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NOTE

ASSISTED OUTPATIENT TREATMENT IN OHIO: IS JASON'S LAW LIFE-SAVING LEGISLATION OR A RASH RESPONSE?

Steven Strang[†]

I. INTRODUCTION

On Friday, May 25, 2007, Cleveland Heights police officer Jason West responded to a call about a street fight.¹ Arriving at the scene, West spotted a car pulling into an adjacent driveway.² West pulled his cruiser in front of the car to block it from escaping.³ West stepped out of his cruiser and the driver of the car opened fire on West, then exited the car and shot West at close range.⁴ West died from the wounds.⁵

The Cleveland Heights police arrested twenty-seven year old Timothy Halton Jr. for the shooting that evening.⁶ Halton is a schizophrenic with a long history of violent behavior.⁷ Convicted in 2005 for assaulting a South Euclid police officer, Halton was sentenced to four years of probation.⁸ During his probationary period, Halton remained on schedule with his medical visits and received the shots that kept his often-violent psychosis under control. In fact, Halton's pa-

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¹ Rachel Dissell, Donna Miller & Scott Stephens, *How the Shooting Occurred*, PLAIN DEALER (Cleveland, Ohio), May 27, 2007, at A14.

² *See id.*

³ *Id.*

⁴ *Id.*

⁵ Phillip Morris, 'We Tried to Get Help,' *Halton's Mother Says*, PLAIN DEALER (Cleveland, Ohio), May 31, 2007, at A1.

⁶ Dissell et al., *supra* note 1.

⁷ *See Halton Crime History*, PLAIN DEALER (Cleveland, Ohio), May 30, 2007, at A6. Halton had recently beaten a man outside of his residence.

⁸ Morris, *supra* note 5.

role ended early because of his improving behavior. That is when his mother, Jeanette Tiggs, began to notice that her son started to withdraw and again display a violent temperament, signs he was not taking his medication.⁹ Because Halton was no longer in the legal system, Tiggs did not know what to do. On Saturday May 26, 2007, she received the call she had been dreading: her son had finally snapped and killed someone.¹⁰

Society poorly understands and roundly fears mental illness. This fear is cultivated by publicized acts of violence by mentally ill individuals,¹¹ recently the shooting at Virginia Tech by an individual a state court had declared “mentally ill and in need of hospitalization.”¹² These instances stir fear in the public, and have prompted lawmakers to adopt programs that facilitate the outpatient commitment of the mentally ill.¹³ Assisted outpatient treatment (“AOT”) involves involuntary court-ordered treatment for the mentally ill that allows them to remain in the community, rather than be hospitalized.¹⁴ Absent these programs, people with mental illness would be hospitalized against their will upon a court determination that they were a danger to themselves or others; if a court does not find this, a mentally ill individual has the same personal freedom as anyone else. AOT is an intermediate step between hospitalization and total autonomy that mandates some level of supervision,¹⁵ and includes steps such as therapy, participation in treatment programs, supervised living arrangements, or the acceptance of psychiatric medication.¹⁶ If the patient fails to

⁹ See *id.*

¹⁰ *Id.*

¹¹ See generally *Don't Let Dangerous Maniacs Roam Free*, N.Y. POST, May 3, 1999, at 34; Joy Alter Hubel, *Patching the Safety Net for the Mentally Ill*, N.Y. TIMES, Oct. 24, 1999, at L11; Jackie Halifax, *Deputy's Killing Behind Passage of New State Law*, MIAMI HERALD, Dec. 31, 2004, at B6; CNN.com, *Killer's Manifesto: 'You Forced Me into a Corner,'* <http://www.cnn.com/2007/US/04/18/vtech.shooting/index.html> (last visited Sept. 26, 2008) (describing the Virginia Tech massacre); Harlan Spector, *Halton Brings Attention to Mandatory Treatment*, PLAIN DEALER (Cleveland, Ohio), July 14, 2007, at A1.

¹² *Killer's Manifesto: 'You Forced Me into a Corner,'* *supra* note 11.

¹³ Jennifer Gutterman, Note, *Waging a War on Drugs: Administering a Lethal Dose to Kendra's Law*, 68 FORDHAM L. REV. 2401, 2402 (2000).

¹⁴ Jeffrey Draine, *Conceptualizing Services Research on Outpatient Commitment*, 24 J. OF BEHAV. HEALTH SERVICES & RES. 306, 306 (1997).

¹⁵ See Gutterman, *supra* note 13, at 2403.

¹⁶ 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).

satisfy the requirements of an AOT program, he is subject to legal consequences that often result in institutionalization.¹⁷

On August 21, 2007, State Representative Mark Patton introduced Ohio House Bill 299,¹⁸ which aims to implement a new mandatory AOT program in Ohio. As of March 18, 2008, the bill is in the House's Health Committee.¹⁹ Patton proposed the bill in response to the killing of Jason West, and he has named the measure "Jason's Law." The bill is intended to protect both the potential victims of violent mentally ill individuals who fail to take prescribed medication, and the mentally ill themselves.²⁰ Under current Ohio law, courts can only order mentally ill people who present an imminent threat to themselves or others into hospitals or treatment.²¹ Only hospitals may administer psychotropic medication to the mentally ill, and to force medication the hospital needs a second court order.²² Under Jason's Law, probate judges could order mentally ill people into outpatient treatment and order them hospitalized if they don't take their medications or participate in treatment.²³ The legal standard for subjecting a patient to these treatment programs is more relaxed than in Ohio's current mental health law.²⁴ Jason's Law is modeled after a law in New York called Kendra's Law, which was passed after a man suffering from schizophrenic delusions pushed a woman into an oncoming subway train.²⁵ In response to similar tragedies, many other states, such as California, North Carolina, Florida, and Alabama, have adopted similar legislation.²⁶

This Note analyzes Jason's Law, highlighting its potential shortcomings. Ultimately it offers suggested revisions by comparing the language of the bill to legislation other states have adopted and im-

¹⁷ *Id.*

¹⁸ H.B. 299, 127th Gen. Assem., Reg. Sess. (Ohio 2007).

¹⁹ *Id.* This is the third step in how a bill becomes a law in Ohio. Next, a bill needs to pass the Rules Committee, pass an open vote in the House by a majority of the membership, and obtain the Governor's signature. See *How a Bill Becomes a Law in Ohio*, http://www.ohio.gov/ASP/ohio_BillBecomesLaw.asp (last visited Sept. 5, 2008).

²⁰ Mark Rollenhagen, *Statehouse Bill Could Force Drugs on Mentally Ill*, PLAIN DEALER (Cleveland, Ohio), Aug. 23, 2007, at B1.

²¹ *Id.*

²² *Id.*

²³ *Id.*

²⁴ *See id.*

²⁵ *Id.*

²⁶ For an exhaustive list of states, see TREATMENT ADVOCACY CTR., STATE STANDARDS FOR ASSISTED TREATMENT (2007), http://www.treatmentadvocacycenter.org/LegalResources/documents/StateStandards-TheText_000.pdf [hereinafter STATE STANDARDS].

plemented. Part II describes the background of AOT programs and what they entail. Part III examines Ohio's current AOT program and analyzes the text of Jason's Law. Part IV compares the most important provisions of Jason's Law with other states' AOT laws. This section specifically compares the Ohio bill to New York's Kendra's Law because of the substantial similarities between the two. Part V examines how state and federal courts have interpreted Kendra's Law, and consequently how Ohio courts may treat Jason's Law. This Note concludes by suggesting several changes that should be made to Jason's Law that would both safeguard the rights of patients, and provide the legal mechanism society needs to protect itself from the dangers unmedicated psychiatric patients may pose.

II. BACKGROUND OF AOT PROGRAMS

AOT programs developed as a result of the deinstitutionalization movement that began in the mid-1950's.²⁷ Deinstitutionalization is the shifting of treatment for the mentally ill away from commitment in hospitals to a community-based setting.²⁸ There are several reasons why the movement picked up steam during this period. In 1955 Smith Kline & French Laboratories introduced Thorazine, the first antipsychotic medication.²⁹ Prior to the drug's availability, mental illnesses such as schizophrenia³⁰ required long-term confinement because there was no way to effectively treat the disease. Medication revolutionized the way patients could be treated by relieving the symptoms of psychosis, such as delusions, hallucinations, paranoia, and agitation.³¹ This eventually led to fewer violent episodes.³² Medication made it

²⁷ See EF Torrey & RJ Kaplan, *A National Survey of the Use of Outpatient Commitment*, 46 PSYCHIATRIC SERVICES 778, 778 (1995).

²⁸ See Gutterman, *supra* note 13, at 2406-07.

²⁹ Ilissa L. Watnik, Comment, *A Constitutional Analysis of Kendra's Law: New York's Solution for the Treatment of the Chronically Mentally Ill*, 149 U. PA. L. REV. 1181, 1184 (2001).

³⁰ "Schizophrenia is a serious brain disorder that distorts the way a person thinks, acts, expresses emotions, perceives reality and relates to others. People with schizophrenia – the most chronic and disabling of the major mental illnesses – often have problems functioning in society, at work and at school, and in relationships. Schizophrenia can leave its sufferer frightened and withdrawn." WebMD.com, Schizophrenia Guide, <http://www.webmd.com/schizophrenia/guide/mental-health-schizophrenia> (last visited Sept. 5, 2008).

³¹ See BRUCE A. ARRIGO, *THE CONTOURS OF PSYCHIATRIC JUSTICE: A POSTMODERN CRITIQUE OF MENTAL ILLNESS, CRIMINAL INSANITY, AND THE LAW* 80 (1996).

³² *Id.*

possible for patients to function in the community, and enabled states to integrate patients into society.

States also had a monetary incentive to discharge patients. When the federal government introduced Medicaid in 1965, Congress excluded Medicaid payments for patients in state psychiatric hospitals.³³ The purpose of excluding payments was to encourage deinstitutionalization, thereby shifting the costs of caring for patients to the individual states.³⁴ States subsequently moved large numbers of patients out of hospital settings and into communities so Medicaid reimbursement would be available.³⁵

Another reason deinstitutionalization became widespread was that state mental hospitals were overcrowded, under-funded, and antiquated.³⁶ Thus, patients did not actually receive adequate care in these institutions. The treatment of individuals in communities was also recognized as superior from a clinical standpoint, as institutional living tends to foster passive and dependant behavior. Individuals in a community setting can develop and maintain basic social capacities and independent behavior that institutionalized patients simply cannot,³⁷ which helps them eventually integrate into society.

Finally, concern for the civil rights of patients motivated the deinstitutionalization movement.³⁸ People became increasingly concerned that institutionalization violated mental patients' rights to refuse commitment and treatment under the Due Process Clauses of the Fifth and Fourteenth Amendments.³⁹ Because of deinstitutionalization, state hospitals have cut more than ninety-percent of their services since 1960, and roughly forty-four state hospitals closed in the 1990's alone.⁴⁰

Outpatient treatment is an outgrowth of the community based-treatment approach. AOT programs add a legal structure to these community programs by requiring mentally ill individuals to partici-

³³ Watnik, *supra* note 29, at 1184.

³⁴ *Id.* at 1185.

³⁵ Treatment Advocacy Ctr., *Homelessness, Incarceration, Episodes of Violence: Way of Life for Almost Half of Americans with Untreated Severe Mental Illness*, <http://www.Psychlaws.org/GeneralResources/fact2.htm> (last visited Sept. 5, 2008) [hereinafter *Homelessness, Incarceration, Episodes of Violence*].

³⁶ Gutterman, *supra* note 13, at 2407.

³⁷ *See id.*

³⁸ *Id.*

³⁹ These amendments forbid the federal government from depriving any person of life, liberty, or property without due process of the law. U.S. CONST. amends. V, XIV, § 1. For a detailed discussion of these rights, *see infra* Part V.A.

⁴⁰ *Homelessness, Incarceration, Episodes of Violence, supra* note 35.

pate in them.⁴¹ Currently, forty-two states permit the use of AOT,⁴² including Ohio.⁴³ Like Ohio, most of these states have the same criteria for admitting patients into AOT and institutionalizing them.⁴⁴ However, the specific treatments available, the people covered by these laws, and the ramifications of violating a court-ordered treatment program differ.⁴⁵ Some states use outpatient care to treat people who do not qualify for inpatient care.⁴⁶ Others use outpatient care as an alternative to forced institutionalization, reserving institutionalization for severely ill individuals who pose an immediate danger.⁴⁷

Of the forty-two states that employ AOT, only thirteen have legal criteria that differ for inpatient and outpatient treatment.⁴⁸ In these states, the standards for inpatient commitment are more stringent than that for outpatient commitment, most likely due to the increased restraint on personal liberty.⁴⁹ The creation of a different standard allows the states to reach people with their AOT programs who would not be subject to commitment under inpatient statutes.⁵⁰

III. AOT TREATMENT IN OHIO AND JASON'S LAW

A. Ohio's Current Statute

Ohio's current AOT law has the same standards for inpatient and outpatient care, which are as follows:

⁴¹ Elizabeth Dickinson Furlong, Note, *Coercion in the Community: The Application of Rogers Guardianship to Outpatient Commitment*, 21 NEW ENG. J. ON CRIM. & CIV. CONFINEMENT 485, 486 (1995).

⁴² Treatment Advocacy Ctr., Treatment Advocacy Center Briefing Paper: Assisted Outpatient Treatment, <http://www.treatmentadvocacycenter.org/BriefingPapers/BP4.pdf> (last visited Sept. 5, 2008) [hereinafter Briefing Paper].

⁴³ See OHIO REV. CODE ANN. §§ 5122.01(B), 5122.15(C) (West 2001 & Supp. 2007).

⁴⁴ See Treatment Advocacy Center, <http://www.treatmentadvocacycenter.org/BriefingPapers/BP4.pdf> (last visited Dec. 30, 2007).

⁴⁵ See STATE STANDARDS, *supra* note 26.

⁴⁶ See ALA. CODE § 22-52-10.2 (LexisNexis 2006) (describing when a mentally ill person may be committed to outpatient treatment).

⁴⁷ See N.D. CENT. CODE § 25-03.1-21 (2002).

⁴⁸ See STATE STANDARDS, *supra* note 26, at 2-3, 9-13, 19-20, 23-24, 26-29, 35-41 (describing the differences in outpatient and inpatient commitment in Alabama, Alaska, Florida, Georgia, Hawaii, Idaho, Minnesota, Nevada, New York, North Carolina, Texas, Virginia, and Washington).

⁴⁹ Watnik, *supra* note 29, at 1191.

⁵⁰ *Id.* at 1191-92 & n.53 (citing WASH. REV. CODE ANN. § 71.05.240 (West Supp. 2001)).

If, upon completion of the hearing, the court finds by clear and convincing evidence that the respondent is a mentally ill person subject to hospitalization by court order, the court shall order the respondent for a period not to exceed ninety days to any of the following [placement options, which include state or private psychiatric facilities and assisted outpatient treatment].⁵¹

A mentally ill patient becomes “subject to hospitalization by court order” when the patient, because of the mental illness:

- (1) Represents a substantial risk of physical harm to self as manifested by evidence of threats of, or attempts at, suicide or serious self-inflicted bodily harm;
- (2) Represents a substantial risk of physical harm to others as manifested by evidence of recent homicidal or other violent behavior, evidence of recent threats that place another in reasonable fear of violent behavior and serious physical harm, or other evidence of present dangerousness;
- (3) Represents a substantial and immediate risk of serious physical impairment or injury to self as manifested by evidence that the person is unable to provide for and is not providing for the person’s basic physical needs because of the person’s mental illness and that appropriate provision for those needs cannot be made immediately available in the community; or
- (4) Would benefit from treatment in a hospital for his mental illness and is in need of such treatment as manifested by evidence of behavior that creates a grave and imminent risk to substantial rights of others or himself.⁵²

If the court finds any of these prongs, it can direct a patient to either an institution or AOT program.⁵³ It is completely within the discretion of the judge to decide which option is appropriate.⁵⁴

B. Jason’s Law

The purpose of Jason’s Law is to differentiate the legal standard for inpatient hospitalization and AOT. The bill requires that findings

⁵¹ OHIO REV. CODE ANN. § 5122.15(C) (West 2001).

⁵² § 5122.01(B).

⁵³ §§ 5122.01(B), .15(C).

⁵⁴ See § 5122.15(C).

be made by “clear and convincing evidence,”⁵⁵ and provides as follows:

(2) The respondent must meet all of the following criteria before the court may order that the respondent participate in assisted outpatient treatment:

(a) The respondent is at least eighteen years old.

(b) The respondent is suffering from mental illness.

(c) The respondent is unlikely to survive safely in the community without supervision based on determination by a mental health professional.

(d) The respondent has a history of lack of compliance with treatment for mental illness and either of the following has occurred:

(i) At least twice in thirty-six months prior to filing the petition, the respondent’s mental illness has been a significant factor in hospitalization, services, or other related treatment, not including any current period of hospitalization, services, or other related treatment or period of hospitalization, services, or other related treatment ending in the six months prior to filing the petition.

(ii) In the forty-eight months prior to filing the petition, the respondent’s mental illness has been a significant cause of one or more acts of serious violent behavior toward the respondent’s self or others or the cause of threats of, or attempts at, serious physical harm to the respondent’s self or other, not including any current period of hospitalization, services, or other related treatment or period of hospitalization, services, or other related treatment ending in the six months prior to filing the petition.⁵⁶

The bill lowers the legal threshold for implementing outpatient care from the substantial risk of harm as manifested by evidence⁵⁷ currently required to a lower standard of potential dangerousness.

C. Analysis of Jason’s Law

The Supreme Court of Ohio has held that the State can medicate individuals once they are involuntarily hospitalized.⁵⁸ Jason’s Law

⁵⁵ H.B. 299, 127th Gen. Assem., Reg. Sess., § 340.22(C)(1)(Ohio 2007).

⁵⁶ H.B. 299 § 340.21(B)(2).

⁵⁷ See § 5122.01(B).

⁵⁸ *Steele v. Hamilton County Cmty. Mental Health Bd.*, 736 N.E.2d 10, 18 (Ohio 2000) (holding that a physician may force antipsychotic medication upon an

takes this a step further by allowing the medication of those not already admitted into a hospital. The legal requirement for administering medication under Jason's Law is lower than what is currently required to hospitalize a patient,⁵⁹ which could present a Due Process problem under the Ohio and Federal Constitutions, both of which afford patients a right to refuse medication.⁶⁰ It is therefore possible courts will find the bill unconstitutional.⁶¹

Jason's Law specifically outlines the procedure required to initiate an AOT proceeding. The bill allows ordinary citizens to "file a petition for an order requiring a person to participate in an assisted outpatient treatment program."⁶² This petition must contain an assertion by the petitioner that the respondent meets certain enumerated criteria,⁶³ as well as an affidavit by a mental health professional.⁶⁴

The list of potential petitioners is long: any person who is at least eighteen and lives with the patient, any parent, sibling, spouse, or child of the patient who is at least eighteen, "a mental health professional who . . . is providing mental health services" to the patient, or a parole or probation officer supervising the patient.⁶⁵ The list includes people who may be in the best position to be able to observe the patient, but is expansive enough to allow individuals who have no medical expertise or little contact with the patient to compel a court to hold an AOT hearing.⁶⁶ Because it could prove costly for patients to defend themselves at a hearing, there is a possibility a petitioner could use this power improperly. For example, an estranged parent or sibling who does not have much contact with a patient could use the threat of a hearing as leverage, or a relative could overreact to harmless behavior and cause the patient considerable inconvenience.

Along with the original petition, Jason's Law requires an affidavit by a single mental health professional that has either examined or attempted to examine the patient, certifying that the patient is "unlikely to survive safely in the community."⁶⁷ This gives an indi-

involuntarily committed patient when three specific criteria are met).

⁵⁹ From the substantial risk of harm as manifested by evidence currently required to a lesser standard of potential dangerousness.

⁶⁰ See *In re Guardianship of Willis*, 599 N.E.2d 745 (Ohio Ct. App. 1991).

⁶¹ However, this is an unlikely result. For a more detailed analysis, see discussion *infra* Part V.

⁶² H.B. 299, 127th Gen. Assem., Reg. Sess., § 340.21(A) (Ohio 2007).

⁶³ H.B. 299 § 340.21(B)(1). For these criteria, see discussion *supra* Part

III.B

⁶⁴ H.B. 299 § 340.21(B)(1)(c).

⁶⁵ H.B. 299 § 340.21(A).

⁶⁶ See H.B. 299 § 340.21(A).

⁶⁷ H.B. 299 §§ 340.21(B)(1)(c), (2)(c).

vidual professional significant discretion and power. The “unlikely to survive safely in the community” test predicts future behavior, and there is no requirement that the professional cite the past behavior that led him to this conclusion. This type of general diagnosis is inherently less specific, more subjective, and potentially less accurate than diagnoses based on specified past behavior.⁶⁸ For this reason, many similar statutes use clearer standards than “unlikely.”⁶⁹

The mental health professional that submits the affidavit may be a member of an expansive list of professions, including a certified nurse-midwife, a physician authorized to practice osteopathic medicine, and independent marriage and family therapists.⁷⁰ This leaves the ability to file an affidavit within the province of thousands of individuals, many of whom do not specialize in diagnoses of psychosis. Furthermore, the professional needs to have made an attempt to speak with the patient, not to actually have done so. If the professional is unsuccessful in this attempt, he can still file an affidavit if he “has reason to suspect that the respondent meets the [required] criteria.”⁷¹ What this “reason to believe” entails is not defined. This exception could make it very easy to subject a patient to an AOT proceeding.

Jason’s Law also specifies procedural steps to be taken after the petition is filed. The hearing after the filing of the initial petition is scheduled within three business days following review of the petition. The subject has a right to counsel at the hearing, and may present evidence and direct and cross-examine any witnesses.⁷² This right to counsel and to confront witnesses is an important constitutional safeguard in the bill, because it addresses the respondent’s Sixth Amendment rights to be “confronted with the witnesses against him; to have compulsory process for obtaining witnesses in his favor, and to have the [a]ssistance of [c]ounsel for his defense.”⁷³

To prevail at the hearing and institute an AOT plan, the State must show that the patient has a “history of lack of compliance”⁷⁴ with

⁶⁸ This is especially troubling because these diagnoses of past behavior have already been found unreliable by the Supreme Court. *Addington v. Texas*, 441 U.S. 418, 430 (1979).

⁶⁹ These statutes require professionals to specify the past episodes that led to the conclusion. See STATE STANDARDS, *supra* note 26, at 11-12, 39-40, 43-44 (citing HAW. REV. STAT. § 334-121 (1993); VA. CODE ANN. § 37.1-67.3(I) (1976) (current version at VA. CODE ANN. § 37.2-814 to -818 (2007)); WYO. STAT. ANN. § 25-10-110(a) (2007).

⁷⁰ H.B. 299, 127th Gen. Assem., Reg. Sess., § 340.20(A)(4) (Ohio 2007).

⁷¹ H.B. 299 § 340.21(B)(1)(c)(ii).

⁷² H.B. 299 §§ 340.22(A), (E)(1).

⁷³ U.S. CONST. amend. VI.

⁷⁴ H.B. 299, 127th Gen. Assem., Reg. Sess., § 340.21(B)(2)(d) (Ohio 2007).

treatment for mental illness. What exactly this history must consist of is never defined or explained. As a result, Jason's Law does not require any *prior* formal finding of lack of compliance, such as evidence from medical records, police reports, or even a complaint lodged with the patient's mental health professional. Presumably, a lay-witness could testify that the patient was noncompliant, and would need no evidence to back up the claim.

Once the lack of compliance prong is satisfied, the State needs to prove either that the patient has attempted to harm himself or another once in the last forty-eight months, or that the patient's mental illness was a significant factor in hospitalization, services, or other related treatment twice in the last thirty-six months.⁷⁵ The "other related treatment" clause appears to include any treatment related to mental illness, including an appointment with a psychologist, or possibly even a meeting with a social worker. If the State was unable to prove either of these elements, or the respondent was able to rebut the showing, the respondent would not be subject to AOT.⁷⁶

The State also must show that the respondent is "unlikely to survive safely in the community without supervision based on determination by a mental health professional."⁷⁷ This is the same standard required for the affidavit in the original petition for the hearing, and the language is not clarified.

In addition, a mental health professional needs to sign an affidavit, certifying that he has examined the respondent and the respondent meets the above criteria.⁷⁸ If the patient is not able to secure an expert of his own, only this one physician needs to examine the patient to subject him to AOT.⁷⁹ This fact is troubling in light of the U.S. Supreme Court's finding that because they are drawn from impressions that result from subjective analysis, psychiatric diagnoses are inherently inaccurate.⁸⁰

Jason's Law also specifies how the AOT plan itself must be drafted and implemented. "[T]he executive director of the board of alcohol, drug addiction, and mental health service[s] . . . of the county in which the petition is filed" is responsible for drafting the plan.⁸¹

⁷⁵ H.B. 299 § 340.21(B)(2)(d) (emphasis added).

⁷⁶ H.B. 299 § 340.22(C)(2).

⁷⁷ H.B. 299 § 340.21(B)(2)(c).

⁷⁸ H.B. 299 § 340.21(B)(1)(c).

⁷⁹ See H.B. 299 § 340.21(C).

⁸⁰ See *Addington v. Texas*, 441 U.S. 418, 430 (1979) (finding that psychiatric diagnoses are too unreliable to meet the "beyond a reasonable doubt" standard). See discussion *infra* Part V.A.

⁸¹ H.B. 299 § 340.22(B).

This plan must be the least restrictive means necessary for providing treatment.⁸² This language could prove significant, because a respondent could contest the AOT plan on the grounds that there are less restrictive means of accomplishing the same ends.

Respondents also have the opportunity to participate in the development of the plan.⁸³ This can make the plan less restrictive and a better fit for the patient's lifestyle. Critics of the law will argue that the patient's opportunity to participate is a mere formality, as the patient does not have any actual power to influence the plan. This is partly because Jason's Law does not specify exactly when this participation is to occur. Between the initial review of the petition and the hearing there is only a three day window in which the patient has the opportunity to participate in drafting the plan. Participation would either have to occur during this brief period, or by modification after the plan's implementation.

Once the plan is implemented, the mental health professional providing treatment to the subject must make any changes by petitioning the issuing court.⁸⁴ If the treatment provider wishes to make any substantive changes, however, the patient must agree to them or there is a formal hearing.⁸⁵ This hearing is important in that it gives the patient a way to contest anything a supervising psychiatrist may want to change that a patient dislikes. Noticeably absent from Jason's Law is a mechanism by which the patient may initiate any changes to the plan on his own.

If the patient fails to comply with the court ordered plan, Jason's Law authorizes the initiation of inpatient hospitalization proceedings.⁸⁶ The bill does not modify Ohio's existing inpatient commitment procedures.⁸⁷

IV. SIMILAR LEGISLATION IN OTHER STATES

Representative Patton introduced Jason's Law in response to a tragedy involving a mentally ill individual. Many other states implemented their AOT programs in response to similar tragedies. Florida enacted an AOT program in 2005⁸⁸ in response to a deadly encounter between a schizophrenic man and Tampa police.⁸⁹ New York enacted

⁸² *Id.*

⁸³ *Id.*

⁸⁴ H.B. 299 § 340.23.

⁸⁵ *Id.*

⁸⁶ H.B. 299 § 340.24.

⁸⁷ *See* H.B. 299 § 340.24.

⁸⁸ FLA. STAT. ANN. § 394.4655(1) (West 2006).

⁸⁹ *See* Alexander Sasha Bardey, *Treatments Before Tragedy: Lessons from*

Kendra's Law⁹⁰ after a schizophrenic man pushed a woman in front of an oncoming subway train.⁹¹ Michigan passed Kevin's Law⁹² in response to an incident in which a schizophrenic individual beat a college man to death.⁹³ California passed Laura's Law⁹⁴ after a mental health patient off of his medication shot a woman to death.⁹⁵ The list of similar statutes does not end there, and Jason's Law has a great deal in common with many of these statutes. Therefore, a survey of a few states' AOT statutes helps cast light on both how effective Jason's Law will be, and what challenges it may face. The statutes that follow are particularly relevant because of either their substantial similarity to Jason's Law, or their contrasting approaches to AOT.

A. Arizona

Arizona's AOT law⁹⁶ is representative of twenty-nine state laws that have the same inpatient and outpatient criteria,⁹⁷ a number that includes Ohio. Its terms are fairly typical of these states' statutes: patients have no say in the formulation of their plans, the medical director may make changes to an already implemented plan without notifying the patient,⁹⁸ and the patient can be returned to inpatient care at any time without a hearing.⁹⁹ While these terms are similar to those in Jason's Law, the bill is more restrictive to patient rights in one significant way: Jason's Law does not require that the patient be eligible for the stricter inpatient commitment criteria.¹⁰⁰

Kendra's Law, TAMPA TRIBUNE, Mar. 15, 2003; Jackie Hallifax, *Deputy's Killing Behind Passage of New Law*, MIAMI Herald, Dec. 13, 2004, at 6B.

⁹⁰ N.Y. MENTAL HYG. LAW § 9.60 (McKinney 2006).

⁹¹ Fredric U. Dicker, *State Law Will Make Mentally Ill Take Medicine*, N.Y. POST, Aug 4, 1999, at 2.

⁹² MICH. COMP. LAWS ANN. § 330.1401 (West 1999)..

⁹³ Editorial, *Jason's Law: Requiring Mentally Ill People to Take Their Medications Would be a Benefit to All Ohioans, Not an Unfair Imposition*, PLAIN DEALER (Cleveland, Ohio), June 3, 2007, at M2.

⁹⁴ CAL. WELF. & INST. CODE § 5346 (West Supp 2008).

⁹⁵ Editorial, *supra* note 93.

⁹⁶ ARIZ. REV. STAT. ANN. § 36-540 (2003); ARIZ. REV. STAT. § 36-450.1 (2003).

⁹⁷ See STATE STANDARDS, *supra* note 26 (listing the statutes and their provisions). For a list of these statutes and their provisions, see Treatment Advocacy Center, http://www.treatmentadvocacycenter.org/LegalResources/documents/StateStandards-TheText_000.pdf (last visited Dec. 30, 2007).

⁹⁸ See ARIZ. REV. STAT. § 36-450.01(A)(3), (H) (2003).

⁹⁹ § 36-540(E)(4).

¹⁰⁰ See Watnik, *supra* note 29, at 1191.

B. California

California's AOT program,¹⁰¹ Laura's Law, is very similar to Jason's Law. For an AOT order to be issued, the patient must:

- (1) be eighteen years or older;
- (2) be suffering from a mental illness; and
- (3) have been subject to a clinical determination that he or she is unlikely to survive safely in the community without supervision.

Additionally, the patient must have a history of lack of compliance with treatment and a mental illness that has either:

- (a) resulted in necessary hospitalization or treatment at least twice within the last thirty-six months; or
- (b) resulted in one or more acts of serious and violent behavior toward himself or others, or threats or attempts at such acts, within the last forty-eight months.¹⁰²

The patient must have a condition that is "substantially deteriorating[.]" and must have had the opportunity to participate in a voluntary treatment plan and failed or refused to do so.¹⁰³

These provisions are nearly identical to Jason's Law. Additionally, Laura's Law requires that the proposed plan be the "least restrictive placement necessary to ensure the person's recovery and stability."¹⁰⁴ This is almost the exact language used in Jason's Law,¹⁰⁵ and is a significant safeguard for a patient.

There are several differences between Laura's and Jason's Laws. Laura's Law requires that the patient have a "substantially deteriorating" condition and have had a prior opportunity to participate in a voluntary plan, a provision not in Jason's Law. This requirement is probably inconsequential, because, without a definition of what "deteriorating" means, this prong would likely be satisfied with a very general allegation of deteriorating behavior.

¹⁰¹ CAL. WELF. & INST. CODE § 5346 (West Supp 2008).

¹⁰² Emily S. Huggins, Note, *Assisted Outpatient Treatment: An Unconstitutional Invasion of Protected Rights or a Necessary Government Safeguard?*, 30 J. LEGIS. 305, 310 (2004) (citing CAL. WELF. & INST. CODE § 5346(a)(1)-(4)).

¹⁰³ § 5346(a)(5)-(6).

¹⁰⁴ § 5346(a)(7).

¹⁰⁵ H.B. 299, 127th Gen. Assem., Reg. Sess., § 340.22(B) (Ohio 2007) ("The services provided pursuant to the assisted outpatient treatment plan shall be the least restrictive services necessary for treating respondent.").

The provision in Laura's Law that a patient must have had a previous opportunity to participate in an optional program provides a significant safeguard for a patient that is not in Jason's Law.¹⁰⁶ In a hearing the patient can show that he was never offered the opportunity to participate in a program, which rebuts any possible court-mandated plan. While this provision does safeguard the rights of a potential patient, it could handcuff a court and release a clearly dangerous individual back into society. Because this handicaps the law's effectiveness so severely, the requirement of a past offer to participate should not be incorporated into Jason's Law.

Laura's Law is applicable in "any county in which services are available."¹⁰⁷ It is up to the individual counties to determine whether they wish to adopt the programs, and then they must make a formal request to the State if they wish to implement a program.¹⁰⁸ In this request, the county must certify that it will not implement Laura's Law at the expense of any other mental health programs.¹⁰⁹ Therefore, the county must raise additional funds to implement a program. This precludes all but the richest counties from even considering AOT. As of 2006, less than half of California's counties had enacted such programs, making the bill largely impotent.¹¹⁰ There is no similar provision in Jason's Law,¹¹¹ nor should there be if the bill is to be fully implemented and effective. Research reveals that there is little jurisprudence devoted to California's AOT because it is not widely implemented.

C. North Carolina

North Carolina is the leader in implementing preventative commitment measures.¹¹² The State's AOT program is particularly interesting because of the extensive research done on its effectiveness.

The statute itself is structured differently from Jason's Law. Any person who has knowledge that another is mentally ill and poses a danger to himself or others, or is in need of treatment to prevent a

¹⁰⁶ § 5346(a)(5).

¹⁰⁷ § 5346(a).

¹⁰⁸ See Eve Bender, *Government News: Law Gives California Counties Commitment Authority*, PSYCHIATRIC NEWS, Nov. 15, 2002, available at <http://pn.psychiatryonline.org/cgi/content/full/37/22/12>.

¹⁰⁹ Editorial, *Carrying Out 'Laura's Law'*, S.F. CHRON., Mar. 21, 2006, at B6, available at <http://www.sfgate.com/cgi-bin/article.cgi?file=/chronicle/archive/2006/03/21/EDGU9GJFMH1.DTL>.

¹¹⁰ *Id.*

¹¹¹ See H.B. 299, 127th Gen. Assem., Reg. Sess. (Ohio 2007).

¹¹² Watnik, *supra* note 29, at 1193.

deterioration that would result in dangerousness, can file a petition to have the person taken into custody and examined by a mental health professional.¹¹³ The physician or eligible psychologist shall recommend outpatient commitment if he finds:

- (a) The respondent is mentally ill;
- (b) The respondent is capable of surviving safely in the community with available supervision from family, friends, or others;
- (c) Based on the respondent's psychiatric history, the respondent is in need of treatment in order to prevent further disability or deterioration that would predictably result in dangerousness as defined by G.S. 122C-3(11); and
- (d) The respondent's current mental status or the nature of the respondent's illness limits or negates the respondent's ability to make an informed decision to seek voluntarily or comply with recommended treatment.¹¹⁴

If a party demonstrates all of the above conditions, a court may order outpatient commitment for a period not exceeding 90 days.¹¹⁵

Like Jason's Law, North Carolina's statute uses a test that tries to predict future behavior.¹¹⁶ Unlike Jason's Law, North Carolina's law allows virtually anyone to submit an affidavit that may result in an AOT hearing. Therefore, before *any* medical diagnosis is made, an individual may be taken into custody and examined.¹¹⁷ This is significantly more restrictive to patients than Jason's Law, which requires a mental health professional to at least attempt to examine the patient before he can be taken into custody.¹¹⁸

The effects of North Carolina's AOT program are well documented.¹¹⁹ One study found that patients who underwent sustained and intense outpatient treatment had fewer hospital admissions and

¹¹³ Compare N.C. GEN. STAT. § 122C-261(a) (2007), with H.B. 299 § 340.21(A) (allowing only an enumerated list of people to file a petition).

¹¹⁴ N.C. GEN. STAT. § 122C-263(d)(1) (2007).

¹¹⁵ § 122C-271(a)(1).

¹¹⁶ See § 122C-263(d)(1)(c).

¹¹⁷ See § 122C-261(b).

¹¹⁸ H.B. 299, 127th Gen. Assem., Reg. Sess., § 340.21 (B)(1)(c) (Ohio 2007).

¹¹⁹ See Marvin S. Swartz et al., *A Randomized Controlled Trial of Outpatient Commitment in North Carolina*, 52 PSYCHIATRIC SERVICES 325 (2001), available at <http://psychservices.psychiatryonline.org/cgi/content/full/52/3/325>; Robert D. Miller & Paul B. Fiddleman, *Involuntary Civil Commitment in North Carolina: The Result of the 1979 Statutory Changes*, 60 N.C. L. REV. 985 (1982); Virginia Aldigé Hiday & Teresa L. Scheid-Cook, *The North Carolina Experience with Outpatient Commitment: A Critical Appraisal*, 10 INT'L J.L. & PSYCHIATRY 215 (1987).

fewer days in the hospital than those who had not.¹²⁰ In addition, “the patients who underwent AOT were more likely to adhere to community treatment, and were less likely to be violent or to be victimized. Extended outpatient commitment was also associated with fewer arrests of participants with a combined history of multiple re-hospitalizations and previous arrests.”¹²¹ The study noted that while court orders may be effective, it is the quality of the treatment itself that ultimately makes the difference.¹²²

Despite this success, another study found that “about half of those ordered to outpatient commitment were not appropriate candidates for such commitment because they had no prior history of hospitalizations, no indications of prior dangerousness, and no prior history of medication refusal.”¹²³ This finding is grounds for a legal challenge that the statute is over-inclusive and not rationally related to the State’s objectives.¹²⁴

Looking at these studies, it is apparent that Jason’s Law could be effective; however, it could also run the risk of being over-inclusive and wasting state resources. Because both Ohio and North Carolina allow so many people to petition the court for a hearing,¹²⁵ Ohio runs the risk of having a similarly high number of frivolous petitions.¹²⁶

D. New York

Jason’s Law is modeled after New York’s Kendra’s Law,¹²⁷ and the two are similar.¹²⁸ Therefore, a clear understanding of Kendra’s and Jason’s Laws will aid an understanding of the obstacles the latter may face both judicially and in terms of practical implementation.

The New York legislature made its intentions in passing Kendra’s Law clear: “[t]he legislature finds that there are mentally ill persons who are capable of living in the community with the help of family, friends and mental health professionals, but who, without routine care

¹²⁰ Swartz et al., *supra* note 119, at 327.

¹²¹ *Id.* at 327-28.

¹²² *See id.* at 329.

¹²³ Watnik, *supra* note 29, at 1193.

¹²⁴ Ronald L. Wisor, Jr., Note, *Community Care, Competition and Coercion: A Legal Perspective on Privatized Mental Health Care*, 19 AM. J.L. & MED. 145, 169 (1993). For a more detailed analysis of potential legal challenges, *see* discussion *infra* Part V.

¹²⁵ *See* N.C. GEN. STAT. § 122C-261(ba) (19972007); H.B. 299, 127th Gen. Assem., Reg. Sess., § 340.21(A)(4) (Ohio 2007).

¹²⁶ N.C. GEN. STAT. § 122C-261(b) (1997); H.B. 299, 127th Gen. Assem., Reg. Sess., § 340.21(A)(4) (Ohio 2007).

¹²⁷ N.Y. MENTAL HYG. LAW § 9.60 (McKinney 2006)..

¹²⁸ *See* Rollenhagen, *supra* note 20.

and treatment, may relapse and become violent or suicidal, or require hospitalization.”¹²⁹ To remedy this problem, Kendra’s law allows the administration of medication in AOT.¹³⁰ A patient qualifies for AOT if he meets seven criteria:

- (1) [the patient] is eighteen years of age or older; and
- (2) [the patient] is suffering from a mental illness; and
- (3) [the patient] is unlikely to survive safely in the community without supervision, based on a clinical determination; and
- (4) [the patient] has a history of lack of compliance with treatment for mental illness that has:
 - (i) prior to the filing of the petition, at least twice within the last thirty-six months been a significant factor in necessitating hospitalization . . . or receipt of services in a . . . mental health unit of a correctional facility . . . ; or
 - (ii) prior to the filing of the petition, resulted in one or more acts of serious violent behavior towards self or others or threats of, or attempts at, serious physical harm to self or others within the last forty-eight months . . . ; and
- (5) [that patient] is, as a result of his or her mental illness, unlikely to voluntarily participate in outpatient treatment that would enable him or her to live safely in the community; and
- (6) [the patient] . . . is in need of assisted outpatient treatment in order to prevent a relapse or deterioration which would be likely to result in serious harm to the [patient] or others . . . ; and
- (7) [the patient] is likely to benefit from assisted outpatient treatment.¹³¹

A court must find that the patient meets these criteria by “clear and convincing evidence,”¹³² the same standard used in Jason’s Law. The similarities do not end there. Both require a finding that the patient is “unlikely to survive safely in the community” and has a history of a “lack of compliance with medical treatment.”¹³³ Neither requires a prior history of hospitalization.¹³⁴

¹²⁹ Michael L. Perlin, *Therapeutic Jurisprudence and Outpatient Commitment Law: Kendra’s Law as Case Study*, 9 PSYCHOL. PUB. POL’Y & L. 183, 194 (2003) (citing 1999 NY. S.B. 5762, § 2).

¹³⁰ *See id.* at 194-95.

¹³¹ N.Y. MENTAL HYG. LAW § 9.60(c) (McKinney 2006).

¹³² *See* § 9.60(j)(1)-(3).

¹³³ § 9.60(c)(4); H.B. 299, 127th Gen. Assem., Reg. Sess., § 340.21(B)(2) (Ohio 2007).

¹³⁴ *See* N.Y. MENTAL HYG. LAW § 9.60(c) (McKinney 2006); H.B. 299 §

AOT court proceedings under Kendra's Law are initiated by petition. Potential petitioners include parents, spouses, persons with whom the subjects reside, children, siblings, treating psychiatrists, or probation or parole officers.¹³⁵ This list is very similar to the list in Jason's Law.¹³⁶

The actual court proceedings under the two are also very similar. Kendra's Law provides the patient with the right to counsel at the initial hearing, which is held within three days of the receipt of the initial petition.¹³⁷ This short period before the hearing puts a patient at a significant disadvantage in finding an attorney. At the actual hearing, the State presents a physician who examined the patient beforehand. The physician presents a treatment plan to the court, which the patient can challenge or rebut, with an expert if the patient can find or afford one.

Kendra's Law requires that the plan be developed in consultation with the subject of the petition.¹³⁸ Critics argue that because the physician has ultimate authority concerning the type of plan presented to the court, and the court has ultimate authority to ratify it, patient participation amounts to nothing more than coerced compliance and provides no substantive protection for the patient.¹³⁹ Jason's Law could fairly be subject to the same criticism.

Both Kendra's Law and Jason's Laws require the plan itself to be the "least restrictive treatment" available for the patient.¹⁴⁰ This provides a significant safeguard, as the patient could challenge the plan by proposing another that could accomplish the same purpose in a less restrictive manner.

Like Jason's Law, Kendra's Law relies on the testimony of only one physician.¹⁴¹ Citing the unreliability of psychological predictions of behavior,¹⁴² critics argue that relying on one physician amounts to guesswork and should never pass the clear and convincing evidence threshold.¹⁴³

340.21 (B)(2).

¹³⁵ N.Y. MENTAL HYG. LAW § 9.60(e)(1) (McKinney 2006).

¹³⁶ See H.B. 299, 127th Gen. Assem., Reg. Sess., § 340.21(A) (Ohio 2007).

¹³⁷ N.Y. MENTAL HYG. LAW § 9.60(g)-(h)(1) (McKinney 2006).

¹³⁸ See § 9.60(h)-(i).

¹³⁹ Huggins, *supra* note 102, at 307.

¹⁴⁰ § 9.60(j)(2); H.B. 299, § 340.22(B).

¹⁴¹ See N.Y. MENTAL HYG. LAW § 9.60(h) (McKinney 2006j).

¹⁴² Huggins, *supra* note 102, at 308.

¹⁴³ For a discussion of this threshold, see *infra* Part V.

V. COURT DECISIONS

While state laws and constitutions vary, all state civil commitment actions must meet the Federal Constitutional minimum.¹⁴⁴ Therefore, this section first explores relevant Supreme Court decisions and how they affect AOT programs. Because the Court has not ruled specifically on AOT, this section will then examine how the New York courts have treated Kendra's Law. This will shed light on how Ohio courts are likely to treat Jason's Law because of the similarities between Jason's and Kendra's Laws. This section takes into account relevant differences between the New York and Ohio State Constitutions, and how these differences may affect the treatment of AOT in Ohio.

A. Federal Case Law

The government's power to involuntarily commit the mentally ill is based on two principles: police power and *parens patriae* authority.¹⁴⁵ The former is the authority to detain an individual who is a danger to himself or another in order to secure the safety of the community.¹⁴⁶ The latter gives the government the authority to care for a citizen who is not able to care for himself, a power similar to parental authority.¹⁴⁷ While the commitment of individuals with psychological disorders has been justified by both principles, the Supreme Court recognizes *parens patriae* authority as the acceptable basis for commitment statutes.¹⁴⁸ This authority is balanced against an individual's right to refuse medication and treatment. Litigants have asserted that this right to refuse medication is found in several amendments to the Constitution, including the "First Amendment's guarantees of freedom of thought and expression."¹⁴⁹ More commonly, however, courts base the right to refuse treatment and medication on the Due Process Clauses of the Fifth and Fourteenth Amendments.¹⁵⁰

¹⁴⁴ *Addington v. Texas*, 441 U.S. 418, 431 (1979).

¹⁴⁵ David A. Zaheer, Note, *Expanding California's Coerced Treatment for the Mentally Ill: Is the Promise of Caring Treatment in the Community a Lost Hope?*, 10 S. CAL. INTERDISC. L.J. 385, 388 (2001).

¹⁴⁶ *Id.*

¹⁴⁷ *Id.*

¹⁴⁸ *Addington*, 441 U.S. at 426 (finding *parens patriae* authority as the proper basis for the government's power to provide care for the mentally disabled).

¹⁴⁹ Gutterman, *supra* note 13, at 2416.

¹⁵⁰ *Id.*

While the Supreme Court has not reviewed AOT laws, it has addressed Due Process concerns of patients by ruling on their rights both to refuse medication and to refuse commitment. *Addington v. Texas* establishes the federal standard for involuntary commitment laws.¹⁵¹ In that case, the appellant's mother filed a petition for his indefinite commitment in a state mental hospital. The trial court instructed the jury that to commit the appellant, they must find him mentally ill and in need of hospitalization for his own protection or the protection of others by "clear, unequivocal and convincing evidence."¹⁵² The jury committed him. Appellant contended that the trial court should have required proof "beyond a reasonable doubt."¹⁵³ The Court ruled that an individual's Due Process rights, as well as an individual's interest in avoiding the stigma of mental illness, require a more substantial burden of proof than a mere "preponderance of the evidence."¹⁵⁴ However, because the psychiatric evaluations necessary to commit a patient are inherently subjective and uncertain, and because civil commitment is not punitive, it is unnecessary and impractical to impose a "beyond a reasonable doubt" standard.¹⁵⁵ Therefore, the Fourteenth Amendment requires a "clear and convincing" standard of proof to commit an individual to a psychiatric hospital in a civil proceeding.¹⁵⁶

The Court addressed a patient's right to refuse medication in *Washington v. Harper*.¹⁵⁷ In that case, a convict challenged the State's ability to forcibly medicate him for his manic-depressive disorder. The Court held that the procedures¹⁵⁸ established by the State satisfy the Due Process Clause because they permit medication only where the patient is dangerous to himself or others, and thus the State has a legitimate interest in requiring administration of the drugs.¹⁵⁹ Although the patient has a right to be free from arbitrary medication, forcible medication with appropriate procedural safeguards is "reasonably related" to the State's legitimate interest in combating the danger posed by potentially violent patients, and a "rational means of furthering the State's . . . objectives."¹⁶⁰ The Court

¹⁵¹ *Addington*, 441 U.S. 418.

¹⁵² *Id.* at 421.

¹⁵³ *Id.*

¹⁵⁴ *Id.* at 427.

¹⁵⁵ *Id.* at 428-30.

¹⁵⁶ *Id.* at 432-33.

¹⁵⁷ 494 U.S. 210, 213 (1990).

¹⁵⁸ These procedures allowed a hospital administrative panel, not a judge, to decide whether to forcibly administer medication to an inmate. *Id.* at 215-16.

¹⁵⁹ *Id.* at 225-26.

¹⁶⁰ *Id.* at 221, 226.

also re-affirmed the “clear and convincing” standard set out in *Addington*.¹⁶¹

After *Harper*, whether the Court’s “reasonably related” standard would apply outside of prisons to include all forced medication was unclear.¹⁶² *Riggins v. Nevada* dispelled any notion that *Harper* should be construed broadly.¹⁶³ In that case, an individual detained for trial, but not yet convicted, was forcibly medicated. The Court refused to extend the *Harper* “reasonably related” test to individuals not yet convicted of a crime, applying a stricter “least restrictive alternative” test.¹⁶⁴ It is thus clear that the right to refuse medication will be afforded more protection outside of prison walls.

In light of these standards, Jason’s Law should pass Federal Constitutional scrutiny. Because of the unreliability of all psychiatric diagnoses,¹⁶⁵ it would be impossible to effectively apply the “beyond a reasonable doubt” standard to any commitment proceeding, whether inpatient or outpatient. Therefore, it makes sense to extend the “clear and convincing” standard of proof necessary for inpatient commitment to outpatient statutes as well. Because outpatient care is less intrusive than inpatient commitment, it could be argued that a lesser burden of proof, such as the “preponderance of the evidence” standard, should apply. This Note need not address this point, however, because “clear and convincing” is the standard in both Ohio’s current AOT statute¹⁶⁶ and Jason’s Law.¹⁶⁷ Because “clear and convincing” is the highest standard of proof the Court would impose, Jason’s Law will pass legal scrutiny on this point.

The *Harper* test requires findings of both dangerousness and that the State has a legitimate interest in forcing medication.¹⁶⁸ Jason’s law does not explicitly require a finding of dangerousness¹⁶⁹ and would seem to violate *Harper*.¹⁷⁰ Yet, New York courts find their

¹⁶¹ *Id.* at 255.

¹⁶² Gutterman, *supra* note 13, at 2421.

¹⁶³ 504 U.S. 127, 133-38 (1992) (holding that it was error to order administration of antipsychotic drugs during the course of defendant’s trial when defendant objected and the court failed to make findings that there were no less intrusive alternatives, that the medication was medically appropriate, and that the medication was essential for defendant’s safety and the safety of others).

¹⁶⁴ *Id.* at 135-36.

¹⁶⁵ *Addington v. Texas*, 441 U.S. 418, 429-30 (1979).

¹⁶⁶ OHIO REV. CODE ANN. § 5122.15(B) (West 2001).

¹⁶⁷ H.B. 299, 127th Gen. Assem., Reg. Sess., § 340.22(C) (Ohio 2007).

¹⁶⁸ *Washington v. Harper*, 494 U.S. 210, 225, 227 (1990).

¹⁶⁹ *See* H.B. 299, 127th Gen. Assem., Reg. Sess. (Ohio 2007).

¹⁷⁰ *But see*, *Steele v. Hamilton County Cmty. Mental Health Bd.*, 736 N.E.2d 10, 18 (Ohio 2000) (holding that the standard of Ohio’s current statute, OHIO REV. CODE ANN. § 5122.15(C) (West 2001), that the patient must present a substantial risk

AOT statute harmonious with *Harper*,¹⁷¹ and Ohio courts should follow this precedent for similar reasons.¹⁷²

The application of the second prong of *Harper* to AOT is less clear because the Supreme Court has yet to elucidate the issue of how an individual's right to refuse medication will be treated outside of the prison context.¹⁷³ The government should have a greater interest in keeping individuals outside of prison walls medicated because in prison the patients are closely monitored, while outside they may pose more of a danger to the community because they are unsupervised. *Riggins* made it clear, though, that an individual's right to reject treatment will be given more deference outside of the prison context. Jason's Law requires that the AOT program be the "least restrictive services necessary" for treating the patient, so even if courts apply the higher "least restrictive alternative" test from *Riggins* to AOT, the bill will pass Federal Constitutional muster.

B. State Case Law

Because Jason's Law is so similar to New York's Kendra's Law, and Kendra's Law has been on the books long enough to face challenges in state court, a survey of how these challenges fared will be helpful in anticipating how Ohio courts may treat Jason's Law.

The right to refuse medication is firmly established in New York. In *Rivers v. Katz*, the New York Court of Appeals held that the due process clause of the New York Constitution afforded involuntarily committed patients a right to refuse antipsychotic drugs.¹⁷⁴ The case involved a challenge by several individuals committed to a state psychiatric facility and medicated against their will. The appeal was based on their rights to refuse such medication.¹⁷⁵ The trial court dismissed the plaintiffs' complaint; however, the court of appeals reversed, holding that the due process clause of the New York Constitution¹⁷⁶ guarantees the mentally ill a fundamental right to refuse medication. The court qualified this right, noting that "under certain circumstances [it] may have to yield to . . . State interests."¹⁷⁷ The court found that the State's interests outweigh a patient's right to re-

of harm as manifested by evidence, is synonymous with the dangerousness requirement in *Harper*).

¹⁷¹ See discussion *infra* Part V.B.

¹⁷² See *id.*

¹⁷³ See Gutterman, *supra* note 13, at 2421.

¹⁷⁴ *Rivers v. Katz*, 495 N.E.2d 337, 341 (N.Y. 1986).

¹⁷⁵ *Id.* at 343.

¹⁷⁶ N.Y. CONST. art. I, § 6.

¹⁷⁷ *Rivers*, 495 N.E.2d at 342-43.

fuse medication in only two circumstances: first, the State may use its *parens patriae* authority to forcibly medicate when the patient is incompetent to make decisions about his own medication; and second, the State may use its police power to administer medication when the patient is a danger to himself or society.¹⁷⁸

Ohio and New York interpret their due process clauses similarly; therefore, Ohio courts should follow the precedent of New York courts and allow medication in AOT. The due process clause of the Ohio Constitution¹⁷⁹ affords a similar, limited right to refuse medication. In *In re Guardianship of Willis*, the Tenth Appellate District recognized that a person must be judicially found either dangerous to society or incompetent in order to justify forcing medication.¹⁸⁰ Since in that case the petitioner was previously found legally incompetent to make decisions, the State was allowed to appoint a guardian who could ultimately force medication.¹⁸¹

Both Kendra's Law and Jason's Law do not have a dangerousness requirement to justify the use of police power, nor do they have a requirement that the patient be incompetent to make decisions to justify the use of *parens patriae* authority.¹⁸² On their faces, then, the two statutes seem to be unconstitutional. However, while the patient may feel pressured to take his medication in accordance with the AOT plan, the laws do not actually authorize forcing medication on participants. Violation of the medication regimen in an AOT program in and of itself does not carry a legal penalty, but does make the patient subject to a commitment hearing for inpatient treatment¹⁸³ through which medication can be compelled.¹⁸⁴ This distinction has proven essential in New York decisions upholding Kendra's Law, and should also validate Jason's Law.

¹⁷⁸ *Id.* at 343.

¹⁷⁹ OHIO. CONST. art. I, § 16.

¹⁸⁰ See 599 N.E.2d 745, 746-47 (Ohio Ct. App. 1991) (“[I]f the patient is declared an incompetent, then she is presumed unable to make an informed decision and the guardian and/or court is authorized to make it for her . . . [and] major adverse intervention can be administered only when the incompetent . . . continues to engage in behavior destructive to himself or others.”).

¹⁸¹ *Id.* at 747-48.

¹⁸² See discussion *infra* Parts III.C, IV.C.

¹⁸³ H.B. 299, 127th Gen. Assem., Reg. Sess., § 340.24 (Ohio 2007); N.Y. MENTAL HYG. LAW § 9.60(n) (McKinney 2006).

¹⁸⁴ See *Rivers v. Katz*, 495 N.E.2d 337, 343 (1986) (explaining that “the State may be warranted . . . in administering antipsychotic medication over the patient’s objections” when the patient presents a danger to himself or members of society); *In re Guardianship of Willis*, 599 N.E.2d 745, 748 (Ohio Ct. App. 1991) (upholding the appointment of a guardian “with the power to authorize the forced administration of psychotropic drugs” on an incompetent patient).

In re Urcuyo involved a challenge to Kendra's Law on the grounds that enforcing a medicinal treatment plan without a prior finding of incapacity violates an individual's right to refuse medication.¹⁸⁵ The court found that the law was constitutional because there was no forced medication, merely the possibility that if the plan is not followed the patient may later be subject to inpatient treatment.¹⁸⁶ The court noted that the State has a compelling interest in preventing patients who may be a risk to the community from becoming dangerous, and that the law was narrowly tailored to achieve its end.¹⁸⁷

New York's most comprehensive endorsement of Kendra's Law came in February of 2004, when the New York Court of Appeals upheld the law against several due process claims in *In re K.L.*¹⁸⁸ In that case, an individual subject to a petition for outpatient treatment argued that Kendra's Law was unconstitutional because "it [did] not require a finding of incapacity before a psychiatric patient may be ordered to comply with assisted outpatient treatment."¹⁸⁹ The court once again distinguished this case from *Rivers*, finding Kendra's Law valid because it "neither authorizes forcible medical treatment in the first instance nor permits it as a consequence of noncompliance with court-ordered AOT."¹⁹⁰ The court went on to reject the argument that Kendra's Law violates due process because it provides for the temporary detention of a psychiatric patient without a hearing or notice.¹⁹¹ The court noted that detention is a significant deprivation of liberty, but reasoned that the State's interest in protecting its citizens outweighs this intrusion.¹⁹²

Jason's Law specifically subjects the patient to the inpatient hearing procedure already in place if the patient does not comply with AOT.¹⁹³ Currently, any individual subject to possible inpatient commitment may be detained for up to seventy-two hours before the hearing,¹⁹⁴ as is the case in New York. Ohio Courts specifically uphold

¹⁸⁵ 714 N.Y.S.2d 862, 865 (N.Y. Sup. Ct. 2000).

¹⁸⁶ *Id.* at 868.

¹⁸⁷ *Id.* at 873.

¹⁸⁸ See *In re K.L.*, 806 N.E.2d 480, 487 (N.Y. 2004).

¹⁸⁹ *Id.* at 483-84.

¹⁹⁰ *Id.* at 484.

¹⁹¹ If a patient violates his AOT program he can be held for up to seventy-two hours for observation to determine if inpatient care is necessary. N.Y. MENTAL. HYG. LAW § 9.60(n) (McKinney 2006).

¹⁹² *In re K.L.*, 806 N.E.2d at 487.

¹⁹³ H.B. 299, 127th Gen. Assem., Reg. Sess., § 340.24 (Ohio 2007).

¹⁹⁴ OHIO REV. CODE ANN. § 5122.10 (West 2001 & Supp. 2007).

this procedure,¹⁹⁵ therefore this part of Jason's Law will be upheld if challenged.

In conclusion, New York courts have upheld Kendra's Law in its entirety. Because there are no substantive differences between Jason's Law and Kendra's Law in any of the areas in which the latter has been challenged, Jason's Law should withstand any legal challenges.

VI. RECOMMENDATIONS

Ohio should adopt an AOT program. North Carolina and New York, the two states with the most notable outpatient statutes, have found that their AOT laws have helped the mentally ill.¹⁹⁶ However, it is important to make sure that Jason's Law is narrowly tailored enough so its application is not overbroad,¹⁹⁷ which would waste state resources and jeopardize the rights of patients. Several changes to the bill would help accomplish this.

Before any changes to Jason's Law are considered, it is important to note that the bill does not direct any more money to mental health services. Many of the county boards of mental health in Ohio are already under-funded, including Cuyahoga County's.¹⁹⁸ Jason's Law would increase administrative costs to county mental health services because of the new procedures it establishes, and many of the county boards of mental health in Ohio are already under-funded, including the board in Cuyahoga County.¹⁹⁹ New York, with a population of approximately 19 million,²⁰⁰ spent a total of \$32 million for operation of services related to Kendra's Law in 2006.²⁰¹ Ohio, with a popula-

¹⁹⁵ See *Dielman v. Roberts*, 442 N.E.2d 104, 104 (Ohio Ct. App. 1981).

¹⁹⁶ For North Carolina, see Swartz, *supra* note 119; N.Y. STATE OFFICE OF MENTAL HEALTH, KENDRA'S LAW: FINAL REPORT ON THE STATUS OF ASSISTED OUTPATIENT TREATMENT (2005), http://www.omh.state.ny.us/omhweb/Kendra_web/finalreport/AOTFinal2005.pdf (last visited Sept. 5, 2008) (summarizing the effectiveness of Kendra's Law in New York). For a summary of the effectiveness of Kendra's Law in New York, see N.Y. St. Off. of Mental Health (March 2005), http://www.omh.state.ny.us/omhweb/Kendra_web/finalreport/AOTFinal2005.pdf.

¹⁹⁷ See Watnik, *supra* note 29, at 1193-94 (describing a study that found North Carolina's statute to be "overinclusive and not rationally related to the State's objectives").

¹⁹⁸ Harlan Spector, *Mental Health HQ Draws Concern: Some Fear \$10 Million Cost Could Hurt Services*, PLAIN DEALER (Cleveland, Ohio), July 23, 2007, at B1.

¹⁹⁹ *Id.*

²⁰⁰ U.S. Census Bureau, State & County QuickFacts: New York, <http://quickfacts.census.gov/qfd/states/36000.html> (last visited Sept. 5, 2008).

²⁰¹ N.Y. STATE OFFICE OF MENTAL HEALTH, *supra* note 196, at 2.

tion of roughly 11.5 million,²⁰² would have to pay \$19 million a year if the per capita costs prove to be the same. Without more money, it is unrealistic to anticipate that other services will not be curtailed to implement AOT.

One possible solution would be to implement a program like California's, where individual counties decide to adopt AOT programs, and then are only allowed to implement them if they pledge that other services will not be cut. However, this is ultimately a bad idea, because, as in California, few counties would agree to the terms, and the programs would never be implemented.²⁰³ As Jason's Law now stands, no new money is granted, so any proposed changes need to take county monetary shortages into account.

Ohio should certainly adopt an AOT program. North Carolina and New York have found that their AOT laws have helped the mentally ill tremendously.²⁰⁴ However, it is important to make sure that Jason's Law is not overbroad,²⁰⁵ which would waste state resources and jeopardize the rights of patients. Several changes to the bill would help accomplish this.

Along with the petition for an AOT proceeding, Jason's Law requires an affidavit by a mental health professional asserting that the patient is "unlikely to survive safely in the community."²⁰⁶ The professional is not required to divulge the bases for his opinion. Jason's Law should require this affidavit to be more detailed, and include at least a cursory description of the behavior that led the professional to his conclusion. This would give patients assurances that those who are subject to the costs and inconveniences of an AOT proceeding actually deserve the hearing.

Jason's Law allows a professional to file this affidavit if he tried to examine the patient but was unable to do so.²⁰⁷ This is necessary to ensure that patients cannot elude AOT by simply refusing to be exam-

²⁰² U.S. Census Bureau, State & County QuickFacts: Ohio, <http://quickfacts.census.gov/qfd/states/39000.html> (last visited Sept. 5, 2008).

²⁰³ See discussion *supra* Part IV.B.

²⁰⁴ For North Carolina, see Swartz, *supra* note 119. For a summary of the effectiveness of Kendra's Law in New York, see N.Y. St. Off. of Mental Health (March 2005), http://www.omh.state.ny.us/omhweb/Kendra_web/finalreport/AOT_Final2005.pdf.

²⁰⁵ As studies have shown the North Carolina Statute to be. Watnik, *supra* note 24, at 1193.

²⁰⁶ H.B. 299, 127th Gen. Assem., Reg. Sess., §§ 340.21(B)(1)(c), (2)(c) (Ohio 2007).

²⁰⁷ If the professional has not examined the patient, then he must assert that the patient is unlikely to survive safely in the community. H.B. 299 § 340.21 (B)(1)(c).

ined. However, there is a danger that this provision could be used by a petitioner to circumvent the requirement of actual examination. Requiring more detail when there has been an unsuccessful attempt to examine the patient should alleviate this concern. First, the professional should be required to outline the specific steps he took to try to examine the patient. This would give respondents the ability to contest whether these steps were actually taken. Second, the professional should still be required to *detail* the reasons why he thinks the patient is unlikely to survive safely in the community.²⁰⁸ This would ensure that there are still legitimate bases for the AOT proceeding even when a patient refuses to be examined.²⁰⁹

There are also several procedural changes that should be made to Jason's Law. While the bill should pass procedural Due Process challenges as is, the changes would temper public opposition to the bill and lead to fewer court challenges, which ultimately waste resources. First, at least two experts should have to testify at an AOT hearing. As the bill is written, the State's physician is the only expert that needs to appear in court to compel an AOT plan.²¹⁰ Therefore, only those patients who have enough money to hire an outside expert can hope to rebut the State's expert. Even then, there is very little time to secure such testimony before the hearing.²¹¹ Ideally, the State would provide funding with which any respondent could hire an outside expert, but because of potentially astronomical costs this is unrealistic.²¹² Requiring the State to present two experts would be a compromise. An additional examining physician should lead to more accurate diagnoses and the exclusion of many individuals from AOT who do not need it. Therefore, actually implementing fewer AOT programs could offset the cost of presenting additional testimony. This does not address the problem of respondents lacking an expert testifying on their behalves, but would lead to fewer patients in AOT programs who do not belong there.

²⁰⁸ Importantly, the professional is not required to divulge the bases for his conclusion. H.B. 299 § 340.21 (B)(1)(c).

²⁰⁹ The fact that an individual refuses examination does not make him *per se* unlikely to survive safely in the community. Presumably, many sane individuals would refuse to submit to an examination if they felt it was unnecessary.

²¹⁰ See H.B. 299 §§ 340.22(A), (E).

²¹¹ H.B. 299 § 340.22(A) (stating that "the court shall schedule a hearing not later than three business days after receipt of the petition").

²¹² Medical experts typically charge at least \$100 per hour for case review, and generally more for actual trial testimony. See *MedicoLegal Consultants, Medical and Scientific Experts: Obtain an Expert*, <http://www.mlegal.com/obtaining%20an%20expert.htm> (last visited Sept. 5, 2008).

Jason's Law should also explicitly outline when and how the respondent can participate in planning the AOT program. Currently, the respondent has the option of participating, but how exactly he may contribute is not specified.²¹³ The patient could be given a formal meeting with the State physician who is charged with presenting the plan at the proceeding. Thus, the patient could voice concern over specific provisions that do not comport with his lifestyle and suggest another, equally effective solution. The physician would not have an obligation to accept these changes, but at least the decision-maker would hear the patient's opinion. This meeting should be within the regularly scheduled window between notice to the patient and the hearing itself, and if a patient fails to show up to a scheduled meeting, his opportunity to participate would be forfeited. This would ensure that these meetings do not unnecessarily delay the proceeding. Giving the patient actual veto power over aspects of the plan would give the patient more power, but would ultimately prove unworkable because a patient would likely take issue with the more restrictive – and often effective – portions of the plan.

Jason's Law allows only the physician supervising a patient's program the power to petition the court to make changes in an implemented AOT plan.²¹⁴ This gives the supervising physician almost absolute power over a patient, and gives patients no available means of relief if they are having problems with an aspect of the plan or have a personality conflict with the supervising physician. To alleviate this concern, patients should be given the opportunity to petition the court. Nevertheless, because patients may abuse this privilege and call a hearing whenever the doctor does not give in to a demand, patients should be allotted a limited number of hearings.

If Jason's Law is implemented, the greatest waste of resources will likely be subjecting individuals who are not appropriate candidates for AOT to hearings and programs. Indeed, these are the problems North Carolina has faced.²¹⁵ The easiest way to avoid this would be to limit the parties who can petition the court for an initial hearing, perhaps to nuclear family members and doctors. However, this would severely curtail the bill's effectiveness. Many of the individuals in need of AOT – perhaps those who need it most – may not be part of a traditional family unit or under the care of a doctor. While expansive, the list of potential petitioners in Jason's Law is large enough to include those who have significant daily contact with almost any

²¹³ H.B. 299, 127th Gen. Assem., Reg. Sess., § 340.22(B) (Ohio 2007).

²¹⁴ *Id.* § 340.23.

²¹⁵ See discussion *supra* Part IV.C.

potential respondent.²¹⁶ Therefore, to maintain the bill's efficacy and at the same time conserve resources, Jason's Law should be more selective about who is enrolled in AOT programs, not who is allowed to petition for a proceeding.

Another way to maximize resources would be to add at least one additional examining psychiatrist, which would help ensure that diagnoses are accurate. Increasing the standard for commitment in the bill from future or potential dangerousness to Ohio's current requirement of a substantial risk of harm as manifested by evidence would also help. This would cut costs by reducing unnecessary participation in AOT while still combating the problem Jason's Law was designed to prevent: keeping clearly dangerous people like Timothy Halton off of the streets.

Jason's Law was introduced in response to a high profile murder by a mentally ill individual, and is supposed to prevent similar tragedies in the future;²¹⁷ the same reason other states introduced their AOT laws, many of which have lowered legal standards for AOT.²¹⁸ However, Timothy Halton exhibited explicit signs that he was dangerous, as did many of the perpetrators of the crimes that caused other states to enact AOT laws.²¹⁹ Halton clearly met the existing threshold for court ordered AOT,²²⁰ yet he was not enrolled in any program at the time he killed Jason West. It is clear that an overly strict legal standard is not to blame. Halton could have been roaming the streets either because someone who noticed his behavior lacked the power to request a court hearing, or because he was not adequately monitored. The expanded list of potential petitioners under Jason's Law can address situations in which the former is the issue; however, it would do nothing to better monitor individuals.

VII. CONCLUSION

Lack of funding is a significant obstacle for Jason's Law. Whatever legal standard or language the bill ultimately employs, its effectiveness will hinge on making sure AOT receives adequate funding to implement its programs. The future success of Jason's Law will

²¹⁶ See discussion *supra* Part III.C.

²¹⁷ Rollenhagen, *supra* note 20.

²¹⁸ See *supra* notes 88-95.

²¹⁹ See sources cited *supra* notes 83-90.

²²⁰ Specifically, there was evidence that Halton manifested a substantial risk of physical harm to others. OHIO REV. CODE ANN. § 5122.01(B) (West 2001 & Supp. 2007).

depend on how the Ohio House of Representatives and the Governor choose to deal with the program's increased costs.

Jason's Law, introduced in the wake of the murder of Jason West by an individual who was clearly ill, was written with the best of intentions. Other states have shown that AOT can be a very effective tool in treating the mentally ill. However, Jason's Law has an unnecessarily low threshold for admission and will subject people to AOT who do not belong there. This will severely infringe on the personal liberties of potential participants. Many view this cost as collateral, and courts are not likely to step in and protect participants. However, such an over-inclusive program will also waste precious state funds and resources. This alone should be enough to convince people that the bill should be amended.

Jason's Law should be amended to require a finding of a substantial risk of harm as manifested by evidence, Ohio's current standard. By allowing people to initiate hearings and providing the means to get help, the bill would still keep clearly dangerous and mentally ill individuals, like Timothy Halton, off the street. It would also conserve resources and protect patient rights. The death of Jason West is tragic. But we need to clear the haze of reactionary outrage from our minds and see Jason's Law for what it really is: a good idea taken a step too far.

