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HOMELESS MENTALLY ILL PEOPLE: NO LONGER OUT OF SIGHT AND OUT OF MIND

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INTRODUCTION

People have been living on the streets of our cities since the nation began. Yet more people in the United States are homeless now than at any time since the Great Depression.¹ The estimated number of homeless people vary widely, ranging anywhere from a low of 250,000² to as many as three million,³ and growing⁴ despite recent alleged improvement in the economy.⁵ Further, no longer are they predominantly middle-aged single men suffering from alcoholism.⁶ Today's homeless are a heterogeneous group—younger and including many more women, chil-

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1. K. HOPPER AND J. HAMBERG, *THE MAKING OF AMERICA'S HOMELESS: FROM SKID ROW TO NEW POOR, 1945-1984*, at 9 (1984).

2. U.S. DEPT. OF HOUSING & URB. DEV., *A REPORT TO THE SECRETARY ON THE HOMELESS AND EMERGENCY SHELTERS 18-19* (1984). HUD's estimate of 250,000-350,000 homeless is widely considered conservative and has been criticized as based on inadequate study resulting in a distortion of the numbers of homeless people as well as the nature of homelessness. *HUD Report on Homelessness: Joint Hearing on S. 98-91 Before the Subcomm. on Housing and Community Dev. and the Subcomm. on Manpower & Housing of the House Comm. on Govt. Operations, 98th Cong., 2nd Sess.* 25 (1984).

3. M. HOMBS AND M. SYNDER, *HOMELESSNESS IN AMERICA: A FORCED MARCH TO NOWHERE* vi (1982), (available from the Community for Creative Nonviolence, Washington, D.C. 20009).

4. REPORT OF THE U.S. GENERAL ACCOUNTING OFFICE, *HOMELESSNESS: A COMPLEX PROBLEM AND THE FEDERAL RESPONSE* 10 (1985) [hereinafter "GAO REPORT"].

5. HOUSE COMM. ON GOVERNMENT OPERATIONS, *THE FEDERAL RESPONSE TO THE HOMELESS CRISIS*, H.R. REP. NO. 47, 99th Cong., 1st Sess. 7 (1985) [hereinafter "HOUSE REPORT ON HOMELESS CRISIS"]; U.S. CONFERENCE OF MAYORS, *THE GROWTH OF HUNGER, HOMELESSNESS AND POVERTY IN AMERICA'S CITIES IN 1985: A 25 CITY SURVEY* 24-26 (1986) [hereinafter "1986 U.S. CONFERENCE OF MAYORS REPORT"]; U.S. CONFERENCE OF MAYORS, *STATUS REPORT: EMERGENCY FOOD, SHELTER AND ENERGY PROGRAMS IN 20 CITIES* 1-2 (1984).

6. See Strauss, *Alcohol and the Homeless Man*, 7 Q. J. STUDY OF ALCOHOL 260 (1946); Meyerson and Meyer, *Origins, Treatment and Testing of Skidrow Alcoholic Men*, 275 N. ENG. J. MED. 419 (1966).

dren and families.⁷ Moreover, they are no longer confined to urban areas. Smaller cities,⁸ rural areas⁹ and even affluent suburbs,¹⁰ perhaps for the first time in their history, are forced to confront the problem of homelessness.

The causes of homelessness have also expanded. Recent studies typically cite several factors contributing to the explosive increase in the number of homeless people: insufficient low-cost housing,¹¹ unemployment,¹² cuts in federal income-assistance, nutrition and job programs,¹³ personal crises¹⁴ and recently added to the list of causes, deinstitutionalization—the policy that led to the release of many patients from mental hospitals.¹⁵

This article will discuss the extent to which deinstitutionalization may have contributed to the increased homeless population. Following a review of the events leading up to deinstitutionalization, such as the landmark lawsuits that secured for patients the right to be free from unnecessary hospitalization, the article will explore obstacles to the establishment of comprehensive services, including housing, for people who are mentally ill and homeless. The article will then review current litigation efforts that seek to establish the right to services in the community for people in need of mental health care. Finally, it will ex-

7. GAO REPORT, *supra* note 4, at 13; 1986 U.S. CONFERENCE OF MAYORS REPORT, *supra* note 5, at 15-16.

8. M. CUOMO, 1933/1983-NEVER AGAIN-A REPORT FOR THE NATIONAL GOVERNORS ASSOCIATION TASK FORCE (1983) [hereinafter "NGA REPORT"].

9. *Homelessness in America: Hearings Before the Subcomm. on Housing and Community Development, House Comm. on Banking, Finance and Urban Affairs*, 98th Cong., 1st Sess. 148 (1984).

10. *E.g.*, a recent study indicated that in Nassau County, N.Y., an affluent New York City suburb, there are thousands of homeless men, women and children. ENZER, REPORT TO THE NASSAU ACTION COALITION (1983).

11. *E.g.*, E. BAXTER AND K. HOPPER, PRIVATE LIVES/PUBLIC SPACES: HOMELESS ADULTS ON THE STREETS OF NEW YORK CITY 31-32 (1981); NGA REPORT, *supra* note 8, at 36-40; GAO REPORT, *supra* note 4, at 24-27; 1986 U.S. CONFERENCE OF MAYORS REPORT, *supra* note 5, at 19-20.

12. U.S. CONFERENCE OF MAYORS REPORT, HOMELESSNESS IN AMERICA'S CITIES: TEN CASE STUDIES 11-21 (1984).

13. *Id.* at 6-7, 26, 30, 36; GAO REPORT, *supra* note 4, at 23-24; HOUSE REPORT ON HOMELESS CRISIS, *supra* note 5, at 15.

14. GAO REPORT, *supra* note 4, at 22-23; NGA REPORT, *supra* note 8, at 41-44.

15. 1986 U.S. CONFERENCE OF MAYORS REPORT, *supra* note 5, at 17. *See also* THE HOMELESS MENTALLY ILL: A TASK FORCE REPORT OF THE AMERICAN PSYCHIATRIC ASSOCIATION 15 (H.R. Lamb, ed. 1984); Bassuk, Rubin, and Lauriat, *Is Homelessness A Mental Health Problem?*, 141 AM. J. PSYCHIATRY 1546 (1984).

amine possible solutions to these problems.

I. DEINSTITUTIONALIZATION

Deinstitutionalization is a philosophy, a process and a fact.¹⁶ As a philosophy, it reflects a liberal humanitarian ideology committed to community-based care for people suffering from mental illness. As a process, it refers to the release of patients from state mental hospitals and the corresponding development of services in the community. As a fact, it is considered synonymous with the dramatic reduction in the daily census of state hospitals.¹⁷

As many as 30 percent of the current homeless population may be mentally disabled—many of them the victims of the incompletely executed deinstitutionalization policy of the past 20 years.¹⁸ Certainly homelessness and psychiatric illness interact. Unresolved psychiatric problems may result in homelessness. Conversely, homelessness may provoke or exacerbate symptoms of mental illness. Yet despite this growing body of literature on the prevalence of psychiatric illness among the homeless, most of it is anecdotal, based on personal impressions, not scientific inquiry. Nevertheless, some critics now see an easy solution to the problems of mentally ill people who are homeless: declare deinstitutionalization an outdated failure and return homeless people who are mentally ill or considered troublesome to mental hospitals. Yet, returning people to mental hospitals is not a solution for reasons discussed below.

Before beginning to assess the relationship, if any, between homelessness and deinstitutionalization, however, it is essential to understand the confluence of factors that contributed to adoption of deinstitutionalization as a national policy.

16. Bachrach, *A Conceptual Approach to Deinstitutionalization*, 29 *HOSP. AND COMMUNITY PSYCHIATRY* 573-78 (1978).

17. Goldman, Adams and Taube, *Deinstitutionalization: The Data Demythologized*, 34 *HOSP. AND COMMUNITY PSYCHIATRY* 129 (1983).

18. According to a 1986 report, an average of 33% of homeless people are mentally ill, ranging from 6% in Yonkers, N.Y., to 60% in Denver, Colo. 1986 U.S. CONFERENCE OF MAYORS REPORT, *supra* note 5, at 16.

A. Historical Trends in Institutional Care

Historically, mentally ill people have been subjected to derision, unequal treatment under the law, segregation and even abuse.¹⁹ Since the days of Colonial America, mentally ill people and people falsely labeled as mentally ill have been convenient scapegoats for public prejudices and fears.²⁰ Their condition had been variously ascribed to moral defect, disease, dereliction or evil spirits and they have been treated as undesirables, criminals or both.²¹

In the early 19th Century, for example, those once called social deviants were instead labeled "insane" and confined in jails and almshouses.²² The squalid and unsanitary conditions of these facilities led reformers such as Dorothea Dix (1802-1887) to regard mentally ill people not as delinquents, but as the unfortunate victims of society. She went from state to state investigating the conditions of the "insane" in poor houses, jails and other institutions. As a result of her work and the work of others, public attention was drawn to the plight of people with mental illness. Dix is credited with the creation of some 30 asylums, and, by the time of the Civil War, 28 of the nation's 33 states had established mental hospitals.

As interest in the nature and causes of behavior grew among the public, it grew among the medical community as well. "Concepts of illness replaced concepts of social deviance: medical treatment became the new rationale for institutionalization."²³ Accordingly, "moral treatment" became popularized based on the "belief that man could be perfected by manipulating his social and physical environment."²⁴

19. See E. BEIS, *MENTAL HEALTH AND THE LAW* 3-6 (1984); see generally A. DEUTSCH, *THE MENTALLY ILL IN AMERICA: A HISTORY OF THEIR CARE AND TREATMENT FROM COLONIAL TIMES* (2d ed. 1949).

20. *Id.*

21. U.S. COMMISSION ON CIVIL RIGHTS, *ACCOMODATING THE SPECTRUM OF INDIVIDUAL ABILITIES* 18 (Sept. 1983).

22. A. DEUTSCH, *supra* note 19 at 129.

23. Bassuk & Gerson, *Deinstitutionalization and Mental Health Services*, 238 *SCI. AM.* 46-47 (1978). See also P. BROWN, *THE TRANSFER OF CARE* 27-29 (1985); D. ROTHMAN, *CONSCIENCE AND CONVENIENCE: THE ASYLUM AND ITS ALTERNATIVES IN PROGRESSIVE AMERICA* 293-317 (1980).

24. Morrisey & Goldman, *Cycles of Reform in the Care of the Chronically Mentally Ill*, 35 *HOSP. AND COMMUNITY PSYCHIATRY* 785-86 (1984).

These therapeutic objectives were defeated, however, by inadequate public funding and an increasing demand for segregation of deviants to "protect society." Institutional care seemed too expensive in terms of the results achieved, and state legislators began to cut funding for institutions.²⁵ Just like the almshouses before them, asylums became large, custodial warehouses -depositories for the mentally ill and others whom society preferred to keep out of sight and out of mind.²⁶

The inhumane conditions in these institutions were eventually documented and made known to the public by journalists such as Albert Deutsch²⁷ and Erving Goffman.²⁸ Sociological studies of the 1950s and 1960s also revealed that state-run institutions, rather than offering a therapeutic environment, were dehumanizing warehouses of abused and neglected people.²⁹ While such exposés heightened public awareness, they produced no real reform. In 1958, the president of the American Psychological Association referred to mental hospitals as "bankrupt beyond remedy."³⁰ However, the exposure did lead, in 1946, to the enactment of the National Mental Health Act, which established the National Institute of Mental Health to study the causes of mental illness and to develop methods for prevention.³¹ The Joint Commission on Mental Illness and Health was also formed in those years, and in 1961 the Commission recommended improving conditions in state hospitals and developing community alternatives to state hospitals.³²

25. D. ROTHMAN, *THE DISCOVERY OF THE ASYLUM* 132 (1971).

26. See P. BROWN, *supra* note 23 at 28.

27. A. DEUTSCH, *THE SHAME OF THE STATES* (1948) and A. DEUTSCH, *THE MENTALLY ILL IN AMERICA* (1948).

28. E. GOFFMAN, *ASYLUMS* (1961).

29. *Id.* at 12-74.

30. Statement of Harry Solomon, *quoted in* Robitscher, *Implementing the Rights of the Mentally Disabled: Judicial, Legislative and Psychiatric Action*, *MEDICAL, MORAL AND LEGAL ISSUES IN MENTAL HEALTH* 145, 146 (F. Ayd ed. 1975).

31. National Mental Health Act, ch. 538, § 2, 60 Stat. 421 (1946); 42 U.S.C. §§ 201, 209, 210, 215, 218, 232, 241, 242(a), 246 (1983).

32. The U.S. Joint Commission on Mental Illness and Health was a quasi-governmental, interdisciplinary body, formed by the American Psychological Association and the American Medical Association's Council on Mental Health. Its mandate was to assess the nation's mental health needs and develop methods of meeting those needs. Its recommendations were published in 1961 in a final report entitled *ACTION FOR MENTAL HEALTH*.

B. Psychotropic Drugs

At the same time as public attention was drawn to the deplorable conditions of mental hospitals, World War II stimulated new thinking about alternatives to institutional care. Many draftees were rejected for psychiatric reasons and many more returned home in need of psychiatric treatment.³³ During the 1950s, the use of psychotropic medication began to stabilize the symptoms of many mentally ill people, and initially the newly discovered drugs were thought to cure schizophrenia.³⁴ As a result, veterans hospitals, followed by state hospitals, began releasing great numbers of patients. These patients were sent out into an unprepared and suspicious community with a medication regimen to help them cope, but not much more. Little planning for their discharge was done, and little support was provided to help them find a place to live, or to learn to adjust to the pressures of day-to-day life "outside", or to find jobs or rehabilitation training. The outcome was predictable (if unforeseen): many released patients simply fell through the "cracks" to land on the street. As a result, a disproportionate number of veterans swelled the population on cities' skid rows in the 1950s and 1960s.³⁵

33. Talbott, *Twentieth Century Developments in American Psychiatry*, 54 *PSYCHIATRIC Q.* 207 (1982).

34. Since the introduction of psychotropic medication, researchers have now established that although these drugs may be quite effective in controlling certain symptoms of schizophrenia (such as delusional thinking and certain hallucinations), they are totally ineffective in controlling other symptoms (such as withdrawal and apathy). It has also been discovered that these medications have serious side effects which may, if untreated, cause permanent damage or death. See Brown and Kocsis, *Sudden Death and Antipsychotic Drugs*, 35 *HOSP. & COMMUNITY PSYCHIATRY* 486 (1984). See generally *PSYCHOPHARMACOLOGY, FROM THEORY TO PRACTICE* (J. BARCHAS, P. BERGER, R. CIARANELLO, G. ELLIOT eds. 1977).

35. To a great extent this policy has continued. Between 1963 and 1981, the Veterans Administration reduced the number of its psychiatric beds nationwide from 59,000 to 28,500; a decrease of over 50%. Partly as a result of this policy, homeless men have continued to include a high proportion of veterans over the years. In San Francisco, for example, it is estimated that 30% of homeless men are veterans. See Hope and Young, *From Backward to Back Alleys: Deinstitutionalization and the Homeless*, 17 *URB. & SOC. CHANGE REV.* 7 (1983).

C. Funding Incentives

Federal funding incentives also accelerated deinstitutionalization. Until 1963, fiscal responsibility for psychiatric patients rested solely with the state. In 1963, as a result of humanitarian and fiscal concerns, Congress responded to President Kennedy's proposal of the Joint Commission Report by enacting the Mental Retardation Facilities and Community Mental Health Centers Construction Act.³⁶ For the first time, the federal government assumed part of the financial responsibility for providing mental health care to people outside of hospitals by providing grants for the initial costs of staffing newly constructed community mental health centers (CMHCs). Under the Act, CMHCs were eligible to receive federal funding if they offered certain services, including inpatient care, outpatient care, emergency services, partial hospitalization, consultation and education. The Act envisioned a nationwide network of CMHCs providing comprehensive services and individual case management for areas of 75,000-200,000 people. It also urged coordination between federal, state and local health planning agencies, welfare departments and urban renewal agencies.³⁷ Yet of the 2,500 CMHCs anticipated in the Act, fewer than 700 have been built, serving less than half of the nation.³⁸

D. Litigation

The final factor which contributed to the policy of releasing large numbers of patients from mental hospitals was litigation. Inspired by the successes of the civil rights movement on behalf of black people in the 1960s, lawyers filed several inpatient lawsuits to protect and expand the rights of mentally disabled people. These civil libertarian concerns for the rights and treatment of patients in mental hospitals and retardation facilities prompted a series of landmark decisions based on novel constitutional theories. These cases established the rights of mentally ill and developmentally disabled people to treatment and pro-

36. Pub. L. No. 88-164, 77 Stat. 282 (1983), repealed by Pub. L. No. 97-35 Section 902(e)(2)(B), 95 Stat. 560 (1981).

37. See P. BROWN, *THE TRANSFER OF CARE*, *supra* note 23 at 41-42.

38. 2 TASK PANEL REPORTS SUBMITTED TO THE PRESIDENT'S COMMISSION ON MENTAL HEALTH 319 (1978).

tection from harm,³⁹ to procedural and substantive protections in the civil commitment process,⁴⁰ to protections against intrusive and hazardous procedures (such as sterilization or forced medication⁴¹), and to appropriate community services.⁴²

The first case to recognize a constitutional right to treatment of mentally disabled patients involuntarily confined in state institutions was *Wyatt v. Stickney*.⁴³ In a 1971 ruling, a district court in Alabama held, that "involuntarily committed patients unquestionably have a constitutional right to receive such individual treatment as will give each of them a realistic opportunity to be cured or improve his or her mental condition."⁴⁴ The court went on to state that "to deprive any citizen of his or her liberty upon the altruistic theory that the confinement is for humane therapeutic reasons and then fail to provide adequate treatment violates the fundamentals of due process."⁴⁵ Accordingly, a year later, a detailed consent decree was adopted requiring compliance with specific standards on floor space, toilet doors and other living arrangements; imposing patient-staff ratios; requiring detailed individual treatment plans within 48 hours of admission; prohibiting excessive medication and the use of medication as a punishment or for staff convenience or as a substitute for programs; requiring that work done by patients be voluntary and compensated at the minimum wage; restricting

39. *New York State Ass'n for Retarded Children v. Carey*, 393 F. Supp. 715 (E.D.N.Y. 1975); *Wyatt v. Stickney*, 325 F. Supp. 781 (M.D. Ala. 1971), 334 F. Supp. 1341 (M.D. Ala. 1971), 344 F. Supp. 373 (M.D. Ala. 1972), 344 F. Supp. 387 (M.D. Ala. 1972), *aff'd sub nom. Wyatt v. Aderholdt*, 503 F.2d 1305 (5th Cir. 1974).

40. *O'Connor v. Donaldson*, 422 U.S. 563 (1975); *Lessard v. Schmidt*, 349 F. Supp. 1078 (E.D. Wis. 1972), *vacated* 414 U.S. 473 (1974), *modified*, 379 F. Supp. 1376 (E.D. Wis. 1974), *remanded*, 421 U.S. 957 (1975), *prior judg. reinstated*, 413 F. Supp. 1318 (E.D. Wis. 1976).

41. *Rogers v. Okin*, 478 F. Supp. 1342 (D. Mass. 1979); *Rennie v. Klein*, 462 F. Supp. 1131 (D.N.J. 1978), *aff'd*, 720 F.2d 266 (3rd Cir. 1983) (recognizing the right to refuse medication in non-emergency situations); *Wyatt v. Aderholdt*, 368 F. Supp. 1382 (M.D. Ala. 1973) (state statute authorizing involuntary sterilization of mentally disabled inmates held unconstitutional); 42 C.F.R. §§ 50.201-50.210 (prohibiting the use of federal funds for involuntary sterilization of mentally handicapped children and adults).

42. *E.g.*, *Dixon v. Weinberger*, 405 F. Supp. 974 (D.D.C. 1975).

43. *Wyatt v. Stickney*, 325 F. Supp. 781 (M.D. Ala. 1971), 334 F. Supp. 1341 (M.D. Ala. 1971), 344 F. Supp. 373 (M.D. Ala. 1972), 344 F. Supp. 387 (M.D. Ala. 1972) *aff'd sub nom.*, *Wyatt v. Aderholdt*, 503 F.2d 1305 (5th Cir. 1974).

44. *Wyatt v. Stickney*, 325 F. Supp. at 784.

45. *Id.* at 785.

physical restraint and isolation; and guaranteeing patients their right to privacy, mail, phone and visitors.

Just three years later, the Eastern District Court of New York held that institutionalized mentally retarded people are entitled to protection from harm, reasoning that they are entitled to at least as much constitutional protection as convicted criminals. The court in *New York Association for Retarded Children v. Rockefeller*⁴⁶ observed that this liberty interest encompassed protection from assaults by other residents or staff, adequate medical care, exercise and outdoor recreation and the necessary elements of personal hygiene. As a result, a detailed consent decree was adopted requiring habilitation for the voluntarily and involuntarily confined mentally retarded residents of Willowbrook Developmental Center. Between 1976 and 1982, 2,000 of Willowbrook's 5,400 residents entered living arrangements in the community that were generally safe, decent and even habilitative.⁴⁷

Most recently, in *Youngberg v. Romeo*,⁴⁸ the Supreme Court, by an 8-1 majority, ruled that a patient in a state institution for the mentally retarded has a right to "adequate food, shelter and clothing and medical care."⁴⁹ *Youngberg* also established that a mentally retarded person involuntarily committed to a state institution retains liberty interests secured by the due process clause of the fourteenth amendment in "safety and freedom from bodily restraint."⁵⁰ Those liberty interests "require the state to provide minimally adequate or reasonable training to ensure safety and freedom from undue restraint."⁵¹ In determining what training is "reasonable," the Court emphasized that "courts must show deference to the judgment exercised by a qualified professional."⁵²

In addition to the *Wyatt*, *Willowbrook* and *Youngberg*

46. *New York State Ass'n for Retarded Children, Inc. v. Rockefeller*, 357 F. Supp. 752 (E.D. N.Y. 1973).

47. This experience shows, therefore, that even the most handicapped and long-term institutional residents can be returned to the community and benefit therefrom. See D. ROTHMAN AND S. ROTHMAN, *THE WILLOWBROOK WARS* 353-54 (1984).

48. 457 U.S. 307 (1982).

49. *Id.* at 315.

50. *Id.* at 319.

51. *Id.*

52. *Id.* at 322.

cases, which addressed conditions in institutions, the Supreme Court decided *Donaldson v. O'Connor*.⁵³ In *Donaldson*, the Court was presented with the question of whether the state has a right to continue confining a nondangerous patient when the hospital fails to provide treatment to the patient. The Court held that patients "who are not dangerous to themselves or others, are receiving only custodial care and are capable of surviving safely in freedom or with the help of family or friends" could not be institutionalized against their will.⁵⁴ Four years later in *Addington v. Texas*,⁵⁵ the Supreme Court held that the state must prove by "clear and convincing" evidence, rather than the lesser standard of "preponderance of the evidence," that a person should be confined in a mental hospital against his will.

Other early cases involved efforts to obtain community services as an alternative to institutionalization. These cases, such as *Brewster v. Dukakis*⁵⁶ and *Dixon v. Weinberger*,⁵⁷ established a right to treatment in the least restrictive alternative setting. *Brewster* was filed in 1976 on behalf of institutionalized and noninstitutionalized people, including residents of Northampton State Hospital, a large state hospital located in the western part of Massachusetts. The case was brought to compel the state to develop a comprehensive system of community programs as required by a 1966 state law empowering the Department of Mental Health to create community-based residential programs instead of developing programs in the large state hospitals. *Brewster* was settled in 1978. The effect of the settlement created vastly improved community-based programs in the western part of Massachusetts.⁵⁸

Filed in 1974 on behalf of patients at the federally operated St. Elizabeth's Hospital in Washington, D.C., plaintiffs in *Dixon*

53. 422 U.S. 563 (1975).

54. *Id.*

55. 441 U.S. 418 (1979).

56. *Brewster v. Dukakis*, 675 F.2d 1 (1st Cir. 1982).

57. *Dixon v. Weinberger*, 405 F. Supp. 974 (D.D.C. 1975).

58. After the *Brewster* decree was finalized, the state legislature refused to appropriate sufficient funds to carry out the decree and the court of appeals refused to compel the legislature to do so. *Brewster v. Dukakis*, 675 F. 2d 1 (1st Cir. 1982). The *Brewster* decree then became the subject of political negotiation and the result is one of the nation's most successful community mental health programs.

sought to establish, under the United States Constitution and District of Columbia statutes, a right to treatment in less restrictive facilities outside of the hospital, so long as such treatment would be consistent with the individual's treatment needs. On December 23, 1975, the federal district court held that the city and federal governments had a joint obligation under D.C. law to provide suitable care and treatment outside the hospital to all patients who did not require hospitalization. Following several years of unsatisfactory implementation by the city and the hospital, the court ordered defendants to develop a plan for the creation of a continuum of community-based facilities as the basis of a remedial order.⁵⁹ After lengthy negotiations, a plan was accepted and approved by the court in April, 1980. The plan and accompanying consent order represented a major effort to address the difficult problems involved in implementing such a judicial order, including stimulating sound planning for the necessary changes, gaining the commitment of people in the bureaucracy to the ordered changes and designing an effective monitoring system to ensure compliance with the order.

Under the settlement, the city and federal governments were obligated to provide plaintiffs with community mental health care; adequate and appropriate residential services, including group homes, foster homes and nursing homes; and community support services. In sum, the decree is a model for a comprehensive mental health system. Nevertheless, the results have not been realized. Even after contempt proceedings, the local government has failed to dedicate the necessary resources and effect the structural changes needed to implement the decree.

In sum, deinstitutionalization stemmed from a combination

59. At the time the lawsuit was filed, St. Elizabeth's Hospital was owned by the federal government on land leased to it by the District. In November 1984, Congress passed legislation providing that by 1991, the hospital would be the sole responsibility of the District of Columbia government. Pub. L. No. 98-621, 98 Stat. 3369-3382 (1984). In particular, the legislation provides that between 1984 and 1987, the District is obligated to develop a plan for a comprehensive integrated community-based mental health system and to submit the plan to local groups for review and to Congress for its approval. The legislation further provides that between 1986 and 1991, the federal government will contribute \$135 million towards the hospital, after which the District will become solely responsible for the hospital. Finally, in an extremely unusual move, the legislation requires that the District's plan be "in full compliance with the federal court consent decree in *Dixon v. Heckler*." *Id.* at 3370.

of therapeutic, economic and libertarian concerns. For many, it has been a great success. Most mentally ill people leaving hospitals have returned to their families or their own apartment. Others have returned to halfway houses, group homes or residential treatment programs. Indeed, most never become homeless. Yet for too many, deinstitutionalization has not yet fulfilled its promise of appropriate services in the community and some, both former patients and people who once might have been institutionalized, have fallen through the "crack" between hospital and community-based mental health care and have become homeless. Deinstitutionalization has thus brought people with mental illness squarely into public view, where they have generated fear and hostility. Consequently, the professional literature is increasingly cynical of the deinstitutionalization process. Yet, rather than focus on the inadequate discharge planning which has occurred in recent years, the next generation of reform should learn from history's lessons and acknowledge that community care must include housing, income and food, as well as mental health services. The next section of this article will address ways of facilitating the development of these much-needed services for people who are mentally ill and homeless.

II. OVERCOMING OBSTACLES TO THE DEVELOPMENT OF HOUSING AND COMMUNITY SERVICES FOR MENTALLY ILL HOMELESS PEOPLE.

A. *The Lack of Housing Funds*

For many homeless mentally ill people their most pressing need is not for mental health services, but for a decent place to live. Access to private and public housing, obviously a problem for all who are homeless, is especially difficult for mentally ill people. They may lack the ability to search for housing or the knowledge of how to apply for it or the skill to negotiate a complex bureaucracy. Further, people who are labeled mentally ill often face blatant discrimination. Even if a homeless person with a mental illness is able (perhaps with the assistance of others) to secure housing in the open market or in a federal housing program, it may not be appropriate for that person's particular needs.

Although most people diagnosed as mentally ill live inde-

pendently in the community,⁶⁰ some require a more supervised and supportive living situation. Such facilities do exist. Models, including group homes, community residences and patient-run alternatives for mentally ill people are not lacking. What is lacking are the resources and political support to develop sufficient alternatives to keep pace with the need.

Medicaid is one source of funding for the development of housing opportunities for mentally ill people, but it is inadequate. In 1981, the Medicaid statute was amended by the Omnibus Budget Reconciliation Act to provide a new funding source for medical and nonmedical community services as alternatives to institutions. The Community Services Waiver Provision, § 1915 of Title XIX of the Social Security Act, 42 U.S.C. § 1396n(c), allows states to apply for a waiver of certain Medicaid requirements in order to offer home and community-based services. Receipt of the waiver depends on the state's showing that the services are needed by certain individuals to avoid institutional care. The state must establish that "but for the provision of such services the individuals would require the level of care provided in a skilled nursing facility or intermediate care facility, the cost of which would be reimbursed under the state [Medicaid] plan."⁶¹

The community service waiver provision was hailed by many because, for the first time, nonmedical services could be funded through Medicaid. States would now be free to provide a range of services for disabled people, including housing. The

60. A recent study by the National Institute of Mental Health reveals that as many as 29.4 million, or approximately 19% of the population, suffer from some form and degree of mental illness. U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, NIMH, MENTAL HEALTH, UNITED STATES 1985 4 (C. Taube and S. Barrett eds. 1985). NIMH also estimates that of the 2.4 million people labeled chronically mentally ill, 1.5 million now live in the community. Of these, 110,000 people are in short-term treatment in hospitals, 290,000 people live in halfway houses or group homes, and 1.1 million people live in private homes by themselves or with friends or families. Morgenthau, *Abandoned*, NEWSWEEK, Jan. 6, 1986.

61. 42 U.S.C. § 1396n(c)(1) (1981). Under this law, the state is allowed to fund a range of services including nursing services, medical supplies and equipment, occupational therapy, homemaker and personal care services, respite care and case management. Educational activities and vocational training are not reimbursable under a waiver. 50 Fed. Reg. 10020 (1985). Further, room and board generally may not be paid for through the community service waiver unless they are deemed to be part of the overall cost of respite care specialized foster care. 42 U.S.C. § 1396n(1) (1981).

waiver provision has not, however, realized this dream. The Health Care Financing Agency (HCFA) has interpreted the waiver legislation not as an approach to shifting resources from institutions to the community, but as a cost-saving device. HCFA now requires states to document a reduction in their Medicaid budget by showing either an actual reduction in the number of institutional beds or a decrease in the number of new institutional beds planned.⁶² In other words, HCFA has refused to approve Medicaid waivers to states seeking to expand Medicaid services or to shift to Medicaid the cost of existing services.⁶³

Another federal program which appears, on paper, to provide funding for the development of community services, including housing, is Supplemental Security Income (SSI). Unlike the community service waiver program, which reimburses states, SSI is a federally funded and administered program under the Social Security Act which provides cash assistance directly to needy blind, disabled and aged persons.⁶⁴ SSI has long provided most of the community-services money for most of the adult disabled population.⁶⁵

But even SSI has not fostered the development of enough appropriate living opportunities for people with mental illness. While it has covered basic living expenses, for many disabled people who are unable to support themselves, SSI is not likely to meet, in any significant way, the needs of people who are mentally ill and homeless.

An SSI recipient can seldom secure permanent housing relying on an SSI check as the sole source of income. SSI pays only a maximum of \$336.00 per month to a single individual.⁶⁶ Given the shortage of low-cost housing, this barely covers rent, not to

62. 50 Fed. Reg. 10027-28 (1985).

63. Further, the community service waiver regulations limit waiver approval to three years. 42 U.S.C. § 1396n(3) (1981). Thus, every three years the state is forced to seek approval and to demonstrate again that its program is cost-effective. For this reason, many states are reluctant to rely too heavily on what may be considered an experimental program.

64. 42 U.S.C. §§ 1381-1383 (1984).

65. SSI is not available to persons in publicly owned or operated facilities housing more than 16 people. See 42 U.S.C. § 1382(e)(1)(A) and (C) (1984).

66. This amount is as of January 1, 1986. SSI pays \$504.00 per couple. See SOCIAL SECURITY ADMINISTRATION, FACTS AND FIGURES AT YOUR FINGERTIPS (1985).

mention food, clothing and other necessities. Some local agencies have begun to overcome this problem by locating low-cost housing for two or more SSI recipients to share. Some states also provide supplementation of SSI payments, which can increase community living opportunities for chronically mentally disabled people. However, even with increased SSI payments, other problems remain.

Delays in determining an individual's eligibility for SSI exacerbate the housing plight of many people. Eligibility for SSI is determined by deciding first whether the individual is disabled on medical grounds and then whether the person is capable of returning to past work or doing other work for which he may be qualified by age, education or work experience.⁶⁷ A determination of medical eligibility requires the opinion of a physician. Unless a homeless person has access to free medical services and transportation to the appropriate offices, obtaining the necessary medical report can be a major barrier to receiving benefits.

Yet even when someone completes the application process, eligibility may not be established for months. In the meantime, survival can be difficult. While some states provide interim assistance, most do not. Further, since there is no presumption that a person leaving a mental hospital is entitled to SSI, the individual may not apply until after release, and then he or she will not receive a check for months. Between the time the individual leaves inpatient care and months later when the first check is received, a former patient with no resources many end up on the street.

67. In recent years, the Social Security Administration's manner of adjudicating claims for disability benefits has been severely criticized for, among other things, relying on outmoded concepts of disability and ignoring certain evidence relevant to a mentally impaired person's ability to work. Successful court actions challenging SSA's methods and policies have been brought in New York and Minnesota. See *City of New York v. Heckler*, 106 S. Ct. 57, 88 L. Ed. 2d 46 (1986) and *Mental Health Association of Minnesota v. Schweiker*, 554 F. Supp. 157 (D. Minn. 1982), *aff'd*, 720 F. 2d 965 (8th Cir. 1983). In addition to these court challenges, Congress has amended Section 5(a) of the Social Security Disability Benefits Reform Act of 1984, Pub. L. No. 98-460, § 5(a), 98 Stat. 1801, requiring SSA to revise its standards for mental impairment cases. The agency has also issued new rules which establish criteria for determining a mentally impaired person's eligibility for benefits. See 20 C.F.R. 404.1520a (1986). See also, Rubenstein, *SSA Issues New Rules Governing Mental Impairment Claims*, 19 CLEARINGHOUSE REV. 715 (1985).

B. *Community Opposition to Community Residences*

An even more insidious obstacle than lack of funding to the development of housing opportunities for people with mental illness is community opposition, expressed by the enactment and application of exclusionary zoning laws and restrictive covenants. These exclusionary tactics have made it difficult and sometimes impossible to expand housing for mentally ill people who are mentally ill and at risk of becoming homeless.⁶⁸

Zoning is the primary means by which localities regulate the use and development of land and is recognized today as a legitimate exercise of the government's common law police power.⁶⁹ Normally, local zoning laws contain few substantive provisions; typically, they protect "the health, safety, morals and welfare of citizens" and afford localities the power of zoning to "prohibit activities that are harmful to the community." Many communities, relying on stereotypes and prejudices, have recently seized upon local zoning laws as a means to exclude mentally disabled people from their neighborhood by preventing the establishment of community residences or group homes. Nevertheless, most recent decisions by federal and state courts have rejected such attempts to exclude group homes and have upheld the rights of people leaving institutions to reside in the community.⁷⁰

Litigation challenging such local zoning laws usually involves the operators of a prospective group home against the local zoning authority. For example, in *Cleburne v. Cleburne Living Center*,⁷¹ the Supreme Court considered whether the city of Cleburne, Texas, had acted improperly in denying a special-use permit to the operator of a group home for 13 mentally retarded

68. Zoning laws have also been used in attempts to prevent the opening of shelters for homeless people. See *St. John's Evangelical Lutheran Church v. City of Hoboken*, 479 A. 2d 935 (N.J. Super. Ct. 1983) (court held church's operation of a shelter was an exercise of religion and could not be prohibited by the city); *S.C.O.P.E., Inc. v. Zoning Board of Vineland*, No. L-053018-84 P.W. (N.J. Super. Ct. 1985) (court reversed zoning board's decision to deny shelter's application for use variance in light of the overwhelming need for a homeless shelter).

69. The exercise of a locality's zoning authority has long been recognized as justified by the state's police power. See, e.g., *Village of Euclid v. Ambler Realty Co.*, 272 U.S. 365 (1926).

70. *Kanter, Recent Zoning Cases Uphold Establishment of Group Homes for the Mentally Disabled*, 18 CLEARINGHOUSE REV. 515-18 (1984).

71. 53 U.S.L.W. 5022 (U.S. July 1, 1985); 105 S. Ct. 3249 (1985).

adults. In a 6-3 decision, the Court upheld the right of the group home to open, but rejected plaintiff's claim that heightened judicial scurtiny was appropriate in cases brought on behalf of mentally retarded people.⁷² According to the majority, the city's ostensible justifications for denying the special-use permit were either impermissible or unworthy of belief.⁷³ The Court found that "mere negative attitudes or fear, unsubstantiated by factors which are properly cognizable in a zoning proceeding, are not permissible bases for treating a home for the mentally retarded differently from apartment homes, multiple dwellings and the like."⁷⁴

In addition to zoning cases, such as *Cleburne*, which pit group-home operators against local zoning authorities, other recent cases have involved individual private property owners opposed to group homes opening in their neighborhoods. The most common vehicle used in such opposition to group homes is litigation over restrictive covenants running with the land. In the vast majority of such cases, courts have allowed the group home to open despite a restrictive covenant limiting the use of property only to residential purposes and single-family homes. Because the homes would be operated by nonprofit corporations and because the residents would function much like any other household, most courts have held that such homes fall within the language of the restrictive covenant.⁷⁵

72. The Fifth Circuit Court of Appeals had held that mentally retarded persons constitute a quasi-suspect class entitled to heightened judicial review under the equal protection clause because of the segregation, political powerlessness and prejudice to which they have been subjected. 726 F.2d 191, 192 (5th Cir. 1984).

73. The justifications were "impermissible" because they were based merely on neighbors' fears and "unworthy of belief" because they were the product of alleged concern for the residents' safety living in a house located on a 500 year flood plain.

74. 53 U.S.L.W. at 5026. For a detailed discussion of the *Cleburne* decision, see Margulies, *The Newest Equal Protection*, 3 N.Y.L.S. HUM. RTS. ANN. 359 (1986).

75. See Kanter, *supra* note 70; Crane Neck Association v. NYC/Long Island County Services Group, 61 N.Y.2d 154, 460 N.E.2d 1336 (1984), *appeal dismissed*, 53 U.S.L.W. 3234 (U.S. Oct. 1, 1984); Knudston v. Trainor, 216 Neb. 653, 345 N.W.2d 4 (1984); Harbour v. Normal Life of Louisiana, 454 So.2d 1208 (La. Ct. App. 1984); Concord Estates Homeowners Assoc., Inc. v. Special Children's Foundation, Inc., 459 So.2d 1242 (La. Ct. App. 1984); Vienna Bend Subdivision Homeowners Assoc. v. Manning, 459 So.2d 1345 (La. Ct. App. 1984); Clark v. Manuel, 463 So.2d 1276 (La. Sup. Ct. 1985); Gregory v. Rhode Island, 495 A.2d 997 (R.I. Sup. Ct. 1985); Collins v. City of El Campo, Texas, 684 S.W.2d 756 (Tex. Civ. App. 1984) See also Craig v. Bossenberg, 351 N.W.2d 591 (Mich. Ct. App. 1984) (court concluded home did not fit language of restrictive covenant, but

A third type of case has been brought to secure the right of a group home to open in the face of community opposition. In *People v. 11 Cornwell Company*,⁷⁶ the Attorney General of New York, as *parens patriae*, brought suit against a group of neighbors who bought a house when they heard the state had planned to purchase the property for use as a group home for mentally retarded adults. The State of New York sued the property owners, alleging they had violated the civil rights of the prospective residents and the New York human rights law. The Second Circuit upheld the district court's decision in favor of the state.⁷⁷

Also, in Greenwich, Connecticut, a group of property owners who were unsuccessful in preventing the opening of a group home for mentally ill adults in their neighborhood, petitioned the town's tax review board to lower the assessments on their homes. The tax board agreed to lower their assessments based on nothing more than the neighbors' fear that the group home justified the reduction.⁷⁸ On April 19, 1985, suit was filed against the tax review board by the Attorney General, acting as *parens patriae*, Senator Lowell P. Weicker, Jr., as a Greenwich taxpayer, an association of residential facilities and others.⁷⁹

C. *Litigation to Secure Community Services*

In addition to housing, some homeless people need mental health care. Today, such care outside of mental institutions is difficult to obtain. The need for community-based mental health care remains acute, and advocates have embarked on new strategies to secure them.

The time and expense involved in litigating class actions combined with the Supreme Court's current conservatism about the judiciary's proper role, have reduced the number of omnibus

upheld right of home to open by declaring covenant void as against public policy). Cf. *Omega Corporation of Chestefield v. Malloy*, 319 S.E.2d 720 (Va. Sup. Ct. 1984).

76. 695 F.2d 34 (2d Cir. 1982).

77. *Id.* at 44.

78. In fact, all studies on the subject establish, without exception, that there is no adverse impact to the property values of homes located near a group home. See MENTAL HEALTH LAW PROJECT, *THE EFFECTS OF GROUP HOMES ON NEIGHBORING PROPERTY: AN ANNOTATED BIBLIOGRAPHY* (Feb. 1986). 2021 L Street, N.W., Suite 800, Washington, D.C. 20036.

79. *Lieberman v. Board of Tax Review*, No. CV 850076085 (Conn. Super. Ct. April 19, 1985). For information on this case, contact the author.

class actions filed on behalf of mentally disabled people who need therapeutic and support services. However, a new strategy has been tried with success.

The most common successful strategy for reallocating mental health dollars from mental institutions to community care has been litigation brought under state law. Because federal courts are reluctant to recognize a federal constitutional right to community mental health treatment, or mental health treatment in the least restrictive environment, litigators have sought to establish the right under state, rather than federal, law.⁸⁰ For example, in a recent Arizona case the plaintiff class, consisting of indigent mentally ill residents of Maricopa County, sought declaratory and injunctive relief against defendants Department of Health Services, Arizona State Hospital and the County Board of Supervisors.⁸¹ Plaintiffs asked the state court to compel defendants to perform their mandatory duties under state mental health law, which included creating a unified and cohesive system of community mental health care. The court found for the plaintiffs and, despite defendants' claim of inadequate funds, ordered them to fulfill their mandatory duties. *Arnold v. Sarn* is the first case in which a state court has ordered the development of a comprehensive system of care for chronically mentally ill people.⁸²

The *Arnold* decision is particularly instructive regarding the

80. Several lower federal courts have discussed whether the state is required to provide community services to mentally disabled people. Although two courts of appeals have held that institutionalized people have no constitutional right to placement in the community (*Society for Goodwill to Retarded Children, Inc. v. Cuomo*, 737 F.2d 1239 (2d Cir. 1984), and *Phillips v. Thompson*, 715 F.2d 365 (7th Cir. 1983)), a recent Fourth Circuit decision reached a different result. In *Thomas S. v. Morrow*, 781 F.2d 367 (4th Cir. 1986), the court held that a mentally disabled young man, who had been in and out of foster homes and institutions throughout his life, had a right to an appropriate placement in the community and supportive services. The court distinguished this case from *Society for Goodwill* and *Phillips* on the grounds that in *Thomas*' case a discrete recommendation for treatment in the community has been made by qualified professionals. Although *Thomas* was no longer institutionalized, the court read *Youngberg* to permit awarding relief to him by noting that the liberty interests in *Youngberg* did not arise because of institutional confinement.

81. *Arnold v. Sarn*, No. C432355 (Ariz. Super. Ct., Maricopa Cty, June 25, 1985).

82. See also *Goebel v. City & County of Denver*, No. 81MH270 (Probate Ct., City & County of Denver, May 7, 1985) (court held lack of sufficient funds did not excuse defendants of their statutory duties to provide plaintiffs with care and treatment in the community).

factors necessary to create a comprehensive community mental health system. Using as a model the consent decree in *Dixon*,⁸³ the court ordered the following services as necessary for the operation of an effective system: case management, residential services, day treatment, outreach, medication, outpatient counseling, crisis stabilization, mobile crisis services, socialization, recreation, work adjustment and transportation. In fact, the court specifically recognized that deinstitutionalized individuals are often at risk of rehospitalization because the "residual impairments of their illness interfere with successful adjustment to community life unless provided with adequate community mental health services."⁸⁴ Accordingly, the court further ordered the Arizona State Hospital to ensure that discharged patients have a place to live as well as an adequate program for necessary treatment.⁸⁵ This decision, therefore, potentially will benefit many homeless people who are mentally ill.

Another example of a case filed under state law which, if successful, will result in services for mentally ill people who are homeless is *Klostermann v. Cuomo*.⁸⁶ In *Klostermann*, nine plaintiffs discharged from state psychiatric facilities into shelters or onto the streets claimed violations of their federal and state constitutional and statutory rights to treatment and housing. The court held first that plaintiffs enjoyed no constitutional right to treatment because they were not currently patients of state mental hospitals. According to the court, the constitutional right to treatment in the least restrictive environment applies only when an individual is under restraint or otherwise confined. However, the court also held that if the state was providing community mental health to plaintiffs who had been discharged from psychiatric facilities but not to other severely mentally ill patients, such as the homeless plaintiffs, plaintiffs had presented a cognizable cause of action for discrimination under federal and state equal protection clauses and Section 504 of the Rehabilita-

83. See *supra* note 57.

84. *Arnold v. Sarn*, *supra* note 81, at 8-9.

85. *Id.*

86. See *Klostermann v. Cuomo*, 61 N.Y.2d 525, 475 N.Y.S.2d 247, 463 N.E.2d 588 (1984); *Joanne S. v. Carey*, 115 App. Div. 2d 4, 498 N.Y.S.2d 817 (1986) (alleged unlawful confinement of 140 patients in Manhattan State Psychiatric Center due to the absence of a place in the community for them to go).

tion Act.⁸⁷

Advocates cannot expect, however, that merely obtaining a state court order or a consent decree will result in an adequately funded high-quality mental health system any more than does a federal court order.⁸⁸ Indeed, some courts will consider a defendant's claim of inadequate resources as a legitimate justification for inaction. For example, in *Mental Health Association v. Deukmejian*,⁸⁹ the California Court of Appeals affirmed the lower court's denial of relief to two named plaintiffs who sought release from a state mental hospital, alleging a violation of a constitutional right to treatment in the community under the California constitution and state law. Although California's mental health law⁹⁰ created a legislative preference for treatment in the least restrictive setting, the court, relying on *Youngberg v. Romeo* and its progeny,⁹¹ held that it did not create an absolute right to such treatment. Although the extensive evidence presented documented the many deficiencies of the hospital-based system, nevertheless, the court refused to assume the authority to determine how the mental health system should be structured and funded. According to this court, states have considerable latitude in deciding how mental health services should be provided, indeed, whether they should be provided at all. The state must only demonstrate that its decision was reasonable.

III. RESISTING EFFORTS TO CHANGE THE STANDARD FOR CIVIL COMMITMENT

As advocates, courts and members of the psychiatric community have agreed upon the need for alternatives to hospitalization, many states have revised their civil commitment laws to make it more difficult for people to be unnecessarily confined to

87. The court also held that plaintiffs had stated a cause of action with respect to defendant's failure to prepare written service plans for each discharged patient.

88. See discussion of *Dixon*, *supra*, notes 57-59 and accompanying text.

89. See *MHA v. Deukmejian*, 186 Cal. App. 3d 1531 (1986), *aff'g*, No. J000-540 (Cal. Super. Ct., L.A. Cty., April 12, 1985) (Memorandum Decision).

90. Cal. Welf. & Inst. Code §§ 5000-5599, especially at 5008. (West 1969).

91. 457 U.S. 307 (1982) and such cases as *Society for Goodwill to Retarded Children v. Cuomo*, 737 F.2d 1239 (2d Cir. 1984); *Rennie v. Klein*, 720 F.2d 266 (3d Cir. 1983); *Phillips v. Thompson*, 715 F.2d 365 (7th Cir. 1983); and *Johnson v. Brelje*, 701 F.2d 1201 (7th Cir. 1983).

inpatient care. About one-third of the states have adopted standards for civil commitment which provide that only persons who are mentally ill and dangerous to themselves or others may be committed.⁹²

With an apparent rise in the number of homeless people who appear to be mentally ill, some commentators⁹³ and psychiatrists⁹⁴ are calling for change in these commitment laws. They claim the effect of our current policy is to abandon to the streets people who urgently need mental health care. To correct this situation, they argue, commitment laws should be changed to make it easier to hospitalize someone against his will. They further blame mental health advocates and civil liberties lawyers who fought the early deinstitutionalization cases for permitting mentally ill people to "die with their rights on."⁹⁵

In its comprehensive report on the homeless mentally ill, for example, the American Psychiatric Association has hailed attempts to allow homeless people to be committed more easily.⁹⁶ Homeless people can be "helped," the APA asserts, if state laws are changed to permit the commitment of anyone who is "likely to suffer substantial mental or physical deterioration."⁹⁷

For several reasons, however, such a change in the commitment standards does not respond to the problems of mentally ill people who are homeless. First, most homeless people do not suffer from mental illness. A study that is often cited as support for the claim that most homeless people are severely mentally ill is imprecise. The study consists of brief interviews at one shelter in one city over only five nights.⁹⁸ It is inappropriate to draw

92. See E. BEIS, *MENTAL HEALTH AND THE LAW*, 297-321 (1984).

93. C. Krauthammer, *For the Homeless: Asylum*, *The Washington Post*, Jan. 4, 1985, op. ed.

94. E.g., Appelbaum, *Civil Commitment: Is the Pendulum Changing Direction*, 33 *HOSP. & COMMUNITY PSYCHIATRY* 703 (1982).

95. Treffert, *Dying With Their Rights On*, 130 *AM. J. PSYCH.* 1041 (1973); See Appelbaum and Gutheil, *Rotting With Their Rights-On: Constitutional Theory and Clinical Reality in Drug Refusal by Psychiatric Patients*, 7 *BULL. AM. ACAD. PSYCHIATRY & LAW* 306 (1979).

96. *THE HOMELESS MENTALLY ILL: A TASK FORCE REPORT OF THE AMERICAN PSYCHIATRIC ASSOCIATION*, *supra* note 15, at 7-8.

97. See Stromberg and Stone, *A Model State Law on Civil Commitment of the Mentally Ill*, 20 *HARVARD J. ON LEGIS.* 275 (1983).

98. Bassuk, Rubin and Lauriat, *Is Homelessness a Mental Health Problem*, 141 *AM. J. PSYCHIATRY* 12 (1984). The study was conducted in Boston and Cambridge, Massachu-

any conclusions from a study so limited in scope and geography, and that was further skewed by being conducted at one of the few shelters in the city to attract mentally disabled people. Other arguably more reliable studies have reached different results, finding that most people are homeless not because of mental illness,⁹⁹ but for economic reasons or because of the depleted supply of low-income housing, unresolved family crises, or cutbacks in benefit programs. Accordingly, if most homeless people are homeless for reasons unrelated to their mental health needs, the search for a solution solely within the mental health system is misplaced.

The argument for changing commitment laws is misdirected for a second reason. Proponents for such change argue that the decline in the census of state mental hospitals reflects the policy of deinstitutionalization. However, although the daily census in state mental hospitals may have declined by more than 75%, from 559,000 in 1955 to fewer than 138,000 in 1980,¹⁰⁰ these hospitals are far from empty. Rather, they have become short-term, acute-care facilities. Indeed, inpatient psychiatric admissions to both state mental hospitals and psychiatric wards of general hospitals have increased to approximately one million a year.¹⁰¹ Moreover, there is little evidence that strict commitment stan-

sets during one week in April 1983. Five psychiatrists, two psychologists and two social workers interviewed 78 homeless men, women and children. At the end of each interview, the clinician completed a questionnaire that included standard psychiatric diagnoses from the Diagnostic and Statistical Manual of Mental Disorder (DSM III). Based on those interviews, the study concluded that 91% of the shelter residents suffered from mental illness.

99. See, e.g., S. CRYSTAL, AND M. GOLDSTEIN, *NEW ARRIVALS: FIRST TIME SHELTER CLIENTS*, NEW YORK HUMAN RESOURCES ADMINISTRATION (1983) (homeless people in need of psychiatric services range from 20%-30%); OHIO DEPARTMENT OF MENTAL HEALTH, *HOMELESSNESS IN OHIO: A STUDY OF PEOPLE IN NEED* (1985) (30% of the people interviewed had once been hospitalized and 30.8% were considered to have psychiatric problems); 1986 U.S. CONFERENCE OF MAYORS REPORT, *supra* note 5, at 16 and 27 (average of 25 cities is 33% of homeless people are considered mentally ill with 6% of the homeless in Yonkers considered mentally ill and 60% in Denver).

100. See J. MORRISSEY, *DEINSTITUTIONALIZING THE MENTALLY ILL: PROCESS, OUTCOMES AND NEW DIRECTIONS IN DEVIANCE AND MENTAL ILLNESS* (W. Gove ed. 1982); H. Goldman, *The Demography of Deinstitutionalization* in *DEINSTITUTIONALIZATION* 34-35 (L. Bachrach ed. 1982), and GAO REPORT, *supra* note 4, at 20-22.

101. Craig and Laska, *Deinstitutionalization and the Survival of the State Hospital*, 34 *HOSP. AND COMMUNITY PSYCHIATRY* 616 (1983); Weinstein and Cohen, *Young Chronic Patients and Changes in State Hospital Populations*, 35 *HOSP. AND COMMUNITY PSYCHIATRY* 595 (1984).

dards have prevented many admissions. Other factors such as a lack of available beds and medical decisions not to treat, have played a larger role.¹⁰² Contrary to popular opinion, therefore, there is no indication that current civil commitment laws result in homelessness to any great extent.

A third fallacy is that existing commitment laws are inadequate to address the needs of severely mentally ill people who are homeless. Approximately two-thirds of states' civil commitment laws currently permit involuntary hospitalization of a person who is "gravely disabled or unable to provide for his or her basic needs."¹⁰³ This standard is commonly defined as applicable to a person who is unable to provide for his or her own food, clothing, or shelter by reason of mental illness or disorder.¹⁰⁴ It seems probable, therefore, that if a homeless person is freezing on the streets or otherwise unable to care for himself, he or she may be committed under current law in most states. To the extent that hospitals refuse admission to people on that basis, the solution is not to change the law, but to educate those who ultimately implement it.

The fourth reason *not* to change commitment laws is that nothing will be accomplished with the change. Most people who are homeless and mentally ill people are completely detached from society. Outreach to them is especially difficult because they often hide purposely trying not to be found.¹⁰⁵ No one proposes that these people be left on the streets to die, but removing them to a mental hospital is not a meaningful solution to their problems. At some point, the homeless person who has been hospitalized must be discharged. What options are then available, other than to return to the life on the streets with little assurance of follow-up care? Because the bulk of most states'

102. Rubenstein, *APA's Model Law: Hurting the People It Seeks to Help*, 36 *HOSP. AND COMMUNITY PSYCHIATRY* 968, 970 (1985).

103. E. BEIS, *MENTAL HEALTH AND THE LAW*, 297-321 (1984).

104. See, e.g., Ark. Stat. Ann. § 59-1401(c) (1981 Supp.); Cal. (Welf. and Inst. Code) § 5008(h)(i) (West); Colo. Rev. Stat. § 27-10-101(5); Conn. Gen. Stat. Ann. §§ 17-176, 17-178(c); Idaho Code §§ 66-317(i), (m) and (n); Ind. Code Ann. § 16-14-9.1(b) (Burns); North Dak. Cent. Code § 25-03.1-02; Ok. Stat. Ann. 43A § 54.3(o) (West); Wash. Rev. Code Ann. § 71.05.020(1).

105. See Cohen, Putnam, and Sullivan, *The Mentally Ill Homeless: Isolation and Adaptation*, 35 *HOSP. AND COMMUNITY PSYCHIATRY* 922 (1984), in which the authors discuss "Project HELP," a program established in 1982 to provide crisis medical and psychiatric services to homeless people in New York City.

mental health dollars remains allocated to hospitals, few community-care options are available to discharged patients.¹⁰⁶ Easing the civil commitment standards would only perpetuate this unfortunate balance, and state hospitals would argue that their increased inpatient populations require more resources.¹⁰⁷

It is difficult to see, therefore, how a relaxation of civil commitment standards could force the federal, state or local governments to begin assuming their respective responsibilities for developing appropriate mental health and support services outside the hospital, in the community, where most people eventually must live.

The fact remains that, in some cities, comprehensive community-based mental health programs do succeed when essential components, such as social support, vocational training and crisis intervention are provided.¹⁰⁸ However, in most places such programs have not been tried, largely because states and localities have been reluctant to reallocate limited funds from the state hospitals for the development of improved community care. Yet, this trend is changing. In Louisiana, for example, 103 state hospital patients were moved into the community and six wards were then closed. The result was a savings of more than one million dollars, which was permanently transferred to support community programs.¹⁰⁹ Even the prospect of closing state hospitals altogether is now taken seriously. In Vermont, a recent

106. As of 1981, 4.2 billion dollars (70 percent of state and federal funds) were dedicated to state mental hospitals, leaving the remaining \$1.8 billion (30 percent) for community-based programs. U.S. DEPT OF HEALTH AND HUMAN SERVICES, NATIONAL INSTITUTE OF MENTAL HEALTH, *MENTAL HEALTH, UNITED STATES* (1985). In fact, funds allocated to inpatient care actually totalled more than 4.2 billion dollars considering that funds for private and county hospitals were not included in the 70 percent figure.

107. Recent reforms in Italy's mental health system are instructive. In 1978, Italy amended its mental health law to limit the number of psychiatric beds and restrict the admission of patients to state hospitals. The same year a national health insurance program was passed guaranteeing mental health coverage to all citizens. Further, community programs were developed and job guarantees were given to all staff of mental hospitals. In the first year the inpatient population decreased by 10 percent and involuntary admissions by 60 percent. Nevertheless, there was virtually no evidence of dumping and no significant increase in admissions to private hospitals. L. Mosher, *Italy's Revolutionary Mental Health Law: An Assessment*, 139 AM. J. PSYCH. 199 (1982).

108. See, e.g., Beiser, Shore, Peters and Tatum, *Does Community Care for the Mentally Ill Make a Difference? A Tale of Two Cities*, 142 AM. J. PSYCH. 1047 (1985).

109. Deiner, *How to Ensure that the Money Follows the Patient: A Strategy for Funding Community Services*, 37 HOSP. AND COMMUNITY PSYCHIATRY 256 (1986).

study recommended closing the state's only mental hospital and using the savings to help pay for community programs.¹¹⁰ Only when federal, state and local governments are convinced that mental health care should be provided where people live, in the community, rather than in remote and expensive state institutions, will adequate community services be developed.

IV. CONCLUSION: WORKING TOWARD A REAL SOLUTION

Undoubtedly a connection exists between the deinstitutionalization movement of the past twenty years and the increase in the number of homeless people. However, the connection is neither as prevalent nor as significant as is often thought. Indeed, the majority of research today indicates that most homeless people are not mentally disabled and that for those who are, it is difficult to determine to what extent one's mental illness is a cause or consequence of living on the streets or in shelters. At least part of the motivation behind labeling homeless people as mentally ill is to ease our collective consciences. If homelessness were indeed simply a matter of personal pathology, then it would not call into question any larger societal failure nor would it challenge society to address the economic needs of its most needy members.

In the final analysis, however, no easy or inexpensive solutions exist for the problems confronting homeless people who are mentally ill. Like all people who are homeless, those who are mentally ill need, more than anything, a home. Without a permanent and, if appropriate, supervised or supportive place to live, these people will continue to be homeless and thus among the most desperate members of our society.

To change this deplorable situation, the mental health professions must begin to address the needs of people who are homeless and mentally ill by altering traditional approaches of service delivery. Rethinking old methods is not an easy task. Before mental health care for homeless people can be adequate, service providers must develop innovative delivery systems, including new kinds of outreach and support programs. Office hours at a community mental health center are not the answer

110. See Rubenstein, *Access to Treatment and Rehabilitation for Severely Mentally Ill Poor People*, special issue, CLEARINGHOUSE REV. 382 (summer 1986).

for homeless people who lack the organization to make and keep appointments or even the bus fare to go across town, or whose pride prevents them from boarding a bus where they know unkind stares will greet them. Rather, social workers and psychiatrists must create the opportunity to work with homeless people where homeless people *are*, on the streets, in abandoned buildings and in shelters.

Moreover, adequate funds must be allocated to ensure quality care for homeless people who need mental health treatment, and it is the federal government which must provide leadership in this area. The continuation of demonstration projects that have proven successful is one way to help localities provide care for homeless mentally ill people.¹¹¹ Second, the home and community-based care Medicaid waivers could be expanded to provide resources necessary to develop quality community mental health systems. Finally, and perhaps most important, states must have an incentive to reallocate their mental health dollars from large institutions to community-based programs.

Homeless people who are mentally ill need decent shelter at least as much as they need mental health services. A former mental patient's successful reintegration into the community is affected more by the quality of his immediate surroundings than by the type of mental health services he receives.¹¹² Therefore, any real solution to the problem of mentally ill people who are homeless must be part of the solution needed by all homeless people, an expansion of affordable housing.

111. For example, the Community Support Programs (CSP), established in 1977, could be expanded to provide additional support to states and localities for developing programs responsive to the needs of mentally ill people who are homeless. Under CSP, the federal government makes grants to state mental health agencies to assume responsibility for planning services for the chronically mentally ill. The state agency then assists localities in developing "community support systems," defined as "a network of caring and responsible people committed to assisting a vulnerable population to meet their needs and develop their potentials without being unnecessarily isolated or excluded from the community." NATIONAL INSTITUTE OF MENTAL HEALTH, DEFINITION AND GUIDING PRINCIPLES FOR COMMUNITY SUPPORT SYSTEMS (May 1983).

112. E. BAXTER, AND K. HOPPER, PRIVATE LIVES/PUBLIC SPACES, *supra* note 11, at 31.

