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BEYOND LEAST RESTRICTIVE ALTERNATIVE: A CONSTITUTIONAL RIGHT TO TREATMENT FOR MENTALLY DISABLED PERSONS IN THE COMMUNITY

*Jan C. Costello**
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I. INTRODUCTION

These are challenging times for legal advocates of a right to community-based treatment services¹ for mentally disabled persons.² The optimism created by early "right to treatment" decisions³ mandating sweeping reforms in institutional conditions has been eroded by the prevailing climate of "judicial restraint"⁴ and "deference to professional judgment."⁵ Before the United States Supreme Court decided *Youngberg*

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1. "Community-based treatment" is defined at *infra* note 26.

2. The term "mental disability" includes individuals diagnosed as mentally ill and individuals who are developmentally disabled. See *Developmentally Disabled Assistance and Bill of Rights Act*, 42 U.S.C. §§ 6000-6081 (1982); *AMERICAN ASSOCIATION ON MENTAL DEFICIENCY, CLASSIFICATION IN MENTAL RETARDATION* (rev. 1983); *AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS* (3d ed. 1980). This Essay is concerned with those mentally disabled persons whose disability is severe enough to prevent them from functioning independently in the community. These people, because of their inability to function, come to the attention of the state through the criminal justice or civil mental health systems; they are "mentally disabled enough" so that the state is compelled to "do something about them."

3. See *infra* text accompanying notes 8-9 & 52.

4. See, e.g., Brant, Pennhurst, Romeo and Rogers: *The Burger Court and Mental Health Law Reform Litigation*, 4 J. LEGAL MED. 323, 348 (1983) (Supreme Court discouraging federal courts from interfering with operation of state facilities for mentally disabled persons).

5. *Youngberg v. Romeo*, 457 U.S. 307, 322 (1982). See *infra* text accompanying notes 94-103 for a discussion of post-*Youngberg* courts' interpretation of this phrase.

v. *Romeo*,⁶ advocates could assert a combination of strict scrutiny and clinical standards when they asked federal courts to order the development of appropriate community-based treatment services and placements for mentally disabled persons.⁷ Several lower courts, appalled by the conditions in institutions, and aware of the disappointing record of court-mandated and supervised reform,⁸ enunciated a constitutional doctrine of "right to treatment in the least restrictive alternative."⁹ "Least restrictive alternative" became a catch phrase for community-based treatment among mental health professionals and advocates.¹⁰

According to some courts and commentators, the Court in

6. 457 U.S. 307.

7. In asserting such a "right to treatment in the least restrictive alternative," advocates equated "least drastic means" with community-based treatment. See generally Chambers, *Alternatives to Civil Commitment of the Mentally Ill: Practical Guides and Constitutional Imperatives*, 70 MICH. L. REV. 1108 (1972); Spece, *Justifying Invigorated Scrutiny and the Least Restrictive Alternative as a Superior Form of Intermediate Review: Civil Commitment and the Right to Treatment as a Case Study*, 21 ARIZ. L. REV. 1049 (1979). Because involuntary hospitalization caused severe loss of liberty, advocates argued that the state's purposes of treatment and protection of nondangerous mentally disabled persons could be fulfilled by non-hospital treatment. Therefore, mentally disabled persons had a constitutional right to receive treatment in such less restrictive settings. See *infra* note 9; see also Chambers, *supra*, at 1145-51. See generally S. HERR, S. ARONS & R. WALLACE, *LEGAL RIGHTS AND MENTAL HEALTH CARE* (1983).

8. See Gary W. v. Louisiana, 601 F.2d 240 (5th Cir. 1979); New York State Ass'n for Retarded Children v. Carey, 596 F.2d 27 (2d Cir.), *cert. denied*, 444 U.S. 836 (1979); Dixon v. Weinberger, 405 F. Supp. 974 (D.D.C. 1975); Wyatt v. Stickney, 325 F. Supp. 781 (M.D. Ala. 1971), *aff'd in part, remanded in part sub nom.*, Wyatt v. Aderholt, 503 F.2d 1305 (5th Cir. 1974). See generally Lottman, *Paper Victories and Hard Realities*, in PAPER VICTORIES AND HARD REALITIES: THE IMPLEMENTATION OF THE LEGAL AND CONSTITUTIONAL RIGHTS OF THE MENTALLY DISABLED 93 (1976); Special Project, *The Remedial Process in Institutional Reform Litigation*, 78 COLUM. L. REV. 784 (1978); Note, *Implementation Problems in Institutional Reform Litigation*, 91 HARV. L. REV. 428 (1977); Note, *The Wyatt Case: Implementation of a Judicial Decree Ordering Institutional Change*, 84 YALE L.J. 1338 (1975).

9. See Rouse v. Cameron, 373 F.2d 451 (D.C. Cir. 1966); Lake v. Cameron, 364 F.2d 657 (D.C. Cir. 1966); Pennhurst State School and Hosp. v. Halderman, 446 F. Supp. 1295 (E.D. Pa. 1977), *aff'd in part, rev'd in part*, 612 F.2d 84 (3d Cir. 1979), *rev'd*, 451 U.S. 1 (1981), *on remand*, 673 F.2d 647 (3d Cir. 1982) [hereinafter *Pennhurst I*]; see also Gary W. v. Louisiana, 601 F.2d 240 (5th Cir. 1979) (consent decree); Brewster v. Dukakis, No. 76-4423-F (E.D. Mass. Dec. 6, 1978) (final consent decree), *reprinted in* 3 MENTAL DISABILITY L. REP. 45 (1979), *enforced*, 544 F. Supp. 1069 (D. Mass. 1982), *aff'd as modified*, 786 F.2d 16 (1st Cir. 1986). As a result of the *Brewster* litigation, Massachusetts implemented a state-wide plan of developing community programs and reducing institutional populations. See *Community Based Residential Services for Mental Health Clients*, 3 MENTAL DISABILITY L. REP. 150 (1979). See also Dixon, 405 F. Supp. 974.

10. Although least restrictive alternative is a legal concept, it has been used by mental health professionals and service providers as a clinical term meaning community placement: "Least restrictive" has taken on new meanings in the legal context in the past twenty years. Because some of these meanings have had an impact on service providers, the idea of "least restriction" has leaked into the lingo, where it has acquired new conno-

Youngberg declared a narrower right to "minimally adequate treatment,"¹¹ thus eliminating any constitutional basis for a right to community-based services. Such a conservative reading emphasized the Court's rejection of a "least intrusive means"¹² test to determine the adequacy of treatment provided to a severely mentally retarded person within an institution. These commentators would interpret the Court's admonition of deference to "professional judgment" as shielding from court scrutiny virtually any decision regarding placement of mentally disabled persons in an institution.¹³

Thus, an increasing number of courts find support in *Youngberg* for the proposition that "there is no constitutional right to a least restrictive environment"¹⁴ and thus no right to community mental health treatment. Other post-*Youngberg* courts find that for some mentally disabled persons, community-based treatment is "minimally adequate"—and thus constitutionally required where there is a professional consensus that hospital confinement is inappropriate and community treatment appropriate.¹⁵ These rulings, however, have thus far been applied only to indi-

tations probably not intended by the lawyers who brought it into the vocabulary of the human service professionals.

Perhaps the greatest problem faced by professionals in adopting the principle has been the tendency to invoke stereotypic responses around "mainstreaming" and "deinstitutionalization" as being, in themselves, mandatory and desirable for every individual.

THE LEAST RESTRICTIVE ALTERNATIVE: PRINCIPLES AND PRACTICES 41 (H. Turnbull, III ed. 1981); see also Miller, *The Least Restrictive Alternative: Hidden Meanings and Agendas*, 8 COMMUNITY MENTAL HEALTH J. 46 (1982) (debate over whether community facilities are *ipso facto* less restrictive than institutions).

The movement of developmentally disabled persons from large institutions into less restrictive community settings was supported by the "normalization principle." This principle advocated the socialization of developmentally disabled persons by "the utilization of means which are as culturally normative as possible, in order to establish and/or maintain personal behaviors and characteristics which are as culturally normative as possible." S. BRAKEL, J. PARRY & B. WEINER, *THE MENTALLY DISABLED AND THE LAW* 617 (3d ed. 1985) (citing W. WOLFENBERGER, B. NIRJE, S. OLSHANSKY, R. PERSKE & P. ROOS, *THE PRINCIPLE OF NORMALIZATION IN HUMAN SERVICES* 28 (1972)).

11. *Youngberg*, 457 U.S. at 322. For courts' varying interpretations of "minimally adequate treatment," see *infra* text accompanying notes 90-94 & 97-102.

12. See *infra* notes 74-80 and accompanying text & notes 86-89 and accompanying text.

13. *Youngberg*, 457 U.S. at 321-23. *Youngberg* only requires deference to decisions made by qualified professionals who actually exercise professional judgment. This Essay argues that professional deference is not required where, for example, a state mental health administrator limits available community placements for non-clinical reasons such as budgetary limits or administrative convenience. See *infra* text accompanying notes 104-10.

14. *Society for Good Will to Retarded Children v. Cuomo*, 737 F.2d 1239, 1249 (2d Cir. 1984); see also *Lelsz v. Kavanagh*, 807 F.2d 1243, 1249 (5th Cir. 1987).

15. *Clark v. Cohen*, 794 F.2d 79, 87 (3d Cir.), *cert. denied*, 107 S. Ct. 459 (1986); *Thomas S. v. Morrow*, 781 F.2d 367, 375 (4th Cir.), *cert. denied*, 106 S. Ct. 1992 (1986) and 107 S. Ct. 235 (1986); *Woe v. Cuomo*, 729 F.2d 96, 105-06 (2d Cir.), *cert. denied*, 469 U.S. 936 (1984);

viduals who are or have been unnecessarily institutionalized. Such a limited right cannot help mentally disabled persons who, although they have never been involuntarily hospitalized, are at risk of losing their liberty through future hospitalization or whose liberty is restricted by other forms of state action. Moreover, a right to adequate treatment should not be conditioned on institutionalization.

We believe that both post-*Youngberg* interpretations are deficient. After *Youngberg*, there may be no federal constitutional right to treatment "in the least restrictive setting." There is, however, a federal constitutional right to *community-based treatment*, where such treatment is "minimally adequate" and institutionalization is not.¹⁶ That constitutional right to community-based treatment belongs not merely to institutionalized mentally disabled persons, but also to those *at risk* of institutional confinement, and those whose liberty is subject to other forms of state restraint. This Essay will describe the right to community-based treatment, explaining how it both builds upon and may be distinguished from the earlier "least restrictive alternative" right. It will critically analyze the post-*Youngberg* decisions, emphasizing their identification of the liberty interests at stake, and their interpretation of "minimally adequate" and "deference to professional judgment." Finally, by reconsidering the concept of "state restriction of liberty," it will propose extending the right to community-based treatment to *noninstitutionalized* mentally disabled persons.¹⁷

II. THE NEED FOR A RIGHT TO COMMUNITY-BASED TREATMENT

The search for a workable theory of right to community-based treatment is more than an intellectual diversion. Now, just as before *Youngberg*, thousands of people with mental disabilities who could be served in a community setting far less restrictive than a large institution

Association for Retarded Citizens of North Dakota v. Olson, 561 F. Supp. 473, 487 (D.N.D. 1982), *aff'd in part, modified and remanded on other grounds*, 713 F.2d 1384 (8th Cir. 1983). These courts stressed that they actually deferred to "professional judgment" in finding a right to community-based services, since a professional consensus exists which mandates, as minimally adequate, treatment in the community for individuals who do not require hospitalization. See *infra* text accompanying notes 95-97 & 100.

16. See *infra* text accompanying notes 71-112.

17. Two earlier commentators have advanced theories of a right to treatment for mentally disabled persons not confined in institutions. Rapson, *The Right of the Mentally Ill to Receive Treatment in the Community*, 16 COLUM. J.L. & SOC. PROBS. 193, 236-39 (1980); Note, *The Constitutional Right to Treatment Services for the Noncommitted Mentally Disabled*, 14 U.S.F.L. REV. 675, 697-99 (1980). However, both articles were written before *Youngberg*. The first relies on a *quid pro quo* analysis; the second assumes a constitutional right to treatment "in the least restrictive setting." See Rapson, *supra*, at 236-39; Note, *supra*, at 697-99.

remain hospitalized.¹⁸ Thousands more find themselves in the community without the treatment and support they need to survive.¹⁹ This lack of treatment and support is the result, in large part, of states' failure to shift mental health resources into the community when large state institutions drastically reduced their populations by discharging patients and limiting bed capacity.

The policy of treating mentally disabled persons in the community rather than in institutions to the maximum extent possible is referred to as "deinstitutionalization."²⁰ Its avowed purpose, to provide more appropriate treatment in the community for mentally disabled persons, has

18. For example:

In 1980, there were approximately 1.8 million episodes of psychiatric in-patient care in the specialty mental health sector and an estimated 1 million or more episodes in the general medical sector. Although the vast majority of hospital stays are for less than 30 days, approximately 125,000-150,000 individuals are long term residents (1 year or longer) of psychiatric hospitals.

REV. GEN. PSYCHIATRY, (H. Goldman ed. 1984), reprinted in 1 MENTAL HEALTH LAW PROJECT, PROTECTION & ADVOCACY FOR PEOPLE WHO ARE LABELED MENTALLY ILL 55, 58 (1987). See also Goldman, Taube, Regier & Witkin, *The Multiple Functions of the State Mental Hospital*, 140 AM. J. PSYCHIATRY 296 (1983).

"Put another way, the answer to the policy question, Are we institutionalizing too many people?, . . . studies . . . indicate a very clear and unqualified yes." Kiesler, *Mental Hospitals and Alternative Care—Noninstitutionalization as Potential Public Policy for Mental Patients*, 37 AM. PSYCHOLOGIST 349, 358 (1982); see H. Lamb, *Deinstitutionalization and the Homeless Mentally Ill*, in THE HOMELESS MENTALLY ILL 55 (H. Lamb ed. 1984) (professional literature shows that it is possible to maintain even severely disabled persons in the community with adequate funding and program design).

19. In Los Angeles County, approximately 35,000-50,000 chronically mentally ill people are not receiving treatment services and are at risk of being rehospitalized. Opening Brief for Appellants at 4, *Mental Health Ass'n v. Deukmejian*, 186 Cal. App. 3d 1531, 233 Cal. Rptr. 130 (1986) (No. 2 Civ. B 014479) (ordered depublished) (citing trial court Statement of Decision, Finding 16). See *infra* note 24.

20. Deinstitutionalization began in the 1950's in response to a variety of diverse factors. The first of these was the introduction of psychotropic medications. "Psychotropic [medications] are chemical agents that have an effect on the mind." R. WALDINGER, FUNDAMENTALS OF PSYCHIATRY 396 (1986). They fall into three major groups: antipsychotic agents, antidepressants and antimanic agents. *Id.* at 397. Accompanying the use of medications was the development of a professional consensus that the long-term warehousing of mentally disabled persons in state institutions was dehumanizing and harmful. See S. HERR, THE NEW CLIENTS: LEGAL SERVICES FOR MENTALLY RETARDED PERSONS 16 (1979); Kiesler, *supra* note 18, at 350-51. See generally E. GOFFMAN, ASYLUMS (1961). Moreover, courts began to recognize that institutionalized persons have civil rights. See generally *Developments in the Law—Civil Commitment of the Mentally Ill*, 87 HARV. L. REV. 1190 (1974); see also *infra* text accompanying notes 50-51 for a discussion of procedural due process cases. Additionally, fiscal conservatives viewed deinstitutionalization as a way to save state resources and shift fiscal responsibility onto federal programs, i.e., community mental health centers, Medicare, Medicaid, Supplemental Security Income and Social Security Disability Insurance. All of these factors contributed to a massive shift of mentally disabled persons into the community, in which the population in state mental hospitals was reduced from approximately 560,000 in 1950 to less than 140,000 in 1980. Goldman & Morrissey, *The Alchemy of Mental Health Pol-*

not been realized.²¹ The result is that today thousands of mentally disabled persons, who once would have been "treated," albeit inappropriately in large institutions, now find themselves in the community without any services or support.²² They are often drawn into a cycle of multiple hospitalizations, short-term involuntary treatment and release known as "the revolving door." The term "revolving door" graphically describes the plight of the chronically mentally disabled as they deteriorate in the community to the point where they are admitted in acute crisis to a hospital, oftentimes via the local jail. They are then stabilized on medication in the hospital and released with no discharge planning or aftercare services. Without treatment or community support services, they again decompensate to the point of requiring hospitalization, revolving continuously back and forth between hospitals and the streets.²³

Thus, for many mentally disabled persons, the continual intrusiveness of institutional life has been replaced by absolute neglect, punctuated by periods of acute state intervention through short-term civil commitment or incarceration via the criminal justice system. This neglect has reached the public consciousness as a result of publicity surrounding the "mentally disabled homeless."²⁴ The likely political

icy: *Homelessness and the Fourth Cycle of Reform*, 75 AM. J. OF PUB. HEALTH 727, 728 (1985).

21. By the 1970's, the deinstitutionalization movement was being severely criticized for "dumping" mentally disabled persons into the community without adequate treatment and support. GENERAL ACCOUNTING OFFICE, RETURNING THE MENTALLY DISABLED TO THE COMMUNITY: GOVERNMENT NEEDS TO DO MORE (1977); PRESIDENT'S COMMISSION ON MENTAL HEALTH: REPORT TO THE PRESIDENT 4-5 (1978); Mills & Cummins, *Deinstitutionalization Reconsidered*, 5 INT'L J.L. & PSYCHIATRY 271, 277 (1982); Rhoden, *The Limits of Liberty: Deinstitutionalization, Homelessness, and Libertarian Theory*, 31 EMORY L.J. 375 (1982).

22. Some of these people end up in jails, inadequate board and care homes, locked skilled nursing facilities, or welfare hotels. S. BRAKEL, J. PARRY & B. WEINER, *supra* note 10 (citing Bassuk & Garson, *Deinstitutionalization and Mental Health Services*, 238 SCI. AMER., Feb. 1978, at 46). Some are homeless. Some are caught in the cycle of hospitalization, release and rehospitalization known as "the revolving door." Those who are severely developmentally disabled or "hard-core" chronically mentally ill, are still subjected to long-term institutional confinement. For statistical information on the developmentally disabled populations in institutions versus community programs, see Braddock, *Deinstitutionalization of the Retarded: Trends in Public Policy*, 32 HOSP. AND COMMUNITY PSYCHIATRY 607 (1981); Braddock & Heller, *The Closure of Mental Retardation Institutions: Trends in the United States*, 23 MENTAL RETARDATION 168-76 (1985).

23. Opening Brief for Appellants at 5, *Mental Health Ass'n v. Deukmejian*, 186 Cal. App. 3d 1531, 233 Cal. Rptr. 130 (1986) (No. 2 Civ. B 014479) (ordered depublished).

24. See, e.g., Morganthau, Agrest, Greenberg, Doherty, Raine, *Abandoned*, NEWSWEEK, Jan. 6, 1986, at 14; Nickerson, *Reformers' Dream That Went Astray*, Boston Sunday Globe, Mar. 10, 1985, at 1, col. 1; *Crimes of Neglect*, (PBS television broadcast, July 23, 1986) (transcript on file at Loyola Law School library).

response, however, will be greater involuntary restrictions on liberty²⁵ rather than the creation of an adequate community-based treatment system. We define "adequate community-based mental health system" as one which provides treatment and support services to enable mentally disabled persons to preserve and exercise liberty.²⁶ For these people, liberty means avoiding confinement in a hospital or other institution and, equally important, functioning in the community as an autonomous person to the maximum extent possible, given the limits of their disabilities. These goals are mutually dependent. Providing appropriate treatment and support services in the community will substantially reduce the risk of confinement in an institution—both the risk of initial hospitalization and of being caught in the revolving door.²⁷ Staying out of the hospital will increase the chance of meaningful involvement in the community for mentally disabled persons. In addition, an adequate community system will reduce many of the problems caused by the cycle of frequent rehospitalization such as interruptions in work and living arrangements, and problems in establishing and maintaining personal relationships.²⁸

25. There are already attempts by states to modify civil commitment statutes in order to make it easier to involuntarily confine mentally disabled persons. *See, e.g.,* Durham and La Fond, *The Empirical Consequences and Policy Implications of Broadening the Statutory Criteria for Civil Commitment*, 3 YALE L. & POL'Y REV. 395, 398 (1985), *see also* Stromberg & Stone, *A Model State Law on Civil Commitment of the Mentally Ill*, 20 HARV. J. ON LEGIS. 275 (1983). Other possibilities include forcing mentally disabled persons to accept treatment outside institutions, by devices such as conservatorships and outpatient commitments. *See* Schwartz & Costanzo, *Compelling Treatment in the Community: Distorted Doctrines and Violated Values*, 20 LOY. L.A.L. REV. 1329 (1987).

26. An adequate system of community-based treatment provides a full continuum of services of varying degrees of restrictiveness. The trial court in *Mental Health Ass'n v. Deukmejian*, No. CA 00540 slip op. (Cal. Super. Ct. May 8, 1985), *aff'd*, 186 Cal. App. 3d 1531, 233 Cal. Rptr. 130 (1986) (ordered depublished), found that:

A full continuum of services, according to all the expert testimony, would include: appropriate long-term hospitalization, 24-hour acute intensive care, short-term crisis residential care, 24-hour transitional care, long-term rehabilitative care, out of home placement, emergency service and evaluation, acute day treatment, outpatient services, case management, community support services, community outreach services, mental health, advocacy, and foster family care.

Id. at 7.

27. For effectiveness of appropriate programs in breaking the revolving door cycle and reducing the recidivism rate, *see* Stein & Test, *Alternative to Mental Hospital Treatment: Conceptual Model, Treatment Program and Clinical Evaluation*, 37 ARCHIVES OF GEN. PSYCHIATRY, 392 (1980); Test & Stein, *Training in Community Living: Research Design and Results*, in ALTERNATIVES TO MENTAL HOSPITAL TREATMENT (1978). For a critical summary of the research in this area, *see* Mills & Cummins, *supra* note 21, at 276.

28. Test & Stein, *supra* note 27. The trial court in *Mental Health Ass'n*, No. CA 00540, slip op., found that: "Appropriate alternative programs and services less restrictive than state hospitals will substantially reduce the rate of rehospitalization and therefore the risk of inappropriate confinement." *Id.* at 5.

So long as fiscal conservatives remain in control, it is unlikely that such a system will be developed solely through the political process. A judicially enforceable right to adequate community-based treatment for mentally disabled persons is therefore essential.

III. SOURCES OF A RIGHT TO COMMUNITY-BASED TREATMENT

A right to community-based treatment can have a statutory or constitutional basis in state or federal law. For a statutory right to be successfully asserted, a court must (1) find that the statute creates a right to treatment services and (2) have the authority to grant the relief.²⁹ In Arizona, a superior court granted declaratory and injunctive relief based on a finding that a combination of several state statutes established a right for chronically mentally ill persons to receive community-based treatment services.³⁰ In California, however, an appellate court rejected similar state law arguments, holding that the statutory scheme created a

29. *Pennhurst State School & Hosp. v. Halderman*, 465 U.S. 89 (1984) [hereinafter *Pennhurst II*] (Eleventh Amendment precludes enforcement by federal court of state law against state official). The history of two pre-*Pennhurst II* cases, a consent decree and a judgment, illustrates the importance of the court's authority to order compliance. See *Brewster v. Dukakis*, 520 F. Supp. 882 (D. Mass. 1981), *vacated and remanded*, 687 F.2d 495 (1st Cir. 1982), *on remand*, 544 F. Supp. 1069 (D. Mass. 1982), *aff'd as modified*, 786 F.2d 16 (1st Cir. 1986); *New York State Ass'n for Retarded Children v. Carey*, 438 F. Supp. 440 (E.D.N.Y. 1977), *aff'd*, 596 F.2d 27 (2d Cir.), *cert. denied*, 444 U.S. 836 (1979); later proceeding, 466 F. Supp. 479, *aff'd*, 612 F.2d 644 (2d Cir. 1979); later proceeding, 492 F. Supp. 1110 (E.D.N.Y.), *rev'd*, 631 F.2d 162 (2d Cir. 1980); later proceeding, 551 F. Supp. 1165 (E.D.N.Y. 1982), *aff'd in part, rev'd in part*, 706 F.2d 956 (2d Cir.), *cert. denied*, 464 U.S. 915 (1983); later proceeding, 727 F.2d 240 (2d Cir. 1984). *But see* *Lelsz v. Kavanagh*, 807 F.2d 1243, 1255 (5th Cir. 1987) (district court could not enforce consent decree beyond guarantees contained in federal Constitution and laws simply because it was consent decree). A case upholding the authority of a state court to enforce a state statutory right is *Klostermann v. Cuomo*, 61 N.Y.2d 525, 463 N.E.2d 588, 475 N.Y.S.2d 252 (1984). There the court reasoned: "If a statutory directive is mandatory, not precatory, it is within the courts' competence to ascertain whether an administrative agency has satisfied the duty that has been imposed on it by the Legislature and, if it has not, to direct that the agency proceed forthwith to do so." *Id.* at 531, 463 N.E.2d at 590, 475 N.Y.S.2d at 249.

30. *Arnold v. Sarn*, No. C 432455 (Ariz. Super. Ct. Mar. 14, 1985), *appeal docketed*, No. 1CA-CIV 9262 (Ariz. Ct. App. Oct. 3, 1986). For a discussion of this case, see Santiago, Gittler, Beigel, Stein & Brown, *Changing a State Mental Health System Through Litigation: The Arizona Experiment*, 143 AM. J. PSYCHIATRY 1575-79 (1986) [hereinafter Santiago]. The Arizona Revised Statutes require the director of the Department of Health Services to provide "[u]nified mental health programs, to include, . . . the functions of the state hospital and community mental health." ARIZ. REV. STAT. ANN. § 36-104(1)(c)(i) (1986). The director must also "[t]ake appropriate steps to provide health care services to the medically dependent citizens of this state." *Id.* § 36-104(17). With respect to mental health care, the county "has the sole and exclusive authority to provide for . . . medical care of the indigent sick . . ." *Id.* § 11-291(A) (Supp.). In presenting their case to the court, the plaintiffs' attorneys argued that these and other statutes imposed mandatory duties to provide services to the chronically mentally ill in the community. Santiago, *supra*, at 1575.

legislative preference for community-based treatment, not a right.³¹ Moreover, even if a right to such treatment existed, the trial court held that it lacked authority to enforce it, because judicial enforcement would impinge upon the powers reserved to the executive and legislative branches of government.³² A right to community-based treatment may also be asserted under a federal statute on a theory of entitlement to services.³³ Arguably, federal anti-discrimination statutes provide another possible basis for a right to services for disabled persons, in that such services are necessary to enable disabled persons to function in society equally with non-disabled persons.³⁴

31. *Mental Health Ass'n v. Deukmejian*, 186 Cal. App. 3d 1531, 233 Cal. Rptr. 130 (1986) (ordered depublished). *Id.* at 1548, 233 Cal. Rptr. at 140. The court affirmed the trial court's finding that the California Lanterman-Petris-Short Act stated only a legislative preference for community-based treatment, not a right. *Id.* at 1536, 233 Cal. Rptr. at 132. That statute provides:

It is the intent of the Legislature that persons with mental illness shall have rights including, but not limited to, the following:

(a) A right to treatment services which promote the potential of the person to function independently. Treatment should be provided in ways that are least restrictive of the personal liberty of the individual.

CAL. WELF. & INST. CODE § 5325.1(a) (West 1984).

The court of appeal reasoned that the legislature could not have intended to create a right because the mental health budget was not substantially increased at the time the legislation was enacted. *Mental Health Ass'n*, 186 Cal. App. 3d at 1540, 233 Cal. Rptr. at 134-35. *But see Klostermann*, 61 N.Y.2d at 535-37, 463 N.E.2d at 593-94, 475 N.Y.S.2d at 252-53 (action claiming that mentally ill patients' rights were violated when released from institution without program ensuring continued treatment and adequate housing presented justiciable controversy which could not be defeated by argument that adjudication would require expenditure of funds and allocation of resources). *Cf.* *Association for Retarded Citizens v. Department of Developmental Servs.*, 38 Cal. 3d 384, 696 P.2d 150, 211 Cal. Rptr. 758 (1985) (limited budget available did not affect existence of developmentally disabled persons' statutory right to services).

32. *Mental Health Ass'n v. Deukmejian*, No. CA 000540, slip op. at 10 (Cal. Super. Ct. May 8, 1985), *aff'd*, 186 Cal. App. 3d 1531, 233 Cal. Rptr. 130 (1986) (ordered depublished). The court of appeal did not reach this issue.

33. The Education For All Handicapped Children Act of 1975 creates an entitlement to special education services for all disabled children who qualify. 20 U.S.C. §§ 1411-1420 (1982). However, the United States Supreme Court in *Pennhurst State School & Hosp. v. Halderman*, 451 U.S. 1 (1981) [hereinafter *Pennhurst I*] found that the language of the Developmentally Disabled Assistance and Bill of Rights Act, 42 U.S.C. §§ 6000-6081 (1982), created a mere preference, not a right, to receive treatment services in the least restrictive setting. *Pennhurst I*, 451 U.S. at 19.

34. The Rehabilitation Act of 1973 prohibits discrimination based upon disability. 29 U.S.C. §§ 701-796i (1982). The Rehabilitation Act's potential for establishing a right to community-based treatment has not been widely explored. In *Pennhurst I*, the trial court relied on § 504 of the Rehabilitation Act along with many other statutory and constitutional bases in finding a right to community-based treatment for residents at Pennhurst State School. *Pennhurst I*, 446 F. Supp. 1295, 1323-24 (E.D. PA. 1977). That federal statutory finding was not addressed on appeal, either in *Pennhurst I* or *Pennhurst II*. In *Pennhurst I*, the Court said it would not reach the issue because it was focusing on the Developmentally Disabled Assistance and Bill of Rights Act. 451 U.S. at 11. In *Pennhurst II*, the Court did not reach the issue

State constitutions may also provide a right to community-based treatment, where their provisions protect liberty and privacy rights, and include a due process clause or its equivalent.³⁵ At a minimum, such provisions offer the same protection as their federal counterparts. However, in some jurisdictions, state constitutions may provide greater rights for mentally disabled persons.³⁶ This is especially so if the state courts construe the constitution as mandating strict scrutiny of state actions which impinge upon fundamental rights of mentally disabled persons.³⁷ Using a strict scrutiny analysis, a court could compel the state to accomplish its legitimate purposes of the treatment and protection of mentally disabled persons by the means least restrictive of their fundamental rights.³⁸ For most mentally disabled persons, that "means" is community-based treatment.³⁹

because of the eleventh amendment issue. In *Clark v. Cohen*, a federal court of appeals upheld the trial court's denial of the § 504 claim where developmentally disabled plaintiff's argument was that the state discriminated against her on the basis of her handicap. However, the evidence showed only that other similarly disabled persons had been placed in community residences and plaintiff had not been so placed. 794 F.2d 79, 84 n.3 (3d Cir.), cert. denied, 107 S. Ct. 459 (1986). But see *Garrity v. Gallen*, 522 F. Supp. 171 (D.N.H. 1981); *Kentucky Ass'n for Retarded Children v. Conn.*, 510 F. Supp. 1233 (W.D. Ky. 1980), aff'd, 674 F.2d 582 (6th Cir.), cert. denied, 459 U.S. 1041 (1982). See also *New Mexico Ass'n for Retarded Citizens v. New Mexico*, 678 F.2d 847 (10th Cir. 1982) (section 504 requires special education to be given in public schools to handicapped children); *Mills v. Board of Educ.*, 348 F. Supp. 866 (D.D.C. 1972); *Pennsylvania Ass'n for Retarded Children v. Commonwealth*, 343 F. Supp. 279 (E.D. Pa. 1972).

35. See generally *Friesen, Recovering Damages for State Bills of Rights Claims*, 63 TEX. L. REV. 1269 (1985).

36. See *Perlin, State Constitutions and Statutes as Sources of Rights for The Mentally Disabled: The Last Frontier?*, 20 LOY. L.A.L. REV. 1249 (1987).

37. The California Supreme Court, relying on the state due process clause, found greater procedural protections mandated for mentally disabled persons than did the United States Supreme Court using the federal Constitution. Compare *Conservatorship of Roulet*, 23 Cal. 3d 219, 590 P.2d 1, 152 Cal. Rptr. 425 (1979) (requiring proof of mental disability beyond reasonable doubt) with *Addington v. Texas*, 441 U.S. 418 (1979) (standard of proof is "clear and convincing" under the fourteenth amendment and due process does not require proof beyond reasonable doubt) and *In re Roger S.*, 19 Cal. 3d 921, 569 P.2d 1286, 141 Cal. Rptr. 298 (1977) (required a precommitment hearing for minors) with *Parham v. J. R.*, 442 U.S. 584 (1979) (precommitment hearing not necessary).

38. In finding the substantive due process right, a state court may look to the language of the state commitment statute for evidence of the state's purposes. For example, if the state law says that mentally disabled persons are to receive individualized treatment, or treatment in the least restrictive setting, or treatment in ways that are least restrictive of personal liberty, such a purpose reinforces the substantive due process right to avoid unnecessary institutional confinement, and to have the risk of such confinement reduced, by receiving community-based treatment. See, e.g., the *Mental Health and Developmental Disabilities Code*, ILL. ANN. STAT. ch. 91½, ¶ 2-102(a) (*Smith-Hurd 1987*) ("A recipient of services shall be provided with adequate and humane care and services in the least restrictive environment, pursuant to an individual services plan . . .").

39. State courts have used such an analysis in restricting commitments of mentally dis-

The final source of an enforceable right to community-based treatment is the federal Constitution which, although limited by *Youngberg v. Romeo*⁴⁰ and some of its progeny, should not be abandoned. Although the other sources discussed above have in some cases provided adequate bases for successful enforcement of a right to community-based treatment,⁴¹ they are not without limitations. In many states the use of state constitutions to enforce civil rights is a relatively new phenomenon. In light of the dearth of state case law to assist in constitutional interpretation, state courts may rely heavily on federal law to interpret state constitutional provisions.⁴² Statutorily-based rights to treatment services are, of course, subject to change at the will of the legislature. State courts may be reluctant to order state officials to implement state statutory and constitutional rights.⁴³ Furthermore, relief is not available in federal

abled persons to those which are "truly necessary," and in mandating procedural protections to avoid "unnecessary" loss of liberty. However, the transition from procedural to substantive due process is a difficult one. The closest step taken by California was in *Conservatorship of Early*, 35 Cal. 3d 244, 673 P.2d 209, 197 Cal. Rptr. 539 (1983). The state supreme court found that a mentally disabled person could not be placed under conservatorship and hospitalized if he or she could care for basic needs alone or with the assistance of others. *Id.* at 254-55, 673 P.2d at 215, 197 Cal. Rptr. at 545. In rejecting an interpretation of the conservatorship statute under which the proposed conservatee would have to provide for basic needs without assistance, the court pointed out that few non-mentally disabled persons could meet such a test.

We all depend, to varying degrees on the assistance of others (e.g., parents, mechanics, the farmer, the tailor) to make our way in the world. Where willing and responsible others are able to assist a person in providing his or her basic personal needs the person is not, in our view, "truly unable to take care of [himself or herself]."

Id. at 251, 673 P.2d at 213, 197 Cal. Rptr. at 543 (quoting *Conservatorship of Roulet*, 23 Cal. 3d 219, 225, 590 P.2d 1, 4, 152 Cal. Rptr. 425, 428 (1979) (brackets in original)). The court applied a necessity test, as required by strict scrutiny, and found that where conservatorship and hospitalization and the concomitant loss of liberty were not necessary to satisfy the state's interests, they could not be imposed. *Id.* at 253-54, 673 P.2d at 215, 197 Cal. Rptr. at 545.

40. 457 U.S. 307 (1982).

41. See *Arnold v. Sarn*, No. C 432455 (Ariz. Super. Ct., Mar. 14, 1985), *appeal docketed*, No. 1CA-CIV 9262 (Ariz. Ct. App. Oct. 3, 1986); see also *Garrity v. Gallen*, 522 F. Supp. 171 (D. N.H. 1981); *Kentucky Ass'n for Retarded Citizens v. Conn*, 510 F. Supp. 1233 (W.D. Ky. 1980); *Eubanks v. Clarke*, 434 F. Supp. 1022 (E.D. Pa. 1977); *Dixon v. Weinberger*, 405 F. Supp. 974 (D.D.C. 1975); *In re Schmidt*, 494 Pa. 86, 429 A.2d 631 (1981).

42. See *Perlin*, *supra* note 28, at 1275.

43. *Mental Health Ass'n v. Deukmejian*, No. CA 000540 (Cal. Super. Ct. May 8, 1985) (trial court decision) (court of appeal did not reach issue whether separation of powers precludes judicial enforcement of right to community-based treatment), *aff'd*, 186 Cal. App. 3d 1531, 233 Cal. Rptr. 130 (1986) (ordered depublished). *But see Mandel v. Myers*, 29 Cal. 3d 531, 629 P.2d 935, 174 Cal. Rptr. 841 (1981) (although separation of powers doctrine may restrict a court from directly ordering the legislature to enact appropriations, it does not preclude the court from ordering state officials to expend appropriations consistent with the requirements of law); *Committee to Defend Reproductive Rights v. Cory*, 132 Cal. App. 3d 852, 183 Cal. Rptr. 475 (1982) (consistent with separation of powers doctrine, courts may intervene to enforce compliance of public officials with the law); *Klostermann v. Cuomo*, 61 N.Y.2d 525, 535, 463 N.E.2d 588, 593, 475 N.Y.S.2d 247, 252 (1984) (deinstitutionalized mentally ill per-

court to enforce state law claims.⁴⁴ For these reasons, it is preferable to find a basis in federal constitutional law for the right to community-based treatment services.

IV. FEDERAL CONSTITUTIONAL ANALYSIS

A. Liberty Interest

The first step in developing a theory of constitutional right to community-based treatment for mentally disabled persons is to show that a liberty interest is at stake. We begin with the premise that no constitutional right to treatment will be upheld unless it is grounded in a deprivation of liberty. Attempts to obtain a minimal level of publicly-funded services as a matter of constitutional right have generally failed.⁴⁵ The Supreme Court has consistently held that need alone is not a basis for asserting a constitutional right;⁴⁶ the State may choose not to serve a needy population, i.e. mentally disabled persons, or to give priority to the needs of another population.⁴⁷ The most that courts have been willing to concede is that, when the state does undertake to provide services, it must do so in a manner consistent with due process of law.⁴⁸ Therefore,

sons and persons awaiting placement in community programs could proceed against state by seeking declaratory relief in mandamus action, where plaintiffs sought "mere declaration and enforcement of the individual's rights that have already been conferred by the other branches of government").

44. *Pennhurst II*, 465 U.S. 89. Cases restricting relief now available in federal court, given eleventh amendment and other restrictions, include *Migra v. Warren City School Dist. Bd. of Educ.*, 465 U.S. 75 (1984) (res judicata bars raising federal § 1983 claim in federal court even where claim not raised in prior state civil litigation because state preclusion law would bar claim in subsequent state court lawsuit); *Parratt v. Taylor*, 451 U.S. 527 (1981) (no federal procedural due process claim exists where state itself provides some remedy for deprivation); see also *Lelsz*, 807 F.2d at 1255 (under *Pennhurst II*, federal district court was without jurisdiction to enforce consent decree where only source of right to community placement was state law).

45. See, e.g., *San Antonio Indep. School Dist. v. Rodriguez*, 411 U.S. 1 (1973); see also *O'Connor v. Donaldson*, 422 U.S. 563, 582 (1975) (Burger, C.J., concurring) ("[T]he idea that States may not confine the mentally ill except for the purpose of providing them with treatment is of very recent origin, and there is no historical basis for imposing such a limitation on state power.") (footnote omitted).

46. The Court in *Youngberg v. Romeo* stated that "[a]s a general matter, a State is under no constitutional duty to provide substantive services for those within its border." 457 U.S. 307, 317 (1982) (citing *Harris v. McRae*, 448 U.S. 297, 318 (1980) (publicly funded abortions); *Maher v. Roe*, 432 U.S. 464, 469 (1977) (medical treatment)).

47. The *Youngberg* Court continued, "[n]or must a State 'choose between attacking every aspect of a problem or not attacking the problem at all.'" *Id.* at 317 (citing *Dandridge v. Williams*, 397 U.S. 471, 486-87 (1970)).

48. *Brown v. Board of Educ.*, 347 U.S. 483 (1954). For application to mental health systems, see *Vitek v. Jones*, 445 U.S. 480, 488-89 (1980) (involuntary transfer of convicted felon to mental hospital without adequate notice and opportunity for hearing deprived him of liberty

simply asserting that mentally disabled persons are in need of treatment in order to survive in the community is not sufficient to establish a constitutional right to community-based treatment.⁴⁹ Rather, such a constitutional right must be grounded in the liberty interests of mentally disabled persons.

Liberty interests are the basis of Supreme Court decisions restricting state justification for civil commitment⁵⁰ and mandating procedural due process protections in commitment hearings.⁵¹ Thus, advocacy efforts

without due process of law); *O'Connor v. Donaldson*, 422 U.S. 563, 575 (1975) (state mental health law authorizing confinement of harmless mentally ill does not establish constitutionally adequate purpose for confinement); *Jackson v. Indiana*, 406 U.S. 715, 738 (1972) (nature and duration of confinement must bear reasonable relationship to legitimate state purpose).

49. Such a broad general right would be supported by a theory of "implied right." That is, a mentally disabled person's right to liberty implies and contains a right to treatment services necessary to enable him or her to exercise that liberty interest. As the Supreme Court noted in *Addington v. Texas*, 441 U.S. 418, 429 (1979): "One who is suffering from a debilitating mental illness and in need of treatment is neither wholly at liberty nor free of stigma." How can an individual function autonomously in the community if a mental disability severely impairs his or her ability to provide for basic needs (such as food, clothing or shelter)? What is the reality of life choices for an individual whose disability isolates him or her from society? This emphasis could form the basis for a general constitutional right to whatever treatment and services are necessary to enable the disabled person to have a meaningful opportunity to function within society. Such an opportunity includes maximizing both the ability to make choices and the range of choices available.

The argument that a person's mental disability impairs his or her autonomy of course has also been used in support of involuntary confinement and treatment. Examples of this argument include Waite, *Why Mill Was For Paternalism*, 6 INT'L J.L. & PSYCHIATRY 101, 109 (1983) (involuntary commitment will help to restore capacity to live a self-directed, self-governed life); Comment, *The Right to Adequate Treatment Versus the Right to Refuse Anti-psychotic Drug Treatment: A Solution to the Dilemma of the Involuntarily Committed Psychiatric Patient*, 33 EMORY L.J. 441, 483 (1984) (patient should not have right to refuse medication because only after treatment can he acquire ability to make competent decisions). We find this proposition self-contradictory. To condition treatment (with the goal of achieving in the future a "cure" or "true autonomy") on relinquishing the fundamental right of liberty is antithetical to the very concept of autonomy. Nevertheless, we recognize the appeal of the proposition in the current political climate and thus the danger that a broad "implied right" theory of right to treatment may "prove too much." Therefore, we do not assert such a theory within this Essay.

50. *O'Connor*, 422 U.S. at 576 (state cannot, without more, confine a nondangerous mentally ill person capable of living outside an institution safely, alone or with the help of family and friends); *Humphrey v. Cady*, 405 U.S. 504, 509 (1972) (civil commitment constituted a "massive curtailment of liberty"); see also *Baxstrom v. Herold*, 383 U.S. 107, 115 (1966) (no justification for confining mentally ill persons when evidence of dangerousness questionable).

51. See *Vitek v. Jones*, 445 U.S. 480 (1980) (prisoner retained a "residuum of liberty" which must be protected against wrongful transfer to a mental institution; due process required notice, hearing with independent decision-maker); *Addington*, 441 U.S. 418 (clear and convincing evidence, rather than preponderance of the evidence, should be the standard of proof in civil commitment proceedings because of the substantial loss of liberty involved).

Even in cases finding that minimal due process was satisfied, the Supreme Court conceded the preciousness of the liberty interest at stake. See *Jones v. United States*, 463 U.S. 354 (1983)

for disabled persons which stress the preciousness of the liberty right at stake, rather than the need for services, have a greater likelihood of success.⁵²

Recognition of the important liberty interests abridged by confinement in a mental institution forms the basis upon which commentators and courts have suggested a constitutional right to treatment.⁵³ The Supreme Court has recognized that although commitment to a mental hospital involves "a massive curtailment of liberty,"⁵⁴ a "residuum of liberty" survives that commitment.⁵⁵ In *Youngberg v. Romeo*,⁵⁶ the Court defined an involuntarily committed mental patient's liberty interest to include safety⁵⁷ and freedom from bodily restraint.⁵⁸ The Court held that the plaintiff, Nicholas Romeo, was entitled to "minimally ade-

(due process not offended by D.C. statute under which not-guilty-by-reason-of-insanity acquittees were automatically committed; legislature's assumption that any law violation constituted proof of dangerousness was reasonable; liberty interest adequately protected by provision permitting acquittees to periodically challenge commitment); *Parham v. J.R.*, 442 U.S. 584 (1979) (minors have constitutionally protected liberty interest even though it is adequately protected by post-admission evaluation by neutral mental health professional).

52. Not surprisingly, therefore, a limited "right to treatment" or "habilitation" was upheld pre-*Youngberg* where the right was closely tied to the deprivation of liberty. See, e.g., *Donaldson v. O'Connor*, 493 F.2d 507 (5th Cir. 1974), *vacated and remanded*, 422 U.S. 563 (1975); *Garrity v. Gallen*, 522 F. Supp. 171 (D.N.H. 1981); *Gary W. v. Louisiana*, 437 F. Supp. 1209 (E.D. La. 1976); *Davis v. Watkins*, 384 F. Supp. 1196 (N.D. Ohio 1974); *Welsch v. Likins*, 373 F. Supp. 487 (D. Minn. 1974), *aff'd*, 525 F.2d 987 (8th Cir. 1975); *Wyatt v. Stickney*, 325 F. Supp. 781 (M.D. Ala. 1971), *aff'd in part, remanded in part sub nom.*, *Wyatt v. Aderholt*, 503 F.2d 1305 (5th Cir. 1974). See generally Spece, *Preserving the Right to Treatment Theories*, 20 ARIZ. L. REV. 1 (1978).

53. See generally *Rouse v. Cameron*, 373 F.2d 451 (D.C. Cir. 1966); Birnbaum, *The Right to Treatment*, 46 A.B.A. J. 499 (1960); *Developments in the Law—Civil Commitment of the Mentally Ill*, 87 HARV. L. REV. 1190 (1974).

The most common form of the argument has been characterized as *quid pro quo*, i.e., the state must provide treatment in return for the loss of one's liberty when involuntarily committed to a mental institution. See *Wyatt*, 325 F. Supp. at 784. But see *O'Connor*, 422 U.S. at 586 (Burger, C.J., concurring) ("[t]he *quid pro quo* theory is a sharp departure from, and cannot coexist with, due process principles"). A variation on this theory is that the civilly committed person is entitled to treatment in return for being confined with lesser procedural protections than are available to persons incarcerated in the criminal justice system. *Rouse*, 373 F.2d at 453. But see discussion in Spece, *supra* note 52, at 4-15.

54. *Humphrey*, 405 U.S. at 509.

55. *Vitek*, 445 U.S. at 491-94; see also *Youngberg*, 457 U.S. at 315.

56. 457 U.S. 307 (1982).

57. *Id.* at 315 (citing *Ingraham v. Wright*, 430 U.S. 651, 673 (1977)); see also *New York State Ass'n for Retarded Children v. Carey*, 393 F. Supp. 715, 718 (E.D.N.Y. 1975) (right to freedom from harm as constitutional basis of treatment).

58. *Youngberg*, 457 U.S. at 316 (citing *Greenholtz v. Inmates of Neb. Penal and Correctional Complex*, 442 U.S. 1, 18 (1979)). The Court also recognized, as conceded by the state, a liberty interest in adequate food, shelter, clothing and medical care. *Id.* at 315.

quate care and treatment" to ensure this liberty interest.⁵⁹

A constitutional right to community-based treatment must build upon the liberty interest enunciated in *Youngberg*. Justice Blackmun's concurring opinion described that interest in vivid, practical terms: "For many mentally retarded people, the difference between the capacity to do things for themselves within an institution and total dependence on the institution for all of their needs is as much liberty as they ever will know."⁶⁰ Justice Blackmun recognized that liberty means more than mere freedom from restraint: it means the right to develop and maintain the skills which will make possible the exercise of that freedom.

Thus, for a developmentally disabled person who is so severely impaired as to require institutional placement, the right to liberty includes the right to learn self-care skills, and not to lose those skills possessed at the time of confinement.⁶¹ In *Clark v. Cohen*,⁶² Judge Becker, in his concurring opinion, extended Justice Blackmun's reasoning by concluding that involuntarily committed persons have a right to treatment sufficient to develop their ability to be independent, at least to the level which would have been attained but for institutionalization.⁶³

The *Youngberg* majority assumed, and counsel for both sides conceded, that Nicholas Romeo could not function outside of an institution.⁶⁴ Thus, the facts presented a situation in which a mentally disabled person, confined in an institution, required treatment services in order to exercise his liberty to any extent at all. Similarly, the plaintiff in *Clark* had been confined in an institution and required training and suitable placement in the community in order to be able to function outside the institution.⁶⁵

The constitutionally-required protection of a mentally disabled person's liberty interest, however, does not and should not depend upon institutional confinement. In *Thomas S. v. Morrow*,⁶⁶ the Fourth Circuit recognized that liberty exists *before* commitment: "The liberty interests

59. *Id.* at 319 (quoting *Youngberg v. Romeo*, 644 F.2d 147, 176 (3d Cir. 1980) (Seitz, C.J., concurring)). "Training" or "habilitation" rather than "treatment" is the proper clinical term to be used for a program designed to improve a developmentally disabled person's ability to function. "Treatment" is used for mentally ill persons. However, for the purposes of the constitutional argument, training/habilitation/treatment are interchangeable terms. *Id.* at 311 n.5 & 313 n.12.

60. *Id.* at 327 (Blackmun, J., concurring).

61. *Id.* (Blackmun, J., concurring).

62. 794 F.2d 79 (3d Cir.), *cert. denied*, 107 S. Ct. 459 (1986).

63. *Id.* at 96 (Becker, J., concurring).

64. *Youngberg*, 457 U.S. at 317.

65. *Clark*, 794 F.2d at 81.

66. 781 F.2d 367 (4th Cir.), *cert. denied*, 106 S. Ct. 1992 (1986) and 107 S. Ct. 235 (1986).

protected in *Youngberg* did not arise because of the institutional confinement. Rather, the Court's premise was that involuntary commitment and other lawful confinement 'do not extinguish' pre-existing liberty interests in safety and freedom from bodily restraint."⁶⁷

The *Thomas S.* court thus acknowledged that whether or not a mentally disabled person is confined in an institution, his liberty interest is a constant, which must be protected against unconstitutional abridgement by the state. Emphasizing that the plaintiff, a behaviorally-disordered man, was dependent upon the state, the Fourth Circuit enunciated a constitutionally-based right to "minimally adequate treatment" in the community.⁶⁸

Extension of the liberty interests set forth in *Youngberg* beyond the institution and into the community follows from the reasoning of the case itself. If the state must provide some mentally disabled persons with "minimally adequate treatment" to enable them to exercise their liberty within an institution, other mentally disabled persons are entitled to the treatment services that would allow them to maintain and exercise their liberty in the community. If "minimally adequate treatment" would make the difference between institutional confinement and life in the community for a mentally disabled person, *Youngberg* provides a solid due process argument for a right to such treatment.

At first glance, this argument seems similar to the broad "needs-based" right to treatment theory rejected earlier.⁶⁹ Both theories define the treatment as that which is needed in order for mentally disabled persons to exercise their fundamental rights. The critical difference is that the *Youngberg* right to "minimally adequate treatment" is triggered, not solely by the person's need, but by the state's abridgment of liberty plus the person's need. If state restriction, as argued below,⁷⁰ is not limited to institutional confinement, then liberty, as defined in *Youngberg* and extended in *Clark v. Cohen* and *Thomas S. v. Morrow*, is sufficient to support a right to treatment in the community.

B. *Minimally Adequate Treatment and the Right to Community-Based Treatment*

A right to adequate community-based treatment may be built upon the constitutional right to "minimally adequate treatment" declared by

67. *Id.* at 374 (citing *Youngberg v. Romeo*, 457 U.S. 307, 315 (1982)).

68. *Id.* at 374-76.

69. See *infra* text accompanying notes 45-49.

70. See *infra* text accompanying notes 118-31.

the Supreme Court in *Youngberg v. Romeo*.⁷¹ The Court held that Nicholas Romeo, a severely mentally disabled man civilly committed to a state institution, was entitled to such "minimally adequate treatment" as was "reasonable in light of [his] liberty interests in safety and freedom from unreasonable restraints,"⁷² balanced against the state's interests.⁷³

The Supreme Court in *Youngberg* rejected the lower court's use of the "least intrusive means" test to evaluate whether the treatment offered to Nicholas Romeo passed constitutional muster.⁷⁴ Rather than apply the traditional strict scrutiny analysis to restrictions on the liberty of institutionalized persons, the Court used a simple balancing test: Nicholas Romeo's liberty weighed against the state's interests in carrying out the purposes of his civil commitment.⁷⁵ Thus, in *Youngberg*, the test of constitutional treatment was not its degree of intrusiveness, but its reasonableness. In deciding whether the treatment provided by the state is "reasonable," the Court counseled deference to decisions made by a qualified professional, for a course of treatment consistent with professional standards. The Court deemed such decisions "presumptively valid."⁷⁶ Therefore, a treatment decision made by a qualified professional for a course of treatment which, although "professionally acceptable," was not the least restrictive of a disabled person's liberty, could satisfy the Constitution.

The Court's failure to adopt the "least intrusive means" analysis should not be interpreted as an undervaluing of the liberty interest at stake. To the contrary, Nicholas Romeo's liberty was both the source and the measure of his right to "minimally adequate treatment." The *Youngberg* Court recognized the state's duty to "provide [him] with such training as an appropriate professional would consider reasonable to ensure his safety and to facilitate his ability to function free from bodily restraints."⁷⁷ Thus, an institutionalized mentally disabled person is entitled to "minimally adequate treatment" which will enable him to enjoy the "constitutionally protected interests in conditions of reasonable care and safety, [and] reasonably nonrestrictive confinement conditions."⁷⁸

71. 457 U.S. 307, 322 (1982).

72. *Id.*

73. Those state interests included protection of other institutional residents and effective administration of institutions. *Id.* at 320.

74. *Id.* at 322.

75. *Id.* at 324.

76. *Id.* at 322-23.

77. *Id.* at 324.

78. *Id.* Justice Blackmun asserted in his concurrence that institutionalized persons were further entitled to that treatment "as is reasonably necessary to prevent a person's pre-existing

The Court in *Youngberg* did not address “the difficult question whether a mentally retarded person, involuntarily committed to a state institution, has some general constitutional right to training *per se*, even when no type or amount of training would lead to freedom.”⁷⁹ Nicholas Romeo sought only the treatment necessary to enable him to exercise the liberty he retained within the institution where he assumed that he would spend the rest of his life. Within the context of *Youngberg* itself, therefore, a “least restrictive” or “least intrusive” means standard was proposed—and rejected by the Court—solely as a measure of the constitutional adequacy of treatment within an institution. Nicholas Romeo never asserted a “least restrictive means”/strict scrutiny argument entitling him to placement and treatment in the community.

These facts could justify a narrow reading of *Youngberg*: the decision only sets out a test for damages liability where a state institution mental health professional is sued.⁸⁰ Its chief concern is to keep federal courts from interfering with the day-to-day operation of state institutions;⁸¹ and its admonished “deference to professional judgment” is only a starting point from which to assess adequate treatment.⁸² It is tempting to try in this way to minimize the harm that *Youngberg* could pose to the right to community-based treatment, so that advocates may continue to rely upon earlier court decisions which used a strict scrutiny analysis in finding such a right.⁸³

self-care skills from *deteriorating* because of his commitment.” *Id.* at 327 (Blackmun, J., concurring) (emphasis in original).

79. *Id.* at 318.

80. *Id.* at 323. The majority stated:

[L]iability may be imposed only when the decision by the professional is such a substantial departure from accepted professional judgment, practice, or standards as to demonstrate that the person responsible actually did not base the decision on such a judgment. In an action for damages against a professional in his individual capacity, however, the professional will not be liable if he was unable to satisfy his normal professional standards because of budgetary constraints; in such a situation, good-faith immunity would bar liability.

Id. (footnote omitted). The Fourth Circuit Court of Appeals in *Thomas S. v. Morrow*, 781 F.2d at 375, underscored the fact that the Supreme Court did not extend the lack of funds defense to “prospective injunctive relief.”

81. *Youngberg*, 457 U.S. at 322. The Court stressed that its admonition of deference to professional judgment was intended to minimize “interference by the federal judiciary with the internal operations of [state mental] institutions.” *Id.* The Court added that hospital “administrators, and particularly professional personnel, should not be required to make each decision in the shadow of an action for damages.” *Id.* at 324-25.

82. See *Rennie v. Klein*, 720 F.2d 266, 271-72 (3d Cir. 1983) (Adams, J., concurring). There, Judge Adams viewed the “professional judgment” language of *Youngberg* as “primarily a starting point for defining the constitutional rights at stake,” *id.* at 271, suggesting that it is not the sole factor to be weighed in considering the “reasonableness” of the state’s action. *Id.*

83. See *supra* note 9.

However, most post-*Youngberg* courts have not read the case narrowly. They have looked beyond its facts and explicit holding and reached broad conclusions about what "deference to professional judgment" and "minimally adequate treatment" mean. Post-*Youngberg* decisions fall into two groups. The first group of cases interprets *Youngberg* as foreclosing any constitutionally-based right to treatment services in the community.⁸⁴ Decisions in the second group find that such a right is not precluded but is actually supported by the Court's definition of "minimally adequate" treatment as that which is consistent with prevailing professional standards. Since courts have read *Youngberg* so broadly and inconsistently,⁸⁵ their reasoning must be examined.

The first group of cases emphasizes *Youngberg's* rejection of the "least intrusive means" analysis.⁸⁶ These decisions find that there is no constitutional right to "community placement or a 'least restrictive environment' under the federal Constitution."⁸⁷ Since they equate "least re-

84. See *infra* notes 86-93 and accompanying text. Several other courts, while stressing the *Youngberg* Court's rejection of "least intrusive means," either did not reach the constitutional right to community-based treatment issue or granted relief on non-constitutional grounds. See *Johnson v. Brelje*, 701 F.2d 1201 (7th Cir. 1983), where the Seventh Circuit stated explicitly that it was not ruling on whether there exists a federal constitutional right for criminal defendants found not guilty by reason of insanity to be treated in the least restrictive setting. Since an Illinois statute provided such a right, the Seventh Circuit found that the prisoners enjoyed a state-created liberty interest requiring procedural due process protections against being inappropriately placed in a more restrictive treatment environment. *Id.* at 1205 & n.3. In *Sabo v. O'Bannon*, 586 F. Supp. 1132, 1143 (E.D. Pa. 1984), the federal district court ruled only that summary judgment was precluded where a question existed whether state officials had deprived the plaintiff of minimally adequate treatment within an institution. See also *Woe v. Cuomo*, 729 F.2d 96 (2d Cir.), cert. denied, 469 U.S. 936 (1984). In *Woe*, appellants had raised as a genuine issue of material fact whether treatment at one mental institution was "minimally adequate." *Id.* at 107. Although these courts did not reach the merits of the federal constitutional claim, these decisions have been cited by the group one post-*Youngberg* courts in support of their holding that there is no constitutional right to community-based treatment. See, e.g., *Society for Good Will to Retarded Children v. Cuomo*, 737 F.2d 1239, 1249 (2d Cir. 1984); see also *Lelsz v. Kavanagh*, 807 F.2d 1243, 1250-51 (5th Cir. 1987) (citing *Society for Good Will to Retarded Children v. Cuomo*, 737 F.2d 1239 (2d Cir. 1984)).

85. The ideal federal constitutional argument, of course, would apply the traditional strict scrutiny test and require the state to accomplish its legitimate purposes of treatment and care for mentally disabled persons in the least restrictive setting. Although an argument can be made that the strict scrutiny analysis survived *Youngberg*, federal courts generally have interpreted *Youngberg* as rejecting a least drastic means analysis. It is probable that courts will continue to do so, until the Supreme Court specifically rules on the issue. See *infra* notes 86-87 and accompanying text.

86. *Lelsz*, 807 F.2d at 1250; *Society for Good Will to Retarded Children*, 737 F.2d at 1249; *Phillips v. Thompson*, 715 F.2d 365, 368 (7th Cir. 1983); *Johnson*, 701 F.2d at 1209; *Sabo*, 586 F. Supp. at 1139.

87. *Society for Good Will to Retarded Children*, 737 F.2d at 1248; see also *Lelsz*, 807 F.2d at 1251. ("It is therefore our conclusion that the federal constitution does not confer . . . a right to habilitation in the least restrictive environment.").

strictive alternative" with "community placement," these cases state that institutionalization per se is not an unconstitutional deprivation of liberty.⁸⁸ According to this view, since "the due process clause only forbids *deprivations* of liberty without due process of law," institutional confinement which provides mere custodial care—as opposed to treatment designed to improve the mentally disabled individual's condition—does not violate the Constitution.⁸⁹

The group one cases, in rejecting mentally disabled persons' claims to a constitutional right to community placement, find that institutional confinement is "minimally adequate" treatment. Ironically, in one case this was because the developmentally disabled plaintiffs were so high-functioning that the court decided they did not require training in order to leave the institution. Under those circumstances, custodial care which amounted to *no* habilitation training was "minimally adequate."⁹⁰ In two other cases, the courts found institutional placement "not unreasonable" because there was disagreement between plaintiffs' and defendants' experts as to whether institutional confinement was "minimally adequate."⁹¹ In essence, they assumed that after *Youngberg*, *credible* plain-

88. In *Society for Good Will to Retarded Children*, the court of appeals, applying *Youngberg's* "minimally adequate" treatment requirement, found that *severely* retarded persons were not deprived of their constitutional rights by "mere residence in a school for the mentally retarded." 737 F.2d at 1243. The Seventh Circuit, in *Phillips*, rejected the argument that the state had a duty to develop community-based programs for high-functioning mentally retarded individuals as an alternative to state-operated institutions. The court found that plaintiffs, who had in the past resided in a private program and were now state institution voluntary residents, did not need training and could choose to live independently in the community. 715 F.2d at 366-68.

89. *Lelsz*, 807 F.2d at 1251 (emphasis in original); see also *Society for Good Will to Retarded Children*, 737 F.2d at 1250 ("Where the state does not provide treatment designed to improve a mentally retarded individual's condition, it deprives the individual of nothing guaranteed by the Constitution; it simply fails to grant a benefit of optimal treatment that it is under no constitutional obligation to grant.").

90. *Phillips*, 713 F.2d at 368. Given the plaintiffs' functioning ability, the mentally disabled persons had not been deprived of their right under *Youngberg* to receive training necessary to enable them to exercise their liberty interests. *Id.*

91. *Society for Good Will to Retarded Children*, 737 F.2d at 1249. Construing *Youngberg*, the Second Circuit stated, "we may not look to whether the trial testimony established the superiority of a 'least restrictive environment' in general or of community placement in particular. Instead, we may rule only on whether a decision to keep residents at [the state institution] is a rational decision based on professional judgment." *Id.* Where experts testified at trial only that some residents would be "safer, happier and more productive" in smaller residences, but not that the consensus of mental health professionals was that institutional confinement was inappropriate, the court found that plaintiffs' placement in an institution was not unreasonable. *Id.* at 1248-49. The record did not support the trial court's order to place the residents in smaller community facilities given the residents' severe impairment and that only *one* resident had been found inappropriately placed. *Id.* at 1247 & n.5.

The Fifth Circuit, in *Lelsz*, found that it was error for the trial court to order state defend-

tiffs' expert testimony to the contrary cannot rebut the "presumptive valid[ity]" of a state administrator's decision to institutionalize.⁹² For the group one courts, there is no right to community-based treatment unless it is "not merely the *best* remedy . . . but the *only* remedy."⁹³

The group two cases also acknowledge that "reasonableness" and not "least restrictive alternative"/strict scrutiny determines, after the *Youngberg* decision, whether institutional confinement is constitutional.⁹⁴ However, these cases find a right to treatment services in the community for those institutionalized persons as to whom there is a professional consensus that institutional care is inappropriate and community-based care appropriate. The federal district court in *Association of Retarded Children v. Olson*,⁹⁵ clearly set out the basis for a right to community-based treatment, post-*Youngberg*:

While the *Youngberg* decision does not directly address this specific right [to community placement for mentally retarded persons confined in state facilities], the Court's analysis indicates that it would reject an absolute right to the least restrictive alternatives. . . . Following this analysis, this court must conclude *that a constitutional right to the least restrictive method of care or treatment exists only insofar as professional*

ants to comply with the consent decree obligations to develop community-based programs according to a schedule. 807 F.2d at 1247. The court disapprovingly noted that "[t]he [trial] court chastised the State for foot-dragging and delay in implementing community placement, and the court insisted that the 'feasible' plan for such furloughs developed by an expert retained in consequence of the class action was more 'convincing' than the rationale adduced by the State." *Id.* at 1246.

92. The court in *Lelsz* opined that the Second Circuit in *Society for Good Will to Retarded Children* reversed because of "the district court's willingness to substitute the judgment of plaintiffs' experts for that of the state's experts, in contravention of *Youngberg*." 807 F.2d at 1251. *Lelsz* arguably expanded the *Youngberg* Court's presumption of validity to a "presumption of *correctness*." *Id.* at 1250 (emphasis added). The *Lelsz* phrasing suggests that administrators' decisions are presumptively "correct," while *Youngberg* holds only that such decisions are presumed not to offend the Constitution.

93. *Id.* at 1250 n.9.

94. *See, e.g., Rennie*, 720 F.2d at 271. The *Rennie* court acknowledged that "[w]hat does not appear to survive *Youngberg* is the least intrusive means test" but found that the Constitution still does not tolerate inappropriate deprivations of mental patient's liberty "for the administrative convenience of state institutions." *Id.*; *see also* *Association of Retarded Citizens v. Olson*, 561 F. Supp. 473, 486 (D.N.D. 1982), *aff'd*, 713 F.2d 1384 (8th Cir. 1983).

95. 561 F. Supp. 473. The district court ordered state officials to devise and implement a plan to reduce the population of two facilities for mentally retarded individuals by developing adequate and appropriate community-based facilities and services and placing the individuals in them. *Id.* at 494. The district court, while acknowledging *Youngberg's* rejection of "least intrusive means," found a right to community-based treatment where there was a professional consensus that such treatment was necessary to enable mentally disabled persons to exercise their liberty. *Id.* at 488, 494.

*judgment determines that such alternatives would measurably enhance the resident's enjoyment of basic liberty interests.*⁹⁶

Following this reasoning, two other federal courts of appeals found a constitutional right to community-based treatment for mentally disabled individuals as to whom there was a professional consensus that institutional confinement was not, and could not be "minimally adequate" treatment.⁹⁷ *Clark v. Cohen* involved a high-functioning mentally retarded woman who had been inappropriately hospitalized for twenty-nine years,⁹⁸ and who required assistance to develop the skills necessary to function in the community. *Thomas S. v. Morrow* concerned a behaviorally-disordered plaintiff who had failed in a variety of inappropriate placements.⁹⁹ In both cases, the right to community-based treatment was based on a clear professional consensus that (1) institutional confinement and treatment were not consistent with good professional standards and (2) community-based care was. Under such circumstances, community-based treatment and "minimally adequate" treatment, are the same thing; thus, the institutional confinement is unconstitutional and community-based treatment is required.¹⁰⁰

96. *Id.* at 486 (emphasis added).

97. *Clark v. Cohen*, 794 F.2d 79 (3d Cir.), *cert. denied*, 107 S. Ct. 459 (1986); *Thomas S.*, 781 F.2d 367.

98. *Clark*, 794 F.2d at 85-86. In *Clark*, the Third Circuit Court of Appeals held that a mentally retarded woman's substantive due process rights had been violated because of her inappropriate institutionalization, and ordered county defendants to develop, and state defendants to fund, a less restrictive community living arrangement in which she could receive appropriate treatment. *Id.* at 82, 87. The plaintiff on appeal did *not* assert a "constitutional right to treatment outside an institution unrelated to any prior violation of her rights." *Id.* at 83. The court of appeals therefore reasoned that the constitutional right to minimally adequate treatment enunciated in *Youngberg* was violated by plaintiff's continued confinement "in the face of unanimous professional opinion that she should be placed in a far less restrictive environment." *Id.* at 87.

99. 781 F.2d at 369-70. Indeed, the fact pattern in *Thomas S.* is a classic illustration of how because of financial and administrative factors, mentally disabled persons are placed in inappropriate settings, despite a clear professional consensus as to the needed treatment services. Thomas was placed in foster homes, group homes for disturbed children, a state mental institution, an emergency shelter, a rest home for the elderly, a group home for developmentally disabled adults, a rest home for elderly and emotionally ill adults and a detoxification and night care facility. In all, Thomas lived in more than forty foster homes and institutions prior to the district court judgment. *Id.* at 369-73.

100. In *Clark*, case workers employed by the defendant state institution had recommended community living for Carolyn Clark for nine years, and had consistently found continued institutionalization inappropriate. 794 F.2d at 85-86. Similarly, in *Thomas S.*, the caseworkers responsible for placement agreed that Thomas required placement in a less restrictive setting and that placement in an institution would be inappropriate. 781 F.2d at 371-73.

Consensus distinguishes these cases from *Society for Good Will to Retarded Children* and *Phillips*. The Fourth Circuit in *Thomas S.* noted this distinction in declining to follow the two

This second group of cases finds that a right to community-based treatment may be asserted based upon professional consensus. However, a more recent decision, *Lelsz v. Kavanagh*, took the position that professional consensus is not enough: courts can declare and enforce a right to community-based treatment only for *individual* plaintiffs where there is complete agreement between the parties that institutional confinement is inappropriate.¹⁰¹ Under this test it is questionable whether a court could ever find that institutional confinement is not "minimally adequate" so long as state experts testify to the contrary.¹⁰² Even where there is a professional consensus that, for example, high-functioning developmentally disabled persons, or chronically mentally ill persons, should be treated in the community,¹⁰³ *Lelsz* seems to deny relief to *groups* of mentally disabled persons.

Is there a way to permit a court to find institutional confinement not "minimally adequate" for a group or, indeed, for an individual where the

cases. 781 F.2d at 375-76 ("[T]hese decisions do not apply to the facts in Thomas's case, in which a discrete recommendation for treatment was made by qualified professionals to meet the needs of an individual, as contemplated by *Youngberg*, 457 U.S. at 319 n.25 . . .").

101. *Lelsz*, 807 F.2d at 1249 n.9. The Fifth Circuit distinguished *Clark* and *Thomas S.* as individual cases where there was only one appropriate placement for the mentally disabled plaintiff.

Clark was an *individual* case where the *only* method to remedy the effects of the unconstitutional confinement was community placement. In other words, community placement was not merely the *best* remedy for the plaintiff but the *only* remedy. The Third Circuit did *not* grant *carte blanche*, a constitutional right to community placement. . . .

As in *Clark*, *Thomas S. v. Morrow* dealt with an *individual* situation Thomas S. had the *potential* to live independent of the state's care, but was unable to live independently without *minimal* habilitation which involved a community setting. This community habilitation was not "better" care but the *only* way in which the state could remedy its past transgressions against Thomas S.

Id. (citations omitted) (emphasis in original). Thus, in *Lelsz*, even though defendants' experts had agreed that community-based services were minimally adequate, the Fifth Circuit rejected the consent decree below because it was not satisfied that for every mentally disabled person in the affected group, community treatment was the "only" remedy. *Id.* at 1250-51.

102. The decisions in *Phillips* and *Society for Good Will to Retarded Children* illustrate the difficulty in reaching consensus as to whether institutional confinement of severely mentally retarded persons or of high-functioning developmentally disabled persons is inconsistent with professional judgment. *Phillips*, 715 F.2d at 366-68; *Society for Good Will to Retarded Children*, 737 F.2d at 1243.

103. In *Pennhurst State School & Hosp. v. Halderman*, 446 F. Supp. 1295 (E.D. Pa. 1977), *aff'd in part and rev'd in part*, 612 F.2d 84 (3d Cir. 1979), *rev'd*, 451 U.S. 1 (1981), *on remand*, 673 F.2d 647 (3d Cir. 1982) [hereinafter *Pennhurst I*], there was professional consensus that institutional confinement was unreasonable and that the developmentally disabled clients should be in the community. Later the parent-intervenors challenged the professional consensus, especially with regard to severely disabled clients. *Halderman v. Pennhurst State School & Hosp.*, 452 F. Supp. 867 (E.D. Pa. 1978) (motion to intervene dismissed for lack of jurisdiction), *aff'd*, 612 F.2d 131 (3d Cir. 1979). For a discussion of the parents' claims, see Rhode, *Class Conflicts in Class Actions*, 34 STAN. L. REV. 1183, 1259-60 (1983).

state's experts have given their contrary "professional" opinion? The state may argue that a state mental health administrator's decision to concentrate resources in mental hospitals rather than in community programs is also a "professional judgment" with a presumption of reasonableness under *Youngberg*. We believe that a court may properly reject state experts' testimony and need not defer to a state administrator's decision where the testimony or decision was not based upon professional—that is, clinical—factors.¹⁰⁴

The Court in *Youngberg* did counsel deference to a qualified professional's decision for a course of treatment that was consistent with professional standards; such a decision is "presumptively valid."¹⁰⁵ However, the *Youngberg* admonition must be read in conjunction with its declaration of a constitutional right to "minimally adequate treatment." The Supreme Court quoted with approval the lower court opinion of Chief Judge Seitz: "It is not appropriate for the courts to specify which of several *professionally acceptable* choices should have been made."¹⁰⁶ In order to satisfy the right to "minimally adequate" treatment, a mental health professional acting for the state must choose a course of treatment which is "professionally acceptable." The mere fact that a decision has been made by a mental health professional does not satisfy the *Youngberg* test; the choice must be consistent with prevailing professional standards and practice.¹⁰⁷

Since *Youngberg*, several federal courts of appeals have explicitly rejected the idea that action by state-employed mental health professionals must be considered "reasonable" or "consistent with prevailing standards" without further scrutiny.¹⁰⁸ These courts distinguish decisions made by mental health professionals on "non-professional" grounds,

104. *Youngberg*, 457 U.S. at 323. See *infra* notes 108-10.

105. *Id.* at 322-23 (footnote omitted).

106. *Id.* at 321 (citing *Romeo v. Youngberg*, 644 F.2d 147, 178 (3d Cir. 1980)) (emphasis added).

107. *Id.* at 323.

108. The Second Circuit Court of Appeals in *Woe*, 729 F.2d 96, emphasized the right and obligation of a court to consider whether a challenged state action fell within the category of exercise of professional judgment: "*Youngberg* did not suggest that the judgment of the state's professionals was necessarily conclusive. On the contrary, the Court indicated that the testimony of Romeo's experts should have been admitted as relevant to the professional acceptability of the training he was receiving." *Id.* at 106 (citing *Youngberg v. Romeo*, 457 U.S. 307, 323 n.31 (1982)).

The *Woe* court demonstrated an awareness that the treatment of a person in a mental institution does not always constitute a "professional decision" to be deferred to. The court distinguished between "minimally adequate treatment" ("treatment that . . . accords with contemporary medical standards") and actual practice in state institutions. *Id.* at 98; see also *Society for Good Will to Retarded Children*, 737 F.2d at 1248, where the Second Circuit found

such as economic constraints or administrative convenience, from the kind of exercise of professional judgment deserving deference.¹⁰⁹

Thus, where the decision to confine a mentally disabled person in an institution is based upon a true exercise of professional judgment, it is presumptively valid, and, unless the presumption is rebutted, confinement is "minimally adequate" treatment. Under such circumstances, there is not a federal constitutional right to be treated outside of the institution. However, the presumption *is* rebuttable; courts can and should consider evidence of prevailing standards of professional practice and reject decisions by state-employed professionals which do not meet those standards.

Moreover, when an individual or a group is confined, not for clinical reasons, but for administrative convenience or due to economic constraints, then the decision to confine is not "presumptively valid" under *Youngberg*. Thus, a mental health professional's involuntary hospitalization of a person because "the hospital was the only placement available," or the state administrators' decisions to devote limited resources to state institutions rather than community programs¹¹⁰ should not be entitled to

it appropriate for the court to hear expert testimony "because [it] may shed light on what constitutes minimally accepted standards across the profession."

The Third Circuit in *Clark*, 794 F.2d at 87, the Seventh Circuit in *Johnson*, 701 F.2d at 1209-10, and the Fourth Circuit in *Rennie*, 720 F.2d at 271, acknowledged that factors such as administrative convenience and limited facilities could influence decisions made by mental health professionals.

109. The Seventh Circuit in *Johnson*, 701 F.2d at 1209, reasoned that to satisfy the *Youngberg* "professional judgment" criterion, it must determine that the state's decision to place a prisoner in a more restrictive environment actually was an exercise of *professional* judgment:

In this case, a "professional judgment" is not synonymous with a decision made by a person "competent, whether by education, training or experience, to make the particular decision at issue." A judgment is not "professional" if it is not based on a view as to how best to operate a mental health facility.

Id. at 1209 n.9 (quoting *Youngberg v. Romeo*, 457 U.S. 307, 323 n.30 (1982)) (citation omitted). Chief Judge Seitz, concurring in *Rennie*, distinguished between decisions to involuntarily medicate patients on clinical grounds, and those made "on economic or administrative grounds, as part of an attempt to 'warehouse' the patient." 720 F.2d at 274 (Seitz, J., concurring). Circuit Judges Weis, Higginbotham and Sloviter, also concurring in *Rennie*, made the point more strongly:

[I]t is not enough to rely on a "professional judgment" unless it includes an evaluation aimed at the least intrusive means—a cost-benefit analysis viewed from the patient's perspective. . . .

. . . [T]he least intrusive doctrine directs that professionals give greater consideration to the potential danger to the patient than to the state's administrative convenience or economic benefits.

Id. at 276-77 (Weis, J., Higginbotham, J. and Sloviter, J., concurring).

110. Since decisions which result in the institutionalization of a *group* are more likely to be based upon non-clinical factors, they should be especially vulnerable to attack under this reasoning.

deference. Under these circumstances, in the absence of other compelling evidence that the treatment provided in the institution is "minimally adequate," due process provides a federal constitutional right to community-based treatment.

It is possible to use the *Youngberg* "reasonableness" test to support a right to receive treatment services in the community. To do so, we must show that the "minimally adequate" treatment to which mentally disabled persons are entitled is *the same thing as* treatment in the community. We must show a professional consensus that, for all mentally disabled persons capable of functioning outside an institution with assistance, institutional care *cannot be* "minimally adequate" treatment.¹¹¹ Finally, to defeat the presumption that the state's decision to confine is "reasonable," we must show that it was based on non-clinical factors, and thus is not entitled to deference under *Youngberg*.¹¹²

C. Restrictions on Liberty

Even if we establish that "minimally adequate" treatment can equal "community-based treatment," whether for an individual or a group, our task is only half done. The right to community-based treatment found by courts since *Youngberg v. Romeo*¹¹³ has thus far been based upon the mentally disabled person's institutional confinement.¹¹⁴ This is consistent with due process analysis: the substantive protection of the fourteenth amendment does not attach without state restriction of liberty.¹¹⁵ Yet, a right to community-based treatment is of limited use if it is condi-

111. For evidence of a professional consensus that prolonged institutional treatment is not appropriate for chronically mentally disabled persons, see Glick, Klar & Braff, *Guidelines for Hospitalization of Chronic Psychiatric Patients*, 35 HOSP. & COMMUNITY PSYCHIATRY 9 (1984), reprinted in MENTAL HEALTH LAW PROJECT, PROTECTION & ADVOCACY FOR PEOPLE WHO ARE LABELLED MENTALLY ILL 131, 131 (1987) ("[T]here are no data to support the use of hospitalization rather than outpatient treatment for most chronic patients."); Talbott & Glick, *The Inpatient Care of the Chronically Mentally Ill*, 12 SCHIZOPHRENIA BULL. 129 (1986) ("[C]urrent thinking holds that [long-term inpatient] treatment should be reserved for a very few specific cases. Short-term inpatient treatment should be the rule for the majority of chronic patients, as opposed to the acutely ill . . .").

112. Advocates must show that the state expert's "professional standard" is limited to "what is done in state hospitals." This would not be a fair measure of the profession's standards. See *Woe*, 729 F.2d at 98, where the Second Circuit deemed itself "forced . . . to acknowledge that institutions for the mentally handicapped often do not provide treatment that remotely accords with contemporary medical standards." *Youngberg* allows budgetary limits as a defense against personal liability, but not against constitutional attack on state practices themselves. *Youngberg*, 487 U.S. at 323.

113. 457 U.S. 307 (1982).

114. See *supra* text accompanying notes 62-68 & 86-96.

115. *Society for Good Will to Retarded Children v. Cuomo*, 737 F.2d 1239, 1250 (2d Cir. 1984); see also *Lelsz v. Kavanagh*, 807 F.2d 1243, 1250 (5th Cir. 1987).

tioned upon institutionalization. The majority of mentally disabled persons with whom we are concerned are not presently involuntarily confined; indeed, as institutional populations shrink, and mentally disabled persons live in the community in greater numbers, the greatest need for community services may be among persons who have never been hospitalized.¹¹⁶ Thus, the second part of our task is to extend the constitutional right to community-based treatment to non-institutionalized persons.

Where a mentally disabled person is subjected to the "massive curtailment of liberty" of involuntary hospitalization,¹¹⁷ the presence of restrictive state action is obvious. Not so obvious are the restrictions of liberty that remain, even after a mentally disabled person is discharged from an institution. More difficult to identify, yet equally real, are the restrictions imposed by a state mental health system on a disabled person who has never been hospitalized. We must identify those restrictions in order to trigger the due process protection upon which rests the right to community-based treatment for non-institutionalized persons.

Two post-*Youngberg* cases have recognized that state restriction on liberty does not end when a mentally disabled person is released from an institution. In both *Clark v. Cohen* and *Thomas S. v. Morrow*, the right to community placement survived discharge from the institution, because the mentally disabled plaintiffs continued to be dependent upon the state.¹¹⁸ In addition, the Third Circuit found Carolyn Clark to be entitled to community placement as reparation for past unlawful institutionalization.¹¹⁹ Both cases, however, relied upon continued state involvement and concomitant restriction of liberty which began with the involuntary confinement, and continues, albeit in diminished form,

116. In the future the problem will only increase, as the community will include "new" schizophrenics, as well as chronically mentally ill persons with a history of multiple short-term hospitalizations.

117. *Humphrey v. Cady*, 405 U.S. 504, 509 (1972). The loss of liberty involved in civil commitment includes not only confinement but the stigma associated with commitment. *Vitek v. Jones*, 445 U.S. 480, 491-92 (1980); see also *Parham v. J.R.*, 442 U.S. 584, 600 (1979); *Addington v. Texas*, 441 U.S. 418, 425-26 (1979).

118. *Clark v. Cohen*, 794 F.2d 79 (3d Cir.), cert. denied, 107 S. Ct. 459 (1986); *Thomas S. v. Morrow*, 781 F.2d 367 (4th Cir. 1986), cert. denied, 106 S. Ct. 1992 (1986) and 107 S. Ct. 235 (1986). In both *Clark* and *Thomas S.*, the mentally disabled persons could not simply have been released from the institutions without further assistance from the state to enable them to exercise their liberty. The Fourth Circuit emphasized *Thomas S.*' continued dependency upon the state, *Thomas S.*, 781 F.2d at 376; the Third Circuit stressed that Carolyn Clark, even after discharge from the state institution, was under conservatorship and would need training to overcome behavioral problems and skills deficiencies due to institutionalization. *Clark*, 794 F.2d at 97 (Becker, J., concurring).

119. *Clark*, 794 F.2d at 86.

through conservatorship.¹²⁰

Yet conservatorship and civil commitment are not the only means by which the state can exercise such control over mentally disabled persons. The state, through operation of the mental health system itself, determines to a great extent where and how mentally disabled persons will live. Licensing requirements for community programs, contracts with services providers, eligibility guidelines for public benefits¹²¹—these can determine whether a mentally disabled person is able to survive in the community or is subjected to repeated institutional confinement. Thus, state actions which lead indirectly to rehospitalization significantly affect the liberty interests of mentally disabled persons who are dependent upon the state.

Like many other mentally disabled persons, Thomas S. and Carolyn Clark required state assistance in order to be able to leave the institution. However, assistance is also necessary to enable them to *remain* in the community. Thomas S.' history of unsuccessful placements, and Carolyn Clark's deficient living skills, demonstrate that they will need training, supervision, economic and psychological support in order to maintain themselves in the community.¹²² That need for assistance *in order to avoid future institutional confinement* is the source of their right to community-based treatment.

The risk of future involuntary hospitalization is a different kind of restriction on liberty from present institutional confinement. Nevertheless, for many mentally disabled persons caught in the "revolving door,"¹²³ it is a very real one. The crucial element of the revolving door is that it is a closed system: the mentally disabled person, once drawn into the mental health system, is thereafter constantly at risk of rehospitalization. This is not a hypothetical or far-fetched concern; the recidivism rate for persons identified as chronically mentally ill demonstrates the seriousness of the risk.¹²⁴ For a person caught in the revolving door,

120. *Id.* at 97 (Becker, J., concurring) (Clark, even in the community placement, was still involuntarily committed); *Thomas S.*, 781 F.2d at 376 (ward of the state).

121. Rapson, *supra* note 16, at 237 (restrictiveness by state in less blatant manner in community).

122. For a discussion of the ways in which adequate community-based services can enable mentally disabled persons to function and to avoid unnecessary rehospitalization, see *supra* notes 26-28 and accompanying text.

123. See *supra* notes 22-23 and accompanying text.

124. For example, the overall rehospitalization rates at Camarillo and Metropolitan State Hospitals, two California state institutions, are very high. According to the most recent statistics available for 1985, 58.4% of patients admitted to Metropolitan and 49% of those admitted to Camarillo had been previously hospitalized. Within Los Angeles County there is a rehospitalization rate of 16.7% within 30 days and 44% within 6 months. Opening Brief for Appel-

just as for Nicholas Romeo, appropriate treatment and services are required to enable him or her to preserve and exercise liberty.

The state, by its enactment and enforcement of laws permitting involuntary commitment, restricts the liberty of mentally disabled person caught in the "revolving door." The recidivism rate is evidence of the real nature of that restriction. Therefore, persons in the revolving door have a right to treatment services in the community to the extent that they *reduce the risk* of loss of liberty through rehospitalization.

For mentally disabled individuals not part of the revolving door, institutionalization may still pose a very real threat. Too often, if the state perceives a mentally disabled person as a legitimate object of concern, under either the *parens patriae* or police power, the result will be a deprivation of liberty. Historically, institutional confinement has been the price exacted by the state from mentally disabled persons, in return for custodial care. As Governor Wallace of Alabama acknowledged as a defendant in *Wyatt v. Aderholt*, the "real clients" of the mental health system are the police, parents, and members of the community who do not want the responsibility of caring for—or learning to live with—disabled individuals.¹²⁵

Because of this demand, the state will probably not "just leave alone" mentally disabled persons perceived as non-dangerous but in need of protection and treatment. Under *parens patriae*, either the state will provide treatment services to enable them to function in the community, or it will place them in an institution.¹²⁶

A mentally disabled person who comes to the attention of the state through the criminal justice system, triggering the police power, is also likely to suffer a loss of liberty. If perceived as mentally disabled, he or she may be charged with a crime "for his or her own good" to make possible a transfer from the jail to the state hospital.¹²⁷ A misdemeanor charge may enable the court to order in-patient evaluation of competency

lants at 14, *Mental Health Ass'n v. Deukmejian*, 186 Cal. App. 3d 1531, 233 Cal. Rptr. 130 (1986) (No. 2 Civ. B 014479) (ordered depublished); see also *Brewster v. Dukakis*, No. 76-4423-F (E.D. Mass. Dec. 6, 1978) (final consent decree), reprinted in 3 MENTAL DISABILITY L. REP. 45, 45 (1979), which included in the definition of the plaintiff class, persons "at risk" of confinement in the state hospital.

125. *Wyatt v. Aderholt*, 503 F.2d 1305, 1312 (5th Cir. 1974).

126. See *Clark*, 794 F.2d at 93-95 (Becker, J., concurring).

127. The court in *Mental Health Ass'n v. Deukmejian*, No. CA 000540 slip op. (Cal. Super. Ct. May 8, 1985), *aff'd*, 186 Cal. App. 3d 1531, 233 Cal. Rptr. 130 (1986) (ordered depublished), found that mentally disabled persons in Los Angeles County are involuntarily hospitalized through the practice known as "mercy bookings"; that is, police officers would arrest mentally disabled persons in order to bring about their transfer from the jail to the mental hospital. *Id.* at 5-6.

to stand trial; such a commitment may extend to the maximum possible sentence for the charged offense.¹²⁸ An acquittal on insanity grounds may yield the same result: confinement in a mental hospital for a fixed or open-ended term, depending upon the law of the jurisdiction.¹²⁹

Mentally disabled persons whose disability is severe enough to attract the attention of the state, will surely have their liberty restricted in some way. Their disability, combined with the risk of institutional confinement, make non-institutionalized persons dependent upon the state for the protection and exercise of their liberty—just as were Thomas S. and Carolyn Clark. Thus, even for non-institutionalized persons, the restrictions on liberty imposed by the state's mental health system, coupled with a mental disability severe enough to carry a substantial risk of institutional confinement, may be shown to trigger the due process clause.

A "minimally adequate" system of community-based programs and services, by increasing mentally disabled persons' ability to function in the community, will reduce the risk of state restriction on their liberty through the criminal justice or the civil mental health systems. Thus, the right to "minimally adequate" treatment in the community may be asserted for mentally disabled persons who are now inappropriately hospitalized, who have been institutionalized and are trapped in the "revolving door," or for those who, although never hospitalized, are dependent upon the state for assistance and thus subject to state restrictions on their liberty.

This argument, of course, goes far beyond the post-*Youngberg* case law. Most of those decisions have been concerned solely with interpreting "minimally adequate" treatment; they have not considered what degree of restriction on liberty, other than institutional confinement, creates a right to such treatment. *Clark* and *Thomas S.* may be cited for the proposition that civil commitment to a community placement and conservatorship are sufficient state restrictions on the liberty of mentally disabled persons outside institutions to trigger the due process clause. Arguably Thomas S.' history of failure in inappropriate community placements shows that he was caught in the "revolving door."¹³⁰ However, neither the Fourth Circuit nor any other court has ruled on the question whether the "revolving door" population have a right to com-

128. See, e.g., CAL. PENAL CODE § 1370(c)(1) (West Supp. 1987).

129. See, e.g., *id.* § 1370(a)(1). But see *Jones v. United States*, 463 U.S. 354, 368-69 (1983) (District of Columbia statute was constitutional even though it permitted commitment of insanity acquittee beyond maximum time he would have served if convicted).

130. See *supra* notes 99 & 120.

munity-based treatment based upon the risk of future confinement.¹³¹ Yet, this issue is critically important to the thousands of mentally disabled persons at risk of involuntary hospitalization or incarceration as criminals. That risk will continue to be acute in the absence of adequate community-based treatment services. Therefore, we hope that advocates and courts will consider the possibilities of a broader definition of restriction on liberty, as a basis for a constitutional right to community-based treatment.

V. CONCLUSION

A federal constitutional right to community-based treatment and services may be argued, based upon the *Youngberg v. Romeo*¹³² "reasonableness" standard, by showing a professional consensus equating "minimally adequate" treatment and community-based care. This right, which protects mentally disabled persons confined in institutions, may be extended to non-institutionalized persons. Mentally disabled persons caught in the "revolving door" or at risk of some other state restriction on liberty based upon their mental disability, as well as those presently confined in institutions, are entitled to the treatment services which will enable them to preserve and exercise their liberty.

131. Plaintiffs in *Mental Health Association v. Deukmejian* argued that the chronically mentally disabled "at risk" of rehospitalization, like mentally disabled persons confined in state institutions, have a constitutional right to "minimally adequate" treatment. Petition for Review at 23-24, *Mental Health Ass'n v. Deukmejian*, 186 Cal. App. 3d 1531, 233 Cal. Rptr. 130 (1986) (No. 2 Civ. B 014479) (ordered depublished). Since the trial court and the court of appeal held that, post-*Youngberg*, there was no constitutional right to community-based treatment, even for institutionalized mentally disabled persons, neither court addressed the issue whether such a right could extend to the "revolving door" population. The court of appeal did find, however, that plaintiffs were entitled to assert the right to community-based treatment on behalf of the "at risk" population. *Mental Health Ass'n v. Deukmejian*, 186 Cal. App. 3d 1531, 1548, 233 Cal. Rptr. 130, 140-41 (1986) (ordered depublished).

132. 457 U.S. 307 (1982).

