment (“AOT”) emerged from the growing need for alternatives to the high standards that inpatient civil commitment statutes maintain.<sup>59</sup>

AOT is court-ordered treatment (including medication) for individuals who have a history of medication non-compliance, as a condition to their remaining in the community. Studies and data from states using AOT prove that it is effective in reducing the incidence and duration of hospitalization, homelessness, arrests and incarcerations, victimization, and violent episodes. AOT also increases treatment compliance and promotes long-term voluntary compliance, while reducing caregiver stress.<sup>60</sup>

Unlike involuntary hospitalization, AOT provides courts the authority to mandate treatment for a prolonged period, which ensures mentally ill persons with violent propensities take medications and engage in the necessary programs to safely live among society.<sup>61</sup>

While AOT statutes have proven helpful to reduce the number of revolving door patients and outbursts of violence, courts

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CAMH, <https://www.camh.ca/en/health-info/guides-and-publications/when-a-family-member-is-unwilling-to-seek-help> (last visited Jan. 3, 2023) (noting that when a person refuses voluntary treatment, a family can only force another member of their family into treatment when they pose a danger).

58. See Cook, *supra* note 57, at 676.

59. See *id.*; see also *infra* Part III.A (explaining the legislative intent behind the enactment of Kendra’s Law).

60. *Assisted Outpatient Treatment Laws*, TREATMENT ADVOC. CTR., <https://www.treatmentadvocacycenter.org/component/content/article/39> (last visited Jan. 3, 2023); see also Cook, *supra* note 57, at 664.

61. See Cook, *supra* note 57, at 664; see also *Guide to How AOT (Assisted Outpatient Treatment) Works*, MENTAL ILLNESS POL’Y ORG, <https://mentalillnesspolicy.org/aot/assisted-outpatient-treatment-guide.html> (last visited Jan. 3, 2023) (providing an overview of AOT); *Assisted Outpatient Treatment*, NAT’L ALL. ON MENTAL ILLNESS N.Y. ST., <https://www.naminys.org/mental-health-support/navigating-details/assisted-outpatient-treatment/> (last visited Jan. 3, 2023) (discussing Kendra’s Law and the authority it grants judges).

can only order AOT in certain circumstances.<sup>62</sup> This is due, in part, to the fact that states are hesitant to allow preventative AOT in absence of a dangerous act.<sup>63</sup> As result, most AOT statutes suffer similar flaws as that of civil commitment laws.

#### A. Kendra's Law

New York's AOT statute is commonly referred to as Kendra's Law.<sup>64</sup> Kendra's Law arose after a young woman, Kendra Webdale, was pushed off a subway platform and was fatally struck by an oncoming train.<sup>65</sup> The man who pushed Kendra was a paranoid schizophrenic who had just been released from a hospital.<sup>66</sup> His actions resulted from his non-compliance to take medication.<sup>67</sup> While many believe that the man should not have been released, the hospital had no legal grounds to retain him under New York's dangerousness standard.<sup>68</sup>

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62. See Cook, *supra* note 57, at 669–70; Michael Gray, *A Way Out of the Revolving Door*, MED. NEWS (Mar. 5, 2015), <https://www.medicalnews.md/a-way-out-of-the-revolving-door/>; see also E. Fuller Torrey, *Impaired Awareness of Illness: Anosognosia*, MENTAL ILLNESS POL'Y ORG., <https://mentalillnesspolicy.org/medical/anosognosia-studies.html> (last visited Jan. 3, 2023) (discussing how individual's with certain mental disorders have impaired awareness, which impacts ability to take their medications).

63. See Cook, *supra* note 57, at 677–83 (discussing the dangerous requirement and weakness of New York's AOT statute, Kendra's Law); see also DJ Jaffe, *Wider Use of Assisted Outpatient Treatment Could Help Individuals With Mental Illness*, STAT NEWS (Sept. 13, 2019), <https://www.statnews.com/2019/09/13/assisted-outpatient-treatment-mental-illness/#wrapper> (“[M]any states still rely on laws that require individuals to become dangerous to themselves or others before they can be treated without their consent . . . . With prevention in mind, every state should supplement their ‘danger to self or others’ standards with ‘grave disability’ and ‘need for treatment’ standards.”).

64. See Schoenfeld, *supra* note 49, at 28; N.Y. MENTAL HYG. LAW § 9.60 (McKinney 2022).

65. See Schoenfeld, *supra* note 49, at 28; Cook, *supra* note 57, at 677.

66. See Schoenfeld, *supra* note 49, at 28; Cook, *supra* note 57, at 677; see also Leah Carroll, *Man Who Pushed Woman in Front of Subway Train to be Released From Prison*, REFINERY 29 (Sept. 5, 2018, 11:42 AM), <https://www.refinery29.com/en-us/kendra-webdale-kendras-law-subway-platform-murder> (discussing the details of Kendra's death and the prior treatment of her attacker).

67. See Schoenfeld, *supra* note 49, at 28.

68. See, e.g., Pat Webdale, *Subway Victim's Legacy Must Not be Allowed to Die*, MENTAL ILLNESS POL'Y ORG. (May 4, 2005), <https://mentalillnesspolicy.org/firstperson/mental-illness-murder-webdale.html> (reprinting Kendra Webdale's mother's statements made to Buffalo News).

Soon thereafter, New York passed an AOT statute, named after Kendra, to provide mandated treatment as a more humane and less restrictive alternative to inpatient commitment.<sup>69</sup> The statute balances the civil liberties of the particular mentally ill individual with the state's interest of preventing deterioration or a relapse of a condition that could result in harm to the public.<sup>70</sup> Under Kendra's Law, the following seven conditions must be established by clear and convincing evidence:

- (1) The individual is of eighteen years of age or older; and<sup>71</sup>
- (2) The individual is suffering from a mental illness; and<sup>72</sup>
- (3) It must be clinically determined that he or she is unlikely to survive safely in the community; and<sup>73</sup>
- (4) He or she must present a lack of compliance with treatment by either:
  - (i) Being hospitalized or incarcerated at least twice in the last 36 months; or
  - (ii) Committed and act or threat of serious violent behavior toward self or others within the last 48 months; and<sup>74</sup>
- (5) The individual is unlikely to participate in voluntary outpatient treatment; and<sup>75</sup>
- (6) AOT is necessary to prevent a relapse or deterioration of the individual's condition that would be likely to result in harm; and<sup>76</sup>
- (7) The individual is likely to benefit from the treatment.<sup>77</sup>

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69. See *Kendra's Law New York's Law for Assisted Outpatient Treatment (AOT)*, MENTAL ILLNESS POL'Y ORG., <https://mentalillnesspolicy.org/kendras-law/kendras-law-overview.html> (last visited Jan. 3, 2023); see also Schoenfeld, *supra* note 49, at 28–29.

70. See *Guide to How AOT (Assisted Outpatient Treatment) Works*, *supra* note 61 (discussing the advances of Kendra's law); see also Press Release, N.Y. State Senate, *Senate Passes Measure to Make Kendra's Law Permanent* (Mar. 26, 2018), <https://www.nysenate.gov/newsroom/press-releases/senate-passes-measure-make-kendras-law-permanent> (“The law helps address the concerns about mentally ill people who are potentially a danger to themselves and society by allowing for court-ordered assisted outpatient treatment (AOT) for individuals who won't voluntarily seek help.”).

71. See N.Y. MENTAL HYG. LAW § 9.60(c)(1) (McKinney 2022).

72. See *id.* § 9.60(c)(2).

73. See *id.* § 9.60(c)(3).

74. See *id.* § 9.60(c)(4).

75. See *id.* § 9.60(c)(5).

76. See *id.* § 9.60(c)(6).

77. See *id.* § 9.60(c)(7).

One of the main motivations for enacting Kendra's Law was the determination made by the legislature that patients could remain safely in the community if released from hospitalization under the structure and supervision provided by a court mandated AOT.<sup>78</sup> The legislature did not intend for Kendra's Law to apply to individuals who have yet to commit or attempt a dangerous act.<sup>79</sup> As result, courts lack the authority to order AOT unless an individual had recently been subjected to civil commitment or incarceration.<sup>80</sup> Like civil commitment, Kendra's Law is indirectly premised on the dangerousness requirement.<sup>81</sup>

### B. Weaknesses of Kendra's Law

While Kendra's Law has been effective at reducing hospital costs, prolonging treatment, and acting as a mechanism to ensure individuals remain compliant with their medication, it fails to address New York's mentally ill population at large.<sup>82</sup> Kendra's Law, like New York's civil commitment statute, continues to impose a high burden of proof.<sup>83</sup> Because the statute is based on prior acts demonstrating dangerousness, it's not truly a preventative measure nor an aid to those that are not a threat to themselves or others.<sup>84</sup>

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78. See *In re K.L.*, 806 N.E.2d 480, 484 (N.Y. 2004); see also *Real Stories: Kendra Webdale (Kendra's Law) - Our Notions of Risk and Liberty*, COURSE HERO., <https://courses.lumenlearning.com/hvcc-abnormalpsychology/chapter/real-stories-3/> (last visited Jan. 3, 2023) ("This law . . . allows courts to order certain people diagnosed with mental illness to attend treatment as a condition for living in the community.").

79. See *In re K.L.*, 806 N.E.2d at 485 (justifying the mandated treatment of Kendra's Law under the state's police power where a patient is a danger to themselves or others); see also MENTAL HYG. § 9.60(c) (containing language that indicates danger is a prerequisite for AOT).

80. See MENTAL HYG. § 9.60(c)(4).

81. See *id.*; see also Cook, *supra* note 57, at 679 (explaining that because involuntary hospitalization of a mentally ill individual is premised on a finding of dangerousness, and said hospitalization is a requisite for New York courts to order AOT, a finding of dangerousness has to be met in both situations).

82. See Cook, *supra* note 57, at 676–80 (discussing who civil commitment statutes fail to protect and the weaknesses of Kendra's Law).

83. See MENTAL HYG. § 9.60(c) (providing the criteria for a person to receive AOT).

84. See *id.* § 9.60(c)(4) (noting that Kendra's law requires either violence or recent hospitalization or incarceration). As discussed in Part II.B, involuntary hospitalization is subject to the dangerousness standard, which is

The law does not account for those, like the college student at Virginia Tech, whose behavior had yet to evidence some leer of danger.<sup>85</sup> Absent a truly preventative exception, Kendra's Law cannot legally protect New York's mentally ill population or its communities.

The recent death of Michelle Go specifically illuminates this flaw.<sup>86</sup> In January of 2022, Ms. Go was waiting for a train at the Times Square Subway Station in New York City.<sup>87</sup> Unexpectedly and unprovoked, Simon Martial attacked Ms. Go and pushed her onto the tracks where she was struck and instantly killed by an oncoming train.<sup>88</sup>

Martial, age sixty-five, is a diagnosed schizophrenic who had been in and out of hospitalization no less than twenty times and had been subject to outpatient treatment pursuant to Kendra's Law.<sup>89</sup> While Martial was homeless at the time of the attack, he was once a productive citizen.<sup>90</sup> Martial was an athlete and hard worker until the illness took control of his life.<sup>91</sup>

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typically defined as a likelihood to cause injury or harm. See discussion *supra* Part II.B. Further, the same holds true for incarceration.

85. Under the requirements of Kendra's Law, the college student was neither hospitalized nor incarcerated. See *Virginia Tech Shootings Fast Facts*, CNN (Mar. 31, 2022), <https://www.cnn.com/2013/10/31/us/virginia-tech-shootings-fast-facts> (listing the medical treatment timeline of the college student prior to the incident).

86. Michelle Go died on January 15, 2022. See Anne Branigin, *Michelle Go Was Pushed to Her Death on the NYC Subway: For Many, it Highlights Failures in Public Safety for Women*, THE LILY (Jan. 19, 2022), <https://www.the-lily.com/michelle-go-was-pushed-to-her-death-on-the-nyc-subway-for-many-it-highlights-failures-in-public-safety-for-women/>.

87. See, e.g., Kimmy Yam, *NYC Subway Station Death of Michelle Go Leaves Asian Americans Reeling*, NBC NEWS (Jan. 19, 2022, 1:36 PM), <https://www.nbcnews.com/news/asian-america/nyc-subway-station-death-michelle-go-leaves-asian-americans-reeling-rcna12650> (explaining how Michelle Go died).

88. See *id.*

89. See, e.g., Andy Newman et al., *Decades Adrift in a Broken System, Then Charged in a Death on the Tracks*, N.Y. TIMES (Apr. 20, 2022), <https://www.nytimes.com/2022/02/05/nyregion/martial-simon-michelle-go.html>; Editorial, *Heed the Pleas of the Subway-Shover's Sister: Stop Letting the Severely Mentally Ill Roam Loose and Untreated*, N.Y. POST (Jan. 17, 2022, 7:58 PM), <https://nypost.com/2022/01/17/stop-letting-the-severely-mentally-ill-roam-loose-and-untreated/>.

90. See Newman, *supra* note 89 (discussing Martial's life prior to the emergence of his disorder).

91. See *id.* (discussing what Martial's sister disclosed in her interview that was conducted regarding the attack).



Martial's sister stated that the effects of his illness became prevalent in his thirties.<sup>92</sup> Despite the fact that treatment and medicine "kept [Martial] going," once he no longer posed a threat to himself or others, he was left on the street to his own devices.<sup>93</sup> Once a court no longer required Martial to take his medicine, he stopped medicating and his delusions resumed.<sup>94</sup> Martial's beloved sister could not understand why the system would abandon him for a prolonged period of time, despite Martial being hospitalized and jailed multiple times.<sup>95</sup> Ultimately, New York's current laws left Martial's sister unable to help him get the treatment he gravely needed.

Kendra's Law has not only failed to forestall the exact danger it was enacted to prevent, but it also unjustly discriminates against those that need treatment. While Martial may be an example of an individual who fell through the cracks of Kendra's Law, unrepresentative of conventional application, this tragedy exposed the little prevention that the statute provides.

Furthermore, Kendra's Law fails to avail itself of the benefits modern medicine provides.<sup>96</sup> Medical science has proven that the earlier treatment is administered to those suffering from a severe mental illness, the more likely it is for those individuals to experience successful long-term recovery.<sup>97</sup> New York's statute ignores this universal consensus by failing to mandate treatment as soon as the illness is recognized.

By not providing preventative care, the statute inadvertently discriminates against and adversely impacts young

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92. *See id.*

93. *See* Editorial, *supra* note 89 ("I remember begging one of the hospitals, 'Let him stay,' because once he's out, he didn't want to take medication, and it was the medication that kept him going.")

94. *See* Newman, *supra* note 89 (noting that records of Martial's numerous commitments and incarcerations, related to his mental illness, also evidence this occurrence).

95. *See id.*

96. *See* Scherer, *supra* note 51, at 433 (discussing how science proves that early treatment yields more successful results but due to the current healthcare system, many severely ill persons cannot avail these benefits); *see also infra* Part IV.A–B.

97. *See* Scherer, *supra* note 51, at 433; *see* Philip S. Wang, et al., *Delay and Failure in Treatment Seeking after First Onset of Mental Disorders in the World Health Organization's World Mental Health Survey Initiative*, 6 *WORLD PSYCHIATRY* 177, 179 (2007) (providing statistics that show treatment, if provided upon the early stages of a mental illnesses, is more likely to improve an individual's condition).

adults.<sup>98</sup> Adolescent persons are typically not afforded the time to develop a concrete history of severe mental illness and, by default, are afforded the most amount of time for their illness to deteriorate their mental health.<sup>99</sup> Because a mental disorder can arise at any moment,<sup>100</sup> it is highly unlikely that a teenager, who recently began to suffer from a mental illness, will be able to meet the high standard of proof for several years.<sup>101</sup> Likewise, this holds true in the case of older individuals, who have suddenly developed a mental illness at a later age. As a result, these people could be forced to suffer for many years before courts can provide help through their *parens patriae* powers.

#### IV. REWRITING KENDRA'S LAW TO BETTER SERVE THE PUBLIC

Kendra's Law, premised on danger, will continue to fail New York unless reform occurs. Contemporary medical understandings allow a court to know when treatment is necessary, prior to an overt act that harms the public.<sup>102</sup> Similarly, medical advancements allow doctors to not only provide an adequate diagnosis of an individual's disorder, but treat them pursuant to the

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98. See Scherer, *supra* note 51, at 433. Also note that the first requirement in Kendra's Law is that an individual be at least eighteen years of age. See N.Y. MENTAL HYG. LAW § 9.60(c)(1) (McKinney 2022). Thus, while a parent has the authority to subject their child to psychiatric treatment, a court does not have the power to order AOT in a scenario in which a parent neglects to provide the proper treatment their child may need. See *id.* Of course, there are other actions a court may take in said scenario, however, in the absence of a person who recently turns eighteen will likely have yet to develop the necessary medical history needed to receive the benefits Kendra's Law can provide. See generally MaryLouise E. Kerwin et al., *What Can Parents Do? A Review of State Laws Regarding Decision Making for Adolescent Drug Abuse and Mental Health Treatment*, 24 J. CHILD & ADOLESCENT SUBSTANCE ABUSE 166 (2015) (discussing state laws regarding parental decisions in their minor children's mental health treatment).

99. See Scherer, *supra* note 51, at 433 (discussing why young adults do not often possess the requisite concrete history for a court to implement any involuntary treatment); see also I. Lipkovich et al., *Predictors of Risk for Relapse in Patients with Schizophrenia or Schizoaffective Disorder During Olanzapine Drug Therapy*, 41 J. PSYCHIATRIC RSCH. 305, 309 (2007).

100. See *Mental Illness*, MAYO CLINIC, <https://www.mayoclinic.org/diseases-conditions/mental-illness/symptoms-causes/syc-20374968> (last visited Jan. 3, 2023).

101. See MENTAL HYG. § 9.60(c)(4).

102. See *infra* Part IV.A–B (discussing how modern medical understandings and treatments can effectively improve one's condition without the need for involuntary confinement).

diagnosis with prescription medication, prior to the need for hospitalization.<sup>103</sup> However, a court's discretion to mandate such minimally invasive treatment is limited to what New York's Mental Hygiene Laws require. In order for New York courts to avail themselves of the benefits that present day medicine can provide, a statutory amendment is required. Adding an exception to Kendra's Law, allowing courts to order AOT, upon individual's suffering from an enumerated list of disorders, even in the absence of the threat of danger, would allow the law to ethically treat the mentally ill while inherently limiting medical providers' ability to infringe upon constitutionally protected rights.<sup>104</sup>

#### A. DSM AXIS I

Amending Kendra's Law to align with modern medicine can elevate the unethical application of New York's Mental Hygiene Laws. The Diagnostic and Statistical Manual of Mental Disorders ("DSM") is the most accepted authority to define and classify mental disorders.<sup>105</sup> While the DSM makes many classifications based on psychological syndromes and patterns, it fails to provide a definition of a "severe and persistent mental illness."<sup>106</sup> Still, many renowned mental health organizations and courts use the phrase to identify a select group of mentally ill persons.<sup>107</sup>

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103. See *infra* Part IV.A–B.

104. See *infra* Part IV.B (noting the benefits an amended statute can provide).

105. See Kendra Cherry, *Diagnostic and Statistical Manual (DSM) Overview*, VERY WELL MIND (May 30, 2022), <https://www.verywellmind.com/the-diagnostic-and-statistical-manual-dsm-2795758> (explaining what the DSM is and how it works); see also Randy Stinchfield et al., *Reliability, Validity, and Classification Accuracy of the DSM-5 Diagnostic Criteria for Gambling Disorder and Comparison to DSM-IV*, 32 J. GAMBLING STUD. 905, 911 (2016) (acknowledging the reliability of the diagnostic and statistical manual of mental disorders).

106. Scherer, *supra* note 51, at 371 (quoting Andrew Barker & Alain Gregoire, *Defining Severe Mental Illness*, in ADULT SEVERE MENTAL ILLNESS 1–10 (2000) (discussing some of the definitions proposed since the 1980s)).

107. See Scherer, *supra* note 51, at 371 (noting that health organizations, like the Treatment Advocacy Center and the National Alliance on Mental Illness used the phrase 'severe and persistent mental illness' to identify certain mentally ill individuals); see also *Klement v. Astrue*, No. 1:08-CV-0640, 2009 WL 3837859, at \*6 (N.D.N.Y. Nov. 16, 2009) ("persistently and severely mentally ill"); *People v. Watt*, 137 N.Y.S.3d 37, 39 (N.Y. App. Div. 1st Dep't. 2020)

Commonly, “a severe and persistent mental illness” is associated with individuals who suffer from specific DSM AXIS I disorders, including schizophrenia, bipolar disorder, and manic depression.<sup>108</sup> The common symptoms among this class of disorders include: hallucinations, paranoia, delusions, and reality distortion.<sup>109</sup> Like the disorders themselves, these symptoms are lifelong and can worsen at any moment.<sup>110</sup> As result, it is common for these individuals to experience frantic and unpredictable episodes with little warning.<sup>111</sup>

Due to the impaired awareness caused by these illnesses, the majority of individuals do not know they are ill.<sup>112</sup> It is therefore inherent to the disease itself to create a resistance to medicine or other forms of treatment.<sup>113</sup> While research suggests that these individuals, if properly medicated, pose no more danger to society than the average mentally healthy adult, New York’s AOT statute takes minimal preventative steps in furtherance of this scientifically accepted consensus.<sup>114</sup>

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108. (“severe and persistent mental illness”); *In re Pima Cnty. Mental Health*, 817 P.2d 945, 946 (Ariz. Ct. App. 1991) (describing the criteria for a severe mental disorder).

109. See Scherer, *supra* note 51, at 371–72 (“This includes schizophrenia, schizoaffective disorder, bipolar disorder, and major depression.”).

110. See *id.* at 372 (citing L.M. Camargo et al., *Disrupted in Schizophrenia 1 Interactome: Evidence for the Close Connectivity of Risk Genes and a Potential Synaptic Basis for Schizophrenia*, 12 MOLECULAR PSYCHIATRY 74, 74 (2007)); see also Daniela Ginta, *Bipolar Disorder and Schizophrenia: What are the Differences?*, HEATHLINE, <https://www.healthline.com/health/bipolar-disorder/bipolar-vs-schizophrenia> (last updated June 23, 2022) (reviewed by Nicole Washington, DO, MPH).

111. See, e.g., Jonna Perala et al., *Lifetime Prevalence of Psychotic and Bipolar I Disorders in a General Population*, 54 ARCHIVES GEN. PSYCHIATRY 19, 19 (2007) (discussing the lifetime prevalence psychotic disorders).

112. See, e.g., *Psychosis*, NHS INFORM, <https://www.nhsinform.scot/illnesses-and-conditions/mental-health/psychosis> (last updated Dec. 12, 2022) (discussing how persons suffering from schizophrenia, bipolar disorder, and manic depression can experience hallucinations and delusions at random unpredictable times).

113. See, e.g., *Anosognosia is Major Reason Why Some Individuals with Severe Psychiatric Disorders Often Do Not Take Their Medications*, MENTAL ILLNESS POL’Y ORG., <https://mentalillnesspolicy.org/medical/medication-non-compliance.html> (last visited Jan. 3, 2023) (“55% of individuals not taking medication did so because they did not believe they were sick.”).

114. See *id.* (describing the most common reasons why psychiatric patients do not take their medication).

115. See Cook, *supra* note 57, at 670 (quoting Christian E. Piccolo, Note, *Falling Through the Cracks: The Need for Enhanced Supervision in the*

Studies show that individuals suffering from these disorders comprise less than 1% of the population but account for approximately 1,000 homicides per year.<sup>115</sup> In New York, like many states, over half of all adults suffering from serious mental illness go untreated.<sup>116</sup> This is in large part because they have not met the high standard of proof required under New York's law.<sup>117</sup>

While case law has demonstrated that these disorders are frequently associated with individuals who are subjected to either inpatient treatment or AOT, New York's mental health statutes do not include any illnesses enumerated in the DSM list of Axis I disorders.<sup>118</sup> Accordingly, the legislature has failed to enact a law that can adequately protect and serve New York's mental health population in accordance with modern psychiatric understandings.<sup>119</sup>

## B. Proposed Statutory Amendment

New York can correct the deficiencies in its mental hygiene statutes by creating a preventative AOT provision which affords courts the authority to mandate AOT for individuals suffering from schizophrenia, bipolar disorder, and manic depression, even in the absence of a threat of danger. The proposed amendment still allows for all other procedural safeguards, which would afford courts the opportunity to properly balance New York's *parens patriae* powers with an individual's constitutional rights.

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*Involuntary Outpatient Civil Commitment Setting*, 54 VILL. L. REV. 309, 318–19 (2009)).

115. See Kathleen Winchell, *The Need to Close Kentucky's Revolving Door: Proposal for a Movement Towards a Socially Responsible Approach to Treatment and Commitment of the Mentally Ill*, 29 N. KY. L. REV. 189, 211 (2002).

116. See TREATMENT ADVOC. CTR., PREVALENCE OF SERIOUS MENTAL ILLNESS AMONG ADULTS, BY STATE (2017), <https://www.treatmentadvocacycenter.org/storage/documents/smi-prevalence-chart.pdf> (showing that in 2017 approximately four million people suffering from schizophrenia and severe bipolar disorder went untreated across the United States).

117. See Cook, *supra* note 57, at 677–80 (discussing Kendra's Law and its weaknesses).

118. See N.Y. MENTAL HYG. LAW §§ 9.01–.63 (McKinney 2022).

119. See *infra* Part IV.A (discussing modern medicine in treating the mentally ill and the supporting historical data).

Because the exception to Kendra's Law would only apply to a narrowly tailored and select group of individuals who have inherently proven to need treatment, there would be little room for erroneous deprivation. The proposed amendment would consist of eliminating the requirement in Kendra's Law that calls for an established history of dangerousness,<sup>120</sup> if an individual is diagnosed with one of three enumerated disorders. In its place, a court will have to prove, by clear and convincing evidence, that treatment is in the patient's best interest. By using the current safeguards, including the use of clear and convincing upon every other current provision in Kendra's Law, courts will be able to ensure equitable application.<sup>121</sup>

This proposed amendment would not only positively affect crime rates of afflicted persons, but also ethically serve hundreds of thousands of New York's residents.<sup>122</sup> In regard to the mentally ill individuals themselves, AOT treatment would provide the medical support to receive the clarity needed to live a productive life, all while remaining in the community.<sup>123</sup> In turn, New York's communities would benefit by the reduced likelihood of violence.

The minimal invasiveness of AOT,<sup>124</sup> as compared to inpatient commitment, would prevent traumatizing events upon

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120. This refers to the fourth requirement in Kendra's law which states in relevant part: in order to be receive treatment under Kendra's Law, the individual must present a lack of compliance with treatment by either: (i) being hospitalized or incarcerated at least twice in the last thirty-six months; or (ii) having committed an act or threat of serious violent behavior toward self or others within the last forty-eight months. *See* MENTAL HYG. § 9.60(c).

121. *See id.* § 9.60(j) (noting that the standard of proof for an individual to receive treatment under Kendra's Law is clear and convincing evidence); *see also infra* Part IV.C (discussing the proposed amendment as it applies to an individual's constitutionally protected liberty interests).

122. *See* TREATMENT ADVOC. CTR., *supra* note 116 (showing that 245,845 untreated individuals suffering from schizophrenia and bipolar disorder in New York state). Furthermore, courts would have the power to help individuals, such as Mr. Martial, treat their illness at a stage sufficient to prevent danger and ultimately lifelong confinement for an act that their disorder made them commit. *See supra* notes 86–95 and accompanying text.

123. *See* Cook, *supra* note 57, at 664–65.

124. *See In re K.L.*, 806 N.E.2d 480, 485 (N.Y. 2004) ("The restriction on a patient's freedom effected by a court order authorizing assisted outpatient treatment is minimal. . .").

many families.<sup>125</sup> The proposed amendment would provide families with the ability to adequately treat their loved ones without fear that the individuals will be held in custody without due cause. Moreover, many families would not have to watch their relatives deteriorate, without any recourse until it is too late.<sup>126</sup>

### C. Constitutionality of Proposed Statutory Amendment

Kendra's Law, as written, has been upheld as constitutional.<sup>127</sup> Under the reasoning provided by courts, the proposed amendment, doing away with the implicit dangerous requirement in limited circumstances, would likewise prove constitutional. "While '[e]very adult human being of sound mind has a right to determine what shall be done with his own body,' including the course of medical treatment, these rights are not absolute."<sup>128</sup> A compelling state interest can override a mentally ill person's fundamental right to refuse treatment.<sup>129</sup> Because AOT

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125. See Cook, *supra* note 57, at 677 (discussing the burden these illnesses pose on afflicted family members and how the current civil commitment statutes fail to protect them).

126. See *id.* (noting how current civil commitment statutes "fail to protect individuals' family members who must watch them suffer and have no ability to stop their deterioration"); *When a Family Member Chooses Not to Seek Help*, *supra* note 57 (discussing the limited actions family members can take in absence of danger).

127. See *In re K.L.*, 806 N.E.2d at 482–83; see also *Coleman v. State Sup. Ct.*, 697 F.Supp.2d 493, 509 (S.D.N.Y. 2010) (holding that Kendra's Law did not violate plaintiff's due process rights); *In re Urcuyo*, 714 N.Y.S.2d 862, 872–73 (N.Y. Sup. Ct. 2000) (holding that Kendra's Law did not violate plaintiff's due process rights); *Meyers v. Sullivan*, No. 14-CV-7448, 2017 WL 5125767, at \*5 (E.D.N.Y. Aug. 23, 2017) (holding that Kendra's Law did not violate of plaintiff's due process rights).

128. *In re K.L.*, 806 N.E.2d at 484 (quoting *Schloendorff v. Soc'y of N.Y. Hosp.* 105 N.E. 92, 93 (N.Y. 1914)); *In re N.Y. Presbyterian Hosp., Westchester Div.*, 593 N.Y.S.2d 405, 408 (N.Y. Sup. Ct. 1999) (quoting *Rivers v. Katz*, 495 N.E.2d 337, 341 (N.Y. 1986)); see also *In re Farrell*, 529 A.2d 404, 410 (N.J. 2019) ("Nevertheless, the right to refuse . . . medical treatment is not absolute."); *Rivers*, 495 N.E.2d at 343–44 (considering the factors a court will address when determining if the court has the ability to override an individual's right to refuse treatment); *Dolan v. K-W*, 950 N.Y.S.2d 419, 424 (N.Y. Sup. Ct. 2012) ("[T]hese fundamental rights are not *absolute*, and are tempered and limited by compelling state interests to exercise its police powers, such as in emergency situations, for the administration of medication over the patient's objection if the 'patient presents a danger to himself or other members of society or engages in dangerous or potentially destructive conduct within the institution.'" (emphasis added) (quoting *Rivers*, 495 N.E.2d at 343)).

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

only “minimally” restricts a patient’s freedom, “the assisted outpatient’s right to refuse treatment is outweighed by the state’s compelling interests in both its police and *parens patriae* powers.”<sup>130</sup>

Under this reasoning, it follows logically that the state has a compelling interest to prevent individuals who suffer from paranoid schizophrenia, bipolar disorder, and manic depression to cause harm, regardless of whether their condition has deteriorated to a point in which harm has already occurred. Science has demonstrated that persons suffering from these disorders lack the ability to logically perceive reality.<sup>131</sup> In these cases, it is the illness itself that creates the threat of danger and not necessarily just the prior acts of the individual that poses the threat. Given the minimal invasiveness of AOT, mandating treatment prior to an overt act, does not pose the abuse of an individual’s constitutional liberty interest as the inpatient treatment in twentieth century had.

Moreover, if the same “clear and convincing” standard of proof was applied to this exception, it would limit a medical provider or court’s ability to abuse its discretion. Under Kendra’s Law, a state can constitutionally exercise its *parens patriae* powers in the form of AOT if a judicial determination has been made after a hearing based upon testimony, a psychiatric examination, medical evidence, and an opinion “which proves by clear and convincing evidence that the patient lacks the capacity to make a rational treatment decision,” and “that the proposed treatment is narrowly tailored to give substantive effect to the patient’s liberty interest.”<sup>132</sup> As applied to the proposed statute, New York would be able to constitutionally tailor AOT on a person-by-person basis. This allows courts to properly balance the “minimal” liberty interests at stake with the state’s interest in

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130. *See id.*; *see also* Addington v. Texas, 441 U.S. 418, 426 (1979) (“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.”).

131. *See* Clara Humpston, *Schizophrenia and the Paradoxes of Insight*, PSYCH. TODAY (January 7, 2020), <https://www.psychologytoday.com/us/blog/hallucinating-the-self/202001/schizophrenia-and-the-paradoxes-insight> (discussing reality distortion among mentally ill individuals); *see also* Perala et al., *supra* note 110, at 20 (discussing the symptoms that persons suffering from a severe and persistent mental illness commonly experience).

132. *Dolan*, 950 N.Y.S.2d at 424.



providing treatment to persons suffering from the previously mentioned enumerated disorders. Hence, a court, while mandating medication, will have the discretion to limit excessive measures such as an appointed guardian who must live with the individual or bi-weekly hygiene hearings, to ensure compliance, particularly to those cases in which the individual poses an immediate danger.

In the case of *Addington v. Texas*, the Supreme Court decided the minimal standard of proof required to meet the constitutional bounds of the Fourteenth Amendment when mandating involuntary hospitalization.<sup>133</sup> In doing so, the Supreme Court acknowledged two important factors: (1) the risk of erroneous confinement is inherently mitigated by continued observation and by concerned family and friends; and (2) it is not better for mentally ill persons to go free because one who suffers from a debilitating mental illness is not “wholly at liberty.”<sup>134</sup>

Applying the reasoning used by the *Addington* court to the proposed amendment not only provides support for its constitutionality, but also illuminates New York's compelling interest.<sup>135</sup> By mandating AOT upon those who fall within the enumerated class, courts will not deprive persons of their liberty, but rather grant them the ability to actually exercise their liberties.<sup>136</sup> The *Addington* court suggests that “debilitating mental illnesses” prevents an individual from possessing the same liberty as a competent adult due to the inherent incapacities the disease creates.<sup>137</sup> To this end, it follows that necessary treatment would provide qualifying individuals with the clarity of mind to function in today's society.

Furthermore, providing such persons with a right to independent counsel at all relevant times, as a safeguard to

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133. *See Addington*, 441 U.S. at 418 (“A ‘clear and convincing’ standard of proof is required by the Fourteenth Amendment in a civil proceeding brought under state law to commit an individual involuntarily for an indefinite period to a state mental hospital.”).

134. *See id.* at 428–29.

135. The proposed amendment inherently limits the risk of erroneous confinement because the statute does not allow for confinement, only a treatment mandate upon those that remain in their community. *See id.* Moreover, the previous two sub-sections of this paper explained why the conditions of these enumerated and debilitating illnesses prevent one from possessing the liberty to function among society. *See id.*; *see also supra* Part IV.A–B.

136. *See Addington*, 441 U.S. at 428–29.

137. *See id.*

institutional abuse, is a practical balance to the threat such a statute could impose on the individual liberty.<sup>138</sup>

## V. FINANCIAL IMPLEMENTATIONS

The cost associated with implementing preventative AOT is not as expensive as one might expect. Although it is near impossible to estimate the exact figures that the amended statute would carry, comparison to current AOT statutes shed light on what New York could expect.<sup>139</sup> Additionally, the proposed amendment could save the state millions of dollars in funds currently being used to incarcerate and or hospitalize the mentally ill persons that the present system promotes.<sup>140</sup>

### A. Realized Saving of Modern Outpatient Statutes

Research confirms that New York's current outpatient treatment laws yielded significant savings for the public mental health system.<sup>141</sup> In 2013, a thirty-six month comprehensive

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138. See, e.g., *In re J.S.*, 401 P.3d 197, 203–06 (Mont. 2017) (discussing the right to counsel in mental hygiene hearings); *State v. Raul L.*, 988 N.Y.S.2d 190, 192–93 (N.Y. App. Div. 2014) (holding that an individual's waiver of counsel in a mental hygiene proceeding must be "unequivocal, voluntary, and intelligent"); *In re Edward G.N.*, 795 N.Y.S.2d 244, 245 (N.Y. App. Div. 2005) (finding that the lower court erred in failing to appoint counsel for appellant in a mental hygiene hearing); Laura M. Brancato, *Navigating Right to Counsel Under Mental Hygiene Law Article 81.10*, MELTZER LIPPE, (Feb. 28, 2022), <https://www.meltzerlippe.com/articles/navigating-right-to-counsel-under-mental-hygiene-law-article-81-10/> (discussing the right to counsel during a mental hygiene proceeding).

139. See *infra* Part V.A (comparing the cost of current AOT statutes to estimate increased cost of the proposed amendment).

140. See *infra* Part V.A–B (discussing the savings realized through current AOT systems).

141. See *AOT Implementation FAQ*, TREATMENT ADVOC. CTR., [https://www.treatmentadvocacycenter.org/component/content/article/180-fixing-the\\_system/3616-aot-implementation-faq#associated-costs](https://www.treatmentadvocacycenter.org/component/content/article/180-fixing-the_system/3616-aot-implementation-faq#associated-costs) (last visited Jan. 3, 2023) (discussing the findings of statistical data on the cost-effective analyses of states that have implemented an AOT statute); see also DJ Jaffe, *Time to Strengthen Kendra's Law*, CITY J. (2011), <https://www.city-journal.org/html/time-strengthen-kendra's-law-13385.html> ("The law also saved money by dramatically reducing psychiatric hospitalizations, arrests, and incarcerations."); Pam Belluck, *Program Compelling Outpatient Treatment for Mental Illness Is Working, Study Says*, N.Y. TIMES (July 30, 2013), <https://www.nytimes.com/2013/07/30/us/program-compelling-outpatient-treatment-for-mental-illness-is-working-study-says.html> (noting that AOT treatment has led to a decrease in costs in caring for these patients).

cost analysis was performed for 634 assisted outpatient treatment participants and 255 voluntary recipients of community-based treatment in New York state.<sup>142</sup> Approximately 80% of the participants “had a diagnosis of a schizophrenia spectrum disorder.”<sup>143</sup> The results of this study found that those subjected to AOT, as opposed to inpatient treatment, saved New York about 50% in overall service costs during its first year after initiation.<sup>144</sup> In the years thereafter, savings continued to increase as ways to improve the system became evident.<sup>145</sup> The vast majority of these savings were attributable to the expensive costs of hospitalization.<sup>146</sup>

Similarly, California’s Lauras’s Law<sup>147</sup> has shown significant net savings, not only for the patients themselves but for the taxpayers.<sup>148</sup> In Nevada County, research has shown that for every \$1 spent on AOT, the average taxpayer saved \$1.81 by preventing re-hospitalization or jailing.<sup>149</sup> Untimely, the program

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142. See generally Jeffery W. Swanson et al., *The Cost of Assisted Outpatient Treatment: Can it Save States Money?*, 170 AM. J. PSYCH. 1423 (2013) (discussing how Kendra’s Law saved New York millions of dollars in mental health care treatment in the years after its enactment).

143. *Id.* at 1425.

144. See *id.* at 1423.

145. See *id.*

146. See *id.* at 1426.

147. Laura’s Law is the name of California’s Assisted Outpatient Treatment Statute that was enacted to target the subset of persons with serious mental illness. See CAL. WELF. & INST. CODE § 5346 (g)–(h) (West 2022); see also *Lauras’s Law*, TREATMENT ADVOC. CTR., <https://www.treatmentadvocacycenter.org/component/content/article/180-fixing-the-system/2009-lauras-law> (last visited Jan. 3, 2023) (“Laura’s Law is California’s state law that provides community-based, assisted outpatient treatment (AOT) to a small population of individuals who meet strict legal criteria and who – as a result of their mental illness – are unable to voluntarily access community mental health services. The law is named for Laura Wilcox[,] . . . who was shot and killed at the age of 19 by a man with untreated severe mental illness.”).

148. See CAMERON QUANBECK ET AL., COST-EFFECTIVENESS ANALYSIS OF ASSISTED OUTPATIENT TREATMENT IMPLEMENTATION IN CALIFORNIA’S CIVIL SECTOR, 1, <https://www.mynevadacounty.com/DocumentCenter/View/10773/Cost-Effectiveness-Analysis-of-AOT-Implementation-in-CA-Civil-Sector-PDF>.

149. See *id.*; see also *Laura’s Law in Nevada County A Model for Action – Saving Money and Lives*, NEV. CTS. CA. 4, <https://www.nevada.courts.ca.gov/sites/default/files/nccourt/default/documents/1112-HEV-AB1421LaurasLaw.pdf> (last visited Jan. 3, 2023) (“This analysis indicates that for each dollar Nevada County ‘invested’ in providing services under Laura’s Law it saved \$1.81.”).

produced a net savings of 45% or \$503,621 in the first thirty months for the county alone.<sup>150</sup> Projecting these statistics upon California as a whole would result in savings of just shy of \$200 million in the same time frame.<sup>151</sup>

Surprisingly, the intentions of New York and California's AOT statutes were never to save money.<sup>152</sup> AOT was "designed to make sure someone who has been in and out of a psychiatric hospital a number of times gets treatment that can help them."<sup>153</sup> The result of saving money is, thus, an unintended and coincidental benefit. This alludes to the possibility that if proper resources and time were devoted to making AOT even more cost effective, further savings could be attained.

Moreover, statistics have shown the upfront costs to be modest at best.<sup>154</sup> In setting up an AOT program, the vast majority of upfront cost is associated with the need to increase staff at mental health agencies and courts, that in turn work together to determine a person's mental status through mental hygiene related proceedings.<sup>155</sup> Most of the requirements are inexpensive

150. See QUANBECK ET AL., *supra* note 148, at 1.

151. See *id.*

152. See Swanson et al., *supra* note 142, at 1423–24 (noting that AOT was designed to help mentally ill individuals, but it also saves a significant amount of money).

153. *New Major Study Shows AOT Cuts Costs in Half*, MENTAL ILLNESS POL'Y ORG. (July 30, 2013), [https://mentalillnesspolicy.org/aot/aot-cuts-costs-in-half.html#:~:text=%E2%80%9COutpatient%20commitment%20is%20not%20designed,help%20them%2C%E2%80%9D%20Swanson%20said;see%20also%20Swanson%20et%20al.,%20supra%20note%20142,%20at%201423%20\(AOT%20was%20designed%20to%20improve%20outcomes%20for%20persons%20with%20serious%20mental%20illness%20and%20a%20history%20of%20repeated%20hospitalizations%20attributable%20to%20nonadherence%20with%20outpatient%20treatment.%20\)](https://mentalillnesspolicy.org/aot/aot-cuts-costs-in-half.html#:~:text=%E2%80%9COutpatient%20commitment%20is%20not%20designed,help%20them%2C%E2%80%9D%20Swanson%20said;see%20also%20Swanson%20et%20al.,%20supra%20note%20142,%20at%201423%20(AOT%20was%20designed%20to%20improve%20outcomes%20for%20persons%20with%20serious%20mental%20illness%20and%20a%20history%20of%20repeated%20hospitalizations%20attributable%20to%20nonadherence%20with%20outpatient%20treatment.%20))

154. See Swanson et al., *supra* note 142, at 1424–25 (discussing the initial expenditures New York made); QUANBECK ET AL., *supra* note 148, at 1–5 (discussing how AOT is more cost effective than alternative ways of ensuring treatment); *AOT Implementation FAQ*, *supra* note 141 ("In truth, the upfront costs associated with AOT are modest.").

155. See *AOT Implementation FAQ*, *supra* note 141 ("It mainly comes down to the staffing needs within public mental health agencies and courts to investigate whether identified patients meet AOT criteria, file petitions as warranted, conduct examinations and hearings, and maintain contacts between the court and treatment team. There are also legal costs associated with preparing and presenting evidence in court of patients' qualification for AOT and with providing counsel to indigent patients.").

to set up because established organizations already exist for inpatient treatment and can be utilized for AOT.<sup>156</sup>

Applying the same principals of economy to the proposed amendment, the upfront costs would likewise prove to be modest. New York has already designated courts and agencies to handle the needs of its AOT programs.<sup>157</sup> While the need for staff members may increase as the number of patients increase, the costs of additional staff is *de minimis* compared to the costs of creating new agencies and new courts.<sup>158</sup>

Moreover, the associated cost of implementing the proposed AOT amendment is analogous to most programs that provide comprehensive community-based services to its recipients.<sup>159</sup> Such programs often receive resistance because of the belief that taxpayers will bear the burden.<sup>160</sup> However, this overlooks the fact that the individuals who would qualify for AOT are in the community whether or not they receive treatment and are in desperate need of the services that such a program could provide.<sup>161</sup> Moreover, the financial obligation of New York's mental

156. Every state has established mental health courts that are commonly used in civil commitment proceedings. See *Mental Health Courts*, THE COUNCIL OF STATE GOV'TS JUST. CTR., <https://csgjusticecenter.org/projects/mental-health-courts/> (last visited Jan. 3, 2023). Likewise, the organizations that handle the medical aspect of mental health law have also been established for many years. See *id.*; see also *supra* Part III.A (discussing the establishment of mental health institutions).

157. See *Mental Health Courts*, N.Y. CTS.GOV, <https://ww2.nycourts.gov/mental-health-courts-overview-27066> (last visited Jan. 3, 2023) (discussing New York's Mental Health Courts and community based treatment).

158. Instead of having to build new infrastructure and establish a new system of courts, New York can simply staff additional employees in its existing courts.

159. See *AOT Implementation FAQ*, *supra* note 141 (“A typical AOT program is a collaboration between the local court with jurisdiction over civil commitment cases and the local publicly-funded agency or organization responsible for community-based mental health services.”); see also *Adult Behavioral Health Home and Community Based Services (BH HCBS) Overview*, N.Y. STATE OFF. OF MENTAL HEALTH, <https://omh.ny.gov/omhweb/bho/hcbs.html> (last visited Jan. 3, 2023) (discussing the many community-based services provided by New York state).

160. See Charlotte Hsu, *Taxpayers Paying for Ineffective Sex-Offender Treatment Programs*, UB REP. (June 24, 2010), [https://www.buffalo.edu/ub-reporter/archive/2010\\_06\\_23/ubts\\_ewing.html](https://www.buffalo.edu/ub-reporter/archive/2010_06_23/ubts_ewing.html) (discussing taxpayers' dislike for paying for community outreach programs).

161. See *AOT Implementation FAQ*, *supra* note 141; see also *supra* Part IV (discussing persons in need of treatment that current law fails to serve).

health system to care for and treat those suffering from mental illness already exists and are largely covered by Medicaid and other providers.<sup>162</sup> Thus, there is no logical argument to be made that these providers would not likewise shoulder the majority of additional expenses that the amended statute could create.

#### B. Long Terms Savings Will Likely Outweigh the Costs

Left untreated, severe and persistent mental disorders result in frequent incarceration.<sup>163</sup> The Department of Justice estimated that “at least sixteen percent of the total jail and prison population in the United States, nearly 300,000 people, have a *serious mental illness* . . . .”<sup>164</sup> Supplemental research shows that of the persons incarcerated with mental illnesses, the vast majority have been arrested in relation to non-violent crimes such as disorderly conduct or alcohol and drug related charges.<sup>165</sup> As a result, New York’s Mental Hygiene Laws provide no assistance to many of these individuals merely because they have yet to exhibit a danger to themselves or others. Yet, the state remains willing to pay for their confinement. Instead of receiving treatment for their illness that caused the negative actions, many mentally ill persons are being put into a system that is designed to punish and deter when they lack the mental competency to be deterred.<sup>166</sup> While it temporarily takes these people off the street, it poses no long-term cost benefit to society or assistance for the afflicted individual.<sup>167</sup>

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162. See *AOT Implementation FAQ*, *supra* note 141 (“[I]t should be noted, these [AOT] costs are largely covered by Medicaid and other insurers.”).

163. See Tammy Seltzer, *Mental Health Courts: A Misguided Attempt to Address the Criminal Justice System’s Unfair Treatment of People with Mental Illnesses*, 11 PSYCH., PUB. POL’Y, & L. 570, 572 (2005) (discussing the cycle of mentally ill person in America’s prisons).

164. See Scherer, *supra* note 51, at 413 (quoting *Criminalization of Americans with Severe Mental Illnesses*, TREATMENT ADVOC. CTR. at 1, <http://www.psychlaws.org/GeneralResources/fact3.pdf> (last visited Mar. 5, 2006)).

165. See *id.*; see also Emmanuel M. Ngu et al., *Mental Disorders, Health Inequalities and Ethics: A Global Perspective*, 22 INT. REV. PSYCHIATRY 235, 240 (2010) (“In developed nations (e.g. USA), deinstitutionalization of people with mental illness results in many patients ... being incarcerated because of limited access and availability of basic mental health services in the community.”).

166. See Scherer, *supra* note 51, at 415.

167. See, e.g., Ed Lyon, *Imprisoning America’s Mentally Ill*, PRISON LEGAL NEWS 4, (Feb. 2019),

Moreover, as a result of deinstitutionalization, “[i]ndividuals with psychiatric diseases like schizophrenia and bipolar disorder are ten times more likely to be in a jail or prison than a hospital bed.”<sup>168</sup> With the minimal treatment that prisons provide, New York is essentially throwing out millions of dollars every year in an attempt rehabilitate citizens in a manner that is scientifically impossible.<sup>169</sup> Not only does this phenomenon constitute economic waste, but it is unethical and creates revolving door criminals.<sup>170</sup> To this end, New York law chooses to criminalize mental illness rather than provide the proper care for its citizens.<sup>171</sup>

New York spends billions of dollars annually on its jails.<sup>172</sup> On average, a typical New York County spends more than \$225 a night or \$82,000 a year to incarcerate a single person.<sup>173</sup> The cost is almost entirely shouldered by the state’s taxpayers.<sup>174</sup> These statistics don’t financially account for the cost of emergency calls, arrests, and prosecutions associated with incarcerating persons.<sup>175</sup> On the other hand, statistics show that the

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<https://www.prisonlegalnews.org/news/2019/feb/4/imprisoning-americas-mentally-ill/> (discussing the costs associated with incarcerating the mentally ill).

168. *Criminalization of Mental Illness*, TREATMENT ADVOC. CTR., <https://www.treatmentadvocacycenter.org/key-issues/criminalization-of-mental-illness> (last visited Jan. 3, 2023).

169. As discussed above, impaired awareness of a person suffering from a severe and persistent mental disorder prevents them from comprehending the consequences of their own actions. *See supra* Part IV.A. As a result, the attempt to rehabilitate individuals without the use of medication and other psychiatric techniques constitutes economic waste.

170. *See* Miriam Becker-Cohen & KiDeuk Kim, *The Revolving Door: Mental Illness, Incarceration, Inadequate Care, and Inadequate Evidence*, URB. INST. (Apr. 7, 2015), <https://www.urban.org/urban-wire/revolving-door-mental-illness-incarceration-inadequate-care-and-inadequate-evidence>; *see also* DEREK DENCKLA & GREG BERMAN, RETHINKING THE REVOLVING DOOR: A LOOK AT MENTAL ILLNESS IN THE COURTS 1 (2001), <https://www.courtinnovation.org/sites/default/files/rethinkingtherevolvingdoor.pdf>.

171. *See Criminalization of Mental Illness, supra* note 168.

172. *See* VERA INST. OF JUST., THE COST OF INCARCERATION IN NEW YORK STATE: NEW YORK STATE COUNTIES 1 (2020), [https://www.vera.org/inline-downloads/new-york-state-counties-summary\\_2021-01-15-204135.pdf](https://www.vera.org/inline-downloads/new-york-state-counties-summary_2021-01-15-204135.pdf) (noting that all the total budget for all the counties outside of New York City is \$26.2 billion).

173. *See id.*

174. *See* Valerie Jenness, *How Much Tax Dollars are Spent on Prisons in America?*, MEDIUM (Aug. 6, 2016), [https://medium.com/@Valerie\\_Jenness/how-much-tax-dollars-are-spent-on-prisons-in-america-df9e40a13523](https://medium.com/@Valerie_Jenness/how-much-tax-dollars-are-spent-on-prisons-in-america-df9e40a13523).

175. *See* VERA INST. OF JUST., *supra* note 172, at 1.

AOT in New York only costs about \$39,000 per person per year.<sup>176</sup>

The proposed amendment to Kendra's Law, in accord with the statistics above, has the potential to save New York millions of dollars. Research proves that the proper treatment of a mentally ill individual will decrease their tendency to commit criminal acts, which in turn lowers incarceration rates. Because the expense of incarceration is sustainably higher than that of outpatient treatment, it likely would not take long for the program's upfront costs to be outweighed by state's overall savings.

## VI. CONCLUSION

While New York's current AOT statute has proven effective in its intention, it does not practically allow afflicted persons suffering from a severe and persistent mental illness to receive the benefits that modern medicine can provide. There is demonstrable evidence that proves modern medicine can effectively provide these persons with the clarity to make an informed decision to accepting treatment, but such ability is predicate on the medical community having the opportunity to deliver such persons the clarity to so decide. A carefully crafted statute, recognizing that a prerequisite to constitutional liberty is the cognitive ability to exercise such rights with specific safeguards and oversight, would allow justice to ethically serve New York. Like the civil rights movement that motivated constitutional compliance, now is the time for a movement that ethically serves the population at large.

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176. See Swanson et al., *supra* note 142, at 1427 (discussing the average cost that New York spent per person on AOT).