LEAST RESTRICTIVE ALTERNATIVES IN INVOLUNTARY CIVIL COMMITMENT:

Summary of Statutes in Seven States, Case Law Review, and Annotated Bibliography

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INTRODUCTION

This is the first report resulting from the Least Restrictive Alternative (LRA) Project, conducted by the Institute on Mental Disability and the Law of the National Center for State Courts and funded by grants from the United States Department of Health and Human Services and the Victor E. Speas Foundation of Kansas City, Missouri.* The purpose of the LRA Project, which began in October 1982 and will end in May 1984, is to develop a model for the fair and workable application of the "least restrictive alternative" doctrine in involuntary civil commitment, the legal and psychosocial process whereby an individual alleged to be mentally disabled is cared for and treated against his or her will, presumably for his or her own good or the good of others.

The application of the least restrictive alternative doctrine represents one of the most important trends in mental health law. The doctrine holds that the government may not impose undue burdens or restrictions on an individual's liberty that are any greater than necessary to serve legitimate governmental interests. The doctrine was first applied in mental health litigation in Lake v. Cameron**, when Chief Judge Bazelon, speaking for the majority of the United States Court of Appeals for the District of Columbia, stated: "Deprivations of liberty solely because of dangers to the ill persons themselves should

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** Complete citations to this case and other sources cited in this Introduction can be found in Chapters Two and Three.

not go beyond what is necessary for their protection." Since the Lake v. Cameron decision, both federal and state courts throughout the country have recognized the doctrine in mental health litigation. All states except Alabama, Mississippi, and Oregon have enacted statutes which require, in some form, that mental health treatment be administered in the manner or setting which is least restrictive of personal liberty (Lyon & Levine, 1982). The least restrictive alternative doctrine has been applied to initial commitment decisions, placements in institutions and community-based facilities, criteria for release, and care and treatment provided to residents of mental health facilities.

The primary method of inquiry of the LRA Project was field research conducted in seven cities across the country, supplemented by the collection, review, and analysis of selected statutes, court rulings, and relevant literature. The project consisted of three phases. The first phase, the results of which are reported here, consisted of a review and analysis of provisions for the application of the least restrictive alternative doctrine in the mental health statutes of seven states, a review of selected court rulings in state and federal jurisdictions, and a review of relevant professional literature.

In the second phase of the LRA Project, to be described in separate reports, field research was conducted in Chicago; Kansas City, Missouri; Los Angeles; Milwaukee; New York City; Tucson; and Williamsburg/James City County, Virginia. Interviews were conducted with hundreds of judges, court personnel, attorneys, and mental health professionals. Involuntary civil commitment hearings and other commitment proceedings conducted during the time of the field research were observed whenever possible.

During the third phase of the LRA Project, the information gathered during the first phase will be integrated with the results of the field research and a model will be developed for the just and practical application of the least restrictive alternative doctrine in involuntary civil commitment proceedings. The model will be described in the final report of the LRA Project.

This report is meant to be a resource guide for policymakers, practitioners, planners, and scholars initiating studies of involuntary civil commitment. It is especially intended to be a useful reference for those who would use the least restrictive alternative doctrine as a guiding principle to scrutinize and improve the legal provisions for and practices of involuntary civil commitment. Chapter One describes provisions for the application of the least restrictive alternative doctrine in the statutes of the seven states selected for in-depth field research during the LRA Project. The seven states and the jurisdictions within these states where field research was conducted are not a representative sample in any technical sense but were chosen on the basis of several considerations including (1) the scope of statutory provisions for the application of the least restrictive alternative doctrine; (2) the ease of access and likelihood of cooperation of the social service and civil justice systems with the project staff; (3) the size and level of effort of the social service and civil justice system; (4) relevant organizational components and structure; (5) the region of the country; (6) the protective services provided; (7) the innovativeness of the services; and (8) the generalizability of the information to be gained from the project sites. Chapter Two reviews court rulings at both the federal and state levels that address the use of the least restrictive alternative doctrine. While the legislative and judicial pronouncements

described in these first two chapters do not necessarily reflect practice, they may dictate the general structure and form of the applications of the doctrine in involuntary civil commitment. Chapter Three consists of an annotated bibliography of professional literature relevant to the least restrictive alternative doctrine. Entries are arranged within four topic areas--involuntary commitment of the mentally ill, elderly persons, mentally retarded persons, and other applications of the doctrine--and address a wide range of issues.

CHAPTER ONE: SUMMARY OF STATE STATUTES

This chapter describes legislative applications of the least restrictive alternative doctrine in the mental health statutes of the seven states (i.e., Arizona, California, Illinois, Missouri, New York, Virginia, and Wisconsin) involved in the LRA Project. While all seven states acknowledge the least restrictive alternative doctrine somewhere in their statutes, they vary considerably in the number and types of areas in which they provide for its application and in the explicitness with which they articulate the doctrine. Interestingly, only Missouri actually defines "least restrictive environment".

The statute summaries in this chapter focus on specific areas in which, in our assessment, the state legislatures have explicitly or implicitly applied the doctrine. The summaries do not provide general overviews of other aspects of the civil commitment statutes. The goal of the summaries is to present the relevant statutory provisions without extensive commentary. We recognize that in paraphrasing statutory provisions, however, we may at times unintentionally alter the meaning of the provisions slightly . The reader is, therefore, encouraged to view the summaries as resource guides and to refer to the statutes themselves for definitive language.

The table that appears below is designed to facilitate comparison of the statutory provisions for the application of the least restrictive alternative doctrine in the seven states involved in the LRA Project. Statutory citations refer to the following: Arizona Revised Statutes Annotated; California Welfare and Institutions Code; Illinois Revised Statutes, Chapter 91 1/2; Missouri Revised Statutes; New York Mental Hygiene Law; Virginia Code; and Wisconsin Statutes Annotated. The

table is not intended to be exhaustive. It is a graphic summary and is not intended as a substitute for the detailed descriptions of statutory provisions that follow. Citations given are generally the primary ones only; additional citations may be found in the succeeding sections. A blank area within the table does not necessarily mean that the state statute fails to address the area. It may mean that the least restrictive alternative doctrine is not apparent in the relevant statutory provisions. For example, one statute may provide for periodic review of a commitment, per se. Another may provide for periodic review to determine if a less restrictive placement would be proper. The latter would be included in the table; the former would not. Alternatively, a blank area may mean that the arguably relevant statutory provision has been categorized under a different heading in the table. The substantive headings are not mutually exclusive and are necessarily general because of the diverse treatment of the doctrine among the states.

STATE	LEGISLATIVE INTENT	LRA DEFINED	COMMUNITY TREATMENT SYSTEM	COMMITMENT CRITERIA	PRELIMINARY SCREENING
ARIZONA	—	—	State-wide plan for community residential treatment of chronically mentally ill. 36-550.01	Petition must allege appropriate or available alternatives. 36-533	Pre-petition. Outpatient evaluation permitted. 36-501.23 36-522
CALIFORNIA	Deinstitutional-ization 5001 5450 5600	—	Continuum of residential alternatives to promote movement to LRA. Program must permit treatment in LRA. 5450 5459 5600.4 5651	—	Pre-petition to determine if voluntary treatment is appropriate. Outpatient evaluation permitted. 5202
ILLINOIS	—	—	Residential alternatives for developmentally disabled. Pilot project to encourage LRAs for mentally ill. 622 - 625 100-16.2	—	—
MISSOURI	Department of Mental Health goal to provide LRA programs. 630.020.1	A reasonably avail-able, appropriate setting for neces-sary individualized services which maxi-mize potential for normal living activities. 630.005.1	Placement program designed to maintain persons in LRA within a continuum of services. 630.605 630.615 632.055	—	Preliminary screening by mental health coordinators. 632.300
NEW YORK	Institutional care for mentally ill only if necessary and appropriate. 7.01	—	Director of community services and commissioner may enter agreements regarding admisaion procedures. 29.05	—	Examiners must consider alternatives to certification. 9.27 15.27
VIRGINIA	—	—	See "Funding" below.	Must be no LRAs. Investigation must establish that LRAs are unsuitable. 37.1-67.3	Prescreening report of community services board or CMHC must state whether LRAs are available. Preadmission examination required. 37.1-67.3 37.1-70
WISCONSIN	To assure full range of treatment while protecting LRA right. No inpatient treatment unless outpatient inappropriate. 51.001	—	—	In specified circumstances, person may not be detained or committed if protection is available in the community. 51.15 51.20	Prior to final hearing, two examiners must recommend appropriate level of treatment, including LRA inpatient, if any. 51.20

STATE	RELEASE PENDING HEARING	ADMISSION STATUS AND PROCEDURES	COURT ORDER	DUTIES OF COUNSEL	PATIENTS' RIGHTS
ARIZONA	—	—	May order outpatient treatment. Must consider all available and appropriate alternatives. 36-540	Must investigate alternatives. 36-537	Developmentally disabled have right to LRA. Rights of mentally ill reflect LRA doctrine. 36-551.01 36-507.5 36-516
CALIFORNIA	—	—	May place conservatee in LRA. Officer must investigate all alternatives. 5354 5358	—	Patients have right to LRA. 5325.1
ILLINOIS	—	Mentally ill respondent may request informal or voluntary admission. Developmentally disabled respondent may request administrative admission. 3-801 4-601	Must order LRA for mentally ill and developmentally disabled respondents. 3-811 4-609	—	Mentally ill and developmentally disabled have right to LRA. 2-102
MISSOURI	—	Volunteers may be used to persuade persons to accept voluntary status. 632.010.2	Must order LRA. 632.335.4 632.350.5 632.355.3	—	Patients have right to LRA 630.115.1
NEW YORK	—	Informal and voluntary preferred to involuntary. Informal preferred to voluntary. 9.21 9.23	May order transfer of patient to relative or committee. 9.31	—	—
VIRGINIA	Judge may release mentally ill person on own recognizance or bond if no imminent danger. 37.1-67.1	Preliminary hearing required to determine if voluntary status is appropriate. 37.1-67.2	Must order outpatient treatment, day treatment, etc. if necessary and appropriate. 37.1-67.3	—	Patients have right to LRA. 37.1-84.1
WISCONSIN	Court may release or conditionally release person pending probable cause and final hearings. 51.20	If voluntary patient fails to apply in writing for admission, physician must advise of LRA right and court must appoint guardian ad litem. 51.10	Must order outpatient treatment if appropriate. 51.20	—	Patients have right to LRA. 51.61

STATE	COURT-ORDERED MEDICAL TREATMENT	MENTAL HEALTH TREATMENT	INTRUSIVE TREATMENT	CONDITIONAL RELEASE	CASE MANAGEMENT
ARIZONA	—	LRA preferred in guardianship of gravely disabled. 36-547.04	No seclusion, mechanical or pharmacological restraint unless emergency. 36-513	Medical director may order outpatient treatment following court-ordered inpatient treatment. 36-540.01	—
CALIFORNIA	—	Must be administered in manner least restrictive of personal liberty. 5325.1	No psychosurgery or electro-convulsive therapy unless is LRA. No unnecessary or excessive restraint, isolation, etc. 5325.1 5326.6 5326.7	Postcertification outpatient treatment permitted. 5305	System established to reduce recidivism and further the use of alternatives. 5675 5677
ILLINOIS	—	—	No restraint or seclusion unless therapeutic. No electroconvulsive therapy or psychosurgery without consent. 2-108 - 2-110	Facility director may conditionally discharge with provision for aftercare. 4-702 100-16	—
MISSOURI	—	—	Right to refuse electroconvulsive therapy can be overridden only by hearing establishing that no LRA exists. 630.130.1 630.130.3	Facility director may conditionally release to outpatient care. 632.385.2	—
NEW YORK	—	—	Restraint only if LRAs insufficient. 33.04	Facility director may conditionally release if inpatient care is not required but absolute discharge is inappropriate. 29.15	—
VIRGINIA	Limits on court's power suggest influence of LRA doctrine. 37.1-134.2	See "Patients' Rights" above.	No unnecessary physical restraints or isolation. 37.1-84.1	State hospital director may place specified patients in private homes, nursing homes, or other facilities. 37.1-121 - 37.1-123	—
WISCONSIN	—	Involuntary treatment must be in least restrictive manner. Community board may transfer person if consistent with LRA doctrine. 51.20 51.22 51.35	No physical restraint, isolation, or nonconsensual psychosurgery without cause. 51.61	Transfer to LRA may be conditional. See "Mental Health Treatment" above. 51.35	—

STATE	PERIODIC REVIEW	DISCHARGE	FUNDING	DEVELOPMENTAL DISABILITY SERVICES	SENIOR CITIZEN SERVICES
ARIZONA	Must state whether alternatives available. If release, must arrange alternative placement. 36-543	Medical Director must arrange appropriate alternative placement for gravely disabled persons. 36-541.01	—	Goal to provide minimally structured setting. No guardianship or conservatorship except to extent necessary. 36-560 36-564	—
CALIFORNIA	—	—	Funding priority scheme encourages use of LRAs. 5704	Goal is community treatment. Group home is residential use for zoning purposes. 5120 5116	Encourages development of alternatives and prevention of unnecessary institutionalization. 9002 9321
ILLINOIS	—	—	—	Administrative admission: examiner must recommend LRA. On judicial review court may order LRA. See "Community Treatment" below. 4-300 4-301 4-308	—
MISSOURI	—	Facility director must release to LRA if in patient's best interests. 632.385.1	—	—	—
NEW YORK	—	—	—	See "Preliminary Screening" above.	—
VIRGINIA	—	Not limited to fully-recovered patients. 37.1-98	Matching grants authorized for development of comprehensive community services. 37.1-194	Lack of LRAs is prerequisite to judge certifying mentally retarded person's eligibility for admission.	—
WISCONSIN	To determine if transfer to LRA appropriate. 51.20	—	—	—	—

Arizona

Arizona's Mental Health Services Act (Ariz. Rev. Stat. Ann., Title 36, Ch. 5) and Developmental Disability Law (Ariz. Rev. Stat. Ann., Title 36, Ch. 5.1) contain the state's statutory provisions regarding court-ordered treatment and other mental health services for mentally disordered persons. Many provisions in Arizona's mental health law, including the most recent revision of the Mental Health Services Act, (S.B. 1312, 36th Leg., 2d Reg. Sess., 1983) effective July 1, 1983, reflect a legislative intent to apply the least restrictive alternative doctrine, although no such intent is expressly articulated.

The application of the least restrictive alternative doctrine to the involuntary civil commitment process is expressed or implied in several areas of Arizona's mental health law: (a) mental health screening and evaluation before the filing of a petition; (b) court options for ordering treatment and care; (c) conditional outpatient treatment and care; and (d) residential treatment and services for the chronically mentally ill. In addition, the Arizona legislature has applied the least restrictive alternative doctrine in several other areas of the law: (1) patients' rights; (2) duties of respondents' counsel in involuntary civil commitment proceedings; (3) the procedures for filing a petition for court-ordered mental health treatment; (4) court-ordered mental health evaluation; (5) the placement of gravely disabled and developmentally disabled persons; and (6) review of and release from court-ordered treatment and care. Each of these areas of the law is discussed below.

Pre-petition Screening and Evaluation

Perhaps the most significant application of the least restrictive alternative doctrine in Arizona's mental health law is the

provision for what is called "pre-petition screening." Pre-petition screening is statutorily defined as the "review of each application requesting court-ordered evaluation, including an investigation of facts alleged in such application, an interview with each applicant and an interview, if possible, with the proposed patient" (36-501.23). Any responsible person in Arizona may apply for a court-ordered mental health evaluation of an allegedly mentally disordered and dangerous, or gravely disabled person, at a mental health facility designated to perform pre-petition screening. The purpose of the pre-petition screening is to determine whether there is reasonable cause to believe the allegations of the applicant (i.e., that the respondent is a fit subject for involuntary mental health treatment and care), and to attempt to persuade the respondent to undergo, on a voluntary basis, mental health evaluation or other mental health services less restrictive than involuntary hospitalization (36-501.23; 36-521). The screening takes place either at a screening agency, at the person's home, or wherever the person may be found (36-520.E. & F.).

The screening agency must act on the application for court-ordered evaluation within 48 hours of the filing of the application, excluding weekends and holidays (36-520.D.). If the screening agency determines that the respondent does not require court-ordered evaluation, the application is not acted upon and the involuntary civil commitment proceedings terminate at this point (36-520.1)

Court Options for Ordering Outpatient Treatment and Care

The Mental Health Services Act, as amended in 1983, permits the court to order involuntary treatment and care in non-hospital settings. In addition to ordering hospitalization, the court has the option of

ordering outpatient treatment (36-540.A.1) or a combination of outpatient and inpatient treatment and care (36-540.A.2). Section 36-540.B specifically directs the court to "consider all available and appropriate alternatives for the treatment and care of the patient."

A unique provision in Arizona's mental health law is the requirement of an initial period of treatment and care provided in a local mental health treatment agency geographically convenient for the respondent (36-541). Whenever a court orders a respondent to undergo involuntary treatment and care, he or she must generally be treated and cared for at least 25 days in a local mental health treatment agency prior to admission to the state hospital unless the respondent is already in the state hospital at the time of the court order (36-541). The court may immediately hospitalize a respondent at the state hospital only if it finds that (a) the respondent's condition and history demonstrate that he or she will not benefit from the local treatment, (b) the state hospital provides a program specific to the respondent's needs which is unavailable in the local agency, or (c) no local agency is readily available to the respondent (36-541).

Conditional Outpatient Care

Section 36-540.01 is a recent extensive addition to the Arizona statutes that allows a medical director of a treatment agency to issue an order for conditional outpatient treatment following a period of court-ordered inpatient treatment and care. The order for conditional outpatient treatment must define the conditions for such care, the identity and extent of authority of the person or agency assigned to supervise outpatient treatment and care, and a written outpatient treatment plan (36-540.01.B.3 & 4). Before the respondent is released for conditional outpatient treatment, the treatment plan must be fully

explained to him or her, and any objections to the plan must be noted in the respondent's hospital records (36-540.01.C).

Community Residential Treatment System

A fourth major application of the least restrictive alternative doctrine in Arizona's mental health law is the provision for a "community residential treatment system." Article 10 of the Mental Health Services Act charges the director of Arizona's Department of Health Services to establish by July 1, 1983 a state-wide plan for community residential treatment for chronically mentally ill persons which provides a wide range of services as alternatives to institutionalization and in the least restrictive setting. Facilities for residential or day treatment must be relatively small, preferably with 15 or fewer beds, and "designed to provide a homelike environment without sacrificing safety or care" (36-550.05.A). Four types of programs are to be included in the community residential treatment system: (1) short-term crisis residential program as an "alternative to hospitalization for persons in an acute episode or situational crisis requiring temporary removal from the home from 1-14 days"; (2) a semi-supervised, structured group living program; (3) a "socialization" or day care program; and (4) a residential treatment program that provides a "full day treatment program for persons who may require intensive support for a maximum of two years" (36-550.05). Chronically mentally ill persons are eligible for services in these programs regardless of whether they voluntarily seek the services or whether a court-appointed guardian requests, the superintendent of the Arizona State Hospital recommends, or a court orders that they receive the services (36-550.06).

Other Applications of the Least Restrictive Alternative Doctrine

Patients' Rights. The least restrictive alternative doctrine is

clearly applied in the statutory provisions of the legal rights accorded to patients in Arizona's mental health facilities. Both mentally ill and developmentally disabled persons undergoing evaluation or treatment have rights including, but not limited to, the right to wear their own clothing (36-507.5), to use their own personal possessions (36-507.5), to refuse all but court-ordered treatment unless a medical emergency exists (36-512), to be free from seclusion or mechanical or pharmacological restraint except in an emergency (36-513), and to be visited by any person, subject to reasonable limitations (36-514). Any violation of these rights gives the patient a cause of legal action for treble damages or $1,000, whichever is greater (36-516).

The least restrictive alternative doctrine is also specifically applied in the provision of rights of developmentally disabled persons. "Every developmentally disabled person who is provided residential care by the state shall have the right to live in the least restrictive alternative, as determined after an initial placement evaluation has been conducted for such persons" (36-551.01.C). Further, each developmentally disabled person has the right to a humane and clean physical environment, to communication and visits, and to personal property (36-551.01.Q). These rights are in addition to all other rights enjoyed under federal and state law (36-551.01.A).

Respondent's Counsel. Arizona's mental health law expressly applies the least restrictive alternative doctrine in the duties prescribed for respondents' counsel in proceedings for court-ordered treatment. At least 72 hours before the court conducts a hearing on a petition for court-ordered treatment, the medical director of the agency which conducted a court-ordered mental health evaluation must make available to the respondent's counsel "a list of alternatives to

court-ordered treatment which are used in similar cases with an explanation of why they are not appropriate or available" (36-537.A). At least 24 hours before the judicial hearing, the attorney must review the list and investigate the possibilities of alternatives to court-ordered treatment (36-537.B). Failure to fulfill these duties may be punished as contempt of court (36-537.B.4).

Petition. A petition for court-ordered treatment must allege (a) that a person is in need of treatment because he or she is a danger to self or others or is gravely disabled as a result of the mental disorder, (b) the treatment alternatives which are appropriate or available, and (c) that the person is unwilling to accept or incapable of accepting treatment voluntarily (36-533.A). The application of the least restrictive alternative doctrine is clearly implied in requirements (b) and (c).

Court-Ordered Evaluation. A respondent in Arizona, who is the subject of a petition for court-ordered mental health evaluation, may voluntarily submit to such an evaluation either on an inpatient or outpatient basis (36-522.A). A respondent presented for emergency admission may be immediately hospitalized for pre-petition screening if "the person is likely without immediate hospitalization to suffer serious physical harm or serious illness or to inflict serious physical harm on another person" (36-526.A). If the person is hospitalized for pre-petition screening, "the medical director may notify a screening agency and seek its assistance or guidance in developing alternatives to involuntary confinement and in counseling the person and his family" (36-526.A).

Placement. An area in which the least restrictive alternative doctrine is evident is the placement of developmentally disabled persons

and gravely disabled persons. No person may be admitted or assigned to a developmental disabilities facility, program, or service unless he or she has received a placement evaluation (36-560.G). This evaluation should determine which program is appropriate for the developmentally disabled person (36-560.G). The standards for assigning a person to a particular service are the person's best interests, the person's particular desires, and the ability to provide the person with the "maximum opportunity to develop his or her maximum potential," to provide a "minimally structured residential program and environment," and to provide "a safe, secure, and dependable residential program environment" for the person (36-560.H). A developmentally disabled person may not be subject to guardianship or conservatorship except to the extent necessitated by his or her mental, physical, or adaptive limitations (36-564.D). The guardianship or conservatorship must promote the person's well being and must be designed to encourage maximum self-reliance and independence in the person (36-564.D).

In the placement of gravely disabled persons in guardianship services, a guardian must seek alternatives to hospitalization in the following order of preference: (a) allowing the person to live at home or with family or friends, (b) placing the person in an agency close to his or her home, or in the home of a relative, "in an environment less restrictive than a mental health treatment agency," and (c) placing the person in a mental health treatment agency (36-547.04.A.4). Prior to placing a gravely disabled person in a mental health treatment agency, the guardian must obtain a court order "after notice and hearing and a finding that an alternative placement is not available" (36-547.04.B). If a gravely disabled person subject to guardianship has been placed in a mental health treatment agency and the medical director later notifies

the guardian that the ward no longer needs the care or treatment offered by the agency, the guardian must find alternative placement within 10 days (36-547.05.A).

Release and Review. An involuntary patient may be released prior to the expiration of the court-ordered treatment period when the medical director of the facility determines that the respondent no longer meets commitment criteria (36-541.01.A). Prior to the release, the medical director must arrange an appropriate alternative placement (36-541.01.A).

A recently enacted section of Arizona's mental health law mandates an annual examination and review of gravely disabled persons "to determine whether the continuation of court-ordered treatment is appropriate and to assess the needs of the patient for guardianship or conservatorship, or both" (36-543.D). The annual examination and review shall include "a statement as to whether suitable alternatives to court-ordered treatment are available" (36-543.E.2). Further, "if the patient is to be released, the medical director shall arrange for an appropriate alternative placement" (36-543.A).

California

The Lanterman-Petris-Short Act (LPS Act) (Welf. & Inst. Code 5000 et seq.) provides for involuntary commitment in California. Other provisions relevant to the care and treatment of mentally disabled persons appear throughout the Welfare and Institutions Code [e.g., the Short-Doyle Act (5600 et seq.) and the Older Californians Act (9000 et seq.)]. "Deinstitutionalization" is a pervasive theme in the LPS Act and related statutes. The specific legislative intent behind the LPS Act is to promote an end to inappropriate, indefinite, and involuntary

commitment of mentally disabled persons, to provide prompt evaluation and treatment of mentally disabled persons, and to safeguard individual rights through judicial review (5001(a), (b), and (d)). Although the overriding intent to promote deinstitutionalization does not expressly include reference to the least restrictive alternative doctrine, many provisions in the LPS Act, and in related statutes, reflect a clear intent to promote alternatives to institutional care and treatment for both voluntary and involuntary patients. For example, one provision articulates the Legislature's intent to establish in every county a range of residential treatment programs which, as alternatives to institutional care, provide a range of services and are based on principles of residential, community-based treatment (5450). Section 5325.1 states that the mentally ill "have a right to treatment services which promote the potential to function independently" and that such services should be provided in the manner "least restrictive of personal liberty."

The California Legislature has applied the least restrictive alternative doctrine in several areas including: (a) establishment and operation of a community residential treatment system, (b) court-ordered mental health evaluation, (c) judicial review of certification, (d) mental health treatment after certification, (e) postcertification treatment on an outpatient basis, (f) conservatorship for gravely disabled persons, and (g) constraints on the provision of highly intrusive treatment. The doctrine is also applied in several additional areas: (1) patients' rights, (2) case management, (3) funding priorities, and (4) services for senior citizens. Each of these areas is discussed below.

Community Residential Treatment System

The California Legislature has directly applied the least

restrictive alternative doctrine by providing for the establishment and operation of residential treatment programs to provide, at every level, alternatives to institutional settings (5450, 5458). Residential alternatives for which counties may receive funding include short-term crisis alternatives, long-term programs, transitional services, structured living arrangements, rehabilitation day treatment programs, socialization centers, in-home programs, and volunteer-based companion programs (5458(a) through (h)). Section 5459 requires that the treatment system be developed in such a way that patients "may move within the continuum to the most appropriate, least restrictive level of service."

Court-Ordered Mental Health Evaluation

Any person allegedly dangerous to him or herself or others, or gravely disabled, because of mental disorder, may be subject to a court-ordered mental health evaluation (5200). All statutory provisions relating to the evaluation must be fulfilled "with the utmost consideration for the privacy and dignity of the individual" (5200). Pre-petition screening must be conducted prior to an evaluation to determine whether a person will voluntarily agree to accept services (5202). The superior court may order an evaluation only if it appears that the person is dangerous or gravely disabled, and is unwilling to voluntarily accept services (5206). Unless the person is detained, he or she may remain at home prior to the evaluation (5206) and may receive the evaluation at home (see 5202). If a person is detained for evaluation, either under Article 1 (5150 et seq.) or Article 3 (5225 et seq.), detention may be for no longer than 72 hours, excluding Saturdays, Sundays, and holidays if treatment and evaluation services are unavailable on those days (5206). Following the evaluation the person detained may be (1) released, (2) referred for voluntary treatment and

care, (3) recommended for conservatorship, or (4) certified for intensive treatment (5206).

Judicial Review of Certification

If certification for continued hospitalization is warranted, then another group of statutory provisions becomes important. The certified person may be entitled to a probable cause hearing (i.e., a "certification review hearing"), a "writ hearing" pursuant to a writ of habeas corpus, or both (see 5256). A probable cause hearing must be held within seven days of the initial detention unless the person or his or her attorney requests a postponement for up to 48 hours or a 5275 writ hearing (5256). The statute may be construed to allow a person to delay requesting a writ hearing until after a probable cause hearing, and thus, the individual may gain an additional opportunity to challenge and terminate the involuntary commitment proceedings (see 5256 and 5275). If requested, a writ hearing must occur within two judicial days after the petition is filed (5276).

Mental Health Treatment After Certification

As stated earlier, treatment must be administered in the manner least restrictive of personal liberty (see 5325.1). In keeping with this mandate, mental health treatment after certification should be provided in the local community (5120); persons receiving evaluation or treatment must be given a choice, within the limits of available staff, of the physician or other professional person to provide the services (5009); the professional person certifying the person should attempt to place the certified person in the treatment facility of his or her preference if administratively possible (5259.2); and the professional person in charge of the intensive treatment facility, or his or her designee, may permit the certified person to leave the facility for short periods during the

treatment term (5268).

Postcertification Outpatient Treatment

After an initial 14-day certification period, a person may be confined for further treatment for up to 180 days if he or she meets the following postcertification criteria: he or she has "attempted, inflicted, or made a substantial threat of physical harm upon the person of another" and "as a result of mental disorder, presents a demonstrated danger of substantial harm to others... . Amenability to treatment is not required..." (5300). The least restrictive alternative doctrine is apparent in a newly enacted provision which permits placing a postcertified person on outpatient status if certain conditions are satisfied (see 5305). The conditions which must be satisfied are that (1) "In the evaluation of the superintendent or professional person in charge of the licensed health facility, the person named in the petition will no longer be a danger to the health and safety of others while on outpatient status and will benefit from outpatient status" (5305(a)(1)), and (2) "The county mental health director advises the court that the person named in the petition will benefit from outpatient status and identifies an appropriate program of supervision and treatment" (5305(a)(2)). After notice to the person's attorney, the district attorney, the court, and the county mental health director, the outpatient treatment plan becomes effective within five judicial days unless one of these parties requests a hearing (5305(b)). Such a hearing must be held within five judicial days of actual notice (5305(b)).

The county mental health director or his or her designee is required to supervise persons on outpatient status and, if the person is placed on outpatient status for at least three months, he or she must submit progress reports every 90 days to the court, the district

attorney, the patient's attorney, and the health facility director, if appropriate (5305(d)). A final report must be submitted at the conclusion of the 180-day commitment (5305(d)).

Outpatient status may be revoked and the patient may be taken into emergency custody only in specified circumstances. Section 5306.5 prescribes procedures for revocation of outpatient status if the outpatient treatment supervisor believes that the patient needs inpatient treatment or refuses to accept further outpatient treatment and supervision. In such a case, the county mental health director must submit to the superior court a written request for revocation (5306.5). The court must hold a hearing within 15 judicial days and, if it approves the request for revocation, must order the person confined in a treatment facility (5306.5).

Section 5307 prescribes similar procedures by which the district attorney may petition the court for revocation if the district attorney believes that the patient is a danger to the health and safety of others while on outpatient status. Upon the filing of a request for revocation under either 5306.5 or 5307, the patient may be confined pending the court's decision if the county mental health director believes that "the person will now be a danger to self or to another while on outpatient status and that to delay hospitalization until the revocation hearing would pose a demonstrated danger of harm to the person or to another" (5308). A patient so detained has a right to review of the detention by habeas corpus procedures (5308 and 5275). If the court approves confinement under either 5306.5 or 5307, then the patient may not later be released to outpatient status without court approval (5308).

Placement in Conservatorship Services

An officer designated by the county governing board to provide

conservatorship investigation must "investigate all available alternatives to conservatorship and ... recommend conservatorship to the court only if no suitable alternatives are available" (5354). A temporary conservator must give preference to arrangements which provide services for the conservatee but "allow the person to return to his home, family, or friends" (5353). When ordered by the court after a hearing, a conservator must place the conservatee in the least restrictive alternative placement, as designated by the court (5358(a)). The conservator may transfer the conservatee "to a less restrictive alternative placement without a further hearing and court approval" (5358(d)).

Constraints on Intrusive Treatment

Psychosurgery and convulsive treatment may be administered, regardless of whether a patient is voluntary or involuntary, only if the attending or treatment physician adequately documents in a patient's treatment record "that all reasonable treatment modalities have been carefully considered" and that the treatment is "the least drastic alternative available for this patient at this time" (5326.6(c) and 5326.7(a)). The LPS Act contains other prerequisites to psychosurgery and convulsive treatment (see 5326.2, 5326.6, 5326.7, and 5326.75).

Other Applications of the Least Restrictive Alternative Doctrine

Patients' Rights. Patients have a right to treatment services "provided in ways that are least restrictive of the personal liberty of the individual" (5325.1(a)). Furthermore, patients have a right to be free from "unnecessary or excessive physical restraint, isolation, medication, abuse, or neglect" (5325.1(c)). Every involuntarily detained person retains all individual rights which are not specifically denied by statute (5327).

Case Management System. The California Legislature has encouraged counties to develop "case management systems for mentally disordered clients who have the highest readmission rate in order to establish a more cost efficient method of reducing hospitalization" (5675). The minimum requirements of such case management systems further the use of alternatives to institutionalization. Guidelines developed pursuant to this statutory scheme should allow each county flexibility to develop a system proper for the specific community and the needs of clients (5676). Each case management system must meet minimum requirements. First, a system must include "[p]revention of unnecessary hospitalization of clients and provision for alternative treatment in the community in order to promote the highest possible level of rehabilitation and independent living compatible with the client's abilities and community resources" (5677(a)). Second, each system must include a case manager who must:

> (1) Serve as coordinator to assure the cooperation of the various elements of the system and to act as an active advocate for the clients in the system.
>
> (2) Assure that each client receives the appropriate type of service, including, but not limited to, administrative structure under which the case manager shall upon request be able to secure appropriate and timely services for the case management client.
>
> (3) Meet regularly with clients and work closely with program staff.
>
> (4) Develop a plan for each client, the elements of which include assessment of mental status with appropriate reassessment, economic need, vocational potential, physical health, needs for resocialization, type of living arrangement each client needs, and appropriate individual treatment.
>
> (5) Involve each client in his or her own treatment and service plan.

(5677(b)). Among other minimum requirements are provisions for "[c]oordination with local agencies and community resources to avoid

and planning" (5677(d)), and "[e]stablishment of specific linkages with local agencies and community resources to maximize the effectiveness of the case management system" (5677(e)).

Funding Priorities. In allocating funds for direct mental health services, the Director of Mental Health must implement the following order of priority: (1) crisis intervention, (2) outpatient and day treatment, and aftercare services, (3) partial hospitalization, (4) residential treatment, and (5) inpatient treatment (5704). This funding priority scheme directly furthers deinstitutionalization and encourages less restrictive treatment alternatives.

Services for Senior Citizens. The legislative intent behind the Older Californians Act is to encourage public and private agencies "to develop alternative services and forms of care that provide a range of services delivered in the community, in the home, in care providing facilities, and services which facilitate access to other services which support independent living in the community and prevent unnecessary institutionalization" (9002(d)). The State Department of Health Services must "[a]dvocate the development of more viable alternatives to institutionalization to ensure an array of available services" (9321(b)) and "[d]evelop alternatives to long-term care in cooperation with the Department of Social Services" (9321(e)). One form of such services is "supportive services ... which maintain individuals in home environments and avoid institutional care" (see 9107). Another stated legislative goal is to "prevent premature disengagement of older persons from their indigenous communities and subsequent commitment to institutions" (9400(a)).

Illinois

Illinois law regarding involuntary civil commitment appears in the Mental Health and Developmental Disabilities Code (Ill. Rev. Stat., ch. 91 1/2). Although the Code specifically applies the least restrictive alternative doctrine in several areas, it states no overriding legislative policy relevant to the doctrine. Specific areas in which the Code applies the least restrictive alternative doctrine include: (a) diversion of mentally ill and developmentally disabled persons from involuntary civil commitment, (b) issuance and modification of a commitment order, (c) residential treatment and care alternatives for the developmentally disabled, (d) administrative admission of developmentally disabled persons, and (e) conditional and temporary release of patients. Other areas in which the Code applies the doctrine include: (1) patients' rights, and (2) community residential alternatives. Each of these areas is discussed below.

Diversion from Judicial Commitment

The Code includes distinct provisions in this area regarding diversion of mentally ill and developmentally disabled respondents yet the substance and procedure regarding each group is essentially the same. An allegedly mentally ill respondent may request "informal or voluntary admission" at any time prior to a judicial determination that he or she is subject to involuntary admission (3-801). If the facility director approves the request, the court may dismiss the pending proceedings (3-801). The court may require proof, however, that dismissal is in the respondent's and the public's best interests (3-801). If a developmentally disabled respondent requests an "administrative admission," identical procedures are required (4-601).

The diversion of mentally ill respondents is distinguished from the diversion of developmentally disabled respondents in that mentally ill respondents may request either of two admission statuses: informal or voluntary (compare 3-801 and 4-601). Informal status is less restrictive than voluntary status. If the facility director decides to admit a person on voluntary status, the director must state in the patient's record why informal admission is inappropriate (3-300(b)). A person may be informally admitted to a mental health facility without making a formal application (3-300(a)); an informal patient is entitled to discharge at any time during the facility's normal day-shift hours (3-300(b)). A voluntary patient, on the other hand, must give written notice of his or her desire to be discharged and then may be discharged "at the earliest appropriate time, not to exceed 5 days, excluding Saturdays, Sundays and holidays ... unless within the 5 day period a petition and 2 certificates are filed with the court" asserting that the patient is subject to involuntary admission (3-403). The court must hold a hearing within 5 days, excluding Saturdays, Sundays, and holidays, after it receives the petition (3-403). Hospitalization may continue pending the court's order (3-403).

Issuance and Modification of Commitment Order

Before the disposition of a commitment case involving an allegedly mentally ill respondent, a mental health facility director, or other court-appointed person, must prepare a report including, among other things, information regarding "the appropriateness and availability of alternative treatment settings," (3-810). If the court finds the respondent to be "subject to involuntary admission," the court must consider the report in determining an appropriate disposition (3-810). A person is "subject to involuntary admission" if he or she is mentally ill

and, thereby, "is reasonably expected to inflict serious physical harm upon himself or another in the near future," or "is unable to provide for his basic needs so as to guard himself from serious harm," (1-119). If the person is found subject to involuntary admission, the court must order "the least restrictive alternative for treatment which is appropriate" (3-811). The court must consider "alternative mental health facilities which are appropriate for and available to the respondent, including but not limited to hospitalization" (3-811). In addition to ordering a respondent to undergo treatment in a public or private hospital or other facility, "the court may place the respondent in the care and custody of a relative or other person willing and able to properly care for him" (3-811). The court may not order alternative treatment unless the alternative program "is capable of providing adequate and humane treatment which is appropriate to the respondent's condition" (3-812(a)). If a court has ordered a respondent into an alternative treatment program, the court has continuing authority to modify its order if the respondent fails to comply with the order or is otherwise unsuitable for the alternative treatment (3-812(b)). Before the court may modify its order, the court must receive from the facility director of the program a report specifying why the alternative treatment is unsuitable and must notify the patient and give him or her an opportunity to respond (3-812(b)).

The least restrictive alternative doctrine is expressly applied in the issuance of a court order committing a developmentally disabled person. A person may be judicially admitted to a facility if the court determines that he or she is mentally retarded and is reasonably expected to inflict serious physical harm upon him or herself or another in the near future (4-500). Before determining a disposition, the court must

consider the diagnostic report and recommendations of any court-appointed examiners (4-609(b)). The court must "select the least restrictive alternative which is consistent with the respondent's needs" (4-609(b)).

Residential Alternatives for the Developmentally Disabled

The "Community Residential Alternatives Licensing Act" was enacted to provide for licensing, regulation, and monitoring of residential alternatives for the developmentally disabled (621). Goals of the Act include promoting participants' "independence, personal growth, self-respect and ability to function in more independent living arrangements" (see 624(b)) and other goals include enabling participants to engage in community activities (see 624(c)), to receive services appropriate to their needs (625(8)), and to participate in decisions regarding their use of programs and services (625(8)).

Administrative Admission of the Developmentally Disabled

Prior to an administrative admission of a developmentally disabled person to a treatment facility, at least one clinical psychologist and one physician must evaluate a person and include in a report of the evaluation "a recommendation as to the least restrictive living arrangement appropriate for the person" (see 4-300 and 4-301). Although the report may be used by a facility director in determining whether to administratively admit a person (see 4-302), statute fails to articulate whether the recommendation concerning the least restrictive arrangement must be considered or adhered to.

If an administratively admitted person, or any interested person, objects in writing to the admission, the admitted person must be discharged at the earliest appropriate time, not more than five days, excluding Saturdays, Sundays, and holidays, after the objection unless a petition and certificate for judicial admission are filed with the court

(4-306). A hearing must be held within five days, excluding Saturdays, Sundays, and holidays (4-307). If the court finds that the person "is not developmentally disabled, that he is not in need of the services which are available at the facility, or that a less restrictive alternative is appropriate, it shall disapprove the admission and order the client discharged," (4-308(a)). If the court finds that the person is developmentally disabled but that a less restrictive alternative is appropriate, the court "may" order the person transferred to a more appropriate facility (4-308(a)).

Conditional and Temporary Release

A facility director may grant a "conditional discharge" if he or she determines that such a discharge is appropriate and consistent with the patient's needs (4-702(a)). "Conditional discharge" means placement out of a facility for continuing habilitation under the facility's or department's supervision (4-702(a)). To provide for aftercare of a conditionally discharged patient, "qualified persons" must consult the patient and his or her family before and at least every six months after discharge (100-16). These quaified persons should determine and advise the family of the existence of "care and occupation most favorable for the patient's continued improvement and return to and maintenance of mental health" (100-16). In addition, a facility director may temporarily release any patient if such release is appropriate and consistent with the patient's needs (4-701(d)). A facility director may temporarily release a mentally ill patient who is not appropriate for discharge if such a release is considered clinically appropriate (3-902(e)).

Other Applications of the Least Restrictive Alternative Doctrine

Patients' Rights. The Code provides that each mentally ill or

developmentally disabled recipient of treatment services has a right to "adequate and humane care and services in the least restrictive environment pursuant to an individual services plan" (2-102(a)). This plan must be formulated and periodically reviewed with the recipient's participation, to the extent possible (2-102(a)).

In addition to this express right to treatment services in the least restrictive environment, the Code sets out specific rights which reflect the least restrictive alternative doctrine. The department director and each facility director may adopt policies and procedures which expand these rights, but must not restrict or limit these rights (2-202). Included among these rights are the rights to not be deprived of any constitutional or statutory rights merely because of receipt of mental health services (2-100); to receive, possess, and use personal property while residing in a facility (2-104); to refuse treatment services unless those services are necessary to prevent the recipient from causing serious harm to him or herself or others (if services are refused, the facility director must inform a recipient or guardian of alternative services available)(2-107); to be free from restraint unless used only as a therapeutic measure (2-108); to be free from seclusion unless used only as a therapeutic measure to prevent harm to the recipient or others (2-109); and to not be "subjected to electroconvulsive therapy, or to any unusual, hazardous, or experimental services or psychosurgery, without his written and informed consent" (2-110).

Pilot Project for Community Residential Alternatives. The Director of the Department of Mental Health is required to have a pilot program established "to demonstrate the effectiveness of a comprehensive continuum of community residential alternatives for the mentally ill with

emphasis on care and treatment of the recidivistic and the long-term institutionalized mentally ill" (100-16.2). As part of this project, a case coordination system linking care at each point in the continuum of alternatives must be established (100-16.2). The purpose of the program is to encourage care in less restrictive components of the continuum (see 100-16.2). The Director is required to designate an employee of the department to supervise and coordinate this program (100-16.2).

Missouri

Missouri law pertaining to the administration of the Department of Mental Health (Chapter 630, RSMo) and its Division of Comprehensive Psychiatric Services (Chapter 632, RSMo) establishes policies, rules, and procedures for provision of services in the least restrictive environment. The statutory basis for the application of the least restrictive alternative doctrine lies in the prescribed goal of the Department of Mental Health: "The department shall ... [m]aintain and enhance intellectual, interpersonal, and functional skills of individuals affected by mental disorders, developmental disabilities or alcohol or drug abuse by operating, funding, and licensing modern treatment and habilitation programs provided in the least restrictive environment possible" (630.020.1.(2)). Section 630.005.1.(17) expressly defines the least restrictive environment as "a reasonably available setting where care, treatment, habilitation or rehabilitation is particularly suited to the level and quality of service necessary to implement a person's individualized treatment, habilitation or rehabilitation plan and to enable the person to maximize his functioning potential to participate as freely as feasible in normal living activities, giving due consideration to potential harmful effects on the person." Patients are entitled to be

"evaluated, treated or habilitated" in the least restrictive environment (630.115.1.(10)).

Specific areas in which the Missouri Legislature has applied the least restrictive alternative doctrine include: (a) preliminary screening and investigation, (b) issuance of 21-day, 90-day, and one-year commitment orders, (c) placement program for mentally disordered persons, (d) continuum of community-based services, and (e) release from or transfer among treatment facilities. Other areas include: (1) patients' rights, (2) administration of electroconvulsive therapy, and (3) use of volunteers in mental health treatment. All these areas are discussed below.

Preliminary Screening and Investigation

Missouri's civil commitment statutes provide for "mental health coordinators" who are required to perform preliminary screening of involuntary civil commitment cases (632.300). Mental health coordinators must be mental health professionals who have "knowledge of the laws relating to hospital admission and civil commitment" (632.005.(10)). Each coordinator serves a designated geographic area or facility (632.005.(10)). Although the statute does not expressly require a mental health coordinator to consider alternatives to commitment or to divert respondents to alternatives, a strict reading of Section 632.300 would permit the coordinator to take such action.

When a mental health coordinator receives information indicating that because of mental disorder a person "presents a likelihood of serious physical harm to himself or others," he or she must "(1) Conduct an investigation; (2) Evaluate the allegations and the data developed by investigation; and (3) Evaluate the reliability and credibility of all sources of information" (632.300.1).

Based on "personal observation or investigation," if the coordinator has reasonable cause to believe that the person is dangerous because of mental disorder, the coordinator "may" file an application for commitment (632.300.2). A strict reading of this last provision permits the mental health coordinator discretion in determining whether or not to file an application even though the criteria are met. A permissive interpretation of this provision would allow the coordinator to pursue alternatives, though this is not required. If the likelihood of harm to self or others is imminent, however, the coordinator would apparently have no discretion. For example, in such emergency circumstances the coordinator "shall" request a peace officer to have the person taken into custody (632.300.2). If the coordinator determines that commitment is inappropriate, he or she might have authority to pursue alternatives. Section 632.300.3. states that he or she "should inform either the person, his family or friends about those public and private agencies and courts which might be of assistance."

Issuance of Commitment Orders

The least restrictive alternative doctrine is expressly applied to the issuance of 21-day (632.335.4), 90-day (632.350.5), and one-year (632.355.3) commitment orders. The commitment criteria applied to each successive hearing are identical. The court must determine (1) that as a result of mental illness, the respondent presents "a likelihood of serious physical harm to himself or to others," and (2) that a facility appropriate to handle the respondent's condition has agreed to accept the respondent (632.335.4; 632.350.5; and 632.355.3). If these criteria are met, the court must order "that the respondent be detained for involuntary treatment in the least restrictive environment for a period not to exceed" the applicable limit (632.335.4, 632.350.5, and 632.355.3).

Placement Program for Mentally Disabled

Section 630.605 provides that the Department of Mental Health should establish "a placement program for persons affected by a mental disorder, mental illness, mental retardation, developmental disability or alcohol or drug abuse." In establishing this placement program, the department is authorized to use "residential facilities, day programs and specialized services which are designed to maintain a person in the least restrictive environment in accordance with the person's individualized treatment, habilitation or rehabilitation plan" (630.605). The department is required to license, certify and fund (to the extent of available funds) a "continuum of facilities, programs and services short of admission to a department facility to accomplish this purpose" (630.605). Before placing a person in a particular residential facility or day program, the department must consider (1) the best interests of the person, (2) the "least restrictive environment for providing care and treatment consistent with the needs and conditions" of the person, (3) the ability of the facility or program to provide that degree of care and treatment as compared with alternative facilities or programs, and (4) the maintenance and encouragement of visits beneficial to the person's relationship with his or her family, guardian or friends (630.615).

Continuum of Community-Based Services

The Division of Comprehensive Psychiatric Services is required to "identify community-based services in each geographic area as entry and exit points into and from the state mental health delivery system offering a continuum of comprehensive mental health services" (632.050). The Division must "provide or arrange for the provision of services in the least restrictive environment to mentally disordered and mentally ill persons based upon their diagnoses and individualized treatment plans on

a continuum of services" (632.055).

Release From or Transfer Among Treatment Facilities

Section 632.385.1 requires the head of a mental health facility to release a voluntary or involuntary patient from the facility to the least restrictive environment when he or she believes that release is in the patient's best interests. The release should include referral to the department's placement program and must include provisions for continuing responsibility to and by the facility (632.385.1). If the patient is an involuntary patient, release to the least restrictive environment may be conditioned on the patient receiving prescribed outpatient care for a period not to exceed the applicable detention period (632.385.2). The facility or agency receiving the patient following release must agree in writing to assume responsibility for providing the prescribed outpatient care in the least restrictive environment (632.385.3). The head of the releasing facility may modify the release conditions if modification is in the patient's best interests (632.385.5). If it becomes necessary to return the patient to inpatient care at the releasing facility, the committing court may, on its own motion, or must, on the patient's motion, order a hearing on the need for the transfer (632.385.5). At any time during a detention period, the head of the detention facility may permit a respondent to leave the facility for prescribed short periods subject to conditions prescribed by the facility head (632.385.4).

Release may occur very early in the commitment process. Whenever 96-hour evaluation and treatment of a respondent has been authorized, a public facility must, and a private facility may, accept the respondent on a provisional basis (632.310.1). If the facility determines that the respondent is not a fit subject for involuntary detention, the facility may immediately release the respondent

(632.310.1). When the application for initial detention and evaluation is made on an emergency basis by a peace officer, but without court authorization, mental health facilities are not required to admit the person even on a provisional basis (632.310.2). When a facility refuses to admit a person, however, the facility must immediately furnish transportation, if not otherwise available, to return the person to his or her residence or to another appropriate place (632.310.3).

Other Applications of the Least Restrictive Alternative Doctrine

Patients' Rights. Each patient, resident or client has an absolute right to be "evaluated, treated or habilitated in the least restrictive environment" (630.115.1.(10)). Several other rights reflect the least restrictive alternative doctrine as well. Unless inconsistent with a person's treatment, each person admitted to a residential facility or day program operated, funded or licensed by the department has rights such as the following: to wear his or her own clothes, to keep and use his or her own possesions, to receive visitors at reasonable times, and to have reasonable access to a telephone for confidential calls (630.110.1). A patient may not be deprived of certain specified rights. Among these are the rights to humane care and treatment, to safe and sanitary housing, to refuse to participate in nontherapeutic labor, to attend or not attend religious services, to be treated with dignity as a human being, to have a nourishing, well-balanced and varied diet, and to be free from verbal and physical abuse (630.115.1).

Administration of Electroconvulsive Therapy. All patients, whether voluntary or involuntary, have the right to refuse electroconvulsive therapy (630.130.1). Strict due process requirements must be adhered to before electroconvulsive therapy may be administered involuntarily. At a full evidentiary hearing where the patient refusing

the therapy is represented by counsel advocating his or her position, it must be shown by clear and convincing evidence that "(1) [t]here is a strong likelihood that the therapy will significantly improve or cure the patient's mental disorder for a substantial period of time without causing him any serious functional harm; and (2) [t]here is no less drastic alternative form of therapy which could lead to substantial improvement in the patient's conditions" (630.130.3). If the petitioner meets the burden of proof, the court may issue an order which sets a maximum number of treatments to be administered over a specified period (630.130.3).

Use of Volunteers in Mental Health Treatment. Section 632.010.2.(10) requires that the Division of Comprehensive Psychiatric Services encourage that volunteers participate in the treatment and rehabilitation of persons affected by mental disorders or mental illness. Volunteers may be used to pursuade these persons to voluntarily seek appropriate treatment services (632.010.2.(10)).

New York

New York statutory law regarding hospitalization of the mentally disabled appears primarily in the Mental Health Act (N.Y. Mental Hygiene Law, Title B (McKinney)) and the Mental Retardation and Developmental Disabilities Act (N.Y. Mental Hygiene Law, Title C (McKinney)). Additional relevant provisions appear throughout the Mental Hygiene Law (§ 1.01 et seq. (McKinney)). The influence of the least restrictive alternative doctrine in the Mental Hygiene Law is apparently minimal. The doctrine is only alluded to in selected provisions articulating legislative policy (7.01, 13.01, and 41.01). One facet of the Mental Health Act policy is to "assure the adequacy and appropriateness of

residential arrangements for people in need of service; and ... [to] rely upon improved programs of institutional care only when necessary and appropriate" (7.01). A policy behind the Mental Retardation and Developmental Disabilities Act is "to develop a comprehensive, integrated system of services to service the full range of needs of the mentally retarded and developmentally disabled by expanding the number and types of community-based services and developing new methods of service delivery" (13.01). One purpose of the Local and Unified Services Law (N.Y. Mental Hygiene Law, Article 41 (McKinney)) is "to enable and encourage local governments to develop in the community preventive, rehabilitative, and treatment services offering continuity of care" (41.01).

The New York Legislature has only applied the least restrictive alternative doctrine in limited areas. Included among these are (a) psychiatric examination prior to involuntary admission on medical certification, (b) hearing following involuntary admission on medical certification, (c) hierarchy of informal status, voluntary status, and involuntary status, and (d) conditional release. Additional areas include: (1) patients' rights, (2) restraint of patients, and (3) community agreements regarding admission procedures.

Psychiatric Examination Prior to Admission on Medical Certification

Upon medical certification of an allegedly mentally ill person by two examining physicians, a hospital director may receive and retain the person as a patient in the hospital (9.27(a)). Before each examining physician completes an examination certificate, however, "he shall consider alternative forms of care and treatment that might be adequate to provide for the person's needs without requiring involuntary hospitalization" (9.27(d)). This provision requires only that each

physician "consider" alternatives but does not require a physician to take any particular action regarding actual alternative placement. A similar requirement is articulated regarding the certification of developmentally disabled persons (15.27(d)).

Hearing Following Admission on Medical Certification

The least restrictive alternative doctrine is apparent in hearings following involuntary admission on medical certification in one limited respect: if the court determines that "relatives of the patient or a committee of his person are willing and able properly to care for him at some place other than a hospital, then, upon their written consent, the court may order the transfer of the patient to the care and custody of such relatives or such committee" (9.31(c)). Because "transfer" is not defined it is unclear whether transfer to relatives or a committee constitutes a "release", meaning mere termination of inpatient care (1.03(29)), or "discharge", meaning release and "termination of any right to retain or treat the patient on an in-patient basis" (1.03(31)). Thus, it is unclear whether a court's exercise of this provision would result in an involuntary placement less restrictive than in-patient care or merely an absolute discharge. This is the only provision in the New York statute which even suggests that a hearing court might order placement less restrictive than hospitalization.

Hierarchy of Admission Classifications

Application of the least restrictive alternative doctrine is implied by the creation of a hierarchy of admission statuses beginning with the least restrictive informal status, followed by voluntary status, and finally involuntary status (see 9.13, 9.15, 9.27, and 9.39). Informal admission is preferred (see 9.21). An informal patient may be admitted without making a formal or written application for admission and

is free to leave the hospital at any time (9.15). A voluntary patient must apply in writing for admission and, prior to being released from the hospital, must apply in writing for release (9.13(b)). Following an application for release, the director must promptly release the patient, unless there are "reasonable grounds for belief" that the patient needs involuntary care and treatment (9.13(b)). The patient may then be retained for up to 72 hours (9.13(b)). A judicial hearing is required before a voluntary patient may be retained beyond 72 hours (9.13(b)).

Voluntary and informal admissions are preferred to involuntary admissions (see 9.21 and 9.23). All state and local officers with responsibilities regarding mentally ill persons have a duty to encourage any person suitable for voluntary or informal admission and "in need of care and treatment" for mental illness to apply for voluntary or informal admission (9.21(a)). "In need of care and treatment" means that a person "has a mental illness for which in-patient care and treatment in a hospital is appropriate" (9.01). If a person requesting admission to a hospital is suitable for either voluntary or informal status, the hospital generally may admit the person on either status (9.21(c)). However, if the person specifically requests informal status, then he or she may be admitted only as an informal patient (9.21(c)). Section 9.23(a) creates a duty in the hospital director to convert "the admission of any involuntary patient suitable and willing to apply therefore to a voluntary status" (9.23(a)). Any patient so converted has the right to a judicial hearing regarding his or her suitability for or willingness to being converted to voluntary status (9.23(b)). The statute creates no duty for the director to convert an involuntary patient to informal status (see 9.23(a)).

Conditional Release

A patient may be conditionally released if he or she "does not require active in-patient care and treatment" (29.15(a)). "A patient may be conditionally released, rather than discharged, when ... the clinical needs of such patient warrant this more restrictive placement ..." (29.15(b)). The conditional release must be in accordance with a written services plan (29.15(f)). This services plan should be prepared by staff familiar with the patient's case history and in cooperation with social services officials and directors of local governmental units (29.15(f)). The patient should be "interviewed, provided an opportunity to actively participate in the development of such plan and advised of whatever services might be available to him through the mental health information service" (29.15(f)). No patient may be released without suitable clothing (29.17). If the patient cannot otherwise obtain money to defray his or her initial expenses, the facility should, upon order of the director or commissioner, provide the patient with up to $50.00 (29.17). Following a conditional release, if the director determines that the patient needs inpatient treatment and care and that the release is no longer appropriate, the director may at any time terminate the release and order the patient to return to the facility (29.15(e)).

Other Applications of the Least Restrictive Alternative Doctrine

Patients' Rights. New York statute does not articulate a specific right to treatment and care in the least restrictive alternative; however, the doctrine is intimated in several provisions regarding patients' rights. For example, Section 33.03(a) provides that "[e]ach patient in a facility and each person receiving services for mental disability shall receive care and treatment that is suited to his needs and skillfully, safely, and humanely administered with full respect

for his dignity and personal integrity." Also, each patient has the following rights: to communicate freely and privately with persons outside the facility (33.05(a)), to have frequent and convenient opportunities to meet with visitors (33.05(b)), and to retain his or her personal belongings (33.07(a)). No person may be deprived of any civil right solely because he or she receives services for mental disability (33.01).

Restraint of Patients. Restraint may be applied "only if less restrictive techniques have been clinically determined to be inappropriate or insufficient" to prevent a patient from seriously injuring him or herself or others (33.04(b)). Only the "camisole," the "full or partial restraining sheet," or "less restrictive restraints authorized by the commissioner" are permissible (33.04(c)). Restraint may be used in an emergency only to the extent necessary to prevent the patient from injuring him or herself or others (33.04(e)). Generally, however, restraint may be used only after a physician has examined the patient and written an order (33.04(d)). While a patient is in restraint, he or she must be monitored to ensure that his or her physical needs, comfort, and safety are properly cared for (33.04(f)).

Community Agreements Regarding Admission Procedures. Community agreements concerning admission procedures may be entered into by a director of community services and the commissioner of mental health should relate to the screening of applications for admission to a facility (29.05). The agreement may provide procedures, among other things, "for offering recommendations on appropriate or alternate modes of care and treatment or any other guidelines on determining options in the community for the care and treatment of an individual" (29.05).

Virginia

Virginia statutory law regarding involuntary civil commitment of mentally disabled persons, found in Va. Code, Title 37.1 ("Institutions for the Mentally Ill; Mental Health Generally"), contains no explicit statement of legislative intent. Several Code provisions, however, suggest that the least restrictive alternative doctrine is a theme underlying Title 37.1. The most salient example is the provision that no mentally ill person may be involuntarily committed to a hospital unless a judge specifically finds that no less restrictive alternative exists (37.1-67.3).

The least restrictive alternative doctrine is applied in several areas of the Code including: (a) prehearing release, (b) preadmission examination, (c) opportunity for voluntary admission at preliminary hearing, (d) requirements concerning the prescreening report from the community services board or community mental health clinic, (e) issuance of a commitment order, (f) judicial certification of mentally retarded persons' admission eligibility, and (g) alternative placement after admission. Additional areas include: (1) patients' rights, (2) community mental health and retardation programs, (3) court-ordered medical treatment, (4) discharge of patients not fully recovered, and (5) appointment of guardians.

Prehearing Release

Prior to the preliminary and commitment hearings a judge may release the allegedly mentally ill person (rather than issue an order of temporary detention) on his personal recognizance or on bond "if it appears from all evidence readily available that such release will not pose an imminent danger to himself or others" (37.1-67.1). This

opportunity to avoid detention while awaiting a hearing implies the influence of the least restrictive alternative doctrine.

Preadmission Screening

Each person presented for admission to a hospital must be examined by one or more staff physicians within 24 hours after arrival (37.1-70). If the examination reveals insufficient cause to believe that the person is mentally ill, then the person must be returned to the locality in which the petition was initiated or in which the person resides (37.1-70). To prevent inappropriate admissions to Department facilities or programs, the State Mental Health and Mental Retardation Board is required to promulgate rules and regulations (37.1-70).

Although the Code does not precisely state when such preadmission examinations should take place, the two most likely interpretations are (a) when the person is transported to the hospital for prehearing detention and (b) when the person is brought to the hospital following a commitment hearing. At either point in the commitment process, this provision allows mental health professionals to make a determination concerning a person's need for hospitalization.

Opportunity for Voluntary Admission at Preliminary Hearing

When a person subject to a temporary detention order is brought before a judge (or magistrate), the judge must inform the person of his or her right to apply for voluntary admission (37.1-67.2) and must hold a preliminary hearing to determine if the person is "willing and capable of seeking voluntary admission and treatment" (37.1-67.2). If the judge ascertains that the respondent is then "willing and capable" of seeking voluntary admission, then such treatment must be granted (37.1-67.2). Persons who agree to voluntary admission must accept treatment for a

minimum period "not to exceed 72 hours, after which they must give the hospital 48 hours notice before leaving" (37.1-67.2). They are subject to prescreening by the community services board or community mental health clinic (37.1-67.2; see 37.1-65) and are subject to being transported to the hospital by procedures identical to those used for certified persons (see 37.1-67.2 and 37.1-71).

Prescreening Report

If a person has not been examined by a psychiatrist before the commitment hearing, the judge must request a prescreening report from the community services board or community mental health clinic where the person resides (37.1-67.3). The board or clinic must provide the report within 48 hours of the court's request (or 72 hours if the 48 hour period terminates on a Saturday, Sunday, or legal holiday) (37.1-67.3). The report must state whether the person is mentally ill, whether the person is an imminent danger to himself or others and in need of involuntary hospitalization, and whether no less restrictive alternative to hospitalization is available (37.1-67.3). In addition, the report must include recommendations for the person's care and treatment (37.1-67.3). If the judge does not receive the report within the specified time, he or she must dispose of the case without the board or clinic's recommendations (37.1-67.3).

Issuance of Commitment Order

No mentally ill person may be involuntarily committed to a hospital unless the commitment hearing judge specifically finds that the person:

> (a) presents an imminent danger to himself or others as a result of mental illness, or (b) has otherwise been proven to be so seriously mentally ill as to be substantially unable to care for

> himself, and (c) that there is no less restrictive alternative to institutional confinement and treatment and that the alternatives to involuntary hospitalization were investigated and were deemed "not suitable ..."

(37.1-67.3). If the judge finds that the above criteria are met, he or she must order the mentally ill person removed to the hospital for a period not to exceed 180 days (37.1-67.3). If the person meets criteria (a) and (b) but is not in need of involuntary hospitalization, the person "shall be subject to court-ordered out-patient treatment, day treatment in a hospital, night treatment in a hospital, referral to a community mental health clinic, or other such appropriate treatment modalities as may be necessary to meet the needs of the individual" (37.1-67.3).

The commitment hearing judge may have one additional placement alternative, although it is unclear whether this placement alternative is available to the commitment hearing judge, whether this placement should occur at a subsequent hearing, or whether this placement may occur at either time. If a responsible person posts bond payable to the state and agrees "to restrain and take proper care" of a mentally ill person, either before the person's admission or after his or her admission but before removal to a hospital, "then the judge may, in his discretion, commit such mentally ill person to the custody of such person" (37.1-125).

Certification of Mentally Retarded Persons' Admission Eligibility

Mentally retarded persons may seek hospitalization under the same procedures as may mentally ill persons (37.1-65). Whenever a person alleged to be mentally retarded is not capable of requesting his or her own admission to a treatment facility as a voluntary patient, a parent or guardian or other responsible person may initiate a proceeding to obtain a judicial certification of eligibility for admission (37.1-65.1.A). Certification of eligibility for admission of a mentally retarded person

is not a judicial commitment (37.1-65.1.D). Such certification merely empowers a parent or guardian or other responsible person to admit the person to a facility and empowers the facility to accept the admission (37.1-65.1.D). Prior to initiating this proceeding, the petitioner must obtain a prescreening report recommending admission from the community services board or community mental health clinic, and the approval of the proposed admitting facility (37.1-65.1.B). At the hearing the judge must certify the mentally retarded person's eligibility for admission if he or she finds:

> (i) that such person is not capable of requesting his own admission, (ii) that the facility has approved the proposed admission ..., (iii) that there is no less restrictive alternative to institutional confinement, consistent with the best interests of the person who is the subject of the proceeding, and (iv) that such person is mentally retarded and in need of institutional training or treatment ...

(37.1-65.1.C.3). Unlike provisions regarding court-ordered treatment of the mentally ill, the Code lists no specific alternatives to institutional treatment for which the court may certify a mentally retarded person's eligibility (compare 37.1-67.3 and 37.1-65.1.C.3).

Alternative Placement Following Admission

The director of each state hospital is authorized to place any patient of the facility in any of several less restrictive alternatives. For example, patients who are "quiet and not dangerous" may be placed in private homes with families (37.1-121). The cost of board and lodging in a private home is borne by "[a]ny patient so placed at board or the estate of any such patient or the person legally liable for the support of any such patient" (37.1-121). The director may also place patients in private homes or other facilities with provisions for special training if he or she believes that the patient will benefit from the training

(37.1-122), or in nursing homes or other institutions licensed by the state (37.1-123).

Other Applications of the Least Restrictive Alternative Doctrine

Patients' Rights. Each patient or resident of a facility operated, funded, or licensed by the Department of Mental Health and Mental Retardation has a right to be treated "under the least restrictive conditions consistent with his condition and not be subjected to unnecessary physical restraint and isolation" (37.1-84.1(6)). This and other rights enumerated in the Code may not be limited except "on the basis of legal incompetence as adjudicated by a court of competent jurisdiction ..." (37.1-84.1). Other enumerated rights which reflect the least restrictive alternative doctrine include the rights to retain legal rights provided by state and federal law (37.1-84.1(1)), to be treated with dignity as a human being (37.1-84.1(2)), to not be subjected to experimental or investigation research without giving consent (37.1-84.1(4)), and to be allowed to send and receive sealed letters (37.1-84.1(7)).

Community Mental Health and Retardation Programs. In an apparent effort to promote the development of community alternatives, the legislature has authorized the Department to make matching grants to any county, city, or political subdivision if the population exceeds a specified minimum (see 37.1-194). The Code requires the State Mental Health and Retardation Board to determine, subject to the General Assembly's approval, a core of community services to be provided by the community services boards by July 1, 1982 in order to provide comprehensive community services (37.1-194). These services may include outpatient diagnostic and treatment services, therapeutic communities, halfway houses, group homes or other residential facilities, community

residences for the mentally ill and mentally retarded, and other specified services (see 37.1-194).

Court-Ordered Medical Treatment. The Code authorizes the circuit court to order treatment of physical injury or illness if because of mental or physical condition a person is incapable of giving informed consent to treatment (37.1-134.2). Limitations on the court's power to make such an order, however, suggest the influence of the least restrictive alternative doctrine. The court may only order treatment if the treatment is medically necessary, if "no legally authorized guardian or committee [is] available to give consent," if an attorney has been appointed to represent the person's interests, and if evidence is presented concerning the person's condition and proposed treatment (37.1-134.2). No court-ordered treatment for any mental, emotional, or psychological condition is authorized under this provision (37.1-134.2).

Discharge of Patients Not Fully Recovered. A state hospital director's authority to discharge is not limited to patients who have fully recovered, or who have been determined to be not mentally ill (see 37.1-98). The director may discharge a patient who is still impaired, but who "will not be detrimental to the public welfare, or injurious to the patient" (37.1-98.A.3). This provision would apparently permit the director to discharge a patient for whom hospitalization is not the least restrictive alternative. Prior to discharging such a patient, the director must formulate a predischarge plan in cooperation with the community services board or community mental health clinic (37.1-98.A).

Appointment of Guardians. The appointment of guardians for those determined to be incapacitated because of mental illness or mental retardation (37.1-128.1), and for those who because of age or impaired health are incapable of taking care of their person or property

(37.1-132) may provide an additional alternative to institutionalization. Furthermore, the powers and duties of the guardian are limited by the incapacitated person's ability to "care for himself and manage his property to the extent that he is capable" (37.1-128.1; 37.1-132).

Wisconsin

The overriding legislative policy of the Wisconsin State Mental Health Act (Wis. Stat. Ann., Chapter 51) is to assure the provision of a full range of mental health treatment and rehabilitation services while protecting personal liberties by application of the "least restrictive alternative" doctrine (51.001). No person who can be adequately treated on an outpatient basis may be involuntarily treated on an inpatient basis (51.001). The State Mental Health Act envisions a unified system of mental health services which will assure all people in need of care access to the least restrictive treatment alternative appropriate to their needs, and which will assure continuity of care by promoting movement through all treatment components (51.001). The Act provides for the establishment of "community boards" to carry out this policy (see 51.42(1)(a) and (3)). Each community board is responsible, among other duties, for continuous planning, development and evaluation of treatment and care programs and services, and for coordination of local services and continuity of care where required (51.42(5)(h)).

In addition to articulating this general legislative policy, the Wisconsin Legislature has applied the least restrictive alternative doctrine in several specific areas including: (a) release of the respondent pending probable cause and final hearings, (b) detention, probable cause, and commitment criteria, (c) mental health examination

prior to a final involuntary commitment hearing, (d) issuance of a final commitment order, (e) treatment and transfer after final commitment order, and (f) periodic review of the commitment. Additional areas include: (1) patients' rights, and (2) voluntary admission to a treatment facility. Each of these areas is discussed below.

Release Pending Probable Cause and Final Hearings

If a law enforcement officer has a detention order issued by a court, or if the officer has cause to believe that an individual meets emergency detention and commitment criteria, the officer generally must take the individual into custody and see that he or she is delivered to a detention facility for detention pending the probable cause hearing (51.20(2)). The State Mental Health Act provides, however, that an individual need not be detained in all circumstances (see 51.20(2)). The statute fails to clearly state under what circumstances an individual should be released, or not initially detained, pending probable cause hearing. One possible circumstance, inferred from a comparison of 51.20(2) and 51.15(1), might be if the officer believes that an individual meets emergency detention criteria but not the final commitment criteria.

Following a finding of probable cause, a court may release an individual pending the final commitment hearing (51.20(8)). During the release, the individual may voluntarily receive treatment services from the board or the department (51.20(8)). The court may condition the release on the individual's acceptance of treatment and may specify the action to be taken if the individual breaches a treatment condition (51.20(8)). If acceptance of treatment is a condition of release, the individual may elect detention instead (51.20(8)).

Detention, Probable Cause, and Commitment Criteria

The criteria for emergency detention pursuant to involuntary commitment (51.15(1)(a)3 and 4), nonemergency petition for involuntary civil commitment (51.20(1)(a)2.c and d), and probable cause hearing (51.20(1)(1m)), may be dealt with jointly. According to these provisions, in two limited situations a person may not be detained or committed, nor may probable cause be found, "if reasonable provision for the individual's protection is available in the community." Both situations arise only if the behavior which spurred others to seek an individual's commitment poses a threat to the individual himself or herself but not to others. The first situation occurs if the individual evidences a "substantial probability of physical impairment or injury to himself or herself due to impaired judgment ..." (51.15(1)(a)3; 51.20(1)(a)2.c; and 51.20(1)(1m)). The second occurs if "due to mental illness or drug dependency, he or she is unable to satisfy basic needs for nourishment, medical care, shelter or safety without prompt and adequate treatment ..." (51.15(1)(a)4; and 51.20(1)2.d). If the individual is suicidal or homicidal, detention or commitment will not be barred by the availability of protection in the community (see 51.15(1)(a)1 and 2; and 51.20(1)(a)2.a and b). The interaction between the "reasonable provision in the community" standard and the authorization of outpatient commitment (51.20(13)(a)3 and (dm)) is unclear.

Prehearing Mental Health Examination

Two court-appointed mental health examiners must conduct independent examinations of a respondent after the probable cause hearing but before the final hearing to determine if, among other things, the respondent is a proper subject for treatment (51.20(9)(a) and (b)). If

an examiner determines that the respondent is a proper subject for treatment, the examiner should include in his or her written report to the probate court a recommendation concerning the appropriate level of treatment (51.20(9)(b)). That recommendation must include "the level of inpatient facility which provides the least restrictive environment consistent with the needs of the individual, if any ..." (51.20(9)(b)). Prior to disposition, the final hearing court may order the staff of the appropriate community board, or the staff of a public treatment facility (if the respondent is detained there pending final hearing), to provide additional information concerning the recommended level of treatment (51.20(9)(b)).

Issuance of a Final Commitment Order

If commitment criteria are met, unless the respondent was or is to be transferred from a state correctional facility or jail or is a non-resident, the court must order commitment to the care and custody of the appropriate community board, "or if inpatient care is not required order commitment to outpatient treatment under the care of such board ..." (51.20(13)(a)3, 4, and 5). The community board then must arrange for treatment in the least restrictive manner consistent with the individual's needs and the maximum level of inpatient facility, if any, designated in the court order (51.20(13)(c)2). If the court finds that the respondent's dangerousness can be controlled with medication administered on an outpatient basis, the court may order that the community board may release the respondent on the condition that he or she take prescribed medication and report to a particular treatment facility as often as required for outpatient evaluation (51.20(13)(dm)).

Treatment and Transfer after Final Commitment Order

The board to which a patient is committed must provide "the

least restrictive treatment alternative appropriate to the patient's needs, and movement through all appropriate and necessary treatment components to assure continuity of care" (51.22(5)). If the final hearing court orders commitment, the treatment disposition prescribed in the court order may be modified as provided in 51.35 (51.20(13)(d)). Under 51.35, the department or board may transfer any patient committed to it between treatment facilities (including but not limited to inpatient, outpatient, and rehabilitation programs (see 512.01(19))) or from a facility into the community if such a transfer is consistent with reasonable medical or clinical judgment and with the least restrictive alternative doctrine (51.35(1)(a)). As part of a transfer to a less restrictive treatment alternative, the department or board may impose terms and conditions beneficial to the patient (51.35(1)(a)). When such a transfer to a less restrictive environment is made subject to such conditions, it is called a "conditional transfer" (51.01(4)). At the time of the transfer, the patient must be informed of the consequences of violating the terms and conditions, including transfer back to a more restrictive setting (51.35(1)(a)).

If a transfer back to a more restrictive facility occurs within seven days of a temporary transfer from that facility and the return was part of a previously established plan of which the patient had notice at the time of the temporary transfer, then no due process rights attach (see 51.35(1)(e)). Also, no due process rights attach, and no "transfer" occurs, when a patient transferred to a medical facility for non-psychiatric medical services is returned to the original facility (51.35(1)(f)). Certain due process rights do attach, however, to any other transfer to a more restrictive setting (see 51.35(1)(e)). Whenever a transfer is from outpatient to inpatient status, or whenever a transfer

between treatment facilities results in greater restrictions of the patient's personal freedom, the patient must be informed orally and in writing of his or her rights to contact an attorney and a member of his or her family, to have an attorney provided at public expense (if the patient is indigent), and to petition a court where the patient is located, or the committing court, for a review of the transfer (51.35(1)(e)).

The department generally may transfer a patient only after notifying the community board of its intent to do so (51.35(1)(d)3). The department must also notify the patient's guardian, if any (51.35(1)(d)3). However, if the transfer is from a state treatment facility or other inpatient facility to an approved treatment facility which is less restrictive of the patient's personal freedom, the department may transfer the patient without the board's approval (51.35(1)(d)1).

Periodic Reevaluation

The purpose of periodic reevaluations is to determine whether the person "has made sufficient progress to be entitled to transfer to a less restrictive facility or discharge" (51.20(17)). These reevaluations must be conducted by the treatment staff or a visiting physician within 30 days after the commitment, within 3 months after the initial reevaluation, and again thereafter at least once each 6 months (51.20(17)).

Other Applications of the Least Restrictive Alternative Doctrine

Patients' Rights. Each "patient" has the "right to the least restrictive conditions necessary to achieve the purposes of admission, commitment, or placement" (51.61(1)(e)). The definition of "patient" is expansive and generally includes persons receiving either inpatient or

outpatient services (see 51.61(1) and (3)). Each patient must be informed orally and in writing of this and other specified rights upon admission or commitment (51.61(1)(a)). Numerous additional rights which connote "restrictiveness" concerns are noted in the State Mental Health Act. These include the rights to petition the court for review or withdrawal of the commitment order, to receive prompt and adequate treatment, rehabilitation and educational services appropriate for the patient's condition, to refuse all but court-ordered medication and treatment, to be free from unnecessary or excessive medication at any time, to be free from physical restraint and isolation, to not be subjected to drastic treatment procedures such as psychosurgery without the patient's express and informed consent after the patient has consulted his or her counsel and legal guardian (if any), to exercise religious worship, to have a humane psychological and physical environment, to have confidentiality of all treatment records, to not be filmed or taped, to make and receive telephone calls within reasonable limits, to use and wear his or her own clothing and personal articles, to have a reasonable amount of individual secure storage space for his or her own private use, to have reasonable protection of privacy, and to see visitors each day (see 51.61(d), (f) through (t)). Any of these rights, including the "least restrictive conditions" right, may be denied for cause if specified procedural safeguards are followed (see 51.61(2)).

Voluntary Admission. An adult who meets the criteria for voluntary admission under 51.10(4) (i.e., mentally ill, developmentally disabled, or alcohol or drug dependent, and may benefit from inpatient care, treatment, or therapy) may be voluntarily admitted to an inpatient treatment facility provided one of two procedures is followed. The first procedure requires only that the person apply for admission in writing

(51.10(4m)(a)2). The second procedure must be followed if the person does not apply for admission in writing. It requires a facility physician to advise the person of a patient's right to the least restrictive form of appropriate treatment and of the facility's responsibility to provide that treatment (51.10(4m)(a)1). The physician must sign and submit a request for voluntary admission and must certify in writing, before at least two witnesses, that in the presence of the witnesses he or she has orally and in writing advised the incoming patient regarding these matters (51.10(4m)(a)1). Under this second procedure, any patient who fails to indicate a desire to leave but who refuses or is unable to request admission in writing is presumed to consent to admission and may be held up to seven days (51.20(4m)(b)). On the first day that the probate court conducts business following the admission, the facility must notify the court of the admission (51.10(4m)(c)). Within 24 hours of receiving notice, excluding Saturdays, Sundays, and holidays, the court must appoint a guardian ad litem to visit the facility and determine whether the above procedures have been followed (51.10(4m)(c)). The guardian ad litem must visit the patient within 48 hours, excluding Saturdays, Sundays, and holidays, to determine if the patient desires less restrictive treatment and, if so, must assist the patient in obtaining proper assistance from the facility (51.10(4m)(c)).

CHAPTER TWO: CASE LAW REVIEW

The least restrictive alternative doctrine has been advanced by courts as well as legislatures. This chapter identifies and provides brief descriptions of selected cases at the state and federal levels that address the use of the least restrictive alternative. Most of these cases concern involuntary placement of individuals in mental health facilities following either a civil commitment or a finding of incompetency to stand trial for a criminal offense. A few deal with the placement of juveniles in correctional facilities following an adjudication of delinquency. Additionally, several decisions by the U.S. Supreme Court that focus on issues or discuss concepts closely related to use of the least drastic means are summarized.

The U.S. Supreme Court decisions are listed first, followed by the decisions of the lower federal courts, with each set listed in reverse chronological order. Finally, decisions of the state courts are listed alphabetically by state and in reverse chronological order.

United States Supreme Court

Youngberg v. Romeo, 457 U.S. 307 (1982).

Romeo was a profoundly retarded resident of the Pennsylvania Institution for the Mentally Retarded. Suit was brought on his behalf as a result of injuries he suffered at the institution. The petitioners alleged that institutionalized persons have a right to safe confinement conditions, to freedom from restraint, and to training or habilitation. The petitioners sought damages for the violation of these rights.

The United States Supreme Court concluded that persons in Romeo's position have constitutionally protected liberty interests in safety and freedom from bodily restraint and that:

> [T]he state is under a duty to provide ... such training as a professional would consider reasonable to ensure ... safety and to facilitate [the] ... ability to function free of bodily restraints.

Pennhurst State School and Hospital v. Halderman , 451 U.S. 1 (1981).

The plaintiff, a mentally retarded minor filed suit on behalf of herself and other residents of the Pennhurst School, a Pennsylvania facility for retarded persons, seeking injunctive and monetary relief because of the "unsanitary, inhumane, and dangerous conditions at the school." The trial court found that conditions at the school were dangerous, that residents were often beaten or drugged, and that habilitation was so inadequate that the physical, intellectual and emotional skills of some residents actually deteriorated. It held that this violated the residents' constitutional rights to due process, to equal protection of the law, and to freedom from cruel and unusual punishment. The trial court also held that the residents had a right under the federal constitution and federal and state statutes to be provided with "minimally adequate habilitation" in the least restrictive environment whether they were voluntarily or involuntarily committed.

The United States Court of Appeals affirmed the trial court's remedial order, but based its decision solely on the Federal Developmentally Disabled Assistance and Bill of Rights Act (D.D. Act), which includes a bill of rights provision prescribing the right of mentally retarded persons to "appropriate treatment, services, and habilitation" in the setting that least restricts a person's liberty. The United States Supreme Court reversed, concluding that the bill of rights provision was advisory and not obligatory even for states accepting funds under the act. Thus, there is no federal statutory right to habilitation through the least restrictive alternative for persons covered by the D.D. Act.

Addington v. Texas, 441 U.S. 418 (1979).

The respondent was involuntarily civilly committed. On appeal he alleged, among other things, that the level of proof in commitment proceedings should be greater than a mere preponderance of the evidence.

The United States Supreme Court concurred, holding that there should be at least clear and convincing proof of commitability (a middle ground between the preponderance standard and the beyond a reasonable doubt standard) before a person can be institutionalized. In its decision the Court observed that the state of mental health knowledge was too limited to require proof beyond a reasonable doubt that a person is mentally ill and dangerous. Also:

> At one time or another, every person exhibits some abnormal behavior which might be perceived by some as symptomatic of a mental or emotional disorder ... . Obviously, such behavior is not basis for compelled treatment and surely not for confinement ... . Loss of liberty calls for a showing that the individual suffers from something more serious than is demonstrated by idiosyncratic behavior.

Increasing the level of proof required was seen as one way of reducing the chances of inappropriate commitment.

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

A patient at a state mental hospital sued the hospital superintendent and staff for damages. At trial, the evidence showed that the plaintiff had been confined in the hospital for nearly 15 years following civil commitment, that for most of this period this confinement "was a simple regime of enforced custodial care, not a program designed to alleviate or cure his supposed illness," and that confinement continued even after the plaintiff was not a danger to himself or others.

The United States Supreme Court concluded that a state "cannot constitutionally confine [without treatment] a non-dangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends."

Jackson v. Indiana, 406 U.S. 715 (1972).

Jackson, an allegedly retarded deaf mute, was charged with committing two robberies. He was found incompetent to stand trial and committed to a state hospital until such time as he could be certified as competent. He appealed, arguing that under the circumstances, commitment constituted a life sentence without conviction of a crime.

The United States Supreme Court agreed, holding that a defendant "cannot be held more than the reasonable period of time necessary to determine whether there is a substantial probability that he will attain competency in the forseeable future." It emphasized that:

> [T]he nature and duration of commitment [must] bear some reasonable relation to the purpose for which the individual is committed.

Shelton v. Tucker, 364 U.S. 479 (1960).

This case is an articulate statement of the least drastic means principle as applied to the government's intrusion into personal liberties. It concerned an Arkansas statute requiring every public school or state college teacher, as a condition of employment, to file annually a list of every organization to which he or she belonged or contributed to regularly within the preceding five years. In striking down this law because it deprived teachers of the right to associational freedom guaranteed by the Due Process Clause of the Fourteenth Amendment, the U.S. Supreme Court stated that:

> [E]ven though the governmental purpose be legitimate and substantial, that purpose cannot be pursued by means that broadly stifle fundamental personal liberties when the end can be more narrowly achieved. The breadth of the legislative abridgment must be viewed in the light of less drastic means for achieving the same basic purpose.

Lower Federal Courts

Caswell v. Secretary of Health and Human Services No. 77-0488-CV-W-8 W.D. Mo. Feb. 8, 1983).

In Missouri, a comprehensive 75 page consent decree settled a class action suit filed to obtain care and treatment in the least restrictive environment for residents of a large, state mental institution. The agreed-upon plan for gradual deinstitutionalization included a uniform system for clinically reviewing inpatients, providing individualized treatment plans, and referring patients to the department of mental health's community placement branch. Clinicians are designated as case managers and advocates for each patient within the hospital, and other staff perform similar functions for individuals when they are placed in the community. The provision of a continuum of residential and support services is the responsibility of the department of mental health and the hospital.

(Excerpted from Mental Disability Law Reporter, 1983, 7 (3), 221)

Halderman v. Pennhurst State School & Hospital. 707 F.2d 702 (3rd Cir. 1983).

The parents of a retarded child objected when the state hospital sought to move the child to a less restrictive setting in the community. They sued to block the transfer.

The United States District Court found the transfer to be both "voluntary" and "more beneficial," and directed that it proceed. The parents appealed. The U.S. Court of Appeals reversed the trial court's decision ruling that the trial court had incorrectly placed on the parents the burden of proving that the proposed transfer would harm their child. The court concluded that even if community placement were shown to be better, absent proof of poor treatment at the institution or a "significant countervailing governmental interest," the parents' views "should have been given the substantial if not dominant role in that transfer decision."

Doe v. Public Health Trust of Dade County, 696 F.2d 901 (11th Cir. 1983).

The parents of a teenager voluntarily admitted their daughter for a one week evaluation period at an adolescent psychiatric ward. They were told that during this period there could be no communication between them and their child. At the conclusion of the week, they agreed to an extended admission during which their daughter would have to earn all privileges including that of communicating with her parents. After a month, they still were not allowed to communicate. Hospital officials declined to give the parents information about their daughter's condition. They discovered that she was not being treated for a kidney ailment as had been requested, and that she was being treated, without permission, for an unnamed gynecological problem.

The father sued the hospital alleging that the hospital's strict enforcement of the non-communication rule denied his constitutional right

to exercise his parental duty to protect his child's interest. It was further argued that the enforcement of the rule violated his daughter's right to treatment in the least restrictive setting. The hospital moved to dismiss. The United States District Court granted the motion. The father appealed and the dismissal was overturned by the U.S. Court of Appeals. In its order, the appellate court directed the District Court to decide whether the noncommunication rule was therapeutic and medically legitimate and whether the girl had become, in fact, an involuntary patient.

In it's decision, the Court of Appeals reasoned that because a "voluntary patient carries the key to the hospital's exit in her hand," the least restrictive environment requirements that apply to involuntarily admitted patients do not necessarily apply to those admitted voluntarily.

Association for Retarded Citizens of North Dakota v. Olson, 561 F. Supp. 473 (D. N.D. 1982).

This class action suit was brought by and on behalf of residents of the North Dakota facilities for the mentally retarded. The case went to trial after the state failed to comply adequately with the terms of a consent decree.

The United States District Court concluded initially that even though most of the residents had been admitted with the consent of their parents or guardian, they should not be considered voluntary patients since they did not or could not voluntarily consent. Even if they had, the court reasoned, they retained "residual rights to liberty" that:

> ... are violated when the institution officials or their agents place the resident in conditions which are not reasonably safe or which result in unreasonable curtailment of the person's freedom of movement.

The judge then analyzed the U.S. Supreme Court's decision in Youngberg v. Romeo (see above) concluding that the right to the least restrictive alternative discussed in the earlier consent decree was not unlimited. The opinion concludes that:

> ... a constitutional right to the least restrictive method of care or treatment exists only insofar as professional judgment determines that such alternatives would measurably enhance the resident's enjoyment of basic liberty interests.

Based on this analysis and on state law, the court ordered, among other things, that:

- individualized habilitation plans be developed for each resident;
- restraints may be used only as part of a habilitation program "designed to lead to a

less restrictive habilitation program ... [using] less restrictive means of behavior management" and not for punishment or staff convenience;

- a comprehensive system of community based resources must be developed; and that
- no one may be admitted to the institution unless it is demonstrated that no less restrictive appropriate setting is available.

Kentucky Association for Retarded Citizens v. Conn, 510 F. Supp. 1233 (W.D. Ky. 1980), aff'd, 674 F.2d 582 (6th Cir. 1982), cert. denied, 103 S.Ct. 457 (1982).

Seeking to block construction of a new hospital for mentally retarded persons, plaintiff asserted that all mentally retarded persons have the right to treatment in "the least restrictive environment possible," that is, in small, community-based facilities and programs, approximating as nearly as possible the living conditions of society in general.

Both the trial and appellate courts concluded the plaintiffs did have a right to the least restrictive alternative under Kentucky law but that "some severely and profoundly retarded persons may be institutionalized." Accordingly, it saw "no reason" why the new modern facility could not be built. The court also observed that placement decisions are "best left to mental health professionals."

Johnson v. Brelje, 521 F. Supp. 723 (N.D. Ill. 1981).

Plaintiffs in this class action were found unfit to stand trial. Some members of the class were transferred to a maximum security facility immediately after the finding. Others were transferred there after an initial placement in a less restrictive facility.

The United States District Court held that following a hearing at which the patient is accorded procedural due process protections, the transfer must be found to be "consistent with the patient's individual treatment needs and ... the patient's need for a secured [sic] setting.

Project Release v. Prevost, 551 F.Supp. 1298 (E.D. N.Y. 1982).

Project Release, a nonprofit organization composed of current and former mental health patients, and Carrie Greene, a state mental patient, brought this action against the Commissioner of the New York State Department of Mental Hygiene and Office of Mental Health to challenge the constitutionality of the voluntary, involuntary and emergency commitment procedures contained in New York Mental Hygiene Law sections 9.13, 9.27, and 9.39. The plaintiffs complained that the statutes were unconstitutional on their face because they failed to include over a dozen specified substantive and procedural due process rights, one of which was the right to receive treatment in a less restrictive setting.

The court upheld the constitutionality of all the challenged commitment procedures. The court summarily dismissed plaintiffs' least restrictive alternative argument, stating that mental health law Section 9.27(d) already required the consideration of "whether the patient's needs can be met in any less restrictive setting." The court referred to Kesselbrenner v. Anonymous, 33 N.Y. 2d 161, 350 N.Y.S. 2d 889 (1973), to support its position on the least restrictive alternative challenge.

Scott v. Plante, 641 F.2d 117 (3rd Cir. 1981), vacated, 102 S. Ct. 3474 (1982); remanded 691 F.2d 634 (1982).

The plaintiff was indicted in 1954 for killing his grandmother. He was found incompetent to stand trial and sent to the maximum security building of the Trenton State Psychiatric Hospital. The indictment was eventually dismissed, but Scott remained at the maximum security unit receiving little psychiatric treatment for over 24 years. After he repeatedly attempted to gain relief through the courts, the U.S. District Court heard his claims. A jury granted $25,000 in compensatory and punitive damages but the judge denied his requests for transfer and improvement of the conditions. The plaintiff appealed the denials.

The United States Court of Appeals observed that "courts have a duty to guard against unnecessary personal restraints ... " and ordered that Scott was entitled to a hearing at which the hospital must demonstrate "that it had considered alternative security accommodations ... and ... explain why it had found them inadequate." The appellate court commented that:

> ... any reservations over applying least restrictive analysis to the conditions of temporary detainment must yield when the deprivation of liberty can last as long as 24 years or more.

The Court of Appeals also directed that if no less restrictive alternative existed, relief from the "intolerable physical conditions" should be ordered as well as the provision of therapeutic, not merely custodial, treatment.

The defendants sought review by the U.S. Supreme Court. That court remanded the case to the Court of Appeals in light of the decision in Youngberg v. Romeo. The Court of Appeals reconfirmed its prior judgment sending the case back to the trial court for determination of the relief and damages to which Scott was entitled.

Philipp v. Carey, 517 F. Supp. 513 (N.D. N.Y. 1981).

The plaintiffs in this action were voluntary, mentally retarded patients at the Syracuse Developmental Center. A principal issue was whether voluntarily admitted persons enjoy a right to treatment in the least restrictive setting. The United States District Court addressed this question in determining whether to grant the defendants' motion to dismiss; however, the court stated that it "in no way expresses an opinion on the ultimate merits of the plaintiffs' claims." The court concluded that, in raising the least restrictive alternative issue, the plaintiffs had stated a cause of action for which relief could be granted.

The court said that "it seems generally accepted that involuntarily committed persons enjoy a right to treatment in settings that pass muster under an appropriate least restrictive alternative inquiry." Some courts have characterized the least restrictive alternative analysis as a component of the "compelling necessity" scrutiny often accorded governmental action, while other courts have adopted a substantive due process analysis such as that used in Shelton v. Tucker, 364 U.S. 479 (1960). In addition to differing in general characterization of the inquiry, courts also differ regarding what the least restrictive alternative requirement entails. Citing specific cases, the court said that "[o]ne court has written in terms of subjective 'good faith attempts' to place persons in appropriate settings ... . Another court has described a duty to "explore and provide ... practical alternatives to confinement ... ." Another has asked "whether the mode of treatment is 'overly restrictive of liberty on a comparative basis.'" A final approach that is deferential to medical judgments in individual cases, probes into "which of two or more major treatment approaches is to be adopted" in regard to "initial environmental disposition, not to ongoing therapeutic regimens or medical prescriptions."

The court said that, regardless of the version of inquiry adopted, the controversy between the parties concerned whether voluntary patients enjoy the same right to treatment in a proper setting that civilly committed patients do. On that question the courts are split. Citing Parham v. J.R., 442 U.S. 584 (1979), the court concluded that the courts should be quick to guard against unnecessary impairments of patients' "substantial liberty interest in not being confined unnecessarily for medical treatment."

Medley v. Ginsberg, 492 F.Supp. 1294 (S.D. W.Va. 1980).

This was a class action brought by institutionalized, mentally retarded children and young adults seeking an order prohibiting the defendants from maintaining the plaintiffs in an institution or state hospital in lieu of providing appropriate care in foster homes or other community-based facilities in their home communities. In denying the defendants' motion for summary judgment, the United Stated District Court stated that "several courts have recognized or alluded to the right to treatment or habilitation in the least restrictive setting pursuant to the due process clause ... ." From the allegations it appeared that long-term institutionalization of Medley was inappropriate and that she remained institutionalized because no foster homes or other residential community placements were available.

Rennie v. Klein, 476 F. Supp. 1294 (D. N.J. 1979), modified 653 F.2d 836 (3d Cir. 1981), vacated and remanded ___ U.S. ___, 102 S.Ct. 3506 (1982) (for further consideration in light of Youngberg v. Romeo).

Residents of New Jersey mental hospitals sued to halt the involuntary administration of psychotropic drugs. The United States District Court issued a detailed preliminary injunction setting forth comprehensive procedures governing involuntary treatment. The U.S. Court of Appeals found that the New Jersey regulations were sufficient, but

held that the constitutional right of involuntary committed mental patients to be free from treatment consisting of antipsychotic drugs that pose substantial risks to their well-being "may be limited only by the least intrusive infringement which does not exceed that required by needed care or legitimate administrative concern." It added that the role of the court is to assure that "the choice of a course of treatment strikes a proper balance between efficacy and intrusiveness."

The U.S. Supreme Court vacated the decision of the Court of Appeals and remanded the case for further consideration in light of Youngberg v. Romeo.

Rone v. Fireman, 473 F. Supp. 92 (N.D. Ohio 1979).

The plaintiffs initiated a class action against the Western Reserve Psychiatric Habilitation Center on behalf of all patients (other than geriatric patients) at the hospital. The court entered a preliminary injunction in 1976 that required upgrading of staff, periodic evaluations of patients, building improvements and admissions. Factfinding continued until a hearing in April 1979, at which the court considered several allegations including the facility's failure to provide adequate treatment and to provide treatment in the least restrictive environment.

With regard to the least restrictive alternative issue, the United States District Court held that:

> As long as treatment within the hospital environment does not by comparison unduly burden the individual's liberty interest, the Court cannot find that the Constitution requires the provision of treatment in alternate settings.

It found, however, that because of the hospital's relatively isolated setting and the lack of transportation between it and community resources, the patients were deprived of their liberty in violation of the Fourteenth Amendment to the Constitution. Therefore, it ordered the defendants to provide patients with "ready and regular transportion or access to community resources."

Eubanks v. Clarke, 434 F.Supp. 1022 (E.D. Pa. 1977)

Plaintiff sued to prevent his transfer from a minimum security facility to a maximum security hospital. In denying a motion to dismiss the court concluded that:

> The purpose of civil commitment in Pennsylvania is care and treatment. While such commitment involves a tremendous loss of fundamental freedoms, the state may not infringe those freedoms more than is necessary to achieve its compelling interests. We hold that, at a minimum,

> where a state has varying available facilities for the mentally ill which differ significantly in the amount of restriction on the rights and liberties of the patients, due process requires that the state place individuals in the least restrictive setting consistent with legitimate safety, care, and treatment objectives.

Gary W. v. Louisiana, 437 F. Supp. 1209 (E.D. La. 1976)

This class action challenged Louisiana's practice of sending large numbers of juveniles committed as a result of mental illness, mental retardation, or delinquency, to out-of-state facilities, and questioned the adequacy of the treatment provided.

In discussing the plaintiffs' right to care and treatment under the Fourteenth Amendment to the U.S. Constitution, the court observed that "the term 'least restrictive setting' is ... a convenient way to sum up the standard applicable to all governmental restrictions on fundamental personal liberties ..." as set forth by the Supreme Court in Shelton v. Tucker, 364 U.S. 479 (1960). It defined the effect of the doctrine as follows:

> [T]he imperative that least drastic means be considered does not imply a constitutional right to a personal judicial determination that the means being employed to improve his condition are the best possible or the least restrictive conceivable. What is required is that the state give thoughtful consideration to the needs of the individual, treating him constructively and in accordance with his own situation, rather than automatically placing in institutions ... all [those] who are rejected by family and society.

Stamus v. Leonhardt, 414 F.Supp. 439 (S.D. Iowa 1976).

Two civilly committed patients brought this action alleging that Iowa's then-existing civil commitment laws were unconstitutional both on their face and as applied to the plaintiffs. On the plaintiff's motion for partial summary judgment and the defendants' motion to dismiss, the United States District Court held the statutes unconstitutional on their face and as applied. The court found many due process deficiencies, including the statutes' failure to authorize "methods regarding subsequent detention which are least restrictive of the subject's constitutional rights." The statutes failed to provide for "less than full-time hospitalization." The court noted that even though the defendants knew outpatient facilities were available in the community, they never used these facilities because they believed they had no power to do so. The Court cited Welsh v. Likins, 373 F.Supp. 487 (D. Minn. 1974), noting "a widespread acceptance by the courts of a constitutional

duty on the part of state officials to explore and provide the least restrictive practicable alternatives to confinement of noncriminals." The Iowa statutes mandated no such exploration, and the defendants had not explored "less drastic alternatives than full-time hospitalization." Thus, the court found the statutes unconstitutional, "[i]n failing to require that less restrictive alternatives be considered prior to ordering full-time hospitalization."

United States v. Ecker, 543 F.2d 178 (D.C. Cir. 1976).

A mental hospital patient, who had been committed following an acquittal by reason of insanity, appealed a District Court order which denied the hospital superintendent's request for his conditional release. The Court of Appeals affirmed the District Court's action, denying the patient's several assignments of error. Regarding one such assignment of error, the court said: "We unhesitatingly agree with appellant's contention that he has a right to treatment under the least restrictive conditions possible. We disagree, however, with his assertion that this right to treatment entitles him to the unsupervised access to the community that would be permittted under the hospital's conditional release plan."

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

Plaintiffs in this class action sought a judicial declaration that the right to treatment under the federal Hospitalization of the Mentally Ill Act includes non-institutional placement when this is consistent with the rehabilitative purpose of the Act. The United States District Court found for the plaintiffs, declaring that patients confined under the Act "must receive suitable care and treatment under the least restrictive conditions" consistent with the individual's needs and the purposes of the Act, and that the District of Columbia and the Federal Government were jointly responsible for providing such treatment.

Davis v. Watkins, 384 F.Supp. 1196 (N.D. Ohio 1974).

Involuntary patients at a state hospital brought this class action to secure present and future patients at that hospital a right to treatment. On joint motions for summary judgment, the United States District Court recognized such a right. In an appendix the court extensively discussed "that bundle of Constitutional rights guaranteed to involuntary mental patients." In that appendix the court said: "The patient should have a right to dignity, privacy and humane care. ... Patients shall have a right to the least restrictive conditions necessary to achieve the purposes of their commitment in accordance with their individual treatment plan." Furthermore,

> The defendants shall place all persons admitted to the Department of Mental Health and Mental Retardation in the Least Restrictive Confinement, which means the minimum limitation of movement or activity of a patient or resident necessary to

> provide reasonable assurance that his dangerousness would not constitute a significant risk to others and in which treatment or habilitation continues to the fullest extent possible.

Welsch v. Likens, 373 F. Supp. 487 (D. Minn. 1974).

Six mentally retarded residents of Minnesota mental institutions sued on behalf of themselves and similarly situated persons alleging that their right to adequate treatment in the appropriate least restrictive alternative had been violated.

The United States District Court found that under both the U.S. Constitution and state law, the class was entitled to "minimally adequate treatment designed to give each committed person a realistic opportunity to be cured or to improve his or her mental condition." It then went on to address the least restrictive alternative issue concluding that:

> The due process clause does no more than require State officials charged with obligations for the care and custody of civilly committed persons [to] make good faith attempts to place such persons in settings that will be suitable to their mental and physical conditions while least restrictive of their liberties.

Lessard v. Schmidt, 349 F. Supp. 1078 (E.D. Wisc. 1972), vacated and remanded on other grounds 414 U.S. 473 (1973), on remand 379 F. Supp. 1376 (E.D. Wisc. 1974), vacated and remanded on other grounds 421 U.S. 957 (1975), on remand 413 F. Supp. 1318 (E.D. Wisc. 1976) (reinstating 379 F. Supp. 1376).

This class action suit was brought by persons involuntarily hospitalized under Wisconsin's civil commitment statute. In the initial decision, the trial court concluded that full time involuntary hospitalization should be ordered "only as a last resort." In one of the clearest statements of the least restrictive alternative doctrine, the court stated:

> It seems clear, then, that persons suffering from the condition of being mentally ill, but who are not alleged to have committed any crime, cannot be totally deprived of their liberty if there are less drastic means for achieving the same basic goal ...
>
> We believe that the person recommending full-time involuntary hospitalization must bear the burden of proving (1) what alternatives are available; (2) what alternatives were investigated; and (3) why the investigated alternatives were not deemed suitable.

Because of procedural reversals, the status of the Lessard case is unclear, but it continues to serve as a leading reference in mental disability law.

Ploof v. Brooks, 342 F.Supp. 999 (D. Vt. 1972).

State hospital staff transferred a juvenile delinquent patient, who had been abusive to other patients and staff, from an open ward to a security ward, which contained patients with severe mental illness. The patient remained there for two days until a bed became available in another security ward, where younger patients with less serious problems were generally transferred. The patient brought this suit alleging violations of the eighth and fourteenth amendments of the United States Constitution. The United States District Court held for the defendants, the hospital superintendent and a staff psychiatrist. Among other things, the court stated: "Intra-hospital dispositions involve considerations of hospital administration which are entrusted in the first instance to the hospital staff. Nonetheless, restrictions beyond those which obtain in the usual hospitalization must be founded on reasonable justifications." The defendants' action in restricting the patient had reasonable justification.

Wyatt v. Stickney, 344 F.Supp. 373 (M.D. Ala. 1972).

In this class action, filed on behalf of involuntary patients in Alabama mental institutions, the United States District Court set out minimum medical and constitutional standards for the adequate treatment of the mentally ill and ordered their implementation. Included among these detailed minimum standards was the statement that "[p]atients have a right to the least restrictive conditions necessary to achieve the purposes of commitment." Elsewhere, the court states that "failure by defendants to comply with the decree cannot be justified by a lack of operating funds."

Wyatt v. Stickney, 344 F.Supp. 387 (M.D. Ala. 1972).

This litigation originally pertained only to Alabama's mentally ill; however, following plaintiffs' motion to amend, the United States District Court expanded the plaintiff class to include involuntary, mentally retarded residents of an Alabama institution. The court concluded that "[i]n the context of the right to appropriate care for people civilly confined to public mental institutions, no viable distinction can be made between the mentally ill and the mentally retarded." The court prescribed minimum medical and constitutional standards for adequate habilitation of the mentally retarded. Included was the requirement that "[n]o person shall be admitted to the institution unless a prior determination shall have been made that residence in the institution is the least restrictive habilitation setting feasible for that person."

Dixon v. Attorney General, 325 F. Supp. 966 (M.D. Pa. 1971).

This was a class action challenging placement of involuntarily committed persons directly into a maximum security facility. The Court held, among other things, that there must be a specific finding that placement at the maximum security facility is necessary and that there is no less restrictive facility to which the patient could be committed.

In re Walls, 442 F.2d 749 (D.C. Cir. 1971) (per curiam).

The District Court committed an allegedly mentally ill person to St. Elizabeth's Hospital. The patient appealed saying that the District Court mistakenly thought it had no authority to evaluate a Commission of Mental Health initial report regarding the patient, or to consider the patient's contentions, absent the patient's demand for a jury trial. The United States Court of Appeals agreed. The court remanded the case with directions that the District Court consider the patient's contentions. One such contention raised the issue: "Are there alternative courses of treatment for appellant less restrictive than total confinement, and have the Hospital and the Mental Health Commission made an adequate investigation of such alternative courses of treatment?"

Covington v. Harris, 419 F. 2d 617 (D.C. Cir. 1969).

An involuntarily civilly committed patient petitioned the District Court for a writ of habeas corpus, seeking transfer from a maximum security ward to some less restrictive ward. The District Court dismissed the petition. The patient appealed and, on joint motions for summary judgment, the United States Court of Appeals remanded the case.

The court reasoned that habeas corpus challenges the place as well as the fact of confinement, even if the challenged place is a hospital ward. Before denying the patient's request for transfer, the hospital was obligated to canvass less restrictive alternatives.

> [T]he principle of the least restrictive alternative consistent with the legitimate purposes of a commitment inheres in the very nature of civil commitment, which entails an extraordinary deprivation of liberty justifiable only when the respondent is "mentally ill to the extent that he is likely to injure himself or other persons if allowed to remain at liberty" [D.C. Code §21-544 (1967)]. A statute sanctioning such a drastic curtailment of the rights of citizens must be narrowly, even grudgingly, construed in order to avoid deprivations of liberty without due process of law.

Furthermore, the least restrictive alternative principle also applies to alternate dispositions within a mental hospital.

> It makes little sense to guard zealously against the possibility of unwarranted deprivations prior to hospitalization, only to abandon the watch once the patient disappears behind hospital doors. The range of possible dispositions of a mentally ill person within a hospital, from maximum security to outpatient status, is almost as wide as that of dispositions without. The commitment statute no more authorizes unnecessary restrictions within the former range than it does within the latter.

The court observed that the only distinctive feature of intra-hospital dispositions is that they involve considerations of hospital administration. Although hospital authorities are primarily responsible for intra-hospital dispositions, as reflected by the narrow scope of judicial review of their decisions, such primary responsibility "does not detract from the principle that additional restrictions beyond those necessarily entailed by hospitalization are as much in need of justification as any other deprivations of liberty; nor does it preclude all judicial review of internal decisions." Before the court can determine if the hospital's placement decision was permissible and reasonable, "it must be able to conclude that the hospital has considered and found inadequate all relevant alternative dispositions within the hospital." Moreover, the state bears the burden of exploring possible alternatives.

Fuller v. United States, 390 F.2d 468 (D.C. Cir. 1967) (per curiam).

The defendant was convicted of sexually violating the person of a five-year-old child. Questions on his appeal included whether the court prejudicially erred in failing on its own initiative to order a mental competency examination after it received a report raising doubt as to the defendant's competency, and whether it was proper to follow criminal procedures rather than civil commitment procedures. The United States Court of Appeals remanded the case for a competency hearing.

Chief Judge Bazelon concurred saying that the prison sentence which the District Court imposed was not designed to provide treatment which would improve Fuller's condition. He said that "some form of supervision or less-than-total deprivation of liberty might provide reasonable protection to the community." Because other alternatives must be explored in civil commitment proceedings, equal protection requires the same for persons committed as "sexual psychopaths". He concluded that "[t]he District Court may resort to absolute confinement ... only after it has determined that no satisfactory alternative exists."

Lake v. Cameron, 364 F.2d 657 (D.C. Cir. 1966).

Plaintiff was taken to a hospital by a police officer who found her wandering about. The hospital transferred her to a mental health facility for observation. She sought release by filing a petition for a writ of habeas corpus. The court summarily denied the petition and she

appealed. Following the filing of the appeal, treatment staff diagnosed her as suffering from "chronic brain syndrome". The appellate court vacated the dismissal of the petition and ordered a hearing.

At the hearing on the petition and a subsequent civil commitment hearing, the trial court concluded that the plaintiff was in need of care and supervision, that her family was not able to provide the needed care, and therefore, that she should remain in the hospital. She appealed again challenging her confinement, particularly in view of a new local law.

In the first decision recognizing a right to a less restrictive alternative (albeit a statutory rather than a constitutional right) in the context of a mental health proceeding, the Court of Appeals held that, in light of the new legislative policy and the trial court's indication that an alternative to hospitalization would be appropriate if one were available, the trial court and the government had a duty to explore alternatives. It noted that an indigent could not possibly do so, and observed that:

> The alternative source of treatment and care should be fashioned as the interests of the person and the public require in the particular case. Deprivations of liberty solely because of dangers to the ill persons themselves should not go beyond what is necessary for their protection.

State Cases

ARIZONA

County Attorney, Pima County v. Kaplan, 124 Ariz. 510, 605 P.2d 912 (1980)

In a proceeding to appoint a guardian, evidence was presented that the respondent was schizophrenic, had a history of mental illness, had given away or squandered most of his money and property, had been arrested at various times driving the wrong way on a freeway and lying beneath a jet preparing to take off. In order to appoint a guardian, the state code requires the court to find that a person is so "gravely disabled" that he or she is "unable to provide for his [or her] basic physical needs." Psychiatric and lay testimony was split on this point. The Arizona Court of Appeals found that the level of proof required under the statute is clear and convincing evidence and that the state failed to prove that the respondent was gravely disabled to the extent required. The court commented that:

> It is one thing to commit an individual who cannot function sufficiently to supply basic survival needs, and another to commit an individual who merely "chooses to live" under conditions that most of society consider to be substandard.

ARKANSAS

Gamble et al. v. Shannon, No. 81-4103 (Ark. Chan. Ct., Pulaski County, Oct. 14, 1982).

The court in Arkansas approved a consent decree ending the state's practice of automatically placing all persons committed by the court for treatment into the Rogers Hall unit of the Arkansas State Hospital. The state agreed to place persons in the least restrictive setting within the hospital.

The consent decree provided that the state will determine the appropriate placement for each person within five working days of receiving a confinement order from the court. All persons in the Rogers Hall unit of the hospital will have their placement reviewed within 60 days of the entry of the decree and each person will have the right to review the state's decision. An individual treatment plan will be developed for each person to document the need for behavior modification.

The consent decree does not apply to persons detained for evaluation or observation by court order.

(Excerpted from Mental Disability Law Reporter, 1982, 6 (6), 394)

CALIFORNIA

Conservatorship of Davis, 124 Cal. App.3d 313, 177 Cal. Rptr. 369 (1981).

The public guardian appealed from the Superior Court's dismissal of a petition to establish a conservatorship based on grave disability. The appellant contended that the lower court improperly instructed the jury on "grave disability" by failing to limit the instruction to the statutory definition of grave disability (i.e., as a result of mental disorder the person is unable to provide for his basic personal needs for food, clothing, or shelter). The Court of Appeal disagreed, concluding that a person is not gravely disabled "if he or she is capable of living safely in freedom with the help of willing and responsible family members, friends or third parties."

The court reasoned that although the statute states that the issue at trial is whether the person is gravely disabled, a reading of the entire act indicates that this includes a determination of whether a conservatorship is necessary in light of all the relevant facts. The statute requires the trier of fact "to determine the question of grave disability, not in a vacuum, but in the context of suitable alternatives ... ." The officer providing conservatorship investigation must recommend conservatorship to the court "only if no suitable alternatives are available." After conservatorship is imposed, a conservatee must be placed "in the least restrictive alternative placement." The adjudication and placement of the gravely disabled person must be purposefully separated. "The Legislative focus of the LPS Act is on protecting the nondangerous gravely disabled person and allowing that person to live safely in freedom or the least restrictive alternative if he or she can do so, with or without the aid of appropriate others." The

court concluded that a person subject to commitment proceedings is entitled to a jury determination of all questions involved in the imposition of conservatorship.

In re Todd W., 96 Cal. App.3d 408, 157 Cal. Rptr. 802 (1979).

The respondent was a 13 year old who had been declared a ward of the court after admitting involvement in an auto theft/joy ride, and who had run away from a number of foster care and other placements. The California Court of Appeals vacated the juvenile court judge's order committing the boy to the state juvenile correctional system. It held that:

> Commitment to the [California Youth Authority] should be made in the more serious case after all else has failed and as a last resort... . If a minor will not benefit from CYA commitment and if no appropriate alternate placement exists, then the proceeding should be dismissed.

Conservatorship of Chambers, 71 Cal. App.3d 277, 139 Cal. Rptr. 357 (1977).

Chambers appealed from an order appointing a conservator on the ground that Chambers was gravely disabled as a result of mental disorder. He alleged, among other things, that the "gravely disabled" standard as defined in statute was unconstitutionally vague and overbroad. The Court of Appeal disagreed.

The court said that Legislatures have had to choose between "the medical objectives of treating sick people without legal delays and the equally valid legal aim of insuring that persons are not deprived of their liberties without due process of law (citations)." The California Legislature incorporated these diverse objectives into the Lanterman-Petris-Short Act. "The statute is designed to provide prompt, short-term, community-based intensive treatment, without stigma or loss of liberty, to individuals with mental disorders who are dangerous to themselves or to others, or who are gravely disabled."

A facility director may recommend the appointment of a conservator for any person he or she determines to be gravely disabled and unwilling or incapable of voluntarily accepting treatment. "Conservatorship will be recommended only when there are no suitable alternatives available (§ 5354)." When a conservatorship is established, "the conservatee may be placed in an approved medical or nonmedical facility pursuant to the court order. Family placement with outpatient treatment is preferred (§ 5358.6); if the conservatee cannot remain at home or be placed with relatives, great care must be taken to place him in a suitable facility as close as possible to his home or that of a relative (§ 5358)."

Aden v. Younger, 57 Cal. App. 3d 662, 129 Cal. Rptr. 535 (1976).

The petitioners, who included both physicians and patients, challenged the restrictions on the use of electroconvulsive therapy and psychosurgery imposed by amendments to California's Lanterman-Petris-Short Act. The California Court of Appeal concluded that the legislative intent was:

> [T]o make the more radical procedures the treatment of "last resort" and to require medically appropriate alternative therapies be attempted first.

It found that the question of which alternative therapies are appropriate is a "purely medical decision within a doctor's professional judgment." In addition, it ruled that a provision requiring such treatment to be "critically" needed for a patient's welfare is unconstitutionally vague because it provides "no guide to the degree of need required."

FLORIDA

Department of Health and Rehabilitative Services, Division of Retardation v. Ownes, 305 So.2d 314 (D.C. App. Florida 1974).

The Department of Health and Rehabilitative Services petitioned for involuntary commitment of several allegedly mentally retarded individuals. The trial court granted the petitions and ordered the Department to provide certain prescribed treatment for several of these committed persons. The court included placement in community or group living homes for specified periods in several of the prescribed treatment plans. A panel of Florida's Court of Appeal reversed the trial court's commitment orders, stating that the statute did not authorize courts to direct treatment or to supervise the treatment and placement of an individual. The appellate court said that the Division of Retardation is responsible for the individual until he or she "is discharged or released to the custody of parent or guardian and that the Division shall assign the person to an appropriate residential program as it may deem proper" (emphasis in original).

In a dissent to the decision, one appellate judge argued that:

> If the judge finds that a person should be admitted because of a specific condition it would, in my view, constitute a deprivation of due process to require the judge under such circumstances to issue a blind order of admission without requiring the specific treatment for which admitted. If the judge has the power, duty and responsibility of admission then he should, and in my view does, have the power, duty and responsibility of asserting appropriate treatment as a condition of admission.

ILLINOIS

People v. Wathan, Gen. No. 482-0453 (Ill. App. 4th Dist., March 30, 1983).

Wathan appealed from a trial court order which involuntarily committed him to a state mental health facility on the grounds that the trial court failed to comply with a state statute which requires that a report be prepared regarding the appropriateness and availability of alternative treatment settings. The appellate court reversed.

The court reasoned that the Illinois Mental Health and Developmental Disabilities Code requires the trial court to "consider alternative mental health facilities which are appropriate for and available to the respondent, including but not limited to hospitalization," and to "order the least restrictive alternative for treatment which is appropriate." To ascertain the least restrictive alternative, the court must consider the report required by statute. The record reflected that no report was prepared or considered by the court.

In re Meyer, 107 Ill. App. 3d 871, 438 N.E.2d 639 (1982).

An Illinois appeals court overturned the involuntary commitment orders for two voluntarily admitted patients who had not given notice of intent to leave the hospital. The court ruled that the state lacked authority over these self-admitted patients.

Both patients were mentally retarded and likely to injure themselves and others. The proposed status change would not affect their treatment, but would curtail their rights to seek discharge. Unless a patient requests release from the hospital, a status change through involuntary commitment proceedings is contrary to state statute and violates the patient's due process rights.

(Excerpted from Mental Disability Law Reporter, 1982, 6 (6), 394)

In re Collins, 102 Ill. App. 3d 138, 429 N.E. 2d 531 (1981).

The issue before the Illinois appellate court was whether an involuntary civil commitment order should be reversed because the trial court failed to suppress testimony of an examining physician and psychiatrist because they failed to comply with the statutory prerequisite that an examiner personally inform the patient of his or her rights. The court held that if examiners do not personally inform a patient of his or her rights, then the examiners' testimony is barred.

Although not raised by the appellant, the court noted that the record was devoid of any indication that mental health personnel prepared a statutorily required report on "the appropriateness and availability of alternative treatment settings." Nor is there any indication that the trial court considered such a report prior to disposition, as is statutorily required. The court stated that, although these deficiencies were not necessary to the disposition of the appeal, they were "but one further indication that certain staff ... are performing their duties with either callous or blithe disregard for the rules."

Matter of Ottolini, 73 Ill. App. 3d 971, 392 N.E.2d 736 (1979).

Respondent was civilly committed in 1937 after being found incompetent to stand trial. At a judicial review hearing in 1978, respondent was found to be both mentally ill and dangerous and ordered to remain at the hospital.

On appeal, the Illinois Court of Appeals upheld the trial court's judgment. It found, among other things, that the implicit rejection of recommendations regarding less restrictive alternatives was sufficient to satisfy the statutory requirement that alternative forms of treatment be considered.

(Note: This case was decided prior to enactment of the current Illinois Mental Health and Developmental Disabilities Code)

People v. Reliford, 65 Ill. App. 3d 177, 382 N.E.2d 72 (1979).

Respondent was institutionalized following a commitment proceeding in which the court found that he was mildly mentally retarded, that he suffered from a social disorder which may have led him to steal, and that he needed treatment. The order was reversed by the Illinois Court of Appeals. The court held that no showing of dangerousness had been made.

> The due process clauses of both state and federal constitutions prevent the involuntary institutionalization of a person by the state solely because he is mentally retarded. Involuntary commitment can only be justified by a state purpose ... .
>
> Much more than the bare assertion from a medical expert that it is his opinion that treatment is necessary and beneficial is required.

People v. Sharkey, 60 Ill. App. 3d 257, 376 N.E. 2d 464 (1978).

The respondent was involuntarily committed on the grounds that he was unable to take care of himself because of a mental illness. The Illinois Court of Appeals held that the trial court's specific finding that the respondent required hospitalization was equivalent to a finding that less restrictive alternatives were inappropriate. The court suggested that permitting the respondent to live at home was "most inappropriate" since his father had filed the commitment petition.

People v. Ralls, 23 Ill. App. 3d 96, 318 N.E.2d 703 (1974).

Ralls appealed from a trial court order which involuntarily hospitalized her in a facility to be designated by the Department of Mental Health. She alleged, among other things, that "the court erred in failing to consider any alternative form of care or treatment ..."

Noting that the statute did provide for alternative treatment, the appellate court stated that the trial court "was justified in finding that the defendant was in need of hospitalization, and therefore, it was not error for the court to fail to give consideration to placing the defendant with a relative."

(Note: This case was decided prior to enactment of the current Illinois Mental Health and Developmental Disabilities Code).

MASSACHUSETTS

Brewster v. Dukakis, CA. NO. 76-4423-F (D.C. Mass. 1978, unpublished consent decree).

Residents of the state mental hospital sued the state claiming that their constitutional and statutory right to treatment through the least restrictive alternative had been violated. The suit was settled via a consent decree under which the state agreed to undertake specific programs to provide a comprehensive system of community mental health and retardation services. The portion of the decree that required the state to provide free legal services for the mentally ill was subsequently vacated.

MISSOURI

In re Estate of Newman, 604 S.W.2d 815 (Mo. Ct. App. 1980).

The guardians of three profoundly retarded persons requested placement of their wards in the state facility for the mentally retarded. Each of the wards had been previously found incompetent. Counsel for the wards argued that the court failed to find that the facility was the least restrictive alternative.

Under the court's interpretation of the state code, the least restrictive alternative doctrine does not apply until the facility director has placed a person in a particular program. If the guardian objects to that placement, he or she may then argue that care and treatment is not being provided in the "least restrictive environment reasonably available."

NEW JERSEY

Patients v. Camden County Board of Chosen Freeholders, No. L-33417-74P.W. (N.J. Super. Ct. January 19, 1981).

This was a class action suit by patients at a county psychiatric hospital. Many of the patients had been ordered to be discharged during periodic review hearings but remained in the hospital because intermediate care or nursing home facilities were unavailable. The court concluded that under New Jersey law, committed persons are entitled to non-institutional as well as institutional mental health services, stating that "[a]dequate treatment with the least possible constitutional infringement is clearly the public policy of this state."

State v. Fields, 77 N.J. 282, 390 A.2d 574 (1978).

The defendant was found not guilty by reason of insanity (NGRI) and committed to a psychiatric hospital. The commitment was reviewed twice within a year. At the second review, the court concluded that the defendant was incurable and extended the review period for one year. The defendant appealed claiming a right to the same periodic reviews granted under state law to civilly committed persons. The New Jersey Supreme Court discerned "no constitutionally satisfactory justification for denying comparable protection to persons committed following an NGRI verdict". It concluded further that when the state is unable to meet its burden of justifying the prevailing restraints upon the liberty of the patient, the trial court must order the least restrictive restraints necessary, based on that person's present condition.

State v. Carter, 64 N.J. 382, 316 A.2d 449 (1974).

A criminal defendant was adjudicated insane and committed to a state hospital. When the hospital director, without court approval, ordered release of the person, and a prosecutor requested judicial review of the release, the trial court ordered the person returned to the hospital. On appeal, the Supreme Court of New Jersey said that "[t]he courts have power to fashion psychiatric out-patient probation in the form of conditional releases," even though not specifically authorized by statutes. A person can be conditionally released, even though the underlying mental condition is incurable, "if a combination of conditions may be found that would reduce the likelihood of dangerous behavior below the standard required for commitment ..." (citing United States v. McNeil, 434 F.2d 502 (D.C. Cir. 1970)). Furthermore, the court's function in conditional release proceedings is to "balance protection of the public safety against the therapeutic value and humaneness of conditional release."

Throughout the conditional release period, the court must maintain frequent contact with the patient and supervising psychiatrists. To facilitate this contact the court should require periodic reports to a probation officer. Jurisdiction should be maintained so that authorities may take immediate custody if psychiatric care is needed. The court may place territorial restrictions on the patient's right to travel while the conditional release is in effect.

The court concluded that "[t]he foundation of conditional release is to consist of assuring the public safety with an individualized program of psychiatric out-patient care coupled with recurrent examinations of social and environmental facts which could affect the patient's recovery."

Application of D.D., 118 N.J. Super. 1, 285 A.2d 283 (1971).

Following an altercation with an attendant, a civilly committed patient was transferred from "a less confining unit" to a maximum security unit at a state mental hospital. This civil patient was the only juvenile in the maximum security unit; the other patients were all adults and the majority had been committed to that unit because they were

criminally insane. The juvenile challenged her confinement there through a petition for a writ of habeas corpus.

Following the trial court's denial of the writ, the patient appealed alleging, among other things, that her transfer to and confinement in the maximum security unit "without a hearing and without a reasoned consideration of less drastic alternatives are unconstitutional as a deprivation of liberty without due process." The appellate court concluded that the maximum security unit was an improper place to confine the patient. The court ordered the patient's transfer from the maximum security unit "to a more appropriate place for suitable treatment," but that administrative officials should select a suitable placement, subject to judicial review if necessary.

NEW YORK

Crane Neck Association, Inc. v. New York City/Long Island County Services Group, 460 N.Y.S. 2d 69 (App. Div. 1983).

The state of New York sought to establish a group home for eight mentally retarded adults in a Long Island village. The village objected and a homeowner's association filed suit to block the opening of the home on the basis of a covenant limiting homes in the area to single family dwellings. The trial court ruled in favor of the homeowners. The state appealed.

The Appellate Division (New York's intermediate appellate court) vacated the trial court's injunction. It ruled that there was a strong public policy in favor of providing treatment services and habilitation programs for persons with developmental disabilities "in a fashion that is least restrictive to personal liberty." To enforce the homeowners' covenant, it held, would violate this strong legislative policy favoring placement of developmentally disabled persons in "normal community settings" whenever possible.

Jenkins v. Wilbur, 72 A.D.2d 822, 421 N.Y.S.2d 665 (1979).

Jenkins was involuntarily hospitalized for psychiatric care and evaluation on the basis of certification prepared and signed by Wilbur, a physician. Jenkins sued for malpractice alleging that the doctor failed to exercise a reasonable standard of care in preparing the certification. On an appeal on procedural grounds, the court held that a duty of care is imposed by the statutory provisions requiring that the physician set forth the facts and circumstances on which he or she based the decision that a person is in need of involuntary treatment, and that before completing the certificate the physician "must consider an alternative form of care and treatment which might provide adequate help short of hospitalization."

In re Andrea B., 94 Misc. 2d 919 (Fam. Ct. N.Y. County 1978).

In a "Person in Need of Supervision" proceeding, a 14 year old respondent challenged her continued involuntary hospitalization, which

was based on alleged mental illness and dangerousness. On due process grounds the court ordered her released, because her needs could be met by services less restrictive than hospitalization.

The court reasoned that involuntary commitment to a mental hospital is a deprivation of liberty which requires due process of law. Citing Jackson v. Indiana, 406 U.S. 715 (1972), the court said that because the nature and duration of the commitment must bear some reasonable relation to the purpose for which the individual is committed, when the basis for the commitment no longer exists the commitment must terminate. The respondent's hospital record and the medical testimony established that the initial purpose of the hospitalization had ended and that the respondent should be placed in a structured residential facility.

Furthermore, "substantive due process requires adherence to the principle of the least restrictive alternative. The least restrictive alternative doctrine comprehends not only the degree of physical restraint but the environment, including fellow patients, to which the individual is confined." Even though the governmental purpose is legitimate and substantial, it must be achieved by the means least restrictive of fundamental personal liberties.

Scopes v. Shah, 59 A.D.2d 203, 398 N.Y.S.2d 911 (1977).

Scopes was involuntarily civilly committed. At the hearing, the jury was instructed that "they could find petitioner in need of further retention if ... he was in need of further treatment and did not realize the necessity for that treatment ... ." New York's intermediate appellate court nullified the commitment and ordered a new trial because the instruction permitted institutionalization even if Scopes was not a danger to himself and others. The court concluded that the constitution forbids civil commitment of a person who is "capable of surviving safely in freedom by himself or with the help of willing and able family members or friends."

Application of Lublin, 85 Misc. 2d 48, 378 N.Y.S. 2d 590 (1976).

Lublin filed a petition for release from a state psychiatric center, to which he had been committed following his acquittal by reason of insanity of the murder of his wife. The trial court held that the petitioner failed to meet his burden of proving by a preponderance of the evidence that he could be discharged or conditionally released without danger to himself or others. The court qualified its decision:

> The decision herein is not designed to, nor should it, obstruct therapeutic goals. If those charged with the responsibility of caring for the petitioner feel he will benefit from a less restrictive environment than confinement affords, it is within their power to provide such an environment (MHL § 29.15). It should be borne in mind that therapy under the least restrictive alternative is the purpose and manner of the

> continued confinement of Mr. Lublin (cites). Should the hospital at any time abandon the pursuit of these goals, such a decision would be an appropriate subject for judicial review (cite).

Kesselbrenner v. Anonymous, 33 N.Y.2d 161, 350 N.Y.S.2d 889 (1973).

The state sought to transfer a civilly committed patient to a department of corrections hospital. The trial court refused to approve the transfer. The state appealed and an intermediate appellate court overturned the trial court's decision. The patient then brought the case to the Court of Appeals. The question presented was whether a statute which required transfer of severely dangerous civilly committed patients (whose confinement was not based on a criminal charge or conviction) to a correctional facility was constitutional.

In holding the provision unconstitutional, the Court of Appeals of New York reasoned: "To subject a person to a greater deprivation of personal liberty than necessary to achieve the purpose for which he is being confined is, it is clear, violative of due process." Citing Jackson v. Indiana, 406 U.S. 715 (1972), the court stated that the "nature and duration of the commitment [must] bear some reasonable relation to the purpose for which the individual is committed." Because the appellant was not a criminal the confinement must be therapeutic, not punitive. The court said that no reasonable relation existed between "so harsh a confinement" in a penal facility and the purpose sought. The court noted that if the statute had required transfer to "some less restrictive alternative" than the correctional facility, its decision may have been different. However, "the principle of the least restrictive alternative consistent with the legitimate purposes of a commitment ... inheres to the very nature of civil commitment ... . A statute sanctioning such a drastic curtailment of the rights of citizens must be narrowly, even grudgingly, construed in order to avoid deprivations of liberty without due process of law" (citing Covington v. Harris, 419 F.2d 617). The court also mentioned that the absence of funds to provide for civil placement of civil patients was no defense of transfer to a correctional facility.

OHIO

Ohio v. Jackson, 2 Ohio App.3d 11, 440 N.E.2d 1199 (1982).

A burglary defendant, acquitted by reason of insanity and committed to a state hospital, was subsequently recommitted following a hearing. The defendant had claimed that there was insufficient evidence to prove that the state hospital was the least restrictive commitment alternative available, that the statute applied at the recommitment hearing was inappropriate because it was retroactively applied, and that the ex post facto application of the statute violated his equal protection rights.

The appeals court found that the trial court decision that the state hospital was the least restrictive alternative was supported by a

preponderance of the evidence. In addition, the court found that the statute applied at the hearing was not ex post facto legislation because its provisions do not "take away any vested rights and do not attach any new obligations ... . [T]he questioned provisions ... are prospective in nature, since they are intended to govern treatment and discharge procedures after the law's effective date."

Finally, the court failed to find a denial of equal protection because the differences in commitment procedures for those persons civilly committed and for insanity acquittees "did not result in a substantially different procedure."

(Excerpted from Mental Disability Law Reporter, 1983, 7 (1), 28)

PENNSYLVANIA

Finken v. Roop, 234 Pa. Super. Ct. 155, 339 A.2d 764 (1975).

On an appeal from the denial of a habeas corpus petition challenging a civil commitment, the Superior Court reversed the commitment order, finding several due process deficiencies. One such deficiency was the committing court's failure to consider alternatives to commitment. The Superior Court said that at the preliminary hearing an expert witness had testified that the appellant did not require confinement in a mental institution. The court was "fully aware of the possibility that both the societal and individual interests at stake could be satsified by some form of custody less drastic than complete and total commitment to a mental institution. Yet, the court made no effort to investigate any alternative ... ." The Superior Court said it is incumbent upon counties, or upon the State if the counties are unable, to provide alternatives to commitment for persons not in need of total confinement. Furthermore, the State has the burden of proving that no such facility exists.

WEST VIRGINIA

State ex rel. R.S. v. Trent, 289 S.E.2d 166 (W.Va. S.Ct. 1982).

In committing a mentally ill juvenile previously found delinquent to the state training school, the juvenile court stated specifically that every reasonable alternative had been explored, that the juvenile presented a danger to himself and others, and that no less restrictive alternative was appropriate. The juvenile sought appellate review on the grounds that the findings were not supported by the facts presented, and therefore, that his commitment was unlawful.

The appellate court ordered the youth released from the training school. It directed the trial court and state welfare department to have a thorough multiprofessional evaluation of the youth conducted, and to develop a comprehensive individualized treatment program. The court reasoned that only in this way could the custody bear a relationship to its rehabilitative purpose.

WISCONSIN

J.K. v. State, 68 Wis. 2d 426, 228 N.W.2d 713 (1975).

A juvenile previously adjudicated delinquent and sent to the state training school, challenged the disposition on the grounds that the juvenile court judge had failed to demonstrate that "no less onerous disposition would serve the purpose of the commitment."

The Wisconsin Supreme Court distinguished delinquency proceedings from the mental health cases used to support the appellant's argument, noting that a broader range of inferents had to be notified in making a delinquency disposition. The court viewed the appellant's position as necessitating a "from-the-bottom-up" process of determining each less onerous disposition unsuitable before the next most onerous alternative could be considered. It concluded that:

> While the selection of any one alternative does involve and require the rejection of others, less and more onerous, as comparatively inappropriate we do not see a juvenile judge as required to climb such a stairway one step at a time.

CHAPTER THREE: ANNOTATED BIBLIOGRAPHY

The following sources represent selected materials that focus on the "least restrictive alternative doctrine" and related issues (e.g., deinstitutionalization). The initial grouping consists of reports by the National Center for State Courts that include sections on LRA in the context of involuntary civil commitment. Thereafter, the bibliography is arranged by topic areas: 1) involuntary civil commitment of the mentally ill, 2) elderly persons, 3) mentally retarded persons, and 4) other applications of the LRA doctrine. The materials address a wide range of issues including constitutional and ethical points, dangerousness, and the role of mental health professionals within the context of LRA.

INVOLUNTARY CIVIL COMMITMENT OF THE MENTALLY ILL

Fitch, W.L. Involuntary civil commitment in Winston-Salem. Williamsburg, Virginia: National Center for State Courts, 1982.

Fitch. W.L., McGraw, B.D., Hendryx, J., & Marvell, T.B. Involuntary civil commitment in the First Judicial Department, New York City. Williamsburg, Virginia: National Center for State Courts, 1982.

Keilitz, I. Involuntary civil commitment in Columbus, Ohio. Williamsburg, Virginia: National Center for State Courts, 1982.

Keilitz, I., Fitch, W.L., & McGraw, B.D. Involuntary civil commitment in Los Angeles County. Williamsburg, Virginia: National Center for State Courts, 1982.

Keilitz, I., & McGraw, B.D. An evaluation of involuntary civil commitment in Milwaukee County. Williamsburg, Virginia: National Center for State Courts, 1982.

Zimmerman, J. Involuntary civil commitment in Chicago. Williamsburg, Virginia: National Center for State Courts, 1982.

The above-referenced monographs (which are listed here out of alphabetical order for convenience) are the result of an evaluation of involuntary civil commitment systems in six metropolitan areas throughout the United States. The monographs contain specific recommendations and

guidelines for improvement of involuntary civil commitment in prehearing matters; review of allegations and screening of cases before detention; functions and duties of respondents' counsel; hearing characteristics; treatment considerations during judicial hearings; and posthearing matters. The series of monographs sets forth more than 250 guidelines and recommendations for improvement, many of them directly germaine to the application of the least restrictive alternative doctrine in involuntary civil commitment proceedings.

Brozost, B.A. Psychiatric community residences: A review of past experiences. Psychiatric Quarterly, 1978, 50 (4), 253-263.

The author notes a trend toward completion of mental treatment in community settings due to changing fiscal, therapeutic, and political ideology. Based on an extensive review of the literature, the author concludes that thorough planning, careful timing, and aggressive, persistent coordination are the keys to success in establishing such community residences.

Budson, R.D., & Jolley, R.E. A crucial factor in community program success: The extended psychosocial kinship system. Schizophrenia Bulletin, 1978, 4 (4), 609-621.

The authors theorize that a crucial factor in community program success is the program's capacity to foster and strengthen an extended psychosocial network of neighbors, friends, and associates at work or school. According to the authors, both the chronically hospitalized patient and the young, isolated, acutely psychotic adult are in need of an enhanced psychosocial system when entering a community program. This article details the experience of Berkeley House, a psychiatric half-way house, that has achieved success through the creation of an extended psychosocial kinship system. The authors conclude with a description of the four principal program elements that sustained the system: (1) the ex-resident program; (2) housing arrangements; (3) employment; and (4) a variety of avocational and social groupings.

Chambers, D. L. Alternatives to civil commitment of the mentally ill: Practical guides and constitutional imperatives. Michigan Law Review, 1972, 70 (6), 1107-1202.

Chambers notes that the most forthright alternative for ending the undue reliance on compulsory hospitalization has been to forbid it altogether. He suggests that the states seek to serve two functions through hospitalization: protecting the individual from himself and providing him care and treatment; both are viewed as questionable bases for involuntary "help". Chambers suggests that a third function, protecting the community from dangers posed by the ill person, does justify compulsory intervention for certain kinds of dangers, but he notes that dangerousness is difficult to predict accurately. The problem of retaining two forms of commitment, "civil" and "criminal", is explored

and the author notes that courts have proved unwilling to curtail civil commitment. This article encourages movement away from hospitalization through approaches that seek to allay the anxieties of the public about mental illness by focusing on the probability that the goals of treatment and protection can be better served by community placement.

Decker, F.H. Changes in the legal status of mental patients as waivers of a constitutional right: The problem of consent. Virginia Polytechnic Institute & State University, Blacksburg, Association Paper, 1979.

This article initially focuses on the discharge procedures that flowed from the 1972 enactment of the Florida Mental Health Act. This Act limits the period of involuntary civil confinement to six months. Continuation of involuntary hospitalization beyond the six month period requires a judicial hearing before an appointed hearing examiner. According to the author, a potential flaw in this limited commitment model allows a patient committed on involuntary status to become, at any time, a voluntary patient. In some cases a change to voluntary status may in effect be a waiver of the statutory right to judicial determination of the need for extended confinement. Relying on United States Supreme Court decisions, Decker argues that a hearing on continued hospitalization is not only a statutory right provided by a state, but also, is a right provided by the United States Constitution. The author presents data which show that a large portion of patients involuntarily admitted to the two major state mental hospitals in Florida between July 1, 1972 and June 30, 1975 were subsequently changed to voluntary status, remained hospitalized well beyond the original six month confinement period. Decker examines several factors which indicate that one should not assume compliance with the Supreme Court mandate that changes to voluntary status must be made with the patient's consent. The article concludes that changes to voluntary status that act as a waiver of the right to judicial review are unconstitutional.

Durham, M. L., & Pierce, G. L. A preliminary analysis of the impact of Washington State's new Involuntary Commitment Act on the delivery of mental health services: A study of the demand for social control of marginal deviants. University of Washington, Seattle, Association Paper, 1980.

State mental health laws designed to narrow the definition of mental illness and thereby also narrow the process through which individuals can be involuntarily committed to mental institutions are discussed. The authors note that this legislative and judicial trend (which occurred during the 1960s), corresponds to the ideology of deinstitutionalization and community-based treatment that characterizes the mental health system today. However, considerable public dissatisfaction with narrow statutory definitions of "mental illness" has led many individuals to formulate new standards for involuntary commitment. Washington was the first state to return to a broader definition of involuntary civil commitment. The article summarizes the developments which led to the

1979 revision of mental health policy in Washington and the initial response of the mental health system to the influx of "new cases". Data are presented that indicate that the rapid increase in involuntary civil commitments was accompanied by an equivalent decrease in voluntary commitments to state institutions. The authors explore implications of this finding for the allocation of scarce resources and the delivery of mental health services.

Elkins, J. R. Legal representation of the mentally ill. West Virginia Law Review, 1979, 82 (2), 157-241.

This article explores the function of an attorney assigned to represent an allegedly mentally ill individual in involuntary civil commitment proceedings. Specific suggestions for more adequate and effective representation of the individual are presented. The author states that statutory requirements for consideration of the least restrictive alternative offer considerable opportunities for defense counsel. He makes recommendations for defense counsel's effective application of the least restrictive alternative doctrine including a thorough investigation of potential alternatives prior to the commitment hearing.

Ennis, B. J. Civil liberties and mental illness. Criminal Law Bulletin, 1971, 7 (2), 101-132.

The author questions the rationales and bases for involuntarily committing persons for treatment of mental illness. He maintains that if society confines allegedly mentally ill persons, the standards and procedures for confinement should guarantee the same rights as those afforded criminal defendants. Ennis argues that the fundamental right to liberty requires that allegedly mentally ill persons be treated by the least drastic means. In addition to civil commitment, the article discusses other mental health issues including incompetence to stand trial, loss of basic rights during hospitalization, and right to treatment.

Ennis, B. J., & Friendman, P. R. Legal rights of the mentally handicapped: Volume Two. Practicing Law Institute, Mental Health Project, 1974.

This work is the second volume of a legal handbook on the rights of the mentally handicapped. Specific implications for treatment, the rights of the mentally handicapped in the community, the right to the least restrictive treatment setting, and the rights of the mentally handicapped in criminal proceedings are examined in light of the First, Sixth, Eighth, Thirteenth, and Fourteenth Amendments. The authors include case summaries and interpretations.

Hiday, V. A. Alternatives to confinement for the dangerous mentally ill. North Carolina State University, Raleigh, Association Paper, 1981.

Reform statutes and court decisions have called for the least restrictive alternative in handling the civil commitment of those found to be mentally ill and dangerous. Most courts, however, have persisted in ordering only hospitalization or release. The author's analysis focuses on patients found to be mentally ill and dangerous who were ordered to outpatient treatment by one court over a 2 year period. The author points out that no study has either sought to discover the effectiveness of less restrictive alternatives, or followed a sample of mentally ill persons who have not been confined despite a finding of dangerousness in order to discover if dangerous behavior recurs and if involuntary hospitalization is necessary.

Hoffman, P. B. & Foust, L. L. Least restrictive treatment of the mentally ill: A doctrine in search of its senses. San Diego Law Review, 1977, 14 (5), 1100-1154.

This article provides an historical overview of the least restrictive alternative doctrine as applied to a variety of constitutional questions germane to the treatment of the mentally ill (due process, equal protection, and commerce clauses, as well as the First and Eighth Amendments). Implicit in the doctrine is the principle that governmental action should not intrude upon constitutionally protected interests to a degree greater than is necessary to achieve a legitimate governmental purpose. The author views the doctrine as a potential means of resolving these competing interests. The article traces the judicial and legislative evolution of the least restrictive alternative doctrine and suggests a framework for the doctrine's future application to treatment of the mentally ill.

Kopolow, L. E. A review of major implications of the O'Connor v. Donaldson decision. American Journal of Psychiatry, 1976, 233 (4), 379-383.

The article concludes that, although the United States Supreme Court's decision in O'Connor v. Donaldson is narrow from the legal perspective, the decision will have wide clinical ramifications for psychiatry if it generates a trend in future court decisions. The author assesses the impact of this decision on the mental health profession in the following areas: dangerousness as grounds for involuntary commitment for psychiatric treatment; the least restrictive alternative principle; the adequacy of treatment in light of the absence of nationally defined standards; and the personal liability of physicians for their professional actions.

Laves, R. G. The prediction of dangerousness as a criterion for involuntary civil commitment: Constitutional considerations. Journal of Psychiatry and the Law, 1975, 3 (3), 291-326.

Because involuntary civil commitment is an adversary procedure whereby an individual may be deprived of fundamental civil liberties, the

author suggests that the standard of proof in civil commitment hearings should equal that required in criminal trials. According to Laves, civil commitments, which are often based on the predictions of psychiatrists, deny Fourteenth Amendment safeguards because psychiatrists cannot accurately predict dangerousness. The article recommends a re-evaluation of current commitment practices and urges psychiatrists to examine the ethical ramifications of their continuing participation in such procedures.

Lennell, M. The Lanterman-Petris-Short Act: A review after ten years. Golden Gate University Law Review, 1977, 7, 733-764.

The California legislature enacted the Lanterman-Petris-Short (LPS) Act to abolish indeterminate periods of civil commitment and to remove the legal disabilities suffered by individuals adjudged to be mentally disordered. Mental health law has since evolved toward even greater rights for the mentally disordered and the author therefore, feels that the LPS Act needs to be re-examined. The author argues that the LPS Act is too vague because it sets no measurable standard for commitment. Lennell also contends that the state's failure to provide effective mental health treatment undermines the state's reliance on the parens patriae power to justify confinement of those who are not dangerous to others. The article concludes with proposals that apply the "least restrictive alternative doctrine" while attempting to better accomodate the state's interest in commitment.

Litwack, T.R. The role of counsel in civil commitment proceedings: Emerging problems. California Law Review, 1974, 62 (3), 816-839.

This article explores the issue of adequate representation in civil commitment proceedings. The author identifies the features of an adequate system of representation and describes difficulties with such a system. The analysis is based on the author's examination of one of the more comprehensive and successful state systems for providing meaningful assistance to mental patients, the Mental Health Information Services of New York. Litwack stresses the proposition that counsel should act as an advocate to achieve the ends desired by the client.

Lyon, M.A., Levine, M.L., & Zusman, J. Patients' bills of rights: A survey of state statutes. Mental Disability Law Reporter, 1982, 6 (3), 178-201.

This article provides a review of the mental health statutes of the fifty states and District of Columbia available in codified form as of February, 1982. The authors survey the extent to which these statutes contain provisions paralleling the major provisions of Section 501, Patients' Bill of Rights, Mental Health Systems Act (MSHA). The Omnibus Budget Reconciliation Act of 1981 repealed MSHA on August 13, 1981, but retained Section 501. The review indicates that all states except Alabama, Mississippi, and Oregon statutorily require consideration of a

person's right to appropriate treatment and related services in a setting which is most supportive and least restrictive of liberty. The authors state that Congress adopted this doctrine as a matter of social policy in the Developmentally Disabled Assistance and Bill of Rights Act of 1976.

McGarry, A.L. & Greenblatt, M. Conditional voluntary mental-hospital admission. New England Journal of Medicine, 1972, 287 (6), 279-280.

The authors consider the practice of voluntary mental hospital admission under certain contractual conditions to be a desirable alternative to court-mediated involuntary commitment. However, total abolition of involuntary civil commitment may lead to destructive consequences through an increased use of the criminal justice system in the management of the mentally ill. The authors conclude that some cases will always require conditional voluntary or involuntary commitment status in mental health facilities.

McGraw, B. D., and Keilitz, I. Civil commitment and the least restrictive alternative in Los Angeles County. Whittier Law Review, 1984, 6 (1), _____ (in press).

The authors discuss the importance of the least restrictive alternative doctrine to recent developments in civil commitment law throughout the country. The article focuses on California statutory provisions which provide opportunity for practical application of the doctrine and on related practices in Los Angeles County. The authors' observations, impressions, and conclusions regarding the least restrictive alternative as it appears in California statutes and as it is applied in Los Angeles County are presented.

Morse, S. J. A preference for liberty: The case against involuntary commitment of the mentally disordered. California Law Review, 1982, 70 (1), 54-106.

This article offers a policy argument in favor of abolishing or severely limiting involuntary commitment of the mentally disordered. The author does not present Constitutional arguments. Morse notes that one could construct an argument against the constitutionality of involuntary commitment. However, the argument would be unpersuasive and probably incorrect. The author's goal is to persuade the reader that regardless of its constitutionality, involuntary commitment is an unwise social policy.

Peck, C. L. Current legislative issues concerning the right to refuse versus the right to choose hospitalization and treatment. Psychiatry, 1975, 38 (4), 303-317.

The author discusses current issues, legislation, and judicial decisions regarding involuntary civil commitment. Peck describes three sources from which states derive the authority to impose involuntary

commitment: (a) the state's duty to protect society from potentially dangerous individuals, (b) the ability of the state to act as parens patriae, and (c) the state's obligation to protect potentially dangerous individuals from themselves. Peck discusses relevant court cases including Lake v. Cameron and Lessard v. Schmidt with reference to the exploration of alternatives to commitment.

Pepper, B., & Ryglewicz, H. Testimony for the neglected: The mentally ill in the post-deinstitutionalized age. American Journal of Orthopsychiatry, 1982, 52 (3), 388-392.

This article surveys the developments that served as catalysts for the trend toward deinstitutionalization and the resulting tendency toward noninstitutionalization. The authors contend that deinstitutionalization is largely the result of (a) the discovery of medications found to be effective in controlling symptoms of major mental illnesses, (b) legal decisions calling attention to the rights of the mentally ill, (c) economic factors raising the cost of caring for the mentally ill, and (d) the realization that treatment in the least restrictive environment provides the best opportunity for functional living. Although institutions have released many patients, little financial support for community alternatives has materialized. The authors suggest that care should be available to young adults who are intermittently psychotic and severely impaired yet have never been institutionalized.

The role of counsel in the civil commitment process: A theoretical framework. Yale Law Journal, 1975, 84 (7) 1540-1563.

This article notes that although most state legislatures and courts have recognized the need for representation by counsel at commitment hearings, neither have defined the role that counsel should play in these proceedings. The article suggests that role ambiguity stems from two basic assumptions underlying the system. First, the respondent's refusal of treatment for mental illness may not truly express his or her desires. Second, the proceeding is designed to help rather than punish the respondent. Thus the civil commitment process presents the lawyer with two alternative models for conduct: the "best interest" role and the traditional adversary or advocacy role. The lack of legislative or judicial guidance has posed to lawyers the dilemma of selecting the appropriate role to adopt.

Rosenzweig, S. The revolution in mental health: Issues and counter-issues. In Legal aspects of health policy: Issues and trends. Westport, CT: Greenwood Press, 1980.

The author examines recent challenges to both the psychiatric establishment and the legal framework within the mental health field and notes that psychiatrists now must routinely consider less restrictive alternatives. Topics discussed by Rosenzweig include: criteria for

involuntary hospitalization, patient advocacy, the right to treatment, the right to refuse treatment, deinstitutionalization, and the conversion to civil status of incompetent criminal defendants.

Rubin, J. Economics, mental health, and the law. Rutgers University, New York: Lexington Books, 1978.

The author outlines an economic analysis of litigation and court orders designed to guarantee an institutionalized patient the right to treatment and the right to care in the least restrictive environment. Rubin identifies the economic factors likely to influence implementation of such court orders and examines the economic rationales underlying public provision of mental health care.

Shah, S. A. Dangerousness and civil commitment of the mentally ill: Some public policy considerations. American Journal of Psychiatry, 1975, 732 (5), 501-505.

"Dangerousness to others" as a basis for involuntary civil commitment of the mentally ill is discussed. The article suggests that the issues involved in this topic often confound legal, public policy and mental health concerns. The questionable nature of the presumption of dangerousness in mental patients and psychiatrists' overprediction of dangerous behavior for this group indicate that the use of such criteria may serve to circumvent legal safeguards designed to ensure due process. Shah recommends that psychiatrists and other mental health professionals assume greater responsibility for the ways in which their services are used in these proceedings.

Shah, S.A. Legal and mental health system interactions: Major developments and research needs. International Journal of Law and Psychiatry, 1981, 4, 219-270.

This article discusses the developments that have occurred in the interactions between the legal and mental health systems in the United States during the last two decades. The author identifies the most salient topics that have current as well as future implications for public policy, service delivery programs, and research needs. The author calls for research aimed at translating legal and other concepts such as the least restrictive alternative doctrine, into relevant program procedures. Shah suggests that the problems related to deinstitutionalization are due to improper planning, a failure to allocate sufficient resources to community-based programs, and the lack of effective implementation of the new mental health laws.

Simon, R. J., & Cookerham, W. Civil commitment, burden of proof, and dangerous acts: A comparison of the perspectives of judges and psychiatrists. Journal of Psychiatry & Law, 1977, 5 (4), 571-594.

The article describes and compares judicial and psychiatric perspectives on dangerousness and the criteria for involuntary civil commitment. Results of the project demonstrate that although judges and psychiatrists had approximately the same expectations that a person would be dangerous to self, others, or property, important attitudinal differences between the two professions exist. Disagreement surfaced on the extent of dangerousness inherent in specific acts, and judges appeared to be more willing to commit persons to a mental hospital with greater degrees of uncertainty than were psychiatrists.

Spece, R. G. Jr. Preserving the right to treatment: A critical assessment and constructive development of constitutional right to treatment theories. Arizona Law Review, 1978, 20 (1), 1-47.

This article provides an historical overview of the application of the least restrictive alternative doctrine. In a discussion of several pertinent cases that apply the doctrine to involuntary civil commitment, the author weighs the state's legitimate interests against fundamental personal liberties. Spece suggests that even in the absence of statutory or constitutional mandates, strong ethical and social policy reasons exist for adopting the least restrictive alternative doctrine. The article develops a right to treatment theory based on the doctrine.

Spece, R. G. Jr. Justifying invigorated scrutiny and the least restrictive alternative as a superior form of intermediate review: Civil commitment and the right to treatment as a case study. Arizona Law Review, 1979, 21, 1049-1094.

This article presents an argument favoring the application of invigorated scrutiny to right to treatment questions. The author enumerates a series of rules that the Supreme Court has implicitly followed in particularly representative precedents, including one case that directly deals with the rights of mental patients. The author then applies these "rules" to the right to treatment issue within the context of the least restrictive alternative theory previously developed by the author in the article noted above.

Stein, L. I., & Test, M. A. From the hospital to the community: A shift in the primary locus of care. New Directions for Mental Health Services, 1979, 1, 15-32.

The authors explain a conceptual model for developing community-based treatment programs for the chronically disabled psychiatric patient. The article then describes a treatment program based on this model entitled "Training in Community Living" (TCL) that was developed as

an alternative to mental hospital treatment. The authors report the first year's results of a controlled experiment which compared TCL with short-term hospitalization plus aftercare.

Stone, A. A. Recent mental health litigation: A critical perspective. American Journal of Psychiatry, 1977, 134 (3), 273-279.

The author examines the effect of recent mental health litigation on the role of the psychiatrist and the provision of mental health care in the following areas: the right to refuse treatment, the least restrictive alternative, and the right to treatment. The author's specified goal is to highlight the fallacy and costs of applying the procedural model of criminal law to the civil commitment system in a wholesale fashion. The LRA doctrine is considered in light of Dixon v. Weinberger and Stone notes the possibility that the doctrine may be used to promote abolition of involuntary civil commitment.

Tieger, A. W., & Kresser, M. A. Civil commitment in California: A defense perspective on the operation of the Lanterman-Petris-Short Act. The Hastings Law Journal, 1977, 28, 1407-1434.

The authors examine the application of the Lanterman-Petris-Short Act (LPS) during its first seven years, with special emphasis on its operation in Santa Clara County, California. Focusing principally on the impact of the LPS Act on the civil liberties of the allegedly mentally ill, the authors highlight those elements which provide crucial leverage for the patient's attorney as well as those which frustrate advocacy and the protection of the patient's rights. The authors conclude that the LPS Act needs to be legislatively and judicially re-evaluated. The "least restrictive alternative doctrine" is discussed in connection with Dixon v. Weinberger (1975).

Ward, P. J. Developments in the law--Civil commitment of the mentally ill. Harvard Law Review, 1974, 87, 1190-1408.

This article examines involuntary commitment standards and procedures and the rights and obligations of involuntarily committed individuals. The authors advocate the use of less restrictive alternatives (particularly in Section II.D., "Commitment and the Least Restrictive Alternative Doctrine"). Ward also discusses the applicability of the LRA doctrine, its impact on commitment standards, and the desirability of creating new alternatives.

Wexler, D. B., & Scoville, S. E. The administration of psychiatric justice: Theory and practice in Arizona. Arizona Law Review, 1971, 13 (1), 1-188.

Within the context of issues concerning mentally disturbed individuals, the authors explore the inherent conflict in our legal

system between personal liberty and the need for an ordered society. In an effort to resolve this conflict, all states have adopted statutes providing for the confinement of certain mentally ill persons. However, most states provide only two alternatives -- commitment or release. Wexler and Scoville examine the ramifications of this approach and suggest that the use of less restrictive treatment alternatives will more adequately treat disordered individuals and still protect society from possible harm. In Appendix A of the article, the authors provide examples of statutes that embody the concept of minimal restriction on human activity.

Whitmer, G. E. From hospitals to jails: The fate of California's deinstitutionalized mentally ill. Journal of the American Orthopsychiatric Association, 1980, 50, 65-75.

Enacted in California in 1968, the Lanterman-Petris-Short Act (LPS) changed the criteria for involuntary hospitalization, limited the duration of involuntary confinement in a psychiatric hospital, legislated rights for mental patients, and provided the financial impetus to shift the locus of treatment from state hospitals to community-based programs. In this article, the author examines one of the major consequences of the LPS Act: the movement of the newly deinstitutionalized patients into the criminal justice system. Whitmer discusses programmatic, clinical, and legal factors involved in this movement and concludes that the failure of less restrictive alternatives is due to unforeseen clinical needs of the new outpatient population, the inability of community mental health centers to meet these needs, and the LPS Act's emphasis on the concept of dangerousness. The author provides a list of specific recommendations for revising the LPS Act.

Wimpfheimer, S. A guide to involuntary admissions of the mentally ill under the revised mental hygiene law. New York State Bar Journal, February 1973, 93-97.

The author explains the changes the New York Mental Hygiene Law of 1973 effected in the involuntary admission of New York's mentally ill. Topics include the procedures for involuntary admission on a two physician certificate, admission on grounds of serious harm, and patient review. At least two provisions of the law are influenced by the least restrictive alternative doctrine. The examining physician must consider less restrictive alternatives before ordering involuntary commitment, and the court may transfer the patient to the care and custody of a willing and able relative upon the relative's written consent.

Zanditon, M., & Hellman, S. The complicated business of setting up residential alternatives. Hospital and Community Psychiatry, 1981, 32 (5), 335-339.

In an effort to fulfill the needs of deinstitutionalized clients characterized by low incomes, isolation from their families, and an inability to function independently, the Massachusetts Mental Health Center has developed a system of carefully monitored independent living alternatives. The article details the authors' experiences with less restrictive alternatives to institutionalization, including how the system was developed, what procedures were instituted, and how crises are handled. The authors conclude that the system provides enormous benefits to the clients for whom it was designed.

ELDERLY PERSONS

Alexander, G. J. On being imposed upon by artful or designing persons - The California experience with the involuntary placement of the aged. San Diego Law Review, 1977, 14 (5), 1083-1099.

The author states that unless California demonstrates some legitimate reason for depriving an elderly person of autonomy, the state's procedures for involuntary placement of the elderly violate both the liberty ethic and constitutionally protected liberty interests. The article explores unexamined assumptions underlying the present law such as the doubtful notion that the involuntary placement process benefits the older person. Alexander maintains that even if the state could demonstrate the benefit, it would not offset the deprivation of liberty unless the "benefited" person would be unlikely to survive if left to his or her own devices. Other issues discussed include diagnoses which are vague and capable of misapplication, the level of involuntary placement, and the effect of protective services (which often shorten rather than prolong life).

Bernotavicz, F. Improving protective services for older Americans: Family, neighbors, and friends. A National Guide Series, prepared by the Human Services Development Institute, Center for Research and Advanced Study, University of Southern Maine, 1982.

The author reports that protective service providers often overlook the informal support network created by family, neighbors, and friends in providing protective services. The article describes the characteristics of the informal network and explains how social workers can employ the services of family, neighbors, and friends as less restrictive alternatives to institutionalization. Bernotavicz suggests that in assisting the family to choose the most suitable legal option for providing protective service, the social worker should encourage the family to take surrogate authority only in those areas in which the elderly person is unable to function and leave decision-making authority in all other areas with the elderly person. The author provides a list of legal options ordered from the least to most restrictive.

Bernotavicz, F., Bergman, J., Schumacher, D., Segars, H., & Wink-Basing, C., Improving protective services for older Americans: Community role. A National Guide Series, prepared by the Human Services Development Institute, Center for Research and Advanced Study, University of Southern Maine, 1982.

This booklet was written to help program developers mobilize and coordinate community resources in an effort to improve protective services. The booklet describes strategies for developing community networks, discusses the role and need for public education, and identifies a range of innovative community-based programs. The authors view the LRA doctrine as a guide for selecting legal and financial management options for clients. A list of options is provided, ordered from the least to most restrictive. The authors believe less restrictive alternatives are particularly desirable and greatly needed in the areas of health care, mental health care, and housing. Examples of less restrictive alternatives in each of these areas are provided.

Coburn, A.F., & Luppens, J. Improving protective services for older Americans: Health care role. A National Guide Series, prepared by the Human Services Development Institute, Center for Research and Advanced Study, University of Southern Maine, 1982.

Health and mental health professionals perform a variety of important protective service functions. They also provide expertise to help states and communities develop non-institutional home and community-based support services that enable elderly clients to remain in their own homes or in the setting that is least restrictive of their life-style and independence. This guide describes health care roles in the delivery of protective services, discusses some of the problems that health care professionals face in the field, and suggests strategies for improving services. The authors stress that less restrictive alternatives best preserve the individual's right to self-determination and privacy.

Cohen, E.S. Civil liberties and the frail elderly. Society, 1978, 5 (115), 34-42.

Cohen examines statutes that confer special status on the elderly and give them certain benefits. Although the elderly are legally defined as adults, they often suffer loss of health, sensory acuity, reaction time, memory, and economic viability. Many elderly people are still capable of making decisions but need assistance in carrying them out. In a claim-based society, many elderly people may need such assistance to benefit from public programs. The author suggests that agency law and the least restrictive alternative principle appear to offer means of helping the elderly obtain appropriate services. The author also addresses the special problems a claim-based system presents for nursing home residents.

Collins, M., & LaFrance, A.B., Improving protective services for older Americans: Social worker role. A National Guide Series, prepared by the Human Services Development Institute, Center for Research and Advanced Study, University of Southern Maine, 1982.

This volume addresses the key decisions social workers must make in casework situations and describes some of the dilemmas they confront. The authors suggest practical methods for improving decision-making such as the development of case plans which include less restrictive alternatives. Four plans are presented that encompass an incremental range of restrictiveness.

Havemeyer, H. Adult protective services: An overview. Conference Background Papers from A National Law and Social Work Seminar, "Improving Protective Services for Older Americans", University of Southern Maine, 1982.

This paper focuses on the complexity of protective services delivery. The author reviews the evaluative and decision-making processes workers have used to integrate theory and law in practice. According to Havemeyer, the least restrictive alternative doctrine tempers the state's parens patriae authority to care for its citizens and requires the state to use the least drastic means available to achieve its purpose. Sample cases are presented which address police power, parens patriae, the least restrictive alternative, and guardianship issues.

Hornby, H., Collins, M., & Segars, H. Improving protective services for older Americans: Program development and administration. A National Guide Series, prepared by the Human Services Development Institute, Center for Research and Advanced Study, University of Southern Maine, 1982.

This booklet presents administrators, legislators, and program developers with a framework for developing or improving a protective services program. The authors' recommendations are based on an analysis of laws in eighteen states and a review of ethical, policy, administrative, and service delivery issues. This booklet identifies twelve substantive areas that states may wish to include in their own statutory provisions. The authors discuss statutory provisions for consideration of less restrictive alternatives in placement decisions and the use of the LRA doctrine by program developers in structuring proper responses to emergency situations.

Horstman, P. M. Protective services for the elderly: The limits of parens patriae. Missouri Law Review, 1975, 40 (2), 215-278.

In section A of the article, entitled "The Least Restrictive Alternative", Horstman discusses state imposition of protective services at the expense of First Amendment rights. The author suggests that state use of protective services is legitimized as a means of preserving the health and life of elderly citizens. The author suggests that this rationale allows the state to adopt means more drastic than necessary to protect the individual. Certain landmark cases are reviewed including Lake v. Cameron and Donaldson v. O'Connor. (See the reviews of these cases in the previous chapter.)

Kapp, M.B. Promoting the legal rights of older adults: Role of the primary care physician. The Journal of Legal Medicine, 1982, 3 (3), 367-412.

This article investigates the current status of physician-attorney collaboration on behalf of older clients and analyzes legal issues of importance to older individuals. Use of the least restrictive alternative doctrine in placement decisions is advocated. Kapp maintains that primary care physicians are unaware of, and unconcerned with, noninstitutional alternatives for their older patients and too readily recommend placement of older patients in nursing homes without adequate exploration.

LaFrance, A.B. Improving protective services for older Americans: Legal role. A National Guide Series, prepared by the Human Services Development Institute, Center for Research and Advanced Study, University of Southern Maine, 1982.

This article explores the roles of attorneys, judges, and legal advocates in adult protection. LaFrance discusses application of the LRA doctrine in terms of guardianship in its various forms, conservatorship, voluntary and involuntary commitment, protective orders, and power of attorney. The author maintains that the least restrictive placement for the client is the preferred alternative.

National Senior Citizen's Law Center. Protective services and guardianships: Legal services and the role of the advocate. Los Angeles, California, undated.

This paper considers the involuntary aspects of protective services for the elderly, focusing on guardianship, redress from guardianships (affirmative remedies), constitutional challenges to state guardianship laws, and the role of the public guardian. The authors include a concise review of case law relevant to the LRA doctrine and discuss application of the doctrine by the courts in the development of guardianships and conservatorships as less restrictive alternatives to involuntary civil commitment.

Regan, J. J. Protecting the elderly: The new paternalism. The Hastings Law Journal, 1981, 2, 1111-1132.

This article examines the effect on the elderly of the expansion of adult protective services legislation. The author summarizes traditional methods of legal intervention (civil commitment and guardianship) and notes that inadequacies of these methods resulted in the evolution of the due process model of intervention that underlies many of the current adult protective services programs. The author analyzes legislation enacted in eleven states, revealing procedural shortcomings, vague and inappropriate standards for identifying who shall receive protective services, and a lack of accountability on the part of the public agencies that administer the services. He concludes that reforming existing statutes to circumscribe the use of involuntary intervention is preferable to eliminating adult protective services.

Schmidt, W., Miller, K., Bell, W., & New, B. Alternatives to public guardianship. State and Local Government Review, 1982, 14 (3), 128-131.

When elderly and certain handicapped individuals who do not have family or friends to serve as guardians are adjudged legally incompetent, many state and local governmental agencies appoint public guardians. The author reports on the need for public guardians in Florida, a state which may represent America's demographic future. The authors explore alternatives to public guardianship including benign neglect, informal guardianship, mental hospitalization, guardianship by banks and trust companies, and guardianship by nonprofit corporations. The author concludes that the existing alternatives to public guardianship in Florida are not meeting the needs of the people, and recommends that Florida develop a system of guardianship that includes less restrictive alternatives.

Wink-Basing, C. Building a community-based network for adult protective services. Conference Background Papers from A National Law and Social Work Seminar, "Improving Protective Services for Older Americans", University of Southern Maine, 1982.

This article considers the benefits of establishing an Adult Protective Services (APS) network. The author details the Kalamazoo County APS Agency Network Model Plan and describes the Policies and Procedures Manual for the Multidisciplinary Case Consultation Team, Kalamazoo Adult Protective Services Consortium. The author suggests that one of the specific advantages of establishing a community-based network is to assist local social service staff in providing the least restrictive alternative to hospitalization for clients.

Barshefsky, C., & Liebenberg, R. Voluntarily confined mental retardates: The right to treatment vs. the right to protection from harm. Catholic University Law Review, 1974, 23, (4), 787-805.

The authors respond to the Willowbrook consent decree, which found a constitutional right to protection from harm but not to treatment. The authors argue that the least restrictive alternative doctrine provides the mentally retarded a constitutional right to treatment. The authors base their argument on decisions concerning treatment of the mentally ill and maintain that the fundamental liberties at stake are the same for both groups. The article proceeds to discuss the complex issues involved in enforcement of the right to treatment.

Kindred, M., Cohen, J., Penrod, D., & Shaffer, T. The mentally retarded citizen and the law. Ohio State University College of Law, New York: Free Press, 1976.

The authors discuss the legal rights of mentally retarded individuals. Among these rights are privacy rights such as the right to not be labelled as mentally retarded and the right to not be subject to nonconsensual medical procedures. The right to due process during civil commitment proceedings and the right to treatment in the least restrictive alternative during institutionalization are also discussed.

Miller, S. R., Miller, T. L., & Repp, A. C. Are profoundly and severely retarded people given access to the least restrictive environment? An analysis of one state's compliance. Mental Retardation, 1978, 16 (2), 123-126.

In order to test one state's adherence to court decisions and federal guidelines that have sought to provide retarded persons access to the least restrictive treatment environment, the authors conducted a study of three mental health facilities for severely and profoundly handicapped persons. Results of the study indicate that although placement staffings are appropriately conducted, only a small percentage of students who could be placed in less restrictive environments are so placed. The researchers also found that parents abrogate their right to monitor their children's services and placements, and that public schools resist placement of the severely or profoundly retarded student.

Roos, P., & McCann, B. M. Major trends in mental retardation. International Journal of Mental Health, 1977, 6 (1), 3-20.

The authors suggest that because human beings value their superior intelligence so highly they tend to regard those lacking in intelligence as less than human. This attitude has stigmatized mentally retarded persons and denied them full participation in society. The article specifies the levels of retardation and briefly outlines the history of

the treatment of retarded individuals. Roos and McCann review current trends in philosophy, attitudes, and practices including the use of the developmental model of retardation, acceptance of the normalization principle, adoption of the goals of individualization and self-actualization, and the growth of advocacy programs. The authors also discuss issues related to the least restrictive alternative.

OTHER APPLICATIONS

Bastress, R. M., Jr. The less restrictive alternative in constitutional adjudication: An analysis, a justification, and some criteria. Vanderbilt Law Review, 1974, 27 (5), 971-1041.

The author examines relevant case law to determine how the LRA doctrine has been applied in several areas of constitutional law. He explores judicial scrutiny of legislative alternatives and concludes that such scrutiny is appropriate. The author's assessment of the scope of judicial review reveals that courts should develop criteria and standards for principled application of the LRA doctrine. The suggested focus is upon the extent to which the courts should pursue alternatives, defer to legislative intent, or rely on their own assessments.

Less drastic means and the First Amendment. The Yale Law Journal, 1969, 78 (3), 464-474.

This article studies the United States Supreme Court's use of the phrase "less drastic means" or similar phrases in decisions involving First Amendment issues. The article discusses the role of the "less drastic means" concept in First Amendment jurisprudence and describes the complex investigation necessary to employ this concept.

Rubin, S. Probation or prison: Applying the principle of the least restrictive alternative. Crime and Delinquency, 1975, 21 (4), 331-336.

Although the least restrictive alternative doctrine has been recognized as a way of remedying unjust and inconsistent prison sentences, most trial and appellate courts have failed to use it. Rubin supports his position that the courts should implement the doctrine by contrasting cases that apply less restrictive alternatives with others that do not. The author suggests that efforts to rationalize sentencing need legislative support. He presents and endorses the sentencing criteria developed by the National Advisory Commission on Criminal Justice Standards and Goals, which emphasize less restrictive alternatives to incarceration.

Struve, G. M. The less-restrictive-alternative principle and economic due process. Harvard Law Review, 1967, 80, 1463-1488.

According to Struve, legal commentary on economic due process has often confused the less restrictive alternative principle with other tests used to determine the validity of economic regulations. The author analyzes the components of the principle and demonstrates its continued influence in state and federal jurisdictions. Struve advocates that the Supreme Court return to its use of the LRA principle as an independent ground for invalidating over broad regulations.

Wormuth, F. D. & Mirkin, H. G. The doctrine of the reasonable alternative. Utah Law Review, 1964, 9 (2), 254-307.

The authors examine the doctrine of the "reasonable alternative" which attempts to balance the state's need to regulate certain aspects of society with the individual's constitutional guarantees such as freedom of speech, freedom from restraint, and freedom of religion. Courts have employed this doctrine to resolve conflicts between the values of an ordered society and individual liberty. The article contains a comprehensive collection and analysis of the Supreme Court's applications of this constitutional principle.

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Least Restrictive Alternatives in Involuntary Civil Commitment: A Summary of Statutes in Seven States, Case Law Review, and an Annotated Bibliography. By Bradley D. McGraw, Richard Van Duizend, Ingo Keilitz, Daina Farthing-Capowich, and Associates. Provisions for the application of the least restrictive alternative (LRA) doctrine in the mental health laws of Arizona, California, Illinois, Missouri, New York, Virginia, and Wisconsin are analyzed. State and federal court rulings and relevant literature are reviewed. 108 pages, including a chart comparing LRA provisions in the mental health laws of the seven states studied. Order No. OPS-007, $6.84.

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