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Compulsory Community Care for the Mentally Ill

*Beatrice K. Bleicher**

DESPITE WIDESPREAD AGREEMENT on the advantages of treating the mentally ill and despite large expenditures on the community mental health movement, community care¹ is not available to many of the people who have demonstrated the greatest need for it. It remains true that almost anyone who is involuntarily civilly committed is committed to the traditional mental hospital. Even when state criteria allow many types and degrees of illness to be grounds for civil commitment, there are usually only two possible dispositions for a case—hospitalization or release. Because of this dichotomy, some people are deprived of their liberties in the attempt to give them psychiatric care. Occasionally, others are deprived of psychiatric care in the attempt to guard their liberties since family, friends, or committing agency² may be unwilling to force the consequences of commitment upon a person who is mentally ill but not so dangerous that commitment appears essential.

Community psychiatric services can eliminate this dilemma by providing a wide range of therapeutic programs in which the degree of deprivation of liberty and interference with ordinary activities can be adjusted depending on the individual's illness. At the present time, the benefits of community care are limited to voluntary patients, but they should be extended to involuntary patients as well. This paper discusses the need for compulsory community care and the steps taken to meet this need in a few states and in Britain. Finally, it proposes legislation which could cope with the problems of providing community care for the civilly committed.

I. Advantages and Availability of Community Care

Interest in community psychiatric services represents a marked change in public attitude from the eagerness to isolate and ignore the mentally ill which formerly prevailed. The pre-

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¹ "Community care" includes inpatient facilities located in the community, such as the psychiatric ward of a general hospital or the acute illness unit in a Community Mental Health Center. It also refers to the services of outpatient facilities, clinics, day hospitals, home care.

² "Committing agency" in this paper refers to the judicial or administrative body that has statutory authority to commit a mentally ill person to treatment or custodial care.

requisites for this change were the developments in therapy, particularly the common use of tranquilizers since the mid-1950's, that made it possible to manage many severely ill people without physical restraints or seclusion. With disruptive behavioral symptoms quieted, patients are more amenable to various kinds of psychiatric treatment and more socially acceptable in the community.³ Today, community care is not only possible but considered desirable. Much has been written about the anti-therapeutic aspects of traditional mental hospitals and about their failure to provide an environment in which a patient can progress toward independent living.⁴ In part the failure results from the inadequate staff and poor facilities available to most mental hospitals, but it also stems from the very nature of the hospital as an isolated institution.

Community care is free from many of the undesirable features of hospitalization in an asylum. One source⁵ reports that forty to fifty percent of the patients who would once have been relegated to long-term, possibly permanent, inpatient care can be treated successfully in day hospitals—either directly or after a brief inpatient stay. Most psychiatric therapy focuses on improving an individual's ability to see himself realistically in relation to other people and to function effectively in his community. Community care offers opportunities for contact with mentally normal people which may contribute to the patient's recovery. Ideally, the emotional support of the family hastens the patient's recovery if he remains with them or close enough for frequent visits. Even if the patient is better living apart from his family, his presence in the community brightens vocational rehabilitation prospects and facilitates personal readjustments after active treatment has ended. Another advantage is that treating the mentally ill in the community makes the mentally healthy population aware of treatment possibilities and more likely to seek treatment if they ever need it.

It is also likely that community care will prove less expensive in the long run.⁶ On the surface it appears to cost more than state hospitals, but this is because state hospitals provide mainly custodial services. Even if treatment in a clinic or day hospital costs more per patient day, it achieves its goals so much

³ Joint Commission on Mental Illness and Health, Final Report, Action for Mental Health 39, 42-43 (1961).

⁴ Caplan, *Principles of Preventive Psychiatry* 110 (1964).

⁵ Ozarin & Brown, *New Directions in Community Mental Health Programs*, 35 *Amer. J. of Orthopsychiatry* 10, 13 (1965). See also, Dinitz *et al.*, *An Experimental Study in the Prevention of Hospitalization of Schizophrenics*, *Id.* at 1. On the advantages of community care, see generally, McMahon, "The Working Class Psychiatric Patient," in *Mental Health of the Poor* 283 (1964).

⁶ H. R. Rep. No. 248, 89th Cong., 1st Sess. 4 (1965).

more rapidly that the total money spent on each patient's illness will be less.⁷

In recognition of these advantages of non-hospital care, the community mental health movement has been growing rapidly.⁸ In 1946, Congress passed the National Mental Health Act which included grants-in-aid for outpatient clinics. By 1953, 400 communities had taken advantage of these funds.⁹ Some community services developed as branches of the state hospitals; some were independent. In 1954, New York enacted legislation for the planned development of community mental health programs throughout the state. Under the legislation, facilities were to be financed jointly by state and community. State standards for personnel would be locally administered, and programs would be optional. By 1962, 14 other states had similar legislation, and state expenditures totalled \$40 million,¹⁰ although expenditures in state hospitals were still almost ten times this amount.¹¹

Recent federal legislation has encouraged the movement. In 1963, Congress passed the "Mental Retardation Facilities and Community Mental Health Centers Construction Act" to provide grants for the construction of community mental health centers which conform generally in structure and operation to federal regulations and to a state-wide plan for mental health services. The Act was amended in 1965 to include grants for initial staffing of the centers. Spurred on by the prospect of federal aid, ten more states enacted community mental health services acts between 1963 and 1965, and many more are expected to do so.

A team from the National Institute of Mental Health recently visited various facilities which are providing at least some of the characteristic community mental health services. They found

⁷ National Institute of Mental Health, U. S. Dep't of H. E. W., *The Comprehensive Community Mental Health Center 10* (Public Health Service Pub. No. 1137, 1964).

⁸ The movement is also attributable to widespread interest in preventive care, designed to ensure the mental health of the well population, but community care for those already ill has been an integral part of most of the programs. In, *An Approach to Community Mental Health* (1961) at vii-viii, Dr. Gerald Caplan describes community care in terms of "preventive psychiatry" and states goals of "secondary prevention"—reducing the duration of mental illness—and "tertiary prevention"—eliminating the crippling effects of mental illness.

⁹ Cal. Senate Interim Comm. on the Treatment of Mental Illness. *Second Partial Report. Community Mental Health Centers 22* (1956).

¹⁰ Council of State Governments, *Interstate Clearing House on Mental Health, Recent Development in the States' Community Mental Health Programs 1960-1962 1* (1962). It was unfortunate, however, that 80.7% of the total spent by states in 1960 was spent by 8 states only. Eagle, *Charges, Costs and other Factors Related to Maintenance of Patients in Public Mental Hospitals, 78 Public Health Reports 775, 786* (1963).

¹¹ U. S. Code Cong. & Admin. News, *Legislative History of Pub. L. No. 88-164, at 1065* (1963).

that one of the pressing problems was the failure of these facilities to cope with individuals under court or police jurisdiction. Sometimes centers provided diagnostic services for the courts on an outpatient basis or at the court or jail. A few even admitted such cases as inpatients in their facilities for short-term acute mental illness, "but there was great reluctance to do so, because the wards were usually open and security could not be guaranteed."¹² It is a fact, however, that many mentally ill persons who have been involuntarily committed do not require the kind of safety precautions that this quotation suggests is necessary. Dangerousness is not always a prerequisite for commitment,¹³ and the lack of safety features cannot excuse the failure to provide community care for involuntary patients who are not dangerous.

These observations of community facilities in action reveal that community mental health developments have not yet solved the dilemma of hospitalization or release which controls the disposition of involuntary cases. It should be noted that in a few states certain people who have been found mentally ill and committable can avoid hospitalization.¹⁴ This is possible under statutes similar to the Washington provision:

Where the mentally ill person is not dangerous to the lives or property of others, and is not dangerous to himself, the court may direct that custody of such person be given to such friends or relatives as are willing and able to care for him.¹⁵

Most of these statutes require that the mentally ill person be harmless or else that the person taking custody put up a bond. All but the Iowa statute make it clear that the custodian must be financially able to support the mentally ill person. The Iowa statute is unusual in providing that there may be care outside the hospital for people "either as public or private patients."¹⁶ Statutory provision for psychiatric care without hospitalization is thus available in very few states and even then, limited to people who have money. Furthermore, custody statutes include

¹² Ozarin & Brown, *New Directions in Community Mental Health Programs*, 35 *Amer. J. of Orthopsychiatry* 10, 17 (1965).

¹³ *Cal. Laws of 1965*, ch. 391 § 5550 at 591; *Colo. Rev. Stat.* § 71-1-1(1) (b) (1963); *Ga. Code Ann.* § 88-501(a) (Supp. 1965).

¹⁴ *Cal. Laws of 1965*, ch. 391 § 5568 at 599; *Colo. Rev. Stat.*, § 71-1-11(2) (1963); *Conn. Gen. Stat. Ann.*, § 17-203 (1958); *Hawaii Rev. Laws*, § 81-21 (1961); *Ill. Rev. Stat.*, ch. 91½, § 8-12 (1965); *Iowa Code Ann.*, § 229.27 (Supp. 1964); *N. Y. Mental Hygiene Law*, § 72(1) (Supp. 1965); *Ohio Rev. Code Ann.*, § 5122.15 (Supp. 1964); *Ore. Rev. Stat.*, § 426.130 (1959); *Wash. Rev. Code Ann.*, § 71.02.240(4) (1959); *W. Va. Code Ann.*, ch. 27, § 2661 (Supp. 1965).

¹⁵ *Wash. Rev. Code Ann.*, § 71.02.240(4) (1959).

¹⁶ *Iowa Code Ann.*, § 229.27 (Supp. 1964).

no way of ensuring that the mentally ill person receives treatment as well as surveillance.

A similar opportunity is afforded to some people in other states by a non-statutory probation procedure whereby a mentally ill person is put on probation with the condition that he obtain psychiatric treatment and under the implied threat of commitment if his behavior becomes objectionable. This procedure is most frequently applied to mentally ill people who have come before the court because of criminal acts.¹⁷ And, again, this privilege is usually reserved to those who can afford private care and psychiatric treatment at their own expense.

At the present time no state law provides a fully developed plan for the public community care of involuntarily committed people although a few states have taken steps in this direction. Thus, an unfortunate by-product of the involuntary hospitalization laws is that the type of treatment received by a mentally ill person will remain a highly class-related matter. This is a serious problem, especially in view of the fact that involuntary commitment occurs so frequently among members of the lower socio-economic classes.

The frequency of commitments can be traced to many factors. Hollingshead and Redlich found higher incidence and prevalence rates of treated mental illness among the lower classes.¹⁸ An explanation of this disparity is that the poor generally undergo greater adult stress and yet lack both the psychological resources—such as feelings of security and identity—and the material resources to help them withstand stress.¹⁹ Another possibility is that a person from the lower socio-economic groups is less likely to seek help until his condition finally deteriorates to the point that he meets the standards for civil commitment. The New Haven study showed that schizophrenic patients in the lowest class group were often psychotic for as long as three years before being referred to psychiatry. They and their families had not recognized the symptoms of mental illness.²⁰ In most cases psychotic patients of this class first received treatment in the state hospital where they were sent involuntarily by police

¹⁷ For example, under 18 U. S. C. § 3651, judges consider themselves empowered to require psychiatric treatment as a condition of probation.

¹⁸ Hollingshead & Redlich, *Social Class and Mental Illness* 210, 212, 216 (1958) [hereinafter cited as Hollingshead & Redlich]. Langner and Michael, *Life Stress and Mental Health*, vol. 2 of the *Midtown Manhattan Study*, at 81 (1963) found that the highest rates of untreated psychosis and character disorders occurred in the lower third of their sample in terms of socio-economic status.

¹⁹ Langner & Michael, *op. cit. supra* n. 18 at 467; Caplan, *Principles of Preventive Psychiatry* 58 (1964).

²⁰ Hollingshead & Redlich, *op. cit. supra* n. 18, at 172-173. See also, Reiff & Scribner, "Issues in the New National Mental Health Program," part of a report by the National Institute of Labor Education Mental Health Project in *Mental Health of the Poor* 442, 443 (1964).

or physicians. The rates of police and court referrals of neurotics to treatment was also class-linked, though less noticeably than rates for psychotics.²¹

Failure to seek medical help voluntarily is only partly the result of being unable to meet the costs of treatment. Numerous studies have indicated that where free or low cost clinics exist, they are more often used by middle class people than by the poor.²² As a general rule, less educated people are more fearful of admitting psychological problems and more ignorant of the ways they can be treated. Not all the blame rests on the potential patient, however. Clinics have sometimes regarded the less educated, poorer person as an unpromising client on the basis that they were not suited to the psychotherapeutic techniques.²³

Another reason that involuntary commitment is an especially serious problem among persons of the lower socio-economic classes is the tendency to consider them more severely ill and therefore, more committable.²⁴ "There is substantial evidence to indicate that clinical judgment is heavily infused with middle class bias; that diagnostic criteria have as their source as much in cultural tradition as in science. . . ." ²⁵ In a recent experiment, psychologists appraised the Rorschach protocols of people identified as of low socio-economic class as evidence of greater sickness than they found in identical records, ostensibly from people of higher class background.²⁶ The same bias may very well be present in a judicial appraisal of the degree of mental illness. And in many cases, the diagnostic evaluation of psychiatric experts will be the deciding factor in a commitment proceeding, whatever the statutory role of the committing agency.

Sociologists and psychologists, studying the characteristics and themes of the culture of different classes, have found that

²¹ Hollingshead & Redlich, *op. cit. supra* n. 18, at 186-187.

²² *E.g.*, Hollingshead & Redlich *op. cit. supra* n. 18, at 328-330; Brill & Storow, "Social Class and Psychiatric Treatment," in *Mental Health of the Poor* 73 (1964); Statement of Lisbeth Bamberger, Assistant Director, Soc. Sec. Dep't AFL-CIO, in Hearings on H. R. 2985, 2986 Before the House Committee on Interstate and Foreign Commerce, 89th Cong., 1st Sess. 286 (1965).

²³ Reissman, Cohen & Pearl, "Preface" to *Mental Health of the Poor* at vii (1964).

²⁴ The researchers of the Midtown Manhattan Study suggest that this greater severity of illness is actual. People from the lower socio-economic groups tend to manifest illness in overtly anti-social symptoms and have a higher rate of psychosis, though a lower rate of neurosis, than other class groups; Langner & Michael, *op. cit. supra* n. 21, at 81.

²⁵ Schneiderman, *Social Class, Diagnosis, and Treatment*, 35 *Amer. J. of Orthopsychiatry* 99, 102 (1965).

²⁶ Haase, "The Role of Socioeconomic Class in Examiner Bias," in *Mental Health of the Poor* 241 (1964).

many of the most distinctive characteristics of the lower socio-economic class are those which are often considered signs of mental illness.²⁷ An analysis of the content of twenty-seven pamphlets from the New York State Department of Mental Hygiene and the National Association for Mental Health, revealed that the prevailing image of mental health corresponded to a well-adjusted middle class person.²⁸ This image inevitably exerts a subtle influence upon lawyers, judges, physicians, and even the psychologists and psychiatrists who make recommendations in civil cases.

Once committed to a mental hospital, a person from the lower socio-economic classes may have considerably more difficulty in obtaining release than a person of higher status. Elimination of this situation is another reason that treatment in the community would be desirable. In most states, discharge is a matter of administrative discretion. Even in states where there are scheduled periodic reviews as in the District of Columbia,²⁹ the government does not have the burden of recommitment, the purpose of the examination being merely to discover whether any patients are ready for discharge.³⁰ A patient has to know how to get his own discharge. The New Haven study found decided class-related differences in the abilities of patients to get what they wanted once they were in a public mental hospital. Those from the lower class were least able to protest effectively and had the least knowledge about whom to contact when they wanted to leave.³¹ Furthermore, at least one leader in the field of mental health has stated that an involuntarily committed patient will generally find it harder to obtain discharge, because psychiatrists are influenced by the connotation of dangerousness which involuntary commitment carries with it.³²

Even when the hospital administrator decides that a patient is ready to leave, there may be special difficulty involved in the discharge if the patient comes from a low income group. Agencies outside the hospital exert pressure. "Social workers in com-

²⁷ Gursslin, Hunt, & Roach, "Social Class and The Mental Health Movement," in *Mental Health of the Poor* 58 (1964).

²⁸ *Id.* at 63.

²⁹ D. C. Code Ann., § 21-357 (Supp. IV, 1965).

³⁰ The 1964 New York Mental Hygiene Law evidently requires affirmative action to continue an involuntary commitment after the expiration of specified time periods. New York Mental Hygiene Law, § 73(3). This theoretically does put the burden of obtaining further authorization on the hospital administrator, although the patient is actually still at a great disadvantage. See, Chaikin, Commitment by Fiat, 1 Col. J. of Law and Social Problems 113 (1965).

³¹ Hollingshead & Redlich, *op. cit. supra* n. 18, at 338-339.

³² Statement of Dr. Addison M. Duval in Senate Comm. on the Judiciary, Subcommittee on Constitutional Rights, Hearings on the Constitutional Rights of the Mentally Ill. Part I. 87th Cong., 1st Sess. 14.

munity agencies, themselves deluged with requests to serve these patients, are tempted to accuse the hospitals of premature release of persons who still need care."³³ Undoubtedly, many people are kept at the hospital, because no one at home can give whatever extra care is still needed or perhaps because there is no home to return to.³⁴ In a recent District of Columbia case, a patient was denied habeas corpus, because the court found that she was:

in need of care and supervision, and that there is no member of the family able to give the petitioner the necessary care and supervision; and that the family is without sufficient funds to employ a competent person to do so; . . .³⁵

In this instance, the woman merely needed someone to keep her from occasionally wandering by herself and to give her limited custodial care, but she was kept at the mental hospital.

Thus patients at the same stage of recuperation may be treated differently—one discharged and one required to remain at the hospital—depending on the financial position of the patient or his family.

That the involuntarily committed people from lower socioeconomic groups do not receive community care is particularly unfortunate, because community care is a method of treatment likely to be successful with these very people. Psychiatrists have recognized that new approaches are needed in working with the poor. Psychoanalysis is too costly to be feasible for the majority of the mentally ill and is ineffective in reaching some severely disoriented psychopaths. Psychotherapy is often unsuccessful with the poor because it depends on verbal communication and works best when therapist and patient have experiences and values in common.

The effectiveness of psychotherapy with the poor is contingent upon a far less detached therapeutic orientation—one in which treatment agents are much more closely integrated with other institutions such as the community, the world of work, and the church.³⁶

³³ Wade, Action for Mental Health, 36 Social Service Review 283, 288 (1963).

³⁴ In Oregon, a statute makes it clear that discharge will depend on sufficient proof that friends or relatives are financially able to care for the former patient. Ore. Rev. Stat., § 426.300 (1959). *But see*, Cal. Welfare & Institutions Code, § 6731 (Supp. 1964) which makes it a policy not to retain patients for such reasons.

³⁵ *Lake v. Cameron*, 331 F. 2d 771 (C. A. D. C. 1965). Also, *In Re Heukelekian*, 24 N. J. Super. 407, 94 A. 2d 501 (1953) (dissent), should be noted in this context.

³⁶ Reissman, Cohen, & Pearl, *op. cit. supra*, n. 23, at viii.

If this suggested approach is valid, treatment of people from the low income groups in the community is one way to achieve good results.

Up to now, one of the major obstacles to community care for all who could benefit from it has been the lack of facilities. But this particular obstacle is much less formidable as increased mental health services are beginning to materialize. It is anticipated that "by July 1966 virtually all the states will have submitted their plans for state-wide mental health programming and will have had them approved."³⁷ The Federal money that will follow is important since even in those states which had enabling legislation, many localities were unable to finance community mental health centers. Also federal grants will stimulate state and local expenditures which have already increased to at least \$95,000,000 for the fiscal year 1965.³⁸ The federal regulations accompanying P. L. 88-164 on the construction of the centers emphasize that future operations in the structures built with federal funds must be accessible to people in the lower socio-economic groups who cannot afford to pay.³⁹ All this will create an increase in voluntary applications for treatment; people, becoming familiar with the work of the community facilities, will probably go to them for help before illness reaches grave proportions. In this way, the necessity for involuntary commitments will diminish, even among the poor.

Increasing the supply of mental health services will not, however, eliminate the problem of involuntary commitments. First of all, it will be many years before most people are reached by the services. The mere presence of outpatient clinics or day hospitals will not be enough to attract all the people who ought to be utilizing them. Educational publicity will help, but the process of familiarizing people with the services will take time. Furthermore, the states are likely to face the situation that developed in Great Britain as its mental health program expanded.

British experience is that increased provision has always resulted in increased demand. . . . Presumably there is a limit to this process somewhere, but it is doubtful whether any country has yet made sufficient psychiatric provision to reach it.⁴⁰

Even if mental health services are ever available to every community, voluntary admissions to treatment will not cover all

³⁷ Letter from Bertram S. Brown, Chief, Community Mental Health Facilities Branch of National Institute of Mental Health to author, December 13, 1965.

³⁸ National Institute of Mental Health, U. S. Dept. of H. E. W., Summary Description of Community Mental Health Services Acts (Nov., 1965).

³⁹ 42 C. F. R., § 54.210 (Supp. 1965).

⁴⁰ Jones, Community and Mental Health, 48 Mental Hygiene, 3, 6 (1964).

situations. It may be that early voluntary treatment cannot always prevent deterioration to a point where the patient no longer comprehends his need for help and must be prevented from discontinuing psychiatric treatment. Other people will not use community services voluntarily even in the early stages of illness. In such cases the mental illness, itself—by distorting the individual's sense of reality and limiting his perception of his mental functioning—prevents the ill person from getting treatment.

Thus, there will continue to be a certain number of people who must be required to obtain psychiatric care, and the laws should entitle them to get the same type and quality of care as the voluntary patients. The involuntary patient should not be punished for his failure to recognize and treat his mental illness. Indeed, since the state has compelled him to obtain treatment, the state has a special responsibility to provide him with effective treatment. If the state's justification for commitment was its role as *parens patriae*, it is certainly in the patient's best interest that he be treated as efficiently as possible with minimal dislocation from his normal environment. If the justifying theory was the state's police power, that method of treatment which has the best chance of cure is the best way of ensuring public safety and, in the long run, lowest public cost.

Consideration of the legal and ethical implications of compulsory community care raises an important question: Will the improved care available to the involuntary patient justify an expansion of the class of people subject to compulsory care? As long as the only disposition of a civil commitment case is institutionalization, there is good reason to define this class narrowly. Should this attitude change? The following remarks about Section Nine of the "Draft Act Governing the Hospitalization of the Mentally Ill"⁴¹ are thought-provoking.

Although it may be desirable from a medical point of view to hospitalize those who are not presently dangerous but who might easily become so in the absence of proper treatment, the question of the propriety of such hospitalization remains a real one in view of the conditions existing in many hospitals. A prime requisite for the success of such a policy is that the hospitals are equipped to offer the care and treatment required by such patients. Many communities have not yet provided the financial resources essential to the establishment and maintenance of such facilities. In the absence of these facilities, of course, there is no justification for

⁴¹ National Institute of Mental Health, Federal Security Agency, Draft Act Governing the Hospitalization of the Mentally Ill (Public Health Service Pub. No. 51, 1952).

broadening the involuntary hospitalization requirements to include non-dangerous persons.⁴²

This quotation suggests an affirmative answer to the question posed above, at least if the expanded criteria are limited to those of Section Nine in the Draft Act. It is not clear whether the authors would endorse broader criteria even if the treatment were greatly improved.

Many states now have commitment criteria, similar to those of the Draft Act, which include the mentally ill who are not dangerous to themselves or to others. In deciding which members of this class to commit, state committing agencies necessarily exercise a certain degree of discretion; decisions are the result of a more or less conscious balancing process. Among the factors weighed are the probable benefits of treatment versus the deprivations of institutionalization. As the likelihood of therapeutic benefits increases and the negative consequences of commitment decrease, it is reasonable to expect more frequent decisions in favor of compulsory treatment. This change in attitude as the committing agency interprets existing criteria is probably inevitable.

A further broadening of the expressed criteria for commitment, beyond what will inevitably happen in interpretation, does not seem to be justified by the fact that the quality of compulsory treatment will be improved. A major consideration is that despite improved psychiatric techniques, the success of treatment cannot be positively assured in every case. In fact, there is considerable disagreement about what "success" means in this context. Even if there were assurance of an agreed degree of success, there are constitutional limits on the state's right to interfere with an individual's freedom of decision. The state has an interest in the mental health of its citizens, but the citizens have an interest in living without continual supervision. Drawing the line is difficult, but the extension of community care to involuntary patients should not be an excuse for erasing all restraints on the power to commit. The purpose of compulsory community care is to enable the state to fulfill its responsibility to the broad class of people already committable under present standards.

II. Meeting the Need for Compulsory Community Care

To provide community care for indeterminate commitments, as a transfer possibility after hospitalization, or even during brief observation periods necessitates changes in the laws governing involuntary hospitalization. It will not be enough to reinterpret

⁴² Lindman & McIntyre, ed., Report of the American Bar Foundation, *The Mentally Disabled and the Law* 21 (1961).

existing laws without changing their language and the structure they support. It is true that there are some states with commitment statutes apparently flexible enough to permit incorporation of community care into the existing structure of institutional commitments. Theoretically, commitment to inpatient services of a community mental health facility could be effected simply by construing the word "hospital" in the statutes to mean any kind of inpatient facility rather than only state or private asylums. The broad language of some statutes might be construed to include outpatient care as well. For example, in Colorado, New Mexico, and North Dakota statutes mention commitment to the state hospitals or other "suitable places."⁴³ In Idaho, a petition to initiate commitment proceedings may be filed if a person believes that someone should be "hospitalized or otherwise cared for by the State Board of Health."⁴⁴ The recently enacted District of Columbia "Hospitalization of the Mentally Ill" Act enables the court in dealing with a civil case to

. . . order his hospitalization for an indeterminate period, or order any alternative course of treatment which the court believes will be in the best interest of such individual or of the public.⁴⁵

In the case of the District of Columbia statutory provision there is no hazard in using it as authorization for compulsory community care, since the statutory history reveals that this was what the legislators had in mind when drafting the provision. The original bill did not provide for any disposition other than indeterminate hospitalization; however, the Committee on the judiciary included the alternative provision in their amendments to the bill "to cover those cases where such treatment as placement in half-way houses or outpatient care may be indicated."⁴⁶ It is not so clear that the other states mentioned above intended this result by their similar language. To avoid doubt on what the legislature intended and to overcome the reluctance of the committing agency to use community facilities, an explicit statutory mandate or option is desirable. Ideally in the process of rewording the statutes, the legislature and the public will be forced to give consideration to the purpose behind the change and to the organizational innovations it will necessitate.

In some states, the statutory language has already been made explicit. Texas appears to be the only state in which the Community Mental Health Services Act states that one function of the new centers will be to render services "to those legally

⁴³ Colo. Rev. Stat., § 71-1-11(2) (1963); N. M. Stat. Ann., § 34-2-13 (Supp. 1965); N. D. Century Code Ann., § 25-03-11 (1960).

⁴⁴ Idaho Code Ann., § 66-329(a) (Supp. 1965) (Emphasis supplied).

⁴⁵ D. C. Code Ann., § 21-356(f) (Supp. IV 1965).

⁴⁶ H. R. Rep. No. 1833, 88th Cong., 2nd Sess. 14 (1964).

committed.”⁴⁷ The statutes on involuntary commitments in Texas, however, have not been amended correspondingly. In California and Wisconsin, a person may be committed to a Community Mental Health Center.⁴⁸ Illinois has explicitly redefined “hospital” to include any mental health center or clinic under control of the Department of Public Health.⁴⁹ The New York law is somewhat ambiguous. It redefines “hospital” so as to include most community facilities.⁵⁰ In a later section, Community Mental Health Centers are also specifically mentioned as a place of *interim* care but then merely implied as an appropriate institution for *indeterminate* commitments.⁵¹

In Ohio the court may commit for ninety days of observation to a community clinic as well as to a private psychiatrist if feasible. Indeterminate commitments may be subsequently ordered to a number of places including “any other suitable facility.”⁵² Presumably this latter phrase means a community clinic, although the fact that community clinics were explicitly included in the subsection on ninety-day observations might indicate a legislative intent to exclude them from the facilities available for indeterminate commitments. In 1963, Colorado made it possible for a person to be sent to the Fort Logan Mental Health Center which up until that time had accepted voluntary patients only.⁵³

States that have clearly designated community care as a mode of compulsory treatment have progressed at least in terms of policy. However, it remains to be seen whether the policy will be implemented. If the policy is to realize its full potential, however, it should be accompanied by administrative changes to cope with the problems it creates. With a much wider range of possible dispositions for each case, there emerges the problem of selecting the best one for each individual for whom the state has assumed responsibility. This requires knowledge of the proliferating facilities and the special services each one offers. There will also be surveillance problems. As the team from the National Institute of Mental Health observed, community facilities are afraid to handle court cases because of their inability to ensure safety.⁵⁴ The potential dangerousness of most people

⁴⁷ Tex. Sess. Laws 1965, ch. 67, § 3.12 at 172.

⁴⁸ Cal. Laws of 1965, ch. 391, § 5567 at 598; Wis. Stat. Ann., § 51.05(3), § 51.24 (Supp. 1965).

⁴⁹ Ill. Rev. Stat., ch. 91½, § 1-4 (1966).

⁵⁰ N. Y. Mental Hygiene Law, § 2(4) (a) (Supp. 1965).

⁵¹ *Ibid.*, § 81, § 81(4).

⁵² Ohio Rev. Code Ann. § 5122.15 (Supp. 1964).

⁵³ Colo. Rev. Stat., § 71-5-5 (1963); Council of State Governments, Interstate Clearing House on Mental Health, Action in the States 36-37 & n.(b) (1963).

⁵⁴ Ozarin & Brown, *op. cit. supra* n. 12.

who have been civilly committed is exaggerated, but some supervision of the involuntary patients will be necessary to make sure that they are getting the treatment that they need. Finally, if community care is to become available to everyone who can benefit from it, transfers between the community services and the state hospitals should be facilitated. At the present time, even informal referrals are not as frequent as they should be, and formal transfers are rare.⁵⁵

It is interesting to note the role the New York Mental Hygiene Law has assigned the community mental health movement in the total picture of involuntary care. Since New York was the first state to pass a state-wide enabling act for the development of Community Mental Health Centers and now spends large sums on these endeavors,⁵⁶ one might expect that state to be particularly conscious of the potentialities of community care. Throughout the Mental Hygiene Law, passed in 1964 and effective in September, 1965, there are references to community services. Public welfare officials, "having duties to perform relating to the poor,"⁵⁷ are urged to see that those who cannot afford private psychiatric treatment get help. In a significant departure from former practice, the statute has replaced judicial commitment with involuntary commitment on physicians' certification, and it appears that the mentally ill can be certified to a community mental health facility. As for making transfers easier, Section 76 gives the director of a community facility authority to certify someone to a mental hospital, but this evidently refers to a new certification and not to special transfers between community care and the state hospital system. Nothing is said about transfers in the other direction either except that they are administrative matters handled by the Commissioner of the Department of Mental Hygiene.⁵⁸

The statute creates a mental health information service which may be instrumental in integrating compulsory community care with the existing system. Section 88 describes the four

⁵⁵ See, Forstenzer, "Legal and Administrative Obstacles to Continuity of Services," in Report of the 38th Annual Milbank Memorial Fund Conference, Decentralization of Psychiatric Services and Continuity of Care 147, 150 (1961). The figures in this article, for the year from April 1960 through March 1961, show that only 1.5% of the 57,407 reported terminations in New York state psychiatric clinics were cases that had been referred from psychiatric hospitals. 2.3% of the cases were terminated with referral to public mental hospitals. Despite the age of the statistics, this information is still pertinent in view of the relatively advanced network of community facilities in New York at that time.

⁵⁶ New York state aid to community mental health programs amounts to at least \$22 million annually. State of New York Dep't of Mental Hygiene, Hospitalization for Mental Illness 1 (1965).

⁵⁷ N. Y. Mental Hygiene Law, § 81(1) (Supp. 1965).

⁵⁸ N. Y. Mental Hygiene Law, § 10a (Supp. 1965).

mental health information services (one in each state judicial department) and the qualifications of its personnel. Among other duties, they perform the following:

- (a) study and review the admission and retention of involuntary patients;
- (b) inform such patients . . . concerning procedure for admission and retention and of the right to have judicial hearing and review, to be represented by legal counsel and to seek independent medical opinion;
- (c) in any case before a court to assemble and provide the court with all the relevant information as to the patient's case, his hospitalization, . . .
- (d) provide services for voluntary patients and informal patients similar to those required under clauses (a) and (b) . . .
- (e) provide such services and assistance to patients and their families and to the courts having duties to perform relating to the mentally ill . . . as may be required by a judge or justice thereof. . . .⁵⁹

As a link between court and patient, the mental health information service is in a position to know whether community care would be desirable in a particular case and to suggest it if the occasion arises, for example, if a person appeals his certification to some facility. Section 73(2) gives the mental health information service the right to demand a review of initial hospitalization on the patient's behalf. This is especially useful when the case involves people who would be afraid to appeal their own cases. Section 87(1) indicates that the mental health information service may also seek review of a denied request for discharge. Both of these powers could be used as a way of getting people suited to community care into such a program if they have already been certified, although the mental health information service, itself, has no power to initiate commitments. It is too soon to tell what use the mental health information service will make of the powers it does have.

Despite the apparent intention to introduce community care for the involuntarily committed, the New York statute does not tackle the problems of administering such a development. In a 1961 amendment to the Community Mental Health Services Act, the legislators added another declaration of purpose: "integration of community, regional and state mental health services and facilities."⁶⁰ This is a recognition of one of the problems in this area, but no solutions are offered.

⁵⁹ *Ibid.*, § 88 (Supp. 1965).

⁶⁰ *Id.*, § 190.

California is a state that has had an interest in community mental health since as early as 1957. Section 5567 of the Welfare and Institutions Code permits judicial commitment of someone:

(a) of such mental condition that he is in need of supervision, treatment, care, or restraint, or (b) of such mental condition that he is dangerous to himself or to the person or property of others and is in need of supervision, treatment, care, or restraint.⁶¹

Assisting the courts in their work with the mentally ill is the Office of the Counselors in Mental Health. Any county board of supervisors can create an Office of Counselors in Mental Health, the counselors to be appointed by the judge of the superior court.⁶² Like the newly created mental health information service in New York, the Office is supposed to inform the allegedly mentally ill of their legal rights. After someone has filed a petition for commitment, a counselor investigates and reports the case to the court. In 1958, the Psychiatric Department of the Los Angeles Superior Court on its own initiative gave its counselors authority to screen petitions to eliminate any groundless cases. This innovation gives the counselors a chance to encourage voluntary applications for psychiatric care by informing the alleged mentally ill person of the pending proceedings and advising him to seek treatment on his own. This procedure has been very successful in reducing the number of court commitments,⁶³ but many petitions pass the initial screening nevertheless, even in the Los Angeles Court. If the court then finds that commitment is justified, it can commit a person to various places including a community mental health facility. Once a person has been committed to an institution, the Counselors in Mental Health follow the case. Any facts constituting a "good cause" for discharge can be brought to the attention of a Counselor who may then get the court to discharge the patient under the court's section 5569 authority.⁶⁴

The possibility of commitment to a community mental health center was added to the statute by section 5100.1 in 1963. This section, operative in October, 1963, was repealed in 1965 and replaced by similar words in section 5567. Despite the explicit language on the books since 1963, it appears that at least one of the California courts, the Los Angeles Superior Court, has never used the provision; evidently because no facilities in

⁶¹ Cal. Laws of 1965, ch. 391, § 5567 at 598.

⁶² *Ibid.*, § 5025 at 575.

⁶³ Nix, Recent Procedural Revisions in the Psychiatric Dep't., Superior Court of Los Angeles, Los Angeles Bar Bulletin, Aug. 1959.

⁶⁴ See, Psychiatric Court, Los Angeles Superior Court, Manual of Policies and Procedures 15 (as revised to January 2, 1964) [hereinafter cited as *Psychiatric Court Manual*].

the county can provide "security measures."⁶⁵ In view of the fact that California allows judicial commitment of people who are not dangerous but merely "in need of supervision, treatment, care, or restraint,"⁶⁶ lack of security measures should not invariably prevent the court from using the community facilities.

The section 5567 definition of mental illness sufficient to warrant hospitalization is fairly typical but section 5568 is unusual in giving the state supervisory powers over a very broadly defined group.

If . . . the court finds a person to be mentally disordered and bordering on mentally ill but not dangerously mentally ill, the court may commit him to the care and custody of the counselor in mental health and may allow him to remain in his home subject to return . . . ; or the court may commit him to be placed in a suitable home, sanitarium, or rest haven home, subject to the supervision of the counselor in mental health and the further order of the court.⁶⁷

Whatever may be thought of such an expansion in state control, at least the code provides for some flexibility in the exercise of this control. The counselor plays an important role. He is authorized to recommend placements based on his knowledge of the patient's needs and wishes. He administers the appropriated funds for the care of those in his custody who are in sanitariums and may move patients or discharge them if it becomes feasible.⁶⁸ Section 5568 is frequently used to give non-psychotic seniles supervision without commitment to a state asylum.⁶⁹ Those who remain at home under section 5568 are urged to obtain private care which probably includes free or low cost psychiatric services although neither the law nor a manual of one of the court psychiatric departments spells this out. If the patient is unable to get the needed care and his condition deteriorates, the Counselor may petition the court for a rehearing of the case. On the patient's improvement, the Counselor can recommend dismissal of the case.⁷⁰

⁶⁵ The reason that the provision has not been used, according to a Counselor in Mental Health at the Los Angeles Superior Court, is "there are no community mental health facilities in this county, in terms of facilities, that can care for and detain persons who are court committed. To detain a person who is court committed, who therefore is an involuntary candidate for treatment, requires certain security measures that, of course, have to be complied with." Letter from Jack B. Tso, Counselor in Mental Health, to author, December 16, 1965.

⁶⁶ Cal. Laws of 1965, ch. 391, § 5567 at 598 (Emphasis supplied).

⁶⁷ Cal. Laws of 1965, ch. 391, § 5568 at 598. See Jans, Commitment of the Mentally Ill—Superior Court of Los Angeles County, 36 So. Cal. L. Rev. 109, 113 (1962).

⁶⁸ *Psychiatric Court Manual* 1, *op. cit. supra* n. 64, at 21.

⁶⁹ See, 34 *Ops. of Cal. Att'y Gen.* 313, 315 (1959).

⁷⁰ *Psychiatric Court Manual*, *op. cit. supra* n. 64, at 19.

Although at the present time, the custody of Counselors in Mental Health is limited to cases where the mental disturbance is so mild as to be outside the basic civil commitment criteria in section 5567, this technique of supervising patients could be expanded to include people committable under section 5567. Knowing that systematic supervision of such patients existed, the courts would be more confident about using community facilities as a place for compulsory psychiatric treatment. The personnel of community facilities would feel more secure about accepting involuntary patients since responsibility would be shared with the court acting through its Counselors. The task of the community facility would be the same as its task in relation to all other patients—the provision of psychiatric assistance; legal and administrative duties would be the province of the Counselor.

The Counselors in Mental Health appear to be suitable agents for this supervisory function, because their relation to the court means that they know the laws and policies relating to the mentally ill. They are also in a position to influence court decisions on the best disposition of cases they have investigated. Their experience in the custody of the mentally distorted under section 5568 has acquainted them with the care and treatment possibilities that the community can offer. Of course, new procedures would be required as the supervision of mentally ill persons will call for more frequent contact between Counselor, patient, and community service than was necessary under a section 5568 custody. The proposed expansion of the California Counselor's duties would require additional personnel; but the transition would be fairly easy once the underlying principle of commitment to community facilities was accepted. Setting up a similar arrangement in other states which presently have no public custody arrangements for outpatients would involve extra work but would not be prohibitively difficult.

A development of the kind described for California would produce a system similar to that of the British guardianship, enabling involuntary patients to benefit from the advantages of community care. British experiences with open wards, day hospitals, and clinics have been helpful in guiding many of our own mental health programs; their system of guardianship might also serve as a guide.

In its 1957 *Report to the Queen*, the Royal Commission on Mental Illness and Mental Deficiency deplored the lack of flexibility in the disposition of involuntary patients.⁷¹ There was then in Britain, as there is in the United States today, no way to compel a person to obtain public psychiatric care or treatment without hospitalizing him. Many of the Royal Commission's suggestions about correcting this situation were given statutory

⁷¹ Royal Commission on the Law Relating to Mental Illness and Mental Deficiency (1954-1957), *Report* CMD. No. 169, at 89-90 (1957).

form in the British Mental Health Act of 1959.⁷² Primarily, the Commission suggested that a guardianship like that already used for some mental defectives living in the community might be an appropriate way to care for mentally ill persons who did not require confinement.

Under the British Mental Health Act, by filing a formal application with recommendations by two physicians, someone can place a mentally ill person in the guardianship of the local health authority or some responsible citizen (perhaps the applicant himself). If the guardian is not the local health authority, then the local health authority must approve the application. The provisions for initial review and renewal of the guardianship are almost identical to those pertaining to involuntary hospitalization in Britain. Anyone placed under guardianship has about six months to appeal the action to the Mental Health Review Tribunal,⁷³ and he also has a right to appeal any subsequent renewal.⁷⁴ Within two months of the expiration of any renewal period (a term which is never longer than two years) the patient must be examined by a qualified physician. If it is "necessary in the interests of the patient or for the protection of other persons,"⁷⁵ he will remain in guardianship, and a report to this effect will be filed with the local health authority.

During the period of guardianship statutory safeguards concerning proper care of hospitalized patients also apply to someone in guardianship.⁷⁶ An additional safeguard in section 42 is that if the guardian dies, resigns, becomes incapacitated or is found by a county court to be negligent, the local health authority will assume his duties. Furthermore, under section 35 (1), the national Minister of Health can make regulations on the behavior of guardians. There are protections for the public also. Section 40 states that if the person in guardianship leaves his usual residence without the guardian's permission, he is subject to return by any officer of the local health authority, any policeman, or by anyone else who has been instructed to return him. Generally, the guardian can control where the mentally ill person lives, for example at a hostel for people who need a sheltered living environment, and how he spends his money.

The guardian's major task is to make sure that the patient receives sufficient psychiatric treatment and protective supervision. If the guardian is not the local health authority, this

⁷² Mental Health Act, 1959, 7 & 8 Eliz. 2, c. 72, § 33(3) [hereinafter cited as British Mental Health Act].

⁷³ The regional Mental Health Review Tribunals have laymen as members and are appointed by the Lord Chancellor. They have many of the powers traditionally held by the courts, and, subject to high court review on matters of law, they can release a patient or deny his release.

⁷⁴ British Mental Health Act, § 34(5).

⁷⁵ *Ibid.*, § 43.

⁷⁶ *Id.*, § 36.

means that he must arrange for continuing contact between the patient and a medical practitioner.⁷⁷ If it ever becomes necessary, a guardian may transfer the patient to a mental hospital without the usual procedures, but section 41(2) provides that this action is reviewable by the Mental Health Review Tribunal at the patient's request. In the same way, a patient can even appeal any reported reclassification of his illness.⁷⁸ Finally, under section 47, the guardianship may be terminated by the patient's physician, the responsible local health officer or, in some situations, by the nearest relative.

The British guardian is thus quite different from an American guardian, appointed by the court after a determination of mental incompetency. Ostensibly the American guardian's duties, like those of the British guardian, are similar to those of a parent toward a minor. Nearly half the states, however, have no statutory provisions concerning the proper care to be given a ward, and there are few safeguards of the ward's rights.⁷⁹ The most important difference is that an American guardian is appointed primarily as a protection for the incompetent's estate. Although some statutes have language about guardianship of "the person," the major purpose of the institution is management of property belonging to the mentally ill.⁸⁰

Introducing some supervisory body like an expanded Office of Counselors in Mental Health or a guardianship system is crucial to the use of community care as an alternative to compulsory hospitalization, but it will not solve all the problems of implementing the policy change. There remains the matter of initial selection of treatment by the committing agency or approval of this selection by the reviewing agency in a state such as New York where commitment can be done through medical certification. Another problem will be the coordination of state hospitals with community mental health facilities. One possible statutory approach to solving these problems follows. It incorporates many features of the British and California statutes discussed above and would have to be adapted by each state to conform to its own special needs.

III. Proposed Legislation

The basic addition to any existing statutory scheme is the establishment of a mental health treatment board whose members could be appointed by the highest court in the state. The board is composed of a psychiatrist experienced in the field of

⁷⁷ *Id.*, § 35(1).

⁷⁸ *Id.*, § 38.

⁷⁹ Lindman & McIntyre, Report of the American Bar Foundation, *The Mentally Disabled and the Law* 226 (1961). In some states, the guardian has great discretion in institutionalizing an incompetent without any of the usual procedural safeguards.

⁸⁰ Lindman & McIntyre, *op. cit. supra* n. 79, at 225.

community mental health services; a lawyer; a psychiatrist from the state department of mental health (or comparable state department); at least two other persons with knowledge of related fields; and a clerical staff. In addition, each committing agency in the state has an office of counselors in mental health, appointed by the mental health treatment board with appointments subject to the approval of the committing agency. In other words, each office is a branch of the mental health treatment board. The number of counselors, who should be trained in fields such as psychiatric social work, can vary depending on the population served by the committing agency.

The close relationship of committing agency to counselors, similar to that found in California, seems to be a good way of encouraging mutual respect and a steady flow of information between them. Furthermore, the counselors have to be located so that they have complete familiarity with all the mental health facilities of the region served by the agency. In fact, when the committing agency serves a large region, it may be necessary to decentralize further with several offices of counselors so that they can perform their supervisory functions effectively.

There are several reasons for having a single mental health treatment board above the separate counselor offices despite the bureaucratic pitfalls that can result from the proliferation of "boards." This board should be a link between the committing agency, the department of mental health, and the various mental health facilities, both in the state system and in the community. Not absorbed by the daily routine of supervision that will occupy the counselors, the board will be in a position to formulate policy. It can also make regulations governing the standards of a counselor's performance in the way that the British Minister exercises some control over the behavior of the guardians by his regulations. In its decisions, the mental health treatment board will rely heavily on the counselors' special knowledge of individual cases and local facilities. It will also have, however, the broader outlook and knowledge about the statewide picture of mental health which should be important in decisions about treatment.

The major function of the mental health treatment board is to act in an advisory capacity to the committing agency on the matter of placing a patient. After the committing agency has made a decision that the person alleged to be mentally ill should be required to obtain treatment, the committing agency confers with the board on the initial program of treatment most beneficial to the patient. In a state like New York which has abolished judicial commitments, the mental health treatment board will merely have power to review the initial placement decision should there be occasion for review on this question. The board and counselors will still have their supervisory and transfer functions.

The patient may be sent to a mental hospital or put in the custody of a counselor near his community who will supervise his program of community care and exercise powers of guardianship like those of the British guardian described above. In order to ensure uniform protection of the public as well as high quality care for the patient, all persons in community care will be assigned to a public counselor even though they may be receiving psychiatric treatment with a private practitioner rather than at a community mental health clinic or other public facility. This is sensible because, as discussed earlier in this paper, so many of the people now committed involuntarily could not afford private psychiatry and have no estates to pay the expenses of a private citizen guardian. The mental health treatment board must ensure that no counselor has so many patients that he cannot see each of them several times a week and be familiar with their health at all times.

The cost of treatment for a person in community care should be paid in the same way as the costs at a state mental hospital. If a fund with state and local contributions pays for all patients regardless of the facility to which they are sent, financial rivalries will not interfere with easy patient transfers. Whether the patient is living at home but unable to work because of attendance at a day hospital or living at a state hospital, his family should be entitled to welfare benefits if necessary. The counselors can help the family make the financial adjustment to the community care situation.

The term of a counselor's custody is one year unless renewed with approval of the mental health treatment board. The fact that the counselors' offices are decentralized and affiliated with the committing agency as well as with the mental health treatment board may help ensure impartiality in the judgments of the board on such matters as applications for renewal of custody.

The mental health treatment board keeps files on each involuntary patient—"involuntary" meaning not free to discontinue treatment whenever he chooses. Frequently, perhaps every three or four months, the counselor or the director of the facility in which the patient is receiving treatment will submit a report on the patient's progress. Every transfer or discharge should be reported immediately. One of the duties of the board is to review transfers and discharges, or the lack of them, in order to implement, wherever possible, the policy of rapid transitions from one kind of care to another as it becomes therapeutically desirable.⁸¹ This is especially important, because there will be

⁸¹ In Hawaii, the community mental health program is attempting to keep central files on all mental patients. One person continually goes through these files and reports on those cases which seem to have been in one unit of the program too long. The associate director of the program then investigates these cases. Caplan, *Principles of Preventive Psychiatry* 153 (1964).

many people among those receiving compulsory treatment who are afraid or unable to express their preferences no matter how much information they are given about their rights to do so.

In addition, the board can hear an appeal, at any time, by a patient or other interested person concerning a transfer or discharge decision. This responsibility is similar to that of the Mental Health Review Tribunals in Britain, although there is no reason to limit the times when appeals can be heard since the board will be operating more frequently than the British Tribunals. The advantage of allowing such appeals to the board, rather than a court, is that the board is in a position to understand the case medically and to suggest flexible alternatives to the decision appealed from. On the other hand, the board, like a court, would be less biased than, for example, a branch of the department of mental health. Appeals from the decisions of the mental health treatment board, however, could go through the state courts.

These are merely the rudiments of a system which could allow the states to make full use of their growing community mental health resources. After years of building community care Britain recognized the need to extend its benefits even to those who were involuntary patients without money for private care. Community mental health in the United States is approaching a stage where a comparable development is appropriate.