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THE MENTALLY ILL HOMELESS: EVOLVING INVOLUNTARY COMMITMENT ISSUES

THE HONORABLE EDMUND V. LUDWIG*

IN the early 1970s, often worn on a large lapel button, there was a sick joke—"Be for mental health or I'll kill you"—that summed up a number of popular and simplistic attitudes toward a complex and deplorable problem.¹ It also presaged the phenomenal increase in homeless persons, many of whom are thought to be mentally ill.²

A commitment case that arose in New York City in 1987 illustrates difficult current issues involving the mentally ill homeless.³ The homeless person was Joyce Brown, also known as "Billie Boggs."⁴ On October 28, 1987, members of the city's Homeless

* United States District Court for the Eastern District of Pennsylvania. Based on a paper presented by Judge Ludwig at Villanova Law School Symposium on The Homeless on November 3, 1990.

1. See Parry, *Civil Commitment: Three Proposals for Change*, 10 MENTAL & PHYSICAL DISABILITY L. REP. 334, 334 (1986).

Historically, the public civil commitment debate was more crude than sophisticated, often pitting friends, relatives and neighbors against state and local governments. The views of the mentally disabled person were at best secondary considerations. [Their] options . . . were usually limited to all or nothing types of choices: remain in the home without government assistance or interference; or ostracized to an unknown fate; or be committed to some awful institution.

Id.

2. National Coalition for the Homeless, *A Briefing Paper for Presidential Candidates: Homelessness In the United States — Background and Federal Response*, in THE RIGHTS OF THE HOMELESS 122-24 (July 1, 1987) (Practicing Law Institute Litigation Course Handbook Series No. 331) [hereinafter *Briefing Paper*] ("Homelessness in America has reached epidemic proportions An estimated two to three million . . . are now homeless."). Approximately one-third of the Nation's homeless are believed to be seriously mentally ill. For a discussion of mental illness and homelessness, see *infra* notes 9-17 and accompanying text.

3. *In re Boggs*, 136 Misc. 2d 1082, 522 N.Y.S.2d 407 (Sup. Ct.), *rev'd sub nom.* *Boggs v. New York City Health & Hosps. Corp.*, 132 A.D.2d 340, 523 N.Y.S.2d 71 (1987), *appeal dismissed as moot*, 70 N.Y.2d 972, 520 N.E.2d 515, 525 N.Y.S.2d 796 (1988).

4. *Id.* at 1083, 522 N.Y.S.2d at 408. The appellate division majority opinion refers to her as follows: "Ms. Billie Boggs (Ms. Boggs) is a forty year old woman, whose real name is Ms. Joyce Brown. She chooses to use the name Ms. Billie Boggs, since she admires a television personality of that name, and she desires to thwart her family's efforts to locate her." *Boggs v. New York City Health & Hosps. Corp.*, 132 A.D.2d at 343, 523 N.Y.S.2d at 72; see also *Forcibly Hospitalized Woman Identified*, N.Y. Times, Nov. 5, 1987, at B1, col. 1 (article also describes Ms. Boggs' situation and choice of name).

(1085)

Emergency Liaison Project (Project HELP) removed her from the street and placed her in a psychiatric unit at Bellevue Hospital where she was given anti-psychotic medication.⁵ After placing much emphasis on Brown's behavior, demeanor and testimony, the trial judge ordered her release, finding that she was not mentally ill or unable to care for herself.⁶ On appeal, the appellate division reversed, three to two, holding that she was involuntarily committable.⁷ The dissenters agreed that she was mentally ill but did not believe there was a likelihood of serious self-harm.⁸ These three opinions, the trial court's decision and the appellate division's majority and dissent, differed considerably in their legal and attitudinal approaches to committability. Each opinion contains important implications for the involuntary commitment of the mentally ill homeless. They are best understood when projected against the historical background of the incidence and composition of mentally ill persons among the homeless and the developments over the years in the field of mental health law.

I. DEINSTITUTIONALIZATION: THE EPIDEMIOLOGY OF THE MENTALLY ILL HOMELESS

Although perhaps not based on scientific data, it is generally believed that deinstitutionalization of the chronically mentally ill without providing sufficient community services has been responsible for a significant segment of the homeless.⁹ The figures usually given are in the range of twenty-five to thirty-five percent.¹⁰

5. *In re Boggs*, 136 Misc. 2d at 1084, 522 N.Y.S.2d at 408.

6. *Id.* at 1086-91, 522 N.Y.S.2d at 410-12. For a discussion of the diagnoses of the psychiatrists, see *infra* notes 113-16 and accompanying text.

7. *Boggs v. New York City Health & Hosps. Corp.*, 132 A.2d at 366, 523 N.Y.S.2d at 87.

8. *Id.* (Minolas, J., dissenting). The dissent noted that the record showed no evidence of "any violence directed at [Ms. Boggs] or any emanating from her," and that all of her hospital evaluations concluded that she was not a danger to herself or others. *Id.* at 378-79, 523 N.Y.S.2d at 94-95 (Minolas, J., dissenting).

9. See *Homelessness in America: Hearing Before the Subcomm. on Housing and Urban Affairs of the Senate Comm. on Banking, Housing and Urban Affairs*, 100th Cong., 1st Sess. 24, 119, 126 (1987) (statements of Sen. Cranston and Harvey Vieth, U.S. Dept. of Health and Human Services, Chairman, Federal Interagency Task Force on Food and Shelter).

10. See *Hunger and Homelessness: Hearing Before the Select Comm. on Hunger of the House of Representatives*, 100th Cong., 1st Sess. 89 (1987). Even writers, such as Professor Kanter, who contend that deinstitutionalization is not a major contributor to the increase in homeless people, agree that homelessness and mental illness can interact. Kanter, *Homeless But Not Helpless: Legal Issues in the Case of the Homeless People With Mental Illness*, 45 J. Soc. ISSUES 91 (No. 3 1989). They concede that unresolved severe psychiatric problems may result in homelessness

In 1984, the authoritative Lamb American Psychiatric Association Task Force estimated that thirty-five percent of the homeless population became homeless, as a result of deinstitutionalization and that an additional fifteen percent of the homeless had mental health problems.¹¹ In 1991, a study showed a sharp rise in drug-addicted homeless.¹² Sometimes, these assessments may seem to be in the eye of the political beholder. Also published in 1984, a study by the City of New York claimed that ninety percent of the homeless were mentally ill, while New York State reported only ten percent.¹³ The State is responsible for the care of the mentally disabled and the city for poor persons, such as the homeless, who are not mentally ill.¹⁴

Definitions of mental illness play a large part in all of the estimates, and the timing of the assessment of a person may be critical.¹⁵ It is well recognized that homelessness, like incarceration, can have a profoundly decompensating effect.¹⁶ Some clinicians say it can mimic severe mental illness in those who have no history of problems. Others claim that most persons in this category are already vulnerable to stress. Although subject to many of the same socioeconomic factors that produce homeless families, the

and, conversely, homelessness may provoke or exacerbate symptoms of mental illness. *Id.* These writers take the position that as many as 20% of the general population will at some time have serious mental problems. For the seriously mentally ill in the general population, most studies suggest a range from five to eight percent.

11. THE HOMELESS MENTALLY ILL: A TASK FORCE REPORT OF THE AMERICAN PSYCHIATRIC ASSOCIATION (C.H. Lamb ed. 1984) [hereinafter HOMELESS MENTALLY ILL]. As the Report documents, much of these computations depend on the definitions of mental illness and the methodologies utilized. *Id.* at 88.

12. *The Changing Face of Street Population*, Phila. Inquirer, Feb. 5, 1991, at B2, col. 3 (reporting on Outreach Coordination Center figures for 1988-90).

13. See Coates, *Legal Rights of Homeless Americans*, 24 U.S.F. L. REV. 297, 330 & n.174 (1990).

14. *Id.* "[T]he City is responsible for those Homeless who are merely economically deprived, and specifically not for the mentally ill Homeless." *Id.*

15. See *supra* note 11; see also *In re Boggs*, 136 Misc. 2d 1082, 1088, 522 N.Y.S.2d 407, 411 (Sup. Ct.), *rev'd sub nom.* *Boggs v. New York City Health & Hosps. Corp.*, 132 A.D.2d 340, 523 N.Y.S.2d (1987), *appeal dismissed as moot*, 70 N.Y.2d 972, 520 N.E.2d 515, 525 N.Y.S.2d 796 (1988). "[A hospital psychiatrist] testified that those few intervening days at the hospital provided Ms. Brown with a structured environment which permitted her to 'reconstitute herself' by the time the NYCLU doctors saw her." *Id.*

16. Comment, *Homeless Families: Do They Have a Right to Integrity?* 35 UCLA L. REV. 159, 164 (1987). "Research shows that homelessness disrupts an individual's emotional well-being, causing confusion and cognitive dissonance. Once this disorientation occurs, others, including other homeless persons who still maintain a resemblance of mental health, shun the individual, thereby leading to further disorientation." *Id.* (footnotes omitted).

mentally ill have been loners who favor single-room accommodations and who are functionally unable to take care of their basic needs.¹⁷

Deinstitutionalization began in the 1950s with the discovery that Thorazine, which was then being used experimentally to ease the pain of post-operative patients, could organize the minds of certain long-term schizophrenics.¹⁸ There is the perhaps apocryphal story of the World War I veteran who, having been institutionalized and disoriented for some thirty-five years, went up to a hospital psychiatrist and said, "Hey, Doc, what am I doing here?"¹⁹ Many of the transformations were unbelievable and seemingly miraculous. Previously "hopeless" patients could be given the chance to live in the community. Some had spent their entire adult lives in the back wards of a state or veterans administration hospital. Many kinds of anti-psychotic or psychotropic medication were formulated, and each year, new drugs continued to be approved.²⁰ In 1990, clozapine became available in the United States.²¹ A so-called new generation of pharmacotherapy, clozapine may enable the release of as many as thirty percent of long-term patients still in state hospitals and improve the lives of a substantial number of those who remain there.

Before anti-psychotic medication came into use, long-term hospitalization often was the rule. A mentally ill person could spend a lifetime in custodial care, particularly when also confined on criminal matters.²² In 1960, the state hospital census in

17. See Comment, *supra* note 16, at 163 ("Although the causes . . . differ, they share the basic trauma of lack of shelter."); Ades, *The Unconstitutionality of 'Antihomless' Laws*, 77 CALIF. L. REV. 595, 601 (1989) ("The stereotype of . . . an older alcoholic male has lost most of its validity . . .").

18. See HOMELESS MENTALLY ILL, *supra* note 11, at 229-30; see also Sobel, *Psychiatric Drugs Widely Misused, Critics Charge*, N.Y. Times, June 3, 1980, at C1, col. 5. For a discussion of the view that deinstitutionalization pre-dated anti-psychotic medications, see A. SCULL, *DECARCERATION, COMMUNITY TREATMENT AND THE DEVIANT—A RADICAL VIEW* (1984).

19. J. SWAZEY, *CHPROPROMAZINE IN PSYCHIATRY*, 200-01 (1974) ("The most memorable experience [was] . . . this small group of patients in the day room . . . with their psychiatric symptoms wiped away.").

20. See Durham & La Fond, *A Search for the Missing Premise of Involuntary Therapeutic Commitment: Effective Treatment of the Mentally Ill*, 40 RUTGERS L. REV. 303, 343 (1988) ("Since 1960, it is estimated that well over 25,000 papers have been published in the scientific literature on the effectiveness of psychotropic drugs.").

21. See *Visser v. Taylor*, 756 F. Supp. 501, 507 (D. Kan. 1990) (requiring Kansas' Medicaid program to include clozapine, under brand name Clozaril, in its list of covered drugs).

22. Farview State Hospital, Pennsylvania's maximum security hospital, is a striking example. In 1979, a group of forensic mental health experts were in-

America was somewhere between 500,000 and one million—the data is that imprecise.²³ By the 1980s, the number was closer to 100,000, and it continues to decline, though less dramatically.²⁴ Who were these long-term patients and what happened to them? In most cases, their family ties were attenuated or severed. They received no ongoing treatment, and their hospitalizations were custodial. In many instances, these people were institutionalized because their families could not or would not take care of them.

As anti-psychotic medication gained widespread acceptance, civil commitment laws were being revised. The commitment standard had been simply “mental illness” plus the need for care and custody or, sometimes, just care.²⁵ In 1975, the United States Supreme Court decision in *O'Connor v. Donaldson*²⁶ notified the states that they could not involuntarily confine a non-dangerous mentally ill person, without more, who was capable of surviving with the help of willing family members or friends.²⁷ If a state

vited to assess the appropriateness of Farview's population, many of whom had been committed as incompetent to stand trial. Case Review and Clinical Seminar on the Least Restrictive Alternative, Conducted by the Office of Mental Health, Pennsylvania Department of Public Welfare (May 30-31, 1979) [hereinafter Office of Mental Health Seminar] (program held at Fairview State Hospital and attended by author). One of the residents was 80 years old and, according to his faded longhand admission note, had been charged with the crime of burglary and committed to Farview in 1921. He was never tried. *Id.* In the early 1970s, following *Humphrey v. Cady*, 405 U.S. 504 (1972), and *Jackson v. Indiana*, 406 U.S. 715 (1972), he was offered re-location to a community home, which he refused. Office of Mental Health Seminar. As of 1979, the Commonwealth was spending about \$75,000 a year for his “hospitalization.” *Id.*

23. See, e.g., Coates, *supra* note 13, at 331 (“perhaps one million”); M. CUOMO, NEVER AGAIN, A REPORT TO THE NATIONAL GOVERNOR'S ASSOCIATION TASK FORCE ON THE HOMELESS, H.R. DOC. NO. 43-749 0-85-13, 98th Cong., 2d Sess. 41 (1983) (from 1963 to 1979, in-patient population of psychiatric institutions decreased from 505,000 to approximately 146,000); Durham & La Fond, *supra* note 20, at 306 n.9.

24. UNITED STATES DEP'T OF HEALTH AND HUMAN SERVS., NATIONAL INST. OF MENTAL HEALTH, MENTAL HEALTH IN THE UNITED STATES, Tables 2.3 & 2.8 (1985).

25. See, e.g., Pennsylvania Mental Health and Mental Retardation Act of 1966, PA. STAT. ANN. tit. 50, § 4406(b) (Purdon 1969) (repealed in part 1976) (“If, upon examination, it is determined that such [mentally disabled] person is in need of care at a facility . . . said court . . . may order the commitment of such person for care and treatment.”); *Goldy v. Beal*, 429 F. Supp. 640, 648 (M.D. Pa. 1976) (§ 4406 civil commitment standard violates due process because “in need of care” and “care” are impermissibly vague).

26. 422 U.S. 563 (1975).

27. *Id.* at 576. The Supreme Court further found that a state may not confine the mentally ill to provide them with a higher standard of living or to protect the state's citizens from exposure to such persons. *Id.* at 575. The Court stated that “[m]ere public intolerance or animosity cannot constitutionally justify the deprivation of a person's physical liberty.” *Id.*

did so, it could be held liable for damages.²⁸ At least equally significant, the decision vacated the holding of a circuit court that an involuntary committee has a constitutional right to treatment.²⁹ The *Donaldson* decision also left open whether an involuntary commitment for the sole purpose of treatment could be constitutionally acceptable.³⁰ Seventeen years later, these questions remain undecided.

The revised commitment laws required a showing of clear and present danger to oneself or others, although the rubrics of the standard, such as "severely mentally disabled," "gravely disabled," "imminent threat," and the particular definitions varied from statute to statute.³¹ In all of these new laws, counseled hearings, time-limited commitments, and periodic administrative and judicial reviews were mandated.³² These statutory limitations, once in place, also served to shrink the state hospital populations.

In 1976, after Pennsylvania's new commitment law went into effect, the state's Office of Mental Health was informed that of the 5,500 long-term "voluntary patients" in the state hospitals, some 3,800 were unable to understand and sign the new voluntary admission forms.³³ What was to be done? How did they become

28. *Id.*

29. *Id.* at 577 n.12. ("Of necessity our decision vacating the judgment of the Court of Appeals [of the Fifth Circuit] deprives that court's opinion of precedential effect, leaving this Court's opinion and judgment as the sole law of the case."). *Id.* at 578.

30. *Id.* at 574 n.10. The *Donaldson* Court noted:

There is . . . no occasion in this case to decide whether the provision of treatment, standing alone, can ever constitutionally justify involuntary confinement or, if it can, how much or what kind of treatment would suffice for that purpose. In its present posture this case involves not involuntary treatment but simply involuntary custodial confinement.

Id.

31. See Note, "Crazy" Until Proven Innocent? *Civil Commitment of the Mentally Ill Homeless*, 19 COLUM. HUM. RTS. L. REV. 333-42 (1988). For example, "[t]he New York Mental Hygiene Law authorizes emergency detention of individuals who have mental illnesses which are 'likely to result in serious harm' to themselves or others and which demand immediate observation, care, and treatment in a hospital." *Id.* at 338.

32. See B. ROCK, *THE MENTALLY DISABLED AND THE LAW*, 164-65 (1971). These procedural safeguards serve to protect the rights of the mentally ill who are involuntarily hospitalized. *Id.* at 155.

33. Information obtained from the Office of Mental Health, Pennsylvania Department of Welfare. See Pennsylvania Mental Health Procedures Act of 1976, PA. STAT. ANN. tit. 50, § 7203 (Purdon Supp. 1991). Under this statute, voluntary commitment requires informed consent. *Id.* The statute provides that "[b]efore a permit is accepted . . . an explanation shall be made . . . including the types of treatment . . . and any restraints or restrictions . . . together with a statement of . . . rights under this act." *Id.* A detailed, executed consent form must also be submitted. *Id.*

hospitalized in the first place? Years ago, "voluntary" could mean "not objecting."³⁴ If a patient could not qualify as voluntary any longer, the only alternative was involuntary. That meant conducting an administrative review every thirty days and counseled hearings every ninety days, assuming that the revised commitment standard could be met.³⁵ If it could not be, the patient had to be released.

Other deinstitutionalization forces were also at work. In the late 1970s, a period of escalating, double-digit inflation, the discharge of long-term patients was welcome news for state budget and welfare officials. In turn, the curtailment of public funding that began during this time period may have had a greater deinstitutionalizing effect than all the successes of the civil rights movement. For the time-being, these synergistic bedfellows accelerated the rate of deinstitutionalization. In 1976, the new commitment act in Pennsylvania was intended to be a prompt service law, not a deinstitutionalization law.³⁶ But its array of due process requirements favored short-term treatment—the longer the commitment period, the more difficult the retention procedures. The necessary corollary was to compel the Commonwealth to consider other dispositions for many of its long-term patients. As in most areas of the country, the service package promised by the Pennsylvania Department of Welfare to accompany the new procedures law did not materialize. The federal Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963³⁷ envisioned a nationwide network of community centers providing comprehensive services

34. See, e.g., Pennsylvania Mental Health and Mental Retardation Act of 1966, PA. STAT. ANN. tit. 50, § 4404 (Purdon 1969) (repealed in part 1976) (application for civil commitment to facility "(a) may be made in the interest of any person who appears to be mentally disabled and in need of care . . . (b) accompanied by the certificates of two physicians"). This "non-involuntary" provision was invalidated a few years after enactment. *Dixon v. Attorney Gen.*, 325 F. Supp. 966, 973 (M.D. Pa. 1971) (court found § 4404 unconstitutional facially and as applied to plaintiffs). The decision in *Dixon* resulted in the release of more than 1,000 maximum security residents of Farview State Hospital who had been committed after the authority for their criminal confinement had expired. Office of Mental Health Seminar, *supra* note 22. For a discussion of the appropriateness of Farview's population, see *supra* note 22.

35. See Pennsylvania Mental Health Procedures Act of 1976, PA. STAT. ANN. tit. 50, §§ 7108, 7304(e)(1) (Purdon Supp. 1991) (by amendment in 1978, recommitment periods were increased up to 180 days).

36. *Id.* § 7102 (Purdon Supp. 1991) ("It is the policy of the Commonwealth of Pennsylvania to seek to assure the availability of adequate treatment to persons who are mentally ill, and it is the purpose of this act to establish procedures whereby this policy can be effected.").

37. 42 U.S.C. §§ 6000-6083 (1988).

and individual case management.³⁸ Of the 2,500 centers contemplated by the Act, fewer than 700 were built.³⁹

Although the cuts in state hospital allocations may have seemed harsh at the time, the consequences for community program funding were even worse.⁴⁰ In Pennsylvania, even after community mental health units were established under the Mental Health and Mental Retardation Act of 1966,⁴¹ the state hospital budget continued to receive three-fourths of the state's mental health dollars.⁴² However, by comparison, the numbers of persons served in each system were more than inversely proportional.⁴³ Traditionally, the state hospitals were political fiefdoms. Shutting down a state hospital was not much different from trying to close a military base or a naval shipyard. Even today, when the state hospital census in Pennsylvania is about 7,000, down from a high of 65,000 in the 1950s, the preponderance of state money available for mental health services goes to the hospitals.⁴⁴

It is not surprising that eighty-five to ninety percent of long-term state hospital patients have been indigent.⁴⁵ By the time of admission, these patients have exhausted or been stripped of

38. *Id.*

39. Note, *Requiring Due Care in the Process of Patient Deinstitutionalization: Toward a Common Law Approach to Mental Health Care Reform*, 98 YALE L.J. 1153, 1156 (1989); Kanter, *supra* note 10, at 98.

40. Coates, *supra* note 13, at 331 ("In California, for example, the allocation for mental health care is less than one fourth the money that was being allocated twenty-five years ago.').

41. PA. STAT. ANN. tit. 50, § 4404 (Purdon 1969) (repealed in part 1976).

42. Pennsylvania Department of Public Welfare, Summary of Fiscal Activity (fiscal years 1966-1980) (spreadsheet including Overview of Governor's Recommended Budget 1981-1991) (document on file at Villanova Law Review office).

43. *Id.* In 1966-67, the year-end state hospital census in Pennsylvania was 33,207. *Id.* By 1975-1976, it had dropped to 13,293. *Id.*; see Note, *supra* note 39, at 1156 n.21 ("State hospitals receive more than twice the funds allocated to [Community Mental Health Services] In 1965, New York State had 85,000 in state psychiatric facilities, but in 1979 it had only 25,000. At both times 80% of state funds were allocated to state psychiatric facilities as opposed to community alternatives.'').

44. Memorandum entitled "Public Health System Historical Information," from Jack A. Wolford, M.D., Psychiatric Director, Office of Mental Health, Pennsylvania Department of Public Welfare (October 4, 1991) (document on file at Villanova Law Review office).

45. Durham & La Fond, "Thank you, Dr. Stone": A Response to Dr. Alan Stone and Some Further Thoughts on the Wisdom of Broadening the Criteria for Involuntary Therapeutic Commitment of the Mentally Ill, 40 RUTGERS L. REV. 865, 879 n.53 (1988) ("Involuntary patients commonly are poor and unemployed. In our Washington study, we found that over 90 percent of all committees were unemployed at the time of their initial commitment.'').

most of their assets or expectancies. In the 1970s and 1980s, when discharged in increasing numbers, their economic and placement needs, as well as a place to live, were well beyond what was left of social service funding streams. Many either had no family to return to or strongly preferred to live on their own. Soon most lost their federal total disability payments, Social Security and other benefits.⁴⁶

The best community programs put in place (to remedy the needs of discharged patients) were conducted in small residential settings. Some of these programs have been excellent. Where these resources are available, many chronically mentally ill have made reasonably good adjustments, and their lives are far better than they were in the state hospital.⁴⁷ However, there were few such programs, and for most of the mentally ill, mere physical survival often became a daily challenge.

As Robert Coates commented in *Legal Rights of Homeless Americans*:

That homeless persons lack a support system and face great difficulties in meeting basic subsistence needs of food, shelter and clothing is axiomatic. A fortiori, the Homeless who are mentally ill face the greatest difficulties in meeting these basic subsistence needs. The application processes to obtain resources to meet *any* of these needs, even those for emergency shelter, are often so complex and daunting that individuals with significant mental impairment have no chance of successfully negotiating these processes.⁴⁸

Aftercare upon discharge from the state hospital has always been problematical.⁴⁹ The necessary coordination between state

46. Coates, *supra* note 13, at 331.

47. *Briefing Paper*, *supra* note 2, at 126.

The proper implementation of deinstitutionalization is clearly a solution. . . . [It] has two parts: patient must be discharged . . . and continued support must be provided in the community [T]here are scores of model programs where chronically mentally ill live decently, fit harmoniously into the community, and require comparatively little public expense. It has been sadly noted that the problem is not that deinstitutionalization failed, but that it is so rarely tried.

Id.

48. Coates, *supra* note 13, at 331 (footnote omitted). Returning to a hostile environment after being deinstitutionalized caused further mental deterioration in former state psychiatric patients. *Id.* at 332.

49. See HOMELESS MENTALLY ILL, *supra* note 11, at 99. The aftercare system generally consists of stringent requirements with respect to attendance, sched-

facilities and community services has been lacking. In many states, different governmental authorities are involved, and there is no intermediary or supervising agency to double-check whether an aftercare plan is being implemented. Anti-psychotic medication has unpleasant side effects and can be irreversibly debilitating.⁵⁰ In medicated remission, many persons deny that they are ill or in need of treatment. If a person decompensates, out-patient treatment or even recommitment to the hospital has been difficult to enforce.

One of the effects of the clear and present danger commitment standard was to increase the numbers of mentally ill persons who wound up in corrections.⁵¹ The jails and prisons began to complain that they were being overloaded with "crazies." Mental health advocates complained that mental illness was being "criminalized."⁵² State hospitals complained that their populations were being infiltrated by commitments of anti-social or sociopathic people, who were not mentally ill in the same sense as their other patients.⁵³

uled appointments, and adherence to rules of participants and behavior. *Id.* Many homeless people are unable or unwilling to comply with such requirements. *Id.*

50. *See, e.g.,* *Washington v. Harper*, 494 U.S. 210, 229 (1990) ("[anti-psychotic drugs] can have serious, even fatal, side effects"); *Rennie v. Klein*, 720 F.2d 266, 275 (3d Cir. 1983) (Weis, J. concurring) ("long-term administration of anti-psychotic drugs may result in permanent physical and mental impairment").

51. *See Lessard v. Schmidt*, 349 F. Supp. 1078, 1095 (E.D. Wis. 1972), *vacated on other grounds*, 414 U.S. 473 (1974), *on remand*, 413 F. Supp. 1318 (E.D. Wis. 1976). In this early, well-noted decision analogizing involuntary commitment to deportation, the court held that the evidentiary burden must be beyond a reasonable doubt. *Id.* at 1094-95. However, in *Addington v. Texas*, 441 U.S. 418, 432-33 (1979), the Supreme Court rejected the reasonable-doubt standard and held that "determination of the precise burden equal to or greater than the 'clear and convincing' standard . . . is a matter of state law." The Court "concluded that the reasonable-doubt standard is inappropriate in civil proceedings because, given the uncertainties of psychiatric diagnosis, it may impose a burden the state cannot meet and thereby erect an unreasonable barrier to needed medical treatment." *Addington*, 441 U.S. at 432; *see The National Center for State Courts' Guidelines for Involuntary Civil Commitment*, 10 MENTAL & PHYSICAL DISABILITY L. REP. 409, 415 (1986) [hereinafter *Guidelines for Involuntary Civil Commitment*] ("By the mid-1970s, many states had enacted restrictive laws that contained narrow commitment criteria and stringent legal safeguards. These laws made it more difficult to commit persons deemed mentally ill and in need of treatment.").

52. *See* HOMELESS MENTALLY ILL, *supra* note 11, at 67-69; Kanter, *supra* note 10, at 92 ("Another result of deinstitutionalization has been the 'criminalization' of a subgroup of individuals with mental illness.").

53. *See Guidelines for Involuntary Civil Commitment*, *supra* note 51, at 415-16. Some observers came to believe that the legal safeguards against improper commitment based on the criminal, due process model created unnecessary barriers to the provision of treatment for seriously mentally ill persons. . . . [Another development was] 'transinstitutionaliza-

Impressionistically at least, all of these observations were correct.⁵⁴ Under the revised standards, many discharged patients could not be involuntarily re-institutionalized. If they were violent, they often would be incarcerated. If they were without food or shelter, jail was, as always, a place of resort. With the emphasis in the standard on harmful conduct, the hospitals began to receive individuals who were unlike the familiar withdrawn or sometimes frenzied long-term patient population. The arrival of severe prison overcrowding in the 1980s meant that cells were not as available for the mentally ill. Hospitals developed strategies to be selective about patient intake.

The tragic dilemma that resulted from the mass discharge and exodus of the chronically mentally ill can be likened to the classic conflict between forms of personal freedom and control. Lon Fuller posited two antithetical models or typologies of freedom.⁵⁵ Freedom can be thought of as the capacity to choose from a large number of possibilities.⁵⁶ However, if the number is bewildering or without priority, or the possibilities are beyond reach, the condition becomes chaos. A psychological manifestation of this phenomena is schizophrenia. Acute schizophrenics must be helped to systemize some of the smallest tasks—putting on socks, shoes, tying shoelaces, brushing teeth.

Or: Freedom can be regarded as order and regularity, the freedom that comes from functioning within known limits or an internalized structure—the freedom epitomized, in one sense, in Prokofiev's "Classical Symphony."⁵⁷ Taken to the extreme, however, this form of freedom leads to rigidity, confinement and loss of autonomy.

The civil rights aspects of deinstitutionalization were humane, well-intentioned, often clinically overdue and constitutionally necessary. Most former state hospital patients found that

tion' of mentally ill patients from mental hospitals to nursing homes, temporary shelters, and jails with inadequate care.

Id.

54. See Ludwig, *The Homeless, the Mentally Ill and the Law*, PA. LAW., June 1989, at 27, 32. As the article suggests, there is an "element of truth" in the positions of both the state hospitals and the jails. *Id.* For a discussion of these positions, see *supra* text accompanying notes 51-53.

55. Fuller, *Freedom—A Suggested Analysis*, 68 HARV. L. REV. 1305-25 (1955). For a discussion of these models or typologies of freedom, see *infra* text accompanying notes 56-57.

56. Fuller, *supra* note 55, at 1309. ("'[F]reedom to,' means the opportunity to choose between alternatives or among a range of alternatives.")

57. *Id.* at 1312-16 (describing necessity of social order for realization of freedom).

they preferred marginal living arrangements or even the street to existence in the institution. Yet the problems and stresses of mere survival without realistic economic or treatment supports could not help but be extremely decompensating and harmful, both mentally and physically. For these unfortunate people, freedom outside of the institution was transformed into a nightmarish kind of self-imprisonment. Their plight demonstrates that freedom without power is not freedom. Given a world without structure or organization, an analogy may be made to florid schizophrenia.⁵⁸

The social politics of the mentally ill homeless had a counter-deinstitutionalizing effect. The constant visibility of the homeless produced waves of complaints stirred by feelings of fear, anger, resentment and sometimes guilt.⁵⁹ The efforts of legislative and executive policymakers to respond to this problem have generated a new set of issues involving the individual's interest in liberty versus the state's interest in protecting its citizens.⁶⁰ As to the mentally ill, it has prompted a re-examination of commitment standards, the question of the right to treatment and to refuse treatment, the legal status and entitlement of a deinstitutionalized person and the nature and extent of the services that the local, state or federal government may be obligated to provide.

The subset of the dangerousness to oneself standard—the inability to care for oneself—has produced little case law. Mentally ill homeless are rarely committable as dangerous to others.⁶¹ In retrospect, the unable-to-care for oneself standards of the 1970s were not drafted with the mentally ill homeless in mind. Instead, they were intended for the psychotic who did not recognize any-

58. See R. LAING, *THE POLITICS OF EXPERIENCE* 79 (1967).

59. Note, *supra* note 31, at 363 (“[M]edical professionals [may] condone commitment because they see few alternatives to the public’s fears of the mentally ill and homeless The media may perpetuate such prejudices which effectively blame these individuals for their condition.”) (footnotes omitted); see also *A First Look at Homeless is Raw Sight for Tourist*, N.Y. Times, Nov. 9, 1987, at B1, col. 5 (article describes “bloated women with ulcerated legs and hollow-eyed men who shout obscenities” living on New York City streets).

60. See Kanter, *supra* note 10, at 92 (“Two issues have emerged. . . . First, whether homeless people should be institutionalized against their will A second issue concerns forced treatment and sheltering.”).

61. See Coates, *supra* note 13, at 344 (“As a Municipal Court judge . . . I have seen hundreds of homeless individuals Very rarely is a theft case seen; and I have been surprised, frankly, at the almost total dearth of Homeless defendants being charged with felonies.”); see also Durham & La Fond, *supra* note 20, at 307 n.10 (“[M]ore recent research indicates that the mentally ill are no more dangerous than the non-mentally ill. Media reporting, however, seems to contribute to the public’s perception that the mentally ill are more dangerous.”).

one or for the family member whom no one wanted to care for or put up with any longer.⁶²

II. THE GREENING OF FORENSIC MENTAL HEALTH

In the period predating the dramatic rise in homelessness, developments occurred in the use of mental health expert testimony that would have a future impact on the commitment of the mentally ill homeless. By the 1960s, the legal and mental health professions had begun, though not always happily, to join forces in a large variety of civil and criminal areas. In 1965, Dr. Leigh Roberts wrote: "The professions of law and psychiatry currently interact with greater intensity and frequency than at any prior point in time."⁶³ Psychiatrists were called upon to testify in court as to "mental illness," "mental disorder," and "mental disease or defect" as they related to various legal states, such as insanity, dangerousness or incompetence.⁶⁴ The theory was that mental impairment is relevant because it can blunt a person's perception and awareness or make it difficult to control one's conduct. As to propensities for harmful behavior and incompetency, the law may ask whether, in a particular case, these conditions are susceptible to improvement or deterioration. Are they treatable? Answers to these question usually require expertise.⁶⁵ In making an evaluation, mental health experts utilize diagnostic categories, which are a part of their esoteric fields of knowledge. They construct hypotheses about future behavior and amenability to treatment. To aid the factfinder in the courtroom, their testimony necessitates a

62. See Ludwig, *supra* note 54, at 30 (unable-to-care for oneself standard of Pennsylvania Mental Health Procedures Act of 1976 "almost sounds as though it was written specifically with the mentally ill homeless in mind"). *Id.* Professor Brooks refers to "a new legal category of mentally ill persons . . . which has generally been described by use of the term 'gravely disabled' . . . They can be regarded as dangerous to themselves due to their inability to attend to their critical life functions." Brooks, *Defining the Dangerousness of the Mentally Ill: Involuntary Civil Commitment*, in MENTALLY ABNORMAL OFFENDERS 280, 298 (M. Craft & A. Craft eds. 1984).

63. Roberts, *Some Observations on the Problem of the Forensic Psychiatrist*, 1965 Wis. L. Rev. 240.

64. R. REISNER & C. SLOBOGIN, LAW AND THE MENTAL HEALTH SYSTEM 327-29, 376-490 (1990). The history and analysis in this section are largely adapted from Professor Slobogin's pre-publication class materials, some of which were incorporated in the textbook.

65. For a discussion of the Supreme Court's views on expert psychiatric testimony, see *infra* notes 98-111 and accompanying text. See also *Addington v. Texas*, 441 U.S. 418, 429 (1979) ("The [clinical] facts . . . must be interpreted by expert psychiatrists and psychologists . . ."); *Ake v. Oklahoma*, 470 U.S. 68, 80 (1985) ("Psychiatrists can translate a medical diagnosis into language that will assist the trier of fact.").

legally sufficient degree of certainty and often involves the use of predictions.⁶⁶

Critics emerged and attacked the reliability of mental health expert testimony from many sides.⁶⁷ Radical psychiatrists contended that mental illness is not the same as physical illness because mental illness is not objectively measurable and cannot be scientifically validated.⁶⁸ In 1970, Thomas Szasz wrote: "My aim . . . is to ask if there is such a thing as mental illness, and to argue that there is not. Of course, mental illness is not a thing or physical object; hence it can exist only in the same sort of way as do other theoretical concepts."⁶⁹ In 1967, R.D. Laing asserted, perhaps prophetically, that "those who are diagnosed as schizophrenic are not ill but are reacting in a sane and rational way to the intolerable emotional pressures placed on them by society and their families."⁷⁰ "Without exception," he continued, "what is labelled schizophrenic is a special strategy that a person invents in order to live in an unlivable situation."⁷¹ In the same year, Dr. Sarbin stated that "[p]ersons who are labeled mentally ill are not regarded as merely sick; they are regarded as a special class of beings, to be feared or scorned, sometimes to be pitied, but nearly always to be degraded."⁷² Goffman had documented the effect of institutionalization on the lives of mental patients, who may eventually view themselves as incapable of living regular lives outside the institution.⁷³

66. See R. REISNER & C. SLOBOGIN, *supra* note 64, at 376-443. The admissibility of clinical opinion testimony is discussed in terms of "normality," "responsibility," "propensity," and "competency"—which can be redefined as diagnoses that relate to past and future conduct and present capability. *Id.* at 378. Predictive testimony is considered under propensity. *Id.* at 417.

67. *Id.* at 350-75.

68. Morse, *Crazy Behavior, Morals and Science: An Analysis of Mental Health Law*, 51 S. CAL. L. REV. 527, 607 (1978). "Unlike much physical disorder that often can be verified by various tests that measure pathology . . . , there is no objective, empirical referent of *mental* disorder other than crazy behavior itself." *Id.*

69. T. SZASZ, *IDEOLOGY AND INSANITY* 12 (1970). *But see* M. MOORE, *LAW AND PSYCHIATRY: RETHINKING THE RELATIONSHIP* 156 (1984) ("The problem is that mental illness is not a myth. It is not some palpable falsehood propagated among the populace by power-mad psychiatrists, as Szasz . . . has proclaimed; it is a cruel and bitter reality that has been with the human race since antiquity.").

70. See R. LAING, *supra* note 58, at 78-79.

71. *Id.*

72. Sarbin, *On the Futility of the Proposition that Some People Be Labeled "Mentally Ill,"* 31 J. CONSULTING PSYCHOLOGY 447, 451 (1967). There are also "beliefs that such 'mentally ill' persons discharge obligations only of the most simple kinds." *Id.*

73. E. GOFFMAN, *ASYLUMS: ESSAYS ON THE SOCIAL SITUATION OF MENTAL*

Civil rights lawyers questioned the trustworthiness of psychiatric testimony. In 1974, commentators Bruce Ennis and Thomas Litwack published *Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom*.⁷⁴ They described the experiences of eight pseudo-patients, persons who feigned hearing voices and were kept in a mental hospital from seven to fifty-two days.⁷⁵ All but one was diagnosed as schizophrenic.⁷⁶ Psychiatrists, they argued, were trained to suspect illness and were strongly biased by their personal value systems.⁷⁷ Each school of psychiatry has a different view of mental illness and how it should be treated. In 1978, Professor Morse proposed that mental health expert testimony should be limited to descriptions of the cognitive and affective states of an individual.⁷⁸ The reason is that "unrestricted testimony tends to obscure the moral and social nature of the questions being asked."⁷⁹ It can be "really a moral guess and not a

PATIENTS AND OTHER INMATES (1961). In his discussion of institutionalization, Erving Goffman stated:

[T]otal institutions disrupt or defile precisely those actions that in civil society have the role of attesting to the actor and those in his presence that he has some command over his world—that he is a person with "adult" self-determination, autonomy, and freedom of action. A failure to retain this kind of adult executive competency, or at least the symbols of it, can produce in the inmate the terror of feeling radically demoted in the age-grading system.

Id. at 43 (footnote omitted).

74. Ennis & Litwack, *Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom*, 62 CALIF. L. REV. 693 (1974).

75. *Id.* at 730.

76. *Id.*

77. *Id.* at 720-29. The authors point out that the "assumption that an individual diagnosed as schizophrenic requires involuntary care and treatment often may be erroneous." *Id.* at 732. They base this conclusion on "a significant ambiguity" present in "the diagnostic manual of the American Psychiatric Association—which presumably provides the basis for psychiatric diagnoses." *Id.* Apparently, the manual provides that patients should be diagnosed as psychotic only if their "mental functioning is sufficiently impaired to interfere grossly with their capacity to meet the ordinary demands of life." *Id.* (quoting AMERICAN PSYCHIATRIC ASSOCIATION, DSM-II: DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 23 (2d ed. 1968)). The authors suggest that, under that definition, almost anyone diagnosed as psychotic would necessarily satisfy the criteria for involuntary commitment. *Id.* at 732. The manual provides that patients may be diagnosed as schizophrenic, a sub-category of psychosis, "even if the individuals 'are not in fact psychotic.'" *Id.* The problem is that many psychiatrists believe that "millions of persons who could be diagnosed as schizophrenic do not require hospitalization." *Id.* Therefore, the authors conclude "the use of diagnoses such as schizophrenia is misleading and can prejudice the prospective patient's rights." *Id.*

78. Morse, *supra* note 68, at 619. Professor Morse suggested that experts should refrain from drawing conclusions and instead provide "descriptive data that would otherwise be unknown and hard, relevant probability data." *Id.*

79. *Id.* at 626. Professor Morse contended that using experts in an un-

scientific fact," he wrote.⁸⁰ From an evidentiary perspective, it exceeds the limits of a mental professional's sphere of expertise.⁸¹

In 1967, in an appendix to *Washington v. United States*,⁸² Judge Bazelon recommended that the mental health expert concentrate on descriptive testimony, although diagnoses were a convenient method of communication and should not be eliminated.⁸³ A number of Supreme Court Justices—for example, Frankfurter, Burger and Thurgood Marshall—have written on the incertitude of mental health clinician testimony.⁸⁴ In the aftermath of the *Hinckley* case, Congress amended the Federal Rules of Evidence to bar expert evidence as to a defendant's mental state or condition constituting an element or defense in a criminal case.⁸⁵ Dr. Alan Stone, past president of the American Psychiatric Association (A.P.A.), explained the psychiatrists' debate concerning

restricted manner fosters the misconception that the questions being asked are predominantly scientific. *Id.*

80. *Id.* at 619. Professor Morse stated that "there are no scientific tests to measure the strength of crazy urges or the strength of the [individual's] self-control." *Id.* at 618.

81. *Id.* at 626. Professor Morse noted that the expert testimony of mental health professionals often can be inefficient, wasteful and prejudicial. *Id.*

82. 390 F.2d 444 (D.C. Cir. 1967).

83. *Id.* at 457. Judge Bazelon stated that an expert witness may testify as to "whether the defendant suffered from a mental disease or defect. . . [and] how defendant's disease or defect relates to his alleged offense, that is, how the development, adaptation and functioning of defendant's behavioral processes may have influenced his conduct." *Id.* Judge Bazelon also noted that the expert's description must be complete in order to allow the jury to make an informed judgment as to whether the alleged crime was a result of the defendant's mental disease or defect. *Id.*

84. See, e.g., *Ake v. Oklahoma*, 470 U.S. 68, 81 (1985) (Marshall, J.) ("Psychiatry is not . . . an exact science, and psychiatrists disagree widely and frequently on what constitutes mental illness, on the appropriate diagnosis to be attached to given behavior and symptoms, on cure and treatment, and on likelihood of future dangerousness."); *O'Connor v. Donaldson*, 422 U.S. 563, 579 (1975) (Burger, C.J. concurring) ("The Court appropriately takes notice of the uncertainties of psychiatric diagnosis and therapy."); *Greenwood v. United States*, 350 U.S. 366, 375 (1956) (Frankfurter, J.) ("The only certain thing that can be said about the present state of knowledge and therapy regarding mental disease is that science has not reached finality of judgment.").

85. FED. R. EVID. 704(b):

No expert witness testifying with respect to the mental state or condition of a defendant in a criminal case may state an opinion or inference as to whether the defendant did or did not have the mental state or condition constituting an element of the crime charged or a defense thereto.

Id. As originally enacted in 1975, Rule 704 eliminated the ultimate issue limitation on expert testimony. The *Hinkley* case amendment is the sole exception to the liberalized rule.

Hinckley as an honest disagreement over the classification of a disorder under the A.P.A.'s then-current diagnostic manual.⁸⁶ Hinckley's condition fell into a gray area between psychosis, a severely impairing illness, and a personality disorder, which is usually not thought of as a basis for nonresponsibility. Much has also been written about "criterion variance" as the cause of disputes among mental health experts.⁸⁷

By the 1970s, the new commitment laws reduced the power of the psychiatrist to control the process. Commitments were no longer medical and administrative in nature, but became judicial proceedings with counseled hearings and, in some instances, jury trials.⁸⁸ In 1974, the California Supreme Court decided in *Tarasoff v. Board of Regents of University of California*⁸⁹ that a mental health professional was vulnerable to personal liability based on a newly articulated duty of the therapist to protect and warn others of potential harm.⁹⁰ By the 1980s, many influential psychiatrists came to the conclusion that they should not be asked to testify as to legal states and, in particular, that they should not be required to predict future dangerousness.⁹¹ The reason given was that they could not reliably make such predictions.⁹²

In 1981, Dr. John Monahan, in *The Clinical Prediction of Violent Behavior*,⁹³ wrote: "[T]he 'best' clinical research currently in

86. A. STONE, LAW, PSYCHIATRY AND MORALITY: ESSAYS AND ANALYSIS 92-93 (1984).

87. See Morse, *supra* note 68, at 608-12. Morse defines criterion variance as the "differences resulting from the imprecision of the diagnostic categories." *Id.* at 608.

88. See *Guidelines for Involuntary Civil Commitment*, *supra* note 51, at 415 ("[T]he plight of mental patients became a civil rights issue . . . and restrictions were placed on the discretionary authority of mental health professionals and family members to commit mentally ill persons indefinitely to large, state-run institutions."). Jury trials are now permitted in a few states. See, e.g., CAL. WELF. & INST. CODE § 5302 (West 1984).

89. 13 Cal. 3d 177, 529 P.2d 553, 118 Cal. Rptr. 129 (1974), *reh'g granted*, 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (1976).

90. *Tarasoff*, 17 Cal. 3d at 440, 551 P.2d at 346, 131 Cal. Rptr. at 26. In reaching this decision, the court weighed the interest in protecting the confidentiality of psychotherapeutic information against the public interest in safety from potential violence by patients. *Id.*

91. See, e.g., Robitscher & Williams, *Should Psychiatrists Get Out of the Courtroom?*, PSYCHOLOGY TODAY, Dec. 1977, at 85, 140. ("Obviously not. . . . The real problem is to make forensic psychiatrists more responsible . . . so that judges and juries get less confusing advice.")

92. *Id.* at 86. ("Many psychiatrists . . . oppose the expansion of forensic psychiatry, particularly in the courtroom. They are embarrassed by stark conflicts in psychiatric testimony that, they fear, undermine the credibility of the profession as a whole.")

93. J. MONAHAN, THE CLINICAL PREDICTION OF VIOLENT BEHAVIOR (1981).

existence indicates that psychiatrists and psychologists are accurate in no more than one out of three predictions of violent behavior over a year period among institutionalized populations that had both committed violence in the past and who were diagnosed as mentally ill."⁹⁴

The American Bar Association Criminal Mental Health Standards, which were the work of six interdisciplinary task forces with seventy-nine nationally recognized experts in law and mental health, formulated the following: "An expert opinion stating a conclusion that a particular person will or will not engage in dangerous behavior in the future should not be admissible in any criminal proceeding or in any special commitment hearing involving a person found not responsible under the criminal law."⁹⁵ While the commentary acknowledged that most mental health expert testimony, characterized as "informed speculation," could be helpful to the trier of fact, predictive speculation could not be helpful because it is not within the "specialized knowledge" of the expert.⁹⁶ Specialized knowledge is the expert qualification threshold of Rule 702 of the Federal Rules of Evidence.⁹⁷

In 1983, the six-member majority of the United States Supreme Court in *Barefoot v. Estelle*,⁹⁸ did not share these restrictive views. The jury had returned a death sentence with a specific finding that there was a probability defendant would commit further acts of violence and represented a continuing threat to society.⁹⁹ Under the Texas statute, this was a death penalty prerequisite.¹⁰⁰ The prosecution's case included the testimony of

94. *Id.* at 470-49 (emphasis omitted).

95. ABA CRIMINAL JUSTICE MENTAL HEALTH STANDARDS, Standard 7-3.9(b) (1989). A distinction is made between past and present mental condition and future mental condition and behavior. *Id.* at 7-3.9(a)-(b). Standard 7-3.9(a) approves of expert testimony as to past or present issues, provided the witness expresses no "opinion on any question requiring a conclusion of law or a moral or social value judgment" *Id.* at 7-3.9(a).

96. *Id.*, Standard 7-3.9, Commentary at 119. See Slobogin, *The Role of Mental Health Professionals in the Criminal Process: The Case for Informed Speculation*, 66 VA. L. REV. 427, 432-34 & nn.9-10(1980) (critiquing of subjectivism in criminal law and distinguishing between "moral skeptics" and "method skeptics"). Professor Morse is characterized as a "moral skeptic." *Id.* at 434 & n.9. For a discussion of Professor Morse's position, see *supra* note 68 and accompanying text. Another commentator, Professor Morris, is referred to as an example of a "method skeptic." Slobogin, *supra* at 433 & n.10; see Morris, *Psychiatry and The Dangerous Criminal*, 41 S. CAL. L. REV. 514, 533 (1968).

97. FED. R. EVID. 702. ("If scientific, technical, or other specialized knowledge will assist the trier of fact . . .").

98. 463 U.S. 880 (1983).

99. *Id.* at 884.

100. *Id.* at 916. For the state to obtain a death sentence in Texas, it must

two psychiatrists, neither of whom had evaluated defendant.¹⁰¹ In response to hypothetical questions, both gave the opinion that defendant was a criminal sociopath, that no treatment could change his condition, and, according to one of them, on a ten-scale of sociopathic severity, defendant was "above 10."¹⁰²

On appeal, defendant claimed that such use of psychiatric testimony "was unconstitutional because psychiatrists, individually and as a class, are not competent to predict future dangerousness."¹⁰³ In affirming, Justice White answered this contention with the prickly observation: "The suggestion that no psychiatrist's testimony may be presented with respect to a defendant's future dangerousness is somewhat like asking us to disinvent the wheel."¹⁰⁴

Seven years before, in *Jurek v. Texas*,¹⁰⁵ the Supreme Court had held that the likelihood of future violence was a constitutionally acceptable standard for imposing the death penalty.¹⁰⁶ In that case, no expert testimony had been presented.¹⁰⁷ Therefore, if laypersons were able to make such a finding unaided by an expert, it made little sense to argue in *Barefoot* that a psychiatrist should not be permitted to testify.

On this issue, *Barefoot* looked to *Addington v. Texas*,¹⁰⁸ a 1979 decision that considered the nature of the involuntary commitment process. The *Addington* Court had opined: "Whether the individual is mentally ill and dangerous to either himself or others and is in need of confined therapy turns on the *meaning* of the

"prove beyond a reasonable doubt that 'there is a probability that the defendant would commit criminal acts of violence that would constitute a continuing threat to society.'" *Id.*

101. *Id.* at 917. Both psychiatrists were qualified as expert witnesses. *Id.*

102. 463 U.S. 918-19. The psychiatrists were questioned by defense counsel as to the "inherent unreliability" of psychiatric predictions of a person's future violent behavior. *Id.* at 919. Both denied such unreliability. *Id.*

103. *Id.* at 884-85. More specifically, defendant argued that the psychiatrists' predictions would likely result in the imposition of erroneous sentences. *Id.* at 835. Therefore, he argued that their use violated the eighth and fourteenth amendments. *Id.*

104. *Id.* at 896. The Court stated that "[w]e are unconvinced . . . that the adversary process cannot be trusted to sort out the reliable from the unreliable evidence and opinion about future dangerousness, particularly when the convicted felon has the opportunity to present his own side of the case." *Id.* at 901.

105. 428 U.S. 262 (1976).

106. *Id.* at 272-76; see also *Estelle v. Smith*, 451 U.S. 454 (1981). The *Smith* Court noted that the state may use evidence with respect to a defendant's past criminal conduct to establish "defendant's propensity to commit other violent acts." *Id.* at 473.

107. *Id.*

108. 441 U.S. 418 (1979).

facts which must be interpreted by expert psychiatrists and psychologists.”¹⁰⁹ Responding to the amicus brief of the American Psychiatric Association, which emphasized the vagaries of assessing future conduct and cited the Monahan study, the *Barefoot* Court stated: “We are not persuaded that such testimony is almost entirely unreliable and that the fact finder and the adversary system will not be competent to uncover, recognize, and take due account of its shortcomings.”¹¹⁰ Counsel for Thomas Barefoot, however, had not presented any evidence challenging the methodology of the prosecution’s psychiatrists. Also, a substantive rebuttal expert, if not an improbable witness, would have serious credibility deficits. Justice Blackmun’s caustic dissent noted that “[n]o reputable expert would be able to predict with confidence that the defendant will *not* be violent”¹¹¹

III. THE JOYCE BROWN CASE: HOMELESSNESS AND COMMITTABILITY

In the case of Joyce Brown, the trial judge, as the factfinder, concluded that the psychiatric testimony was unhelpful.¹¹² Seven psychiatrists testified, four of whom were called by the hospital and three by petitioner.¹¹³ The hospital psychiatrists stated that Brown suffered from schizophrenia, paranoid type, and that she was delusional, incapable of insight, incompetent to make decisions, and unable to take care of herself.¹¹⁴ On the other hand, petitioner’s psychiatrists, who evaluated her after she was hospitalized and medicated, testified that in their opinion she was not

109. *Id.* at 429 (emphasis supplied by the Court).

110. *Barefoot*, 463 U.S. at 899. The Court pointed out that some psychiatrists are willing to testify concerning the likelihood of a defendant’s future dangerousness and claim to be knowledgeable on the subject. *Id.* The Court also noted that there are psychiatrists who “expressly disagree with the Association’s point of view.” *Id.*

111. *Id.* at 934 (Blackmun, J., dissenting). Justice Blackmun expressed concern over an erroneous death verdict resulting from allowing psychiatrists to predict a defendant’s propensity for future violence. *Id.* at 935.

112. See *In re Boggs*, 136 Misc. 2d 1082, 1089, 522 N.Y.S.2d 407, 411 (Sup. Ct.) *rev’d sub nom.* *Boggs v. New York City Health & Hosps. Corp.*, 132 A.D.2d 340, 523 N.Y.S.2d 71 (1987), *appeal dismissed as moot*, 70 N.Y.2d 972, 520 N.E.2d 515, 525 N.Y.S.2d 796 (1988). Judge Lippmann, the trial judge, stated: “Considering all the evidence and the contradictory expert psychiatric opinions offered, I find the proof neither clear nor convincing on the question of [Brown’s] mental state.” *Id.*

113. *Id.* at 1084, 522 N.Y.S.2d at 408.

114. *Id.* The hospital psychiatrist concluded that Brown should continue to be hospitalized because her mental condition would deteriorate rapidly if she returned to the streets. *Id.*

psychotic.¹¹⁵ The rest of their assessments were also diametrically opposed to those of the hospital psychiatrists.¹¹⁶

The trial judge's opinion states that because of the sharp disagreement in the psychiatric testimony, great weight had to be given to the demeanor and testimony of Joyce Brown herself in evaluating her behavior as a homeless person.¹¹⁷ Recounting that testimony in detail, the opinion describes the issue as whether, under New York's Mental Hygiene Law, Brown had a mental illness likely to result in serious harm to herself or others, the burden of persuasion being on the hospital by clear and convincing evidence.¹¹⁸ As to mental illness, the trial judge found the evidence to be insufficient.¹¹⁹ But further, even assuming that she were mentally ill, the likelihood of serious harm had not been established. There was no evidence that she was suicidal.¹²⁰ Additionally, the trial judge concluded that she was able to meet the essential needs of food and clothing.¹²¹

As to shelter, the eloquent opinion in *Boggs* bears repeating:

Can Joyce Brown provide herself with shelter? Housing in New York is an expensive commodity, so expensive that in this rich city many no longer can afford it and are driven to live on the street. Who among us is not familiar with the tattered, filthy, malodorous presence of the wretched homeless? The tired, poor, huddled masses need no longer be invited to our shores. Our society has created them at home. The blame and shame must attach to us, not to them. The predicament

115. *Id.* at 1085-86, 522 N.Y.S.2d at 409. One of petitioner's psychiatrists, for instance, found her logical, coherent and able to know right from wrong. *Id.* at 1085, 522 N.Y.S.2d at 409.

116. *Id.* at 1085-86, 522 N.Y.S.2d at 409. For a discussion of the hospital psychiatrists' assessments of Brown's condition, see *supra* notes 4-8 and accompanying text.

117. *Id.* at 1086, 522 N.Y.S.2d at 410.

118. *Id.* at 1088, 522 N.Y.S.2d at 411. "[I]f the patient has a mental illness which is likely to result in serious harm to herself or others," the patient may be involuntarily retained under the New York statute. *Id.*

119. *Id.* at 1089, 522 N.Y.S.2d at 411.

120. *Id.* at 1089, 522 N.Y.S.2d at 412. The Court found all seven psychiatrists to be in agreement that her tests did not show "suicidal ideation," and there was no evidence to support a finding that she would likely cause harm to herself or others. *Id.*

121. *Id.* at 1091, 522 N.Y.S.2d at 412. "In addition to the statutory definition, decisional law holds the likelihood of serious harm exists where mental illness results in the refusal or inability to meet essential needs for food, clothing and shelter." *Id.* at 1091, 522 N.Y.S.2d at 411.

of Joyce Brown and the countless homeless raises questions of broad social, economic, political and moral implications not within the purview of this court.¹²²

Then, noting that she was physically well, despite living on the street for a year, the opinion continued:

But how can anyone living in security and comfort even begin to imagine what is required to survive on the street? It cannot be reasoned that because Joyce Brown is homeless she is mentally ill. What must be proved is that because she is mentally ill she is incapable of providing herself with food, clothing and shelter. Yet, though homeless, she copes, she is fit, she survives.

She refuses to be housed in a shelter. That may reveal more about conditions in shelters than about Joyce Brown's mental state. It might, in fact, prove that she's quite sane. She refuses confinement in Bellevue's psychiatric facilities, preferring freedom on the street with all its attendant risks.

. . . There must be some civilized alternatives other than involuntary hospitalization or the street.¹²³

In reversing, the appellate division rejected the trial court's findings as against the weight of the evidence, in particular, in crediting petitioner's testimony over the hospital experts' testimony.¹²⁴ The three-judge majority reviewed the evidence of Joyce Brown's year on the street and her psychiatric history, which included hospitalization for mental illness two years before with large dosages of Thorazine for acute psychosis.¹²⁵ During the year, she had been observed on the sidewalk at 65th Street and 2nd Avenue almost daily by a clinical team of city psychiatrists, nurses, and social workers known as Project HELP. According to Project HELP witnesses, she urinated and defecated on the sidewalk, was unclean, disheveled, tore up dollar bills, threw things, cursed and shouted obscenities, flashed her but-

122. *Id.* at 1090, 522 N.Y.S.2d at 412.

123. *Id.* at 1090-91, 522 N.Y.S.2d at 412-13.

124. *Boggs v. New York City Health & Hosps. Corp.*, 132 A.D.2d 340, 361-62, 523 N.Y.S.2d 71, 84 (1987) *appeal dismissed as moot*, 70 N.Y.2d 972, 520 N.E.2d 515, 525 N.Y.S.2d 796 (1988). The majority concluded that "we must make our own findings of fact, since there is no fair interpretation of the evidence that can support the fact findings of the Hearing Court, and we reject these findings." *Id.*

125. *Id.* at 358-60, 362-63, 523 N.Y.S.2d at 82-83, 85.

tocks, spoke in sexual rhymes, twirled an open umbrella although it was not raining, screamed racial epithets at delivery men and accused them of thinking she was a prostitute. She slept on a hot-air vent. On one occasion she was seen running into moving traffic. She also became increasingly hostile to the Project HELP team.

In discussing the testimony of Brown's three psychiatrists, the appellate majority emphasized that these doctors had not observed her outside of the hospital, noting that the hospital, unlike the street, is a structured, safe environment and that a mentally ill person can go through a period of remission in the hospital.¹²⁶ It was not surprising that Joyce Brown's testimony was rational, coherent and intelligent because by then she had received a week of hospital treatment. Until 1985, Joyce Brown had been a productive member of society for almost a decade. She worked for Bell Laboratories and a human rights agency in New Jersey. In the majority's view, having suffered a severe psychosis, she deteriorated to the point where she lived on the street. The need for her continued hospitalization was shown because she was in danger of doing serious harm to herself.

The dissent found Brown to be mentally ill but viewed the self-danger issue as one of lifestyle.¹²⁷ It stressed that in her year on the street she had not harmed herself or anyone else.¹²⁸

The Joyce Brown case was utilized by the New York Civil Liberties Union to challenge Mayor Edward Koch's decision in 1987 to reduce, by executive directive, the state involuntary commitment standard.¹²⁹ The mayor ordered Project HELP to take in persons who might be dangerous in "the reasonable foreseeable future."¹³⁰ The constitutionality of the foreseeable future standard has been disputed as vague and overbroad. It was rejected by the New York Legislature six times in the 1980s.¹³¹

126. *Id.* at 355, 365, 523 N.Y.S.2d at 80, 86.

127. *See id.* at 377, 523 N.Y.S.2d at 93-94 (Milonas, J., dissenting) ("We cannot accept the majority's total disregard for the fact finding of the hearing court. . . . [I]f the court's judgment . . . is to be completely ignored, then what was the purpose of the hearing in the first place?").

128. *Id.* at 378, 523 N.Y.S.2d at 94 (Milonas, J., dissenting). The court stated that her "conduct on the street is understandable if we appreciate her obvious pride in her independence and in her ability to survive on her own." *Id.* (Milonas, J., dissenting).

129. Note, *supra* note 31, at 340. The Mayor's policy consisted of involuntarily committing homeless people who appeared to be unable to care for themselves. *Id.* Temperature was not a factor. *Id.*

130. *Id.* at 340-41.

131. *Id.* at 341-42.

It can be argued that anyone living on the streets is in constant danger of violence, theft, cold and hunger.¹³² Moreover, the definition of foreseeable danger to oneself may include both physical and mental well-being, which is, arguably, overbroad and circuitous. By comparison, the Pennsylvania statute restricts self-danger to physical debilitation within a time-frame of thirty days.¹³³ This is an imminent danger standard, which eliminates psychological deterioration as a basis for commitment. In this way, intervention is permissible only if the potential harm would clearly cause objectively demonstrable injury.

Where does eccentricity and bizarre behavior end and committable mental disorder begin? In the early 1970s, a number of psychiatrists in Pennsylvania wanted to include in the commitment standard a manic behavior provision, said to apply to middle-aged, affluent men.¹³⁴ These men suddenly left their families, let their hair grow long, dressed outlandishly and began spending money in uninhibited ways. Psychiatrists said that this often represented a form of hypomania and the person could be brought to his senses with a short period of force treatment. The legislature, a group predominantly of middle-aged men, was not moved to make that behavior committable.

Project HELP originally was intended to save homeless persons from freezing to death.¹³⁵ Gradually, the state standard was modified by the city's executive order to permit mentally ill homeless to be detained regardless of the temperature. The policy, announced in 1987, was to detain what were termed "gravely disabled" people—those foreseeably at risk—but this proved to be self-defeating.¹³⁶ The homeless were taken to emergency rooms and kept there as long as five days because there was no bed space. The mental health wards were already full. Eventually, the mayor was convinced to give up the idea when advised that it was creating a special class of emergency commitments. Also, the New York Civil Liberties Union, in 1988, filed a class action claiming that nine named plaintiffs had been held in emergency rooms for days strapped to stretchers or handcuffed to

132. *Id.* at 341.

133. PA. STAT. ANN. tit. 50, § 7301(b)(2) (Purdon Supp. 1991).

134. In 1974, this proposal was made by a committee of the Pennsylvania Psychiatric Society to Senator Coppersmith, chair of the Pennsylvania Senate Health and Welfare Committee, which was considering a bill that, in 1976, became Pennsylvania's new commitment law.

135. Note, *supra* note 31, at 340-41.

136. *Id.* at 340.

wheelchairs under crowded, foul conditions.¹³⁷

The Project HELP approach, to the extent that it deals with life-saving emergencies, is commendable. However, in emergency cases there is a common law power to act without the need for tinkering with the commitment standard, and existing commitment laws usually allow such intervention.¹³⁸ Moreover, as a remedy for dealing with the mentally ill homeless, Project HELP is a gesture, not a solution. Long-term re-institutionalization is so expensive that it will never again receive serious consideration, and in many instances it is unnecessary and inappropriate.¹³⁹ The demonstrated effectiveness of anti-psychotic medication makes it possible for large numbers of mental patients, with proper service support, to live in the community.¹⁴⁰

If a person is involuntarily committable, it would seem to follow that upon discharge, usually in medicated remission, otherwise unavailable living arrangements and services should be provided to preserve that condition.¹⁴¹ If not, the course of decompensation is highly likely and is a reasonably certain prediction that requires no expertise to make. This is similar to the habilitation or preservation of skills thesis recognized in *Youngberg v. Romeo*.¹⁴² That argument, however, has not been constitutionally applied to the mentally ill. Indeed, as to the mentally ill, no federal right to treatment theories have been upheld.¹⁴³ Least restrictive alternative and right to treatment contentions have been rejected.¹⁴⁴ As a result, advocacy cases are proceeding under

137. See *Lizotte v. New York City Health & Hosps. Corp.*, No. 85 Civ. 7548 (S.D.N.Y. May 8, 1990); see also *Lizotte v. New York City Health & Hosps. Corp.*, No. 85 Civ. 7548 (S.D.N.Y. March 13, 1990).

138. See, e.g., *Rogers v. Okin*, 634 F.2d 650, 654 (1st Cir. 1980). "Given these circumstances, the state asserts primarily its police power and its *parens patriae* power as justification for the forcible administration of antipsychotic drugs to those individuals who are in state run hospitals as a result of mental illness." *Id.*

139. Kanter, *supra* note 10, at 92 ("[S]ome critics now see an easy response . . . [—]return homeless or troublesome mentally ill people to state hospitals. Yet such proposals are simplistic at best, and at worst, profoundly dangerous.")

140. See *Durham & La Fond*, *supra* note 20, at 344-45.

141. See *Clark v. Cohen*, 794 F.2d 79, 98 (3d Cir. 1986) (Becker, J., concurring) (released patient may have right to obtain care in community); see also Note, *supra* note 39, at 1153-55 (contending that inadequate discharge planning and lack of community resources violates fundamental tort principles).

142. 457 U.S. 307, 319 (1982) (liberty interests require state to provide minimal training).

143. For a discussion of the Supreme Court's consideration of this issue, see *supra* notes 26-30 and accompanying text.

144. See, e.g., *Rennie v. Klein*, 720 F.2d 266, 269 (3d Cir. 1983) (court re-

state law.¹⁴⁵ Many states have statutes providing for a right to adequate treatment in the least restrictive setting as well as support for the indigent.¹⁴⁶ However, courts are reluctant to order the legislature or executive to make funding allocations.¹⁴⁷ The greatest long-range hope lies in building a constituency of determined citizenry.

Perhaps the disagreement between the two groups of psychiatrists in the Joyce Brown case is instructive. While some partisan bias may have been present, all of these expert witnesses appeared to have impressive credentials and, as Dr. Alan Stone said of the *Hinckley* psychiatrists, in "honest disagreement."¹⁴⁸ In *Hinckley*, the disagreement may have been attributable to the difficulty in diagnostic classification and criterion variance. But as to Joyce Brown, the critical margin may have been the timing of the evaluations: one set at or before admission to the hospital and the other following hospitalization and anti-psychotic treatment.¹⁴⁹ Otherwise, the disagreement over psychosis versus no-psychosis is incongruous and difficult to explain. Can it be writ-

jected "least intrusive means" analysis and held involuntarily committed mentally ill patients have "constitutional right to refuse anti-psychotic drugs").

145. See Note, *supra* note 39, at 1167-72.

146. *Id.* at 1154.

The possibility of pursuing legal remedies has been effectively foreclosed at the federal level. . . . [T]he Supreme Court's recent, unanimous decision in *Youngberg* . . . recognized only minimal rights of mentally disabled persons under the federal constitution. As a result, state courts and legislatures have now become the principal fora for determining the rights of the mentally ill.

Id. (footnotes omitted); see also Durham & LaFond, *supra* note 20, at 318 ("[E]ven if Constitutional analysis did not generate a right to treatment, most states have conferred it as a matter of state statutory law.").

147. See Coates, *supra* note 13, at 340 ("Courts are traditionally disinclined to impose affirmative mandates on local governments where enforcement will unduly burden the courts, or prove impossible.").

148. For a discussion of Dr. Stone's explanation of the psychiatrists' debate, see *supra* notes 86-87 and accompanying text.

149. For a discussion of Ms. Bogg's psychiatric reports, see *supra* notes 4-8 and accompanying text. The trial judge in *Boggs* also conjectured that "[p]erhaps the disparity [in the diagnoses of the psychiatrists] results from the lapse of time between examinations by the two groups." *In re Boggs*, 136 Misc.2d 1082, 1088, 522 N.Y.S.2d 407, 411 (Sup. Ct.) *rev'd sub nom. Boggs v. New York City Health & Hosps. Corp.*, 132 A.D.2d 340, 523 N.Y.S.2d 71 (1987), *appeal dismissed as moot*, 70 N.Y.2d 972, 520 N.E.2d 515, 525 N.Y.S.2d 796 (1988). In the *Guidelines for Involuntary Civil Commitment*, it was noted that: "Conflicting interests . . . are at stake in regard to the issue of mental health treatment . . . before full judicial review." *Guidelines for Involuntary Civil Commitment*, *supra* note 51, at 37-38. It further notes that "a respondent who is medicated will frequently make a better appearance before the hearing officer . . . and will not display gross symptoms of psychosis that influence decision to commit." *Id.* at 38 n.2.

ten off merely as the reflection of two different occupational outlooks—as between hospital and community psychiatrists? Or, is it evidence that supports the theorizing of R.D. Laing and others—as to the plasticity of schizophrenia and its symptoms?

It is well known, as the appellate division majority observed, that many schizophrenics are able to do reasonably well in a structured setting, whether it is a family, a group home, a school or an institution. This is particularly so if treatment services are readily obtainable.

IV. A RESPONSE FOR THE MENTALLY ILL HOMELESS: THERAPEUTIC FAMILIES

The mentally ill homeless, metaphorically, have traveled a long and calamitous road.¹⁵⁰ Many have left or been rejected by their families, institutionalized for long-term custodial care in state hospitals, discharged to a generally unsupportive, unreceptive community and regarded on the street, not as people, but as objects to be avoided. What is needed are therapeutic families, small groups and clustered single-living arrangements with boarding-house types of facilities—a place that the residents can feel is home. From a legal, psychological and economic standpoint, individually and societally, this is the best approach to resolving the difficult and troubling issues of the mentally ill homeless.¹⁵¹

150. See HOMER, *THE ODYSSEY* 13 (R. Fitzgerald trans. 1961). “Sing in me, Muse, and through me tell the story of that man skilled in all ways of contending, the wanderer, harried for years on end” *Id.*; see also Nocera, *The Long, Lonesome Road*, 14 *TEX. MONTHLY* 43-53 (Nov. 1986).

151. See Durham & La Fond, *supra* note 20, at 368 (arguing against involuntary hospitalization: “[C]onstitutional theory, state legislation, and informed public policy require public mental health systems . . . to concentrate . . . on creating a system of community-based facilities that can provide . . . care, treatment, and social support.”) (footnotes omitted).

