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Competency, Deinstitutionalization, and Homelessness: A Story of Marginalization

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COMPETENCY, DEINSTITUTIONALIZATION, AND HOMELESSNESS: A STORY OF MARGINALIZATION

*Michael L. Perlin**

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PROLOGUE: LIFE IMITATES ART

On the day before I finished the penultimate draft of this article, I saw the movie, *Enemies, A Love Story*, Paul Mazursky's powerful adaptation of Isaac Bashevis Singer's novel about the lives of several Jewish people who came to the United States in the late 1940's after having been imprisoned in Nazi concentration camps or after having spent the war in hiding from the SS. Ron Silver plays the male protagonist and suffers from what would now be called posttraumatic stress disorder. Whenever something abnormally stressful happens to him in America (five years after his emigration), he "flashes back" to the stormtroopers searching for him, and the aural image is of vicious police dogs barking as part of the search. The metaphor is a vivid one.

About two days later, as I emerged from the depths of the World Trade Center in Manhattan as part of my commute to work, I heard the unmistakable sounds of police dogs. As I walked through the transportation terminal, the barking grew louder. I finally came across a crowd of commuters—all motionless. A Port Authority Transit policeman was holding on to a police dog, barking, snarling, and attempting to break loose. They were both about three feet away from a homeless man, who was supine, perhaps unconscious, and sprawled out on the floor of the lower level of the World Trade Center. As the dog growled, seemingly poised to attack the homeless man (although I doubt that would have happened), many of the commuters broke out in spontaneous applause

in clear support of the officer. I will never forget that moment.

I. INTRODUCTION: CIVILIZATION'S DISCONTENTED

Institutional reform litigators in the early and mid-1970s regularly adapted Winston Churchill's well-travelled aphorism:¹ you can judge the state of a civilization by the way it treats its institutionalized.² It is now necessary to amend his dictum: we can also judge the state of a civilization by the way it treats those without a home. By this test, the United States, as a civilization, is an abject failure. We have failed, and we continue to fail, our dispossessed, our displaced, and our unwanted. The homeless, as Robert Hayes has eloquently stated, are "the shame of America."³ Daily and exponentially, our shame increases.

Our national policy toward the homeless is shameful and mean. In the past decade we have, as a nation, adopted a policy that accepts, condones, and encourages the inevitability of the status of poverty, as well as an attitude of cruelty toward the poor.⁴ The shame of socially-sanctioned homelessness taints our society today in very much the same way as did official policies of racial segregation in the 1950s and official policies of sexual inequality in the 1960s.⁵

Our policy toward the homeless is one of economic greed, social myopia, psychological brutality, and political cynicism.⁶ We justify our policy through reliance on symbolic stereotypes and so-

1. Churchill originally declared that "[t]he mood and temper of the public with regard to the treatment of crime and criminals is one of the most unfailing tests of the civilization of any country." H. BLOCH & G. GEIS, *MAN, CRIME AND SOCIETY* 557 (1962).

2. See *Arnold v. Arizona Dep't of Health Servs.*, 160 Ariz. 593, 775 P.2d 521, 537 (1989) (quoting former Vice President Hubert Humphrey, "[T]he moral test of a government is how it treats those. . .who are in the shadows of life, the sick, the needy and the handicapped").

3. *Homeless in America: Hearing Before the Subcomm. on Housing and Community Development of the House Comm. on Banking, Finance and Urban Affairs*, 97th Cong., 2d Sess. 60 (1982) [hereinafter *Housing Hearings*] (statement of Robert Hayes).

4. See generally Marmor & Gill, *The Political and Economic Context of Mental Health Care in the United States*, 14 J. HEALTH POL., POL'Y & L. 459, 459 (1989) (penetrating analysis of the effect of the Reagan Administration's social and economic strategies on mental health policy).

5. Cf. Letter from Martin Luther King, Jr. to eight Alabama clergymen (Apr. 16, 1963), reprinted in M. KING, *WHY WE CAN'T WAIT* 76, 79 (1964) ("Injustice anywhere is a threat to justice everywhere."). See generally Luban, *Difference Made Legal: The Court and Dr. King*, 87 MICH. L. REV. 2152, 2156 & n. 13 (1989) (considering Dr. King's letter).

6. See Jahiel, *The Situation of Homelessness*, in *THE HOMELESS IN CONTEMPORARY SOCIETY* 99, 114-15 (R. Bingham ed. 1987) (discussing the role of greed).

cial myths,⁷ through prereflective "ordinary common sense,"⁸ and through the employment of what cognitive psychologists refer to as "heuristic thinking."⁹ Our policies reveal the atrophied state of our national moral development. It is not too extreme to express the fear that, absent an external cataclysmic force too "outrageous to ignore," our policies have become nearly irreversible.¹⁰

We can no longer ignore the homeless.¹¹ In the words of the writer Peter Marin, they are "the sum total of our dreams, policies, intentions, errors, omissions, [and] cruelties . . ."¹² They serve as a screen upon which we project our visions of our entire social welfare system.¹³ Homelessness¹⁴ is *not* new.¹⁵ Its causes are many and

7. Refer to notes 174, 285-87 *infra* and accompanying text.

8. Refer to note 153 *infra* and accompanying text.

9. Refer to note 113 *infra* and accompanying text.

10. Cf. 3 P. FONER, *HISTORY OF THE LABOR MOVEMENT IN THE UNITED STATES: THE POLITICS AND PRACTICES OF THE AMERICAN FEDERATION OF LABOR, 1900-09* 21 (2d ed. 1973) (death of workers in the Triangle Shirtwaist factory fire of 1911 led to the appointment of the New York State Factory Investigating Commission); C. WHALEN & B. WHALEN, *THE LONGEST DEBATE: A LEGISLATIVE HISTORY OF THE 1964 CIVIL RIGHTS ACT* 33-34 (1985) (1963 church bombing killing four youths in Birmingham, Alabama served as the impetus for the passage of civil rights laws).

11. 2 M. PERLIN, *MENTAL DISABILITY LAW: CIVIL AND CRIMINAL* § 7.23, at 672 (1989).

12. Marin, *Helping and Hating the Homeless: The Struggles at the Margins of America* HARPER's, Jan. 1987, at 39, 41.

13. Much of the text accompanying notes 14-25 is adapted from M. PERLIN, *supra* note 11, § 7.23.

14. Differing definitions of homelessness abound. See Fischer & Breakey, *Homelessness and Mental Health: An Overview*, 14 INT'L J. MENTAL HEALTH 6, 7 (1986) (emphasizing lack of shelter and disaffiliation). See generally Santiago, Bachrach, Berren & Hannah, *Defining the Homeless Mentally Ill: A Methodological Note*, 39 HOSP. & COMMUNITY PSYCHIATRY 1100, 1101 (1988) [hereinafter Santiago] (emphasizing methodological flaws in current studies that are designed to promote a specific political agenda).

The definitions focus on various factors, including (1) whether the individual resides in a shelter, (2) whether hospital admission records designate the individual as "undomiciled", or (3) the length of time that the individual has been without an official residence. See, e.g., Morrison, *Correlations Between Definitions of the Homeless Mentally Ill Population*, 40 HOSP. & COMMUNITY PSYCHIATRY 952, 952 (1989) (further subdividing definitions into those homeless for extended periods, those episodically homeless, those potentially homeless and those in a precarious living situation with family or friends); see also Arce, Tadlock, Vergare & Shapiro, *A Psychiatric Profile of Street People Admitted to an Emergency Shelter*, 34 HOSP. & COMMUNITY PSYCHIATRY 812, 814 (1983) [hereinafter *Psychiatric Profile*] (classifying the homeless as street people, episodic homeless, or others); Chafetz & Goldfinger, *Residential Instability in a Psychiatric Emergency Setting*, 56 PSYCHIATRIC Q. 20, 20 (1984) (examining two levels of residential instability: lack of shelter and transient living arrangements); Mowbray, Johnson & Solarz, *Homelessness in a State Hospital Population*, 38 HOSP. & COMMUNITY PSYCHIATRY 880, 880 (1987) (analyzing characteristics of homeless or potentially homeless psychiatric patients).

The Alcohol, Drug Abuse and Mental Health Administration of the United States De-

complex.¹⁶ However, the public discourse on "the deinstitutionalized" has distorted the public discourse on the issue of "homelessness." The media, in its presentation of the story of the homeless, has equated the "homeless" with the "deinstitutionalized homeless." Conventional wisdom posits that the policy of deinstitutionalization has "caused" the increase in homelessness and urban troubles.¹⁷ The public perceives homeless individuals as a nearly monolithic population—ex-patients, improvidently released from psychiatric hospitals, incompetent to care for themselves, and a danger to themselves and to the citizenry.¹⁸ In his typically florid way, former New York City Mayor Ed Koch has characterized deinstitutionalization as one of the "lunacies of government."¹⁹

This blame-laying is misplaced. Its focus on the tree of deinstitutionalization, while of vital importance to the one-third of the homeless somehow affected by their histories as ex-patients, obscures the forest of deeper and broader shame: the crushing costs of homelessness to *all* of the less visible displaced and the dispossessed—the children, the young mothers, and, increasingly, the Vietnam veterans.²⁰ Homelessness remarginalizes these individuals

partment of Health and Human Services developed perhaps the most commonly used definition: "anyone who lacks adequate shelter, resources and community ties." Fischer & Breakey, *supra*, at 7.

On the political significance of the choice of definition, see P. ROSSI, *DOWN AND OUT IN AMERICA: THE ORIGINS OF HOMELESSNESS* 12 (1989) (disputes over definitions not merely "scholastic issues," but involve "central political values"); Santiago, *supra*, at 1101 (observing that the estimated number of homeless changes by 50% when the definition changes).

15. P. ROSSI, *supra* note 14, at 17-33; Arce & Vergare, *Identifying and Characterizing the Mentally Ill Among the Homeless*, in *THE HOMELESS MENTALLY ILL* 75, 75 (H. Lamb ed. 1984).

16. Refer to notes 65-108 *infra* and accompanying text. See also Hatfield, Farrell & Starr, *The Family's Perspective on the Homeless*, in *THE HOMELESS MENTALLY ILL*, *supra* note 15, at 279, 283-89.

17. E.g., Lamb, *Deinstitutionalization and the Homeless Mentally Ill*, in *THE HOMELESS MENTALLY ILL*, *supra* note 15, at 55, 56-60 [hereinafter *Deinstitutionalization*] (deinstitutionalization did not anticipate, but caused criminalization and homelessness among many); see also A. SCULL, *DECARCERATION: COMMUNITY TREATMENT AND THE DEVIANT: A RADICAL VIEW* 2 (1977) [hereinafter *DECARCERATION*] (deinstitutionalization has meant a "nightmare existence" for ex-patients); A. SCULL, *SOCIAL ORDER/MENTAL DISORDER: ANGLO-AMERICAN PSYCHIATRY IN HISTORICAL PERSPECTIVE* 300-29 (1989) [hereinafter *SOCIAL ORDER/MENTAL DISORDER*]; Rhoden, *The Limits of Liberty: Deinstitutionalization, Homelessness, and Libertarian Theory*, 31 *EMORY L.J.* 375, 375 (1982) ("Deinstitutionalization, once hailed as an ideal social reform, is now decried as a near disaster.").

18. Refer to note 114 *infra* and accompanying text.

19. Koch, *Lunacies of Government: Legal, Bureaucratic, Ideological*, 200 *N.Y.L.J.* at 1, col. 1 (1988).

20. See 2 M. PERLIN, *supra* note 11, § 7.23, at 672.

who have already once been marginalized by poverty, by race, and by social status.

The blame-laying, moreover, ignores the hundreds of thousands of homeless persons²¹ who have never been institutionalized or who are not mentally ill.²² It also ignores the concessions made by virtually every critic of deinstitutionalization policies: deinstitutionalization is not the *sole* cause of the increase in homelessness.²³ Further, it is the *misexecution* of deinstitutionalization rather than the "clinically sound and economically feasible"²⁴ *concept* of deinstitutionalization that has exacerbated the problems in question.²⁵ It is necessary to add an important *caveat*: as long as we direct our attention to some of the frivolous nonissues interspersed in the American Psychiatric Association's (APA's) otherwise thoughtful agenda (for example, blaming the American Civil Liberties Union—counsel for many plaintiff classes in the early 1970s mental patient civil rights test cases—as the true villain in the homelessness saga),²⁶ we will continue to blind ourselves to the harsher realities and true causes of urban poverty.

The *same* powerful forces of racism and classism that have helped distort the deinstitutionalization movement²⁷ are at work in the larger context of homelessness.²⁸ Ironically, many of those who

21. See P. Rossi, *supra* note 14, at 38 (all estimates point to a national disgrace). Cf. Langdon & Kass, *Homelessness in America: Looking for the Right to Shelter*, 19 COLUM. J.L. & SOC. PROBS. 305, 305 n.1, 310 n.27 (1985) (noting population estimates ranging from 250,000 to 2,000,000); Note, *Homelessness: Halting the Race to the Bottom*, 3 YALE L. & POL'Y REV. 551, 553 n.11 (1985) [hereinafter *Halting the Race*] (comparing United States Congressman Henry Gonzales' conservative estimate of 2,000,000 with the Department of Housing and Urban Development's estimate of between 192,000 and 586,000). *But cf.* Milburn & Watts, *Methodological Issues in Research on the Homeless and the Homeless Mentally Ill*, 14 INT'L J. MENTAL HEALTH 42, 53 (1986) (criticizing methodology used to reach estimates).

22. Few analyses have differentiated between the mentally ill and the mentally ill who were formerly hospitalized. *But see* NEW YORK CITY HUMAN RESOURCES ADMIN., NEW YORK CITY PLAN FOR HOMELESS ADULTS, 13 (April 1984); NEW YORK CITY HUMAN RESOURCES ADMIN., CORRELATES OF SHELTER UTILIZATION: ONE DAY STUDY, Table D-1 (Aug. 1984).

23. See *Deinstitutionalization*, *supra* note 17, at 56 ("we can[not] simply explain homelessness as a result of deinstitutionalization").

24. Talbott & Lamb, *Summary and Conclusions*, in THE HOMELESS MENTALLY ILL, *supra* note 15, at 1, 3.

25. See, e.g., *Deinstitutionalization*, *supra* note 17, at 55 ("problems such as homelessness are not the result of deinstitutionalization per se but rather of the way deinstitutionalization has been implemented").

26. Refer to notes 192-93 *infra* and accompanying text.

27. Refer to notes 157-66 *infra* and accompanying text.

28. Refer to notes 173 *infra* and accompanying text.

have regularly espoused liberal and "left" political positions in the national and international political debate possess the same sort of virulent bias and prejudice in dealing with the deinstitutionalized as do those members of the community who regularly articulate racist and sexist positions.²⁹ It is this *extra* bias of "sanism"³⁰ that is especially pernicious in the context of homelessness.

This article suggests several overlapping propositions. First, the extent of the homelessness problem is the inevitable result of a decade of soul-crushing economic policies, Presidentially-sanctioned mean-spiritedness, and born-again socially acceptable racism and classism. Second, the public's conflation of "misguided deinstitutionalization" and "homelessness"³¹ has effectively obscured from the public debate the two-thirds of the homeless who never were institutionalized in mental hospitals (but many of whom stand in clear and present danger of *becoming mentally ill* as their status of homelessness becomes institutionalized). Third, our deinstitutionalization policies have been driven by a series of interrelated social and political agendas that obscure the sober reality; protests over deinstitutionalization policies are really, *sub silentio*, protests of deinstitutionalization of *poor* people, and these protestors willfully blind themselves to the long term moral and social bankruptcy of most public psychiatric systems. Fourth, the infusion of standard medical/legal categories of "competency" into the discussion will most likely be counterproductive.³²

Part II of this article discusses the myths of homelessness and how these myths have helped distort our official policies.³³ Part III examines the myths of deinstitutionalization and again, how *these* myths have shaped *these* policies.³⁴ Part IV outlines the perceived homelessness/deinstitutionalization linkage, in particular how the treatment of this linkage in the policy debate has had a severe negative impact on our attitudes toward the homeless, the deinstitutionalized, and the deinstitutionalized homeless, and how this is reflected in our "sanist" policies.³⁵ Part V attempts to deconstruct the meanings of "competency," suggesting some additional mean-

29. Refer to note 173 *infra* and accompanying text.

30. *Id.*

31. See, e.g., Cohen, *Killer Conservatism*, Wash. Post, Mar. 16, 1989, at A27, col. 2 ("We are inundated with the homeless, beggars, the insane and the just plain weird.").

32. Refer to notes 292-302 *infra* and accompanying text.

33. Refer to notes 38-108 *infra* and accompanying text.

34. Refer to notes 109-74 *infra* and accompanying text.

35. Refer to notes 175-290 *infra* and accompanying text.

ings not usually found in the legal or mental disability texts.³⁶ Finally, Part VI offers some modest explanations of the current state of affairs and some recommendations to policy makers and academic experts, as well as the only constituency that really matters, the general public.³⁷

II. THE MYTHS OF HOMELESSNESS

A. Introduction

Homelessness has been present in Western societies for centuries, and has always existed in the United States.³⁸ Religious houses of worship were used as long ago as the fourth century to shelter homeless Greeks and Romans.³⁹ In colonial times, poorhouses and almshouses were established in part to serve the needs of those without adequate housing.⁴⁰ The economic depressions of the late nineteenth and early twentieth centuries significantly in-

36. Refer to notes 291-424 *infra* and accompanying text.

37. Refer to notes 425-64 *infra* and accompanying text.

38. Much of the text accompanying notes 39-64 *infra* is adapted from M. PERLIN, *supra* note 11, § 7.24. See also P. ROSSI, *supra* note 14, at 17 (observing that "[c]oncern about homelessness can be discerned in the minutes of seventeenth-century New England town meetings"); Rossi, *The Old Homeless and the New Homeless in Historical Perspective*, 45 AM. PSYCHOLOGIST 954 (1990) (historical overview). See generally J. CROUSE, *THE HOMELESS TRANSIENT IN THE GREAT DEPRESSIONS: NEW YORK STATE, 1929-1941*, 11-23 (1986) (history of American sentiment toward indigent transients dates back to early English heritage); M. KATZ, *IN THE SHADOW OF THE POORHOUSE* (1986) (historical perspective); Hoch, *A Brief History of the Homeless Problem in the United States*, in *THE HOMELESS IN CONTEMPORARY SOCIETY*, *supra* note 6, at 16 (examining historical phases of homelessness in America from the early years of colonial development to the present).

39. This dates to at least the time of Constantine and Theodosius in the fourth century. See *St. John's Evangelical Lutheran Church v. Hoboken*, 195 N.J. Super. 414, 418, 479 A.2d 935, 938 (1983) (finding that municipality's use of zoning to prohibit a church from sheltering the homeless was a violation of the free exercise of religion); see also *Greentree at Murray Hill Condominium v. Good Shepherd Episcopal Church*, 146 Misc. 2d 500, 511, 550 N.Y.S.2d 981, 988 (Sup. Ct. 1989) ("'There was no room for them in the inn.' (Luke 2:7)"). See generally Goldberg, *Gimme Shelter: Religious Provision of Shelter to the Homeless as a Protected Use Under Zoning Laws*, 30 WASH. U. J. URB. & CONTEMP. L. 75 (1986) (providing shelter to the homeless is a religious obligation which is protected from zoning principles by the first amendment).

40. Talbot, *Foreword*, in *THE HOMELESS MENTALLY ILL*, *supra* note 15, at xiii. While limited public support existed in colonial times, public attitudes were not substantially different than attitudes today. "Reports dating back to the colonial period . . . note both the official resentment of the indigent and the particular burden posed by the 'indigent insane,' who no doubt elicited fear of their mental illness as well as irritation at their dependence." Goldfinger & Chafetz, *Developing a Better Service Delivery System for the Homeless Mentally Ill*, in *THE HOMELESS MENTALLY ILL*, *supra* note 15, at 92.

creased the number of uprooted homeless persons. These persons were the residents of the cities' first "skid rows."⁴¹ Social care for the homeless was traditionally organized by upper- and middle-class "caretakers," whose desire for moral reform and fear of social disorder demanded that homelessness be classified as a "social problem."⁴²

The contemporary homeless defy such easy group categorization.⁴³ "They are a cross section of American society. They are men, women and children of all ages and all ethnic and religious backgrounds. They are single persons, couples and families. They represent all educational levels, occupations and professions."⁴⁴

Most recent thoughtful investigations of homelessness focus on this "new class."⁴⁵ Lacking a "social network"⁴⁶ or "social margin,"⁴⁷ these individuals exist at the fringe of society. They are "socially isolated, unmarried, out of touch or at odds with their families or friends, and [possess] few occupational skills."⁴⁸ As many as half the homeless are under the age of forty.⁴⁹ They are increas-

41. Arce & Vergare, *Identifying and Characterizing the Mentally Ill Among the Homeless*, in *THE HOMELESS MENTALLY ILL*, *supra* note 15, at 75. See P. Rossi, *supra* note 14, at 31 (pointing out that studies of Skid Row residents present a picture of "dire conditions": extreme poverty, disability through advanced age, alcoholism, physical or mental illness, and disaffiliation—absent or tenuous ties to family and kin and few or no friends); see also E. TORREY, *NOWHERE TO GO: THE TRAGIC ODYSSEY OF THE HOMELESS MENTALLY ILL* 37-40 (1988) (arguing that the presence of large numbers of the homeless mentally ill during the early 19th century led to the building of insane asylums).

42. Hoch, *supra* note 38, at 17.

43. See Baxter & Hopper, *Shelter and Housing for the Homeless Mentally Ill*, in *THE HOMELESS MENTALLY ILL*, *supra* note 15, at 109, 111.

44. Arce & Vergare, *supra* note 15, at 76-77; see Note, *Homeless Families: Do They Have a Right to Integrity?* 35 *UCLA L. REV.* 159, 160 (1987) (dividing homeless into: (1) the chronically homeless single males and females; (2) the deinstitutionalized mentally ill; (3) the chemically dependent; and (4) the "new poor"); see also J. ERICKSON & C. WILHELM, *HOUSING THE HOMELESS* xxvii (1986) (defining nine categories of the homeless).

45. Baxter & Hopper, *The New Mendicancy: Homeless in New York City*, 52 *AM. J. ORTHOPSYCHIATRY* 393, 393 (1982).

46. See Lipton & Sabatini, *Constructing Support Systems for Homeless Chronic Patients*, in *THE HOMELESS MENTALLY ILL*, *supra* note 15, at 153, 156 (defining social network as "the set of concrete interpersonal relationships linking individuals with other individuals").

47. See Segal, Baumohl & Johnson, *Falling Through the Cracks: Mental Disorder and Social Margin in a Young Vagrant Population*, 24 *SOC. PROBS.* 387, 387 (1977) (defining social margin as "all personal possessions, attributes or relationships which can be traded for help in time of need").

48. Cf. Wing, *Who Becomes Chronic?*, 50 *PSYCHIATRIC Q.* 178, 182-83 (1978) (describing typical social characteristics of chronically mentally ill persons).

49. *Family's Perspective*, in *THE HOMELESS MENTALLY ILL*, *supra* note 15, at 231; see also Werner, *On the Streets: Homelessness Causes and Solutions*, 17 *CLEARINGHOUSE REV.*

ingly more likely to be female⁵⁰ and more likely to be members of racial minorities.⁵¹ We cannot understand homelessness or the homeless without recognition of the significance of this economic and social marginality.⁵²

The popular images of the homeless are mythic—there is virtually no empirical support for any of the three popular images of the homeless. The homeless are not “independent, eccentric descendants of the nomadic hoboes of the past,” “lazy, degenerate bums,” or “crazy, possibly dangerous people who ought to be put away.”⁵³ It is not enough to say that the only problem with the homeless is that they do not have “the good sense to come in from the cold.”⁵⁴

The problems of the homeless do not stop at homelessness.⁵⁵ They are “jobless, penniless, functionless, and supportless as well as homeless”;⁵⁶ marginalized and “unconnected”;⁵⁷ generally in

11, 12 (1984) (indicating that a 1981 New York City study revealed that 63% of all homeless persons were under 40 years of age, and a 1982 Baltimore survey revealed that 42% were between 20 and 29 years of age).

50. P. Rossi, *supra* note 14, at 39 (while a 1963 study showed that only 3% of the homeless were women, recent investigations reveal rates ranging from 7-33%); Rossi, *supra* note 38, at 956 (discussing increase in number of homeless women). See generally Carty, *Preventing Homelessness: Rent Control or Rent Assistance*, 4 NOTRE DAME J.L., ETHICS & PUB. POL'Y 365, 383 (1989) (discussing “feminization of poverty”); Sullivan & Damrosch, *Homeless Women and Children*, in *THE HOMELESS IN CONTEMPORARY SOCIETY*, *supra* note 6, at 82 (noting considerable change in the composition of the female homeless population in recent years).

51. P. Rossi, *supra* note 14, at 122-26.

52. See generally *id.*; Wagenaar & Lewis, *Ironies of Inclusion: Social Class and Deinstitutionalization*, 14 J. HEALTH POL., POL'Y & L. 503, 507-19 (1989) (examining the social and economic characteristics of institutionalized mentally ill). For a compelling and moving reportorial account, see J. KOZOL, *RACHEL AND HER CHILDREN: HOMELESS FAMILIES IN AMERICA* (1988).

53. Baxter & Hopper, *supra* note 45, at 397. For an analysis of the homelessness that attempts to break the population into subclasses, see Fischer & Breakey, *supra* note 14, at 10-13 (differentiating between the chronically mentally ill, “street people,” chronic alcoholics and “the situationally distressed”).

54. Baxter & Hopper, *supra* note 45, at 397.

55. See Benda & Dattalo, *Homelessness: Consequences of a Crisis or a Long-Term Process?* 39 HOSP. & COMMUNITY PSYCHIATRY 884, 885 (1988) (explaining that homelessness is often the most recent stage in a series of problems).

56. Lipton & Sabatini, *supra* note 46, at 156; see also Williams, Bellis & Wellington, *Deinstitutionalization and Social Policy: Historical Perspectives and Present Dilemmas*, 50 AM. J. ORTHOPSYCHIATRY 54, 61-64 (1980) (minorities and the poor, who have traditionally suffered the worst institutional care, will be most at risk in community settings). As the former Commissioner of New Jersey's Department of Human Services testified at a Congressional hearing:

[W]e must all recognize . . . that one of the primary problems of the chronically

poor physical health;⁵⁸ in need of social and human services;⁵⁹ and often without any social support systems.⁶⁰ Homeless children are routinely deprived of a thorough and adequate education.⁶¹ The homeless are extremely poor.⁶² It is essential that any serious consideration of homelessness acknowledge the critical link between homelessness and extreme poverty.⁶³ Standing alone, the provision

cally mentally ill is poverty. These people are very, very poor and one reason that it is difficult to provide services for them is that they simply do not have the wherewithal to buy decent housing or any of the services that they require.

Community Support for Mental Patients: Hearing Before the Subcomm. on Health and the Environment of the Comm. in Interstate and Foreign Commerce, on Programs in the Community for the Chronically Mentally Ill Adults, 96th Cong., 1st Sess. 92 (1979) (testimony of Ann Klein).

57. Wagenaar & Lewis, *supra* note 52, at 518; *see also* P. Rossi, *supra* note 14, at 31 (homeless suffer from "disaffiliation").

58. *See* Fischer & Breakey, *supra* note 14, at 13-15 (39% of respondents in one survey reported that they were in "poor health"; 22% of those sampled in another had "a significant health problem"). Homeless chronic alcoholics are particularly at risk. *Id.*

59. *See, e.g.,* Dorwart, *A Ten-Year Follow-up Study of the Effects of Deinstitutionalization*, 39 *HOSP. & COMMUNITY PSYCHIATRY* 287, 290 (1988) (deinstitutionalized persons may require "social, rehabilitative, psychotherapeutic, . . . vocational, transitional, residential and community aftercare services . . ."); Morse & Calsyn, *Mentally Disturbed Homeless People in St. Louis: Needy, Willing, But Underserved*, 14 *INT'L J. MENTAL HEALTH* 74, 82-85 (1986) (finding a need for more mental health care as well as physical health care, housing, employment training, financial assistance, and informal social support).

60. *See* Belcher, *Defining the Service Needs of Homeless Mentally Ill Persons*, 39 *HOSP. & COMMUNITY PSYCHIATRY* 1203, 1204 (1988) (none of the 33 homeless, formerly institutionalized individuals studied had relationships with family members).

61. *See generally* DIVISION OF STUDENT DEV. & FAMILY SUPPORT SERVS., NEW YORK STATE EDUC. DEP'T, *THE NEW YORK STATE PLAN FOR THE EDUCATION OF HOMELESS CHILDREN AND YOUTH, 1989-1991* (1989). *But cf. Orozco ex rel. Arroyo v. Sobol*, 674 F. Supp. 125, 131 (S.D.N.Y. 1987) (school district required to enroll homeless child in school pending decision on the merits).

62. For a recent overview, *see* Sard, Roisman & Hartman, *Homeless: A Dialogue on Welfare and Housing Strategies*, 23 *CLEARINGHOUSE REV.* 104, 105-06 (1989). *See generally* Jahiel, *supra* note 6, at 114 (because the chief problem for the homeless is poverty, any attempted solution to homelessness must take that into account). Peter Rossi defines the "extremely poor" as members of households whose annual incomes are below \$4000 in 1988 dollars. P. Rossi, *supra* note 14, at 13.

63. While testifying before a congressional subcommittee investigating the problems of the homeless and urging the adoption of legislation which would grant a federal right to shelter, Robert Hayes, counsel to the National Coalition for the Homeless, stated graphically:

It is fair to say that without concerted governmental action soon, there will be United States cities teeming with hundreds of thousands of what in India are referred to as "pavement dwellers." Inaction, Mr. Chairman, is all that is necessary to create, coast to coast, dozens of Calcuttas in this country.

. . . .
The homeless, living and dying on the streets of our cities, are a standing challenge to the moral legitimacy of this nation. The homeless are the shame of

of emergency shelter is simply not enough to reverse these long-term effects: if society's sole response to homelessness is the creation of an extensive shelter system, we are "effectively accepting the permanency of a large population of people with no place to call home."⁶⁴

B. Contributing Factors

In addition to deinstitutionalization,⁶⁵ at least four independent social factors have had a significant impact on the problems of the homeless: the baby boom, the shrinking housing market, the general reduction in the availability of governmental benefits, and the persistently high rate of unemployment among unskilled and semiskilled workers.⁶⁶

1. *The baby boom.* As the numbers of the homeless steadily grow,⁶⁷ their average age drops precipitously.⁶⁸ Younger, more mobile, episodically or permanently homeless individuals have been drawn to "magnet" communities through "migration streams" that also attract the chronically mentally ill.⁶⁹ Younger people also

America.

Housing Hearings, *supra* note 3, at 57.

64. Benda & Dattalo, *supra* note 55, at 886.

65. Refer to notes 175-290 *infra* and accompanying text.

66. See Arce & Vergare, *supra* note 15, at 77. Much of the text accompanying notes 91-136 *infra* is adapted from 2 M. PERLIN, *supra* note 11, § 7.25.

67. Hayes, *Reforming Current City Policies*, 2 CBC Q. 1, 1 (1982) (noting that the number of homeless is reaching "epidemic" proportion).

68. Bachrach, *The Homeless Mentally Ill and Mental Health Services: An Analytical Review of the Literature*, in *THE HOMELESS MENTALLY ILL*, *supra* note 15, at 14; see also P. ROSSI, *supra* note 14, at 40 (a large number of homeless are in their twenties and thirties; the median age has dropped rapidly over the past decade); Reich & Segal, *The Emergence of the Bowery as a Psychiatric Dumping Ground*, 50 PSYCHIATRIC Q. 191, 194 (1978) (the Bowery's population has a large percentage of mentally ill persons, and the number is increasing).

As the post-World War II baby-boom children reach maturity, "the absolute number of young persons at risk for developing schizophrenia and . . . other chronic mental disorders has increased dramatically." Bachrach, *supra*, at 11, 15.

69. Bachrach, *supra* note 68, at 15. *But see* Ball & Havassy, *A Survey of the Problems and Needs of Homeless Consumers of Acute Psychiatric Services*, 35 HOSP. & COMMUNITY PSYCHIATRY 917, 917-19 (1984) (disputing the accuracy of a San Francisco study that stereotypes the mentally disabled homeless as nomads); *cf.* Fischer & Breakey, *supra* note 14, at 26 (observing that while the "migration stream" theory applies to the young, chronic population, other homeless groups, such as chronic alcoholics, are significantly less transient); Snow, Baker, Anderson & Martin, *The Myth of Pervasive Mental Illness Among the Homeless*, 33 Soc. PROBS. 407, 411-12 (1986) [hereinafter *Myth*] (while the homeless in general are

show a greater tendency to use addictive substances (both drugs and alcohol), which often exacerbate the symptoms of illness⁷⁰ and make homelessness more likely.⁷¹ Vietnam veterans are one hidden subset of this population,⁷² and one commentator recently characterized them in this context as "soldiers of misfortune."⁷³

2. *The shrinking housing market.* The elimination of available housing stock has had a tremendous impact on the growth of the homeless, especially in the larger cities.⁷⁴ A 1982 New York

quite mobile, the chronically mentally ill homeless are among the least mobile of all homeless individuals).

70. Bachrach, *supra* note 68, at 15.

71. See, e.g., Kaufmann, *Implications of Biological Psychiatry for the Severely Mentally Ill: A Highly Vulnerable Population*, in *THE HOMELESS MENTALLY ILL*, *supra* note 15, at 201, 216 (40% of all shelter residents manifest primary or secondary alcohol abuse).

Some commentators have suggested that the counterculture that developed in the late '60s provided a temporary refuge for a significant percentage of today's young homeless population. E.g., Bachrach, *supra* note 68, at 16.

72. See generally Hope & Young, *Deinstitutionalization and the Homeless*, 17 *URB. & SOC. CHANGE REV.* 7, 8 (1983) (veterans comprise 30% of San Francisco's homeless); Kanter, *Homeless Mentally Ill People: No Longer Out of Sight and Out of Mind*, 3 *N.Y.L. SCH. HUM. RTS. ANN.* 331, 336 n.35 (1986) (veterans traditionally comprise a high proportion of the homeless); Robertson, *Homeless Veterans: An Emerging Problem?* in *THE HOMELESS IN CONTEMPORARY SOCIETY*, *supra* note 6, at 64, 78 (providing a study of all studies, and concluding that Vietnam veterans comprise between 16% and 43% of all homeless veterans); Rosenheck, Leda, Gallup, Astrachan, Milstein, Leaf, Thompson & Errera, *Initial Assessment Data From a 43-Site Program for Homeless Chronic Mentally Ill Veterans*, 40 *HOSP. & COMMUNITY PSYCHIATRY* 937, 937-38 (1989) [hereinafter *Initial Assessment Data*] (available data indicate that a substantial number of homeless are veterans); Lewin, *Nation's Homeless Veterans Battle a New Foe: Defeatism*, *N.Y. Times*, Dec. 30, 1987, at A1, col. 5 (according to studies by various researchers, a quarter to a third of homeless persons are veterans). On the significance of the inclusion of Vietnam veterans into the mental health system in the 1960s and '70s, see Durham, *The Impact of Deinstitutionalization on the Current Treatment of the Mentally Ill*, 12 *INT'L J.L. & PSYCHIATRY* 117, 123 (1989); see also Robertson, *supra*, at 78-79 (the largest group of homeless veterans served during Vietnam war). On the prevalence of post-traumatic stress disorder (PTSD) among the homeless, see Jones, Gray & Goldstein, *Psychosocial Profiles of the Urban Homeless*, in B. JONES, *TREATING THE HOMELESS* 47, 63 (1986); see also *Initial Assessment Data*, *supra*, at 941 (over 30% of homeless mentally ill veterans reported they were under combat fire during their term of service).

73. Robertson, *supra* note 72, quoting H. GOLDIN, *SOLDIERS OF MISFORTUNE* 3-4 (1982).

74. Carmody, *Study Blames Poverty For Most Homelessness*, *N.Y. Times*, Nov. 2, 1984, at B2, col. 5 (Governor Mario Cuomo, quoting a study by the New York State Department of Social Services, stating "[h]omelessness is by its nature a crisis of housing"). More recent studies echo this conclusion. See, e.g., P. Rossi, *supra* note 14, at 181 (declaring that "it is easy to lose sight of the fact that the essential and defining symptom of homelessness is lack of access to conventional housing"); Rossi, *supra* note 38, at 957 ("*Homelessness today is a more severe condition of housing deprivation than in decades past.*" (emphasis in original)); Stevens, *U.S. Advocacy Group for Homeless is Born*, *N.Y. Times*, Feb. 16, 1986,

State study found that the "single most critical factor in preventing effective service coordination and implementation of rational discharge planning is the lack of . . . adequate specialized housing for the chronically disabled."⁷⁵

The shrinkage of alternative housing in New York, which has an *overall* rental vacancy rate of one percent⁷⁶ is paradigmatic. The Single Room Occupancy Hotels (SRO's), which for years provided their only affordable housing,⁷⁷ were a haven for ex-patients and other high risk homeless persons who gravitated to such facilities for shelter.⁷⁸ Between 1970 and 1982, New York City lost over 110,000 SRO units, which represented eighty-seven percent of the total supply.⁷⁹ These SRO units disappeared largely as a result of tax abatement programs⁸⁰ which encouraged developers to convert

at B1, col. 1 (quoting Boston Mayor Raymond Flynn, keynote speaker at a national conference on problems of the homeless: "Housing is the real issue").

75. Baxter & Hopper, *supra* note 43 (quoting New York State Office of Mental Health, COMMITTEE REPORT TO THE COMMISSIONER OF MENTAL HEALTH (Jan. 1, 1982)); see also Rapson, *The Right of the Mentally Ill to Receive Treatment in the Community*, 16 COLUM. J.L. & SOC. PROBS. 193, 207 (asserting that "[h]ousing, the core of any community-based treatment plan, is the most striking testament to the breakdown of deinstitutionalization theory"). For a discussion of the relationship of housing issues to homelessness, see generally P. ROSSI, *supra* note 14, at 181-86; COALITION FOR THE HOMELESS, *STEMMING THE TIDE OF DISPLACEMENT: HOUSING POLICIES FOR PREVENTING HOMELESSNESS* (1986) [hereinafter *STEMMING THE TIDE*]; J. KOZOL, *supra* note 52; Milstein, Pepper & Rubenstein, *The Fair Housing Amendments Act of 1988: What It Means for People With Mental Disabilities*, 22 CLEARINGHOUSE REV. 127, 128 (1989) (discussing the linkage between federal reform legislation, housing and the mentally disabled).

76. E. BAXTER & K. HOPPER, *PRIVATE LIVES/PUBLIC SPACES—HOMELESS ADULTS ON THE STREETS OF NEW YORK* 6-7 (1981).

77. B. KATES, *THE MURDER OF A SHOPPING BAG LADY* 160 (1985). Cf. Rhoden, *supra* note 17, at 391-92 ("The New York City subway system has been called 'the largest SRO' in existence").

78. Cf. P. ROSSI, *supra* note 14, at 35 (contending that "[t]he new 'emergency shelters' that have been provided in city after city are certainly better than having no roof at all over one's head, but a case can be made that in some respects the cubicle hotels were better").

79. Baxter & Hopper, *supra* note 43, at 113 (citing Green, *HOUSING SINGLE, LOW-INCOME INDIVIDUALS* (paper presented at the Conference on New York State Social Welfare Policy, Oct. 1-2, 1982)); see also B. KATES, *supra* note 77, at 164 (115,000 SRO units lost since 1970). See generally *STEMMING THE TIDE*, *supra* note 75, at 29-32 (discussing loss of housing units). Nationwide, over one million SRO units were lost during the same time period, or nearly half of the entire nation's available single occupancy stock. Baxter & Hopper, *supra* note 43, at 113. Perhaps partially because of this lack of available housing, hospitals discharged patients in increasingly greater numbers to "unknown" living arrangements in urban states. In 1979-80, this happened to 23% of all discharged New York state patients, including 59% of one hospital's total discharges. *Id.* at 114 (citing New York State Office of Mental Health, MEMO FROM POLICY PLANNING AND PROGRAM DEVELOPMENT DIVISION: OCT. 29, 1980 (Mar. 31, 1980)).

80. See Langdon & Kass, *supra* note 21, at 311-12 n.35 (providing an analysis of the

(and "gentrify") these hotels into luxury housing.⁸¹ The tax abatement laws were thus "subverted into a mechanism for converting unprofitable housing for the poor into extremely profitable housing for the well-to-do,"⁸² "greatly accentuat[ing] the problem."⁸³ At the same time, federal funding for subsidized housing has been reduced eighty-one percent in the past decade.⁸⁴ The waiting list for public housing in New York City is now estimated at eighteen years.⁸⁵

States and communities, fearing they will become a "magnet" for the homeless, systematically compete in an effort to minimize their populations of homeless people.⁸⁶ While the lengths to which some cities have gone in an effort to rid themselves of homeless persons may be extreme (for example, Phoenix made it a criminal misdemeanor to lie on a park bench),⁸⁷ the general lack of state and federal funding for shelter services creates a strong incentive for other localities to "rid their jurisdictions of homeless people."⁸⁸

specific impact of the so-called "J-51" tax abatement program in New York City); *STEMMING THE TIDE*, *supra* note 75, at 33; *see also* Cohen, *What To Do About the Homeless, Starting Now*, N.Y. Times, Jan. 4, 1985, at A26, col. 3 (letter to the editor) (discussing role of J-51 tax abatement in causing homelessness in New York City).

Joel Dvoskin recently reported seeing a bumper sticker in Albany, New York, that read: "Houses—Nobody Gets 2 Until Everybody Gets 1."

81. B. KATES, *supra* note 77, at 160-65.

82. *Id.* at 162.

83. Lipton, Sabatini & Katz, *Down and Out in the City: The Homeless Mentally Ill*, 34 *HOSP. & COMMUNITY PSYCHIATRY* 817, 821 (1983).

84. Carmody, *supra* note 74, at B2, col. 5 (where 47,000 New York state households once received housing subsidies, only 8,000 currently receive them).

85. Hollings, *Bush's Real Problem—The Ruins of Reaganism*, Wash. Post, Apr. 30, 1989, at C1, col. 4.

86. *Halting the Race*, *supra* note 21, at 555-56; *cf.* P. Rossi, *supra* note 14, at 35 (discussing study reported in Crystal & Goldstein, *Chronic and Situational Dependency: Long Term Residents in a Shelter For Men* (1982) (shelter residents rated prisons as superior to shelters in safety, cleanliness and food quality)).

87. The Phoenix City Council also defined all trash as "city property." *Halting the Race*, *supra* note 21, at 556 n.21. Other municipalities have considered even more grotesque approaches. A city councilman in Fort Lauderdale suggested that the city spray all garbage cans with poison to prevent the "disgusting sight" of homeless persons picking through garbage. Langdon & Kass, *supra* note 21, at 322-23 n.91 (quoting Robert Hayes, Remarks at the National Conference on Social Welfare, Boston, Mass. (Apr. 29, 1982)); *see also* Note, *An Overview of Homelessness in America*, 35 *LOV. L. REV.* 216, 229 (1989) (discussing recently proposed similar local ordinances).

88. *Halting the Race*, *supra* note 21, at 557. According to the commentators, the approach of the governmental entities paradoxically mirrors that of states in efforts to attract corporations. The phrase "race to the bottom" originally described interstate competition to offer the most permissive regulatory or statutory scheme. Whereas this strategy was designed to attract corporate business, the states now compete to rid themselves of home-

3. *Reduction in governmental benefits.* The procedures initiated by the Reagan Administration to review all Supplemental Security Income (SSI) recipients⁸⁹ resulted in over 350,000 people losing their benefits after fall 1981.⁹⁰ In this group, the mentally disabled were overrepresented by a factor of three.⁹¹ Similarly, about a third of all persons whose benefits were discontinued were mentally impaired.⁹² As of November 1981, *every* client of Project Reach Out—a mobile outreach program funded by the New York State Office of Mental Health to serve the homeless—who applied for SSI based on psychiatric disability was rejected.⁹³ A survey of another group of the homeless found that less than one-quarter received any sort of governmental financial assistance and that none received SSI.⁹⁴

While these cutbacks have diminished to some extent in the face of public outrage,⁹⁵ congressional response,⁹⁶ and United States Supreme Court action,⁹⁷ the reduction of disability benefits

less people. *See, e.g.,* Cary, *Federalism and Corporate Law: Reflections Upon Delaware*, 83 YALE L.J. 663, 690 (1974); *Halting the Race*, *supra* note 21, at 555 n.19. For an explanation of how this reflects "bile barrel politics," see generally Pitney, *Bile Barrel Politics: Siting Unwanted Facilities*, 3 J. POL'Y ANALYSIS & MGMT. 446, 448 (1984) (describing political manipulations to bar siting of hazardous waste sites, nerve gas warehouses, and prisons); Marmor & Gill, *supra* note 4, at 467. Refer to notes 184-85 *infra* and accompanying text. *But see* Dunlap, *Listing Shows Homeless Sites To Aid Census; New York's First Count Finds 2,100 Locations*, N.Y. Times, Jan. 22, 1990, at B1, col.5 (discussing New York City's strategy to determine true number of the homeless for census purposes).

89. *Cf. Stieberger v. Heckler*, 615 F. Supp. 1315, 1398-99 (S.D.N.Y. 1985) (secretary's nonacquiescence policy, allowing administrative law judges to disregard federal court decisions that conflicted with Secretary's policies, violates separation of powers clause).

90. Baxter & Hopper, *supra* note 43, at 132 (citing MENTAL HEALTH LAW PROJECT, ARBITRARY REDUCTIONS OF DISABILITY ROLLS (Mar. 3, 1982)).

91. *Id.*

92. *Id.*

93. *Id.* at 117 (citing Barrow & Lovell, *The Referral of Outreach Clients to Mental Health Services: Progress Report for 1982-1983*, (New York State Psychiatric Inst. 1983)).

94. Bassuk, Rubin & Lauriat, *Is Homelessness a Mental Health Problem?* 141 AM. J. PSYCHIATRY 1546, 1548 (1984) (three percent of the individuals studied received Social Security Disability Insurance, a parallel entitlement program). *Cf. Hart v. Perales*, Nos. 40 & 49-85 (N.Y. Sup. Ct. 1986), reported in N.Y.L.J., Apr. 10, 1986, at 7, col. 2 (granting new hearing in case of welfare recipient who lost his benefits on the grounds that he "lived in a men's shelter that meets all of his food, shelter and incidental needs and . . . is not actively seeking housing").

95. *See* Simon, *Rights and Redistribution in the Welfare System*, 38 STAN. L. REV. 1431, 1471 n.119 (1986) (discussing public attitudes toward need for continued Social Security benefits program).

96. *See* 42 U.S.C. § 423 (1988).

97. *See, e.g., City of New York v. Heckler*, 578 F. Supp. 1109, 1112-16 (E.D.N.Y.) (concluding that denial of social security disability and supplemental security income bene-

remains a significant factor in the increased number of homeless persons.⁹⁸ Additionally, the more recent amelioration in entitlement policy has not aided those individuals who lost benefits in the early 1980s.⁹⁹ These changes caused the annual income of homeless individuals to drop from \$1058 in 1958 to the equivalent of \$383 (in 1958 dollars)¹⁰⁰ at the present time. In other words, the homeless are more than two-thirds poorer than they were thirty years ago.¹⁰¹

4. *Unemployment rates.* Most of the "new homeless" are unskilled and were chronically unemployed even *before* they became homeless.¹⁰² Even the mobile, physically and mentally capable homeless have had little opportunity for advancement because of poverty and atrophied skills levels.¹⁰³ To a significant extent, this group has helped reshape the demographic picture of the homeless; members of the racial and ethnic minority groups¹⁰⁴ who have been disproportionately hurt by the increase in unemployment rates in unskilled and semiskilled jobs¹⁰⁵ are more rapidly joining the ranks of the homeless.¹⁰⁶

fits without due process is not permissible), *aff'd*, 742 F.2d 729, 740 (2d Cir. 1984), *aff'd sub nom.* Bowen v. City of New York, 476 U.S. 467 (1986).

98. See Bassuk & Lauriat, *The Politics of Homelessness*, in *THE HOMELESS MENTALLY ILL*, *supra* note 15, at 301-02.

99. See generally Note, *Building a House of Legal Rights: A Plea for the Homeless*, 59 ST. JOHN'S L. REV. 530, 533-38 (1985) (considering ways in which the administration of such entitlement programs as AFDC, SSI, and food stamps are negatively affecting the plight of the homeless, and noting that "by requiring bona fide residence for AFDC and SSI relief, the legislative intent behind the programs is defeated").

100. P. Rossi, *supra* note 14, at 40.

101. *Id.*

102. See *Halting the Race*, *supra* note 21, at 552.

103. *Id.*

104. See P. Rossi, *supra* note 14, at 40 ("We can generalize that minorities are consistently overrepresented among the new homeless in ratios that are some multiple of their presence in the community.").

105. See Langdon & Kass, *supra* note 21, at 313 ("If the focus of productivity continues to shift away from the heavy industry sector of the economy, it is likely that a growing number of workers will become jobless and then temporarily, if not chronically, homeless.").

106. See *Homelessness in America II: Hearings Before the Subcomm. on Housing and Community Development of the House Comm. on Banking, Finance and Urban Affairs*, 98th Cong., 2d Sess. 1874 (1984); see also Langdon & Kass, *supra* note 21, at 303 n.21 (90% of the population using municipal men's shelters in New York City are now minority). See generally Wagenaar & Lewis, *supra* note 52, 511-13 (for an increasing number of men between 1970 and 1980, the labor market ceased to function as the provider of the resources necessary for an adequate existence in society); *Halting the Race*, *supra* note 21, at 530-31 n.3 (discussing Price v. Cohen, 715 F.2d 87, 97 (3d Cir. 1983), and observing that the needy

C. Conclusion

The homeless are becoming increasingly marginalized. Always disaffiliated and unconnected with mainstream society, they are now poorer, more estranged, younger, and disproportionately female and racial minorities. To many, they symbolize poverty as well as the failures and the excesses of the Reagan [social] program."¹⁰⁷ In response, organized government has merely "shrug[ged] its fiscal shoulders."¹⁰⁸

III. THE MYTHS OF DEINSTITUTIONALIZATION¹⁰⁹

A. Historical Background

Our public mental health policy is cyclical, spurred by reform movements that seek to transform social problems into mental health issues¹¹⁰ and medical issues.¹¹¹ In an important way, the deinstitutionalization debate¹¹² provides yet one more example of

have difficulty finding work); Werner, *On the Streets: Homelessness Causes and Solutions*, 18 CLEARINGHOUSE REV. 11, 12 (1984) (presenting demographic problems of homeless individuals). *But cf.* H. BAHR, *SKID ROW: AN INTRODUCTION TO DISAFFILIATION* 100 (1973) ("skid row" residents traditionally were white, middle-aged males).

107. Oreskes & Toner, *The Homeless at the Heart of Poverty and Policy*, N.Y. Times, Jan. 29, 1989, § 4, at 5, col. 1.

108. *Williams v. Department of Human Servs.*, 228 N.J. Super. 529, 536, 550 A.2d 505, 509 (App. Div. 1988), *rev'd on other grounds*, 116 N.J. 102, 114, 561 A.2d 244, 256 (1989).

109. Much of the text accompanying notes 110-17 is adapted from 2 M. PERLIN, *supra* note 11, § 7.02.

110. Durham, *supra* note 72, at 117-19; Goldman & Morrissey, *The Alchemy of Mental Health Policy: Homelessness and the Fourth Cycle of Reform*, 75 AM. J. PUB. HEALTH 727, 728-29 (1985); Morrissey & Goldman, *Care and Treatment of The Mentally Ill in the United States: Historical Developments and Reforms*, 484 ANNALS 12 (1986). See generally E. TORREY, *supra* note 41; Armour, *Mental Health Policymaking in the United States: Patterns, Process, and Structures*, in HANDBOOK ON MENTAL HEALTH POLICY IN THE UNITED STATES 173-92 (1989) (D. Rochefort ed.); Rochefort, *Mental Illness and Mental Health as Public Policy Concerns*, in HANDBOOK ON MENTAL HEALTH POLICY IN THE UNITED STATES, *supra* at 1, 3, 16-17.

111.

An almost natural corollary of this excessive emphasis on deinstitutionalization is the medicalization of homelessness. When a social condition or problem is medicalized, several important consequences follow. First, the medical profession becomes the major source of expertise, functioning to define in large measure the nature and parameters of the problem. Second, the problem is framed from the standpoint of the medical model such that it is both individualized and depoliticized. And third, this perspective comes to function as the screen through which the problem is viewed and debated publicly.

Myth, *supra* note 69, at 420.

112. As defined by the National Institute of Mental Health (NIMH), the concept of

how a discrete reform policy that fails to address the full range of underlying social issues is inevitably doomed. While the historical basis of deinstitutionalization is fairly clear, this history must be read upon a canvas of social and economic politics in order to understand the depths of the problems we face today as well as the intractable irrationality of our response to them. Our willful blindness towards both the underlying politics and the irrationality of our response calls into question our social competence to respond.

Deinstitutionalization is society's "whipping boy." Heuristically,¹¹³ we perceive it as a massive social failure that has "worsened conditions of care, created community resistance and under-

"deinstitutionalization" involves three processes: (1) the prevention of inappropriate admissions to facilities for the mentally handicapped through the provision of community alternatives for treatment; (2) the release or transfer to the community of those institutionalized patients who are adequately prepared for the change; and (3) the establishment and continued maintenance of community support systems for non-institutionalized persons receiving mental disability services. L. BACHRACH, DEINSTITUTIONALIZATION: AN ANALYTICAL REVIEW AND SOCIOLOGICAL PERSPECTIVE 1 (1977) (citing B. Brown, Director of NIMH, Deinstitutionalization and Community Support Systems, Statement (Nov. 4, 1975)); see also Bachrach, *A Conceptual Approach to Deinstitutionalization*, 29 HOSP. & COMMUNITY PSYCHIATRY 573, 574 (1978) (the concept of deinstitutionalism is broad and diverse, and many people contemplate different solutions); Perlin, *The Deinstitutionalization Myths: Old Wine in New Bottles*, in CONFERENCE REPORT: THE SECOND NATIONAL CONFERENCE ON THE LEGAL RIGHTS OF THE MENTALLY DISABLED 20 (K. Menninger & W. Watts eds. 1979) (the phrase "deinstitutionalization" has become a "shibboleth, catch phrase, litmus test and call to arms to groups across the entire social and political spectrum").

113. "Heuristics" refers to principles that individuals use in attempting to simplify complex information-processing tasks. Application of the heuristic method leads to distorted and systematically erroneous decisions and lead decisionmakers to "ignore or misuse items of rationally useful information." Carroll & Payne, *The Psychology of the Parole Decision Process: A Joint Application of Attribution Theory and Information Processing Psychology*, in COGNITION AND SOCIAL BEHAVIOR 13, 21 (1976). See generally Saks & Kidd, *Human Information Processing and Adjudication: Trial By Heuristics*, 15 L. & Soc'y REV. 123, 131 (1980-81) (heuristic biases can effect decision making dramatically). For a discussion of other mental disability law issues from this perspective, see Perlin, *Psychodynamics and the Insanity Defense: 'Ordinary Common Sense' and Heuristic Reasoning*, 67 NEB. L. REV. 3, 12-22 (1990) [hereinafter *Psychodynamics*] (insanity defense). See also Perlin, *Are Courts Competent to Discuss Questions of Competency? Stripping the Facade from United States v. Charters*, 38 U. KAN. L. REV. 957, 958-68 (1990) [hereinafter *Facade*] (right of pre-trial detainees to refuse antipsychotic medication); Perlin, *Morality and Pretextuality, Psychiatry and Law: Of "Ordinary Common Sense," Heuristic Reasoning, and Cognitive Dissonance*, 19 BULL. AM. ACAD. PSYCHIATRY & L. ____ (1991) (in press) [hereinafter *Morality*] (expert testimony in civil commitment cases).

For an example of the use of heuristics in the deinstitutionalization context, see Cohen & Marcos, *The Bad-Mad Dilemma For Public Psychiatry*, 40 HOSP. & COMMUNITY PSYCHIATRY 677, 677 (1989) (discussing public attitudes towards discharge of mental patients following the murder of a church usher by a chronically mentally ill individual in St. Patrick's Cathedral in New York City).

mined patient reintegration."¹¹⁴ In order to determine the accuracy of this characterization, we must consider the forces that helped bring about current policies.¹¹⁵ When these forces are considered in light of the social forces that have dramatically increased homelessness,¹¹⁶ the relationship between the two should become clearer. The problems attributed to deinstitutionalization are far more complex than the debate suggests: they reflect important changes in national demography, in concepts of civil liberties, in social welfare policies, and in the provision of medical services.¹¹⁷ Until we confront this complexity, we will remain in a social policy gridlock.

114. Mills & Cummins, *Deinstitutionalization Reconsidered*, 5 INT'L J.L. & PSYCHIATRY 271, 274 (1982). See generally Baron, *Changing Public Attitudes About the Mentally Ill in the Community*, 32 HOSP. & COMMUNITY PSYCHIATRY 173 (1981) (the public's continued negative response to deinstitutionalization remains a substantial barrier to the integration of the mentally ill into the community); Talbott, *Deinstitutionalization: Avoiding the Disasters of the Past*, 30 HOSP. & COMMUNITY PSYCHIATRY 621, 621 (1979) (recognizing the primary reasons for the problems caused by deinstitutionalization as lack of consensus about policy, failure to properly test its philosophical bases, are lack of planning for alternative facilities and services, and inadequacies of mental health care delivery system in general). But see *City of Cleburne v. Cleburne Living Centers*, 473 U.S. 432, 448 (1985), quoting *Palmore v. Sidoti*, 466 U.S. 429, 433 (1984) ("Private biases may be outside the reach of the law, but the law cannot, directly or indirectly, give them effect."). Refer to notes 331-32 *infra* and accompanying text.

115. For short and helpful overviews, see generally Kanter, *supra* note 72, at 333-42 (historical trends in institutional care); Langdon & Kass, *supra* note 21, at 312-13 (arguing that deinstitutionalization is a major cause of the rise in the homeless population); Mills & Cummins, *supra* note 114, at 272-74 (consideration of relevant social forces).

In 1955, the national census of state hospitals peaked at slightly over half a million persons. Talbott, *supra* note 114, at 621. Currently, there are little more than 100,000 residents so institutionalized. Bachrach, *Deinstitutionalization: What Do the Numbers Mean?*, 37 HOSP. & COMMUNITY PSYCHIATRY 118 (1986) (pointing out that during a recent typical year, there were still 344,000 "admissions" and 342,000 "discontinuations"—discharges plus placements on leave—in the same hospitals; see also Goldman, Adams & Taube, *Deinstitutionalization: The Data Demythologized*, 34 HOSP. & COMMUNITY PSYCHIATRY 129, 131 (1983) ("as the census fell, admissions increased"). See generally C. KIESLER & A. SIBULKIN, MENTAL HOSPITALIZATION: MYTHS AND FACTS ABOUT A NATIONAL CRISIS 147 (1987) ("episodic rate of mental hospitalization has been increasing quite rapidly over the past 15 years"); Kiesler, *Mental Hospitals and Alternate Care: Noninstitutionalization as Potential Public Policy for Mental Patients*, 37 AM. PSYCHOLOGIST 349 (1982) (showing that the number of mental hospital episodes increased 38% from 1955 to 1975); *The Federal Role in Providing Services to the Mentally Ill: Hearing Before the Subcomm. on Human Resources and Intergovernmental Relations of the House Comm. on Government Operations*, 100th Cong., 1st Sess. 45 (1988) (testimony of Dr. Charles A. Kiesler) (asserting that rate of mental hospitalization has increased over 60% in the past 15 years).

116. Refer to notes 38-107 *supra* and accompanying text.

117. Mechanic, *Correcting Misconceptions in Mental Health Policy: Strategies for Improved Care of the Seriously Mentally Ill*, 65 MILBANK Q. 203, 226 (1987).

As the extent of serious deficiencies in state hospitals became apparent to social reformers,¹¹⁸ psychiatrists,¹¹⁹ lawyers,¹²⁰ and political leaders,¹²¹ they realized that alternatives to large, impersonal institutions needed to be developed.¹²² Recognition of these deficiencies is not new.¹²³ For instance, in 1884, Dr. Pliny Earle (then

118. See generally, A. DEUTSCH, *THE MENTALLY ILL IN AMERICA* (1949) (analysis of the evolution of people's perception of the insane and modern trends of state care); D. ROTHMAN, *THE DISCOVERY OF THE ASYLUM* (1971) (historical background of the introduction of asylums in the Jacksonian era); E. GOFFMAN, *ASYLUMS: ESSAYS ON THE SOCIAL SITUATION OF MENTAL PATIENTS AND OTHER INMATES* (1961); Bell, *From the Asylum to the Community in U.S. Mental Health Care: A Historical Overview*, in *HANDBOOK ON MENTAL HEALTH POLICY IN THE UNITED STATES*, *supra* note 110, at 89-120; Dain, *Deinstitutionalization: Intended and Unintended Impacts on the Community: Three Centuries of Vicissitudes of Mental Health*, in *THE COMMUNITY IMPERATIVE: PROCEEDINGS OF A NATIONAL CONFERENCE ON OVERCOMING PUBLIC OPPOSITION TO COMMUNITY CARE FOR THE MENTALLY ILL* 189 (1980) [hereinafter *THE COMMUNITY IMPERATIVE*].

119. See, e.g., Solomon, *The American Psychiatric Association in Relation to American Psychiatry*, 115 *AM. J. PSYCHIATRY* 1, 2 (1958) (psychiatric profession has failed to meet one of its great challenges—to provide care to the long-term mentally ill).

Other psychiatrists began to examine the high *readmissions* rate at public hospitals in an effort to determine if some recidivism was preventable. In one of the first studies, Dr. John Talbott revealed that one hospital might have prevented 84% of readmissions in a sample of 100 cases studied, and that, in half of these cases, only minor improvements in existing services—not necessitating any further expenditures of money—were needed. Talbott, *Stopping the Revolving Door—A Study of Readmissions to a State Hospital*, 48 *PSYCHIATRY Q.* 159 (1974).

120. See, e.g., Birnbaum, *The Right to Treatment*, 46 *A.B.A. J.* 499, 500-01 (1960) (developing theoretical basis for the right to treatment).

121. See *Special Message to the Congress on Mental Illness and Mental Retardation*, in *PUBLIC PAPERS OF THE PRESIDENT OF THE UNITED STATES: JOHN F. KENNEDY* 126 (1964).

122. For a study of early alternatives, see B. PASAMANICK, F. SCARPITTI & S. DINITZ, *SCHIZOPHRENICS IN THE COMMUNITY: AN EXPERIMENTAL STUDY IN THE PREVENTION OF HOSPITALIZATION* (1967). See also Kanter, *supra* note 72, at 334-35 (tracing the role of social reformers such as Dorothea Dix, Deutsch, and Erving Goffman).

123. As early as 1919, the superintendent of a state school for the mentally retarded endorsed the "trial outside" the institution for the "few defectives [sic] [who] do not need or deserve life-long segregation." Ferleger, *Anti-Institutionalization and the Supreme Court*, 14 *RUTGERS L.J.* 595, 620 n.119 (1983) (citing Fernald, *After-Care Study of the Patients Discharged from Waverley for a Period of Twenty-five Years*, 5 *UNGRADED 25* (1919)); see also DAVIES, *SOCIAL CONTROL OF THE MENTALLY DEFICIENT* 202 (1930) (cited in Ferleger, *supra*, as quoting a second such superintendent that "the number of feeble-minded that can be safely cared for in the community is in direct ratio to the supervision that the community is willing to provide"); Williams, *supra* note 55, at 55 (historical survey of social and economic forces on the placement and treatment of chronically mentally ill persons). See generally Ferleger, *supra*, at 619-24 (tracing historical roots of "disillusionment with institutional care in the 20th century"); Goldman & Morrissey, *supra* note 110, at 727 (citing E.N. GROB, *MENTAL ILLNESS AND AMERICAN SOCIETY, 1875-1940* (1983) and J.M. GRIMES, *INSTITUTIONAL CARE OF MENTAL PATIENTS IN THE UNITED STATES* (1934)) (the term "deinstitutionalization" was used as early as 1934).

superintendent of a Massachusetts state hospital) wrote to that state's governor suggesting "an experiment . . . of giving [a patient] the opportunity of showing how far he could control himself away from the hospital."¹²⁴

Mental health professionals and others thus began to turn their attention to different mechanisms to provide for community care of the mentally ill.¹²⁵ The debate as to whether this stemmed from humanitarian concerns or social expediency and economics has been waged for over forty years.¹²⁶ New and amended federal grant and entitlement programs¹²⁷ then appeared to provide a mechanism through which community programs could be reimbursed for the care of mentally disabled persons.¹²⁸ Clearly, most of the programs never fulfilled the mandate of treating the original target population—the deinstitutionalized.¹²⁹

124. Geller, *Deinstitutionalization in 19th-Century America*, 40 HOSP. & COMMUNITY PSYCHIATRY 85, 85 (1989).

125. See, e.g., Bassuk & Gerson, *Deinstitutionalization and Mental Health Services*, 238 SCI. AM. 46 (1978) (historical and analytical discussion of alternatives in treating the mentally ill). On the other hand, critics of deinstitutionalization have questioned both the level of care and the value of treatment received in many of the community facilities to which patients have been deinstitutionalized, and have suggested that, in many instances, these facilities have simply taken over the function of the state hospital. See Lamb, *The New Asylums in the Community*, 36 ARCHIVES GEN. PSYCHIATRY 129 (1979); Lamb & Goertzel, *Discharged Mental Patients—Are They Really in the Community?*, 24 ARCHIVES GEN. PSYCHIATRY 29, 29 (1971); Scherl & Macht, *Deinstitutionalization in the Absence of Consensus*, 30 HOSP. & COMMUNITY PSYCHIATRY 599, 599 (1979).

126. Note, *1986 Amendments to Georgia's Mental Health Statutes: The Latest Attempt to Provide a Solution to the Problem of the Chronically Mentally Ill*, 36 EMORY L.J. 1313, 1315-16 (1987).

127. See, e.g., Ewing, *Health Planning and Deinstitutionalization: Advocacy Within the Administrative Process*, 31 STAN. L. REV. 679, 695-701 (1979) (discussing Health Planning and Resources Act, 42 U.S.C. § 300e-4, 300m-300t (1976)). For a discussion of the availability of federal grant programs for housing services for the mentally disabled, see Kanter, *supra* note 72, at 342-45. See also Note, *The National Health Planning and Resources Development Act and State Action: A Reappraisal of the Role of Private Health Care Institutions*, 57 B.U.L. REV. 511, 513-17 (1977) (analysis of the act).

128. Talbott, *The History of the State Mental Hospital*, reprinted in J. TALBOTT, *THE DEATH OF THE ASYLUM* 13-23 (1978).

129. See E. TORREY, *supra* note 41, at 142-50. See generally Durham, *supra* note 72, at 120; Marmor & Gill, *supra* note 4 (subjectiveness in mental health diagnoses creates problems with third party insurers because mental illness treatments fail to fit into the traditional medical model).

It is well known that, following the rise of deinstitutionalization as a social movement, "money did not follow patients into the community." As a result of political and employee union pressures, state hospitals still receive an increasingly disproportionate share of the state budget as deinstitutionalization continues. See E. TORREY, *supra* note 41, at 155-56; Durham, *supra* note 72, at 121-22; Marmor & Gill, *supra* note 4, at 472-73.

Next, the development of antipsychotic drugs¹³⁰ created a modality of treatment which could, in many instances, be administered in the community in much the same manner as in institutions.¹³¹ While the common wisdom that "the drugs emptied out the hospitals"¹³² has been called sharply into question by revisionist social historians such as Andrew Scull,¹³³ many perceive the availability of these drugs as a primary precipitant of massive deinstitutionalization.¹³⁴ Importantly, at least one recent research study suggests that a significant number of deinstitutionalized mentally ill persons *prefer* homelessness to hospitalization because they can thus avoid the involuntary administration of such drugs.¹³⁵

130. For a discussion of legal issues relating to antipsychotic drugs, see generally 2 M. PERLIN, *supra* note 11, ch. 5; Brooks, *The Constitutional Right to Refuse Antipsychotic Medications*, 8 BULL. AM. ACAD. PSYCHIAT. & L. 179, 180-81 (1980); Brooks, *The Right to Refuse Antipsychotic Medications: Law and Policy*, 39 RUTGERS L. REV. 339, 339 (1987) (analysis of whether involuntarily committed mental patients have a legal right to refuse antipsychotic medication); Winick, *Right to Refuse Mental Health Treatment: A First Amendment Perspective*, 44 U. MIAMI L. REV. 1, 69-76 (1989). For a list of other important sources, see THE RIGHT TO REFUSE ANTIPSYCHOTIC MEDICATION 101-10 (D. Rappaport & J. Parry eds. 1986) (providing an annotated bibliography).

131. See, e.g., Baldessarini, *Schizophrenia*, 297 NEW ENG. J. MED. 988 (1977); Berger, *The Medical Treatment of Mental Illness*, 200 SCI. 974 (1978) (discussing the revolutionary treatment of mental illness through drugs and the scientific and ethical issues raised). On the incidence of use of these drugs in non-hospital settings, see Gelman, *Mental Hospital Drugs, Professionalism, and the Constitution*, 72 GEO. L.J. 1725, 1727 n.23 (1984) ("[d]rugging of the mentally ill in the 'community' is all but universal").

132. See e.g., H.R. REP. NO. 541, 100th Cong., 2d Sess. 3 (199). The common view is that the development of these medications has been the major precipitant of deinstitutionalization. See, e.g., Brill & Patton, *Analysis of 1955-1956 Population Fall in New York State Mental Hospitals in First Year of Large Scale Use of Tranquilizing Drugs*, 114 AM. J. PSYCHIATRY. 509 (1957) (discusses the consequences of the large scale introduction of psychotropic drugs); Brill & Patton, *Analysis of Population Reduction in New York State Mental Hospitals During the First Four Years of Large-Scale Therapy With Psychotropic Drugs*, 116 AM. J. PSYCHIATRY. 495,495 (1959).

133. See DECARCERATION, *supra* note 17, at 79-89 (concluding that it is "highly implausible" to suggest that the efficacy of such drugs was "primarily responsible" for the early roots of deinstitutionalization). Cf. Durham, *supra* note 72, at 120 (concluding that drugs played "an important but circumscribed role in the original development of deinstitutionalization as a mental health policy"); Kaplan, *State Control of Deviant Behavior: A Critical Essay on Scull's Critique of Community Treatment and Deinstitutionalization*, 20 ARIZ. L. REV. 189, 193 (1978) (critical analysis of Scull's methodology). For Scull's most recent contributions to the debate, see SOCIAL ORDER/MENTAL DISORDER, *supra* note 17; Scull, *Mental Patients and the Community: A Critical Note*, 9 INT'L J.L. & PSYCHIATRY 383 (1986).

134. See, e.g., Lamb, *supra* note 17, at 60-62; E. TORREY, *supra* note 41, at 87-88.

135. See Fischer & Breakey, *supra* note 14, at 29; see also Stefan, *Preventive Commitment: The Concept and Its Pitfalls*, 11 MENTAL & PHYSICAL DISABILITY L. REP. 288, 294 (1987) ("the core of outpatient treatment is forced medication"). Refer to notes 247-50 *infra*

Finally, as the United States Supreme Court and lower federal courts extended the "due process revolution"¹³⁶ to include the mentally disabled,¹³⁷ courts began to strike down vaguely-drafted involuntary civil commitment statutes¹³⁸ to impose durational limitations on commitments¹³⁹ and to extend the "least restrictive alternative" doctrine to institutional decision making.¹⁴⁰ Also, legislatures passed more restrictive commitment laws¹⁴¹ and adopted periodic review mechanisms¹⁴² so as to limit the numbers of those who would be initially institutionalized and who would subsequently remain institutionalized.¹⁴³ This aspect of deinstitutionalization has served as the bogeyman for the APA, the mass media, and—to a great extent—the public. Thus, the APA Task Force on the Homeless Mentally Ill has argued that legal advocacy efforts on behalf of institutionalized mental patients "neglected [the pa-

and accompanying text.

136. See generally Perlin, *Rights of Ex-Patients in the Community: The Next Frontier?*, 8 BULL. AM. ACAD. PSYCHIATRY & L. 33 (1980):

[Recent] development of mental health rights law must be seen as a logical culmination of the expansion of such parallel fields as civil rights, consumer rights, criminal procedure, and inmates' rights: to a large extent, mental health law is at the crossroads of all of these paths, as an outgrowth of a process by which lawyers have become able to contribute to "public consciousness of inequities or shortcomings in the society" through "substantive concerns with issues of social policy."

Id. at 34 (footnotes omitted). Refer also to notes 136-50 *infra*.

137. See, e.g., *O'Connor v. Donaldson*, 422 U.S. 563, 573 (1975) (right to liberty); *Jackson v. Indiana*, 406 U.S. 715, 738 (1972) (due process applies to involuntary civil commitment decisionmaking).

138. E.g., *Lessard v. Schmidt*, 349 F. Supp. 1078, 1093 (E.D. Wis. 1972) (applying procedural due process methodology to all aspects of involuntary civil commitment process), *vacated and remanded*, 414 U.S. 473 (1974), *on remand*, 379 F. Supp. 1376 (E.D. Wis. 1974), *vacated and remanded*, 421 U.S. 957 (1975), *reinstated*, 413 F. Supp. 1318 (E.D. Wis. 1976).

139. *O'Connor*, 422 U.S. at 575 (even when involuntary confinement is initially permissible, "it could not constitutionally continue after [a constitutionally adequate] basis no longer existed"); see also Comment, *Bitter Freedom: Deinstitutionalization and the Homeless*, 3 J. CONTEMP. HEALTH L. & POL'Y 205, 214-21 (1987) (discussing *O'Connor*).

140. See, e.g., *Lessard*, 349 F. Supp. at 1096.

141. See, e.g., WIS. STAT. ANN. § 51.001 (2) (West 1985). See generally 1 M. PERLIN, *supra* note 11, § 2.16, at 130-38; Zander, *Civil Commitment in Wisconsin: The Impact of Lessard v. Schmidt*, 1976 WIS. L. REV. 503, 504 (arguing that decisions such as *Lessard* will force courts and legislatures to consider fundamental notions of liberty and individuality).

142. See, e.g., N.C. GEN. STAT. § 122C-276 (1989).

143. See S. BRAKEL, J. PARRY & B. WEINER, *THE MENTALLY DISABLED AND THE LAW* 21, 72 (3d ed. 1985) (concluding that periodic review spelled the "virtual demise" of "indeterminate involuntary commitment"); see also Note, *Substantive Limits on the Duration of Civil Commitment for the Treatment of the Mentally Ill*, 16 HARV.C.R.-C.L. L. REV. 205, 219-23 (1981) (discussing cases).

tients'] right to high-quality comprehensive outpatient care."¹⁴⁴ The task force chairman, Dr. H. Richard Lamb, asserted that "some mental health lawyers and patients' rights advocates . . . have contributed heavily to the problems of homelessness."¹⁴⁵ Other deinstitutionalization critics, such as E. Fuller Torrey, have characterized inappropriate deinstitutionalization as the "primary" cause of homelessness,¹⁴⁶ accusing "civil liberties lawyers" of "compound[ing the disaster]" by filing such diverse suits as *Wyatt v. Stickney*,¹⁴⁷ *O'Connor v. Donaldson*,¹⁴⁸ *Dixon v. Weinberger*,¹⁴⁹

144. *Recommendations of the American Psychiatric Association Task Force on the Homeless Mentally Ill*, in *THE HOMELESS MENTALLY ILL*, *supra* note 15, at 7 [hereinafter *APA Task Force*]. Cf. 2 M. PERLIN, *supra* note 11, § 7.03, at 569 ("[T]he U.S. Supreme Court's holding in *Youngberg v. Romeo*, 457 U.S. 307 (1982), that there was no general [constitutional] right to services in the community appeared to diminish the likelihood that . . . a universal right [to treatment in the community] would be found in the near future."). *But cf.* *Patients v. Camden County Bd. of Chosen Freeholders*, No. L-33417-74 P.W. (N.J. Super. Ct., Camden County, Jan. 19, 1981) (right to aftercare found by trial court based on state constitution and state statutes), *vacated*, Nos. A-3271-80T3, A-4407-80T3 (App. Div., Feb. 17, 1982) (finding complexity of issues made summary judgment inappropriate) as reported in *Patients*, 5 MENTAL DISABILITY L. REP. 108, 108 (1981); *see also* Meisel, *The Rights of the Mentally Ill Under State Constitutions*, 45 L. & CONTEMP. PROBS. 7, 31 n.115 (1982).

For a general discussion of state constitutional basis for the rights in question, *see* Meisel, *supra*; Perlin, *State Constitutions and Statutes as Sources of Rights for the Mentally Disabled: The Last Frontier?*, 20 LOY. L.A.L. REV. 1249, 1283-86 (1987).

145. *Deinstitutionalization*, *supra* note 17, at 62; *see also* Lamb, *Deinstitutionalization and the Homeless Mentally Ill*, 35 HOSP. & COMMUNITY PSYCHIATRY 899, 902 (1984) (observing that patients' right to freedom "not synonymous with releasing them to streets where they cannot take care of themselves, are too disorganized or fearful to avail themselves of what help is available, and are easy prey for every predator"). For a clinical perspective alleging that aggressive patient advocacy can lead to clinical passive-aggressivity, *see* Peele, Gross, Arons & Jafri, *The Legal System and the Homeless*, in *THE HOMELESS MENTALLY ILL*, *supra* note 15, at 261, 263.

146. Engel, *D.C.'s Homeless Schizophrenics Get Little Help, Report Finds*, Wash. Post, Apr. 24, 1985, at C1.

147. 325 F. Supp. 781 (M.D. Ala. 1971), 334 F. Supp. 1341 (M.D. Ala.), 344 F. Supp. 373 (M.D. Ala. 1972), 344 F. Supp. 387 (M.D. Ala.), *aff'd sub nom.* *Wyatt v. Aderholt*, 503 F.2d 1305 (5th Cir. 1974) (broadly based constitutional right to treatment). *See generally* 2 M. PERLIN, *supra* note 11, Ch. 4 (discussing, *inter alia*, the role of *Wyatt* in the development of mental disability law).

It is worth noting that the American Psychiatric Association declined the court's request to participate as *amicus* in *Wyatt*. For a discussion of the APA's possible motivations, *see* Sadoff, *Changes in the Mental Health Law: Progress for Patients, Problems for Psychiatrists*, in 4 NEW DIRECTIONS IN MENTAL HEALTH SERVICES: COPING WITH THE LEGAL ON-SLAUGHT 1, 2 (S. Halleck ed. 1979) (psychiatric concern that "courts will usurp their medical functions by telling them how they must treat their patients"); *see also* Stone, *The Right to Treatment and the Medical Establishment*, 2 BULL. AM. ACAD. PSYCHIATRY & L. 159, 161 (1974) (APA position stands as a "a monument to bureaucratic myopia").

148. 422 U.S. 563 (1975) (right to liberty).

149. 405 F. Supp. 974, 978 (D.D.C. 1975) (statutory right to aftercare in the commu-

and *Lessard v. Schmidt*.¹⁵⁰ These critics argue that, while the lawyers were "well-intentioned," their "outmoded ideas about the nature of serious mental illness"—brought on in some important part by their "having read Freud and Szasz"—have created significant legal impediments to care.¹⁵¹ Former New York City Mayor Ed Koch chimed in by characterizing libertarian patients' rights lawyers as "crazies."¹⁵²

B. Myths and "Ordinary Common Sense"

When we reflect on the importance of this position, we must consider how this critique "fits" with our "ordinary common sense" conceptions of the mentally ill¹⁵³ and how certain heuristi-

city). See generally 2 M. PERLIN, *supra* note 11, § § 7.06, 7.07, at 578-98 (discussing *Dixon*, and reprinting subsequent order in *Dixon v. Harris*, No. 74-285 (D.D.C. 1980)); *Deinstitutionalization Case Settled*, 11 MENTAL & PHYSICAL DISABILITY L. REP. 191, 191 (1987) (discussing approval of final settlement in *Dixon v. Bowen*, No. 74-285 (D.D.C., Mar. 31, 1987)).

150. 349 F. Supp. 1078 (E.D. Wis. 1972) (applying procedural due process concepts to involuntary civil commitment process).

151. E. TORREY, *supra* note 41, at 156-59; see also Lamb, *supra* note 145, at 902 (blaming patients' rights advocates for contributing to homelessness); Lamb, *Involuntary Treatment for the Homeless Mentally Ill*, 4 NOTRE DAME J.L., ETHICS & PUB. POL'Y 269, 276 (1989) (discussing Szasz, Goffman and Laing as intellectually animating sources for "many attorneys"); McGrath, *A Hoax Called 'Deinstitutionalization'*, Wash. Post, Oct. 19, 1989, at A26, col. 4-5 (letter-to-the-editor) (arguing that a Washington-based legal advocacy office for patients has helped to escalate the homeless problem); cf. Haber, *The Freedom to Be Psychotic*, 2 J.L. & HEALTH 157, 165 n.51 (1987-88) (legal barriers to care "have been erected primarily by the American Civil Liberties Union"); see also Monahan, *From the Man Who Brought You Deinstitutionalization*, 33 CONTEMP. PSYCHOLOGY 492, 492-93 (1988) (considering Szasz' historical influence).

Criticism of patients' rights lawyers in this context is not a recent development. See, e.g., M. PESZKE, *INVOLUNTARY TREATMENT OF THE MENTALLY ILL* 134-35 (1975) (lawyers and law students perceived by doctor as individuals "who will distort the truth," whose scholarship shows "gross ignorance or even a conscious malevolence and dishonesty alien to worthy scholarship," and whose interest in law and psychiatry matters comes from a desire "to learn how to punch holes and to show the psychiatrist up in court"). Cf. Bursztajn, *More Law and Less Protection: 'Critogenesis,' 'Legal Iatrogenesis,' and Medical Decision Making*, 18 J. GERIATRIC PSYCHIATRY 143, 152 (1985) (incompetent patient's interests are best served by family and physicians rather than by judicial intervention); Gutheil, Bursztajn, Kaplan & Brodsky, *Participation in Competency Assessment and Treatment Decisions: The Role of the Psychiatrist-Attorney Team*, 11 MENTAL & PHYSICAL DISABILITY L. REP. 446, 449 (1987) (discussing "critogenesis"—the "intrinsic risks of legal intervention" in medical decision-making). For a new and important perspective on the underlying issues, see D. WEXLER, *THERAPEUTIC JURISPRUDENCE: THE LAW AS A THERAPEUTIC AGENT* (1990) (discussing therapeutic impacts of legal interventions).

152. Lambert, *Psychologists Back Koch Policy on Hospitalizing Homeless People*, N.Y. Times, Sept. 1, 1987, at A1, col. 2.

153. Compare *Psychodynamics*, *supra* note 113, at 22-39 and Sherwin, *Dialects and*

cally-driven images¹⁵⁴ have allowed us to obsessively focus on *this* social force while blithely ignoring others.¹⁵⁵ While it is common wisdom that deinstitutionalization has failed, there coexists an ample, largely uncontradicted but regularly ignored body of evidence that indicates that a well-conceived deinstitutionalization program offering a variety of intensive rehabilitative services has a positive and significant effect on the length of the ex-patients' "tenure" in the community.¹⁵⁶ We must ask *why* this body of evidence continues to be ignored by all important "players" in this game.

Perhaps these social forces are nothing more than the "cover" for a series of other "covert agendas"¹⁵⁷ that may have been the *true* impetus¹⁵⁸ behind deinstitutionalization: budget shifting,¹⁵⁹

Dominance: A Study of Rhetorical Fields in the Law of Confessions, 136 U. PA. L. REV. 729, 737 (1988) (ordinary common sense is a "prereflective attitude exemplified by the attitude of 'what I know is self-evident'; it is 'what everybody knows'") with E. TORREY, *supra* note 41, at the unnumbered page prior to title page (quoting from a review of Torrey's book in the *Wall Street Journal*): "Intuitively, everyone seems to sense that the process of deinstitutionalization . . . has produced a large population of street people incapable of taking care of themselves." (emphasis added).

154. See, e.g., Rosenhan, *Psychological Realities and Judicial Policy*, 19 STAN. LAW. 10, 13 (1984) (discussing the "vividness effect," a phenomenon through which concrete and vivid information about a specific case overwhelms the abstract data upon which rational choices should be based); *Facade*, *supra* note 113, at 987; *Morality*, *supra* note 113. Visual images, particularly those dealing with the mentally disabled, are especially vivid. See S. GILMAN, *SEEING THE INSANE* 2-11 (1982); see also Gutheil, *supra* note 151, at 447 (discussing the vividness heuristic in a clinical setting).

155. See Hyde, *Homelessness in America: Public Policy, Public Blame*, 8 PSYCHOSOC. REHAB. J. 21, 22 (1985) (APA task force report inevitably led to "quick fix," blame-allocating mentality; public perceptions that "all homeless people are mentally ill and that all mentally ill people are homeless" increased).

156. See, e.g., Cohen, Sichel & Berger, *The Use of a Mid-Manhattan Hotel as a Support System*, 13 COMMUNITY MENTAL HEALTH J. 76 (1977) (demonstrates the feasibility of using community resources for follow-up care of the mentally ill); Solomon, *Discharged State Hospital Patients' Characteristics and Use of Aftercare: Effect on Community Tenure*, 141 AM. J. PSYCHIATRY 1566 (1984) (discussing tracking of discharged patients through an aftercare program). For a thoughtful defense of deinstitutionalization, see Clarke, *In Defense of Deinstitutionalization*, 57 MILBANK MEM. FUND. Q. 461 (1979). See also Lehmann, Possidente & Hawken, *The Quality of Life of Chronic Patients in a State Hospital and in a Community Residence*, 37 HOSP. & COMMUNITY PSYCHIATRY 901, 911 (1986) (community residents perceived their living conditions more favorably, had more financial resources, and were less likely to have been assaulted in the past year than inpatients).

157. Mills & Cummins, *supra* note 114, at 273.

158. See, e.g., Borus, *Sounding Board: Deinstitutionalization of the Chronically Mentally Ill*, 305 NEW ENG. J. MED. 339, 339 (1981) (deinstitutionalization policy supported by a "curious political marriage of liberals, who decry the custodial-level care in state mental hospitals, and conservatives, who see the closing of expensive public institutions as an easy way to save tax dollars").

159. See, e.g., *id.* at 340-41 ("Deinstitutionalization may have been embraced by state

deprofessionalization,¹⁶⁰ oversimplification,¹⁶¹ and privatization.¹⁶² In this context, we must consider the rarely-articulated but never-refuted reality that community mental health services have never

governments as a way to decrease spending by phasing down expensive state institutions and shifting the burden of mental health care to local governments through Community Mental Health Centers . . . and to the federal government through Medicaid."); see also E. TORREY, *supra* note 41, at 150-51 (noting that "the power of federal money . . . was the real driving force behind deinstitutionalization"); Goldman, Adams & Taube, *supra* note 115, at 133 ("State mental hospitals have gained control over the admission of potential chronic patients."). Cf. Glenn, *Community Programs for Chronic Patients—Administrative Financing*, 5 PSYCHIATRIC ANNALS 174, 175 (1975) (noting that administrative problems can occur between two levels of government at all eight separate stages of planning process); Scull, *Finance and Mental Health Policy: A Brief Historical Overview*, in THE COMMUNITY IMPERATIVE, *supra* note 118, at 263 (exploring financial issues in this context).

For the parallel British experience, see Brahams & Weller, *Crime and Homelessness Among the Mentally Ill*, 54 MEDICO-LEGAL J. 42, 45 (1986); for the Canadian experience, see Richman & Harris, *Mental Hospital Deinstitutionalization in Canada: A National Perspective With Some Regional Examples*, 11 INT'L J. MENTAL HEALTH 64 (1983). In a powerful social critique, Professor Carol Warren has argued that deinstitutionalization is a "myth," masking the "transfer of responsibility for 'social junk' from state budgets to various combined welfare-private profit options that cost the state less and provide numerous entrepreneurial opportunities. Warren, *New Forms of Social Control: The Myths of Deinstitutionalization*, 24 AM. J. BEHAVIORAL SCI. 724, 726 (1981), cited in M. PERLIN, *supra* note 11, at 726.

160. See, e.g., Mills & Cummins, *supra* note 114, at 273. According to Mills and Cummins, the deinstitutionalization movement coincided with a lapse in psychiatry's credibility, as reflected in the writings of its critics. See, e.g., T. SZASZ, *THE MYTH OF MENTAL ILLNESS* xxi (1961) (arguing that the myth denigrated the value of psychiatry, and promoted the assertion that mental illness does not exist).

161. Mills & Cummins, *supra* note 114, at 273-74 (governmental neglect of differing skill levels and therapeutic needs among mental patients led to the implementation of inadequate deinstitutionalization plans); see also McCarrah, *The Deinstitutionalization Process, the Patients, and the Employees: A View From the American Federation of State, County and Municipal Employees*, in THE COMMUNITY IMPERATIVE, *supra* note 118, at 201 (discussing the labor unions' perspective in deinstitutionalization politics); Friedman, *Resistance to Alternatives to Hospitalization*, 8 PSYCHIATRIC CLINICS N. AM. 471, 477-78 (1985) (considering the psychological roots of hospital staff resistance to deinstitutionalization).

162. See Eisenberg, *Health Care: For Patients or Profits?*, 143 AM. J. PSYCHIATRY 1015, 1016 (1986) (deinstitutionalization has "privatized" community care by accelerating the pace at which publicly-financed services have been shifted to private management); see also Schlesinger & Dorwart, *Ownership and Mental Health Services, A Reappraisal of the Shift Toward Privately Owned Facilities*, 311 NEW ENG. J. MED. 959, 960 (1984) (defining privatization as a growth in the importance of both private nonprofit and for-profit providers); Gelman, *supra* note 131, at 1751-52 (discussing the role of psychotropic drugs in the shift to private forms of custody).

On the specific issues implicated in the privatization of childrens' hospitals (and the concomitant increases in population censuses and admissions rates), see Dalton & Foreman, *Conflicts of Interests Associated With the Psychiatric Hospitalization of Children*, 57 AM. J. ORTHOPSYCHIATRY 12, 13 (1987). I discuss the ethical implications of these conflicts in Perlin, *Power Imbalance in Therapeutic and Forensic Relationships* 9 BEHAV. SCI. & L. — (1991) (in press).

been truly accessible to former state mental hospital patients.¹⁶³ These services are used instead by what is called, colloquially, the "worried well"—whole new classes of previously untreated patients.¹⁶⁴ As a result, the deinstitutionalized upon whom society focuses—the poor, the minorities, the marginalized—have never received *any*, much less *adequate*, community care.¹⁶⁵ Deinstitutionalization has thus "inadvertently accentuated a two-class system of mental health hospitalization in the United States."¹⁶⁶

It is precisely *this* unserved population—"the voiceless, those persons traditionally isolated from the majoritarian, democratic political system"¹⁶⁷—who have suffered disproportionately from

163. See E. TORREY, *supra* note 41, at 138-60; see also Rhode Island Dept. of Mental Health v. R.B., 549 A.2d 1028, 1031 (R.I. 1988) (concluding that community mental health centers have right to refuse admission to outpatients).

For an analysis of Community Mental Health Center (CMHC) policies, see Cameron, *A National Community Mental Health Program: Policy Initiation and Progress*, in HANDBOOK ON MENTAL HEALTH POLICY IN THE UNITED STATES, *supra* note 110, at 121-42; Dowell & Ciarlo, *An Evaluative Overview of the Community Mental Health Centers Program*, in HANDBOOK ON MENTAL HEALTH POLICY IN THE UNITED STATES, *supra* note 110, at 195-236.

164. Bellack & Mueser, *A Comprehensive Treatment Program for Schizophrenia and Chronic Mental Illness*, 22 COMMUNITY MENTAL HEALTH J. 175, 177-78 (1980); see also E. TORREY, *supra* note 41, at 145-46 (the "worried well" is a new class of mental patients). See also Note, *supra* note 126, at 1323 ("A weakness in the community treatment system that has emerged in practice is community mental health centers' preference for treating 'good patients' rather than the chronically mentally ill"); Durham, *supra* note 72, at 122 ("the fledgling community mental health services reached a new and different clientele than had been treated in hospitals by attending to caseloads of more affluent, acute care patients receiving brief therapy for much less severe problems and conditions"). Only about one-quarter of all CMHC patients have ever been hospitalized. Hope & Young, *Who Cares For the Mentally Ill?*, NATION, Dec. 26, 1987-Jan. 2, 1988, at 782-83.

165. Compare Goldman, Adams & Taube, *supra* note 115, at 130 (outpatient care does not replace inpatient care, state hospitals will not become obsolete; costs have not shifted from public to private sources, but from one public source to another) with Mechanic, *Toward the Year 2000 in United States Mental Health Policymaking and Administration*, in HANDBOOK ON MENTAL HEALTH POLICY IN THE UNITED STATES, *supra* note 110 ("The community mental health movement was a blend of idealism, optimism, opportunism, and naivete.").

166. Durham, *supra* note 72, at 126-27; see also Eisenberg, *supra* note 162, at 1016 (transfer of indigent patients in Chicago from private hospital to public facility rose from 70 per month in 1983 to 500 per month in 1985); *id.* at 7016 (quoting a 1984 brokerage advisory touting private psychiatric hospital stock offerings):

[Additional] advantages over general hospitals include the widespread acceptance of two classes of psychiatric care (high quality care in private psychiatric hospitals . . . versus lower-quality care in government owned mental health centers).

Id. at 1016.

167. Perlin, *Institutionalization and the Law*, in PSYCHIATRIC SERVICES IN INSTITU-

the "pathology of oppression."¹⁶⁸ When such individuals are deinstitutionalized, society's irrational mechanisms of oppression—paralleling in important ways society's traditional oppression of racial, religious, and sexual minorities¹⁶⁹—create the condition of "sanism." Dr. Morton Birnbaum (perhaps ironically, the acknowledged father of the "right to treatment" doctrine)¹⁷⁰ has characterized "sanism" as "the irrational thinking, feeling and behavior patterns of response by an individual or by a society to . . . a mentally ill individual."¹⁷¹ The concentrated efforts to "zone out" group homes and congregate residences for the mentally disabled¹⁷² offers a paradigm of "sanist" behavior. It is especially

TIONAL SETTINGS 75, 77 (American Hosp. Ass'n ed. 1978). On deinstitutionalization's disproportionate negative impact on women, see Sullivan & Damrosch, *supra* note 50, at 87 (homeless women have a higher rate of more serious mental illness than homeless men, are exposed to rape and violence, and find shelter space to be less available).

168. Birnbaum, *The Right to Treatment: Some Comments on Its Development*, in MEDICAL, MORAL AND LEGAL ISSUES IN MENTAL HEALTH CARE 97, 107 (F. Ayd ed. 1974) (quoting civil rights lawyer Florynce Kennedy); see also G. ALLPORT, THE NATURE OF PREJUDICE 9 (1955) (defining prejudice as "an antipathy based upon a faulty and inflexible generalization"). On the irrational bases of the way disfavored social minorities are treated, see Boswell, *Jews, Bicycle Riders, and Gay People: The Determination of Social Consensus and Its Impact on Minorities*, 1 YALE J.L. & HUM. RTS. 205, 205 (1989); Dalton, *'Disgust' and Punishment*, 96 YALE L.J. 881, 901 (1987).

169. Birnbaum, *supra* note 168, at 107.

170. See Perlin, *Patients' Rights*, in 2 PSYCHIATRY, ch. 35, at 2 (J. Cavenar ed. 1985); see also Wallach, *A Constitutional Right to Treatment: Past, Present, and Future*, 7 PROF. PSYCHOLOGY 453, 454 (1976) (discussing Birnbaum's pioneer effort, beginning in the 1960's, foreshadowing efforts to define minimum standards for treatment, including tort liability and funding difficulties); Rachlin, *One Right Too Many*, 3 BULL. AM. ACAD. PSYCHIATRY & L. 99, 99 (1975) (hailing Birnbaum's proposal as "the turning point of patients' rights").

171. Birnbaum, *supra* note 168, at 106-07; see also Birnbaum, *The Right to Treatment' Updated*, in AMERICAN HOSP. ASS'N, *supra* note 167, at 85, 89. On public attitudes in general, see Rabkin, *Dangerousness of Discharged Mental Patients: Public Beliefs and Empirical Findings*, THE COMMUNITY IMPERATIVE, *supra* note 118, at 39.

172. Refer to note 173 *infra*. See also Note, *supra* note 44, at 167-68 n.41; 2 M. PERLIN, *supra* note 11, § 7.22, at 657-59 n.522. Similar litigation continues unabated. See, e.g., *Incorporated Village of Freeport v. Association for Help of Retarded Children*, 94 Misc. 2d 1048, 1051, 406 N.Y.S.2d 221, 223 (Sup. Ct.) (a community residence in which eight young women live as a family unit is consistent with the lifestyle intended for single family neighborhoods and thus conforms to the purpose of the zoning ordinance), *aff'd*, 60 A.D.2d 644, 400 N.Y.S.2d 724 (1977); *Little Neck Community Ass'n v. Working Org. for Retarded Children*, 52 A.D.2d 90, 94, 383 N.Y.S.2d 364, 368 (Sup. Ct.) (a group home for retarded children constituted a family for zone restricted to single family dwellings), *leave to appeal denied*, 40 N.Y.2d 803, 356 N.E.2d 482, 387 N.Y.S.2d 1030 (1976); *Allegheny Valley School v. Zoning Hearing Bd.*, 102 Pa. Commw. 290, 517 A.2d 1385, 1388-89 (1986) (group home for the mentally retarded persons, living as one household, is the functional equivalent of a single family residence); Kohn, *L.I. Town Fails To Bar Home for Mentally Ill*, N.Y.L.J., Oct. 3, 1989, at 1, col. 5. Such exclusionary zoning policies can "zone in" residential facilities in "disabil-

ironic that "liberals," traditionally counted upon to support the full range of social welfare legislation, condemn, often virulently, deinstitutionalization policies.¹⁷³ If we are to understand the underlying social problems besetting the homeless, the deinstitutionalized, and the deinstitutionalized homeless, we necessarily must acknowledge the importance and power of "sanism" in our society.¹⁷⁴

ity ghettos." See Boyd, *Strategies in Zoning and Community Living Arrangements for Retarded Children: Parens Patriae Meets Police Power*, 25 VILL. L. REV. 273, 278-79 (1979-80). Such overconcentrations occur disproportionately in poor and minority neighborhoods and tend to cause fear of a drop in property values. *Id.* at 278-79, 288-89.

Exclusion can also result from official and unofficial governmental policies. See Alisky & Iczkowski, *Barriers to Housing for Deinstitutionalized Psychiatric Patients*, 41 HOSP. & COMMUNITY PSYCHIATRY 93 (1990) (waits of up to a year for public housing reflect poor public policies and private discrimination). See generally Devers & West, *Exclusionary Zoning and Its Effect on Housing Opportunities for the Homeless*, 4 NOTRE DAME J.L., ETHICS & PUB. POL'Y 349, 351 (1989) ("[T]he exclusionary policies of local governments . . . produce far more spatial separation [among racial, ethnic, and economic groups] than would be the case if only economic and social factors influenced the distribution of people in the spreading metropolis.") (quoting M. DANIELSON, *THE POLITICS OF EXCLUSION* 23 (1976)).

173. See Perlin, *supra* note 112, at 28, 38 nn.69-70 (discussing sanist responses to deinstitutionalization by state senator traditionally aligned with mental health law reform legislation and by head of local community board on Manhattan's traditionally liberal Upper West Side); see also *BAM Historic Dist. Ass'n v. Koch*, 723 F.2d 233, 235 (2d Cir. 1983) (evidence of irreparable injury stemming from operation of shelter for homeless men concerned only one occasion when resident of shelter asked one plaintiff for money to buy wine; public interest would have been seriously impaired if City forced to abandon shelter). Cf. Quindlen, *Rooms of Their Own*, N.Y. Times, Jan. 21, 1990, § 4, at 21, col. 6 ("It seems the homeless have always been with us, and it's begun to occur to us that lots of them are people we don't like very much."). See generally D. ROTHMAN & S. ROTHMAN, *THE WILLOW-BROOK WARS* 188-89 (1984) (discussing role of paradigmatically liberal Congresswoman Elizabeth Holtzman—"fresh from her role in the Watergate investigations"—in attempting to block the opening of group homes for the mentally retarded in her Brooklyn district).

174. See generally Bach, *Requiring Due Care in the Process of Patient Deinstitutionalization: Toward a Common Law Approach to Mental Health Care Reform*, 98 YALE L.J. 1153, 1160 n.41 (1989) (discussing NIMBY ["not in my back yard"] phenomenon); Rosenberg, *Combating NIMBY*, 1 *Mental Health Law Project Action Line* 1 (Sept. 1989) Schonfeld, *'Not In My Neighborhood: Legal Challenges to the Establishment of Community Residences for the Mentally Disabled in New York State*, 13 *FORDHAM URB. L.J.* 281 (1984-1985). See generally Perlin, *supra* note 112 (discussing "sanism" in deinstitutionalization context). Professor Margulies recently has called for "rule-directed empathy" as a partial solution to some NIMBY-related problems. See P. Margulies, *Opening Up My Backyard: Formulating and Evaluating Approaches to Siting Community Human Service Facilities in light of the Fair Housing Amendments Act of 1988* (unpublished manuscript). It is probably worth pointing out that, while race and sex are immutable, we all can become mentally ill, homeless, or both. Perhaps this illuminates the level of virulence we experience here.

IV. DEINSTITUTIONALIZATION AND HOMELESSNESS

It is next necessary to ask how (if at all) these deinstitutionalization policies connect to homelessness. Three interrelated phenomena must be examined: (1) the extent to which (and the reasons why) the social policy of deinstitutionalization is perceived to have failed; (2) the extent of the empirical connection between homelessness, the failure of deinstitutionalization, and the forces that have led to these problems; and (3) the way our social policies are influenced by how we distinguish between the "deserving" or "undeserving poor" and how the social myths surrounding mental illness exacerbate our feelings of anger and revulsion towards the homeless mentally ill. After we critically examine these forces, we can then see (1) how public perceptions drive official social policy and (2) how "blaming the victim" fails to resolve social problems.

A. *The Perceived Failures of Deinstitutionalization*

The public at large, the media, and politicians perceive deinstitutionalization as an abject failure.¹⁷⁵ Mayor Koch's characterization of deinstitutionalization as one of the "lunacies of government"¹⁷⁶ is slightly modified by social critics who recharacterize it as a failure in the *execution* and focus instead on the *implementation* of deinstitutionalization programs,¹⁷⁷ the *disorganization* of such programs,¹⁷⁸ the *unrealistic way* such programs were con-

175. See, e.g., *Cuomo's Curious View of History*, N.Y. Post, Nov. 27, 1989, at 11, col. 1 ("government erred by releasing [mental patients] en masse from asylums, due to pressure from the American Civil Liberties Union and kindred groups"). See generally Kiley, *The Homeless Are Dying in the Subway*, N.Y. Times, Feb. 17, 1990, at A27 (reporting the growing problem of urban homelessness).

176. Koch, *supra* note 19, at 1, Col. 2.

177. See, e.g., Lamb, *supra* note 17, at 55 (concluding that homelessness results not from "deinstitutionalization per se but rather . . . the way deinstitutionalization has been implemented"); see also Lamb, *Deinstitutionalization at the Crossroads*, 39 HOSP. & COMMUNITY PSYCHIATRY 941, 944 (1988) ("We should acknowledge that while deinstitutionalization was a positive step and the correct thing to do, it has gone too far.").

178. See Rhoden, *supra* note 17, at 393 (deinstitutionalization services are seldom provided in any organized, systematic manner); see also Myers, *Involuntary Civil Commitment of the Mentally Ill: A System in need of Change*, 29 VILL. L. REV. 367, 405-07 (1983-84) (society's failure to provide adequate community services has caused "incalculable" human suffering); Note, *Establishing a Right to Shelter for the Homeless*, 50 BROOKLYN L. REV. 939, 948 n.45 (1984) ("failure to provide for care or treatment of mental patients released into the community" results from "a lack of planning either prior to or during the process of deinstitutionalization, assumptions on the part of public officials that communities or other agencies or levels of government would deliver the required services, and a lack of support

ceived,¹⁷⁹ the *unarticulated* goals of many such programs,¹⁸⁰ the *incoherence* of funding policies,¹⁸¹ and the lack of *social consensus* supporting such programs.¹⁸² In the words of E.F. Torrey, "the policy of deinstitutionalization has been a disaster whose dimensions are apparent everywhere."¹⁸³ Our policies appear to reflect perfectly what Jack Pitney has called "bile barrel politics":¹⁸⁴ when a theoretically-approved, benefit-dispersing social policy (the *concept* of deinstitutionalization) results in specific burdens on individual communities (the presence of unwanted, unsupported deinstitutionalized patients), "no one should be surprised by the determined resistance of the concentrated losers—the communities most affected."¹⁸⁵

Although some commentators have recognized the occasional successful deinstitutionalization program¹⁸⁶ (almost as if it somehow emerged successfully by accident),¹⁸⁷ they pay little attention

in communities for the establishment of group homes in residential areas").

179. See Rhoden, *supra* note 17, at 394 (deinstitutionalization policies have been implemented in a "disorganized and unrealistic manner").

180. *Id.* at 392.

181. *Id.* at 393-94.

182. See, e.g., *id.* at 393 (efforts to establish group homes in residential areas have often been thwarted by restrictive zoning laws, contributing to the concentration of mental patients in deteriorating neighborhoods). But see *City of Cleburne v. Cleburne Living Center, Inc.*, 473 U.S. 432, 435 (1985) (local ordinance banning group homes for the mentally retarded violates equal protection).

183. E. TORREY, *supra* note 41, at 36.

184. Pitney, *supra* note 88 (defining the term as signifying a category opposite to that of desirable of "pork barrel" projects; "bile barrel" projects include such as prisons, nerve gas warehouses, and hazardous waste sites).

185. Marmor & Gill, *supra* note 4, at 467.

186. See LaFave, Grunberg, Woodhouse & Barrington, *Is the Community Ready?*, in *STATE MENTAL HOSPITALS: WHAT HAPPENS WHEN THEY CLOSE* 184 (1976) (describing the closing of a state hospital in the southern part of Saskatchewan, and characterizing the process as a successful one because "'careful development of community programs [preceded] rapid rates of discharge'"); Rhoden, *supra* note 17, at 394 (where community alternatives are developed first, deinstitutionalization "has been a generally positive experience"); see also Bachrach, *supra* note 68, at 14 (underscoring that "it should not be concluded that [the growth of a homeless mentally ill population] is entirely an artifact of deinstitutionalization"); J. Costello, *Autonomy and the Homeless Mentally Ill: Rethinking Civil Commitment in the Aftermath of Deinstitutionalization* (paper presented at the American Association of Law Schools, section on Law & Psychiatry, Annual Conference in San Francisco, California, Jan. 1990).

For a table of all state statutes conferring responsibility on states for patients' aftercare after release from state mental hospitals, see Langdon & Kass, *supra* note 21, at 362-92.

187. E.g., *Deinstitutionalization*, *supra* note 17, at 70 (comparing the effect of the deinstitutionalization on the mentally ill to that on the developmentally disabled, concluding that the success in deinstitutionalization of the latter group demonstrates "what can be

to the countless examples of adequate community programs and facilities.¹⁸⁸ These programs and facilities, through the provision of supportive social structures, often facilitate the reintegration of chronic patients into the community.¹⁸⁹ Further, when patients are deinstitutionalized into alternative out-patient treatment programs, the latter are invariably more effective than inpatient treatment.¹⁹⁰ Even the American Psychiatric Association has issued a

accomplished when there is determined advocacy and adequate funding and community resources").

188. See Gudeman, Dickey, Rood, Hellman, & Grinspoon, *Alternative to the Back Ward: The Quarterway House*, 32 HOSP. & COMMUNITY PSYCHIATRY 330 (1981) (describing program which increased personal freedom and interpersonal skills, helped patients re-enter society in a limited manner, and helped residents readjust to community living); Rhoden, *supra* note 17, at 389 n.77; Sandall, *Community Alternatives in Mental Health Care*, in PAPER VICTORIES AND HARD REALITIES: THE IMPLEMENTATION OF THE LEGAL AND CONSTITUTIONAL RIGHTS OF THE MENTALLY DISABLED 23 (V. Bradley & G. Clarke eds. 1976); see also Shore, *Alternatives to Hospitalization Developed by an Urban Mental Health Center: An Overview*, 32 HOSP. & COMMUNITY PSYCHIATRY 323 (1981) (including as suggested follow-up programs for deinstitutionalized patients a quarterway house, a network of residential placements, and a program for training psychiatric residents); Levine & Rog, *Mental Health Services for Homeless Mentally Ill Persons: Federal Initiatives and Current Social Trends*, 45 AM. PSYCHOLOGIST 963 (1990) (discussing current federal initiatives). Cf. *Stemming the Tide*, *supra* note 75, at 25 (noting that, in a three month period, not a single story devoted to homelessness in any of New York City's daily newspapers addressed possible approaches to keeping people in their homes).

189. See, e.g., Mosher & Keith, *Psychosocial Treatment: Individual, Group, Family and Community Support Approaches*, 6 SCHIZOPHRENIA BULL. 10 (1980); see also Greenblatt & Budson, *A Symposium: Follow-Up Studies of Community Care*, 133 AM. J. PSYCHIATRY 916, 917 (1976) (devoted to studies of follow-up community care). See generally Heskin, *Los Angeles: Innovative Local Approaches*, in R. BINGHAM, *supra* note 5, at 170 (reviewing housing projects for the homeless and other very low income populations of the last decade); Lipton & Sabatini, *supra* note 46, at 157-59.

Dr. Bachrach also concludes that even the chronically mentally ill will benefit from deinstitutionalized service initiatives "when those initiatives are implemented under ideal circumstances." Bachrach, *supra* note 68, at 26. See generally ALTERNATIVES TO MENTAL HOSPITAL TREATMENT (L. Stein & M. Test eds. 1978). In one matched study, patients released from public hospitals to a city with a "rich network of accessible private services and a [model] public mental health system" experienced fewer readmissions, were more apt to be employed, and reported a higher level of well-being than similar patients released in a city with "limited" aftercare services. Beiser, Shore, Peters, & Tatum, *Does Community Care for the Mentally Ill Make a Difference? A Tale of Two Cities*, 142 AM. J. PSYCHIATRY 1047, 1047 (1985).

For a systematic investigation of the full literature, see charts reproduced in C. KIESLER & A. SIBULKIN, *supra* note 115, at 158 (Table 9.1), and in Kiesler, *supra* note 115, at 353 (Table 1).

190. See, e.g., Kiesler, *supra* note 115, at 349 (review of 10 studies showed that in "no case were the outcomes of hospitalization more positive than alternative treatment"). See generally Barnes & Toews, *Deinstitutionalization of Chronic Mental Patients in the Canadian Context*, 24 CAN. PSYCHOLOGIST 22 (1983) (providing a comprehensive review of alternate out-patient treatment programs).

series of generally thoughtful and provocative recommendations¹⁹¹ geared toward the assurance that similar "supportive social structures" are in place in all community settings.¹⁹² While these recommendations are not without some controversy,¹⁹³ they reflect at least a first attempt at sketching out the basic needs of an important percentage of the homeless population.

Ironically, most of these recommendations have had a negligible effect on the substance of the homelessness debate. Conversely, the APA's more florid blame of libertarian patients' rights lawyers as the true culprits has vividly caught the public's attention. This teaches us an important lesson: our unwitting refuge in heuristic images applies whether we are considering the alleged problem or the proposed solution.

191. See M. HOPE & J. YOUNG, *THE FACES OF HOMELESSNESS* 189 (1986) (recommending a range of graded housing settings in the community, general medical care, including psychiatric services, a community link, and a one-to-one patient-staff ratio).

192. See, e.g., *APA Task Force*, *supra* note 144, at 5-10. Among the Task Force's recommendations are the following:

3) Adequate, comprehensive, and accessible psychiatric and rehabilitative services must be available, and must be *assertively* provided through outreach services when necessary.

5) Crisis services must be available and accessible to both the chronically mentally ill homeless and the chronically mentally ill in general.

6) A system of responsibility for the chronically mentally ill living in the community must be established, with the goal of ensuring that ultimately each patient has one person responsible for his or her own care.

7) Basic changes must be made in legal and administrative procedures to ensure continuing community care for the chronically mentally ill.

Id. at 6-7 (emphasis added). Cf. U.S. COMPTROLLER GEN., *REPORT TO CONGRESS, RETURNING THE MENTALLY DISABLED TO THE COMMUNITY: GOVERNMENT NEEDS TO DO MORE* 184-91 (1977) (recommending deinstitutionalization policies for governmental agencies).

The APA recommendations raise some potentially serious constitutional issues. A well-known patients' rights lawyer has predicted that the "assertive" employment of outreach services will "coerce" patients into making use of such services. See Rhoden, *supra* note 17, at 408 (quoting Christopher Hansen). Refer to text accompanying notes 245-68 *infra*. Compare *APA Task Force*, *supra* note 144, at 7 (viewing the call for "basic changes" in legal procedures as guaranteeing a right to treatment in the community) with *In re S.L.*, 94 N.J. 128, 462 A.2d 1252, 1257 (1983) (recommendation to loosen commitment standards would impermissibly "widen the net" of the civil commitment process, creating the danger that due process protections could be diminished).

193. Refer to note 192 *supra*. Importantly, the recommendations begin by stressing that "[a]ny attempt to address the problems of the homeless mentally ill must begin with provisions for meeting their basic needs: food, shelter, and clothing." *APA Task Force*, *supra* note 144, at 5.

B. The Connection Between Homelessness and the Failures of Deinstitutionalization

It is no longer¹⁹⁴ seriously disputed that a significant percentage of the homeless exhibit significant characteristics of mental illness,¹⁹⁵ that a significant (albeit minority) percentage of the mentally ill homeless were once hospitalized,¹⁹⁶ that the percentage is growing,¹⁹⁷ and that, for some homeless mentally ill individuals no longer under the supervision of public mental health agencies, shelters have become "permanent institutions."¹⁹⁸ These empirical facts, however, fall short of answering the questions of causation: Does deinstitutionalization "cause" homelessness? If deinstitutionalization had never come about, would there be significantly fewer homeless individuals? Are the deinstitutionalized homeless a representative sample of all the homeless? Even if we find there to be very little causal link between the two, does that minimize the social problems faced by (and caused by) the homeless mentally ill?

We now know that some percentage of the homeless have always been mentally ill, even before deinstitutionalization policies made significant reductions in state hospital population censuses.¹⁹⁹ While there has been some incremental increase in that

194. Nine years ago, a New York City mental health official took the position that the homeless were "relatively well-educated, relatively well-functioning, well-traveled, middle-class dropouts, who have learned to maneuver the system and who move around." Carmody, *New York is Facing Crisis on Vagrants*, N.Y. Times, June 28, 1981, § 1, at 1, col. 1. (quoting Dr. Stanley Hoffman, director of research and evaluation for the New York City Regional Office of Mental Health). See Baxter & Hopper, *supra* note 41, at 114.

195. See, e.g., Belcher, *Defining the Service Needs of Homeless Mentally Ill Persons*, 39 HOSP. & COMMUNITY PSYCHIATRY 1203 (1988) (in six months after initial release from hospital, 36% of patients studied became homeless). But see *Myth*, *supra* note 69, at 413 (15% of sample studied showed evidence of mental illness).

196. Gelberg, Linn & Leake, *Mental Health, Alcohol and Drug Use, and Criminal History Among Homeless Adults*, 145 AM. J. PSYCHIATRY 191, 192 (1988) (29% of sample of homeless previously hospitalized). As of 1984, it was estimated by the American Psychiatric Association that 17-22% of shelter residents had once been institutionalized in state hospitals. See *Hearings Before the Subcomm. on Housing and Consumer Interests of the House Select Comm. on Aging*, 98th Cong., 2d Sess. 4 (1984) (statement of Dr. A. Anthony Arce, for the American Psychiatric Association).

197. See Appleby & Desai, *Documenting the Relationship Between Homelessness and Psychiatric Hospitalization*, 36 HOSP. & COMMUNITY PSYCHIATRY 732, 736 (1985) ("The data clearly support the contention that homelessness is increasing among the severely mentally ill.").

198. Bassuk, Rubin & Lauriat, *Is Homelessness a Mental Health Problem?* 141 AM. J. PSYCHIATRY 1546, 1549 (1984) [hereinafter *Is Homelessness a Mental Health Problem?*].

199. P. Rossi, *supra* note 14, at 41 (asserting that "[t]he current homeless suffer from much the same levels of mental illness, alcoholism and physical disability as the old home-

percentage, it in no way supports the conventional view directly linking the two.²⁰⁰ We also know that, notwithstanding the public perception that it is virtually impossible for an individual to be involuntarily committed to a psychiatric hospital, the number of admissions continues to rise.²⁰¹ In spite of the APA's repeated assertion that significant commitment "reform" is necessary to provide for a more liberal commitment policy, over two-thirds of all American jurisdictions now provide for precisely the sort of substantive commitment standard that the APA insists is necessary to "deal with" inappropriate deinstitutionalization.²⁰² In addition, recent case law shows that, in some instances at least, appellate courts *are* willing to sensitively and carefully weigh facts and medical opinion testimony in assessing whether the party seeking institutionalization has met the appropriate standard.²⁰³

At the same time, we must rethink the Torrey/Lamb/Koch critique that blames patients' rights lawyers for bringing litigation that narrows civil commitment standards. Without even considering the proper role of counsel in the representation of the mentally disabled,²⁰⁴ the application of the sixth amendment in the involuntary civil commitment context,²⁰⁵ the historically pathetic track

less"); see also *id.* at 41-42 (reviewing studies of Chicago and New York City "flopouses" of the 1950's and 1960's which showed a mental illness prevalence rate of 20% finding that 16% of the Philadelphia homeless in 1960 had been previously hospitalized).

200. *Myth*, *supra* note 69, at 421 (linkage between homelessness and mental illness "overstated").

201. Refer to note 115 *supra*.

202. Compare Kanter, *supra* note 72, at 354 (noting that, contrary to popular opinion, "there is no indication that current civil commitment laws result in homelessness to any great extent") with Schwartz & Costanzo, *Compelling Treatment in the Community: Distorted Doctrines and Violated Values*, 20 *LOV. L.A.L. REV.* 1329, 1345 n.71 (1987) ("Some critics . . . would attribute America's housing shortage and its resultant homelessness crisis to the reaffirmation by the Supreme Court, lower federal courts and state legislatures of the dangerousness standard for civil commitment"). Cf. Saccomando, *Deinstitutionalization Has Failed—Miserably*, *Wash. Post*, Apr. 26, 1989 (letter to the editor) (alleging that homeless individuals cannot be institutionalized "under present regulations" absent a dangerousness finding).

203. See, e.g., *In re LaBelle*, 107 Wash. 2d 196, 728 P.2d 138, 146-51 (1986) (weighing facts in four separate commitment cases).

204. See generally 2 M. PERLIN, *supra* note 10, at Ch. 8 (considering the proper role of counsel as advocates).

205. See, e.g., *Heryford v. Parker*, 396 F.2d 393, 396 (10th Cir. 1968) (when involuntary incarceration is likely, state has inescapable duty to observe constitutional safeguards of due process); *Lessard*, 349 F. Supp. at 1097-98 (applying the right to counsel to the commitment process).

record of individually and sporadically appointed counsel,²⁰⁶ the significance of broad-based legally oriented mental health advocacy organizations,²⁰⁷ or the specific fact contexts in which much of the litigation focused on arose,²⁰⁸ it remains necessary to contextualize the evolution of the criticized case law.

"Inspired by the success of the civil rights movement on behalf of black people in the 1960's,"²⁰⁹ lawyers representing the mentally disabled replicated the experiences of "public interest lawyers"²¹⁰ who had successfully counseled other unrepresented and powerless minority groups²¹¹ and helped them to obtain equal access to justice.²¹² Cases such as *Wyatt v. Aderholt*²¹³ and *Pennhurst State School v. Haldeman*²¹⁴ arose from conditions that shocked the conscience of a civilized society.²¹⁵

The case law that developed brought about massive changes in

206. See N. KITTRIE, *THE RIGHT TO BE DIFFERENT: DEVIANCE AND ENFORCED THERAPY* 92 (1973) (characterizing counsel as "superficial and at times totally inadequate"); Cohen, *The Function of the Attorney and the Commitment of the Mentally Ill*, 44 *TEX. L. REV.* 424, 448 (1966) (charging that attorneys perfunctorily performed their task); Weihofen, *Mental Health Service for the Poor*, 54 *CALIF. L. REV.* 920 (1966) (viewing counsel as "passive"). See generally Perlin & Sadoff, *Ethical Issues in the Representation of Individuals in the Commitment Process*, 45 *LAW & CONTEMP. PROBLEMS* 161, 162-63 (1982) (ethical issues in the commitment process demand more attention).

207. See, e.g., N.J. *STAT. ANN.* § 52:27E-21 (West 1986) (establishing state Division of Mental Health Advocacy).

208. See *Facade*, *supra* note 113, at 996-97 (right to refuse imposition of antipsychotic medication).

209. Kanter, *supra* note 72, at 337.

210. Public rights litigation is discussed comprehensively in Chayes, *The Role of the Judge in Public Law Litigation*, 89 *HARV. L. REV.* 1281 (1976).

211. See 1 M. PERLIN, *supra* note 11, § 1.03, at 6-7; Fleming, *Shrinks vs. Shysters: The (Latest Battle) for Control of the Mentally Ill*, 6 *L. & HUMAN BEHAVIOR* 355, 356 (1982) (discussing increased social and judicial emphasis on civil rights "during the 1960s and 1970s for minority groups—juveniles, ethnic minorities, women, and the mentally ill").

212. See Johnson, *Equal Access to Justice*, 41 *ALA. L. REV.* 1, 1 (1989) (the impossibility of enforcing our most important rights "without access to the legal process"). On the special role of courts in the politics of mental health, see Marmor & Gill, *supra* note 4, at 469-71.

213. 503 F.2d 1305 (5th Cir. 1974).

214. 451 U.S. 1 (1981).

215. See, e.g., *Wyatt*, 503 F.2d at 1311 n.6 (relating an incident in which "[o]ne [Alabama state hospital patient] . . . died after a garden hose had been inserted in his rectum for five minutes by a working patient who was cleaning him; one died when a fellow patient hosed him with scalding water; another died when soapy water was forced into his mouth . . ."); L. LIPPMANN & I. GOLDBERG, *THE RIGHT TO EDUCATION: ANATOMY OF THE PENNSYLVANIA CASE AND ITS IMPLICATION FOR EXCEPTIONAL CHILDREN* 17 (1973) (recounting that the chairman of the legal action committee of the National Association of Retarded Children characterized *Pennhurst* as "Dachau, without ovens").

the way public mental health institutions are run and in the way the involuntary civil commitment process operates. This litigation *empowered* the ultimate clientele: the mentally disabled.²¹⁶ As Hendrik Wagenaar and Dan Lewis have explained:

The extension of civil rights to the mentally ill has irrevocably altered the relationship between patients and therapists. For instance, patients gained the right to request release from the hospital and to have their request considered in court within a specified number of days. With this right, patients gained leverage in their negotiations with staff for release More than anything else, patients' increased leverage over their treatment has determined the utilization patterns that are characteristic of the modern public hospital system.²¹⁷

Beyond these *empirical* facts, we know additional *social* facts. We know that discourse about the deinstitutionalized refers, virtually exclusively, to the *poor* and to the *black*.²¹⁸ We also know that individuals who formerly were institutionalized at expensive private facilities do not enter into this social debate.²¹⁹ After Elizabeth Ashley divulged that she had been a psychiatric patient in an expensive New York City private hospital, no one raised stereotypical deinstitutionalization myths when she was released to star in *Barefoot in the Park* with Robert Redford and to live with George Peppard in a Central Park West penthouse.²²⁰ Conversely, many

216. See, e.g., *Pitts v. Black*, 608 F. Supp. 696, 708 (S.D.N.Y. 1984) (election board's refusal to allow homeless persons to register to vote violated equal protection clause); see 1 M. PERLIN, *supra* note 11, § 1.03, at 8 n.34 (explaining the role of self-help, ex-patient groups in litigation); Hopper, *Homelessness: Reducing the Distance*, NEW ENG. J. HUM. SERVS., Fall 1983, at 316 (reviewing the role of non-legal advocacy for the homeless); Jahiel, *supra* note 6, at 112-13 (discussing the empowerment of the homeless); see also Funicello, *Give New Shelters*, NATION, Apr. 2, 1988, at 1 (homeless woman's criticism of traditional legal advocacy efforts); Whitaker, *Helping Them Help Themselves*, TIME, Feb. 26, 1990, at 56 (pointing out the significance of the creation of a monthly newspaper staffed by homeless individuals).

217. Wagenaar & Lewis, *supra* note 52, at 506.

218. See *id.* at 510 (deinstitutionalization has largely failed nonwhite men); 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) (90% of all individuals civilly committed in Washington study were unemployed at the time of civil commitment); Perlin, *supra* note 112, at 29 (99% of all patients subject to involuntary civil commitment at New Jersey's state and county mental hospitals were indigent).

219. See Ashley, *A Short Time Out*, NEW YORK, Aug. 14, 1978, at 37; see also Perlin, *supra* note 112, at 23-24 (discussing Ashley's case in this context).

220. *Id.*

patients have remained hospitalized "solely because they are too poor to be released."²²¹

We now know that the deinstitutionalized have the greatest number of social problems of all the homeless²²² and that their needs are not currently being met by the mental health system,²²³ the social service system, or by a combination of the two systems.²²⁴ We know that massive reinstitutionalization²²⁵ is not a viable solution for a variety of reasons²²⁶ including the fact that such movement inevitably diverts "scarce resources" away from treatment of others in the community.²²⁷ We know that the homeless deinstitutionalized need psychosocial and rehabilitation programs beyond those available in the hospital setting.²²⁸ We also know that persons of lower socioeconomic status are more likely than those of middle and upper status to develop symptoms of distress in response to problematic life experiences.²²⁹ Additionally, we now

221. Saphire, *The Civilly-Committed Public Mental Patient and the Right to After-care*, 4 FLA. ST. U.L. REV. 232, 288 (1976); see also Levine & Haggard, *Homelessness as a Public Mental Health Problem*, in THE COMMUNITY IMPERATIVE, *supra* note 117 ("Perhaps no group of disabled people in the United States are as impoverished and underserved as the homeless mentally ill population").

222. Gelberg, Linn & Leake, *supra* note 146, at 194.

223. *Id.* at 195; Chavetz & Goldfinger, *supra* note 14, at 22 (lack of fit between the needs of the homeless and the aims of the mental health system).

224. Morse & Calsyn, *supra* note 59, at 84-85, 89-91.

225. For a variety of discussions relating to massive reinstitutionalization, see, e.g., *Is Homelessness a Mental Health Problem?*, *supra* note 198, at 1549; Krauthammer, *For the Homeless: Asylum*, Wash. Post, Jan. 4, 1985 (using data from *Is Homelessness a Mental Health Problem?* to recommend reinstitutionalization). Bassuk, the principal author of *Is Homeless a Mental Health Problem?*, has taken issue with Krauthammer's reinstitutionalization recommendation. See M. HOPE & J. YOUNG, *supra* note 190, at 20-21 (also critiquing Krauthammer's conclusions on methodological and analytical bases); Detzer, *Still Looking for the Rose Garden: The Effects of Deinstitutionalizing Mental Health Services*, HUMANIST, Nov.-Dec. 1983, at 37 (suggesting less draconian reinstitutionalization recommendations).

226. See Kanter, *supra* note 72, at 351-56 (asserting that most homeless people are not mentally ill, that inpatient psychiatric admissions actually continue to increase, that existing civil commitment laws adequately address the needs of the severely mentally ill homeless, and that a change in commitment laws will not increase money available to community alternative programs).

227. Durham, *supra* note 72, at 128.

228. See Dorwart, *A Ten-Year Follow-up Study of the Effects of Deinstitutionalization*, 39 HOSP. & COMMUNITY PSYCHIATRY 287, 290 (1988) (in order to be prepared for deinstitutionalization, "patients may require social, rehabilitative, psychotherapeutic (individual, family, and group), vocational, transitional-residential, and community aftercare services to prepare to live outside the hospital").

229. Kessler & Cleary, *Social Class and Psychological Disorders*, 45 AM. SOC. REV. 463 (1980).

know that the deinstitutionalized homeless have even fewer social supports in the community than do other homeless individuals.²³⁰ Lastly, we know, anecdotally, that this clientele is neither a particularly "easy" nor "preferred" one to deal with professionally.²³¹

If anything, these facts may prove the converse of "ordinary common sense": even though there is virtually no reliable evidence that either deinstitutionalization or mental illness is a major cause of homelessness,²³² it may be that homelessness causes mental illness.²³³ This does *not* mean that the problems of the deinstitutionalized homeless mentally ill are either trivial or marginal: twice cursed,²³⁴ their problems are neither. As long as we see *homelessness* as a problem caused by inappropriate deinstitutionalization, however, we will remain blind to the underlying economic discontinuities²³⁵ that would perpetuate homelessness even if *all* mentally ill individuals were massively (albeit illegally) reinstitutionalized.

A "joker" in this entire analysis is the role played by the massive use of psychotropic drugs in state mental hospitals. Common wisdom has suggested that one of the key factors in the creation of deinstitutionalization policies was the mass marketing of psychiatric drugs.²³⁶ Whether or not Scull's revisionist position is correct,²³⁷ a statistically significant number of formerly hospitalized patients now receive psychotropic drug treatment in the community.²³⁸ Yet,

230. Morse & Calsyn, *supra* note 59, at 89 (the "safety net" of social welfare fails to catch most homeless, and thus is "woefully inadequate" for their needs).

231. See generally E. TORREY, *supra* note 41, at 1-36 (discussing case histories).

232. Durham & La Fond, *A Search for the Missing Premise of Involuntary Therapeutic Commitment: Effective Treatment of the Mentally Ill*, 40 RUTGERS L. REV. 303, 306-07 & n.9 (1988); see also Connell, *A Right to Emergency Shelter for the Homeless Under the New Jersey Constitution*, 18 RUTGERS L.J. 765, 784-85 (1987) (recent "findings de-emphasize the significance of deinstitutionalization as a source of homelessness").

233. See Kaufman, *Homelessness: A Comprehensive Policy Approach*, 17 Soc. Sci. REV. 21, 23 (1984) (arguing that homelessness results in mental disorientation); Steff, *The New Homelessness: A National Perspective*, in THE HOMELESS MENTALLY ILL, *supra* note 15, at 54 (Some homeless individuals assume the coloration of mental illness as a protective, defensive device).

234. Cf. Hochstedler, *Twice-Cursed: The Mentally Disabled Criminal Defendant*, 14 CRIM. JUST. & BEHAV. 251, 260-62 (1987).

235. See Hopper, *supra* note 216, at 314-17.

236. Refer to notes 100-04 *supra* and accompanying text. Compare E. TORREY, *supra* note 41, at 87-88 (use of drugs in state hospital "a miracle") with Gelman, *supra* note 131, at 1727 n.23 ("Drugging of the seriously mentally ill in the 'community' is all but universal."). See generally Schwartz & Costanzo, *supra* note 202, at 1335 (analyzing the issues involved in right to refuse medication decisionmaking in community settings).

237. Refer to note 103 *supra*.

238. Gelman, *supra* note 131, at 1727 ("the mentally ill live a drugged existence in . . .

no one has explored what may be the most important hidden issue: the impact of forced public hospital drugging on increased homelessness.

We no longer question the epidemic prevalence of tardive dyskinesia and psychotropic drug side effects in the state hospital population.²³⁹ As Judge Stanley Brotman noted over a decade ago in *Rennie v. Klein*,²⁴⁰ the same drugs prescribed to lessen the severity of thought disorders also served to "inhibit a patient's ability to learn social skills needed to fully recover from psychosis"²⁴¹ Side effects such as akinesia and akathisia²⁴² have the inevitable effect of retarding social skill progress and of making ex-patients even less employable once they are deinstitutionalized.²⁴³ While the drugs may be effective in reducing the floridity of symptomatology and lessening the excesses of psychic pain,²⁴⁴ no one—neither the patients' rights advocates, the spokespersons for the APA, nor the deinstitutionalization theorists—has yet critically considered the linkage between these drug side effects, the failure

private settings"); see also *id.* at 1750: "Drugs make custody possible without its traditional physical trappings. To house a drugged population, the thick walls, physical barriers, geographical isolation and staff supervision of state mental hospitals are generally unnecessary." (footnote omitted).

239. See, e.g., *Rennie v. Klein*, 476 F. Supp. 1294, 1299-1300 (D.N.J. 1979) (recognizing that possibly 35-50% of all state hospital patients suffer tardive dyskinesia and drug-induced parkinsonism), modified, 653 F.2d 836 (3d Cir. 1981), vacated, 458 U.S. 1119 (1982), on remand, 720 F.2d 266 (3d Cir. 1983).

240. *Id.*

241. *Id.* at 1299.

242. See *United States v. Charters*, 829 F.2d 479, 493-94 (4th Cir. 1987), vacated en banc, 863 F.2d 302 (4th Cir. 1988), cert. denied, 110 S. Ct. 1317 (1990).

243. Cf. *Rennie*, 462 F. Supp. at 1146 (remarking that the likelihood of a patient contracting tardive dyskinesia raises the question of whether "the cure would be worse than the illness"); Bellack & Mueser, *supra* note 164, at 177 (asserting that as many as 50% of schizophrenics may not benefit from antipsychotic medication, and that it does not help patients "develop skills of daily living that enhance the quality of life"). See generally Diamond, *Drugs and the Quality of Life: The Patient's Point of View*, 46 J. CLINICAL PSYCHIATRY 29 (1985).

244. See *Rennie v. Klein*, 462 F. Supp. 1131, 1137 (D.N.J. 1978), supplemented, 476 F. Supp. 1294 (D.N.J. 1979), modified, 653 F.2d 836 (3d Cir. 1981), vacated, 458 U.S. 1119 (1982). The court observed that "[p]sychotropic drugs are effective in reducing thought disorder in a majority of schizophrenics. With first admission patients, success rates of as high as 95% have been obtained. . . . Success rates are less impressive with chronic patients However, no other treatment modality has achieved equal success in the treatment of schizophrenia" *Id.*; see also Hollister, *Choice of Antipsychotic Drugs*, 127 AM. J. PSYCHIATRY 104, 104 (1970); May, et al., *Schizophrenia - A Follow up Study of Results of Treatment*, 33 ARCH. GEN. PSYCHIATRY 474, 474-78, 481-86 (1976) (both relied on by the court in making its assessment).

of patients to be meaningfully reintegrated into society after their release, and homelessness.²⁴⁵ The linkage is especially pernicious in light of the parallel literature illuminating the ways in which institutional dependency progressively leads to losses of social and vocational competencies, *precisely* the sort of "competencies" that are essential if homeless individuals are to reintegrate themselves meaningfully into mainstream society.²⁴⁶

The deinstitutionalization literature on this point offers tantalizing clues. Evidence suggests that some deinstitutionalized homeless individuals remain on the streets to avoid regimens of compulsory drugging in hospitals.²⁴⁷ Parenthetically, other researchers have learned that the deinstitutionalized homeless *will* accept medication in alternative social service settings.²⁴⁸ This difference in behavior may be explained when one examines other evidence. For instance, the deinstitutionalized homeless reject the alternative of mental hospitals²⁴⁹ but frequently seek out medical care in

245. There is significant literature decrying the purported antitherapeutic outcomes of right-to-refuse litigation. See, e.g., Haber, *supra* note 151; Appelbaum & Gutheil, *Rotting With Their Rights On: Constitutional Theory and Clinical Reality Drug Refusal by Psychiatric Patients*, 7 BULL. AM. ACAD. PSYCHIATRY & L. 306 (1979); Rachlin, *One Right Too Many?*, 3 BULL. AM. ACAD. PSYCHIATRY & L. 99 (1975); see also Treffert, *Dying With Their Rights On*, 130 AM. J. PSYCHIATRY 1041, 1041 (1973). But see Schwartz & Costanzo, *supra* note 202, at 1345 n.70 (contending that such "doomsday predictions" rarely materialize). Cf. Blackburn, *The "Therapeutic Orgy" and the "Right to Rot" Collide: The Right to Refuse Antipsychotic Drugs Under State Law*, 27 Hous. L. REV. 447, 448 (1990) (arguing for a balancing of therapeutic concerns with the right to medical self-determination).

Scholars are now beginning to examine critically the therapeutic and antitherapeutic outcomes of mental disability litigation and legislation. See generally D. WEXLER, THERAPEUTIC JURISPRUDENCE: THE LAW AS A THERAPEUTIC AGENT (1990).

246. C. KIESLER & A. SIBULKIN, *supra* note 151, at 148; see also Goldstein, *The Sociology of Mental Health and Illness*, 5 AM. REV. SOC. 381 (1979); McEwen, *Continuities in the Study of Total and Non-total Institutions*, 6 AM. REV. SOC. 143 (1980).

247. See Fischer & Breakey, *supra* note 14, at 29. The authors found that a proportion of the mentally ill homeless have opted out of the mental health system, preferring the "street" life to institutional life, and have elected to live with the symptoms of mental illness rather than suffer from the side effects of antipsychotic medication. *Id.* The reader may view this result either as a rational choice or as evidence of impairment of the mentally ill individual's thought systems. See also *id.* (of a series of 15 problem areas, the homeless rated mental illness as 13th in importance); Gelberg, Linn & Leake, *supra* note 196, at 193 (determining that deinstitutionalized patients are the least likely of the homeless to sleep in emergency shelters).

248. *Psychiatric Profile*, *supra* note 14, at 812 (concluding that 86% of the homeless mentally ill were willing to comply with psychotropic medications in community support service settings).

249. See Farr, *A Mental Health Treatment Program for the Homeless Mentally Ill in the Los Angeles Skid Row Area*, in B. JONES, *supra* note 72, at 64, 71 (finding that the vast majority of those studied "would rather live in filth and be subjected to beatings and vio-

general hospitals.²⁵⁰ Some explanation, other than the tautology that suggests that this behavior merely indicates the depths of the population's underlying mental illness, is necessary.

We can suggest as a hypothesis that the deinstitutionalized homeless know, from searing personal experience, that the indictment of public mental hospitals leveled by then-APA president Dr. Harry Solomon over thirty years ago—"bankrupt beyond remedy"²⁵¹—is still frequently a valid critique.²⁵² While there is episodic evidence of idiosyncratic improvement,²⁵³ a reading of case law and literature suggests little reason for the wide-ranging optimism that implicitly buttresses the APA critique: if these folks were back in the hospital, they'd be a lot safer.²⁵⁴

lence than to be institutionalized, even in our *finest* mental hospitals") (emphasis added).

250. See Silver, *Voluntary Admission to New York City Hospitals: The Rights of the Mentally Ill Homeless*, 19 COLUM. HUM. RTS. L. REV. 399, 400-01 n.3, 402-03 n.5 (1988) (noting that substantial numbers of homeless mentally ill seek treatment in emergency rooms of city general hospitals); Basler, *Mentally Ill Rise in City Hospitals*, N.Y. TIMES, Dec. 8, 1985, §1, pt. 2, at 89 (reporting that the number of mentally ill people taken to New York City's municipal hospitals for treatment has more than doubled in the last three years, while the number of those patients accepted by state mental hospitals has dropped 25%).

251. See Robitscher, *Implementing the Rights of the Mentally Disabled: Judicial, Legislative and Psychiatric Action*, in F. AYD, *supra* note 168, at 145, 146 (commenting on inadequate staffing in state mental hospitals).

252. See, e.g., Thomas S. by Brooks v. Flaherty, 699 F. Supp. 1178, 1201-02 (W.D.N.C. 1988) (holding that conditions at a North Carolina public hospital violated the "reasonable professional judgment" standard of *Youngberg v. Romeo*, 457 U.S. 307 (1982)), *aff'd*, 902 F.2d 250 (4th Cir.), *cert. denied*, 111 S. Ct. 373 (1990); cf. *Beds For Mental Patients*, Miami Herald, Feb. 7, 1990 ("For the lack of bed space, patients suffering from crises wait, restrained with leather ankle straps, in the emergency rooms at Broward General Medical Center or Memorial Hospital in Hollywood. . . . Shackling patients for several days in an emergency room is a scandal in 1990").

253. According to Dr. Joseph Bloom, president of the American Academy of Psychiatry and Law, a "number" of state hospitals are "vastly improved," pointing to in particular, "dramatic" improvement in Oregon, partially as a result of salary increases, the creation of linkages with strong academic and research programs, and a "stabilization" of the entire state mental health system. Remarks at the Association of American Law Schools, Section on Law and Psychiatry, Annual Conference, in San Francisco, Cal. (Jan. 1990) (tape nos. 140-41 available from AALS). See generally Morrissey, *The Changing Role of the Public Mental Hospital*, in D. ROCHEFORT, *supra* note 110, at 311-38.

On the willingness of the judiciary to confront meaningfully the underlying issues, compare *Arnold v. Department of Health Servs.*, 160 Ariz. 593, 775 P.2d 521 (1989) (state and county under mandatory statutory duty to provide mental health care to indigent chronically mentally ill persons) with *K.C. v. State*, 771 P.2d 774 (Wyo. 1989) (no constitutional right to treatment in community residential facilities); see also *Board of Supervisors v. Superior Court*, 207 Cal. App. 3d 552, 254 Cal. Rptr. 905, 909 (1989) (reading state statute to set "absolute limit" on county's mental health obligations).

254. See, e.g., Lamb, *supra* note 17, at 66. Dr. Lamb limits the universe of those whom he sees to be in need of rehospitalization to "a small proportion of long-term, severely-

They might not be safer, but perhaps *we* would be relieved. Again, the issue is one of social class and of racial and economic marginalization.²⁵⁵ The deinstitutionalized homeless reflect the socio-economic characteristics of those hospitalized in public facilities—a universe increasingly more populated by ethnic minorities, the poor, the young,²⁵⁶ and those with few social supports.²⁵⁷ Those who have been hospitalized and feel a profound sense of social isolation are subsequently cut adrift without social support.²⁵⁸ No inquiry into the specific problems can begin to make sense if *we* fail to come to grips with the significance of *this* reality: it is the “once

disabled psychiatric patients [that] lack sufficient impulse control to handle living in an open setting such as a board-and-care home or with relatives.” *Id.* He also criticizes the views of those who recommend massive rehospitalization as simplistic, exaggerative and overly romantic (as to the role and capabilities of state hospitals). *See id.* at 67. Nevertheless, the APA Task Force report prepared under his direction, is viewed in the public debate as an important argument in favor of exactly such massive reinstitutionalization. *See, e.g.,* Hyde, *supra* note 155, at 22 (APA report evaluated through the “give me an immediate solution” demands of the public). *But cf.* Durham & La Fond, *supra* note 232, at 357-59 (contending that expansion of commitment authority “may actually *harm* the very persons the state is seeking to help” by creating institutional dependency in patients); Durham & La Fond, *The Empirical Consequences and Policy Implications of Broadening the Statutory Criteria for Civil Commitment*, 3 YALE L. & POL’Y REV. 395, 401 (1985) (observing that the overcrowding that resulted from such expansion caused voluntary patients to be “virtually excluded from state hospitals”); Morse, *A Plea for the Mentally Disordered Homeless*, AP-LS NEWSLETTER, Summer 1987, at 1 (opposing expansion of involuntary hospitalization in this context). For background information relating to the debate, see C. KIESLER & A. SIBULKIN, *supra* note 115, at 114 (discussion of institutional dependency); Friedman, *supra* note 161, at 475-76 (discussing psychosocial costs of hospital care).

255. *See* Wagenaar & Lewis, *supra* note 52, at 508 (pointing out that “the class dimension in mental hospitalization is largely ignored”). Interestingly, Dr. Lamb explicitly acknowledges the role of cultural bias on our deinstitutionalization policy:

An important issue related to goal setting is that the kinds of criteria that theorists, researchers, policymakers, and clinicians use to assess social integration have a distinct bias in favor of the values held by these professionals and by middle-class society generally. Thus holding a job, increasing one’s socialization and relationships with other people, and living independently may be goals that are not shared by a large proportion of the long-term mentally ill.

Likewise, what makes the patient happy may be unrelated to these goals. . . .

Lamb, *supra* note 145, at 942.

256. P. ROSSI, *supra* note 14, at 120-39; *see also* Wagenaar & Lewis, *supra* note 52, at 508-13.

257. *See, e.g.,* Fischer & Breakey, *supra* note 14, at 22-24, 31-32.

258. *See generally* W. WILSON, *THE TRULY DISADVANTAGED: THE INNER CITY, THE UNDERCLASS, AND PUBLIC POLICY* (1987) (graphically demonstrating the extent to which the “extremely poor” or “socially marginalized” are cut off from mainstream society); *see also* Luban, *supra* note 5, at 2160 n.22 (citing the “wealth of horrendous detail concerning the emiseration of black Americans,” and the “grim, even terrifying, summary of the emergency conditions under which we live”).

and future" marginalized that we target in our attacks on the deinstitutionalized homeless mentally ill.²⁵⁹

C. *Our Attitude Towards the Poor*

The deinstitutionalized homeless represent the latest group of the "undeserving poor" to feel public and political wrath.²⁶⁰ As a result of the social myths and meta-myths that have evolved about the mentally ill over centuries, the deinstitutionalized homeless exacerbate that wrath,²⁶¹ heightening our feelings of "anger and revulsion" towards them,²⁶² especially those whom we feel have "given in" to their dependency needs.²⁶³ It is probably not coincidental that former Mayor Koch has chosen to blame a "social worker's philosophy" as the cause of homelessness among the de-

259. See, e.g., Schumer, *Shutting the Doors on the Poor*, N.Y. Times, Mar. 9, 1988, at A31 (noting that the effect of the deinstitutionalization of many mentally ill patients in the 1960s and 1970s reinforced already existing stereotypes of the homeless).

260. See Collin & Barry, *Homelessness: A Post-Industrial Society Faces a Legislative Dilemma*, 20 AKRON L. REV. 409, 429-31 (1987); Note, *supra* note 44, at 160 n.2. Collin and Barry read the New York State Constitution's Article XVII, section I, which mandates the provision of care to the needy, to reflect the following drafting intent: "Aid is to be provided to all those individuals who are 'involuntarily needy'; but it is properly within the realm of legislative discretion to deny aid to employable persons who are deemed not 'needy' because they have wrongfully refused to avail themselves of an opportunity for employment." Collin & Barry, *supra*, at 409 n.2. The latter group of individuals is deemed to be "voluntarily in need." See *id.*

261. See Perlin, *Unpacking the Myths: The Symbolism Mythology of Insanity Defense Jurisprudence*, 40 CASE W. RES. L. REV. 599, 706-30 (1989-90).

262. Cf. Goldstein & Katz, *Abolish the "Insanity Defense"—Why Not?*, 72 YALE L.J. 853, 868-69 (1963) (our "largely unconscious feelings of apprehension, awe and anger toward the 'sick' . . . are hidden by the more acceptable conscious desire to protect [them]"); Perlin, *The Supreme Court, the Mentally Disabled Criminal Defendant, Psychiatric Testimony in Death Penalty Cases, and the Power of Symbolism: Dulling the Ake in Barefoot's Achilles Heel*, 3 N.Y.L. SCH. HUM. RTS. ANN. 91, 168 (1985) (speculating that when dealing with the mentally ill, Supreme Court justices, like most people "are beset by ambiguous and ambivalent feelings in need of self-rationalization: unconscious feelings of awe, of fear, of revulsion, of wonder"). Some commentators advocate the need to overcome these destructive biases. See Friedman, *supra* note 161, at 472-73 (tracing society's treatment of the mentally ill through history); Wagenaar & Lewis, *supra* note 52, at 521 (it is necessary to "deal effectively with the moral dimension of mental disorder without reneging on the humanitarian and egalitarian promise of the current inclusive system of care"). Cf. J. ROBERTSCHER, *THE POWERS OF PSYCHIATRY* 1 (1980) ("We must be aware of the dangers which lie in our most generous wishes").

263. Lamb, *supra* note 145, at 943 (observing that as "products of our culture and society," we tend to "morally disapprove of persons who 'give in' to their dependency needs, who have adopted a passive, inactive life-style, and who have accepted public support instead of working"); J. Costello, *supra* note 186 (public assumes mentally ill homeless individuals are "bad, . . . stubborn, . . . weak, or . . . lack willpower").

stitutionalized,²⁶⁴ while former President Reagan urged voters to support Republican law-and-order senators as a vehicle for ensuring a conservative federal judiciary, stating, "We don't need a bunch of sociology majors on the bench."²⁶⁵

To a significant degree, these feelings drive our social policies toward the homeless and help explain why it is easier for us to focus upon the deinstitutionalized homeless: it is much easier for us to rationalize policies of "frugality" and "economic responsibility" when our target is the formerly institutionalized mentally ill than when it is the sort of homeless individual written about so evocatively and poignantly in Jonathon Kozol's *Rachel and Her Children*.²⁶⁶ Indeed, this focus allows us to ignore society's "fundamental economic dislocations" and allows us to "salve [our] conscience by attributing the problem to pathology rather than poverty."²⁶⁷ In actual fact, more recent empirical studies suggest that deinstitutionalization has played a minimal role in causing homelessness.²⁶⁸

Our focus creates a "perceptual trap" through which the most

264. Lambert, *supra* note 152, at A1, col. 2.

265. Rowland, Songer & Carp, *Presidential Effects on Criminal Justice Policy in the Lower Federal Courts: The Reagan Judges*, 22 L. & Soc'y Rev. 191, 194 (1988).

266. Kozol's book is an eloquent reportorial account of the lives of homeless residents of the Hotel Martinique in New York City. It focuses on issues of race, class, poverty, and housing shortages. Kozol specifies what he is *not* writing about:

[T]he emphasis is not on those who were confined in mental hospitals and were deinstitutionalized ten years ago. The emphasis, if anything, is the reverse: It is the creation of an institution that makes healthy people ill, normal people clinically depressed, and those who may already be unwell a great deal worse

J. KOZOL, *supra* note 52, at 20-21; cf. Note, *Between Helping the Child and Punishing the Mother: Homelessness Among AFDC Families*, 12 HARV. WOMEN'S LJ. 237-38 (1989) (reporting findings of U.S. Conference of Mayors 1987 study that families with children constitute 95% of the homeless in Norfolk, Virginia, 75% in Massachusetts, 70% in Trenton, New Jersey and that in major American cities, 25% of all homeless individuals are children). See generally Note, *supra* note 44, at 179-201 (discussing the specific problems faced by homeless families).

267. McKittrick, *The Homeless: Judicial Intervention on Behalf of a Politically Powerless Group*, 16 FORDHAM URB. LJ. 389, 428 (1988). On the heuristic of attribution, see *Facade*, *supra* note 113, at 986-87 & n.200 (once a stereotype is adopted, a wide variety of evidence can be read to support that stereotype, including events that could equally support the opposite interpretation); *Psychodynamics*, *supra* note 112, at 17-18; see also Lord, Ross & Lepper, *Biased Assimilation and Attitude Polarization: The Effects of Prior Theories on Subsequently Considered Evidence*, 37 J. PERS. & SOC. PSYCHOLOGY 2098, 2099 (1979) ("[T]here is considerable evidence that people tend to interpret subsequent evidence so as to maintain their initial beliefs.").

268. K. CLARY & D. VENEZIO, *EXPLORATORY STUDY OF HOMELESS FAMILIES: SOCIO-ECONOMIC FACTORS LEADING TO HOMELESSNESS* 7-9 (1986); Connell, *supra* note 232, at 783.

florid and bizarre behavior of the most mentally ill individual comes to typify *all* homeless people, creating an "illusion of homogeneity."²⁶⁹ Our public perceptions drive our official policies.²⁷⁰ We reduce complex and multidimensional social problems to stereotypes,²⁷¹ a policy of reductionism encouraged by media distortions²⁷² and exacerbated by the vividness heuristic and "ordinary common sense."²⁷³ Our official policies—"harsh in execution"²⁷⁴—blame the deinstitutionalized homeless for their plight²⁷⁵

269. *Myth*, *supra* note 69, at 420. For an example of typification involving the mentally disabled, see Van Zandt, *Common Sense Reasoning, Social Change, and the Law*, 81 Nw. U.L. Rev. 894, 914 (1987).

270. Goldman & Morrissey, *supra* note 110, at 729-30.

271. McKittrick, *supra* note 267, at 428 ("By focusing on the mentally ill, [New York City] perpetuates the stereotype that the homeless are insane, while creating the perception that it is addressing the problem."); Note, *supra* note 185, at 256-57 (critiquing the "explicitly racist and sexist stereotype of the 'typical' AFDC family . . . immortalized by President Ronald Reagan"); J. Costello, *supra* note 186; M. Perlin, *Authoritarianism, The Mystique of Ronald Reagan and the Future of the Insanity Defense* (work in progress). On the significance of former President Reagan's anecdotal style on the debate on another mental health/social policy issue (the insanity defense), see Perlin, *supra* note 112, at 20 & n.81.

272. For a range of mass media depictions, see *Myth*, *supra* note 69, at 407-08. See also Kaufman, "Crazy" *Until Proven Innocent: Civil Commitment of the Mentally Ill Homeless*, 19 COLUM. HUM. RTS. L. REV. 333, 363 (1988) (critically assessing the influence of media prejudices toward mentally ill and homeless individuals on public policy decision making); Protess, Leff, Brooks & Gordon, *Uncovering Rape: The Watchdog Press and the Limits of Agenda Setting*, 49 PUB. OPINION Q. 19, 19-20 (1985). See generally Nunnally, *The Communication of Mental Health Information: A Comparison of the Opinions of Experts and the Public With Mass Media Presentations*, 2 BEHAV. SCI. 222, 230 (1957) (discussing mass media's emphasis on "bizarre symptoms").

For a critical evaluation of mass media depictions of the so-called "criminally insane," see Steadman & Coccozza, *Selective Reporting and the Public's Misconceptions of the Criminally Insane*, 41 PUB. OPINION Q. 523, 531 (1977-78).

273. See generally Perlin, *supra* note 112, at 22-39; *Facade*, *supra* note 113, at 966. On the heuristic fallacy in mental health decision making, see Durham & La Fond, *supra* note 218, at 886; Gutheil, Bursztajn, Kaplan & Brodsky *supra* note 151, at 447; Hoge, Sachs, Appelbaum, Greer & Gordon, *Limitations on Psychiatrists' Discretionary Civil Commitment Authority by the Stone and Dangerousness Criteria*, 45 ARCH. GEN. PSYCHIATRY 764, 768 (1988); Comment, *Pennsylvania Standard for Involuntary Civil Commitment of the Mentally Ill: A Clear and Present Danger?*, 27 DUQ. L. REV. 325, 346 (1989).

274. Fischer & Breakey, *supra* note 14, at 27; see also Ball & Havassy, *supra* note 69, at 920 (serious mismatch exists between services provided by community mental health systems and services the homeless feel they need); Bassuk, *The Homelessness Problem*, 251 SCI. AM. 40, 45 (1984) (arguing that public officials have failed to recognize the implications of mental illness among the homeless); Baxter & Hopper, *supra* note 45, at 394 (deinstitutionalization subjects the mentally ill to the hazards of a marginal existence in the community; one result is a high suicide rate for the group).

275. Goldman & Morrissey, *supra* note 110, at 729; Hyde, *supra* note 155, at 22-23; Lamb, *supra* note 145, at 906; Oreskes & Toner, *supra* note 107, at E5.

and thus legitimate political bias toward this population.²⁷⁶ This undercuts any pretense of a commitment to equality.²⁷⁷ Under the rubric of the state's right to "improve itself,"²⁷⁸ we launch lengthy and increasingly vicious counterattacks when community groups seek to open halfway houses or group homes in residential neighborhoods.²⁷⁹ We respond to the moral dimensions of the underlying problems by seeking to exert total social control over the deinstitutionalized homeless. Deinstitutionalization is unacceptable to the public because it runs counter to conventional wisdom and to "ordinary common sense."²⁸⁰

Our response to the homeless mentally ill must then be considered through these two filters: *social classism* (the homeless being "jobless, penniless, functionless and supportless")²⁸¹ and *sanism* (via the same sort of irrational thought processes that spawn racism and other similar social pathologies).²⁸² To avoid dealing with issues of economic marginality²⁸³ and racial exclusion,²⁸⁴ we

276. Kaufman, *supra* note 272, at 363 ("politically astute" public officials may advocate broad civil commitment standard to "convince" the public that the government is both "helping the unfortunate and eliminating the problem of unsightly 'crazies'"). See generally Kanter, *supra* note 72, at 346-48 (discussing strategies of community opposition to community residences for the mentally handicapped).

277. See generally Field, *Honest Differences in Discerning the Constitution's Meaning—The Task of Defining Constitutional Rights for Persons Who Are Retarded*, 72 IOWA L. REV. 1301, 1305-06 (1987) (demonstrating that differences exist in determining the constitutional rights of the retarded such as their right to live in a specific community); Minow, *When Difference Has Its Home: Group Homes for the Mentally Retarded, Equal Protection and Legal Treatment of Difference*, 22 HARV. C.R.-C.L. L. REV. 111, 113 (1987) (arguing that categorical approaches undermine commitments to equality).

278. Note, *supra* note 126, at 1340 (quoting N. KITTRE, *supra* note 206, at 47).

279. Perlin, *supra* note 112, at 22-28. See generally 2 M. PERLIN, *supra* note 11, § 7.22 (discussing the right of the mentally disabled to be free from discrimination in housing); D. LEWIS, J. GRANT & D. ROSENBAUM, *THE SOCIAL CONSTRUCTION OF REFORM: CRIME PREVENTION AND COMMUNITY ORGANIZATIONS* (1988) (discussing the politics of community organizations, with emphasis on an analysis of groups receiving grants for community crime prevention programs); Margolis, *Conceptual Puzzles About Community Responses*, in *THE COMMUNITY IMPERATIVE*, *supra* note 118, at 223; Stickney, *Siting Residential Facilities: Strategies for Gaining Community Acceptance*, in *THE COMMUNITY IMPERATIVE*, *supra* note 118, at 331; cf. Boydell, Trainor & Pierri, *The Effect of Group Homes for the Mentally Ill on Residential Property Values*, 40 HOSP. & COMMUNITY PSYCHIATRY 957, 958 (1989) (all empirical literature demonstrates that group homes do not have a negative effect on neighborhood property values; in fact, in some markets, nearby property values were strengthened).

280. Friedman, *supra* note 161, at 472.

281. Lipton & Sabatini, *supra* note 46, at 156.

282. Refer to notes 167-73 *supra* and accompanying text.

283. See Wagenaar & Lewis, *supra* note 52, at 513-19.

284. See Luban, *supra* note 5, at 2160 n.22; Wagenaar & Lewis, *supra* note 52, at 509-

perpetuate symbolic stereotypes²⁸⁵ of mental illness²⁸⁶ that reify centuries of social myths and meta-myths²⁸⁷ and that have traditionally colored and shaped the ways we treat the mentally ill. We thus focus our attention upon a group of victims against whom there is significant social prejudice instead of questioning the societal problems that are the true sources of homelessness.²⁸⁸ In the end, it is precisely these "sanist" policies²⁸⁹ that best explain the moral bankruptcy of our treatment of the homeless mentally ill. As Neil McKittrick has pointed out:

By focusing on the mentally ill, [New York City] perpetuates the stereotype that the homeless are insane, while creating the perception that it is addressing the problem. By categorizing the homeless as insane, no fundamental economic dislocations need to be examined, and society can salve its conscience by attributing the problem to pathology rather than poverty.²⁹⁰

V. THE MULTIPLE MEANINGS OF "COMPETENCY"

Having considered the relationship between deinstitutionaliza-

285. See Perlin, *supra* note 261, at 618-23; see also O.W. HOLMES, JOHN MARSHALL, COLLECTED LEGAL PAPERS 270 (1920) ("We live by symbols, and what shall be symbolized by any image of the sight depends upon the mind of him who sees it.").

286. McKittrick, *supra* note 267, at 428. See generally Perlin, *supra* note 257 (discussing the symbolism and mythology underlying the insanity defense policy).

287. Perlin, *supra* note 261, at 706-31.

288. See generally Levy, *Coexistence Implies Reciprocity*, in THE COMMUNITY IMPERATIVE, *supra* note 118, at 323 (discussing the importance of coexistence in the social community in this context).

289. See *The Homelessness Test: There is a Right Answer*, N.Y. Times, Mar. 1, 1990, at A26 (editorial):

Why did so many people, especially the mentally ill, begin living on the streets of New York City during the 1990's?

(1) Because misguided reformers threw tens of thousands of patients right out of New York State mental hospitals under a policy called "deinstitutionalization."

(2) Because New York City failed to provide adequate mental health programs.

(3) Because the law prevents the police from taking homeless people off the streets.

(4) Because a shift in the real estate market eliminated tens of thousands of cheap rooms.

Nos. 1 and 2 might have been plausible answers 10 years ago, but they don't explain the problem now. Though No. 3 is often glibly cited, it has never been a big factor. The only correct answer is No. 4. . . .

(emphasis in original).

290. McKittrick, *supra* note 267, at 428.

tion and homelessness, we turn now to the question of "competency" and its relationship to these two phenomena. This inquiry has two different dimensions: (1) a "plain meaning" investigation into the way that varying *legal* definitions of "competency" affect deinstitutionalization and homelessness and (2) a "deconstructed" analysis of some other "competencies" not usually discussed in this context.²⁹¹

A. "Plain Meanings"

After stating the obvious—that the search for a unitary test of competency is, in the words of Dr. Loren Roth, a "search for a Holy Grail"²⁹²—we are confronted immediately with the perception that the legal and mental health professions "understand the very notion of competence in characteristically different ways."²⁹³ Thus, Paul Appelbaum and Dr. Roth have set up this duality:

The law has tended to address competency as a fixed attribute of an individual, a characteristic in itself with an inherent stability. The clinician, on the other hand, knows that what the law calls competency is, in fact, a set of deductions from a variety of clinical data that can be as subject to influence and change as the more basic mental attributes on which it is based.²⁹⁴

This dichotomy may be more illusory than real. Thus, while a Pennsylvania statutory definition—an incompetent is one who "lacks sufficient capacity to make or communicate responsible decisions concerning his person"²⁹⁵—provides a fairly generic legal definition, a flood²⁹⁶ of recent opinions have offered differing definitions of the term in a wide variety of cases.²⁹⁷ Thus, competency

291. Refer to text accompanying note 363 *infra*.

292. Roth, Meisel & Lidz, *Tests of Competency to Consent to Treatment*, 134 *AM. J. PSYCHIATRY* 279, 283 (1977). See generally T. GRISSO, *EVALUATING COMPETENCIES: FORENSIC ASSESSMENTS AND INSTRUMENTS* 15-29 (1986) (suggesting an important model of legal competency containing six elements: functional abilities, context, causal inference, interaction, judgment and disposition).

293. Gutheil, Bursztajn, Kaplan & Brodsky, *supra* note 151, at 446-47.

294. Appelbaum & Roth, *Clinical Issues in the Assessment of Competency*, 138 *AM. J. PSYCHIATRY* 1462, 1466 (1981).

295. 20 PA. CONS. STAT. ANN. § 5501(2) (Purdon 1975); see also *In re Estate of Wood*, 368 Pa. Super. 173, 533 A.2d 772, 775 (1987) (despite memory loss, nursing home patient was held competent to manage her financial affairs).

296. *Facade*, *supra* note 113, at 967.

297. See, e.g., *Ford v. Wainwright*, 477 U.S. 399, 410 (1986) (competency to be executed); *Colorado v. Connelly*, 479 U.S. 157, 167 (1986) (competency to confess); *Drope v.*

is thus not necessarily a "fixed state";²⁹⁸ a person may be competent for some legal purposes and incompetent for others at the same time.²⁹⁹ Therefore, incompetency and mental illness are not identical states.³⁰⁰

Mental health professionals frequently couch definitions of competence in more functionalist language: for example, a patient's ability to balance risks and benefits.³⁰¹ The functionalist perspective in assessing competency in criminal cases looks beyond the question of "mental illness" to take account of "the psychopathological, cognitive and affective capacities of the defendant [as] related to the specific demands of the legal case and the competencies in question."³⁰²

How does this relate to the problem of deinstitutionalization and homelessness? Putting aside the specific issues raised by the deinstitutionalization of individuals who were originally committed pursuant to a finding of incompetency to stand trial on criminal

Missouri, 420 U.S. 162, 172 (1975) (competency to stand trial); *Malinauskas v. United States*, 505 F.2d 649, 654 (5th Cir. 1974) (competency to plead guilty); *State v. Cameron*, 146 Ariz. 210, 704 P.2d 1355, 1358 (Ct. App. 1985) (competency to waive a jury); *People v. Kessler*, 113 Ill. App. 3d 354, 447 N.E. 2d 495, 501 (1983) (competency to waive counsel); *State v. Khan*, 175 N.J. Super. 72, 417 A.2d 585, 588-89 (App. Div. 1980) (competency to waive insanity defense).

298. Appelbaum & Roth, *supra* note 294, at 1465.

299. Roth, Meisel & Lidz, *supra* note 292, at 279.

300. Cf. N.J. STAT. ANN. § 30:4-24.2(c) (West 1981) (a patient may not be presumed incompetent merely because he has been treated for mental illness); *In re LaBelle*, 107 Wash. 2d 196, 728 P.2d 138, 146 (1986) ("the mere fact that an individual is mentally ill does not mean that the person so affected is incapable of making a rational choice with respect to his or her need for treatment"). *But see* Appelbaum, Mirkin & Bateman, *Empirical Assessment of Competency to Consent to Psychiatric Hospitalization*, 138 AM. J. PSYCHIATRY 1170, 1175 (1981) (empirical evidence suggests that "the presumption of competency to consent to psychiatric hospitalization will have to fall").

301. Gutheil, Bursztajn, Kaplan & Brodsky, *supra* note 151, at 447. *See generally* Chodoff, *The Case for Involuntary Hospitalization of the Mentally Ill*, 133 AM. J. PSYCHIATRY 496, 498 (1978) (patient dissatisfaction actually reflects a deeper desire to be treated; preference is subtly masked by the same thought disorder that needs treating); cf. J. CHAMBERLIN, ON OUR OWN (1978) (ex-patient consumer movement policy positions reflect dissatisfaction with traditional mental health programs).

On the competency of the mentally ill to engage in their own decisionmaking about their treatment, see Fischer & Breakey, *supra* note 14, at 29. *See also* Ball & Havassy, *supra* note 69, at 917 (ex-patients chose to remain homeless on the streets untreated rather than endure the side effects of psychotropic medication).

302. Golding & Roesch, *Competency for Adjudication: An International Analysis*, in 4 LAW AND MENTAL HEALTH: INTERNATIONAL PERSPECTIVES 73, 102 (D. Weisstub ed. 1988). Cf. Roth, Meisel & Lidz, *supra* note 292, at 280 (competency tests "fall into five categories: (1) evidencing a choice, (2) a 'reasonable' outcome of choice, (3) a choice based on 'rational' reasons, (4) ability to understand, and (5) actual understanding").

charges,³⁰³ it would seem that the relevant medico-legal inquiry here has at least two important dimensions: (1) competency as a

303. See generally Arvanites, *The Impact of State Mental Hospital Deinstitutionalization on Commitments for Incompetency to Stand Trial*, 26 CRIMINOLOGY 307, 318 (1988) (although increases in incompetency to stand trial (IST) commitments are positively related to deinstitutionalization, there is no evidence that deinstitutionalization "has resulted in the wholesale criminalization of the mentally ill or that [IST procedures] are increasingly being used to hospitalize minor offenders through incompetency commitments"). In a more recent study, Professor Arvanites has found that, after deinstitutionalization, non-whites had significantly more state mental hospitalizations than did whites. Arvanites, *The Differential Impact of Deinstitutionalization on White and Nonwhite Defendants Found Incompetent to Stand Trial*, 17 BULL. AM. ACAD. PSYCHIATRY & L. 311, 318-19 (1989). See generally Steadman, Vanderwyst & Ribner, *Comparing Arrest Rates of Mental Patients and Criminal Offenders*, 135 AM. J. PSYCHIATRY 1218, 1220 (1978) (former mental patient arrest rates have increased as the composition of state mental hospitals has changed to include more persons with prior criminal records); 3 M. PERLIN, *supra* note 11, §§ 14.01-14.23 (discussing IST issues, including due process contours of the competency determination, burden of proof at trial, medication of defendants to achieve competency, counsel's role at the incompetency hearing, nonpsychiatric physiological disorders and mentally retarded defendants); Perlin & Dvoskin, *AIDS Related Dementia and Competency to Stand Trial: A Potential Abuse of the Forensic Mental Health System?*, 18 BULL. AM. ACAD. PSYCHIATRY & L. 349 (1990).

Some critics argue that overly restrictive involuntary civil commitment laws have resulted in the "criminalization of psychosis" as a result of which individuals who would formerly have been involuntarily civilly committed are now charged with minor criminal offenses such as trespassing. E. TORREY, *supra* note 41, at 13-14. Arrest is thus seen as "a more expedient method" of case disposition than is referral for hospitalization. Pogrebin & Poole, *Deinstitutionalization and Increased Arrest Rates Among the Mentally Disordered*, 15 J. PSYCHIATRY & L. 117, 120 (1987); see also Briar, *Jails: Neglected Asylums*, 64 SOC. CASEWORK 387, 388 (1983) (jail may be "our most enduring asylum"). See generally Brahmans & Weller, *supra* note 159, at 43; Morrissey & Goldman, *supra* note 110, at 24-26 (discussing the increasing use of the criminal process to hospitalize seriously mentally ill but nondangerous persons); Pogrebin & Poole, *supra*, at 122, quoting Roesch & Golding, *The Impact of Deinstitutionalization*, in AGGRESSION AND DANGEROUSNESS (1985) (increases in imprisonment rate for the mentally disabled "reflect the manner in which the institutions of our society react to individual behavior" rather than changes in crime rates among the mentally disabled); Snow, Baker & Anderson, *Criminality and Homeless Men: An Empirical Assessment*, 36 SOC. PROBS. 532, 539 (1989) (empirical data showed that most offenses committed by homeless men were "relatively minor and victimless" and not a "direct threat to domiciled citizens"). Persons of low social class are disproportionately overrepresented both in populations of correctional institutions and mental hospitals. Monahan & Steadman, *Crime and Mental Disorder*, in NATIONAL INST. OF JUSTICE, RESEARCH IN BRIEF (1984). Mary Durham has suggested that the mental health system, the criminal justice system and other segments of the human services systems may work in a "hydraulic" fashion so that change in one institutional system forces changes in another part of the system. Durham, *supra* note 72, at 129. On the effect of similar "hydraulic" pressures in insanity defense decision-making, see Perlin, *supra* note 261, at 614-15; on its effect in cases involving forensic testimony in general, see *Morality*, *supra* note 113.

For a radical criminology perspective, see Barak & Bohm, *The Crimes of the Homeless or the Crime of Homelessness? On the Dialectics of Criminalization, Decriminalization, and Victimization*, 13 CONTEMP. CRISES 275 (1989).

factor in voluntary hospital admissions and (2) competency as a factor in release decisions.

1. *Voluntary hospitalization.* Considering its importance and the number of individuals it affects,³⁰⁴ it is astonishing how little scholarly and judicial attention is paid to the voluntary hospital admissions process. We do know that courts and legislatures generally articulate their preference of voluntary to involuntary treatment.³⁰⁵ Among the shards of the scattered case law, we can find expressions of support for, variously, judicial review of voluntary patient status,³⁰⁶ the need for a finding of inability or unwillingness to accept voluntary treatment as a prerequisite to involuntary commitment,³⁰⁷ and the argument that the denial of mental illness and refusal to accept treatment could be a sufficient basis upon which the voluntary commitment alternative could be rejected in an involuntary commitment proceeding.³⁰⁸

304. In 1980, there were 840,000 voluntary mental health admissions to public hospitals. See MENTAL HEALTH, U.S., 1983 45 (1985). See generally 1 M. PERLIN, *supra* note 11, § 3.69 (reviewing litigation on questions of voluntary status).

305. See, e.g., Stromberg & Stone, *A Model State Law on Civil Commitment of the Mentally Ill*, 20 HARV. J. LEGIS. 275, 325 (1983) (the model state law for civil commitment seeks to encourage voluntary admissions); Shuman, Hegland & Wexler, *Arizona's Mental Health Services Act: An Overview and An Analysis of Proposed Amendments*, 19 ARIZ. L. REV. 313, 324-25 (1977) (voluntary treatment is preferable from both medical and legal perspectives); *Developments in the Law—Civil Commitment of the Mentally Ill*, 87 HARV. L. REV. 1190, 1399 (1974) [hereinafter *Developments*] (proposed reforms to current mental health care programs encourage voluntary admissions).

306. See *In re G.M.*, 217 N.J. Super. 629, 526 A.2d 744, 745 (Ch. Div. 1987).

307. *In re Alleged Mentally Disordered Person*, 145 Ariz. 81, 699 P.2d 1312, 1313-14 (Ct. App. 1985).

308. *In re Melas*, 371 N.W.2d 653, 655 (Minn. Ct. App. 1985). While involuntary civil commitment courts have split on the extent to which they should rely on evidence of refusal to take medication in ordering involuntary commitment, they generally rely upon such proof in deciding to commit. See, e.g., *In re J.B.*, 217 Mont. 504, 705 P.2d 598, 602 (1985) (viewing the patient's failure to take medication as requiring institutionalization and precluding further consideration of community outpatient treatment or services). For cases considering this factor in affirming commitment orders, see *Delaware State Hosp. v. Morris*, 541 A.2d 139, 141 (Del. Super. Ct. 1988); *In re Fusa*, 355 N.W.2d 456, 457 (Minn. Ct. App. 1984); *In re L.R.*, 146 Vt. 17, 497 A.2d 753, 757 (1985). *But cf.* *People v. Nunn*, 108 Ill. App. 3d 169, 438 N.E.2d 1342, 1345 (App. Ct. 1982) (reversing commitment order). This issue appears in the release context as well. Compare *Johnson v. State*, 536 So. 2d 1054, 1055 (Fla. Dist. Ct. App. 1988) (denial of conditional release erroneous where denial based solely on inability of experts to "guarantee" that patient would abstain from alcohol and take prescribed medication if released) with *Butler v. State*, 258 Ga. 344, 369 S.E.2d 252, 253 (1988) (denial of insanity acquittee's application for release properly supported by testimony that defendant had poor history of taking prescribed medication).

Many judges perceive it as a matter of "ordinary common sense" that the failure of the

Cases involving voluntary patients rarely address the question of competency.³⁰⁹ Yet, because most involuntary civil commitment statutes fail to define the level of competence necessary for a valid voluntary admission, many patients who consent to their hospitalization are, in fact, incompetent to do so.³¹⁰ If psychiatric patients were to meet a stricter standard of competency, the number of voluntary admissions—steadily on the rise³¹¹ and regularly encouraged by both the legal and medical communities³¹²—would inevitably be reduced.³¹³

This becomes even murkier when one examines the underside of the voluntary admissions process. Scholars have begun to question critically whether an actual difference exists in the way that voluntary and involuntary patients are treated once hospitalized.³¹⁴ Indeed, evidence suggests that voluntary patients are subject to

mentally ill individual to take prescribed antipsychotic medications provides the stepping stone in the pathway from premature deinstitutionalization to homelessness. *E.g.*, *In re Melton*, 565 A.2d 635, 649 (D.C. 1989) (Schwelb, J., dissenting):

Once upon a time, long, long ago, the King of Epirus defeated his Roman adversaries in a battle at Asculum . . . The king's name was Pyrrhus, and [his] kind of triumph . . . has come to be known as a Pyrrhic victory.

I am very much afraid that what [the appellant] has won through litigation may be as counter-productive in the long run as the famous monarch's flawed win at Asculum. Indeed, I am constrained to wonder how many of the homeless persons who live wretched and squalid lives on grates and benches and pavements in our nation's capital are there because they have "won," through litigation or the threat thereof, or as a result of premature deinstitutionalization, the "liberty" not to be required to take medication essential to their mental health.

Id. (footnotes omitted).

309. See Olin & Olin, *Informed Consent in Voluntary Mental Hospital Admissions*, 132 AM. J. PSYCHIATRY 938, 938 (1975); Palmer & Wohl, *Voluntary-Admission Forms: Does the Patient Know What He's Signing?*, 23 HOSP. & COMMUNITY PSYCHIATRY 250, 251 (1972); Perlin & Sadoff, *supra* note 206, at 190.

310. See Appelbaum, Mirkin & Bateman, *supra* note 300, at 1175; Legemaate, *Legal Aspects of Voluntary Psychiatric Hospitalization*, 11 INT'L J.L. & PSYCHIATRY 259, 261 (1988); Perlin & Sadoff, *supra* note 206, at 190. See generally Winick, *Competency to Consent to Treatment: The Distinction Between Assent and Objection*, 28 HOUS. L. REV. 15 (1990).

311. *Legal Issues in State Mental Health Care: Proposals for Change—Civil Commitment*, 2 MENTAL DISABILITY L. REV. 75, 94 nn.135-36 (1977).

312. Perlin & Sadoff, *supra* note 206, at 189-90; *Developments*, *supra* note 305, at 1399.

313. Legemaate, *supra* note 310, at 260.

314. See Ellis, *Volunteering Children: Parental Commitment of Minors to Mental Institutions*, 62 CALIF. L. REV. 840, 845-46 (1974). Compare Herr, *Civil Rights, Uncivil Asylums and the Retarded*, 43 U. CIN. L. REV. 679, 722 (1974) (distinction between voluntary and involuntary often "illusory") with *New York State Ass'n for Retarded Children, Inc. v. Rockefeller*, 357 F. Supp. 752, 756 (E.D.N.Y. 1973) (voluntary residents at state school for retarded not treated differently than those who were involuntarily committed).

“abuse”³¹⁵ and “substantial elements of coercion;”³¹⁶ they have even fewer opportunities for discharge than involuntary patients.³¹⁷

Thus, the competency inquiry creates a self-contained paradox. Notwithstanding scholarly criticism, voluntary admission remains preferable to involuntary status. Yet, a close consideration of competency questions will probably serve to *reduce* the number of voluntary admissions, thus potentially re-increasing the number of involuntary patients. While such reinstitutionalization might serve as a palliative to the public’s demand that “something be done about those people,” it will probably not ameliorate the underlying social problems.

This likelihood is now even greater in the wake of the United States Supreme Court’s decision in *Zinermon v. Burch*,³¹⁸ which held that a voluntary patient could proceed with a section 1983 civil rights action against a state hospital.³¹⁹ In *Zinermon*, the plaintiff had charged that hospital officials should have known that he was incompetent to consent to admit himself voluntarily to the hospital at the time he signed hospital admission forms.³²⁰ This complex procedural decision³²¹ raises for the first time the concerns of a majority of the court that some “voluntary” patients may not be competent to admit themselves to psychiatric facili-

315. *Developments, supra* note 305, at 1400-01.

316. Legemaate, *supra* note 310, at 261-262; Wexler, *Foreword: Mental Health Law and the Movement Toward Voluntary Treatment*, 62 CALIF. L. REV. 671, 676 (1974). See generally Gilboy & Schmidt, “Voluntary” Hospitalization of the Mentally Ill, 66 NW. U.L. REV. 429, 452 (1971) (in a study of voluntary admissions in Illinois, a majority of individuals who voluntarily committed themselves did so under threat of involuntary commitment).

317. Herr, *supra* note 314, at 723. The most recent literature suggests that voluntary patients are hospitalized twice as long as involuntary patients and are less frequently considered to have received maximum benefits from their hospitalizations. Nicholson, *Characteristics Associated With Change in the Legal Status of Involuntary Psychiatric Patients*, 39 HOSP. & COMMUNITY PSYCHIATRY 424, 427 (1988).

318. 110 S. Ct. 975 (1990).

319. *Id.* at 984-86.

320. *Id.* at 986.

321. *Zinermon* confronted the extent to which *Parratt v. Taylor*, 451 U.S. 527 (1981), and *Hudson v. Palmer*, 468 U.S. 517 (1984), controlled a situation in which predeprivation procedural safeguards might have had value in preventing the alleged deprivation. *Zinermon*, 110 S. Ct. at 977-79. Both prior cases held that deprivation of constitutionally protected interests caused by a state employee’s random, unauthorized conduct does not give rise to a section 1983 procedural due process action. *Id.* See 1 M. PERLIN, *supra* note 11, § 3.69, at 33-35 (1990 Supp.); 3 M. PERLIN, *supra* note 11, § 12.33, at 10-12 (1990 Supp.). *Zinermon* is discussed in B. Winick, *Competency to Consent to Voluntary Hospitalization: An Analysis of Zinermon v. Burch* (unpublished manuscript).

ties.³²² Especially in light of public hospital staff mental health professionals' growing fear of litigation,³²³ *Zinermon* probably will have a further reductive effect on state hospital voluntary admissions.

2. *The decision to release.* The question of competency in release decision making is even more problematic. 'Cases such as *O'Connor v. Donaldson*³²⁴ and *Addington v. Texas*³²⁵ make it clear that patients cannot be forced to stay in institutions once they are no longer dangerous to themselves or others.³²⁶ State court decisions such as *State v. Fields*³²⁷ and *Fasulo v. Arafah*³²⁸ extend procedural due process commitment protections to periodic review hearings.³²⁹ Questions of competency are not generally cognizable at such hearings where the question is the patient's present dangerousness.³³⁰

Yet, the public's perception of deinstitutionalization as being fueled by "inappropriate" civil liberties decisions such as *O'Connor*

322. *Zinermon*, 110 S. Ct at 987-88.

323. See, e.g., Brodsky, *Fear of Litigation in Mental Health Professionals*, 15 *CRIM. JUST. & BEHAV.* 492, 497 (1988) (disproportionate reactions by mental health professionals responding to fear of suit have reached phobic proportions); Breslin, Taylor & Brodsky, *Development of a Litigaphobia Scale: Measurement of Excessive Fear of Litigation*, 58 *PSYCHOLOGICAL REP.* 547, 547-48 (1986) (the fear of malpractice litigation is widespread; the irrational or excessive fear of litigation—"litigaphobia"—may detrimentally affect the quality of practitioners' work). See generally *Facade*, *supra* note 113, at 989 n.211 (discussing this issue).

324. 422 U.S. 563, 576 (1975) (a state cannot confine, without more, a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of family or friends merely because he is mentally ill).

325. 441 U.S. 418, 431-33 (1979) (clear and convincing proof is needed to sustain involuntary civil commitment).

326. See generally 1 M. PERLIN, *supra* note 11, §§ 2.06-2.13 (discussing multiple meanings of "dangerousness" for involuntary civil commitment purposes).

327. 77 N.J. 282, 390 A.2d 574, 583 (1978) (the state must renew its authority to continue to deprive a committed individual of his liberty at each periodic review hearing).

328. 173 Conn. 473, 378 A.2d 553, 556 (1977) (the due process clause of the Connecticut constitution mandates that involuntarily confined civilly committed individuals be granted periodic judicial reviews of the propriety of their continued confinement).

329. See generally 1 M. PERLIN, *supra* note 11, § 3.60 (discussing the right of involuntarily confined civilly committed individuals to periodic judicial review).

330. Cf. Brahams & Weller, *supra* note 159, at 47-48 (in England, "no decision" as to whether a mentally ill patient can form the necessary intent to "voluntarily" discharge himself or herself from a psychiatric hospital). But see *In re S.L.*, 94 N.J. 128, 462 A.2d 1252, 1258-59 (1983) (ordering placement review hearings for patients no longer dangerous but unable to survive independently in the community).

*v. Donaldson*³³¹ or *Lessard v. Schmidt*³³² attributes homelessness, in an important way, to the inevitable outcome of such decisions:³³³ patients who, while perhaps not "technically" dangerous³³⁴ to others (especially where they have committed no "overt act")³³⁵ inevitably decompensate after release because, in the vernacular sense of the phrase, they are not competent to make life decisions.³³⁶

In partial response, attention has turned to the option of outpatient commitment "OPC" as a solution to the perceived problems. The APA has recommended that legislatures revise involuntary civil commitment laws to allow for this option and that existing OPC laws be "more widely used."³³⁷ The prototype North Carolina statute provides for OPC where:

- (a) The respondent is mentally ill;
- (b) The respondent is capable of surviving safely in the community with available supervision from family, friends, or others;

331. 422 U.S. 563 (1975). Refer to notes 137 & 139 *supra* and accompanying text.

332. 349 F. Supp. 1078 (E.D. Wis. 1972). Refer to notes 138 & 140 *supra*.

333. Compare E. TORREY, *supra* note 41, at 156-60 with Wagenaar & Lewis, *supra* note 52, at 506 (extension of civil rights to the mentally ill has "irrevocably altered" their relationships with their therapists). On the therapeutic potential of the legal process for mentally ill individuals, see generally D. WEXLER, *supra* note 245, at 3-20 (discussing the therapeutic aspects of civil commitment hearings, voluntary confinement compared to forced hospitalizations, and the roles of judges and lawyers in the process); Ensminger & Liguori, *The Therapeutic Significance of the Civil Commitment Hearing: An Unexplored Potential*, 6 J. PSYCHIATRY & L. 5, 7 (1978) (the civil commitment process contains considerable potential for therapeutic effects on the involuntarily committed patient); *Facade*, *supra* note 113, at 981-82 (discussing Supreme Court's failure to consider therapeutic outcomes in juvenile commitment cases); Wexler, *Grave Disability and Family Therapy: The Therapeutic Potential of Civil Libertarian Commitment Codes*, 9 INT'L J.L. & PSYCHIATRY 39, 54 (1986) (the very process of gathering evidence of a person's committability under a libertarian law may operate therapeutically to render commitment unnecessary).

334. On the question of the way "moral" psychiatrists may consciously subvert the legislative commitment standards to insure commitment of individuals who may not "technically" meet such standards, see Bagby & Atkinson, *The Effects of Legislative Reform on Civil Commitment Admission Rates: A Critical Analysis*, 6 BEHAV. SCI. & L. 45, 58-59 (1988); *Morality*, *supra* note 112. Refer to notes 388-92 *infra* and accompanying text.

335. See 1 M. PERLIN, *supra* note 11, § 2.13, at 110-15.

336. See, e.g., Fischer & Breakey, *supra* note 14, at 27-32; Hiday & Scheid-Cook, *The North Carolina Experience with Outpatient Commitment: A Critical Appraisal*, 10 INT'L J.L. & PSYCHIATRY 215, 215-16 (1987).

337. APA Task Force, *supra* note 144, at 8; see also Miller, *Commitment to Outpatient Treatment: A National Survey*, 36 HOSP. & COMMUNITY PSYCHIATRY 265, 267 (1985) (while OPC can be effective for those who will not obtain treatment voluntarily, states must seek input from clinicians to properly develop OPC procedures); Peele, Gross, Arons, & Jafri, *supra* note 145, at 265-68 (discussing trends in commitment laws, including OPC and alternatives to OPC).

(c) Based on the respondent's treatment history, the respondent is in need of treatment in order to prevent further disability or deterioration which would predictably result in dangerousness [to himself or others]; and

(d) His current mental status or the nature of his illness limits or negates his ability to make an informed decision to seek voluntarily or comply with recommended treatment.³³⁸

Supporters of OPC argue that such statutes are necessary to prevent a discrete group of the mentally ill from "slip[ping] through [the law's] cracks[:] [t]he chronic mentally ill who failed to obtain treatment on their own, who then decompensated and exhibited bizarre behavior, [but who] could not be civilly committed until they did something dangerous even though they had a history of becoming dangerous in the later stages of decompensation following the bizarre behavior."³³⁹

Such statutes would insure that these individuals—a group that appears to include many of the deinstitutionalized mentally ill most susceptible to homelessness³⁴⁰—would have enhanced access to what proponents have characterized as "protective liberty" through broad-based treatment mechanisms in an atmosphere that would overcome "rehabilitative inertia."³⁴¹ Its opponents respond that outpatient commitment means little more than disguised "benevolent coercion" accompanied by excessive state intervention; where implemented, it will subvert the dangerousness standard, lead to significant quality control problems, defeat the right to re-

338. N.C. GEN. STAT. §§ 122C-263(d) (1989). In determining the appropriateness of OPC, the committing physician must consider a variety of factors, including current and prior history of mental illness, treatment history, risk of danger to self or others, "ability to survive safely without inpatient commitment, . . . availability of supervision from family, friends or others[,] and capacity to make an informed decision concerning treatment." *Id.* §§ 122C-263(c). For a state-by-state survey of OPC statutes, see Schwartz & Costanzo, *supra* note 202, at 1363-72, 1405-29.

339. Hiday & Scheid-Cook, *supra* note 336, at 215. Compare *id.* at 215-16 (asserting that OPC provisions are necessary to treat the mentally ill who do not seek voluntary treatment, but do not meet the involuntary commitment criteria) with Kanter, *supra* note 72, at 354 (arguing that two-thirds of states already provide for inpatient commitment based on a "grave disability" theory for precisely this group of individuals). Refer to note 202 *supra* and accompanying text.

340. Refer to text accompanying notes 260-69 *supra*.

341. See Mulvey, Geller & Roth, *The Promise and Peril of Involuntary Outpatient Commitment*, 42 AM. PSYCHOLOGIST 571, 577-79 (1987) ("involuntary outpatient commitment rests on the state's obligation to provide positive liberty rather than simple noninterference, the likelihood of more efficacious treatment through broad-based intervention, and the possibility of initiating a positive cycle of community involvement").

fuse treatment, and "undermin[e] therapeutic relationships."³⁴²

Empirical response has been mixed.³⁴³ One of the most recent analyses concludes that, while outpatient commitment succeeds in terms of keeping patients on medication, thus extending their maintenance in the community,³⁴⁴ its ultimate success may depend on the dedication of community mental health centers ("CMHC"s) "to making [it] work".³⁴⁵ Where centers pay only "lip service" to outpatient commitment, the law becomes undermined.³⁴⁶ This is especially troubling in light of Torrey's broad indictment of CMHCs: they have never provided aftercare for ex-patients and have exhibited attitudes toward public hospitals ranging from "difficult" to "adversarial."³⁴⁷ In their desire to treat the "worried well"—patients with inter- and intrapersonal problems amenable to counseling and psychotherapy—CMHCs have historically turned their back on precisely the population that OPC was designed to serve.³⁴⁸

In a powerful critique from a civil libertarian perspective, Steven Schwartz and Cathy Costanzo focus on outpatient commit-

342. See *id.* at 575-77 (setting forth opposing arguments to OPC that the costs to individual rights and professional relationships are too great).

343. Compare, e.g., Hiday & Goodman, *The Least Restrictive Alternative to Involuntary Hospitalization, Outpatient Commitment: Its Use and Effectiveness*, 10 J. PSYCHIATRY & L. 81, 88-91 (1982) (results of court-ordered outpatient treatment indicate that OPCs are successful; in a two-year study, only 15.7% of patients in the first year and 9.5% in the second year subsequently required rehospitalization) with Miller & Fiddelman, *Involuntary Civil Commitment in North Carolina: The Result of the 1979 Statutory Changes*, 60 N.C.L. REV. 985, 1009-13 (1982) (asserting that North Carolina's statutory amendments did not make a significant difference in OPC use, based upon a study of patients committed before and after the amendments).

344. See Hiday & Scheid-Cook, *supra* note 336, at 229.

345. *Id.* at 230; see also Note, *supra* note 126, at 1344 n.183, quoting Perry, *The Status of Mental Health Partial Hospitalization Services in the Atlanta Region*, in 2 EXPLORING MENTAL HEALTH PARAMETERS 66 (1976) (concluding that "[e]ven if clinicians support community treatment in theory, 'the attitudes, prejudices, and non-coordination of support staff in a program of [community] treatment can be quite debilitating in lowering the quality of an existing program and in preventing an increase in the scale of the program'").

346. See Hiday & Scheid-Cook, *supra* note 336, at 230-31; see also *id.* at 230:

Some centers paid lip service to OPC, treating a respondent ordered to them as another deinstitutionalized chronic patient who soon would have to be readmitted to the hospital or as another problem patient with whom no one could do anything. They showed little understanding of the intent or provisions of the law. Some primary clinicians at these centers did not know that OPC was not for alcoholics, that the sheriff could be called to bring in a respondent or that the OPC could be extended.

347. E. TORREY, *supra* note 41, at 142-51.

348. *Id.*; see also Schwartz & Costanzo, *supra* note 202, at 1386-89.

ment as "an expression of the much enlarged authority which developed over the past century to promote the health or interests of persons considered to be mentally infirm."³⁴⁹ Schwartz and Costanzo characterize outpatient commitment as a "significant distortion of the historical purpose and benign motivation of the *parens patriae* principle"³⁵⁰ and, primarily, as a "guise for substantially modifying the criteria for state-imposed psychiatric intervention."³⁵¹ Additionally, Professor Susan Stefan has "unpacked" outpatient commitment to differentiate "traditional" OPCs (premised on least restrictive alternative constructs and conditional release *schemata*) from the post-deinstitutionalization model which she characterizes as "preventative commitment."³⁵² According to Stefan, by focusing on the spectre of *deterioration*, an implied presumption of incompetency, and an assumed availability of treatment,³⁵³ preventative commitment "broadens the class of people subject to commitment, and expands the conditions under which the state can intervene in a person's life."³⁵⁴ While this is clearly a laudable goal to critics such as Torrey and Lamb, this expansion inadequately considers the additional procedural and substantive due process dilemmas regarding the right to treatment, the right to refuse treatment, and rights of economic sovereignty that are raised by the possibility of a greatly expanded use of this commitment status.³⁵⁵ In short, this attempt to "solve" the perceived deinstitutionalization-homelessness link through focusing on a patient's "competency" may not prove to be a panacea at all.³⁵⁶

Stefan and Schwartz and Costanzo focus sharp criticism on precisely the issue which is frequently seen as the lynch-pin of OPC's efficiency value: its use as a tool to compel medication compliance in the community.³⁵⁷ Stefan characterizes forced medica-

349. *Id.* at 1346.

350. *Id.* at 1348.

351. *Id.* at 1404.

352. Stefan, *supra* note 135, at 288. See generally 1 M. PERLIN, *supra* note 11, §§ 3.46-3.54, at 341-68 (discussing "least restrictive alternative" and "conditional release" models).

353. Stefan, *supra* note 135, at 288-91.

354. *Id.* at 296.

355. *Id.* at 291-95.

356. *Id.* at 289; see also Schwartz & Costanzo, *supra* note 202, at 1379-80 (arguing that states will not be likely to provide the necessary funds to adequately assist those who will not seek help voluntarily).

357. See Schwartz & Costanzo, *supra* note 202, at 1380-85. See generally Winick, *supra* note 310. But see Miller & Fiddelman, *Outpatient Commitment: Treatment in the Least Restrictive Environment?*, 35 HOSP. & COMMUNITY PSYCHIATRY 147, 149 (1984)

tion as the "core of OPC";³⁵⁸ Schwartz and Costanzo speculate that OPC "already has or will become synonymous with forced medications."³⁵⁹ While the OPC statutes rarely address this issue squarely,³⁶⁰ it raises serious constitutional, philosophical, and operational concerns³⁶¹ that must be addressed. This is especially true when we remind ourselves that, as is the case with all other involuntary commitment mechanisms, it is the socially marginalized, indigent patient—precisely the one in whom CMHCs traditionally have been disinterested—who likely will be disproportionately represented in any outpatient commitment caseload.³⁶²

In short, neither of the two traditional "competency" inquiries help us focus our attention on more than discrete fragments of the larger and more complex underlying social problems.

B. *Deconstructed Meanings*

In attempting to solve the deinstitutionalization-homelessness conundrum, the importance of competency determinations requires further analysis. A more fully deconstructed reading of "competency" raises other "competencies" to consider: (1) the competence of bureaucrats to implement deinstitutionalization policies; (2) the competence of mental health professionals to effectively treat the institutionalized mentally disabled so that, once released, they do not decompensate to such a degree as to become homeless; (3) the competence of legislators to effectively draft statutes that stand a reasonable likelihood of ameliorating the current conditions; (4) the competence of lawyers to effectively represent this population on an individualized basis; and (5) the competence of public interest litigators, judges, and academics to offer creative

(presenting clinicians' arguments that patient's history of psychotic behavior when medication is stopped justifies coercion and continued court supervision).

358. Stefan, *supra* note 135, at 294; *see also* J. La Fond, *The Homeless Mentally Ill: Is Coercive Psychiatry the Answer?* (paper presented at annual meeting of American Association of Law Schools, January 1990, San Francisco, CA, tape available through AALS) (in outpatient settings, "[d]rugs—with all their risks—will undoubtedly be the treatment of choice").

359. Schwartz & Costanzo, *supra* note 202, at 1368.

360. *See id.* (reporting that as of 1987, "only seven states explicitly authorize[d] [forced] medication as a form of community treatment," although no OPC statutes precluded it).

361. *See id.* at 1382; *see also* Mulvey, Geller & Roth, *supra* note 341, at 580-81.

362. *See* Note, *supra* note 126, at 1323-24, 1341.

solutions to the underlying social problems.³⁶³

1. *The competency of bureaucrats to implement deinstitutionalization policies.* Deinstitutionalization, as implemented, frequently has been an operational disaster.³⁶⁴ Officials in state mental health departments, for a combination of reasons, choose to wilfully blind themselves to the realities of much of the wretched conditions facing some deinstitutionalized individuals, especially in our big cities.³⁶⁵ Although a psychological inquiry into *why* such policies have been doggedly followed³⁶⁶ goes beyond the scope of this paper, this inquiry deserves re-emphasis since we have kept our collective heads "buried in the sands" for years.³⁶⁷ Planned reconceptualization appears to be in progress only because of persistent and massive criticism.³⁶⁸

2. *The competency of treatment staffs.* The record of state hospital staffs in the provision of adequate treatment to institutionalized patients historically has been a national scandal.³⁶⁹ Many of the legislative solutions that would "widen the net"³⁷⁰ and expand the civil commitment power assume, *sub silentio*, the availability of adequate treatment in public inpatient facilities. This assumption is utterly belied by the hospitals' track record over the past several decades, a record that demonstrates, in many in-

363. I have recently attempted to do this elsewhere in connection with the jurisprudence of the right of pretrial detainees to refuse antipsychotic medication, see *Facade*, *supra* note 113, at 994-1001, and the pretextuality in the way lawyers and forensic mental health professionals address systemic problems, see *Morality*, *supra* note 112.

364. See, e.g., Baxter & Hopper, *supra* note 43, at 114 (reporting from a 1979-80 study that 59% of all discharges from a single New York state hospital were to "unknown" living arrangements).

365. Refer to notes 252-53 *supra* and accompanying text. Cf. Wagenaar & Lewis, *supra* note 52, at 521 (stating that, as state hospitals' control over the "socially disruptive" diminishes, the burden of dealing with such individuals shifts to groups "least equipped to do so: families and inner-city neighborhoods").

366. See P. Margulies *supra* note 174, at 43-57 (analyzing interests and ambivalences of bureaucrats in community residential care decisionmaking).

367. Refer to notes 163 & 165 *supra*.

368. See, e.g., Bach, *supra* note 174, at 1163-65 (considering whether state hospital failure to locate and arrange for community aftercare prior to patient discharge violates common law tort principles).

For a recent optimistic effort, see *Cuomo and Dinkins Agree to House 5,225 Mentally Ill*, N.Y. Times, Aug. 23, 1990, at A1, col. 2. (state and city service units agreed to provide residential housing for over 5,000 homeless New York city residents).

369. Refer to notes 214-15 *supra* and accompanying text.

370. Refer to note 396 *infra*.

stances, that hospitalization caused harm or retarded recovery.³⁷¹ Even in the case of preventative commitment or outpatient commitment, significant problems surround the implementation of a right to treatment.³⁷² Further, public hospitals' dismal performance in the administration of antipsychotic medication is troubling in light of the likelihood that, especially for the population in question here,³⁷³ drug regimens will be the treatment of choice.³⁷⁴ Beyond this, the sociological critique that focuses upon the inculcation of institutional dependency in public psychiatric facilities has never been effectively rebutted.³⁷⁵ The track record is deplorable, and there is no reason to believe that significant amelioration will occur.³⁷⁶

3. *The competency of lawyers to represent state hospital patients.* Traditionally, lawyers assigned to represent state hospital patients have failed miserably in their mission.³⁷⁷ Recent studies corroborate earlier findings that organized counsel provide far more adequate representation than those lawyers occasionally or sporadically assigned.³⁷⁸ In most jurisdictions, however, counsel are

371. See 2 M. PERLIN, *supra* note 11, at chs. 4 & 5.

372. See Stefan, *supra* note 135, at 293-94.

373. See Hiday & Scheid-Cook, *supra* note 336, at 215-16 (describing the group of chronic mentally ill served by OPC statutes as those who have "slipped through the cracks").

374. See, e.g., Note, *A Common Law Remedy for Forcible Medication of the Institutionalized Mentally Ill*, 82 COLUM. L. REV. 1720, 1723-27 (1982) (discussing the use of antipsychotic drugs for schizophrenic and non-schizophrenic patients, and arguing that the use is often unwarranted and even dangerous to the patient).

375. See C. KIESLER & A. SIBULKIN, *supra* note 115, at 148.

376. *But see* Mossman, Macaulay, Johnson, & Baker, *Improving State-Funded Child Psychiatric Care: Reducing Protracted Hospitalization Through Changes in Treatment Planning*, 16 QUALITY REV. BULL. 20, 24 (1990) (reporting that a study completed by a state-funded children's hospital suggests that "community-focused efforts yielded shorter hospitalizations and fewer needlessly motivated ones").

377. See generally Perlin & Sadoff, *supra* note 206, at 164 (discussing surveys that indicate that counsel sporadically appointed to represent the mentally ill were reluctant to investigate, lacked expertise, and did not assume an active role as advocate for the clients' rights). The heuristic public perception here is both inapposite and wrong. *Cf.* J. Costello, *supra* note 186 ("Occasionally at cocktail parties . . . I'm buttonholed by friends who say, 'Weren't you one of those people who got everybody out of the mental hospital? This is all your fault!'") (Costello, a law professor, has served as counsel in several patients' rights cases.).

378. See, e.g., Durham & La Fond, *supra* note 254, at 425-28, 439-43 (concluding that a public defense system provides better legal representation for clients resisting commitment, based upon a study of commitment cases under a public defense system and a court-appointment system).

not assigned in an organized way. Most attorneys do not specialize in this area, and few are supported by mental health professionals.³⁷⁹ This track record is especially problematic in cases of patients released from state hospitals without hearings.³⁸⁰ In those cases, lack of adequate counsel (or, more probable, *any* counsel) will likely "translate" into a lack of adequate investigation and inquiry into the sufficiency or availability of posthospital living arrangements.³⁸¹

The U.S. Supreme Court may have delivered the *coup de grace* here six years ago in the case of *Strickland v. Washington*,³⁸² which established a vague and weak "reasonableness" standard to assess adequacy of counsel in criminal cases under the sixth amendment.³⁸³ Cases after *Strickland* have starkly revealed the minimal level of competency expected by courts when mentally disabled criminal defendants are involved.³⁸⁴ Thus, we can have no realistic expectations of a more vigorous or searching inquiry in

379. See 2 M. PERLIN, *supra* note 11, § 8.19, at 802-04.

380. Dr. Robert L. Sadoff, past president of the American Academy of Psychiatry and Law, recently questioned whether courts should be involved in release decision making in all cases of patients involuntarily committed to hospitals pursuant to a dangerousness to others finding. Telephone interview with Dr. Robert L. Sadoff (Feb. 19, 1990). This precise question was the topic of a panel discussion, "Discharging 'Dangerous' Patients: Who Decides?" presented at the annual American Academy of Psychiatry and Law Conference, October, 1990, in San Diego (debate between Dr. Sadoff and Dr. Abraham Halpern moderated by the author). This is a cutting-edge topic, albeit one that has not yet attracted significant scholarly attention.

381. On the broader question of the duties of lawyers representing putatively incompetent clients, see Margulies, "Who Are You To Tell Me That?": *Attorney-Client Deliberation Regarding Nonlegal Issues and the Interests of Nonclients*, 68 N.C.L. Rev. 213, 235 n.83 (1990) (a hospitalized client may still have the capacity to make certain decisions; if the client does not have such capacity, the attorney should counsel the client's guardian or even other colleagues); Tremblay, *On Persuasion and Paternalism: Lawyer Decisionmaking and the Questionably Competent Client*, 1987 UTAH L. Rev. 515, 517-21 (discussing the problems and possible solutions presented to an attorney representing an incompetent client).

382. 466 U.S. 668 (1984).

383. *Id.* at 688. See generally 2 M. PERLIN, *supra* note 11, § 8.30 (discussing implications of *Strickland* for litigation involving mentally disabled clients); Perlin, *supra* note 261, at 145-69 (discussing *Strickland's* reasonableness test, and criticizing it as "nearly-standardless, seemingly-impossible-to-fail test for adequacy of counsel").

384. See, e.g., *Alvord v. Wainwright*, 469 U.S. 956, 959 (1984) (Marshall, J., dissenting from *certiorari* denial) (discussing counsel's total failure to pursue a possible insanity defense, and arguing that the resulting standard of reasonableness imposes no duty on the attorney to pursue any defenses the defendant does not desire).

For a recent excellent overview of all relevant issues, see Klein, *The Relationship of the Court and Defense Counsel: The Impact of Competent Representation and Proposals for Reform*, 29 B.C.L. Rev. 531 (1988).

cases involving mentally disabled or homeless *civil* plaintiffs or individuals subject to the civil commitment process.

4. *The competency of legislators to offer effective solutions.*

The issue is clearly drawn on the wisdom of broadening the criteria for involuntary civil commitment as a strategy for "correcting" deinstitutionalization errors and thus reducing the number of the homeless mentally ill.³⁸⁵ Whether or not we accept the premise that civil-libertarian-based statutes "went too far" and that it has become time for "the pendulum to be reversed,"³⁸⁶ we must confront an important reality: legislative activity in this area is driven by heuristic reasoning. The vivid, "outrageous" case that shows the public what happens when "someone falls through the cracks" animates legislative reform designed to insure that such errors are not

385. Compare Durham & La Fond, *supra* note 232, at 357-62 (arguing that involuntary commitment for nondangerous mentally ill patients does more harm than good) and Durham & La Fond, *supra* note 218, at 886-88 (asserting that coercive commitment is ineffective in treating the mentally ill, and that scarce resources should be concentrated on providing care on a voluntary basis) and Durham & La Fond, *supra* note 254, at 444 (concluding through empirical research that expanding involuntary commitment results in overcrowding in state institutions, chronic use of state psychiatric hospitals, and lack of available treatment for voluntary patients) with Stone, *Broadening the Statutory Criteria for Civil Commitment: A Reply to Durham & La Fond*, 5 YALE L. & POL'Y REV. 412, 422-27 (1987) (attacking Durham and La Fond's research, and asserting that "therapeutically oriented criteria" for commitment protects the patient's rights and limits inappropriate confinements). For clinical evaluations of Stone's proposals, see Beck & Golowka, *A Study of Enforced Treatment in Relation to Stone's "Thank You" Theory*, 6 BEHAV. SCI. & L. 559, 564 (1988) (reporting 15 of 39 patients in their study stated that they benefited from the involuntary hospitalization); Hoge, Appelbaum, & Greer, *An Empirical Comparison of the Stone and Dangerousness Criteria for Civil Commitment*, 146 AM. J. PSYCHIATRY 170, 174-75 (1989) (arguing that the Stone criteria would exclude currently committable patients without adding other patients, and that the criteria would dramatically affect the delivery of psychiatric services); Hoge, Sachs, Appelbaum, Greer & Gordon, *supra* note 273, at 767-68 (asserting that, although the Stone criteria is more restrictive than the dangerousness standard, it may not significantly decrease the number of patients committed).

386. On the pendulum theory, see 1 M. PERLIN, *supra* note 11, § 1.04, at 24 n.134 (discussing Durham & La Fond, *supra* note 254, at 398); Fisher, Pierce, & Appelbaum, *How Flexible Are Our Civil Commitment Statutes?*, 39 HOSP. & COMMUNITY PSYCHIATRY 711, 711 (1988) (providing that the restrictiveness and inflexibility of statutes based on dangerousness have led several states to broaden commitment requirements); Myers, *supra* note 178, at 379 (some mental health professionals who initially applauded the changes in involuntary commitment laws, eventually criticized them as "anti-therapeutic" and even harmful); Shuman, *Innovative Statutory Approaches to Civil Commitment: An Overview and Critique*, 13 L. MED. & HEALTH CARE 284, 286 (1985) (trend away from the dangerousness standard precipitated by the apparently inappropriate exclusion of people from hospitals, thus forming the "mental patient ghettos" in the larger cities); Wexler, *supra* note 333, at 39 (asserting that statutory broadening of commitment criteria results from public opinion that "the pendulum has swung too far in favoring 'rights' over 'therapy'").

replicated.³⁸⁷

Scholars who have studied this process carefully have reached two divergent conclusions. First, when new, broader criteria are actually adhered to, the results raise troubling issues relating to social control, allocation of resources, and the role of the public hospital in the mental health system.³⁸⁸ Second, and perhaps even

387. See, e.g., Bagby & Atkinson, *supra* note 334, at 46 ("publicly salient events such as a heinous murder of an innocent victim at the hands of a discharged mentally ill patient, or community intolerance of deviance, may have the effect of increasing the rate of commitments"); Durham & La Fond, *supra* note 232, at 416-18 (increase in commitments *before* the effective date of Washington's new broadened statutory commitment criteria may have been attributable to a well-publicized murder by a person denied voluntary admission to a state hospital); Fischer, Pierce, & Appelbaum, *supra* note 379, at 712 (reporting that after an individual was denied admission to a Washington state hospital and murdered two elderly neighbors, commitments from that vicinage rose by nearly 100% even *prior to* legislative reform); Tsiantar, *New York State Seeks To Reduce Psychiatric Beds; City Officials Fear Results Will Be an Increase in Mentally Ill Homeless People*, Wash. Post, Sept. 19, 1986, at F5 (discussing impact on deinstitutionalization debate of highly publicized murder of 11 people on the Staten Island Ferry committed by ex-patient).

Durham & La Fond respond to the major psychiatric critique of their earlier work, see Stone, *supra* note 385, by accusing Stone of relying on "anecdotal accounts, armchair speculation, and two idiosyncratic prospective studies." Durham & La Fond, *supra* note 218, at 886; see also Lamb, *supra* note 151, at 277 (criticizing the utilization of improperly narrow civil commitment criteria, but without citing to a single court decision demonstrating a tendency to apply such criteria too "literally").

In an analysis of civil commitment decisionmaking in cases involving the homeless mentally ill in Ohio, Professor John Belcher suggests that "aggressive use" of the civil commitment power is necessary to "ensure appropriate care." Belcher, *Defining the Service Needs of Homeless Mentally Ill Persons*, 39 HOSP. & COMMUNITY PSYCHIATRY 1203, 1204 (1988). A careful reading of the prevailing Ohio state case law indicates, however, that Ohio's judiciary has carefully set out substantive commitment criteria in a way that suggests "regular" use of the civil commitment power is sufficient to ensure appropriate care. See, e.g., *State v. Bruton*, 27 Ohio App. 3d 362, 368-69, 501 N.E.2d 651, 653-59 (1985) (finding that a patient's probable failure to take medication provided a sufficient basis for a court to find that he posed a danger to himself and others and warranted his confinement); *In re Burton*, 11 Ohio St. 3d 147, 464 N.E.2d 530, 534 (1984) (setting forth various factors to guide lower courts in commitment cases, including the risk of danger to the patient or others and the probability that the patient will not continue treatment); *In re McKinney*, 8 Ohio App. 3d 278, 456 N.E.2d 1348, 1351-52 (1983) (holding that statutory definition of mental illness is met when a patient exhibits substantial thought or mood disorder that affects the patient's ability to meet the ordinary demands of life, whether or not psychiatric experts so denominate it).

388. Under new criteria in Washington, the number of involuntarily committed patients increased significantly, including many first-time commitments. The Washington guidelines also extended the lengths of stay for new patients, thus raising the number of chronic users of inpatient mental health services. The extreme overcrowding caused by the implementation of these guidelines virtually excluded voluntary admissions from all state hospital facilities. See Durham & La Fond, *supra* note 232, at 401.

Conversely, when legislatures have attempted to *tighten* civil commitment criteria, the number of involuntary admissions has not been significantly reduced. See Bagby & Atkinson, *supra* note 328, at 57-59; see also Bagby, *The Effects of Legislative Reform on Admis-*

more important for our purposes, in cases of jurisdictions where commitment standards are more narrow, little evidence suggests that mental health professionals adhere to the legislative guidelines.³⁸⁹ Here, Doctors Bagby and Atkinson speculate that such professionals exhibit "psychological reactance"³⁹⁰ in resisting legislative attempts to reduce their prerogative.³⁹¹ Because of this resistance—grounded in what some professionals see as their "moral obligation"—restrictive laws are ignored and some psychiatrists continue to commit those "whom they believe should be committed."³⁹²

sion Rates to Psychiatric Units of General Hospitals, 10 INT'L J.L. & PSYCHIATRY 383, 385-86 (1987) (analyzing the impact of legislative revision on involuntary admission rates).

389. Cf. Bagby & Atkinson, *supra* note 334, at 57 (reaction of mental health professionals who perceive legislation as an unnecessary constraint upon the treatment of the mentally ill); Page, *New Civil Commitment Legislation: The Relevance of Commitment Criteria*, 25 CAN. J. PSYCHIATRY 646, 646 (1980) (Canadian Civil Liberties Union concluded that about 70% of civil commitment criteria did not meet the requirements of the mental health act); Page, *Civil Commitment: Operational Definition of New Criterion*, 26 CAN. J. PSYCHIATRY 419, 420 (1981) (due to low compliance the Canadian mental health act was modified); Page & Firth, *Civil Commitment Practices in 1977: Troubled Semantics and/or Troubled Psychiatry*, 24 CAN. J. PSYCHIATRY 329, 330-31 (1979) (exploring why civil commitment practices are not followed); Page & Yates, *Civil Commitment and the Danger Mandate*, 18 CAN. PSYCHIATRIC ASS'N. 267, 268-70 (1973) (examination of Ontario's new mental health act as contrasted with the narrow criteria of the Canadian mental health act).

390. S. BREHM & J. BREHM, *PSYCHOLOGICAL REACTANCE: A THEORY OF FREEDOM AND CONTROL* 357-72 (1981); *Psychodynamics*, *supra* note 112, at 12 n.46; *Morality*, *supra* note 112.

391. Bagby & Atkinson, *supra* note 334, at 58; *see also* Friedman, *supra* note 161, at 477-78 (examining why clinicians do not aggressively pursue alternatives to clinical determinants). *See generally* M. Perlin, *Pretexts Within the Forensic System: Why Are We Really Doing This This Way?* (paper presented at Grand Rounds, Clarke Institute of Psychiatry, Toronto, Ontario, Canada, June 1990) (on file at Houston Law Review).

392. *See* Chodoff, *supra* note 301, at 498; *see also* Kaufman, *supra* note 272, at 362 (broad statutory criteria "invite [medical witnesses] to implement hidden agendas about treating the mentally ill and protecting society"); Lamb, *supra* note 151, at 277 (criticizing courts for interpreting civil commitment laws "literally"). *See generally* Bagby, Silverman, Ryan & Dickens, *Effects of Mental Health Legislative Reform in Ontario*, 28 CAN. PSYCHOLOGIST 21, 27-28 (1987) (raising serious questions about the ability of lawmakers to legislate the practices of mental health professionals); *Compare* Martin & Cheung, *Civil Commitment Trends in Ontario: The Effect of Legislation on Clinical Practice*, 30 CAN. J. PSYCHIATRY 259, 259 (1985) (mental health legislation had little effect on local commitment practice) *with* Tremblay, *supra* note 381, at 538-39 n.97 (legal mandate of presumption of competence "is seldom followed by the medical profession").

Although Peters and his colleagues have reported significant changes in Florida's admissions and census following legislative change, *see* Peters, Miller, Schmidt, & Meester, *The Effects of Statutory Change on the Civil Commitment of the Mentally Ill*, 11 L. & HUM. BEHAV. 73, 77 (1987), Bagby & Atkinson suggest that such *initial* post-reform changes are not predictive of subsequent commitment rates. Bagby & Atkinson, *supra* note 334, at 56-57.

This final conclusion raises deeply troubling questions as to the ultimate competence of legislators to craft a commitment standard that both meets constitutionally mandated criteria and is "accepted" by expert witnesses on whose testimony contested civil commitment cases will inevitably turn. If legislators are unable to do this, then their competence to "solve" the problems of the deinstitutionalized, homeless mentally ill is seriously suspect.³⁹³

5. *The competency of public interest lawyers and legal scholars to offer creative solutions.* On the other hand, there may be one glimmer of hope. In individual law reform actions, attorneys representing patients, former patients, and homeless individuals have offered a number of innovative answers to the underlying problems.³⁹⁴ In addition, scholars have suggested other strategies that may eventually yield further solutions for the classes in question.³⁹⁵

Thus, to deal with the dilemma of posthospital placement of the nondangerous patient with "nowhere to go," lawyers have successfully convinced state courts to establish a separate set of placement hearings to insure the availability of appropriate aftercare.³⁹⁶

393. For a recent legislative effort, increasing financial incentives for communities to treat patients in non-hospital community settings, see OHIO REV. CODE ANN. § 5199.01 (Mental Health Act of 1988).

394. For a helpful survey, see McKittrick, *supra* note 267, at 428; see also Dakin, *Homelessness: The Role of the Legal Profession in Finding Solutions Through Litigation*, 21 FAM. L.Q. 93, 111-26 (1987) (explicitly calling upon lawyers to develop creative solutions); Hopper, *supra* note 216, at 317-23 (discussing the role of legal advocacy for the homeless); Hayes, *Litigating on Behalf of Shelter for the Poor*, 22 HARV. C.R.-C.L. L. REV. 79, 79 (1987) (one of the pre-eminent litigators in the field declaring that the lawsuit must fit "into the context of building a consensus for more equitable distribution" of wealth); Hayes, *Homelessness and the Legal Profession*, 35 LOY. L. REV. 1, 1 (1989) (litigation the equivalent of the "bull in a china shop") See generally Alfieri, *The Antimonies of Poverty Law and a Theory of Dialogic Empowerment*, 16 N.Y.U. REV. L. & SOC. CHANGE 659, 693-70 (1987-88) (philosophical inquiry into the relationship between lawyers and their clients in such litigation); White, *Mobilization on the Margins of the Lawsuit: Making Space for Clients to Speak*, 16 N.Y.U. REV. L. & SOC. CHANGE 535, 538-40 (1987-88) (discussing litigation and marginalization).

395. See generally Chackes, *Sheltering the Homeless: Judicial Enforcement of Governmental Duties to the Poor*, 31 WASH. U.J. URB. & CONTEMP. L. 155, 195-98 (1987) (discussing the various remedies that can be fashioned by state courts when state and local governments fail to perform their common law and statutory duties to the poor); Reid, *Law, Politics and the Homeless*, 89 W. VA. L. REV. 115, 117-34 (1986) (arguing that more statutory entitlement programs are needed because the judicial system is failing to meet the needs of the homeless).

396. See, e.g., *In re S.L.*, 94 N.J. 128, 133-34, 462 A.2d 1252, 1253 (1983) (establishing hearing schedule and criteria). For cases following and construing *S.L.*, see *In re A.F.* &

Others have sought, with varying success, the establishment of a constitutional or statutory right to treatment in community settings.³⁹⁷ Still others have brought civil rights actions on behalf of deinstitutionalized ex-patients³⁹⁸ and on behalf of mentally handicapped individuals residing in the community who seek to maintain funding of community services so as to avoid the need for institutionalization.³⁹⁹

Additionally, lawyers representing homeless groups have brought actions seeking to establish constitutional and statutory rights to shelter⁴⁰⁰ and attempting to force local officials to develop

E.S., 94 N.J. 597, 597, 468 A.2d 231, 231 (1983); *K.P. v. Albanese*, 204 N.J. Super. 166, 497 A.2d 1276, 1282 (App. Div. 1985); *In re B.R.*, 202 N.J. Super. 182, 494 A.2d 333-334 (App. Div. 1985); *In re G.M.*, 217 N.J. Super. 629, 526 A.2d 744, 745 (Ch. Div. 1987).

397. In the furthest reaching statutory case, the Arizona Supreme Court has interpreted that state's community mental health services statutes, (ARIZ. REV. STATS. § 11-251(5); 11-291(A); 36-550-36-558; 36-3403(B) (1)), to mandate a wide variety of state and county-provided services to the chronically mentally ill in the community. *Arnold v. Arizona Dep't of Health Servs.*, 160 Ariz. 593, 775 P.2d 521, 532-34, 538 (1989); see also Santiago, *The Evolution of Systems of Mental Health Care: The Arizona Experience*, 147 AM. J. PSYCHIATRY 148, 148-52 (1990) (*Arnold* case an "interactive variable" which led to change in the Arizona mental health system).

Constitutional litigation has yielded inconsistent results. Compare *Phillips v. Thompson*, 715 F.2d 365, 367-68 (7th Cir. 1983), and *Society for Good Will to Retarded Children v. Cuomo*, 737 F.2d 1239, 1247 (2d Cir. 1984) (finding no constitutional right to community placement) with *Clark v. Cohen*, 794 F.2d 79, 86 (3d Cir. 1986) and *Thomas S. v. Morrow*, 781 F.2d 367, 367-374 (4th Cir. 1986) (finding constitutional right to community placement where consonant with professional judgment). See generally 2 M. PERLIN, *supra* note 11, § 7.18, at 646-49 (analyzing the impact of *Youngberg*—"no general right to services in the community"—on other cases involving community treatment rights).

398. See 2 M. PERLIN, *supra* note 11, §§ 7.20-7.21, at 652-57 (discussing litigation of patients civil rights in after care facilities and in the community).

399. See *Philadelphia Police & Fire Ass'n v. City of Philadelphia*, 874 F.2d 156, 159 (3d Cir. 1989) (reversing trial court decision that had invalidated a city budgetary plan that denied certain support services and benefits for retarded individuals living at home, and ordering the state to pay for such services), *enforced*, 705 F. Supp. 1103 (E.D. Pa. 1989).

400. In *Callahan v. Carey*, N.Y.L.J., Dec. 11, 1979, at 10, col. 2 (N.Y. Sup. Ct. Dec. 5, 1981), the trial court ruled that, under both the New York State Constitution and the applicable regulatory scheme, both the city and state were obligated to provide shelter to homeless males. When city defendants refused to extend the terms of the decree to homeless women, a subsequent suit was filed on their behalf. *Eldredge v. Koch*, 118 Misc. 2d 163, 459 N.Y.S.2d 960, 961 (Sup. Ct. 1983), *rev'd in part on other grounds*, 98 A.D.2d 675, 676, 469 N.Y.S.2d 744, 745 (1983). The trial court ruled that the *Callahan* decree applied equally to women. 459 N.Y.S.2d at 961. As the court noted, the plaintiffs' "contention is so obviously meritorious that it scarcely warrants discussion." *Id.* The Court went on to find that several of the women's shelters violated *Callahan's* substantive standards. Although the Appellate Division ruled that more evidence was needed on the question of specific violations, it affirmed the applicability of *Callahan* to women. *Id.*; see also *Wilkins v. Perales*, 128 Misc. 2d 265, 487 N.Y.S.2d 961, 964-65 (Sup. Ct. 1985) (holding that the decisions of the state commissioner of department of social services amounted to a waiver of the regulations establish-

comprehensive plans to deal with homelessness problems.⁴⁰¹ Others have turned to state welfare, mental health services, and entitlement laws in efforts to mandate the availability of shelter and benefit programs for the homeless.⁴⁰²

More recent litigation has focused upon the availability of congregate shelters for homeless individuals with AIDS,⁴⁰³ the right of deinstitutionalized homeless individuals to have individualized service discharge plans,⁴⁰⁴ the right of homeless individuals to interpose tenancy law defenses in eviction cases,⁴⁰⁵ the right of

ing maximum limits for capacity of each shelter facility).

In another New York case, that state's highest court held that the trial court had the power to enjoin state departments of social service and housing to provide emergency housing for homeless families with children which satisfied minimum standards of "sanitation, safety and decency." *McCain v. Koch*, 70 N.Y.2d 109, 109, 511 N.E.2d 62, 63, 517 N.Y.S.2d 918, 919 (1987). See Finder, *New York Lags in Goal to Move Homeless Families From Hotels*, N.Y. Times, Feb. 19, 1990, at B1, col. 2. Cf. Sherburne, *The Judiciary and the Ad Hoc Development of a Legal Right to Shelter*, 12 HARV. J.L. & PUB. POL'Y 193, 215-20 (1989) (criticizing litigation aimed at a construction of right to shelter).

401. In what has been characterized as "perhaps the most far-reaching" right to shelter case, *Stille, Seeking Shelter in the Law*, NAT'L L.J., Feb. 10, 1986, at 1, 25, col. 1, a New Jersey trial court judge used state law as the basis for an order compelling Atlantic City to develop a comprehensive plan to deal with its homeless problems. *Maticka v. Atlantic City*, No. L8306-84E (N.J. Super. Ct., Law Div., Atlantic County, Jan. 29, 1986), remanded, 216 N.J. Super. 434, 524 A.2d 416, 423 (App. Div. 1987) (remanded to state Department of Human Services for rulemaking hearing); see also 2 M. PERLIN, *supra* note 10, § 7.26, at 689 n.701 (discussing *Maticka*).

402. See, e.g., *Williams v. Department of Human Servs.*, 116 N.J. 10, 16, 561 A.2d 244, 251 (1989) (interpreting the state's General Assistance (GA) law, N.J. STAT. ANN. §§ 44:8-107-44:8-152 (West 1989), to impose a continuing obligation to provide shelter to GA-eligible individuals). Consequently, the *Williams* court ordered a remand to the state Office of Administrative Law for further clarification. *Id.* at 256. On February 2, 1990, the Office of Administrative Law found that the State Department of Human Services had failed to communicate clearly to municipal welfare departments their continuing obligation to provide such shelter to GA-eligible individuals after the initial five month period of emergency assistance had expired. *Williams v. Department of Human Servs.*, No. HPW 38-90, slip op. at 3 (N.J. Off. Admin. Law Feb. 9, 1990). On March 1, 1990, the Acting Commissioner of the Department of Human Services accepted that finding, and agreed to promulgate regulations to implement it. *Id.* (N.J. Dept. Hum. Servs., Mar. 1, 1990), final dec. at 4. See also *Hodge v. Ginsberg*, 303 S.E.2d 245, 250 (W. Va. 1983) (finding that a homeless person was an "incapacitated adult" under state welfare laws); *Newark Div. Pub. Welfare v. Ragin*, 197 N.J. Super. 225, 484 A.2d 716, 719 (App. Div. 1984) (finding that a homeless person could not have his welfare benefits suspended after he was discharged from work for sleeping on employment premises after hours). *But see Williams v. Barry*, 703 F.2d 789, 792 (D.C. Cir. 1983) (limiting procedural due process rights of homeless individuals prior to local government's decision to close shelters).

403. *Mixon v. Phillips*, 157 A.D.2d 423, 426, 556 N.Y.S.2d 835, 837 (1989).

404. *Heard v. Cuomo*, 142 A.D.2d 537, 539, 531 N.Y.S.2d 253, 255 (1988).

405. See *Brohim v. Holt*, N.Y.L.J., Jan. 26, 1990, at 27, col. 5 (N.Y. City Ct. 1990); *Universal Motor Lodges v. Seignious*, 146 Misc. 2d 395, 550 N.Y.S.2d 800, 804 (Just. Ct.

homeless individuals to have access to drug treatment services,⁴⁰⁶ and most controversially, the right of homeless individuals to panhandle in public facilities.⁴⁰⁷

Scholars have suggested that health planning laws be considered as sources of rights for ex-patients in the community⁴⁰⁸ and view litigation and administrative activity under these laws as an "opportunity for advocacy on behalf of the mentally ill"⁴⁰⁹ as well as part of an overall scheme to help the deinstitutionalized obtain community benefits.⁴¹⁰ They have similarly considered welfare laws as potential rights sources.⁴¹¹ Student commentators have suggested that at least two "as yet untried alternatives" might result in judicial recognition of a right to shelter for the homeless:⁴¹² (1) an *entitlement* right on the part of deinstitutionalized mental patients to state-provided shelter⁴¹³ and (2) a *tort* remedy⁴¹⁴ based on

1990) (reported in N.Y.L.J., Jan. 26, 1990, at 27, col. 5). See generally Adams, *Rulings Expand Rights of Homeless in Hotels*, N.Y.L.J. Jan. 26, 1990, at 1, col. 3 (discussing court ruling that give homeless persons due process rights when evicted).

406. Palmieri v. Cuomo, reported in N.Y.L.J., Jan. 10, 1990, at 22, col. 5 (Sup. Ct. 1990).

407. Young v. New York City Transit Auth., 903 F.2d 146, 152-53 (2d Cir. 1990) (transit authority rule prohibiting panhandling did not violate plaintiffs' first amendment rights).

On the question of the causal relationship between panhandling, deinstitutionalization, and homelessness, see Butterfield, *New Yorkers Growing Angry Over Aggressive Panhandlers*, N.Y. Times, July 29, 1988, at A1, col. 2. For other innovative litigation, see also Canady v. Koch, 598 F. Supp. 1139, 1141 (E.D.N.Y. 1984) (homeless mothers challenged the government's failure to provide lawful emergency housing) 608 F. Supp. 1460, 1463-64 (S.D.N.Y. 1985), *aff'd sub nom.* Canady v. Valentin, 768 F.2d 501, 502-03 (2d Cir. 1985) (affirming the district court's decision to abstain pending resolution of a similar state court action); Koster v. Webb, 598 F. Supp. 1134, 1137 (E.D.N.Y. 1983) (plaintiff's allegation that the state violated the Social Security Act by failing to provide emergency shelter for the homeless stated a cause of action under 42 U.S.C. § 1983).

408. Rhoden, *supra* note 17, at 434-35 (focusing upon those sections of the Social Security Act and the National Health Planning and Resources Development Act).

409. *Id.* at 434.

410. See *id.* at 436.

411. Morawetz, *Welfare Litigation to Prevent Homelessness*, 16 N.Y.U. REV. L. & SOC. CHANGE 565, 567-68 (1987-88).

412. Note, *supra* note 178, at 941.

413. *Id.* at 941-42. The author contends that, since state action deprives the mental patient "of the capacity to independently obtain even the bare essentials needed to survive—shelter and food—that he received while in a state mental hospital," the government is responsible to him after release. *Id.* at 974.

414. *Id.* at 942. Courts, however, have not been receptive to such tort claims. See, e.g., Klostermann v. Cuomo, 126 Misc.2d 247, 481 N.Y.S.2d 580, 585 (Sup. Ct. 1984) (refusing to find a common law duty to protect state hospital patients from reasonably foreseeable harm).

the twin theories that the "treatment" which hospitalized patients received prior to deinstitutionalization "aggravated, if not caused, the present inability of the homeless to care for themselves,"⁴¹⁵ and that in many situations, such discharge "was premature, contrary to sound medical judgment and accomplished without inquiry into the ability of individual patients to contend with conditions outside the institution."⁴¹⁶ Others have argued that the fundamental right of families to "remain intact" creates a derivative right to shelter for homeless families.⁴¹⁷ Also, state constitutional provisions have been considered as another source of emergency shelter rights.⁴¹⁸

Other advocates have turned to fair housing laws as a source of rights for the homeless and the mentally ill,⁴¹⁹ while others have focused on the potential importance of National Health Insurance.⁴²⁰ Still others have weighed alternative state statutory and common-law strategies in support of community treatment alternatives.⁴²¹ Finally, some advocates have stressed the importance of

415. Note, *supra* note 178, at 984.

416. *Id.* Each of these theories poses serious difficulties. First, in recent terms, the Supreme Court has not indicated a great receptivity toward any efforts to expand entitlement theories in community settings. See *Youngberg v. Romeo*, 457 U.S. 307, 317 (1982); see also 2 M. PERLIN *supra* note 11, § 7.03, at 569 (discussing *Youngberg*). Second, the Court's recent expansion of the doctrine of immunity from damages in suits brought pursuant to 42 U.S.C. § 1983 against mental health care providers working in public settings inevitably will have a chilling effect on future filings. See *Youngberg*, 475 U.S. at 323. But see *Zinerman v. Burch*, 110 S. Ct. 975 (1990); refer also to text accompanying notes 318-23 *supra* for a discussion of *Zinerman*.

Finally, the premature discharge argument flies in the face of much of the deinstitutionalization litigation which has been brought in recent years. See 2 M. PERLIN, *supra* note 11, §§ 7.02-7.09, at 560-603. While there is no reason to expect a uniform doctrinal consistency on the part of lawyers bringing cases on behalf of ex-patients, it is likely that the premature discharge theory will be employed only episodically. In short, none of these theories will change significantly the legal status of homeless ex-patients.

417. Note, *supra* note 44, at 190.

418. Connell, *supra* note 232, at 784-85 (discussing the enforcement of state constitutional laws as a remedy for the homeless problem). See generally Perlin, *supra* note 144, at 1249 (state constitutional law basis of rights of mentally disabled).

419. See, e.g., Milstein, Pepper & Rubenstein, *supra* note 75; Sard, Roisman & Hartman, *supra* note 61, at 106. 42 U.S.C. § 3604(f)(1)(3) (barring discrimination in sale or rental of dwellings). But see *Familystyle of St. Paul, Inc. v. City of St. Paul* 728 Supp. 1396, 1402-04 (D. Minn. 1990) (state licensing statute imposing space requirement on residential programs for mentally disabled not preempted by 1988 Fair Housing Act Amendments).

420. See Hope & Young, *supra* note 72; Marmor & Gill, *supra* note 4, at 467-69. Refer to note 253 *supra*. On an innovative, foundation-driven alternative, see Wright, *The National Health Care for the Homeless Program*, in *THE HOMELESS MENTALLY ILL*, *supra* note 15, at 150.

421. See, e.g., Bach, *supra* note 174; Silver, *supra* note 250; Note, *The Duty of Cali-*

full funding and implementation of the McKinney Act,⁴²² the first federal legislation authorizing the creation or expansion of programs designed specifically to assist the homeless.⁴²³ Many of these various solutions share a major unstated conceptual premise: the assumption that courts will be receptive to such litigation strategies.⁴²⁴ Is this assumption an example of a "fact not in evidence," or does the judiciary's track record inspire encouragement here? Our attention must next turn to this question.

VI. CONCLUSION: TWO "WILD CARDS"

Before case law and the scholarly proposals are viewed as a panacea to the social problems in question, two "wild cards" must be weighed carefully, both separately and in combination: (1) the meaning of cases such as *Pennhurst State School & Hospital v. Halderman*⁴²⁵ that have sent a clear message that the United

formia Counties to Provide Mental Health Care for the Indigent and Homeless, 25 SAN DIEGO L. REV. 197, 208-12 (1988). For a successful example of litigation based on such theories, see *Arnold v. Arizona Dep't of Health Servs.*, 160 Ariz. 543, 775 P.2d 521, 538 (1989); refer also to discussion of the case in note 397 *supra*.

422. See 42 U.S.C. § 11361 (1988).

423. See, e.g., Spector, *Finding a Federal Forum: Using the Stewart B. McKinney Homeless Assistance Act to Circumvent Federal Abstention Doctrines*, 6 L. & INEQUAL. 273, 280-81 (1988); O'Connor, *Homeless: A Local View of the McKinney Act*, 23 CLEARINGHOUSE REV. 116, 117, 121-22 (1989). For a model emergency shelter statute, see Evans, *Federal Emergency Shelter Assistance to the Homeless: Mandating a Standard of Decency*, 4 NOTRE DAME J.L., ETH. & PUB. POL'Y 325 (1989). For a consideration of state legislation, see Note, *Hunger and Homelessness in America: A Survey of State Legislation*, 66 DENV. U.L. REV. 277, 283-87 (1989). For a consideration of a British counterpart, see Collin & Barry, *supra* note 182, at 425-28. Cf. Note, *supra* note 21, at 564-70 (urging Congress to pass federal legislation to establish a "uniform, minimum level of care for the homeless").

424. This recitation of scholarly and litigative creativity should not lead the reader to assume that either public interest lawyers or legal scholars are somehow personally immune from bias and the power of heuristics. Cf. Jackson, *Psychiatric Decision-making For the Courts: Judges, Psychiatrists, Lay People?*, 9 INT'L J.L. & PSYCHIATRY 507, 511-16 (1986) (psychiatric decision makers may be as susceptible to heuristic biases as lay persons); Jackson, *The Clinical Assessment and Prediction of Violent Behavior: Toward a Scientific Analysis*, 16 CRIM. JUST. & BEHAV. 114, 124-27 (1989) (recognizing that mental health practitioners are no less likely to be swayed by heuristic biases than lay persons); C. WEBSTER, R. MENZIES & M. JACKSON, *CLINICAL ASSESSMENTS BEFORE TRIAL* 121 (1983). The record seems clear that factual education alone is not enough. See Poythress, *Psychiatric Expertise in Civil Commitment: Training Attorneys to Cope With Expert Testimony*, 2 L. & HUM. BEHAV. 1, 15 (1978) ("trained" attorneys' courtroom behavior not materially different from that of "untrained" attorneys in cases involving psychiatric testimony where attitudes of "trained" attorneys toward their clients remained unchanged).

425. 465 U.S. 89, 106-12 (1984) (greatly expanding the states' eleventh amendment immunity from suit in cases involving the right of institutionalized mentally retarded individuals to community treatment); see also, Rudenstine, *Pennhurst and the Scope of Fed-*

States Supreme Court will be more sympathetic to *majoritarian* rather than *minoritarian* claims in civil rights cases involving similarly disenfranchised groups,⁴²⁶ and (2) the depth of the hostility on the public's part toward the individuals in question.⁴²⁷

A. Court Hostility

The United States Supreme Court's undisguised hostility⁴²⁸ in cases such as *Pennhurst* has had a clear "trickle-down" effect. Federal intermediate appellate courts have grown increasingly more hostile to the sort of creative litigation suggested as palliatives for the current crisis involving homeless mentally ill individuals.⁴²⁹ The federal courts see the Constitution increasingly "through the eyes of mainline America," through means that are "insensitive or at least unempathetic to those most in need of its protection."⁴³⁰ Judges appear to endorse the implicit existence of a

eral Judicial Power to Reform Social Institutions, 6 CARDOZO L. REV. 71, 76 (1984) (arguing that a majority of the Court wants to limit the federal courts' power to vindicate federal rights in cases involving social institutions).

426. See Perlin, *supra* note 144, at 1258-59 ("the significance of the *Pennhurst* line of cases lies in the undeniable fact that, at least until there is a significant restructuring of the Supreme Court, the terrain of federal courts will prove to be far more hostile to suits brought on behalf of the mentally disabled than it was a decade ago"). Compare *Facade*, *supra* note 113, with Chayes, *supra* note 210, at 1308 ("One must ask whether democratic theory really requires deference to majoritarian outcomes whose victims are . . . inmates of mental institutions . . .").

427. See, e.g., Note, *supra* note 421, at 352 ("There seems little sense in changing the standard for involuntary civil commitment unless changes in the system are accompanied by changes in societal attitudes . . .").

428. See, e.g., *Washington v. Harper*, 110 S. Ct. 1028, 1036-37 (1990) (state administrative procedures satisfy due process requirements in cases involving convicted prisoners wishing to refuse the administration of antipsychotic drugs). But see *Zinerman v. Burch*, 110 S. Ct. 975, 983 (1990) (voluntary patient could maintain § 1983 action in which he alleged hospital officials should have known he was incompetent to seek admission). Refer to notes 313-18 *supra* and accompanying text.

429. See *Valley Forge Christian College v. Americans United for Separation of Church and State*, 454 U.S. 464, 487 (1982) (illustrating the Court's hostility to public interest lawyers: "The Federal courts were simply not constituted as ombudsmen of the general welfare"). Cf. *Philadelphia Police & Fire Ass'n v. City of Philadelphia*, 874 F.2d 156, 159 (3d Cir.), *enforced*, 705 F. Supp. 1103 (E.D. Pa. 1989); *United States v. Charters*, 829 F.2d 479, 493-94 (4th Cir. 1987) *vacated en banc*, 863 F.2d 302 (4th Cir. 1988), *cert. denied*, 110 S. Ct. 1317. Refer to notes 238 and 392 *supra*.

On the renaissance of the "hands off" doctrine in institutional litigation, see Caszak, *Hearing the Cries of Prisoners: The Third Circuit's Treatment of Prisoners Rights Litigation*, 19 SETON HALL 526, 531-34 (1989).

430. Stone, *O.T. 1983 and the Era of Aggressive Majoritarianism: A Court in Transition*, 19 GA. L. REV. 15, 19, 22 (1984).

"community tolerance threshold"⁴³¹ frequently consonant with the imposition of their own psychological, social, economic, or moral preconceptions.⁴³² Heuristically-driven social attitudes reject attempts at reasoned discourse. The courts mimic public figures and the media by taking refuge in distorted stereotypes, with rhetoric substituting for meaningful debate.⁴³³ This final question of competency—the competency of the judicial system to change deep-seated social attitudes⁴³⁴—remains the insoluble dilemma.

B. *The Depth of Social Attitudes*

In *City of Cleburne v. Cleburne Living Center*,⁴³⁵ the United States Supreme Court rejected the city's argument that the "negative attitudes" of neighbors and nearby property owners sanctioned a local zoning ordinance which excluded group homes for the retarded.⁴³⁶ The Court stated, "'private biases may be outside the reach of the law, but the law cannot directly or indirectly give them effect.'"⁴³⁷

As laudable as this aspiration might be,⁴³⁸ our treatment of the deinstitutionalized and the homeless does not clearly fit within this ban. It is our social attitudes—attitudes born in bias, honed by the thoughtless acceptance of stereotypes, and perpetuated by the cognitive error of heuristics—that resonate in the discourse on the homeless mentally ill. We focus on the mentally ill and thus

431. Boehmert, *Psychological and Demographic Factors Associated With Individuals Using the Insanity Defense*, 13 J. PSYCHIATRY & L.Q. 27, 28 (1985); Perlin, *supra* note 261, at 704-06 (discussing use of this standard in insanity defense decisionmaking).

432. Finer, Gates, Leon, and the *Compromise of Adjudicative Fairness (Part II): Of Aggressive Majoritarianism, Willful Deafness, and the New Exception to the Exclusionary Rule*, 34 CLEV. ST. L. REV. 199, 205-06 (1986).

433. Cf. *Psychodynamics*, *supra* note 113, at 61-69 (considering Chief Justice Rehnquist's treatment of cases involving mentally disabled criminal defendants in this context).

434. Cf. *Facade*, *supra* note 113, at 999-1000 (considering this question in the context of the insanity defense); Perlin, *supra* note 261, at 713-30 (considering this question in the context of the insanity defense).

435. 473 U.S. 432 (1985).

436. *Id.* at 448.

437. *Id.* (quoting, *Palmore v. Sidoti*, 466 U.S. 429, 433 (1984)).

438. See P. Margulies, *Pursuit of a Mirage: Equitable Interpretation, Legislative Intent and the Legal Process* (unpublished manuscript) (classifying certain laws as "aspirational," and counseling that courts try to construe the purpose of such laws as consistent with a "best view of social and political transformation"). See generally *State v. Hoyt*, 21 Wis. 2d 284, 291, 128 N.W.2d 645, 652 (1964) (Willkie, J., concurring) (discussing aspirational component of law).

perpetuate the stereotype that the homeless are all "insane."⁴³⁹ By doing so, we perpetuate the perception that we are "doing something" about the problem.⁴⁴⁰ By perpetuating this stereotype, we can avoid examining the fundamental economic and social questions underlying homelessness and look, instead, for easy targets to blame. Who better to criticize than the patients' rights lawyers originally responsible for the litigation strategies developed in response to the United States Supreme Court's tardy acknowledgment that the due process clause applies to the institutionalized mentally ill?⁴⁴¹

Our "sanist" attitudes, reinforced by political⁴⁴² and media distortions,⁴⁴³ are shaped by the heuristic fallacies of thinking through which vivid individual cases overwhelm our ability to rationally consider social data. It is not coincidental that the power of heuristics is especially potent in dealing with populations as rife with symbolic ideation as the mentally ill; the previously hospitalized mentally ill; and the poor, minority, previously hospitalized mentally ill. We attribute our social woes to pathology, to activist courts, and to "radical" lawyers. We wilfully blind ourselves to the underlying social and economic problems. We ignore the role of economic greed in the transformation of our urban areas, the significance of "bile barrel" politics,⁴⁴⁴ and the depth of the "pathology of oppression" that drives much of our social and political policies. Without a significant and dramatic change in our social attitudes, the "glimmer of hope" presented by innovative law reform strategies may be nothing more than an illusion.

Dr. Rene Jahiel, professor of medicine at New York University Medical School, pulls no punches in his indictment of our failings: "The current situation of homelessness in our social order is—brutally stated—that a significant part of the population is becoming very affluent at the expense of another significant part of the population made up of its most vulnerable members who are

439. See McKittrick, *supra* note 267, at 428.

440. Durham, *supra* note 72, at 128.

441. See *Jackson v. Indiana*, 406 U.S. 715, 731-39 (1972).

442. See Kaufman, *supra* note 272, at 363 (politically astute public officials argue for broad commitment standards so as to create a perception that the mentally ill are being helped and that the general public is being sheltered from the socially undesirable).

443. See *id.* at 363-64 (discussing media perpetuation of stereotypes that encourage blaming the mentally ill and homeless for their condition).

444. See Marmor & Gill, *supra* note 4, at 467 (discussing how burdens of deinstitutionalization are concentrated while benefits are dispersed).

forced into malignant homelessness."⁴⁴⁵

Not coincidentally, the Heritage Foundation, one of the Reagan Administration's most favored policy "think tanks," recently stated flatly that "deinstitutionalization . . . is the major cause of homelessness."⁴⁴⁶ A more cogent argument is that considerable blame for this social catastrophe must rest at the feet of Ronald Reagan, Reaganomics, and the legacy of a "malfeasant" Reagan Administration that "hollow[ed] out . . . the federal government" ⁴⁴⁷ Indeed, the Reagan era helped create a social and economic environment in which "large-scale innovation for the socially disfavored [became] practically unthinkable."⁴⁴⁸

Goldman and Morrissey state flatly, "[p]ublic attitudes . . . must change if there is to be progress."⁴⁴⁹ By "medicaliz[ing]"⁴⁵⁰ the problem of homelessness, we reify public images and simultaneously confirm and assuage public fears. Our "hydraulic"⁴⁵¹ response is doomed to failure. Five years after *Cleburne*, the "insidious obstacle" of exclusionary zoning laws⁴⁵² remains a nearly insurmountable barrier to the development of successful community alternatives for former residents of state mental institutions.⁴⁵³ In short, even if the United States Supreme Court de-

445. Jahiel, *supra* note 6, at 115.

446. *STEMMING THE TIDE*, *supra* note 75, at 26 (emphasis added).

447. Hollings, *supra* note 85, at C1, col. 4.

448. Marmor & Gill, *supra* note 4, at 474.

449. Goldman & Morrissey, *supra* note 110, at 730.

450. See Durham & La Fond, *supra* note 232, at 306-07 n.9 (stating that no one has documented any reliable evidence that deinstitutionalization or mental illness is a major cause of homelessness).

451. Durham, *supra* note 72, at 129. Refer to note 243 *supra*.

452. Kanter, *supra* note 72, at 346.

453. See *id.* For a sampling of representative litigation decided in the past two years, see *Mehta v. Surles*, 720 F. Supp. 324, 332-33 (S.D.N.Y. 1989) (dismissing suit by landowners who shared common driveway with premises selected as community residence for mentally disabled persons alleging unconstitutional taking without due compensation), *aff'd in part, vacated in part*, 905 F.2d 595 (2d. Cir. 1990); *Westwood Homeowners Ass'n v. Tenhoff*, 155 Ariz. 229, 745 P.2d 976, 981-84 (Ct. App. 1987) (restrictive covenant found to be contrary to policy of Arizona Developmental Disabilities Act); *Overlook Farms Home Ass'n v. Alternate Living Serv.*, 143 Wis. 2d 485, 422 N.W.2d 131, 133-34 (Ct. App. 1988) (upheld as constitutional a group home statute that expressly voided restrictive covenants and local zoning ordinances); see also *Frick v. Patrick*, 165 Mich. App. 689, 419 N.W.2d 55, 58-9 (1988) (refusing to recognize a mentally handicapped individual as a third party beneficiary of a lease agreement between the state and property owners); *Step-By-Step, Inc. v. Zoning Hearing Bd.*, 117 Pa. Commw. 547, 549, 543 A.2d 1293, 1295 (1988) (permitting a group home not qualifying for residential single-family status to locate in a residential district, so long as owner obtained proper special use permits).

clared a broad-based constitutional right to shelter and even if accessible, voluntary community mental health services were made available to all mentally ill homeless individuals, the problems we face probably would not disappear.

So, the questions must be recast: Are the *courts* competent to stem this tide? Is that the proper role of courts? Does the public insist on a majoritarian judiciary in the face of its increasing frustration with social policies that it perceives to be an abject failure? Can public attitudes be changed? To what extent can the judiciary deal with the problems spawned by the economic greed that has so contributed to the underlying social problems?⁴⁵⁴ These questions are especially important in light of the remarkable role the judiciary has played for the past two decades in all aspects of the politics of the American mental health system.⁴⁵⁵

There is a stunning degree of cognitive dissonance in the case law. On the one hand, there are the broad-based, institutional reform/public-law decisions such as *Wyatt v. Stickney*⁴⁵⁶ and *Rennie v. Klein*,⁴⁵⁷ and civil libertarian, commitment-standard-narrowing decisions such as *O'Connor v. Donaldson*⁴⁵⁸ and *Lessard v. Schmidt*,⁴⁵⁹ on the other, there are the jurisdiction-narrowing opinions by the United States Supreme Court such as *Pennhurst*,⁴⁶⁰ which evince hostility to both public interest lawyers and their cli-

454. See Jahiel, *supra* note 6, at 115 (discussing the importance of shifting emphasis toward prevention of homelessness and rehabilitation of the homeless).

[We must take] a firm stand against greed. The greed of developers must be overcome . . . Greed of business must be overcome . . . Greed at the labor union-management bargaining table must be overcome . . . Greed of industries dealing with the government . . . should be overcome . . . ; finally, the greed of the average citizen should be overcome, to make room for social support for the disabled and elderly, and to provide a more accessible health care system.

Id. Cf. Karmel, *A Decade of Greed*, N.Y.L.J. Dec. 20, 1990, at 3 (discussing the Reagan Administration's policies and greed in the securities industry).

455. See generally Marmor & Gill, *supra* note 4, at 469-71 (demonstrating that the judiciary exerts considerable influence over mental health practices).

456. 325 F. Supp. 781 (M.D. Ala. 1971), 334 F. Supp. 1341 (M.D. Ala.), 344 F. Supp. 373 (M.D. Ala. 1972), 344 F. Supp. 387 (M.D. Ala.), *aff'd sub nom.* *Wyatt v. Aderholt*, 503 F.2d 1305 (5th Cir. 1974). Refer to text accompanying note 147 *supra*.

457. 462 F. Supp. 1294 (D.N.J. 1978), *supplemented*, 476 F. Supp. 1131 (D.N.J. 1979), *modified*, 653 F.2d 836 (3d Cir. 1981), *vacated*, 458 U.S. 1119 (1982) *on remand*, 720 F.2d 266 (3d Cir. 1983). Refer to text accompanying note 239 *supra*.

458. 422 U.S. 563 (1975). Refer to text accompanying note 137 *supra*.

459. 349 F. Supp. 1078 (E.D. Wis. 1972), *vacated*, 414 U.S. 473, *on remand*, 379 F. Supp. 1376 (E.D. Wis. 1974), *vacated*, 421 U.S. 957 (1975), *on remand*, 413 F. Supp. 1318 (E.D. Wis. 1976). Refer to text accompanying note 138 *supra*.

460. 451 U.S. 1 (1981). Refer to text accompanying note 214 *supra*.

ents. The latter both sanction and encourage the type of "ordinary justice" meted out in local courts, as reflected in the chilling statistic that the average *contested* civil commitment hearing lasts less than ten minutes.⁴⁶¹

Moral suasion may not be enough.⁴⁶² It is, however, the first step that we all must take.⁴⁶³ We must "unpack" the broad, stereotypical presentations of vivid, heuristic evidence. We must consider, carefully and soberly, the underlying social dislocations; the malignancy of greed; the dominant social, racial, ethnic, and class-based prejudices; the "pathology of oppression" exemplified by "sanism"; and the degree to which we are willing coconspirators in the re-marginalization of the already-marginalized. We must do this consciously and openly if we are to afford the homeless any "measure of dignity,"⁴⁶⁴ and if we are to have any chance to succeed in stemming the shameful tide that threatens to sweep away our nation's cities.

461. Cf. *Parham v. J.R.*, 442 U.S. 584, 609 n.17 (1979) (a number of studies conclude that the average time for commitment hearings is less than ten minutes).

462. See Jahiel, *supra* note 6, at 115. For moral suasion to be effective, it must operate in a setting in which the actors can somehow rid themselves of the type of belief perseverance that flows from heuristic thinking; see, e.g., R. NISBETT & L. ROSS, *HUMAN INFERENCES: STRATEGIES AND SHORTCOMINGS OF SOCIAL JUDGMENT* 169-88, 273-96 (1980) (weighing strategies to cope with the irrationality of such devices).

463. Cf. King, *supra* note 5, at 167. ("American politics needs nothing so much as an injection of the idealism, self-sacrifice and sense of public service which is the hallmark of our movement [O]thers must move out into political life as candidates and infuse it with their humanity, their honesty and their vision.")

464. *In re Rulemaking*, N.J.A.C. 10:82-1, 117 N.J. 311, 314, 566 A.2d 1154, 1155 (1989).