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COMMENTS

BITTER FREEDOM: DEINSTITUTIONALIZATION AND THE HOMELESS

*They both knew intimately the etiquette, the taboos, the protocol of bums. By their talk to each other they understood that they shared a belief in the brotherhood of the desolate; yet in the scars of their eyes they confirmed that no such fraternity had ever existed, that the only brotherhood they belonged to was the one that asked that enduring question: How do I get through the next twenty minutes?*¹

The plight of the homeless in America has taken on new significance as one of the major urban social issues of the 1980's. Whether the increased public awareness of the homeless situation is a result of the battle over the closing and relocation of the shelter run by Mitch Snyder and the Community for Creative Non-Violence ("CCNV") in Washington, D.C., or a result of the simple presence of homeless men and women in our cities, the problem of urban homelessness has aroused the curiosity and compassion of the American public. It has also raised many important questions for courts and legislatures to consider, questions regarding the causes and prevention of homelessness and questions regarding the adequacy of society's response to this problem at the federal, state, and local levels.

One sub-population of the homeless, deinstitutionalized mental patients, has become the particular object of legislative and professional scrutiny in the search for at least a partial solution to the homeless problem. The federal government, the judicial system, and the psychiatric community have begun to re-evaluate therapy and release strategies, collectively known as "deinstitutionalization,"² that have been utilized in releasing mental patients

1. W. KENNEDY, IRONWEED 23 (1983).

2. The normative definition of deinstitutionalization offered by an unpublished 1977 report from the Government Accounting Office ("GAO") is:

[T]he process of (1) preventing both unnecessary admission to and retention in institutions, (2) finding and developing appropriate alternatives in the community for housing, treatment, training, education, and rehabilitation of the mentally disabled who do not need to be in institutions, and (3) improving conditions, care, and treatment for those who need institutional care. This approach is based on the principle that mentally disabled persons are entitled to live in the least restrictive environment necessary and lead their lives as normally and independently as they can.

from state mental institutions. Unfortunately, many of these patients are unable to provide for themselves outside of the institutional environment. As a result, it is claimed that large numbers of former mental patients are now homeless.³

This re-evaluation involves taking a hard look at some of the basic premises and policies that have been the foundation of the deinstitutionalization movement. Is the ideal of treatment in the "least restrictive setting," the cornerstone of deinstitutionalization,⁴ still a valid therapy strategy? What has been the impact of homelessness upon the commitment and release strategies of state mental institutions? Finally, should scarce mental health resources be expended on establishing an outpatient community support system aimed at the prevention of homelessness among the non-institutionalized mentally ill, or should the effort be aimed at helping those existing at the shelter level? This comment shall probe these questions and posit that although much attention has been given to providing the most basic and rudimentary care for the homeless at the shelter level, the only true humane solution to the problem of homelessness among the mentally ill in America is a renewed commitment to the establishment of community mental health centers aimed at the prevention of homelessness, not just an alleviation of its symptoms.

I. THE DEINSTITUTIONALIZED HOMELESS: THE SCOPE AND NATURE OF THE POPULATION.

The exact number of homeless persons in America is unknown. Informed estimates range from a figure of 250,000 reported by the Department of Housing and Urban Development ("HUD"),⁵ to a dramatically larger figure of 3,000,000 offered by the Community for Creative Non-Violence.⁶ Walter Fauntroy, Congressional Delegate from the District of Columbia, estimates that there are 12,000 homeless persons in the District of Columbia alone.⁷

Reprinted in P. LERMAN, *DEINSTITUTIONALIZATION: A CROSS PROBLEM ANALYSIS* 2 (1981).

3. See *infra* notes 13-18 and accompanying text.

4. See Mental Health Systems Act, 42 U.S.C. § 9501(1)(A)(ii) (1982). See generally *Shelton v. Tucker*, 364 U.S. 479 (1960); *Halderman v. Pennhurst State School*, 446 F. Supp. 1295 (E.D. Pa. 1977); *N.Y. State v. Carey*, 393 F. Supp. 715 (E.D.N.Y. 1975); *Wyatt v. Stickney*, 344 F. Supp. 387 (M.D. Ala. 1972).

5. Based on an estimate that between 250,000 and 350,000 persons were homeless on an average night in December 1983 and January 1984. H.R. REP. NO. 47, 99th Cong., 1st Sess. 7 (1985).

6. Based on an estimate that during the winter of 1984 between 2,000,000 and 3,000,000 persons were homeless each night. *Id.*

7. Evans, *Experts Decry Dumping of Mental Patients*, Wash. Post, Mar. 20, 1985, at C6, col. 2.

Of this population, the number said to be suffering from mental illness also varies. The National Institute of Mental Health ("NIMH") estimates that fifty percent of the homeless may have "severe mental disorders."⁸ A 1981 study by the New York State Office of Mental Health of Manhattan shelters reported that seventy-five percent of those surveyed suffered some form of mental illness, including thirty-seven percent who were alcoholics and nineteen percent who were diagnosed as schizophrenic.⁹ Tim Siegel of the Coalition for the Homeless, an advocacy group for the homeless in the greater-Washington, D.C. area, estimates that in the District of Columbia seventy to ninety percent of the homeless women and fifteen to fifty percent of the homeless men suffer from some form of mental illness.¹⁰

While these estimates may appear broad, they uniformly indicate that a major portion of the homeless population is mentally ill. Perhaps most significant, however, is a *caveat* to these figures suggested in a recent House of Representatives report¹¹ advising that any estimates (and, specifically, the NIMH estimates) of mental illness among the homeless should be revised upwards: "the very state of homelessness can cause varying degrees of

8. H.R. REP. NO. 47, *supra* note 5, at 4.

9. Nelson, *Nation's Psychiatrists Give "High Priority" to the Homeless*, N.Y. Times, May 10, 1983, at C2, col. 2.

10. Guillermprieto & Alma, *Streets Called "Asylums of the '80's" at Conference on Homeless*, Wash. Post, Apr. 26, 1984, at D3, col. 2. A 1983 report by New York Governor Mario Cuomo to the National Governor's Association Task Force on the Homeless stated the following findings from several cities:

In *New York City*: estimates of those who are severely disabled and/or are ex-mental patients among the homeless range from a low of 20% to a high of 66% in one study of a probably atypical sheltered population. The safest, most commonly reported figure is about a third.

In *Albany*, outreach workers report 38% of the homeless contacted have significant psychiatric problems.

In *Phoenix*, the estimate of the "severely mentally disturbed" among the three hundred and forty-five of the city's homeless interviewed in two shelters . . . is put conservatively at 20%, since more of these individuals tend to refuse interviews than any other group.

In *Boston*, a clinical evaluation of 78 men and women in a public shelter . . . found that 39.5% of them show signs of "major mental illness," and a third of the total had been previously hospitalized.

In *San Francisco*, a study by the Department of Psychiatry at San Francisco General Hospital estimated that seven hundred of the city's four thousand homeless were chronically mentally disabled.

1933-1983 - *Never Again, a Report to the National Governor's Association Task Force on the Homeless, reprinted in Homelessness in America — II: Hearing Before the Subcomm. on Housing and Community Development of the House Comm. on Banking, Finance and Urban Affairs*, 98th Cong., 2d Sess. 398 (1984) (footnotes omitted) (statement of Mario Cuomo, Governor of New York).

11. H.R. REP. NO. 47, *supra* note 5.

mental illness in relatively short periods, there may be even larger percentages of the homeless who are mentally ill"¹²

What portion of the mentally ill homeless is made up of deinstitutionalized mental patients? Again, as could be expected, the figures differ. For example, Delegate Fauntroy estimates that half of the homeless in Washington, D.C. are deinstitutionalized mental patients.¹³ A 1983 study in New York of Bellevue Hospital's psychiatric emergency service revealed that 96.6% of the sample had previous psychiatric hospitalization.¹⁴ However, one of the authors of the report, Dr. Steven E. Katz, warned that these figures may overstate the problem because the sample included only homeless persons seeking mental help and not the homeless population as a whole.¹⁵ Still, a recent article in *Newsweek* cites only a sixty-five percent success rate among released mental patients in adapting to the outside world,¹⁶ although no mention is made of the ultimate fate of the thirty-five percent who were unsuccessful.

Another aspect of deinstitutionalization is the restrictions placed on the number of patients admitted to state mental institutions. This has created another class of mentally ill homeless: persons who previously would have been committed to a hospital but now have no place to go.¹⁷ While the size of this population has not been quantified, a recent congressional report agrees that restrictions on admissions to state mental hospitals have contributed to the number of mentally ill homeless.¹⁸

The increased presence of former mental patients and those who would previously have been institutionalized among the homeless is reflected in a demographic shift within the homeless population over the last ten years. The 1981 Manhattan shelter study found the median age of their sample population to be thirty-six and getting younger.¹⁹ Ten years earlier the median age had been forty-one,²⁰ with the majority of that population being comprised of older alcoholics.²¹ These findings correlate with the results of a similar study of 560 persons in eleven cities conducted by Harvey A. Siegal

12. *Id.* at 4-5.

13. *See Evans, supra* note 7.

14. Nelson, *Mental Illness Cited Among Many Homeless*, N.Y. Times, Oct. 2, 1983, at 25, col. 2.

15. *Id.*

16. Morganthau, Agrest, Greenberg, Doherty & Raine, *Abandoned*, NEWSWEEK, Jan. 6, 1986, at 14, col. 2 [hereinafter Morganthau].

17. Nelson, *supra* note 9; H.R. REP. NO. 47, *supra* note 5, at 4.

18. H.R. REP. NO. 47, *supra* note 5.

19. Nelson, *supra* note 9.

20. *Id.*

21. *Id.*

and James A. Inciardi.²²

There have also been noticeable changes in the social and economic background of today's homeless. The 1983 Bellevue Hospital study found that fourteen percent of the homeless surveyed were college graduates,²³ with another twenty percent being high school graduates or having some college background.²⁴ The parents of thirty-one percent of the men in the 1981 Manhattan shelter study were classified as being in the middle or upper social and economic classes.²⁵ Finally, the Siegal and Inciardi study noted a stronger representation of ethnic minorities among the homeless, a jump from twenty-two percent in 1950²⁶ to forty-two percent in the 1970's,²⁷ in what had been almost exclusively a white population.

This shift in the demographics of the homeless population marks the displacement of the "traditional" skid row inhabitant, the older white male alcoholic,²⁸ by persons who are younger and more mentally disturbed.²⁹ One may conclude, as did Siegal and Inciardi,³⁰ that an explanation of this phenomenon is that there has been a shift over time of the psychological make-up of the homeless: "[e]ven though these people are physically on skid row, they're socially and psychologically different than the skid rowers we are used to."³¹ Logically, it follows that one reason for this change in the psychological and social profile of the homeless has been the influx of former mental patients into the community as a result of the drastic reduction in the state mental institution population over the last thirty years.³² Releasing

22. Siegal & Inciardi, *The Demise of Skid Row*, SOCIETY, Jan. - Feb. 1982, at 39.

23. Nelson, *supra* note 9, at C2, col. 3.

24. *Id.*

25. *Id.*

26. Siegal & Inciardi, *supra* note 22, at 44.

27. *Id.*

28. For a fascinating survey of the history and decline of the traditional skid row, see Siegal & Inciardi, *supra* note 22, at 44. The term "skid row" came from a street in Seattle, Washington, where logs were dragged ("skidded") down the street to a saw mill. The street was primarily inhabited by unemployed and homeless lumberjacks. According to the study, a *hobo* is a migratory worker, a *tramp* is a migratory non-worker, and a *bum* is a stationary non-worker. *Id.*

29. Nelson, *supra* note 9, at C2, col. 4.

30. Siegal & Inciardi, *supra* note 22, at 44.

31. *Id.*

32. The General Accounting Office ("GAO") estimates that between 1955 and 1980, the population in state mental institutions decreased by more than 75%, from 559,000 to 138,000, even though the total U.S. population increased significantly over this period. H.R. REP. NO. 47, *supra* note 5, at 4. Interestingly, the institutionalized population in *private* mental hospitals (such as nursing homes) has actually increased. From 1968 to 1975, NIMH estimates the number of private admissions increased by about 34%, and the one day resident counts increased by 10%. M. BURT & K. PITTMAN, TESTING THE SOCIAL SAFETY NET 646-66 (1985); P. LERMAN, *supra* note 2, at 3. Finally, even though the patient populations in mental hospi-

mental patients into the general population³³ and limiting the availability of treatment for prospective patients by tightening the criteria for admission into state mental hospitals³⁴ has placed in the community a population that has a high risk of becoming homeless, the mentally ill. And, as the figures show, that risk has taken its toll.

II. *O'CONNOR V. DONALDSON*: TEN YEARS LATER — NEW QUESTIONS

In 1975 the Supreme Court decided *O'Connor v. Donaldson*,³⁵ which effectively outlines the purposes for which a state may constitutionally justify the continued confinement of a mental patient.³⁶ The Court based its holding on the premise that a determination of mental illness alone is not a sufficient justification for retaining a person in a state mental institution:

A finding of "mental illness" alone cannot justify a State's locking up a person against his will and keeping him indefinitely in simple custodial confinement. Assuming that term [mental illness] can be given a reasonably precise content and that the "mentally ill" can be identified with reasonable accuracy, there is still no constitutional basis for confining such persons involuntarily if they are dangerous to no one and can live safely in freedom.³⁷

The Court in *O'Connor* went on to recognize a constitutional right to freedom applicable to institutionalized mental patients,³⁸ and held that a state may not continue to confine such individuals without a finding that they could not survive safely in freedom either by themselves or with the help of willing and responsible family members or friends.³⁹ This right to freedom appears to involve the whole spectrum of constitutional rights attached to the concept of personal liberty and suggests that, absent a showing of danger to self or others, a mental patient has a right to enjoy these liberties.

While few would argue with the intuitive correctness of such a holding, some question the necessity of emphasizing these freedoms in a situation

tals has decreased, the staff-per-patient ratio has actually increased, reflecting that staff reductions in mental hospitals have not kept pace with patient reductions. Morganthau, *supra* note 16.

33. H.R. REP. NO. 47, *supra* note 5, at 4.

34. *Id.*

35. 422 U.S. 563 (1975).

36. For a fascinating account of the internal politics and personal motives within the Supreme Court that helped shape the *O'Connor* decision, see B. WOODWARD & S. ARMSTRONG, *THE BRETHERN* 369-83 (1979).

37. *O'Connor*, 422 U.S. at 575.

38. *Id.* at 576.

39. Presumably, the Court has recognized this right to freedom in connection with the Equal Protection Clause of the Constitution, as it is not an enumerated right.

where continuing mental illness renders a patient incapable of enjoying these rights:

The problem with this approach is its unquestioning assignment of value to the primary rights affected by commitment. On one hand, if the illness has no effect on, say, the schizophrenic's competence to vote, the state would show more respect for his constitutional right by providing an absentee ballot than it would by providing treatment leading to an earlier release. On the other hand, it is difficult to see how the inmate has a fundamental right to those freedoms affected by his illness — in the case of one who believes he is radioactive and shuns all contact with other human beings, for example, freedom of association or interests related to sexual relations. If he is unable to make rational choices regarding such matters, he is "free" before commitment only in the descriptive sense that he is subject to no governmental constraint.⁴⁰

There are several false assumptions in such logic. First, it assumes that constitutional rights are worthy of protection only if those who hold them are medically or mentally capable of enjoying them. Generally, the law recognizes no such qualification to a person's constitutional rights.⁴¹ Such reasoning would import that the protection of a person's constitutional rights is dependent upon the vagaries of a psycho-medical determination of their ability to enjoy and utilize them, an inexact science at best. Second, while the author of this passage, Professor Garvey, claims that one may overestimate the value of this constitutional right to freedom in the case of the mentally ill, he underestimates the value of freedom from governmental constraint to the inmate, especially where conditions within the mental institution are substandard.⁴²

However, there is some indication that the Court is willing to consider such qualifications regarding the constitutional rights of mental patients. In *Addington v. Texas*,⁴³ a case considering the burden of proof necessary to justify commitment, the Court commented that mental illness could render a deprivation of constitutional rights less odious because of the debility involved:

[M]oreover, it is not true that the release of a genuinely mentally ill person is no worse for the individual than the failure to convict the guilty. One who is suffering from a debilitating mental illness and

40. Garvey, *Freedom and Choice in Constitutional Law*, 94 HARV. L. REV. 1756, 1789 n.140 (1981).

41. For a general discussion in this area, see Garvey, *supra* note 40, at 1758-62; *see also* note 78 and accompanying text.

42. Garvey, *supra* note 40, at 1758-62.

43. 441 U.S. 418 (1978).

in need of treatment is neither wholly at liberty nor free of stigma.⁴⁴

As shall be discussed later, perhaps the foundation underlying this stance is the idea or ethic that in the case of the mentally ill, a court should take a paternalistic stance emphasizing actions that would facilitate the treatment of mental illness, rather than protect a patient's civil rights.⁴⁵

The Court's subsequent treatment of the liberty interest of mental patients recognized in *O'Connor* in terms of substantive and procedural rights has been more fully treated in *Mills v. Rogers*.⁴⁶ Essentially, *Mills* held that the rights outlined in *O'Connor* represent only the bare minimum that a state must provide to a mental patient, both substantively and procedurally. State law may recognize rights more extensive than those protected by the Federal Constitution:

Because state-created liberty interests are entitled to the protection of the federal Due Process Clause, the full scope of a patient's due process rights may depend in part on the substantive liberty interests that extend beyond those minimally required by the Constitution of the United States. If a state does so, the minimal requirements of the Federal Constitution [as outlined by *O'Connor*] would not be controlling, and would not need to be identified in order to determine the legal rights and duties of persons within the State.⁴⁷

The possibility of heightened legal deference to the mentally ill, and by extension the mentally ill homeless, as a class is doubtful. A recent case, *City of Cleburne v. Cleburne Living Center*,⁴⁸ involving city zoning restrictions that prevented a group from operating a housing project for the mentally retarded, essentially precludes arguing that the rights of the mentally ill should receive heightened judicial scrutiny and protection by categorizing them as a "suspect class." The Court specifically held that mental retardation is not a suspect or quasi-suspect classification, meaning that laws relating to that group need only be rationally related to a legitimate state interest to be constitutional.⁴⁹ While clinically and medically there is a distinction between the mentally retarded and the mentally ill, there is no room to distinguish *Cleburne* on the grounds that the Court was considering the mentally retarded, not the mentally ill. Justice White's majority opinion clearly

44. *Addington*, 441 U.S. at 428.

45. See *infra* notes 79-89 and accompanying text.

46. 457 U.S. 291 (1982).

47. *Id.* at 299.

48. 105 S. Ct. 3249 (1985).

49. *Id.* at 3255-58.

sets the ground rules for arguments that the Court will entertain in this area in the future:

[I]f the large and amorphous class of the mentally retarded were deemed quasi-suspect for the reasons given by the court of appeals, it would be difficult to find a principled way to distinguish a variety of other groups who have perhaps immutable disabilities setting them off from others, who cannot themselves mandate the desired legislative responses, and who can claim some degree of prejudice from at least part of the public at large. One need mention in this respect on the aging, the disabled, the mentally ill, and the infirm. We are reluctant to set out on that course, and we decline to do so.⁵⁰

Setting itself against the potential avalanche of suspect classifications posed by the situation in *Cleburne*, the Court left the question of whether mental retardation would become a suspect classification to the legislatures, where the Court evidently believes the issue should be decided. Citing the landmark case *Massachusetts Board of Retirement v. Murgia*,⁵¹ the Court reminds us that:

[T]he lesson of *Murgia* is that where individuals in the group affected by a law have distinguishing characteristics relevant to interests the state has the authority to implement, the courts have been very reluctant, as they should be in our federal system and with our respect for the separation of powers, to closely scrutinize legislative choices as to whether, how, and to what extent those interests should be pursued. In such cases, the Equal Protection Clause requires only a rational means to serve a legitimate end.⁵²

Weakness in the Court's logic is ironically illuminated by the *Murgia* case itself. Justice White refers to a passage from *Murgia* to the effect that the Court declined to extend heightened review to differential treatment based on age because the aged "have not experienced a history of purposeful unequal treatment or been subjected to unique disabilities on the basis of stereotyped characteristics not truly indicative of their abilities."⁵³ By specifically citing this section, the *Cleburne* Court infers that the mentally retarded also have not been discriminated against on the basis of false stereotypes, a conclusion that is radically at odds with the history of treatment of the mentally retarded in this country.⁵⁴

50. *Id.* at 3257-58.

51. 427 U.S. 307 (1976).

52. *Cleburne*, 105 S. Ct. at 3255.

53. *Murgia*, 427 U.S. at 313.

54. For a discussion of this point, see Torari, *City of Cleburne v. Cleburne Living Center: Equal Protection for the Mentally Retarded?*, 9 HARV. J.L. & PUB. POL'Y 231 (1986).

But perhaps more important is that *Cleburne* could be a signal from the Court that the impetus and direction in shaping social policy in the area of mental health should come from Congress and the state legislatures, and not the judiciary. If this is the case, *O'Connor* and its progeny may have become the high-water mark in defining the rights of mental patients: for as long as the mentally ill remain a non-suspect class, restrictive and possibly quasi-discriminatory laws relating to the mentally ill can pass muster as long as the proposed statute is rationally related to a legitimate governmental interest. The possibilities are endless. Future measures could include toughening up state commitment statutes defining what types of behavior exhibited by the mentally ill constitute a "danger" to self and others. Additionally, zoning codes could be made more restrictive to exclude group houses and mental health centers, as was done in *Cleburne*. For while the court in *Cleburne* knocked down the zoning restrictions at issue, the court did not per se rule out restrictive zoning in relation to group homes. Health benefits, employment practices — in short any law relating to the mentally ill — could be affected by the lesser standard of review. The full impact of *Cleburne* remains to be seen.

Living Safely: New Issues in the Context of Homelessness

The *O'Connor* standard that a mental patient must be able to "live safely in freedom"⁵⁵ in order to gain release from an institution opens many areas of discussion regarding a released mental patient's potential for homelessness. The concept of "living safely" relates to the danger to himself and to others posed by the effects of a patient's mental illness, and his lifestyle and standard of living subsequent to release.⁵⁶ State statutes regarding commitment or continued confinement based upon a showing of danger to the patient or the public often incorporate definitions of dangerous behavior within the statute itself.⁵⁷ This guidance is often supplemented by a professional

55. *O'Connor v. Donaldson*, 422 U.S. 563, 575 (1975).

56. The Supreme Court in *Jackson v. Indiana* noted:

The bases [for the justification of involuntary civil commitments by the state] that have been articulated include dangerousness to self, dangerousness to others, and the need for care or treatment or training. Considering the number of persons affected, it is perhaps remarkable that the substantive constitutional limitations on this power have not been more frequently litigated.

406 U.S. 715, 738 (1972) (citations omitted).

57. An example of this is the Pennsylvania statute. It is particularly explicit. While naturally the statute includes under "danger to self" the risk of suicide or self-mutilation, the statute is very clear as to the danger posed by less immediate threats, requiring a finding that the:

[P]erson has acted in such manner as to evidence that he would be unable, without care, supervision, and the continued assistance of others, to satisfy his need for nour-

psychiatric evaluation of the patient.

When a state justifies the continued commitment of a mental patient based upon danger posed to the public at large, the state invokes its "police powers" to protect its citizens from harm or trauma.⁵⁸ A key consideration in the decision to commit or release a mental patient is the kind of harm to the public that the relevant statute, or subsequent judicial interpretation, seeks to prevent. In a 1961 District of Columbia case, *Overholser v. Russel*,⁵⁹ the court interpreted "dangerousness" in the then-current civil commitment statute⁶⁰ to include the commission of any criminal act, not just violent ones.⁶¹ In this case the criminal act was passing a bad check. For the mentally ill homeless, such an interpretation of what constitutes "dangerous behavior" could result in commitment if, for example, they were convicted of violating a vagrancy statute. Since violating the law — any law — is regarded as dangerous behavior, this situation would meet the constitutional requirement mandated by *O'Connor* that a mentally ill person pose a danger to himself or others before they legitimately could be confined.

The concept of dangerousness to self invokes the *parens patriae* power of a state to prevent a citizen from bringing harm to himself. The primary difficulty with this concept involves the imminence of harm to self necessary to constitute a danger sufficient to justify government intervention.⁶² Must the danger posed by a patient's behavior have immediate harmful consequences before the state may act, or could the applicable standard of dangerousness allow state action where the immediate harm to the patient is small but where there is a very harmful cumulative effect over time, such as the deleterious effects of slow starvation or malnutrition?

In the ground-breaking case of *Lessard v. Schmidt*,⁶³ the court defined dangerousness as a condition where there is an extreme likelihood that if the

ishment, personal or medical care, shelter, or self-protection and safety; and there is a reasonable probability that death, serious bodily injury, or serious physical debilitation would ensue within 30 days, unless adequate treatment were afforded under this act.

PA. STAT. ANN. tit. 50, § 7301 (Purdon 1985).

58. Frederick, *An Overview of Dangerousness: Its Complexities and Consequences*, in *DANGEROUS BEHAVIOR: A PROBLEM IN LAW AND MENTAL HEALTH* 9 (C. Frederick ed. 1978).

59. 283 F.2d 195 (D.C. Cir. 1960). See also *Fhagan v. Miller*, 29 N.Y.2d 348, 278 N.E.2d 615, 328 N.Y.S.2d 393, cert. denied, 409 U.S. 845 (1972).

60. D.C. CODE ANN. § 24-301 (Supp. VII 1959).

61. *Overholser*, 283 F.2d at 198.

62. See generally Brooks, *Notes on Defining the "Dangerousness" of the Mentally Ill*, in *DANGEROUS BEHAVIOR: A PROBLEM IN LAW AND MENTAL HEALTH* 37-60 (C. Frederick ed. 1978).

63. 349 F. Supp 1078 (E.D. Wis. 1972), remanded 414 U.S. 473 (1973).

person is not confined, he will do immediate harm to himself or others.⁶⁴ On remand from the Supreme Court, this standard was clarified as meaning "imminent dangerousness to self or others . . . based, at minimum, upon a recent act, attempt, or threat to do substantial harm."⁶⁵ The *Lessard* court emphasized the need for immediate harm to self or others for an act to be considered dangerous. In practice, such a standard of dangerousness would rule out state action where the danger involved is the long-term harm to a person that would result from malnutrition or exposure to the elements, the main physical dangers posed by homelessness.

However, in subsequent cases, most significantly *State ex rel. Hawks v. Lazaro*⁶⁶ and *Lynch v. Baxley*,⁶⁷ courts have taken the position that the danger posed by a slow deterioration that leads to death, such as through starvation or bodily neglect, could justify state intervention. With such a standard, the harm suffered by an individual need not be immediate or imminent to invoke the state's *parens patriae* power. This trend away from a requirement of immediate harm is reflected in *O'Connor*, where the Court noted that: "even if there is no foreseeable risk of self-injury or suicide, a person is literally 'dangerous to himself' if for physical or other reasons he is helpless to avoid the hazards of freedom either through his own efforts or with the aid of willing family members or friends."⁶⁸

During the winter of 1986, the question of danger to self became the focus of attention regarding the rights of homeless persons in New York City. There, Mayor Ed Koch granted police officers an expanded power to detain homeless persons whom they deemed not properly protected against the cold, and possibly to cause their subsequent commitment to a mental institution.⁶⁹ As a rule, the police in New York are empowered to detain anyone who appears mentally ill and is conducting himself in a manner "likely to result in serious harm to himself or others."⁷⁰ In past winters this power to detain has been invoked against those inadequately bundled against the freezing temperatures only on the coldest nights of the year, when the dan-

64. *Id.* at 1093.

65. *Lessard v. Schmidt*, 379 F. Supp. 1376, 1379 (E.D. Wis. 1974). It is noteworthy that *Newsweek* has reported a movement in Wisconsin, the state where *Lessard* was decided, to broaden the "danger" standard and allow involuntary commitment for the "obviously mentally ill." Morganthau, *supra* note 16, at 19, col. 2.

66. 157 W. Va. 417, 202 S.E.2d 109 (1974).

67. 386 F. Supp. 378 (M.D. Ala. 1974).

68. *O'Connor v. Donaldson*, 422 U.S. 564, 574 n.9 (1975).

69. Barbanel, *Homeless in City Facing Koch Edict*, N.Y. Times, Nov. 14, 1985, at A1, col. 3. For a suggestion of similar action by the Washington, D.C. police, see Engel, *Barry Urged to Use Police to Get Homeless Into Shelters*, Wash. Post, Dec. 28, 1985, at A1, col. 5.

70. Barbanel, *supra* note 69, at A1, col. 3.

ger posed by staying out-of-doors is most acute.⁷¹ During the winter of 1986, however, the Mayor authorized police to detain those endangered by the cold when the temperature dropped below thirty-two degrees Fahrenheit. Detentions potentially could occur far more often than under the former "coldest nights" standard.⁷² Those thought to be properly bundled against the cold were not to be disturbed.⁷³ If the detained person did not have recourse to a shelter, the officer was then instructed to call a supervisor and have the person ordered to a hospital, where he would be examined by a psychiatrist.⁷⁴ The psychiatrist would then make a determination if the person was to be released or admitted to the hospital.⁷⁵ The detainee would then be afforded the right to a lawyer and be bound over for a hearing before a judge.⁷⁶ An ironic twist is that the New York Civil Liberties Union mounted its own "Freeze Patrol" in an effort to inform the homeless of their right to resist this type of treatment.⁷⁷

*Value Judgments on Lifestyle: May a Person Prefer Homelessness
and Still Gain Release?*

One could conclude from the implications of judicial policy regarding danger to self that homelessness or the potential for homelessness could cause the commitment of a homeless person or bar a patient's release from a mental institution. Such conclusions, however accurate in practice, must be tempered somewhat by a statement in *O'Connor* that would place an upper limit on the extent to which a state can justify invoking its *parens patriae* power to "improve" a patient's lifestyle or standard of living:

May the state confine the mentally ill merely to ensure them a living standard superior to that they enjoy in the private community? That the state has a proper interest in providing care and assistance to the unfortunate goes without saying. But the mere presence of mental illness does not disqualify a person from preferring his home to the comforts of an institution. Moreover, while the state may arguably confine a person to save him from harm, incarceration is rarely if ever a necessary condition for raising the living standards of those capable of surviving safely in freedom, on their own or with the help of family or friends.⁷⁸

71. *Id.*

72. *Id.*

73. *Id.* at B11, col 4.

74. *Id.*

75. *Id.*

76. *Id.*

77. Morgenthau, *supra* note 16, at 19, col. 1.

78. *O'Connor v. Donaldson*, 422 U.S. 564, 575 (1975).

The distinction between what constitutes the permissible state objective of preventing harm to a patient or others, and the impermissible state objective of institutionalizing a person to raise their standard of living becomes crucial when one realizes the complexity of issues posed by the condition of homelessness. At what point does the prevention of harm end and social engineering by the state begin? Could retaining a patient in a mental institution to prevent him from becoming homeless be considered an improper attempt by the state to raise a person's standard of living? The issue becomes whether homelessness is a viable, acceptable, and constitutionally protectable lifestyle for some, or a dangerous behavior that legitimately invokes the state's *parens patriae* power to commit the dangerous mentally ill.

Again, *O'Connor* serves as the focal point of the analysis. Assuming, arguing, that the mentally ill could be easily and readily classified as those truly dangerous to themselves or others and those who demonstrate merely eccentric or strange behavior, it is clear that there is no constitutionally valid justification for retention by the state of the benign "oddball":

May the state fence in the harmless mentally ill solely to save its citizens from exposure to those whose ways are different? One might as well ask if the state, to avoid public unease, could incarcerate all who are physically unattractive or socially eccentric. Mere public intolerance or animosity cannot constitutionally justify the deprivation of a person's physical liberty.⁷⁹

The Court appears to recognize a "freedom of lifestyle" only to the point where the lifestyle in question constitutes a danger. It is not difficult conceptually to accept that homelessness, such as in the form of vagabondage,⁸⁰ would be classified as "socially eccentric" behavior.⁸¹ If it could be proved that such persons could "live safely" in this fashion, it follows that the Court's analysis in *O'Connor* would preclude homelessness as constituting a bar to release from a state mental hospital, or as causing a person's commit-

79. *Id.*

80. Webster defines a *vagabond* as "one who wanders about from place to place" and "one who wanders from place to place with no fixed dwelling or if he has one not abiding in it and who is without visible means of support." WEBSTER'S THIRD NEW INTERNATIONAL DICTIONARY 2528 (1981).

81. It must be emphasized that homelessness under these circumstances must be the result of rational choices freely arrived at, and these choices must not be the result of physical and mental debility. The problem lies in sorting out those who, although mentally ill, have made free and rational choices to live on the streets, and those who, through affliction by mental illness, have arrived at that decision impaired by such debility or delusion. It would be immoral to justify denying help to those who are on the streets involuntarily due to mental illness by claiming they have a right to live on the streets, or that they are in no danger. This "freedom of lifestyle" argument should apply only to those rational enough to make a deliberate choice for street life.

ment. However, the psychiatric community has, through its advisory role to the judiciary during commitment proceedings, effectively ruled out homelessness as a judicially/constitutionally protectable lifestyle. Almost invariably, psychiatrists advising the court find the innocuous-yet-strange behavior common to street people to be "dangerous," often disregarding the actual danger posed by the behavior to the individual or to the community. Behavior such as wandering,⁸² being a vagabond,⁸³ and eating out of trash cans,⁸⁴ are all characterized as dangerous behavior by psychiatrists during commitment proceedings. Indeed, as one commentator observes:

[L]eft by the courts to their own devices, psychiatrists are prepared to characterize virtually all deviant behaviors of mentally ill persons as dangerous. Since very few mentally ill persons are presented for commitment unless their behavior is perceived as somewhat deviant, the extent to which deviance is equated with dangerousness tends to render the dangerousness standard meaningless.⁸⁵

While it may be said that *O'Connor* stands for a reduction in the discretion allowed the psychiatric community regarding the commitment or retention of mental patients by requiring a finding of dangerousness, any judicial reliance upon a determination of dangerousness rendered by modern psychiatry reintroduces into the process an institutional bias of the psychiatric community. That bias favors commitment of the mentally ill for the treatment and ultimate cure of mental illness — any mental illness — regardless of the actual danger posed by the individual suffering from the disorder.

There is inherent conflict between the judiciary and the psychiatric profession regarding the disposition of mentally ill homeless. On one side, courts must protect a patient's constitutional rights as required by *O'Connor*.⁸⁶ On

82. Brooks, *supra* note 62, at 42.

83. *Id.*

84. *Id.*

85. *Id.* at 42-43. An extreme example of this misuse of the danger standard is reported by R. Schwitzgebel:

A 78-year-old female patient was found who had been committed to the Territorial Asylum for the Insane at Phoenix in 1912, shortly before Arizona became a state. When committed, she was a 19-year-old who, according to the official records, had several major "symptoms" which led to her commitment for dangerousness. Among her "symptoms" were: laughter, singing, a desire to dance, and a willingness to talk to anyone. These are behaviors not unlike those of a teenage girl who has, as the saying goes, fallen in love.

Schwitzgebel, *Legal and Social Aspects of the Concept of Dangerousness*, in DANGEROUS BEHAVIOR: A PROBLEM IN LAW AND MENTAL HEALTH 83 (C. Frederick ed. 1978) (citation omitted).

86. Bazelon, *Institutionalization, Deinstitutionalization and the Adversary Process*, 75 COLUM. L. REV. 897 (1975).

the other side is the psychiatric community's conservatism regarding the characterization of dangerous behavior that underlies an interest in the treatment of mental illness, not the protection of a person's civil rights.⁸⁷ This is not a passive conflict. Some have postured that while many psychiatrists are aware of the increasingly restrictive statutory definitions of dangerousness, they may at times actually "ignore this and manipulate the dangerousness concept in order to accomplish their treatment objectives."⁸⁸ Thus, the proper functioning of the civil commitment laws are subverted by a type of clandestine medical activism, at the expense of the patient's civil rights.

While the judiciary may not have the clinical expertise to diagnose and predict dangerousness in the mentally ill, if the freedoms to mental patients granted by *O'Connor* are to mean anything, then the judiciary must guarantee that the psychiatric diagnosis upon which a commitment decision is based is worthy of such reliance. Judge Bazelon summed up the duty for the judiciary very well when he stated:

[T]here is a central but limited role for courts in this system — that role is to guide professional decisionmaking, and may be best described by the familiar model of judicial review of administrative decisionmaking. Courts must determine whether there has been a full exploration of all relevant facts, opposing views and possible alternatives, whether the results of the exploration relate rationally to the ultimate decision, and whether constitutional and statutory procedural safeguards have been faithfully observed. *Our function is thus not to determine whether the decisions taken by those charged with handling disturbed or disturbing individuals are correct or wise — but whether they are rational in the manner I have just described*⁸⁹ (emphasis added).

What is necessary is recognition by the judiciary of the institutional biases,

87. Former Chief Judge David L. Bazelon, United States Court of Appeals for the District of Columbia Circuit, and a main participant in the struggle for civil rights for mental patients, writes:

Courts have traditionally been the protector of individual rights against state power, and there is no reason why the particularly difficult problems in the area of state intervention [in the institutionalization or deinstitutionalization of disturbed individuals] are any different. We cannot delegate this responsibility to the medical professions. Those disciplines are, naturally enough, orientated toward helping people by treating them. Their value system assumes that disturbed or disturbing individuals need treatment, that medical disciplines can provide it, and that attempts to resist it are misguided or delusory. The medical disciplines can no more judge the legitimacy of state intervention into the lives of disturbed or disturbing individuals than a prosecutor can judge the guilt of a person he has accused.

Bazelon, *supra* note 86, at 910 (footnotes omitted).

88. Brooks, *supra* note 62, at 43.

89. Bazelon, *supra* note 86, at 910 (footnotes omitted).

judicial as well as psychiatric, at work in the commitment process. There should be a balance struck between the liberty rights of the mentally ill and the general welfare of the community (and the individual as a member of that community) that has an interest in the treatment of mental illness. The goal should be not only to respect the rights of the citizen to be free from unnecessary governmental restraint and the right of the community to be free from dangerous behavior, but also to treat mental illness in order to preserve the quality of life for society at large, as well as for the individual.

Homelessness or potential homelessness has been treated by the courts (on the advice of the psychiatric community) as posing a danger to the mentally ill. It is, for all practical purposes, a viable justification for the state to commit or retain a patient in a mental institution. Even so, the problems of the mentally ill homeless do not end here. What of the deinstitutionalized mentally ill currently living in the streets and shelters today despite the psychiatric community's paternalistic view of commitment? The next section will evaluate the judicial and legislative responses to the growing number of mentally ill homeless on the streets.

III. PRESENT APPROACHES TO MENTAL ILLNESS AND HOMELESSNESS

The lame and the halt put their hymnals down joylessly, and Reverend Chester leaned over his lectern to look at tonight's collection. Among them, as always, were good men and straight, men honestly without work, victims of a society ravaged by avarice, sloth, stupidity, and a God made wrathful by Babylonian excesses. Such men were merely the transients in the mission, and to them a preacher could only wish luck, send prayer, and provide a meal for the long road ahead. The true targets of the preacher were the others: the dipsos, the deadbeats, the wetbrains, and the loonies, who needed more than luck. What they needed was a structured way, a mentor and guide through the hells and purgatories of their days.⁹⁰

While there is something to be said for abstract discussions regarding the constitutional rights of mental patients, it can be but cold comfort to a former mental patient who is now homeless to know that while he may take his meals from a dumpster and sleep on a park bench, he can rest assured that his very homelessness is a testament to the fact that his civil liberties have been adequately protected. Indeed, it is ironic that the rigorous protection of such a person's constitutional rights could result in their homelessness. One of the reasons for this harsh result is that, in general, most communities have little in the way of ability, facilities, or desire to take the steps necessary

90. W. KENNEDY, *supra* note 1, at 34.

to successfully absorb the deinstitutionalized mentally ill into the mainstream of their society. More often than not, the deinstitutionalized mental patient is released into an area lacking the aftercare support structures that would ensure his successful transition into the community. While homelessness resulting from deinstitutionalization is unfortunate, it should not come as a surprise because the success of deinstitutionalization was predicated on the presence of aftercare facilities, called community mental health centers, for the released patient.⁹¹ The lack of these facilities has been cited as a major factor in the general failure of deinstitutionalization.⁹² While it may not seem odd to find that two current strategies aimed at combatting homelessness have concentrated on providing services to the homeless at the survival-oriented shelter level and toughening up the standard for releasing patients from mental hospitals, it is disconcerting that the psychiatric community is still calling for the establishment of community mental health centers twenty years after deinstitutionalization began.⁹³

Shelters for the Homeless

Perhaps the most visible and direct form of aid for the homeless is the effort to provide for the most basic needs of those on the street: food and shelter. The majority of this effort is administered and funded locally because officially the federal government does not officially become directly involved in providing money and materials at the shelter level. The Department of Health and Human Services ("HHS") has stressed that "the primary responsibility in helping the homeless lies with local government and private and/or philanthropic organizations."⁹⁴ Official policy statements aside, the federal government has become involved to a certain extent in the effort at the shelter level, but not without controversy.

91. Nelson, *supra* note 9, at C1, col. 2. The motivation behind deinstitutionalization is subject to numerous explanations. First, an anti-institutional ideology has existed among the American public since the mid-nineteenth century, if not earlier. Americans abhor and fear the prospect of life in an institution. Second, "fiscal expediency" (i.e. a money crisis) may have prompted the state move to deinstitutionalize as a way to reduce costs. An example of this is New York. In the 1960's, New York lagged behind other states in reducing its mental hospital population. However, deinstitutionalization in New York accelerated (primarily through reduced admissions) in the late 1960's and early 1970's as its financial crisis loomed. Finally, the advent of deinstitutionalization has been prodded by entrepreneurial state leadership that seeks to take advantage of federal resources and adapt them to the purpose of deinstitutionalization. For example, a reduction in New Jersey of its institutionalized mentally retarded was not due to an assessment of their capabilities for living in the community, but rather it was an attempt to maximize Medicaid collections for the state. See generally P. LERMAN, *supra* note 2, at 79-87.

92. Nelson, *supra* note 9, at C1, col. 2.

93. *Id.*

94. Nelson, *supra* note 9, at C2, col. 5; H.R. REP. NO. 47, *supra* note 5, at 15.

Although the current federal administration maintains that the shelter effort should be handled at the local level, HHS does provide federal aid for emergency shelters, in the form of the HHS Homeless Task Force, Federal Emergency Management Agency ("FEMA") grants, and the Community Services Block Grant ("CSBG"). The latter two programs have funds that may be used to run shelters.⁹⁵

95. Department of Health and Human Services, *Shelter and Feeding the Homeless, A Resource Guide for Communities* 1 (undated), quoted in H.R. REP. NO. 47, *surpa* note 5, at 15. Most of the recent litigation regarding the homeless has concerned the due process necessary for a city or government to shut down a homeless shelter. The most celebrated case involves the proposed closing of the Washington, D.C. shelter run by the Community for Creative Non-Violence ("CCNV") located in a federally owned building at Second and D Street. *Robbins v. Reagan*, 616 F. Supp. 1259 (D.D.C.), *aff'd in part, rev'd in part*, 780 F.2d 37 (D.C. Cir. 1985). In district court, the judge held that the federal government could not close the facility until an alternate shelter had been found for the homeless housed there. On appeal, the court affirmed except to the extent that the lower court imposed requirements on the government that went beyond the resolution of the dispute at hand. Generally, a government may close a shelter if it follows proper procedures as set forth in its administrative laws. See *Williams v. Barry*, 708 F.2d 789 (D.C. Cir. 1983). The following is a chronology of events (as of Mar., 1986) in the CCNV shelter situation:

1. *January 15, 1984*: CCNV opens shelter at Second and D Street in Washington, D.C. in vacant federal building donated for that purpose. *Wash. Post*, Aug. 20, 1985, at A1, col. 5.
2. *Early 1984*: CCNV proposes five-million dollar renovation plan for the shelter, and asks the federal government to do the work. *Id.*
3. *September 15, 1984*: CCNV leader Mitch Snyder begins fast in an attempt to secure federal renovation of the shelter. *Id.*
4. *November 4, 1984*: Health and Human Services Secretary Margaret Heckler tells Snyder that President Reagan has agreed to make the Second and D Street facility a "model shelter." Snyder ends his fast. *Id.*
5. *March 18, 1985*: GSA estimates cost of the CCNV renovation plan at ten-million dollars. *Id.*
6. *May 30, 1985*: Federal government authorizes \$2.7 million for repair work on shelter. Snyder says planned repairs are inadequate. *Id.*
7. *June 17, 1985*: CCNV files suit to force the federal government to perform the proposed renovation. *Id.*
8. *June 21, 1985*: Federal government announces plans to close the Second and D Street shelter, stating that CCNV blocked rehabilitation efforts. *Id.*
9. *August 19, 1985*: Judge allows the federal government to close the shelter if inhabitants are relocated and a long-range plan is devised to eliminate homelessness in the Nation's Capitol. *Id.*
10. *November 14, 1985*: Federal government and D.C. Coalition for the Homeless open a shelter in Anacostia. Inhabitants at the CCNV Second and D Street shelter rumored to be preparing armed resistance to a federal eviction. *Wash. Post*, Nov. 10, 1985, at B1, col. 1; *Wash. Post*, Nov. 13, 1985, at A1, col. 2.
11. *December 28, 1985*: President Reagan blocks GSA plan to stage an assault on the CCNV shelter and delays any plans for eviction. *Wash. Post*, Dec. 29, 1985, at A1, col. 4.
12. *January 3, 1986*: Mayor Marion Barry pledges \$250,000 for emergency repairs to CCNV shelter. *Wash. Post*, Jan. 4, 1986, at A1, col. 2.

While not primarily designed as a source of money for shelters, the CSBG may be used to fund various anti-poverty programs, including emergency shelters. In fiscal year 1983, HHS estimated that twenty percent of these funds (a total of \$60 million) went to support emergency services.⁹⁶ However, these figures have not been verified.⁹⁷

Congress authorized FEMA to distribute \$100 million to groups providing services to the homeless during fiscal years 1983-85.⁹⁸ The fund is directed to state and local governments, with the remainder being earmarked for distribution to volunteer groups via an entity called the National Board.⁹⁹ The Board itself is comprised of representatives from charitable groups and FEMA.¹⁰⁰ However, the FEMA grants have several limitations. First, there are limits placed on the use of the money allocated by the National Board, especially in the area of capital expenditures, such as money earmarked for improvements on shelter facilities. Generally, there is a cap on capital expenditures for shelter facilities from this fund of \$500 per bed and \$5,000 per building.¹⁰¹ More importantly, however, is that the current funding of \$70 million a year is inadequate to meet the needs of the nation's homeless. It is estimated that the cost of services needed to aid the homeless in New York City alone were expected to exceed \$217 million in 1985.¹⁰²

The most visible direct aid from the federal government at the shelter level has been grants of government materials and facilities as a result of the efforts of the HHS Homeless Task Force. Created in 1983, the Task Force has attempted to arrange the transfer of materials to shelter groups from several federal agencies, most notably the Department of Defense ("DOD") and the General Services Administration ("GSA"). The materials slated to be transferred so far have consisted mostly of surplus building space from the GSA and DOD, and food from DOD commissaries. Unfortunately, this program has been ineffective due to HHS mismanagement, with little actual help being rendered.¹⁰³

13. *Mid-January, 1986*: Filming starts for television movie about Mitch Snyder and the CCNV shelter, starring Martin Sheen as Snyder. *Wash. Post*, Jan. 15, 1986, at B1, col. 1.

96. H.R. REP. NO. 47, *supra* note 5, at 20.

97. *Id.*

98. *Id.* at 19.

99. *Id.*

100. *Id.*

101. *Id.* at 19-20.

102. *Id.* at 15.

103. The history of the HHS Homeless Task Force almost strains credulity regarding the ineptitude with which the effort has been handled.

1. In fiscal 1984, the Department of Defense ("DOD") received eight million dollars from Congress to renovate 600 potential sites for emergency shelters identi-

"Least Restrictive Setting" and the McKinney Bill

On November 8, 1983, Representative Stewart B. McKinney introduced a bill¹⁰⁴ modifying the Public Health Service Act.¹⁰⁵ The bill was aimed directly at alleviating the problem of homelessness among deinstitutionalized mental patients.¹⁰⁶ Although the bill eventually died in committee, it was subsequently reintroduced into the House¹⁰⁷ in March 1986. Although its passage is still in doubt, the bill is worthy of further consideration because of the generally favorable response originally accorded to the bill by the press¹⁰⁸ and because it has been drafted specifically with the mentally ill homeless in mind.

The goal of the McKinney bill is to clarify the policy set down in the Public Health Service Act by requiring that mental patients be treated in the "optimum therapeutic setting."¹⁰⁹ The present policy under section 9501 of the Mental Health Systems Act is that a mental patient has a right to be treated in the "least restrictive setting."¹¹⁰ The McKinney bill defines the

fied by the DOD from among vacant military facilities. Of the eight-million dollars, only \$900,000 was obligated for the repair of two facilities, the balance going to maintain Army Reserve facilities. Since most of the eight-million dollars was not spent, Congress allotted the DOD only \$500,000 for the emergency shelter program in fiscal 1985. (However, the DOD has promised to supplement the program from elsewhere in its budget, if necessary.)

2. The Task Force also arranged with the DOD for the transfer of surplus food from 195 military commissaries to the homeless. According to the records of the Task Force, only 38 commissaries provided any amount of food. These contributions were of such limited quantity that they were described in HHS records as "unknown" and "minimal."

3. Another agreement made by the Task Force with the DOD was to provide vacant military warehouses to store emergency food. No military warehouses could be identified as being put to this purpose.

4. The GSA promised to provide the Task Force with surplus federal buildings for use as emergency shelters. Of 3,874 buildings that were surplus as of October 30, 1984, only three were under agreement for use as shelters.

H.R. REP. NO. 47, *supra* note 5, at 15-16.

104. H.R. 4330, 98th Cong., 1st Sess. (1983).

105. Public Health Service Act, ch. 288, 37 Stat. 309 (1912) (codified as amended throughout 42 U.S.C.).

106. Rep. McKinney stated that:

It is evident that the implementation of our original deinstitutionalization goals have been a failure at the very best. . . . I think in the rush to do right by the mentally ill we have replaced the institutions with the cold sidewalks of the East Side of New York and Southeast Washington.

Evans, *supra* note 7, at C6, col. 1.

107. H.R. 1479, 99th Cong., 2d Sess. (1986).

108. Raspberry, *Providing Help After the Institution*, Wash. Post, Nov. 7, 1983, at A19, col. 1.

109. H.R. 4330, *supra* note 104, at 1.

110. Mental Health Systems Act of 1980, 42 U.S.C. § 9501(a)(ii) (1982).

“optimum therapeutic setting” as being: “The environment that is least restrictive of an individual’s personal liberty and where the care, treatment, habilitation, or rehabilitation is particularly suited to the level of services necessary to properly implement an individual’s treatment, habilitation, and rehabilitation.”¹¹¹ The bill would require that mental patients be treated in facilities where they would be provided with support services “appropriate to such individual’s level of functioning.”¹¹² The practical effect of such a treatment policy would be to intensify the scrutiny of release/treatment programs by emphasizing the placement of a patient in the “best” location for the treatment of mental illness, rather than emphasizing the protection of personal liberties suggested by the “least restrictive setting” standard.

Such a common-sense approach to deinstitutionalization certainly has appeal — attacking the problem at its perceived source, the treatment and release goals of state mental hospitals. However, this plan has not escaped criticism. To some, the bill does not address the true problem with deinstitutionalization: the lack of community mental health centers. Rather, the McKinney bill seeks to solve the problem of homelessness among former patients by limiting the numbers that would be released instead of providing for an aftercare support system that would allow more patients to be released. Norman Rosenberg, director of the Mental Health Law Project, criticized the bill because it would actually reduce the pressure on local governments to develop appropriate community mental health facilities,¹¹³ with the result that the states would go back to relying on institutions for the treatment of the mentally ill.¹¹⁴

Although such criticism may be warranted, the McKinney bill does recognize that the availability of adequate out-patient mental health facilities should be a factor in the decision for release. The bill provides:

Individuals who are discharged from, or are in need of placement in, inpatient mental health facilities are informed of available community-based facilities and programs providing mental health treatment and related support services, and provided access to a sufficient number of adequately funded community-based facilities and programs providing mental health and related support services.¹¹⁵

These requirements relate back to the considerations of “living safely in free-

111. H.R. 4330, *supra* note 104, at 2.

112. *Id.*

113. Evans, *supra* note 7, at C6, col. 1.

114. *Id.*

115. H.R. 4330, *supra* note 104, at 2.

dom" discussed in *O'Connor*.¹¹⁶ Here, "optimum therapeutic setting" would take into consideration the existence of adequate community support systems that would enable the released patient to survive outside the institution and "avoid the hazards of freedom."¹¹⁷ While the McKinney bill shows an appreciation for the necessity of providing an adequate aftercare support structure in a release/treatment program, the spotty existence of community mental health facilities could mean that a mental patient's *O'Connor* rights to release could be restricted. Release would depend upon the existence of adequate post-release support facilities in the area where he is to be released, making him a prisoner to geography if his area has no acceptable system.

The Missing Element: Community Mental Health Centers

As has been previously noted, many of the problems associated with the deinstitutionalization movement can be attributed to the lack of community mental health centers available to provide guidance, counseling, and outpatient treatment needed by the mentally ill in the community.¹¹⁸ With fewer persons institutionalized because of restricted admissions to state mental hospitals and the release of mental out-patients,¹¹⁹ such centers are crucial to the successful care and treatment of the mentally ill in the community. In terms of this discussion, these centers represent a means to prevent the con-

116. *O'Connor v. Donaldson*, 422 U.S. 564, 575 (1975). The Court in *O'Connor* also considered the necessity of an aftercare support structure of some type when making a release decision: "In short, a State cannot constitutionally confine without more a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing responsible family members or friends." *Id.* at 576 (emphasis added).

117. *Id.* at 574 n.9.

118. The need for community mental health centers has emphatically been brought home by the case of Joel Rabinowitz of Alexandria, Virginia. Diagnosed as schizophrenic in 1976, he had been receiving psychiatric treatment and appeared to be making progress. However, in January of 1985 he began to feel that he required more care than the outpatient treatment he had been receiving. He checked into Alexandria Hospital, but was discharged after one night because his condition was not considered acute enough to require hospitalization. This pattern was to continue. Alexandria has few available facilities to provide a non-institutional supervised environment for the mentally ill not in immediate crisis, such as Joel. As of January 2, 1986, Joel has been shuttled between 14 facilities and is still not permanently placed. He has been placed in a YMCA, an alcoholism detoxification center (although Joel has no alcohol problem), jail, Western State Hospital after assaulting a nurse at Alexandria Hospital when he was told that he would not be re-admitted, and a city-supervised apartment where, unfortunately, he caused a fire because of a smoking accident. At one point, while Joel was staying with his parents, the Rabinowitz's were forced to have Joel arrested for trespassing in order to create a "crisis" situation to get him immediate help. This episode landed Joel in jail for three days, another stay at an alcoholism detox center, and back to the YMCA. Jordan, *After 14 Moves, Alexandria Psychiatric Patient Still Has No Home*, Wash. Post, Jan. 2, 1986, at C1, col. 1.

119. H.R. REP. NO. 47, *supra* note 5, at 4.

dition of homelessness among the mentally ill, not just alleviate the symptoms.

The number of community mental health centers that have actually been established is much lower than the projected need. Currently, fewer than 800 of the estimated 2000 centers needed to provide such care have been established.¹²⁰ This is not to suggest, however, that no new facilities are coming into existence. Some communities have exhibited a newfound sensitivity to the problem of homelessness among the mentally ill due to irresponsible release and outpatient treatment programs. Recent developments in the District of Columbia are a case in point. There, massive reductions of the inmate population at St. Elizabeth's Mental Hospital (a drop from 1600 to 800 on-site patients)¹²¹ will be carried out only when appropriate mental health facilities to handle these former patients have been created within the community.¹²²

It is interesting to note the problems that have beset the District of Columbia effort to find neighborhood facilities to handle and care for these released patients — community resistance to the placement of centers in their neighborhood and the inability to find suitable low-cost residential facilities. Most of the facilities being set up in Washington, D.C. have had to be placed in small homes situated in poor neighborhoods.¹²³ As a result, locations for facilities that have been found have been criticized because they are situated in areas low in employment opportunities and other community facilities, and because the sites selected are in dangerous or volatile neighborhoods.¹²⁴ Additionally, there has been resistance to the placement of mental health facilities in these neighborhoods.¹²⁵ This resistance should come as no surprise, however, because from the inception of the deinstitutionalization movement it was foreseen that communities would react adversely to the suggestion that an outpatient facility for the mentally ill be placed in their

120. *Id.*

121. Evans, *The District Plans Patient Cutbacks at St. Elizabeth's*, Wash. Post, Nov. 19, 1985, at A1, col. 4.

122. *Id.* at A12, col. 2.

123. *Id.*

124. *Id.*

125. *Id.* at A1, col. 4. In the case of restrictive zoning, the future impact of *Cleburne* remains to be seen. *City of Cleburne v. Cleburne Living Center*, 105 S. Ct. 3249 (1985). In that case *Cleburne Living Center* challenged a restrictive local ordinance that prevented them from establishing a group home for the mentally retarded in a housing development. Although the Court struck down the statute in question, they held that the mentally retarded are not a "suspect classification," hence any law regarding the mentally retarded need only be rationally related to a legitimate state interest to pass constitutional muster. This could open the door to more restrictive zoning laws, ostensibly founded on legitimate interests, that could prevent community mental health centers from being established.

neighborhood. Ten years ago, Judge Bazelon remarked that a certain amount of community backlash to the creation of community mental health centers could be expected: “[i]t [the uproar over deinstitutionalization] provides a glimpse of the backlash that could be expected — from demands of restrictive zoning laws to editorial demands for the establishment of “rural havens” for the mentally disturbed. The solution sounds suspiciously like the institutional refugees of the nineteenth century.”¹²⁶ While the reaction has not been quite this virulent, one need only to refer back to the restrictive zoning laws at issue in *Cleburne* for a case in point.

As with the shelter system, the federal government sees the establishment of community mental health centers as a local problem. At present, there is little direct participation in the establishment of such centers by the federal government, although there are grants available from Health and Human Services (the Alcohol, Drug Abuse and Mental Health (“ADAMH”) Block Grant) to fund such centers through the states.¹²⁷

Initially, the federal government became directly involved in the funding of community mental health centers with the passage in 1963 of the Community Mental Health Centers Construction Act.¹²⁸ The idea was to stimulate state and local contributions for the establishment of these centers by making monies available directly to the programs being established, with the goal of eventually phasing out federal participation. In the years following the passage of the Act, Congress passed legislation that increased the scope of the care offered beyond the mentally ill, eventually including drug and alcohol treatment centers, and facilities for missing children. Federal funding grew from an initial figure of thirty million dollars in 1965, to a high of \$298 million in 1979.¹²⁹ In 1981, the last year of the program before it was repealed by the Reagan Administration, the federal outlay was \$270 million, with only twenty percent of that figure going to the chronically mentally ill.¹³⁰

The Omnibus Budget Reconciliation Act of 1981¹³¹ repealed most of the existing provisions and amendments to the Community Mental Health Centers Construction Act and the subsequent Mental Health Systems Act of

126. Bazelon, *supra* note 86, at 907.

127. H.R. REP. NO. 47, *supra* note 5, at 20.

128. Mental Retardation Facilities and Community Health Centers Construction Act of 1963, Pub. L. No. 88-164, 77 Stat. 282 (codified as amended throughout 20 U.S.C. and 42 U.S.C.).

129. M. BURT & K. PITTMAN, TESTING THE SOCIAL SAFETY NET 73 (1985).

130. *Id.*

131. Omnibus Budget Reconciliation Act of 1981, Pub. L. No. 97-35, 95 Stat. 357 (codified as amended in scattered sections of 42 U.S.C.).

1980,¹³² and replaced them with the Alcohol, Drug Abuse, and Mental Health Block Grant ("ADAMH"). The Block Grant program made two major changes to the then existing federal funding program. First, instead of making direct payments of federal funds to the centers in question, the government makes these funds available to the state to spend in line with their own priorities and programs. Second, the amount of federal money being spent has decreased significantly. In the years immediately following the establishment of the ADAMH Block Grant (1982-1984), the level of federal spending decreased by twenty-two to twenty-six percent (in constant 1981 dollars) from the 1981 level.¹³³ Roughly fifty percent of the grant money is spent on mental health programs, however; HHS has no data on the number of homeless people benefitting from this funding.¹³⁴

Surprisingly, these cuts in federal funding do not necessarily mean that state mental health programs have suffered during the Reagan years. While the overall amount of federal money available has been reduced, increased state control over monies available has meant that the funds are being spent more in line with state priorities.¹³⁵ According to at least one commentator, individual state priorities have always been somewhat more directed toward the chronically mentally ill, which would include the mentally ill homeless, than the wide range of populations served under the former federal program.¹³⁶ As a result of this focus upon programs designed for the chronically mentally ill, some have concluded that these individuals, and by inclusion the mentally ill homeless, probably have not suffered greatly from reductions in federal funds.¹³⁷

It would appear that the federal government has little inclination to establish its own series of community mental health centers. The most that a recent house report (which was very critical of the current administration's effort on behalf of the homeless) was willing to suggest in terms of direct federal participation in creating aftercare support facilities was to have the National Institute of Mental Health formulate models of community mental health centers, with no actual federal creation of such facilities.¹³⁸ Additionally, the report suggested that Congress should appropriate funds for shelter demonstration projects in order to study effective means of providing mental health care at the shelter level.¹³⁹ More direct federal aid is not going to

132. Mental Health Systems Act of 1980, 42 U.S.C. § 9501(i)(a)(ii) (1982).

133. M. BURT & K. PITTMAN, *supra* note 129, at 76.

134. H.R. REP. NO. 47, *supra* note 5, at 20.

135. M. BURT & K. PITTMAN, *supra* note 129, at 75.

136. *Id.* at 76.

137. *Id.* at 77.

138. H.R. REP. NO. 47, *supra* note 5, at 29.

139. *Id.* at 30.

happen during this Administration, given its stated position and the general tightening of the federal budget.¹⁴⁰ It is to the credit of Congress that it has consistently appropriated more funding in the mental health area than the Administration has requested.¹⁴¹

V. CONCLUSIONS

The most important factor in deriving a humane solution to the problem of mentally ill homeless is the establishment of community mental health centers to provide a support structure for those needing help, helping both the released mental patient and the mentally ill who do not qualify for institutional care. Such centers are aimed at the prevention of homelessness, not just the alleviation of the most visible symptoms. Additionally, the creation of such centers would allow more liberal treatment/release programs designed to protect the *O'Connor* rights of a mental patient regarding non-restrictive treatment, absent a showing of dangerousness. This is not to say that these programs should be implemented at the expense of the shelter effort to provide for the immediate and pressing needs of the homeless; in light of the realities of limited manpower and funds to devote to the plight of the homeless, some hard choices might have to be made regarding government funding. Hopefully, private or local efforts will be able to compensate where the need for shelter is great and funds are short. The key to establishing community mental health centers will be motivating federal, state and local governments to coordinate efforts utilizing the resources that are on hand,¹⁴² and to create new and as yet unfound resources in the community itself. The increasing presence of the homeless within the community just may be the pressure needed to rouse politicians and citizens to action at the local level. Given the serious nature and size of the problems, finding a solution to homelessness is not just a priority, it is a necessity.

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140. Lerman notes that:

There has been a lack of interest at the federal level in allocating funds to significantly favor community over traditional placements in the [mental retardation] and [mental illness] fields. The tendency instead has been for the federal government to rhetoricize in favor of [deinstitutionalization], while leaving it to the States to deal as best they can with issues of implementation.

P. LERMAN, *supra* note 2, at 89.

141. M. BURT & K. PITTMAN, *supra* note 129, at 75.

142. "Given these disparate sources of operational policies and the absence of any central 'lead' agency within the federal government, it is not surprising that there is a clear lack of consistent policy at the national level." P. LERMAN, *supra* note 2, at 12.

