Competency, Deinstitutionalization, and Homelessness: A Story of Marginalization

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COMPETENCY, DEINSTITUTIONALIZATION, AND HOMELESSNESS: A STORY OF MARGINALIZATION

Michael L. Perlin*

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PROLOGUE: LIFE IMITATES ART

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

About two days later, as I emerged from the depths of the World Trade Center in Manhattan as part of my commute to work, I heard the unmistakable sounds of police dogs. As I walked through the transportation terminal, the barking grew louder. I finally came across a crowd of commuters—all motionless. A Port Authority Transit policeman was holding on to a police dog, barking, snarling, and attempting to break loose. They were both about three feet away from a homeless man, who was supine, perhaps unconscious, and sprawled out on the floor of the lower level of the World Trade Center. As the dog growled, seemingly poised to attack the homeless man (although I doubt that would have happened), many of the commuters broke out in spontaneous applause.
in clear support of the officer. I will never forget that moment.

I. INTRODUCTION: CIVILIZATION'S DISCONTENTED

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

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

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

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

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


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

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

7. Refer to notes 174, 285-87 infra and accompanying text.
8. Refer to note 153 infra and accompanying text.
9. Refer to note 113 infra and accompanying text.
13. Much of the text accompanying notes 14-25 is adapted from M. Perlin, supra note 11, § 7.23.

The definitions focus on various factors, including (1) whether the individual resides in a shelter, (2) whether hospital admission records designate the individual as "undomiciled", or (3) the length of time that the individual has been without an official residence. See, e.g., Morrison, Correlations Between Definitions of the Homeless Mentally Ill Population, 9 Hosp. & COMMUNITY PSYCHIATRY 952, 952 (1989) (further subdividing definitions into those homeless for extended periods, those episodically homeless, those potentially homeless and those in a precarious living situation with family or friends); see also Arce, Tadlock, Vergare & Shapiro, A Psychiatric Profile of Street People Admitted to an Emergency Shelter, 34 Hosp. & COMMUNITY PSYCHIATRY 812, 814 (1983) (hereinafter Psychiatric Profile) (classifying the homeless as street people, episodic homeless, or others); Chafetz & Goldfinger, Residential Instability in a Psychiatric Emergency Setting, 56 PSYCHIATRIC Q. 20, 20 (1984) (examining two levels of residential instability: lack of shelter and transient living arrangements); Mowbray, Johnson & Solarz, Homelessness in a State Hospital Population, 38 Hosp. & COMMUNITY PSYCHIATRY 880, 880 (1987) (analyzing characteristics of homeless or potentially homeless psychiatric patients).

The Alcohol, Drug Abuse and Mental Health Administration of the United States De-
complex. However, the public discourse on "the deinstitutionalized" has distorted the public discourse on the issue of "homelessness." The media, in its presentation of the story of the homeless, has equated the "homeless" with the "deinstitutionalized homeless." Conventional wisdom posits that the policy of deinstitutionalization has "caused" the increase in homelessness and urban troubles. The public perceives homeless individuals as a nearly monolithic population—ex-patients, improvidently released from psychiatric hospitals, incompetent to care for themselves, and a danger to themselves and to the citizenry. In his typically florid way, former New York City Mayor Ed Koch has characterized deinstitutionalization as one of the "lunacies of government." This blame-laying is misplaced. Its focus on the tree of deinstitutionalization, while of vital importance to the one-third of the homeless somehow affected by their histories as ex-patients, obscures the forest of deeper and broader shame: the crushing costs of homelessness to all of the less visible displaced and the dispossessed—the children, the young mothers, and, increasingly, the Vietnam veterans. Homelessness remarginalizes these individuals.

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

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


18. Refer to note 114 infra and accompanying text.


20. See 2 M. PERLIN, supra note 11, § 7.23, at 672.
who have already once been marginalized by poverty, by race, and by social status.

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

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

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22. Few analyses have differentiated between the mentally ill and the mentally ill who were formerly hospitalized. But see New York City Human Resources Admin., New York City Plan for Homeless Adults, 13 (April 1984); New York City Human Resources Admin., Correlates of Shelter Utilization: One Day Study, Table D-1 (Aug. 1984).

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


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

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

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

28. Refer to notes 173 infra and accompanying text.
have regularly espoused liberal and "left" political positions in the national and international political debate possess the same sort of virulent bias and prejudice in dealing with the deinstitutionalized as do those members of the community who regularly articulate racist and sexist positions.\textsuperscript{29} It is this extra bias of "sanism"\textsuperscript{30} that is especially pernicious in the context of homelessness.

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

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

\begin{itemize}
\item \textsuperscript{29} Refer to note 173 \textit{infra} and accompanying text.
\item \textsuperscript{30} \textit{Id.}
\item \textsuperscript{31} \textit{See, e.g.,} Cohen, \textit{Killer Conservatism}, Wash. Post, Mar. 16, 1989, at A27, col. 2 ("We are inundated with the homeless, beggars, the insane and the just plain weird.").
\item \textsuperscript{32} Refer to notes 292-302 \textit{infra} and accompanying text.
\item \textsuperscript{33} Refer to notes 38-108 \textit{infra} and accompanying text.
\item \textsuperscript{34} Refer to notes 109-74 \textit{infra} and accompanying text.
\item \textsuperscript{35} Refer to notes 175-290 \textit{infra} and accompanying text.
\end{itemize}
ings not usually found in the legal or mental disability texts. Finally, Part VI offers some modest explanations of the current state of affairs and some recommendations to policy makers and academic experts, as well as the only constituency that really matters, the general public.

II. THE MYTHS OF HOMELESSNESS

A. Introduction

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

36. Refer to notes 291-424 infra and accompanying text.
37. Refer to notes 425-64 infra and accompanying text.
39. This dates to at least the time of Constantine and Theodosius in the fourth century. See St. John's Evangelical Lutheran Church v. Hoboken, 195 N.J. Super. 414, 418, 479 A.2d 935, 938 (1983) (finding that municipality's use of zoning to prohibit a church from sheltering the homeless was a violation of the free exercise of religion); see also Greentree at Murray Hill Condominium v. Good Shepherd Episcopal Church, 146 Misc. 2d 550, 561, 550 N.Y.S.2d 981, 988 (Sup. Ct. 1989) ("There was no room for them in the inn." (Luke 2:7)). See generally Goldberg, Gimme Shelter: Religious Provision of Shelter to the Homeless as a Protected Use Under Zoning Laws, 30 WASH. U. J. URB. & CONTEMP. L. 76 (1986) (providing shelter to the homeless is a religious obligation which is protected from zoning principles by the first amendment).
40. Talbott, Foreword, in THE HOMELESS MENTALLY ILL, supra note 15, at xiii. While limited public support existed in colonial times, public attitudes were not substantially different than attitudes today. "Reports dating back to the colonial period . . . note both the official resentment of the indigent and the particular burden posed by the 'indigent insane,' who no doubt elicited fear of their mental illness as well as irritation at their dependence." Goldfinger & Chafetz, Developing a Better Service Delivery System for the Homeless Mentally Ill, in THE HOMELESS MENTALLY ILL, supra note 15, at 92.
creased the number of uprooted homeless persons. These persons were the residents of the cities' first "skid rows." Social care for the homeless was traditionally organized by upper- and middle-class "caretakers," whose desire for moral reform and fear of social disorder demanded that homelessness be classified as a "social problem."

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

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

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

42. Hoch, supra note 38, at 17.
43. See Baxter & Hopper, Shelter and Housing for the Homeless Mentally Ill, in The Homeless Mentally Ill, supra note 15, at 109, 111.
44. Arce & Vergare, supra note 15, at 76-77; see Note, Homeless Families: Do They Have a Right to Integrity? 35 UCLA L. Rev. 159, 160 (1987) (dividing homeless into: (1) the chronically homeless single males and females; (2) the deinstitutionalized mentally ill; (3) the chemically dependent; and (4) the "new poor"); see also J. Erickson & C. Wilhelm, Housing the Homeless xxvii (1986) (defining nine categories of the homeless).
46. See Lipton & Sabatini, Constructing Support Systems for Homeless Chronic Patients, in The Homeless Mentally Ill, supra note 15, at 153, 156 (defining social network as "the set of concrete interpersonal relationships linking individuals with other individuals").

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

49. Family's Perspective, in The Homeless Mentally Ill, supra note 15, at 281; see also Werner, On the Streets: Homelessness Causes and Solutions, 17 CLEARINGHOUSE REV.
ingly more likely to be female and more likely to be members of racial minorities. We cannot understand homelessness or the homeless without recognition of the significance of this economic and social marginality.

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

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

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

50. P. Rossi, supra note 14, at 39 (while a 1963 study showed that only 3% of the homeless were women, recent investigations reveal rates ranging from 7-33%); Rossi, supra note 38, at 956 (discussing increase in number of homeless women). See generally Carty, Preventing Homelessness: Rent Control or Rent Assistance, 4 Notre Dame J.L., Ethics & Pub. Pol'y 365, 383 (1989) (discussing “feminization of poverty”); Sullivan & Damrosch, Homeless Women and Children, in The Homeless in Contemporary Society, supra note 6, at 82 (noting considerable change in the composition of the female homeless population in recent years).


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

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

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

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

[W]e must all recognize . . . that one of the primary problems of the chroni-
poor physical health; in need of social and human services; and often without any social support systems. Homeless children are routinely deprived of a thorough and adequate education. The homeless are extremely poor. It is essential that any serious consideration of homelessness acknowledge the critical link between homelessness and extreme poverty. Standing alone, the provision
cally mentally ill is poverty. These people are very, very poor and one reason that it is difficult to provide services for them is that they simply do not have the wherewithal to buy decent housing or any of the services that they require.


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

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


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


62. For a recent overview, see Sard, Roisman & Hartman, Homeless: A Dialogue on Welfare and Housing Strategies, 23 CLEARINGHOUSE REV. 104, 105-06 (1989). See generally Jahiel, supra note 6, at 114 (because the chief problem for the homeless is poverty, any attempted solution to homelessness must take that into account). Peter Rossi defines the "extremely poor" as members of households whose annual incomes are below $4000 in 1983 dollars. P. Rossi, supra note 14, at 13.

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

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

. . . .

The homeless, living and dying on the streets of our cities, are a standing challenge to the moral legitimacy of this nation. The homeless are the shame of
of emergency shelter is simply not enough to reverse these long-
term effects: if society's sole response to homelessness is the cre-
ation of an extensive shelter system, we are "effectively accepting
the permanency of a large population of people with no place to
call home." 64

B. Contributing Factors

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

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

64. Benda & Dattalo, supra note 55, at 886.
65. Refer to notes 175-290 infra and accompanying text.
66. See Arce & Vergare, supra note 15, at 77. Much of the text accompanying notes
91-136 infra is adapted from 2 M. PERLIN, supra note 11, § 7.25.
67. Hayes, Reforming Current City Policies, 2 CBC Q. 1, 1 (1982) (noting that the
number of homeless is reaching "epidemic" proportion).
68. Bachrach, The Homeless Mentally Ill and Mental Health Services: An Analytical
Review of the Literature, in THE HOMELESS MENTALLY ILL, supra note 15, at 14; see also P.
Rossi, supra note 14, at 40 (a large number of homeless are in their twenties and thirties;
the median age has dropped rapidly over the past decade); Reich & Segal, The Emergence
of the Bowery as a Psychiatric Dumping Ground, 50 PSYCHIATRIC Q. 191, 194 (1978) (the
Bowery's population has a large percentage of mentally ill persons, and the number is
increasing).
As the post-World War II baby-boom children reach maturity, "the absolute number of
young persons at risk for developing schizophrenia and . . . other chronic mental disorders
has increased dramatically." Bachrach, supra, at 11, 15.
69. Bachrach, supra note 68, at 15. But see Ball & Havassy, A Survey of the Problems
and Needs of Homeless Consumers of Acute Psychiatric Services, 35 Hosp. & COMMUNITY
PSYCHIATRY 917, 917-19 (1984) (disputing the accuracy of a San Francisco study that stereo-
types the mentally disabled homeless as nomads); cf. Fischer & Breakey, supra note 14, at
26 (observing that while the "migration stream" theory applies to the young, chronic popu-
lation, other homeless groups, such as chronic alcoholics, are significantly less transient);
Snow, Baker, Anderson & Martin, The Myth of Pervasive Mental Illness Among the Home-
less, 33 Soc. Probs. 407, 411-12 (1986) [hereinafter Myth] (while the homeless in general are
show a greater tendency to use addictive substances (both drugs and alcohol), which often exacerbate the symptoms of illness and make homelessness more likely. Vietnam veterans are one hidden subset of this population, and one commentator recently characterized them in this context as "soldiers of misfortune."

2. The shrinking housing market. The elimination of available housing stock has had a tremendous impact on the growth of the homeless, especially in the larger cities. A 1982 New York quite mobile, the chronically mentally ill homeless are among the least mobile of all homeless individuals.

70. Bachrach, supra note 68, at 15.

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

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

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

73. Robertson, supra note 72, quoting H. Goldin, Soldiers of Misfortune 3-4 (1982).

74. Carmody, Study Blames Poverty For Most Homelessness, N.Y. Times, Nov. 2, 1984, at B2, col. 5 (Governor Mario Cuomo, quoting a study by the New York State Department of Social Services, stating "[h]omelessness is by its nature a crisis of housing"). More recent studies echo this conclusion. See, e.g., P. Rossi, supra note 14, at 181 (declaring that "it is easy to lose sight of the fact that the essential and defining symptom of homelessness is lack of access to conventional housing"); Rossi, supra note 38, at 957 ("Homelessness today is a more severe condition of housing deprivation than in decades past." (emphasis in original)); Stevens, U.S. Advocacy Group for Homeless is Born, N.Y. Times, Feb. 16, 1985,
State study found that the "single most critical factor in preventing effective service coordination and implementation of rational discharge planning is the lack of . . . adequate specialized housing for the chronically disabled."  

The shrinkage of alternative housing in New York, which has an overall rental vacancy rate of one percent, is paradigmatic. The Single Room Occupancy Hotels (SRO's), which for years provided their only affordable housing, were a haven for ex-patients and other high risk homeless persons who gravitated to such facilities for shelter. Between 1970 and 1982, New York City lost over 110,000 SRO units, which represented eighty-seven percent of the total supply. These SRO units disappeared largely as a result of tax abatement programs which encouraged developers to convert at B1, col. 1 (quoting Boston Mayor Raymond Flynn, keynote speaker at a national conference on problems of the homeless: "Housing is the real issue").

75. Baxter & Hopper, supra note 43 (quoting New York State Office of Mental Health, COMMITTEE REPORT TO THE COMMISSIONER OF MENTAL HEALTH (Jan. 1, 1982)); see also Rapson, The Right of the Mentally Ill to Receive Treatment in the Community, 16 COLUM. J.L. & SOC. PROBS. 193, 207 (asserting that "[h]ousing, the core of any community-based treatment plan, is the most striking testament to the breakdown of deinstitutionalization theory"). For a discussion of the relationship of housing issues to homelessness, see generally P. Rossi, supra note 14, at 181-86; COALITION FOR THE HOMELESS, STEMMING THE TIDE OF DISPLACEMENT: HOUSING POLICIES FOR PREVENTING HOMELESSNESS (1986) (discussing the linkage between federal reform legislation, housing and the mentally disabled).


77. B. Kates, The Murder of a Shopping Bag Lady 160 (1985). Cf. Rhoden, supra note 17, at 391-92 ("The New York City subway system has been called 'the largest SRO in existence'").

78. Cf. P. Rossi, supra note 14, at 35 (contending that the 'emergency shelters' that have been provided in city after city are certainly better than having no roof at all over one's head, but a case can be made that in some respects the cubicle hotels were better").

79. Baxter & Hopper, supra note 43, at 113 (citing Green, HOUSING SINGLE, LOW-INCOME INDIVIDUALS (paper presented at the Conference on New York State Social Welfare Policy, Oct. 1-2, 1982)); see also B. Kates, supra note 77, at 164 (115,000 SRO units lost since 1970). See generally STEMMING THE TIDE, supra note 75, at 29-32 (discussing loss of housing units). Nationwide, over one million SRO units were lost during the same time period, or nearly half of the entire nation's available single occupancy stock. Baxter & Hopper, supra note 43, at 113. Perhaps partially because of this lack of available housing, hospitals discharged patients in increasingly greater numbers to "unknown" living arrangements in urban states. In 1979-80, this happened to 23% of all discharged New York state patients, including 59% of one hospital's total discharges. Id. at 114 (citing New York State Office of Mental Health, MEMO FROM POLICY PLANNING AND PROGRAM DEVELOPMENT DIVISION: OCT. 29, 1980 (Mar. 31, 1980)).
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(and "gentrify") these hotels into luxury housing. The tax abatement laws were thus "subverted into a mechanism for converting unprofitable housing for the poor into extremely profitable housing for the well-to-do," greatly accentuating the problem. At the same time, federal funding for subsidized housing has been reduced eighty-one percent in the past decade. The waiting list for public housing in New York City is now estimated at eighteen years.

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

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

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

81. B. Kates, supra note 77, at 160-55.
82. Id. at 162.
84. Carmody, supra note 74, at B2, col. 5 (where 47,000 New York state households once received housing subsidies, only 8,000 currently receive them).
86. Halting the Race, supra note 21, at 555-56; cf. P. Rossi, supra note 14, at 35 (discussing study reported in Crystal & Goldstein, Chronic and Situational Dependency: Long Term Residents in a Shelter For Men (1982) (shelter residents rated prisons as superior to shelters in safety, cleanliness and food quality)).
87. The Phoenix City Council also defined all trash as "city property." Halting the Race, supra note 21, at 556 n.21. Other municipalities have considered even more grotesque approaches. A city councilman in Fort Lauderdale suggested that the city spray all garbage cans with poison to prevent the "disgusting sight" of homeless persons picking through garbage. Langdon & Kass, supra note 21, at 322-23 n.91 (quoting Robert Hayes, Remarks at the National Conference on Social Welfare, Boston, Mass. (Apr. 29, 1982)); see also Note, An Overview of Homelessness in America, 35 Loy. L. Rev. 216, 229 (1989) (discussing recently proposed similar local ordinances).
88. Halting the Race, supra note 21, at 557. According to the commentators, the approach of the governmental entities paradoxically mirrors that of states in efforts to attract corporations. The phrase "race to the bottom" originally described interstate competition to offer the most permissive regulatory or statutory scheme. Whereas this strategy was designed to attract corporate business, the states now compete to rid themselves of home-
3. Reduction in governmental benefits. The procedures initiated by the Reagan Administration to review all Supplemental Security Income (SSI) recipients resulted in over 350,000 people losing their benefits after fall 1981. In this group, the mentally disabled were overrepresented by a factor of three. Similarly, about a third of all persons whose benefits were discontinued were mentally impaired. As of November 1981, every client of Project Reach Out—a mobile outreach program funded by the New York State Office of Mental Health to serve the homeless—who applied for SSI based on psychiatric disability was rejected. A survey of another group of the homeless found that less than one-quarter received any sort of governmental financial assistance and that none received SSI.

While these cutbacks have diminished to some extent in the face of public outrage, congressional response, and United States Supreme Court action, the reduction of disability benefits less people. See, e.g., Cary, Federalism and Corporate Law: Reflections Upon Delaware, 83 Yale L.J. 663, 690 (1974); Halting the Race, supra note 21, at 555 n.19. For an explanation of how this reflects “bile barrel politics,” see generally Pitney, Bile Barrel Politics: Siting Unwanted Facilities, 3 J. Pol’y Analysis & Mgmt. 446, 448 (1984) (describing political manipulations to bar siting of hazardous waste sites, nerve gas warehouses, and prisons); Marmor & Gill, supra note 4, at 467. Refer to notes 184-85 infra and accompanying text.
remains a significant factor in the increased number of homeless persons. Additionally, the more recent amelioration in entitlement policy has not aided those individuals who lost benefits in the early 1980s. These changes caused the annual income of homeless individuals to drop from $1058 in 1958 to the equivalent of $383 (in 1958 dollars) at the present time. In other words, the homeless are more than two-thirds poorer than they were thirty years ago.

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

fits without due process is not permissible), aff'd, 742 F.2d 729, 740 (2d Cir. 1984), aff'd sub nom. Bowen v. City of New York, 476 U.S. 467 (1986).
99. See generally Note, Building a House of Legal Rights: A Plea for the Homeless, 59 St. John's L. Rev. 530, 533-38 (1985) (considering ways in which the administration of such entitlement programs as AFDC, SSI, and food stamps are negatively affecting the plight of the homeless, and noting that "by requiring bona fide residence for AFDC and SSI relief, the legislative intent behind the programs is defeated").
100. P. Rossi, supra note 14, at 40.
101. Id.
102. See Halting the Race, supra note 21, at 552.
103. Id.
104. See P. Rossi, supra note 14, at 40 ("We can generalize that minorities are consistently overrepresented among the new homeless in ratios that are some multiple of their presence in the community.").
105. See Langdon & Kass, supra note 21, at 313 ("If the focus of productivity continues to shift away from the heavy industry sector of the economy, it is likely that a growing number of workers will become jobless and then temporarily, if not chronically, homeless.").
106. See Homelessness in America II: Hearings Before the Subcomm. on Housing and Community Development of the House Comm. on Banking, Finance and Urban Affairs, 98th Cong., 2d Sess. 1874 (1984); see also Langdon & Kass, supra note 21, at 303 n.21 (90% of the population using municipal men's shelters in New York City are now minority). See generally Wagenaar & Lewis, supra note 52, 511-13 (for an increasing number of men between 1970 and 1980, the labor market ceased to function as the provider of the resources necessary for an adequate existence in society); Halting the Race, supra note 21, at 530-31 n.3 (discussing Price v. Cohen, 715 F.2d 87, 97 (3d Cir. 1983), and observing that the needy
C. Conclusion

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

III. The Myths of Deinstitutionalization

A. Historical Background

Our public mental health policy is cyclical, spurred by reform movements that seek to transform social problems into mental health issues and medical issues. In an important way, the deinstitutionalization debate provides yet one more example of
how a discrete reform policy that fails to address the full range of underlying social issues is inevitably doomed. While the historical basis of deinstitutionalization is fairly clear, this history must be read upon a canvas of social and economic politics in order to understand the depths of the problems we face today as well as the intractable irrationality of our response to them. Our willful blindness towards both the underlying politics and the irrationality of our response calls into question our social competence to respond. Deinstitutionalization is society’s “whipping boy.” Heuristically, we perceive it as a massive social failure that has “worsened conditions of care, created community resistance and under-

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


For an example of the use of heuristics in the deinstitutionalization context, see Cohen & Marcos, The Bad-Mad Dilemma For Public Psychiatry, 40 Hosp. & Community Psychiatry 677, 677 (1989) (discussing public attitudes towards discharge of mental patients following the murder of a church usher by a chronically mentally ill individual in St. Patrick’s Cathedral in New York City).
mined patient reintegration.” In order to determine the accuracy of this characterization, we must consider the forces that helped bring about current policies. When these forces are considered in light of the social forces that have dramatically increased homelessness, the relationship between the two should become clearer. The problems attributed to deinstitutionalization are far more complex than the debate suggests: they reflect important changes in national demography, in concepts of civil liberties, in social welfare policies, and in the provision of medical services. Until we confront this complexity, we will remain in a social policy gridlock.

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

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

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

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

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


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

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

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


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

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

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


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


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

It is well known that, following the rise of deinstitutionalization as a social movement, "money did not follow patients into the community." As a result of political and employee union pressures, state hospitals still receive an increasingly disproportionate share of the state budget as deinstitutionalization continues. See E. Torrey, supra note 41, at 155-66; Durham, supra note 72, at 121-22; Marmor & Gill, supra note 4, at 472-73.
Next, the development of antipsychotic drugs\textsuperscript{130} created a modality of treatment which could, in many instances, be administered in the community in much the same manner as in institutions.\textsuperscript{131} While the common wisdom that "the drugs emptied out the hospitals"\textsuperscript{132} has been called sharply into question by revisionist social historians such as Andrew Scull,\textsuperscript{133} many perceive the availability of these drugs as a primary precipitant of massive deinstitutionalization.\textsuperscript{134} Importantly, at least one recent research study suggests that a significant number of deinstitutionalized mentally ill persons prefer homelessness to hospitalization because they can thus avoid the involuntary administration of such drugs.\textsuperscript{135}

\textsuperscript{130} For a discussion of legal issues relating to antipsychotic drugs, see generally 2 M. Perlman, supra note 11, ch. 5; Brooks, The Constitutional Right to Refuse Antipsychotic Medications, 8 BUL\textsuperscript{L} AM. AC\textsuperscript{D}. PSYCHIAT. & L 179, 180-81 (1980); Brooks, The Right to Refuse Antipsychotic Medications: Law and Policy, 39 Rutgers L. Rev. 339, 339 (1987) (analysis of whether involuntarily committed mental patients have a legal right to refuse antipsychotic medication); Winick, Right to Refuse Mental Health Treatment: A First Amendment Perspective, 44 U. M\textsuperscript{A}I\textsuperscript{M}. L. REV. 1, 69-76 (1989). For a list of other important sources, see The Right to Refuse Antipsychotic Medication 101-10 (D. Rappaport & J. Parry eds. 1986) (providing an annotated bibliography).

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

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

\textsuperscript{133} See Decarceration, supra note 17, at 79-89 (concluding that it is "highly implausible" to suggest that the efficacy of such drugs was "primarily responsible" for the early roots of deinstitutionalization). Cf. Durham, supra note 72, at 120 (concluding that drugs played "an important but circumscribed role in the original development of deinstitutionalization as a mental health policy"); Kaplan, State Control of Deviant Behavior: A Critical Essay on Scull's Critique of Community Treatment and Deinstitutionalization, 20 ARIZ. L. REV. 189, 193 (1978) (critical analysis of Scull's methodology). For Scull's most recent contributions to the debate, see Social Order/Mental Disorder, supra note 17; Scull, Mental Patients and the Community: A Critical Note, 9 INT'L J.L. & PSYCHIATRY 383 (1988).

\textsuperscript{134} See, e.g., Lamb, supra note 17, at 60-62; E. Torrey, supra note 41, at 87-88.

\textsuperscript{135} See Fischer & Breakey, supra note 14, at 29; see also Stefan, Preventive Commitment: The Concept and Its Pitfalls, 11 MENTAL & PHYSICAL DISABILITY L. REP. 288, 294 (1987) ("the core of outpatient treatment is forced medication"). Refer to notes 247-50 infra.
Finally, as the United States Supreme Court and lower federal courts extended the "due process revolution" to include the mentally disabled, courts began to strike down vaguely-drafted involuntary civil commitment statutes to impose durational limitations on commitments and to extend the "least restrictive alternative" doctrine to institutional decision-making. Also, legislatures passed more restrictive commitment laws and adopted periodic review mechanisms so as to limit the numbers of those who would be initially institutionalized and who would subsequently remain institutionalized. This aspect of deinstitutionalization has served as the bogeyman for the APA, the mass media, and—to a great extent—the public. Thus, the APA Task Force on the Homeless Mentally Ill has argued that legal advocacy efforts on behalf of institutionalized mental patients "neglected [the pa-


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

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


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

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

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


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


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


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

149. 405 F. Supp. 974, 978 (D.D.C. 1976) (statutory right to aftercare in the commu-
and Lessard v. Schmidt. These critics argue that, while the lawyers were "well-intentioned," their "outmoded ideas about the nature of serious mental illness"—brought on in some important part by their "having read Freud and Szasz"—have created significant legal impediments to care.

Former New York City Mayor Ed Koch chimed in by characterizing libertarian patients' rights lawyers as "crazies."

B. Myths and "Ordinary Common Sense"

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


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


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


— 153. Compare Psychodynamics, supra note 113, at 22-39 and Sherwin, Dialects and
cally-driven images have allowed us to obsessively focus on this social force while blithely ignoring others. While it is common wisdom that deinstitutionalization has failed, there coexists an ample, largely uncontradicted but regularly ignored body of evidence that indicates that a well-conceived deinstitutionalization program offering a variety of intensive rehabilitative services has a positive and significant effect on the length of the ex-patients’ "tenure" in the community. We must ask why this body of evidence continues to be ignored by all important "players" in this game.

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

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154. See, e.g., Rosenhan, Psychological Realities and Judicial Policy, 19 Stan.律. 10, 13 (1984) (discussing the "vividness effect," a phenomenon through which concrete and vivid information about a specific case overwhelms the abstract data upon which rational choices should be based); Facade, supra note 41, at the unnumbered page prior to title page (quoting from a review of Torrey's book in the Wall Street Journal): "Intuitively, everyone seems to sense that the process of deinstitutionalization... has produced a large population of street people incapable of taking care of themselves." (emphasis added).

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

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


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

159. See, e.g., id. at 340-41 ("Deinstitutionalization may have been embraced by state
deprofessionalization,\textsuperscript{160} oversimplification,\textsuperscript{161} and privatization.\textsuperscript{162} In this context, we must consider the rarely-articulated but never-refuted reality that community mental health services have never
governments as a way to decrease spending by phasing down expensive state institutions and shifting the burden of mental health care to local governments through Community Mental Health Centers . . . and to the federal government through Medicaid.\textsuperscript{11}); see also E. Torrey, supra note 41, at 150-51 (noting that "the power of federal money . . . was the real driving force behind deinstitutionalization"); Goldman, Adams & Taube, supra note 115, at 133 ("State mental hospitals have gained control over the admission of potential chronic patients."). Cf. Glenn, Community Programs for Chronic Patients—Administrative Financing, 5 Psychiatric Annals 174, 175 (1975) (noting that administrative problems can occur between two levels of government at all eight separate stages of planning process); Scull, Finance and Mental Health Policy: A Brief Historical Overview, in The Community Imperative, supra note 118, at 263 (exploring financial issues in this context).

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

\textsuperscript{160} See, e.g., Mills & Cummins, supra note 114, at 273. According to Mills and Cummins, the deinstitutionalization movement coincided with a lapse in psychiatry's credibility, as reflected in the writings of its critics. See, e.g., T. Szasz, The Myth of Mental Illness x-xi (1961) (arguing that the myth denigrated the value of psychiatry, and promoted the assertion that mental illness does not exist).

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

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

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

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

\begin{footnotesize}
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\item See E. Torrey, supra note 41, at 138-60; see also Rhode Island Dept. of Mental Health v. R.B., 549 A.2d 1028, 1031 (R.I. 1988) (concluding that community mental health centers have right to refuse admission to outpatients).
\item For an analysis of Community Mental Health Center (CMHC) policies, see Cameron, A National Community Mental Health Program: Policy Initiation and Progress, in Handbook on Mental Health Policy in the United States, supra note 110, at 121-42; Dowell & Ciarlo, An Evaluative Overview of the Community Mental Health Centers Program, in Handbook on Mental Health Policy in the United States, supra note 110, at 195-236.
\item Bellack & Mueser, A Comprehensive Treatment Program for Schizophrenia and Chronic Mental Illness, 22 Community Mental Health J. 175, 177-78 (1980); see also E. Torrey, supra note 41, at 145-46 (the "worried well" is a new class of mental patients). See also Note, supra note 126, at 1323 ("A weakness in the community treatment system that has emerged in practice is community mental health centers' preference for treating 'good patients' rather than the chronically mentally ill"); Durham, supra note 72, at 122 ("the fledgling community mental health services reached a new and different clientele than had been treated in hospitals by attending to caseloads of more affluent, acute care patients receiving brief therapy for much less severe problems and conditions"). Only about one-quarter of all CMHC patients have ever been hospitalized. Hope & Young, Who Cares For the Mentally Ill?, Nation, Dec. 26, 1987-Jan. 2, 1988, at 782-83.
\item Compare Goldman, Adams & Taube, supra note 115, at 130 (outpatient care does not replace inpatient care, state hospitals will not become obsolete; costs have not shifted from public to private sources, but from one public source to another) with Mechanic, Toward the Year 2000 in United States Mental Health Policymaking and Administration, in Handbook on Mental Health Policy in the United States, supra note 110 ("The community mental health movement was a blend of idealism, optimism, opportunism, and naïveté.").
\item Durham, supra note 72, at 126-27; see also Eisenberg, supra note 162, at 1016 (transfer of indigent patients in Chicago from private hospital to public facility rose from 70 per month in 1983 to 500 per month in 1985); id. at 7016 (quoting a 1984 brokerage advisory touting private psychiatric hospital stock offerings):

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

Id. at 1016.
\item Perlin, Institutionalization and the Law, in Psychiatric Services in Institu-
the “pathology of oppression.” When such individuals are deinstitutionalized, society's irrational mechanisms of oppression—paralleling in important ways society's traditional oppression of racial, religious, and sexual minorities—create the condition of “sanism.” Dr. Morton Birnbaum (perhaps ironically, the acknowledged father of the “right to treatment” doctrine) has characterized “sanism” as “the irrational thinking, feeling and behavior patterns of response by an individual or by a society to a mentally ill individual.” The concentrated efforts to “zone out” group homes and congregate residences for the mentally disabled offers a paradigm of “sanist” behavior. It is especially

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


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


172. Refer to note 173 infra. See also Note, supra note 44, at 167-68 n.41; 2 M. PERLIN, supra note 11, § 7.22, at 657-59 n.522. Similar litigation continues unabated. See, e.g., Incorporated Village of Freeport v. Association for Help of Retarded Children, 94 Misc. 2d 1048, 1051, 406 N.Y.S.2d 221, 223 (Sup. Ct.) (a community residence in which eight young women live as a family unit is consistent with the lifestyle intended for single family neighborhoods and thus conforms to the purpose of the zoning ordinance), aff'd, 60 A.D.2d 644, 400 N.Y.S.2d 724 (1977); Little Neck Community Ass'n v. Working Org. for Retarded Children, 52 A.D.2d 90, 94, 383 N.Y.S.2d 384, 368 (Sup. Ct.) (a group home for retarded children constituted a family for zone restricted to single family dwellings), leave to appeal denied, 40 N.Y.2d 803, 356 N.E.2d 482, 387 N.Y.S.2d 1030 (1976); Allegheny Valley School v. Zoning Hearing Bd., 102 Pa. Commw. 290, 517 A.2d 1385, 1388-89 (1986) (group home for the mentally retarded persons, living as one household, is the functional equivalent of a single family residence); Kohn, L.I. Town Fails To Bar Home for Mentally Ill, N.Y.L.J., Oct. 3, 1989, at 1, col. 5. Such exclusionary zoning policies can “zone in” residential facilities in “disabil-
ironic that "liberals," traditionally counted upon to support the full range of social welfare legislation, condemn, often virulently, deinstitutionalization policies. If we are to understand the underlying social problems besetting the homeless, the deinstitutionalized, and the deinstitutionalized homeless, we necessarily must acknowledge the importance and power of "sanism" in our society.

Exclusion can also result from official and unofficial governmental policies. See Alisky & Iczkowski, Barriers to Housing for Deinstitutionalized Psychiatric Patients, 41 Hosp. & Community Psychiatry 93 (1990) (waits of up to a year for public housing reflect poor public policies and private discrimination). See generally Devers & West, Exclusionary Zoning and Its Effect on Housing Opportunities for the Homeless, 4 Notre Dame J.L., Ethics & Pub. Pol'y 349, 351 (1989) ("[T]he exclusionary policies of local governments . . . produce far more spatial separation [among racial, ethnic, and economic groups] than would be the case if only economic and social factors influenced the distribution of people in the spreading metropolis.") (quoting M. Danielson, The Politics of Exclusion 23 (1976)).

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

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

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

A. The Perceived Failures of Deinstitutionalization

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


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

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

178. See Rhoden, supra note 17, at 393 (deinstitutionalization services are seldom provided in any organized, systematic manner); see also Myers, Involuntary Civil Commitment of the Mentally Ill: A System in need of Change, 29 VILL. L. REV. 367, 406-07 (1983-84) (society's failure to provide adequate community services has caused "incalculable" human suffering); Note, Establishing a Right to Shelter for the Homeless, 50 BROOKLYN L. REV. 939, 948 n.45 (1984) ("failure to provide for care or treatment of mental patients released into the community" results from "a lack of planning either prior to or during the process of deinstitutionalization, assumptions on the part of public officials that communities or other agencies or levels of government would deliver the required services, and a lack of support
ceived,\textsuperscript{179} the \textit{unarticulated} goals of many such programs,\textsuperscript{180} the \textit{incoherence} of funding policies,\textsuperscript{181} and the lack of \textit{social consensus} supporting such programs.\textsuperscript{182} In the words of E.F. Torrey, "the policy of deinstitutionalization has been a disaster whose dimensions are apparent everywhere."\textsuperscript{183} Our policies appear to reflect perfectly what Jack Pitney has called "bile barrel politics":\textsuperscript{184} when a theoretically-approved, benefit-dispersing social policy (the \textit{concept} of deinstitutionalization) results in specific burdens on individual communities (the presence of unwanted, unsupported deinstitutionalized patients), "no one should be surprised by the determined resistance of the concentrated losers—the communities most affected."\textsuperscript{185}

Although some commentators have recognized the occasional successful deinstitutionalization program\textsuperscript{186} (almost as if it somehow emerged successfully by accident),\textsuperscript{187} they pay little attention

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\item in communities for the establishment of group homes in residential areas\textsuperscript{179}).
\item \textsuperscript{179} See Rhoden, \textit{supra} note 17, at 394 (deinstitutionalization policies have been implemented in a "disorganized and unrealistic manner").
\item \textsuperscript{180} Id. at 392.
\item \textsuperscript{181} Id. at 393-94.
\item \textsuperscript{182} See, e.g., id. at 393 (efforts to establish group homes in residential areas have often been thwarted by restrictive zoning laws, contributing to the concentration of mental patients in deteriorating neighborhoods). \textit{But see} City of Cleburne v. Cleburne Living Center, Inc., 473 U.S. 432, 455 (1985) (local ordinance banning group homes for the mentally retarded violates equal protection).
\item \textsuperscript{183} E. Torrey, \textit{supra} note 41, at 36.
\item \textsuperscript{184} Pitney, \textit{supra} note 88 (defining the term as signifying a category opposite to that of desirable of "pork barrel" projects; "bile barrel" projects include such as prisons, nerve gas warehouses, and hazardous waste sites).
\item \textsuperscript{185} Marmor & Gill, \textit{supra} note 4, at 467.
\item \textsuperscript{186} See LeFave, Grunberg, Woodhouse & Barrington, \textit{Is the Community Ready?}, in \textit{STATE MENTAL HOSPITALS: WHAT HAPPENS WHEN THEY CLOSE} 184 (1976) (describing the closing of a state hospital in the southern part of Saskatchewan, and characterizing the process as a successful one because "careful development of community programs [preceded] rapid rates of discharge"); Rhoden, \textit{supra} note 17, at 394 (where community alternatives are developed first, deinstitutionalization "has been a generally positive experience"); \textit{see also} Bachrach, \textit{supra} note 68, at 14 (underscoring that "it should not be concluded that [the growth of a homeless mentally ill population] is entirely an artifact of deinstitutionalization"); J. Costello, Autonomy and the Homeless Mentally Ill: Rethinking Civil Commitment in the Aftermath of Deinstitutionalization (paper presented at the American Association of Law Schools, section on Law & Psychiatry, Annual Conference in San Francisco, California, Jan. 1990).
\item For a table of all state statutes conferring responsibility on states for patients' aftercare after release from state mental hospitals, see Langdon & Kass, \textit{supra} note 21, at 382-92.
\item \textsuperscript{187} \textit{E.g., Deinstitutionalization,} \textit{supra} note 17, at 70 (comparing the effect of the deinstitutionalization on the mentally ill to that on the developmentally disabled, concluding that the success in deinstitutionalization of the latter group demonstrates "what can be
to the countless examples of adequate community programs and facilities. These programs and facilities, through the provision of supportive social structures, often facilitate the reintegration of chronic patients into the community. Further, when patients are deinstitutionalized into alternative out-patient treatment programs, the latter are invariably more effective than inpatient treatment. Even the American Psychiatric Association has issued a

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

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

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

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

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

190. See, e.g., Kiesler, supra note 115, at 349 (review of 10 studies showed that in "no case were the outcomes of hospitalization more positive than alternative treatment"). See generally Barnes & Toews, Deinstitutionalization of Chronic Mental Patients in the Canadian Context, 24 Can. Psychologist 22 (1983) (providing a comprehensive review of alternate out-patient treatment programs).
A series of generally thoughtful and provocative recommendations geared toward the assurance that similar "supportive social structures" are in place in all community settings. While these recommendations are not without some controversy, they reflect at least a first attempt at sketching out the basic needs of an important percentage of the homeless population.

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

191. See M. Hope & J. Young, THE FACES OF HOMELESSNESS 169 (1986) (recommending a range of graded housing settings in the community, general medical care, including psychiatric services, a community link, and a one-to-one patient-staff ratio).

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

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

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

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

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

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

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

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

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

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

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

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


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


199. P. Rossi, supra note 14, at 41 (asserting that "[t]he current homeless suffer from much the same levels of mental illness, alcoholism and physical disability as the old home-
percentage, it in no way supports the conventional view directly linking the two.\textsuperscript{200} We also know that, notwithstanding the public perception that it is virtually impossible for an individual to be involuntarily committed to a psychiatric hospital, the number of admissions continues to rise.\textsuperscript{201} In spite of the APA’s repeated assertion that significant commitment “reform” is necessary to provide for a more liberal commitment policy, over two-thirds of all American jurisdictions now provide for precisely the sort of substantive commitment standard that the APA insists is necessary to “deal with” inappropriate deinstitutionalization.\textsuperscript{202} In addition, recent case law shows that, in some instances at least, appellate courts are willing to sensitively and carefully weigh facts and medical opinion testimony in assessing whether the party seeking institutionalization has met the appropriate standard.\textsuperscript{203}

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

\textsuperscript{200} Myth, supra note 69, at 421 (linkage between homelessness and mental illness “overstated”).

\textsuperscript{201} Refer to note 115 supra.

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

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

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

\textsuperscript{205} See, e.g., Heryford v. Parker, 396 F.2d 393, 396 (10th Cir. 1968) (when involuntary incarceration is likely, state has inescapable duty to observe constitutional safeguards of due process); Lessard, 349 F. Supp. at 1097-98 (applying the right to counsel to the commitment process).
record of individually and sporadically appointed counsel, the significance of broad-based legally oriented mental health advocacy organizations, or the specific fact contexts in which much of the litigation focused on arose, it remains necessary to contextualize the evolution of the criticized case law.

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

The case law that developed brought about massive changes in

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

209. Kanter, supra note 72, at 337.


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

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

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


215. See, e.g., Wyatt, 503 F.2d at 1311 n.6 (relating an incident in which "[o]ne [Alabama state hospital patient] . . . died after a garden hose had been inserted in his rectum for five minutes by a working patient who was cleaning him; one died when a fellow patient hosed him with scalding water; another died when soapy water was forced into his mouth . . . . "); L. Lipmann & I. Goldberg, The Right to Education: Anatomy of the Pennsylvania Case and Its Implication for Exceptional Children 17 (1973) (recounting that the chairman of the legal action committee of the National Association of Retarded Children characterized Pennhurst as "Dachau, without ovens").
the way public mental health institutions are run and in the way the involuntary civil commitment process operates. This litigation empowered the ultimate clientele: the mentally disabled. As Hendrik Wagenaar and Dan Lewis have explained:

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

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

216. See, e.g., Pitts v. Black, 608 F. Supp. 696, 703 (S.D.N.Y. 1984) (election board's refusal to allow homeless persons to register to vote violated equal protection clause); see 1 M. Perlin, supra note 11, § 1.03, at 8 n.34 (explaining the role of self-help, ex-patient groups in litigation); Hopper, Homelessness: Reducing the Distance, New Eng. J. Hum. Servs., Fall 1983, at 316 (reviewing the role of non-legal advocacy for the homeless); Jahiel, supra note 6, at 112-13 (discussing the empowerment of the homeless); see also Funicello, Give New Shelters, Nation, Apr. 2, 1988, at 56 (pointing out the significance of the creation of a monthly newspaper staffed by homeless individuals).

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

218. See id. at 510 (deinstitutionalization has largely failed nonwhite men); Durham & La Fond, "Thank You, Dr. Stone": A Response to Dr. Alan Stone and Some Further Thoughts on the Wisdom of Broadening the Criteria for Involuntary Therapeutic Commitment of the Mentally Ill, 40 Rutgers L. Rev. 865, 879 n.53 (1988) (90% of all individuals civilly committed in Washington study were unemployed at the time of civil commitment); Perlin, supra note 112, at 29 (99% of all patients subject to involuntary civil commitment at New Jersey's state and county mental hospitals were indigent).


220. Id.
patients have remained hospitalized "solely because they are too poor to be released."\footnote{221}

We now know that the deinstitutionalized have the greatest number of social problems of all the homeless\footnote{222} and that their needs are not currently being met by the mental health system,\footnote{223} the social service system, or by a combination of the two systems.\footnote{224} We know that massive reinstitutionalization\footnote{225} is not a viable solution for a variety of reasons\footnote{226} including the fact that such movement inevitably diverts "scarce resources" away from treatment of others in the community.\footnote{227} We know that the homeless deinstitutionalized need psychosocial and rehabilitation programs beyond those available in the hospital setting.\footnote{228} We also know that persons of lower socioeconomic status are more likely than those of middle and upper status to develop symptoms of distress in response to problematic life experiences.\footnote{229} Additionally, we now

\begin{footnotes}
\begin{enumerate}
\item Saphire, The Civilly-Committed Public Mental Patient and the Right to Aftercare, 4 Fla. St. U.L. Rev. 232, 288 (1976); see also Levine & Haggard, Homelessness as a Public Mental Health Problem, in The Community Imperative, supra note 117 ("Perhaps no group of disabled people in the United States are as impoverished and underserved as the homeless mentally ill population").
\item Gelberg, Linn & Leake, supra note 146, at 194.
\item Id. at 195; Chavetz & Goldfinger, supra note 14, at 22 (lack of fit between the needs of the homeless and the aims of the mental health system).
\item Morse & Calsyn, supra note 59, at 84-85, 89-91.
\item For a variety of discussions relating to massive reinstitutionalization, see, e.g., Is Homelessness a Mental Health Problem?, supra note 198, at 1549; Krauthammer, For the Homeless: Asylum, Wash. Post, Jan. 4, 1985 (using data from Is Homelessness a Mental Health Problem? to recommend reinstitutionalization). Bassuk, the principal author of Is Homeless a Mental Health Problem?, has taken issue with Krauthammer's reinstitutionalization recommendation. See M. Hope & J. Young, supra note 190, at 20-21 (also critiquing Krauthammer's conclusions on methodological and analytical bases); Detzer, Still Looking for the Rose Garden: The Effects of Deinstitutionalizing Mental Health Services, Humanist, Nov.-Dec. 1983, at 37 (suggesting less draconian reinstitutionalization recommendations).
\item See Kanter, supra note 72, at 351-56 (asserting that most homeless people are not mentally ill, that inpatient psychiatric admissions actually continue to increase, that existing civil commitment laws adequately address the needs of the severely mentally ill homeless, and that a change in commitment laws will not increase money available to community alternative programs).
\item Durham, supra note 72, at 128.
\item See Dorwart, A Ten-Year Follow-up Study of the Effects of Deinstitutionalization, 39 Hosp. & Community Psychiatry 287, 290 (1988) (in order to be prepared for deinstitutionalization, "patients may require social, rehabilitative, psychotherapeutic (individual, family, and group), vocational, transitional-residential, and community aftercare services to prepare to live outside the hospital").
\item Kessler & Cleary, Social Class and Psychological Disorders, 45 Am. Soc. Rev. 463 (1980).
\end{enumerate}
\end{footnotes}
know that the deinstitutionalized homeless have even fewer social supports in the community than do other homeless individuals. Lastly, we know, anecdotally, that this clientele is neither a particularly "easy" nor "preferred" one to deal with professionally.

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

A "joker" in this entire analysis is the role played by the massive use of psychotropic drugs in state mental hospitals. Common wisdom has suggested that one of the key factors in the creation of deinstitutionalization policies was the mass marketing of psychiatric drugs. Whether or not Scull's revisionist position is correct, a statistically significant number of formerly hospitalized patients now receive psychotropic drug treatment in the community. Yet,
no one has explored what may be the most important hidden issue: the impact of forced public hospital drugging on increased homelessness.

We no longer question the epidemic prevalence of tardive dyskinesia and psychotropic drug side effects in the state hospital population. As Judge Stanley Brotman noted over a decade ago in *Rennie v. Klein*, the same drugs prescribed to lessen the severity of thought disorders also served to "inhibit a patient's ability to learn social skills needed to fully recover from psychosis . . . ." Side effects such as akinesia and akathesia have the inevitable effect of retarding social skill progress and of making ex-patients even less employable once they are deinstitutionalized. While the drugs may be effective in reducing the floridity of symptomatology and lessening the excesses of psychic pain, no one—neither the patients' rights advocates, the spokespersons for the APA, nor the deinstitutionalization theorists—has yet critically considered the linkage between these drug side effects, the failure
of patients to be meaningfully reintegrated into society after their release, and homelessness.\textsuperscript{246} The linkage is especially pernicious in light of the parallel literature illuminating the ways in which institutional dependency progressively leads to losses of social and vocational competencies, precisely the sort of “competencies” that are essential if homeless individuals are to reintegrate themselves meaningfully into mainstream society.\textsuperscript{249}

The deinstitutionalization literature on this point offers tantalizing clues. Evidence suggests that some deinstitutionalized homeless individuals remain on the streets to avoid regimens of compulsory drugging in hospitals.\textsuperscript{247} Parenthetically, other researchers have learned that the deinstitutionalized homeless will accept medication in alternative social service settings.\textsuperscript{248} This difference in behavior may be explained when one examines other evidence. For instance, the deinstitutionalized homeless reject the alternative of mental hospitals\textsuperscript{248} but frequently seek out medical care in
general hospitals. Some explanation, other than the tautology that suggests that this behavior merely indicates the depths of the population's underlying mental illness, is necessary.

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

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


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

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


254. See, e.g., Lamb, supra note 17, at 66. Dr. Lamb limits the universe of those whom he sees to be in need of rehospitalization to "a small proportion of long-term, severely-
They might not be safer, but perhaps we would be relieved. Again, the issue is one of social class and of racial and economic marginalization. The deinstitutionalized homeless reflect the socio-economic characteristics of those hospitalized in public facilities—a universe increasingly more populated by ethnic minorities, the poor, the young, and those with few social supports. Those who have been hospitalized and feel a profound sense of social isolation are subsequently cut adrift without social support. No inquiry into the specific problems can begin to make sense if we fail to come to grips with the significance of this reality: it is the “once disabled psychiatric patients [that] lack sufficient impulse control to handle living in an open setting such as a board-and-care home or with relatives.” Id. He also criticizes the views of those who recommend massive rehospitalization as simplistic, exaggerative and overly romantic (as to the role and capabilities of state hospitals). See id. at 67. Nevertheless, the APA Task Force report prepared under his direction, is viewed in the public debate as an important argument in favor of exactly such massive reinstitutionalization. See, e.g., Hyde, supra note 155, at 22 (APA report evaluated through the “give me an immediate solution” demands of the public). But cf. Durham & La Fond, supra note 232, at 357-59 (contending that expansion of commitment authority “may actually harm the very persons the state is seeking to help” by creating institutional dependency in patients); Durham & La Fond, The Empirical Consequences and Policy Implications of Broadening the Statutory Criteria for Civil Commitment, 3 Yale L. & Pol’y Rev. 395, 401 (1985) (observing that the overcrowding that resulted from such expansion caused voluntary patients to be “virtually excluded from state hospitals”); Morse, A Flea for the Mentally Disordered Homeless, APS NewsLetter, Summer 1987, at 1 (opposing expansion of involuntary hospitalization in this context). For background information relating to the debate, see C. Kesler & A. Smulkin, supra note 115, at 114 (discussion of institutional dependency); Durham & La Fond, supra note 161, at 475-76 (discussing psychosocial costs of hospital care).

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

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

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

Lamb, supra note 145, at 942.

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

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

258. See generally W. Wilson, The Truly Disadvantaged: The Inner City, the Underclass, and Public Policy (1987) (graphically demonstrating the extent to which the “extremely poor” or “socially marginalized” are cut off from mainstream society); see also Luban, supra note 5, at 2160 n.22 (citing the “wealth of horrendous detail concerning the emiseration of black Americans,” and the “grim, even terrifying, summary of the emergency conditions under which we live”).
and future" marginalized that we target in our attacks on the deinstitutionalized homeless mentally ill.269

C. Our Attitude Towards the Poor

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

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

260. See Collin & Barry, Homelessness: A Post-Industrial Society Faces a Legislative Dilemma, 20 Akron L. Rev. 409, 429-31 (1987); Note, supra note 44, at 160 n.2. Collin and Barry read the New York State Constitution's Article XVII, section 1, which mandates the provision of care to the needy, to reflect the following drafting intent: "Aid is to be provided to all those individuals who are 'involuntarily needy'; but it is properly within the realm of legislative discretion to deny aid to employable persons who are deemed not 'needy' because they have wrongfully refused to avail themselves of an opportunity for employment." Collin & Barry, supra, at 409 n.2. The latter group of individuals is deemed to be "voluntarily in need." See id.


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

263. Lamb, supra note 145, at 943 (observing that as "products of our culture and society," we tend to "morally disapprove of persons who 'give in' to their dependency needs, who have adopted a passive, inactive life-style, and who have accepted public support instead of working"); J. Costello, supra note 186 (public assumes mentally ill homeless individuals are "bad, . . . stubborn, . . . weak, or . . . lack willpower").
stitutionalized, while former President Reagan urged voters to support Republican law-and-order senators as a vehicle for ensuring a conservative federal judiciary, stating, "We don't need a bunch of sociology majors on the bench."

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

Our focus creates a "perceptual trap" through which the most
florid and bizarre behavior of the most mentally ill individual comes to typify all homeless people, creating an “illusion of homogeneity.”

Our public perceptions drive our official policies. We reduce complex and multidimensional social problems to stereotypes and exacerbated by the vividness heuristic and “ordinary common sense”. Our official policies—“harsh in execution”—blame the deinstitutionalized homeless for their plight.


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


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

275. Goldman & Morrissey, supra note 110, at 729; Hyde, supra note 155, at 22-23; Lamb, supra note 145, at 906; Oreskes & Toner, supra note 107, at E5.
and thus legitimate political bias toward this population.\textsuperscript{270} This undercuts any pretense of a commitment to equality.\textsuperscript{277} Under the rubric of the state’s right to “improve itself,”\textsuperscript{278} we launch lengthy and increasingly vicious counterattacks when community groups seek to open halfway houses or group homes in residential neighborhoods.\textsuperscript{279} We respond to the moral dimensions of the underlying problems by seeking to exert total social control over the deinstitutionalized homeless. Deinstitutionalization is unacceptable to the public because it runs counter to conventional wisdom and to “ordinary common sense.”\textsuperscript{280}

Our response to the homeless mentally ill must then be considered through these two filters: social classism (the homeless being “jobless, penniless, functionless and supportless”)\textsuperscript{281} and san\textsuperscript{282}ism (via the same sort of irrational thought processes that spawn racism and other similar social pathologies).\textsuperscript{282} To avoid dealing with issues of economic marginality\textsuperscript{283} and racial exclusion,\textsuperscript{284} we

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

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

\textsuperscript{278} Note, supra note 126, at 1340 (quoting N. KittRE, supra note 206, at 47).

\textsuperscript{279} Perlin, supra note 112, at 22-33. See generally 2 M. Perlin, supra note 11, § 7.22 (discussing the right of the mentally disabled to be free from discrimination in housing); D. Lewis, J. Grant & D. Rosenbaum, The Social Construction of Reform: Crime Prevention and Community Organizations (1988) (discussing the politics of community organizations, with emphasis on an analysis of groups receiving grants for community crime prevention programs); Margolis, Conceptual Puzzles About Community Responses, in The Community Imperative, supra note 118, at 229; Slichter, Siting Residential Facilities: Strategies for Gaining Community Acceptance, in The Community Imperative, supra note 118, at 331; cf. Boydell, Trainor & Pierri, The Effect of Group Homes for the Mentally Ill on Residential Property Values, 40 Hosp. & COMMUNITY PSYCHIATRY 937, 938 (1989) (all empirical literature demonstrates that group homes do not have a negative effect on neighborhood property values; in fact, in some markets, nearby property values were strengthened).

\textsuperscript{280} Friedman, supra note 161, at 472.

\textsuperscript{281} Lipton & Sabatini, supra note 46, at 156.

\textsuperscript{282} Refer to notes 167-73 supra and accompanying text.

\textsuperscript{283} See Wagenaar & Lewis, supra note 52, at 513-19.

\textsuperscript{284} See Luban, supra note 5, at 2160 n.22; Wagenaar & Lewis, supra note 52, at 509-10.
perpetuate symbolic stereotypes of mental illness that reify centuries of social myths and meta-myths and that have traditionally colored and shaped the ways we treat the mentally ill. We thus focus our attention upon a group of victims against whom there is significant social prejudice instead of questioning the societal problems that are the true sources of homelessness. In the end, it is precisely these "sanist" policies that best explain the moral bankruptcy of our treatment of the homeless mentally ill. As Neil McKittrick has pointed out:

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

V. THE MULTIPLE MEANINGS OF "COMPETENCY"

Having considered the relationship between deinstitutionalization-

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

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


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

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

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

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

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

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

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

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

(Emphasis in original).

290. McKittrick, supra note 267, at 428.
tion and homelessness, we turn now to the question of "competency" and its relationship to these two phenomena. This inquiry has two different dimensions: (1) a "plain meaning" investigation into the way that varying legal definitions of "competency" affect deinstitutionalization and homelessness and (2) a "deconstructed" analysis of some other "competencies" not usually discussed in this context.  

A. "Plain Meanings"

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

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

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

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291. Refer to text accompanying note 363 infra.
293. Gutheil, Bursztajn, Kaplan & Brodsky, supra note 151, at 446-47.
296. Facade, supra note 113, at 967.
is thus not necessarily a "fixed state"; a person may be competent for some legal purposes and incompetent for others at the same time. Therefore, incompetency and mental illness are not identical states.

Mental health professionals frequently couch definitions of competence in more functionalist language: for example, a patient’s ability to balance risks and benefits. The functionalist perspective in assessing competency in criminal cases looks beyond the question of "mental illness" to take account of "the psychopathological, cognitive and affective capacities of the defendant [as] related to the specific demands of the legal case and the competencies in question." How does this relate to the problem of deinstitutionalization and homelessness? Putting aside the specific issues raised by the deinstitutionalization of individuals who were originally committed pursuant to a finding of incompetency to stand trial on criminal


298. Appelbaum & Roth, supra note 294, at 1465.  
299. Roth, Meisel & Lidz, supra note 292, at 279.  
300. Cf. N.J. STAT. ANN. § 30:4-24.2(c) (West 1981) (a patient may not be presumed incompetent merely because he has been treated for mental illness); In re LaBelle, 107 Wash. 2d 196, 728 P.2d 138, 146 (1986) ("the mere fact that an individual is mentally ill does not mean that the person so affected is incapable of making a rational choice with respect to his or her need for treatment"). But see Appelbaum, Mirkin & Bateman, Empirical Assessment of Competency to Consent to Psychiatric Hospitalization, 138 Am. J. Psychiatry 1170, 1175 (1981) (empirical evidence suggests that "the presumption of competency to consent to psychiatric hospitalization will have to fall").

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

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

302. Golding & Roesch, Competency for Adjudication: An International Analysis, in 4 LAW AND MENTAL HEALTH: INTERNATIONAL PERSPECTIVES 73, 102 (D. Weisstub ed. 1988). Cf. Roth, Meisel & Lidz, supra note 292, at 280 (competency tests "fall into five categories: (1) evidencing a choice, (2) a 'reasonable' outcome of choice, (3) a choice based on 'rational' reasons, (4) ability to understand, and (5) actual understanding").
charges,\textsuperscript{303} it would seem that the relevant medico-legal inquiry here has at least two important dimensions: (1) competency as a

\textsuperscript{303} See generally Arvanites, \textit{The Impact of State Mental Hospital Deinstitutionalization on Commitments for Incompetency to Stand Trial}, 26 CRIMINOLOGY 307, 318 (1988) (although increases in incompetency to stand trial (IST) commitments are positively related to deinstitutionalization, there is no evidence that deinstitutionalization "has resulted in the wholesale criminalization of the mentally ill or that [IST procedures] are increasingly being used to hospitalize minor offenders through incompetency commitments"). In a more recent study, Professor Arvanites has found that, after deinstitutionalization, non-whites had significantly more state mental hospitalizations than did whites. Arvanites, \textit{The Differential Impact of Deinstitutionalization on White and Nonwhite Defendants Found Incompetent to Stand Trial}, 17 \textsc{Bull. Am. Acad. Psychiatry & L} 311, 318-19 (1989). \textsc{See generally Steadman, Vanderwyst & Ribner, \textit{Comparing Arrest Rates of Mental Patients and Criminal Offenders}, 135 \textsc{Am. J. Psychiatry} 1218, 1220 (1978) (former mental patient arrest rates have increased as the composition of state mental hospitals has changed to include more persons with prior criminal records); 3 M. Perlin, supra note 11, §§ 14.01-14.23 (discussing IST issues, including due process contours of the competency determination, burden of proof at trial, medication of defendants to achieve competency, counsel's role at the incompetency hearing, nonpsychiatric physiological disorders and mentally retarded defendants); Perlin & Dvoskin, \textit{AIDS Related Dementia and Competency to Stand Trial: A Potential Abuse of the Forensic Mental Health System?}, 18 \textsc{Bull. Am. Acad. Psychiatry & L} 349 (1980).

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

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

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

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


Many judges perceive it as a matter of "ordinary common sense" that the failure of the
Cases involving voluntary patients rarely address the question of competency.\textsuperscript{309} Yet, because most involuntary civil commitment statutes fail to define the level of competence necessary for a valid voluntary admission, many patients who consent to their hospitalization are, in fact, incompetent to do so.\textsuperscript{310} If psychiatric patients were to meet a stricter standard of competency, the number of voluntary admissions—steadily on the rise\textsuperscript{311} and regularly encouraged by both the legal and medical communities\textsuperscript{312}—would inevitably be reduced.\textsuperscript{313}

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

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

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

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

\textit{Id.} (footnotes omitted).


\textsuperscript{311} \textit{Legal Issues in State Mental Health Care: Proposals for Change—Civil Commitment, 2 MENTAL DISABILITY L REP. 75, 94 nn.135-36 (1977).}

\textsuperscript{312} Perlin & Sadoff, supra note 206, at 189-90; \textit{Developments, supra} note 305, at 1399.

\textsuperscript{313} Legemaate, supra note 310, at 260.

"abuse" and "substantial elements of coercion;" they have even fewer opportunities for discharge than involuntary patients.

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

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

315. Developments, supra note 305, at 1400-01.
317. Herr, supra note 314, at 723. The most recent literature suggests that voluntary patients are hospitalized twice as long as involuntary patients and are less frequently considered to have received maximum benefits from their hospitalizations. Nicholson, Characteristics Associated With Change in the Legal Status of Involuntary Psychiatric Patients, 39 Hosp. & COMMUNITY PSYCHIATRY 424, 427 (1988).
319. Id. at 984-86.
320. Id. at 986.
ties.\textsuperscript{322} Especially in light of public hospital staff mental health professionals’ growing fear of litigation,\textsuperscript{323} \textit{Zinermon} probably will have a further reductive effect on state hospital voluntary admissions.

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

Yet, the public’s perception of deinstitutionalization as being fueled by “inappropriate” civil liberties decisions such as \textit{O’Connor}...
v. Donaldson\textsuperscript{331} or Lessard v. Schmidt\textsuperscript{332} attributes homelessness, in an important way, to the inevitable outcome of such decisions:\textsuperscript{333} patients who, while perhaps not "technically" dangerous\textsuperscript{334} to others (especially where they have committed no "overt act")\textsuperscript{335} inevitably decompensate after release because, in the vernacular sense of the phrase, they are not competent to make life decisions.\textsuperscript{336}

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

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

\textsuperscript{331} 422 U.S. 563 (1975). Refer to notes 137 & 139 supra and accompanying text.
\textsuperscript{332} 349 F. Supp. 1078 (E.D. Wis. 1972). Refer to notes 138 & 140 supra.
\textsuperscript{333} Compare E. Torrey, supra note 41, at 166-60 with Wagenaar & Lewis, supra note 52, at 506 (extension of civil rights to the mentally ill has "irrevocably altered" their relationships with their therapists). On the therapeutic potential of the legal process for mentally ill individuals, see generally D. Wexler, supra note 245, at 3-20 (discussing the therapeutic aspects of civil commitment hearings, voluntary confinement compared to forced hospitalizations, and the roles of judges and lawyers in the process); Ensminger & Liguori, The Therapeutic Significance of the Civil Commitment Hearing: An Unexplored Potential, 6 J. PSYCHIATRY & L. 5, 7 (1978) (the civil commitment process contains considerable potential for therapeutic effects on the involuntarily committed patient); Facade, supra note 113, at 981-82 (discussing Supreme Court's failure to consider therapeutic outcomes in juvenile commitment cases); Wexler, Grave Disability and Family Therapy: The Therapeutic Potential of Civil Libertarian Commitment Codes, 9 Int'l J.L. & PSYCHIATRY 39, 54 (1986) (the very process of gathering evidence of a person's committability under a libertarian law may operate therapeutically to render commitment unnecessary).
\textsuperscript{334} On the question of the way "moral" psychiatrists may consciously subvert the legislative commitment standards to insure commitment of individuals who may not "technically" meet such standards, see Bagby & Atkinson, The Effects of Legislative Reform on Civil Commitment Admission Rates: A Critical Analysis, 6 BEHAV. SCI. & L. 45, 58-59 (1988); Morality, supra note 112. Refer to notes 388-92 infra and accompanying text.
\textsuperscript{335} See 1 M. Perlman, supra note 11, § 2.13, at 110-15.
\textsuperscript{337} APA Task Force, supra note 144, at 8; see also Miller, Commitment to Outpatient Treatment: A National Survey, 36 Hosp. & Community Psychiatry 265, 267 (1986) (while OPC can be effective for those who will not obtain treatment voluntarily, states must seek input from clinicians to properly develop OPC procedures); Peele, Gross, Arons, & Jafri, supra note 145, at 265-68 (discussing trends in commitment laws, including OPC and alternatives to OPC).
Based on the respondent’s treatment history, the respondent is in need of treatment in order to prevent further disability or deterioration which would predictably result in dangerousness [to himself or others]; and

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

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

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

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

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

\textsuperscript{340} Refer to text accompanying notes 260-69 supra.

\textsuperscript{341} See Mulvey, Geller & Roth, The Promise and Peril of Involuntary Outpatient Commitment, 42 AM. PSYCHOLOGIST 571, 577-79 (1987) (“involuntary outpatient commitment rests on the state’s obligation to provide positive liberty rather than simple noninterference, the likelihood of more efficacious treatment through broad-based intervention, and the possibility of initiating a positive cycle of community involvement”).
fuse treatment, and "undermin[e] therapeutic relationships."\textsuperscript{343}

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

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

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

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

\textsuperscript{344} See Hiday & Scheid-Cook, supra note 336, at 229.

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

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

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

\textsuperscript{347} E. TORREY, supra note 41, at 142-51.

\textsuperscript{348} Id.; see also Schwartz & Costanzo, supra note 202, at 1386-89.
ment as "an expression of the much enlarged authority which developed over the past century to promote the health or interests of persons considered to be mentally infirm." Schwartz and Costanzo characterize outpatient commitment as a "significant distortion of the historical purpose and benign motivation of the parens patriae principle" and, primarily, as a "guise for substantially modifying the criteria for state-imposed psychiatric intervention." Additionally, Professor Susan Stefan has "unpacked" outpatient commitment to differentiate "traditional" OPCs (premised on least restrictive alternative constructs and conditional release schemata) from the post-deinstitutionalization model which she characterizes as "preventative commitment." According to Stefan, by focusing on the spectre of deterioration, an implied presumption of incompetency, and an assumed availability of treatment, preventative commitment "broadens the class of people subject to commitment, and expands the conditions under which the state can intervene in a person's life." While this is clearly a laudable goal to critics such as Torrey and Lamb, this expansion inadequately considers the additional procedural and substantive due process dilemmas regarding the right to treatment, the right to refuse treatment, and rights of economic sovereignty that are raised by the possibility of a greatly expanded use of this commitment status. In short, this attempt to "solve" the perceived deinstitutionalization-homelessness link through focusing on a patient's "competency" may not prove to be a panacea at all.

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

349. Id. at 1346.
350. Id. at 1348.
351. Id. at 1404.
352. Stefan, supra note 135, at 288. See generally 1 M. Perlro, supra note 11, §§ 3.46-3.54, at 341-68 (discussing "least restrictive alternative" and "conditional release" models).
354. Id. at 296.
355. Id. at 291-95.
356. Id. at 289; see also Schwartz & Costanzo, supra note 202, at 1379-80 (arguing that states will not be likely to provide the necessary funds to adequately assist those who will not seek help voluntarily).
tion as the "core of OPC";\textsuperscript{358} Schwartz and Costanzo speculate that 
OPC "already has or will become synonymous with forced medica-
tions."\textsuperscript{359} While the OPC statutes rarely address this issue 
squarely,\textsuperscript{360} it raises serious constitutional, philosophical, and oper-
ational concerns\textsuperscript{361} that must be addressed. This is especially true 
when we remind ourselves that, as is the case with all other invol-
untary commitment mechanisms, it is the socially marginalized, indigent 
patient—precisely the one in whom CMHCs traditionally have been disinterested—who likely will be disproportionately re-
presented in any outpatient commitment caseload.\textsuperscript{362}

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

\textbf{B. Deconstructed Meanings}

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

\footnotesize{(presenting clinicians' arguments that patient's history of psychotic behavior when medica-
tion is stopped justifies coercion and continued court supervision).}

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

\footnotesize{359. Schwartz & Costanzo, supra note 202, at 1368.}

\footnotesize{360. See id. (reporting that as of 1987, "only seven states explicitly authorize[d] [forced] medication as a form of community treatment," although no OPC statutes pre-
cluded it).}

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

\footnotesize{362. See Note, supra note 126, at 1323-24, 1341.}
solutions to the underlying social problems.  

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

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

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

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

365. Refer to notes 252-53 supra and accompanying text. Cf. Wagenaar & Lewis, supra note 52, at 821 (stating that, as state hospitals’ control over the “socially disruptive” diminishes, the burden of dealing with such individuals shifts to groups “least equipped to do so: families and inner-city neighborhoods”).


367. Refer to notes 163 & 165 supra.

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

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

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

370. Refer to note 396 infra.
stances, that hospitalization caused harm or retarded recovery.\textsuperscript{371} Even in the case of preventative commitment or outpatient commitment, significant problems surround the implementation of a right to treatment.\textsuperscript{372} Further, public hospitals’ dismal performance in the administration of antipsychotic medication is troubling in light of the likelihood that, especially for the population in question here,\textsuperscript{373} drug regimens will be the treatment of choice.\textsuperscript{374} Beyond this, the sociological critique that focuses upon the inculcation of institutional dependency in public psychiatric facilities has never been effectively rebutted.\textsuperscript{375} The track record is deplorable, and there is no reason to believe that significant amelioration will occur.\textsuperscript{376}

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

\begin{footnotes}
\footnote{371}{See 2 M. Perlin, supra note 11. at chs. 4 & 5.}
\footnote{372}{See Stefan, supra note 135, at 299-94.}
\footnote{373}{See Hiday & Scheid-Cook, supra note 336, at 215-16 (describing the group of chronic mentally ill served by OPC statutes as those who have “slipped through the cracks”).}
\footnote{374}{See, e.g., Note, A Common Law Remedy for Forcible Medication of the Institutionalized Mentally Ill, 82 COLUM. L. REV. 1720, 1723-27 (1982) (discussing the use of antipsychotic drugs for schizophrenic and non-schizophrenic patients, and arguing that the use is often unwarranted and even dangerous to the patient).}
\footnote{375}{See C. Kiesler & A. Sibulkin, supra note 115, at 148.

\begin{footnotes}
\footnote{377}{See generally Perlin & Sadoff, supra note 206, at 164 (discussing surveys that indicate that counsel sporadically appointed to represent the mentally ill were reluctant to investigate, lacked expertise, and did not assume an active role as advocate for the clients' rights). The heuristic public perception here is both inappposite and wrong. Cf. J. Costello, supra note 186 ("Occasionally at cocktail parties . . . I'm buttonholed by friends who say, "Weren't you one of those people who got everybody out of the mental hospital? This is all your fault!" ") (Costello, a law professor, has served as counsel in several patients' rights cases.).}
\footnote{378}{See, e.g., Durham & La Fond, supra note 254, at 425-28, 439-43 (concluding that a public defense system provides better legal representation for clients resisting commitment, based upon a study of commitment cases under a public defense system and a court-appointment system).}
not assigned in an organized way. Most attorneys do not specialize in this area, and few are supported by mental health professionals.\textsuperscript{379} This track record is especially problematic in cases of patients released from state hospitals without hearings.\textsuperscript{380} In those cases, lack of adequate counsel (or, more probable, any counsel) will likely "translate" into a lack of adequate investigation and inquiry into the sufficiency or availability of posthospital living arrangements.\textsuperscript{381}

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

\textsuperscript{379} See 2 M. Perlin, supra note 11, § 8.19, at 802-04.
\textsuperscript{380} Dr. Robert L. Sadoff, past president of the American Academy of Psychiatry and Law, recently questioned whether courts should be involved in release decision making in \textit{all} cases of patients involuntarily committed to hospitals pursuant to a dangerousness to others finding. Telephone interview with Dr. Robert L. Sadoff (Feb. 19, 1990). This precise question was the topic of a panel discussion, "Discharging 'Dangerous' Patients: Who Decides?" presented at the annual American Academy of Psychiatry and Law Conference, October, 1990, in San Diego (debate between Dr. Sadoff and Dr. Abraham Halpern moderated by the author). This is a cutting-edge topic, albeit one that has not yet attracted significant scholarly attention.

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

\textsuperscript{382} 466 U.S. 668 (1984).
\textsuperscript{383} Id. at 688. See generally 2 M. Perlin, supra note 11, § 8.30 (discussing implications of \textit{Strickland} for litigation involving mentally disabled clients); Perlin, supra note 261, at 145-69 (discussing \textit{Strickland}'s reasonableness test, and criticizing it as "nearly-standardless, seemingly-impossible-to-fail test for adequacy of counsel").

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

For a recent excellent overview of all relevant issues, see Klein, \textit{The Relationship of the Court and Defense Counsel: The Impact of Competent Representation and Proposals for Reform}, 29 B.C.L. Rev. 531 (1988).
cases involving mentally disabled or homeless civil plaintiffs or individuals subject to the civil commitment process.

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

385. Compare Durham & La Fond, supra note 232, at 357-62 (arguing that involuntary commitment for nondangerous mentally ill patients does more harm than good) and Durham & La Fond, supra note 218, at 886-88 (asserting that coercive commitment is ineffective in treating the mentally ill, and that scarce resources should be concentrated on providing care on a voluntary basis) and Durham & La Fond, supra note 254, at 444 (concluding through empirical research that expanding involuntary commitment results in overcrowding in state institutions, chronic use of state psychiatric hospitals, and lack of available treatment for voluntary patients) with Stone, Broadening the Statutory Criteria for Civil Commitment: A Reply to Durham & La Fond, 5 YALE L. & POL’Y REV. 412, 422-27 (1987) (attacking Durham and La Fond’s research, and asserting that “therapeutically oriented criteria” for commitment protects the patient’s rights and limits inappropriate confinements). For clinical evaluations of Stone’s proposals, see Beck & Golowka, A Study of Enforced Treatment in Relation to Stone’s “Thank You” Theory, 6 BEHAV. SCI. & L. 569, 564 (1988) (reporting 15 of 39 patients in their study stated that they benefited from the involuntary hospitalization); Hoge, Appelbaum, & Greer, An Empirical Comparison of the Stone and Dangerousness Criteria for Civil Commitment, 146 AM. J. PSYCHIATRY 170, 174-75 (1989) (arguing that the Stone criteria would exclude currently committable patients without adding other patients, and that the criteria would dramatically affect the delivery of psychiatric services); Hoge, Sachs, Appelbaum, Greer & Gordon, supra note 273, at 767-68 (asserting that, although the Stone criteria is more restrictive than the dangerousness standard, it may not significantly decrease the number of patients committed).

386. On the pendulum theory, see 1 M. PERLIN, supra note 11, § 1.04, at 24 n.134 (discussing Durham & La Fond, supra note 254, at 398); Fisher, Pierce, & Appelbaum, How Flexible Are Our Civil Commitment Statutes?, 39 HOSP. & COMMUNITY PSYCHIATRY 711, 711 (1988) (providing that the restrictiveness and inflexibility of statutes based on dangerousness have led several states to broaden commitment requirements); Myers, supra note 178, at 379 (some mental health professionals who initially applauded the changes in involuntary commitment laws, eventually criticized them as “anti-therapeutic” and even harmful); Shuman, Innovative Statutory Approaches to Civil Commitment: An Overview and Critique, 13 L. MED. & HEALTH CARE 284, 286 (1985) (trend away from the dangerousness standard precipitated by the apparently inappropriate exclusion of people from hospitals, thus forming the “mental patient ghettos” in the larger cities); Wexler, supra note 333, at 39 (asserting that statutory broadening of commitment criteria results from public opinion that “the pendulum has swung too far in favor of ‘rights’ over ‘therapy’ ”).
Scholars who have studied this process carefully have reached two divergent conclusions. First, when new, broader criteria are actually adhered to, the results raise troubling issues relating to social control, allocation of resources, and the role of the public hospital in the mental health system. Second, and perhaps even

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

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

In an analysis of civil commitment decisionmaking in cases involving the homeless mentally ill in Ohio, Professor John Belcher suggests that "aggressive use" of the civil commitment power is necessary to "ensure appropriate care." Belcher, Defining the Service Needs of Homeless Mentally Ill Persons, 39 Hosp. & Community Psychiatry 1203, 1204 (1988). A careful reading of the prevailing Ohio state case law indicates, however, that Ohio's judiciary has carefully set out substantive commitment criteria in a way that suggests "regular" use of the civil commitment power is sufficient to ensure appropriate care. See, e.g., State v. Bruton, 27 Ohio App. 3d 362, 368-69, 501 N.E.2d 651, 658-69 (1985) (finding that a patient's probable failure to take medication provided a sufficient basis for a court to find that he posed a danger to himself and others and warranted his confinement); In re Burton, 11 Ohio St. 3d 147, 464 N.E.2d 530, 534 (1984) (setting forth various factors to guide lower courts in commitment cases, including the risk of danger to the patient or others and the probability that the patient will not continue treatment); In re McKinney, 8 Ohio App. 3d 278, 455 N.E.2d 1348, 1351-52 (1983) (holding that statutory definition of mental illness is met when a patient exhibits substantial thought or mood disorder that affects the patient's ability to meet the ordinary demands of life, whether or not psychiatric experts so denominate it).

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

Conversely, when legislatures have attempted to tighten civil commitment criteria, the number of involuntary admissions has not been significantly reduced. See Bagby & Atkinson, supra note 328, at 57-59; see also Bagby, The Effects of Legislative Reform on Admis-
more important for our purposes, in cases of jurisdictions where commitment standards are more narrow, little evidence suggests that mental health professionals adhere to the legislative guidelines. Here, Doctors Bagby and Atkinson speculate that such professionals exhibit "psychological reactance" in resisting legislative attempts to reduce their prerogative. Because of this resistance—grounded in what some professionals see as their "moral obligation"—restrictive laws are ignored and some psychiatrists continue to commit those "whom they believe should be committed."
This final conclusion raises deeply troubling questions as to the ultimate competence of legislators to craft a commitment standard that both meets constitutionally mandated criteria and is “accepted” by expert witnesses on whose testimony contested civil commitment cases will inevitably turn. If legislators are unable to do this, then their competence to “solve” the problems of the deinstitutionalized, homeless mentally ill is seriously suspect.  

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

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

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


395. See generally Chackes, Sheltering the Homeless: Judicial Enforcement of Governmental Duties to the Poor, 31 Wash. U.J. Urb. & Contemp. L. 155, 195-98 (1987) (discussing the various remedies that can be fashioned by state courts when state and local governments fail to perform their common law and statutory duties to the poor); Reid, Law, Politics and the Homeless, 89 W. Va. L. Rev. 115, 117-34 (1985) (arguing that more statutory entitlement programs are needed because the judicial system is failing to meet the needs of the homeless).  

396. See, e.g., In re S.L., 94 N.J. 128, 133-34, 462 A.2d 1252, 1258 (1983) (establishing hearing schedule and criteria). For cases following and construing S.L., see In re A.F. &
Others have sought, with varying success, the establishment of a constitutional or statutory right to treatment in community settings. Still others have brought civil rights actions on behalf of deinstitutionalized ex-patients and on behalf of mentally handicapped individuals residing in the community who seek to maintain funding of community services so as to avoid the need for institutionalization.

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


In the furthest reaching statutory case, the Arizona Supreme Court has interpreted that state's community mental health services statutes, (Ariz. Rev. Stats. § 11-251(5); 11-291(A); 36-550-36-556; 36-3403(B) (1)), to mandate a wide variety of state and county-provided services to the chronically mentally ill in the community. Arnold v. Arizona Dept of Health Servs., 160 Ariz. 593, 549 A.2d 521, 532-34, 538 (1989); see also Santiago, The Evolution of Systems of Mental Health Care: The Arizona Experience, 147 Am. J. Psychiatry 148, 148-52 (1990) (Arnold case an "interactive variable" which led to change in the Arizona mental health system).

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

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

See Philadelphia Police & Fire Ass'n v. City of Philadelphia, 874 F.2d 156, 169 (3d Cir. 1989) (reversing trial court decision that had invalidated a city budgetary plan that denied certain support services and benefits for retarded individuals living at home, and ordering the state to pay for such services), enforced, 705 F. Supp. 1103 (E.D. Pa. 1989).

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

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

ing maximum limits for capacity of each shelter facility).


402. See, e.g., Williams v. Department of Human Servs., 116 N.J. 10, 16, 561 A.2d 244, 251 (1989) (interpreting the state's General Assistance (GA) law, N.J. STAT. ANN. §§ 44:8-107-44:8-152 (West 1989), to impose a continuing obligation to provide shelter to GA-eligible individuals). Consequently, the Williams court ordered a remand to the state Office of Administrative Law for further clarification. Id. at 256. On February 2, 1990, the Office of Administrative Law found that the State Department of Human Services had failed to communicate clearly to municipal welfare departments their continuing obligation to provide such shelter to GA-eligible individuals after the initial five month period of emergency assistance had expired. Williams v. Department of Human Servs., No. HPW 38-90, slip op. at 3 (N.J. Off. Admin. Law Feb. 9, 1990). On March 1, 1990, the Acting Commissioner of the Department of Human Services accepted that finding, and agreed to promulgate regulations to implement it. Id; (N.J. Dept. Hum. Servs., Mar. 1, 1990), final dec. at 4. See also Hodge v. Ginsberg, 303 S.E.2d 245, 250 (W. Va. 1983) (finding that a homeless person was an "incapacitated adult" under state welfare laws); Newark Div. Pub. Welfare v. Ragan, 197 N.J. Super. 228, 484 A.2d 716, 719 (App. Div. 1984) (finding that a homeless person could not have his welfare benefits suspended after he was discharged from work for sleeping on employment premises after hours). But see Williams v. Barry, 703 F.2d 789, 792 (D.C. Cir. 1983) (limiting procedural due process rights of homeless individuals prior to local government's decision to close shelters).


homeless individuals to have access to drug treatment services,\textsuperscript{406} and most controversially, the right of homeless individuals to pan-handle in public facilities.\textsuperscript{407}

Scholars have suggested that health planning laws be considered as sources of rights for ex-patients in the community\textsuperscript{408} and view litigation and administrative activity under these laws as an “opportunity for advocacy on behalf of the mentally ill”\textsuperscript{409} as well as part of an overall scheme to help the deinstitutionalized obtain community benefits.\textsuperscript{410} They have similarly considered welfare laws as potential rights sources.\textsuperscript{411} Student commentators have suggested that at least two “as yet untried alternatives” might result in judicial recognition of a right to shelter for the homeless:\textsuperscript{412} (1) an \textit{entitlement} right on the part of deinstitutionalized mental patients to state-provided shelter\textsuperscript{413} and (2) a \textit{tort} remedy\textsuperscript{414} based on


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

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

\textsuperscript{409.} Id. at 434.

\textsuperscript{410.} See id. at 436.


\textsuperscript{412.} Note, \textit{ supra} note 178, at 941.

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

\textsuperscript{414.} \textit{Id.} at 942. Courts, however, have not been receptive to such tort claims. \textit{See, e.g.,} Klostermann v. Cuomo, 126 Misc. 2d 247, 481 N.Y.S.2d. 580, 585 (Sup. Ct. 1984) (refusing to find a common law duty to protect state hospital patients from reasonably foreseeable harm).
the twin theories that the "treatment" which hospitalized patients received prior to deinstitutionalization "aggravated, if not caused, the present inability of the homeless to care for themselves," and that in many situations, such discharge "was premature, contrary to sound medical judgment and accomplished without inquiry into the ability of individual patients to contend with conditions outside the institution." Others have argued that the fundamental right of families to "remain intact" creates a derivative right to shelter for homeless families. Also, state constitutional provisions have been considered as another source of emergency shelter rights.

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

415. Note, supra note 178, at 984.

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

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


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

421. See, e.g., Bach, supra note 174; Silver, supra note 250; Note, The Duty of Cali-
full funding and implementation of the McKinney Act, the first federal legislation authorizing the creation or expansion of programs designed specifically to assist the homeless. Many of these various solutions share a major unstated conceptual premise: the assumption that courts will be receptive to such litigation strategies. Is this assumption an example of a "fact not in evidence," or does the judiciary's track record inspire encouragement here? Our attention must next turn to this question.

VI. CONCLUSION: TWO "WILD CARDS"

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

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


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

425. 465 U.S. 89, 106-12 (1984) (greatly expanding the states' eleventh amendment immunity from suit in cases involving the right of institutionalized mentally retarded individuals to community treatment); see also, Rudenstine, Pennhurst and the Scope of Fed-
States Supreme Court will be more sympathetic to *majoritarian* rather than *minoritarian* claims in civil rights cases involving similarly disenfranchised groups,\(^4\)\(^2\)\(^8\) and (2) the depth of the hostility on the public's part toward the individuals in question.\(^4\)\(^2\)\(^7\)

A. Court Hostility

The United States Supreme Court's undisguised hostility\(^4\)\(^2\)\(^3\) in cases such as *Pennhurst* has had a clear "trickle-down" effect. Federal intermediate appellate courts have grown increasingly more hostile to the sort of creative litigation suggested as palliatives for the current crisis involving homeless mentally ill individuals.\(^4\)\(^2\)\(^9\) The federal courts see the Constitution increasingly "through the eyes of mainline America," through means that are "insensitive or at least unempathetic to those most in need of its protection."\(^4\)\(^3\)\(^0\) Judges appear to endorse the implicit existence of a

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\(^4\)\(^2\)\(^6\) See Cardozo L. Rev. 71, 76 (1984) (arguing that a majority of the Court wants to limit the federal courts' power to vindicate federal rights in cases involving social institutions).

\(^4\)\(^2\)\(^8\) See *Perlin*, supra note 144, at 1258-59 ("the significance of the *Pennhurst* line of cases lies in the undeniable fact that, at least until there is a significant restructuring of the Supreme Court, the terrain of federal courts will prove to be far more hostile to suits brought on behalf of the mentally disabled than it was a decade ago"). *Compare Facade*, supra note 113. *with Chayes*, supra note 210, at 1305 ("One must ask whether democratic theory really requires deference to majoritarian outcomes whose victims are ... inmates of mental institutions...").

\(^4\)\(^2\)\(^7\) See, e.g., Note, supra note 421, at 352 ("There seems little sense in changing the standard for involuntary civil commitment unless changes in the system are accompanied by changes in societal attitudes...").

\(^4\)\(^2\)\(^8\) See, e.g., *Washington v. Harper*, 110 S. Ct. 1028, 1036-37 (1990) (state administrative procedures satisfy due process requirements in cases involving convicted prisoners wishing to refuse the administration of antipsychotic drugs). *But see Zinermon v. Burch*, 110 S. Ct. 975, 983 (1990) (voluntary patient could maintain § 1983 action in which he alleged hospital officials should have known he was incompetent to seek admission). Refer to notes 313-18 supra and accompanying text.


"community tolerance threshold"\textsuperscript{431} frequently consonant with the imposition of their own psychological, social, economic, or moral preconceptions.\textsuperscript{432} Heuristically-driven social attitudes reject attempts at reasoned discourse. The courts mimic public figures and the media by taking refuge in distorted stereotypes, with rhetoric substituting for meaningful debate.\textsuperscript{433} This final question of competency—the competency of the judicial system to change deep-seated social attitudes\textsuperscript{434}—remains the insoluble dilemma.

\textbf{B. The Depth of Social Attitudes}

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

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

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


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

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

\textsuperscript{435} 473 U.S. 432 (1985).

\textsuperscript{436} Id. at 448.

\textsuperscript{437} Id. (quoting, Palmore v. Sidoti, 466 U.S. 429, 433 (1984)).

\textsuperscript{438} See P. Margulies, Pursuit of a Mirage: Equitable Interpretation, Legislative Intent and the Legal Process (unpublished manuscript) (classifying certain laws as "aspirational," and counseling that courts try to construe the purpose of such laws as consistent with a "best view of social and political transformation"). See generally State v. Hoyt, 21 Wis. 2d 284, 291, 128 N.W.2d 645, 652 (1964) (Willkie, J., concurring) (discussing aspirational component of law).
perpetuate the stereotype that the homeless are all "insane." By doing so, we perpetuate the perception that we are "doing something" about the problem. By perpetuating this stereotype, we can avoid examining the fundamental economic and social questions underlying homelessness and look, instead, for easy targets to blame. Who better to criticize than the patients' rights lawyers originally responsible for the litigation strategies developed in response to the United States Supreme Court's tardy acknowledgment that the due process clause applies to the institutionalized mentally ill?

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

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

439. See McKittrick, supra note 267, at 428.
440. Durham, supra note 72, at 128.
442. See Kaufman, supra note 272, at 363 (politically astute public officials argue for broad commitment standards so as to create a perception that the mentally ill are being helped and that the general public is being sheltered from the socially undesirable).
443. See id. at 363-64 (discussing media perpetuation of stereotypes that encourage blaming the mentally ill and homeless for their condition).
444. See Marmor & Gill, supra note 4, at 467 (discussing how burdens of deinstitutionalization are concentrated while benefits are dispersed).
forced into malignant homelessness.”

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

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

445. Jahiel, supra note 6, at 115.
446. Stemming the Tides, supra note 75, at 26 (emphasis added).
447. Hollings, supra note 85, at Cl, col. 4.
448. Marmor & Gill, supra note 4, at 474.
449. Goldman & Morrissey, supra note 110, at 730.
450. See Durham & La Fond, supra note 232, at 306-07 n.9 (stating that no one has documented any reliable evidence that deinstitutionalization or mental illness is a major cause of homelessness).
451. Durham, supra note 72, at 129. Refer to note 243 supra.
452. Kanter, supra note 72, at 346.
453. See id. For a sampling of representative litigation decided in the past two years, see Mehta v. Surles, 720 F. Supp. 324, 332-33 (S.D.N.Y. 1989) (dismissing suit by landowners who shared common driveway with premises selected as community residence for mentally disabled persons alleging unconstitutional taking without due compensation), aff’d in part, vacated in part, 905 F.2d 595 (2d. Cir. 1990); Westwood Homeowners Ass’n v. Tenhoff, 155 Ariz. 229, 745 P.2d 976, 981-84 (Ct. App. 1987) (restrictive covenant found to be contrary to policy of Arizona Developmental Disabilities Act); Overlook Farms Home Ass’n v. Alternate Living Serv., 143 Wis. 2d 485, 422 N.W.2d 131, 133-34 (Ct. App. 1988) (upheld as constitutional a group home statute that expressly voided restrictive covenants and local zoning ordinances); see also Frick v. Patrick, 165 Mich. App. 689, 419 N.W.2d 55, 58-9 (1988) (refusing to recognize a mentally handicapped individual as a third party beneficiary of a lease agreement between the state and property owners); Step-By-Step, Inc. v. Zoning Hearing Bd., 117 Pa. Commw. 547, 549, 543 A.2d 1293, 1295 (1988) (permitting a group home not qualifying for residential single-family status to locate in a residential district, so long as owner obtained proper special use permits).
clared a broad-based constitutional right to shelter and even if accessible, voluntary community mental health services were made available to all mentally ill homeless individuals, the problems we face probably would not disappear.

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

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

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

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

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

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


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


ents. The latter both sanction and encourage the type of "ordinary justice" meted out in local courts, as reflected in the chilling statistic that the average contested civil commitment hearing lasts less than ten minutes.\footnote{Cf. Parham v. J.R., 442 U.S. 584, 609 n.17 (1979) (a number of studies conclude that the average time for commitment hearings is less than ten minutes).}

Moral suasion may not be enough.\footnote{See Jahiel, supra note 6, at 115. For moral suasion to be effective, it must operate in a setting in which the actors can somehow rid themselves of the type of belief perseverance that flows from heuristic thinking; see, e.g., R. Nisbett & L. Ross, Human Inferences: Strategies and Shortcomings of Social Judgment 169-88, 273-98 (1980) (weighing strategies to cope with the irrationality of such devices).} It is, however, the first step that we all must take.\footnote{Cf. King, supra note 5, at 167. ("American politics needs nothing so much as an injection of the idealism, self-sacrifice and sense of public service which is the hallmark of our movement . . . . [O]thers must move out into political life as candidates and infuse it with their humanity, their honesty and their vision.").} We must "unpack" the broad, stereotypical presentations of vivid, heuristic evidence. We must consider, carefully and soberly, the underlying social dislocations; the malignancy of greed; the dominant social, racial, ethnic, and class-based prejudices; the "pathology of oppression" exemplified by "sanism"; and the degree to which we are willing coconspirators in the re-marginalization of the already-marginalized. We must do this consciously and openly if we are to afford the homeless any "measure of dignity,"\footnote{In re Rulemaking, N.J.A.C. 10:82-I, 117 N.J. 311, 1154, 314, 566 A.2d (1989).} and if we are to have any chance to succeed in stemming the shameful tide that threatens to sweep away our nation's cities.