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Involuntary Civil Commitment of the Mentally Ill: A System in Need of Change

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IN VOLUNTARY CIVIL COMMITMENT OF THE MENTALLY ILL: A SYSTEM IN NEED OF CHANGE

JOHN E. B. MYERS†

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INTRODUCTION

THIS article is written to propose a change in the law of involuntary civil commitment of the mentally ill. The impetus for such a change is found in the present commitment system, which is outmoded and unresponsive to the needs of the mentally ill in contemporary society. To set the stage for the proposed change, an examination of the development of institutions for the mentally ill and the concomitant development of involuntary civil commitment is necessary. Furthermore, the development and effects of the deinstitutionalization movement must be scrutinized.

I. THE RISE OF INSTITUTIONS

In 1842 Charles Dickens traveled through much of America.1 During his travels, he visited several types of institutions, including hospitals for the mentally ill. In Boston, he described in glowing terms a “State Hospital for the insane, admirably conducted on . . . enlightened principles of conciliation and kindness.”2 Dickens’ description of the physical plant could easily be applied to many state operated facilities in existence today:

Each ward in this institution is shaped like a long gallery or hall, with the dormitories of the patients opening from it on either hand. Here they work, read, play at skit-

tles, and other games; and when the weather does not admit of their taking exercise out of doors, pass the day together. 3

On a later visit to another "Lunatic Asylum," Dickens offered a much less optimistic assessment:

I cannot say that I derived much comfort from the inspection of this charity. The different wards might have been cleaner and better ordered; I saw nothing of that salutary system which had impressed me so favorably elsewhere; and everything had a lounging, listless, madhouse air, which was very painful. The moping idiot, cowering down with long dishevelled hair; the gibbering maniac, with his hideous laugh and pointed finger; the vacant eye, the fierce wild face, the gloomy picking of the hands and lips, and munching of the nails: there they were all without disguise, in naked ugliness and horror. In the dining-room, a bare, dull, dreary place, with nothing for the eye to rest on but the empty walls, a woman was locked up alone. She was bent, they told me, on committing suicide. If anything could have strengthened her in her resolution, it would certainly have been the insupportable monotony of such an existence. 4

These few lines from Dickens' pen indicate that the use of large institutions for the confinement of the mentally ill was commonplace by the middle of the nineteenth century. Already present were many of the institutional abuses challenged in the courts more than a century later. 5

Prior to American independence, the mentally ill did not fare well. 6 The dangerous or violent were frequently incarcerated with criminals, 7 while the non-dangerous were treated like common pau-
pers. Responsibility for poor relief fell to local authorities, who followed the lines set down by the Elizabethan Poor Law of 1601. The Act’s guiding spirit was repression, rather than relief, of pauperism. By the second quarter of the eighteenth century, the dependent mentally ill were often found languishing in workhouses and almshouses. These early institutions were anything but therapeutic, and the lot of the mentally ill was certainly not pleasant. Many were left to wander aimlessly about the countryside. In fact, early town records reveal that local authorities not infrequently escorted such individuals to the edge of town and instructed them not to return. Some officials, who were still more resourceful, physically removed hapless individuals from one town and, under cover of darkness,

they were not considered as a special class, but were disposed of as criminals or as paupers, as the case might be. They were ordinarily confined in jails, workhouses, poorhouses, or in private pens, cages and strongrooms. The object of public provision was frankly repressive or custodial; no thought was given to therapy.

A. Deutsch, supra note 6, at 420.

8. The American Bar Foundation has opined that the non-dangerous mentally ill were treated as a monolithic mass; there was no attempt to analyze its components. A “drifter” was a “drifter” and nothing more. Whether he was mentally or physically disabled or simply lazy made no difference to the townspeople, who feared they would have to support him. For these reasons the mentally disabled, during the colonial period, were often subjected to the same treatment as the itinerant poor. In the strongly Puritanical atmosphere of the time, which equated work and industry with the moral life, it was inevitable that the laws should be aimed at compelling a man to labor, rather than at providing for his needs. In the case of the mentally disabled, these measures led to such grotesque incidents as whipping the hapless. The victims of society wandered aimlessly about the countryside, undergoing ridicule from village children and idlers and eking out an existence by begging.

American Bar Foundation, supra note 6, at 4.

Another author describes the living conditions of the mentally ill in colonial America as follows:

In colonial America the mentally ill were found (to say they were cared for or treated would be misleading) in a number of settings. 1. Their own or relatives’ homes. 2. Physicians’ homes. 3. Jails. 4. Workhouses. 5. Alms-houses or poorhouses. 6. Wandering freely about. 7. Areas near their homes, where they had been “dumped.”


9. A. Deutsch, supra note 6, at 44.

10. An Act for the Relief of the Poor, 1601, 2 Eliz. 702, Ch. 2.

11. A. Deutsch, supra note 6, at 44.

12. Id. at 50-51.

13. For a moving description of life in an English workhouse, see C. Dickens, Oliver Twist, at chs. I-III.

“relocated” them in another community.15

In 1751, Benjamin Franklin played a major role in establishing the first general hospital built in America to receive and care for the mentally ill.16 Located in Pennsylvania, this institution pioneered attempts to treat the mentally ill. The first “asylum” dedicated exclusively to treatment of the mentally ill was established in Virginia in 1773.17 Throughout the colonial period, however, the majority of the mentally ill continued to be treated as paupers.18

During the first half of the nineteenth century, a “general trend toward institutionalization, a natural outgrowth of the increase and centralization of population, manifested itself.”19 Conditions within the institutions varied in accordance with the thinking of the individual in charge. Some particularly enlightened and humane superintendents followed the teachings of Phillippe Pinel,20 Benjamin Rush,21 and William Tuke.22 These early leaders in what eventually

15. Id. at 45.
16. Id. at 58-59. A book written by the American Bar Foundation states that the establishment of hospitals to which the mentally disabled could be sent for treatment developed in the eighteenth century. In response to a petition drawn by Benjamin Franklin, the Pennsylvania Assembly, in May 1751, authorized the establishment of the first general hospital, to receive and cure the mentally ill as well as the sick poor. AMERICAN BAR FOUNDATION, supra note 6, at 5.
17. AMERICAN BAR FOUNDATION, supra note 6, at 5.
18. See id. The Virginia asylum established in 1773 was the only public hospital devoted exclusively to the treatment of the mentally ill until the Eastern Lunatic Asylum was established in Lexington, Kentucky in 1824. Id.
19. A. DEUTSCH, supra note 6, at 114-15. During the 1830’s, the public began to believe that mental illness was curable. While the belief was premised largely on unfounded reports, it had the effect of adding support to the movement in the direction of institutions for the treatment of mental illness. Id. at 132.
20. See TEXTBOOK OF PSYCHIATRY, supra note 6, at 57-59. As superintendent of the Bicêtre and Salpêtriére institutions for the insane in France, Pinel is remembered for freeing the inmates from their chains. Id.
21. See id. at 60-64. Benjamin Rush, called the “father of American Psychiatry,” was a leader during this time in placing the observation and treatment of the mentally ill on a scientific footing. AMERICAN BAR FOUNDATION, supra note 6, at 7.
22. See TEXTBOOK OF PSYCHIATRY, supra note 6, at 55-57. Tuke was the leader of the moral treatment movement in England. Id. His work influenced the Quakers of New England, who established one of the most progressive and enlightened institutions of the time. In a letter dated July 17, 1815 from Tuke to Thomas Eddy, who was a leader of the movement in New York, Tuke stressed the importance of treatment in an environment structured to be as “normal” as possible: “The employment of insane persons should, as far as is practicable, be adapted to their previous habits, inclinations, and capacities.” Id.

For a description of the treatment of the mentally ill at the facility established under the leadership of Thomas Eddy in New York, see S. Tuke, DESCRIPTION OF THE RETREAT (1964). See also MADHOUSES, MAD-DOCTORS, AND MADMEN, supra note 8.
became the discipline of psychiatry. Proceeding upon principles of respect for human dignity and individuality, as well as upon the belief that mental illness was curable, these men and their followers treated their patients in as normal and pleasant an environment as possible. By calling on their patients to act responsibly, and encouraging them in their efforts to do so, these early psychiatrists witnessed an improvement in their patients' conditions and a lessening of aberrant and violent behavior. Unfortunately, however, most of the mentally ill did not come under the care of such progressive practitioners. As Professor Albert Deutsch stated:

It is a melancholy fact that the great majority of the mentally ill who were public dependents remained unaffected by the great psychiatric reforms of the time. As far as they were concerned time stood still. They were subjected to substantially the same methods of care and treatment existing in the late colonial period.

23. The forerunner of the American Psychiatric Association was founded in Philadelphia in 1844 by thirteen hospital superintendents. See AMERICAN BAR FOUNDATION, supra note 6, at 7. For a discussion of the origins of the discipline of psychiatry and the early movement toward institutionalization, see TEXTBOOK OF PSYCHIATRY, supra note 6, at 72-73.

24. See A. DEUTSCH, supra note 6, at 88-113. The moral treatment movement called for "humane treatment, kindness, open wards, pleasant surroundings, no or minimal restraints, structured activity, and, above all, a familiar, if not parental, relationship between superintendent and patients, which included joint dining, walks in the countryside, etc." J. TALBOTT, supra note 8, at 16. See also TEXTBOOK OF PSYCHIATRY, supra note 6, at 60-64; MADHOUSES, MAD-DOCTORS, AND MADMEN, supra note 8, at 105-15.

25. A. DEUTSCH, supra note 6, at 88-113. Most large mental hospitals were built away from urban centers. Few people realize that, at least in some cases, this was done for therapeutic and humanitarian reasons. It was felt that the quiet and peace of the countryside would have a salubrious effect upon the patients. See id. at 93. Furthermore, institutions in urban areas often drew crowds of curious sightseers, hoping for some "entertainment" at the expense of the mentally ill. This problem was remedied by locating facilities away from crowded communities.

26. See id. at 116. During the first quarter of the nineteenth century, specialized institutions for the treatment of the mentally ill were established in nine states. Id. at 114. There were not enough beds to care for everyone, and while the institutions were nominally open to all, the poor were frequently discouraged from entering them. Id. at 115-16.

Local authorities developed four principal methods for dealing with the poor mentally ill: (1) appropriating funds to support the mentally ill in the homes of family members; (2) sending the ill to almshouses where they were mixed with other paupers; (3) contracting with a local individual to care for all of the mentally ill at a fixed per capita price; and (4) auctioning off the mentally ill to the bidder with the best offer. Id. The auction method was practiced for as long as 50 years after the American Revolution in some rural areas. Id. at 117-20.

27. Id. at 116.
Much of the credit for the rise of institutions during the mid-nineteenth century rightfully goes to a former school teacher with a deep-seated social conscience and an inexhaustible reservoir of energy. When Dorothea Lynde Dix was exposed to the plight of the mentally ill, she undertook a campaign on their behalf which resulted in the erection of more than thirty institutions for the care and treatment of the mentally ill. Miss Dix's movement was timely and progressive, and she unquestionably improved the lives of many individuals. "But in social processes, what originates as a progressive idea may become rigid, inflexible and anachronistic with the passing of time." Such was the fate of large mental hospitals.

During the latter half of the nineteenth century, as more and larger institutions were erected, the forms of institutional neglect so poignantly described by Dickens became the rule rather than the exception. The mentally ill were locked away, often for life, in settings sometimes reminiscent of Dante's Inferno. This situation carried

28. AMERICAN BAR FOUNDATION, supra note 6, at 8. For discussions of Miss Dix's crusade, see A. DEUTSCH, supra note 6, at 158-86; J. TALBOTT, supra note 8, at 17-18. In testimony before a state legislature, Miss Dix made an interesting statement: "No fact is better established in all hospital annals than this: that it is cheaper to take charge of the insane in a curative institution than to support them elsewhere for life." A. DEUTSCH, supra note 6, at 172. Many present day advocates of deinstitutionalization would take issue with Miss Dix on this economic point. The argument is often made that institutional care is far more expensive, financially and socially, than treatment outside institutional walls.

29. A. DEUTSCH, supra note 6, at 187. Describing the rise of institutions for the mentally ill, Professor Deutsch states:

The ideal of institutionalization . . . was peculiarly a product of the nineteenth century. It owed its rise mainly to the industrial revolution, with concomitant changes in the social order, rapidly evolving complexities in social relationships, tremendous expansion of population, and closer grouping of that population in large towns and cities. . . . This was all very well in so far as the building of institutions represented a radical improvement over the former anarchy and indifference and neglect. Id. at 186-87.

30. During the second half of the nineteenth century, services for the mentally ill gradually became centralized in state agencies. Until that time, they were primarily the responsibility of local governments. For a description of the nineteenth-century trend toward the establishment of institutions, see TEXTBOOK OF PSYCHIATRY, supra note 6, at 72-74.

31. See AMERICAN NOTES, supra note 2, at 93. For a detailed description of institutional conditions during the second half of the nineteenth century, see A. DEUTSCH, THE SHAME OF THE STATES 40-96 (1948).

32. See J. Perceval, A Lunatic's Protest, in THE AGE OF MADNESS 29-42 (T. Szasz, ed. 1973). Mr. Perceval was an English gentleman. When he was twenty-seven, he suffered a psychotic episode, and was placed in an asylum by his family. After his recovery and release, he published two books describing the treatment he received in the asylum. His observations, though written more than a century ago, remain poignant and timely:

Now with regard to my treatment, I have to make at first two general observations, which apply, I am afraid, too extensively to every system of
over well into the twentieth century. It was in part the appalling conditions found in many state-operated institutions which gave rise to the deinstitutionalization movement during the 1950's and 1960's. In his 1963 State of the Union message, President Kennedy acknowledged the beginnings of the movement to deinstitutionalize when he said: "I believe that the abandonment of the mentally ill and the mentally retarded to the grim mercy of custodial institutions too often inflicts on them and on their families a needless cruelty

management yet employed towards persons in my condition. First, the suspicion and the fact of my being incapable of reasoning correctly, or de

ranged in understanding, justified apparently every person who came near me, in dealing with me . . . in a manner contrary to reason and contrary to nature. . . . Secondly, my being likely to attack the rights of others gave these individuals license, in every respect, to trample upon mine. My being incapable of feeling, and of defending myself, was construed into a reason for giving full play to this license. . . . Instead of great scrupulousness being observed in depriving me of any liberty or privilege, and of the exercise of so much choice and judgment as might be conceded to me with safety;—
on the just ground, that for the safety of society my most valuable rights were already taken away, on every occasion, in every dispute, in every argument, the assumed premise immediately acted upon was, that I was to yield, my desires were to be set aside, my few remaining privileges to be infringed upon, for the convenience of others. Yet I was in a state of mind not likely to acknowledge even the justice of my confinement, and in a state of defencelessness calculated to make me suspicious, and jealous of any further invasion of my natural and social rights: but this was a matter that never entered into their consideration.

Against this system of downright oppression, enforced with sycophan
tish adulation and affected pity by the doctor, adopted blindly by the cre

dulity of relations, and submitted to by the patients with meek stupidity, or

vainly resisted by natural but hopeless violence, I had to fight my way for two years, wringing from my friends a gradual but tardy assent to the most urgent expostulations: not from the physicians; their law is the same for all qualities and dispositions, and their maxim to clutch and hold fast. . . . I was never asked, Do you want any thing? do you wish for, prefer any thing? have you any objection to this or to that? I was fastened down in bed; a meagre diet was ordered for me; this and medicine forced down my throat, or in the contrary direction; my will, my wishes, my repugnances, my habits, my delicacy, my inclinations, my necessities, were not once consulted, I may say, thought of. I did not find the respect paid usually even to a child. . . .

J. Perceval, supra, at 31-33.

33. See J. Talbott, supra note 8, at 21. Although the deinstitutionalization movement was strongest during the 1950's and 1960's, some advocated deinstitutionalization early in the twentieth century. For example, Clifford Beers, who was not a mental health professional, became interested in mental health issues after he was hospitalized. In 1909, Mr. Beers founded the National Committee for Mental Hygiene. Id. He stressed the importance of prevention, community organization in support of the mentally ill, and child guidance. Id. In the words of Professor Talbott, Beers "was to have probably the most profound effect of all on the delivery of mental health services in twentieth century America." Id. Mr. Beers' views on mental health issues can be found in C. Beers, A Mind That Found Itself (1908).
which this Nation should not endure." While thousands of individuals continue to reside in institutions, significant progress has been made to improve institutional conditions and decrease the number of individuals for whom institutional care is necessary.

II. DEVELOPMENT OF INVOLUNTARY COMMITMENT LAW

A. Historical Development

The development of involuntary commitment statutes in America followed a steady course from little or no legislation to the present-day scheme of complex and carefully designed statutes which attempt to balance the liberty interests of those for whom commitment is sought against the legitimate interests of the state.35

In colonial times, there were no statutes governing commitment of the mentally ill.36 Persons who were "furiously insane" could be detained as necessary in order to prevent harm.37 For the most part, the mentally ill were left to their own devices or were confined in workhouses, almshouses, or prisons. For those seeking release from confinement, the procedure was to file a writ of habeas corpus.38 However, it must have been a rare occasion when legal proceedings were instituted by, or on behalf of, those considered to be "insane."

With the proliferation of large institutions during the nineteenth century, states began to enact involuntary commitment statutes.39

36. A. DEUTSCH, supra note 6, at 419.
37. Id. at 419-20. Professor Deutsch states that the common law which the colonies inherited from the mother country upheld the right to deprive insane persons of their liberty. Anyone could arrest a "furiously insane" person, or one deemed "dangerous to be permitted to be at large," and confine him for the duration of his dangerous condition, provided that this were done in a humane manner. It was permitted to "confine, bind and beat" him if his condition rendered it "necessary." Insane persons recognized as such (namely, the violent and the dangerous) were dealt with by the police powers.

38. See AMERICAN BAR FOUNDATION, supra, note 6, at 6-7.
39. An early commitment statute was enacted by the New York legislature in 1788. It provided that persons found to be "furiously mad" could be "locked up" in some secure place. A. DEUTSCH, supra note 6, at 420. In 1797 Massachusetts enacted a statute entitled "An Act for Suppressing Rogues, Vagabonds, Common Beggars and other idle, disorderly and lewd Persons," which was invoked to "commit" mentally ill persons. Id.

Professor Deutsch offers these observations regarding the early development of commitment laws:
This development was given great impetus by the efforts of Mrs. E.P.W. Packard, who herself had been committed to an institution by her husband. Upon her release, she began a campaign for stricter legislation. In 1865, Mrs. Packard lobbied in Illinois for passage of a commitment bill which read as follows: "No person shall be imprisoned . . . and treated as an insane person except for irregularities of conduct, such as indicate that the individual is so lost to reason as to render him an unaccountable moral agent." While her bill did not become law, she was successful in obtaining the enactment in Illinois and Iowa of so-called "personal liberty" bills which required trial by jury before an individual could be involuntarily committed.

According to Professor Deutsch, legislative efforts to regulate in-
Voluntary commitment grew significantly during the 1870's as a public response to the continued expansion of large institutions.\textsuperscript{44} Through the efforts of Mrs. Packard and others, the public became increasingly aware of the tremendous loss of liberty and dignity associated with commitment.\textsuperscript{45}

With the growth of institutions, popular distrust of mental hospitals increased. In 1874, for example, Nathan Allen quoted a hospital trustee as follows: "'It seems as if the public believed that every man connected in any way with a hospital for the insane had entered into a conspiracy to deprive the patients of all their rights and to do violence to all the relations of life.'"\textsuperscript{46} Legislators responded to rising public concern by continuing to enact and refine statutes designed to regulate involuntary commitment and protect against unwarranted loss of liberty.\textsuperscript{47} Although by present standards these statutes would be considered unconstitutionally vague and overbroad,\textsuperscript{48} they constituted a valuable first step in the evolution of commitment standards designed to balance legitimate state interests against individual liberty.

From the beginning of the twentieth century through the 1950's, civil commitment law remained fairly static.\textsuperscript{49} Although there was significant variation from state to state, many statutes afforded relatively little in the way of procedural protections.\textsuperscript{50} Others permitted

\begin{footnotesize}
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\item 1867 Ill. Laws 1.
\item This compulsory jury trial law was repealed in 1893. A. Deutsch, supra note 6, at 427 n. *.
\item 44. A. Deutsch, supra note 6, at 427.
\item 45. For a discussion of the popular effects of Mrs. Packard's legislative efforts, see American Bar Foundation, supra note 6, at 34-35.
\item 46. A. Deutsch, supra note 6, at 427.
\item 47. For examples of these early statutes, see notes 41-43 and accompanying text supra.
\item 48. See A. Deutsch, supra note 6, at 418-28.
\item 49. The American Bar Foundation has stated that "'[t]he . . . legislation enacted during the latter part of the nineteenth century constitutes the basic legislative pattern currently in force.'" American Bar Foundation, supra note 6, at 8. There was relatively little litigation concerning involuntary civil commitment during the first half of this century. The explosion of case law in the area had to await the general awakening of social conscience witnessed during the civil rights movement of the 1960's. For a discussion of civil commitment laws in force during the first half of this century, see W. Bromberg, Psychiatry Between the Wars, 1918-1945 (1982). See also, T. Gutheil & P. Appelbaum, Clinical Handbook of Psychiatry and the Law 40 (1982).
\item 50. It has been estimated that as late as 1909, 18% of the persons admitted to New York state hospitals for mental illness in the preceding year had been detained in jails pending their commitment. A. Deutsch, supra note 6, at 435. In 1933, 14 states permitted persons alleged to be insane to be detained in jails pending commitment. Id. An Alabama statute provided that "'a]ny insane person who is at large and not under the control or restraint or management of any person may be taken
\end{itemize}
\end{footnotesize}
indeterminate commitment on the basis of vague standards such as whether the individual was a "social menace" or "a fit and proper candidate for institutionalization." The combined effects of lenient commitment standards and a predisposition of many psychiatrists of the time in favor of institutionalization\(^5\) contributed to the overpopulation of state hospitals. Thousands, and, over time millions, of individuals were forced into large and often inhumane institutions which were little more than human warehouses.

Courts began to address substantive and procedural aspects of involuntary commitment on a significant scale during the 1960's. One of the most important decisions, *Lessard v. Schmidt*,\(^5\) was decided in 1972 by a federal district court sitting in Wisconsin. In this landmark case, the court articulated standards for procedural due process\(^5\) which have been widely followed by courts\(^5\) and legislature.

into custody or arrested by any officer or person and carried immediately to the probate judge of the county..." 15 ALA. CODE § 432 (1958). This statute was declared unconstitutional as violating the due process rights of insane persons in 1974. See *Lynch v. Baxley*, 386 F. Supp. 378 (M.D. Ala. 1974).


53. These standards include the following: (1) Notice of a hearing given sufficiently in advance to afford a reasonable opportunity to prepare; (2) A requirement that the government prove beyond a reasonable doubt all facts necessary to show that the individual is mentally ill and dangerous; (3) The application of the privilege against self-incrimination to statements made to a psychiatrist. 349 F. Supp. at 1090-1101.

turers throughout the country. Other courts fine-tuned the substantive commitment standards employed by the states to ensure that vague and overbroad provisions were eliminated.

Mental health professionals applauded many of the changes in the substantive and procedural aspects of involuntary commitment. Legal commentators are nearly unanimous in their support of stricter involuntary commitment laws. There is growing concern, however, that the pendulum may have swung too far. Some argue that it has become so extraordinarily difficult to treat the ill-but-unwilling that many are going without essential therapy and support services. As one commentator observed, patients are "rotting with their rights on." Mental health experts are beginning to mount the argument that existing commitment laws are anti-therapeutic, and in many cases, harmful. The narrowness and rigidity of present commitment


57. See, e.g., Roth, A Commitment Law for Patients, Doctors, and Lawyers, 136 AM. J. PSYCHIATRY 1121, 1122 (1979). Dr. Roth acknowledges the fact that physicians and attorneys often have conflicting views concerning the issue of involuntary commitment, and proposes a commitment scheme designed to satisfy both preferences. See id.

58. Hundreds of articles have been published in the legal literature on involuntary commitment. Most have favored enactment of stricter procedures in commitment proceedings. See generally, DuBose, Of the Parens Patriae Commitment Power and Drug Treatment of Schizophrenia: Do the Benefits to the Patient Justify Involuntary Treatment?, 60 MINN. L. REV. 1149 (1976); Comment, Overt Dangerous Behavior as a Constitutional Requirement for Involuntary Civil Commitment of the Mentally Ill, 44 U. CHI. L. REV. 562 (1977). For a thorough discussion of involuntary commitment laws, see LaFond, An Examination of the Purposes of Involuntary Civil Commitment, 30 BUFFALO L. REV. 499 (1981).

59. See, Slovenko, Criminal Justice Procedures in Civil Commitment, 28 HOSP. & COMMUNITY PSYCHIATRY 817 (1977) (criticizing the use of procedures designed for the adjudication of criminal matters in the context of civil commitment).

60. Applebaum & Gutheil, Rotting With Their Rights On: Constitutional Theory and Clinical Reality in Drug Refusal by Psychiatric Patients, 7 BULL. OF THE AM. ACAD. OF PSYCHIATRY AND LAW 306 (1979). While the article deals with the right to refuse treatment, its title echoes the battle cry being raised against strict commitment criteria.
standards make it impossible for the mental health delivery system to work effectively for the seriously disabled.

B. The Authority of the State to Impose Involuntary Commitment: The Parens Patriae Power

The power of the state to involuntarily commit the mentally ill is derived from two sources: the police power and the parens patriae power. The police power vests in the states "a plenary power to make laws and regulations for the protection of the public health, safety, welfare, and morals." Under this authority, the state may involuntarily commit mentally ill persons who constitute a danger to others or themselves.

The second, and for present purposes more important, source of authority for involuntary commitment is the parens patriae power. Under its parens patriae authority, the state may care for those who are a danger to themselves or are unable to care for themselves. Because the involuntary treatment scheme proposed in this article is based on this source of state authority, it is important to examine its origins and development.

The doctrine of parens patriae originated in Roman law, and was incorporated into English law. 65 Blackstone described some of the

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62. The requirement of dangerousness has been an element of involuntary commitment law throughout its history. See, e.g., Lessard v. Schmidt, 349 F. Supp. at 1084-86; In re Oakes, 8 Law Rep. 123 (Mass. 1845). For a discussion of Lessard, see notes 52-54 and accompanying text supra.

Critics of involuntary commitment argue that mental health professionals cannot predict dangerousness, and that when called on to do so, they regularly err on the side of overcommitment. For examples of this criticism, see Cocozza & Steadman, The Failure of Psychiatric Predictions of Dangerousness: Clear and Convincing Evidence, 29 RUTGERS L. REV. 1084 (1976); Morse, supra note 51, at 62-63, 74-78.

63. For a discussion of the parens patriae power in the area of mental health law, see generally Lafond, supra note 58, at 504-09, 516-25; Developments, supra note 61, at 1207-22.

64. For a discussion of cases affirming the use of the parens patriae power in the involuntary commitment context, see notes 91-107 and accompanying text infra.

65. For a general discussion of the development of the doctrine of parens patriae in the area of the commitment of the mentally ill, see Developments, supra note 61, at 1207-12. See also N. Kitttrie, THE RIGHT TO BE DIFFERENT: Deviance and Enforced Therapy (1971). Kitttrie states as follows:

The role of the sovereign as parens patriae was rather limited in the common-law tradition. Social institutions for the care of the ill and disabled were either within the ecclesiastical dominion or the responsibility of the local feudal lord. Continuing the Roman legal tradition, however, the English sovereign also assumed the functions of protecting certain incompetent
similarities between the civil law and the common law in these words:
"In th[e] case of idiots and lunatics, the civil law agrees with ours, by assigning them tutors to protect their persons, and curators to manage their estates." 66

In early feudal times, the lord of the fief "was entitled to the wardship of the lands and persons of those of unsound mind." 67 Unfortunately, this power was frequently abused by avaricious individuals interested more in profit than their responsibility to provide for the disabled. 68 Between 1255 and 1290, "[t]he crown acquired this wardship, to the exclusion of the lord, probably by virtue of some statute or ordinance." 69 The statute referred to is probably "the so-called statute de Praerogativa Regis." 70 Soon after the Crown ac-

subjects. Suggestions of the sovereign's role as parens patriae are evident in [an] eleventh-century enactment . . . [which] decreed: "If an attempt is made to deprive any wise man in orders or a stranger of either his goods or his life, the king shall act as his kinsman and protector . . . unless he has some other." Another early manifestation of the parens patriae role in English law was the recognition by Edward II in the fourteenth century of the sovereign's responsibility towards the property and later the person of the insane.

In medieval England the mentally disordered were first the responsibility of the church and the lord of the manor. When a national law of guardianship developed, its emphasis was proprietary, to protect the feudal succession and the heirs against the dissipation of assets. The original guardianships dealt with children and the mentally defective only, but by the middle of the fourteenth century they were extended to the mentally ill and were made a duty of the Crown. From this modest beginning, followed by the slow process of welfare functions shifting from the feudal lords, the medieval guilds, and the church to the state in the seventeenth, eighteenth, and nineteenth centuries, the parens patriae state of present day came into full bloom.

N. Kittrie, supra at 9 (footnotes omitted).

66. 1 W. Blackstone, Commentaries *305. While Blackstone draws upon the similarities between English and Roman law, he also points out the differences. In arguing the superiority of the English system, he stated:

But, in another instance, the Roman law goes much beyond the English. For, if a man, by notorious prodigality, was in danger of wasting his estate, he was looked upon as non compos, and committed to the care of curators or tutors by the praetor. And, by the laws of Solon, such prodigals were branded with perpetual infamy. But with us, when a man on an inquest of idiocy hath been returned an unthrif, and not an idio, no further proceedings have been had. And the propriety of the practice itself seems to be very questionable. It was doubtless an excellent method of benefiting the individual, and of preserving estates in families; but it hardly seems calculated for the genius of a free nation, who claim and exercise the liberty of using their own property as they please. . . .

Id. at *305-06.


68. See W. Blackstone, supra note 66, at *303.

69. W. Holdsworth, supra note 67, at 473.

70. Id. The "statute" came into being sometime between 1255 and 1290. Professor Holdsworth points out that its origins are uncertain: "Throughout the Middle
quired authority over the person and property of the mentally disabled, the power was delegated to the courts of Chancery.\textsuperscript{71}

While never completely divorced from humanitarian purposes,\textsuperscript{72} the doctrine of \textit{parens patriae} under English law was principally concerned with setting forth rules for management of the wealth and property of the disabled.\textsuperscript{73} Indeed, Blackstone's discussion of "the custody of idiots [and] . . . lunatics" is found in the portion of his \textit{Commentaries} concerned with "the King's ordinary revenue."\textsuperscript{74}

Over time, the distinction between the "idiot" and the "lunatic" took on legal significance.\textsuperscript{75} According to Blackstone, "An idiot, or natural fool, is one that hath had no understanding from his nativity; and therefore is by law presumed never likely to attain any."\textsuperscript{76} If an individual was found to be an idiot,\textsuperscript{77} the Crown was responsible for providing him with necessaries.\textsuperscript{78} Concurrent with this duty, the Crown was entitled to retain the profits produced by the idiot's property during his lifetime.\textsuperscript{79} The law developed differently for persons

\begin{footnotescope}
\item 71. Ages it was accepted as a genuine statute; it may have been merely private work, or have emanated from some official on the instructions of the King." \textit{Id.} at 473 n.8. For the provisions of the statute, see \textit{Perogativa Regis}, 1329, 17 Edw. 2, ch. 9-10.

\item 72. For a discussion of the humanitarian goals of the \textit{parens patriae} power, see notes 84-87 and accompanying text \textit{infra}.

\item 73. Critics of the \textit{parens patriae} justification for involuntary commitment often point out that the doctrine had its origins in legal rules concerned with issues of wealth. One court has stated that "[e]arly reported English law primarily adjudicated disputes among men of property, and the early development of \textit{parens patriae} was more a state fiscal policy than a humanitarian doctrine." State \textit{ex rel.} Hawks \textit{v. Lazaro}, 157 W. Va. 417, 427, 202 S.E.2d 109, 118 (1974). Despite its focus on wealth, the doctrine was intended from its inception as a means of ensuring that the interests of individuals would be protected. Indeed, during a time when personal well-being was closely tied to ownership and profit from real property, it is not surprising that the principal legal device for the protection of personal security would be based on the protection of wealth and property.

\item 74. \textit{W. Blackstone, supra note 66, at *302.}

\item 75. \textit{See 1 F. Pollock & F. Maitland, The History of English Law 481 (2d ed. 1968).}

\item 76. \textit{W. Blackstone, supra note 66, at *302. If it were possible to evaluate individuals categorized as "idiots" by means of modern intelligence tests, many would be diagnosed as mentally retarded. \textit{See generally R. Scheerenberger, A History of Mental Retardation} (1983).}

\item 77. At early common law the writ \textit{de idiota inquirendo} was used to determine whether an individual was an idiot. \textit{W. Blackstone, supra note 66, at *303}. For an American case discussing the writ, see \textit{In re Barker}, 2 Johns. Ch. 232 (N.Y. 1816). For a discussion of \textit{In re Barker}, see notes 94-99 and accompanying text \textit{infra}.

\item 78. \textit{See W. Blackstone, supra note 66, at *303}. An idiot was entitled during his lifetime to be supported by the Crown from the profits of his lands. \textit{F. Pollock & F. Maitland, supra note 75, at 481.}

\item 79. \textit{W. Blackstone, supra note 66, at *303}. Following the death of an idiot,
\end{footnotescope}
found to be lunatics. Blackstone states that

[a] lunatic or non compos mentis, is one who hath had understanding, but by disease, grief, or other accident, hath lost the use of his reason. A lunatic is indeed properly one that hath lucid intervals, sometimes enjoying his senses, and sometimes not, and that frequently depending upon the change of the moon. 80

During periods of incapacitation, it was the King's responsibility to "provide for the custody and sustentation of lunatics, and preserve their lands and the profits of them for their use, when they come to their right mind." 81 During periods of lucidity, however, lunatics were entitled to manage their own affairs. 82

While legal rules differed for the idiot and the lunatic, the personal treatment accorded the intellectually disabled hinged on the compassion and understanding of the individuals charged with their welfare. For the wealthy mentally ill and retarded, life was sometimes pleasant; for the impecunious, however, existence must have been very difficult.

Early English law was grounded in large measure on the law of property, and was geared to the goal of economic stability. The parens patriae authority was designed in part to enrich the Royal treasury and protect the heirs of wealthy "idiots" and "lunatics" from disinheritance. 83 In defense of parens patriae, however, it must be emphasized that the doctrine did not ignore the welfare of the incapacitated individual. 84 The Crown was plainly charged with a duty to provide for the well-being of those under its protection. "In acting as parens patriae, the King or his representative was required to promote the interests and welfare of his wards and was not empowered to sacrifice

the King was required to "render the estate to the heirs; in order to prevent such idiots from alienating their lands, and their heirs from being disinherited." Id.; see also F. Pollock & F. Maitland, supra note 75, at 481.

80. W. Blackstone, supra note 66, at *304. This passage from the Commentaries evidences the primitive understanding of mental illness prevalent during Blackstone's day. It was the prevailing wisdom that the phases of the moon were responsible for periods of lucidity or lunacy.

81. W. Blackstone, supra note 66, at *304. See W. Holdsworth, supra note 67, at 261-63; F. Pollock & F. Maitland, supra note 75, at 481.

82. See F. Pollock & F. Maitland, supra note 75, at 481.

83. See note 73 supra.

84. See F. Pollock & F. Maitland, supra note 75, at 481 ("The King is to provide that the lunatic and his family are properly maintained out of the income of his estate"). See also W. Holdsworth, supra note 67, at 476 ("The underlying principle of these rules is the interest of the lunatic").
the ward's welfare to the welfare of others."\(^{85}\) As Blackstone noted, the Crown became "the general and supreme guardian of all infants, as well as idiots, and lunatics..."\(^{86}\) Clearly discernable in the English development of *parens patriae* authority is a sense of a societal responsibility to care for those incapable of caring for themselves.

The fact that the doctrine was as much concerned with issues of wealth as with care and protection of the mentally ill is not reason to eschew it as tainted. The aspects of the doctrine concerned with sovereign authority and responsibility to provide for those unable to care for themselves grew and matured into an important source of state authority to improve the lives of seriously disabled people.\(^{87}\)

When the American colonies gained their independence from England, the *parens patriae* power was vested in the state legislatures.\(^{88}\) In the 1855 case of *Fontan v. Ravenel*,\(^{89}\) the Supreme Court stated that the "[s]tate, as a sovereign, is the *parens patriae*."\(^{90}\) Review of the early authorities indicates that as developed in America, the doctrine of *parens patriae* was directed as much to the power of the states to provide for individuals unable to protect themselves as to matters of property and wealth. For example, in 1890 the Supreme Court used sweeping language to describe the power: "Th[e] prerogative of *parens

\(^{85}\) *Developments*, supra note 61, at 1208.

\(^{86}\) *W. Blackstone*, supra note 66, at *47.

\(^{87}\) See *In re Hudson*, 126 P.2d 765, 777 (Wash. 1942). In *Hudson*, the Washington Supreme Court discussed the *parens patriae* authority in the context of court ordered medical treatment for minors in the face of parental objection. The court observed that *parens patriae* authority was "in former times... involved chiefly for children with property... [T]his ancient chancery doctrine is today turned to wider service on behalf of infants suffering from poverty, vice and neglect..." Id. The development of the *parens patriae* power to act on behalf of children parallels the growth in authority to protect the seriously mentally ill.

\(^{88}\) *Developments*, supra note 61, at 1208. "In the United States, the 'royal prerogative' and the 'parens patriae' function of the King passed to the States." *Hawaii v. Standard Oil Co.*, 405 U.S. 251, 257 (1972). *See Wheeler v. Smith*, 50 U.S. (9 How.) 55, 82-83 (1849). *See also* 67A C.J.S. *Parens Patriae* 159:

The words "*parens patriae,*" meaning "father of his country," were applied originally to the king. Since, on this country's achieving its independence, the prerogatives of the crown devolved on the people of the states, the state, as a sovereign, is the *parens patriae*.

The doctrine of *parens patriae* expresses the inherent power and authority of the state to provide protection of the person and property of a person non sui juris, and under the doctrine the state has the sovereign power of guardianship over persons of disability, and in the execution of the doctrine the legislature is possessed of inherent power to provide protection to persons non sui juris and to make and enforce such rules and regulations as it deems proper for the management of their property.

*Id.* (footnotes omitted).

\(^{89}\) 58 U.S. (17 How.) 369 (1855).

\(^{90}\) *Id.* at 384. In *Fontain*, the Court was speaking of the *parens patriae* power generally; not as specifically applied to the mentally ill.
patriae is inherent in the supreme power of every State. . . . [I]t is a most beneficent function, and often necessary to be exercised in the interests of humanity, and for the prevention of injury to those who cannot protect themselves. 91 In 1922, the Oklahoma Supreme Court stated that “[t]he doctrine . . . may be defined as the inherent power and authority of a Legislature of a state to provide protection of the person and property of persons non sui juris. . . .” 92

Pursuant to the parens patriae authority, state legislatures enacted statutes to protect minors, establish juvenile courts, create guardianships, establish protective services for incapacitated adults, and provide for the involuntary commitment of the mentally ill. 93 The authority is firmly entrenched in the law and tradition of American government.

Turning to early cases concerned specifically with application of parens patriae authority to the mentally ill, it is well to begin with the 1816 case In re Barker. 94 Mr. Barker was eighty-five years of age when his children sought a writ de lunatico inquirendo to determine whether he was of unsound mind and “wholly unfit and unable to manage his affairs.” 95 The Chancellor first considered whether a court of equity had jurisdiction in such a case. 96 Concluding that it did, the court

91. Mormon Church v. United States, 136 U.S. 1, 57 (1890).

The doctrine of parens patriae is the inherent power and authority of the state to provide protection of the person and property of a person non sui juris. . . . The legislature is possessed of inherent power to provide protection of persons non sui juris, and to make and enforce such rules and regulations as it deems proper for the management of their property.

See generally 179 P.2d at 64. LaFond, supra note 58, at 504-06. See also Horstman, Protective Services for the Elderly: The Limits of Parens Patriae, 40 Mo. L. REV. 215, 221 (1975) (“the individual’s well-being is the sole justification for the exercise of the state’s authority as parens patriae”).

93. See Developments, supra note 61, at 1208-09; Horstman, supra note 92, at 217-21.
94. 2 Johns. Ch. 232 (N.Y. 1816).
95. Id.
96. Id. at 233-34. Mr. Barker evidently suffered from an infirmity of the aging process, perhaps senility. Under the early common law, an individual with this sort of disability was considered neither an idiot nor a lunatic, but rather fell into the category denominated non compos mentis. Id. at 233. Early English cases held that courts lacked “any jurisdiction over the case of mere weakness of mind.” Id. The Chancellor rejected the early authorities in favor of later decisions upholding the jurisdiction of the court of equity to adjudicate such matters:

I am satisfied that these later decisions are not only founded in good sense, and the necessity of the case, but are a sound exposition of the common law which gave to the King, as parens patriae, the care and custody of all persons who had lost their intellects, and become non compos, or incompetent to take care of themselves.
stated that "[t]he court of chancery is the constitutional and appro-
riate tribunal to take care of those who are incompetent to take care
of themselves. There would be a deplorable failure of justice, without
such a power. The object is protection to the helpless. . . ." 97

The Chancellor observed the consequences of holding that the
equity court lacked jurisdiction: "A numerous class of persons, whose
minds have sunk under the power of disease, or the weight of age,
would, in that case, be left without protection, and liable to become
the victims of folly, or fraud. This would be a blemish in the jurispru-
dence of the country." 98

The Barker opinion demonstrates that American courts very
early defined their jurisdiction to encompass matters related to the
protection of the mentally ill. 99 This assumption of responsibility is
further evidenced by the 1845 case In re Oakes 100 in which the Massa-
chusetts Supreme Judicial Court employed parens patriae and police
power rationales to order the detention of a mentally ill individual
"[where] restraint [was] necessary to his restoration or [would be] con-
ducive thereto." 101 Chief Justice Shaw stated that "the right to re-
strain an insane person of his liberty is found in that great law of
humanity, which makes it necessary to confine those whose going at
large would be dangerous to themselves or others." 102

Later cases affirmed the parens patriae responsibility of a state to

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97. Id. at 234.
98. Id. at 237.
99. Though the Barker case was decided in 1816, the issues with which the
Chancellor struggled are still before the courts and are still without definitive resolu-
tion. For example, the Barker court acknowledged the great difficulty in ascertaining
whether an individual is legally incapacitated. Judges today address this question on
a regular basis. The Chancellor in Barker stated as follows: I am aware, however, that the inquiry must, in many cases, be peculiarly
delicate, because it concerns the character of the party, and his natural
rights, and because of the difficulty there is in ascertaining the extent of the
decay of the mind, necessary to form a proper case for the interference of
the court.
2 John. Ch. at 234.

101. Id. at 125. The Oakes case has been thoroughly discussed by several com-
mentators. Professor Deutsch states that the case represents "probably the first time
that the therapeutic justification for restraint was explicitly stated in a decision
handed down by an American court." A. Deutsch, supra note 6, at 422. See also
American Bar Foundation, supra note 6, at 6-7; Horstman, supra note 92, at 222-
24; Developments, supra note 61, at 1209-10.
102. 8 Law Rep. at 125. The Oakes court combined the police power and parens
patriae justifications for involuntary treatment. See Horstman, supra note 92, at 222-
23.
provide for the mentally ill. In a 1915 case, for example, a federal district court stated that “[a] state would indeed be derelict of its duty if it failed to make adequate provision for the care and treatment of the insane. The state is the parens patriae of the insane.” And, in the oft-cited 1979 case of Colyar v. Third Judicial District Court, the district court expressly upheld the parens patriae authority as a legitimate source of state power to involuntarily commit the mentally ill.

The foregoing authorities demonstrate that the parens patriae power runs as a continuous thread through the fabric of American law. It has been held since colonial times that the sovereign may, and in some instances must, intervene in the lives of individuals suffering mental disability. It may be that the ancient doctrine of parens patriae has been in “full retreat” in recent years, as courts and commentators criticize the abuses of liberty sometimes carried out in its name. However, it remains true that the beneficent purposes underlying the doctrine are sound. So long as the state’s use of parens patriae authority is carefully circumscribed with substantive and procedural safeguards, the doctrine serves as the principal vehicle by

103. See, e.g., In re Ballay, 482 F.2d 648, 658-59 (D.C. Cir. 1973). In Ballay the court discussed the use of parens patriae authority to compel treatment for a non-dangerous individual:

Since the individual poses no danger to society, society’s interference must be justified on the basis of the state’s status as parens patriae. It is clearly recognized that the state may act in this capacity and that relaxed procedures may be justified in certain circumstances, and, indeed, it has been suggested that a duty to so act may occasionally exist.


105. Id. at 1000.


107. Id. at 429 (parens patriae power upheld, but state must afford due process).

108. In In re Pickle’s Petition, a Florida court referred to “the state’s duty to protect [the mentally ill] as a class incapable of protecting themselves.” In re Pickle’s Petition, 170 So. 2d 603, 610 (Fla. Dist. Ct. App. 1965). See R. Rock, M. Jacobson & R. Janopaul, supra note 35, at 7 (“[t]he doctrine of parens patriae . . . refers to the state’s duty to protect persons under disability”).


110. See LaFond, supra note 58, at 516-25.

111. See Colyar v. Third Judicial Dist. Court, 469 F. Supp. at 429 (“the humanitarian motivation of the state when acting under parens patriae does not shield the use of the power from due process requirements.”); Developments, supra note 61, at 1210 (stressing the need for substantive and procedural due process as requisite to the exercise of the parens patriae power).
which the government can care for thousands of mentally ill individuals who are unable to care for themselves.

III. THE DEINSTITUTIONALIZATION MOVEMENT

A. Historical Development

The mid-nineteenth century social reform movement sponsored by Dorothea Dix began as an enlightened and humane attempt to improve the lot of the mentally ill.112 In days when scientific understanding and treatment were at best primitive, mental hospitals could at least offer shelter, food, and a degree of safety.

Well into the present century, large state hospitals carried primary responsibility for care of the mentally ill.113 The number of patients in mental hospitals grew to a high of 559,000 in 1955.114 For thousands of chronically mentally ill individuals, state hospitals became lifetime residences.115 The deplorable conditions found in many of these institutions are well documented by numerous authors.116 Institutions were chronically understaffed,117 and many staff members were unqualified to work with, let alone treat, patients.118 Prior to the discovery of antipsychotic medications during the 1950's, violent and uncontrolled behavior was a constant problem, and restraints and seclusion rooms119 were routinelly employed in nearly

112. For a discussion of this reform movement, see notes 28-34 and accompanying text supra.


119. Even with the discovery of antipsychotic medications, some abusive physical restraint persisted. In 1974, the Court of Appeals for the Fifth Circuit observed that "[a]ides frequently put patients in seclusion or under physical restraints, including straightjackets, without physician's orders. One resident had been regularly confined in a straightjacket for more than nine years." Wyatt v. Aderholt, 503 F.2d 1305, 1310-11 (5th Cir. 1974). See Haldeman v. Pennhurst State School & Hosp., 446 F. Supp 1295, 1306-07 (E.D. Pa. 1977), aff'd, 612 F.2d 84 (3d Cir. 1979) (en banc),
Meaningful treatment was largely unavailable, and hospitalization amounted to little more than custody. Many long-term chronic patients became dependent on their institutional providers, losing social skills essential for independent living. Facilities not only lacked treatment programs, but were dehumanizing and dangerous places to live. Physical attacks by residents and staff were not uncommon, sometimes causing death. In sum, life inside institutional walls was often “nasty, mean, brutish and short.”

As early as 1920, some academic psychiatrists realized that hospital care was inadequate. As a result, psychiatrists in training were encouraged to avoid state hospitals and develop practices in the community. This was the beginning of the movement toward community mental health care. In 1946, the National Institute of Mental Health was established, and funds became available to create community mental health care facilities.
community mental health services, thereby reducing reliance on state institutions. In the 1950's, antipsychotic medications became available throughout the United States, permitting “for the first time significant alleviation of psychiatric symptoms without resort to physical restraints.” While the antipsychotics were vital to deinstitutionalization, they were not the sole therapeutic advance. Non-medicinal psychiatric treatment was also improving significantly.

In 1963, Congress passed the Mental Retardation Facilities and Community Mental Health Centers Construction Act (CMHC).

128. Schoonover & Bassuk, Deinstitutionalization and the Private General Hospital Inpatient Unit: Implications for Clinical Care, 34 Hosp. & Community Psychiatry 135 (1983). For an in-depth analysis of the growth of services for the mentally ill since the end of World War II, see H. Foley, supra note 115.

The National Institute of Mental Health (NIMH) is a government-supported institution. Since its creation, NIMH has played a key role in the formulation and implementation of federal policy in the field of mental health. See Segal, supra note 121, at 28.

129. Schoonover & Bassuk, supra note 128, at 135.

130. See Rhoden, supra note 122, at 378-80.


Talbott states that “[a] development that directly benefited the lives of the seriously and chronically mentally ill residing in state hospitals, and perhaps the most significant development ever in the history of institutional psychiatry, was the discovery in the 1950’s, of effective psychopharmacological agents.” J. Talbott, supra note 8, at 26.

The use of antipsychotic drugs has been criticized by some courts and commentators. See, e.g., Halderman v. Pennhurst State School & Hosp., 446 F. Supp. at 1307 (recognizing abuse of the drugs); Segal, supra note 121, at 239 (criticizing the drugs as “chemical straight jackets”). For a detailed discussion of the limitations of the “miracle” qualities of the antipsychotic drugs, see A. Scull, Decarceration: Community Treatment and the Deviant: A Radical View 79-94 (1977).

132. See Textbook of Psychiatry, supra note 6, at 87-92.


Rhoden comments on the CMHC Act as follows:

Once deinstitutionalization became a recognized social policy, legislatures acted to aid and encourage it. For example, in 1963, Congress adopted the Mental Retardation Facilities and Community Mental Health Centers Construction Act, which represented the first comprehensive federal commitment to developing community residences and programs for the mentally retarded and mentally ill. Under this act, community mental health centers (CMHC’s) qualified for federal funding if they offered certain services, including outpatient and inpatient care, emergency aid, transitional care and follow-up, and treatment for alcohol and drug abuse. Such centers served a growing number of mental patients in the community. Other federal and state legislation has likewise emphasized and provided incentives for community care. Although it generally is agreed that community mental health centers have fallen short of their promise, federally sponsored incentives to establish such centers clearly contributed to the acceleration and widespread acceptance of deinstitutionalization.

Rhoden, supra note 122, at 383 (footnotes omitted).
This important social legislation made possible the creation of community-based mental health services throughout the country. In 1965, the Medicare and Medicaid programs were created, providing crucial funding for community-based mental health care. The combined effects of the CMHC Act, antipsychotic medications, advances in treatment, increased funding, and the Medicare and Medicaid programs added vital support to the growing professional and lay perception that community-based treatment was preferable to institutionalization.

The foregoing factors laid the groundwork for widespread deinstitutionalization, which began in the 1950's. The number of residents in state and county mental hospitals declined from 559,000 in 1955 to approximately 138,000 in 1980. For the first time, a significant percentage of the seriously mentally ill, for whom institutionalization was formerly the only alternative, could avail themselves of an expanding array of services offered by community mental health centers. For example, outpatient psychiatric care grew significantly during this period. Other services became available such as

135. Id. §§ 1396-1396i.
136. See Rhoden, supra note 122, at 384-85.
137. See Goldman, supra note 114, at 130; Nordwind, supra note 131, at 643; Rhoden, supra note 122, at 378-87. See also Pepper & Ryglewicz, Testimony for the Neglected: The Mentally Ill in the Post-Deinstitutionalized Age, 52 Am. J. ORTHOPSYCHIATRY 388 (1982); J. TALBOTT, supra note 8, at 33. Some critics of the policy of deinstitutionalization argue that the primary force behind the movement was an effort by the states to shift financial responsibility for the mentally ill to the federal government. See Rhoden, supra note 122, at 381-82; A. SCULL, supra note 131, at 151.
138. See Grob, supra note 113, at 15; TALBOTT, supra note 8, at 32-33.
140. Id. at 130. Goldman states that
[i]t is widely accepted that between 1955 and 1975 outpatient care expanded rapidly while inpatient care remained relatively stable. During this period, particularly from 1965 to 1975, outpatient clinics and community mental health centers were established and expanded. This new availability of services accounts for most of the twelvefold increase in outpatient care episodes. However, while ambulatory services grew dramatically, the rate of inpatient care episodes remained relatively stable, at about 800 to 850 per 100,000 population.

Some of the growth in outpatient care represents the aftercare of discharged hospital patients. Yet most outpatients today have had no prior inpatient experience and have not shifted their locus of care; they simply have availed themselves of new services. Our clinical experience fails to support belief in the ready substitution of ambulatory services for hospitalization. Outpatient services, however, may permit a reduction in the length of hospitalization, contributing to the decline in inpatient days of care since 1955. Without question, outpatient services have become a major part of
medication monitoring and maintenance,\textsuperscript{141} day hospital services,\textsuperscript{142} crisis intervention, outreach, and short stay residential treatment. Many of the patients still requiring hospitalization chose care in the growing number of private psychiatric hospital beds,\textsuperscript{143} thus further reducing utilization of public mental hospitals.\textsuperscript{144}

the mental health service system, but there is no evidence that episodes of outpatient care have replaced episodes of inpatient care, particularly for the chronic and severely disturbed patient.

\textit{Id.}

\textit{See also} L. Bachrach, \textit{Deinstitutionalization: An Analytical Review and Sociological Perspective} 4 (NIMH, Series D, No. 4, 1976). "In 1955, about half of the psychiatric patient care episodes in the Nation were in State mental hospitals, as contrasted with about one-fifth in 1971. Outpatient services accounted for only 23 percent of psychiatric patient care episodes in 1955 but for 42 percent in 1971." \textit{Id}. Bachrach concluded that the use of antipsychotic drugs, along with increased reliance on nursing homes, account for the shift in service delivery. \textit{Id}.

\textsuperscript{141} Many chronically mentally ill individuals can be maintained in the community so long as they continue to take prescribed medications. Numerous community mental health centers maintain clinics for the prescription and monitoring of medications for chronic patients. Many patients need no other contact with the mental health system. \textit{See Segal, supra note 121, at 232-51.}


Rehabilitation services are crucially important to the chronically mentally ill. For a recent article on the subject by leading experts, see Anthony, Cohen & Cohen, \textit{Philosophy, Treatment Process, and Principles of the Psychiatric Rehabilitation Approach}, in \textit{Deinstitutionalization} (L. Bachrach ed. 1983).

\textsuperscript{143} \textit{See Bachrach, The Effects of Deinstitutionalization on General Hospital Psychiatry}, 32 Hosp. \& Community Psychiatry 786 (1981); Goldman, supra note 114, at 131; Schoonover \& Bussuk, supra note 128.

\textsuperscript{144} Professor Goldman and his colleagues stress that, while there has been a decline in the number of patients in state hospitals, such institutions continue to play a central role in the mental health system:

The data fail to demonstrate the absolute shift in the locus of treatment that is regarded as the hallmark of deinstitutionalization. What emerges instead is the reality of deinstitutionalization—an expanding mental health services system in which the relative role of public inpatient institutions has diminished dramatically while their absolute role has endured, albeit somewhat altered.

\ldots The fall of the state mental hospital has been proclaimed because of the decline in the resident census of state and county mental hospitals from 559,000 in 1955 to approximately 138,000 in 1980. Yet this decline to one quarter of the previous census does not mean the demise of the state mental hospital because, as the census fell, admissions increased. Even today these institutions continue to provide 64 percent of all inpatient days of psychiatric care. \ldots

\ldots The resident patient census of state and county mental hospitals fell dramatically while admissions to these facilities continue to increase. In
While many chronically mentally ill individuals left state hospitals during the initial period of deinstitutionalization, many did not leave institutional life permanently. For hundreds of thousands of these individuals, the movement brought not deinstitutionalization but reinstitutionalization in a privately-owned nursing home. The number of nursing home beds occupied by the mentally ill increased significantly during this period of "deinstitutionalization." Often the conditions found in such facilities were the same as, or worse than, those found in state hospitals.

Although there has been a significant expansion of community-based services available to the mentally ill, and a concomitant decline in the overall census of public mental hospitals, one observer has noted that this "decline . . . does not mean the demise of the state mental hospital because, as the census fell, admissions increased. Even today these institutions continue to provide 64 percent of all inpatient days of psychiatric care. . . ." The phenomenon of decreased census but increased admissions is explained by the fact that the number of short-term inpatient admissions increased. For most patients the state hospital is no longer the last stop. Rather, treatment is given to stabilize the patients and then an attempt is made to integrate them back into the community, with support from community mental health services.

The deinstitutionalization movement thus had its genesis in an amalgam of increasingly effective treatment methods and an awareness that institutions were often damaging to those within their walls. The movement has had an ameliorative effect on the lives of thousands of individuals and, while many serious problems remain, on balance the movement has been positive.

Other words, fewer patients received long-term custodial care in state and county hospitals, but the number of short-term inpatient care episodes increased.

Goldman, supra note 114, at 130-31.
145. See J. Talbott, supra note 8, at 36-37.
146. Id.
147. Id.
149. Id.
150. This method of inpatient treatment and reintegration into the community has been termed the "revolving door policy." See Segal, supra note 121, at 82. See also Goldman, supra note 114, at 133.
B. The Contribution of the Courts to Deinstitutionalization

Primary credit for the deinstitutionalization movement lies with the mental health profession. The courts entered the picture well after mental health workers had made substantial progress. While judicial opinion did not chart the course of the movement, it had a significant impact, and played an important secondary role.

In the 1966 case of Lake v. Cameron, Chief Judge Bazelon of the Court of Appeals for the District of Columbia Circuit grappled with the issue of alternatives to involuntary institutionalization. Catherine Lake, the plaintiff, was an elderly woman who suffered from chronic brain syndrome associated with aging. She had a tendency to wander away from home and become lost and confused. One of the psychiatrists who examined her stated that rather than institutionalization, she needed supervision and care to prevent her from "wandering off." Although such care could have been provided in the community, the district court committed Mrs. Lake to St. Elizabeth's Hospital as a person of unsound mind. Following commitment, she filed a writ of habeas corpus. The district court denied the writ, but instructed Mrs. Lake that she could reapply if she could establish the availability of community-based facilities for her treatment. In other words, the trial court recognized that Mrs. Lake might have a right to less restrictive, community-based care if it were available, "but required her to carry the burden of showing [its] availability." The court of appeals reversed and ruled that the burden rests with the state to show the non-availability of community-based facilities. This approach, requires the state to make "an earnest effort . . . to review and exhaust available resources of the community" before depriving individuals of their liberty.

The Lake decision is an important early effort to limit institutionalization to those for whom less restrictive alternatives are not available. The opinion focused attention on the importance of community placement; however, it stopped short of requiring the establishment of community facilities. Under Lake, the state could meet its burden by

151. 364 F.2d 657 (D.C. Cir. 1966).
152. Id. at 658. It was determined at the district court level that Catherine Lake suffered from "a mental illness with the diagnosis of chronic brain syndrome associated with Cerebral Arteriosclerosis. . . ." Id. at 659.
153. Id. at 660.
154. Id. at 658-60.
155. Id. at 659.
156. Id.
157. Id. at 660-61.
investigating "available resources." Nearly a decade passed before a federal judge took the next crucial step: ordering the creation of community treatment facilities. In 1975, Judge Robinson held in Dixon v. Weinberger that the statutes of the District of Columbia imposed a duty on both the federal and District of Columbia governments to establish alternatives to institutionalization in St. Elizabeth's Hospital. The plaintiffs in Dixon argued constitutional as well as statutory theories in support of the right to community treatment. The importance of the case is diminished somewhat by the fact that the court limited its holding to the statutory theory. However, it remains a landmark in the deinstitutionalization movement for ordering the creation of community-based treatment facilities.

The litigation culminating in the cornerstone of judicial opinion in the field of deinstitutionalization, Wyatt v. Stickney, began innocuously in 1970 as a dispute over money. Ninety-nine employees of state-operated Bryce Hospital, located at Tuscaloosa, Alabama, were fired due to funding cuts. Bryce Hospital was built during the 1850's, and was an archetypical example of what had gone wrong with large institutions. Approximately 5,000 individuals were confined at Bryce at the time the litigation was commenced, yet the staff was woefully insufficient in numbers and training to meet even the basic needs of the inmates. Dismissal of nearly 100 sorely needed employees was the final insult.

The conditions present throughout the institution were unsafe and dehumanizing. Patients lived in dormitories which were described as "barn-like structures with no privacy." The wards were overcrowded; there was no furniture where patients could keep clothing; there were no partitions.

158. Id. at 660 (emphasis added).
159. 405 F. Supp. 974 (D.D.C. 1975). Dixon was decided in 1975. However, implementation of the court's requirement of community-based facilities took several years. In 1979, the government finally submitted an implementation plan. In 1980, a consent order designed to implement the original decision was issued. See MENTAL HEALTH LAW PROJECT, SUMMARY OF ACTIVITIES, JULY 1979-JUNE 1981 6 (1981).
160. 405 F. Supp. at 978-79.
161. 405 F. Supp. at 976.
163. Wyatt v. Aderholt, 503 F.2d 1305, 1307 (5th Cir. 1974).
164. Id. at 1307.
165. 325 F. Supp. at 782.
166. 334 F. Supp. at 1343.
167. Id.
between commodes in the bathrooms. There were severe health and safety problems: patients with open wounds and inadequately treated skin diseases were in imminent danger of infection because of the unsanitary conditions . . . such as permitting urine and feces to remain on the floor. . . .\textsuperscript{168}

Buildings were fire and safety hazards,\textsuperscript{169} and poor ventilation caused living areas to smell of excrement, stale urine, and unwashed bodies.\textsuperscript{170} Food was inedible.\textsuperscript{171} Residents were often placed in physical restraint for long periods of time purely for the convenience of the staff, and unsupervised isolation in solitary confinement was an everyday occurrence.\textsuperscript{172} Injury, sickness, abuse and misery were pervasive, and meaningful treatment was nonexistent. The conditions at Bryce in 1970 were perhaps worse than those described by Charles Dickens in 1842.\textsuperscript{173} Certainly any excuse available during Dickens’ time based upon lack of scientific and practical knowledge of mental illness and its treatment was unavailable in 1970.

Such were the institutional conditions which gave rise to the litigation in \textit{Wyatt v. Stickney}.\textsuperscript{174} In this seminal litigation, then District Judge Frank M. Johnson\textsuperscript{175} took far-reaching steps to correct the horrendous conditions at Bryce. He did so by holding that involuntarily committed patients enjoy “a constitutional right to receive such individual treatment as will give each of them a realistic opportunity to be cured or to improve his or her mental condition.”\textsuperscript{176} This constitu-

\begin{footnotesize}
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\item \textsuperscript{168} 503 F.2d at 1310.
\item \textsuperscript{169} 334 F. Supp. at 1343.
\item \textsuperscript{170} 503 F.2d at 1310; 334 F. Supp. at 1343.
\item \textsuperscript{171} 334 F. Supp. at 1343.
\item \textsuperscript{172} 503 F.2d at 1310-11.
\item \textsuperscript{173} For Dickens’ description of the conditions of institutions in the 1800’s, see notes 1-5 and accompanying text supra.
\item \textsuperscript{174} 325 F. Supp. 781 (M.D. Ala. 1971). For the procedural history of \textit{Wyatt v. Stickney}, see note 162 supra.
\item \textsuperscript{175} Judge Frank M. Johnson is now a Circuit Court Judge on the Eleventh Circuit Court of Appeals.
\item \textsuperscript{176} 325 F. Supp. at 784.
\item Adequate and effective treatment is constitutionally required because, absent treatment, the hospital is transformed “into a penitentiary where one could be held indefinitely for no convicted offense.” . . . The purpose of involuntary hospitalization for treatment purposes is treatment and not mere custodial care or punishment. This is the only justification, from a constitutional standpoint, that allows civil commitments to mental institutions such as Bryce.
\item \textsuperscript{176} (emphasis in original) (citations omitted). There are numerous authorities discussing the right to treatment for mental patients. \textit{See}, e.g., Rapson, \textit{The Right of the Mentally Ill to Receive Treatment in the Community}, 16 \textsc{Colum. J.L. \\ & Soc. Probs.} 192, 219-22 (1980); Rachlin, \textit{The Influence of Law on Deinstitutionalization}, in \textsc{Deinstitutionalization} 48-49 (L. Bachrach ed. 1983); \textit{Developments}, supra note 61, at 1316-33.
\end{enumerate}
\end{footnotesize}
tional right was termed a "present" right that could not be postponed until adequate funds became available. Failure to provide constitutionally mandated treatment could not "be justified by a lack of operating funds."

In discussing the right to treatment, Judge Johnson identified "three fundamental conditions for adequate and effective treatment programs in public mental institutions." These were: "(1) a humane psychological and physical environment, (2) qualified staff in numbers sufficient to administer adequate treatment and (3) individualized treatment plans." At the time of the district court decision, Bryce Hospital did not satisfy any of these conditions. The court therefore ordered the defendants to prepare a plan to bring the institution into compliance with minimally adequate standards of treatment. When the state failed to come up with an acceptable plan, the court was compelled to impose its own. The court's standards were exceedingly detailed, covering such matters as physical facilities, staffing ratios, nutrition standards, the content of individualized treatment plans, and limitations on the use of restraints and seclusion.

During the course of the Wyatt litigation, the plaintiffs expanded the scope of the case to embrace Partlow State School and Hospital, a state institution for the mentally retarded. Conditions at Partlow were in some respects more deplorable than those at Bryce. In his decision regarding the mentally retarded inmates at Partlow, Judge Johnson held that "[i]n the context of the right to appropriate care for people civilly confined to public mental institutions, no viable distinction can be made between the mentally ill and the mentally retarded." Judge Johnson stated that once the mentally retarded person is committed he becomes "possessed of an inviolable constitutional right to habilitation." Because conditions at Partlow fell far below constitutionally required standards, the court imposed a set of minimum standards similar in most respects to those which it applied

177. 325 F. Supp. at 784-85.
179. 334 F. Supp. at 1343.
180. Id.
181. Id. at 1344.
182. See 344 F. Supp. at 376-86.
184. See id. at 391. For a detailed discussion of the conditions at both Partlow and Bryce, see Wyatt v. Aderholt, 503 F.2d at 1310-12.
185. 344 F. Supp. at 390.
186. Id.
to the mentally ill.\textsuperscript{187}

The \textit{Wyatt v. Stickney} litigation is important for several reasons. From a social policy perspective, the decision was instrumental in focusing national attention on the plight of the institutionalized mentally ill and mentally retarded. From a pragmatic point of view, the case had a direct impact on conditions within institutions across the country. The case also marked the beginning of intense judicial scrutiny of nearly all aspects of institutional life. Following \textit{Wyatt}, right to treatment cases were instituted in several other jurisdictions.\textsuperscript{188} Finally, the decision had an important influence on the deinstitutionalization movement. This is so despite the fact that the court did not concern itself directly with the discharge of patients from the institutions under scrutiny. It would be difficult—probably impossible—to implement the minimally adequate conditions required by the court in institutions the size of Bryce and Partlow.\textsuperscript{189} As a result, the decision spurred the transfer of patients out of institutions and into community-based alternatives.

Some critics argue that \textit{Wyatt v. Stickney} and cases like it do not go far enough. In an article concerning institutionalization of the mentally retarded, Professors Mason and Menolascino argue that “[i]nstitutions, by their very structure—a closed and segregated society founded on obsolete custodial models—can rarely normalize and habilitate the mentally retarded citizen to the extent of community programs.”\textsuperscript{190} By concentrating their efforts on improving conditions within institutions, the authors contend, courts missed the essential point that the rights they were seeking to protect simply can not be effectively exercised or protected within institutional walls.\textsuperscript{191} Institutions are \textit{per se} antithetical to the concept of treatment and habilitation in the least restrictive setting. Therefore, they argue that it is a

\begin{footnotesize}
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  \item[187.] See id. at 395-407.
  \item[188.] See, e.g., Rapson, \textit{supra} note 176, at 220-22 (discussing the constitutional basis of right to treatment); \textit{Developments, supra} note 61, at 1316-33 (discussing cases involving statutory and constitutional right to treatment issues).
  \item[189.] At the time of the \textit{Wyatt} litigation, Bryce Hospital housed approximately 5,000 patients, most of whom had been involuntarily committed through civil proceedings before the probate court of Alabama. 325 F. Supp. at 782. At that time, Bryce employed 1,500 persons, only 931 of whom were involved in direct patient care and therapy. \textit{id.} at 782-83. For a further description of the conditions at Bryce, see notes 162-73 and accompanying text \textit{supra}. At Partlow, the staff was inadequate and the hospital 60\% overcrowded. 503 F.2d at 1310-11. Four patients at Partlow died due to these conditions. \textit{See id.} at 1311 & n.6.
  \item[191.] \textit{Id.} at 156-58.
\end{itemize}
\end{footnotesize}
non sequitur to state that constitutionally acceptable care can be rendered in such settings.

The above reasoning was adopted by a federal court in *Halderman v. Pennhurst State School & Hospital*.192 The district court opinion in *Pennhurst* represents the zenith of deinstitutionalization litigation. Established in 1908, Pennhurst, like so many other state institutions for the intellectually handicapped, was “overcrowded and understaffed.”193 During the early 1960’s, it housed nearly 4,000 residents, though at the time of the litigation the population had been reduced to approximately 1,230.194 Psychological testing revealed that residents lost basic social skills while institutionalized at Pennhurst. They regressed rather than progressed.195 Physical conditions in the institution were reminiscent of those found at Bryce and Partlow.196 All parties involved in the case were “in agreement that Pennhurst as an institution [was] inappropriate and inadequate for the habilitation of the retarded.”197

Based on the record before it, the court could have fashioned a remedy similar to that in *Wyatt v. Stickney*.198 Judge Broderick, however, went beyond the earlier case. He reasoned, as did Judge Johnson in *Wyatt*,199 that residents of Pennhurst had a constitutional right to habilitation. Judge Broderick reasoned that when a “state involuntarily commits retarded persons, it must provide them with such habilitation as will afford them a reasonable opportunity to acquire and maintain those life skills necessary to cope as effectively as their


For a detailed discussion of *Pennhurst*, see Ferleger & Boyd, *Anti-Institutionalization: The Promise of the Pennhurst Case*, 31 Stan. L. Rev. 717 (1979). See also Ferleger, *Anti-Institutionalization and the Supreme Court*, 14 Rutgers L. Rev. 595 (1983); Rhoden, supra note 122, at 406-10. One important reason for the effectiveness of early deinstitutionalization litigation was that families of institutionalized residents were nearly unanimous in their support of the litigation. This unanimity has evaporated, however, and in some cases family groups are opposed to deinstitutionalization efforts. See Frohbuase & Soles, *Parental Opposition to Deinstitutionalization*, 4 Law and Human Behavior 1 (1980). See also Rhoden, supra note 122, at 406-10.

193. 446 F. Supp. at 1302.

194. Id.

195. Id.

196. For a description of the conditions which existed at Bryce and Partlow, see notes 162-72 & 184 and accompanying text supra.

197. 446 F. Supp. at 1304.

198. For a discussion of the remedy fashioned by the court in *Wyatt v. Stickney*, see notes 175-81 and accompanying text supra.

199. For Judge Johnson's ruling on the constitutional right to treatment, see text accompanying notes 176-85 supra.
capacities permit.\textsuperscript{200} In addition, habilitation had to be provided “under the least restrictive conditions consistent with the purpose of the commitment.”\textsuperscript{201} The judge concluded that he could not reconcile institutionalization in Pennhurst with the principle of habilitation in the least restrictive alternative. In the court’s words, “[M]inimally adequate habilitation cannot be provided in an institution such as Pennhurst.”\textsuperscript{202} That being so, the court had no alternative but to order the eventual closure of the institution. In the final analysis, the court concluded that “Pennhurst, as an institution . . . , should be regarded as a monumental example of unconstitutionality with respect to the habilitation of the retarded.”\textsuperscript{203} Although the Pennhurst case, in which Judge Broderick announced his landmark order, is still being litigated,\textsuperscript{204} it constitutes an important and lasting contribution to the body of caselaw defining the rights of the mentally ill and mentally retarded.

There has been a plethora of litigation in recent years seeking both to improve institutional conditions and move patients into the community.\textsuperscript{205} This litigation has spurred legislative reform\textsuperscript{206} and changes in social policy. Thus, the law has played an important, though secondary, role in the deinstitutionalization movement.

C. Treatment in the Least Restrictive Environment

The litigation concerning deinstitutionalization and involuntary commitment has given rise to the constitutional requirement that treatment be provided in the least restrictive environment.\textsuperscript{207} The
roots of the doctrine of least restriction can be traced to Shelton v. Tucker, a 1960 case in which the Supreme Court addressed the issue of state intrusion upon first amendment rights. The Court stated that

\begin{quote}

... even though the governmental purpose be legitimate and substantial, that purpose cannot be pursued by means that broadly stifle fundamental personal liberties when the end can be more narrowly achieved. The breadth of legislative abridgment must be viewed in the light of less drastic means for achieving the same basic purpose.
\end{quote}

In the context of involuntary commitment of the mentally ill, the governmental purposes are the protection of society and the provision of treatment designed to alleviate suffering and return the patient to a fulfilling life in the community. Although these purposes are undoubtedly "legitimate and substantial," involuntary treatment nevertheless constitutes a "massive curtailment of liberty." Courts have found that the liberty lost through commitment is as fundamental as the first amendment rights at stake in Shelton v. Tucker. Therefore,

\begin{quote}

... Because of this, due process demands that if a state undertakes the habilitation of a retarded person, it must do so in the least restrictive setting consistent with that individual's habilitative needs. As we have heretofore pointed out, isolation and confinement are counter-productive in the habilitation of the retarded. Furthermore, since the law recognizes that habilitation other than in the least restrictive setting is a violation of one's constitutional rights, there is no question that Pennhurst, as an institution for the retarded, should be regarded as a monumental example of unconstitutionality with respect to the habilitation of the retarded. The Commonwealth and its subdivisions have a constitutional duty to explore and provide the least stringent practicable alternatives to confinement of retarded individuals at Pennhurst.
\end{quote}

446 F. Supp. at 1319-20 (footnote and citation omitted).

It should be noted that the Supreme Court overturned the district court Pennhurst decision on other grounds. See Halderman v. Pennhurst State School and Hosp., 451 U.S. 1 (1981). The Supreme Court has yet to squarely address the constitutional violations found by Judge Broderick. See Pennhurst State School & Hosp. v. Halderman, 104 S. Ct. 900 (1984).

208. 364 U.S. 479 (1960).

209. At issue in Shelton v. Tucker was an Arkansas statute requiring teachers to file annually affidavits listing all organizations to which they previously belonged or donated money. Filing of the affidavits was a condition to employment in state-supported schools or colleges. 364 U.S. at 480. The Supreme Court held that the statute violated the teachers' right to freedom of association, protected by the fourteenth amendment. Id. at 487.

210. 364 U.S. at 488 (footnotes omitted).

211. See Humphrey v. Cady, 405 U.S. 504, 509 (1972). See also O'Connor v. Donaldson, 422 U.S. 563 (1975) (there is no constitutional basis for confining the mentally ill involuntarily if they are not dangerous and can safely live in freedom); Colyar v. Third Judicial Dist. Court, 469 F. Supp. 424 (D. Utah 1979) (describing
when the state undertakes to treat the mentally ill against their will, it
must do so by means calculated to avoid unnecessary infringement of
liberty. In practical terms, this means that treatment must be pro-
vided in the least restrictive environment which can effectively meet
the individual’s treatment needs. Because institutionalization en-
tails use of one of the most restrictive treatment modalities available,
it can only be justified if less restrictive treatment, such as commu-
nity-based therapy, would not be effective.

the enormity of the deprivation and the denial of the right to freedom caused by
hospitalization).

The California Supreme Court described the potentially devastating affect of
commitment upon the individual:

[C]ivil commitment to a mental hospital... threatens a person’s liberty
and dignity on as massive a scale as that traditionally associated with crim-
inal prosecutions. One has only to imagine the horror experienced by a
competent person falsely committed as mentally disturbed in order to ap-
preciate that freedom is openly on trial at a civil commitment proceeding.
Conservatorship of Roulet, 23 Cal. 3d 219, 223, 590 P.2d 1, 3, 152 Cal. Rptr. 424, 427
(1979).

212. See Wyatt v. Stickney, 344 F. Supp. at 379 ("[p]atients have a right to the
least restrictive conditions necessary to achieve the purposes of commitment"); Lessard
v. Schmidt, 349 F. Supp. at 1096 (mentally ill persons cannot be deprived of freedom if
there are less drastic means for achieving the same basic goal). See also Comment, The
Scope of the Involuntarily Committed Mental Patient’s Right to Refuse Treatment with Psycho-
tropic Drugs: An Analysis of the Least Restrictive Alternative Doctrine, 28 Vill. L. Rev. 101,

213. The application of the least restrictive alternative doctrine to the police
power and parens patriae power standards for involuntary commitment is described by
one authority as follows:

The threshold determinations of mental incapacity or substantially di-
minished responsibility required for parens patriae or police power commit-
ments are not affected by the application of least restrictive alternative
analysis. For both types of commitment, these findings serve to justify treat-
ing the mentally ill differently from those who are not mentally ill. In parens
patriae commitments, moreover, the initial determination of incapacity is
required to identify the individual as properly subject to state authority.
Since reducing the deprivations of commitment would eliminate neither the
need to justify the differential treatment of the mentally ill nor the inherent
limitation of the parens patriae power to protection of incompetents, the
threshold standards for commitment would not be altered by less burden-
some alternatives to hospitalization.

Least restrictive alternative analysis also leaves unchanged the balanc-
ing standard for parens patriae commitments. By requiring that the state act
in its ward’s best interest, the parens patriae doctrine compels an evaluation
of potential means of protecting the incapacitated individual. If the incre-
mental benefits of institutionalization are not sufficient to outweigh the in-
creased loss of liberty when compared with an available alternative, the
state’s duty as parens patriae is to choose that alternative. Least restrictive
alternative analysis provides an independent constitutional basis for this duty.

Developments, supra note 61, at 1248-49 (footnotes omitted).

For a discussion of a recent article questioning the utility of least restrictive alter-
native analysis in the context of involuntary treatment, see note 272 infra.
The deinstitutionalization movement has wrought sweeping changes in the manner in which society cares for the mentally ill. Social planners, mental health professionals, legislators, and judges have played important roles in the movement. In many respects the mentally ill have been well served by their efforts. The movement has not been without shortcomings, however, and, as will be seen in the next section, it has failed in certain respects.

IV. FAILINGS OF THE DEINSTITUTIONALIZATION MOVEMENT

A. The "Community's" Failure to Provide Adequate Community-Based Treatment Resources

Thousands of mentally ill individuals have been released into the community through the process of deinstitutionalization. For many, the welcome afforded by society has been cold.214 As one commentator has noted: "Today a large number of the returnees can be found in nursing and board-and-care homes, in 'welfare' hotels, and in flop-houses."215 Many more are living and dying on the streets of every

214. Rhoden offers the following penetrating observation:

It is not unusual for the proponents of a policy to optimistically overestimate its benefits, ease of implementation, and cost effectiveness. However, in this case the inflated rhetoric may have contributed to the current problems with deinstitutionalization by implying that being in the community was per se therapeutic. Advocates frequently suggested that "keeping [persons] out of institutions, even if the community is not geared to serve them, is all to the good." Such rhetoric obscured both the difficulties inherent in establishing community facilities and the desperate need for such facilities. It also misrepresented the nature of the community to which most ex-patients would return; had the "community care" movement been called "subsistence in slums," there might have been a more widespread recognition that mere release to the community would not be enough. Similarly, had advocates considered the treatment that many of the mentally disturbed had received back in the golden age before institutions, they might have questioned the wisdom of releasing patients first and creating community programs afterwards. After all the institution itself was a reform designed to protect the mentally ill from neglect and abuse in the community.

Rhoden, supra note 122, at 400-01 (footnotes omitted). See Deinstitutionalization of the Mentally Ill: Hearings Before the Subcomm. on Fiscal Affairs and Health of the House Comm. on the District of Columbia, 97th Cong., 1st Sess. (1981) [hereinafter cited as Deinstitutionalization Hearings]; L. BACHRACH, DEINSTITUTIONALIZATION: AN ANALYTICAL REVIEW AND SOCIOLOGICAL PERSPECTIVE (NIMH Series D. No. 4, 1976). Bachrach observes that chronically mentally ill individuals are sometimes considered "undesirable" by professionals and community members alike. She stresses the fact that many deinstitutionalized patients fail outside the hospital because they have not been adequately prepared for life in the community. See also Lamb, Roots of Neglect of the Long-Term Mentally Ill, 42 PSYCHIATRY 201 (1979); Talbott, Toward a Public Policy on the Chronic Mentally Ill Patient, 50 AM. J. ORTHOPSYCHIATRY 43 (1980).

large city.\textsuperscript{216}

(1982); Lehman, Ward & Linn, \textit{Chronic Mental Patients: The Quality of Life Issue}, 139
AM. J. PSYCHIATRY 1271 (1982).

Rapson described the housing problem as follows:

Housing, the core of any community-based treatment plan, is the most
striking testament to the breakdown of deinstitutionalization theory.
Whether gathered in nursing homes, adult homes, single-room-occupancy
hotels, or left to find a vacant bench or unoccupied subway heating duct,
countless thousands of mentally ill persons find themselves in environments
in which their most basic psychiatric and resocialization needs cannot be
met.

Rapson, \textit{supra} note 176, at 207-08 (footnotes omitted).

One commentator states that NIMH data show there are between 800,000 and
1.5 million chronically mentally ill persons living in the “community.” Of this
number, approximately 65\% return to their families following discharge from the
hospital. Goldman, \textit{Mental Illness and Family Burden: A Public Health Perspective}, 33
HOSP. & COMMUNITY PSYCHIATRY 557, 558 (1982). However, many have no family
to which to return. Even those who do return to the family may not stay, or may not
be welcome. Caring for a seriously disabled adult imposes a tremendous strain on the
entire family. Not infrequently, the strain is too much for all concerned, and the
mentally ill individual finds him or herself in a hospital or on the streets. The system
of involuntary treatment proposed in this article should enable mental health profes-
sionals to aid families that are attempting to support mentally ill members in the
community.

216. \textit{See} Rhoden, \textit{supra} note 122, at 391-92. Rhoden states as follows:

Some former patients are not even so fortunate as to have a dirty room
in a crumbling [single residency occupancy hotel (SRO)] in which to live.
Mental patients who have been evicted from their SRO, or have in some
other way “fallen between the cracks,” and failed to negotiate the bureau-
cratic requirements for receiving financial assistance may wind up literally
on the streets. It has been estimated that in New York City alone, approxi-
mately 30,000 homeless men sleep on doorsteps, unoccupied benches, heat-
ing ducts, or other such places. The New York City subway system has
been called “the largest SRO” in existence. Large number of the homeless
are mentally ill, and they are without a doubt the ultimate victims of our
carelessly enacted mental health reforms. Such persons frequently are
preyed upon by criminals or the violently disturbed, and they die in dispro-
portionate numbers. Some incidents gain notoriety, such as the mentally ill
young Vassar graduate who lived at Union Station in Washington, was not
committed because she was not dangerous, and was soon found brutally
stabbed near her “home.” Many more such incidents go unreported be-
cause no one cares.

\textit{Id.} (footnotes omitted). Rhoden notes statistics which show that 50-70\% of the men
inhabiting some of New York’s shelters for the homeless evidence signs of mental
illness. \textit{Id.} at 391 n.88.

The problem of the homeless mentally ill was described poignantly in another
article:

Among those who are utterly disaffiliated, madness may compound the
hardships of street life to produce a new class of misfits—the so-called
“space cases.” Their transience, the chronicity of their affliction, the fact
that available services are ill-suited to their needs, community fear of and
distaste for their numbers, and their alleged propensity for violence all
conspire to keep them beyond the pale of traditional outreach measures. Nor
should the hazards of a marginal existence in the community be underesti-
mated. One study of 119 “new chronic” patients discharged after short hos-
pital stays and referred to aftercare clinics, reported an astonishing 4.2\%
suicide rate for the group.
Some commentators have cogently suggested that the practical effect of deinstitutionalization is to make the community the functional equivalent of the hospital:

[W]hen a chronically mentally ill person leaves a psychiatric hospital, the community becomes, in effect, that person's hospital. That is, the community must then provide, in some fashion, all of those aspects of hospital care that are noncustodial in the restrictive sense: financial support, low-cost housing, employment or vocational rehabilitation, socialization, recreation, a degree of protection and supervision, advocacy and [case] management, medication, crisis intervention, and psychotherapy. 217

This array of services is essential if the seriously impaired are to live with any degree of dignity and well-being in the community. The services which are actually available, however, are all too often woefully inadequate. 218 This is due in large measure to a lack of ade-
quate funding for community programs. "In the simplest terms, the patients from [the] state hospitals have been discharged into the community, but the dollars to support their care have not followed."219

Many former state hospital patients are now languishing in nursing homes.220 For most of these individuals, life is little different than when they were hospitalized. There is seldom adequate psychiatric care beyond administration of medication. The nursing home has, in effect, become the new "back ward" for the chronically mentally ill.

The age of deinstitutionalization has witnessed a growing number of younger mentally disabled adults "who are not deinstitutionalized but uninstitutionalized."221 These individuals have not experienced long periods of institutional care, but have been treated with varying degrees of success in the community mental health system.222 "These young adults, roughly in the age group 18-35, who may be intermittently psychotic and who are severely and persistently impaired, both psychiatrically and socially, . . . grow up spending little if any time in psychiatric hospitals, and most of their time in the stressful life of the community."223 Many of these individuals

live in the community in mental and emotional states which, in the past, would have brought about their hospitalization. Although they are diverted [from hospitalization] to alternative programs such as day hospital, they may or may not follow through on such alternatives, and in most states they are under no legal constraint to do so.224

Many of these younger patients are in dire need of treatment, but for a variety of reasons either refuse treatment or cannot find it.225

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219. Pepper & Ryglewicz, supra note 217, at 389. See J. Talbott, supra note 8, at 38 (discussing the current inadequacies of treatment and care of the mentally ill); Homeless in America, supra note 216, at 28.

220. See Rapson, supra note 176, at 210-11; Goldman, supra note 114, at 134.

221. Pepper & Ryglewicz, supra note 217, at 389 (emphasis in original). For an excellent demographic profile of the homeless in America, see Lipton, Sabatini & Katz, Down and Out in the City: The Homeless Mentally Ill, 34 Hosp. & Community Psychiatry 817 (1983).

222. For a moving example of the failure of the community mental health system, see Eisenhuth, Profiles of Street People: Mark X, 34 Hosp. & Community Psychiatry 809 (1983).

223. Pepper & Ryglewicz, supra note 217, at 389.

224. Id. at 389-90.

225. Id. at 390. Pepper & Ryglewicz describe the growing number of younger patients:
In their in-depth report titled *Homelessness in America*, Hombs and Snyder describe vividly the growing tragedy of thousands of former mental patients living on the streets of America's cities. The authors estimate that between one-third and one-half of these homeless are former mental patients. They describe the deplorable conditions in which many of these individuals live:

By the hundreds of thousands, patients have been discharged and sent to unfit, unsafe, or unlawfully operated boarding homes and flop houses, without the necessary supportive medical or social aftercare services.

Since depopulation of America's mental asylums began, the majority of the state mental hospital patients have been released into a world unprepared or unwilling to care for them. They are the victims of a social reform movement aimed at liberating them. Many are now living, and dying, in alleys, parks, vacant lots, and abandoned buildings, with little more than garbage for food, rags for clothes, and no shelter or medical care whatsoever.

The magnitude of the problem created by society's failure to provide adequate community facilities and treatment, along with workable channels for access to care, cannot be overemphasized. The toll in terms of human suffering is incalculable. To appreciate the human tragedy involved, it seems appropriate to consider a case example reported by Hombs and Snyder:

While nearly all categories of psychiatric patients are affected by these policies, our young adult patients present the most dramatic risks, both to themselves and to their communities. They typically present recurrent crises and only intermittent engagement in treatment. As a group they show: 1) a low rate of hospitalization; 2) a high incidence of use of alcohol and other drugs; 3) a high incidence of suicide attempts as well as of successful suicides; 4) a high incidence of conception of children, who become our next high-risk generation; 5) a sizeable incidence of law violations involving violence; 6) for the majority, a history of mental health treatment before age 18; and 7) for the majority, a high or total degree of financial dependence on public assistance programs or on family. These are some of the characteristics that make this new, uninstitutionalized generation a high-risk, high-priority, and high-anxiety group, both for professionals and for the public.

*Id.*


228. *Id.* at 43. See also Haugland, Craig, Goodman & Siegel, *Mortality in the Era of Deinstitutionalization*, 140 AM. J. PSYCHIATRY 848 (1983).
In the coldest days of January 1982, Rebecca Smith, age 61, died of hypothermia in New York City. She was living in a rug-covered cardboard box on the corner of Tenth Avenue and West 17th Street.

In the days and weeks before her death, she was visited by at least 50 people who offered her food and shelter. Two weeks prior to her death, the Red Cross had informed police of her living arrangements. Following that, she was approached by . . . a psychiatrist. The psychiatrist declared her an “endangered adult” under the first application of New York’s Protective Services Law. She died a few hours before the implementation of a 72-hour protective custody order could take effect.

Rebecca Smith came to the ranks of New York’s homeless from a different sort of life. She was one of thirteen children; she was valedictorian of her class at the prestigious Hampton Institute in her native Virginia . . . . Rebecca was hospitalized as a schizophrenic. . . .

She came to New York in 1959 to live with her sister. Again she was hospitalized. For the next 20 years, she was in and out of hospitals and clinics. During that time, she was heavily drugged. In 1981, she failed to appear for recertification interviews, and thereafter—having lost her public assistance and other benefits—she lived on the streets.

On a public street corner, her human vulnerability to the cold overwhelmed her. She was visible—yet not—to countless people. There were repeated offers of help, official and otherwise. It is telling that, after all of those visits, according to one city official, “Little was known about her other than her name.” As is so often the case, we learned the most about her only after her death. We do not know if she understood these offers of assistance or not; custody came too late.229

The story of Rebecca Smith illustrates a social problem of immense proportions. Hundreds of thousands of mentally ill individuals have been released from state hospitals into the community. Many of these individuals are seriously and chronically disabled and unable to survive safely and with dignity unless they receive appropriate community-based mental health services.

229. M. Hombs & M. Snyder, supra note 226, at 56.
While the “community” has undeniably failed in its responsibility to establish adequate community-based treatment resources for the mentally ill, one should not lose sight of the tremendous advances of the past twenty-five years. Community-based resources are available on an impressive scale in many communities, and mental health professionals continue to improve treatment methods for the chronically mentally ill. Much remains to be done before the deinstitutionalization movement can be termed a success, but progress continues. As the following section illustrates, however, the law may stand as an obstacle in the path of further achievement.

B. The Shortcomings of Deinstitutionalization are Exacerbated by Restrictive Involuntary Commitment Laws

During the past fifteen years, there has been a steady trend toward greater restriction of state authority to provide involuntary treatment to the mentally ill. Considerable judicial and scholarly criticism has been leveled at the parens patriae authority as a vehicle for the imposition of treatment. As a result, it is now extraordinarily difficult for the state to compel treatment except in the most extreme cases. While this outcome undoubtedly protects liberty interests, it has led to the de facto abandonment of many seriously mentally ill people. It is so difficult to provide involuntary treatment to those in need of care that thousands go without.

When the results of the deinstitutionalization movement are combined with the highly restrictive commitment statutes found in most states, the result is a crisis of serious proportions. Thousands of individuals living in the community, who are in undisputed need of treatment, are left to their own devices. Many of them are simply unable to cope with life in the community and, as a result, suffer unnecessary physical deprivation and psychological injury.

The crisis precipitated by the concurrent developments of deinstitutionalization and restrictive commitment laws is compounded by the fact that existing involuntary commitment schemes fail to address the crucial issue of community-based treatment. Current law offers a dichotomous system under which there are but two alternatives: total “freedom” from involuntary treatment, or total institutionalization in the restrictive environment of a hospital. The array of community-based mental health services is ignored by current commitment law. The system does not allow the authority charged with the involuntary treatment decision to pick the therapeutic alternative which will be

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230. See generally Rhoden, supra note 122, at 405-06.
most effective and, at the same time, least restrictive of personal liberty. The result can only be described as a major system failure; and failure that leads inevitably to tragic cases such as that of Rebecca Smith.231

While specific standards, practices, and procedures vary from state to state, a fairly uniform system for the delivery of involuntary treatment to the mentally ill is in effect throughout the country.232 This system grew and matured in the era of institutions.233 During this period, which lasted from the mid-nineteenth century until the 1960's, there was an extremely limited array of alternatives available to an authority faced with the decision whether to order involuntary treatment. The person could be involuntarily committed to an institution or left at liberty without treatment. Statutes regulating involuntary treatment were an all or nothing proposition.234 This system of involuntary commitment is understandable when viewed from an historical perspective. During most of our history there was no middle ground between institutionalization and non-interference by the state.235 As legislatures enacted statutes to govern involuntary treatment, they did so necessarily in the context of then-current theory and practice in the mental health field. Since the only form of treatment was institutionalization, involuntary commitment statutes were couched in terms of hospitalization versus freedom.

Contemporary statutory schemes for involuntary treatment of the mentally ill may thus be seen as a product of a bygone era. When viewed in the light of current knowledge and practice, the entire involuntary treatment scheme appears to be an anachronism, for the

231. Several states have enacted provisions that permit mental health authorities to release involuntarily committed patients from the hospital to less restrictive community-based treatment while they remain under court order. See, e.g., ALASKA STAT. § 47.30.200 (1979); N.M. STAT. ANN. § 43-1-21 (1979); UTAH CODE ANN. § 64-7-43 (1983 Supp.). See also Stromberg & Stone, A Model State Law on Civil Commitment of the Mentally Ill, 20 HARV. J. ON LEGIS. 275, 383-84 (1983). While such statutes are an improvement over the traditional commitment statute, they do not solve the problem because they require initial commitment to the hospital before release to less restrictive treatment can be authorized. The proposal for involuntary community-based treatment espoused in the instant article would not require initial hospitalization.

232. This article discusses both involuntary commitment and involuntary treatment. "Involuntary commitment" is limited to involuntary "commitment" to a hospital. "Involuntary treatment" is a broader concept, embracing numerous types of community-based treatments.

233. For discussion of the historical development of involuntary commitment law, see text accompanying notes 35-60 supra.

234. For discussion of typical commitment statutes allowing only commitment to hospitals, see notes 35-60 and accompanying text supra.

235. For an historical discussion of the treatment of the mentally ill, see text accompanying notes 1-34 supra.
presently available range of treatments goes well beyond institutionalization. For the law to restrict involuntary treatment to the single alternative available in the past is to ignore the array of treatments and treatment settings now available; yet, that is precisely what involuntary commitment statutes do.

Continued reliance on an outmoded involuntary treatment scheme has several harmful effects. Most significantly, patients in genuine need of treatment outside the hospital do not receive it since there is no way to afford it to them if they refuse. Thus, patients who could be maintained adequately in the community if they were to attend group therapy sessions or take prescribed medications go without essential treatment. There is no workable method under current law to require such individuals to participate in community-based therapy. At the same time, it is neither desirable, nor presently legally possible, to involuntarily commit such individuals.

Another harmful effect of current statutes is that seriously impaired individuals who could survive safely in the community with appropriate treatment are sometimes involuntarily committed because they refuse care. When voluntary treatment is refused, mental health professionals and family members are left with no alternative to institutionalization. In such situations, current statutes actually encourage commitment of individuals who may not be suitable for institutional care, seriously undercutting the doctrine of least restriction. Judges faced with such cases may stretch the commitment criteria in order to extend care to those who appear to be in serious need, but who could function adequately in less restrictive treatment settings.

The North Carolina Legislature recognized the shortcomings of the traditional involuntary commitment system, and, in 1983, enacted a statute authorizing involuntary commitment to outpatient treatment. The North Carolina commitment scheme, which became effective on January 1, 1984, sets a standard for other states to emulate.


237. The North Carolina Division of Mental Health/Mental Retardation and Substance Abuse Services has been studying the issue of involuntary treatment in the community for several years. Division officials came to the conclusion that it is essential to provide involuntary treatment in the community as well as in the hospital. Authorization of community-based treatment should help break the cycle of periodic rehospitalization that so frequently occurs with the chronically mentally ill. Telephone interview with Ms. Angie McMillan, Special Assistant in the North Carolina Division of Mental Health/Mental Retardation and Substance Abuse Services.
V. ALTERNATIVES FOR CHANGE IN THE SYSTEM OF INVOLUNTARY TREATMENT OF THE MENTALLY ILL

When the shortcomings of the deinstitutionalization movement are combined with the exceedingly strict standards of the current generation of involuntary commitment statutes, the result is a critical failure to provide essential mental health services to a large and growing number of seriously impaired people. In light of this failure, it is necessary to determine whether anything can be done to remedy the situation. There are at least five alternative solutions: (1) abolish involuntary treatment of any kind; (2) attempt to fine-tune the present system; (3) utilize guardianship law to appoint guardians empowered to authorize treatment on behalf of incapacitated individuals; (4) employ adult protective service statutes to afford treatment to those at risk; or (5) create a system of involuntary treatment for persons incapable of rational decisionmaking which would require treatment in the least restrictive setting, and which would permit hospitalization only as a last resort.

Division of Mental Health/Mental Retardation and Substance Abuse Services (Apr. 13, 1984).

The North Carolina Commitment statute defines outpatient treatment as follows:

"Outpatient treatment" may include medication; individual or group therapy; day or partial day programming; services and training including educational and vocational activities; supervision of living arrangements; and any other services prescribed to either alleviate the person's illness or disability, to maintain semi-independent functioning, or to prevent further deterioration that may reasonably be predicted to result in the need for inpatient commitment to a mental health facility.

N.C. GEN. STAT. § 122-58.2(8) (1983 Cum. Supp.). Involuntary outpatient treatment may be ordered if the following criteria are satisfied:

a. The respondent is mentally ill, and
b. The respondent is capable of surviving safely in the community with available supervision from family, friends or others, and
c. Based on the respondent's treatment history, the respondent is in need of treatment in order to prevent further disability or deterioration which would predictably result in dangerousness . . . , and
d. His current mental status or the nature of his illness limits or negates his ability to make an informed decision to voluntarily seek or comply with recommended treatment.

Id. § 122-58.4(c)(2). These criteria may permit involuntary treatment in circumstances where it would not be available under the proposal espoused in the instant article. North Carolina permits intervention where rational decisionmaking capacity is limited or negated, whereas my proposal allows it only in the latter case. See notes 293-94 and accompanying text infra.

The North Carolina statute sets forth detailed procedures to be followed in involuntary community-based treatment cases. It also creates mechanisms for periodic review of treatment orders.
A. Abolition of Involuntary Treatment

Several able authorities, among them Doctor Thomas Szasz, have advocated abolition of involuntary treatment. The arguments of these scholars are well documented elsewhere, and will not be reviewed at length. It is sufficient to say that the abolitionists combine a basic preference for liberty with a pervasive distrust of psychiatry's ability and will to limit treatment to those who are unquestionably in need. Professor Morse summarized many of the arguments with these words:

"In sum, for a variety of reasons—the desire to control deviance, difficulties in the proper definition and diagnosis of mental disorder, vagueness of commitment standards, difficulties in accurately predicting future behavior, and procedural laxity—the involuntary civil commitment system will produce unacceptably high numbers of improper commitments and thus will continue to function as an unjust system."

Although the abolitionists' arguments are appealing at first blush, they must be rejected for at least two reasons. The first is pragmatic. While the mere existence of a system can never be sufficient justification for its continued use, it cannot be ignored that the system of involuntary commitment is operating in one form or another in every state. The overwhelming majority of mental health professionals believe that the system, while far from perfect, is performing a useful, beneficent, and necessary function in society.

The second reason is premised on a fundamental disagreement.


239. See, e.g., Rhoden, supra note 122, at 404-06.

240. See id.


242. See Caton, Effect of Length of Inpatient Treatment for Chronic Schizophrenia, 139 AM. J. PSYCHIATRY 856 (1982). Caton argues that the need for hospitalization has not been eliminated by the growth of community services. Even in effective community-based treatment programs, the rate of rehospitalization is as high as 60%. Id. at 856. See also Chodoff, The Case for Involuntary Hospitalization of the Mentally Ill, 133 AM. J. PSYCHIATRY 496 (1976); LaFond, supra note 58; Rachlin, supra note 176, at 43-44; Roth, A Commitment Law for Patients, Doctors, and Lawyers, 136 AM. J. PSYCHIATRY 1121 (1979).
with the abolitionists. A convincing argument can be advanced that mental illness does in fact exist, that it can rob its victims of the power of rational decisionmaking, that individuals so affected simply will not and cannot protect their own best interests, and that as a humane society we have an obligation—medical, legal, and moral—to treat such individuals, even against their will. If this is accepted as true, it follows that some form of involuntary treatment is necessary until the day arrives when mental illness is eliminated.

B. Fine Tuning the Present System

The present system of involuntary commitment is tied to hospitalization. It does not embrace the full panoply of therapeutic alternatives currently available. In this respect, the present system is outmoded and unresponsive to the needs of patients. Rather than adhere tenaciously to a system whose time has passed, society should move forward to a more flexible scheme that reflects current concepts of mental illness and available treatment alternatives.

C. Guardianship Law

The law of guardianship has evolved to provide for the appointment of substitute decisionmakers when the personal or financial interests of incapacitated individuals require protection. It can be argued that since most state statutes allow a guardian to consent to ordinary medical care on behalf of a ward, the guardian also should be entrusted to decide whether to submit the ward to mental

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243. For arguments against these propositions, see Morse, supra note 51, at 64-65.

244. Rhoden responds to the abolitionists by pointing out that they underestimate the suffering which results from a lack of proper treatment. He states that there are times when lawyers may have overemphasized liberty, and consequently ignored the needs of severely ill patients unable to recognize their need for treatment. ... Opponents of all involuntary commitment would do well to ask themselves whether the emphasis on liberty does not sometimes lead to unacceptably great sacrifice of health, safety, and well being. Rhoden, supra note 122, at 405-06.

As early as 1750, Benjamin Franklin described the quality of life of many mentally ill individuals who were too ill to seek treatment voluntarily: "[F]ew or none of them are so sensible of their Condition, as to submit voluntarily to the treatment that their respective Cases requires and therefore continue in the same deplorable state during their Lives. . . ." A. Deutsch, supra note 6, at 59 (quoting Franklin's petition to the provincial assembly for a hospital).


246. The Uniform Probate Code provides that "a guardian of an incapacitated person is responsible for care, custody, and control of the ward. . . . [Such] guardian has the same duties, powers and responsibilities as a guardian for a minor." UNIF. PROB. CODE § 5-309, 8 U.L.A. 471 (1983). Section 5-309(c) provides in part:
health treatment. Since most guardians are close family members and presumably have the patient's best interest in mind, they should be in a position to make correct and responsible decisions.

There are, however, several reasons why the law of guardianship is poorly suited to the purpose of providing involuntary treatment to the mentally ill. Guardians do not necessarily possess the desire or the ability to balance the intrusion of treatment against the liberty interests of the individual. In the typical case, the guardian will be the very individual seeking to impose treatment. Therefore, he or she lacks the disinterested objectivity of a judge, who can more fairly weigh the competing interests. The fact that family members frequently serve as guardians militates against affording them the authority to require treatment, for individuals so close to the situation, and with such a personal stake in the outcome, can hardly be expected to pay proper deference to the wishes of the proposed patient.

Sometimes a close family member is not available to serve as guardian, and a distant relative or agent of the state may be appointed. In such cases there is no assurance that the guardian will have the well-being of the ward in mind when making decisions. The decision to impose treatment could turn on the level to which the guardian finds him or herself out of patience with, or inconvenienced by, the ward.

As a practical matter, a guardian would not be able to implement a substituted decision regarding treatment if the ward refused to participate. The guardian would probably have to seek the assistance of the civil commitment system to effectuate treatment. For the foregoing reasons, the law of guardianship does not offer a useful tool to provide involuntary community-based treatment to the mentally ill.

“A guardian may . . . consent to medical or other professional care, treatment, or advice for the ward.” Id. § 5-209(c)(4), 8 U.L.A. at 452-53.

247. See Rhoden, The Right to Refuse Psychotropic Drugs, 15 HARV. C.R.-C.L. L. REV. 363, 402-06 (1980). On the issue of sterilization of the mentally disabled, courts and legislatures have recognized the conflict of interest faced by guardians, and have determined that the decision whether to authorize sterilization must be made by a court, not a guardian. See, e.g., ME. REV. STAT. ANN. tit. 34 §§ 2471-2487 (Supp. 1982-83); UTAH CODE ANN. §§ 64-10-1 to -16 (Supp. 1983); In re Grady, 85 N.J. 235, 426 A.2d 467 (1981); In re A.W., 202 Colo. 263, 637 P.2d 366 (1981).

248. Family members are sometimes indifferent to the fate of a mentally ill relative. See Homeless in America, supra note 216, at 23 (a woman found living on the streets in Philadelphia just a block from her daughter's apartment).

D. Adult Protective Services Statutes

Over the past ten years, a movement toward enactment of adult protective service statutes (APS) has emerged. More than half the states have adopted some form of APS statute. Legislative action grew out of an awareness that thousands of disabled and older adults are the victims of abuse, neglect, and exploitation at the hands of family members, "friends," and caretakers. In some respects, the APS statutes are modeled after the child protective service and child abuse reporting statutes that swept the country during the 1960's. Of the legal mechanisms currently available, APS statutes offer the best hope of providing necessary treatment for the mentally ill.

Although APS statutes vary significantly from state to state, all are designed to protect a class of adults incapable of protecting themselves from abuse, neglect, or exploitation. The statutes express a preference for voluntary protective services, and stress service in the least restrictive environment consistent with individual liberty and freedom of choice. Many of the APS statutes contain provi-

250. See Horstman, supra note 92.


252. See, e.g., ME. Rev. Stat. Ann. tit. 22, § 3471 (Supp. 1983-84). The legislature observed that "many adult citizens of the State, because of incapacitation, are unable to manage their own affairs or to protect themselves from abuse, neglect, exploitation or physical danger." Id.

253. See generally ABA, Protecting Children Through the Legal System (1981).

254. Most of the statutes permit intervention only when an incapacitated person becomes the victim of abuse, neglect, or exploitation. See, e.g., LA. Rev. Stat. Ann. § 14:403.2 (West Supp. 1984) (purpose of statute is to protect incapacitated adults who are adversely affected by abuse or neglect).

255. See, e.g., ME. Rev. Stat. Ann. tit. 22, §§ 3481-3482 (Supp. 1983-84). Under the Maine statute, consent of the abused adult is sought in the first instance. If consent is not obtained, protective services are not rendered unless it can be shown that the adult "lacks capacity to consent." Id.

sions for emergency services. Under some, services can be provided involuntarily on court order. Many require use of existing guardianship provisions when involuntary services become necessary. Nearly all APS statutes require that persons who know or suspect instances of abuse, neglect, or exploitation report them to designated law enforcement or social services officials.

The APS statutes define the range of protective services quite broadly. The Wisconsin statute, for example, lists the following as protective services: outreach, counseling and referral for services, provision of case management services, legal counseling or referral, guardianship referral, and diagnostic evaluation. The Wisconsin statute also lists protective placement as one of the available services. Many statutes do not articulate a list of services, leaving to professional judgment the determination of what is essential to protect the individual at risk.

Almost without exception, the primary purpose of the APS statutes is to remove incapacitated adults from situations involving physical or mental abuse, neglect, or exploitation of resources. To the extent the statutes are limited to these purposes, they are not satisfactory as a device to provide therapeutic services to the mentally ill. While it is certainly true that the APS model will be useful in many instances to protect the mentally disabled, involuntary treatment may be necessary in cases involving none of the APS triggering events. Furthermore, statutes which require appointment of a guardian must be rejected for the reasons outlined above. Finally, the APS statutes were not enacted to address the problem under discussion. Their provisions and procedures are not responsive to the special needs of the mentally ill. While some of the statutes could be amended to incorporate appropriate standards and procedures, the


258. See, e.g., DEL. CODE ANN. tit. 31, § 3906 (Supp. 1982).
259. See, e.g., COLO. REV. STAT. § 26-3-107 (1982).
262. Id. § 55.06.
263. Two states' APS statutes provide that they may not be used to commit an individual to a mental hospital involuntarily. See N.H. REV. STAT. ANN. § 161-D:2 (Supp. 1981); N.C. GEN. STAT. § 108A-105(c) (Supp. 1981).
264. Some APS statutes contain excellent standards for determining the competence or mental capacity of the mentally ill individual. Others provide no standards or poorly drafted standards. Compare KY. REV. STAT. §§ 209.010-150 (Supp. 1980) (no standards given) with WIS. STAT. ANN. §§ 55.01, 55.06(2)(c) (West Supp. 1983-84) (incapacitated persons include those suffering from developmental disabilities,
wiser course is to leave the APS statutes as they are, and address the problem of involuntary treatment squarely in the context of a distinct body of involuntary commitment law.

E. A Proposal for Alteration of the System of Involuntary Civil Commitment

1. Overview of the Proposal

The present system of involuntary commitment is seriously defective because it fails to address the need for community-based involuntary treatment for some mentally ill individuals. Thousands of seriously ill people who previously would have been hospitalized are now living in the community. Many are involved in treatment on their own accord. Others are capable of community living without treatment. Still others may need treatment, but in the exercise of rational judgment choose to forgo it. The proposal which follows is not intended to apply to these groups of individuals. Respect for autonomy mandates that those capable of rational decisionmaking be allowed to choose their own course. They must be permitted to accept or reject therapy as they desire.

The alternative proposed below focuses on the group of mentally ill persons who, because of their mental illness, lack or have lost the intellectual capacity to engage in a rational decisionmaking process regarding whether to accept mental health treatment. Under the infirmities of aging, chronic mental illness who are "so totally incapable of providing for [their] own care or custody as to create a substantial risk of serious harm to [themselves] or others").

265. For a discussion of the need to preserve freedom of choice for the rational mentally ill, see Developments, supra note 61, at 1212-14. See also Stromberg & Stone, A Model State Law on Civil Commitment of the Mentally Ill, 20 HARV. J. ON LEGIS. 276 (1983). The Stromberg & Stone article sets forth and comments on a model commitment statute. The statute, which was the result of extensive drafting and research, was approved in 1982 by the American Psychiatric Association. Id. at 279. It authorizes commitment under both parens patriae and police power rationales, and establishes extensive procedural and substantive safeguards against unwarranted commitment.

The APA model statute is an excellent effort to provide workable guidelines for involuntary treatment of the mentally ill. It is respectfully submitted, however, that the model does not satisfactorily address the problem of community-based involuntary treatment. The model continues the traditional adherence to hospitalization as the principle method for provision of involuntary treatment. The model makes provision for conditional release from the hospital to outpatient treatment. Id. at 383-84. However, its primary focus remains on hospitalization. The proposal espoused in the instant article, on the other hand, authorizes commitment to a broader range of treatment alternatives. See text accompanying notes 268-71 infra. Commitment to a hospital would be permitted only if less restrictive alternatives would not be therapeutically effective.

266. For discussion of the requirement of incompetence to decide whether to
proposal, a finding of incapacity is a condition precedent to involuntary treatment. Furthermore, treatment can only be ordered when the individual’s living conditions constitute a present danger to his or her psychological or physical well-being. Finally, treatment must be provided in the setting that will be effective from a clinical standpoint, but least restrictive of personal liberty. Thus, involuntary treatment will be provided in the community if at all possible. Com-

accept treatment, see Stromberg & Stone, supra note 265, at 301-02. Under the APA model statute, a proposed patient must lack capacity to make an informed decision concerning treatment. The statute defines the capacity as follows:

[T]he person by reason of his mental disorder or condition, is unable, despite conscientious efforts at explanation, to understand basically the nature and effects of hospitalization or treatment or is unable to engage in a rational decisionmaking process regarding such hospitalization or treatment, as evidenced by inability to weigh the possible risks and benefits.

Id. at 301. The authors offer the following commentary on the standard:

Before assessing a patient’s capacity or lack thereof, the treatment team must conscientiously try to explain the nature and effects of the proposed hospitalization or treatment to the patient. When appropriate, the treatment staff may enlist the aid of a patient’s family, friends, clergy, or others. A person lacks capacity if, due to his mental disorder or condition, he cannot understand the basic nature and effects of the proposed hospitalization or treatment. A person does not lack capacity simply because he refuses treatment, which he might do, for example, because he is a Christian Scientist or is risk-averse (being excessively so in the physician’s opinion). The Model Law makes lack of “capacity to make an informed decision concerning treatment” a specific criterion for involuntary commitment. Where the issue of capacity arises in a commitment proceeding, the court makes the determination. Understanding requires a fundamental appreciation of those aspects of the proposed treatment that a reasonable person would find significant in decisionmaking. A patient need not understand every technical feature of a proposed therapy.

Even if an individual can understand the nature and effects of treatment, he lacks capacity if, due to his mental disorder or condition, he cannot engage in any rational decisionmaking process because, for example, he is unable to weigh the risks and benefits of the proposed therapy. The definition requires inability to engage in any rational process, not simply the one that the physician or court would employ. Rational modes of thinking may be unusual, eccentric, or even inconsistently related to reality. A patient’s phobia, for example, might distort his apprehension or appreciation of particular facts without impairing his ability to reason concerning other facts or decisions. Another patient’s delusions, however, might broadly impair his ability to reason. An individual afflicted with a severe mental disorder may be unable to pay attention to and assimilate information, or his disorganized thoughts may preclude him from engaging in anything resembling a rational process. Only this type of patient lacks capacity under the Model Law.

Id. at 301-02 (footnotes omitted). See also Colyar v. Third Judicial Dist. Court, 469 F. Supp. 424, 429-32 (D. Utah 1979); A. Stone, Mental Health and Law: A System in Transition 66-69 (1975); LaFond, supra note 58, at 504-06; Developments, supra note 61, at 1212-19.

267. See Developments, supra note 61, at 1212-19 (a finding of incapacity should be a “threshold requirement” for treatment).
mitment to the restrictive environment of a hospital will only be used if less restrictive alternatives would be ineffective.

To conceptualize the proposed involuntary treatment scheme, it is helpful to picture a continuum, with treatment modalities arrayed along a line from the least to the most restrictive. The continuum is not rigid. No particular therapeutic intervention is affixed inexorably to a specific position. Rather, certain forms of therapy will be more or less restrictive depending upon the patient involved.268 Despite the flexibility of the continuum, it is possible to array some of the currently available therapeutic techniques along its trajectory.269 Close to the least restrictive end of the continuum are outreach and crisis intervention services available on the basis of individual need. Slightly further in the direction of restriction is outpatient psychotherapy. The antipsychotic and other medications can be found at all points along the continuum, but are placed near the center for purposes of illustration. Further along the continuum are community-based day-hospital services and partial hospitalization. Next comes short-term residence in a small, unlocked, residential treatment facility. At a position approaching the restrictive end of the continuum is hospitalization. Near the end is electro-shock therapy. Finally, at a point completely off the scale, is psychosurgery.

A system of involuntary treatment which is to be effective in caring for patients must embrace the entire continuum of available treatments. As advances are made in the treatment of mental illness, they should be incorporated into the system as promptly as they are accepted by practicing professionals. The principal shortcoming of the present involuntary commitment system is that it ignores options along the continuum save for hospitalization—one of the most restrictive alternatives.

The essential need to incorporate the full continuum of treatment modalities into the system of involuntary treatment leads to the proposal espoused in this section. Simply stated, the entire treatment continuum should be available to the state authority responsible for


269. Id. Doctor Talbott is a leading authority on deinstitutionalization. In his remarks before the Subcommittee, he discussed community-based living arrangements for the mentally ill. As an appendix to his testimony, he attached a figure demonstrating the spectrum of optimal treatment services and living situations. The figure is reproduced below to assist in illustrating the concept of an array of treatment alternatives:
deciding whether to require treatment. To be responsive to the unique needs of each individual, the court would impose the degree

Id. at 167, Figure 2.

270. Nothing in existing law precludes implementation of a system of involuntary treatment along the lines proposed in this article. See R. Rock, M. Jacobson & R. Janopaul, Hospitalization and Discharge of the Mentally Ill. (1968). The authors state:

It is a significant fact that American law concerning treatment of the mentally ill implicitly—and in many jurisdictions explicitly—links mental illness with hospitalization. The notion of compulsory non-institutional treatment for mental illness is legally inchoate in this country, although there is nothing in our legal traditions that makes it obnoxious. In current practice the legal processes for identifying and dealing with those who re-
of treatment which would be (1) effective in returning the individual to a mental state in which he or she possesses the capacity to engage in rational decisionmaking regarding whether to accept treatment, and (2) least restrictive of personal liberty. To accomplish these goals, the treatment of choice is the therapeutic intervention, or combination of interventions, that will satisfy both requirements. The task of the court is to move along the continuum, beginning at the point of least restriction, until the appropriate intervention is reached. Once the least restrictive, effective therapy is isolated, it is ordered. Anything less restrictive would be ineffective. More restrictive treatment would be unnecessary and violative of the constitutional principle of less drastic means.

It can be argued that it is unrealistic to build a commitment system on the principle that treatment alternatives are measurable in normalizing the intervention of mental treatment are legal processes that look to hospitalization.

Id. at 2.

271. Some individuals are so seriously and permanently disabled that no amount of treatment will permit them to engage in rational decisionmaking. For such individuals, long-term custodial care is sometimes necessary. Others can live in the community so long as they are financially and therapeutically supported. For patients in need of custodial care, the conditions of care must be humane, safe and pleasant. Treatment must be provided to maintain skill levels possessed by such patients. Care should be provided with the least restriction of liberty and autonomy that is consistent with safety.

272. For a discussion of the principle of least restrictive alternatives, see text accompanying notes 207-13 supra.

In a recent article, three leading experts in mental health law cast doubt on the utility of least restrictive alternative analysis in the context of involuntary treatment. See Gutheil, Appelbaum & Wexler, The Inappropriateness of “Least Restrictive Alternative” Analysis for Involuntary Procedures With the Institutionalized Mentally Ill, 11 J. PSYCHIATRY & L. 7 (1983). The authors point out that a continuum of restriction cannot be rigid. They state as follows:

It seems likely that treatments are more or less restrictive according to the needs of the patient for whom they are employed: an unnecessary treatment is always highly restrictive, but the restrictiveness of an indicated modality varies with the degree of freedom it is likely to restore to the patient who receives it. It is difficult to imagine how restrictiveness can be judged except on a case-by-case basis.

Id. at 12 (emphasis in original). The instant proposal is consistent with the teachings of Professors Gutheil, Appelbaum, and Wexler, since it requires the judge to base a decision ordering involuntary treatment on the unique facts of the case and the particular treatment needs of the patient. Reaching appropriate individualized decisions that are consistent with the principle of least restriction will not be a simple matter; however, it can be done. For an opinion questioning this proposition, see Stromberg & Stone, supra note 265, at 292. See also Hoffman & Foust, Least Restrictive Treatment of the Mentally Ill: A Doctrine in Search of Its Senses, 14 SAN DIEGO L. REV. 1100, 1103-04 (1977); McGraw & Keilitz, The Least Restrictive Alternative Doctrine in Los Angeles County Civic Commitment, 6 WHITTIER L. REV. 35 (1984).

273. See notes 207-13 supra.
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terms of restrictiveness. Inappropriate restriction for one individual is therapeutic for another. Most would agree, however, that the level of restriction necessary for effective intervention is ascertainable in individual cases. So long as the system eschews creation of a rigid continuum of restrictiveness, and instead embraces a flexible approach designed to assess the treatment needs of individual patients, it should be possible to reach correct results that will comport with both therapeutic goals and constitutional mandates.

There are important advantages to the proposed system of involuntary treatment. The proposal comports with the present reality of mental health treatment. The day is past when the only alternative was institutionalization. The proposal would replace the old system with one which is flexible and contemporary. Another obvious advantage is that the mentally ill would be afforded necessary treatment in the setting least restrictive of their personal liberty.

Adoption of an involuntary treatment system along the lines suggested should reduce the need for hospitalization. In the past, patients were often subject to prolonged hospitalization, sometimes for

274. See Stromberg & Stone, supra note 265, at 291-94, 330-88. Stromberg and Stone argue that it is neither therapeutically beneficial to the patient nor analytically useful to the court to create a rigid, "hierarchical array of less-to-more restrictive facilities" and mechanically pigeonhole patients into the least restrictive placement. Id. at 291. Restrictiveness is only half the equation; the other half is the therapeutic effectiveness of the treatment. They point out that it may be less constraining for a patient to participate for thirty days in an effective therapeutic program in a "restrictive" institution than to be treated for a year in a less effective "community" program. The reverse also may be true. The point is that there is probably "no relationship between restrictiveness and [treatment] effectiveness, let alone a stable or singular one." What is or is not in the patient's interests cannot be measured on a simplistic scale of restrictiveness.

Id. at 292.

While a system of involuntary treatment cannot focus solely on the level of restriction of liberty in making treatment choices, neither can it ignore this important factor. The key to a responsive commitment system is an amalgamation of the twin requirements of therapeutic effectiveness and least restriction. If two treatment settings are equally effective in returning a patient to appropriate functioning, and one is more restrictive of personal liberty than the other, then principles of medicine, psychology, and law dictate choice of the less restrictive. The proposal set forth in this article requires simultaneous consideration of these two crucial factors. The task of the court, aided by expert testimony, is to choose the therapeutic alternative that is effective and, at the same time, least restrictive of liberty and autonomy. To do so, the court draws from the entire continuum of currently available treatments. Unlike most contemporary commitment statutes which limit the court to hospitalization, the proposal expands the array of choices and creates much more flexibility for creative consideration of both restrictiveness and effectiveness. Level of restriction is not accorded "talismatic legal significance" but it is not ignored either.

275. See Gutheil, Appelbaum & Wexler, supra note 272, at 12.
276. Id.
many years. As a result of the deinstitutionalization movement, the number of long-term hospital residents decreased. Despite the overall decline in the number of hospitalized patients, however, the aggregate number of hospital admissions increased. This phenomenon can be accounted for in part by the fact that a large number of chronically-ill individuals experience periodic exacerbation of their symptoms. When decompensation occurs, hospitalization is sometimes necessary. The cycle of re-hospitalization has prompted some authors to describe these individuals as “revolving door” patients. While the factors leading to decompensation and hospitalization vary, the cycle often begins when the individual drops out of therapy or discontinues taking medication. Under the current scheme of involuntary commitment, there is no way to require the decompensating, hospital-bound patient to resume or participate in the community-based therapy that could break the cycle and restore him or her to satisfactory functioning. Presently, nothing can be done

278. See text accompanying note 139 supra.
279. For a discussion of this statistical phenomenon, see text accompanying notes 148-49 supra.
280. For a discussion of rehospitalization, see note 150 supra.
281. DeRisi & Vega, The Impact of Deinstitutionalization on California’s State Hospital Population, 34 Hosp. & Community Psychiatry 140, 144 (1983). One author states:

A major impact of de-institutionalization on the mental health system concerns the phenomenon of readmission. While the residual chronic population of state facilities decreased, total admissions continued to rise (until 1972) largely as a result of the increasing number of readmissions. This phenomenon—more patients spending less time per episode in a hospital but entering the hospital a greater number of times—is what the author has described elsewhere as the “revolving door.” Readmissions, which in 1969 had accounted for 47 percent of those entering state hospitals, by 1972 constituted 54 percent of all admissions. In some states the figures rose from 43 percent in 1963 to 70 percent in 1974. In some areas, such as New York City, many professionals doubt whether any patient can be provided prompt, effective and efficient psychiatric treatment if he or she is treated by different facilities for either each particular episode of illness or for separate episodes.

J. Talbott, supra note 8, at 39.

Rhoden states that

[p]atients released to the community frequently fall victim to the “revolving door” syndrome, moving to dilapidated hotels or residences, relapsing, and then being rehospitalized, only to begin the cycle over again. Although such patients spend fewer total days in hospitals, they may account for many more admissions and readmissions. Thus the chronically ill patient often moves from one inadequate environment to the next, the net result being that what has been achieved is not deinstitutionalization but “trans-institutionalization” with the patient’s locus of living and care transferred “from a single lousy institution to multiple wretched ones.”

Rhoden, supra note 122, at 390-91 (footnotes omitted).
until the individual has decompensated to the point at which strict statutory criteria for hospitalization are met. At that point the patient can be hospitalized, resulting in disruption of the patient's life due to loss of employment, strain on interpersonal relationships, and a sense of failure and regression. Under the proposed treatment system, a different result would obtain. If the patient lacked the capacity to rationally decide whether to accept treatment needed to forestall hospitalization, appropriate intervention could be ordered in time to maintain the individual at a level of functioning which would, in many cases, keep him or her in the community. This result would be beneficial in many respects. Most important would be its great value to the individual, enabling him or her to continue working toward greater stability and success in the community. If the proposal were to accomplish nothing more than breaking the tragic cycle of re-hospitalization for a substantial number of chronically mentally ill individuals, then its implementation would be worthwhile.

Development in the law often lags behind social change. Deinstitutionalization and advances in the treatment of mental illness have rendered the current scheme of involuntary commitment outmoded and anachronistic. The system ignores reality and fails to meet the needs of the mentally ill. While it is not yet possible to abandon hospitalization as one form of involuntary treatment, neither is it wise or humane to ignore less restrictive forms of treatment. Adoption of the proposed system for involuntary treatment should lead to creative restructuring of current law. Such restructuring promises to have a positive effect on the lives of the mentally ill.

2. Operational Aspects of the Proposed System of Involuntary Treatment

a. Procedural safeguards

The proposed system for involuntary treatment could be integrated into the present scheme with relative ease. None of the procedural due process protections required by Lessard v. Schmidt and other authorities would be abandoned. Indeed, such protections would become more important because the state would be intervening in people's lives under circumstances where it cannot now do so. The potential for abuse inherent in any system of involuntary treatment requires strict adherence to the full panoply of procedural safeguards articulated by the authorities.


283. For a discussion of Lessard v. Schmidt, see notes 52-56 and accompanying text supra.
b. Judicial supervision of the system

Some writers take the position that decisions regarding involuntary treatment should be removed from the courts and turned over to administrative bodies or mental health professionals. In Parham v. J.R., the Supreme Court seemed to move in this direction by holding that a minor may be involuntarily hospitalized by his or her parents without formal legal proceedings. The Court reasoned that while due process requires the admitting psychiatrist to adhere to certain procedures, the law does not mandate an adversarial proceeding with judicial supervision.

Although it is true that "neither judges nor administrative hearing officers are better qualified than psychiatrists to render psychiatric judgments," since an individual's freedom of choice and liberty are at stake, it is essential that judges remain the decisionmakers for adults. Experience teaches that the delicate balance between state and individual interests can be accomplished best in the context of adversarial proceedings in which a judge retains decisionmaking authority. This is especially important under the proposed system, which will permit intervention earlier than is presently the case.

c. Intervention is permitted only after efforts to secure voluntary participation fail

Under the proposal, the state would be required to make a good faith effort to involve the individual in voluntary treatment before proceedings for involuntary care could be commenced. If these efforts failed, and the state commenced involuntary treatment proceedings, it would be required to demonstrate by clear and convincing evidence that it had made the required effort.

284. See Textbook of Psychiatry, supra note 6, at 369.
286. Id. at 606-07. The Court required a neutral factfinder to ascertain whether the statutory standards for institutionalization were met by "carefully prob[ing] the child's background." Id. The Court required the factfinder to interview the child. Id.
287. Id. at 607-12. The Court stated that the states were free to require formal hearings, but that "due process is not violated by use of informal, traditional medical investigative techniques." Id. at 607.
288. Id. at 607 (quoting In re Roger S., 19 Cal. 3d 921, 942, 569 P.2d 1286, 1299 (1977) (Clark, J., dissenting)).
d. Involuntary treatment may be ordered only when an individual is likely to cause harm to him or herself, or suffer substantial mental or physical deterioration.

Critics of the proposed system of involuntary treatment will focus attention on the potential for abuse inherent in any scheme that legitimizes interference in the lives of others. They will argue—and not without merit—that well-intentioned mental health professionals will use the system to impose treatment on individuals capable of choosing to forego it. Their concerns bring to mind the words of Justice Louis D. Brandeis:

> Experience should teach us to be most on our guard to protect liberty when the government's purposes are beneficent. . . . The greatest dangers to liberty lurk in insidious encroachments by men of zeal, well-meaning but without understanding.\(^{289}\)

It must be admitted that the proposal risks unwarranted state interference. It will no doubt occur. However, it is submitted that this risk is far outweighed by the benefits of an involuntary treatment system responsive to the needs of the mentally ill. To reduce the potential for benevolent misuse of the involuntary treatment system, intervention would be permitted only where the mentally ill individual lacks rational decisionmaking capacity, and where this incapacity poses a clear threat to his or her psychological or physical well-being. Substance can be added to this requirement, by adoption of the definition of harm employed in the American Psychiatric Association's *Model State Law on Civil Commitment of the Mentally Ill*.\(^ {290}\) Under the model statute, one of the criteria for involuntary commitment inquires whether the individual is likely to cause harm to him or herself or suffer substantial mental or physical deterioration. Commitment may be appropriate if

> the person (1) is likely in the near future to inflict substantial physical injury upon himself, or (2) is substantially unable to provide for some of his basic needs such as food, clothing, shelter, health, or safety, or (3) will if not treated suffer or continue to suffer severe and abnormal mental, emotional, or physical distress, and this distress is associated

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\(^{289}\) Olmstead v. United States, 277 U.S. 438, 479 (1928) (Brandeis, J. dissenting). The point has also been stated as follows: "It is no less possible to do injustice to a person when undertaking to act on his behalf than when acting against him on behalf of others." R. Rock, *supra* note 270, at 7.

\(^{290}\) See Stromberg & Stone, *supra* note 265.
with significant impairment of judgment, reason, or behavior causing a substantial deterioration of his previous ability to function on his own. 291

Under the proposed treatment system, mental illness alone would not constitute sufficient ground for intervention. This is consistent with the Supreme Court's observation in *O'Connor v. Donaldson* 292 that "the mere presence of mental illness does not disqualify a person from preferring his home to the comforts of an institution." 293 Furthermore, mental illness in combination with need for treatment would not be sufficient to trigger intervention. Finally, mental illness plus need for treatment plus lack of rational decisionmaking power would not suffice. Only when these three factors are present in combination with the required level of threatened harm would intervention be permitted. The requirement of threatened harm should reduce inappropriate intervention to acceptable levels.

e. Lack of rational decisionmaking capacity

The proposed system of involuntary treatment is based on the state's *parens patriae* authority to care for individuals unable to care for themselves. In the context of mental illness, imposition of treatment under the *parens patriae* rationale is appropriate only when an individual lacks the intellectual capacity to rationally decide whether to accept treatment. 294 Respect for autonomy and freedom of choice require that individuals capable of rational decisionmaking be permitted to accept or reject therapy as they see fit. The determination of capacity is central to the entire concept of *parens patriae* involuntary treatment. Therefore, the determination of this crucial issue must always precede the imposition of treatment. In order to comport with principles of due process of law, the decision regarding capacity should be a formal, judicial determination based on admissible evidence presented in the context of an adversarial proceeding. The burden of proof must rest squarely on the state to prove incapacity by clear and convincing evidence. 295

291. *Id.* at 302-03.
293. *Id.* at 575. The Court stated that "[a] finding of 'mental illness' alone cannot justify a State's locking up a person against his will and keeping him indefinitely in simple custodial confinement." *Id.*
294. For an overview of this aspect of the proposal, see notes 265-67 and accompanying text *supra*.
295. For an application of this aspect of the proposal, see Addington v. Texas, 441 U.S. 418 (1979) (a showing of incapacity by "clear, unequivocal and convincing" evidence satisfies due process).
The danger of benevolent paternalism

Critics of involuntary treatment of the mentally ill are quick to point out the danger that benevolent paternalism may run roughshod over individual liberty. They cite examples in which personal rights have been inappropriately sacrificed to paternalistic intervention. These critics will argue that the changes proposed here will open the door to further paternalistic intervention into the lives of the mentally ill.

Critics raising the spectre of benevolent paternalism and social control often fortify their position by relying on John Stuart Mill's *On Liberty*. Professor Feinberg describes the "central thesis" of *On Liberty* to be

that the fully voluntary choice or consent of a mature and rational human being concerning matters that affect only his own interests is such a precious thing that no one else (and certainly not the state) has a right to interfere with it simply for the person's "own good." Note the word "rational" in the quotation. Most philosophers agree that there are occasions when paternalism is warranted—for example, paternalistic intervention on behalf of mentally ill individuals incapable of "rational" decisionmaking. Professor Dworkin restates the proposition in different words when he writes that "Mill intends his principles to be applicable only to mature individuals." In his book, *A Theory of Justice*, Professor Rawls states the point as follows:

296. See, e.g., Morse, supra note 51.

297. Some may argue that this proposal opens not only a door to paternalistic intervention, but a Pandora's box from which will emerge the ugly head of excessive government control. To this I respond that the fact of unwarranted intervention in some instances does not justify abandonment of the mentally ill. To quote Justice Musmanno, "I would rather see the opening of a Pandora's box than the closing of a coffin over an elementary principle of Justice." Knaub v. Gotwalt, 422 Pa. 267, 220 A.2d 650 (1966) (Musmanno, J., dissenting). The combined failings of strict commitment statutes and deinstitutionalization deny basic equality and justice to thousands of the most seriously mentally ill. While the proposal espoused in this article is far from perfect, it goes some distance toward rectifying this gross injustice.


If mental disturbance causes individuals to be unable to "rationally advance their interests . . . [o]thers [are] authorized and sometimes required to act on [their] behalf and to do what [they] would do for [themselves] if [they] were rational, this authorization coming into effect only when [they] cannot look after [their] own good."302

The proposed system of involuntary treatment is consistent with the predominant view that paternalism is sometimes called for on behalf of individuals lacking rational decisionmaking capacity. Unwarranted intervention will be avoided by strict adherence to the procedural and substantive safeguards built into the system. These requirements are supportive of the position that "paternalism should be allowed only when the impairment is likely to have undesirable consequences for the agent."303 The undesirable consequences which befall thousands of the seriously mentally ill are undeniable; there-

302. Id. at 249.
303. Hodson, The Principle of Paternalism, 14 AM. PHI. Q. 61 (1977). Professor Hodson begins his article by specifying some of the cases about which there seems to be agreement that paternalistic intervention can be justified. Id. at 61. The "cases" he describes are as follows:

Ignorance. Cases involving potential harm of which the threatened person is unaware provide clear examples of paternalistic coercion widely thought to be justified. For instance, it is thought to be unobjectionable to forcibly prevent children from getting themselves into dangerous circumstances which they do not understand. . . . However, not all examples of this type involve children; if an adult is in a seriously dangerous situation and is unaware of it, it can also be permissible to intervene paternalistically.

Emotional stress. People sometimes decide to inflict harm on themselves when they are in periods of great emotional stress. If, for instance, a person attempts suicide while subject to extreme and unusual stresses, it seems that another party would be justified in intervening in at least some such cases.

Compulsion and Undue Influence. Self-harming behavior can also be caused, it seems, by action done under compulsion or undue influence. If self-harming behavior is due to, say, some irresistible psychological influence, or to threats of greater, other-imposed harm, many would hold that interference with the behavior could be justified even if the failure to interfere would harm no one other than the person interfered with.

Mental Illness. Closely related to the previous category is that of persons labeled mentally ill or insane. When such persons behave in self-destructive ways, and when this self-destructiveness appears to be part of their affliction, paternalistic intervention again appears to be justifiable.

Nonrationality. Sometimes persons who are in states of impaired consciousness can be the subjects of apparently justified paternalism. A person who is, for instance, unconscious due to a blow received in an accident would be unable to decide for himself whether to do such things as go to a hospital; in such a case it hardly seems objectionable for someone else to take the unconscious person to a hospital.

Serious harm. Sometimes the mere fact that a person is about to cause himself serious harm may be taken as sufficient to justify paternalistic intervention even if the person is not known to fall into any of the above categories. If, for instance, there is no time to ascertain whether the person threatened with harm has chosen to be in that position, surely it could be
fore, intervention is sometimes appropriate. The twin safeguards of presently-existing danger and lack of rational decisionmaking capacity should protect against unwarranted paternalism.

(ii) Adjudication of capacity for rational decisionmaking

Capacity for rational decisionmaking is a crucial element of the proposed system. How are the courts to adjudicate this difficult question? At the outset, it is conceded that judges rely heavily on expert testimony to make this determination. In their recent treatise on psychiatry and the law, Doctors Gutheil and Appelbaum observe that

[although competency is a legal concept and, under the law, can only be determined by a judge, the practical realities of clinical care require that clinicians often make their own assessments of whether a patient is competent or not. We might call this a determination of “psychological competency” (or “capacity”) rather than “legal competency,” but the impact of these findings are often just as significant as those emanating from the bench. It is the clinician who usually decides if a judicial determination of competency is warranted and, in many cases, it is the clinician’s assessment that serves as the basis, often the sole basis, for the judge’s decision.]

While courts must make the final decision on the issue of capacity, Gutheil and Appelbaum correctly assert that in practice, judges rely heavily on expert opinion to determine this issue—an issue which is essentially psychological in nature. To bemoan this reality is unwise, however, because it is precisely in the context of evaluation of rationality and its effect on decisionmaking capacity that mental health professionals are at their strongest. The training and experience of psychiatrists, psychologists, and clinical social workers renders them uniquely competent to give reliable expert testimony on such matters. In the final analysis, it is appropriate to rely on expert opinion.

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305. See TEXTBOOK OF PSYCHIATRY, supra note 6, at 906-19.
In the interest of fairness, however, the law should permit the proposed patient to select an expert of his or her own choosing. In the event the individual is poor, as is frequently the case, the state should bear the cost of the individual’s expert.

f. Police power commitment will continue to be available

The proposal does nothing to displace involuntary commitment under the police power. Detention would remain available under this source of state authority. While commitment under the police power would continue to be an option in severe cases, the proposal should significantly reduce the need to resort to it.

g. The problem of enforcement

While community-based involuntary treatment in the least restrictive appropriate setting makes theoretical sense, some will argue that such a system cannot work in practice. An order for involuntary treatment is, after all, nothing more than a piece of paper. If the incapacitated person is living in the community, with freedom to come and go as he or she pleases, the order may simply be ignored. Yet, the fact that the proposed system (or any other) will fail in a percentage of cases is an insufficient reason to give it up entirely. In most instances, it will provide significant benefit. For some individuals, the fact that a judge has ordered them into treatment may prove incentive enough to win compliance. In other cases, the order will provide mental health professionals with a tool they now lack to convince reluctant patients to engage in treatment.307

If an individual under court order simply refuses to participate in treatment, professionals may conclude that his or her wishes should be respected. In such cases, the court could dismiss the order. On the other hand, mental health professionals may decide that treatment

307. Critics will argue that the “tool” described in the text resembles the stick more than the carrot. Mental health professionals may use inappropriate threats of more restrictive treatment to coerce compliance with prescribed therapy. As stated elsewhere in this article, the potential misuse of the proposed system of involuntary treatment should not be overemphasized. In most cases, the system will be utilized in an appropriate manner by professionals genuinely concerned with provision of treatment in the least restrictive alternative. This statement evidences a bias which I readily admit—I believe that the mental health system and those who work within it strive for the best possible treatment for those afflicted with serious mental illness. What is more, I believe that treatment is effective and essential for many individuals. The time has arrived to build bridges rather than walls between lawyers and mental health professionals.

These views reflect those expressed by Paul Chodoff, M.D., in a recent article. See Chodoff, Involuntary Hospitalization of the Mentally Ill as a Moral Issue, 141 AM. J. PSYCHIATRY 384 (1984).
must be given. In such a case they could petition the court to increase the restrictiveness of the order to an extent sufficient to obtain compliance. For example, if an individual refuses to take prescribed medication as ordered, the court could increase the restrictiveness of the order to include a short-term stay in a community residential treatment facility. Many other examples can be constructed. The general principle should be clear, however. The court would have the authority to review its own orders, and adjust them to meet individual needs by moving along the proposed continuum of treatment methods. More or less restrictive treatment would be ordered depending on the facts of the case.

VI. CONCLUSION

The time has arrived for the mental health and legal professions to work cooperatively toward improving the system by which society affords involuntary psychiatric treatment to the seriously mentally ill. The present involuntary commitment system is unresponsive to patient needs because it ignores the broad array of community-based treatment modalities that are available. To be more responsive to the needs of patients, the system should be expanded to include the complete continuum of treatment modalities. Furthermore, greatly enhanced efforts must be made to expand and adequately fund community-based treatment alternatives. Under the proposed system, the individual treatment needs of each patient will be met by affording effective treatment with the least possible restriction of personal liberty and autonomy.