The Final Report of the Least Restrictive Alternative Project*

A MODEL FOR THE APPLICATION OF THE LEAST RESTRICTIVE ALTERNATIVE DOCTRINE IN INVOLUNTARY CIVIL COMMITMENT

Institute on Mental Disability and the Law
National Center for State Court

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ACKNOWLEDGEMENT

As with any project of the size and duration of the Least Restrictive Alternative Project, many individuals had a hand in its completion in addition to the project staff listed by name on the title page of this report. During the field research in Chicago, Kansas City, Los Angeles, Milwaukee, New York, Tucson, and Williamsburg-James City County, literally hundreds of individuals helped to explain and demonstrate the workings of the involuntary civil commitment process. Their generous help is gratefully acknowledged.

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The staff and management of the National Center for State Courts are acknowledged for their contributions to the project. The National Center Library staff provided enormous aid in locating and acquiring reference materials throughout the project period. The staff of the Word Processing Center, the Xeroxing Center and the Publication Department provided invaluable support to the project.

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PROJECT ABSTRACT

Involuntary civil commitment is the legal and psychosocial process whereby a mentally disordered person is restrained and treated against his or her will, presumably for his or her own good and the good of others. In the 1960s and 1970s, during a time when the humane and fair treatment of mentally disordered persons became a civil rights issue of the first order, policymakers began to recognize that mentally disordered individuals have a constitutionally protected interest in being left alone and, if they are to be subjected to involuntary commitment they should be treated in the least restrictive setting. The application of the doctrine of the "least restrictive alternative" to involuntary civil commitment became one of the most important trends in mental health law. The "least restrictive alternative" in involuntary civil commitment is that combination of therapeutic and preventative intervention that is (a) conducive to the most effective and appropriate treatment which will give the mentally disordered person a realistic opportunity to improve his or her level of functioning, and (b) no more restrictive of a person's physical, social, or biological liberties than is necessary to achieve legitimate state purposes of protection of society and helping those that cannot help themselves. Unfortunately, the translation of the least restrictive alternative doctrine from theory into practice has faced difficulties.

In October 1982, the Institute on Mental Disability and the Law of the National Center for State Courts began a twenty-one month project, the Least Restrictive Alternative Project, to develop a model for the fair and workable application of the "least restrictive alternative" doctrine in involuntary civil commitment proceedings. The primary method of inquiry of the project was field research conducted in seven localities throughout the country: Chicago, Kansas City, Los Angeles, Milwaukee, New York, Tuscon, and Williamsburg-James City County. The project had three phases. The first phase consisted of a review and analysis of state mental health statutes, court rulings, and professional literature. In the second phase of the project, extensive field research focused on the application of the doctrine at the level of actual practice. Interviews were conducted with hundreds of judges, court personnel, attorneys, and mental health professionals throughout the country. Project staff also observed judicial hearings and other commitment proceedings. In the third and final phase of the project, the information gathered during the first phase was intergrated with the results of the field research and a model was developed for the just and practical application of the least restrictive alternative doctrine in involuntary civil commitment proceedings. The model, described in the final project report, attempts to bridge the wide gap between the theoretical demands of the doctrine and the difficulties of applying it in practice.

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POLICY AND PROGRAM IMPLICATIONS STATEMENT

During the 1960s and 1970s, when the humane and fair treatment of mentally disordered persons became a civil rights issue of the first order, policymakers began to recognize that mentally disordered individuals have a constitutionally protected interest in being left alone and, if they are to be subjected to involuntary commitment they should be treated in the least restrictive environment. The application of the doctrine of the "least restrictive alternative" to involuntary civil commitment of mentally disordered persons, many of them older Americans, became one of the most important trends in mental health law. However, the translation of the least restrictive alternative doctrine from theory into practice faces considerable difficulties. To be effective, the least restrictive alternative doctrine must be translated into specific procedures and programs routinely applicable on a case-by-case basis. No simple formula exists that will give practical meaning to the doctrine. Because its application in involuntary civil commitment proceedings implicates several professional disciplines, giving practical meaning to the doctrine demands much collaborative thought and action.

The Least Restrictive Alternative Project resulted in detailed descriptions of the application of the least restrictive alternative doctrine to involuntary civil commitment in Chicago, Kansas City, Los Angeles, Milwaukee, New York, Tucson, and Williamsburg-James City County (Virginia), as well as a set of guidelines for the doctrine's application to involuntary civil commitment proceedings in general. Together, these detailed descriptions of exemplary practices and the guidelines may be used as a model that may bridge the wide gap between the theoretical demands of the doctrine and the difficulties of applying it in practice. To the extent that the model developed by the Least Restrictive Alternative Project is communicated to and used by policy makers and practitioners, and to the extent that it gives practical meaning to the doctrine of the least restrictive alternative, needed improvements in the involuntary civil commitment processes involving mentally disordered persons can be facilitated.

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DISSEMINATION AND UTILIZATION STATEMENT

Dissemination of the research findings and reports of the Least Restrictive Alternative Project during the project's active period has been both extensive and timely. Throughout the project period, the National Center's Publication Department publicized the project in numerous periodicals. Articles about the project have appeared in journals and newsletters such as the New Jersey Law Journal, the State Court Journal, Bench Plan (the official publication of the National Council for Judicial Planning), The Column (published by the National Association of Trial Court Administrators), and the Court Improvement Bulletin.

The first project report, titled "The Least Restrictive Alternative in Involuntary Civil Commitment," included a thorough case law review, a summary of the statutes in the seven states selected for study, and an annotated bibliography of materials relevant to the philosophical and legal issues surrounding the use of the least restrictive alternative doctrine. This report was distributed initially in draft form to the members of the Advisory Board of the National Center's Institute on Mental Disability and the Law, and to selected participants in the various project study sites. Following revision and expansion, the report was sent to numerous project participants and others interested in the project. It was added recently to the National Center's comprehensive publications list and appears as the most recent issue of the Institute's Occasional Paper Series, Perspectives on Mental Health and the Law. Announcements of its availability appeared in several of the National Center's publications, including the monthly Report, which is distributed to more than 2,100 courts and interested organizations and individuals throughout the country.

Reports for each of the seven localities studied (Chicago, Kansas City, Los Angeles, Milwaukee, New York, Tucson, and Williamsburg-James City County) were distributed to key individuals who participated in the research effort to solicit their comments concerning the factual accuracy of the content and the cogency of the inferences drawn. Approximately twenty-five reviews were solicited in each of the project sites.

The individual site reports in Section II of the final project report have been, or will be in the future, submitted for publication in law reviews in the various states in which the project was conducted. This dissemination has resulted in publication of the Los Angeles Report in the Whittier Law Review, Volume 6, Number 1, 1984. The St. Louis University Law Review and the UMKC Law Review have agreed to publish the Kansas City Report subject to the approval of revisions. Other site reports are currently under consideration for publication by other law reviews. Section III of the final report, containing the general guidelines for the application of the least restrictive alternative doctrine in involuntary civil commitment proceedings, will be submitted for publication in an appropriate professional journal (e.g., the International Journal of Law and Psychiatry) upon receipt and incorporation of review comments.

In addition to these dissemination activities, the project staff has promoted the working relationships developed during the project's field research in order to increase the prospects of utilization of the project's findings. In Milwaukee, a subcommittee of the Task Force on Human Services and the Law of Milwaukee's Planning Council for Mental Health and Social Services has begun to review the Milwaukee Report and consider its findings and implications. Similarly, the Task Force on Less Restrictive Alternatives in Kansas City, Missouri, convened at the request of the Victor E. Speas Foundation, has begun to consider the project's findings in Kansas City.

After review and approval by the Administration on Aging, copies of the project's final report will be sent to federal, state, and local agencies that may be likely to participate in efforts to coordinate social services to facilitate the application of the least restrictive alternative doctrine. Copies will also be distributed to interested legal and mental health professionals across the country. The final report will become part of the National Center's publications listing. Finally, all project documents will become a part of the National Center's Library collection of more than 11,000 volumes. The library is readily accessible to the students and faculty of the College of William and Mary, to major universities and libraries through inter-library loans, and to many court and mental health professionals through the Center's Research and Information Service loan program.

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EXECUTIVE SUMMARY

Introduction

Involuntary civil commitment, the subject of litigation, legislative activity, and public debate over the last two decades, is the legal and psychosocial process whereby a person alleged to be mentally disordered and dangerous is restrained and treated against his or her will, presumably for his or her own good and the good of others. Thirty years ago, mentally disordered persons "certified" as suitable for compulsory hospitalization were likely to be confined for long periods of time with little or no treatment, usually in large institutions with inadequate staff and disgraceful conditions. However, during the 1960s and 1970s, the humane and fair treatment of mentally disordered persons became a civil rights issue of the first order. Policymakers and courts soon recognized that mentally disordered individuals have a constitutionally protected interest in being left alone, and if they are to be subjected to involuntary commitment, they should be treated in the least restrictive environment and therapeutic program. The application of the doctrine of the "least restrictive alternative" to involuntary civil commitment became one of the most important trends in mental health law.

The least restrictive alternative in involuntary civil commitment is that combination of therapeutic and preventative intervention provided by mental health and social service providers that is (a) conducive to the most effective and appropriate treatment which will give the mentally disordered person a realistic opportunity to improve his or her level of functioning, and is (b) no more restrictive of his or her physical, social, or biological liberties than necessary to achieve legitimate state purposes of protection of society and provision of mental health treatment and care for the person's own good.

One cannot seriously consider the involuntary civil commitment process, and the state's intrusions upon individual liberties that the process may entail, without confronting fundamental differences of opinion and conflicting attitudes about mental disorder and society's proper response and responsibility. Questions about the effectiveness of, efficiency of, equity of, and public satisfaction with, the

involuntary civil commitment process combine in a basic concern with the best balance among complex and often competing societal interests: those of the individual, the family, and the state. The individual has an interest in being left alone, and even if compelling reasons exist for infringing upon his or her privacy or freedom, the individual has a further interests in being treated fairly, honestly, and as well as possible. Family, friends, or acquaintances of the individual may have interests in making sure the individual is given the care and treatment he or she needs but is unwilling or unable to seek voluntarily. They may also have an interest in alleviating the burden upon themselves that the person's failure to seek help voluntarily has placed upon them. Finally, the state has two primary interests: to protect its citizenry from dangerously mentally disturbed persons and to care for its sick and helpless. In protecting these interests, the state has a duty not to create undue programmatic, fiscal, and administrative burdens by any procedures that it may be require. The "least restrictive alternative" doctrine may be useful for scrutinizing state intrusions upon individual liberties to the extent that it can balance, if not reconcile, these complex societal interests.

Within the last ten years, the doctrine's focus has shifted from applications aimed at testing the rationality of broad policies, statutes, and rules to applications on a case-by-case basis. However, the translation of the least restrictive alternative doctrine from theory into practice has faced difficulties. As Dr. Saleem Shah of the National Institute of Mental Health has noted, "while the doctrine prescribing the use of the 'least restrictive alternative' has fairly clear meaning and reference to certain legal and constitutional values concerning infringement of personal freedom and liberty, the notion does not translate readily into mental health procedures and programs." Other serious difficulties facing the translation of legal and social concepts into reality are the unavailability of resources, the barriers of formidable state and federal bureaucacies, and the sheer size and complexity of the cooperative effort required.

In their seminal study of the least restrictive alternative doctrine, Professors Hoffman and Foust concluded that "the doctrine's current conceptualization and application to the involuntary treatment of the mentally ill ... raises serious questions about its implementation, definition and fundamental purpose." This conclusion, reached seven years ago, may still be valid today.

Study Method

The purpose of the Least Restrictive Alternative Project, which was conducted by the Institute on Mental Disability and the Law from October 1982 to June 1984, was to develop a model (i.e., a representation to show the general structure) for the fair and workable application of the least restrictive alternative doctrine in involuntary civil commitment proceedings. The project was designed to develop new knowledge about the application of the least restrictive alternative doctrine in involuntary civil commitment proceedings. More specifically, project efforts were to

focus on studying existing procedures for identifying, exploring, and using less restrictive alternatives for the placement of mentally disordered, developmentally disabled, and elderly persons in mental health care and treatment settings in seven locations across the country: Chicago, Kansas City, Los Angeles, Milwaukee, New York, Tucson, Williamsburg (Virginia).

The primary data collection method was field research in the seven project sites. Field research was supplemented by the collection, review, and analysis of relevant state statutes, court rulings, scholarly literature, and other background documentary materials. The project was conducted in three phases: a state-of-the-knowledge assessment, field research, and model development.

In the first phase, the statutes of the seven states pertaining to the provision and use of less restrictive alternatives were collected, reviewed, analyzed and compared. The prescribed legal process for the application of the least restrictive alternative to the commitment proceedings in each site was delineated carefully to aid the field research and allow for comparisons across states. Relevant court rulings were identified using traditional legal research methods. Finally, a broad search and analysis of the legal, mental health, and social science literature relevant to the study was undertaken.

The field research focused on the application of the least restrictive alternative doctrine at the level of practice. 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.

Finally, in the last phase of the project, project staff attempted to integrate the state-of-the-knowledge assessment of the first phase with the results of the field research conducted in the second phase. A qualitative content analysis was performed on the interview data. Interview data, observational data, and other documentary material (e.g., forms and agency reports) were compared to validate information. Note was made of topics of significance, points of consistent agreement, and points of disagreement. Project staff prepared seven detailed reports describing the application of the least restrictive doctrine to the involuntary civil commitment proceedings in the seven localities studied. Lastly, project staff developed guidelines for the application of the doctrine. Based on the detailed accounts of the doctrine's application in the seven localities, these guidelines represent a model meant to bridge the wide gap between the theoretical demands of the doctrine and the difficulties of applying it in practice.

The model is meant to assist those applying the doctrine on a case-by-case basis in the myriad of situations arising in the involuntary civil commitment of mentally disordered person. Section II of the full report describes and discusses in great detail the application of the least restrictive alternative doctrine in the involuntary civil commitment systems of seven localities (Chicago, Kansas City, Los Angeles,

Milwaukee, New York, Tucson, and Williamsburg-James City County). In Section III of the full report, specific guidelines are presented for the application of the doctrine to the commitment system and its procedures. To the extent that this model, supported by the detailed descriptions of the involuntary civil commitment systems in seven localities and of the contingencies of the application of the least restrictive alternative doctrine in those localities, is available for public knowledge and discussion, needed improvements in involuntary civil commitment can be facilitated.

Guidelines

Following the presentation of several guidelines dealing with definitional and organizational issues, the guidelines are presented generally in an order parallelling the chronology of events in involuntary civil commitment proceedings, from preliminary screening to ultimate release from compulsory hospitalization. The first crucial decision to detain a mentally disordered person and to coerce hospitalization, a decision most often made by family members, police officers, or community mental health personnel, is often not reviewed and checked until involuntary hospitalization is a fait accompli. Several guidelines highlight the preliminary stages of involuntary civil commitment, before a respondent is detained against his or her own will. These guidelines propose the mechanisms and procedures whereby such reviews and checks may be accomplished in accordance with the least restrictive alternative doctrine. Preliminary screening, negotiation, and cooperation among members of the mental health-law community are stressed.

Thirty years ago, the decision to commit a mentally disordered person to an institution was practically irrevocable. Today, mentally disordered persons have the right to be treated, if they are to be treated at all, in the least restrictive alternative facility and treatment program. The decision to treat in a restrictive setting became, at least in theory, reversible at any time. Several guidelines seek to translate this theory into practical terms by proposing involuntary outpatient treatment, on a conditional basis or in combination with inpatient treatment, as an alternative to inpatient hospitalization.

Finally, several guidelines stress cooperation among the professional groups involved in the involuntary commitment process. The mentally disordered person who becomes involved in this process is a "shared client" of the courts, law enforcement, mental health, and social work agencies. The realization of patients' rights, including the right to be treated in the least restrictive alternative environment, and the overall improvement of mental halth services is an immense job that cannot be done by the courts alone or by any other single unit of the mental health law system.

The guidelines are summarized below. The full report should be consulted for a commentary on each of the guidelines.

1. Definition of Least Restrictive Alternative

(A) THE "LEAST RESTRICTIVE ALTERNATIVE" IN INVOLUNTARY CIVIL COMMITMENT PROCEEDINGS IS THAT COMBINATION OF THERAPEUTIC AND PREVENTATIVE INTERVENTION THAT IS (1) CONDUCIVE TO THE MOST EFFECTIVE AND APPROPRIATE TREATMENT WHICH WILL GIVE THE RESPONDENT A REALISTIC OPPORTUNITY TO IMPROVE HIS OR HER LEVEL OF FUNCTIONING AND THAT IS (2) NO MORE RESTRICTIVE OF A RESPONDENT'S PHYSICAL, SOCIAL, OR BIOLOGICAL LIBERTIES THAN IS NECESSARY TO ACHIEVE THE LEGITIMATE STATE PURPOSES OF PROTECTION OF SOCIETY AND OF MENTAL HEALTH TREATMENT AND CARE FOR THE RESONDENT.

(B) IN DETERMINING THE LEAST RESTRICTIVE ALTERNATIVE ON A CASE-BY-CASE BASIS, JUDGES, ATTORNEYS, LAW ENFORCEMENT PERSONNEL, MENTAL HEALTH PROFESSIONALS, SOCIAL SERVICE PROVIDERS, OR ANY OTHER INDIVIDUALS WHO MAKE SUCH A DETERMINATION AT VARIOUS STAGES OF THE INVOLUNTARY CIVIL COMMITMENT PROCESS, SHOULD BALANCE THE INTERESTS OF THE RESPONDENT, HIS OR HER FAMILY, AND THE STATE WHILE CONSIDERING AND WEIGHING THE FOLLOWING FACTORS:

(1) THE ENVIRONMENTAL RESTRICTIVENESS OF THE TREATMENT SETTING (E.G., INPATIENT HOSPITAL, HALF-WAY HOUSE, OR COMMUNITY MENTAL HEALTH CENTER);

(2) THE PSYCHOLOGICAL OR PHYSICAL RESTRICTIVE-NESS OF BEHAVIORAL, CHEMICAL, OR BIOLOGICAL TREATMENTS;

(3) CLINICAL VARIABLES INCLUDING THE RESPONDENT'S BEHAVIOR AS IT RELATES TO THE LEGAL CRITERIA FOR COMMITMENT, THE RELATIVE RISKS AND BENEFITS OF TREATMENT ALTERNATIVES, AND THE FAMILY AND COMMUNITY SUPPORT AVAILABLE IN THE RESPONDENT'S ENVIRONMENT;

(4) THE QUALITY AND LIKELY EFFECTIVENESS OF THE CARE AND TREATMENT;

(5) THE DURATION OF THE TREATMENT;

(6) THE RISK THAT A RESPONDENT MAY POSE;

(7) THE AVAILABILITY, COST, AND ACCESSIBLITY OF THE TREATMENT;

(8) THE LIKELIHOOD OF THE RESPONDENT'S COOPERATION IN OR COMPLIANCE WITH THE TREATMENT PROGRAM; AND

(9) THE MECHANISM FOR MONITORING AND REVIEWING A RESPONDENT'S COMPLIANCE WITH THE CONDITIONS OF THE TREATMENT PROGRAM.

2. Right to Least Restrictive Alternative

STATE LEGISLATURES SHOULD PROVIDE RESPONDENTS WITH A COMPREHENSIVE STATUTORY RIGHT TO THE LEAST RESTRICTIVE ALTERNATIVE, AS DEFINED IN GUIDELINE 1.

3. Goals of the Mental Health System

THE APPLICATION OF THE LEAST RESTRICTIVE ALTERNATIVE DOCTRINE SHOULD BE INCORPORATED INTO STATUTORY AND REGULATORY LANGUAGE ARTICULATING A STATE'S GOALS AND PURPOSES IN PROVIDING MENTAL HEALTH CARE.

4. Continuum of Services

LEGISLATURES AND MENTAL HEALTH AGENCIES SHOULD DEVELOP AND IMPLEMENT A COORDINATED, COMPREHENSIVE MENTAL HEALTH SYSTEM THAT INCLUDES A CONTINUUM OF SERVICES FROM INTENSIVE INPATIENT TREATMENT AND CARE THROUGH VARIOUS NON-HOSPITAL RESIDENTIAL PROGRAMS TO OUTPATIENT COMMUNITY-BASED TREATMENT.

5. Guide to Less Restrictive Alternatives

MEMBERS OF THE MENTAL HEALTH/LEGAL COMMUNITY INVOLVED IN THE INVOLUNTARY CIVIL COMMITMENT PROCESS SHOULD HAVE FOR THEIR USE A COMPREHENSIVE, CURRENT GUIDE TO MENTAL HEALTH, MENTAL RETARDATION, AND OTHER SOCIAL SERVICES POTENTIALLY AVAILABLE TO RESPONDENTS. THIS GUIDE SHOULD BE DESIGNED TO FURTHER THE APPLICATION OF THE LEAST RESTRICTIVE ALTERNATIVE DOCTRINE ON A CASE-BY-CASE BASIS AND SHOULD INCLUDE, AT THE MINIMUM, THE FOLLOWING INFORMATION:

(1) A COMPLETE LISTING OF PUBLIC, PRIVATE, NON-PROFIT AND VOLUNTARY RESOURCES, AND THEIR LOCATIONS, SERVING MENTALLY DISORDERED PERSONS;

(2) A SHORT DESCRIPTION OF THE TYPES OF SERVICES OFFERED BY EACH RESOURCE LISTED;

(3) A BRIEF HISTORY OF SERVICES, IF ANY, PROVIDED TO PERSONS INVOLVED IN INVOLUNTARY CIVIL COMMITMENT PROCEEDINGS; AND

(4) THE SERVICE CAPACITY OF EACH RESOURCE INCLUDING:

(i) STAFF;

(ii) SIZE OF RESOURCE OR BED CAPACITY; AND

(iii) FISCAL ARRANGEMENTS FOR CLIENTS.

6. Interdisciplinary Cooperation

ALL AGENCIES, SERVICES, AND FACILITIES INVOLVED IN THE INVOLUNTARY CIVIL COMMITMENT PROCESS SHOULD CONVENE PERIODIC MEETINGS OF AN INTERDISCIPLINARY GROUP OF REPRESENTATIVES. THESE MEETINGS SHOULD PROVIDE A FORUM FOR DISCUSSION OF THE ROLE AND FUNCTION OF EACH ACTOR IN THE PROCESS AND OF PROBLEMS, AND THEIR POSSIBLE SOLUTIONS, ARISING IN THE PROCESSING OF RESPONDENTS. THIS GROUP SHOULD ENCOURAGE LINKAGES, COORDINATION, AND COOPERATION AMONG THE ACTORS IN THE CIVIL COMMITMENT PROCESS IN ORDER TO PROTECT AND FUTHER RESPONDENTS' RIGHTS AND INTERESTS IN LIBERTY AND TREATMENT IN THE LEAST RESTRICTIVE ALTERNATIVE.

7. Screening Before Involuntary Detention

REGARDLESS OF WHETHER COMMITMENT PROCEEDINGS ARE INTITIATED ON A NON-EMERGENCY OR EMERGENCY BASIS, PRELIMINARY SCREENING OF ALL RESPONDENTS SHOULD BE ACCOMPLISHED BY A COMMUNITY-BASED MENTAL HEALTH CARE AGENCY BEFORE A RESPONDENT IS ORDERED TO UNDERGO INVOLUNTARY TREATMENT AND CARE.

8. Screening Agents and Their Functions

(A) COMMUNITY-BASED SCREENING AGENTS, OR GATEKEEPERS, SHOULD FUNCTION AT THE THRESHOLD OF INVOLUNTARY CIVIL COMMITMENT PROCEEDINGS AND MAKE INFORMED DECISIONS ABOUT WHETHER INVOLUNTARY CIVIL COMMITMENT SHOULD BE PURSUED ALONG EMERGENCY OR NONEMERCENCY ROUTES IN A PARTICULAR CASE, OR WHETHER LESS RESTRICTIVE ALTERNATIVES SHOULD BE CONSIDERED.

(B) GATEKEEPERS SHOULD BE MENTAL HEALTH PROFESSIONALS, OR COURT PERSONNEL WORKING IN COOPERATION WITH MENTAL HEALTH PROFESSIONALS, EXPERIENCED IN THE DIAGNOSIS OF MENTAL ILLNESS AND FACILE IN APPLYING THE LEGAL, PSYCHOLOGICAL, AND SOCIAL CONSTRUCTS USED IN MAKING DECISIONS CONCERNING DETENTION PURSUANT TO INVOLUNTARY HOSPITALIZATION, RELEASE, AND ALL INTERMEDIATE ALTERNATIVES. GATEKEEPERS SHOULD HAVE THE AUTHORITY TO ORDER INVOLUNTARY DETENTION AND TO REQUEST AMBULANCE OR

POLICE ASSISTANCE FOR TRANSPORTING RESPONDENTS TO AND FROM APPROPRIATE MENTAL HEALTH FACILITIES.

(C) WHEN A COMMUNITY MENTAL HEALTH AGENCY OR SOME OTHER HEALTH CARE AGENCY (HEREINAFTER "PORTAL") RECEIVES A REQUEST FOR AN APPLICATION FOR INVOLUNTARY COMMITMENT, A GATEKEEPER SHOULD: (1) IMMEDIATELY DETERMINE WHETHER TO PURSUE COMMITMENT PROCEEDINGS, OR TO ADVISE THE APPLICANT TO SEEK ALTERNATIVES; (2) IF SUCH ALTERNATIVES ARE NOT PURSUED BY THE APPLICANT, ASSIST THE APPLICANT IN COMPLETING THE APPLICATION FOR INVOLUNTARY COMMITMENT; AND (3) REVIEW AND INVESTIGATE THE APPLICATION AND SCREEN THE RESPONDENT.

(D) INVESTIGATION AND REVIEW OF THE APPLICATION SHOULD INCLUDE THE FOLLOWING: (1) REVIEW AND ASSESSMENT OF THE RELIABILITY AND CREDIBILITY OF ALL FACTUAL INFORMATION CONTAINED IN THE WRITTEN APPLICATION, (2) INTERVIEWS OF THE APPLICANT AND AVAILABLE WITNESSES WHO HAVE KNOWLEDGE OF THE RESPONDENT THROUGH PERSONAL INFORMATION.

SCREENING SHOULD INCLUDE A PERSONAL INTERVIEW WITH THE RESPONDENT WHEREUPON A DETERMINATION IS MADE TO PURSUE INVOLUNTARY CIVIL COMMITMENT OR TO DIVERT THE RESPONDENT TO LESS RESTRICTIVE TREATMENT AND CARE. THE INTERVIEW SHOULD BE CONDUCTED AT A COMMUNITY PORTAL AT A SPECIFIC TIME AND DATE OR, IF THE RESPONDENT IS UNWILLING OR UNABLE TO COME TO THE PORTAL, AT THE RESIDENCE OR OTHER LOCATION OF THE RESPONDENT OR, IF A PERSONAL FACE-TO-FACE INTERVIEW CANNOT BE ARRANGED WITHIN THE PRESCRIBED TIME LIMITS, THE INTERVIEW MAY BE CONDUCTED BY TELEPHONE. THE INTERVIEW SHOULD INCLUDE: (1) GIVING THE RESPONDENT A COPY OF THE COMPLETED APPLICATION AND AN ORAL EXPLANATION OF THE NATURE, PURPOSE, AND POSSIBLE CONSEQUENCES OF THE INTERVIEW; (2) WRITTEN NOTICE AND ORAL EXPLANATION OF ALL RIGHTS PRESCRIBED BY LAW, AND AN OFFER OF ASSISTANCE TO THE RESPONDENT TO REALIZE THOSE RIGHTS; AND (3) MENTAL HEALTH SERVICES SUCH AS CRISIS INTERVENTION, COUNSELING, MENTAL HEALTH THERAPY, AND OTHER PSYCHIATRIC, WELFARE, PSYCHOLOGICAL, AND LEGAL SERVICES AIMED AT AVOIDING UNNECESSARY AND INAPPROPRIATE INVOLUNTARY HOSPITALIZATION AND PROVIDING CARE AND TREATMENT IN THE LEAST RESTRICTIVE SETTING.

(E) AT THE COMPLETION OF THE INVESTIGATION, REVIEW, AND SCREENING, THE GATEKEEPER SHOULD AGAIN DETERMINE WHETHER TO PURSUE COMMITMENT PROCEEDINGS, TO DIVERT THE CASE TO SOME

ALTERNATIVE TREATMENT OR CARE, OR TO TERMINATE ANY FURTHER ACTIONS IN THE CASE.

IF THE GATEKEEPER DETERMINES THAT THE RESPONDENT MEETS THE COMMITMENT CRITERIA AND THAT THE RESPONDENT CANNOT BE SERVED IN A SETTING LESS RESTRICTIVE THAN THAT PROVIDED BY HOSPITALIZATION WITHOUT GIVING RISE TO IMMEDIATE AND SUBSTANTIAL RISKS TO THE RESPONDENT OR OTHERS, THE GATEKEEPER SHOULD CAUSE THE RESPONDENT TO BE TAKEN TO A MENTAL HEALTH FACILITY PURSUANT TO INVOLUNTARY COMMITMENT.

(F) THE GATEKEEPER SHOULD SUBMIT A REPORT OF THE REVIEW, INVESTIGATION, AND SCREENING TO THE COURT WITH THE APPLICATION FOR INVOLUNTARY CIVIL COMMITMENT.

9. Diversion at Various Points

LAW ENFORCEMENT PERSONNEL, MENTAL HEALTH PROFESSIONALS, SOCIAL WORKERS, JUDGES, AND OTHERS IN THE POSITION TO EFFECT THE INVOLUNTARY CIVIL COMMITMENT PROCESS AT ITS VARIOUS STAGES, SHOULD HAVE KNOWLEDGE OF, AND BE ABLE TO DIVERT RESPONDENTS TO, LESS RESTRICTIVE ALTERNATIVES AT ANY OF THE VARIOUS POINTS AT WHICH THESE AGENTS OPERATE.

10. Commitment Criterion

A REQUIREMENT THAT INVOLUNTARY CIVIL COMMITMENT BE CONSISTENT WITH THE LEAST RESTRICTIVE ALTERNATIVE DOCTRINE SHOULD BE INCORPORATED AS PART OF THE COMMITMENT CRITERIA FORMALLY BY STATUTE OR COURT RULE OR INFORMALLY AS A MATTER OF PRACTICE.

11. Voluntary Admission

RESPONDENTS WHO HAVE BEEN COMMITTED INVOLUNTARILY TO INPATIENT TREATMENT SHOULD BE ABLE TO CONVERT TO VOLUNTARY INPATIENT ADMISSION STATUS AT ANY TIME IF THE DIRECTOR OF THE TREATMENT FACILITY OR HIS OR HER DESIGNEE DETERMINES THAT THE CONVERSION IS APPROPRIATE AND MADE IN GOOD FAITH.

12. Petitions

PETITIONS OR APPLICATIONS FOR INVOLUNTARY TREATMENT AND CARE, INCLUDING COURT-ORDERED MENTAL HEALTH EVALUATIONS PURSUANT TO INVOLUNTARY COMMITMENT, SHOULD ALLEGE THAT LESS RESTRICTIVE ALTERNATIVES ARE INAPPROPRIATE.

13. Negotiation and Settlement of Cases.

(A) ATTORNEYS REPRESENTING RESPONDENTS AND THE STATE IN INVOLUNTARY CIVIL COMMITMENT PROCEEDINGS SHOULD NEGOTIATE AND SETTLE CASES IN WHICH THE THERAPEUTIC AND PREVENTATIVE GOALS OF THE PROCEEDINGS CAN BE ACHIEVED BY ALTERNATIVES TO INVOLUNTARY COMMITMENT.

(B) IN THE NEGOTIATION AND SETTLEMENT OF EACH APPROPRIATE CASE:

(1) ATTORNEYS SHOULD ACTIVELY OBTAIN AND CONSIDER INFORMATION FROM LAW ENFORCEMENT OFFICERS, MENTAL HEALTH PROFESSIONALS, PETITIONERS, AND FAMILIES OF RESPONDENTS; AND

(2) SETTLEMENT PROPOSALS BY THE RESPONDENT'S ATTORNEY SHOULD BE THOROUGHLY EVALUATED, FIRST BY THE STATE'S ATTORNEY AND THEN BY THE COURT.

(C) POLICIES AND PROCEDURES SHOULD BE DEVELOPED FOR MONITORING RESPONDENTS' COMPLIANCE, AND RESPONDING TO CASES OF NONCOMPLIANCE, WITH THE TERMS AND CONDITIONS OF SETTLEMENTS.

(D) A SYSTEM SHOULD BE ESTABLISHED SO THAT CURRENT INFORMATION IS READILY ACCESSIBLE ABOUT COMMUNITY-BASED, LESS RESTRICTIVE TREATMENT AND CARE FACILITIES AND PROGRAMS AND THEIR WILLINGNESS AND CAPACITY TO ACCEPT RESPONDENTS DIVERTED FROM INVOLUNTARY COMMITMENT.

14. Orientation and Education for Attorneys

AN ORIENTATION AND A CONTINUING EDUCATION PROGRAM FOR ATTORNEYS SHOULD BE PREREQUISITE TO INCLUSION ON AN APPOINTMENT LIST OF RESPONDENTS' ATTORNEYS AND SHOULD INCLUDE INSTRUCTION REGARDING (1) THE LEGAL AND PRACTICAL APPLICABILITY OF THE LEAST RESTRICTIVE ALTERNATIVE DOCTRINE; (2) THE RESPONSIBILITY OF RESPONDENT'S COUNSEL FOR EXPLORING LESS RESTRICTIVE ALTERNATIVES AND FOR OFFERING THESE ALTERNATIVES TO THE COURT; (3) THE CONTINUUM OF SERVICES, FROM INTENSIVE INPATIENT TREATMENT TO OUTPATIENT CARE, AVAILABLE TO RESPONDENTS IN THE COMMUNITY; AND (4) ENLISTING THE ASSISTANCE OF MENTAL HEALTH AND SOCIAL SERVICE WORKERS IN IDENTIFYING, EXPLORING, AND COMMUNICATING LESS RESTRICTIVE ALTERNATIVES TO INVOLUNTARY HOSPITALIZATION.

15. Burdens of Proof

(A) THE STATE SHOULD BEAR THE BURDEN OF PROVING THAT THE COURSE OF TREATMENT AND CARE IT ADVOCATES, FROM THE INITIAL STAGES OF INVOLUNTARY CIVIL COMMITMENT PROCEEDINGS TO EVIDENTIARY HEARINGS ON CONTINUED COMMITMENT IS THE LEAST RESTRICTIVE ALTERNATIVE.

(B) ATTORNEYS REPRESENTING RESPONDENTS IN INVOLUNTARY CIVIL COMMITMENT PROCEEDINGS SHOULD EXPLORE TREATMENT ALTERNATIVES LESS RESTRICTIVE THAN INVOLUNTARY HOSPITALIZATION AND SHOULD PRESENT THESE ALTERNATIVES TO THE COURT. RESPONDENTS' ATTORNEYS SHOULD ENLIST THE ASSISTANCE OF SOCIAL WORKERS IN IDENTIFYING, EXPLORING, AND COMMUNICATING LESS RESTRICTIVE ALTERNATIVES.

16. Cross-Examination of Mental Health Experts

ATTORNEYS REPRESENTING RESPONDENTS AT COMMITMENT HEARINGS SHOULD CAREFULLY CROSS-EXAMINE EXPERT WITNESSES OFFERED BY THE STATE AS PROPONENTS FOR INVOLUNTARY HOSPITALIZATION.

17. Court Disposition and Review

AFTER CONSIDERING THE EVIDENCE AND ARGUMENTS PRESENTED, INCLUDING THE TREATMENT PLAN FOR THE RESPONDENT, IF ANY, THE COURT SHOULD IMPOSE THE LEAST RESTRICTIVE ALTERNATIVE AS DEFINED BY GUIDELINE 1.

18. Outpatient Treatment and Care

(A) WHENEVER APPROPRIATE, INVOLUNTARY OUTPATIENT TREATMENT OR A COMBINATION OF OUTPATIENT AND INPATIENT TREATMENT AND CARE SHOULD BE ORDERED BY THE COMMITMENT COURT AS A LESS RESTRICTIVE ALTERNATIVE TO INVOLUNTARY INPATIENT HOSPITALIZATION.

(B) THE DIRECTOR OF THE MENTAL HEALTH CARE FACILITY PROVIDING INVOLUNTARY OUTPATIENT TREATMENT AND CARE, OR HIS OR HER DESIGNEE, SHOULD HAVE THE RESPONSIBILITY OF SUPERVISING RESPONDENTS ORDERED TO UNDERGO OUTPATIENT TREATMENT AND CARE AND MONITORING THEIR COMPLIANCE WITH THE TREATMENT PLAN. THE DIRECTOR OR DESIGNEE MAY REVOKE THE OUTPATIENT TREATMENT STATUS OF ANY RESPONDENT WHO FAILS TO COMPLY WITH THE OUTPATIENT TREATMENT PLAN.

19. Treatment Close to Respondent's Community

WHENEVER POSSIBLE, INVOLUNTARY TREATMENT AND CARE SHOULD BE PROVIDED IN OR BY A LOCAL MENTAL HEALTH TREATMENT AGENCY GEOGRAPHICALLY CONVENIENT FOR THE RESPONDENT.

20. Release and Conditional Outpatient Treatment

(A) AT ANY TIME WITHIN A PERIOD OF COURT-ORDERED COMMITMENT TO INPATIENT HOSPITALIZATION, THE DIRECTOR OF THE MENTAL HEALTH CARE FACILITY PROVIDING INPATIENT TREATMENT, OR HIS OR HER DESIGNEE, MAY, IN APPROPRIATE CASES, ORDER CONDITIONAL OUTPATIENT TREATMENT OR A COMBINATION OF PROVISIONAL OUTPATIENT TREATMENT AND INPATIENT TREATMENT.

(B) THE DIRECTOR OR DESIGNEE SHOULD HAVE THE RESPONSIBILITY OF MONITORING AND SUPERVISING THE RESPONDENT. HE OR SHE MAY REVOKE THE CONDITIONAL OUTPATIENT STATUS IF THE RESPONDENT FAILS TO COMPLY WITH THE CONDITIONS OF THE OUTPATIENT PROGRAM.

21. Least Restrictive Setting Within a Hospital

JUDICIAL COMMITMENT TO INVOLUNTARY INPATIENT CARE SHOULD NOT PRECLUDE CONSIDERATION OF THE LEAST RESTRICTIVE TREATMENT SETTING WITHIN A HOSPITAL. ALSO IT SHOULD NOT PRECLUDE MODIFICATIONS IN THE TREATMENT AND CARE CONSISTENT WITH THE LEAST RESTRICTIVE ALTERNATIVE DOCTRINE, AT ANY TIME, IF WARRANTED BY CHANGES IN A RESPONDENT'S CONDITION.

22. Discharge Plan

RELEASE OF RESPONDENTS FROM MORE RESTRICTIVE TO LESS RESTRICTIVE TREATMENT AND CARE SETTINGS SHOULD BE ACCOMPLISHED IN ACCORDANCE WITH A DISCHARGE TREATMENT PLAN DEVELOPED IN ACCORDANCE WITH THE LEAST RESTRICTIVE ALTERNATIVE DOCTRINE.

SECTION I

INTRODUCTION AND STUDY METHODS

INTRODUCTION

Involuntary civil commitment, the subject of considerable litigation, legislative activity, and public debate over the last two decades,[1] is the legal and psychosocial process whereby a person alleged to be mentally disordered and dangerous is restrained and treated against his or her will, presumably for his or her own good and the good of others. Thirty years ago, mentally disordered persons "certified" as suitable for compulsory hospitalization were likely to be confined for long periods of time with little or no treatment, usually in large institutions with inadequate staff and disgraceful conditions.[2]

During the 1960s and 1970s, the humane and fair treatment of mentally disordered persons became a civil rights issue of the first order. The indeterminate confinement of allegedly mentally disordered persons to large, public "mega-institutions" came under close public scrutiny and attack. Vigorous legal challenges led to improvements in the conditions of public mental hospitals and the provision of significant rights and legal safeguards for mentally disturbed persons facing compulsory hospitalization. These challenges addressed three related concerns: (1) the fairness of the procedures and the breadth of the legal standards for

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1. See Keilitz & Van Duizend, Current Trends in the Involuntary Civil Commitment of Mentally Disabled Persons, __ Rehabilitation Psychology __ (in press); Stromberg & Stone, A Model Law on Civil Commitment of the Mentally Ill, 20 Harv. J. Legislation 275 (1983); Shah, Legal and Mental Health Interactions: Major Developments and Research Needs, 4 Int. J. L. & Psychiatry 219, 225-230 (1981).

2. See Goffman, Essays on the Social Situation of Mental Patients and Other Inmates (Garden City, New York: Doubleday, 1961); Mechanic, Mental Health and Social Policy (Englewood Cliffs, New Jersey: Prentice Hall, 1980).

coercive hospitlization (it was too easy to get people into mental hospitals); (2) the fairness of the procedures and the narrowness of the standards for release (it was too hard to get them out); and (3) the poor conditions and the inadequate or abusive treatment afforded those who had been involuntarily committed (people were not helped, and in some cases were harmed while they were confined).[3]

Policymakers and courts soon recognized that mentally disordered individuals have a constitutionally protected interest in being left alone, and if they are to be subjected to coercive interventions, they should be treated in the least restrictive environment and therapeutic program. The application of the doctrine of the "least restrictive alternative" to involuntary civil commitment became one of the most important trends in mental health law.[4]

The least restrictive alternative in involuntary civil commitment proceedings is that combination of therapeutic and preventative intervention provided by mental health and social service providers that is (a) conducive to the most effective and appropriate treatment which will give the mentally disordered person a realistic opportunity to improve his or her level of functioning, and is (b) no more restrictive of a person's physical, social, or biological liberties than is necessary to achieve legitimate state purposes of protection of society and provision of mental health treatment and care for the person's

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3. Keilitz & Van Duizend, supra note 1, at __.

4. Hoffman & Foust, Least Restrictive Treatment of the Mentally Ill: A Doctrine in Search of its Senses, 14 San Diego L. Rev. 1100 (1977); Chambers, Alternatives to Civil Commitment of the Mentally Ill: Practical Guides and Constitutional Imperatives, 70 Mich. L. Rev. 1107 (1972); Keiltz & Van Duizend, supra note 1, at __.

own good.[5] In balancing the interests of the person, his or her family, and the state in determining what is the least restrictive alternative in a particular case, judges, attorneys, law enforcement personnel, mental health professionals, social service providers, and others who make such a determination must consider and weigh a number of conflicting factors. These factors include the environmental restrictiveness of the treatment setting; the psychological or physical restrictiveness of behavioral, chemical, or biological treatments; clinical variables including the person's behavior as it relates to the legal criteria for involuntary commitment; the relative risks and benefits of treatment alternatives; the family and community support available in the person's environment; the quality or likely effectiveness of the alternative care and treatment; the duration of treatment; the likely risk that a person may pose to public safety; the availability, cost, and effective access to alternative treatment and care; the likelihood of the person's cooperation in, or compliance with, an alternative treatment program; and, finally, the mechanism for monitoring and reviewing a person's compliance with the conditions of alternative treatment programs.[6]

One cannot seriously consider the involuntary civil commitment process, and the state's intrusions upon individual liberties that the process may entail, without confronting fundamental differences of opinion and conflicting attitudes about mental disorder and society's proper response and responsibility to it. Questions about the

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5. See Guideline 1, Section III, this volume.

6. Id.

effectiveness of, efficiency of, equity of, and public satisfaction with, the involuntary civil commitment process combine in a basic concern with the best balance among complex and often competing societal interests: those of the individual, the family, and the state. The individual has an interest in being left alone, and even if compelling reasons exist for infringing upon his or her privacy or freedom, the individual has further interests in being treated fairly, honestly, and as well as possible. The family, friends, or acquaintances of the individual may have interests in making sure the individual is given the care and treatment he or she needs but is unwilling or unable to seek voluntarily. They may also have an interest in alleviating the burden that the person's failure to seek help voluntarily has placed upon them. Finally, the state has two primary interests: to protect its citizenry from dangerously mentally disturbed persons, and to care for its sick and helpless. In protecting these interests, the state has a duty not to create undue programmatic, fiscal, and administrative burdens by any procedures that it may be require. The "least restrictive alternative" doctrine may be useful for scrutinizing state intrusions upon individual liberties to the extent that it can balance, if not reconcile, these complex societal interests.[7]

An important distinction must be made between the application of the least restrictive alternative doctrine on a case-by-case basis, and its "more broadly focused constitutional application to scrutinize state action."[8] Within the last ten years, the doctrine's focus has shifted

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7. See Hoffman & Foust, at 1102-3.

8. Id., at 1104.3.

from applications aimed at testing the rationality of policies, statutes, and rules to applications in individual cases.[9] However, the translation of the least restrictive alternative doctrine from theory into practice has faced difficulties. As one observer has noted, "while the doctrine prescribing use of the 'least restrictive alternative' has fairly clear meaning and reference to certain legal and constitutional values concerning infringement of personal freedom and liberty, the notion does not translate readily into mental health procedures and programs."[10] Part of the difficulty may, of course, be attributed to the fact that the meaning of any "open concept" or "concept with open texture," like the doctrine of the least restrictive alternative, can never be "fully reduced to a set of concrete operations and observational terms."[11]

Another difficulty faced in translating legal and social concepts into reality is the unavailability of resources, the barriers of formidable state and federal bureaucacies, and the sheer size and complexity of the cooperative effort required.[12] As Shah has observed,

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9. Id.

10. Shah, supra note, 1, at 254 (emphasis in original).

11. Roesch & Golding, Competency to Stand Trial 12 (Chicago: University of Illinois Press, 1980).

12. See, e.g., Halderman v. Pennhurst State School and Hospital, 467 F. Supp. 1504 (E.D. Pa. 1983) (Parents objected to movement of their 12-year old son from Pennhurst to less restrictive community placement); Halderman v. Pennhurst State School and Hospital, 566 F. Supp. 185 (E.D. Pa. 1983) (Contractual dispute between the state and a community-based service provider that threatened to close community home and return resident to hospital); see also, Chicago Report, Section II, this volume.

"[i]t is one thing to legislate or judicially mandate legal and other policy changes; it is quite another matter to secure their actual implementation. Thus, as important as reforms in legal policies (viz., the 'law on the books') certainly are, these accomplishments must not be confused with the end result (viz., 'law in practice')."[13] The difficulties of translating law into practice seriously threaten the value of the least restrictive alternative doctrine in mental health law.

In their seminal study of the least restrictive alternative doctrine, Hoffman and Foust, concluded that "the doctrine's current conceptualization and application to the involuntary treatment of the mentally ill ... raises serious questions about its implementation, definition and fundamental purpose."[14] This conclusion, reached seven years ago, may still be valid today.

This volume is the final report of a project, the Least Restrictive Alternative Project, to develop a model for the application of the doctrine of the least restrictive alternative in involuntary civil commitment proceedings. The model is meant to assist those applying the doctrine on a case-by-case basis in the myriad of situations arising in the involuntary civil commitment of mentally disordered person. What follows in Section II of this report is a detailed description and discussion of the application of the least restrictive alternative doctrine in the involuntary civil commitment systems of seven localities (Chicago, Kansas City, Los Angeles, Milwaukee, New York, Tucson, and Williamsburg-James City County). In Section III, we offer specific

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13. Shah, supra note _, at 255.

14. Hoffman & Foust, supra note 4, at 1139.

guidelines for the application of the doctrine to the commitment system and its procedures. Based upon the detailed account in Section II of the doctrine's application in the seven localities, these guidelines are a model meant to bridge the wide gap between the theoretical demands of the doctrine and the difficulties of applying it in practice. To the extent that this model, supported by the detailed descriptions of the involuntary civil commitment systems in seven localities and of the contingencies of the application of the least restrictive alternative doctrine in those localities,[15] is available for public knowledge and discussion, needed improvements in involuntary civil commitment can be facilitated.

STUDY METHODS

The purpose of the Least Restrictive Alternative Project, which began in October 1982 and ended June 1984, was to develop a model (i.e., a representaton to show the general structure) for the fair and workable application of the "least restrictive alternative" doctrine in involuntary civil commitment proceedings. This project was designed to develop new knowledge about the application of the least restrictive

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15. See, Shah, supra note 1, at 253 ("Although many useful descriptive studies of courts, other legal system agencies, mental hospitals, and social agencies have been done, such research needs to be updated fairly regularly. ... What was known a few years ago may not be relevant now; what is learned about the behaviors in one setting or context may not be true in others. In short, since most social science findings pertain to phenomena that are constantly changing, the relevant knowledge and information must regularly be refreshed and updated.").

alternative doctrine in involuntary civil commitment proceedings. More specifically, project efforts were to focus on studying existing procedures for identifying, exploring, and using less restrictive alternatives for the placement of mentally disordered, developmentally disabled, and elderly persons in mental health care and treatment settings in seven locations across the country.

Site selection was based on a purposive sampling scheme including the following considerations: 1) locations where project staff could expect relatively easy access to information due to prior professional contacts with prospective participants; 2) geographic distribution; and 3) population of potential sites. Based on these considerations, the seven sites selected were:

	Geographic Distribution	City Population[16]	County Population[16]
Chicago, IL	Midwest-North	3,005,072	5,253,655
Kansas City, MO	Midwest-Central	448,159	629,266
Los Angeles, CA	Southwest	2,966,850	7,477,503
Milwaukee, WI	Midwest-North	636,212	964,988
New York City, NY	Northeast	7,071,639	--
Tucson, AZ	Southwest	330,537	531,443
Williamsburg-James City County, VA	Mid-Atlantic	9,870	22,763

The primary data collection method was field research conducted by project staff in the seven project sites. Field research was supplemented by the collection, review, and analysis of relevant state statutes, court rulings, scholarly literature, and other background documentary materials. The project was conducted in three phases: state-of-the-knowledge assessment, field research, and model development.

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16. United States Bureau of the Census, A Statistical Abstract Supplement: County and City Data Book 1983 (Washington, D.C.: U.S. Government Printing Office, 1983).

In the first phase, the statutes of the seven states pertaining to the provision and use of less restrictive alternatives were collected, reviewed, analyzed and compared. The prescribed legal process for the application of the least restrictive alternative to the commitment proceedings in each site was delineated carefully to aid the field research and allow for comparisons across states. Relevant court rulings were identified using traditional legal research methods. Finally, a broad search of the legal, mental health, and social science literature relevant to the study was undertaken. The comprehensive review of the state statutes, case law, and professional literature provided the basis for identifying the issues and problems related to the application of the doctrine of least restrictive alternative. The results of the project's first phase are documented in the project report, Least Restrictive Alternatives in Involuntary Civil Commitment: Summary of Statutes in Seven States, Case Law Review, and Annotated Bibliography.[17] The results of this first phase are also reflected in the site reports in Section II of this volume.[18]

Although the least restrictive alternative doctrine's legal meaning in other contexts is relatively clear, its translation into involuntary civil commitment practices has been problematic. By studying, in the

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17. Perspectives on Mental Disability and the Law, (Occasional Paper No. 7; National Center for State Courts). The Occasional Paper Series, Perspectives on Mental Disability and the Law, is published by the Institute on Mental Disability and the Law of the National Center for State Courts. The Series consists of papers and monographs that address questions arising from the interaction of the mental health and justice system.

18. See, for example, Comparison of Statutory Provisions, Appendix, Los Angeles Report, Section II, this volume.

second phase of the Least Restrictive Alternative Project, the civil commitment system in seven localities throughout the country, the project staff assessed the use of the doctrine to determine how its application may be improved. Preliminary site visits were made to identify knowledgable interview respondents in each site. Contacts in each site, most often starting with a local judge or a mental health official, were approached by letter and telephone prior to each visit. The preliminary visits, which generally lasted two or three days, were used to develop additional contacts, establish rapport with local officials, and obtain preliminary information about the existence and use of less restrictive alternatives. In addition, whenever schedules permitted, relevant court proceedings were observed by project staff.

Refinement of the project staffs' understanding of the issues, problems and actual use of less restrictive alternatives took place following the preliminary visits. This refinement included review and analysis of field notes, statements of administrative policies, agency manuals, and memoranda obtained in each of the sites. In addition, schedules for the field research were prepared and coordinated with project participants.

The field research focused on the application of the least restrictive alternative doctrine at the level of practice. 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. Two project staff members travelled to each site. This allowed one staff member to concentrate on conducting the interviews while the other staff member recorded

information. This procedure increased the reliability of the record. Following the interviews, project staff members verified the consistency of their impressions and reconciled any differences.

Interview respondents (including judges, social service administrators, attorneys, hospital and community mental health center administrators, patient advocates, and other social service providers) were generally interviewed individually. The foci of the interviews varied depending on the occupation or responsibilities of the interviewee but always included details relevant to the operation of the involuntary civil commitment system in the site, actual application of the least restrictive alternative doctrine, perceived problems, and innovative techniques.

The interviewees were purposively chosen because they were identified as the most well-informed and influencial individuals in the involuntary civil commitment system. It is important to note that the people with whom interviews were conducted were not a statistically representative sample in any sense, nor was it feasible for project staff to validate, in any technical sense, whether the interviewees' responses actually coincided with practice. This approach was generally consistent with the goal of the project; that is, to gain insight into how the doctrine of the least restrictive alternative is actually applied in involuntary civil commitment proceedings and how such application may be improved based upon the perspectives of individuals with extraordinary and authoritative abilities to understand and comment on it. It is acknowledged, however, that the responses may not represent the norm for

practice in the project site or elsewhere. Some perspectives may have been underrepresented or not represented at all.[19]

Finally, in the last phase of the project, project staff attempted to integrate the state-of-the-knowledge assessment of the first phase with the results of the field research conducted in the second phase. A qualitative content analysis was performed on the interview data. Interview data, observational data, and other documentary material (e.g., forms and agency reports) were compared to validate the information. Note was made of topics of significance, points of consistent agreement, and points of disagreement. Project staff prepared seven detailed reports describing the application of the least restrictive doctrine to the involuntary civil commitment proceedings in the seven localities studied.[20] Lastly, project staff developed guidelines for the application of the doctrine. Together with the detailed accounts of the doctrine's application in the seven localities, these guidelines represent a model meant to bridge the wide gap between the theoretical demands of the doctrine and the difficulties of applying it in practice.

The results of this final phase of the project are documented in the following Section II and III of this report.

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19. For example, persons who were the subject of involuntary civil commitment proceedings and who may have benefitted most from the application of the least restrictive alternative doctrine were not interviewed. The perspectives of these persons may be drastically different than the perspectives of those who execute the involuntary civil commitment proceedings. The observation of actual cases as they move through the various stages of the involuntary civil commitment process, possibly enriched by the accounts of the patients themselves is a particularly attractive inquiry which was, unfortunately, beyond the scope of the Least Restrictive Alternative Project. Such omissions do not make the present work less valid but only incomplete--an unfortunate flaw of most social research.

20. See Section II, this volume.

SECTION II

SITE REPORTS

INTRODUCTION

Project staff conducted intensive field research in each of the seven Project sites (Chicago, Kansas City, Los Angeles, Milwaukee, New York, Tucson, and Williamsburg) from February through July of 1983. Interviews were conducted with judges, court personnel, attorneys, police officers and mental health professionals in each of the seven sites. Commitment hearings and other proceedings conducted during the field research were observed whenever possible. The results of this field research are presented in the seven site reports included in this section.

Each report examines the requirements for application of the least restrictive alternative doctrine that appear in that jurisdiction's statutes and case law, and any relevant regulations or guidelines. These requirements vary substantially from state to state. The reports focus primarily on how and whether these requirements are translated into actual practices in the localities studied. Particular attention is given to practices or provisions that are unique or innovative. Practices arising independently of legal requirements are also discussed. The field research and resulting site reports comprised the raw materials for development of the Guidelines appearing in Section III.

THE LOS ANGELES REPORT*

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THE LEAST RESTRICTIVE ALTERNATIVE DOCTRINE IN LOS ANGELES COUNTY CIVIL COMMITMENT

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THE LEAST RESTRICTIVE ALTERNATIVE DOCTRINE IN LOS ANGELES COUNTY CIVIL COMMITMENT

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> In the practice of law, just as in the practice of other professions or trades, it is often the mores and customs which deserve the attention usually paid to the written rules of substance and procedure. Although thousands of words are written about the subtle points of a significant court decision or statutory revision, usually limited analysis is given to what can be termed the socialization of the law.[1]

INTRODUCTION

Although the least restrictive alternative doctrine's legal meaning in other contexts is relatively clear,[2] its translation into involuntary civil commitment practice has been problematic.[3] By studying the civil commitment systems in Los Angeles County and six other localities throughout the country,[4] the Institute on Mental Disability

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1. Perlin, *The Legal Status of the Psychologist in the Courtroom*, 4 MENTAL DISABILITY L. REP. 194 (1980).

2. *See infra* note 10 and accompanying text.

3. Shah, *Legal and Mental Health System Interactions: Major Developments and Research Needs*, 4 INT'L J. OF LAW & PSYCHIATRY 219, 253 (1981).

4. Chicago, Kansas City (Missouri), Milwaukee, New York, Tucson, and Williamsburg/James City County (Virginia).

and the Law of the National Center for State Courts[5] is assessing the use of the doctrine to determine how its application may be improved.[6] The study focuses on the application of the least restrictive alternative doctrine at the practice level.[7] The Institute plans to develop methods which will enhance the symbiotic functioning of the mental health and judicial systems in achieving the ideal of the least restrictive alternative doctrine. This article focuses not on reported appellate case law, but rather, it documents observations, impressions and conclusions regarding the least restrictive alternative doctrine as it appears in California statutes and as it is applied in Los Angeles County in the vast majority of cases which never reach appellate review.

In the seventeen years since it was first the subject of mental health litigation,[8] the application of the "least restrictive alternative" doctrine has been one of the most important trends in mental health law.[9] The doctrine holds that "governmental action must not intrude upon constitutionally protected interests to a degree greater than necessary to achieve a legitimate purpose."[10] The doctrine was first applied in mental health litigation in *Lake v. Cameron*,[11] 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 not go beyond what is necessary for their protection."[12]

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5. The National Center for State Courts (founded in 1971) is a private, nonprofit organization dedicated to the improvement of court operations and the administration of justice at the state and local levels throughout the country. It functions as an extension of the state court systems, working on their behalf and responding to their priorities. The Institute on Mental Disability and the Law was established in 1981 as an arm of the National Center for State Courts to provide applied research, program evaluation, and technical assistance to the state courts and allied agencies in the area of mental disability and the law.

6. This study was made possible by a grant (#90AJ1001) from the United States Department of Health and Human Services and a grant from the Victor E. Speas Foundation of Kansas City, Missouri. Points of view and opinions expressed herein are those of the authors and do not necessarily represent the official policies of the funding agencies or the National Center for State Courts.

7. The primary method of inquiry is field research in the seven cities, supplemented by the collection, review, and analysis of selected statutes, court rulings, and relevant literature.

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

9. Hoffman & Foust, *Least Restrictive Treatment of the Mentally Ill: A Doctrine in Search of its Senses*, 14 SAN DIEGO L. REV. 1100 (1977); *see* Chambers, *Alternatives to Civil Commitment of the Mentally Ill: Practical Guides and Constitutional Imperatives*, 70 MICH. L. REV. 1107 (1972).

10. Hoffman & Foust, *supra* note 9, at 1101.

11. 364 F.2d 657.

12. *Id.* at 660. This decision derived from a statutory rather than a constitutional right to the least restrictive alternative. *See id.* at 659. The district court had denied writ of *habeas*

Since the *Lake v. Cameron* decision, both federal[13] and state[14] 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.[15]

The California Community Mental Health Services Act[16] contains many provisions which either explicitly or implicitly acknowledge the least restrictive alternative doctrine.[17] For instance, mental health treatment should be provided in ways least restrictive of per-

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corpus to an involuntary patient seeking release from a hospital. *Id.* at 658-59. The court of appeals remanded the case to the district court for inquiry into alternative courses of treatment. *Id.* at 661. The court of appeals said that "[t]he alternative course of treatment or care should be fashioned as the interests of the person and of the public require in the particular case." *Id.* at 660.

13. *See e.g.*, Covington v. Harris, 419 F.2d 617 (D.C. Cir. 1969). A civilly committed patient petitioned for writ of *habeas corpus*, seeking transfer from a maximum security ward to some less restrictive ward within the same hospital. *Id.* at 619. In reversing the district court's denial of the writ, the court of appeals stated:

> [T]he principle of the least restrictive alternative consistent with 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 deprivation of liberty without due process of law.

Id. at 623. *See also* Association for Retarded Citizens of North Dakota v. Olson, 561 F. Supp. 473 (D.N.D. 1982); Eubanks v. Clarke, 434 F. Supp. 1022 (E.D. Pa. 1977); Gary W. v. Louisiana, 437 F. Supp. 1209 (E.D. La. 1976); Welsch v. Likins, 373 F. Supp. 487 (D. Minn. 1974); Lessard v. Schmidt, 349 F. Supp. 1078 (E.D. Wis. 1972), *vacated and remanded on other grounds*, 414 U.S. 473 (1974), *on remand*, 379 F. Supp. 1376 (E.D. Wis. 1974), *vacated and remanded on other grounds*, 421 U.S. 957 (1975), *on remand* 413 F. Supp. 1318 (E.D. Wis. 1976) (reinstating 379 F. Supp. 1376).

14. *See e.g.*, Kesselbrenner v. Anonymous, 33 N.Y.2d 161, 350 N.Y.S. 2d 889 (1973). The Court of Appeals of New York held unconstitutional 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. The court 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." *Id.* at 892. *See also In re* Gandolfo, 136 Cal. App. 3d 205, 185 Cal. Rptr. 911 (1982); Aden v. Younger, 57 Cal. App. 3d 662, 129 Cal. Rptr. 535 (1976); *In re* Collins, 102 Ill. App. 3d 138, 429 N.E.2d 531 (1981); *In re* Estate of Newman, 604 S.W.2d 815 (Mo. Ct. App. 1980); Patients v. Camden County Board of Chosen Freeholders, No. L-33417-74P.W. (N.J. Super. Ct. January 19, 1981); *In re* D.D., 118 N.J. Super. 1, 285 A.2d 283 (1971); *In re* Andrea B., 94 Misc. 2d 919 (1978).

15. Lyon, Levine & Zusman, *Patient's Bill of Rights: A Survey of State Statutes*, 6 MENTAL DISABILITY L. REP. 178, 181-83 (1982). In 1977, thirty-five jurisdictions either explicitly or implicitly acknowledged the least restrictive alternative doctrine in statute. Hoffman & Foust, *supra* note 9, at 1115.

16. CAL. WELF. & INST. CODE §§ 5000-5999 (West 1972 & Supp. 1983).

17. *See* Appendix to compare California's statutory provisions with those of the six other

sonal liberty.[18] A county-designated agency must investigate less restrictive alternatives before the court may order conservatorship for a gravely disabled person.[19] In addition, community residential treatment systems must be developed in such a way that individuals may be served in the most appropriate, least restrictive level of service.[20]

How are these and similar statutory provisions applied in the actual, every day practices of the mental health/judicial system? Does their presence affect the decision-making process of the court, agency, or persons responsible for placing a person in a particular setting for mental health services? Or more fundamentally, does the least restrictive alternative doctrine make any practical difference in the placement decision?[21]

Before discussing the various areas in which the least restrictive alternative doctrine is applied in the Los Angeles County involuntary civil commitment system, we shall first summarize the involuntary civil commitment process to provide a framework for our discussion.

I. Overview of Civil Commitment[22]

The involuntary civil commitment process in Los Angeles County can be described in terms of six steps. These steps are presented here in roughly chronological order, although the procedures a particular person may undergo will depend on his or her alleged mental condition and, thus, on the form of commitment pursued for the person. The steps include initiation of commitment proceedings, 72-hour evaluation and treatment, 14-day certification, probable cause hearings, continued commitment, and judicial hearings.

California's Lanterman-Petris-Short Act[23] provides for two

jurisdictions in which the Institute is studying the application of the least restrictive alternative doctrine.

18. Cal. Welf. & Inst. Code § 5325.1(a) (West Supp. 1983).

19. *Id.* at § 5354.

20. *Id.* at § 5459.

21. At least two commentators have feared that the least restrictive alternative doctrine is a "hollow promise of humane assistance to those who have already suffered too long from society's indifference." Hoffman & Foust, *supra* note 9 at 1154.

22. A detailed description of civil commitment in Los Angeles County may be found in I. Keilitz, W. L. Fitch & B.D. McGraw, Involuntary Civil Commitment in Los Angeles County (1982); or Keilitz, Fitch & McGraw, *A Study of Involuntary Civil Commitment in Los Angeles County*, 14 Sw. L. J. — (1983).

23. Cal. Welf. & Inst. Code §§ 5000-5550 (West 1972 & Supp. 1983).

methods of initiating commitment, an emergency and a non-emergency procedure. Emergency[24] commitment of an allegedly mentally disordered individual, or respondent,[25] entails detention by a peace officer, or a county-designated mental health professional, and 72-hour emergency treatment and evaluation in a county-designated facility. The non-emergency[26] procedure, entailing preliminary screening and the filing of a petition, is virtually never used in Los Angeles County.[27] After a respondent is involuntarily admitted for 72-hour treatment and evaluation, the facility's staff determines the initial course of treatment and whether a continued period of commitment is warranted.[28]

The respondent may be "certified" for an additional 14 days of involuntary treatment if: (1) the respondent has been found to be a danger to him or herself or others, or is gravely disabled, as a result of mental disorder; (2) the respondent has been advised of, but has not accepted, voluntary treatment; and (3) the facility can provide treatment.[29] The 14-day certification is performed *ex parte* by mental health professionals.[30] Each certified respondent is entitled to a probable cause hearing within seven days of initial detention.[31] The burden to seek *habeas corpus* relief, however, is on the respondent.[32] If such judicial review is sought, a hearing must take place in the superior court within two days after the petition is filed.[33]

Three legal avenues may lead to continued involuntary commitment following the 14-day certification period: 14-day *re*certification of imminently suicidal respondents, 180-day *post*certification of respondents dangerous to others, and conserva-

24. *Id.* at § 5150 et seq. A strict reading of § 5150 suggests that "emergency" procedures may be an incorrect way of characterizing these procedures. While § 5150 authorizes detention, it applies the same substantive criteria as prescribed for court-ordered evaluation (*i.e.*, danger to self or others or grave disability; compare *Id.* at §§ 5150 and 5200). Thus, no "emergency" is expressly required. As a practical matter, however, the provision is generally interpreted as applying to situations in which expedited procedures are needed.

25. Hereinafter, the term "respondent" will be used to refer to any individual who is the subject of involuntary civil commitment proceedings, including those less formalized proceedings occurring before court intervention.

26. CAL. WELF. & INST. CODE § 5200 (West 1972). *See infra* note 82.

27. Los Angeles County Superior Court, 1978 and 1979 Executive Officer Report 25 (1979). *See infra* note 82.

28. CAL. WELF. & INST. CODE § 5152 (West 1972).

29. *Id.* at § 5250 (West Supp. 1983).

30. *Id.* at § 5251.

31. *Id.* at §§ 5254, 5256.

32. *Id.* at § 5275 (West 1972).

33. *Id.* at § 5276.

torship (either 30-day or one-year) of gravely disabled persons. Recertification of imminently suicidal respondents is effected identically to the original 14-day certification.[34] California law apparently limits continuous involuntary treatment of respondents who are "only" dangerous to themselves (suicidal) to a maximum of 31 days (72-hour detention for evaluation and treatment, plus 14-day certification, plus 14-day recertification). A person dangerous to others because of mental disorder may be detained for up to 180 days.[35] During this 180-day postcertification period, however, the respondent may be released to involuntary outpatient treatment rather than being confined in an inpatient hospital.[36] Temporary (30-day) conservatorship for a person alleged to be mentally ill and gravely disabled can be effected by an *ex parte* judicial order.[37] A mandatory judicial review is held to determine whether a full (one-year) conservatorship should follow.[38]

In addition to the initial probable cause hearing, three hearings may be held on behalf of respondents involved in California's civil commitment process. A respondent may request a *habeas corpus* hearing whether detention is based on danger to self, danger to others, or grave disability.[39] Two hearings are mandatory: if the respondent is to be detained beyond the 14-day certification period on the basis of danger to others, a postcertification hearing must be held;[40] if a one-year conservatorship is sought for a gravely disabled person, a conservatorship hearing must be held.[41] A 180-day postcertification hearing must be held within four days after the treating mental health personnel petitioned the court to order the additional treatment period.[42] A facility may hold a respondent for three days beyond the 14-day certification period to file a conservatorship petition.[43] The hearing is to be held within 30 days during which time a designated agency performs an extensive investigation of the respondent's condition and alternatives to the appointment of a conservator.[44]

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34. *Id.* at § 5261 (West Supp. 1983).
35. *Id.* at § 5300.
36. *Id.* at § 5305.
37. *Id.* at § 5352.1.
38. *Id.* at § 5365.
39. *See id.* at § 5275.
40. *Id.* at § 5303.
41. *Id.* at § 5365.
42. *Id.* at § 5303.
43. *Id.* at § 5352.3.
44. *Id.* at § 5354.

II. LEGISLATIVE INTENT

The Community Mental Health Services Act,[45] consisting of the Lanterman-Petris-Short (LPS) Act[46] and the Short-Doyle Act,[47] contains three statements of legislative intent to promote alternatives to institutional care and treatment for voluntary and involuntary patients in California.[48] First, the legislative intent behind LPS, among other things, is to promote an end to inappropriate, indefinite, and involuntary commitments of mentally disabled persons.[49] "Deinstitutionalization,"[50] as expressed in this first provision, is a pervasive theme in LPS and related statutes. Although the overriding intent to promote deinstitutionalization does not expressly include reference to the least restrictive alternative doctrine, many provisions in LPS and related statutes reveal a clear intent to promote alternatives. We will discuss these provisions in subsequent sections of this article.

A second statement of legislative intent more directly reflects the least restrictive alternative doctrine.[51] In 1978, the California Legislature amended LPS by enacting the Community Residential Treatment System Act.[52] The Legislature declared in amending LPS: "It is the intent of the Legislature to establish a system of residential treatment programs in every county which provide, in each county, a range of available services which will be alternatives to institutional care and are based on principles of residential, community-based treatment."[53] Section 1 of the 1978 Statutes of California, chapter 1233, provided:

> The Legislature finds and declares that the current Mental Health system provides insufficent alternatives to institutionalization and hospitalization for those citizens entering that system, and further finds and declares that the need exists for a full system of alternatives to institutional settings which have as a focus the rehabilitation of clients of the mental health system, and further finds and declares that a full system of alternatives to institutionalization, with coordination in each county, is necessary to provide a real

45. CAL. WELF. & INST. CODE, §§ 5000-5999 (West 1972 & Supp. 1983).

46. *Id.* at §§ 5000-5368.

47. *Id.* at §§ 5600-5767.

48. *Id.* at §§ 5001, 5450, 5600 (West Supp. 1983).

49. *Id.* at § 5001(a)-(d).

50. *See infra* text accompanying note 58.

51. *See* CAL. WELF. & INST. CODE § 5450 (West Supp. 1983).

52. 1978 Cal. Stats. 3978 (codified at CAL. WELF. & INST. CODE §§ 5450-5466 (West Supp. 1983)).

53. CAL. WELF. & INST. CODE § 5450 (West Supp. 1983).

alternative to institutionalization.[54]

The Community Residential Treatment System Act is more fully discussed in this article's next section.

Finally, the legislative intent behind the Short-Doyle Act is "to organize and finance community mental health services for the mentally disordered in every county through locally administered and controlled community mental health programs."[55] A goal of the community mental health programs provided under the Short-Doyle Act is "[t]o assist persons who are institutionalized, or who have a high risk of becoming institutionalized, because of a mental disorder, to lead lives which are as normal and independent as possible, consistent with their individual capacities and desires."[56]

When LPS and the Short-Doyle Act were enacted, California was the front-runner in the deinstitutionalization movement.[57] The three statements of legislative intent discussed above express the goal of deinstitutionalization more directly than they address the least restrictive alternative doctrine. Simply stated, deinstitutionalization is "removing [patients] from hospitals and other institutions to alternative care settings."[58] Although the deinstitutionalization movement was, in part, a specific response to the least restrictive alternative concept,[59] both in its expression as a legislative goal and in its implementation, deinstitutionalization has created an artificial dichotomy between institutions and alternatives to institutions. The least restrictive alternative doctrine does not require such a dichotomy. The doctrine requires the least restrictive setting and manner of treatment and care appropriate for an individual. The setting may be community-based or it may be one of a continuum of settings within an institution.[60]

Commentators have suggested that the increasing criticism of deinstitutionalization has resulted not from its policy but from its

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54. 1978 Cal. Stats. 3978.

55. CAL. WELF. & INST. CODE § 5600 (West Supp. 1983).

56. *Id.* at § 5600(a).

57. *See* Whitmer, *From Hospitals to Jails: The Fate of California's Deinstitutionalized Mentally Ill*, 50 AM. J. ORTHOPSYCHIATRY 65 (1980); Kiesler, *Mental Hospitals and Alternative Care*, 37 AM. PSYCHOLOGIST 349 (1982).

58. Kiesler, *supra* note 57, at 349. One researcher has suggested that LPS was enacted for fiscal reasons — to save the state money by replacing the costly state hospital care system with less expensive alternatives. C. WARREN, THE COURT OF LAST RESORT 22 (1982); *See also* CAL. WELF. & INST. CODE § 5001(f).

59. Kiesler, *supra* note 57, at 349.

60. *See infra* note 91 and accompanying text.

ineffective implementation.[61] Patients have been released into the community without adequate provision for their treatment and care, a situation exacerbated by the inadequate funding provided for development of community resources.[62] Refinement of deinstitutionalization policy may, however, encourage solutions to the implementation problem. One possibility is to enhance the scope and meaning of deinstitutionalization by recognizing the least restrictive alternative doctrine as an operative principle. Another is to simply replace deinstitutionalization policy with the least restrictive alternative doctrine.

The California Legislature's exclusion of a clear expression of the least restrictive alternative doctrine in its statement of legislative intent does not make California unique among states.[63] Importantly, however, it means that the statutory provisions enacted pursuant to the intent need not be specifically construed in light of the doctrine. This becomes increasingly important because the Legislature has not uniformly applied the least restrictive alternative doctrine throughout the mental health statutes. It has expressly applied the doctrine in only three areas: development of community residential treatment systems,[64] the right to treatment,[65] and placement in conservatorship services.[66]

III. COMMUNITY RESIDENTIAL TREATMENT SYSTEM

The California Legislature has directly applied the least restrictive alternative doctrine in providing for the establishment and operation of a continuum of alternatives to institutional settings:[67] a community residential treatment system must be developed in such a way that patients "[m]ay move within the continuum to the most appropriate, least restrictive level of service."[68] Residential and day

61. *See* Pepper & Ryglewicz, *Testimony for the Neglected: The Mentally Ill in the Post-Deinstitutionalization Age*, 52 AM. J. ORTHOPSYCHIATRY 388 (1982); Whitmer, *supra* note 57.

62. Pepper & Ryglewicz, *supra* note 61, at 388.

63. *See* Appendix. At least one state expresses the least restrictive alternative doctrine as the legislative policy behind its mental health act. WIS. STAT. ANN. § 51.001(1) (West Supp. 1983) (intent to "assure all people in need of care access to the least restrictive treatment alternative appropriate").

64. CAL. WELF. & INST. CODE § 5459. *See infra* notes 67-79 and accompanying text.

65. *Id.* at §§ 5325.1, 5326.6, 5326.7. *See infra* notes 88-99 and accompanying text.

66. *Id.* at §§ 5354, 5358. *See infra* notes 100-53 and accompanying text. Statute does not require, for example, that recertification of suicidal persons or postcertification of persons dangerous to others be the least restrictive alternative.

67. *See id.* at §§ 5450, 5458.

68. *Id.* at § 5459. The Los Angeles County Department of Mental Health's primary goal

facilities included in the system must be as similar as possible to normal home environments without sacrificing client safety and care.[69] Residential alternatives that must be included in a system are 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.[70]

Many interviewed members of the mental health and judicial community in Los Angeles County[71] stated that the availability of alternatives is the key to applying the least restrictive alternative doctrine. Although a wide array of residential care services is desperately needed in Los Angeles County, however, such services are sparsely available.[72] The lack of community residential facilities is a problem not only in Los Angeles County but statewide, as demonstrated by the "California Model," a prototype developed "to serve as the framework for the development and financing of a comprehensive community mental health program in California so that individual and community needs can be met."[73]

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for the 1980's reflects the Legislature's purpose of providing a spectrum of care. That goal is "to establish a comprehensive and coordinated single system of care with a full range of services in each Region at multiple locations, available and accessible to all the residents of the County, primarily focusing on the severely and chronically mentally disordered population." ELPERS, J.R., LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH GOALS AND OBJECTIVES — PRIORITIES FOR THE '80'S 1 (1981).

69. CAL. WELF. & INST. CODE § 5453(a)(1). Residential treatment centers must be "relatively small, preferably 15 beds or less, but in any case with the appearance of a noninstitutional setting." *Id.* at § 5453(a)(2) and (3). The individual elements of the system must be in separate facilities whenever possible, not in one large facility attempting to serve an entire range of clients. *Id.*

70. *Id.* at § 5458(a)-(h).

71. Persons interviewed in Los Angeles County were promised anonymity and are, thus, not individually identified in this article.

72. ELPERS, *supra* note 68, at 4. The 1980-81 Los Angeles County Short-Doyle Plan acknowledges the deficiency in available residential services: "The percentage of persons who receive Short-Doyle residential treatment, day treatment or resocialization services which focus on normalization and alternatives to institutional care is at best very low. The most obvious gap in services is in the area of residential treatment programs." LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH, COUNTY OF LOS ANGELES 1980-81/1980-83 SHORT-DOYLE PLAN FOR MENTAL HEALTH SERVICES, PHASE II, PART III 4 (1980).

> It is obvious from the data that the need for community residential care facilities is dire. In the various categories, the need which remains unmet ranges from 79% to 100%.
>
> There are not sufficient appropriate places with the required professional backup to maintain the [chronically mentally ill] persons in the community and abate the treadmill of recidivism.

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH, COUNTY OF LOS ANGELES 1980-81/1980-83 SHORT-DOYLE PLAN FOR MENTAL HEALTH SERVICES, PHASE I, 4-15 (1980).

73. LEGISLATIVE WORK GROUP, CALIFORNIA MENTAL HEALTH ASSOCIATION, SACRA-

The California Model sets the standards for community programs which the Department of Mental Health in Los Angeles County strives to achieve. It sets forth a comprehensive system of alternatives to institutional settings, ranging from short-term crisis residential care and 24-hour transitional care to case management and community support services.[74] It details the fiscal implications of such a comprehensive system,[75] including the observation that full implementation of the Model would cost only about half as much as the institutional system.[76] The Model notes, however, that the resources needed to provide the continuum of services it proposes are almost double the current levels.[77] One author of the Model, whom Institute staff interviewed, stated that the only area in which mental health services in California are not underfunded is 24-hour acute inpatient care.

One mental health administrator suggested that the lack of fiscal resources per se may be less of a problem to the proper application of the least restrictive alternative doctrine than the allocation of available resources. The manner in which the major mental health funding sources are organized—County (Short-Doyle) funds, Medi-Cal "fee for service" funds, private providers funds, and pri-

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MENTO, CALIFORNIA, A MODEL FOR CALIFORNIA COMMUNITY MENTAL HEALTH PROGRAMS, PHASE II (1982). The California Assembly Permanent Subcommittee on Mental Health and Developmental Disabilities asked the Legislative Work Group, a coalition of mental health providers and consumers facilitated by the Mental Health Association in California, to develop the California Model. The Model, at this stage, focuses only on the public (Short-Doyle) mental health service system. *Id.* at 3. The next phase of the model will discuss incorporating fee-for-service Medi-Cal, Veteran's Administration, and other private sector services. *Id.* at 5-6. The Model envisions a balanced system emphasizing "the consumer's right to receive services in the least restrictive level of care and setting." *Id.* Executive Summary, at 1. If this balanced system were realized it would include individual levels of service for persons needing specialized treatment. *Id.* These individual services would be linked together in a network which would allow each person to move through the services to assure the most appropriate level and type of service, as indicated by diagnosis and assessment of each person's functioning level. *Id.* at 8. In describing patients' right to be served in the least restrictive, appropriate setting, the Executive Summary of the Model states:

> A balanced system addresses "least restrictive" in terms of both attitude to clients and an environment which can help to create a non-rigid system. These services should be culturally, linguistically, and age relevant in a continuum from acute intensive inpatient treatment through various non-hospital residential programs to outpatient and community support . . . the system should include smaller facilities, recipient involvement in decision making, [and] immersion of the individual in the community in normative settings.

Id. Executive Summary, at 1.

74. *See id.* at 37-38.

75. *See id.* at 41.

76. *Id.* Executive Summary, at 4.

77. *Id.*

vate insurance system funds—actually impedes the use of alternatives to institutions despite statements of program goals and purposes consistent with the least restrictive alternative doctrine.[78] Because of the great demand for public services, limited County Short-Doyle funds must meet, as a matter of first priority, the needs of the poorest and sickest segment of the population in Los Angeles. Most Short-Doyle funds are, thus, allocated for crisis intervention programs and acute inpatient facilities. Precious few resources remain for the realization of a spectrum of services despite the commitment, as a matter of principle, of most mental health administrators in Los Angeles County to the development of such a system. Unlike Short-Doyle funds, which can be used to pay for alternative care, the other sources of funds available to individuals in need in Los Angeles are difficult, if not impossible, to apply to the type of psychosocial, rehabilitative services demanded by those respondents likely to benefit from noninstitutional care. A patchwork of services including outpatient mental health services, monitoring of psychotropic medication, social work, financial assistance, and housing assistance is alien to the medical model upon which these funds are predicated.

Many, perhaps most, of those individuals interviewed in Los Angeles stated that the availability of alternative resources was the key to effectuating the least restrictive alternative doctrine. Aside from the importance of the least restrictive alternative doctrine to mental health treatment *within* institutional settings,[79] the availability of alternative resources is certainly fundamental to the application of the least restrictive alternative doctrine.

IV. Preliminary Screening and Evaluation

Formal civil commitment proceedings generally follow rather than trigger attempts to place a person into less restrictive settings.[80] Only when less severe measures fail and when someone coming in contact with an apparently mentally disabled person feels that more drastic steps are needed will the involuntary civil commitment process be initiated. Neither the emergency nor the non-emergency LPS

78. *See* Kiesler, *supra* note 57, for a national perspective on essentially the same viewpoint.

79. *See infra* note 91 and accompanying text.

80. Hoffman & Foust, *supra* note 9, at 1139 ("the unworkability of less restrictive alternatives, and not the failure to consider them, ultimately leads to most commitment proceedings").

prescriptions[81] expressly require the person or agency initiating a commitment to consider less restrictive alternatives; however, neither do these prescriptions prohibit the consideration of alternatives. Both provide opportunity for diversion from involuntary hospitalization.[82] In Los Angeles County, if the relatives, friends or neighbors of a mentally disordered person wish to seek involuntary mental health treatment or services for the person, they must rely on emergency procedures since the non-emergency procedures are rarely, if ever, used.[83]

The procedures which have developed in Los Angeles County emergency practice sometimes provide more extensive screening than that statutorily prescribed for either the emergency or the non-emergency routes to involuntary commitment. The statute mandates only that the 72-hour detention facility provide screening.[84] No screening is required prior to the individual's arrival at a detention

81. *See supra* notes 23-26 and accompanying text.

82. The non-emergency LPS procedures, which are not used in Los Angeles County, *see supra* note 27 and accompanying text, provide that 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. CAL. WELF. & INST. CODE § 5200. Any person may apply to a county-designated agency for an evaluation petition. *Id.* at § 5201. Before filing a petition with the court, however, the agency must screen the application to determine not only whether probable cause to believe the allegations exists, but also whether the allegedly mentally disordered person will voluntarily receive evaluation or crisis intervention services in his or her own home. *Id.* at § 5202. Thus, although the door to non-emergency involuntary commitment is seemingly open wide (*i.e.*, "any" person may initiate it), LPS pre-petition screening permits minimal intrusion into the individual's affairs by authorizing voluntary in-home mental health services. Furthermore, the statute provides that all LPS provisions relating to the evaluation procedure must be fulfilled "with the utmost consideration for the privacy and dignity of the individual." *Id.* at § 5200. Even following the filing of a petition and the issuance of a court order for an evaluation, the individual must be permitted to remain home or at some other place of his or her choosing prior to the evaluation. *Id.* at § 5206. If the individual is detained for the evaluation he or she must be evaluated as promptly as possible but, in any event, detention may be for no longer than 72 hours, excluding Saturdays, Sundays, and holidays if treatment and evaluation services are unavailable on those days. *Id.* Following the evaluation the individual may be released, referred for voluntary treatment and care, recommended for conservatorship, or certified for intensive treatment. *Id.* Reportedly, the non-emergency petition process was rejected in Los Angeles after a protracted period of trial and error in the 1970's. I. KEILITZ, W.L. FITCH & B.D. MCGRAW, *Involuntary Civil Commitment In Los Angeles County* 16 (1982). The demise of the petition process may have, in effect, performed a screening function by barring from involuntary treatment all but the most urgent cases.

83. *See supra* note 27 and accompanying text.

84. If the facility director, or his or her designee, determines that the individual can be properly served without being detained, then "he shall be provided evaluation, crisis intervention, or other inpatient or outpatient services on a voluntary basis." CAL. WELF. & INST. CODE § 5151.

facility.[85]

Preliminary screening may be conducted, however, by community mental health centers and by crisis intervention teams.[86] Screening and informal evaluation typically begins with a telephone or personal referral to a local community mental health center. A community mental health technician receiving the referral queries the informant about the potential respondent's present mental condition and behavior, and prior mental health history. If it appears that the potential respondent does not meet commitment criteria, he or she is diverted to community outreach services. If crisis intervention or 72-hour emergency treatment and evaluation appear appropriate, the technician contacts a crisis intervention team.

Although the operating procedures of Los Angeles County crisis intervention teams vary, when a team responds to a technician's request for intervention, it provides on-location intervention.[87] As a result of screening by crisis intervention teams, approximately half of the potential respondents are reportedly diverted from emergency commitment to voluntary treatment. A team's decision is based upon its assessment of legal criteria for involuntary detention and its common sense assessment of the respondent's mental condition and environment. Even when a crisis intervention team has found sufficient grounds for 72-hour detention, some respondents may still be diverted from involuntary procedures because of a shortage of hospital beds. Thus, in the absence of a statutory mandate, much screening occurs early in the emergency process.

V. Mental Health Treatment After Certification

All persons with mental illness in California have a right to treatment services "provided in ways that are least restrictive of the personal liberty of the individual."[88] Responsibility to protect that right lies not only with the courts, but also with the treatment providers themselves. It is beyond the scope of this article to look in

85. Statute requires only that the peace officer or county-designated person initiating the custody-taking have probable cause to believe that the individual is a danger to him or herself or others, or is gravely disabled, because of mental disorder. *See id.* at § 5150.

86. *See id.* at § 5651.7. These crisis intervention teams were formerly called "psychiatric" emergency teams or "PET teams". Some Los Angeles practitioners continue to use the latter designation.

87. Crisis intervention "may be conducted in the home of the person or family, or on an inpatient or outpatient basis with such therapy, or other services, as may be appropriate." *Id.* at § 5008(e).

88. *Id.* at § 5325.1(a).

depth at actual treatment practices *within* facilities designated for 14-day certification, except to the extent that the mental health and judicial systems might interact in prescribing or providing that treatment. Such interaction is non-existent in probable cause hearings, which are required when individuals are certified for 14 days of involuntary intensive treatment following initial 72-hour detention for emergency evaluation and treatment.[89] The referees presiding at probable cause hearings in Los Angeles decide merely whether probable cause exists to support the certification decision—they do not reach treatment questions.

Also, such interaction is very infrequent in writ of *habeas corpus* hearings before Superior Court, Department 95, in Los Angeles. Department 95 hears all writ hearings, which are available upon request to persons certified for 14-day intensive treatment.[90] Reportedly, the court rarely becomes involved in determining actual treatment. The court very rarely may order specific treatment, following denial of a writ, but only if counsel has presented evidence in court that a specific treatment is needed. The court generally assumes that facilities are providing proper treatment. The court views hospital treatment as the facility's responsibility and the onus to challenge that treatment is on the public defender, or the patient him or herself.[91] During Institute research on a previous project in Los Angeles County, staff observed *habeas corpus* hearings in which the judge then presiding *denied* the writ yet allowed the respondent to be released to his or her parents or some other person.[92]

> When questioned about this practice, one attorney stated that, although nothing in the California Statute specifically provides for such procedure (in essence, a commitment to a less restrictive al-

89. *Id.* at § 5256.

90. *Id.* at § 5275.

91. *See* Ploof v. Brooks, 342 F. Supp. 999, 1005 (D. Vt. 1972). "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 justification." *Id.* Other courts have emphasized, however, that the least restrictive alternative doctrine applies to alternative dispositions with a mental health hospital. *E.g.*, Covington v. Harris, 419 F.2d 617, 623-24 (D.C. Cir. 1969):

> 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.

Id. See also Dep't. of Health v. Owens, 305 So. 2d 314 (Fla. Dist. Ct. App. 1974) (Boyer, J., dissenting); *Ex parte* D.D., 118 N.J. Super. 1, 285 A.2d 283, 287 (1971).

92. *See* I. KEILITZ, W.L. FITCH & B.D. MCGRAW, *supra* note 82, at 68.

> ternative), it often works as a useful compromise between a rejection of the evidence supporting hospitalization and a denial of the respondent's potential for coping outside of the institution. The judge noted that the procedure was, in fact, a denial of the writ that results in a return of the respondent to the hospital. In effect, however, the denial gave notice from the court that if the treating professional felt that it was appropriate to release the patient to the particular relative or other person specified by the court, the court would join in the decision to release the respondent.[93]

LPS provides respondents with certain rights that may be the subject of judicial review, although their protection is entrusted primarily to facility staff. In keeping with the statutory mandate that treatment be administered in the manner least restrictive of personal liberty,[94] mental health treatment after certification should be provided in the local community;[95] respondents 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;[96] the professional person certifying the respondent should attempt to place the respondent in the treatment facility of his or her preference if administratively possible;[97] and the professional person in charge of the intensive treatment facility, or his or her designee, may permit the respondent to leave the facility for short periods during the treatment term.[98] Psychosurgery and electro-convulsive treatment may be administered only if, among other things, 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."[99]

VI. Placement in Conservatorship Services

The LPS conservatorship provisions require more extensive im-

93. *Id.*

94. *See* Cal. Welf. & Inst. Code § 5325.1 (West Supp. 1983).

95. *Id.* at § 5120 (West Supp. 1983).

96. *Id.* at § 5009 (West 1972).

97. *Id.* at § 5259.2 (West Supp. 1983).

98. *Id.* at § 5268 (West 1972).

99. *Id.* at §§ 5326.6(c) (West 1972), 5326.7(a) (West Supp. 1983). Following the California Supreme Court's decision in Aden v. Younger, 57 Cal. App. 3d 662, 129 Cal. Rptr. 535 (1976) (holding relevant statutes unconstitutional), the Legislature enacted extensive due process protections for voluntary and involuntary patients faced with possible psychosurgery or elecro-convulsive therapy. *See id.* at §§ 5326.6, 5326.7 (West 1972). These due process protections reportedly involve such onerous restrictions that these therapies are virtually never used in Los Angeles County.

plementation of the least restrictive alternative doctrine than do any other LPS civil commitment provisions.

> The legislative focus of the LPS [conservatorship provisions] 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. . . . Nor is it to allow the appointment of the Public Guardian or any other person, no matter how benevolent, as conservator of that person unless it is absolutely necessary to do so. The Act thus takes cognizance of the very short step it is from the appointment of a conservator to the involuntary confinement or commitment of the conservatee.[100]

The purpose of LPS conservatorship is to provide individualized treatment, supervision and placement services to "gravely disabled" persons.[101] Section 5008(h)(1) defines "gravely disabled" as "[a] condition in which a person, as a result of mental disorder, is unable to provide for his basic personal needs for food, clothing, or shelter. . . ."[102] In *Conservatorship of Davis*,[103] a recent case originating in the Superior Court of Los Angeles County, the Court of Appeal, Second District, Division 4, concluded that "a person is not 'gravely disabled' within the meaning of section 5008(h)(1) if he or she is capable of surviving safely in freedom with the help of willing and responsible family members, friends or third parties."[104] As we shall discuss later, this interpretation may have broadened the significance of the statutory prescription that the county-designated officer providing conservatorship investigation may recommend conservatorship to the court "only if no suitable alternatives are available."[105]

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100. Conservatorship of Davis, 124 Cal. App. 3d 313, 326, 177 Cal. Rptr. 369, 377 (1981).

101. CAL. WELF. & INST. CODE §§ 5001(e), 5350.1 (West 1972). The LPS conservatorship provisions do not affect persons mentally ill and dangerous to self or others.

102. *Id.* at § 5008(h)(1) (West Supp. 1983).

103. 124 Cal. App. 3d 313, 177 Cal. Rptr. 369. *See also* Conservatorship of Wilson, 137 Cal. App. 3d 132, 186 Cal. Rptr. 748 (1982); Conservatorship of Early, 190 Cal. Rptr. 578 (Ct. App. 1983). *But see* Conservatorship of Buchanan, 78 Cal. App. 3d 281, 144 Cal. Rptr. 241 (1978).

104. 124 Cal. App. 3d at 321, 177 Cal. Rptr. at 374. A jury instruction consistent with this language is used in Los Angeles conservatorship hearings and reads in part:

> You are instructed that the term 'gravely disabled' means a condition in which a person, as a result of mental disorder, is unable to provide for his basic personal needs for food, clothing or shelter. The ability to provide for these basic needs requires more than the physical and mechanical ability to do certain acts; it means that the person be able to function and maintain himself *with or without the assistance of other available resources*.

105. CAL. WELF. & INST. CODE § 5354 (West Supp. 1983). *See also infra* text accompanying note 116.

Conservatorship proceedings begin when the director of an evaluation or intensive treatment facility recommends conservatorship to the county-designated officer providing conservatorship investigation for the county in which the proposed conservatee is a resident or was a resident prior to admission to the facility.[106] This recommendation is accomplished in Los Angeles by an application for conservatorship investigation mailed or delivered to the Office of the Public Guardian and signed by two physicians, including their diagnosis and a description of the person's behavior which indicates that conservatorship is appropriate.

If the county-designated officer providing conservatorship investigation—in Los Angeles, a deputy public guardian from the Office of the Public Guardian—concurs with the recommendation, he or she must petition the superior court to establish a conservatorship.[107] The court may establish a temporary conservatorship on the basis of a comprehensive report of the officer providing conservatorship investigation or on the basis of an affidavit of the professional person who recommended conservatorship.[108] The Los Angeles County public guardian does not, however, submit a report at this stage. Rather, the two physicians' application serves as the affidavit upon which the court bases its conservatorship decision.

The requirement that the deputy public guardian concur with the two physicians' recommendation prior to petitioning for temporary conservatorship provides the first opportunity for implementation of the least restrictive alternative doctrine in conservatorship proceedings. It provides the opportunity for a deputy public guardian to perform screening and to direct the allegedly gravely disabled person from conservatorship to a less restrictive alternative. No such screening occurs in Los Angeles County. The public guardian's office forwards the application for conservatorship investigation to the Office of the County Counsel in essentially the same form as received. It appears that, at this pre-petition stage, the public guardian's office serves merely as an administrative control for conservatorship applications. Thus, although a number of people in Los Angeles believe that the public guardian serves a screening function, the public guardian's "concurrence" with the facility director's recommendation is, in practice, merely "acquiescence".

The county counsel may, however, take further action. Report-

106. CAL. WELF. & INST. CODE § 5352 (West Supp. 1983).
107. *Id.*
108. *Id.* at § 5352.1.

edly, the county counsel screens and removes a large percentage of temporary conservatorship petitions due to lack of merit. The county counsel's role consists of reviewing the conservatorship application on its face without direct assessment of the proposed conservatee's suitability for conservatorship. If an application appears meritorious, county counsel prepares a petition for temporary conservatorship and delivers it to the Judge of the Superior Court, Department 95, for signature. The court orders temporary conservatorship in virtually every case for which county counsel files a petition. The court typically orders temporary conservatorship on the same day that county counsel receives and reviews the application. Thus, from the time that two physicians sign and submit a conservatorship application to the time the Department 95 judge signs the petition authorizing temporary conservatorship, the screening process merely addresses whether the application *on its face* warrants conservatorship—no clinical review of the recommendation occurs.

The second opportunity for implementation of the least restrictive alternative doctrine in conservatorship proceedings arises during temporary conservatorship. The county-designated officer providing conservatorship investigation acts as the temporary conservator.[109] The public guardian's office in Los Angeles employs deputies who are solely responsible for investigating conservatorship and others who serves as conservators. LPS requires the deputy public guardian acting as temporary conservator to determine the arrangements necessary to provide the temporary conservatee with food, shelter and care pending the judicial determination of whether a full, one-year conservatorship should follow the temporary conservatorship.[110] In making his or her placement decision, the temporary conservator "shall give preference to arrangements which allow the person to return to his home, family or friends."[111] The court must "order the temporary conservator to take all reasonable steps to preserve the status quo concerning the conservatee's place of residence."[112] The temporary conservatee may place the person in a facility providing intensive treatment only if necessary.[113]

During the temporary conservatorship period, the officer providing conservatorship investigation must conduct a thorough inves-

109. *Id.* at § 5352.
110. *Id.* at § 5353.
111. *Id.*
112. *Id.*
113. *Id.* Other important facilities in which the temporary conservator may place the temporary conservatee are listed in § 5358. *Id.* at § 5353 (West 1972).

tigation to determine if full conservatorship is necessary.[114] The least restrictive alternative doctrine is operative here. LPS requires the officer to investigate all available alternatives to conservatorship and to recommend conservatorship only if no suitable alternatives are available.[115] The court of appeal's decision in *Conservatorship of Davis*[116] may have expanded the range of suitable alternatives which, if available, should lead the deputy public guardian to not recommend conservatorship. The range of suitable alternatives apparently includes freedom with the assistance of willing and responsible family members, friends or third parties.

Although the court's holding specifically addressed whether a proposed conservatee was entitled to a jury determination of his or her grave disability under the expanded definition, the court's reasoning spoke directly to the proper definition of "gravely disabled" to be applied throughout LPS.[117] That definition incorporates a threshold consideration of alternatives to conservatorship. Grave disability must be determined "not in a vacuum, but in the context of suitable alternatives. . . ."[118] According to the court, a person is not gravely disabled for LPS purposes "if he or she is capable of surviving safely in freedom with the help of willing and responsible family members, friends or third parties."[119] Even if a proposed conservatee is strictly "unable to provide for his basic personal needs for food, clothing, or shelter"[120] if unassisted, an acceptable alternative to conservatorship is freedom with the assistance of a third party. Thus, the deputy public guardian should not recommend conservatorship if such an alternative is suitable. If the deputy recommends against conservatorship, he or she must set forth in the report all available alternatives.[121]

As many as 75 percent of all temporary conservatorships in Los Angeles are terminated before a full conservatorship hearing. A temporary conservatee may be released during the temporary conservatorship period for any of several reasons: (1) he or she may no longer be gravely disabled, (2) he or she may have chosen to be a voluntary patient, (3) a suitable alternative to conservatorship may

114. *See id.* at § 5354.
115. *Id.*
116. 124 Cal. App. 3d 313, 177 Cal. Rptr. 369.
117. *Id.* at 321, 177 Cal. Rptr. at 374.
118. *Id.* at 325, 177 Cal. Rptr. at 376.
119. *Id.* at 321, 177 Cal. Rptr. at 374.
120. CAL. WELF. & INST. CODE § 5008(h)(1) (West Supp. 1983).
121. *Id.* at § 5354 (West 1972).

have been found, or (4) the treating physician may simply have wished to avoid court proceedings. Treating physicians may use temporary conservatorship merely to extend the opportunity to treat a conservatee rather than to investigate the person's suitability for conservatorship.[122] However, such use of temporary conservatorship is contrary to LPS authorization and the patient's personal liberty interest.

If a temporary conservatorship is not prematurely terminated, a conservatorship hearing must occur within thirty days of the filing of the petition.[123] Conservatorship hearings are heard before a court commissioner in Los Angeles County Superior Court, Department 95A. At the conservatorship hearing, the commissioner determines whether a full conservatorship is warranted.[124] If so, the commissioner appoints a new conservator[125] and orders placement of the conservatee in the least restrictive alternative.[126]

In 1980, extensive amendments to LPS section 5358 authorized the court to order the least restrictive alternative placement of a conservatee.[127] A strict reading of section 5358, as amended, would not require the court to order the least restrictive placement in every case; rather, it would require the *conservator* to place the conservatee in the least restrictive alternative placement *when* so ordered by the court.[128] LPS would permit the court to designate a particular placement[129] or to generically order the least restrictive alternative.[130]

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122. Tieger & Kreser, *Civil Commitment in California: A Defense Perspective on the Operation of the Lanterman-Petris-Short Act*, 28 HASTINGS L.J. 1407, 1427 (1977); *see also*; ENKI RESEARCH INSTITUTE, A STUDY OF CALIFORNIA'S NEW MENTAL HEALTH LAW 159 (1971). Section 5352.3 permits continued detention for up to three days beyond the initial 14-day certification period—this extension is needed for pursuing temporary conservatorship. CAL. WELF. & INST. CODE § 5352.3 (West 1972). In addition, the perfunctory process for screening conservatorship petitions in Los Angeles makes temporary conservatorship relatively easy to accomplish. *See infra* text accompanying note 160.

123. CAL. WELF. & INST. CODE § 5365 (West Supp. 1983).

124. *See id.*

125. *See id.* at § 5355.

126. *Id.* at § 5358.

127. 1980 CAL. STAT. 2067.

128. *See In re* Gandolfo, 136 Cal. App. 3d 205, 208-09, 211, 185 Cal. Rptr. 911, 914, 916 (1982) (trial court had ordered conservator to place conservatee in hospital). LPS is equivocal regarding how the court should ascertain the least restrictive and most appropriate placement. Section 5354 states that the court *may* consider the report of the officer providing conservatorship investigation. The court is apparently not required to consider the report. CAL. WELF. & INST. CODE § 5354 (West Supp. 1983). *When* the court considers the report, it must consider available placement alternatives. *Id.* at § 5358(c). The court must *determine* the least restrictive and most appropriate alternative placement after considering "all the evidence." *Id.*

129. Section 5358(a) reads in pertinent part: "When ordered by the court after the hearing

Department 95A takes the latter approach.

Department 95A has incorporated into a standardized form the powers and disabilities it might grant or impose in any particular conservatorship case.[131] The court indicates which clauses in the form apply in a given case by checking the appropriate clauses. The court-order form includes language by which the commissioner generically orders appropriate placement:

> In determining the placement or residence of the conservatee, the conservator shall choose the least restrictive setting which is appropriate for the conservatee's care and needs. Where possible, the conservator shall permit the conservatee to reside in a home or other residential setting if the conservatee so desires. If the conservatee is not to be placed in his own home or the home of a relative, first priority shall be to placement in a suitable facility in California as close as possible to his home or the home of a relative.[132]

The court, thus, makes the conservator primarily responsible for choosing the particular placement. In stating the priorities a conservator should follow in determining placement, the form echoes the first sentence of section 5358(c).[133] Section 5358(c) continues the statement of priorities, however, by defining "suitable facility," a term used without definition in the court-order form. The second sentence of section 5358(c) states that "suitable facility means the least restrictive residential placement available and necessary to achieve the purposes of treatment."[134] Thus, the priority scheme be-

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required by this section, a conservator appointed pursuant to this chapter shall place his or her conservatee in the least restrictive alternative placement, as designated by the court." CAL. WELF. & INST. CODE § 5358(a) (West Supp. 1983). No reported case has construed this language. The California Supreme Court, in Conservatorship of Roulet, 574 P.2d 1245, 143 Cal. Rptr. 893 (1978) *modified*, 23 Cal. 3d 219, 152 Cal. Rptr. 425 (1979), interpreted the pre-1980 formulation of section 5358(a) to mean that only the conservator could commit the conservatee, but only if the court order authorized commitment. According to section 5002, the court may not commit a mentally disordered person. Section 5358(a) as amended, however, permits the court to "designate" where the conservator must place the conservatee. 574 P.2d at 1245, 143 Cal. Rptr. at 896. *Quaere*: If the court *designates* a facility where the conservator *must* place the conservatee, is this not, effectively, a judicial commitment?

130. CAL. WELF. & INST. CODE § 5358(a) (West Supp. 1983).

131. Order (Re)Appointing Conservator Pursuant to Lanterman-Petris-Short Act (standardized form) [hereinafter cited as Order].

132. *Id.*

133. Section 5358(a) reads in part: "If the conservatee is not to be placed in his or her own home or the home of a relative, first priority shall be to placement in a suitable facility as close as possible to his or her home or the home of a relative." CAL. WELF. & INST. CODE § 5358(c) (West Supp. 1983).

134. *Id.*

gins with the person's own home or that of a relative and progresses to the least restrictive available and necessary residential facility as close as possible to the person's own home or that of a relative.

The court-order form continues this hierarchy by giving conservators indicated powers:

> 4. To place the conservatee in a private residence, psychiatric or non-psychiatric residential care facility, board and care, skilled nursing facility or convalescent facility whereat conservatee has free access into or out of the premises.
>
> 5. To place the conservatee in a portion of a private, acute care psychiatric hospital, state or county hospital or hospital operated by the Regents of the University of California or by the United States Government whereat the conservatee has free access into or out of such hospital.
>
> 6. To place the conservatee in a medical or psychiatric nursing facility, skilled nursing facility or convalescent facility whereat the conservatee does not have free access into or out of the premises. Pending further order of the Court this power shall terminate _____.
>
> 7. To place the conservatee in that portion of a state of [sic] county hospital facility or a hospital operated by the Regents of the University of California or by the United States Government or of a private acute care psychiatric hospital, whereat the conservatee does not have free access into or out of such hospital. Pending further order of the court, this power shall terminate _____.[135]

The scheme progresses to unlocked facilities and then to locked facilities. Conservators receive a handbook[136] which instructs them regarding this hierarchy and their obligation to place conservatees in least restrictive settings. The handbook simplifies the priority scheme as stated in the standardized court-order by saying that, for guideline purposes, settings are more or less restrictive in the following order (beginning with the least restrictive):

1. Living with family/friends or independently.
2. Residential Care Facilities: (board and care, family care homes, halfway houses, transitional living centers, etc.).
3. Unlocked Skilled Nursing Facilities and Convalescent Hospitals.

135. Order, *supra* note 131. Several attorneys who represent respondents at conservatorship hearings have stated that this checklist formula does not always work; an individual, case-by-case approach is needed.

136. LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH, A GUIDE FOR PRIVATE CONSERVATORS (1981).

4. Locked Skilled Nursing Facilities.
5. Acute Psychiatric Hospitals.[137]

Despite these details in LPS, the court-order form, and the handbook, placement of conservatees in alternatives less restrictive than acute psychiatric hospitals is often frustrated by the unavailability of alternative resources. A Department 95A commissioner stated that most gravely disabled persons appearing in his court do not need hospitalization; however, finding less restrictive placement is difficult. He suggested that few skilled nursing facilities, either locked or unlocked, are appropriate for conservatees and that board and care facilities are the only viable and available alternative. Thus, for conservatees unable to live independently or with a friend or relative, a hospital may be the only option.

The California Supreme Court said in *Conservatorship of Roulet*[138] that even though common sense dictates that, if anything, gravely disabled persons should receive more procedural safeguards than imminently dangerous persons, LPS makes it *easier* to commit gravely disabled persons. An LPS conservator can place a conservatee in a locked facility.[139] A conservator's power to place a conservatee in an acute psychiatric hospital is referred to in Los Angeles as "Power 7", because of its designation in the standardized court-order form.[140]

A conservator's exercise of Power 7 can result in a drastic curtailment of the conservatee's liberty. The California Supreme Court has said that LPS conservatorship provisions "assure in many cases an unbroken and indefinite period of state-sanctioned confinement. 'The theoretical maximum period of detention is *life* as successive petitions may be filed. . . .' "[141] A temporary conservator may require the conservatee to be detained in a treatment facility for up to thirty days.[142] If the temporary conservatee petitions for writ of *habeas corpus*, this detention may last up to six months, pending disposition of the trial.[143] If a conservator is appointed and granted

137. *Id.*

138. 23 Cal. 3d 219, 590 P.2d 1, 152 Cal. Rptr. 425 (1979), *modifying* 574 P.2d 1245, 143 Cal. Rptr. 893 (1978).

139. *See* 5 Op. Cal. Att'y Gen. 50 (1975). This power derives from CAL. WELF. & INST. CODE § 5358(a) (West Supp. 1983).

140. *See* Order, *supra* note 131.

141. Conservatorship of Roulet, 23 Cal. 3d at 224, 590 P.2d at 3, 152 Cal. Rptr. at 427 (citing *In re* Gary W., 5 Cal. 3d 296, 300, 486 P.2d 1201, 1204, 96 Cal. Rptr. 1, 4 (1971)) (emphasis in original).

142. CAL. WELF. & INST. CODE § 5353 (West Supp. 1983).

143. *Id.* at §§ 5352.1, 5353.

Power 7, the conservatee may be placed in an institution for up to a year,[144] excluding the temporary conservatorship period,[145] and then for additional one-year extensions.[146] A conservatee's loss of personal liberty through civil commitment may be "scarcely less total than that effected by confinement in a penitentiary."[147]

If a conservatee's initial placement following the conservatorship hearing is in a less restrictive alternative, such as a board and care home or an unlocked skilled nursing facility, the conservator retains the powers to transfer the conservatee to a *more* restrictive facility or hospital.[148] The conservator must, however, have "reasonable cause to believe that his or her conservatee is in need of immediate more restrictive placement,"[149] and he or she must give written notice, including the reason for the placement change, to the court and designated persons.[150] Conservators in Los Angeles accomplish this notice by completing a "Private Conservator's Notification of Change of Placement" form and sending it to the Los Angeles County Department of Mental Health Patients' Rights Advocate within one week after the placement change. No similar requirements limit the conservator's power to transfer his or her conservatee to a less restrictive placement. He or she may transfer the conservatee to a less restrictive alternative without another hearing and court approval.[151]

If a conservatee initially placed in a treatment facility no longer needs that facility's care or treatment, the facility director may so notify the conservator, who must then find alternative placement.[152] However, the LPS provision requiring alternative placement in this situation is open to criticism.[153] The conservator has seven days to place the conservatee, but if "unusual conditions or circumstances" prevent alternative placement, the conservator has 30 days to place the conservatee; and if placement cannot be found within the 30 days, then the conservator and facility director must determine the

144. *Id.* at §§ 5361, 5358(a).
145. *Id.* at § 5361.
146. *Id.*
147. *Roulet*, 23 Cal. 3d at 224, 590 P.2d at 3, 152 Cal. Rptr. at 427-28. The court lists many liberties in addition to physical restraint that a conservatee may lose. *Id.* at 226-29, 590 P.2d at 5-6, 152 Cal. Rptr. at 429-30.
148. *See* CAL. WELF. & INST. CODE § 5358(d) (West Supp. 1983).
149. *Id.*
150. *Id.*
151. *Id.*
152. *Id.* at § 5359.
153. *See* Tieger & Kresser, *supra* note 122, at 1430-31 n.105.

"earliest practicable date when such alternative placement may be obtained."[154] Under this provision, a conservatee could potentially remain for an indefinite period in a facility more restrictive than justified by his or her condition. This possibility is enhanced when alternative facilities are scarce.

Although the LPS conservatorship provisions provide numerous opportunities for application of the least restrictive alternative doctrine, they also provide opportunity for drastic curtailment of a respondent's liberty. This latter possibility is enhanced if, as several interviewees and commentators[155] have stated, grave disability is used as a "catchall" category for respondents who are no longer dangerous to self or others. One interviewer stated that suicidal persons are often called gravely disabled so that they may be held longer than the 14-day recertification period. Moreover, statistical evidence has supported the conclusion that the conservatorship device is often used to prolong hospitalization of nondangerous persons.[156]

VII. Postcertification Outpatient Treatment

A newly enacted LPS provision permits placing a person postcertified on the basis of dangerousness to others on outpatient status if certain conditions are satisfied.[157] In addition to authorizing outpatient status, the Legislature increased the maximum permissible postcertification period from 90 to 180 days.[158] This period is renewable.[159] Although LPS requires a judicial hearing prior to postcertification and authorizes the court to determine the maximum duration of postcertification,[160] LPS leaves to the treatment facility director the decision of whether the respondent should be detained or released to outpatient status.[161]

LPS fails to explicitly require the director to release or detain a respondent in accordance with the least restrictive alternative doc-

154. Cal. Welf. & Inst. Code § 5359 (West Supp. 1983).

155. Warren, *Involuntary Commitment for Mental Disorder: The Application of California's Lanterman-Petris-Short Act*, 11 Law & Soc'y 629, 645-47 (1977); Morris, *Conservatorship for the "Gravely Disabled": California's Nondeclaration of Nonindependence*, 1 Int'l J. of Law & Psychiatry 395, 407 (1978).

156. Morris, *supra* note 156, at 405 (citing A. Stone, Mental Health and Law: A System in Transition 64 (1975)).

157. *See* Cal. Welf. & Inst. Code § 5305 (West Supp. 1983).

158. *See id.* at § 5300.

159. *Id.* at § 5304.

160. *Id.*

161. *Id.* at § 5305. The court must approve outpatient status only if an interested party challenges the treatment director's decision. *Id.* at § 5305(2)(b).

trine. Only the respondent's general right to treatment administered in the manner least restrictive of personal liberty[162] would require the director to do so. The Legislature's authorization of outpatient postcertification, however, provides new opportunity for application of the doctrine.

This new provision has not at this writing been widely used in Los Angeles County. Postcertification has traditionally been unpopular in Los Angeles, primarily because practitioners generally believe it is virtually impossible to prove, beyond a reasonable doubt, that someone is dangerous to others.[163] Whether the availability of outpatient status will affect the frequency of postcertifications in Los Angeles is yet to be seen.

The potential application of the least restrictive alternative doctrine in the commitment of dangerous persons is consistent with practices in other jurisdictions.[164] An argument frequently asserted against application of the doctrine in civil commitment proceedings, however, is that a respondent's participation and cooperation in a treatment program less restrictive than hospitalization cannot be ensured.[165] The outpatient postcertification provisions combat this problem by providing methods to ensure compliance: outpatient supervision and revocation of outpatient status in specified circumstances. The specifics of the LPS scheme are outlined briefly below.

The conditions which must be satisfied before a treatment facility director may place a respondent on outpatient status 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,"[166] 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."[167] 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

162. *Id.* at § 5325.1.

163. Postcertification has also been infrequently used throughout California. ENKI RESEARCH INSTITUTE, *supra* note 122, at 154.

164. *See e.g.*, I. KEILITZ & B.D. MCGRAW, AN EVALUATION OF INVOLUNTARY CIVIL COMMITMENT IN MILWAUKEE COUNTY, 102-14 (1983).

165. *Id.* at 103.

166. CAL. WELF. & INST. CODE § 5305(a)(1) (West Supp. 1984).

167. *Id.* at § 5305(a)(2).

requests a hearing.[168] Such a hearing must be held within five judicial days of actual notice.[169]

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.[170] A final report must be submitted at the conclusion of the 180-day commitment.[171]

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 if the patient 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.[172] 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.[173]

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 section 5306.5 or section 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 impose a demonstrated danger of harm to the person or to another."[174] A patient so detained has a right to review of the detention by *habeas corpus*.[175] If the court approves confinement under either section 5306.5 or section 5307, then the patient may not later be released to outpatient status without court approval.[176]

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168. *Id.* at § 5305(b).
169. *Id.*
170. *Id.* at § 5305(d).
171. *Id.*
172. *Id.* at § 5306.5.
173. *Id.*
174. *Id.* at § 5308.
175. *Id.* at §§ 5308, 5275.
176. *Id.* at § 5308.

LPS postcertification provisions provide a potential for drastic deprivations of liberty similar to those permitted by the conservatorship provisions. Although a respondent *may* be placed on outpatient status, he or she might also be confined for initial and successive postcertification periods. To the extent that there is a shortage of pscyhiatric beds in Los Angeles County, however, facilities have little incentive to improperly detain respondents.

CONCLUSION

In the civil commitment practices in Los Angeles County, the mores and customs[177] do not always coincide with the Legislature's vision as expressed in statute. The envisioned community residential treatment has not developed.[178] The LPS conservatorship provisions have been used as a catchall for respondents not satisfying other commitment criteria.[179] On the other hand, the preliminary screening provided to all respondents has often surpassed statutory requirements.[180] Legislating and implementing procedures and policies are separate processes that must not be viewed as one and the same.[181]

The statutory requirement of a community residential treatment system,[182] even if it is met, is no guarantee of less restrictive treatment and care. Agents of the mental health/judicial system responsible for effectuating the involuntary civil commitment process must first be aware of existing less restrictive alternatives and then be able and willing to use them. Courts and their officers are generally unfamiliar with community-based care and treatment programs and, unfortunately, make little inquiry into the availability or suitability of such programs as alternatives to institutionalization. Mechanisms must be developed to enable law enforcement agencies, crisis intervention units, courts, and attorneys to identify and access such resources in order to serve the needs of persons facing involuntary civil commitment proceedings. Linkages must be established between the courts and community-based programs so that the former will be informed about and enabled to draw upon the services of the latter.

The Legislature has failed to either define "least restrictive al-

177. *See supra* note 1 and accompanying text.
178. *See supra* note 72 and accompanying text.
179. *See supra* note 156 and accompanying text.
180. *See supra* text accompanying note 84.
181. Shah, *supra* note 3, at 255.
182. CAL. WELF. & INST. CODE § 5450 (West Supp. 1984).

ternative"[183] or to articulate what the doctrine's specific application in involuntary civil commitment proceedings entails. California appellate courts have similarly given little practical guidance.[184] Although several courts throughout the country have addressed the problem of application, many disagree regarding the solution.[185] The divergent judicial approaches are similar, however, insofar as they appear to test "restrictiveness" by objective criteria—they view mental institutions as more restrictive than independent living programs. They look at the physical characteristics of the treatment setting and decide that the less a setting looks like an institution, the less it infringes upon the liberty interests of mentally ill persons. In short, they measure restrictiveness by the number of locks on the doors.

As a general rule, this objective approach is probably sufficient in most cases. This approach may fail, however, in the case-by-case analysis of restrictiveness because it overlooks subjective factors, such as the patient's personal preferences and his or her familial surroundings and the larger social context. Although most people would consider a locked psychiatric hospital to be more restrictive than a community residence, a particular person involuntarily placed in a treatment setting may indeed prefer an institution. The courts should minimize infringement of the individual's subjective freedom of choice. Restrictiveness should be viewed not merely through the eye of the beholder, but also from the perspective of the individual whose freedom is impinged upon.

To be effective, the least restrictive alternative doctrine must be translated into specific procedures and programs routinely applicable on a case-by-case basis. No simple formula exists that will give practical meaning to the doctrine. Because its application in invol-

183. Only one of the seven mental health statutes studied by Institute staff defines "least restrictive environment." *See* Appendix. *See also* MO. REV. STAT. § 630.006.1 (17) (1980).

184. The courts merely acknowledge or reiterate relevant statutory language. *See e.g., In re* Gandolfo, 136 Cal. App. 3d 205, 185 Cal. Rptr. 911 (1982); Conservatorship of Davis, 124 Cal. App. 3d 313, 177 Cal. Rptr. 369 (1981); Aden v. Younger, 57 Cal. App. 3d 662, 129 Cal. Rptr. (1976).

185. *E.g.*, Rone v. Fireman, 473 F. Supp. 92, 125 (N.D. Ohio 1979) (treatment setting should not be overly restrictive on comparative basis); Eubanks v. Clarke, 434 F. Supp. 1022, 1028 (E.D. Pa. 1977) (if state has facilities significantly differing in restrictiveness, it must choose the least restrictive consistent with treatment objectives); Gary W. v. Louisiana, 437 F. Supp. 1209, 1217 (E.D. La. 1976) (required consideration of respondent's needs rather than automatic placement in institution); Davis v. Watkins, 384 F. Supp. 1196, 1203 (N.D. Ohio 1974) (required "the minimum limitation of movement or activity"); Welsch v. Likens, 373 F. Supp. 487, 502 (D. Minn. 1974) (required "good faith attempts" to place respondents in suitable, least restrictive settings).

untary civil commitment proceedings implicates several professional disciplines, however, giving practical meaning to the doctrine demands much collaborative thought and action.

APPENDIX
COMPARISON OF STATUTORY PROVISIONS

The table that appears on the next four pages is designed to facilitate comparison of California statutory provisions for the application of the least restrictive alternative (LRA) doctrine with statutory provisions in the six other states (*i.e.*, Arizona, Illinois, Missouri, New York, Virginia, and Wisconsin) involved in the Institute study. Statutory citations are respectively: 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 and the citations given are generally only the primary ones. 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 particular 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. While all seven states acknowledge the least restrictive alternative doctrine somewhere in their statutes, they vary considerably in the number and types of categories in which they provide for its application and in the explictness with which they articulate the doctrine.

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	Deinstitutionalization 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 available, appropriate setting for necessary individualized services which maximize 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 admission 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 electroconvulsive 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 "Patient's 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	—	—	—	—

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LEAST RESTRICTIVE TREATMENT OF INVOLUNTARY PATIENTS: TRANSLATING CONCEPTS INTO PRACTICE*

INTRODUCTION

Over the last twenty years, two related concepts, the "least restrictive alternative" doctrine and "deinstitutionalization," have been increasingly applied to address the problems and abuses of institutionalized mentally disabled persons. The first, the "least restrictive alternative" doctrine, was built upon the legal principle of "least drastic means," which has a rich and varied history in legal cases outside the mental health field.[2] Adherence to the "least restrictive alternative" doctrine in the mental health area means that treatment and care are no more harsh, hazardous, intrusive, or restrictive than necessary to achieve legitimate therapeutic aims and to protect the patient or others from physical harm.[3]

The doctrine was first applied in mental health litigation in 1966 in Lake v. Cameron,[4] a case in which the appellant, a sixty-year old woman involuntarily committed to St. Elizabeths Hospital, argued that she should be treated in a setting less restrictive than total confinement. Chief Judge David Bazelon, writing for the majority of the United States Court of Appeals for the District of Columbia, held that "[d]eprivations of liberty solely because of dangers to the ill persons

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themselves should not go beyond what is necessary for their protection."[5] Since the Lake v. Cameron decision, both federal[6] and state[7] courts have recognized the doctrine in mental health litigation. All states except Alabama, Mississippi, and Oregon have enacted statutes which require that mental health care and treatment provided be the least restrictive alternative available to achieve legitimate purposes.[8]

The second concept, "deinstitutionalization," is a sociopolitical concept that grew out of increasing public and professional dismay with the institutionalization of mentally disabled persons. Simply stated, deinstitutionalization means removing patients from hospitals and placing them in alternative care settings.[9] The U.S. General Accounting Office (GAO) report in 1977 defined deinstitutionalization as

> the process of (1) preventing both unnecessary admission to and retention in institutions; (2) finding and developing appropriate alternatives in the community for housing, treatment, training, education, and rehabilitation of the mentally disabled who do not need to be in institutions, and (3) improving conditions, care, and treatment for those who need institutional care. This approach is based on the principle that mentally disabled persons are entitled to live in the least restrictive environment necessary and lead their lives as normally and independently as they can.[10]

The 1963 Community Mental Health Centers Act increased support at the state and federal level for community-based care and helped make deinstitutionalization a national policy.[11]

These two concepts, one emerging from law, the other from social policy, have increasingly been joined in expressions of public policy and legislative intent.[12] Since the so-called right-to-treatment lawsuits

were first litigated, institutionalized persons have used the habilitative ideals of deinstitutionalization and the least restrictive alternative, supplanting the use of such litigation to improve the conditions of institutional care.[13]

The translation of these concepts into relevant, effective programs and procedures has, however, faced difficulties. As Saleem A. Shah, then the head of the Center for Studies of Crime and Delinquency, National Institute of Mental Health, has written, "while the doctrine prescribing use of the 'least restrictive alternative' has fairly clear meaning in reference to certain legal and constitutional values concerning infringement of personal freedom and liberty, the notion does not translate readily into mental health procedures and programs."[14] One difficulty lies in the fact that the meaning of any "open concept" or "concepts with open texture" can never be "fully reduced to a set of concrete operations and observational terms."[15]

Whether the translation of concepts into practice in mental health law is more problematic than translation in other areas of law is, of course, arguable. However, several commentators have found the "gap problem"[16] in mental health law, especially the involuntary civil commitment process, particularly vexing.[17]

Other difficulties in translating legal and social concepts into reality are the unavailability of resources, the barriers of formidable state and federal bureaucracies, and the sheer size and complexity of the cooperative effort required.[17a] As Shah has observed, "it is one thing to legislate or judicially mandate legal and other policy changes; it is quite another matter to secure their actual implementation." Thus, as

important as reforms in legal policies (viz., 'the law on the books') certainly are, these accomplishments must not be confused with the end result (viz., the 'law in practice').[18]

This article traces one jurisdiction's difficulties in translating the "least restrictive alternative" doctrine into equitable, effective, and efficient procedures for the involuntary civil commitment of mentally disabled persons.[19] The succeeding sections of this article survey the attempt of the Kansas City, Missouri mental health-law community (i.e., judges, attorneys, mental health professionals, law enforcement personnel, and social service providers) to apply the doctrine, as prescribed by state law, to the various procedures and practices of the involuntary civil commitment process. To provide a framework for subsequent sections of this article, the first section provides a brief overview of Missouri's statutory provisions for involuntary civil commitment.

OVERVIEW OF THE INVOLUNTARY CIVIL COMMITMENT PROCESS IN MISSOURI

In Missouri, a respondent[49] can be involuntarily detained for four sequential detention periods (four days, 21 days, 90 days, and one-year), predicated upon judicial reviews, with continued one-year detentions if he or she is suffering from a mental disorder[50] and, as a result of that disorder, presents a likelihood of serious physical harm[50a] to himself or to others. Figure 1 presents a schematic summary of the statutory provisions for involuntary civil commitment in Missouri.

It is important to emphasize that the summary provided in Figure 1 and the text that follows describe the mechanics of the commitment

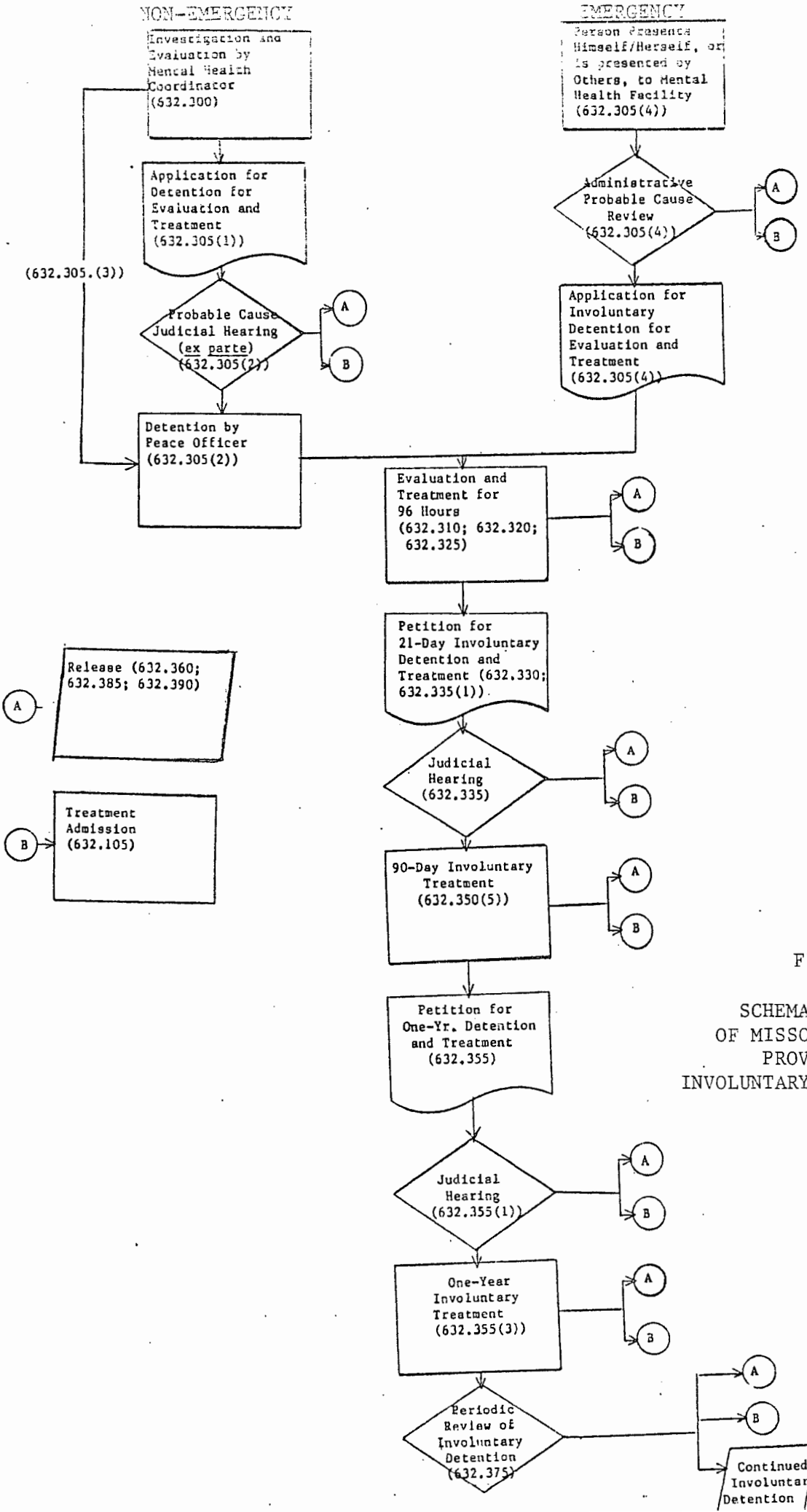

FIGURE 1

SCHEMATIC SUMMARY
OF MISSOURI STATUTORY
PROVISIONS FOR
INVOLUNTARY CIVIL COMMITMENT

is imminent, the mental health coordinator may request that a peace officer take the respondent into custody and transport him to a mental health facility.[55] Alternatively, in emergency cases not involving the prior intervention of a mental health coordinator, a respondent may present himself, or be presented by others, to a mental health facility. If the head of the facility believes that the respondent is mentally disordered and serious physical harm is imminently likely unless the respondent is admitted, a public mental health facility shall and a private mental health facility may admit the respondent for evaluation and treatment for a period not to exceed 96 hours.[56] Based on her own personal observations or investigations, a licensed physician, a mental health professional, or a nurse of the facility may involuntarily detain the respondent and complete an application for detention for evaluation and treatment or care not to exceed 96 hours.[57]

In non-emergency cases, a written application filed by any adult person must always precede the actual involuntary detention of a respondent. Upon receipt of a valid application for involuntary treatment and care, the court makes a determination on an ex parte basis whether there is probable cause to believe that the respondents meets involuntary detention criteria and should be transported to the mental health facility for evaluation treatment for a period not to exceed 96 hours.[58] In emergency situations, when a respondent presents himself to a mental health facility, or is brought there by a peace officer or mental health coordinator, an application for initial detention must, nevertheless, be filed with the court, even though a respondent's involuntary detention may have preceded the filing of a formal

application.[59] At this juncture, the non-emergency and emergency routes to involuntary civil commitment merge.

Whenever the initial involuntary detention and mental health evaluation of a respondent has been authorized on a non-emergency basis, public mental health facilities shall and private mental health facilities may admit a respondent on a provisional basis.[60] Within three hours of the respondent's arrival at the mental health facility, he shall be "seen" by a mental health professional and be given notice of his rights, including the right to be represented by counsel.[60a] He must be examined by a licensed physician within eighteen hours after arrival at the mental health facility.[60b] Within 96 hours after the respondent's arrival at the mental health facility, a mental health coordinator must meet with the respondent and explain his legal rights during involuntary detention.[60c] The respondent must be released from the mental health facility within 96 hours, unless the head of the mental health facility or the mental health coordinator files a petition requesting that the respondent be hospitalized under involuntarily commitment criteria for an additional period not to exceed 21 days.[61]

Within two judicial days after the filing of a petition for 21-day involuntary detention and treatment, a full evidentiary hearing must be held. At this hearing, the respondent is accorded all the customary legal safeguards in civil commitment proceedings, including representation by council.[62] At the conclusion of the hearing, if the court finds clear and convincing evidence that the respondent is a fit subject for involuntary civil commitment, it shall order that the respondent be detained for involuntary treatment in the least restrictive environment for not more than 21 days.[63]

Before the 21-day detention and treatment period expires, the court may order the respondent to be involuntarily treated for an additional period of 90 days,[64] and before the expiration of the 90 days, for an additional period of time not to exceed one year.[65] Additional treatment periods may be ordered if: (1) the respondent is mentally ill and continues to present a likelihood of serious physical harm to self or others; (2) a petition for additional involuntary detention and treatment is filed with the court; and (3) the court, after an evidentiary hearing, orders the respondent detained and involuntarily treated for the additional period. At least twice every year, each respondent who is committed to a mental health facility for a one-year period must be examined and evaluated to determine if he continues to meet the criteria for involuntary civil commitment. Upon review of the examination report and the respondent's individualized treatment plan prepared by the mental health facility, the court may order a hearing to determine the need for continued involuntary hospitalization.[66]

Involuntary in-patient care and treatment may be ended by several procedures: (1) outright discharge from the mental health facility prior to the expiration of the treatment period authorized by statute if, in the opinion of the mental health facility staff, the respondent no longer meets statutory commitment criteria;[67] (2) conversion from involuntary detention to voluntary hospital admission status;[68] (3) conditional out-patient care in the least restrictive environment determined by the mental health facility releasing the respondent;[69] (4) discharge once the statutorily prescribed durational limits of involuntary treatment have been reached.[69a]

LEGISLATIVE INTENTS AND PROGRAM GOALS

Statutory Provisions

With the passage of the "Omnibus Mental Health Bill" (House Bill No. 1724) in 1980,[70] Missouri's 80th General Assembly codified Missouri's mental health law and gave legal status to the goals and duties of the various divisions of the Missouri Department of Mental Health. The law pertaining to the administration of the Department of Mental Health[70a] and it's division of Comprehensive Psychiatric Services[71] established the policies, rules, and procedures for providing services to mentally disordered individuals in the least restrictive environment. The statutory basis for the application of the least restrictive alternative doctrine lies in the prescribed goal of Missouri's Department of Mental Health.

> The department shall seek to ... [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.[72]

A "least restrictive environment" has been given the following meaning:

> [A least restrictive environment is a] reasonably available setting where care, treatment, habilitation or rehabilitation is particularly suited to the level and quality of services 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, given due consideration to potential harmful affects on a person. For some mentally disordered or mentally retarded persons, the least restrictive environment may be a facility operated by the department.[73]

A number of statutorily prescribed rights and entitlements accorded to all voluntary and involuntary patients under the jurisdiction of the Department of Mental Health implicitly or explicitly give expression to the least restrictive alternative doctrine. Each patient, resident, or client has an absolute right to be "evaluated, treated or habilitated in the least restrictive environment."[75] Unless inconsistent with a person's treatment plan, each person admitted to a residential facility or day program operated, funded or licensed by the Department of Mental Health has the following rights: to wear his own clothes, to keep and use personal possessions, to communicate with other individuals inside and outside the facility, to receive visitors, to have access to his own mental and medical records, and to have opportunities for physical exercise and outdoor recreation.[76]

A patient, resident, or client may not be deprived of certain rights. Among these are the rights to safe and sanitary housing, to refuse to participate in non-therapeutic labor, to attend or not to attend religious services, to receive prompt evaluation and care, not to be the subject of experimental research, to have access to consultation with a private physician at his own expense, not to be subjected to any hazardous treatment or surgical procedures, to a nourishing, well balanced and varied diet, and to be free from verbal and physical abuse.[77]

One statutory entitlement specifically expresses the least restrictive alternative doctrine. Specifically, every voluntary and involuntary patient has the right to refuse electroconvulsive therapy.[78] Strict due process requirements must be adhered to before

electroconvulsive therapy may be administered to a respondent involuntarily. The therapy may be administered on an involuntary basis only after a full evidentiary hearing where the patient is represented by counsel and the state shows that the electroconvulsive therapy is necessary under the following criteria:

> (1) there 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) there is no less drastic alternative form of therapy which could lead to substantial improvement in the patient's condition.[79]

Caswell Consent Decree

Legislative provisions for the application of the least restrictive alternative doctrine in involuntary civil commitment proceedings were given extensive interpretation in the recent consent decree in Caswell v. Secretary of Health and Human Services.[80] This comprehensive consent decree settled a class action suit to obtain mental health care and treatment in the least restrictive environment for mentally ill and mentally retarded persons residing at the St. Joseph State Hospital, a large state mental institution in Missouri. The action challenged the Missouri Department of Mental Health's failure to "fund, create and monitor appropriate, less restrictive environments for those plaintiffs in need of community settings in violation of federal and state law as well as plaintiff's civil rights."[81] The five plaintiffs named in Caswell were all involuntary patients confined at St. Joseph Hospital for periods ranging from seven to eighteen years. While the state defendants denied any wrongdoing, they agreed "with the concept that mental patients should be treated and cared for in the least

restrictive facilities and settings appropriate to the individual needs of each patient."[82] Significantly, the Caswell consent decree acknowledged the limited financial resources available to the state defendants and their inability "to spend money which is neither available nor appropriated for the specific purposes set forth" in the decree.[83]

The decree provides for a plan to improve available mental health services based upon the following fundamental principles:

> (1) mental health care and treatment should be based upon an individual's specific needs and his or her specific "level of psychosocial functioning, and should be provided in the least restrictive environment";
>
> (2) in accordance with "normalization" principles, mental health services should be designed to maximize the development of social abilities that "are as close to community norms as possible";
>
> (3) whenever possible, patient should be placed in the "most home-like facility possible";
>
> (4) community support services should be expanded to allow former residents of in-patient facilities to "live as normally as possible in the community";
>
> (5) a "transitional living program" should be maintained for the purpose of the resettlement of patients into "normal residential situations" that provide access to community support services; and
>
> (6) "long-term or chronic mentally ill patients also have a right to high quality treatment and rehabilitation in the least restrictive environment."[84]

PRE-COMMITMENT SCREENING AND EVALUATION

Formal, restrictive civil commitment proceedings generally follow rather than precede the attempts to place a respondent into less restrictive treatment and care settings.[85] Typically, only when less

restrictive measures (e.g., coping with the situation or counseling the person to seek professional help on a voluntary basis) fail and when someone who comes into contact with a mentally disordered person feels that more drastic measures are required will the involuntary civil commitment process be formally initiated.

The Missouri statutory provisions for emergency and non-emergency detention[86] do not explicitly require the person or agency initiating commitment proceedings to consider the least restrictive alternative. However, several statutory provisions for preliminary screening and investigation strongly imply that the least restrictive alternative doctrine should be applied.[86a] Most important among these is the provision for "mental health coordinators" who are required to perform preliminary screening of involuntary civil commitment cases.[87]

Only a small minority of respondents penetrate the involuntary civil commitment system beyond short-term detention and receive a judicial hearing.[88] Therefore, occurences prior to an evidentiary hearing may have more bearing on the equity, effectiveness, and efficiency of a commitment system, and on the public's satisfaction with the system, than the events in the other stages of the commitment process. Systems that provide for a prompt, reliable, and thorough screening procedure, with early diversion of cases appear to protect both the liberty interest of respondents and the pocketbooks of taxpayers.[89] However, in most jurisdictions, practices during the initial stages of the commitment process evolved in the absence of rigorous scrutiny by the judiciary and mental health professionals.[90]

The initial decisions regarding a respondent's entry into the mental health system entail much more than determining whether the legal and psychosocial criteria for involuntary civil commitment have been met. Sound decisions are based on considerations of the mental health delivery system in a particular locale, the conditions of accessible mental health facilities, the availability of less restrictive alternatives for particular classes of respondents (e.g., those harmless to others), and the budgetary constraints on the specific unit of the mental health system likely to be involved. Such decisions also involve an understanding of the links between the courts, law enforcement agencies, social service agencies, and the units of the mental health system that result in cooperative strategies.[91]

Apparently recognizing the importance of the prehearing aspects of commitment proceedings, the Missouri legislature provided that mental health coordinators serving designated regions or facilities perform mental health screenings and evaluations and investigate individuals referred to them as candidates for involuntary civil commitment.[92] Mental health coordinators must be mental health professionals (i.e., psychiatrists, residents in psychiatry, psychologists, psychiatric nurses, or psychiatric social workers) who have "knowledge of the laws relating to hospital admission and civil commitment."[93] Although the Missouri statute does not require mental health coordinators to consider less restrictive settings to involuntary inpatient treatment and care, the statutory provisions permit them to do so.

When a mental health coordinator receives information indicating that due to a mental disorder a person "presents a likelihood of serious

physical harm to himself or others," she shall (1) conduct an investigation, (2) evaluate the information gathered by that investigation, and (3) assess the reliability and credibility of all sources of information.[94] If, as a result of her personal observations or investigation, the coordinator believes that a respondent is dangerous because of mental disorder, the coordinator may file an application for the respondent's involuntary detention for evaluation and treatment for a period not to exceed 96 hours.[95] A strict reading of this provision permits the mental health coordinator discretion in determining whether to file an application for involuntary detention, even when the criteria for involuntary civil commitment are met. Further, a permissive interpretation of this provision would allow the mental health coordinator to pursue alternatives, though this is not required. If the likelihood of the respondent causing harm to self or others is imminent, however, the mental health coordinator would apparently have no such discretion. In such emergency circumstances, the coordinator shall request a peace officer to take the respondent into custody and transport him to a mental health facility.[96] If the mental health coordinator determines that involuntary civil commitment is not appropriate, she "should inform either the person, his family or friends about those public and private agencies and courts which might be of assistance."[97] This provision seems to give mental health coordinators the authority to screen and divert appropriate cases to less restrictive treatment and care settings.

At the time of our inquiry, eleven mental health coordinators were appointed and funded by the Missouri Department of Mental Health,

down from fifteen in 1979.[98] According to the mental health coordinators and an official of the Missouri Department of Mental Health whom we interviewed, the powers, duties, and responsibilities of the mental health coordinators were founded in the least restrictive alternative doctrine. Mental health coordinators were to function much like the gatekeepers for involuntary civil commitment proposed by the Institute on Mental Disability and the Law,[99] and the mental health review officers in a suggested statute on civil commitment proposed by the Mental Health Law Project.[100] These gatekeepers or mental health review officers would function at the threshold of involuntary civil commitment proceedings and in most, if not all, cases make informed decisions about whether involuntary civil commitment should be pursued along emergency or non-emergency routes in a particular case, or whether less restrictive alternatives should be considered. They would also provide the vital links between the courts, law enforcement agencies, social service agencies, various units of the mental health system, and the community.[100a]

Information received by mental health coordinators alleging that a person, as a result of mental disorder, presents a likelihood of serious physical harm to self or others is typically communicated by telephone referral. According to one mental health coordinator, most of the potential applicants who pursue another person's commitment in Jackson County are referred to the mental health coordinators by court personnel.

Beginning with this initial telephone contact and continuing with the interview of the potential applicant(s) and other individuals

significant to the case, mental health coordinators conduct an investigation, collect affidavits to support the allegations that a respondent meets the involuntary detention criteria, evaluate the credibility of the information presented, and make personal observations whenever possible. The mental health coordinator receiving the referral discusses the case briefly with the caller and, if she has a reasonable cause to believe that the individual referred is fit for involuntary civil commitment, schedules an appointment to interview the caller or some other person who may have personal knowledge of the potential respondent. While the mental health coordinators do provide information and some consultation during the telephone referral, only approximately five percent of the referrals are diverted from the involuntary civil commitment process at this stage.

Mental health coordinators typically interview family members or other applicants for about an hour. During this interview they make a threshold determination about the potential respondent's fitness for involuntary civil commitment. Most applicants come to the mental health coordinator's office to be interviewed. According to one mental health coordinator, the practice of requiring applicants to travel to the mental health coordinator's office to initiate commitment proceedings causes hardships for some applicants who may need to take time off from work, travel long distances to the interview, and contend with transportation and parking difficulties.[100b] Only when applicants are extremely reluctant to get involved do mental health coordinators seek out the applicant and conduct an interview in the community.

Approximately ten to fifteen percent of the referrals received by mental health coordinators result in the filing of an application for involuntary detention with the Probate Division of the Circuit Court of Jackson County. The majority of the potential cases that initially come to the attention of the mental health coordinators are handled by the following actions which divert the case from formal civil commitment proceedings: (1) limited intervention by the mental health coordinators--for example, provision of information about the workings of the mental health and judicial system, consultation with parents of respondents, and informal counseling of applicants--causing the applicants to abandon the pursuit of court-ordered hospitalization; (2) referral of the respondent, their family members, or acquaintances to mental health treatment settings less restrictive than inpatient hospitalization; (3) acceptance of voluntary outpatient or inpatient treatment and care by the respondent (according to the mental health coordinators we interviewed, this action is infrequent); (4) in approximately one percent of the cases, initiation of guardianship proceedings; and (5) interventions by the mental health coordinators that "initiate a crisis" causing one of the above options to be pursued.

If, after evaluating the reliability of all sources of information, the mental health coordinator believes that the respondent is a fit subject for involuntary civil commitment, the mental health coordinator or the applicant may file a formal petition for involuntary detention of the respondent for evaluation and treatment. The petition causes the matter to be brought before the probate court on an ex parte basis to determine whether the respondent should be taken into custody and transported to a mental health facility.[101]

In approximately eight out of ten cases brought before the Court in the manner described above, the Court finds probable cause to believe that the respondent is a fit subject for involuntary civil commitment and, thereupon, issues an order to take the respondent into custody and transport him to an appropriate mental health facility. During the ex parte hearing a judge, commissioner, or hearing officer typically questions the applicant about the allegations in the application for involuntary civil commitment. According to mental health coordinators and court personnel, few applications are rejected as a result of ex parte hearings due to the Court's heavy reliance upon, and confidence in, the coordinator's investigations of the applicant's allegations and prior screening.

Of the relatively few petitions rejected following an ex parte hearing, most are rejected because they fail to establish probable cause to believe the "dangerousness" of the respondent, i.e., the likelihood that the respondent presents a serious physical harm to self or others as a result of mental disturbance. Infrequently, petitions are rejected because of a lack of other evidence and because of the Court's lack of jurisdiction in the matter. According to court personnel, rejection of an application following an ex parte hearing usually results in the applicant abandoning the application. On rare occasions, the applicant requests and is granted a full evidentiary hearing on the petition for a 96 hour involuntary detention.

According to mental health coordinators, court personnel, and attorneys who were interviewed, the relationships between mental health coordinators and the Court, attorneys, and law enforcement personnel in

cases brought before the Court on an ex parte basis are regarded as good. Calls by individuals requesting information about or assistance in pursuing the involuntary civil commitment of others are typically referred to mental health coordinators. Mental health coordinators are regarded as providing a valuable service to the Court and the community in investigating the factual basis for applications for involuntary civil commitment.[102] Following an ex parte determination, if the court finds that there is probable cause to proceed with a 96 hour period of involuntary detention for evaluation and treatment, the Court will generally follow the recommendations of the mental health coordinator with regard to the receiving mental health facility. Placement options in Jackson County, which depend upon a respondent's domicile, include the Western Missouri Mental Health Center, three private psychiatric facilities, and four community mental health centers. The latter, according to one mental health coordinator, are considered private facilities for the purposes of involuntary civil detention. Three of the four community mental health centers provide both outpatient and residential mental health services.

In addition to the duties and responsibilities associated with the preliminary screening and evaluation of candidates for involuntary civil commitment, mental health coordinators have provided education and training to mental health and law enforcement personnel throughout Missouri in the past. For example, they have provided presentations and training for law enforcement personnel in cooperation with the Missouri Sheriff's Association and the University of Missouri.[103] Mental health coordinators in the St. Louis area have also provided field placements

for university students seeking advanced degrees in social work, nursing, and psychology.[104]

Although the mental health coordinators in Kansas City, Missouri appear to perform their duties well and seem to be regarded highly by the mental health law community, their powers, duties, and responsibilities appear to have fallen far short of the potential provided by statute. Mental health coordinators are rarely involved in emergency cases even though the majority of the respondents facing involuntary detention in Jackson County enter the mental health system on an emergency basis.[105]

Although mental health coordinators are theoretically on call 24 hours a day, for all practical purposes, they function only during the daytime hours. Further, although mental health coordinators are obligated by law to meet with all respondents within the 96 hour involuntary detention period unless released sooner,[105a] one mental health coordinator admitted that it is often difficult to meet this requirement.

The mental health coordinators' virtually exclusive involvement in non-emergency cases may have some unfortunate consequences. Potential respondents who come to the attention of mental health coordinators in Kansas City are arguably those respondents with more means at their disposal and more social supports than their counterparts who come to the attention of peace officers, attorneys, and judges on emergency bases. At the very least, those respondents who are the subject of a formal petition have one person, i.e., the petitioner, who cares enough to act on their behalf. Ironically, this subgroup of respondents is provided

the greater social and legal protections in the form of the screening performed by mental health coordinators and the ex parte hearing provided by the court though they may have maintained some social support in the community and may also have less severe mental disturbances. In contrast, emergency cases are not reviewed by legal or mental health professionals until after the respondent has been taken into custody, transported to a mental health facility, and involuntarily detained for at least several hours.

This difference in judicial and mental health oversight of emergency and nonemergency cases would be fully justifiable if respondents who entered the mental health system by the non-emergency and emergency routes were clearly distinguishable on the basis of the imminence of the harm they would likely cause if not involuntarily detained immediately. However, the presence of an emergency is not a reliable discriminator for determining movements along emergency and non-emergency routes to involuntary civil commitment in other parts of the country,[105b] and it is, undoubtedly, not a very good one in Kansas City. Factors such as the dangerousness of the respondent and the imminence of possible harm may have less bearing on the traffic along the emergency and non-emergency routes to involuntary civil commitment than factors associated with the access to those routes (e.g., the availability of mental health coordinators).

According to one mental health coordinator, the legislature intented mental health coordinators to provide preliminary mental health screening of all involuntary civil detention cases, regardless of whether those cases come to the attention of the mental health system on an

emergency or non-emergency basis, but inadequate funding limited their involvement to non-emergency cases. One mental health professional involved in screening emergency cases stated that mental health coordinators were the "best kept secret in town." He stated that while the powers, duties, and responsibilities of the mental health coordinators were conceptually sound, they only "looked good on paper" and only added another layer of bureaucracy to an already overburdened involuntary civil commitment system.

Regardless of the involuntary civil detention route,[106] it seems to be eminently sensible that most, if not all, entries into the mental health-judicial system should be monitored and regulated by authorized "gatekeepers" at designated "portals" in the community.[107] The Institute on Mental Disability and the Law has proposed guidelines for the role of gatekeepers that function on the threshold of involuntary civil commitment much as judges function during hearings later in the commitment process. Gatekeepers should be knowledgable and talented individuals, capable of making and empowered to implement decisions about release, immediate involuntary detention, and all the options between those extremes, within the context of legal requirements, good mental health practices, social values, and resource allocations.[108] Such gatekeeper functions appear to have been similar to those envisioned at the later stages in the commitment proceedings, for the "hospital case manager," "pre-placement coordinator," and "community placement casemanager" as provided in the Caswell consent decree.[109]

By providing that mental health coordinators function at the initial stages of involuntary civil commitment, the Missouri legislature

is among only a handful of state legislatures[110] that has recognized the importance of the prehearing aspects of commitment proceedings. Mental health screening and evaluation, including an investigation of the information supporting a respondent's fitness for involuntary civil commitment, before a respondent is involuntarily detained in a hospital is generally preferrable to a review of allegations and screening only after a respondent is admitted to a hospital. Although progressive state statutes acknowledge implicitly the desirability of screening and diversion from involuntary commitment prior to involuntary detention, only a few prescribe the mechanisms by which such actions can be taken.[110a]

Though most commentators consider the judicial hearing to be the centerpiece of the involuntary civil commitment process, the occurrences before such hearings can be much more important in individual cases and can have a pervasive effect on the commitment process and the work of the mental health system and the courts as a whole.[111] Unfortunately, with regard to the powers, duties, and responsibility of mental health coordinators in Missouri, there appears to be a great discrepancy between the "law on the books" and the "law in practice." Notwithstanding the very real practical difficulties engendered by scarce resources, much more attention should be paid to the implementation, not simply the enunciation, of progressive provisions founded on the least restrictive alternative doctrine.[112]

INVOLUNTARY DETENTION PROCEDURES

Civil detention provisions that are applicable following court acceptance of a petition for 96 hour involuntary detention, in which the Missouri Legislature has enunciated the least restrictive alternative doctrine, include: (a) the issuance of involuntary civil commitment orders, (b) placement of respondents in the least restrictive setting, and (c) provision of a continuum of community-based services.

Issuance of Commitment Orders

The least restrictive alternative doctrine is applied explicitly to the issuance of 21-day,[113] 90-day,[114] and one-year commitment orders.[115] The commitment criteria applied to each successive hearing on a petition for continued involuntary treatment and care are identical. The court must determine (1) that as a result of mental illness, the respondent presents or continues to present "a likelihood of serious physical harm to himself or to others," and (2) that a mental health facility appropriate to "handle the respondent's condition" has agreed to accept the respondent for admission. If these criteria are met, the court must order the respondent detained "for involuntary treatment in the least restrictive environment" for a period of time not to exceed the applicable limit.[116]

Missouri law is similar to the civil commitment laws in many other states in that it permits but does not expressly provide for court-ordered outpatient care and treatment.[117] In practice, outpatient commitment is virtually non-existent in the Kansas City, Missouri area. Among the numerous individuals we interviewed in Kansas

City, only one mental health coordinator could recall a single case in which outpatient commitment was ordered by the court. In that case, a respondent was ordered to participate for 90 days in an outpatient hospital program under the direction of the Veteran's Administration Medical Center. Outpatient commitment was ordered contingent upon the respondent's compliance with a treatment plan which included psychotropic medication. The court authorized the Medical Center to take the respondent into custody and involuntarily detain him for inpatient care for the balance of the commitment period if he failed to comply with the condition of outpatient commitment.

Several factors may account for the rare use of commitment to outpatient treatment as an alternative to involuntary hospitalization in Kansas City, despite the mental health-law community's growing awareness of, and emphasis on, treatment in the least restrictive environment. Perhaps the strongest factor is the screening and diversion of cases before the expiration of the initial 96 hour involuntary detention. This reduces effectively the number of potential respondents for whom outpatient commitment may clearly be the least restrictive alternative. As discussed earlier, the pre-commitment mental health screening and evaluation performed by mental health coordinators in non-emergency cases contributes to this reduction. According to estimates by court personnel, attorneys, and mental health professionals, approximately one of ten respondents detained involuntarily for the initial 96 hour period proceeds to a judicial hearing on a petition for an additional 21 days of involuntary treatment and care. One community mental health center staff member stated that the majority of those respondents committed

involuntarily to an acute, inpatient unit of the center invariably shift to voluntary patient status within the initial 96 hour detention period. This staff member suggested that the conversion to voluntary patient status is typically due to staff members' abilities to develop trusting relationships with respondents and their family members. Petitions for 96 and one-year involuntary commitments are very rare. Therefore, notwithstanding an inclination to consider, at least theoretically, outpatient commitment as a viable alternative to inpatient commitment, the Circuit Court of Jackson County may, as a practical matter, have few opportunities to consider outpatient treatment as a dispositional option.

Other factors, perhaps less salient, may contribute to the infrequent use of outpatient commitment. Less restrictive alternatives to involuntary hospitalization may not be available because staff of community-based facilities may be disinclined, as a matter of policy or practice, to treat unwilling patients.[118] One psychiatrist with the Western Missouri Mental Health Center contended that the major problem with outpatient commitment is Missouri's statutory requirement of "dangerousness" as a criteria for involuntary commitment. If a respondent presents a threat of serious physical harm to self or others, he should be committed to a secure inpatient facility, if not a secure ward of a state hospital. On the other hand, if a respondent poses no threat, he should be released and given the opportunity to seek voluntary treatment and care. This "either/or" view, which is shared by mental health professionals and judicial personnel throughout the country,[119] clearly limits the use of outpatient commitment as a viable dispositional option between inpatient treatment and release.

Two other related factors may contribute to mental health professionals' skepticism about outpatient commitment. As one mental health professional we interviewed stated, there is in Kansas City, as there is throughout the country, a growing concern for public safety. Reportedly, this concern has resulted in the establishment of additional secure wards at the Western Missouri Mental Health Center. With a greater emphasis on secure facilities that are purported to enhance public protection from mentally disordered persons, mental health professionals may come to view less restrictive, community-based facilities as the exclusive domain of willing patients. It is conceivable that the development of mental health facilities and resources may be consistent with this view. For example, the day care program of the Western Missouri Mental Health Center is considered inappropriate for involuntary patients due to the facility's inability to control or restrict a participating patient's actions both within and outside of the program operating hours.

A final factor may have subtle, yet pervasive effects on mental health professionals' reluctance to embrace the idea of outpatient commitment. The decisions in Tarasoff v. Regents of the University of California[120] and related cases,[121] which established mental health professionals' legal liability for actions of potentially dangerous patients, may have dampened mental health professionals' enthusiasm for outpatient commitment and cause them to practice conservative or "defensive" therapy.

In Kansas City, limited opportunities for appropriate outpatient commitment and skeptical attitudes among mental health professionals may

have effectively eliminated outpatient commitment as a realistic alternative to court ordered hospitalization or release. Nevertheless, in the interest of those few respondents who can be maintained successfully outside of residential facilities, community-based treatment under court ordered conditions remains attractive as the least restrictive alternative. As suggested by two commentators who have investigated the problems of outpatient commitment in North Carolina, "major attitudinal shifts will have to occur, however, before this alternative is used effectively and with appropriate frequency."[122] These attitudinal changes must be coupled with structural changes to accomodate the use of legally available alternatives for treating patients.

Placement Programs in the Least Restrictive Setting

Missouri law provides that the Department of Mental Health shall establish and maintain a placement program for "persons effected by mental disorder, mental illness, mental retardation, developmental disability or alcohol or drug abuse."[123] In establishing and maintaining the program, the legislature department authorized to use "residential facilities, day programs and specialized services with a design to maintain a person in the least restrictive environment in accordance with the person's individualized treatment, habilitation or rehabilitation plan."[124] Subject to appropriations, the department is required to license, certify and fund a "continuum of facilities, programs and services short of admission to a department facility to accomplish this purpose."[125] Before placing any client in a particular

facility, the department must consider, among other criteria, the "least restrictive environment for providing care and treatment consistent with the needs and conditions of the patient or resident."[126]

Unfortunately, with regard to involuntary patients, the therapeutic ideals suggested by the legislative provisions for a placement program founded in the least restrictive alternative doctrine are frustrated by the realities discussed earlier. Because of inadequate staffing and the lack of a controlled, secure setting of nonresidential facilities (e.g., the day program of the Western Missouri Mental Health Center and the facilities associated with the Community Placement Program), less restrictive, community-based programs are generally perceived by the mental health professionals we interviewed as inappropriate for involuntary patients.

Involuntary patients, who are viewed as posing serious threats to themselves or others if placed in a minimally controlled community setting, are generally considered as bad legal, medical, and ethical risks by the mental health professionals. According to a staff member of the Community Placement Program in Kansas City, of the approximately 550 persons in the program at the time of our inquiry (February 1983), only approximately one percent were involuntary patients. The Community Placement Program serves as a coordinating agency, screening referrals for many mental health facilities for placement of chronically mentally ill persons in a variety of community-based facilities including nursing homes, boarding homes, foster homes, residential treatment facilities, intermediate care facilities for persons with special medical needs, group homes, and private apartments. Preference is given to clients who

participate on a voluntary basis. Although many of the patients in the programs were at some point in the past involuntary patients, only eight percent of the community placement program's clients during 1982 were involuntary patients when they entered the program. According to one staff member, most of these involuntary patients agreed to a change in their status to voluntary participation shortly after their acceptance into the program.

A Continuum of Community-Based Services

In concert with the least restrictive alternative doctrine, the Division of Comprehensive Psychiatric Services of Missouri's Department of Mental Health 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."[127] The Division must base the provision of services upon diagnosis and individualized treatment plans and arrange for delivery of these services in the least restrictive environment.[128]

In practice, the legislatively mandated, less restrictive end of the continuum of community-based services is likely to be accessed only by those respondents who may have been screened and diverted from further involuntary treatment and care before or during the initial 96 hour period of involuntary hospitalization. For the reasons discussed above, once a respondent's "dangerousness" has been certified by a court, less restrictive, community-based mental health facilities are generally closed to the respondent due to the policies and attitudes resistant to outpatient treatment and care of involuntary patients.[128a]

RELEASE, TRANSFER, AND DIVERSION

Statutory mechanisms for a respondent's outright release from involuntary hospitalization, and transfer or diversion from restrictive, inpatient treatment are clearly consistent with the least restrictive alternative doctrine. Most state mental health laws permit mental health facilities to discharge respondents without judicial review.[129] Broad discretion is given to mental health personnel to make decisions about release, transfer and diversion to less restrictive treatment settings.

Release of a respondent typically occurs if the mental health professional in charge of the respondent's involuntary treatment and care believes that compulsory inpatient mental health care and treatment are no longer necessary. In most states, diversion from involuntary detention is accomplished if the respondent requests voluntary patient status and if the mental health facility or the court agrees to the conversion from involuntary to voluntary status. In congruence with the least restrictive alternative doctrine, the mental health law in some states (e.g., North Carolina and New York) explicitly encourages conversion from involuntary to voluntary patient status.[130]

Missouri mental health law applies the least restrictive alternative doctrine in a number of provisions for release, transfer, and diversion of respondents from involuntary hospitalization. As a general principle, a mental health facility official shall release a patient, whether he or she may be a voluntary or involuntary patient, from the facility to the least restrictive environment if and when it is determined that release is in the patient's best interests.[131] Such release may be accompanied by referral to a placement program operated by

the Department of Mental Health. In any event, release to the least restrictive environment shall include provisions for continuing responsibility on the part of the mental health facility from which the respondent is released.[132] The mental health facility or agency receiving the respondent must agree in writing to assume responsibility for providing the required outpatient care in the least restrictive environment.[133]

Release to the least restrictive environment may be conditioned on the respondent receiving prescribed outpatient care for a period not to exceed the duration of the applicable involuntary detention period.[134] The head of the mental health facility may modify the release conditions if such modification is in the patient's best interests.[135] If it becomes necessary to return the respondent to more restrictive, inpatient care, the committing court may order an evidentiary hearing on the need for such a transfer.[136] Finally, at any time during a detention period, the head of a mental health facility may permit a respondent to leave the facility for short periods of time.[137] The principles for the application of the least restrictive alternative doctrine in the release, transfer and diversion of respondents from restrictive settings have recently been enunciated in the consent decree in Caswell.[138]

As discussed earlier, once a respondent has been an involuntary patient for longer than the initial 96 hours of involuntary detention and his status as an involuntary patient has been certified by a court, it is unlikely that the statutory provisions for release, transfer, and diversion from involuntary hospitalization will be implemented.

According to one staff member of the Western Missouri Mental Health Center, the granting of requests for conditional release of involuntarily committed patients is contrary to the Center's policy. Similarly, as a matter of general policy, respondents are not provided passes to leave the facility. In practice, release, transfer, or diversion from the involuntary civil commitment process either occurs very early in the commitment process, i.e., within the initial detention period, or by means of a conversion of the respondent's admission status from involuntary to voluntary.

Whenever 96 hour involuntary detention has been authorized by a court, a public facility must and a private facility may accept a respondent on a provisional basis.[139] After evaluating the respondent's condition, if the mental health facility determines that he is not a fit subject for involuntary treatment and care, the facility may release the respondent immediately.[140] When a respondent is involuntarily detained on an emergency basis by a police officer without prior court authorization, mental health facilities are not required to admit the respondent, even on a provisional basis.[141] However, when a mental health facility refuses to admit a person, the facility must furnish transportation, if necessary, to return the person to his residence or to another appropriate location.[142] Similarly, when a mental health coordinator investigates a case and determines that involuntary commitment of a prospective respondent is not appropriate, then the person, his family or friends must be informed about public and private services which might be of assistance.[143]

As discussed earlier in this section, the majority of respondents who come into contact with the involuntary civil commitment process in Kansas City, Missouri are diverted from involuntary hospitalization at the very early stages of the commitment process, either (a) by actions taken by mental health coordinators in non-emergency cases or (b) by mental health facilities during the initial 96 hour detention period prior to judicial certification. One specific mechanism for diverting a respondent from the process--conversion from involuntary to voluntary patient status--has engendered some concern among attorneys and mental health professionals in Kansas City.

Once a respondent is detained involuntarily and awaiting a determination of his legal status by the court or the head of a mental health facility, should he be given the opportunity to become a voluntary patient? If so, under what conditions? Missouri mental health law, like that in many states,[144] acknowledges that a person who has been hospitalized involuntarily, but who does not necessarily object to the mental health treatment and care provided, may benefit from his conversion to voluntary patient status. Accordingly, whenever a respondent who has been detained involuntarily applies for a voluntary admission and his application is accepted in good faith by the head of the mental health facility, the respondent's involuntary detention shall cease and the head of the facility shall notify, in writing, the court and the mental health coordinator.[145]

A conversion to voluntary status may have both therapeutic and legal advantages for a respondent. A patient who recognizes his need for treatment and hospitalization, and seeks it voluntarily, may be more

likely to benefit from treatment. By electing voluntary admission prior to a formal judicial determination of his legal status, the respondent may also avoid the potential stigma of compulsory hospitalization. However, if the respondent's conversion to voluntary patient status is not voluntary and informed, applications for voluntary treatment may be the products of coercion.[146] One attorney expressed the fear that voluntary admissions may be coerced by hospital staff in Kansas City. According to this attorney, approximately half of those respondents capable of comprehending the information furnished to patients by facility personnel[147] reported undue pressure to accept treatment on a voluntary basis. Reportedly, mental health personnel were suggesting conversion to a voluntary status without explaining the legal safeguards during and durational limits on involuntary detention, thereby implying that respondents could be detained indefinitely. Although another defense attorney flatly denied that such coercion existed, one mental health coordinator and several mental health professionals acknowledged its existence.[148]

Several factors other than legitimate treatment considerations may motivate mental health personnel to encourage, if not coerce, respondents to convert to voluntary patient status. Most treating professionals shun the real and imagined consequences of contact with the adversarial system and may feel very uncomfortable in treating patients who may have been ordered to undergo treatment and care against their will. Indeed, mental health professionals may consider it contrary to their purpose to treat patients whose rights have been curtailed. Finally, hospital staff understandably may prefer to avoid the burden of

the paperwork and the expenditure of resources necessitated by the involuntary civil commitment process.

At a meeting of attorneys and mental health professionals held shortly after our study, when confronted with the concern that respondents may have been pressured or coerced into voluntary patient status, mental health professionals at the Western Missouri Mental Health Center denied that they abuse their position of authority by coercing respondents into voluntary patient status. They readily acknowledged the importance of protecting respondents' rights during mental health treatment and care, whether provided on a voluntary or an involuntary basis. Agreement was reached on the position that all actions taken by mental health professionals are taken in the respondent's best interest. Following the meeting, the attorney who had expressed the worst fears about coerced voluntary admissions, stated that though the problem may not be totally solved, she was satisfied that the meeting produced an improved "working atmosphere."

In response to similar concerns about the possible abuse of procedures for the conversion of respondents from involuntary to voluntary patient status, a Chicago court introduced a rule that required defense counsel to certify that a respondent requested voluntary admission willingly and with full understanding of the consequences of his action. By means of this procedure, judges were assured by the attorneys that respondents were not pressured into "voluntary" treatment against their wishes.[149]

Assuming that such a formal certification would be a legitimate and desirable check against abuse, several statutory bases for this action may be identified in Missouri mental health law. Perhaps the

strongest base lies in the provision that requires a mental health coordinator to meet with respondents to explain their statutory rights within four days after their arrival at a mental health facility.[150] Although a mental health coordinator is not explicitly required to certify that those respondents who elected to convert to voluntary patient status did so knowingly and willingly, the statute can be broadly interpreted to require such a check. Similarly, an assurance that the respondent has had an opportunity to consider his rights, as well as the probable consequences of conversion to voluntary patient status, could be required as part of the written notification that the head of a mental health facility must provide to the court and the mental health coordinator upon the voluntary admission of a patient.[151]

Social rules may arguably work best when they are not written into law but are followed because they are accepted as part of the mores and customs of the individuals involved. The written and implied rules governing involuntary civil commitment in Kansas City are probably no exception. In the absence of factual evidence of abuse of the procedures for converting respondents from involuntary to voluntary patient status, the best approach to dealing with the concern over possible abuse may be the type of cooperation illustrated by the meeting, mentioned above, of attorneys and mental health professionals who are closest to the concern and best able to deal with the it. The formal, adversary system has often wrought procedures that are too complex and onerous to be workable.[152] A litigious approach to improving involuntary civil commitment proceedings, often involving confrontational interactions between attorneys and mental health professionals, may have given way to cooperation as the best approach to promoting positive change.[153]

FOOTNOTES

1. [Open]

2. For a brief survey of the "least drastic means" concept's application by the federal courts, see P.B. Hoffman & L.L. Foust Least Restrictive Treatment of the Mentally Ill: A Doctrine in Search of Its Senses, 14 San Diego L. Rev. 1100, 1101, n. 1 (1977). This legal concept may have its roots in fourteenth-century philosophy. "Ockam's razor," also called the "law of parsimony," was the name given to the principle of Sir William of Ockham, a late medieval philosopher, that entities are not to be multiplied beyond necessity ("non sunt multiplicanda entia praeter necessitatem"). In modern times, "Ockham's razor" (given its name because Sir Ockham employed it so sharply) has been exalted to the lofty principle that, all things being equal, nature and human action are most truthfully reflected by the simplest and most economical conceptual formulations. See Ockham's Razor, VII Encyclopedia Britannica 475 (15th ed. 1976).

3. See Suggested Statute on Civil Commitment, 2 Mental Disability Law Reporter 127, 129 (1977); see also Hoffman & Foust, id. at 1101.

4. 364 F. 2d 657 (D.C. Cir. 1966).

5. Id., at 660.

6. See, e.g., Covington v. Harris, 419 F 2d 617 (D.C. Cir. 1969); Association for Retarded Citizens of North Dakota v. Olson, 561 F. Supp. 473 (D. N.D. 1982); Eubanks v. Clarke, 434 F. Supp. 1022 (E.D. Pa. 1977); Gary W. v. Louisiana, 437 F. Supp. 1209 (E.D. La. 1976); Welsch v. Likens, 373 F. Supp. 487 (D. Minn. 1974); Lessard v. Schmidt, 349 F. Supp. 1078 (E.D. Wis. 1972), vacated and remanded on other grounds, 414 U.S. 473 (1974), 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).

7. See e.g., Kesselbrenner v. Anonymous, 33 N.Y. 2d 161, 350 N.Y.S. 2d 889 (1973); In re Gandolfo, 185 Cal. Rptr. 911 (Cal. Ct. App. 1982); Aden v. Younger, 57 Cal. App. 3d 662, 129 Cal. Rptr. (1976); In re Collins, 102 Ill. App. 3d 138, 429 N.E. 2d 531 (1981); In re Estate of Newman, 604 S.W. 2d 815 (Mo. Ct. App. 1980); Patients v. Camden County Board of Chosen Freeholders, No. L.-33417-74P.W. (N.J. Super Ct. January 19, 1981); Applicatin of D.D., 118 N.J. Super 1, 285 A. 2d 283 (1971); In re Andrea B, 98 Misc. 2d 919 (Fam. Ct. N.Y. County 1978).

8. M.A. Lyon, M.L. Levine, & J. Zusman, Patients' Bill of Rights: A Survey of State Statutes, 6 Mental Disability Law Reporter 178, 181-183 (1982).

9. C.A. Kiesler, Mental Hospitals and Alternative Care: Noninstitutionalization as Potential Public Policy for Mental Patients, 37 American Psychologist 349, 349 (1982).

10. Quoted in C.A. Kiesler, T. McGuire, D. Mechanic, L.R. Mosher, S.H. Nelson, F.L. Newman, R. Rich, & H.C. Schulberg, Federal Mental Health Policymaking: An Assessment of Deinstitutionalization, 38 American Psychologist 1291, 1293 (1983).

11. Id.

12. See generally Kiesler, supra note 9; Kiesler et al., supra note 10; B.D. McGraw & I. Keilitz, The Least Restrictive Alternative in Los Angeles County Civil Commitment, __Whittier L. Rev.__ (in press 1984).

13. See J.B. Yohalem & J. Manes, The Rights of the Mentally Disabled: Progress in the Face of New Realities, 19 Trial 68, 69 (1983).

14. S.A. Shah, Legal and Mental Health System Interactions: Major Developments and Research Needs, 4 Int'l J. of Law & Psychiatry 219, 253 (1981).

15. R. Roesch & S.L. Golding, Competency to Stand Trial 12 Univ. of Ill. Press 1980 Chicago (emphasis omitted) (1980).

16. See generally R.L. Able, Redirecting Social Studies of Law, 14 Law and Soc'y Rev. 805 (1980).

17. See e.g., J. Monohan & E. Loftus, The Psychology of Law, 33 Annual Rev. of Psychology 441 (1982); Shah, supra note 14, at 254; see also I. Keilitz & R. Van Duizend, Current Trends in the Involuntary Civil Commitment of Mentally Disabled Persons, __Rehabilitation Psychology__ (in press 1984); infra note 112.

17a. See, e.g., Halderman v. Pennhurst State School and Hospital, 467 F. Supp. 1504 (E.D. Pa. 1983) (Parents objected to movement of their 12-year old son from Pennhurst to less restrictive community placement); Halderman v. Pennhurst State School and Hospital, 566 F. Supp. 185 (E.D. Pa. 1983) (Contractual dispute between the state and a community-based service provider that threatened to close community home and return resident to hospital).

18. Shah, supra note 14, at 255 (notes omitted).

19. The study of the involuntary civil commitment process in Kansas City, Missouri, upon which this article is based is part of a national-scope project to develop a model for applying the "least restrictive alternative" doctrine in involuntary civil commitment proceedings. The project was begun in October 1982 and is funded by the Administration on Aging and the Administration on Develomental Disabilities, United States Department of Health and Human Services. By studying the civil commitment systems in

Kansas City, Missouri and six other localities throughout the country (Chicago, Milwaukee, New York, Tucson, and Williamsburg/James City County, Virginia), the Institute on Mental Disability and the Law of the National Center for State Courts is assessing the use of the doctrine to determine how its application may be improved.

20-48. [Open]

49. Hereafter, the term respondent will refer to any individual who is the subject of involuntary civil commitment proceedings, including those less formalized proceedings that occur before court intervention.

50. Mental disorder is defined as "any organic, mental or emotional impairment which has substantive adverse effects on a person's cognitive, volitional or emotional function and which constitutes a substantial impairment in a person's ability to participate in activities of normal living. Mo. Rev. Stat. § 630.005(19)(19__).

50a. "Likelihood of serious physical harm" means any one or more of the following:

(a) A substantial risk that serious physical harm will be inflicted by a person upon his own person, as evidenced by recent threats, including verbal threats, or attempts to commit suicide or inflict physical harm on himself;

(b) A substantial risk that serious physical harm to a person will result because of an impairment in his capacity to make decisions with respect to his hospitalization and need for treatment as evidenced by his inability to provide for his own basic necessities of food, clothing, shelter, safety or medical care; or

(c) A substantial risk that serious physical harm will be inflicted by a person upon another as evidenced by recent overt acts, behavior or threats, including verbal threats, which have caused such harm or which would place a reasonable person in reasonable fear of sustaining such harm. Id. § 632.005 (9).

50b. See, e.g., Caswell v. Secretary of Health and Human Services, No. 77-0488-CV-W-8 (W.D. Mo. Feb. 8, 1983).

51. A mental health coordinator is "a mental health professional who has knowledge of the laws relating to hospital admissions and civil commitment and who is appointed by the director of the department, or his designee, to serve a designated geographic area or mental health facility." Mo. Rev. Stat. § 632.005 (10).

52. Id. § 632.300.

53. Id. § 632.300.3.

54. Id. § 632.305.1.

55. Id. §§ 632.305.3, 632.300.3.

56. Id. §§ 632.305.4, 310.1.

57. Id. § 632.305.4.

58. Id. § 632.305.2.

59. Id. § 632.300-310.

60. Id. § 632.310.1.

60a. Id. § 632.320.1 (1).

60b. Id. § 632.320.2.

60c. Id. § 632.320.3.

61. Id. § 632.330.

62. Id. §§ 632.335.1.-2..

63. Id. § 632.335.4.

64. Id. § 632.340.

65. Id. § 632.355.

66. Id. § 632.375.

67. Id. §§ 632.310.1-3, 385, 390.

68. Id. §§ 632.105, 390.3.

69. Id. § 632.385.

69a. Id. § 632.360.

70. The "Omnibus Mental Health Bill" (House Bill No. 1724) established chapters 630 through 633 of the Missouri Revised statutes and contains procedures for civil commitment.

70a. Id. § 630.

71. Id. § 632.

72. Id. § 630.020.1 (2); emphasis added.

73. Id. § 630.005.1 (18).

74. [Open].

75. Id. § 630.115.1 (10).

76. Id. § 630.110.1.

77. Id. Mo. Rev. Stat. § 630.115.1.

78. Id. § 630.130.1.

79. Id. § 630.130.3.

80. No. 77-0488-CV-W-8 (W.D. Mo. Feb. 8, 1983; see also Deinstitutionalization Standards Detailed in Consent Decree, 7 Mental Disability Law Reporter 221 (1983).

81. Caswell v. Secretary of Health and Human Services, id., at 1.

82. Id., at 2, emphasis added.

83. Id., at 4.

84. Id., at 8-9.

85. Hoffman and Foust, supra note 2, at 1139 ("[T]he unworkability of less restrictive alternatives, and not the failure to consider them, ultimately leads to most commitment proceedings").

86. See supra notes 50-59 and accompanying text.

86a. See, e.g., Mo. Rev. Stat § 632.310.1 (19__) (A mental health facility may, upon evaluating a respondent shortly after his or her provisional admission, order release); id. § 632.385.1 (Facility may release to less restrictive setting whenever deemed appropriate).

87. Id. § 632.300 (19__).

88. According to estimates by court personnel and mental health coordinators, only five to ten percent of the respondents involved in involuntary civil commitment proceedings in the Circuit Court of Jackson County are involuntarily detained beyond the initial 96 hours of evaluation and treatment.

89. See generally Institute on Mental Disability and the Law, Provisional Substantive and Procedural Guidelines for Involuntary Civil Commitment Part II (Williamsburg, Virginia: National Center for State Courts, 1982).

90. See, e.g., I. Keilitz & B. McGraw, Initiating Involuntary Civil Commitment, An Evaluation of Involuntary Civil Commitment in Milwaukee County 15, 47-55 (Williamsburg, Virginia: National Center for State Courts, 1983).

91. See Institute, supra note 89, at II-13.

92. Mo. Rev. Stat. §632.300 (19__).

93. Id. § 632.005 (10), (12).

94. Id. § 632.300.1.

95. Id. § 632.300.2.

96. Id.

97. Id. §632.300.3.

98. See Missouri Department of Mental Health, 1980 Civil Involuntary Detention Annual Report 18 (1981).

99. The Institute on Mental Disability and the Law proposed the following provisional guidelines for the community portals and gatekeepers regulating involuntary civil commitment cases.

> GUIDELINE II-A. (1) Regardless of the commitment route -- emergency, judicial, non-judicial, or guardianship -- entry into the mental health-judicial system should be monitored and regulated by authorized "gatekeepers" at designed "portals" in the community. These gatekeepers should be empowered and qualified to initiate involuntary civil commitment along its various routes or to divert cases to less restrictive alternatives.
>
> (2) Community portals, serving as screening agencies within the community, should review and investigate applications for involuntary commitment, and, if appropriate, should divert cases to less restrictive treatment alternatives. Screening reports should be filed with the court.
>
> GUIDELINE II-B. Judges, court administrators, and court managers should influence the policies of portal agencies (e.g., police departments, community mental health agencies, and hospitals) to foster a uniform, understandable, and controllable procedure for initiating and screening involuntary commitment cases.

GUIDELINE II-C. The court should review, monitor, and regulate, the access to the mental health-judicial system by the various involuntary civil commitment routes.

GUIDELINE II-D. Judges and attorneys should be thoroughly familiar with the methods and operations of the community portals and gatekeepers regulating involuntary civil commitment cases.

GUIDELINE II-E. (1) Gatekeepers should be mental health professionals, or court personnel working in cooperation with mental health professionals, experienced in the diagnosis of mental illness and facile in applying the legal, psychological, and social constructs used in making decisions concerning detention pursuant to involuntary hospitalization, release, and all intermediate alternatives.

(2) Gatekeepers shall serve as screeners, or work in close cooperation with screeners, to cause review and investigation of commitment applications, and the screening and diversion of cases from compulsory hospitalization.

GUIDELINE II-F. Gatekeepers should have the authority to order involuntary detention and to request ambulance or police assistance for transporting respondents to and from appropriate mental health facilities.

Institute on Mental Disability and the Law, supra note 89, at II-10-13.

100. "Mental Health Review Officer" means a person designated as such by [the community mental health authority or Human Rights Committee] who was actively engaged in the treatment and diagnosis of mental disorder during at least two of the three years immediately preceeding such designation." Suggested Statute on Civil Commitment, 2 Mental Disability Law Reporter 132 (1977).

> The "Mental Health Review Officer" is a mental health professional, preferably independent of evaluation and treatment facilities, whose functions include the screening of petitions for evaluation and various preliminary or short-term determinations in the course of a commitment proceeding, evaluation and treatment. Id. at 134.
>
> In all cases the Mental Health Review Officer must accomplish a screening investigation in order to avoid unnecessary detention and evaluation when there are inadequate grounds to believe that the individual presents a likelihood of serious harm to self or others as a result of severe mental disorder. This investigation must be completed prior to detention unless the Mental Health Review Officer or peace officer determines that immediate detention is necessary to prevent serious bodily harm to the respondent or others. If the respondent is, as a result of such an emergency, detained prior to the completion of the screening investigation, the investigation must be completed within 18 hours of the initiation of detention. Id., at 136.

100a. "Citizens, as well as law enforcement agencies, judges, correctional authorities, physicians, and mental health professionals have used the services of the coordinator increasingly. The coordinator is a vital link in the coordination of the involuntary detention process between the courts, community, and mental health systems as well as to help assure that the involuntarily detained peson is provided an opportunity to access all statutory rightrs and due process. This responsibility is in addition to the many hours of training, public presentations, and consultations with mental health administrators pursuant to involuntary detention procedures." Missouri Department of Mental Health, supra note 98, at 16.

100b. It could be argued that these practical difficulties facing applicants who pursue the involuntary detention of others are justified. The potential respondent's liberty interests justify a heavy burden placed on those seeking his or her involuntary detention. On the other hand, it can be argued that the inaccessibility of mental health coordinators for many applicants who may not be able to meet mental health coordinators during daytime hours causes the more orderly, non-emergency route to involuntary commitment to be closed and, consequently, cause more cases to be initiated on an emergency basis.

101. Mo. Rev. Stat. §632.305.1-2 (19__).

102. According to one mental health coordinator, courts in the rural areas outside of Kansas City place less reliance upon mental health coordinators.

103. Missouri Department of Mental Health, supra note 98, at 16.

104. Id.

105. According to statistics provided by the Circuit Court of Jackson County, 63 of 75 petitions for involuntary detention filed in January 1983 were emergency cases.

105a. See Mo. Rev. Stat. § 632.320.3 (19__).

105b. See I. Keilitz W.L. Fitch, & B.D. McGraw, Involuntary Civil Commitment in Los Angeles County, 14 Sw. L. Rev. __ (1983)(in press): J. Zimmerman, Involuntary Civil Commitment in Chicago (Williamsburg, Virginia: National Center for State Courts, 1982): see also, Institute, supra note 89.

106. See Figure 1; see also notes 50-59 and accompanying text.

107. See supra note 99.

108. At a minimum, the powers, responsibilites and duties of gatekeepers, and the arrangements of community portals through which all involuntary civil commitment cases flow should:

(1) be visibile, accessible, and manageable by the courts, working in cooperation with mental health and social service agencies involved in the initial stages of the civil commitment process;
(2) be monitored, if not regulated, by the courts with jurisdiction over involuntary civil commitment matters;
(3) provide all legal safeguards mandated by state statutes;
(4) be an extension or an adaptation of existing service delivery systems, generally accessible to the public (e.g., community mental health centers or court clinics);
(5) provide prompt access to mental health facilities without undue delay in emergency treatment and care;
(6) provide fair, prompt, and reliable decision making about involuntary hospitalization and diversion alternatives in both emergency and non-emergency cases;
(7) facilitate diversion of the maximum number of cases from involuntary hospitalization to less restrictive alternatives;

(8) be fair, effective, and efficient; and
(9) avoid onerous complexity.

See Institute, supra note 89, at II-12.

109. Caswell, No. 77-0488-CV-W-8 (W.D. Mo. Feb. 8, 1983), supra note 50a, at 25-35.

110. See McGraw & Keilitz, supra note 12, at __.

110a. See, e.g., I. Keilitz, Involuntary Civil Commitment in Columbus, Ohio (Williamsburg, Virginia: National Center for State Courts); I. Keilitz, W.L. Fitch, & B.D. McGraw, A Study of Involuntary Civil Commitment in Los Angeles County, 14 Southwestern L. Rev. ___ (in press 1984); see also, generally, Keilitz & Van Duizend, supra note 17.

111. See Institute, supra note 89.

112. For a discussion of the wide gap between formal policy (i.e., statute, litigation, and administrative rule) and actual practice in mental health law, see generally Shah, supra note 14, at 255; Institute, supra note 89, at I-4; see also M. Perlin, The Legal States of the Psychologist in the Courtroom, 4 Mental Disability Law Reporter 194, (1980); and S. S Herr, S. Arons & R.E. Wallace, Jr., Legal Rights and Mental Health Care (1983).

113. Mo. Rev. Stat § 632.335.4 (19__).

114. Id. § 632.350.5.

115. Id. § 632.355.3.

116. Id. §§ 632.335.4, 350.5, and 355.3.

117. For surveys of state statutory provisions for involuntary treatment and care in the least restrictive setting, see Lyon, Levine, & Zusman, supra note 8; B.D. McGraw & I. Keilitz, The Least Restrictive Alternative Doctrine in Los Angeles County Civil Commitment, ____ Whittier L. Rev. Appendix (1984); see also Institute, supra note 89, at V-11-14. A North Carolina statute specifically provides for involuntary civil commitment to outpatient treatment, although the provision has had a limited impact; see R.D. Miller & P.B. Fiddleman, Outpatient Commitment in the Least Restrictive Environment, 35 Hospital and Community Psychiatry 147 (1984).

118. See Miller & Fiddleman, id., at 148.

119. Id., at 149 ("A major problem with outpatient commitment is that most laws cite dangerousness as a necessary criterion for commitment.").

120. 551 P. 2d 334 (Cal. Sup. Ct. 1976).

121. See e.g., Summary and Analysis, 7 Mental Disability Law Reporter 443, 449 (1983).

122. Miller & Fiddleman, supra note 117, at 150.

123. Mo. Rev. Stat. § 630.605 (19__).

124. Id.

125. Id.

126. Id. § 630.615 (2).

127. Id. § 632.050.9

128. Id. § 632.055.

128a.

129. See Institute, supra note 89, at II-49-55.

130. See generally, id., at II-50, IV-13-19.

131. Mo. Rev. Stat. § 632.385.1 (19__).

132. Id.

133. Id. § 632.385.3

134. Id. § 632.385.2

135. Id. § 632.385.5

136. Id.

137. Id. § 632.385.4.

138. The "ultimate goal of a patient's hospitalization is his/her discharge and successful (re-)integration into the community." Caswell, supra note 50a, at 18.

139. Mo. Rev. Stat. § 632.310.1 (19__).

140. Id.

141. Id. § 632.310.2.

142. Id. § 632.310.3.

143. Id. § 632.300.3.

144. Institute, supra note 89, at Part IV, Chapter 2.

145. Mo. Rev. Stat. §632.330.3 (19__).

146. See Suggested Statute on Civil Commitment, supra note 3, at 141.

147. See Mo. Rev. Stat. §632.325 (19__).

148. One mental health coordinator stated that the question of voluntary admission is sometimes put to respondents as follows: "Sign in or you're going to court."

149. See J. Zimmerman, supra note 105b, at 44.

150. Mo. Rev. Stat. §632.325(3) (19__).

151. Id. §632.325(3) (19__).

152. See generally Institute, supra note 89, at I-5, II-6,

153. Id.

THE MILWAUKEE REPORT*

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THE LEAST RESTRICTIVE ALTERNATIVE DOCTRINE IN MILWAUKEE COUNTY CIVIL COMMITMENT†

Bradley D. McGraw*

INTRODUCTION

Prior to the landmark decision of Lessard v. Schmidt,[1] Wisconsin's civil commitment procedure made it possible to detain a respondent[2] in a hospital for up to 145 days without a hearing.[3]

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The National Center for State Courts (founded in 1971) is a private, nonprofit organization dedicated to the improvement of court operations and the administration of justice at the state and local levels throughout the country. It functions as an extension of the state court systems, working on their behalf and responding to their priorities. The Institute on Mental Disability and the Law was established in November 1981 as an arm of the National Center for State Courts to provide applied research, program evaluation, and technical assistance to the state courts and allied agencies in the area of mental disability and the law.

1. 349 F. Supp 1078 (E.D. Wisc. 1972) (Wisconsin civil commitment procedure violative of due process in several respects), vacated and remanded 414 U.S. 473 (1973), on remand 379 F. Supp. 1376 (E.D. Wisc. 1974), vacated and remanded 421 U.S. 957 (1975), on remand 413 F. Supp. 1318 (E.D. Wisc. 1976) (reinstating 379 F. Supp. 1376). Despite procedural reversals, Lessard continues to serve as a leading reference in mental disability law.

2. Hereafter, the term "respondent" will be used to refer to any individual subject to involuntary civil commitment proceedings, including the less formalized proceedings occurring before court intervention.

3. Remington, Lessard v. Schmidt and Its Implications for Involuntary Civil Commitment in Wisconsin, 57 Marq. L. Rev. 65, 68 (1973).

In Lessard, the United States District Court for the Eastern District of Wisconsin concluded that Wisconsin's civil commitment procedure was defective in that, among other things, it failed "to require those seeking commitment to consider less restrictive alternatives to commitment."[4] The Lessard decision prompted substantial legislative changes to Wisconsin's commitment procedures.[5] This article focuses on the resulting legislative directives regarding the "least restrictive alternative doctrine," and their controversial application in Milwaukee County commitment practice.[6]

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4. 349 F. Supp at 1103. The court said that full-time, involuntary hospitalization should be ordered "only as a last resort." Id. at 1095. The court explained:

> [P]ersons 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. These alternatives include voluntary or court-ordered out-patient treatment, day treatment in a hospital, night treatment in a hospital, placement in the custody of a friend or relative, placement in a nursing home, referral to a community mental health clinic, and home health aide services.

Id. at 1096.

5. See 1975 Wis. Laws ch. 430, § 11.

6. This article does not exhaustively review appellate case law, but rather, it documents observations, impressions, and conclusions regarding the vast majority of commitment cases which never reach appellate review. By studying civil commitment systems in Chicago, Kansas City (Missouri), Los Angeles, Milwaukee, New York, Tucson, and Williamsburg/James City County (Virginia), the Institute on Mental Disability and the Law of the National Center for State Courts is assessing the use of the least restrictive alternative doctrine to determine how its application may be improved. The Institute plans to

Much controversy in Milwaukee County centers on a negotiated settlement approach used by respondent's attorneys to divert their clients from involuntary hospitalization to outpatient or voluntary inpatient treatment. Although this procedure is not prescribed by Wisconsin's commitment statute, various sources estimate that as many as 25 to 50 percent of all involuntary civil commitment cases in Milwaukee County are diverted by means of these tactics.[7] Before discussing negotiated settlements and the practical application of statutory directives, this article briefly discusses the least restrictive alternative doctrine's development in civil commitment law and the civil commitment process as envisioned in Wisconsin's State Mental Health Act (SMHA).[8]

The least restrictive alternative doctrine holds that "governmental action must not intrude upon constitutionally protected interests to a degree greater than necessary to achieve a legitimate

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develop methods which will enhance the symbiotic functioning of the mental health and judicial systems in achieving the ideal of the least restrictive alternative doctrine. The author conducted field research in Milwaukee during March and April 1983.

7. Precise statistics are unavailable. The estimate of 25 to 50 percent is based on statistics compiled by the Wisconsin Correctional Service for July 1, 1981 through July 30, 1982, statistics for 1981 compiled by the Clerk of Circuit Court, and estimates by various interviewees in Milwaukee.

A similar settlement process is used in Hennepin County, Minnesota, where about two-thirds of all involuntary civil commitment cases are settled at a preliminary hearing three days after the petition is filed. A Pre-Petition Screening Report, usually about eight pages long, is used by all parties in reaching an agreement in which the respondent stipulates to adhere to a voluntary treatment plan or the case is dismissed. Additional settlements occur at trial. Arthur, The New Civil Commitment Process in Hennepin County, 53(2) The Hennepin Lawyer 8 (1983).

8. Wis. Stat. Ann. ch. 51 (West Cum. Supp. 1983-1984). Statutory citations hereinafter are to the State Mental Health Act unless otherwise specified.

purpose."[9] The doctrine was first applied in mental health litigation in Lake v. Cameron,[10] 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 not go beyond what is necessary for their protection."[11] The doctrine's debut in Wisconsin's commitment law occurred in Lessard, six years following the Lake v. Cameron decision.[12] The district court relied on Lake[13] and Shelton v. Tucker.[14] In the later case, the United States Supreme Court explicitly recognized the "least drastic means principle," saying:

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9. Hoffman & Foust, Least Restrictive Treatment of the Mentally Ill: A Doctrine in Search of Its Senses, 14 San Diego L.R. 1100, 1101 (1977); see Chambers, Alternatives to Civil Commitment of the Mentally Ill: Practical Guides and Constitutional Imperatives, 70 Michigan L.R. 1107 (1972).

10. 364 F. 2d 657 (D.C. Cir. 1966).

11. Id. at 660. The District Court had denied writ of habeas corpus to an involuntary patient seeking release from a hospital. Id. at 658-659. Based on a statutory rather than a constitutional right to the least restrictive alternative, the Court of Appeals remanded the case to the District Court for inquiry into alternative courses of treatment. Id. at 661. The Court of Appeals said that "[t]he alternative course of treatment or care should be fashioned as the interests of the person and the public require in the particular case." Id. at 660.

12. A brief survey of the doctrine's use in other jurisdictions appears in McGraw & Keilitz, The Least Restrictive Alternative Doctrine in Los Angeles County Civil Commitment, 6 Whittier L. Rev. __ (1984) (in press).

13. See Lessard, 349 F. Supp. at 1096.

14. 364 U.S. 479 (1960) (Arkansas statute requiring every public school teacher, as condition of employment, to annually file list of organizations to which he or she belonged or contributed violated due process by depriving teachers of right to associational freedom). See Lessard at 1095.

> [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.[15]

Although not cited in Lessard, an opinion written by Chief Judge Bazelon three years after the Lake decision is enlightening regarding the least restrictive alternative doctrine's emerging importance in civil commitment law. In Covington v. Harris,[16] a civilly committed patient petitioned for writ of habeas corpus, seeking transfer from a maximum security ward to a less restrictive ward within the same hospital. In reversing the district court's denial of the writ, Chief Judge Bazelon wrote:

> [T]he principle of the least restrictive alternative consistent with 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 deprivation of liberty without due process of law.[17]

A quick perusal of the revised SMHA reveals that the Wisconsin Legislature believed the least restrictive alternative doctrine "inheres in the very nature of civil commitment."[18] The doctrine is central to

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15. 364 U.S. at 488 (footnote ommitted).

16. 419 F. 2d 617 (D.C. Cir. 1969).

17. Id. at 623.

18. See e.g., Wis. Stat. Ann. §51.001; 51.22(5) (West Cum. Supp. 1983-1984).

the legislative policy of the SMHA. That policy includes, among other things, that "[t]here shall be ... provision of services which will assure all people in need of care access to the least restrictive treatment alternative appropriate to their needs."[19] The policy also mandates that "[t]o protect personal liberties, no person who can be treated adequately outside of a hospital, institution or other inpatient facility may be involuntarily treated in such a facility."[20] As Shah has observed, however:

> It is one thing to legislate or judicially mandate legal and other policy changes; it is quite another matter to secure their actual implementation. ... Thus, as important as reforms in legal policies (viz., the "law on the books") certainly are, these accomplishments must not be confused with the end result (viz., the "law in practice").[21]

Following an overview of the commitment process envisioned by the Legislature, we will focus on selected statutory provisions in which the doctrine is operative and on related practices in Milwaukee County.

I. OVERVIEW OF CIVIL COMMITMENT IN WISCONSIN[22]

The involuntary civil commitment process may be initiated pursuant to the SMHA either by filing with the probate court a written

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19. Id. at §51.001(1).

20. Id. at §51.001(2).

21. Shah, Legal and Mental Health System Interactions: Major Developments and Research Needs, 4 Int'l J. of L. & Psychiatry 219, 255 (1981). "[W]hile the legal doctrine prescribing use of the 'least restrictive alternative' has fairly clear meaning in reference to certain legal and constitutional values concerning infringement of personal freedom and liberty, the notion does not translate readily into mental health procedures and programs." Id. at 254.

22. A detailed description of civil commitment in Milwaukee County may be found in I. Keilitz & B.D. McGraw, An Evaluation of Involuntary Civil Commitment in Milwaukee County (1983).

petition for examination signed by three adults[23] or by a law enforcement officer initiating emergency detention.[24] A petition must allege that the respondent is mentally ill, drug dependent, or developmentally disabled, a proper subject for treatment, and dangerous.[25] Emergency detention of a respondent may be initiated if there is cause to believe that the respondent is mentally ill, drug dependent, or developmentally disabled, and evidences a substantial probability of harm to himself or herself or others, or is unable to satisfy his or her basic physical needs.[26]

Upon the filing of a petition, the probate court reviews the petition to determine whether to issue a detention order.[27] The respondent should be detained only if there is cause to believe that he or she meets commitment criteria.[28] Statute fails to clearly state under what circumstances the respondent should be released, or not initially detained, pending a mandatory probable cause hearing. If the respondent is detained, he or she has a right to a hearing to determine probable cause for commitment within 72 hours after arrival at the detention facility, excluding Saturdays, Sundays, and legal holidays.[29] If the

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23. Wis. Stat. Ann. §51.20 (West Cum. Supp. 1983-1984).

24. Id. at §51.15.

25. Id. at §51.20(1). Dangerousness is determined by any of four tests articulated in statute. See id. at §51.20(1)2.a - d.

26. Id. at §51.15(1). Substantial probability of harm is determined by tests similar to the dangerousness tests of section 51.20. See supra note 25.

27. Id. at §51.20(2).

28. Id.

29. Id. at §51.20(7)(a).

respondent is not detained, the probable cause hearing should be held within a reasonable time.[30] If the court determines that probable cause exists, it schedules a final commitment hearing within 14 days from the time of initial detention if the respondent is detained,[31] or within 30 days of the probable cause hearing if the respondent is not detained.[32] The court may condition the respondent's release pending the final hearing upon the respondent's acceptance of treatment.[33]

Before the final hearing, the court appoints two examiners to examine the respondent.[34] Each examiner must make an independent report to the court concerning the respondent's mental condition. If the examiner determines that the respondent is a proper subject for treatment, the examiner should make recommendations concerning the least restrictive level of treatment appropriate for the respondent.[35]

If the final hearing court determines that the respondent meets commitment criteria, the court should order commitment to appropriate inpatient or outpatient care and treatment.[36] The court should designate the facility or service which is to receive the respondent.[37]

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30. Id. at §51.20(7)(b).
31. Id. at §51.20(7)(c).
32. Id. at §51.20(8).
33. Id.
34. Id. at §51.20(9)(a).
35. Id. at §51.20(9)(b).
36. Id. at §51.20(13)(a)3.
37. Id. at §51.20(13)(c)1.

The community board[38] should arrange for treatment in the least restrictive manner consistent with the respondent's needs and the maximum level of inpatient care permitted by the court order.[39] The initial commitment period may never exceed six months and each subsequent, consecutive order of commitment may not exceed one year.[40]

The staff treating a committed person must periodically reevaluate the person to determine whether he or she has progressed sufficiently to warrant discharge or transfer to a less restrictive facility.[41] Periodic reevaluations must occur within 30 days after the commitment, within three months after the initial reevaluation, and again thereafter at least once each six months.[42] In addition to these automatic reevaluations, a respondent may at any time file a petition requesting a reexamination or requesting the court to modify or cancel the commitment order.[43]

II. BEYOND THE STATE MENTAL HEALTH ACT

In addition to articulating the general policy that the state should assure all people access to the least restrictive, appropriate

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38. See id. at §§51.42; 51.437.

39. Id. at §51.20(13)(c)2.

40. Id. at §51.20(13)(g)1. If the basis for commitment is that the respondent is unable to satisfy his or her own basic needs for nourishment, medical care, shelter, or safety, the commitment period may not exceed 45 days in any 365 day period. Id. at §51.20(13)(g)2.

41. Id. at §51.20(17).

42. Id.

43. Id. at §51.20(16).

treatment, the Legislature has provided each "patient" with a specific "right to the least restrictive conditions necessary to achieve the purposes of admission, commitment, or placement."[44] Because the term "patient" includes any person who is receiving services for mental disability or who is detained under the SMHA,[45] the right to the least restrictive alternative attaches as soon as commitment proceedings are initiated under the three-party petition or the emergency detention process. Although the SMHA includes many more provisions reflecting the least restrictive alternative doctrine, the policy and patients' right provisions have made the most dramatic marks on involuntary civil commitment practice in Milwaukee County.

Hoffman and Foust have observed that formal civil commitment proceedings generally follow rather than trigger attempts to place a person into less restrictive settings.[46] In Milwaukee County this might be rephrased to say that statutory commitment procedures, including those implicating the least restrictive alternative doctrine, generally follow less formal, pragmatically developed screening and diversion procedures. Many, perhaps most, respondents are diverted to alternative treatment and care before a petition is filed or an emergency detention is initiated. Even after the commencement of proceedings a respondent may be diverted before a judicial hearing occurs. Most of the statutory prescriptions come into play only if a respondent is not diverted during these early proceedings.

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44. Id. at §51.61(1)(e).

45. See id. at §51.61(1).

46. Hoffman & Foust, supra note 9, at 1139 ("the unworkability of less restrictive alternatives, and not the failure to consider them, ultimately leads to most commitment proceedings").

The principles stated in the policy and patients' right provisions of the SMHA have greatly influenced the early screening and diversion process. Although the SMHA never defines "least restrictive alternative," a two-pronged definition has emerged in Milwaukee County. One prong reflects the policy that, to protect personal liberties, no person may be treated in a hospital, institution, or other inpatient facility if he or she may be treated adequately outside such a facility.[47] This policy presumes that institutional settings restrict individuals' liberty interests more than noninstitutional settings do. Thus, the first prong is an objective test: institutions are more

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47. Wis. Stat. Ann. §51.001(2) (West Cum. Supp. 1983-1984). A recently proposed model commitment statute would require the most effective treatment rather than merely adequate treatment:

> "consistent with the least restrictive alternative principle" means that (1) each patient committed solely on the ground that he is likely to cause harm to himself or to suffer substantial mental or physical deterioration shall be placed in the most appropriate and therapeutic available setting, that is, a setting in which treatment provides the patient with a realistic opportunity to improve, and which is no more restrictive of his physical or social liberties than is believed conducive to the most effective treatment for the patient; and (2) each patient committed solely or in part on the ground that he is likely to cause harm to others shall be placed in a setting in which treatment is available and the risks of physicial injury or property damage posed by such placement are warranted by the proposed plan of treatment.

Stromberg & Stone, A Model State Law on Civil Commitment of the Mentally Ill, 20 Harv. J. on Legis. 275, 291 (1983). This provision also differentiates between respondents committed solely on a parens patriae basis and those committed on a police power basis. Part (1) thus requires "the most effective treatment" for the respondent committed for his or her own good, for whom treatment is the primary goal. Id. at 293. Part (2) requires that if the respondent is committed to protect society, any reduction in restrictiveness must be "warranted by the proposed plan of treatment," because of the security concern. Id. at 293-94.

restrictive than noninstitutions. One commentator in Milwaukee has put it this way:

> In the context of civil commitment, [the least restrictive alternative doctrine] means, for example, that if outpatient treatment would be adequate to ameliorate the individual's mental illness or dangerousness, involuntary inpatient treatment cannot be imposed even if it is clinically preferrable for the individual. Obviously, this principle and policy favors the use of community-based treatment, including outpatient treatment, halfway house placement, and transitional housing.[48]

This objective approach results in many potential civil committees being diverted from the road to the Milwaukee County Mental Health Complex to community-based programs. This approach dominates the screening done by the Protective Services Management Team, which prescreens three-party petitions; the Mental Health Emergency Service, which provides prescreening in petition and emergency cases; and the staff of Ward 53B at the Milwaukee County Mental Health Complex, the admitting ward for civil detainees. The mechanics of the screening process will be discussed in more detail later.

The second prong is more subjective. Under this prong, restrictiveness is gauged by the personal preferences of the respondent. Milwaukee's Office of the State Public Defender and the Legal Aid Society of Milwaukee, Inc., which represent the vast majority of respondents, emphasize their clients' personal preferences by evaluating the extent to which alternative placements comport with the wishes of the client to be

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48. T.K. Zander, The Mental Commitment Law as a Scapegoat: The Real Problem is Not with the Mental Commitment Law, but with the Lack of Community-Based Mental Health Services (August 1979) (report to Milwaukee County's Advisory Committee on Mental Commitment Standards and Procedures).

served. A particular respondent may prefer an institutional placement, even though objectively it may be more restrictive than community-based care. If because of his or her mental condition a respondent does not or is unable to express a personal preference, counsel simply assumes that the client would prefer the objectively less restrictive placement.

This assumption highlights the way that the patients' right to the least restrictive alternative comes into play during the prescreening process. At that stage the right is not primarily a civil libertarian device for protecting respondents from intrusive and unwanted mental health treatment. It is, rather, a means of ensuring that respondents have prompt access to much needed treatment under minimally intrusive conditions. Helping respondents get adequate treatment is the primary goal of the screening agencies.

When a petition is filed or a respondent is detained and formal commitment proceedings begin, civil libertarian concerns become more pronounced. The legal obligation of counsel for the respondent to be adversary counsel,[49] however, does not prevent him or her from also encouraging the respondent to accept treatment. A respondent's attorney should function as both an advocate and a counselor. As one attorney interviewed[50] in Milwaukee stated, a respondent's attorney should advocate his or her client's wishes and should never deviate from those wishes, but as counselor he or she should also try to influence a client's wishes when it is in the client's best interests to do so.

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49. See Wis. Stat. Ann. §51.20(3) (West Cum. Supp. 1983-1984); Memmel v. Mundy, 75 Wis. 2d 276, 249 N.W. 2d 573, 577 (1977).

50. Persons interviewed in Milwaukee County were promised anonymity and are, thus, not individually identified in this article.

Attorneys of the State Public Defender's Office and the Legal Aid Society of Milwaukee, Inc., assume both of these roles. Their counselor role is most apparent in the negotiated settlement process. Although this process begins after the formal initiation of commitment procedures, it is not statutorily required. Before discussing it we look in more detail at the prescreening process which largely precedes and transcends the statutorily required procedures.

A. Informal Screening

Screening by the Protective Services Management Team (PSMT) and the Mental Health Emergency Service (MHES) often undercuts the need for a three-party petition or an emergency detention. Although the SMHA does not require any such screening,[51] a respondent may be diverted from the commitment process if preliminary screening warrants diversion.

When the PSMT receives a telephone call from a person seeking a three-party petition, the prescreening process begins. Callers might be law enforcement officers, MHES members, mental health or social service personnel, attorneys, or other persons or agencies in the community. The PSMT intake worker answering a call typically asks a caller about the respondent's behavior, present mental condition, and prior mental health history, and about whether the respondent's family or others have taken any action to mitigate the condition or circumstances prompting the telephone call. If such actions have had no or minimal success, the intake worker schedules an appointment for the caller and two other adult persons to complete a three-party petition at the PSMT office. If mitigating action has not been taken, however, the intake worker may

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51. See Wis. Stat. Ann. §§51.15; 51.20 (West Cum. Supp. 1983-1984); see also supra notes 23-26 and accompanying text.

refer the caller to the nearest community mental health center, the MHES, or some other agency or facility. Involuntary civil commitment is pursued only as a last resort.

When the intake worker transfers a call to the MHES, an MHES counselor continues the telephone screening, which may include assessment, negotiating a care plan, and referring the caller to a treatment facility or agency. In many cases this telephone intervention resolves the crisis situation. If warranted, however, a mobile MHES team may continue the intervention and screening on site.

The MHES also provide screening for the police in emergency situations. The SMHA authorizes a law enforcement officer to take a respondent into emergency detention if he or she has cause to believe that the respondent meets detention criteria.[52] Although no screening is required before this detention, the police may call MHES for assistance in determining if the respondent meets emergency detention criteria. This provides another opportunity for diversion from commitment proceedings.[53]

B. Screening at Ward 53B

If a law enforcement officer takes a respondent into emergency custody, the officer delivers the respondent to Ward 53B at the Milwaukee

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52. Wis. Stat. Ann. §51.15(1) (West Cum. Supp. 1983-1984).

53. The availability of MHES screening has been compromised by an ever-shrinking budget and staff. The MHES was formed in early 1983 by a merger of the Crisis Intervention Service and the Psychiatric Emergency Service. The Crisis Intervention Service was formed two years earlier, with a staff of 20 persons, to provide 24-hour services seven days a week. Before the merger, cutbacks resulted in the Crisis Intervention Service being unable to respond to about 25 percent of the incoming calls requiring mobile intervention. The MHES now can provide such services only on weekdays from 8 a.m. to 10:00 p.m.

County Mental Health Complex, the admitting ward for civil detainees. The SMHA requires that within 24 hours after a respondent is delivered to a detention facility, the treatment director, or his or her designee, shall determine whether the respondent shall be detained or released.[54] Ward 53B staff meet and exceed this minimum requirement.

Staff promptly conduct a mental health evaluation of incoming detainees. If a detainee arrives at 53B during the night, a psychiatric resident on call does an initial assessment of him or her. In rare cases the resident may release the respondent immediately or the next morning. Detainees who arrive during the day and those remaining after night arrival are generally evaluated by a staff psychiatrist and a social worker.

During this evaluation, the SMHA requires only an "either/or" decision--detention or no detention. Ward 53B staff exceed this minimum requirement by counseling respondents regarding the availability of voluntary admission, outpatient treatment, and community placement. Many initial evaluations result in referral to objectively less restrictive treatment alternatives.

One notable alternative is a "14-day voluntary pending" arrangement, which is made available by an SMHA provision.[55] Under this arrangement, the respondent may elect to become a voluntary patient with restrictions. Practically speaking, the respondent signs into the hospital for 14 days but cannot sign out during that period. The respondent has 14 days to prove his or her suitability for voluntary

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54. Wis. Stat. Ann. §51.15(4)(b) (West Cum. Supp. 1983-1984).

55. See id. at §51.10(6).

rather than involuntary admission. The treatment director must approve the voluntary admission within this time. Unless the director disapproves the admission, the civil commitment proceedings are suspended until the end of the 14-day period. The patient then becomes a regular voluntary patient and the civil commitment proceeding is dismissed.

C. Negotiated Settlements

The most significant and controversial step beyond the SMHA commitment procedures in Milwaukee County is the negotiated settlement process. Negotiated settlements take two forms: (1) "court-ordered voluntary" agreements (COVs),[56] which result in voluntary inpatient status, and (2) stipulated settlements, which result in outpatient status. A negotiated settlement results from relatively unstructured conferences and negotiations between the attorney representing the respondent and the corporation counsel, who represents the state. These conferences and negotiations generally occur prior to the probable cause hearing, but may follow it. The parties negotiate, reach an agreement, and then seek postponement of the probable cause hearing or final commitment hearing for a specified time, during which the respondent participates in the agreed-upon treatment program. Unless the respondent fails to comply with the terms of the agreement, the matter is dismissed at the end of the treatment period. If the respondent has failed to comply, the corporation counsel requests that the case be reopened.

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56. In I. Keilitz & B.D. McGraw, supra note 22, at 72 n.70, the authors suggested that part of the controversy surrounding court-ordered voluntary agreements has resulted from the inherently inconsistent label used to refer to these agreements. The authors suggested an alternative label, such as "stipulated voluntary".

A stipulated settlement may result in the case being held open for up to 90 days. Typical conditions of these agreements include outpatient administration of psychotropic medication, psychotherapy, vocational rehabilitation, day care, placement in a group home or board-and-care facility, social services such as General Assistance or Supplementary Security Income, food stamps, "meals-on-wheels," homemaker services, and other conditions peculiar to the case. At the time of the originally scheduled probable cause hearing, the parties present the stipulated settlement to the court, which usually adopts it as the order of the court.

Under the conditions of a COV, judicial proceedings may be adjourned for up to six months or until (1) the respondent's counsel notifies the court that his or her client wishes the case to be set for hearing, or (2) Milwaukee County Mental Health Complex staff determine that the respondent no longer needs inpatient treatment and notify the court to that effect, in which case the pending commitment proceedings are dismissed. The court orders the COV conditions subject to the approval of the treatment staff. Under the resulting "voluntary" admission, the respondent agrees to cooperate with treatment staff.

The elements of a proposed settlement are initially formulated by the respondent's counsel. In constructing a proposal, the attorney talks with the respondent (usually the evening before the scheduled probable cause hearing), Ward 53B staff, social workers affiliated either with the Legal Aid Society or the Combined Community Services Board, and, although less frequently, family members and petitioners. Although the corporation counsel may investigate alternative arrangements before the respondent's counsel presents a proposed settlement, he typically waits

for that proposal. Once he receives a proposal, he may review it with a Ward 53B psychiatrist and with members of the respondent's family. Corporation counsel might then accept the proposal as presented, negotiate modifications of conditions of the proposal, or reject the proposal outright and proceed to probable cause hearing.

Supporters of the negotiated settlement process state that it furthers the legislative policy of the SMHA by assuring access to the least restrictive treatment alternative appropriate to the respondent's needs. Critics argue that it tips the balance too much in favor of the respondent's liberty interests while compromizing much needed treatment and care. A criticism aimed at stipulated settlements is that the monitoring of a respondent's compliance with outpatient treatment terms and conditions is inadequate.

Lack of resources lies at the root of the monitoring problem. Corporation counsel does not have the time or the resources to monitor a respondent's compliance with the conditions of a stipulated settlement once it is approved by the court. The only real check on compliance occurs when petitioners, members of the respondent's family, mental health professionals, or others in the community bring a respondent's noncompliance to the attention of the corporation counsel. While additional resources appear to be the only complete solution to the problem, a coordination and linking of existing services, and a modification of the legal proceedings to better accomodate the stipulated settlement process, may provide partial solutions.[57]

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57. See id. at 102-114 (details how such coordination and modification could be accomplished). In early 1983, the Combined Community Services Board created a position for a social worker who would be responsible for investigating alternative treatment plans for respondents. This social worker could also be used for monitoring purposes.

III. PRESCRIPTION AND PRACTICE

Though preliminary screening and negotiated settlements have essentially superseded the more formal SMHA procedures in many cases, if a respondent is not diverted by informal means, the SMHA procedures provide additional opportunities for diversion. They also provide the means for respecting a respondent's right to the least restrictive alternative as he or she proceeds through the stages of involuntary civil commitment, even through the ultimate commitment order and the ensuing placement.

In Milwaukee County practice, however, diversion pursuant to formal procedures is unlikely. A presumption seems to arise that if a respondent has not been diverted by informal means, a high probability exists that the respondent is not a proper subject for treatment less restrictive than involuntary hospitalization. Additionally, though there is no evidence that the means of respecting a respondent's right to the least restrictive alternative are neglected or abused, not all of the statutory prescriptions are fully applied.

The following discussion outlines procedures envisioned in the SMHA and their translation into Milwaukee County practice.

A. Detention, Probable Cause, and Commitment Criteria

A potentially significant but inconspicuous phrase appears in the statutory criteria that must be satisfied before an emergency detention may be effected, probable cause may be found, or commitment may be ordered. This phrase comes into play only if the respondent's behavior that spurred others to seek his or her commitment poses a threat to the respondent but <u>not</u> to others. According to this phrase, in two limited situations, a respondent 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."[58] The first situation occurs if the respondent evidences a "probability of physical impairment or injury to himself or herself due to impaired judgment... ."[59] The second occurs if "due to mental illness or drug dependency, he or she is unable to satisfy basic needs for nourishment, shelter or safety without prompt and adequate treatment ... ."[60] These situations may be contrasted with two other situations in which the availability of protection in the community does not bar detention, probable cause, or commitment. The latter occur if the respondent's condition poses a threat to others or an extreme threat to him or herself, such as if the respondent is homicidal or suicidal.[61] The rationale for the "reasonable provision in the community" standard apparently is that community alternatives may be more available or effective for respondents who have impaired judgment or an inability to satisfy basic needs than for respondents who are homicidal or suicidal. The significance of the standard as applied in Milwaukee County, however, is unclear.

When a Milwaukee police officer must decide whether to take a respondent into emergency custody, the officer's decision is shaped much

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58. Wis. Stat. Ann. §§51.15(1)(a)3 & 4; 51.20(1)(a)2.c & d; 51.20(1)(1m) (West Cum. Supp. 1983-1984).

59. Id. at §§51.15(1)(a)3; 51.20(1)(a)2.c; 51.20(1)(1m). Specifically, the availability in the community of reasonable provision for the individual's protection negates the requirement that the probability of harm be "substantial" before a judicial sanction is warranted. See id.

60. Id. at §§51.15(1)(a)4; 51.20(1)2.d.

61. See id. at §§51.15(1)(a)1 & 2; 51.20(1)(a)2.a & b.

less by a close tracking of the statutory criteria, including this particular standard, than by his or her operational style and assessment of the risks and opportunities in the given situation.[62] The emergency detention statute gives officers broad discretion in determining whether to initiate emergency detention.[63] According to a representative of Milwaukee's Department of Police, an officer's decision process is no different in an emergency detention than in a criminal arrest. That is, it is determined by the respondent's recent and specific actions threatening the respondent or others. An officer does not, therefore, discretely apply the "reasonable provision in the community" standard. Rather, the officer assesses the situation to determine if an emergency detention, a referral for a three-party petition, or a referral to the MHES or some other service or facility would be appropriate.[64]

The standard may become more important later in the commitment process, during the probable cause and final commitment hearings, if the respondent is not diverted through preliminary screening or a negotiated settlement. Presumably, this standard would bar a probable cause finding or commitment order if community placement is available. Other SMHA provisions, however, authorize the court to order community placement of

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62. See M.K. Brown, Working the Street: Police Discretion and the Dilemmas of Reform (1981).

63. See Wis. Stat. Ann. §51.15(1)(a) (West Cum. Supp. 1983-1984) ("A law enforcement officer ... may take an individual into custody if the officer has cause to believe that ...") (emphasis added).

64. This does not imply that the statutory criteria are unimportant or should be ignored. It simply recognizes the realities of police work. Nor does it imply that police officers in Milwaukee improperly detain respondent's because they fail to closely track the detention criteria. If anything, officers are reluctant to take respondents into custody and do it only as a last resort.

a respondent.[65] If the statutory criteria are proven, including that no reasonable provision for protecting the respondent is available in the community, can the court then order community placement? A negative answer would defeat the legislative policy of the SMHA.

This possible conflict in the SMHA may be resolved by focusing on the requirement that the provision for the respondent's protection be "reasonable."[66] For example, dismissal of a commitment case and voluntary placement in a board and care home may be unreasonable if the respondent is unlikely to voluntarily continue in the treatment and care program. A commitment order requiring placement in the same board and care facility might be reasonable, however, because a commitment order activates statutory mechanisms for ensuring that the respondent participates in the program. The SMHA requires treatment staff to periodically reevaluate a committed person and report their findings to the court.[67] These reevaluations provide an opportunity to determine if the respondent is properly participating in the ordered program, especially when the program is in a community setting. Also, the court may direct in its commitment order that an inpatient facility detain the respondent long enough to evaluate him or her and develop a treatment plan, and then release the respondent on the condition that he or she take prescribed medication and report to a treatment facility on an

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65. See infra notes 71-74, 86-88 and accompanying text.

66. Wis. Stat. Ann. §§51.15(1)(a)3 & 4; 51.20(1)(a)2.c & d; 51.20(1)(1m) (West Cum. Supp. 1983-1984).

67. Id. at §51.20(17) (periodic reevaluations must be conducted within 30 days after the commitment order, within three months after the initial reevaluation, and again thereafter at least once each six months).

outpatient basis as often as required.[68] The order may direct that if the respondent fails to meet either of these conditions, the treatment director may request that a law enforcement officer take the respondent into custody and that the medication be administered involuntarily.[69] If the respondent fails to comply with the conditions, the respondent may be transferred back into the facility that detained him or her following the commitment order.[70] For many respondents, the mere fact that they have been judicially ordered into treatment may ensure participation in the program. These factors may make community placement pursuant to a commitment order appropriate when it would be inappropriate, or "unreasonable", on a voluntary basis. The reasonable provision in the community standard should provide respondents protection against unnecessary commitment orders when less supervision is needed.

B. Release Pending Commitment Hearing

Following a finding of probable cause, the court may release a respondent pending the final commitment hearing.[71] While released, the respondent has a right to receive voluntary treatment services.[72] On the other hand, the court may issue a conditional release order requiring the respondent to accept treatment and specifying the action to be taken if the respondent breaches a treatment condition.[73] If the court makes

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68. Id. at §51.20(13)(dm). See infra notes 88-89 and accompanying text.

69. Id.

70. Id. at §§51.20(13)(dm); 51.35(1)(a).

71. Wis. Stat. Ann. §51.20(8)(a) (West Cum. Supp. 1983-1984).

72. Id.

73. Id.

treatment a condition of release, the respondent may accept this condition or elect detention instead.[74]

An unconditional release is virtually never used in Milwaukee County, and the conditional release is only infrequently used. In most cases, if detention at Ward 53B is unnecessary, the probate court commissioner will authorize alternative placement by accepting a negotiated settlement. According to one commissioner, excluding cases in which no probable cause is found or in which a negotiated settlement is reached, the only situation in which a respondent would be released is if the harm threatened by the respondent's condition is related to situational factors that can be controlled. For example, if the threat of harm is presented by an adult child living with his or her parents and the threat may be eliminated by requiring the adult child to live elsewhere. He stated that release is rare because probable cause has been found to believe that the respondent is "dangerous."[75]

C. Mental Health Examination and Testimony

After a probable cause hearing in which the commissioner has found probable cause to believe the allogations that the respondent is a proper subject for involuntary commitment, two examiners are appointed to

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74. Id.

75. The dangerousness standard as articulated in the SMHA is much more flexible than the standard currently applied in Milwaukee County. Section 51.20(1)(a)2 contains four formulations from which the court may infer dangerousness. The meaning of dangerousness may vary within these formulations depending primarily upon the type of harm which may result from a respondent's condition and upon whether the respondent or some other person might suffer that harm. These criteria were formulated in contemplation of the least restrictive alternative doctrine. See id. at §51.001. Thus, in accordance with proper rules of statutory construction, the dangerousness standard should be construed to allow a finding that a respondent is dangerous, but that, under appropriate circumstances, he or she may be placed in treatment less restrictive than hospitalization.

independently examine the respondent.[76] If an examiner determines that the respondent meets commitment criteria, the examiner is required by the SMHA to make a "recommendation concerning the appropriate level of treatment ... . [including] the level of inpatient facility which provides the least restrictive environment consistent with the needs of the individual ... ."[77] Although statute requires that the examiners file independent reports of their examinations with the court,[78] it does not require that the examiners actually testify at the final hearing. If examiners do testify, however, each should testify concerning his or her belief regarding whether the respondent meets commitment criteria and regarding the appropriateness of various treatment modalities or facilities.[79]

Although the examiners appointed in Milwaukee County generally do testify at final hearings, their testimony that the author observed insufficiently addressed alternatives to the Milwaukee County Mental Health Complex.[80] This observation does not lead inevitably to the conclusion that the examiners have failed to consider alternatives. It points more directly toward the failure of counsel to challenge their testimony.

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76. Id. at §51.20(9)(a).

77. Id. at §51.20(9)(b).

78. Id. at §51.20(9)(a).

79. Id.

80. Although the author was able to observe several initial examinations of Ward 53B detainees and to interview three examiners who frequently conduct prehearing examinations, the author was unable to observe examinations conducted by court-appointed examiners.

Corporation counsel bears the burden of proving that the respondent meets commitment criteria and that the level of treatment he advocates, usually hospitalization, is the least restrictive treatment alternative appropriate given the respondent's condition.[81] Although this burden of proof technically lies with corporation counsel, as a practical matter, the responsibility for investigating and offering less restrictive alternatives falls on the respondent's counsel. The SMHA does not require corporation counsel as part of his case in chief to explore treatment alternatives less restrictive than that which he advocates. Rather, the ultimate responsibility lies with the court to determine whether corporation counsel's preferred treatment of the respondent, or some less restrictive modality, is appropriate.[82] Corporation counsel has neither the responsibility, nor the incentive, to present the court with less restrictive alternatives. Once corporation counsel has presented evidence supporting the treatment it advocates, the onus shifts to the respondent's counsel to rebut that evidence, and to present alternatives to the court. The respondent's counsel has the incentive to explore and present evidence of less restrictive alternatives to protect his or her client's liberty interests.

Although the court ordered involuntary hospitalization in all but one of the hearings the author observed,[83] the court reached this disposition not because corporation counsel presented sufficient

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81. Cf. Wis. Stat. Ann. §51.20(13)(e) (West Cum. Supp. 1983-1984) ("The petitioner has the burden of proving all required facts by clear and convincing evidence").

82. See id. at §51.20(13)(a), (c), & (dm).

83. The hearing that did not result in hospitalization resulted in the court approving a stipulated settlement.

treatment evidence, but because the respondent's counsel failed to present less restrictive alternatives evidence. In most of the cases, the treatment evidence that corporation counsel presented consisted of counsel asking the examiners, "Would you recommend the Milwaukee County Mental Health Complex for treatment?" The examiners unanimously responded, "Yes."

Such a leading question and affirmative response, without more, should be insufficient to carry corporation counsel's burden of proof if a respondent's attorney challenges the adequacy of that evidence and presents less restrictive alternatives to the court. During each of the hearings observed, however, the respondent's counsel simply failed to do so. In all of these hearings, and in most cases reaching the final hearing stage, respondents were represented by private attorneys, not by public defenders or Legal Aid Society attorneys. The failure of these attorneys to present even minimal evidence of less restrictive alternatives should probably be attributed to their relative inexperience in civil commitment cases and their lack of assistance by social workers in preparing for hearing.

Even before presenting alternatives evidence, these attorneys should effectively cross-examine the expert witnesses that corporation counsel has presented in support of hospitalization. Although attorneys representing respondents must determine case-by-case and witness-by-witness how, and whether, to cross-examine expert witnesses, they should carefully consider whether to probe conclusory and cursory treatment evidence. It may be very appropriate for a respondent's attorney to ask the expert witness to specifically detail how he or she reached the conclusion that hospitalization was the least restrictive

alternative sufficient for the respondent. For example, the attorney might ask the witness what alternatives, if any, the witness considered and why they were insufficient. The attorney may find that no explicit alternatives were considered.[84]

D. Commitment Order and Disposition

If commitment criteria are met, the court must order commitment to the care and custody of the community baord,[85] "or if inpatient care is not required order commitment to outpatient treatment under the care of such board ... ."[86] The community board then must arrange for treatment in the least restrictive manner consistent with the respondent's needs and the maximum level of inpatient facility, if any, designated in the court order.[87] If the court finds that the respondent's dangerousness can be controlled with medication administered on an outpatient basis, the court in its commitment order may authorize the community board to release the respondent on the condition that the respondent take prescribed medication and report to a particular treatment facility as often as required for outpatient evaluation.[88]

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84. One glaring example of a respondent's attorney failing to effectively cross-examine an expert witness occurred when the witness stated that he had seen the respondent for only 15 seconds--the respondent had merely told the examiner that he did not want to talk to him. Nevertheless, the witness stated not only that the respondent was committable, but also that he must be committed to the Milwaukee County Mental Health Complex. The respondent's attorney did not cross-examine.

85. The community board, or the Combined Community Services Board in Milwaukee, is appointed by the County Board of Supervisors to provide services for the program needs of mentally disabled persons. Wis. Stat. Ann. §51.42(5) (West Cum. Supp. 1983-1984).

86. Id. at §51.20(13)(a)3, 4, & 5.

87. Id. at §51.20(13)(c)2.

88. Id. at §51.20(13)(dm). See supra notes 68-70 and accompanying text.

During the hearings the author observed, the court did not appear seriously to consider alternatives to inpatient placement at the Milwaukee County Mental Health Complex. The court failed to distinguish "commitment," which may include alternative placement, from "hospitalization." This is not surprizing given that the negotiated settlement process has resulted in most respondents being diverted at the probable cause hearing to less restrictive care and treatment. Although the probability is higher that a respondent not diverted before the final hearing is not a proper subject for less restrictive placement, such speculation is not a proper working presumption in a final commitment hearing. Even after unsuccessful settlement negotiations, a respondent in Wisconsin is entitled to commitment in the least restrictive alternative sufficient to meet his or her treatment needs.[89]

For the court to make a well-informed placement decision, it must be presented with sufficient alternatives evidence. Expert testimony as described above[90] does not provide sufficient information for the court to order anything but hospitalization. If a respondent's counsel fails to present alternatives evidence, the court itself should inquire regarding alternatives.

The court and the respondent's counsel have responsibilities implicating the least restrictive alternative doctrine. Once a court orders commitment, however, all responsibility shifts to the community board.[91] The board must provide "the least restrictive treatment

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89. See id. at §§51.61(1)(e); 51.20(13)(a)3 & 4(c)(2); 51.001(1) & (2).

90. See supra notes 83-84 and accompanying text.

91. See supra note 87 and accompanying text.

alternative appropriate to the patient's needs, and movement through all appropriate and necessary treatment components to assure continuity of care."[92] A respondent must be periodically reevaluated to determine if he or she "has made sufficient progress to be entitled to transfer to a less restrictive facility or discharge."[93] The board may transfer any respondent committed to it between treatment facilities, including, but not limited to inpatient, outpatient, and rehabilitation programs,[94] 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.[95] As part of a transfer to a less restrictive alternative, the board may impose terms and conditions beneficial to the patient.[96] At the time of the conditional transfer,[97] the respondent must be informed of the consequences of violating the terms and conditions, including transfer back to a more restrictive setting.[98]

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92. Wis. Stat. Ann. §51.22(5) (West Cum. Supp. 1983-1984).

93. Id. at §51.20(17). See supra note 67 and accompanying text.

94. See id. at §51.01(19).

95. Id. at §51.35(1)(a).

96. Id.

97. Id. at §51.01(4).

98. Id. at §51.35(a)(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 respondent had notice at the time of the temporary transfer, then no due process rights attach. See id. at §51.35(1)(e). Certain due process rights do attach, however, to any other transfer to a more restrictive setting. Whenever a transfer is from outpatient to inpatient status, or whenever a transfer between treatment facilities results in greater restrictions of the respondent's personal freedom, the respondent 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 respondent is indigent), and to petition a court where the respondent is located, or the committing court, for a review of the transfer. Id.

Several interviewees told the author that the Combined Community Services Board (CCSB) of Milwaukee County has failed to achieve the use of alternatives as envisioned in the SMHA. One stated that the CCSB has an "institutional bias" that has persisted during the deinstitutionalization era. That is, the CCSB first funds the Mental Health Complex[99] then apportions residual funds among other programs. Other interviewees agreed that the CCSB has not given sufficient attention to alternatives but needs to do so.

Although the lack of available community alternatives is a common complaint in Milwaukee, the problem is not nearly as pronounced as in other cities across the country, particularly larger cities.[100] Although more resources are needed, many board and care homes and community-based residential facilities are used regularly in connection with stipulated settlements. The use of existing alternative resources following a commitment order may be improved, however.

The CCSB operates six catchment area clinics, which are available for patients transferred or referred from the Mental Health Complex or the community. Only a minority of the catchment area clinics' clients, about one in 12, come from the Mental Health Complex.[101] Respondents

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99. The Mental Health Complex administration determines how CCSB funds are allocated between the inpatient facility and six catchment area clinics operated by the Mental Health Complex.

100. See e.g., McGraw & Keilitz, supra note 12, at ___.

101. The remaining clients are referred by the criminal courts, private physicians, family members, and others.

referred from the Mental Health Complex, usually by a social worker or psychiatric intern, often do not show up for the initial appointment. If a respondent was referred by means of a conditional transfer and does not show, the clinic so informs the person who referred the respondent. That social worker or psychiatric intern then attempts to communicate with the respondent or the respondent's family. That effort may end the respondent's treatment. A respondent is rarely re-detained simply for not showing up at the clinic, but only if he or she begins acting out.

Respondents who do come to the clinic receive an initial assessment, then the staff develops a treatment plan. Treatment typically includes counseling, development of social skills, and administration of psychotopic medication. The staff member assigned to the client may arrange for housing, supervision, and additional support services for him or her.

The services provided by catchment area clinics represent a vital, albiet scarce, resource in Milwaukee County. The clinics could be an effective link between involuntary commitment in the Mental Health Complex and other community resources, if fiscal and administrative constraints, such as the ineffective follow-up with respondents who fail to keep appointments, are overcome. To round out the in-office services that the clinics now provide, these services should be supplemented or linked with in-home and on-site services.

IV. CONCLUSION

Since 1975, the SMHA has been the catalyst for involuntary civil commitment procedures in Milwaukee County. The practices that predominate civil commitment in Milwaukee, preliminary screening and

negotiated settlements, were not required by the statute, but flowed from the legislative policy favoring application of the least restrictive alternative doctrine. Many of the more detailed statutory provisions have, in practice, been of secondary importance.

The practitioners, courts, and legislatures of other jurisdictions can learn from the catalysis in Milwaukee. The message is that legislation need not be the focal point for positive reform in the commitment process. Most commitment statutes do not address a myriad of processing details. The very early stages of the commitment process in particular are largely ungoverned by settled law and are malleable without resort to the legislature.[102] Thus, actors in the commitment process should focus primarily on how to directly alter everyday practices to improve civil commitment, including the use of alternatives.

Legislative reform should not be abandoned as a long-range goal, however. To some extent, the tables may have now turned so that legislatures should learn from the "socialization"[103] of existing commitment statutes. For example, the Wisconsin Legislature might extend its purview to include the initial portion of the commitment process. To encourage other localities in Wisconsin to conduct preliminary screening

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102. See Institute on Mental Disability and the Law, Provisional Substantive and Procedural Guidelines for Involuntary Civil Commitment II-5 (1982) ("Provisional Guidelines"). Provisional Guidelines includes detailed guidelines and commentary that focus on practical rather than legislative measures for improving commitment processes throughout the country. The National Task Force on Guidelines for Involuntary Civil Commitment, with staff support from the Institute on Mental Disability and the Law, is redrafting Provisional Guidelines for final publication in early 1986.

103. Perlin, The Legal Status of the Psychologist in the Courtroom, 4 Mental Disability L. Rptr. 194, 194 (1980).

and seek early diversion from commitment,[104] the Legislature could specifically require such efforts. Also, the Legislature might require respondents' attorneys to investigate alternatives to hospitalization[105] and present them to the court.[106]

The Wisconsin Legislature might also articulate in statute a definition of "least restrictive alternative." The definition that has emerged in Milwaukee emphasizes that alternative treatment need only be adequate to be preferred to inpatient treatment.[107] Although this definition is proper under current law,[108] the emphasis may be contrary to the legislative intent. If the State places any restriction on a respondent's freedom, it would seem that the State should make its best effort to ameliorate the respondent's disabling condition by maximizing beneficial mental health treatment. Stromberg and Stone emphasize that the most effective treatment should be required.[109] Another recent proposal requires only "acceptable treatment objectives."[110]

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104. See supra notes 51-55 and accompanying text.

105. Arizona statute requires respondents' attorneys to investigate alternatives and makes failure to do so punishable as contempt of court. Ariz. Rev. Stat. Ann. §36-537B (1983).

106. See supra notes 81-84 and accompanying text.

107. See supra notes 47-48 and accompanying text.

108. See Wis. Stat. Ann. §51.001(2) (West Cum. Supp. 1983-1984).

109. Stromberg & Stone, supra note 47, at 291-94. See also, Mo. Rev. Stat. §630.005.1(18) (Supp. 1984).

110. Suggested Statute on Civil Commitment, 2(1) Mental Disability L. Rptr. 131 (1977).

The commitment statutes of most jurisdictions, including Wisconsin,[111] in some form require application of the least restrictive alternative doctrine but fail to define the term,[112] probably because when many of the statutes were enacted the concept was relatively new in the commitment context and was difficult to define in practical terms.[113] The Wisconsin Legislature now has a history of trial and error to draw upon in determining whether the legislative goals are being achieved and, if not, how to define least restrictive alternative to achieve those goals. The Legislature may look to actual practice, such as in Milwaukee County, to scholarly literature,[114] to the efforts of

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111. All states except Alabama, Mississippi, and Oregon have enacted states that require, in some form, that mental health treatment be administered in the manner or setting that is least restrictive of personal liberty. See Lyon, Levine, & Zusman, Patients' Bill of Rights: A Survey of State Statutes, 6 Mental Disability L. Rptr. 178, 181-83 (1982).

112. See McGraw & Keilitz, supra note 12, at __ app. But see infra note 115.

113. Cf. Shah, supra note 21, at 254.

114. See e.g., Rubin, Economics, Mental Health, and the Law (1978); Chambers, supra note 9; Hoffman & Faust, supra note 9; McGraw & Keilitz, supra note 12; Pepper & Ryglewicz, Testimony for the Neglected: The Mentally Ill in the Post-Deinstitutionalization Age, 52 Am. J. Orthopsychiatry 388 (1982); Stromberg & Stone, supra note 47; Suggested Statute, supra note 110; Ward, Developments in the Law--Civil Commitment of the Mentally Ill, 87 Harv. L. Rev. 1190)1974); and Hiday, Alternatives to Confinement for the Dangerous Mentally Ill (1981)(Association Paper, N.C. State U.).

other legislatures,[115] and to the variety of approaches suggested by the courts.[116]

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115. At least four legislatures have defined "least restrictive alternative." See Ga. Code §37-3-1(10) (1982) ("the least restrictive available alternative, environment, or care and treatment, as appropriate, within the limits of state funds specifically appropriated therefor"); Ky. Rev. Stat. §202A.011(7) (Interim Supp. 1982) ("that treatment which will give a mentally ill individual a realistic opportunity to improve his level of functioning, consistent with accepted professional practice in the least confining setting available");

> [A] reasonably available setting where care, treatment, habilitation or rehabilitation is particularly suited to the level and quality of services 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. For some mentally disordered or mentally retarded persons, the least restrictive environment may be a facility operated by the department.

Mo. Rev. Stat. §630.005.1(18) (Supp. 1984);

> [T]he habilitation or treatment and the conditions of habilitation or treatment for the client separately and in combination [that]: (1) are no more harsh, hazardous, or intrusive than necessary to achieve acceptable treatment objectives for such client; (2) involve no restrictions on physical movement nor requirement for residential care except as reasonably necessary for the administration of treatment or for the protection of such client or others from physical injury; and (3) are conducted at the suitable available facility closest to the client's place of residence.

N.M. Stat. Ann. §43-1-3(D) (1978).

116. See e.g., Rone v. Fireman, 473 F. Supp. 92, 125 (N.D. Ohio 1979) (treatment setting should not be overly restrictive on comparative basis); Eubanks v. Clarke, 434 F. Supp. 1022, 1028 (E.D. Pa. 1977) (if state has facilities significantly differing in restrictiveness, it must choose the least restrictive consistent with treatment objectives); Gary W. v. Louisiana, 437 F. Supp. 1209, 1217 (E.D. La. 1976) (required consideration of respondent's needs rather than automatic placement in institution); Davis v. Watkins, 384 F. Supp. 1196, 1203 (N.D. Ohio 1974) (required "the minimum limitation of movement or activity"); and Welsch v. Likens, 373 F. Supp. 487, 502 (D. Minn. 1974) (required "good faith attempts" to place respondents in suitable, least restrictive settings).

THE CHICAGO REPORT

THE APPLICATION OF THE LEAST RESTRICTIVE ALTERNATIVE DOCTRINE TO INVOLUNTARY CIVIL COMMITMENT: LAW AND PRACTICE IN CHICAGO*

INTRODUCTION

In the late 1960's the nation's mental hospitals began to be subjected to judicial scrutiny as a result of lawsuits on behalf of mentally disabled persons alleged to be inappropriately and unneccesarily confined and treated.[1] One of the legal doctrines which emerged from this litigation was the principle of using the least restrictive alternative--i.e., that treatment and care should be no more harsh, hazardous, intrusive, or restrictive than necessary to achieve legitimate therapeutic aims and to protect the patient or others from physical harm.[2]

The doctrine was first applied in mental health litigation in 1966 in Lake v. Cameron,[3] a case in which the appellant, a sixty-year old woman involuntarily committed to St. Elizabeths Hospital, argued that she should be treated in a less restrictive setting. In the majority opinion, Chief Judge David Bazelon, of the United States Court of Appeals for the District of Columbia, wrote that "[d]eprivations of liberty solely because of dangers to the ill persons themselves should not go

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beyond what is necessary for their protection."[4] Since the Lake v. Cameron decision, both federal and state courts have applied the doctrine to initial commitment decisions,[5] institutional placements,[6] criteria for release,[7] and the use of medication and physical means to restrain residents of institutions.[8] All states except Alabama, Mississippi, and Oregon have now enacted statutes which require that the mental health care and treatment provided be the least restrictive alternative available to achieve legitimate purposes.[9]

Coincident with these legal developments was the increasing acceptance of "deinstitutionalization" of mentally disabled persons--i.e., the transfer of patients from hospitals and their placement in community based outpatient or inpatient care settings.[10] This concept had several roots, including recognition of the inadequate conditions in many mental health facilities, misgivings about the need for long-term hospitalizations, the development of psychotropic medications which could relieve many of the effects of mental illness, and the desire to find lower cost treatment alternatives.[11] By the late 1960's, the Community Mental Health Centers Act, signed into law in 1963,[12] and increased support at the state and federal level for community-based care had made deinstitutionalization a national policy.[13]

These two concepts, one emerging from law, the other from social policy, have increasingly been joined in expressions of public policy and legislative intent.[14] The translation of these concepts into relevant and effective programs and procedures has, however, faced difficulties. As Saleem A. Shah, then the head of the Center for Studies of Crime and

Delinquency, National Institute of Mental Health, has written, "while the doctrine prescribing use of the 'least restrictive alternative' has fairly clear meaning in reference to certain legal and constitutional values concerning infringement of personal freedom and liberty, the notion does not translate readily into mental health procedures and programs."[15]

Whether the translation of concepts in the mental health law field into practice is more problematic than any other concept is, of course, arguable. However, several commentators have found the "gap problem"[16] in mental health law, especially the involuntary civil commitment process, particularly vexing.[17]

Another difficulty in translating legal and social concepts into reality is the unavailability of resources, the barriers of formidable state and federal bureaucracies, and the sheer size and complexity of the cooperative effort required. As Shah has observed, "it is one thing to legislate or judically mandate legal and other policy changes; it is quite another matter to secure their actual implementation. Thus, as important as reforms in legal policies (viz., 'the law on the books') certainly are, these accomplishments must not be confused with the end result (viz., the 'law in practice')."[18]

In October, 1982, the National Center for State Courts undertook a national scope project to develop a model for applying the "least restrictive alternative" doctrine in involuntary civil commitment proceedings. The project was funded by the Administration on Aging and the Administration on Developmental Disabilities, United States Department of Health and Human Services. Project staffs examined the

civil commitment systems in seven jurisdictions (Chicago, Kansas City, Milwaukee, New York City, Tucson, and Williamsburg/James City County, Virginia) in order to assess the use of the doctrine and determine how its effectiveness may be improved. This monograph reports the results of our fieldwork in Chicago. It presents an overview of the statutory procedures and standards, a description of the statutory provisions and actual practices regarding use of the least restrictive alternative, and our conclusions.

I. OVERVIEW OF THE INVOLUNTARY CIVIL COMMITMENT PROCESS IN CHICAGO

In Illinois, a person is subject to involuntary admission if the individual is "mentally ill, and . . . because of his illness is reasonably expected to inflict serious physical harm upon himself or another in the near future, or . . . who because of his illness is unable to provide for his basic physical needs so as to guard himself from serious harm," or who is mentally retarded and "is reasonably expected to inflict serious physical harm upon himself or another in the near future" and for whom immediate admission is necessary to prevent such harm."[19]

Commitment proceedings may be initiated by any person at least eighteen years of age.[20] The first step is to prepare a petition which includes a "detailed statement of the reason for the assertion that the respondent is subject to involuntary admission . . . [and] a description of acts or significant threats supporting the assertion . . ."[21] The petition may either be filed directly with the court or with the director of a mental health facility.[22] The petition must be accompanied by a

certificate signed by a physician, qualified or clinical psychologist which states that the respondent is subject to an emergency involuntary admission.[23] (For persons who are mentally ill, a certificate may also be executed by a certified social worker or registered nurse who meet certain educational and experience requirements.[24] Upon receipt of the petition and certificate, a peace officer is authorized to transport the person to the appropriate facility.[25] If a certificate has not been acquired, the individual may be held for no more than twenty-four hours.[26] For persons alleged to be mentally ill and subject to involuntary admission, a second certificate must be filed if the individual is to be held for treatment for more than twenty-four hours.[27] At least one of the two certificates must be completed by a psychiatrist.[28]

A court also can initiate involuntary admission proceedings "when as a result of personal observation and testimony in open court . . . [it] has reasonable grounds to believe that a person appearing before it" meets the involuntary commitment standard.[29] Again, however, the person may be detained no longer than twenty-four hours if no petition and certificate is filed following the court's action.[30]

There are many procedural safeguards built into the system to protect the rights of patients and prospective patients. For example, within twelve hours after the admission of a person to a mental health facility, either by emergency certificate or by court order, the facility director must give the person a copy of the petition and a clear and concise written statement explaining the person's legal status, right to counsel, and right to a court hearing.[31] Futhermore, following any changes in

legal status, the person is provided with the address and phone number of the appropriate advocacy agency and is assisted in contacting that agency upon request.[32] In addition, prior to an examination, respondents must be informed "in a simple comprehensible manner of the purpose of the examination; that . . . [they do] not have to talk to the examiner; and that any statements [made] may be disclosed at a court hearing on the issue" of eligibility for involuntary admission.[33] Mentally retarded persons must be advised, in addition, that they are "entitled to consult with a relative, friend or attorney before the examination, and that an attorney will be appointed . . ." upon request.[34] Failure to so advise a respondent bars the examiner from testifying "at any subsequent court hearing concerning the respondent's admission."[35]

The next step following the filing of the second examination certificate for respondents alleged to be mentally ill is the setting of the date for a hearing. Hearings must be held within five days (excluding weekends and holidays) after the filing of the second certificate or the respondent's admission to a mental health facility, whichever occurs first.[36] For respondents alleged to be mentally retarded, the next step after the filing of the petition and certificate is a thorough evaluation including "appropriate psychological, physical, neurological, social, educational, and developmental evaluations."[37] The evaluation report must include, among other things, a description of the methods used in the evaluation, "the person's disability and need for services, if any . . . [and] a recommendation as to the least restrictive living arrangement appropriate for the person."[38] The report must be filed no more than seven days after the respondent has been admitted and

a hearing within five days of the filing of the report.[39] At any time prior to the hearing, a respondent may request admission as an informal or a voluntary patient (mentally ill) or as an administratively admitted patient (mentally retarded). "If the facility director approves such a request, the court may dismiss the pending proceedings but may require proof that such dismissal is in the best interests of the [patient] and of the public.[40] "Informal" admittees may leave the facility at any time.[41] "Voluntary" and "administrative" admittees must file a written notice or objection with the treatment facility indicating their desire to leave. Following this announcement of intent, the facility has five days in which to file a petition for involuntary or emergency commitment. If such a petition is not filed, the individual must be discharged.[42]

Pending the hearing on a petition for involuntary or emergency admission, the facility may provide treatment/habilitation to a respondent. However, the respondent has the right to refuse medication (unless such medication is necessary to prevent the respondent from "causing serious harm to himself or others") and to be informed of that right.[43]

Respondents must be represented by counsel unless the court accepts an informed waiver of the right to counsel. The court must appoint an attorney for indigent or unrepresented respondents who have not requested to represent themselves.[44]

The respondents are to be present at the hearing, "unless their attorney waives their right to be present and the court is satisfied by a clear showing that attendance would result in a "substantial risk of

serious physical or emotional harm."[45] Additionally, the respondent has a right to have the determination of his or her eligibility for commitment made by any person, jury,[46] and to have an independent examination by an unpartial expert appointed by the court.[47] Respondents cannot be involuntarily admitted unless it has been established by clear and convincing evidence that they meet the statutory standard.[48]

If a person is found eligible for commitment, the appropriate disposition must be determined. For mentally ill persons, the director of the facility in which the respondent is hospitalized, or such other person as the court may direct, must prepare a report prior to disposition including information about the appropriateness and availability of less restrictive alternatives to hospitalization, and describing the respondent's needs, treatment, and an appropriate timetable for treatment.[49] For mentally retarded persons, this information is contained in the evaluation report described earlier.[50] The judge must then order the least restrictive alternative for treatment/habilitation which is consistent with the respondent's needs.[51]

For mentally ill persons found subject to involuntary commitment, treatment in a less restrictive mode, such as care and custody through an outpatient clinic, as well as treatment in a hospital, will continue as ordered by the judge until either the sixty day statutorily prescribed commitment period ends, the symptoms remit, or an attempt is made to change the patient's status.[52] A current treatment plan must be filed by the facility director for a hospitalized respondent thirty days after

an involuntary admission.[53] If, during the course of outpatient treatment, it is decided that the patient requires hospitalization after all, a court hearing must be held to determine whether or not hospitalization should be ordered.[54] The initial commitment order may be extended for an additional sixty days. Subsequent extensions may be for periods up to 180 days. For a commitment to be extended, a new petition and new certificate must be filed along with a current treatment plan showing the patient's progress, and a hearing held before the court.[55]

For mentally retarded persons found subject to emergency admission, the admission period to either a developmental disabilities facility or a nonresidential habilitation program, may last up to 180 days. The admission order may be extended for additional 180 day periods subject to procedures identical to those outlined above.[56] A habilitation plan must be filed for persons admitted to a developmental disabilities facility within sixty days of admission.[57]

A person may be discharged from treatment/habilitation before the end of the commitment period whenever the facility director concludes he or she no longer meets the statutory commitment standard.[58] Persons whom facilities continue to treat on an involuntary basis may seek their release in several ways. They have the right to appeal the original commitment decision;[59] they may file a petition for discharge, which will guarantee a prompt judicial hearing on the question of whether the patient still meets the criteria of being subject to involuntary admission;[60] and they may file a writ of habeas corpus, which may also result in a judicial hearing.[61]

II. THE LEAST RESTRICTIVE ALTERNATIVE DOCTRINE IN STATUTE AND PRACTICE

The doctrine of using the least restrictive alternative appears throughout the provisions of the Illinois Mental Health and Developmental Disabilities Codes pertaining to involuntary commitment of mentally ill persons and emergency admission of mentally retarded persons. It has been found to constitute a "state created liberty interest," at least in some circumstances, for purposes of applying due process guarantees.[61A] Specifically, the doctrine is applied to: a) the provision of mental health or habilitation services on a voluntary basis prior to the initiation of an involuntary commitment proceeding; b) diversion to voluntary services after a petition has been filed but prior to the court hearing; c) the formulation and modification of a dispositional order following a finding that a person is subject to involuntary commitment; d) the conditional or temporary release of persons subject to a commitment order; e) the rights of persons subject to commitment; and f) the development of a continuum of services.

A. Provision of Services Prior to Initiation of A Commitment Proceeding

The Illinois Code includes a Community Mental Health Act which seeks to foster the development of community based mental health and habilitation services.[62] Nineteen Community Mental Health Centers are located throughout Chicago. The CMHCs provide a variety of crisis intervention, evaluation counseling, therapy, medical community education, life skills development and outreach services. These services are primarily directed toward persons who are mentally ill and their

families, although some CMHC's have programs for mentally retarded individuals as well. Also at the time of our site visit there was one triage center which in addition to providing diagnostic counselling and community linkage services, offered short term inpatient services intended to stablize persons in crisis and direct them toward community based resources. The large number of centers, along with their community orientation, makes it easy for people seeking help to receive it, and probably lowers the demand for extensive inpatient care.[63] By providing evaluation services, at least for persons who may be mentally ill, these Centers also serve an important screening function that can direct individuals to sevices before an involuntary commitment proceeding is begun.

With the closing of additional long-term facilities for the mentally ill and the developmentally disabled, and the general tightening of social benefit program budgets, many of these Centers are being faced with increasing numbers of clients and static if not decreasing resources on which to draw. As in other cities around the country, low-cost housing and small community-based residential treatment programs are in short supply.[64] One CMHC staff member observed that Illinois' new mental health code has been successful in clearing out the back wards but has not provided enought money to assist people in the community. The absence of such housing and program increases the likelihood of recurrent institutionalization of persons who could be served by less restrictive community resources.

B. Diversion To Voluntary Services After The Filing Of A Commitment Petition

Diversion out of the involuntary civil commitment process may occur at anytime prior to adjudication.[65] Although as indicated in the overview section, the provisions of the MH&DD Code governing the proceedings for mentally ill and mentally retarded persons are largely parallel, the issue of diversion is limited to the processing of mentally ill persons, because, in Chicago, few mentally retarded individuals face emegency admission proceedings. Long-term placements of mentally retarded persons are almost entirely the result of an administrative ("voluntary") admissions initiated by their guardians.

For allegedly mentally ill respondents, the first opportunity for diversion occurs during the initial screening examination. Most screening occurs at the Illinois State Psychiatric Institute or at the Tinley Park and Chicago-Read Medical Center. Estimates of the percentage of persons presented to an inpatient mental health facility for emergency commitment who were referred following the initial screening to outpatient services or to the care of family and friends ranged from ten to twenty-seven percent. (The percentage of those initially presented to a Community Mental Health Facility who are not referred for inpatient care is probably even higher.) Another substantial percentage choose to sign themselves in as voluntary admittees. The informal admission option is seldom if ever used, at least at Chicago public facilities for mental health commitments.[66] Hospitals are apparently unwilling for mentally ill persons in need of inpatient care to be able to leave at will. The informal status is used more often for persons needing treatment for substance abuse in Chicago.

When an individual is referred to an outpatient clinic following screening, it is the practice of at least one screening hospital to call the outpatient clinic to notify it that the individual is coming and to make certain that a staff member will be available. The referred individual is given directions to the clinic, and, if necessary, cabfare as well. Before leaving, he or she is asked to sign a release of information from the hospital.

After admission, the respondent's status and rights must be explained to him or her by hospital staff.[67] Usually this explanation is repeated by counsel during their initial interview with their client.[68] The MH&DD Code provides that an allegedly mentally ill or mentally retarded respondent may request "informal or voluntary admission" (mentally ill) or "administrative" admission (mentally retarded at any time prior to a judicial determination that he or she is subject to involuntary admission. If the facility director approves the request, the court may dismiss the pending proceeding.[69] Accordingly, respondents are often told that they have the option of becoming voluntary of administrative patients, and that a major benefit will be that they will be able to leave the facility by giving five days notice. The degree to which they understand, or are informed at least, that this five day period is to provide the facility with the option of filing a new involuntary/emergency commitment petition is unclear. At least some patient attorneys believed that their respondents are sometimes subtley prodded into signing the change of status request.

Whether such encouragement is good or bad depends on the circumstances and one's viewpoint. For those individuals in need of

inpatient care, the voluntary or administrative status does represent a less restrictive alternative since they have greater control over their release and avoids the stigma of an involuntary commitment. For the facility staff it saves time and paperwork, and may result in a more effective treatment/habilitation relationship. For those individuals, however, who may be able to take advantage of outpatient services and who do not fully understand the restrictions imposed under a voluntary/administrative status, the change in status may not represent a less restrictive alternative. As a formal safeguard against coerced conversion to a voluntary status following an application to change an involuntary to a voluntary status, counsel regularly file a form confirming that the attorney has explained "to the respondent his/her rights as a voluntary patient, [and] . . . his/her right to demand a ccourt hearing . . ." or the involuntary commitment petition. The attorney must also state that the filing of the application was "the respondent's free, willing and informed act."[70] An informal safeguard is that the demand for public mental health and developmental disabilities beds in the Chicago area is so great that the facilities have little interest in or incentive to hold individuals not requiring inpatient services.

Another procedure, encouraged for mentally ill persons by at least some hospitals, is a stipulation negotiated between the state's attorney and the respondent's attorney. The stipulation provides that there will be no formal adjudication of the petition if the respondent agrees to go to an outpatient clinic for a specified length of time. The stipulation is submitted to and signed by a judge. The petition is subsequently

dismissed. This procedure is used for persons who show some indication of mental illness requiring treatment but not hospitalization, but who are not willing to avail themselves of outpatient services at a CMHC.

C. Formulation and Modification of Dispositional Orders

As outlined earlier, 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."[71] If the court finds the respondent to be "subject to involuntary admission," the court must consider the report in determining an appropriate disposition, and order "the least restrictive alternative for treatment which is appropriate."[72] the court must consider "alternative mental health facilities which are appropriate for and available to the respondent, including but not limited to hospitalization." 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."[73] 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."[74]

If a court has ordered a mentally ill 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. Before the court may modify

its order, it 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.[75]

With regard to mentally retarded persons found subject to emergency admission, before determining a disposition, the court must consider the diagnostic report and recommendations of any court-appointed examiners. It must then "select the least restrictive alternative which is consistent with the respondent's needs."[76] In the above described statutory sections, the court must conclude that a non-residential habilitation program is "capable of providing adequate and humane habilitation appropriate to the respondent's condition," and has continuing authority to modify a dispositional order if a mentally retarded individual fails to comply or is found to be "unsuitable for such habilitation."[77]

In the hearings we observed, the respondent's treatment history and the actions leading to the current commitment proceeding were presented by a certified social worker. the issue of whether alternatives to the state hospital were appropriate usually arose through a question from the assistant State's Attorney to the psychiatrist or clinical psychologist who examined the respondent. In response the examiner generally stated that non-hospital alternatives were not appropriate: 1) because of the nature of the respondents condition (e.g., suicidal); or 2) because of the respondent's past failures to adhere to a nonresidential treatment program (e.g., neglected to take medication, skipped sessions, went on a drinking binge). Seldom were the attributes or availability of specific programs discussed other than where the respondent might live if he or she were not committed.

The issue of whether treatment outside the hospital may be appropriate was often explored, however, by respondent's counsel during cross-examination of the examiner or in presenting the respondent's case. Sometimes the issue was addressed directly; other times counsel asked a series of questons regarding the actual availability of appropriate treatment programs in the state hospital, arguing that if the inpatient services were not directly focused on the respondent's needs, the hospital was not the most appropriate treatment site.

In making dispositional orders, judges were willing to consider less restrictive alternatives but were constrained from using them frequently by a number of factors. The first of these factors is the absence of effective mechanisms for enforcing conditional orders and outpatient placements. The primary enforcement tool used is to require the respondent to report to the court once a week or every two weeks, with a note from the treatment program stating that he or she is showing up for appointments and making progress. This continues for six to twelve weeks unless need for hospitalization becomes evident. In some instances, such a probationary disposition is made permanent to a conditional order following a finding that the individual is subject to commitment. In other instances, this type of program is ordered persuant to a stipulation prior to a finding that the respondent is mentally ill and dangerous. Many respondents are willing to comply with the reporting requirements to avoid hospitalization. If a person fails to report, however, and drops out of the treatment program, the limited follow-up sevices available make it difficult to bring that individual back to court to modify the order, particularly when he or she has no fixed place

of residence. Although the court may cite a person for civil contempt and issue an arrest warrant, this remedy is apparently used infrequently if at all. Accordingly, little is done until the individual's conduct triggers a new commitment petition.

The second factor is the paucity of community based residential treatment facilities for indigent mentally ill persons. Judges are understandably reluctant to release persons who have no place to go. There is currently no network of public alternative residential facilities, or private board and care homes under contract to the city or state to serve this population group. The few residential programs that are available to persons receiving SSI benefits[79] usually have long waiting lists. Thus, when a respondent has no family available and willing to provide assistance, care and supervision, the choice is usually between a hotel or rooming house catering to welfare clients, the hospital, or the streets. Judges on occasion direct the hospital social worker to arrange for outside housing for a respondent, but it is a time-consuming and difficult task, particularly when the respondent has not been cleared for SSI payments.

The third factor is the emphasis on screening and diversion prior to the hearing. Because of the extensive CMHC program in Chicago, people who might benefit from outpatient treatment alternatives are likely to receive treatment from the CMHC's Triage, or other available programs. Thus, most of the people who reach the judicial hearing stage are seriously ill and currently unable or unwilling to take part in community-based treatment. There is an inherent danger that the operation of the system in this manner may lead to a tacit presumption

that hospitalization is required. Indeed, we were told that the failure to give adequate consideration to less restrictive alternatives is often agreed when a commitment order is appealed. There is no reason to believe that such an assumption influences cases generally; it may be a factor against which judges, counsel and examiners must be on guard.

The final factor is the short duration of most commitments. We were told that most respondents are hospialized for no more than ten to twenty-two days. Thus, in close cases, the anticipated brief term of confinement and the authority of the facility director to discharge the individual[80] may outweigh the risk of non-participation if a non-residential alternative is ordered.

D. Conditional and Temporary Release

In addition to authorizing a facility director to discharge an involuntarily admitted person when that person no longer meets the statutory criteria for involuntary or emergency admission,[81] the Illinois MH&DD Code provides that a facility director may temporarily release a mentally ill patient who is not appropriate for discharge if such a release is considered clinically appropriate[82] and may release a developmentally disabled client when it is "appropriate and consistent with the habilitation needs of the client."[83] The Code further authorizes directors of facilities for developmentally disabled persons to grant a "conditional discharge" if he or she determines that such a discharge is appropriate and consistent with the patient's needs.[84] "Conditional discharge" means placement out of a facility for continuing habilitation under the facility's or department's supervision.[85] 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. These qualified 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."[86]

In Chicago, the authority to temporarily release an involuntarily committed mentally ill patient appears to be seldomly invoked. The primary reason is the brief period of hospitalization experienced by most involuntary committed respondents. In few cases are patients hospitalized long enough to require submission of the thirty day update of their treatment plan.[87] Discharge planning is begun by staff members of one large mental health facility almost immediately upon admissions. When necessary, the SSI eligibility process is initiated by the hospital on behalf of the patient. Preceding discharge, the patient is introduced to the liaison from the Community Mental Health Center serving the catchment area in which the patient lived prior to hospitalization.[88] The liaison will explain the services available at the CMHC, help set up an initial appointment, and serve as an initial contact person for the patient upon release. If required upon release, the patient is given enough medication to last a few days, and the address and the name of the contact person at the appropriate CMHC. The CMHC receives a form and discharge notice, and is asked to notify the hospital if the initial appointment is not kept.[90] The hospital does not have staff available to provide post release follow-up and case management. Several interviewees commented that because of the limited

bedspace and staff available at the hospitals, some patients were released prematurely, or with insufficient discharge planning, or on levels of medicaion that inhibited their ability to function in the community. Moreover, with increasing caseloads and decreasing social services available, CMHC's find it more and more difficult to provide the initial case management and stablization-in-the-community assistance required.[91]

E. Patients' Rights

In addition to guaranteeing recipients of treatment and habilitative services the right to "adequate and humane care and services in the least restrictive environment,"[92] the Illinois MH&DD Code specifies that such services must be provided pursuant to an individual services plan that must be "periodically reviewed with the participation of the recipient to the extent feasible and, where appropriate, such recipients' nearest kin or guardian.[93] In addition, the Code sets forth several specific rights that 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.[94] Among these are the rights to not be deprived of any constitutional or statutory rights merely because of receipt of mental health services;[95] to receive, possess, and use personal property while residing in a facility;[96] 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);[97] to be free from restraint unless used only as a therapeutic measure;[98] to be free from seclusion unless used only as a therapeutic measure to prevent harm to the recipient or others;[99] and to not be "subjected to electroconvulsive therapy, or to any unusual, hazardous, or experimental services or psychosurgery, without his written and informed consent."[100]

We did not have an opportunity to explore these rights during the course of the field research, except with regard to the development and revision of treatment plans. discussion of the implementation of those guarantees are contained in paragraphs C) and D), supra.

F. Development of a Continuum of Services

The Director of the Department of Mental Health is required to establish a pilot program "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."[101] As part of this project, a case coordination system linking care at each point in the continuum of alternatives must be established. The purposes of the program is to encourage care in less restrictive components of the continuum. The Director is required to designate an employee of the department to supervise and coordinate this program.[102]

Several of the persons interviewed during the study commented about the fragmentation of the mental health and developmental disabilities services delivery system in Chicago. Licensing and overnight authority is split not only on state, county and city lines, but on the state level, among the Department of Mental Health and Developmental

Disabilities, the Department of Public Health and the Department of Children and Family Services, depending upon the resources offered, the population served, and the choice of the facility operator. This hampers the development of community-based residential programs that address the physical, mental health, and socialization needs of their clients. This also hampers the monitoring of program quality and building safety, the enforcement of patient rights, and the ability to release indigent hospitalized patients because the facility that may have the appropriate services lacks the license necessary to receive funds from the agency responsible for assisting the individual involved.

At the time of the study, two efforts were underway in metropolitan Chicago to provide greater coordination and a broader array of services. The first, sponsored under the above cited provisions, was referred to as the "Elgin Model." Under this plan, coordination procedures were established among twelve agencies providing aftercare services to facilitate transfers of individuals and a program of continuing care. The second, established under the auspices of the state's Bureau of the Budget, is the Northside Triage and Crisis Stabilization Facility. This facility, housed in a nursing home, provides a small (8 beds) inpatient unit designed for short term stays to stabilize crisis situations, evaluation services, highly active care management, referral and community linkage services, supervision for a few shared apartments, and short-term post-release counseling services. Also of note are the programs operated by the Institute of Psychiatry of Northwestern Memorial Hospital, and by Thresholds, a program directed at reducing readmission of chronically mentally ill persons[103] and for easing the transition from the hospital to the community.

III. CONCLUSION

The key problem in applying the least restrictive alternative doctrine in Chicago is the lack of resources. The Illinois Mental Health and Developmental Disabilities Code explicitly recognizes the applicability of the doctrine at key decision-making points throughout the process. The individuals responsible for making placement decisions recognize and accept the doctrine. For the most part, the informal practices through which the involuntary civil commitment process operates are consistent with the doctrine. But, particularly after a case has reached the hearing stage, and following an involuntary commitment or emergency services order, there are insufficient personnel on both the hospital staff and the Public Defender staff to thoroughly explore the community sevices that are appropriate and available to assist an individual respondent or provide necessary follow-up assistance. Even if the needed staff were added, the current level of community services is not sufficient to meet the demand. The most pressing need is for structured community based residential settings in which individuals can develop, or redevelop, the skills needed for coping with the problems of daily life. Increasingly, the population involved in the civil commitment process in Chicago and elsewhere are without family support, and are unable to find decent housing given their limited fiancial resources. The experience of assertive community treatment programs[104] and of independent patient support groups suggests that the cycle of hospitalization, release, arrest or readmission, release etc., can be broken and that the drain on overall public services reduced. The

network of CMHC's in Chicago provide a strong base. What is needed is to build upon this base by providing either directly or by contract, publicly supported or subsidized supervised housing. As indicated earlier, some community based residential settings are available, particularly for mentally retarded persons, but more are required if the continuum of services envisioned by the Illinois Code and implicit in the least restrictive alternative doctrine is to become reality.

Footnotes

1. See e.g., Lake v. Cameron, 364 F.2d 657 (D.C.Cir. 1966); Covington v. Harris, 419 F.2d 617 (D.C. Cir. 1969); Wyatt v. Stickney 325 F. Supp. 781 (M.D. Ala. 1971); 334 F. Supp. 341 (M.D. Ala. 1971); 344 F. Supp. 373 (M.D. Ala 1972) aff'd sub nom. Wyatt v. Aderholt 503 F.2d 1305 (5th C.F. 1974). New York Association for Retarded Children v. Carey, 393 F. Supp. 715 (E.D. N.Y. 1975); Lessard v. Schmidt 349 F. Supp. 1078 (E.D. Wis. 1972); vacated 421 U.S. 957 (1975); on remand 413 F. Supp. 1318 (E.D. Wis. 1976); Pennhurst State School Hospital v. Halderman, 451 U.S. 1 (1981); Youngberg v. Romero ___ U.S. ____, 102 S. Ct. 2452 (1982); O'Connor v. Donaldson, 422 U.S. 563 (1978). For a brief survey of the "least drastic means" concept's application by the federal courts see Hoffman & Foust, Lease Restrictive Treatment of the Mentally Ill: A Doctrine in Search of Its Senses, 14 San Diego L.Rev. 1100, 1101 (1977); see also Chamber, Alternatives to Civil Commitment of the Mentally Ill: Practical Guides and Constitutional Imperatives, 70 Michigan L. Rev. 1107 (1972).

2. See Mental Health Law Project, Suggested Statute on Civil Committment, 2 Men. Dis. L. Rptr. 127, 129 (1977); see also Hoffman & Foust, id., at 1101.

3. 364 F.2d 657 (D.C. Cir. 1966).

4. Id., at 660.

5. E.g., Lessard v. Schmidt, 349 F. Supp. 1078 (E.D. Wis. 1972); vacated on other grounds 421 U.S. 957 (1975); on remand 413 F. Supp. 1318 (E.D. Wis. 1976). Welsch v. Likens 373 F. Supp. 487 (D. Minn. 1974).

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

7. Wyatt v. Stickney, 334 F. Supp. 341 (M.D. Ala. 1971); 344 F. Supp. 373 (M.D. Ala. 1972); aff'd sub nom. Wyatt v. Aderholt 503 F.2d 1305 (5th Cir. 1974).

8. Youngberg v. Romero, ___ US. ____, 102 S. Ct. 3452 (1972).

9. Lyon, Leone, and Zusman, Patient's Bill of Rights: A Survey of State Statutes, 6 Men. Dis. L. Rptr. 1978, 181-183 (1982).

10. Kiesler, Mental Hospitals and Alternative Care: Noninstitutionalization as Potential Public Policy for Mental Patients, 37 American Psychologist 349 (1982).

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12. ___ U.S. ____ ( ).

13. Kiesler, McGuire, Mechanic, Mosner, Nelson, Newman, Rich, and Schulberg, Federal Mental Health Policymaking: An Assessment of Deinstitutionalization, 38 Am. Psychologist 1291 (1983).

14. Kiesler, supra note 10; Kiesler, et. al. supra note 13; McGraw and Keilitz, The Least Restrictive Alternative in Los Angeles County Civil Commitment, 6 Whittier L. Rev. 35 (1984).

15. Shah, Legal and Mental Health System Interactions: Major Developments and Research Needs, 4 Inst'l. J. of Law and Psychiatry 219, 253 (1981).

16. See Generally, Abbe, Redirecting Social Studies of Law, 14 Law and Society Rev. 805 (1980).

17. Monohan and Loftus, The Psychology of Law, 33 Ann. Rev. of Psychology 441 (1982); Shah, supra note 15, at 254; see also Keilitz and Van Duizend, Current Trends in the Involuntary Civil Commitment of Mentally Ill Persons, ____ Rehabilitation Psychology _____ (1984).

18. Shah, supra note 15, at 255 (notes omitted).

19. Ill. Rev. Stat. ch. 91 1/2, §§ 1-119 and §4-400(a) (1983).

20. Id. §§ 3-601(a), 3-70(a), 4-401, and 4-501.

21. Id.

22. Id., at §§ 3-601; 3-701; 4-401; 4-501. Directors of mental health facilities can assist prospective petitioners in filling out the form. Id. .

23. Id., at §§ 3-602 and 4-402. The examiner who executes the certificate must have conducted the examination less than 72 hours prior to admission. Id. In some circumstances the patient may be allowed to remain at home until the committment examination. Id. §§ 3-704(a); 4-504.

24. Id., at §§ 1-122 and 3-602.

25. Id., at §§ 3-605 and 4-404.

26. Id., at §§ 3-604; 3-607; 3-704; 5-502; 4-504

27. Id., at § 3-610; 3-703.

28. Id.

29. Id., at § 3-607 and 4-405.

30. Id.

33. Id., at §§ 3-208 and 4-210.

34. Id., at § 4-210.

35. Id., at §§ 3-208 and 4-210.

36. Id., at §§ 3-611 and 3-706.

37. Id., at §§ 4-300, 4-407(b); and 4-502(b).

38. Id., at § 4-301(a).

39. Id., at §§ 4-407 and 4-505.

40. Id., at §§ 3-801, 4-601.

41. Id., at § 3-300.

42. Id., at §§ 3-403; 4-306.

43. Id., at §§ 3-608; 4-408.

44. Id., at §§ 3-805; 4-605.

45. Id., at §§ 3-806; 4-606.

46. Id., at §§ 3-802; 4-602.

47. Id., at § 804; 4-604.

48. Id., at §§ 3-808; 4-608. For the statutory standards, see note 19, supra and the accompanying text.

49. Id., at § 3-810.

50. Id., at § 4-609(b); see note 38, supra and accompanying text.

51. Id., at §§ 3-811; 4-609(b).

52. Id., at 3-812, 3-813, 3-815.

53. Id., at § 3-814.

54. Id., at § 3-815.

55. Id., at § 3-813.

56. Id., at § 4-611.

57. Id., at § 4-612.

58. Id., at §§ 3-902(b); 4-701(b).

59. Id., at §§ 3-816(b); 4-613(b).

60. Id., at §§ 3-900; 3-901; 4-705; 4-706.

61. Id., at §§ 3-905; 4-617.

61A. Johnson v. Brelje, ___ F.2d ___ (7th Cir. 1983).

62. Ill. Rev. Code ch. 91 1/2, §§ 300.1 et. req. (Smith Hurd 1983).

63. J. Zimmerman, Involuntary Civil Commitment in Chicago (NCSC, 1982).

64. For example, in 1982, there were just under 1500 beds available statewide in small community-based residential programs for developmentally disabled adults. Small community residential programs included in this figure are: Intermediate Care Facilities for the Developmentally Disabiled of 15 beds or less, Community Living Facilities, Supportive Living Arrangement, and Home Individual Placements. PACT Journal, 6-7 (Sept. 1982).

65. Ill. Rev. Stat., ch. 91 1/2, §§3-801; 4-601 (1983).

66. Down state facilities may use this alternative in mental illness cases at least occasionally.

67. Ill. Rev. Stat., ch. 91 1/2, §§2-200; 3-205, 4-406; 4-503; andd 4-601.

68. See Zummerman, supra note 63.

69. Ill. Rev. Stat., ch. 91 1/2, §§3-801 and 4-601. The court may require proof, however, that dismissal is in the respondent's and the public's best interests. Id.

70. See also Id., at §3-402.

71. Id., at §3-801.

72. Id., at §3-810 and 3-811.

73. Id., at §3-811.

74. Id., §3-812(a).

75. Id., at §3-812(b).

76. Id., at §4-609(b). The doctrine is applied as well when an objection is filed to an administrative admission, the court may disapprove the admission entirely if it is not the least restrictive appropriate alternative or order the person transferred to a "more appropriate Department facility." Id., at §4-308.

77. Id., at §4-610.

78. Zummerman, supra note 63, at 89.

79. E.g., the Thresholds program and those oprated by the Institute of Psychiatry at Northwestern Memorial Hospital.

80. Ill. Rev. Stat. ch. 91 1/2, §3-902(b).

81. Id., and §4-701(b).

82. Id., at §3-902(e).

83. Id., at §4-701(d).

84. Id., at §4-702(a).

85. Id.

86. Id., at §100-16.

87. Id., at §3-814.

88. Some liaisons talk with patients before a decision has been made to discharge the individual, and discuss the community programs available to assist the patient with hospital staff.

89. All interviewees in Chicago were provided anonymity, and therefore, are not identified in this report.

90. The Illinois Guardianship and Advocacy Agency is also authorized to develop discharge plans, although it cannot provide or purchase direct resources. Its efforts are directed, in large part, to long-term residents of state mental health and developmental disabilities facilities particularly those which are being closed, rather than the individuals passing through the Chicago area hospitals.

91. A new departmental rule scheduled to go into effect after the research was completed contains more explicit directions on the responsibilities of facilities during the discharge planning process. [See Rule 125.50, 7 Ill. Reg. 1599 et reg. (2/14/83).] The impact that this rule will have on the discharge planning process and the formation more defined links between inpatient and community services was unclear.

92. Ill. Rev. Stat. ch. 91 1/2, §2-102(a) (Smith Hurd 1983).

93. Id.

94. Id., at §2-202. See also Id. at §§3-810; 3-814; 4-301; 4-407(b); 4-612.

95. Id., at §2-100.

96. Id., at §2-104.

97. Id., at §2-107.

98. Id., at §2-108.

99. Id., at §2-109.

100. Id., at §2-110.

101. Id., at 100-16.2.

102. Id.

103. A special anti-admission intensive follow-up program is also operating at one of CMHC for persons with three hospital admissions within one year or five overall.

104. E.g., The Bridge program undertaken by Thresholds.

THE WILLIAMSBURG-JAMES CITY COUNTY REPORT

THE LEAST RESTRICTIVE ALTERNATIVE DOCTRINE: ITS APPLICATION IN THE INVOLUNTARY CIVIL COMMITMENT OF THE MENTALLY ILL

INTRODUCTION

The least restrictive alternative doctrine has long been a part of our legal system.[1] In the 1960's, under the influence of the United States Supreme Court, the concept began to develop important social implications.[2] The doctrine requires that the state pursue its goals in a manner least intrusive of the interests of its citizens. Courts and commentators have described the "least restrictive alternative" doctrine in ways such as "less drastic means,"[3] "the reasonable alternative,"[4] "the less instrusive alternative,"[5] "precision of regulation,"[6] and "necessity,"[7] all of which may be used interchangeably.[8]

The most significant judicial application of the doctrine has been in the area of personal liberties.[9] The least restrictive alternative has been used as a standard to assess governmental intrusions into constitutionally protected activity under the equal protection[10] and due process[11] clauses of the Fourteenth Amendment, the freedom of speech,[12] religion,[13] and association[14] clauses of the First Amendment, and under the Eighth Amendment.[15] The doctrine also has received significant legislative endorsement. The "Education of All Handicapped Children Act of 1975", for example, mandates education of handicapped youth in the least restrictive environment.[16]

Judicial and legislative usage of the least restrictive alternative doctrine in the area of mental health has been particularly auspicious. Not only does it appear that the application of the doctrine

helps protect the liberty interests of individuals, but many social scientists also believe that it increases treatment effectiveness.[17] In Lake v. Cameron,[18] a case in which an involuntary patient sought release from a hospital under a writ of habeas corpus,[19] the United States Court of Appeals for the District of Columbia Circuit first applied the doctrine in the area of mental health. This decision initiated one of the most important trends in mental health law.[20] In Lake, the court held that "(d)eprivations of liberty solely because of dangers to the ill persons themselves should not go beyond what is necessary for their protection."[21] Since Lake, both federal[22] and state[23] courts have employed the doctrine in mental health litigation. The least restrictive alternative doctrine also has received significant statutory recognition. All states except Alabama, Mississippi, and Oregon have enacted statutes that mandate, in some form, that courts or mental health facilities administer treatment in a manner or setting least restrictive of personal liberty.[24]

Despite judicial and statutory endorsement of the least restrictive doctrine on a theoretical level, some courts and mental health personnel have been unsure of the purpose and scope of the doctrine in practice. For example, one commentator states "while the legal doctrine prescribing use of the 'least restrictive alternative' has fairly clear meaning in reference to certain legal and constitutional values concerning infringement of personal freedom and liberty, the notion does not translate readily into mental health procedures and programs (emphasis original)."[25] This assessment reflects the theories of commentators in other areas of mental health and the law, who believe

that theoretical concepts, like the least restrictive alternative doctrine, never can be fully understood and implemented. According to these writers, "the meaning of a construct (a theoretical concept, such as the least restrictive alternative doctrine) can never be fully reduced to a set of concrete operations and observational terms."[26]

One important consequence of this uncertainty is that state and federal governments are failing to comply with judicial and legislative mandates to place and treat the mentally disabled in the least restrictive environment. On the one hand, courts and legislatures have endorsed formally a policy of outpatient care and deinstitutionalization.[27] On the other hand, the primary method of treatment continues to be inpatient hospitalization.[28] Perhaps the difficulties surrounding implementation of the least restrictive alternative doctrine explain this gap between de jure[29] and de facto[30] mental health policies. A more likely explanation is that lawmakers have failed to properly implement the doctrine. A brief review of the development of deinstitutionalization, a concept related to the least restrictive alternative doctrine, illustrates how improper implementation undercuts successful translation of a concept into practice.

Deinstitutionalization, simply stated, means "removing [patients] from hospitals and other institutions and placing them in alternative care settings."[31] The movement to deinstitutionalize developed in the early 1960s[32] in response to several clinical, social, and economic developments.[33] New medications that abated the acute symptoms of mental illness permitted some hospitalized persons to return to the community.[34] Studies on the debilitating effects of

institutionalization suggested to practitioners that treatment in the community might be much more beneficial.[35] Other studies exposed the massive deprivation of personal liberties that involuntary commitment of mentally ill citizens imposes.[36] Finally, the belief that treatment of the mentally ill in the communities would be less costly prompted state legislatures to reduce drastically their psychiatric inpatient populations.[37] The lure of federal funds for the development of local facilities, as a result of the Community Mental Health Centers Act of 1963,[38] also encouraged states to empty their hospitals.[39]

Deinstitutionalization failed to meet, however, with the success that its proponents envisioned. Poor planning for the release of the hospitalized and inadequate funding for treatment facilities and housing in the community overloaded local social service agencies and left thousands homeless.[40]

The least restrictive alternative doctrine differs from deinstitutionalization in two significant ways. First, the doctrine envisions a much broader range of treatment modalities than does the deinstitutionalization concept.[41] Second, the doctrine originated as judicial protection of liberty interests[42] and theoretically has the power of a legal mandate.

Unfortunately, poor planning and inadequate funding plague effective implementation of the least restrictive alternative doctrine just as they hampered the success of the deinstitutionalization movement. Although many states can ill afford to increase their mental health budgets in these fiscally austere times, states can allocate their limited resources between state hospitals and local facilities in a

manner that encourages care in the community. Continued legislative apportionment of the bulk of mental health funds for inpatient hospitalization undercuts community efforts to provide humane care.[43] A variety of financial disincentives also operate against those persons seeking outpatient care. For example, under Medicaid and Medicare it is more expensive to the patient to receive care on a continuing outpatient basis than in a hospital.[44]

If legislators do not find the curtailment of liberty interests resulting from involuntary civil commitment sufficiently compelling to increase or reallocate funds for mental health services, other convincing reasons exist for treating the mentally disabled in the least restrictive environment. First, recent studies reveal that treatment in the least restrictive environment is both more effective and less costly for most mentally disabled persons.[45] One study found that although the costs of community treatment initially may exceed the costs of inpatient care, comprehensive community treatment alternatives eventually result in savings.[46] Second, the age group most subject to schizophrenic disorders is increasing and will continue to do so until the end of the century.[47] As the average life expectancy of Americans lengthens, the percentage of disabled elderly also is expanding rapidly.[48] By proactively seeking new solutions for treating these groups, states can prevent the problems inherent in reactive policies.[49]

The purpose of this study is to report observations of one jurisdiction[50] in Virginia implementing the state's policy of providing mentally disabled persons with the least restrictive form of care.[51] Like other states, Virginia's de jure mental health policy differs

significantly from its de facto practices.[52] For example, one recent study[53] found that despite a statutory mandate to inquire into the availability of treatment alternatives during involuntary civil commitment hearings, many Virginia courts do not do so.[54] Another study, conducted by the Virginia State Department of Mental Health and Mental Retardation,[55] found that court assessments of the seriousness of psychiatric conditions and the availability of alternatives were substantially erroneous.[56]

This article describes the attempts of the Williamsburg-James City County mental health and legal communities to apply the least restrictive alternative doctrine in the involuntary civil commitment process. We have interviewed judges, attorneys, mental health professionals, and social service providers to ascertain how their attitudes and actions influence the effectiveness of the doctrine in practice. First, the article explores briefly the judicial and legislative development of the least restrictive alternative doctrine from a national perspective. Next, an overview of the mental health system and the involuntary civil commitment process in Virginia establishes a framework for the subsequent discussion of how the least restrictive alternative doctrine is applied in Williamsburg-James City County.

JUDICIAL AND LEGISLATIVE DEVELOPMENT

Lower federal courts have recognized that mentally disabled persons have a right to treatment in the least restrictive environment. In Lake v. Cameron,[57] the United States Court of Appeals for the District of Columbia found that the plaintiff's right to treatment in the least restrictive manner derived from a local statute.[58] Three years

later, the same court held in Covington v. Harris,[59] that the due process clause of the Fourteenth Amendment also grants patients the right to treatment in the least restrictive environment.[60] Since these two decisions were rendered, both federal[61] and state[62] courts throughout the country have applied the doctrine in mental health litigation. The United States Supreme Court has yet to rule directly on whether mentally disabled persons have a constitutional right to treatment in the least restrictive environment. In Youngberg v. Romeo,[63] however, the Court addressed for the first time whether the fourteenth amendment confers some substantive due process rights upon the mentally disabled.[64]

In Youngberg a mentally retarded person had been injured a number of times during his residence at a state hospital. The Court unanimously held that mentally retarded persons have constitutionally protected rights to safe conditions of confinement and freedom from unreasonable restraints.[65] The Court also recognized a constitutional right to a minimal level of training, but only to the extent necessary to ensure safety and freedom from undue restraint.[66] Thus, the Court reserved for another day the question whether the mentally disabled have a constitutional right per se to treatment. The Court also failed to rule directly on whether restraints may be used only if they are the least restrictive alternative. The Court's formula for determining whether these limited rights are violated, however, suggests an answer in the negative.

Writing for the Court, Justice Powell stated that balancing the individual's liberty interests against the state's interests in

protecting the health and safety of all citizens determines whether the state has violated the individual's constitutional rights.[67] In balancing these interests, however, any judgment made by a professional is "presumptively valid."[68] Only a decision that is "a substantial departure from accepted professional judgment, practice, or standards" fails to meet this standard.[69] In involuntary civil commitment proceedings, the decisionmakers most often rely on psychiatric testimony which tends to favor hospitalizaton.[70] Thus, the Court consistently could not maintain its deference to professional judgment and mandate a least restrictive alternative standard for involuntary civil commitment.[71]

Mentally disabled plaintiffs also have asserted rights to appropriate mental health services under the equal protection clause of the fourteenth amendment. In Schweiker v. Wilson,[72] for example, plaintiffs challenged the validity of a statute that excluded most patients in public mental institutions from eligibility for certain federal welfare benefits.[73] The plaintiffs claimed that the statute improperly classified the plaintiffs on the basis of their mental illness and therefore was subject to a heightened degree of court scrutiny.[74] Plaintiffs argued that the mentally ill are not unlike other "suspect" classes such as racial minorities. They "historically have been subjected to purposeful unequal treatment; they have been relegated to a position of political powerlessness; and prejudice against them curtails their participation in the pluralist system and strips them of political protection against discriminatory legislation."[75] Because the Court determined that the challenged statute did not classify directly on the

basis of mental illness[76] it did not decide whether the mentally disabled are a suspect class requiring greater constitutional protection.[77]

All states except Alabama, Mississippi, and Oregon have statutes that grant hospitalized mental patients the right to treatment in a manner or setting that is least restrictive of personal liberty.[78] Only five states include a definition of the least restritive alternative in their mental health statutes.[79] Although the application of the least restrictive alternative doctrine at the post-commitment stage is significant, the primary focus of this study is the application of the doctrine to placement decisions prior to or at the time of commitment. Therefore only statutory provisions regarding involuntary civil commitment criteria are reviewed.

A substantial majority of state legislatures require their courts to consider alternatives to hospitalization prior to or at the time of commitment.[80] This seemingly enlightened state of affairs would have significant practical effect were it not for the fact that most state statutes limit court-ordered treatment in the least restrictive alternative to available alternatives.[81] Without court authority, based either upon a statutory provision[82] or a constitutional right,[83] to order the creation of alternative, statutory provisions for treatment in the least restrictive alternative have little value in protecting the interests of mentally disabled citizens. Moreover, court observance of these statutory provisions may become perfunctory.[84]

APPLICATION OF THE LEAST RESTRICTIVE ALTERNATIVE DOCTRINE IN WILLIAMSBURG, VIRGINIA

Overview: Mental Health Services and the Civil Commitment Process

The Department of Mental Health and Mental Retardation directs state supported services for the mentally disabled in Virginia. State hospitals and training centers and local community service boards deliver these services. Each of the state hospitals provides institutional care for a particular region. The community services boards evaluate the need for mental health and mental retardation services in particular areas of each region and develop programs to meet those needs. Local mental health centers operate under the direction of community service boards and provide out-patient and other mental health services.

Eastern State Hospital, located in James City County, serves a population of 1.9 million people in 10 cities and 16 counties, including Williamsburg and James City County. Eastern State provides voluntary and court-ordered in-patient treatment to residents of this catchment area who cannot pay for hospitalization at a private facility. Hancock Geriatric Treatment Center, located on the campus of Eastern State, serves elderly mentally ill persons. The Colonial Community Services Board, one of nine community service boards in Eastern state's service region, directs and coordinates mental health, mental retardation, and substance abuse programs for the counties of York and James City and the cities of Poquoson and Williamsburg.[85] The programs receive funds from

the state legislature through the Department of Mental Health and Mental Retardation, and from local governments and fees charged for services.[86]

Williamsburg area residents in need of mental health treatment may apply for voluntary admission[87] to Eastern State Hospital. The Colonial Community Mental Health Center prescreens all voluntary applicants[88] to determine if hospitalization is the most appropriate available treatment alternative. The state mental health system thus attempts to treat all mentally disabled individuals in the least restrictive environment but the process by which the mental health and judicial systems provide services to individuals who cannot or will not seek mental health treatment differs significantly from the voluntary procedures.

Any responsible person may initiate the process of involuntary civil commitment of another individual by requesting that a district court judge, magistrate, or special justice order that individual to appear before the judge or magistrate.[89] If the judge or magistrate has probable cause to believe that the individual is mentally ill and in need of hospitalization he or she usually issues an order to detain the individual in a hospital for a period not longer than 48 hours, or 72 hours if the 48 hour period of detention would end on a Saturday, Sunday or legal holiday.[90]

Before the detention period expires a judge must conduct a preliminary hearing to determine if the individual is willing and capable of seeking voluntary admission to a hospital.[91] If the presiding judge concludes that the person neither can nor will accept voluntary admission, the judge holds a commitment hearing. A court appointed attorney represents the individual at both hearings.[92]

Prior to the preliminary and commitment hearings, a psychiatrist, a physician qualified in the diagnosis of mental illness, or a clinical psychologist, must examine the individual.[93] In most cases the community mental health clinic that serves the area where the person resides also evaluates the person and prepares a pre-screening report. The judge bases his or her decisions at the preliminary and commitment hearings on the prescreening report and testimony from the examining physician[94] and other witnesses.

If the judge finds that, as a result of mental illness, the person either is a danger to himself or herself or to others, or is substantially unable to care for himself or herself, but that there is a treatment alternative that is less restrictive than involuntary hospitalization, the judge may order the person to seek the alternative treatment. If no appropriate less restrictive alternatives to involuntary hospitalization are available, the judge may order hospitalization of the person for a maximum of 180 days.[95] The hospital to which the judge commits the person may release the person at any time before the 180 day period expires if the hospital staff determines that he or she no longer requires hospitalization.[96] If the person remains an involuntary patient at the end of the 180 day treatment period and the hospital staff believes that he or she continues to require hospitalization, the hospital may seek another detention order and another commitment hearing is held.[97]

Opportunities for the application of the least restrictive alternative doctrine arise in all stages of the civil commitment process. The description of the doctrine's application in Williamsburg

therefore chronologically traces the commitment process from intiation to release from hospitalization.

Initiation of ICC process

Any responsible person may request a judge to issue an order to temporarily detain another individual who may be mentally ill.[98] The judge may issue such orders based "[u]pon the advice of a person skilled in the diagnosis or treatment of mental illness,[99] or upon his or her own motion based on probable cause."[100] A judge or special justice must be available to consider requests for temporary detention orders seven days a week, 24 hours a day.[101] In Williamsburg-James City County, the chief judge of the circuit court[102] has appointed two practicing attorneys to serve as special justices who perform the functions of a judge[103] in civil commitment proceedings. A person requesting a temporary detention order during business hours usually calls the district court judge first.[104] If he is unavailable, the person calls one of the special justices. At all other times requests for temporary detention orders come first to the special justices.

The process of determining whether probable cause exists to issue a detention order affords the judge his or her first opportunity to consider the appropriateness and availability of less restrictive alternatives to the detention and possible involuntary hospitalization of the individual. Although a number of factors influence the judge's decision, the expertise of the person requesting the temporary detention order probably carries the most weight. When a mental health professional or a law enforcement officer whose judgment has been reliable in the past[105] recommends or requests a detention order, the

judge almost automatically issues the order. When a family member requests a detention order the judge usually requires a prescreening report from Colonial Community Mental Health Center (Mental Health Center) which is responsible for screening all allegedly mentally ill adults or mentally retarded persons who reside in the Williamsburg area. Hence, the judges usually have consulted with a mental health professional regarding the appropriateness of detaining the individual prior to ordering detention.

An administrator of the Mental Health Center reported that in approximately 60% of the cases judges request prescreening reports before issuing a detention order. Most Mental Health Center personnel thought that judges should require prescreening reports before issuing any detention orders[106] because one of the purposes of preparing prescreening reports is to determine if there are approaches more appropriate than hospitalization to meet the person's mental health needs.[107] For example, during the prescreening the person may agree to receive counseling from the Mental Health Center or to participate in an outpatient substance abuse program. The person also may be experiencing only temporary emotional difficulties that prompt professional attention could alleviate but that civil commitment proceedings would exacerbate.[108]

Both special justices agree in principle that the prescreener's early assessment of the person's mental health condition and needs is important for preventing unnecessary disruption of the person's life and possible inappropriate hospitalization. Practical problems arise, however, when Mental Health Center staff cannot prescreen an individual

because staff cannot go to where the person is or the person will not come voluntarily to the Mental Health Center. In such cases the court must issue a detention order as a legal mechanism for detaining the person until mental health professionals can evaluate his or her condition.[109] Although Mental Health Center administrators would prefer a formalized procedure requiring prescreening before a person is detained, they communicate fairly openly with the judges and cooperative efforts are leading to more frequent court attempts to obtain prescreening information before issuing detention orders.

The Virginia Code authorizes two alternative procedures for initiating the commitment process that are less restrictive of the allegedly mentally ill person's liberty than are the procedures used in Williamsburg. The judge may order an individual to appear before the judge immediately[110] rather than issuing an order to temporarily detain the individual pending a hearing; the judge also may permit the allegedly mentally ill person to remain free on his or her own recognizance or bond pending a hearing "if it appears from all evidence readily available that such release will not pose an imminent danger to himself or others."[111] The judges in Williamsburg, however, never use these less restrictive commitment procedures.

Perhaps the judges issue temporary detention orders to ensure greater involvement of mental health professionals in the commitment process and because they believe less restrictive procedures do not protect adequately either society or the person whose commitment is sought. According to one special justice, ordering a person to appear before a judge would not only subject the person to judicial proceedings

without benefit of counsel but also would place the judge in the position of determining without the advice of mental health professionals whether the person requires hospitalization. This special justice explained further that if the person's behavior creates probable cause to believe that he or she will meet commitment criteria, i.e., he or she is a danger to self or others, or is substantially unable to care for himself or herself, releasing the person pending the commitment hearing will most likely pose an imminent danger to someone. Prehearing release thus rarely would satisfy the criteria of the prehearing release provision.

Prescreening

The Virginia Code requires that community mental health clinics screen all persons who wish to become voluntary patients at a state mental hospital or training facility.[112] The screening procedure primarily entails the preparation of a prescreening report that screening committees use along with other information to determine if treatment in a state institution is appropriate for the individual seeking admission. In practice, prescreening reports generally are submitted for all persons who may be admitted voluntarily or involuntarily to Eastern State Hospital, Hancock Geriatric Treatment Center, or one of the institutions that serve the mentally retarded.[113] The Colonial Community Mental Health Center prescreens all allegedly mentally ill adults or mentally retarded persons who reside in the Williamsburg area. Because of its proximity to Eastern State, the Mental Health Center also prescreens persons from other areas brought to the hospital under detention orders who have not been prescreened by their own community service boards.[114]

The prescreening report is an essential component of the evaluation of an individual's mental health status and serves as the

primary source of information about less restrictive treatment methods that are appropriate and available.[115] One judge indicated that the prescreening report is the sole source of less restrictive alternatives. The majority of persons interviewed believed that mental health professionals who prepare the prescreening reports should ascertain treatment alternatives because they should be more intimately aware of the person's needs and should possess more information about available resources in the community.[116] One psychiatrist at Eastern State said that prescreening has two purposes: to find less restrictive alternatives to hospitalization, and to alert the community to the fact that the individual is in need of help and headed for the state hospital.[117] This psychiatrist added that psychiatrists do not know what less restrictive alternatives are available. One of Eastern State's professional staff questioned whether communities really seek alternatives, but stated that decision makers assume from the existence of a prescreening report that communities have investigated alternatives.

The staff of the Extended Care Unit[118] at the Mental Health Center prepares the prescreening reports. The staff includes social workers, psychologists and a psychiatrist who is available for consultation. During business hours 10 professionals are available to prescreen, one of whom is assigned specifically to be prepared for emergencies. A friend, relative or law enforcement officer brings the person who is to be screened to the Mental Health Center, or if this is not possible, the prescreener will go to where the person is. The person may already be at Eastern State, at Williamsburg Community Hospital, in a jail, or at home. Sometimes the person is already a client of the Mental

Health Center and his or her therapist has decided that the person may need a more restrictive environment or more intensive care. The Mental Health Center also has some screening staff on call 24 hours a day. The special justices often call upon these professionals to assess a person's status and advise them about the appropriateness of detaining the person for further evaluation.

The Department of Mental Health and Mental Retardation has designed the prescreening report form to reflect the prescreener's assessment of three areas that correspond to statutory commitment criteria.[119] These areas are: 1) the person's capability of caring for himself or herself; 2) the danger the person poses to himself or herself or to others; and 3) the availability and appropriateness of less restrictive alternatives to hospitalization.[120] The prescreener primarily bases his or her assessment on the person's current level of functioning, including whether the person is presently under medication and/or participating in any mental health treatment programs and whether he or she has family or other support. The prescreener also takes into account any history of mental health problems and the person's record of performance in any previous treatment settings.[121] The prescreener documents in a separate section of the report form what less restrictive alternatives to hospitalization the prescreener or others investigated based on the prescreener's assessment.[122]

The Mental Health Center forwards the completed prescreening report to Eastern State where it becomes part of the screened individual's medical records and a significant part of the information the judge uses to determine if the person should be hospitalized. A

Mental Health Center administrator estimated that their reports recommend commitment in 49% of the cases and that in approximately 25% of all cases the court does not follow the report's recommendation.

Although some communities do not provide useful prescreening reports[123] the consensus among the participants in the commitment process at Eastern State was that the Colonial Community Mental Health Center provides excellent, reliable reports. Although the Mental Health Center's reports are sufficiently thorough, they often state that there are no less restrictive residential treatment settings because few alternative facilities exist presently in the Williamsburg area.[124] One administrator at Eastern State expressed the opinion that Williamsburg has had little incentive to develop alternative residential facilities because of its proximity to Eastern State. Although administrators at the Mental Health believe that alternative settings are needed, they pointed out that their close working relationship with Eastern State has resulted in relatively short treatment periods for Williamsburg patients in Eastern State.[125]

Although the Virginia Code does not provide for involuntary civil commitment of mentally retarded persons to residential settings, the procedure for finding appropriate voluntary placements bears some similarity to civil commitment proceedings. Most significantly, the Code mandates that there be no less restrictive alternative to placement in a state residential facility.[126] The Focus Team which operates under the direction of the Mental Health Center prescreens mentally retarded persons from the Williamsburg area who are seeking admission to a state facility. Members of the Focus Team include representatives from the

local school divisions and social service agencies, the Mental Health Center, the psychology department of the College of William and Mary, and the institutions for the mentally retarded in which the team might recommend placing an individual.[127] Although the team usually has been involved with the individual and his or her family and is familiar with their situation, the team nevertheless formally reviews all the information relevant to deciding the best placement or treatment for the mentally retarded individual. The team then makes its recommendation and presents it to a judge.[128] A form stating that less restrictive alternatives to residential placement have been investigated and a letter from the proposed institution stating that the setting is appropriate for the individual must accompany the recommendation. The judge then meets with the individual and decides whether to certify him or her for placement in the proposed institution.

Procedures for screening elderly persons are not followed as consistently as are the procedures for screening the mentally ill under age 65 and the mentally retarded. According to a social worker at Hancock Geriatric Treatment Center, the preadmission screening committee at Hancock would prefer to screen all admissions.[129] Presently the committee screens only about half of those admitted, and the other half are screened only in their communities. According to three professionals at Hancock, many of those supposedly screened in the community actually have been civilly committed solely on the basis of a local physician's report that the person is substantially unable to care for himself or herself. Hancock sources complained that in these cases the communities virtually ignore the requirement that the person be mentally ill.

Williamsburg reportedly is not guilty of such subversion of prescreening procedures.

When prescreening procedures proceed properly, the local community mental health center first evaluates the allegedly mentally ill person. If the person appears to require mental health treatment and no appropriate treatment alternatives are available in the community, the local mental health center prepares an application for admission to Hancock and presents it to Hancock's preadmission screening committee. The committee consists of a psychiatrist, a registered nurse, a psychologist and a social worker who coordinates the committee and communicates admissions decisions to the local mental health center and the applicant's family. If the committee determines that the person would benefit from treatment at Hancock, he or she is admitted. If the applicant would not benefit from such treatment, the committee refers the applicant to other appropriate agencies and also recommends that the community further explore local treatment alternatives. The committee rejects about one third of the applicants it screens.[130] A psychiatrist and an administrator at Hancock indicated that a few of these rejected applicants are admitted eventually to Hancock through inappropriate detention orders and commitment hearings.

The Colonial Community Mental Health Center apparently has a relatively good relationship with Hancock. Mental Health Center administrators indicated that its staff not only prescreens all the Williamsburg area clients who apply for admission to Hancock but also attends the staffings of clients admitted to Hancock. The Mental Health Center also has a full-time geriatrics coordinator whose efforts to serve

the elderly were corroborated by two social workers not affiliated with the Mental Health Center. Unfortunately, alternative treatment settings for the elderly mentally ill in Williamsburg-James City County are as lacking as are such facilities for other mentally disabled persons.

In Detention

In most cases, after a judge issues an order to detain an individual pending a preliminary hearing, a law enforcement officer executes the order by taking the person to Eastern State Hospital.[131] During the person's temporary detention, two opportunities for release and possible treatment in a less restrictive alternative arise under one statute provision.[132] Within several hours of the detainee's arrival in the Admissions Unit,[133] a physician administers a cursory mental and physical exam and must release the detainee if the examination reveals insufficient cause to retain him or her.[134] An Eastern State administrator reported that the hospital never releases detained persons after this initial examination.

After the hospital transfers the detainee out of the Admissions Unit and into a detention area,[135] a psychiatrist performs a complete physical and mental exam. The psychiatrist evaluates the person's communication skills and attempts to determine whether he or she suffers from hallucinations, delusions or thought blocking. As in the case of the initial examination in the Admissions Unit, the psychiatrist must release the person if insufficient cause exists to believe the person is mentally ill. The hospital occasionally releases detained persons at this point in the commitment process, but never without the permission of the judge who issued the detention order.

Prior to the pending preliminary and commitment hearings other professionals meet with the detainee and gather information in preparation for the hearings. If no one prepared a prescreening report prior to the execution of the detention order, a mental health worker from the Mental Health Center will evaluate the detainee.[136] This evalution may yield information about less restrictive treatment alternatives but consideration of proposed alternatives must await the preliminary hearing.

A social worker[137] also meets with the detainee to explain his or her rights, including the right to counsel and to summon witnesses. One unit social worker told us that a number of respondents initially request to hire their own attorney but withdraw the request when they learn that obtaining a private attorney would require a continuance of the hearing. The social worker phones any witnesses the detainee wishes to have at the hearings to determine whether the witnesses' testimony would be helpful and if so, to request their attendance at the hearing. One Eastern State administrator complained that this is para-legal work and should be the responsibility of the detainee's attorney. The social worker also contacts witnesses for the hospital when necessary and asks the petitioner to attend the hearing, although no case law or statute mandates the petitioner's presence. One social worker said she generally has little involvement in finding less restrictive alternatives to hospitalization because that task is the responsibility of the community mental health centers, but she occasionally participates in arranging alternative placements.

Commitment hearings

The preliminary and commitment hearings provide the forum for hearing evidence from all interested parties and for officially determining whether any less restrictive alternatives to involuntary commitment of the individual exist. Both hearings are held at Eastern State Hospital and are open to the public.[138] A special justice, the examining psychiatrist, the respondent,[139] and his or her attorney are always present.[140] In addition, the hospital patient advocate, a unit social worker, a security officer, a psychiatric aide, and a secretary from an administrative office attend regularly. The petitioner seldom attends.[141] One attorney strongly condemns this practice, maintaining that the petitioner's absence allows the court to commit the detained person on hearsay evidence, and denies the attorney an opportunity for cross-examination. In most instances the judge has a community prescreening report, but, according to one social worker, community mental health workers rarely appear before the court.[142]

The special justice begins the proceedings by instructing the respondent of his or her right to appointed counsel, and the right to secure the services of a private attorney.[143] Next, the special justice gives the respondent an opportunity to apply for voluntary admission. If the person wishes to apply for voluntary admission, the court holds a preliminary hearing to determine the person's capacity to make such a decision.[144] The special justice hears testimony from the examining psychiatrist and counsel cross-examines the doctor. If the special justice denies the application for voluntary admission, he or she

commences the commitment hearing;[145] if the special justice grants the application for voluntary admission, the hearing is over. In some cases the special justice allows the respondent to renew his or her motion for voluntary admission after additional testimony has been heard at the commitment hearing.

One hospital employee worried that the quickness of the preliminary hearing increases the likelihood of inappropriate voluntary admissions because the special justice infrequently addresses alternatives at the preliminary hearing. The respondent perceives that the voluntary "route" is the only way to avoid an involuntary commitment and to get out of the locked detention. Thus, the court discharges its duty to order the least restrictive alternative treatment because the respondent has chosen the supposedly less restrictive voluntary hospitalization.

Voluntary admission to Eastern State is less restrictive than involuntary admission only in terms of the length of mandatory treatment and the treatment setting.[146] Persons who agree to voluntary admission must accept treatment for a minimum of five days;[147] those persons whom the hospital commits involuntarily are subject to treatment for 180 days.[148] The hospital rarely confines a voluntary patient to a locked ward; involuntary patients usually stay on a locked ward ten to fourteen days. Hospital officials explained that this initial restrictive setting is necessary to stablize involuntary patients who, by statutory definition, are a danger to themselves or others, or substantially unable to care for themselves.

The commitment hearing immediately follows the preliminary hearings although it is not always clear where one ends and the other begins. The special justice informs the respondent of the right of appeal, and the right of a jury trial on appeal. The special justice also tells the respondent that the hearing can be continued to allow the respondent time to summon witnesses, or to obtain an independent psychiatric evaluation at his or her own expense.[149] The special justice occasionally grants a continuance on these grounds, but usually the hearing proceeds.

The examining psychiatrist usually begins the testimony by summarizing briefly the respondent's mental health status and giving his or her opinion whether the respondent is mentally ill, an imminent danger to himself or herself or others, and in need of hospitalization.[150] Although Virginia law does not require the psychiatrist to investigate less restrictive alternatives, the special justice routinely asks the doctor whether alternatives to hospitalization are appropriate and available. Often the psychiatrist may recommend a less restrictive treatment plan without a less restrictive setting in mind.[151]

Next, the respondent's attorney cross-examines the psychiatrist and presents any witnesses who wish to testify on behalf of the respondent. Occasionally the special justice calls upon the patient advocate or a social worker to testify, particularly if either has information not before the court about the respondent.[152] Because the hearings are not truly adversarial, the special justice often considers such hearsay testimony in attempting to reach an informed decision. Finally, the judge allows the respondent to make a statement.

The judge then must evaluate the testimony as well as the community mental health center's prescreening report to determine whether the person meets the statutory criteria for involuntary admission: whether he or she "(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 alternaties to involuntary hospitalization were investigated and deemed not suitable..."[153] According to the records of the Director of Eastern State, of the 422 persons whom the hospital held in detention last year, the hospital admitted 48 voluntarily, involuntarily committed 215, and released 96.[154]

Contrary to the findings of a 1982 study of civil commitment in Virginia,[155] the special justices who conduct the commitment hearings at Eastern State Hospital always consider less restrictive alternatives to hospitalization. Although these special justices attempt to comply with the statutory commitment procedures, the Virginia Code does not clearly place the responsibility of finding less restrictive alternatives with either the court or the mental health system. Thus, confusion among the participants in the commitment process interferes with orderly investigation of alternatives.[156]

Most of the Eastern State psychiatrists, administrators, and social workers believe that the community mental health clinics have the responsibility to investigate alternatives because they can evaluate best their own resources and because the prescreening report form specifically

addresses whether less restrictive alternatives for the respondent exist. The judges substantially agree with this view; one noted that the hospital as representative of the state should bear the burden,[157] whereas the judges bear the ultimate responsibility of insuring that alternatives were investigated.[158] Two attorneys shared the latter opinion. The lack of designated responsibility for investigating alternatives de-emphasizes the least restrictive alternative doctrine. Thus, the focus of the court's inquiry becomes the severity of the respondent's mental illness and the availability of less restrictive treatment alternatives plays a less prominent role in decision-making.

Although the Virginia Code does not mandate procedures for investigating alternative treatment, the special justices have the authority to order such treatment.[159] The Code lists the following possible dispositions upon a finding that the person does not require hospitalization: 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".[160]

The alternative treatment the special justices most frequently order in Eastern State hearings is referral to a community clinic for out-patient treatment.[161] Like other areas of Virginia, the Williamsburg-James City County area does not provide day or night treatments in a hospital,[162] but the Colonial Community Mental Health Center makes available out-patient services.[163] Although the court has the authority to order the community mental health centers to provide

periodic patient progress reports, the Williamsburg judges rarely issue such orders. One judge stated that ordering progress reports not only would overburden the community clinics but also would place them in a "policing" role that is inconsistent with and counterproductive to their "helper" role.[164]

The Virginia civil commitment provisions neither limit the consideration of less restrictive treatment to available alternatives nor mandate the creation of alternatives where none exist.[165] Thus, when alternative treatment of an individual is appropriate but unavailable, the special justices must choose between ordering overrestrictive treatment or releasing the person to an environment in which the likelihood of the person receiving treatment is low. In 1974, Hoffman and Faust hypothetically presented this dilemma to Virginia judges who presided over commitment hearings.[166] Eighty-eight percent of the judges surveyed favored commitment. Hoffman and Faust theorized that a broad interpretation of the least restrictive alternative doctrine requires the state to provide alternative settings, whereas a narrow interpretation allows the state to impose restrictive treatment when equally effective alternatives are not available;[167] judges are forced to implement one or the other of these interpretations.[168]

Although ten years have passed since Hoffman and Faust studied the implementation of the least restrictive alternative doctrine by Virginia judges, community treatment alternatives remain scarce and the low percentage[169] of individuals released from commitment hearings indicates that the application of the doctrine in court ordered treatment remains pragmatic and ad hoc. The Virginia legislature apparently

interprets the least restrictive alternative doctrine both broadly and narrowly. Judges are bound by the legislature to insure that less restrictive treatment alternatives are investigated and are permitted to order such alternatives, but the legislature's failure to commit funds for development of community treatment facilities severely limits the judges' ability to comply fully with the letter and spirit of the law.

The orders issued by the special justices at the commitment hearings almost always stand because patients rarely appeal the special justices' decisions to the circuit court. According to a circuit court judge in Williamsburg, the court hears an average of ten appeals per year, only one of which in the last five years was by a local resident. This judge also never has conducted a jury trial on the issue of an involuntary civil commitment.

Those involved in the civil commitment process have proposed various explanations for the infrequency of patient appeals. The most simple reason could be the lack of express instructions on the mechanics of filing an appeal. Although both special justices inform the respondent of his or her right to appeal,[170] one special justice merely instructs the respondent to "tell your lawyer within thirty days if you want to appeal" and the other special justice gives no explanation of how the respondent should go about filing an appeal. On the other hand, the lack of appeals might indicate that the system is working well because the special justices do a good job of preventing inappropriate admissions. An Eastern State official's description of the special justices as "conscientious and knowledgeable" supports the latter view.

The perceived inferior representation provided by court appointed attorneys also possibly explains the lack of appeals. Mental health personnel variously describe the lawyers as passive, meddlesome, inexperienced, and ill-prepared.[171] Any attorney who is a member of the Virginia bar may serve as appointed counsel by putting his or her name on a rotation list of approximately 20 to 25 attorneys. The attorneys need no expertise with mental health issues to place their names on the list. They agree to serve as counsel for a one week period, usually three times a year, for which the state pays them $25.00 for each preliminary hearing and each commitment hearing.[172] One of the special justices reported that he gives attorneys new to the list a short orientation to representing respondents. He also encourages them to observe several sets of hearings before representing any respondents. This special justice stated that he has removed attorneys' names from the list for unsatisfactory work.

No statute or judicial decision specifies the duties of appointed counsel. The attorneys with whom we spoke told us that they typically arrive at the hospital at the earliest approximately an hour and a half before the hearing. A unit administrator gives the attorney the client's files which contain the community prescreening reports and a copy of the detention order. During a ten to twenty minute interview with the client, the attorney discusses the client's rights, whether the client desires to admit himself or herself voluntarily, and whether the client wishes to have the court summon witnesses other than those already called by the unit social worker. Because of the brief time between the client interview and the commencement of the hearings, any patient

requests for additional witnesses will necessitate a continuance, and the attorney will be responsible for contacting the witnesses. None of the people we interviewed believe the attorneys have the responsibility of investigating less restrictive alternatives. One attorney said she has the duty to broach the subject at the hearing, and then the hospital must demonstrate why less restrictive alternatives are inappropriate.

The participants in the civil commitment process at Eastern State disagree about the attorney's proper role in the procedure. As one judge stated, the attorney is obligated ethically to act as an advocate in a situation in which the adversarial process may be inappropriate. In fact, civil commitment proceedings are not truly adversarial because an attorney does not represent the state's interest in commiting the individual. One hospital administrator reported that on occasion the judge or the examining psychiatrist is forced into an inappropriate adversarial role. Moreover, because of the client's incapacity, some attorneys maintain that pursuing the client's best interests as a guardian may be more appropriate than advocating the client's wishes.[173] To avoid the dangers of paternalism inherent in such non-adversarial hearings, one judge suggested that the court appoint independent examining psychiatrists.

Several people suggested that the best way to improve the quality of representation would be for the court to limit the number of appointed attorneys to give them greater opportunity to develop expertise in mental health law. Proponents of such a system point to the success of the special justice system which is based upon a similar principle. Those opposed to limiting the number of appointed attorneys cite the

favoritism inherent in the attorney selection process, and maintain that limiting the number of attorneys does not guarantee higher quality performance.

Because the commitment hearing is such a crucial component of the civil commitment process disagreement concerning the proper proportion of legal and medical involvement in commitment decisions focuses on the hearing. Most people with whom we talked think the present system is basically sound and that efforts to improve the involuntary civil commitment process should be directed toward refining the present system, not revamping it.

The Executive Secretary's Office of the Virginia Supreme Court, however, is investigating a radical change in the commitment procedures: transfering the responsibility for commitment hearings from the judiciary to the State Department of Mental Health to be handled as an administrative matter.[174] Several persons including one judge agree that lawyers and judges are too involved in the involuntary civil commitment process and that medical professionals should make commitment decisions.[175] Yet those who would prefer statutory changes to provide more authority to the mental health community acknowledge the need to involve the legal community at some point in the system to ensure procedural fairness. In fact, two Eastern State psychiatrists and administrators disapprove of the radical shift of responsibilities that the Executive Secretary's Office proposes. They contend that such a shift would be inappropriate both for due process reasons and liability concerns.

What happens after commitment?

At the conclusion of the commitment hearing, if the detained person has not agreed to voluntary admission the court will order either the release or hospitalization of the person. The release order may be unconditional, or it may require the person to seek outpatient treatment. If the person is hospitalized either voluntarily or involuntarily he or she remains at Eastern State.

The same provision in the Virginia code that requires an examining physician to release detained persons if insufficient cause exists to believe that the person is mentally ill[176] also allows psychiatrists at Eastern State to prevent inappropriate admissions of persons evaluated elsewhere and committed in local hearings in Eastern State's catchment area.[177] Psychiatrists are less reluctant to release these individuals than they are to release persons brought in on detention orders because a judicial determination to hospitalize already has been made and the psychiatrist's decision at this point is purely clinical.

If the hospital admits an individual, plans for his or her discharge begin immediately.[178] The hospital assigns the patient a treatment team composed of a psychiatrist, a psychiatric resident, a psychologist, a social worker, a nurse, and other appropriate person. The treatment team holds an Evaluation, Planning, and Discharge conference shortly after the person is admitted. In addition, the hospital must conduct periodic reviews of involuntarily committed patients every thirty days for the first ninety days, then every six months thereafter.[179] The purpose of the review is to gauge the patient's progress and update his or her treatment plan.

If the treatment team believes the patient no longer needs hospitalization, the hospital will release the patient. The appropriateness of the environment into which the patient is released depends upon the degree of cooperation the patient's local community mental health center provides and the efforts of Eastern State staff.

Cooperation between Eastern State and the Colonial Community Mental Health Center apparently is high. The two organizations have discharge agreements describing each others general responsibilities for discharge planning and follow-up. The Mental Health Center's Williamsburg-James City County case manager regularly attends the Evaluation, Planning, and Discharge conferences of clients from her geographical area. A Mental Health Center psychiatrist reportedly attends these team meetings on occasion. According to one Eastern State psychiatrist, representatives of Eastern State and the Mental Health Center also meet at least once each month.

Observations of several of the persons interviewed indicate that the cooperative efforts of the Mental Health Center may be anomolous. One Eastern State administrator stated that it is unusual for a community mental health clinic to be so receptive to placement of patients, especially since relatively few Williamsburg area residents are admitted to Eastern State. A social worker at Hancock Geriatric Treatment Center complained that community mental health centers generally forget about their elderly clients after the hospital has admitted them. In her view, the community ultimately is responsible for the patient, even throughout his or her stay at the hospital. This social worker also believes that the hospital and the community mental health clinics perform some

duplicative follow-up services. One special justice believes that the lack of cooperation between the hospital and the community clinics contributes to an excessive number of emergencies. Her opinion supports the conclusion that Eastern State and community mental health clinics should increase their cooperative efforts.

Increased communication among the court, Eastern State and the community mental health centers may facilitate the provision of a more appropriate and therapeutic continuum of mental health services. The Virginia Code does not encourage, however, such communication. The Code requires the court to notify a community clinic within ten days if the hospital involuntarily hospitalizes one of the community's residents,[180] but does not require notification if the hospital voluntarily admits a person, or if the court disposes of the case in some other manner. One Colonial Community Mental Health administrator explained that court or hospital notification of the disposition of all cases involving their residents would be extremely helpful. Even in Williamsburg, where cooperation among the courts and the mental health community is relatively high, communication is unorganized. For example, one judge meets regularly with the Colonial Community Mental Health Center, but has little involvement with Eastern State. The special justices, on the other hand, are routinely at the hospital to conduct commitment hearings and thus see hospital personnel frequently. The special justices reportedly do not meet on an organized basis, however, with representatives of the Mental Health Center.

Because Eastern State generally determines when a patient will be released, the hospital usually initiates the process of helping

patients move back into the community. The Virginia Code authorizes the director of Eastern State to place patients in less restrictive treatment settings such as private homes or nursing homes.[181] Although the director at Eastern State never makes these placements while patients are subject to court ordered treatment, the hospital sometimes finds such placements for patients who are released unconditionally.

To both reduce its patient population and enhance successful transitions from hospital to community, Eastern State has developed the Community Support Services program (CSS). The program began in early 1982 with the assistance of community mental health centers. Its primary mission was to create appropriate placements for clients who, because of long periods of hospitalization, would find moving back into the community very difficult. In the past one and a half years CSS has served fifty-one patients all of whom participate in the program on a voluntary basis. Their average length of stay in the hospital has been eight years. The hospital has discharged twenty-six of the participating patients, four or five of whom are from the Williamsburg-James City County area, and twenty-five patients are now in the program. The staff of CSS has identified an additional 110 of the 527 adult psychiatric patients as potential users of their services.

Pre-vocational skills training and programs that help integrate patients into the community are essential to the success of CSS placements. The CSS staff takes a group of thirteen to fifteen clients on weekly visits to the day care programs in the localities in which the clients will reside upon their release from the hospital.[182] These trips familiarize patients with the locations and the staff of the day

care facilities. CSS clients also have begun to particpate in monthly "clubhouse" meetings which newly formed ex-patient groups have organized in several cities in Eastern State's catchment area.[183] These outings help the patients make new friends and become more motivated to leave the hospital. After the clients are discharged from the hospital, CSS maintains follow-up services for up to eighteen months. CSS staff believe that these support services increase the likelihood that ex-patients will take their medications regularly, and enjoy a successful, permanent community placement.

Alternatives to Involuntary Civil Commitment in the Williamsburg Area

Until recently, there were no alternative residential facilities for mentally handicapped persons in the Williamsburg area. In 1983, in recognition of the need for more community alternatives to hospitalization, the Virginia General Assembly appropriated an additional two and one-half million dollars to the Department of Mental Health and Mental Retardation for a hospital census reduction fund. The Department distributed monies from the fund to local community service boards that submitted proposals for alternative treatment programs. In conjunction with the Mid-Peninsula Community Services Board, the Colonial Community Services Board (hereafter Colonial Services Board) received a grant for its proposed program to provide apartments and other support services, including a sheltered workshop, for long-term mental health clients. Consequently, the Colonial Services Board now has three transitional living apartments available to serve nine people. The Colonial Community Mental Health Center administers the program. Administrators at the

Mental Health Center reported that they eventually would like to include accommodations for one or two clients who need short-term treatment either before or in lieu of hospitalization.

The Mental Health Center evaluated the needs of its clients to determine who most likely would succeed in and benefit from its census reduction program. According to an administrator at Eastern State Hospital, priority was given to placing people in the program who are presently patients at Eastern State. But, as this administrator pointed out, the eventual effect of the program will be not only to reduce the number of people currently in Eastern State, but also to eliminate the need for hospitalization.

No community residential treatment settings for the mentally retarded currently exist in Williamsburg. The director of the mental retardation services unit at the Mental Health Center reported that the cost of care for one person in a state facility has been estimated to be $32,000 per year, whereas the cost of serving one person in the community would be $15,000. Despite the potential reduction in expenditures for services for the mentally retarded, the Virginia legislature has been reluctant to abandon traditional funding mechanisms. The director suggested that the mentally retarded could be served at a lower cost in less restrictive settings if funds were allocated for individuals, to be used for the most appropriate individual treatment plan. As the system now operates, funds are allocated in a manner that favors the use of state facilities as the primary treatment setting. Other administrators at the Mental Health Center noted that the several attempts to develop community living programs have been frustrated not only by insufficient

financial resources, but also by community opposition to such programs.[184]

Although the Colonial Services Board provides only limited alternative residential treatment facilities, the Mental Health Center provides a variety of mental health services to mentally disabled and mentally retarded individuals.[185] Counseling and post-hospitalization programs are the two primary psychiatric services offered by the Mental Health Center. Counseling services include psychiatric evaluation and treatment, individual and group counseling, family therapy, and emergency services. Such services often prevent individuals from developing severe mental health problems that would require hospitalization. Nevertheless, one member of the local Human Rights Committee[186] lamented that many persons either cannot or will not avail themselves of these counseling services and thus deteriorate to the point where hospitalization is necessary.

The Extended Care Program provides follow-up care for individuals who have completed inpatient treatment in psychiatric hospitals. Structured individual and group counseling, and vocational training are among the services offered to help these individuals maintain their treatment progress and remain in the community.

Assessments of the success of the Extended Care Program varied among the persons interviewed. One agency social worker commented that although ex-patients can participate in these treatment programs indefinitely, many do not continue participation as long as they should. This social worker observed that these ex-patients either do not feel welcome or they cannot receive the services with the regularity the

treatment programs require. She noted that drop-in services would meet more appropriately the needs of many of her clients.[187] This somewhat negative assessment of the Extended Care Program was balanced by reports from several individuals that the Mental Health Center provides for the most part good mental health programs. Indeed, one judge praised the Mental Health Center for its flexibility and imagination despite its heavy workload.

Under the umbrella of the Extended Care Program is an acute care, partial hospitalization day program. This program provides short-term treatment to stabilize quickly a person who is experiencing a mental health crisis. An administrator at the Mental Health Center noted that the acute care program is most appropriate for persons who have not had severe mental health problems in the past and who do not require extensive support services such as housing, job training, or employment. Although the acute care program generally is inappropriate as an alternative to civil commitment, it nevertheless has served as an alternative to hospitalization.

The Mental Health Center provides both direct and indirect services to the mentally retarded. The Colonial Workshop offers training programs designed to develop or improve vocationally related skills and provides sheltered employment to developmentally disabled individuals. The Mental Retardation Services Unit directs the tasks of the Focus Team which is responsible for screening mentally retarded individuals seeking state services.[188] The Unit also coordinates client services with other community organizations such as Respite as Family Therapy (RAFT). RAFT is a community coordinated relief program that provides temporary

placement. According to an administrator at the Williamsburg Social Service Bureau, companion-homemaker services usually are provided only on a short-term basis in emergency situations, and only five clients are presently receiving one of the services.

Placement in a group home provides the next less restrictive alternative to hospitalization available to mentally disabled as well as other social service clients. Group homes are supervised residential settings licensed by the Virginia State Department of Welfare and Institutions. The homes vary in size and sophistication of services. A social worker at Hancock Geriatric Treatment Center described group homes as accommodating a range of from five to three hundred residents and providing services ranging from meal preparation to professional nursing care. Because there are no group homes in the Williamsburg-James City County area, social workers at both social service agencies and Hancock Geriatric Treatment Center try to place clients in group homes in nearby communities. These social workers all commented that not enough group homes exist and consequently clients usually must wait for such placements.[190] Placements in group homes are financed from the individuals' private financial sources, or social security benefits plus supplemental grants from Williamsburg and James City County social services.

Both social service agencies participate in screening clients seeking Medicaid funds for nursing home placement. Many persons viewed nursing homes as less restrictive settings for the elderly than Hancock Geriatric Treatment Center, but, according to one of Hancock's administrators, elderly persons who are ineligible for Medicaid funds

care services to families of developmentally disabled, and mentally and physically handicapped persons. RAFT helps families cope with the problems a disabled family member can present, and often prevents the placement of the family member in an institution.

Social service agencies in Williamsburg and James City County also provide services that divert clients from the civil commitment process and help recipients of mental health services remain in the community. Both the Williamsburg Social Service Bureau and the James City County Social Service Department work with families to find various support services for needy family members. One social worker in James City County reported, however, that families often ask for help only after their family member's condition has deteriorated to the extent that support services are either ineffective or inappropriate to meet that person's needs. One social worker at the Hancock Geriatric Treatment Center pointed out that delayed requests for help particularly impede serving the elderly.

The least restrictive environment is usually the home,[189] and both the Williamsburg and James City County social service agencies provide companion and homemaker services to help clients remain living in their homes. James City County uses at least three professional homemaker services whose employees perform light housekeeping chores and prepare meals in clients' homes. According to a social worker at the James City County Social Service Department, family members are often paid to do these tasks for relatives. The James City County reportedly provides a maximum of twenty hours of service per week to six or seven people, primarily as an alternative to nursing home

often are admitted inappropriately to Hancock. The social service agencies' involvement in the Medicaid screening process may be an effective diversionary mechanism because the process alerts the agencies to the needs of their elderly clients. At this point agencies may initiate services which could prevent hospitalizing the client.

The only nursing home in the Williamsburg-James City County area is the Pines Convalescent Center. Both social service agencies sponsor clients' placements at the Pines and help pay the placement costs. One Williamsburg Social Service administrator noted that the local community provides many other support activities and programs for the Pines' residents. An administrator of the Pines viewed these activities as therapeutic and important for preventing mental illness in the elderly.

The Pines occasionally serves as an alternative to hospitalization for elderly mentally ill patients and as a discharge placement from Hancock Geriatric Treatment Center. According to one Pines administrator, six persons had been placed in the Pines from Hancock in 1983. This administrator also reported that many residents receive geriatric medications and some receive psychotropic medication. At the time of the interview only one person was receiving psychiatric counseling.

The social service and mental health agencies often cooperate to provide a combination of services to particular clients. For example, an administrator of the Williamsburg Social Services Bureau reported that the Bureau currently was serving eighteen clients in conjunction with the Mental Health Center, and that the two agencies have a good working relationship. Although there is no mental health counselor at

Williamsburg Social Services, the social workers often counsel clients who are reluctant to go to the mental health center. Counseling continues until the client either no longer requires counseling or he or she is willing to receive the service from the Mental Health Center. Williamsburg Social Services also often provides follow-up care to people who have been receiving services from the Mental Health Center. A social worker at James City County Social Service Department mentioned similar cooperative efforts with the Mental Health Center, emphasizing that many of James City County's clients are uncomfortable receiving services at the Mental Health Center.

Another example of efforts to combine professional resources is the multi-disciplinary team. This group meets monthly and includes a psychiatrist, a pediatrician, and representatives from the Mental Health Center, both Williamsburg and James City County social service agencies, and the local public schools and court services units. Individual cases are presented to the team, which develops service plans to address the individuals' needs.

6. NAACP v. Button, 371 U.S. 415, 438 (1963).

7. Dunn v. Blumstein, 405 U.S. 330, 342 (1972); Shapiro v. Thompson, 394 U.S. 618, 634 (1969).

8. Some mental health professionals advocate the use of the phrase "least restrictive environment" in place of "least restrictive alternative." See, e.g., J. Avellar, D. Bisbin, A. Gause, An Evaluation of Pre-Admission Screening (Oct. 14, 1982) (available from the Virginia State Department of Mental Health and Mental Retardation) [hereinafter cited as Screening Report.]

9. The doctrine also has been applied in commerce clause litigation. See, e.g., Dean Milk Co. v. City of Madison, 340 U.S. 349, 354 (1951) (statute that discriminated against interstate commerce invalid because "reasonable nondiscriminatory alternatives, adequate to conserve legitimate local interests, are available").

10. See, e.g., Dunn v. Blumstein, 405 U.S. 330 (1972)(right to vote under equal protection scrutiny).

11. See, e.g., Roe v. Wade, 410 U.S. 113 (1973) (no government regulation of abortion procedures during the first trimester of pregnancy); Griswold v. Connecticut, 381 U.S. 479, 485-86 (1965)(right to privacy under due process scrutiny).

12. Talley v. California, 362 U.S. 60, 62-66 (1960).

13. Sherbert v. Verner, 374 U.S. 398, 406-09 (1963).

14. NAACP v. Button, 371 U.S. 415 (1963); Shelton v. Tucker, 364 U.S. 479 (1960).

15. Brenneman v. Madigan, 343 F. Supp. 128 (N.D. Cal. 1972). The doctrine was used in the "context of eighth amendment and equal

NOTES

1. In 1821, the United States Supreme Court held that Congress's contempt power was restricted to "the least possible adequate to the end proposed." Anderson v. Dunn, 19 U.S. (6 Wheat.) 204, 231 (1821). See Note, The less restrictive alternative in constitutional adjudication: An analysis, a justification, and some criteria, 27 Vanderbilt Law Review, 971, 972 (1974).

2. Note, supra note 1, at 972, n. 2. The author suggests that the use of the doctrine in NAACP cases in the early sixties provided the impetus for the increased use of the doctrine. See, NAACP v. Button, 371 U.S. 415 (1963); Shelton v. Tucker, 364 U.S. 479 (1960); Bates v. Little Rock, 361 U.S. 516 (1960).

3. United States v. Robel, 389 U.S. 258, 268 (1967); Shelton v. Tucker, 364 U.S. 479, 488 (1960). In Shelton, the Court held that the state of Arkansas could protect its interests by means less drastic than compelling disclosure of a teacher's associational ties. The Court found 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 legislative abridgment must be viewed in the light of less drastic means for achieving the same basic purpose." (cite).

4. Wormuth and Mirkin, The Doctrine of the Reasonable Alternative, 9 Utah L. Rev. 254 (1964).

5. Ratner, The Function of the Due Process Clause, 116 U. Pa. L. Rev. 1048, 1982-93 (1968).

protection considerations to mitigate the government's confinement of accused criminals waiting trial to only that level of restrictiveness necessary to ensure the accused criminals' appearance at trial and to prevent danger to prison security." Hoffman & Foust, Least Restrictive Treatment of the Mentally Ill: A Doctrine in Search of its Senses, 14 San Diego L. Rev. 1100, 1101, n. 1 (1977).

16. P.L. 94-142, 89 Stat. 775 (1975) (codified as amended at 20 U.S.C. §§1400 et. seg. (1982).).

17. See generally, Kiesler, Mental Hospitals and Alternative Care: Noninstitutionalization as Potential Public Policy in Mental Patients, 37 Am. Psychologist 349 (1982); Chambers, Alternatives to Civil Commitment of the Mentally Ill: Practical Guides and Constitutional Imperatives, 70 Michigan L.R. 1107 (1972). Kiesler surveys ten recent studies comparing the costs and effectiveness of inpatient vs. outpatient treatment. The author found that "[i]n almost every case, the alternative care had more positive outcomes. There were significant and powerful effects on such life-related variables as employment, school attendance, and the like. There were significant and important effects on the probability of subsequent readmission: Not only did the patients in the alternative care not undergo the initial hospitalization, but they were less likely to undergo hospitalization later, as well." Kiesler, at 357-358. These studies also suggest that outpatient treatment is less expensive. See infra, note 44.

18. 364 F.2d 657 (D.C. Cir. 1966).

19. Id. at 658-59.

20. Hoffman and Foust, supra note 15, at 1101. See also, Chambers, supra note 17.

21. 364 F.2d 657, 660 (D.C. Cir. 1966). The United States Court of Appeals found that the plaintiff's right to treatment in the least restrictive manner derived from a local statute, rather than a federal constitutional provision, Id. at 659. The Court of Appeals remanded the case to the district court for inquiry into alternative courses of treatment. Id. at 661. The Court of Appeals said that "(t)he alternative course of treatment or care should be fashioned as the interests of the person and the public require in the particular case." Id. at 660.

22. See, e.g., Covington v. Harris, 419 F. 2d 617 (D.C. Cir. 1969); Association for Retarded Citizens of North Dakota v. Olson, 561 F. Supp. 473 (D. N.D. 1982); Eubanks v. Clarke, 434 F. Supp. 1022 (E.D. Pa. 1977); Gary W. v. Louisiana, 437 F. Supp. 1209 (E.D. La. 1976); Welsch v. Likens, 373 F. Supp. 487 (D. Minn. 1974); Lessard v. Schmidt, 349 F. Supp. 1078 (E.D. Wis. 1972), vacated and remanded on other grounds, 414 U.S. 473 (1974), on remand 421 U.S. 957 (1975), on remand 413 F. Supp. 1318 (E.D. Wisc. 1976) (Reinstating 379 F. Supp. 1376).

23. See, e.g., In re Gandolfo, Cal. Ct. App. (1982); 185 Cal. Rptr. 911; Aden v. Younger, 57 Cal. App. 3d 662, 129 Cal. Rptr. (1976); In re Collins, 102 Ill. App. 3d 138, 429 N.E. 2d 531 (1981); In re Estate of Newman, 604 S.W. 2d 815 (Mo. Ct. App. 1980); Application of D.D., 118 N.J. Super. 1, 285 A. 2d 283 (1971); Kesselbrenner v. Anonymous, 33 N.Y. 2d 161, 350 N.Y.S. 2d 889 (1973); In re Andrea B, 98 Misc. 2d 919 (N.Y. Fam. Ct. 1978).

24. Lyon, Levine, and Zusman, Patients' Bill of Rights: A Survey of State Statutes, 6 Mental Dis. L. Rep. 178, 181-183 (1982).

25. Shah, S.A. Legal and Mental Health System Interactions: Major Developments and Research Needs, 4 Int'l J. L. & Psychiatry 219, 254 (1981).

26. Roesch and Golding, Competency to Stand Trial at 12, (1980).

27. Kiesler, Public and Professional Myths about Mental Hospitalization: An Empirical Reassessment of Policy-Related Beliefs, 37 Am. Psychologist 1323, 1323 (1982).

28. Id.

29. A de jure policy is one "that we legislatively and collectively intend to carry out". Id.

30. A de facto policy is one "that occurs, regardless of public intent or agreement". Id.

31. Kiesler, supra note 17, at 349.

32. Deinstitutionalization began prior to the application of the least restrictive alternative doctrine to civil commitment of the mentally ill.

33. See Pepper and Ryglewicz, Testimony for the Neglected: The Mentally Ill in the Post-Deinstitutionalization Age, 52 Am. J. Orthopsychiatry 388, 388 (1982).

34. Id. at 388. See also, Miller and Fiddleman, Outpatient Commitment: Treatment in the Least Restrictive Environment?, 35 Hosp. and Com. Psychiatry 147, 147 (1984).

35. Kiesler, supra note 17 at 350. (citing E. Goffman, Asylums: Essays on the Social Situations of Mental Patients and Other Inmates (1961) and M.S. Goldstein, The Sociology of Mental Health and Illness, Ann. Rev. of Soc., 1979, 5, 381-409.)

36. See, Pepper and Ryglewicz, supra note 33, at 388; (citing studies by Szasz and Goffman).

37. Hiday and Goodman, The Least Restrictive Alternative to Involuntary Hospitalization, Outpatient Commitment: Its Use and Effectiveness, J. of Psychiatry and Law, 81, 83 (Spring 1982); Pepper and Ryglewicz, supra note 33 at 388.

38.

39. See, Kiesler, Federal Mental Health Policymaking: An Assessment of Deinstitutionalization, 38 Am. Psychologist 1292, 1293 (1983).

40. Pepper and Ryglewicz, supra note 33, at 388. Lawmakers continue to struggle with competing fiscal and liberty interests. For example, in the recent legislative debate over proposed changes in Virginia's civil commitment provisions, lawmakers expressed strong concern that stricter commitment procedures would deprive many mentally ill persons of treatment and decent places to live. See, The Daily Press, Jan. 19, 1984, at 15, col. 1.

41. The application of deinstitutionalization overlaps somewhat with the application of the least restrictive alternative doctrine. For example, the definition of "deinstitutionalization" in a U.S. General Accounting Office report of 1977 incorporates inpatient care in the least restrictive environment into its definition. See Kiesler, supra note 30 at 1203. Also, one description of deinstitutionalization and its corrollary policies of "admissions diversion and short-stay hospitalization" suggests that there is more to deinstitutionalization that just releasing patients. Pepper and Ryglewicz, supra note 33 at 388.

42. Covington v. Harris, 419 F.2d 617 (D.C. Cir. 1969); Lake v. Cameron, 364 F.2d 657 (D.C. Cir. 1966). See also, infra notes ( ) and accompanying text.

43. For example, the federal government spends over 70% of its mental health funds on hospitalization. Kiesler, supra note 27, at 1323.

44. Kiesler, supra note 17, at 350. This financial coercion operates irrespective of the judgment of the attending mental health professional. Kiesler, supra note 39, at 1296. If the state wishes to realize its de jure policy of providing care in the least restrictive manner, it must reverse the present system of financial discentives, particularly in light of the fact that state and community mental health agencies are increasingly securing third-party payments. Id.

45. Kiesler, supra note 17, at 357. The most detailed of the cost-comparison studies found that the cost of day care treatment was 38% less than inpatient care. Id. at 357.

46. Id. at 352.

47. "[T]he postwar baby boom means that the number of schizophrenics is increasing substantially. Today nearly one third of the nation's population is between the ages of 21 and 36." Kiesler, supra note 39, at 1294.

48. Cite Clearinghouse for the Handicapped, Sept./Oct. 1983, p. 8. "The primary reasons for the prevalence of disability among the elderly is a 27 year increase in the average life expectancy of Americans since the turn of the century - from 47 years in 1900 to 74 years in 1980. Barrett, Information Resources on the Disabled Elderly, 5 Clearinghouse on the Handicapped, 8 (Sep.-Oct. 1983). (Citing DeJong and Lifchez, Physical Disability and Public Policy, SCIENTIFIC AMERICAN (June 1983). "As a result, the population of older persons has increased eight-fold from three million to over twenty-five million. One out of every nine persons is presently 65 or older. By the year 2000 the ratio will increase to one out of every eight persons, an increase of 32 percent (32 million persons)." Id.

49. For example, United States Senator Bill Bradley believes that the development of programs to provide the elderly with long-term medical and psychological services at home would be both more humane and less costly than our present system. Bradley, Toward Continued Independent Living for Older Americans, 38 Am. Psychologist 1353, 1353 (1983).

50. Williamsburg-James City County, Virginia.

51. No person may be involuntarily hospitalized unless a judge shall specifically find 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) 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 . . . Va. Code §37.1-67.3 (Repl. Val. 1976 & Cum. Supp. 1983).

52. cf. Perlin, The Legal Status of the Psychologist in the Courtroom, 4 Mental Dis. L. Rep. 194 (1980). "In the practice of law, just as in the practice of other professions or trades, it is often the mores and customs which deserve the attention usually paid to the written rules of substance and procedure. Although thousands of words are written about the subtle points of a significant court decision or statutory revision, usually limited analysis is given to what can be termed the socialization of the law". Id.

53. N. Ehrenreich, v. Roddy and E. Baxa, Civil Commitment in Virginia: Variations Between Law and Practice (June, 1982) (University of Virginia Institute of Law, Psychiatry and Public Policy) [hereinafter cited as Civil Commitment Study.]

54. Id., at 10.

55. Screening Report, supra note 8.

56. See id. at 1. See infra note 154.

57. 364 F.2d 657 (D.C. Cir. 1966).

58. The statute, D.C. Code §21-545 (b) provided for court-ordered alternative treatment "in the best interests of the person or the public."

59. 419 F.2d 617 (D.C. Cir. 1969).

60. Id. at 623.

61. See supra, n. 22.

62. See supra, n. 23.

63. 457 U.S. 307 (1983).

64. Substantive due process rights include the rights to privacy, Griswold v. Connecticut, 381 U.S. 479 (1965); autonomy, Roe v. Wade, 410 U.S. 113 (1973); liberty, Meyer v. Nebraska, 262 U.S. 390 (1923); and procreation, Skinner v. Oklahoma, 316 U.S. 535 (1942). When the Supreme Court recognizes a fundamental substantive due process right, the state must have a compelling reason to deny the right.

65. 457 U.S. at 319. The Court's remand of Scott v. Plante, 641 F.2d 117 (3d Cir. 1981), vacated, 102 S.Ct. 3474 (1982) (get U.S. cite), remanded 691 F.2d 634 (1982) in light of Youngberg suggests that Youngberg is equally applicable to the mentally ill. See Cook, The Substantive Due Process Rights of Mentally Disabled Clients, 7 Mental Dis. L. Rep., 346, 352, n. 2 (1983).

66. 457 U.S. at 319.

67. Id. at 321.

68. Id. at 323.

69. Id.

70. See, Civil Commitment Study, supra note 53, at 15.

71. One mental health journal states that the Court's "presumptively valid" standard in Youngberg either implicitly rejects the least restrictive alternative doctrine or makes the doctrine of little value to patients who allege a deprivation of their liberty interests. See 2 Developments in Mental Health Law 25, 25 (1982). But see Cook, supra note 65, at 350. Cook states that Youngberg's right to be free from unreasonable bodily restraints (and rights conferred on mental patients in prior cases) suggests that "the right to be held in the least restrictive environment, whatever its scope, requires individualized treatment," Id.

It is also unclear whether Youngberg will limit the holding in Dixon v. Weinberger, 405 F. Supp. 974 (D.D.C. 1975) and its progeny. See, e.g., Brewster v. Dukakis, Civil Action No. 76-4423 F (D. Mass. 1977) and Wuori v. Zitnay, Civil Action No. 75-80-5 D (D.Me. 1978). In Dixon, the United States District Court for the District of Columbia interpreted a statutory option to alternative treatments when the court believes it would be "in the best interests of the person or of the public" (D.C. Code §21-545(b)) as imposing a duty upon the government to create alternative treatment facilities when alternative treatment is appropriate and no treatment facilities exist. 405 F. Supp. at 977-78. The court's holding may have been influenced by testimony offered by the District of Columbia's Saint Elizabeth's Hospital that 43% of its patients could be treated more appropriately in alternative facilities. Id. at 976.

Although the court grounded its authority to order the creation of alternatives in the local statute, courts likely will not find constitutional authority to order the creation of alternatives after Youngberg. Since most state statutes enacted subsequent to the decision in Dixon have limited court ordered treatment in the least restrictive alternative to available alternatives, see infra note 80, courts most likely will not order the creation of alternatives. This situation is unfortunate because it limits courts to the unreasonable choice between unnecessarily retrictive care and no care at all.

72. 450 U.S. 221 (1981).

73. Id. at 225.

74. Id. at 226-27. Laws that adversely effect the interests of a particular group of people must be related to important government interests. If the law classifies groups on the basis of race, the government must have a compelling interest in enforcing the law and the law must be related closely to achieving the government's goals.

75. Id. at 230 (quoting from appellees' brief).

76. Id. at 231.

77. Id.

78. Lyon, Levine, and Zusman, Patients' Bill of Rights: A Survey of State Statutes, 6 Mental Dis. L. Rep. 178, 181-183 (1982). The authors found that all but these three states have statutory provisions that are substantially or partially equivalent to a federal statutory provision that recommends that patients have "(t)he right to appropriate treatment and related services in a setting which is most supportive and least restrictive of a person's liberty." Section 501, "Mental Health Systems

Act of 1980" (MHSA), Pub. L. No 96-398, 94 Stat. 1564 (1980). With the exception of §501, most of MHSA was repealed by the Omnibus Budget Reconciliation Act of 1981, Pub. L. No. 97-35, 95 Stat. 357 (1981). State legislatures increasingly have incorporated the least restrictive alternative doctrine into their mental health statutes in the last ten years. As of 1972, seventeen states' statutes expressed the least restrictive alternative doctrine in some form. Hoffman and Foust (supra note 15 at 1112, n. 41, 42. (citing Chambers, supra note 17 at 1139, n. 140, and Wexler and Scoville, The Administraton of Justice: Theory and Practice in Arizona, 13 ARIZ. L. REV. 1, 243-49 (1971)). Neither Chambers' or Wexler's survey, however, discovered any explicit references to the least restrictive alternative. Hoffman and Foust, supra note 15 at 1112, n. 44. As of 1977 thirty-five states had acknowledged the LRA doctrine either explicitly or by reference in their statutes. Id. at 1115. This characterization of state's mental health statutes is somewhat misleading because the actual scope of patients' rights is much more circumscribed. Section 501 of the MHSA recommends that states grant patients a series of twenty-five rights. Lyon, Levine, and Zusman, supra note 24, have concluded, however, that "the scope of state-recognized rights is significantly narrower than the federal patients' bill of rights." Id. at 180. The authors also note that Congress based in part its decision to make states' compliance with §501 discretionary on an inflated estimate that 35 states already had enacted similar provisions. Id. at 178, 180.

79. Ga. Code §37-3-1(10) defines "least restricitve alternative"; Ky. Rev. Stat. §202A.011(7) defines "least restrictive alternative mode of

treatment"; Mo. Rev. State §630.055.1(18) defines "least restrictive environment"; N.M. Stat. Ann. §43-1-3(D) defines "consistent with the least drastic means principle"; Tex. Code Ann. §5547-4(16) defines "least restrictive appropriate setting for treatment".

80. Our survey of the fifty states and the District of Columbia reveals that thirty-eight states now require courts to consider alternatives to hospitalization at this stage of the involuntary civil commitment process. Ala. Code §22-52-10(a) (Cum. Supp. 1983); Alaska Stat. §47.30.735(d) (Cum. Supp. 1983); Ariz. Rev. Stat. Ann. §36-540(B) (Supp. 1983); Conn. Gen. Stat. §17-178(c) (Supp. 1984); Del. Code Ann. Tit. 16, §5010 (Repl. Vol. 1983); Fla. Stat. §394.467(1)(b) (Supp. 1983); Ga. Code §37-3-81(c) (Cum. Supp. 1983); Hawaii Rev. Stat. §334-60(b)(1)(c) (Supp. 1982); Idaho Code §66-329(k) (Cum. Supp. 1983); Ill. Rev. Stat. ch. 91 1/2, §3-811 (1983); Ind. Code §16-14-9.1-9(g) (Cum. Supp. 1982) (commitment must be to an "appropriate facility" which is defined as a facility in which mentally ill persons can receive care in the least restrictive environment, §16-14-9.1-1(i); Kan. Stat. Ann. §59-2917 (Supp. 1982); Ky. Rev. Stat. §202A.026 (Supp. 1982); La. Rev. Stat. Ann. §28:55(E) (1984); Me. Rev. Stat. Ann. tit. 34-B, §3864(5)(E) (Supp. 1984); Md. Health-Gen. Code Ann. §10-632(d)(2)(r) (Cum. Supp. 1983); Mass. Gen. Laws Ann. ch. 123, §§1, 8 (1983) (LRA requirement limited to cases in which there is a "likelihood of serious harm" to the person himself); Mich. Comp. Laws §330.1469(1) (1980); Minn. Stat. §253B.09 (Supp. 1984); Mo. Rev. Stat. §632.335.4 (Supp. 1984); Mont. Code Ann. §53-21-127(2)(c) (1983); Neb. Rev. Stat. §83-1037 and 1038 (Cum. Supp. 1980); Nev. Rev. Stat. §433.A.310; N.M. Stat. Ann. §43-1-11(c)(3) (Cum.

Supp. 1982); N.D. Cent. Code §25-03.1-21 (Supp. 1983); Ohio Rev. Code Ann. §5122.15(E) (Supp. 1983); Okla. Stat. tit. 43A, §54.9(A) (Supp. 1983); Pa. Stat. Ann. tit. 50, §7304(f) (Supp. 1983); R.I. Gen. Laws §40.1-5-8(10) (Cum. Supp. 1983); S.D. Codified Laws Ann. §27A-9-16.1 (Supp. 1983) (a county board of mental health, not a court, determines whether placement can be made in the community rather than a state hospital); Tenn. Code. Ann. §33-604 (1983); Tex. Code Ann. §5547-50(e) (1984 Supp.); Utah Code Ann. §64-7-36(10) (Supp. 1983); Vt. Stat. Ann. tit. 18, §7617(c) (Supp. 1983); Va. Code §37.1-67.3 (Cum. Supp. 1983); W.Va. Code §27-5-4(j)(2) (Supp. 1983); Wis. Stat. §51.20(13) (Supp. 1983); Wyo. Stat. §25-10-110(j) (Supp. 1982). Of the thirteen jurisdictions without this statutory requirement, six jurisdictions allow the courts at their discretion to consider least restrictive alternatives, but they are not required to do so. Ark. Stat. Ann. §59-1409 (Supp. 1983); Cal. Welf. & Inst. Code §5354 (Cum. Supp. 1984) (limited to the area of placement in conservatorship services; although social services must investigate alternatives to conservatorship, the court's consideration of these alternatives is discretionary); D.C. Code Ann. §21-545(b) (1981); Iowa Code §229.14(3) (Supp. 1983); Miss. Code Ann. §41-21-75 (1981); N.C. Gen. Stat. §122-58.8(a)(4) (Cum. Supp. 1983). Six states make no mention of the doctrine in their commitment criteria. N.H. Rev. Stat. Ann. §135-B:26 (Repl. Vol. 1977); N.J. Rev. Stat. §30:4-44 (1981); N.Y. Mental Hygiene Law §9.27; 9.37 (Supp. 1983); Or. Rev. Stat. §426.130 (Supp. 1983); S.C. Code Ann. §44-17-580 (Cum. Supp. 1983); Wash. Rev. Code Ann. §71.05.280 (Supp. 1983). New York, however, has a group of state-funded mental health advocates who work to

ensure the protection of mentally disabled persons). Colorado incorporates the right to treatment in the least restrictive available alternative in a legislative declaration, but not in its commitment criteria. Colo. Rev. Stat. §27-10-101 (Repl. Vol. 1982).

Edward Beis' recent survey of state involuntary commitment statutes fails to reveal the extent to which the least restrictive alternative doctrine has been incorporated in commitment criteria. E. Beis, State Involuntary Commitment Statutes, 7 Mental Dis. L. Rep., 358 (1983).

81. Of the thirty-eight states that require consideration of alternatives to hospitalization prior to or at the time of commitment, twenty-five expressly limit court consideration of alternatives to those available. The states that require court consideration of alternatives to hospitalization but do not expressly limit the search to available alternatives include Kansas, Louisiana, Massachusetts, Minnesota, Missouri, Nebraska, Nevada, South Dakota, Utah, Virginia, West Virginia, Wisconsin, Wyoming. Of the six states that give their courts discretion to consider least restrictive alternatives, California and North Carolina expressly limit the search to available alternatives.

82. See supra notes 57, 58 and accompanying text.

83. See supra notes 63-71 and accompanying text.

84. See infra note 156.

85. Representatives of each of these political entities, usually interested citizens, serve on the Board.

86. The Department of Mental Health and Mental Retardation provides approximately 40% of the funds. Local governments supply 20% and fees for services generate the remaining 40%.

87. Va. Code §37.1-65. (Repl. Vol. 1976 & Cum. Supp. 1983).

88. See infra notes 112-114 and accompanying text.

89. Va. Code §37.1-67.1. (Repl. Vol. 1976 & Cum. Supp. 1983).

90. Id.

91. Va. Code §37.1-67.2. (Repl. Vol. 1976 & Cum. Supp. 1983).

92. Va. Code §37.1-67.3. (Repl. Vol. 1976 & Cum. Supp. 1983). The respondent may employ his own counsel at his or her own expense.

93. Va. Code §37.1-67.3. (Rep. Vol. 1976 & Cum. Supp. 1983).

94. The judge may accept written certification of the mental examiner's findings if the examination was made personally within the preceding five days and the person or his or her attorney does not object to such written certification. Va. Code §37.1-67.3. (Repl. Vol. 1976 & Cum. Supp. 1983).

95. Id. The person may appeal the judge's decision within 30 days of the court order.

96. Id.

97. Id.

98. Va. Code §37.1-67.1. (Repl. Vol. 1976 & Cum. Supp. 1983). See Civil Commitment Study, supra note 53 at 5-6 for statistics on who initiates civil commitment proceedings and what types of behavior trigger the petitioner to initiate proceedings.

99. Va. Code §37.1-67.1. (Repl. Vol. 1976 & Cum. Supp. 1983).

100. Id.

101. Id.

102. Although the circuit court judge appoints the special justices, he has no further involvement in the civil commitment process except to hear appeals of the speical justices' decisions.

103. Va. Code §37.1-1. (11). (Repl. Vol. 1976 & Cum. Supp. 1983). The Virginia Code's definition of "judge" includes judges, associate judges, and substitute judges of general district courts, as well as special justices as authorized by 37.1-88.

> The chief judge of each judicial circuit may appoint one or more special justices, for the purpose of performing the duties required of a judge by this title. At the time of appointment each such special justice shall be a person licensed to practice law in this Commonwealth, shall have all the powers and jurisdiction conferred upon a judge by this title and shall serve under the supervision and at the pleasure of the chief judge making the appointment. Special justices shall collect the fees prescribed in this title for such service . . .

Va. Code §37.1-88. (Repl. Vol. 1976 & Cum. Supp. 1983). Except where this report refers to a particular judge or special justice, "judge" denotes the person who performs the function of a judge in the civil commitment process.

104. Under the Virginia Code, the district court judge also could preside at commitment hearings. Va. Code §37.1-67.3. (Repl. Vol. 1976 & Cum. Supp. 1983).

105. Other reportedly reliable sources are the social services, the Williamsburg-James City County jail, and the Pines Convalescent Center.

106. The Screening Report, supra note 8, supports this view.

107. See infra notes 115-117 and accompanying text.

108. See Screening Report, supra note 8, at 20. The report states that detention beyond the prescreening should be contingent upon the results of the prescreening assessment. The report also recommends the development of local and regional detention centers to prevent detentions and hearings in state facilities where commitment decisions are made without accurate information about community resources.

109. See Screening Report, supra note 8, at 20. The authors recommend that temporary detention orders specify detention in the community mental health facility for the purpose of prescreening.

110. Va. Code §37.1-67.1. (Repl. Vol. 1976 & Cum. Supp. 1983).

111. Id.

112. Va. Code §37.1-65. (Repl. Vol. 1976 & Cum. Supp. 1983).

113. The civil commitment process in Williamsburg incorporates prescreening procedures in a manner that others have advocated. In a 1975 report commissioned by the Commonwealth of Virginia, the Arthur Bolton Associates stated that "nobody should be placed in a state institution without the recommendation of the [community] screening service." Report of the Commission on Mental Health and Mental Retardation to the Governor and the General Assembly of Virginia (Governor's Report), 1980, at 28 (quoting the 1975 Report of the Arthur Bolton Associates). In 1980, the Governor's Report emphatically affirmed the Bolton Associates report:

> All admissions to State institutions should be substantiated by referral of the local community services board. The board must be responsible for: (i) assessing the service needs of the mentally handicapped individual; (ii) referring the client to the appropriate State or community services; and (iii) presenting recommendations to the court regarding commitment to or certification for treatment in a State institution.

Governor's Report at 29. See also recommendation eight, Screening Report supra note 55, at 20.

114. Community service boards located close to State institutions bear the extra burdens of greater prescreening duties and contending with former patients who do not return after discharge to their original communities. Screening Report, supra note 8, at 7.

115. The Screening Report lists three goals of pre-admission screening:

> 1) establishing a consistent method for the determination and documentation of a client's need for hospitalization,
>
> 2) establishing a single point of entry into state psychiatric hospitals, and
>
> 3) screening out people who are not in need of hospitalization, but who need other more appropriate community resources."

Screening Report supra note 8, at 3. According to the report, 40% of all prescreened clients are diverted back into community-based services. Id. at 1.

116. Accord, Screening Report, supra note 8, at 20.

117. See supra note 115.

118. See infra notes 185-187 and accompanying text.

119. Respondents to a survey of institutional and community mental health staff conducted in the preparation of the Screening Report expressed strong concern about the utility of the prescreening form, especially in emergency situations. Screening Report, supra note 8, at 5.

120. Results of the Screening Report survey indicated that

> [s]everal components of the pre-admission screening had become so routinized as to be of questionable validity [and that] items concerning imminent dangerousness, substantial inability to care for self, need of institutional treatment and least restrictive environment were reported to have been completed in only a perfunctory manner. Most frequently cited as such was the item inquiring into the least restrictive treatment environment.

Id. at 5-6. Because of these information gathering deficiencies and the finding that 36% of all admissions to state hospitals are unsubstantiated, the Screening Report recommends that the Department investigate the clinical and legal indicators of the need for

hospitalization and adapt these indicators into a standardized prescreening form. Id. at 18.

121. Responses to the Screening Report survey indicated that prescreening for readmissions had become so routinized that prescreening was almost "automatic" and that alternatives are considered infrequently. In light of the Department's goal of treating patients in the least restrictive and most appropriate setting, the Screening Report recommends more thorough examination of previous in-patient services, changes in behavior since the person's last discharge, and his or her "behavior and potential relative to a chronic population." Id. at 19.

122. The staff at the Colonial Community Mental Health Center reported that completion of a prescreening evaluation requires __ hours. Those persons responding to the Screening Report survey reported an average time of 1 1/2 to 2 hours per screening evaluation, and an additional one hour of administrative followup work such as paperwork, contacting judicial and law enforcement personnel, and making admission arrangements for each person admitted to a hospital. Id. at 7.

123. The Screening Report attributes this lack of quality in part to the inadequacy of training in pre-admission screening procedures and recommends extensive training for prescreeners. Screening Report supra note 8, at 23. The authors report that "[f]or some community service boards, prescreening had become the paperwork to be completed only after a decision to hospitalize had been made, rather than a procedural component of service." Id. at 6.

124. The Mental Health Center presently is developing apartments to serve as less restrictive residential placements for long term psychiatric patients. See infra Section G-Alternatives to Involuntary Civil Commitment in the Williamsburg Area.

125. During the past year, the average length of stay in the unit that serves the Williamsburg area (Building 11) was 37 days. Another Eastern State administrator reported that, because there are fewer admissions to Building 11 and space is not lacking, the length of stay tends to be longer. This discrepancy most probably is based on the fact that the patients in Building 11 come from several localities. Eastern State no longer treats patients in geographically assigned units. See infra note 133.

126. Va. Code §37.1-65.1. (Repl. Vol. 1976 & Cum. Supp. 1983).

127. The Focus Team most frequently places the mentally retarded from the Williamsburg area at Southeastern Virginia Training Center in Chesapeake, Virginia, Petersburg Training Center and Sarah Bonwell Hudgins Regional Center in Hampton, Virginia. Some Eastern State Hospital patients reportedly are diagnosed as both mentally retarded and mentally ill but an Eastern State official did not know whether any of these patients are from the Williamsburg area.

128. In Williamsburg, one of the special justices who presides over civil commitment hearings also presides over hearings for mentally retarded adults.

129. One geriatric specialist described Hancock's prescreening procedures as model.

130. The total number of admissions prescreened in fiscal year 1982-83 was 42. The total number of rejected applicants was 21.

131. "The officer executing the order of temporary detention shall place such person in some convenient and willing institution or other willing place for a period not to exceed forty-eight hours prior to a hearing." Va. Code §37.1-67.1. (Repl. Vol. 1976 & Cum. Supp. 1983). One special

justice noted that persons are detained occasionally at a state approved alternate facility, including private hospitals such as Peninsula Psychiatric Hospital, Tidewater Psychiatric Hospital, and Riverside Hospital.

132. "Any person presented for admission to a hospital shall forthwith, and not later than twenty-four hours after arrival, be examined by one or more of the physicians on the staff thereof." Va. Code §37.1-70. (Repl. Vol. 1976 & Cum. Supp. 1983). This provision also appears to apply to examinations of individuals who have been brought to the hospital under a commitment order issued at a commitment hearing. One Eastern State administrator interpreted the statute to encompass both pre and post commitment examinations. See infra note 176 and accompanying text.

133. The hospital opened a new admissions suite in Building 2 in January, 1984. This new unit combines under one roof three activities -- admissions, detention, and post-commitment treatment. In the past, the hospital carried out these activities in separate buildings. This change is part of a larger organizational change in which the hospital no longer will be organized according to geographical units, but rather according to levels of care: short-term intensive treatment (Building 2), intermediate care, and long-term care for chronic patients. The new admissions-detention-treatment unit will have a capacity of 78 persons and is expected to expand to 90. The unit's administrator expects the average length of stay to be three to four weeks, although some stays will be as short as several days.

134. Va. Code §37.1-70. (Repl. Vol. 1976 & Cum. Supp. 1983).

135. Eastern State formerly held detainees in Building 27 which also sometimes housed violent or hard to manage patients from other units within the hospital.

136. See supra notes 112-122 and accompanying text.

137. At the time of this study, a social worker assigned to Building 27 met with the detainees. Presumably, a social worker in the Admissions suite now performs these tasks.

138. During the 1982-83 fiscal year, two special justices conducted a total of 422 commitment hearings at Eastern State Hospital. The hearings were held on Monday, Wednesday, and Friday afternoons in a conference room in Building 27. Occasionally, the hospital holds a hearing for a non-ambulatory person in an area of the hospital more convenient for that person. We observed twenty-four commitment hearings in five afternoons. The hearings lasted an average of eight to ten minutes, and ranged from three to twenty-two minutes. Recertification hearings are held monthly at the hospital's initiative to recommit patients who have been hospitalized for the maximum court ordered 180 days. Generally, special justices from other localities within Eastern State's catchment area conduct recertification hearings. The day we observed the hearings, however, a Williamsburg Special Justice presided. We observed 15 recertification hearings in one morning. Each hearing lasted an average of 10 minutes and ranged from 5 to 19 minutes.

139. The Virginia Code does not mandate the respondent's presence at the hearing, but the United States District Court for the Eastern District of Virginia has held that the respondent's presence at the hearing is required:

145. The special justice receives $25 if the respondent accepts voluntary admission but $50 if a commitment hearing is held.

146. The patient's right to refuse medication formerly depended in part on whether he or she was a voluntary patient. A patient's ability to make an informed decision about the risks and benefits of the medication now determines his or her right to refuse medication.

147. After seventy-two hours, the patient may give the hospital forty-eight hours notice that he or she wishes to leave the hospital. The forty-eight hour period permits the hospital to file a petition for involuntary commitment. Virginia Code §37.1-67.2. (Repl. Vol. 1976 & Cum. Supp. 1983).

148. Va. Code §37.1-67.3. (Repl. Vol. 1976 & Cum. Supp. 1983). In 1982, the average length of stay at Eastern State was 112 days. This figure includes chronically mentally ill patients. The average length of stay for newly committed patients was ___ days.

149. Va. Code §37.1-67.3. One special justice informs respondents of all of their rights at the beginning of the preliminary hearing. For statistics on the frequency with which judges read rights to respondents, see Civil Commitment Study, supra note 53, at 29.

150. Va. Code §37.1-67.3.

151. See supra text following note 117. The Civil Commitment Study revealed that mental health professionals paid much less attention to the commitment requirement that there be no less restrictive alternative placement than to the requirement that the person be dangerous or unable to care for himself or herself. "In 63 (79.8%) of the 79 cases where the merits of hospitalization per se were specifically

> "Even if Virginia law permitted the commitment hearing to be conducted without the presence of the person whose commitment is sought, the federal Constitution would require the presence of the person whose involuntary commitment is sought prior to an order of hospitalization being entered. The most elementary notions of due process require that an individual be permitted to be heard, and to hear the evidence adduced against him before actions are taken by the State which substantially deprive him of his liberty." Evans v. Paderick, 443 F. Supp. 583 (E.D. Va. 1977).

140. No attorney represents the hospital.

141. The respondent's right to summon other witnesses under Va. Code §37.1-67.3 implies the right to subpoena the petitioner as a witness. In conjunction with another suggestion that would transfer most commitment hearings to the localities from the state institutions, the State Department of Mental Health and Retardation similarly has recommended that the petitioner provide direct testimony at commitment hearings. Screening Report, supra note 55, at 21.

142. Because the court does not reimburse the community services boards for participation in commitment hearings, the services boards have difficulty justifying a major investment of staff time in commitment hearings. Their absence results in minimal input or consideration of community alternatives. Screening Report, supra note 55, at 8.

143. In every hearing we observed, the respondent accepted the services of the court-appointed attorney.

144. Va. Code §37.1-67.2. (Repl. Vol. 1976 & Cum. Supp. 1983). In our study, the special justices always gave the respondents an opportunity to apply for voluntary admission. In the Civil Commitment Study, however, "the judicial officer failed to follow the law's requirement that the respondent be offered the opportunity to become a voluntary patient" in over half of the cases. Civil Commitment Study, supra note 53, at 11.

addressed, the physician testified either that it was the best or that it was the only treatment available. In 56.6% of the cases, no testimony about less restrictive alternatives was elicited at all." Civil Commitment Study, supra note 53, at 10.

152. A 1974 survey of judges found that judges asked advice of attorneys and examining physicians in over half the cases but social workers were consulted routinely only 26% of the time. The judges participating in the survey consulted the patient in 47% of the cases, and the patient's family and friends in 42% of the cases. Hoffman & Foust, supra note 15, at 1133.

153. Va. Code §37.1-67.3. (Repl. Vol. 1976 & Cum. Supp. 1983).

154. In the evaluation of civil commitment in Virginia described in the Screening Report, supra note 8, a Level of Care Survey was carried out for adults involuntarily committed during a two week period. The Level of Care Survey used in the study measured 18 areas of the individual's functioning and included information from the commitment hearing evaluation. Avellor, Biskin, and Gouse, A Clinical and Legal Evaluation of the Need for Involuntary Commitment. 2 DEVELOPMENTS IN MENTAL HEALTH LAW 32 (Oct.-Dec. 1982). The authors of the Screening Report found that 33.3% of all psychiatric commitments during the two week study period were unsubstantiated based on the Level of Care Survey validation standard. Of this 33.3%, 40.5% had faulty least restrictive environment assessments. Id. at 34.

155. The authors of the Civil Commitment Study, supra note 53, found that the subject of less restrictive alternatives was not mentioned in 48.5% of commitment hearings (and 69.4% of recommitment hearings) and

that "[a] specific finding regarding the availability and/or suitability of a less restrictive alternative (LRA) was made in [only] 24.3% of the commitments and 30.6% of its recommitments." Id. at 7.

156. The Civil Commitment Study, supra note 53, attributes the perfunctory consideration of less restrictive placements to several factors: a) attorney passivity; b) the special justice's awareness of the shortage of alternative placements in Virginia; and c) the special justice's belief that they lack the power to enforce orders for alternative placements. Id. at 12.

Hoffman & Foust, supra note 15, express the different view that the "unworkability of less restrictive alternatives and not the failure to consider them, ultimately leads to most commitment proceedings...[I]t is little wonder, therefore, that many judges in Virginia believe the requirement to find less restrictive alternatives inappropriate before ordering involuntary hospitalization to be a mere formality." Id. at 1139.

157. One Eastern State psychiatrist stated that the hospital clearly bears the burden in hearings to recommit patients.

158. Although the Virginia Code does not state who has the burden of proving there are no less restrictive alternatives, Hoffman and Foust suggest that "it may be agreed that listing the review and rejection of less restrictive alternatives in a three-part statutory requirement for involuntary treatment places the burden on the petitioner." Hoffman & Foust, supra note 15, at 1137. Moreover, Hoffman and Foust's survey of Virginia judges found that given a choice between assigning the burden of proof to the petitioner or the respondent, 68% of the judges stated that

"the petitioner must show the undesirability of alternatives before hospitalization can be ordered." Fifteen percent of the judges placed the burden on the respondent and 17% were undecided. Id. These results do not reflect necessarily the attitude of judges today because the survey was taken ten years ago, shortly after the law was changed to include the least restrictive alternative criterion. The survey also did not give the judges the choice of placing the burden on other parties, such as the hospital, or the community mental health clinics. No Virginia court has addressed directly the issue of who has the burden of investigating less restrictive alternatives to hospitalization, but several other jurisdictions have addressed this issue. (update this).

159. Va. Code §37.1-67.3. (Repl. Vol. 1976 & Cum. Supp. 1983).

160. Id. Court appointment of guardians, Va. Codes §37.1-128.1., -128.2. (Repl. Vol. 1976 & Cum. Supp. 1983) and release of the person to the custody of one who posts bond, Va. Code § 37.1-125 (Repl. Vol. 1976), appear to be additional less restrictive dispositions available to the court in commitment proceedings, but the Williamsburg judges do not use either provision. Although one special justice said that he could order the initiation of guardianship proceedings in circuit court, he has never done so. At one recertification hearing, the special justice continued the hearing to allow the hospital time to appoint a committee to dispose of a patient's property. The patient had been prevented from receiving funds for admission to a nursing home because she owned a small piece of property. The court also occasionally returns a patient to his family, but never under a court order.

161. According to the records supplied by the administrator of Eastern State, the court ordered out-patient treatment for 48 of the 98 persons released at commitment hearings during 1982.

162. The Governor's Report, supra note 113, noted the dearth of community alternatives: "[u]nfortunately, the impetus to remove individuals from institutional care has superceded the development of viable alternatives for the appropriate care of the mentally handicapped at the community level." Id. at 17.

163. See infra note 185 and accompanying text.

164. The Civil Commitment Study, supra note 53, found that some judges hesitated to order alternative placements because they believed that they lacked the power to enforce those orders. "[Judges] seemed to be interpreting the statute to imply that a special justice loses jurisdiction over the respondent once the commitment hearing is completed and therefore cannot subsequently order the police to pick him or her up for violation of a court order. Furthermore, the judges believed that ... charging [respondents] with contempt of court and imposing a jail sentence was an inappropriate response to a mentally ill person's failure to report for treatment." Id. at 13.

165. In Dixon v. Weinberger, 405 F. Supp. 974 (D. D.C. 1975), the United States District Court for the District of Columbia held that both the District of Columbia and the federal government violated the 1964 Hospitalization of the Mentally Ill Act, 21 D.C. Code §§501 et. seq. The defendants had failed to place in alternate facilities patients whose needs could be served in settings less restrictive than St. Elizabeth's Hospital. Id. at 979.

166. Hoffman and Foust, supra note 15, at 1128.

167. Id. at 1127.

168. Id.

169. According to the Director of Eastern State Hospital, from 359 commitment hearings held in 1982, 96 were released.

170. The Civil Commitment Study, supra note 53, found that in 52.8% of observed commitment hearings, the judge did not inform the respondent of his or her right to appeal. Id. at 7.

171. Attorney passivity in civil commitment proceedings has been the subject of a number of studies. See, e.g., Slobogin, The Attorney's Role in Civil Commitment, 1 MENTAL HEALTH LEGAL STUDY CENTER NEWSLETTER, (March, 1979); Cyr, The Role and Functions of the Attorney in the Civil Commitment Process: The District of Columbia Approach," 6 J. PSYCHO. & LAW 107 (1978).

172. Va. Code §37.1-89. (Repl. Vol. 1976 & Cum. Supp. 1983).

173. Slobogin, supra note 171, states that "a phenomenon ... appears to exist nationwide: attorneys who have been trained to represent their clients' interests zealously within the bounds of the law, and probably do so in other contexts, undergo a metamorphosis when they participate in the commitment process. Instead of taking an active advocacy role, they abdicate their responsibilities as lawyer and assume an 'amicus' or 'guardian ad litem' position." Id. (citing Woe & Mundy) (get cites & names).

174. The Executive Secretary's office postponed this study pending the 1983-84 General Assembly's action on proposed changes in Virginia's civil commitment statutes. Telephone interview with Executive Secretary's office (Dec. , 1983). The proposed changes would have provided stricter procedural safeguards and were aimed at reducing inappropriate admissions to state mental hospitals. See Geraty, Civil Commitment in Virginia:

1984 Legislative Proposals, 3 DEVS. IN MENTAL HEALTH LAW 25 (Oct.-Dec. 1983). Opponents of the proposed changes expressed fear that the stricter commitment procedures would prevent treatment for many persons in need of mental health services. Washington Post, Feb. 1, 1984, at B1, col.____.

175. The authors of the Civil Commitment Study, supra note 53, suggest that the structured commitment process mandated by the Virginia Code, which requires both a judge and medical testimony, indicates that the legislature prefers independent judicial decisions informed but not dominated by medical opinion. Id. at 16. Transferring the responsibility for commitment hearings to mental health professionals may have no significant effect on the outcome of commitment hearings because, as the Civil Commitment Study notes, "most of the available data suggests [sic] that judicial officers' performance under statutes similar to Virginia's tend to virtually accept without question the recommendations of expert witnesses." Id.

176. Va. Code §37.1-70. (Repl. Vol. 1976 & Cum. Supp. 1983). See supra notes 132-134 and accompanying text.

177. Inappropriate commitments of elderly persons from rural areas who have no other place to go are particularly problematic for the Hancock Geriatric Treatment Center at Eastern State. Although these persons may be deteriorating physically, and their mental faculties are diminished, they are not mentally ill. These elderly persons typically are committed in other localities after Hancock has refused them voluntary admission. Often, their medical benefits have expired, and the nursing home or hospital where they had been no longer will treat them. Because

the people are desperate, the geriatric unit admits some of them. This practice has created a dilemma for Hancock. Admitting elderly persons who are not mentally ill contributes to Hancock's image as a crisis center for people with no where else to go. Hancock also is not eager to increase admissions because it does not benefit financially from increased admissions. Moreover, Hancock has agreed to reduce its population to comply with State Mental Health Commissioner Bevilacqua's census reduction policy.

178. Hospital regulations do not permit discussions with the patient's community mental health center without the patient's consent, but consent rarely is withheld.

179. (Cite for periodic review.)

180. Va. Code §37.1-67.3. (Repl. Vol. 1976 & Cum. Supp. 1983).

181. Va. Code §§37.1-121 to 123. (Repl. Vol. 1976 & Cum. Supp. 1983).

182. Currently, CSS clients visit day care programs in Hampton, Newport News and Virginia Beach. In the near future, Chesapeake will be added to the program. Because few Williamsburg area patients participate in the CSS program, CSS staff do not take Williamsburg patients to the Community Mental Health Center on a regular basis. Because of limited alternative housing in Williamsburg, CSS staff encourages Williamsburg patients to reside elsewhere upon discharge.

183. The clubhouse concept is based on the psychological model of mental health therapy. Participants in the clubhouse usually operate a business activity such as a thrift store and thus learn social and self-help skills.

184. See generally, Guernsey, The Mentally Retarded and Private Restrictive Covenants, 25 WM & MARY L. REV. 421 (1984).

185. The Mental Health Center also administers a substance abuse program.

186. The Human Rights Committee is a group composed of seven members of the community appointed by the State Human Rights Committee. The Committee's task is to insure humane treatment and care of mentally disabled patients in the least restrictive manner possible.

187. [cite to articles discussing tailoring services to meet needs of different kinds of populations].

188. See supra note 127 and accompanying text.

189. If the client can not meet his or her own needs, home is not the least restrictive alternative.

190. The Virginia Code requires that local zoning ordinances provide for group homes for the mentally retarded, the developmentally disabled and the mentally ill in "appropriate residential zoning district." Va. Code §15.1-486.2. (Repl. Vol. 1981). Local ordinances may impose special conditions on group homes "only when such additional conditions are related to the physical or mental handicap of the residents and are necessary to protect the health and safety of the residents of such homes." Id. at §15.1-486.2.C.

THE NEW YORK REPORT

INTRODUCTION

> The long-term rehabilitation of mentally disabled persons is promoted by maintenance of relationships with other persons and agencies in the community, avoidance of institutionalization, and minimization of disruption of life rhythms. The civil rights of mentally disabled persons require that such persons be treated and served in the least restrictive setting possible in which treatment or service goals can be met.[1]

This statement of philosophy, which appears in a section of the New York Code of Rules and Regulations promolgated by the Commissioner of Mental Health,[2] has no parallel in New York's Mental Health Act.[3] Rather than requiring the least restrictive setting possible, the Legislature's policy statement calls for the development of a mental health system that "should include, whenever possible, the provision of necessary treatment services to people in their home communities; ... should assure the adequacy and appropriateness of residential arrangements for people in need of service; and ... should rely upon improved programs of institutional care only when necessary and appropriate."[4] Although this policy aspires to shift the locus of mental health services away from institutional settings, the statutes provide mental patients an expressed right to less restrictive treatment only in one limited situation. That is, a patient may be placed in physical restraints "only if less restrictive techniques have been clinically determined to be inappropriate or insufficient to avoid" serious injury to the patient or others.[5]

The Court of Appeals of New York has recognized, however, that involuntarily committed patients have a due process right to the least

restrictive institutional placement. In Kesselbrenner v. Anonymous,[6] the court held unconstitutional a statutory provision that authorized the confinement of a dangerously mentally ill person, who had not been charged with or convicted of a crime, in Matteawan State Hospital, a correctional facility for mentally ill convicts. In reaching this result, the court said: "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."[7] The court concluded that no reasonable relationship existed between such punitive confinement and the therapeutic purpose sought to be achieved.[8] In addition, the court quoted with approval from a United States Court of Appeals for the District of Columbia opinion:[9]

> "[T]he principle of the least restrictive alternative consistent with the legitimate purposes of a commitment inheres in the very nature of civil commitment. ... A statute sanctioning such a drastic curtailment of the rights of citizens must be narrowly, even grudgingly, contrued in order to avoid deprivations of liberty without due process of law.[10] The court held that only confinement in a mental health facility was acceptable."

Kesselbrenner directly addressed the proper placement of an institutionalized patient. Its rationale arguably applies, however, not to just where a patient should be placed, but whether the patient should be subject to involuntary hospitalization. The Family Court of New York County used a similar rationale in In re Andrea B.[12] to hold that a 14-year-old patient who challenged her continued involuntary hospitalization should be released because her needs could be met by services less restrictive than hospitalization. The court reasoned that "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."[13] Furthermore, even though a governmental purpose is legitimate and substantial, it must not be achieved by "means that broadly stifle fundamental personal liberties when the end can be more narrowly achieved."[14]

Although the precedential value of In re Andrea B. is dubious, Kesselbrenner has implications regarding involuntary civil patients. Unlike many jurisdictions,[15] New York does not provide involuntary patients with a comprehensive statutory right to the least restrictive treatment alternative, including a right to noninstitutional placement when appropriate. In fact, the Mental Health Act precludes the initial placement of an involuntary patient in a non-hospital setting.[16] Kesselbrenner qualifies the statutory language requiring hospital placement by suggesting that, on constitutional grounds, the particular hospital chosen must be the least restrictive appropriate setting, that the placement within that hospital be the least restrictive, and that the actual treatment administered be the least restrictive.

Two cases currently pending in New York City go beyond Kesselbrenner and present the issue of whether patients are entitled to receive treatment in the least restrictive environment upon release or discharge from a psychiatric hospital. These cases, Klosterman v. Cuomo[17] and Joanne S v. Carey,[18] were refiled in the Supreme Court after the Court of Appeals unanimously reversed the Appellate Division's holdings that the complaints failed to present justiciable controversies.[19] The plaintiffs in Klosterman were each treated in a psychiatric hospital and discharged, thereafter joining the homeless wandering the streets of New

York City.[20] The plaintiffs contend that they are entitled under State law to receive appropriate residential placement, supervision, and care.[21] The plaintiffs in Joanne S. are currently hospitalized at the Manhatten Psychiatric Center, have been found ready for release or discharge, but have not been released or discharged because adequate residential placements are unavailable.[22] They seek their release into community treatment settings.[23] The plaintiffs in both cases seek to compel the development of sufficient community alternatives for the plaintiffs and the members of the classes they represent.[24]

The Court of Appeals addressed only the justiciability issue and not the merits of the plaintiff's causes of action.[25] If the merits are ultimately decided in favor of the plaintiffs, the results could be as far-reaching for the mentally ill as the Willowbrook consent decree has been for the mentally retarded. The Willowbrook consent decree was signed by then New York Governor Hugh L. Carey on April 22, 1975, and subsequently was approved by the United States District Court for the Eastern District of New York in New York State Ass'n for Retarded Children v. Carey.[26] The decree required, among other things, that the defendants "take all steps necessary to develop and operate a broad range of non-institutional community facilities and programs" to meet the needs of persons residing at the Willowbrook State Developmental Center, now the Staten Island Developmental Center.[27] Despite the defendants' failure to comply with the decree in several respects,[28] the decree has resulted in the care for mentally retarded persons becoming primarily community-based rather than institution-oriented,[29] and in a proliferation of community residences for the mentally retarded.[30]

This article explores the use of alternative treatment for mentally

ill persons subject to involuntary civil commitment proceedings under current New York law. More specifically, it focuses on the effect that the Mental Health Act and other relevant statutes have had on the application of the least restrictive alternative doctrine[31] in New York City. It also explores other factors that have facilitated or confounded application of the doctrine. To provide a framework for this discussion, a brief overview of the involuntary civil commitment process in New York follows.

I. OVERVIEW OF CIVIL COMMITMENT IN NEW YORK

The Mental Health Act provides four basic procedures for initiating involuntary civil commitment proceedings. The one most frequently used in New York City is the emergency admission procedure.[32] Under this procedure, a peace officer or police officer may take into custody and transport to a hospital any person who is apparently mentally ill and whose behavior is likely to result in serious harm to the person or others.[33] The hospital may retain the person for up to 15 days if immediate observation, care, and treatment in a hospital is appropriate for his or her mental illness and if the mental illness is likely to result in serious harm to the person or others.[34] The next basic procedure may be used either to initiate an involuntary admission[35] or to extend the detention of a person subject to 15-day emergency admission.[36] Any person alleged to be mentally ill and in need of care and treatment in a hospital may be retained for up to 60 days upon certification by two examining physicians and application by any of

several specified persons, including certain relatives or the hospital director.[37] This second procedure is called a "two-physician certification" or a "two-PC" in New York City. The third procedure permits a director of community services or his or her designee to apply for immediate 72-hour admission of an allegedly mentally ill person if the person meets criteria identical to the emergency admission criteria.[38] A hospital staff physician must confirm the need for immediate hospitalization before the admission.[39] Certification by a second physician is necessary within 72 hours, excluding Sundays and holidays, to continue the involuntary admission for up to 60 days.[40] The fourth procedure allows a hospital director to retain for up to 72 hours any voluntary patient who has applied in writing for discharge if reasonable grounds exist to believe that the patient may need involuntary care and treatment.[41] The hospital director must apply to the court for a 60-day retention order to extend the involuntary status beyond the 72-hour period.[42]

This last initiation procedure is the only one that requires a judicial retention order before the initial 60-day commitment period. The first three procedures require a retention order before the 60-day period expires if the hospital wants to involuntarily retain the patient for a longer peiod.[43] Whenever a hospital applies for a retention order, the patient may request a hearing on the application.[44] In addition, the patient on his or her own initiative may challenge the commitment by requesting a hearing on the need for involuntary care and treatment.[45] Regardless of whether the hospital has applied for a retention order or the patient has challenged the commitment, the hearing is conducted in the same manner.[46] Following the initial 60-day

treatment period, the court may order continued involuntary hospitalization for up to six months if the patient remains in need of involuntary care and treatment.[47] At the end of this period, the court may order treatment for up to an additional year.[48] Subsequent treatment periods of up to two years each may be ordered.[49]

II. ALTERNATIVE TREATMENT AND THE MENTAL HEALTH ACT

The involuntary civil commitment procedures prescribed by the Mental Health Act do not require that treatment be administered in the setting or manner least restrictive of patients' liberty.[50] The least restrictive alternative doctrine and the State's policy to shift the locus of mental health services away from institutional settings[51] are apparent in only four limited areas, each of which is discussed below. In general, the ideals of the doctrine and the State's policy have not been realized in New York City. The constraints of limited alternative resources often have frustrated serious attempts by the courts and the mental health system to guide persons subject to involuntary commitment procedures to appropriate levels of treatment.

A. Hierarchy of Admission Classifications

The availability of alternative resources is not a factor in the first area. This area relates to alternative dispositions within an institution or hospital.[52] Influence of the least restrictive alternative doctrine is apparent in the creation of a hierarchy of addmission statuses, beginning with the least restrictive informal status, followed by voluntary status, and finally involuntary

status.[53] Informal admission is preferred.[54] 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.[55] A voluntary patient must apply in writing for admission and, prior to being released from the hospital, must apply in writing for release.[56] Following an application for release, the director may retain the patient for up to 72 hours if there are "reasonable grounds for belief" that the patient needs involuntary care and treatment.[57]

Voluntary and informal admissions are preferred to involuntary admissions.[58] All state and local official with responsibilities regarding mentally ill persons have a duty to encourage any person suitable for voluntary or informal admission and in need of inpatient care and treatment for mental illness to apply for voluntary or informal admission.[59] Furthermore, 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."[60]

The apparent legislative intent that involuntary admission be the admission status of last resort, and that informal be preferred to voluntary admission, is only partially realized in New York City. Informal status is virtually never used. Several practitioners whom the author interviewed[61] said that few patients understand the distinction between the voluntary and informal statutes well enough to know to ask for informal admission. They suggested that even though the hospital is obligated to explain these statuses to patients,[62] they often do not. Informal status is disfavored among practitioners in New York City because a disturbed patient may simply leave at any time, thereby terminating ongoing treatment. Some expressed the concern that the

hospital might be liable if a released informal patient harmed someone. The Supreme Court, Appellate Division has found, however, that no such liability would attach.[63]

Hospital staff report that patients seldom are converted from involuntary to voluntary status. It appears that staff are reluctant to convert patients to voluntary status unless they believe that the patients are sincerely motivated to accept treatment. It is generally acknowledged in New York that involuntary patients sometimes convert to voluntary status in hope of signing themselves out of the hospital.

B. Two-PC Examination

Before each examining physician certifies a patient for involuntary admission to the hospital,[64] the Mental Health Act requires that he or she "consider alternative forms of care and treatment that might be adequate to provide for the person's needs without requiring involuntary hospitalization."[65] This provision requires only that each physician "consider" alternatives but does not require a physician to take any particular action regarding actual alternative placement. Several attorneys interviewed suggested that the least restrictive alternative doctrine, as expressed in this provision, makes little difference in the admission decision because physicians generally fail to seriously consider alternatives. They said that the two-PC papers are used as a way of giving legal status to a clinical situation. That is, they are procedural and not substantive. These attorneys suggested that at retention hearings, the examiners have become sophisticated enough to answer quesions regarding alternatives so as to support the recommendation for hospitalization.

During hearings that the author observed, the examiners' testimony

tended to include general statements to the effect that no suitable alternatives existed, without mentioning any specific facilities or programs. The testimony focused on the severity of the particular patient's condition and the necessaity for 24-hour, inpatient supervision. In rare instances, examiners testified generically about possible alternatives. For example, one examiner testified that support services provided to the patient in her own home would be inappropriate. Another testified that a patient could not be released to his family because the family was not receptive. In all cases observed, the court ordered the maximum, six-month retention.

C. Hearing Following Admission on Two-PC

The Mental Health Act does not require the court to consider alternatives to inpatient treatment, nor does it permit the court to order alternatives.[66] The least restrictive alternative doctrine is apparent in the statutory provisions for hearings following involuntary admission on medical certification in only 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 committees."[67] Because "transfer" is not defined it is unclear from the face of the provision whether transfer to relatives or a committee constitutes a "release," meaning mere termination of inpatient care,[68] or "discharge," meaning release and "termination of any right to retain or treat the patient on an in-patient basis."[69] Thus, it is unclear whether a court's exercise of this provision would result in an involuntary placement less restrictive than inpatient care or merely an

absolute discharge.

This is the only provision in the New York statute that even suggests that a hearing court might order placement less restrictive than hospitalization. Section 9.01 implies, however, that the court's authority is limited to deciding whether treatment in a hospital is appropriate and would not permit involuntary placement outside of a hospital. This interpretation is applied in New York City. In any event, the court rarely orders a patient discharged to his or her family because they are usually absent. When the court does order discharge, it follows no established procedure. Rather than requiring written consent as provided in statute,[70] the court typically asks present family members if they will care for the patient and evaluates their sincerity.

Statutes of many states authorize the courts to order placement outside of a hospital.[71] For example, the Virginia Code permits the court to order outpatient 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."[72] Several interviewees stated that, in principle, they would favor a statutory amendment giving New York courts this authority, but that it would make little practical difference until new alternative facilities and programs were developed.

As a practical matter, judges in New York City view less restrictive alternatives as a threshold question; that is, if a less restrictive placement is appropriate and available, involuntary retention is not ordered. In each case, attorneys of the Mental Health Information Services (MHIS), who represent patients at retention hearings, prepare a memorandum for the court which quotes the New York Code of Rules and

Regulations, cited at the beginning of this article,[73] that expresses a right to treatment in the least restrictive setting. At the hearing, a MHIS attorney may challenge an examining physician's testimony regarding alternatives through cross-examination, or may actually present an alternative treatment plan to the court. One judge interviewed stated that the MHIS usually do not realistically present detailed alternatives to the court, but that in a borderline case he would be receptive to such a presentation. He suggested that the MHIS seldom inquire into community alternatives, but rather present legalistic, "boiler plate" arguments.

An MHIS representative, on the other hand, stated that in most hearings they are forced to hammer away at the legal commitment criteria because of the lack of available alternatives. He stated that the MHIS frequently does investigate alternatives, but that it is difficult to arrange for a patient to be accepted in a community treatment program before the hearing. Understandably, many judges are reluctant to refrain from ordering retention simply because a community program exists that might be appropriate for the patient. Most judges require some assurance that the patient will be accepted by and enter the program before they will order the patient's discharge.

D. Discharge and Conditional Release

Statute permits the hospital to discharge or conditionally release an involuntary patient if he or she "does not require active in-patient care and treatment."[74] The patient may be conditionally released, rather than discharged, if his or her clinical needs warrant this more restrictive placement.[75] 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.[76]

The conditional release provisions provide the hospital an opportunity to release a suitable patient to a less restrictive placement while retaining the authority to supervise the patient and to bring the patient back into the hospital if the community placement is ineffective or if the patient fails to participate in the treatment program. The status is not used at acute care hospitals in New York, such as Bellevue Hospital, and is rarely used at long-term care facilities, such as Manhatten Psychiatric Center. The primary reason is, once again, lack of available resources. Hospital staff state that there are insufficient alternative facilities or programs and insufficient personnel to follow-up with released patients to monitor their progress. Thus, the hospital must either simply discharge or retain the patient. Another reason is that, because hospitals have no mechanism to control potentially dangerous patients on release status, they fear third-party liability.

Since the conditional release provisions were added to the Mental Health Act in 1975, only about 30 patients at Manhatten Psychiatric Center have been placed on that status. Because of the resource limitations discussed above, the hospital reportedly, has not followed statutorily required monitoring procedures.[77]

According to one MHIS attorney, at any given time at least six or seven patients ready for discharge or release are held at Manhatten Psychiatric Center because they have no place to go. Some of these patients wait as long as six months to a year for alternative placement. This situation resulted in the filing of Joanne S. v. Carey discussed earlier.[78]

III. THE AVAILABILITY OF ALTERNATIVES

The primary obstacle to application of the least restrictive doctrine in New York is not that statute fails to require it or that the actors in the commitment process are insensitive to the merits of alternative treatment,[79] but that alternatives to the hospital are virtually non-existent. For example, in the Bronx 1,200 residential beds are needed but only 218 now exist. Alternatives such as community residential facilities[80] are drawing up because of rising real estate costs[81] in the City and because of insufficient state funding appropriations.[82] Also, the alternatives that are available are plagued by long waiting lists and formidable bureaucratic intake requirements that can result in placement delays of one to two months or more.[83] The creation of more alternatives is the obvious prerequisite to the effectiveness of legal or regulatory reforms aimed at promoting the use of alternative treatment.[84]

Footnotes

1. N.T. Admin. Code tit. 14 §36.1 (1982).

2. See N.Y. Mental Hug. Law §29.01 (Supp. 1983-1984).

3. See id. at §7.01 (1978).

4. Id.

5. Id., at §33.04(b).

6. 33 N.Y. 2d 161, 305 N.E. 2d 903, 350 N.Y.S. 2d (1973).

7. Id., 350 N.Y.S. 2d at 892 (citing Jackson v. Indiana, 406 U.S. 715 (1972)).

8. Id.

9. Covington v. Harris, 419 F.2d 617, 623 (D.C. Cir. 1969).

10. Kesselbrenner, 350 N.Y.S. 2d at 894.

11. Id.

12. 94 Misc. 2d 919 (Fam. Ct. N.Y. County 1978).

13. Id. at 925.

14. Id.

15. See e.g., Welf. & Inst. Code §5325.1(a) (Supp. Pamplet 1973-1983) (California); Ill. Ann. Stat. ch. 91 1/2, §2-102(a) (Smith-Hurd Cum. Pocket 1983-1984); Mo. Ann. Stat. §630.115.1(10) (Vernon's Cum. Pocket 1984); Va. Code §37.1-84.1(6) (Repl. Vol. 1976); Wis. Stat. Ann. §51.61(1)(3) (West Cum. Supp. 1983-1984).

16. See N.Y. Mental Hyg. Law §9.01 (Cum. Supp. 1983-1984) (defines "in need of involuntary care and treatment" as having "a mental illness for which care and treatment as a patient in a hospital is essential ..." (emphasis added)). After initial placement in a hospital, a patient may be conditionally released into the community. See id. at §29.15 and infra notes 74-78 and accompanying text.

17. Index No. _____ (Sup. Ct. N.Y. County filed ____).

18. Index No. 18493/82 (Sup. Ct. N.Y. County filed _____).

19. The cases were consolidated for argument in the Court of Appeals. See Klosterman v. Cuomo, Nos. 87, 88 (N.Y. Ct. App. Mar. 27, 1984).

20. Id. at 2.

21. Id. at 3. These claims are grounded in N.Y. Mental Hyg. Law §29.15(f)-(h) (Cum. Supp. 1983-1984).

22. Klosterman at 6.

23. Id.

24. Id. at 5, 6.

25. See id. at 7.

26. 393 F. Supp. 715 (E.D.N.Y. 1975), enforced, 551 F. Supp. 1165 (E.D.N.Y. 1982), cert. denied, 104 S. Ct. 277 (1983) (complete prior and subsequent case history may be found in 551 F. Supp. at 1167 n.1).

27. 393 F. Supp. at 717.

28. See 551 F. Supp. at 1167, 1192.

29. See id. at 1168.

30. See id. at 1188.

31. The least restrictive alternative doctrine holds that "governmental action must not intrude upon constitutionally protected interests to a degree greater than necessary to achieve a legitimate purpose." Hoffman and Foust, Least Restrictive Treatment of the Mentall Ill: A Doctrine in Search of Its Senses, 14 San Diego L. Rev. 1100, 1101 (1977). Within the mental health area, the doctrine means, generally, that treatment and care should be no more restrictive than necessary to achieve legitimate therapeutic aims. See Suggested Statute on Civil Commitment, 2 Mental Disability L. Rptr. 127, 129 (1977). The doctrine has not been defined in the statutes or case law of New York. The definition varies among states that have defined it. See Ga. Code §37-3-1(10) (1982) ("the least restrictive available alternative, environment, or care and treatment, as appropriate, within the limits of state funds specifically appropriated therefor"); Ky. Rev. Stat. §202A.011(7) (Interim Supp. 1982) ("that treatment which will give a mentally ill individual a realistic opportunity to improve his level of functioning, consistent with accepted professional practice in the least confining setting available");

> [A] reasonably available setting where care, treatment, habilitation or rehabilitation is particularly suited to the level and quality of services 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 activites, giving due consideration to potential harmful effects on the

person. For some mentally disordered or mentally retarded persons, the least restrictive environment may be a facility operated by the department.

Mo. Rev. Stat. §630.005.1(18) (Supp. 1984);

[T]he habilitation or treatment and the conditions of habilitation or treatment for the client separately and in combination [that]: (1) are no more harsh, hazardous, or intrusive than necessary to achieve acceptable treatment objectives for such client; (2) involve no restrictions on physical movement nor requirement for residential care except as reasonably necessary for the administration of treatment or for the protection of such client or others from physical injury; and (3) are conducted at the suitable available facility closest to the client's place of residence.

N.M. Stat. Ann. §43-1-3(D) (1978).

32. See N.Y. Mental Hyg. Law §9.39 (1978).

33. Id. at §9.41 (Supp. 1983-1984).

34. Id. at §9.39(a) (1978) "Likelihood to result in serious harm" means:

(1) substantial risk of physical harm to himself as manifested by threats of or attempts at suicide or serious bodily harm or other conduct demonstrating that he is dangerous to himself, or

(2) a substantial risk of physical harm to other persons as manifested by homicidal or other violent behavior by which others are placed in reasonable fear of serious physical harm.

35. Id. at §9.27(a) (1978).

36. Id. at §9.39(b).

37. Id. at §9.27(a) & (b).

38. Id. at §§9.37(a); 9.45 (1978 and Supp. 1983-1984). See supra note 19 and accompanying text.

39. Id. at §9.37(a) (1978).

40. Id.

41. Id. at §9.13(b).

42. Id.

43. See id. at §§9.33; 9.37(a); 9.39(b).

44. Id. at §9.33(a) & (c).

45. Id. at §9.31(a).

46. See id. at §§9.31; 9.33(c).

46. Id. at §9.33(b).

48. Id. at §9.33(d).

49. Id.

50. At this writing, the scope of a civilly committed person's right to the least restrictive alternative treatment in New York is very limited. A patient has a constitutional right to the least restrictive alternative if the choice is between two or more institutional settings, see Kesaselbrenner v. Anonymous, 33 N.Y. 2d 161, but the patient has no right to placement outside an institution. Decisions for the plaintiffs in Klosterman and Joanne S., see supra notes 17-30 and accompanying text, would establish a right to community placement, but only after the patient has been institutionalized for some period of time, assuming that the court limits its holding to the facts presented.

    Although New York statute does not articulate a specific right to the least restrictive alternative, the least restrictive alternative doctrine is intimated in several provisions regarding patients rights. See e.g., N.Y. Mental Hyg. Law §33.03(a) (19__) ("[e]ach patient in 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"); id. at §33.05(a) (right to communicate freely and privately with persons outside the facility); id. at §33.05(b) (right to have frequent and convenient opportunities to meet with visitors); id. at §33.07(a) (right to retain his or her personal belongings). No person may be deprived of any civil right solely because he or she receives services for mental disability. Id. at §33.01.

51. See supra note 4 and accompanying text.

52. Other jurisdictions have recognized that the least restrictive alternative doctrine applies to alternate dispositions within the hospital. E.g., Covington v. Harris, 419 F.2d 617, 623-24 (D.C. Cir. 1969); Ploof v. Brooks, 342 F. Supp. 999, 1005 (D. Vt. 1972). See also, Department of Health and Rehabilitative Services, Division of Retardation v. Ownes, 305 So. 2d 314 (D.C. App. Florida 1974) (Boyer dissenting); Application of D.D., 118 N.J. Super. 1, 285 A.2d 283, 287 (1971).

53. See N.Y. Mental Hyg. Law §§9.13; 9.15; 9.27; 9.39 (1978 & Supp. 1983-1984).

54. See id. at §9.21 (1978).

55. Id. at §9.15.

56. Id. at §9.13(b).

57. Id. A judicial hearing is required before a voluntary patient may be retained beyond 72 hours. Id.

58. See id. at §§9.21; 9.23 (1978).

59. Id. at §9.21(a). 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. Id. at §9.21(c). If a person suitable for informal status specifically requests that status, however, then he or she may be admitted only as an informal patient. Id.

60. 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. Id. at §9.23(b). The statute creates no duty for the director to convert an involuntary patient to informal status. See id. at §9.23(a).

61. The author conducted interviews in New York City during June and July 1983. Interviewees were promised anonymity and are thus not individually identified in this article.

62. See N.Y. Mental Hyg. Law §9.17 (1978).

63. See Paradies v. Benedictine Hospital, 77 A.D. 2d 757, 758, 431 N.Y.S. 2d 175 (1980) (hospital not liable for informal patient's suicide because patient had right to leave hospital and hospital could not involuntarily commit him).

64. See supra notes 35-37 and accompanying text.

65. N.Y. Mental Hyg. Law §9.27(d) (1978).

66. See supra note 16 and accompanying text.

67. N.Y. Mental Hyg. Law §9.31(c)(19__).

68. Id. at §1.03(29).

69. Id. at §1.03(31).

70. Id. at §9.31(c).

71. See Miller & Fiddleman, Outpatient Commitment: Treatment in the Least Restrictive Environment, 35 Hospital and Community Psychiatry 147 (1984).

72. Va. Code §37.1-67.3 (Repl. Vol. 1976 & Cum. Supp. 1983). See also Ariz. Rev. Stat. Ann. §36-540A (19__); Wis. Stat. Ann. §51.20(13)(a) 3, 4, & 5 (West Cum. Supp. 1983-1984).

73. N.Y. Admin. Code tit. 14 §36.1 (1982). See supra text accompanying notes 1-2.

74. N.Y. Mental Hyg. Law §29.15(a) (19__).

75. Id. at §29.15(b). The release must be in accordance with a written services plan. Id. at §29.15(f).

76. Id. at §29.15(e).

77. See id. at §29.15(f).

78. See supra notes 17-30 and accompanying text.

79. See Kiesler, Mental Hospitals and Alternative Care: Noninstitutionalization as Potential Public Policy, 37 Am. Psychologist 349, 350 (1982); M.S. Goldstein, The Sociology of Mental Health and Illness, 5 Ann. Rev. of Soc. 381 (1979); E. Goffman, Asylums: Essays on the Social Situations of Mental Patients and Other Inmates (1961).

80. See N.Y. Mental Hyg. Law §41.36 (19__).

81. Single room occupancy hotels and apartments that were once converted into community residential facilities are now being converted into condominiums and cooperatives, thereby reducing the number of available units and driving up their costs.

82. For example, the federal government spends over 70 percent of its mental health funds on hospitalization. Kiesler, supra note 79, at 1323. See also Joanne S. v. Carey, No. 88 (N.Y. Ct. App. Mar. 27, 1984) (Brief of Plaintiffs-Appellants), at 4:

> There is also evidence that the state is not even using all of the money currently appropriated for the development of community residences. See "In re Dr. Steven E. Katz, Nominated as Commissioner of the State Office of Mental Health," Hearings Before the New York State Committee on Mental Hygiene and Addiction Control (July 29, 1983), at 8 (remarks of Senator Joseph G. Montalto); Id. at 50 (remarks of Dr. Bert Pepper, Chairman of the New York State Conference of Local Mental Hygiene Directors); Id. at 120-21 (remarks of Chairman Frank Padavan).

83. The delay results from the time required to process a "Request for Residential Placement" (Form 418) through the Department of Social Services. Each placement desision made by the Department of Social Services is based on a Form 418, not on a clinical examination of the patient.

84. The Local and Unified Services Law, N.Y. Mental Hyg. Law, Article 41 (19__), requires extensive planning of community residential and treatment services but never actually requires creation of the services themselves. See, e.g., id. at §41.21. Furthermore, State matching funds for construction costs and other capital expenditures (see id. at §41.03.09) connected with creating these services must be authorized by the legislature after the commissioner of mental health has requested and the governor has recommended the appropriations. See id. at §41.27.

THE TUCSON REPORT

PREPETITION SCREENING AND OUTPATIENT TREATMENT: APPLICATIONS OF THE LEAST RESTRICTIVE ALTERNATIVE DOCTRINE IN INVOLUNTARY CIVIL COMMITMENT PROCEEDINGS

INTRODUCTION

Arizona's Mental Health Services Act[1] and Developmental Disability Law[2] contain the state's statutory provisions for court-ordered treatment and other mental health services for mentally disordered individuals. Following a national trend toward "deinstitutionalization,"[3] "normalization,"[4] and community-based treatment and care for mentally disturbed individuals, Arizona's mental health law, including the most recent revision of the Mental Health Services Act,[5] reflect a legislative intent to apply the least restrictive alternative doctrine, although no such intent is explicitly articulated.

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1. Ariz. Rev. Stat. Ann., Title 36, Ch. 5 (19__).

2. Ariz. Rev. Stat. Ann., Title 36, Ch. 5.1 (19__).

3. Basically, deinstitutionalization means putting patients in treatment and care settings other than hospitals. The concept grew out of the geneal public and professional movement away from the institutionalization of the mentally disabled. As a result of this trend, the average daily number of persons subject to commitment in public hospitals declined from over one-half million in 1955 to about 138,000 in 1983; see Eisenbery, Psychiatric Intervention, 229 Sci. Am. 117, 118 (1973).

4. This concept, stemming from concern over the inhuman and emotionally crippling treatment of mentally retarded persons, requires that every human being should be treated with dignity and as "normally" as possibly, respecting individual needs and potentials. See U.S. President's Comm. on Mental Retardation, Changing Patterns in Residential Services for the Mentally Retarded (1969); Roos, Normalization, De-humanization and Conditioning: Conflict or Harmony? 8 Mental Retardation 12 (1970).

5. S.B. 1312, 36th Leg. 2d Reg. Sess., 1983 (effective July 1, 1983).

Adherence to the least restrictive alternative doctrine in the mental health area means that treatment and care are no more harsh, hazardous, intrusive, or restrictive than necessary to achieve legitimate therapeutic aims and to protect patients or others from physical harm.[7] The doctrine is central to nine provisions for involuntary civil commitment in Arizona's mental health law: (1) a state-wide plan for community residential treatment for chronically mentally ill persons;[8] (2) placement of gravely disabled and developmentally disabled persons;[9] (3) the procedures for filing a petition for court-ordered mental health treatment;[10] (4) court-ordered mental health evaluation;[11] (5) patients' rights;[12] (6) duties and responsibilities of counsel in involuntary civil commitment proceedings;[13] (7) the review of and release from court-ordered treatment and care;[14] (8) mental health screening and evaluation before the

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7. See Suggested Statute on Civil Commitment, 2 Mental Disability Law Reporter 127, 129 (1977). For a review of the doctrine's legislative and judicial development see, P.B. Hoffman L. L. Foust, Least Restrictive Treatment of the Mentally Ill: A Doctrine in Search of Its Senses, 14 Sand Diego L. Rev. 1100, (1977); B. McGraw and I. Keilitz, The Least Restrictive Alternative Doctrine in Los Angeles County Civil Commitment, 6 Whittier L. Rev. 35 (1984); I. Keilitz, Least Restrictive Treatment of Involuntary Patients: Translating Concepts Into Practice §III, Milwaukee Report, this volume; B. McGraw, R. Van Duizend, I. Keilitz, D. Farthing-Capowich, Least Restrictive Alternatives In Involuntary Civil Commitment, Perspective on Mental Disability and the Law, Occasional Paper number 7, Institute on Mental Disability and the Law, National Center for State Courts, (1983).

8. Ariz. Rev. Stat. Ann. § 36-550 (19__).

9. Id. §§ 36-547, 36-560-4.

10. Id. § 36-533.A.

11. Id. §§ 36-522.A., 36-526-A.

12. Id. §§ 36-507, 512-514, 551.01.

13. Id. § 36-537.B.

14. Id. §§ 36-541.01, 543.A., D., and E.

filing of a petition;[15] and (9) court options for ordering outpatient treatment and care.[16]

All states except Alabama, Mississippi, and Oregon have enacted statutes which in some form require that mental health treatment be administered in the manner or setting which is least restrictive of personal liberty.[17] As Shah has observed, however:

> It is one thing to legislate or judicially mandate legal and other policy changes; it is quite another matter to secure their actual implementation.... Thus, as important as reforms and legal policies (viz., the "law on the books") certainly are, these accomplishments must not be confused with the end result (viz., the "law and practice").[18]

One difficulty, of course, lies in the fact that the meaning of any concept can never be "fully reduced to a set of concrete operations and operational terms."[19] Another difficulty in translating legal and social concepts into reality is the lack of adequate resources, the barriers of very formidable state and federal bureauracies, the sheer size and complexity of the cooperative effort required.[20]

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15. Id. §§ 36-501.23, 520.E-F, 520.1, and 521.

16. Id. §§ 36-540 and 541.

17. Lyon, Levine & Zusman, Patient's Bill of Rights: A Survey of State Statutes, 6 Mental Disability Law Rep. 178, 181-83 (1982). In 1977, thirty-five jurisdictions either explicitly or implicitly acknowledged the least restrictive alternative doctrine in statute. Hoffman & Foust, supra note 7, at 1115.

18. Shah, Legal and Mental Health System Interactions: Major Developments and Research Needs, 4 Int'l J. of L. & Psychiatry 219, 255 (1981).

19. R. Roesch & S. L. Golding, Competency to Stand Trial, 12 (1980).

20. See e.g., Halderman v. Pennhurst State School and Hospital, 467 F. Supp. 1504 (E. D. Pa. 1983) (Parents objected to movement of their 12 year-old son from Pennhurst to less restrictive community placement); Halderman v. Pennhurst State School and Hospital, 566 F. Supp. 185 (E.D. Pa. 1983) (Contractual dispute between the state and a community-based service that threatened to close community home and return resident to hospital).

This Article describes one jurisdiction's mental health-law community's (i.e., judges, attorneys, mental health professionals, law enforcement personnel, and social service providers) attempts to apply the statutorily prescribed least restrictive alternative doctrine to the various procedures and practices of the involuntary civil commitment process. It is based on a study of the involuntary civil commitment system in Tucson, Arizona conducted in June 1983 as part of the Least Restrictive Alternative Project,[21] conducted by the Institute on Mental Disability and the Law of the National Center for State Courts and made possible by grants from the United States Department of Health and Human Services and the Victor E. Speas Foundation of Kansas City, Misouri. The Article begins with a brief overview of the involuntary civil commitment process in Tucson to provide a framework for discussion. Three sections following the overview describe the application of the least restrictive alternative doctrine to the involuntary civil commitment process in Tucson. The first section provides a relatively brief discussion of the first seven provisions of Arizona's mental health law (outlined above) which express or imply the application of the least restrictive alternative doctrine. The next two sections describe

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21. The project had three phases. The first phase consisted of a review and analysis for the use of the least restrictive alternative doctrine in the mental health statutes of seven states, as well as a review of selected state and federal court rulings and relevant professional literature.
The second phase consisted of the site specific field research which, combined with phase one, is reflected in §III of this volume. In the various regions, interviews with hundreds of judges, court personnel, attorneys and mental health professionals were used to gather information. The second phase also included observations of involuntary civil commitment hearings and other commitment proceedings.
The third phase, which is essentially the compilation of this volume, integrates the field research results of the second phase with information gathered from the first phase. The model for the just and practical application of the least restrictive alternative doctrine in involuntary civil commitment, described in this volume, completes the project.

in much greater detail what are perhaps the more significant provisions for the application of the doctrine in Arizona's mental health law: the provisions for mental health screening and evaluation before the filing of a formal petition and the provisions for outpatient treatment and care.

OVERVIEW OF THE INVOLUNTARY CIVIL COMMITMENT PROCESS

In Arizona, a respondent[29] can be involuntarily detained for mental health evaluation and treatment if he or she is, as a result of mental disorder,[30] a danger to self[31] or others,[32] or is gravely disabled.[33] Figures 1-3 represent a schematic summary of the statutory provisions for involuntary civil commitment in Arizona.[34]

In non-emergency cases (see Figure 1), the involuntary civil commitment process may be initiated by an application from any responsible person for a court-ordered mental health evaluation of a respondent who is unwilling or unable to undergo voluntary evaluation.[35] The application is filed

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29. The term "respondent" refers to any individual who is the subject of involuntary civil commitment proceedings, including those less formalized proceedings that occur before court intervention.

30. Ariz. Rev. Ann. §36-501.17 (19xx).

31. Id. §36-501.4.

32. Id. §36-501.3.

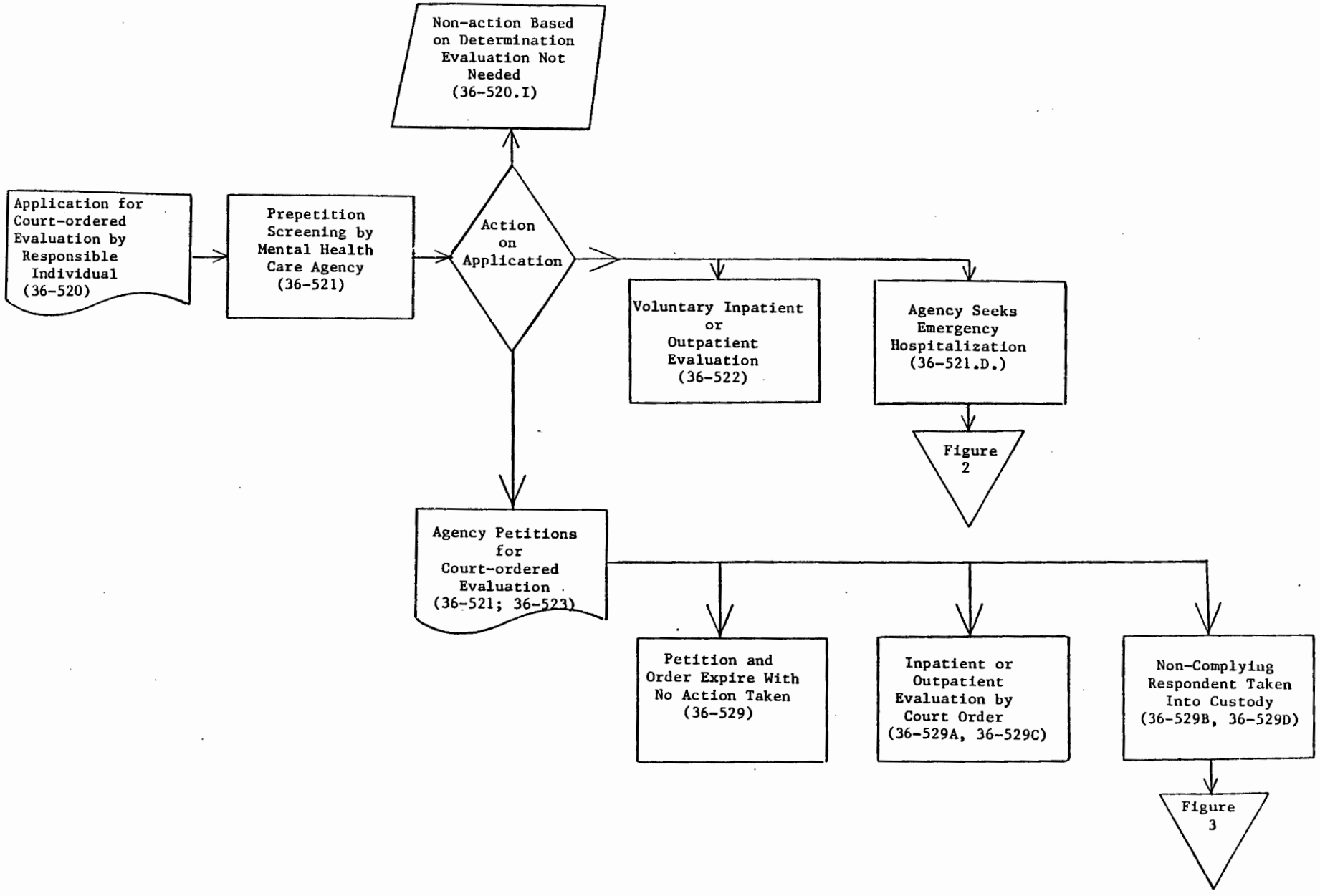
33. Id. §36-501.11.

34. The summary provided in Figures 1-3 and accompanying text describes the mechanics of the commitment process according to Arizona statutes as interpreted by individuals involved with the process in Tucson. Descriptions based on case law or other interpretations may differ.

35. Ariz. Rev. Stat. Ann. §36-520.A.-C (19xx).

FIGURE 2

INITATION OF
INVOLUNTARY CIVIL COMMITMENT
ON A NON-EMERGENCY BASIS



with a screening agency, a community mental health agency, that may assist the applicant in preparation of the application.[36] Within forty-eight hours, the screening agency must complete a prepetition screening including a review and investigation of the facts alleged in the application and, if possible, an interview with the respondent.[37] Prepetition screening results in one of several consequences: (a) the application is not acted upon by the screening agency because it has determined that the respondent does not need mental health evaluation;[38] (b) the respondent is persuaded to receive mental health evaluation on a voluntary basis;[39] (c) the screening agency seeks hospitalization of the respondent on an emergency basis if it has reasonable cause to believe that the respondent is likely to harm himself or herself or others if immediate action is not taken;[40] or, (d) if the screening agency determines that the respondent meets commitment criteria, it files a petition requesting that the court issue an order for mental health evaluation of the respondent.[41]

In Tucson, the great majority of the respondents who undergo prepetition screening are counseled and subsequently diverted from involuntary evaluation to less restrictive settings (e.g., voluntary inpatient or outpatient treatment or half-way house placement).[42]

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36. Id. §36-520.D.

37. Id. §36-501.23; see also §36-521.

38. Id. §36-520.I.; see also §36-521.C.

39. Id. §36-501.23; see also §36-522.

40. Id. §36-521.D.

41. Id.; see §36-523.

42. See supra notes ___ and accompanying text.

However, if the screening agency determines that involuntary mental health evaluation of the respondent is warranted, it petitions the court to order the respondent to submit to a professional multidisciplinary evaluation by two licensed physicians and two other individuals "one of whom, if available, shall be a psychologist and in any event a social worker familiar with mental health services which may be available [as] placement alternatives appropriate for treatment."[43]

Upon the advice of the screening agency,[44] the court may order the respondent to submit to a mental health evaluation at a designated time and place either on an inpatient or outpatient basis.[45] If the respondent does not or cannot comply, the court may order that the respondent be taken into custody by a peace officer and transported to a mental health agency providing in-patient court-ordered evaluations.[46] In Tucson, court-ordered evaluations are almost always conducted on an inpatient basis in several mental health facilities designated to perform these evaluations.[47]

The majority of the respondents in Tucson who make contact with a prepetition screening agency in non-emergency cases are diverted from involuntary hospitalization. Consequently, four out of five respondents forced to undergo court-ordered evaluation constitute emergency cases.[48] In these cases (see Figure 2), no prepetition screening is performed and a

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43. Ariz. Rev. Stat. Ann. §36-501.8 (19xx).

44. Id. §36-523.B.

45. Id. §36-529.A.

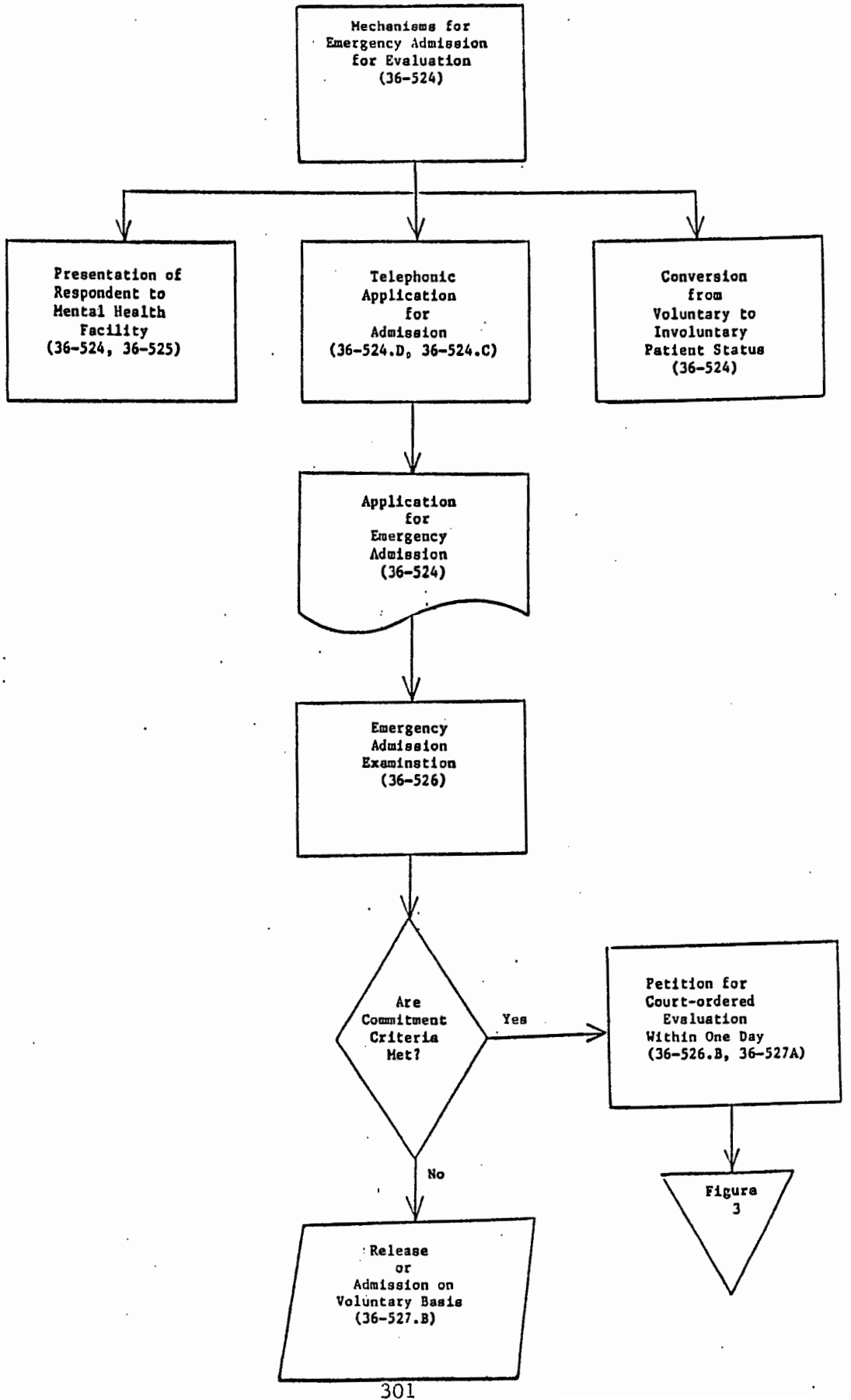
46. Id.; see also §36-530.D.

47. See supra notes and ___ accompanying text.

48. See supra notes and ___ accompanying text.

FIGURE 3

INITIATION OF
INVOLUNTARY CIVIL COMMITMENT
ON AN EMERGENCY BASIS



respondent may be involuntarily hospitalized without prior court approval upon written application for emergency admission by "a person with knowledge of the facts requiring emergency admission."[49] In Tucson, emergency admissions are initiated by several mechanisms: (a) presentation of a respondent to a mental health facility, usually accompanied by relatives, friends, or peace officers;[50] (b) if the respondent is not already present at the evaluation agency, telephonic application to an emergency facility by, or in the presence of, a peace officer;[51] and (c) conversion of a voluntary patient to involuntary emergency admission status in cases where the patient seeks to leave the hospital against the advice of hospital staff.[52] Based upon review of the written or telephonic application, and upon presentation of the respondent for emergency admission, if the admitting officer of the mental health facility determines by his or her examination that the respondent meets statutory commitment criteria and should be hospitalized against his or her will or an emergency basis, the mental health agency detaining the person must file a petition for a court-ordered evaluation by the next day.[53] At this point in the proceedings, the emergency commitment procedures, which

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49. Ariz. Rev. Stat. Ann. §36-524.B. (19xx).

50. See id. §§36-524, 36-525. These respondents, referred to as "walk-ins," constitute an estimated forty percent of the respondents who receive court-ordered evaluation; see supra notes ___ and accompanying text.

51. Id. §36-524.D.-C. Respondents for whom telephonic applications precede emergency admission, constitute approximately twenty percent of the respondents in Tucson; see supra note ___ and accompanying text.

52. These cases represent another twenty percent of the respondents in Tucson; see supra note ___ and accompanying text.

53. Ariz. Rev. Stat. Ann. §§36-526, 36-527 (19xx).

account for approximately eighty percent of the respondents in Tucson, merge with nonemergency procedures for involuntary civil commitment.

A respondent receiving inpatient evaluation (see Figure 3) must be released from the hospital within three days of involuntary admission unless the hospital files a petition with the court for further involuntary treatment and care, or the respondent chooses to become a voluntary patient.[54] Within six days after the petition for court ordered treatment is filed, an adversarial hearing on the petition must be held. In this hearing the respondent is accorded the customary legal safeguards in civil commitment proceedings, including representation by counsel.[55]

In Tucson, hearings are held in the mental health facilities where the respondent has been detained pending the judicial hearing. Although respondents are almost never released from inpatient hospitalization pending the hearing on the petition for court-ordered treatment, most respondents are discharged from the hospital or elect to become voluntary patients prior to a judicial hearing.[56] Due to outright discharges of respondents or conversions to voluntary patient status within six days of inpatient admission, only three or four out of ten respondents in Tucson for whom court-evaluations have been conducted receive judicial hearings of their commitment.[57]

If in cases proceeding to a judicial hearing, the court finds clear and convincing evidence that the respondent poses a danger to himself or herself or others as a result of mental disorder, or is gravely disabled

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54. Id. §36-531.

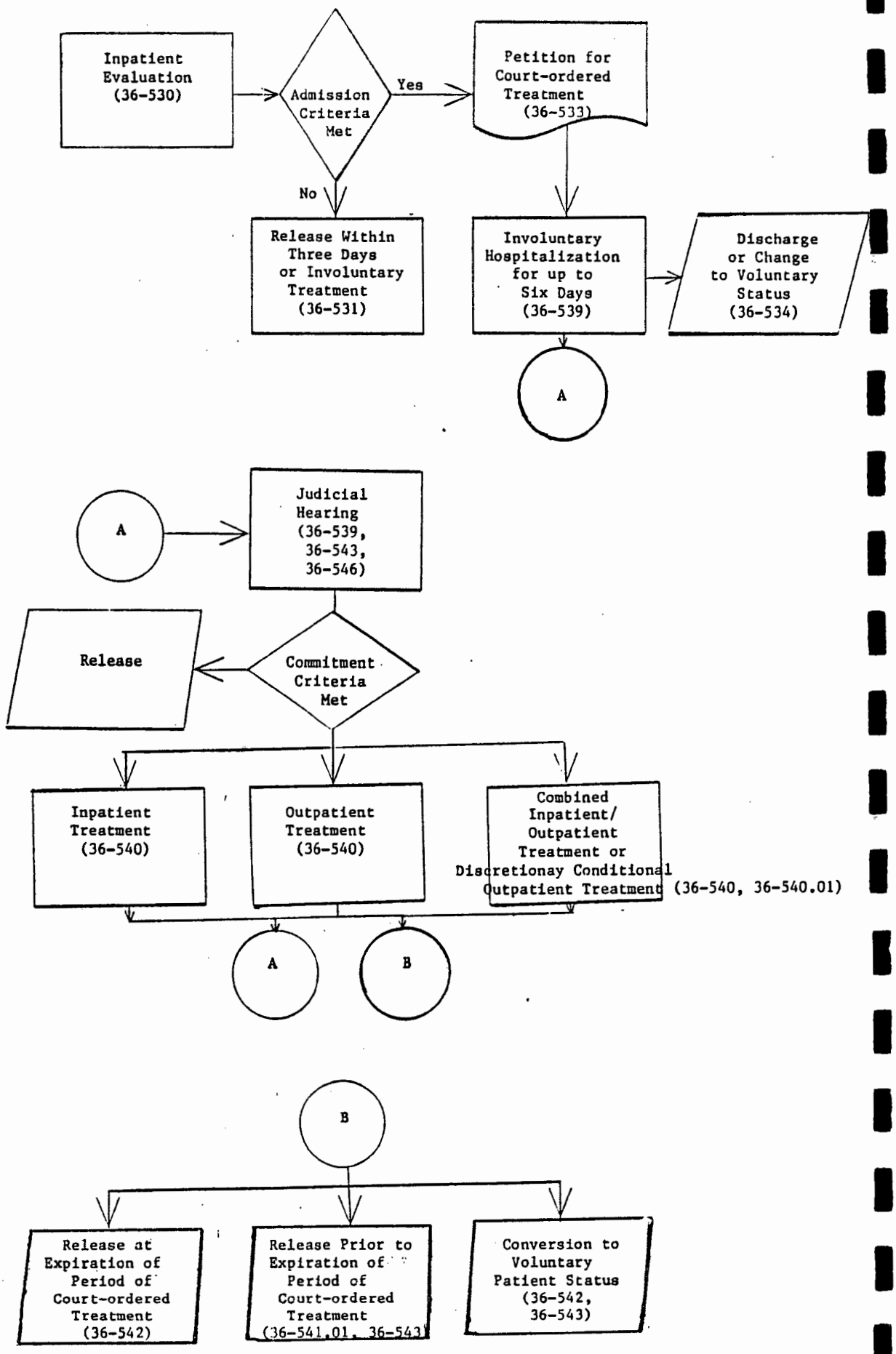
55. See id. §§36-533 through 36-539.

56. See id. §36-534.

57. See supra notes ___ and accompanying text.

FIGURE 4

INVOLUNTARY TREATMENT AND CARE



and in need of treatment, and will not or cannot voluntarily submit to treatment, the court may order inpatient treatment, outpatient treatment, or a program of combined inpatient and outpatient treatment not to exceed one year.[58] The maximum period which the Court may order involuntary treatment is subject to several durational limits: ninety days for respondents found to be a danger to themselves, 180 days for respondents dangerous to others, and one year for respondents who are determined to be gravely disabled.[59] Also, whenever possible, a respondent "shall undergo treatment for at least twenty-five days in a local mental health treatment agency geographically convenient . . . before being hospitalized in the state hospital."[60] In any event, the court is required to "consider all available and appropriate alternatives for treatment and care" including outpatient treatment.[61]

Once a respondent has been committed to involuntary inpatient care and treatment, he or she may be released by several mechanisms: (1) discharge from the inpatient mental health facility prior to the expiration of the treatment period ordered by the court if the mental condition of the respondent improves to such a degree that he or she, in the opinion of the medical director of the facility, no longer meets statutory commitment criteria;[62] (2) conditional outpatient treatment;[63] (3) conversion to

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58. Ariz. Rev. Stat. Ann. §36-540 (19xx).

59. Id. §36-540.E.

60. Id. §36-541.

61. Id. §36-540.B.

62. Id. §36-541.01; see also §36-543.

63. Id. §36-540.01.

voluntary hospital admission status;[64] and (4) release once the statutorily prescribed durational limits of court-ordered treatment have been reached.[65] There is an exception in cases of grave disability; in such cases a respondent may be hospitalized for more than one year following a mandatory annual mental health examination and review, and a judicial hearing if one is requested.[66] In addition, a respondent may apply for a writ of habeas corpus at any time, or request release and a judicial review at least once every sixty days after the first sixty days of court-ordered treatment.[67] In practice, few respondents in Tucson are involuntarily hospitalized up to the statutorily prescribed durational limits. Judicial reviews of continued court-ordered treatment are rare and most respondents are discharged or become voluntary patients prior to the expiration of the period of court-ordered treatment.[68]

POLICIES, PROCEDURES AND PATIENTS' RIGHTS

The legislative applications of the least restrictive alternative doctrine varied considerably among the mental health statutes of the seven states studied as part of the least restrictive alternative project (i.e., Arizona, California, Illinois, Missouri, New York, Virginia, and Wisconsin). While all seven states acknowledged the least restrictive alternative doctrine somewhere in their statutes, they varied considerably

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64. Id. §§36-542, 543.

65. Id. §36-542.

66. Id. §36-543.

67. Id. §36-546.

68. See supra notes ___ and accompanying text.

in the number, types, and specificity of expression of the doctrine.[69] For example, only Missouri actually defines "least restrictive environment,"[70] while six out of the seven states provide some statutory expression of the doctrines relevance to patients' rights.[71] Among the seven states, the following general categories of statutory expressions of the least restrictive alternative doctrine in provisions for involuntary civil commitment are represented: legislative intent, definition of the least restrictive alternative, community treatment system, commitment criteria, preliminary mental health screening, release pending judicial hearing, admission status and procedures, court orders, duties of counsel, patients' rights, court-ordered medical treatment, mental health treatment, intrusive treatment, conditional release, case management, periodic review, discharge, funding, developmental disability services, and senior citizen services.[71a]

An important application of the least restrictive alternative doctrine in Arizona's mental health law, at the level of policy if not practice, 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 a state-wide plan for community residential treatment for chronically mentally ill persons. The plan would provide a wide range of services in the least restrictive setting as

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69. See, McGraw and Keilitz, supra note 7; McGraw, Van Duizend, Keilitz & Farthing-Capowich, supra note 7; Appendix.

70. See Mo. Rev. Stat. § 630.005.1 (19__).

71. Supra note 69.

71a. McGraw & Keilitz, supra note 7; McGraw Van Duizend, Keilitz & Farthing-Capowich, supra note 7; Appendix.

alternatives to institutionalization. Facilities for residential or day treatment must be relatively small, preferably with fifteen or fewer beds, and "designed to provide a homelike environment without sacrificing safety or care."[72] Four types of programs are to be included in the community residential treatment system: (1) a 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 for one-fourteen days"; (2) a semi-supervised, structured group living program; (3) a "socialization" or daycare program; and (4) a residential treatment program that provides a "full day treatment program for persons who may require intensive support for the maximum of two years."[73] Chronically mentally ill persons are eligible for services in these programs regardless of whether they voluntarily seek the services, a court-appointed guardian requests, the superintendent of the Arizona State Hospital recommends, or a court orders that they receive the services.[74]

The least restrictive alternative doctrine is clearly applied in the statutory provisions of the legal rights accorded patients in Arizona 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,[75] to use their own personal possessions,[76] to refuse all but court-ordered treatment

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72. Ariz. Rev. Stat. Ann. § 36-550.05.A (19__).

73. Id. §36-550.05.

74. Id. 36-550.06.

75. Id. 36-507.5.

76. Id. 36-507.5.

unless a medical emergency exists,[77] to be free from seclusion, mechanical, or pharmacological restraint except in an emergency,[78] and the right to be visited by any person, subject to reasonable limitations.[79] Any violation of these rights gives the patient a cause for legal action for treble damages or $1,000, whichever is greater.[80]

The least restrictive alternative doctrine is also specifically applied in the provision of rights of developmentally disabled persons in Arizona in so far as "[e]very 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."[81] Further, each developmentally disabled person has the right to a humane and clean physical environment, to communication and visits, and to personal property.[82] These rights are in addition to all other rights enjoyed under federal and state law.[83]

Arizona's mental health law provides for the application of the least restrictive alternative doctrine to involuntary civil commitment proceedings in a number of procedural matters. A petition for court-ordered treatment must (a) allege that a person is in need of treatment because he or she is a danger to self or others or is gravely

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77. Id. 36-512.

78. Id. 36-513.

79. Id. 36-514.

80. Id. 36-516.

81. Id. 36-551.01.C.

82. Id. 36-551.01.Q.

83. Id. 36-551.01.A.

disabled as a result of mental disorder, (b) identify the treatment alternatives which are appropriate or available, and (c) allege that the person is unwilling to accept or incapable of accepting treatment voluntarily.[84] The application of the least restrictive alternative doctrine is clearly implied in requirments of subsection (b) and (c).

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.[85] 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."[86] If the person is hospitalized for pre-petition screening, "the medical director may notify the screening agency and seek its assistance or guidance in developing alternatives to involuntary confinement and in counseling the person and his family."[87]

Arizona's mental health law explicitly applies the least restrictive alternative doctrine in the duties prescribed for respondents' counsel in proceedings for court-ordered treatment. At least seventy-two hours before the court conducts the 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

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84. Id. 36-533.A.

85. Id. 36-522.A.

86. Id. 36-526.A.

87. Id.

cases with an explanation of why they are not appropriate or available."[88] At least twenty-four hours before the judicial hearing, the attorney must review the list and investigate the possibilities of alternatives to court-ordered treatment.[89] Failure to fulfill these duties may be punished as contempt of court.[90]

A significant 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 disability facility, program, or service unless he or she has received a placement evaluation.[91] This evaluation should determine which program is appropriate for the developmentally disabled person. The standards for assigning a person to a particular service are: the person's best interest, the person's particular desires, and the ability to provide the person with (a) a "maximum opportunity to develop his or her maximum potential," (b) a "minimally structured residential program environment," and (c) "a safe, secure, and dependable residential program environment."[93] 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.[94] The guardianship or

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88. Id. 36-537.A.

89. Id. 36-537.B.

90. Id. § 36-537.B.4.

91. Id. § 36-560-G.

92. Id.

93. Id. § 36-560.H.

94. Id. § 36-564.D.

conservatorship must promote the person's well-being and must be designed to encourage maximum self-reliance and independence in the person.[95]

A guardian of gravely disabled persons 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 in a mental health treatment agency," and (c) placing the person in a mental health treatment agency.[96] 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 finding an alternative placement is not available."[97] 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 ten days.[98]

Statutory mechanisms for a respondent's outright release from involuntary hospitalization, and transfer or diversion from restrictive, inpatient treatment are clearly consistent with the least restrictive alternative doctrine. Most state mental health laws permit mental health facilities to discharge respondents without judicial review.[99] Broad

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95. Id.

96. Id. § 36-547.04.A.4.

97. Id. § 36-547.04.B.

98. Id. § 36-547.05.A.

99. See, Institute on Mental Disability and the Law, Provisional Substantive and Procedural Guidelines for Involuntary Civil Commitment Part II (Williamsburg, Virginia: National Center for State Courts, 1983), 49-55.

discretion is given to mental health personnel to make decisions about release, transfer and diversion to less restrictive treatment facilities.

Release of a respondent typically occurs if the mental health professional in charge of the respondent's involuntary treatment and care believes that compulsory inpatient mental health care and treatment no longer are, or never were, necessary. In most states, diversion from involuntary detention is accomplished if the respondent requests voluntary patient status and if the mental health facility or the court agrees to the conversion from involuntary to voluntary status. In accord with the least restrictive alternative doctrine, the mental health law in some states (e.g., North Carolina and New York) explicitly encourages converstion from involuntary to voluntary patient status.[100]

Arizona mental health law applies the least restrictive alternative doctrine in a number of provisions for review of and release from involuntary hospitalization. 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.[101] Prior to the respondent's release, the medical director must arrange an appropriate alternative placement.[101]

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."[102] The annual examination and review shall include "a statement

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100. Id. at II-50, IV-13-19.

101. Ariz. Rev. Stat. Ann. § 36-541.01.A (19__).

102. Id. § 36-543.D.

as to whether suitable alternatives to court-ordered treatment are available."[103] Again, "[i]f the patient is to be released, the medical director shall arrange for an appropriate alternative placement."[104]

PREPETITION MENTAL HEALTH SCREENING

Most individuals with mental disorders never come into contact with the mental health-law system. A mentally disordered person, and those around him or her, may simply choose to deny the disorders, or learn to cope with them. Alternatively, the individual may voluntarily seek mental health care and treatment on an inpatient or outpatient basis. When such voluntary action is not taken, and when persons other than the mentally disturbed individual believe that coerced treatment is necessary, the involuntary civil commitment process may be initiated. Even then, however, formal civil commitment proceedings generally follow rather than proceed any attempts to place a respondent into less restrictive treatment and care settings than a mental hospital.[105]

Only a small minority of respondents penetrate the involuntary civil commitment process beyond short-term detention. Therefore, the occurrences prior to a formal civil commitment hearing may have more bearing on the equity, effectiveness, and efficiency of, and public satisfaction with, a commitment system than the events in the subsequent stages of the commitment process. Systems that provide for a prompt, reliable, and

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103. Id. § 36-543.E.2.

104. Id. § 36-543.A.

105. Hoffman and Foust, supra note 7, at 139 ("[T]he unworkability of less restrictive alternatives, and not the failure to consider them, ultimately leads to most commitment proceedings").

thorough screening procedure, and a diversion of appropriate cases at the earliest stages of the commitment proceedings would appear to protect both the liberty interest of respondents and the pocketbooks of taxpayers.[106]

The initial decisions regarding a respondent's entry into the mental health system entail much more than a determination whether the legal and pyschosocial criteria for involuntary civil commitment have been met. Better decisions are based on knowledge of the mental health delivery system in a particular locale, including the conditions of accessible mental health facilities, the availability of less restrictive alternatives for particular classes of respondents (e.g., gravely disabled individuals who are harmless to others), and the budgetary constraints on the portions of the mental health system likely to be involved with a particular class of respondents. Better decisions also involve an understanding of the mechanisms for linking together the courts, law enforcement agencies, social service agencies, and the units of the mental health system in cooperative strategies to achieve the highest quality of treatment.[107]

In an apparent recognition of the importance of the initial stages of the involuntary civil commitment proceedings, the Arizona legislature provided for the pre-petition screening of all applications for court-ordered mental health evaluations of potential candidates for involuntary civil commitment. By statute, prepetition screening is the review of each application requesting court-ordered evaluation, including "an investigation of facts alleged in such application, an interview with

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106. Institute, supra note 99.

107. Id., at II-13.

each applicant and an interview, if possible, with the proposed patient."[108] One purpose of the screening, performed by a health care agency licensed by the Arizona Department of Mental Health,[109] is to determine whether there is reasonable cause to believe the allegations in the application for court-ordered mental health evaluation (i.e., that the respondent is a fit subject for involuntary mental health treatment and care). A second purpose is to attempt to persuade the respondent to undergo, on a voluntary basis, mental health evaluation or other mental health services less restrictive than coerced inpatient hospitalization.[110]

In Tucson, three mental health care agencies perform prepetition screening. Most are performed by the Southern Arizona Mental Health Center, a community-based facility which operates as a public, non-profit agency within the division of behavioral health services of the Arizona Department of Health Services. Except in emergency cases, all applicants seeking the involuntary hospitalization of a respondent are referred to one of the three screening agencies. 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, in a mental health facility designated to perform prepetition screening.[111] If appropriate, the screening agency shall offer assistance to the applicant in the preparation of the application.[112]

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108. Ariz. Rev. Stat. Ann. § 36-501.23 (19__).

109. Id. § 36-501.28.

110. Id. § 36-501.23; see also § 36-521.

111. Id. § 36-520.A.

112. Id. § 36-520.D.

The screening agency must act on the application for court-ordered evaluation within forty-eight hours of the filing of the application, excluding weekends and holidays.[113] According to estimates provided by staff of the Southern Arizona Mental Health Center and corroborated by others we interviewed, only one out of ten potential applications for involuntary evaluation results in the filing of a petition by the screening agency. Ninety percent of the cases that come to the attention of the screening agency as candidates for involuntary civil commitment are diverted to voluntary inpatient or outpatient care, placement in one of four half-way houses in Tucson, or to some other mental health or social service. In the cases in which the screening agency determines that the potential respondent does not require court-ordered evaluation, the application is not acted upon and the involuntary civil commitment proceedings terminate.[114]

Although estimates by interviewees varied, no more than one out of three respondents forced to undergo court-ordered evaluation in Tucson comes into contact with the involuntary civil commitment system on an nonemergency basis and, therefore, becomes the subject of prepetition screening. In emergency cases, no prepetition screening is performed and a respondent may be voluntarily hospitalized without prior court approval and without a prior review of the case by mental health personnel upon written application for emergency admission by a person with knowledge of facts requiring emergency admission.[115]

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113. Id.

114. Id. § 36-520.1.

115. Id. § 36-524.B.

There is obviously less curtailment of liberty for most of those respondents who are successfully screened and diverted from involuntary hospitalization. The screening procedures, when successful and appropriately applied, embody the best intents of Arizona's mental health law by facilitating the provision of treatment in the least restrictive environment that is less disruptive of family, social, and economic ties. However, two important practical questions can be asked about the prepetition screening procedures in Tucson. First, to what extent is the prepetition screening circumvented in favor of emergency procedures because individuals seeking the forced hospitalization of a respondent choose, for whatever reason, to proceed directly to a facility able to admit a respondent on an emergency basis? It may be, for example, that the nonemergency route is avoided in favor of the emergency route simply because it is a more direct, less onerous undertaking for those seeking to force another person into compulsory treatment, not necessarily because an "emergency" exists. Second, what proportion of those potential respondents diverted from involuntary hospitalization a the screening agency (approximately ninety percent of the respondents coming into contact with screening agencies in Tucson.) would wind up involuntarily hospitalized in the absence of the screening procedures? Simply put, do the screening agencies actually screen and divert respondents from compulsory hospitalziation? Or, would the same proportions of individuals find their way to involuntary treatment and care or avoid it, in the absence of formal prepetition screening procedures? Both questions have policy implications. Practice is clearly inconsistent with statutory provisions for prepetition screening if the traffic along the emergency and nonemergency routes to involuntary civil commitment cannot be discriminated

on the basis of the existence of a mental health emergency. A strict adherence to the statutes would require, in other words, that emergency admissions for evaluation be permitted only if "during the time necessary to complete the prepetition screening procedures... the person is likely without immediate hospitalization to suffer serious physical harm or serious illness or is likely to inflict serious physical harm upon another person"[115A] If there is time to do the prepetition screening, and to afford the respondent the opportunity of treatment in a less restrictive setting, it should be done. The ideal, however, may sink into the sands of reality. Screening agencies may be inaccessible to individuals seeking access to the commitment system via nonemergency admission procedures because of the agency's limited hours of operation,[115B] their distance from the individual's location,[115C] or the individual's problems with transportation or time off from work.[115C]

115.A. Id. §36-524.C.1. (emphasis added)

115.B. Mental health screening agencies in Tucson are theoretically accessible 24 hours a day. But for all practical purposes, they function only during limited day-time hours. A similar impediment limits the use of nonemergency admission in Kansas City. (See, Kansas City Report, this section.) there, due in part to the limited operating hours of designated mental health coordinators, who function much like Tucson's screening agencies, the majority of respondents enter the mental health system on an emergency basis.

115.C. Arguably, these practical difficulties facing applicants who pursue the involuntary detention of other are justified. The potential respondent's liberty interests justify a heavy burden being placed on those seeking his or her involuntary detention. Alternatively, it can be argued that the relative inaccessibility of screening agencies for many applicants with regard to hours and distance and transportation, etc., causes the more expedient emergency admission procedure to be used, circumventing the respondent's liberty interests the screening process provides.

COMPULSORY OUTPATIENT TREATMENT AND CARE

In what is perhaps the most recent development of the least restrictive alternative doctrine in mental health law, some states have provided specific alternatives to involuntary hospitalization in their mental health statutes, including court-ordered treatment in community mental health centers and nursing homes, and release from involuntary hospitalization contingent on compliance with a program of outpatient treatment.[116] Arizona's Mental Health Services Act, as amended in 1983, permits the court to order treatment and care in non-hospital settings.

Following the judicial hearing, the court has four dispositional options (see Figure 3): release, if the commitment criteria have not been met by clear and convincing evidence; outpatient treatment; inpatient treatment; and a combination of outpatient and inpatient care.[117] The court must consider "all available and appropriate alternatives for the treatment and care" of the respondent. But it may order outpatient or a combination of outpatient and inpatient treatment only if (a) the prescribed treatment is indeed more appropriate, (b) if the respondent does not require continuous inpatient hospitalization, and will follow the treatment plan, and (c) only if the respondent is not likely to become dangerous or suffer serious health consequences as a result of following the prescribed treatment plan.[118] The court may also order outpatient or

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116. See Miller & Fiddleman, Outpatient Commitment: Treatment in the Least Restrictive Environment 35 HOSPITAL AND COMMUNITY PSYCHIATRY 147 (1984).

117. Ariz. Rev. Stat. Ann. §36-540.A.

118. Id. §36-540.B.

a combination of outpatient and inpatient treatment only if it is presented with a written treatment plan,[119] which includes a statement of the respondents' needs for medication, supervision, and assistance in obtaining basic needs such as employment, food, clothing, or shelter. It must also include the address of the resident where the respondent is to live and the name of the individual in charge of the residence; the name and address of the responsible person or agency assigned to supervise outpatient treatment and the authority of that person or agency in carrying out the terms of the treatment plan; and, the conditions for continued outpatient treatment.[120]

Despite a growing emphasis on treatment and care in the least restrictive setting, outpatient treatment and care has been hampered by the reluctance of community-based treatment facilities to treat unwilling patients.[121] Perhaps in recognition of the disinclination of community mental health facilities to treat involuntary patients on an outpatient basis, Arizona's Mental Health Services Act provides for a number of procedures aimed at assuring a continuity and linkage between the commitment court and the treatment facility. Court-ordered outpatient or combined outpatient and inpatient treatment must include the identification of the medical director of the mental health treatment agency that will supervise and administer the treatment program.[122] The individual assigned to supervise the treatment program must be notified at least three days before a treatment referral, and the medical director making the

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119. Id.

120. Id. §§36-540.B.2, 36-540.01.

121. Supra, note 116, at 150.

122. Ariz. Rev. Stat. Ann. §36-540.D.1.

referral and the treatment supervisor must share relevant information about the respondent to provide a continuity of services.[123] The court may provide a hearing or amend its order for outpatient or a combination of outpatient and inpatient treatment if the respondent fails to comply with the treatment plan or it is determined that the respondent needs inpatient treatment.[124] If the respondent refuses to comply with an amended order for inpatient treatment, the court may order the respondent to be taken into protective custody and transported to an inpatient facility.[125]

The medical director of a mental health care facility may pursue conditional outpatient treatment for any respondent ordered to undergo inpatient treatment if he or she determines with a reasonable degree of medical probability that (1) the respondent no longer requires continuous hospitalization; (2) the respondent will be more appropriately treated on an outpatient basis; (3) the respondent is likely to follow a prescribed outpatient treatment plan; and (4) the respondent will not likely become dangerous or suffer more serious physical harm or serious illness if he or she follows the prescribed outpatient treatment plan.[126]

Before the release of a respondent found to be dangerous to <u>others</u> for outpatient treatment, the medical director must give notice to the court and any other persons with a legitimate reason for receiving such a notice. Such notice provides the opportunity for the filing of a motion for determination by the court as to whether the standard for a conditional release of the respondent has been met.[127] At least every 30 days, the

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123. <u>Id.</u> §36-540.D.3.

124. <u>Id.</u> §36-540.D.4.

125. <u>Id.</u>

126. <u>Id.</u> §36-540.01.A.

127. <u>Id.</u> §§36-540.01.E, 36-541.01.B.

medical director must receive a report about and review the condition of a respondent on conditional outpatient treatment and enter his or her findings in the respondent's file.[128] The medical director may amend any part of the outpatient treatment plan or rescind the order for a conditional outpatient altogether and order the respondent returned to an inpatient treatment program.[129] The medical director is not civilly liable for any act committed by a respondent undergoing conditional outpatient treatment if the medical director has in good-faith adhered to the requirements for conditional outpatient treatment and care.[130]

An interesting and unique element 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.[131] Whenever a court orders a respondent to undergo involuntary treatment and care, he or she must generally be treated and cared for at least twenty-five 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. The court may immediately hospitalize the 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 and care, (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.[132]

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128. Id. § 36.540.01.F, G.

129. Id. § 36.540.01.H, I, K.

130. Id. § 36.540.01.L.

131. Id. § 36.541.

132. Id.

SECTION III

GUIDELINES FOR THE APPLICATION OF THE LEAST RESTRICTIVE ALTERNATIVE DOCTRINE

INTRODUCTION

> The shortcomings of the doctrine of the least restrictive alternative as it is now applied to treatment of the mentally ill lie not in its well-intentioned purposes but rather in its naive optimism that its goals can be attained by mere rhetoric without critical analysis. At best, judges, lawyers, legislators, clinicians, and even patients have only begun the arduous task of determining the doctrine's proper construction and application. There is no magical calculus for striking the difficult balance. Instead, modest suggestions are appropriate.[1]

Mindful of the above quote, we offer in this concluding section guidelines for the application of the least restrictive alternative doctrine in the involuntary civil commitment of mentally disordered individuals. These guidelines, supported by the detailed accounts of the doctrine's application in seven localities presented in Section II, comprise a model meant to bridge the wide gap between the theorectical demands of the doctrine and the difficulties of applying it in practice, a gap that seriously threatens the doctrine's value.

Following several guidelines dealing with definitional and organizational issues, the guidelines are presented generally in an order paralleling the chronology of events in involuntary civil commitment proceedings, from preliminary screening to ultimate release. Several guidelines highlight the preliminary stages of involuntary civil commitment, before a respondent is detained against his or her will. The first crucial decision to detain a respondent, a decision most often made by family members, police officers, or community mental health personnel,

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1. Hoffman & Foust, Least Restrictive Treatment of the Mentally Ill: A Doctrine in Search of Its Senses, 14 San Diego L.R. 1100, 1152 (1977).

is often not reviewed or checked until involuntary hospitalization is a fait accompli. These guidelines propose the mechanisms and procedures whereby such reviews and checks may be accomplished in accordance with the least restrictive alternative doctrine. Preliminary screening, negotiation, and cooperation among members of the mental health/legal community are stressed.

Twenty-five years ago, an individual certified as suitable for involuntary hospitalization was likely to be committed for a long period of time, usually to a large institution with inadequate staff, little treatment and care, and often disgraceful conditions. The decision to commit was practically irrevocable. During the reform movement in mental health law in the 1960s and 1970s, policymakers and the courts began to recognize that mentally disordered individuals have the right to be treated in the least restrictive alternative facility and treatment program. The decision to treat in a restrictive setting became, at least in theory, reversible at any time. Several guidelines seek to translate this theory into practical terms by proposing involuntary outpatient treatment, on a conditional basis or in combination with inpatient treatment, as an alternative to inpatient hospitalization.

Finally, several guidelines stress cooperation among the professional groups involved in the involuntary commitment process. The mentally disordered person who becomes involved in this process is a "shared client" of law enforcement, mental health, and social agencies, and the courts. The realization of patients' rights, including the right to be treated in the least restrictive alternative, and the overall improvement of mental halth services is an immense job that cannot be done by the courts alone or by any other single unit of the mental health/legal system.

GUIDELINES

1. Definition of Least Restrictive Alternative

(A) THE "LEAST RESTRICTIVE ALTERNATIVE" IN INVOLUNTARY CIVIL COMMITMENT PROCEEDINGS IS THAT COMBINATION OF THERAPEUTIC AND PREVENTATIVE INTERVENTION THAT IS (1) CONDUCIVE TO THE MOST EFFECTIVE AND APPROPRIATE TREATMENT WHICH WILL GIVE THE RESPONDENT A REALISTIC OPPORTUNITY TO IMPROVE HIS OR HER LEVEL OF FUNCTIONING AND THAT IS (2) NO MORE RESTRICTIVE OF A RESPONDENT'S PHYSICAL, SOCIAL, OR BIOLOGICAL LIBERTIES THAN IS NECESSARY TO ACHIEVE THE LEGITIMATE STATE PURPOSES OF PROTECTION OF SOCIETY AND OF MENTAL HEALTH TREATMENT AND CARE FOR THE RESONDENT.

(B) IN DETERMINING THE LEAST RESTRICTIVE ALTERNATIVE ON A CASE-BY-CASE BASIS, JUDGES, ATTORNEYS, LAW ENFORCEMENT PERSONNEL, MENTAL HEALTH PROFESSIONALS, SOCIAL SERVICE PROVIDERS, OR ANY OTHER INDIVIDUALS WHO MAKE SUCH A DETERMINATION AT VARIOUS STAGES OF THE INVOLUNTARY CIVIL COMMITMENT PROCESS, SHOULD BALANCE THE INTERESTS OF THE RESPONDENT, HIS OR HER FAMILY, AND THE STATE WHILE CONSIDERING AND WEIGHING THE FOLLOWING FACTORS:

(1) THE ENVIRONMENTAL RESTRICTIVENESS OF THE TREATMENT SETTING (E.G., INPATIENT HOSPITAL, HALF-WAY HOUSE, OR COMMUNITY MENTAL HEALTH CENTER);

(2) THE PSYCHOLOGICAL OR PHYSICAL RESTRICTIVE-NESS OF BEHAVIORAL, CHEMICAL, OR BIOLOGICAL TREATMENTS;

(3) CLINICAL VARIABLES INCLUDING THE RESPONDENT'S BEHAVIOR AS IT RELATES TO THE LEGAL CRITERIA FOR COMMITMENT, THE RELATIVE RISKS AND BENEFITS OF TREATMENT ALTERNATIVES, AND THE FAMILY AND COMMUNITY SUPPORT AVAILABLE IN THE RESPONDENT'S ENVIRONMENT;

(4) THE QUALITY AND LIKELY EFFECTIVENESS OF THE CARE AND TREATMENT;

(5) THE DURATION OF THE TREATMENT;

(6) THE RISK THAT A RESPONDENT MAY POSE;

(7) THE AVAILABILITY, COST, AND ACCESSIBLITY OF THE TREATMENT;

(8) THE LIKELIHOOD OF THE RESPONDENT'S COOPERATION IN OR COMPLIANCE WITH THE TREATMENT PROGRAM; AND

(9) THE MECHANISM FOR MONITORING AND REVIEWING A RESPONDENT'S COMPLIANCE WITH THE CONDITIONS OF THE TREATMENT PROGRAM.

Commentary

This guideline defines the "least restrictive alternative" at a conceptual level in subparagraph (A) and identifies the factors and operations to determine it on a case-by-case basis in subparagraph (B). It suggests, if nothing else, that a wide gap exists between the theoretical demands of the least restrictive alternative doctrine and what two commentators have referred to as the "harsh realities" of applying it.[2] It is diffuclt, if not impossible, to reduce a concept or a tenet of law to a set of concrete operations and observational terms.[3] The guideline strives to give greater operational meaning to such vague phrases as "appropriateness of treatment" and the "best interests" of the patient and society. It requires a balancing of interests in determining the least restrictive alternative in a particular case. Importantly, it requires the consideration and

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2. Id. at 1138.

3. Kansas City Report (this volume), notes 14-18 and accompanying text. For examples of several previous attempts to define least restrictive alternative, see Ga. Code §37-3-1(10) (1982); Ky. Rev. Stat. §202A.011(7) (Interim Supp. 1982); Mo. Rev. Stat. §630.005.1(18) (Supp. 1984); N.M. Stat. Ann. §43-1-3(D) (1978); Stromberg & Stone, A Model State Law on Civil Commitment of the Mentally Ill, 20 Harv. J. on Legis. 275, 291 (1983); Suggested Statute on Civil Commitment, 2(1) Mental Disability L. Rptr. 131 (1977).

weighing of specific factors in that balance, factors that may be related to each other and cannot be viewed in isolation. The duration of treatment, for example, has obvious bearing on the restrictiveness of the therapeutic setting and the psychological and physical restrictiveness of the prescribed treatment modality. But while most would agree that the longer the treatment the more restrictive it is, there may be no agreement, except on a case-by-case basis, on how duration relates to the treatment environment on a scale of restrictiveness (e.g., short-term intensive inpatient treatment with psychotropic medication versus long-term community-based care).

2. Right to Least Restrictive Alternative

STATE LEGISLATURES SHOULD PROVIDE RESPONDENTS WITH A COMPREHENSIVE STATUTORY RIGHT TO THE LEAST RESTRICTIVE ALTERNATIVE, AS DEFINED IN GUIDELINE 1.

Commentary

Although many state commitment statutes include a right to the least restrictive alternative, few define the meaning and scope of that right.[4] By requiring a comprehensive statutory right to the least restrictive alternative as defined in Guideline 1, this guideline seeks to clarify the meaning and scope of that right in operational terms and, thereby, reduce the necessity for piecemeal judicial shaping of such a right based on constitutional principles or vague statutory provisions.[5]

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4. Los Angeles Report (this volume), Appendix.

5. See id. at note 185.

The problem that this guideline addresses is exemplified by the developing right to the least restrictive alternative in New York.[6] New York's mental health statute provides respondents a right to the least restrictive treatment in only one limited situation. That is, a respondent may be placed in physical restraints "only if less restrictive techniques have been clinically determined to be inappropriate or insufficient to avoid" serious injury to the patient or others.[7] The New York Court of Appeals decision in Kesselbrenner v. Anonymous[8] found a constitutional right to the least restrictive alternative if the choice is between two or more institutional settings, but did not address whether a right to placement outside an institution exists. Decisions for the plaintiffs in two consolidated cases currently on remand from the Court of Appeals[9] would establish a right to community placement, but only after the respondent has been institutionalized for some period of time, assuming that the court limits its holding to the facts presented. Thus, even after years of litigation in New York, a comprehensive right is yet to emerge.

3. Goals of the Mental Health System

> THE APPLICATION OF THE LEAST RESTRICTIVE ALTERNATIVE DOCTRINE SHOULD BE INCORPORATED INTO STATUTORY AND REGULATORY LANGUAGE ARTICULATING A STATE'S GOALS AND PURPOSES IN PROVIDING MENTAL HEALTH CARE.

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6. New York Report (this volume), notes 1-30, 50 and accompanying text.

7. N.Y. Mental Hyg. Law §33.04(b) (Supp. 1983-1984).

8. 33 N.Y. 2d 161, 305 N.E. 2d 903, 350 N.Y.S. 2d __ (1973).

9. Klosterman v. Cuomo, Nos. 87, 88 (N.Y. Ct. App. Mar. 27, 1984).

Commentary

The value of the least restrictive alternative doctrine can be measured, in part, by a state's commitment to its promotion and application. Legislative intent to apply the doctrine provides the conceptual framework for implementation. For example, the doctrine is central to the legislative policy underlying Wisconsin's State Mental Health Act. That policy includes, among other things, that "[t]there shall be ... provision of services which will assure all people in need of care access to the least restrictive treatment alternative appropriate to their needs."[10] This policy has dramatically affected the commitment process in at least one locality.[11] In Missouri, the statutory basis for the application of the least restrictive alternative doctrine lies in the prescribed goal of the state's Department of Mental Health:

> The department shall seek to ... [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.[12]

4. Continuum of Services

> LEGISLATURES AND MENTAL HEALTH AGENCIES SHOULD DEVELOP AND IMPLEMENT A COORDINATED, COMPREHENSIVE MENTAL HEALTH SYSTEM THAT INCLUDES A CONTINUUM OF SERVICES FROM INTENSIVE INPATIENT TREATMENT AND CARE THROUGH VARIOUS NON-HOSPITAL RESIDENTIAL PROGRAMS TO OUTPATIENT COMMUNITY-BASED TREATMENT.

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10. Milwaukee Report (this volume), note 19 and accompanying text.

11. See id. notes 44-57 and accompanying text.

12. Kansas City Report (this volume), note 72 and accompanying text.

Commentary

The existence of a comprehensive system of alternatives to institutional mental health treatment is a necessary prerequisite to the proper application of the least restrictive alternative doctrine. Many state statutes require such a system. For example, the California Legislature has directly applied the least restrictive alternative doctrine in providing for the establishment and operation of a continuum of alternatives to institutional settings:[13] a community residential treatment system must be developed in a such a way that patients "[m]ay move within the continuum to the most appropriate, least restrictive level of service."[14] Residential alternatives that must be included in a system are short-term crisis alternatives, long-term programs, transitional services, structured living arrangements, rehabilitation programs, day treatment programs, socialization centers, in-home programs, and volunteer-based companion programs.[15]

Arizona's Mental Health Services Act charges the director of Arizona's Department of Health Services to establish a state-wide plan for community residential treatment for chronically mentally ill persons. The plan would provide a wide range of services in a least

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13. See Cal. Welf. & Inst. Code §§5450, 5458.

14. Id. at §5459. The Los Angeles County Department of Mental Health's primary goal for the 1980's reflects the Legislature's purpose of providing a spectrum of care. That goal is "to establish a comprehensive and coordinated single system of care with a full range of services in each region at multiple locations, available and accessible to all the residents of the County, primarily focusing on the severely and chronically mentally disordered population."

15. Id. at §5458(a)-(h).

restrictive setting as alternatives to institutionalization. Four types of programs are to be included in the community residential treatment system: (1) a short-term crisis residential program as an "alternative to hospitalization for persons in an acute episode or situational crises requiring temporary removal from the home for 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 the maximum of two years."[16] Chronically mentally ill persons are eligible for services in these programs regardless of whether they voluntarily seek the services, a court-appointed guardian requests, the superintendent of the Arizona state hospital recommends, or a court orders that they receive the services.[17]

It is important to note, however, that legislating procedures and policies and implementing them are separate processes that can not be viewed as one and the same.[18] Although the California and Arizona statutes provide extensively for comprehensive systems, such a continuum of services have not yet been developed in the localities studied by the Institute. The guideline, thus, urges not just detailed planning of a system, but affirmative implementation of a full range of services.

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16. Ariz. Rev. Stat. Ann. §36-550.05. (19__).

17. Id. §36-550.06.

18. Shah, Legal and Mental Health System Interactions: Major Developments and Research Needs, 4 Int'l J. of Law & Psychiatry 219, 255 (1981). For an example of the difficulties of implementing legislative directives to provide alternatives to involuntary civil commitment, see Williamsburg-James City County Report (this volume), "Alternatives to Involuntary Civil Commitment in the Williamsburg Area."

5. Guide to Less Restrictive Alternatives

MEMBERS OF THE MENTAL HEALTH/LEGAL COMMUNITY INVOLVED IN THE INVOLUNTARY CIVIL COMMITMENT PROCESS SHOULD HAVE FOR THEIR USE A COMPREHENSIVE, CURRENT GUIDE TO MENTAL HEALTH, MENTAL RETARDATION, AND OTHER SOCIAL SERVICES POTENTIALLY AVAILABLE TO RESPONDENTS. THIS GUIDE SHOULD BE DESIGNED TO FURTHER THE APPLICATION OF THE LEAST RESTRICTIVE ALTERNATIVE DOCTRINE ON A CASE-BY-CASE BASIS AND SHOULD INCLUDE, AT THE MINIMUM, THE FOLLOWING INFORMATION:

(1) A COMPLETE LISTING OF PUBLIC, PRIVATE, NON-PROFIT AND VOLUNTARY RESOURCES, AND THEIR LOCATIONS, SERVING MENTALLY DISORDERED PERSONS;

(2) A SHORT DESCRIPTION OF THE TYPES OF SERVICES OFFERED BY EACH RESOURCE LISTED;

(3) A BRIEF HISTORY OF SERVICES, IF ANY, PROVIDED TO PERSONS INVOLVED IN INVOLUNTARY CIVIL COMMITMENT PROCEEDINGS; AND

(4) THE SERVICE CAPACITY OF EACH RESOURCE INCLUDING:

(i) STAFF;

(ii) SIZE OF RESOURCE OR BED CAPACITY; AND

(iii) FISCAL ARRANGEMENTS FOR CLIENTS.

Commentary

Due to the interdisciplinary nature of commitment proceedings during which the "client" is shared by the various units comprising the mental health/legal system (i.e., law enforcement, hospitals, courts, the local bar, community mental health, and social services), disciplinary parochialism limits the knowledge of and, consequently, the access to less restrictive alternatives.

The development and preparation of a guide to services potentially available to respondents is an important step following the establishment of a coordinated, comprehensive mental health system including a continuum of services, as required by Guideline 4. If the least

restrictive alternative doctrine is to have any practical meaning on a case-by-case basis, it is important that court officials, attorneys, mental health personnel, social service personnel, law enforcement officers, and others involved in the involuntary civil commitment process have access to current information about available facilities that are alternatives to hospitalization. The proposed guide should be updated regularly by a local mental health association or agency that has regular access to the services available to respondents.[19]

6. Interdisciplinary Cooperation

> ALL AGENCIES, SERVICES, AND FACILITIES INVOLVED IN THE INVOLUNTARY CIVIL COMMITMENT PROCESS SHOULD CONVENE PERIODIC MEETINGS OF AN INTERDISCIPLINARY GROUP OF REPRESENTATIVES. THESE MEETINGS SHOULD PROVIDE A FORUM FOR DISCUSSION OF THE ROLE AND FUNCTION OF EACH ACTOR IN THE PROCESS AND OF PROBLEMS, AND THEIR POSSIBLE SOLUTIONS, ARISING IN THE PROCESSING OF RESPONDENTS. THIS GROUP SHOULD ENCOURAGE LINKAGES, COORDINATION, AND COOPERATION AMONG THE ACTORS IN THE CIVIL COMMITMENT PROCESS IN ORDER TO PROTECT AND FUTHER RESPONDENTS' RIGHTS AND INTERESTS IN LIBERTY AND TREATMENT IN THE LEAST RESTRICTIVE ALTERNATIVE.

Commentary

In most cities throughout the country, linkages, coordination, and cooperation among the various actors involved in the involuntary civil commitment process are, at best, in the formative stages. The prehearing portion of the commitment process, for example, involves conplex interorganizational factors, shifting authorities, and unfocused

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19. Keilitz & McGraw have recommended the development of such a guide to comprehensive services in Milwaukee County. An Evaluation of Involuntary Civil Commitment in Milwaukee County (1983).

responsibilities as a case moves through the process toward a judicial hearing. The court usually becomes actively involved in a case only after law enforcement officers, mental health prfoessionals, and attorneys have made both formal and informal determinations regarding the validity of the commitment of an individual. From the perspective of one component of the mental health/legal system, processing procedures might be equitable, efficient and understandable, but these same procedures may be onerous, complex, and meaningless to another component with different goals and operations.

Periodic meetings of an interdisciplinary group should provide a forum for finding creative solutions to processing problems by accommodating the duties and responsibilities of the various components represented. For example, law enforcement and detention facility representatives might discuss the difficulties of transporting respondents to the facility and transferring custody. Also, larger questions such as the overall access to the involuntary commitment process by means of the emergency or non-emergency routes might be discussed by the entire group. Many such questions cannot be adequately addressed from the perspective of only one component of the mental health/legal system. A broad overview that recognizes the important effects of a change in the operation of one component upon another component is often necessary.

7. Screening Before Involuntary Detention

REGARDLESS OF WHETHER COMMITMENT PROCEEDINGS ARE INTITIATED ON A NON-EMERGENCY OR EMERGENCY BASIS, PRELIMINARY SCREENING OF ALL RESPONDENTS SHOULD BE ACCOMPLISHED BY A COMMUNITY-BASED MENTAL HEALTH CARE AGENCY BEFORE A RESPONDENT IS ORDERED TO UNDERGO INVOLUNTARY TREATMENT AND CARE.

Commentary

Formal civil commitment proceedings generally follow rather than procede attempts to place a respondent into treatment and care less restrictive settings than a mental hospital.[20] Only a small minority of respondents are subject to involuntary civil commitment processes beyond short-term detention. Therefore the events prior to a formal civil commitment hearing may have more bearing on the equity, effectiveness and efficiency of, and public satisfaction with, a commitment system than the events in the subsequent stages of the commitment process. Systems that provide for a prompt, reliable, and thorough preliminary screening procedure, and a diversion of appropriate cases at the earliest stages of the commitment process, would appear to protect both the liberty interests of respondents and the pocketbooks of taxpayers.[21]

The initial decisions regarding a respondent's entry into the mental health/legal system entail much more than a determination of whether the legal and psychosocial criteria for involuntary civil commitment have been met. Good decisions are based on knowledge of the mental health delivery system in a particular locale, including the conditions of accessible mental health facilities, the availability of less restrictive alternatives for particular classes of respondents (e.g., gravely disabled individuals who are harmless to others), and the budgetary

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20. See Hoffman & Foust, supra note 1, at 1139 ("The unworkability of less restrictive alternatives, and not the failure to consider them, ultimately leads to most commitment proceedings.").

21. See, Institute on Mental Disability and the Law, Provisional Substantive and Procedural Guidelines for Involuntary Civil Commitment (1982), at II-7 to II-14.

constraints on the portions of the mental health system likely to be involved with a particular class of repondents. They also involve an understanding of the mechanisms for linking together the courts, law enforcement agencies, social service agencies, and the units of the mental health system in cooperative strategies to achieve the highest quality of treatment.[22]

In an apparent recognition of the importance of the initial stages of the involuntary civil commitment proceedings, the Arizona legislature provided for the prepetition screening of all applications for court-ordered mental health evaluations of potential candidates for involuntary civil commitment. Prepetition screening is 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."[23] The purposes of the screening, performed by a health care agency licensed by the Arizona Department of Health Services,[24] are to determine whether there is reasonable cause to believe the allegations in the application for court-ordered mental health evaluation (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 inpatient hospitalization.[25]

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22. Id., at II-13.

23. Ariz. Rev. Stat. Ann. §36-501.23 (19__).

24. Id. §36-501.28.

25. Id. §36-501.23; see also §36-521.

Preliminary screening may be conducted, for example, by community mental health centers and by crisis intervention teams associated with the centers. Screening may begin with a telephone or a personal referral to a local community mental health center. Mental health personnel receiving the referral may query the informant about the potential respondent's current behavior and situation and prior mental health history. If it appears that the potential respondent does not meet commitment criteria, he or she may be diverted to appropriate mental health care services outside of, and presumably less restrictive than, the involuntary civil commitment system. If some type of crisis intervention or emergency treatment appears appropriate, the mental health worker may contact a crisis intervention team to provide on-location intervention. As a result of screening by crisis intervention teams, many potential respondents may be diverted from emergency commitment to some type of voluntary treatment or care. A crisis intervention team's decision may be based upon its assessment of the legal criteria for involuntary detention and its assessment of the respondent's mental condition and environment. Even in the absence of statutory provisions for preliminary screening, such as Arizona's, much mental health screening and diversion from involuntary civil commitment proceedings may occur early in the commitment process.[26]

The mental health law in most states[27] provides two major means for intiating the involuntary commitment of a respondent--emergency and

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26. Milwaukee report (this volume), notes 51-53 and accompanying text.

27. See Institute supra note 21, at II-7 to II-8; for a specific example see, Cal. Welf. & Inst. Code §§5150-5157, 5200-5213; see also Keilitz, Fitch & McGraw, A Study of Involuntary Civil Commitment in Los Angeles County, 14 Southwestern L. R. 238, 246 (1984).

non-emergency. The first is characterized and differentiated from the latter by the actual or perceived need for immediate mental health or medical intervention. This immediate action may include temporary involuntary detention without judicial order or approval, and often crisis intervention by mental health or law enforcement personnel. Non-emergency procedures, on the other hand, are generally more deliberate and typically require a formal application to the court, judicial review of the application, and a subsequant court order for detention of the respondent for some type of mental health intervention. Although estimates vary,[28] fewer respondents proceed toward involuntary civil commitment along the non-emergency routes than proceed along the emergency routes. Emergency commitment, perhaps because it is perceived to be the easiest way to get a person hospitalized against his or her will, without invoking the procedural safeguards present along the non-emergency commitment route, is the predominant commitment route in many states, especially in big cities.[29] Our studies in New York City, Chicago, and Los Angeles strongly suggest that the emergency route is very often used when clearly no emergency actually exists.[30]

By requiring preliminary screening regardless of whether the commitment proceedings are initiated on a non-emergency or emergency basis, this guideline recognizes that only a small minority of respondents may fail to benefit from some type of preliminary screening

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28. See Tucson Report (this volume), note 115 and accompanying text.

29. Keilitz & Van Duizend, Current Trends in the Involuntary Civil Commitment of Mentally Disabled Persons, __ Rehabilitation Psychology __ (in press).

30. See Institute, supra note 21, at II-7 to II-9.

before they are transported to a hospital on an emergency basis. We strongly suspect that the non-emergency route is avoided in favor of the emergency route in many cases simply because it is a more direct, less onerous undertaking for those seeking to force another into treatment, not necessarily because an emergency exists. No diversion to less restrictive alternatives can occur if procedures for preliminary screening before hospitalization exist only along the non-emergency route, as is the case in most states.[31]

It makes little sense to provide preliminary screening along the route which is seldom travelled, and to fail to do so along the route to involuntary civil commitment along which most respondents travel. The opportunity for preliminary screening should occur in all cases, and that opportunity should only be limited, not entirely eliminated, in emergency cases.

The statutory mechanisms, if not the practice, for this type of preliminary screening of all cases, emergency or non-emergency, seems to be in place in Virginia. Any responsible person may initiate the process of involuntary civil commitment by requesting that a respondent appear before a district court judge, magistrate, or special justice.[32] A judge or special justice must be available to consider requests for temporary detention orders seven days a week, twenty-four hours a day.[33] If the judge or magistrate has probable cause to believe that the respondent meets commitment criteria, he or she issues an order for

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31. See, e.g., Tucson Report (this volume).

32. Williamsburg-James City County Report (this volume), note 89-90 and accompanying text.

33. Id. at notes 98-104 and accompanying text.

temporary detention of the respondent.[34] Determining whether probable cause exists to issue a detention order affords the opportunity for consideration of the appropriateness and availability of less restrictive alternatives to the detention and possible involuntary hospitalization of the individual. The judge or magistrate may issue a detention order based upon the advice of a mental health professional or upon his or her own motion, based on probable cause. Although a number of factors influence the judge's decision, the expertise of the person requesting the temporary detention order probably carries the most weight. When a mental health professional or law enforcement officer whose judgment has been reliable in the past recommends or requests a detention order, the judge almost automatically issues the order. When a family member requests a detention order, however, the judge usually requires a prescreening report from a community mental health center which is responsible for screening of all allegedly mentally ill adults or mentally retarded persons who reside in the area. Hence, judges usually consult with a mental health professional regarding the appropriateness of detaining the individual prior to ordering detention. Also, the judge or magistrate, when the respondent appears before him or her, "shall afford such person an opportunity for voluntary admission."[35] Although the judge or magistrate, may, in practice, issue an order for the detention of the respondent without affording him or her the opportunity to undergo less restrictive mental health intervention, the framework for performing preliminary screening, regardless of the commitment route, exists in Virginia's mental health statute.

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34. Id. at notes 89-90 and accompanying text.

35. Va. Code §37.1-67.1 (Repl. Vol. 1976 & Cum. Supp. 1983).

8. Screening Agents and Their Functions

(A) COMMUNITY-BASED SCREENING AGENTS, OR GATEKEEPERS, SHOULD FUNCTION AT THE THRESHOLD OF INVOLUNTARY CIVIL COMMITMENT PROCEEDINGS AND MAKE INFORMED DECISIONS ABOUT WHETHER INVOLUNTARY CIVIL COMMITMENT SHOULD BE PURSUED ALONG EMERGENCY OR NONEMERCENCY ROUTES IN A PARTICULAR CASE, OR WHETHER LESS RESTRICTIVE ALTERNATIVES SHOULD BE CONSIDERED.

(B) GATEKEEPERS SHOULD BE MENTAL HEALTH PROFESSIONALS, OR COURT PERSONNEL WORKING IN COOPERATION WITH MENTAL HEALTH PROFESSIONALS, EXPERIENCED IN THE DIAGNOSIS OF MENTAL ILLNESS AND FACILE IN APPLYING THE LEGAL, PSYCHOLOGICAL, AND SOCIAL CONSTRUCTS USED IN MAKING DECISIONS CONCERNING DETENTION PURSUANT TO INVOLUNTARY HOSPITALIZATION, RELEASE, AND ALL INTERMEDIATE ALTERNATIVES. GATEKEEPERS SHOULD HAVE THE AUTHORITY TO ORDER INVOLUNTARY DETENTION AND TO REQUEST AMBULANCE OR POLICE ASSISTANCE FOR TRANSPORTING RESPONDENTS TO AND FROM APPROPRIATE MENTAL HEALTH FACILITIES.

(C) WHEN A COMMUNITY MENTAL HEALTH AGENCY OR SOME OTHER HEALTH CARE AGENCY (HEREINAFTER "PORTAL") RECEIVES A REQUEST FOR AN APPLICATION FOR INVOLUNTARY COMMITMENT, A GATEKEEPER SHOULD: (1) IMMEDIATELY DETERMINE WHETHER TO PURSUE COMMITMENT PROCEEDINGS, OR TO ADVISE THE APPLICANT TO SEEK ALTERNATIVES; (2) IF SUCH ALTERNATIVES ARE NOT PURSUED BY THE APPLICANT, ASSIST THE APPLICANT IN COMPLETING THE APPLICATION FOR INVOLUNTARY COMMITMENT; AND (3) REVIEW AND INVESTIGATE THE APPLICATION AND SCREEN THE RESPONDENT.

(D) INVESTIGATION AND REVIEW OF THE APPLICATION SHOULD INCLUDE THE FOLLOWING: (1) REVIEW AND ASSESSMENT OF THE RELIABILITY AND CREDIBILITY OF ALL FACTUAL INFORMATION CONTAINED IN THE WRITTEN APPLICATION, (2) INTERVIEWS OF THE APPLICANT AND AVAILABLE WITNESSES WHO HAVE KNOWLEDGE OF THE RESPONDENT THROUGH PERSONAL INFORMATION.

SCREENING SHOULD INCLUDE A PERSONAL INTERVIEW WITH THE RESPONDENT WHEREUPON A DETERMINATION IS MADE TO PURSUE INVOLUNTARY CIVIL COMMITMENT OR TO DIVERT THE RESPONDENT TO LESS RESTRICTIVE TREATMENT AND CARE. THE INTERVIEW SHOULD BE CONDUCTED AT A COMMUNITY PORTAL AT A SPECIFIC TIME AND DATE OR, IF THE RESPONDENT IS UNWILLING

OR UNABLE TO COME TO THE PORTAL, AT THE RESIDENCE OR OTHER LOCATION OF THE RESPONDENT OR, IF A PERSONAL FACE-TO-FACE INTERVIEW CANNOT BE ARRANGED WITHIN THE PRESCRIBED TIME LIMITS, THE INTERVIEW MAY BE CONDUCTED BY TELEPHONE. THE INTERVIEW SHOULD INCLUDE: (1) GIVING THE RESPONDENT A COPY OF THE COMPLETED APPLICATION AND AN ORAL EXPLANATION OF THE NATURE, PURPOSE, AND POSSIBLE CONSEQUENCES OF THE INTERVIEW; (2) WRITTEN NOTICE AND ORAL EXPLANATION OF ALL RIGHTS PRESCRIBED BY LAW, AND AN OFFER OF ASSISTANCE TO THE RESPONDENT TO REALIZE THOSE RIGHTS; AND (3) MENTAL HEALTH SERVICES SUCH AS CRISIS INTERVENTION, COUNSELING, MENTAL HEALTH THERAPY, AND OTHER PSYCHIATRIC, WELFARE, PSYCHOLOGICAL, AND LEGAL SERVICES AIMED AT AVOIDING UNNECESSARY AND INAPPROPRIATE INVOLUNTARY HOSPITALIZATION AND PROVIDING CARE AND TREATMENT IN THE LEAST RESTRICTIVE SETTING.

(E) AT THE COMPLETION OF THE INVESTIGATION, REVIEW, AND SCREENING, THE GATEKEEPER SHOULD AGAIN DETERMINE WHETHER TO PURSUE COMMITMENT PROCEEDINGS, TO DIVERT THE CASE TO SOME ALTERNATIVE TREATMENT OR CARE, OR TO TERMINATE ANY FURTHER ACTIONS IN THE CASE.

IF THE GATEKEEPER DETERMINES THAT THE RESPONDENT MEETS THE COMMITMENT CRITERIA AND THAT THE RESPONDENT CANNOT BE SERVED IN A SETTING LESS RESTRICTIVE THAN THAT PROVIDED BY HOSPITALIZATION WITHOUT GIVING RISE TO IMMEDIATE AND SUBSTANTIAL RISKS TO THE RESPONDENT OR OTHERS, THE GATEKEEPER SHOULD CAUSE THE RESPONDENT TO BE TAKEN TO A MENTAL HEALTH FACILITY PURSUANT TO INVOLUNTARY COMMITMENT.

(F) THE GATEKEEPER SHOULD SUBMIT A REPORT OF THE REVIEW, INVESTIGATION, AND SCREENING TO THE COURT WITH THE APPLICATION FOR INVOLUNTARY CIVIL COMMITMENT.

Commentary

The decision by mental health personnel or police to initiate the involuntary civil commitment process, in most jurisdictions, invariably causes an individual some curtailment of liberty, loss of rights, and stigma of being labeled "mentally ill." Thorough mental health screening

and evaluation and judicial review of a case before detention and hospitalization has remained a matter of theory.[36]

This guideline encourages the accomplishment of reviewing, investigating, and screening, of mental health cases by gatekeepers before a respondent is taken into custody pursuant to involuntary civil commitment. In all cases, gatekeepers should review and investigate applications for involuntary civil commitment and screen respondents to avoid unnecessary detention and hospitalization when (1) there are inadequate grounds to believe that the respondent presents a likelihood of serious harm to self or others as a result of mental disorder, and (2) when there are less restrictive alternatives for care and treatment available to the respondent. The review, investigation, and screening should be completed prior to custody-taking and detention, unless a gatekeeper, or a peace officer upon consultation with a gatekeeper, determines that immediate detention is necessary to prevent serious harm to the respondent or others. In such emergency cases, at least telephone contact and consultation between a gatekeeper and a peace officer should establish the necessity for immediate detention.

The development of mechanisms for screening, investigation, and review of cases before a formal judicial hearing takes place should be achieved by a cooperative effort involving mental health practitioners, court personnel, and to a lesser extent, law enforcement officials.

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36. "The majority of courts addressing the issue of whether there is a right to a probable-cause hearing in civil commitment proceedings, implicitly acknowledge the need for a hearing before a non-emergency admission is made, but primarily address the arguments for or against a prompt probable-cause hearing soon after the initial detention." 4 Mental Disability Law Reporter, 290 (1981 emphasis added).

Review and investigation of cases, and screening and diversion of respondents from involuntary hospitalization, serve the interests of the respondent, the applicant or petitioner, the court, and the taxpayer. The respondent's interests are met by the avoidance of unnecessary detention and involuntary hospitalization, as well as his or her interest in access to less restrictive mental health care and treatment. The applicant or petitioner's interests are served by providing immediate support and assistance for a person whom he or she believes is incapable of caring for him or herself, and by providing an education resource during a time of crisis. The courts and the community are served by a more efficient and economical allocation of resources.

9. Diversion at Various Points

LAW ENFORCEMENT PERSONNEL, MENTAL HEALTH PROFESSIONALS, SOCIAL WORKERS, JUDGES, AND OTHERS IN THE POSITION TO EFFECT THE INVOLUNTARY CIVIL COMMITMENT PROCESS AT ITS VARIOUS STAGES, SHOULD HAVE KNOWLEDGE OF, AND BE ABLE TO DIVERT RESPONDENTS TO, LESS RESTRICTIVE ALTERNATIVES AT ANY OF THE VARIOUS POINTS AT WHICH THESE AGENTS OPERATE.

Commentary

Although the state should bear the burden of demonstrating that the course of treatment and care it advocates is the least restrictive alternative, as required by Guideline 15, all the agents along the route toward hospitalization should be able to divert respondents to the least restrictive alternative. Just as mental illness and dangerousness are generally considered as appropriate criteria applicable to all stages of the commitment proceedings, the informed determination of the least restrictive alternative should be viewed as an integral part of the decision making of those agents whose responsibility it is to move respondents along the route to involuntary civil commitment.

10. Commitment Criterion

A REQUIREMENT THAT INVOLUNTARY CIVIL COMMITMENT BE CONSISTENT WITH THE LEAST RESTRICTIVE ALTERNATIVE DOCTRINE SHOULD BE INCORPORATED AS PART OF THE COMMITMENT CRITERIA FORMALLY BY STATUTE OR COURT RULE OR INFORMALLY AS A MATTER OF PRACTICE.

Commentary

Some commentators believe that the particular wording of statutory criteria will have little bearing on practice and that mental health personnel, judges, and juries will continue to do as they wish and use involuntary civil commitment based on their own biases and preconceptions.[37] In our view, the skeptism about the value of modifying terms such as "mental illness" or "dangerousness" in the substantive commitment criteria may be justified if only because some evidence exists that such changes have had relatively little impact on practice. Such skeptism about introducing precise language requiring the application of the least restrictive alternative doctrine may not justify similar criticism. While definitional problems abound in the legislative and judicial construction of the least restrictive alternative doctrine, the elements of the definition have not been subject to the bickering among civil libertarians, mental health professionals, and others regarding the traditional commitment criteria of mental illness and dangerousness. Thus, while we do not expect that those law enforcement personnel, mental health professionals, and social service providers primarily affecting the involuntary civil commitment process will ever pay as much attention

37. See Stromberg & Stone, A Model State Law on Civil Commitment of the Mentally Ill, 20 Harvard Journal on Legislation 274, 285 (1983); Institute supra note 3, at I-4; Keilitz & McGraw, supra note 19, at 100-102.

to the statutory criteria for involuntary civil commitment that legal advocates would like them to, the least restrictive alternative doctrine's expression in the statutory criteria would, if nothing else, alluminate the importance of the doctrine at the various stages of the commitment proceeding. Most jurisidictions reproduce the language of the statutory criteria in the initial petitions and applications invoking the commitment court's jurisdiction. If nothing else, the incorporation of the least restrictive alternative doctrine within the statutory commitment criteria would cause such an advertisement of the doctrine in the paperwork that must move in tandem with the commitment proceedings.

Virginia serves as an example of a state that has formally incorporated the least restrictive doctrine into its commitment criteria. A respondent may be committed only if he or she is an imminent danger to him of herself or others as a result of mental illness or is seriously mentally ill and substantiably unable to care for him or herself, and if the alternatives to institutional confinement and treatment were investigated and deemed not suitable.[38]

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38. Williamsburg-James City County Report (this volume), note 153 and accopmanying text. Although a substantial majority of state legislatures require their courts to consider alternatives to hospitalization prior to or at the time of involuntary civil commitment (see notes 78-84 and accompanying text, Williamsburg-James City County Report, this volume), only eight states have incorporated the least restrictive alternative doctrine as part and parcel of their commitment criteria. For example, in Utah, a respondent may not be involuntarily hospitalized if "[t]here is no appropriate less restrictive alternative to a court order of hospitalization." Utah Code Ann. §64-7-36(10)(d) (Supp. 1983)]; see Alaska Stat. §47.30.730(a)(2) (Supp. 1983); Hawaii Rev. Stat. §334-60(b)(1)(c) (Supp. 1979); Me. Rev. Stat. Ann. tit. 34, §2251(7) (1964); Mo. Ann. Stat. §632.335(4) (Vernon Supp. 1984); N.M. Stat. Ann. §43-1-12(c) (Repl. Pamphlet 1979); Tenn. Code Ann. §33-604 (Supp. 1983); and Va. Code §37.1-67.3 (Cum. Supp. 1983).

11. Voluntary Admission

RESPONDENTS WHO HAVE BEEN COMMITTED INVOLUNTARILY TO INPATIENT TREATMENT SHOULD BE ABLE TO CONVERT TO VOLUNTARY INPATIENT ADMISSION STATUS AT ANY TIME IF THE DIRECTOR OF THE TREATMENT FACILITY OR HIS OR HER DESIGNEE DETERMINES THAT THE CONVERSION IS APPROPRIATE AND MADE IN GOOD FAITH.

Commentary

A respondent who willingly and ably chooses to become a voluntary patient in a hospital to which he or she has been committed on an involuntary basis should be granted this request as expeditiously as possible. Therapeutic efforts are probably enhanced when a patient voluntarily cooperates in a treatment program.[39] In most jurisdictions, voluntary admission status is generally less restrictive than involuntary admission status in terms of length of mandatory treatment and the treatment setting. For example, in Virginia respondents who choose to convert to involuntary admission status must accept treatment for a minimum of five days, whereas respondents committed involuntarily are subjected to treatment for up to 180 days.[40] After seventy-two hours, the respondent turned voluntary patient may give the hospital forty-eight hours notice that he or she wishes to leave the hospital. The forty-eight period permits the hospital to file a petition for an involuntary commitment. Eastern State Hospital in Williamsburg, Virginia rarely confines a voluntary patient to a locked ward; involuntary patients usually stay on a locked ward

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39. Stromberg & Stone, supra note 3, at 328.

40. Williamsburg-James City County Report (this volume), notes 146-148 and accompanying text.

anywhere from ten to fourteen days. Hospital officials explained that this initial restrictive setting is necessary to stabalize involuntary patients who, by statutory definition, are a danger to themselves or others, or substantially unable to care for themselves.[41]

No doubt, the procedures for conversion from involuntary admission status to voluntary status can be abused. Respondents who may be inappropriate for voluntary hospitalization may seek to manipulate the system by seeking conversion simply in order to request immediate discharge. Abuses by respondents can be checked by the guideline's requirement that conversions from involuntary to voluntary admission status may be prevented by the treatment facilities.[42] On the other hand, hospital staff may encourage the election of voluntary admission by respondents for reasons other than treatment considerations.[43] Abuses of the voluntary conversion by treatment facility staff can be checked by requiring respondent's counsel to certify that a patient who has requested voluntary admission did so willingly and with full understanding of the consequences of his or her action. By means of this procedure, the court may be assured by attorneys that respondents are not being talked into treatment against their wishes and without a judicial hearing. A court may still require a respondent to appear in court so

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41. Id.

42. For a review of approval and conditions, see Institute, supra note 21, IV-15 to II-19.

43. See Keilitz, Involuntary Civil Commitment in Columbus, Ohio 49-51 (Williamsburg, Virginia: National Center for State Courts).

that the court may be satisfied that the application for voluntary admission status was made willingly.[44]

If used appropriately, conversion of respondents from involuntary to voluntary hospitalization has advantages for all interested parties and is consistent with the least restrictive alternative doctrine. Respondents voluntarily admitted generally have more freedom within the facility and are able to affect their release more easily than if they were involuntarily committed. They also avoid the continuing stigma of an involuntary commitment. Because voluntary patients are generally favorably disposed toward treatment, that treatment is more likely to be successful. In addition, treatment staff avoid the paperwork and hearing requirments of involuntary commiment.

12. Petitions

PETITIONS OR APPLICATIONS FOR INVOLUNTARY TREATMENT AND CARE, INCLUDING COURT-ORDERED MENTAL HEALTH EVALUATIONS PURSUANT TO INVOLUNTARY COMMITMENT, SHOULD ALLEGE THAT LESS RESTRICTIVE ALTERNATIVES ARE INAPPROPRIATE.

Commentary

This guideline requires that petitioners or applicants pursuing the involuntary civil commitment of another person bear the initial burden of alleging the inappropriateness or undesirability of less restrictive alternatives before involuntary hospitalization can occur. Only a

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44. This type of certification procedure to check potential abuse of voluntary admissions by mental health staff is in place, by court rule, in Chicago. See Zimmerman, Involuntary Civil Commitment in Chicago, 43-44 (Williamsburg, Virginia: National Center for State Courts 1982).

minority of jurisdictions require the petition for commitment to allege that alternatives to involuntary hospitalization are unacceptable to petitioners.[45] Guideline 15 places that burden of proof on the state.

13. Negotiation and Settlement of Cases.

(A) ATTORNEYS REPRESENTING RESPONDENTS AND THE STATE IN INVOLUNTARY CIVIL COMMITMENT PROCEEDINGS SHOULD NEGOTIATE AND SETTLE CASES IN WHICH THE THERAPEUTIC AND PREVENTATIVE GOALS OF THE PROCEEDINGS CAN BE ACHIEVED BY ALTERNATIVES TO INVOLUNTARY COMMITMENT.

(B) IN THE NEGOTIATION AND SETTLEMENT OF EACH APPROPRIATE CASE:

(1) ATTORNEYS SHOULD ACTIVELY OBTAIN AND CONSIDER INFORMATION FROM LAW ENFORCEMENT OFFICERS, MENTAL HEALTH PROFESSIONALS, PETITIONERS, AND FAMILIES OF RESPONDENTS; AND

(2) SETTLEMENT PROPOSALS BY THE RESPONDENT'S ATTORNEY SHOULD BE THOROUGHLY EVALUATED, FIRST BY THE STATE'S ATTORNEY AND THEN BY THE COURT.

(C) POLICIES AND PROCEDURES SHOULD BE DEVELOPED FOR MONITORING RESPONDENTS' COMPLIANCE, AND RESPONDING TO CASES OF NONCOMPLIANCE, WITH THE TERMS AND CONDITIONS OF SETTLEMENTS.

(D) A SYSTEM SHOULD BE ESTABLISHED SO THAT CURRENT INFORMATION IS READILY ACCESSIBLE ABOUT COMMUNITY-BASED, LESS RESTRICTIVE TREATMENT AND CARE FACILITIES AND PROGRAMS AND THEIR WILLINGNESS AND CAPACITY TO ACCEPT RESPONDENTS DIVERTED FROM INVOLUNTARY COMMITMENT.

Commentary

This guideline encourages the use of negotiation and settlement procedures similar to those now evolving in Milwaukee County, Wisconsin. Although the settlement process in Milwaukee has sparked much controversy,

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45. See supra note 38; see also Hoffman & Foust, note 1, at 1118, n. 64.

in our opinion, this controversy has resulted from aspects of the procedures needing refinement, not from the merits of the general process itself. The settlement process can ensure that through cooperative strategies a respondent is effectively guided to optional treatment and care while protecting civil libertarian concerns.

In Milwaukee, negotiated settlements take two forms: (1) "court-ordered voluntary" agreements (COVs),[46] which result in voluntary inpatient status, and (2) stipulated settlements, which result in outpatient status. A negotiated settlement results from relatively unstructured conferences and negotiations between the attorney representing the respondent and the corporation counsel, who represents the state. These conferences and negotiations generally occur prior to the probable cause hearing, but may follow it. The parties negotiate, reach an agreement, and then seek postponement of the probable cause hearing or final commitment hearing for a specified time, during which the respondent participates in the agreed-upon treatment program. Unless the respondent fails to comply with the terms of the agreement, the matter is dismissed at the end of the treatment period. If the respondent has failed to comply, the corporation counsel requests that the case be reopened.

A stipulated settlement may result in the case being held open for up to 90 days. Typical conditions of these agreements include outpatient administration of psychotropic medication, psychotherapy, vocational

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46. In I. Keilitz & B.D. McGraw, supra note 19, at 72 n.70, the authors suggested that part of the controversy surrounding court-ordered voluntary agreements has resulted from the inherently inconsistent label used to refer to these agreements. The authors suggested an alternative label, such as "stipulated voluntary".

rehabilitation, day care, placement in a group home or board-and-care facility, social services such as General Assistance or Supplementary Security Income, food stamps, "meals-on-wheels," homemaker services, and other conditions peculiar to the case. At the time of the originally scheduled probable cause hearing, the parties present the stipulated settlement to the court, which usually adopts it as the order of the court.

Under the conditions of a COV, judicial proceedings may be adjourned for up to six months or until (1) the respondent's counsel notifies the court that his or her client wishes the case to be set for hearing, or (2) Milwaukee County Mental Health Complex staff determine that the respondent no longer needs inpatient treatment and notify the court to that effect, in which case the pending commitment proceedings are dismissed. The court orders the COV conditions subject to the approval of the treatment staff. Under the resulting "voluntary" admission, the respondent agrees to cooperate with treatment staff.

The elements of a proposed settlement are initially formulated by the respondent's counsel. In constructing a proposal, the attorney talks with the respondent (usually the evening before the scheduled probable cause hearing), detention ward staff, social workers affiliated either with the Legal Aid Society or the community services board, and, although less frequently, family members and petitioners. Although the corporation counsel may investigate alternative arrangements before the respondent's counsel presents a proposed settlement, he typically waits for that proposal. Once he receives a proposal, he may review it with a detention ward psychiatrist and with members of the respondent's family. Corporation counsel might then accept the proposal as presented,

negotiate modifications of conditions of the proposal, or reject the proposal outright and proceed to probable cause hearing.

Supporters of the negotiated settlement process in Milwaukee state that it furthers Wisconsin's legislative policy of assuring access to the least restrictive treatment alternative appropriate to the respondent's needs. Critics argue that it tips the balance too much in favor of the respondent's liberty interests while compromizing much needed treatment and care. A criticism aimed at stipulated settlements is that the monitoring of a respondent's compliance with outpatient treatment terms and conditions is inadequate.

Lack of resources lies at the root of the monitoring problem. Corporation counsel does not have the time or the resources to monitor a respondent's compliance with the conditions of a stipulated settlement once it is approved by the court. The only real check on compliance occurs when petitioners, members of the respondent's family, mental health professionals, or others in the community bring a respondent's noncompliance to the attention of the corporation counsel. While additional resources appear to be the only complete solution to the problem, a coordination and linking of existing services, and a modification of the legal proceedings to better accomodate the stipulated settlement process, may provide partial solutions.

14. Orientation and Education for Attorneys

AN ORIENTATION AND A CONTINUING EDUCATION PROGRAM FOR ATTORNEYS SHOULD BE PREREQUISITE TO INCLUSION ON AN APPOINTMENT LIST OF RESPONDENTS' ATTORNEYS AND SHOULD INCLUDE INSTRUCTION REGARDING (1) THE LEGAL AND PRACTICAL APPLICABILITY OF THE LEAST RESTRICTIVE ALTERNATIVE DOCTRINE; (2) THE RESPONSIBILITY OF

RESPONDENT'S COUNSEL FOR EXPLORING LESS RESTRICTIVE ALTERNATIVES AND FOR OFFERING THESE ALTERNATIVES TO THE COURT; (3) THE CONTINUUM OF SERVICES, FROM INTENSIVE INPATIENT TREATMENT TO OUTPATIENT CARE, AVAILABLE TO RESPONDENTS IN THE COMMUNITY; AND (4) ENLISTING THE ASSISTANCE OF MENTAL HEALTH AND SOCIAL SERVICE WORKERS IN IDENTIFYING, EXPLORING, AND COMMUNICATING LESS RESTRICTIVE ALTERNATIVES TO INVOLUNTARY HOSPITALIZATION.

Commentary

Because of their infrequent involvement in involuntary civil commitment cases, private attorneys are often inexperienced in substantive, procedural, and tactical matters involved in these cases. One response to this pervasive problem is to establish prerequisites to initial and continued inclusion on the list of attorneys from which counsel for commitment respondents are appointed. Effective prerequisites are an orientation program and a continuing education program for potential respondents' counsel. The content and operation of these programs should preferably be a joint effort of the judiciary, the local bar, and the mental health system.

The initial orientation might be as simple as a one-to-one or group meeting between a judge and potential appointees to discuss the role and functions of respondents' counsel in civil commitment proceedings. Similarly, a seminar might be conducted to initiate the orientation program. The seminar might be videotaped or audiotaped for presentation to attorneys subsequently added to the appointment list. Continuing education requirements might also be met by use of tapes of periodic seminars.

The overriding purpose of such an educational program should be to ensure that respondents represented by private counsel have a fair

opportunity to protect their liberty interests yet still get needed mental health treatment in accordance with the least restrictive alternative doctrine. The futherance of this purpose requires that respondents' counsel understand their functions as advocates and counselors within the civil commitment context. Counsel should understand these functions not only on a conceptual level, but also on a practical level. The conceptual understanding should be addressed during the initial orientation and may require input from the various components of the mental health/legal system. The practical understanding should be addressed in both the initial and the continuing education programs. This would require input from the legal community, but also from mental health treatment providers. When requested by the coordinator of the program, treatment providers should provide information concerning the types of services and treatment they provide. The legal community should provide information concerning the mechanics of the formal and informal proceedings.

15. Burdens of Proof

(A) THE STATE SHOULD BEAR THE BURDEN OF PROVING THAT THE COURSE OF TREATMENT AND CARE IT ADVOCATES, FROM THE INITIAL STAGES OF INVOLUNTARY CIVIL COMMITMENT PROCEEDINGS TO EVIDENTIARY HEARINGS ON CONTINUED COMMITMENT IS THE LEAST RESTRICTIVE ALTERNATIVE.

(B) ATTORNEYS REPRESENTING RESPONDENTS IN INVOLUNTARY CIVIL COMMITMENT PROCEEDINGS SHOULD EXPLORE TREATMENT ALTERNATIVES LESS RESTRICTIVE THAN INVOLUNTARY HOSPITALIZATION AND SHOULD PRESENT THESE ALTERNATIVES TO THE COURT. RESPONDENTS' ATTORNEYS SHOULD ENLIST THE ASSISTANCE OF SOCIAL WORKERS IN IDENTIFYING, EXPLORING, AND COMMUNICATING LESS RESTRICTIVE ALTERNATIVES.

Commentary

The state should bear not only the burden of proving that the substantive involuntary civil commitment criteria are met, but also should bear the burden of proving that the treatment and care that it advocates is the least restrictive alternative appropriate given the respondent's condition. Although the burden of proof technically should lie with the state, as a practical matter, the burden of identifying and exploring alternatives to hospitalization may fall on the respondent's counsel. Most mental health statutes do not require the state as part of its case in chief to explore treatment alternatives less restrictive than that which it advocates.[47] Rather, the ultimate responsibility lies with the court to determine whether the state's proposed treatment of the respondent or some less restrictive modality is appropriate. Thus, the state may have neither the responsibility, nor the incentive, to present the court with less restrictive alternatives. Once the state has presented its evidence supporting the treatment it advocates, the onus shifts to the respondent's counsel to rebut that evidence and to present alternatives to the court. The respondent's counsel has the incentive to explore and present evidence of less restrictive alternatives to protect his or her client's liberty interests. Thus, the shifting of the onus places the responsibility for presenting alternatives evidence on the party with the incentive to present it. Once the respondent's counsel presents his or her treatment evidence, the court should determine whether the state's evidence clearly and convincingly outweighs the respondent's evidence. The court should then order the least restrictive alternative.

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47. See, Keilitz & McGraw, supra note 19, at 96-97; Hoffman & Foust, supra note 1, at 1109-10.

16. Cross-Examination of Mental Health Experts

ATTORNEYS REPRESENTING RESPONDENTS AT COMMITMENT HEARINGS SHOULD CAREFULLY CROSS-EXAMINE EXPERT WITNESSES OFFERED BY THE STATE AS PROPONENTS FOR INVOLUNTARY HOSPITALIZATION.

Commentary

Before actually presenting alternatives evidence to the court, a respondent's counsel has opportunities to cross-examine expert witnesses presented by the state to support the treatment and care that it advocates. Important cross-examination concerns for a respondent's counsel include how the witness reached the conclusion that involuntary hospitalization is the least restrictive alternative given a respondent's disabling condition, and specifically which treatment alternatives the witness investigated and why they were insufficient.

Many attorneys fail to effectively cross-examine mental health experts testifying on behalf of the state.[48] In many instances the state may present only minimal evidence supporting a particular mode of treatment and care. The presentation may consist of nothing more than the state's counsel asking the mental health expert, "would you recommend this facility for treatment?," and the expert responding, "yes."[49] Although attorneys representing respondents must determine on a case-by-case basis how and whether to cross-examine mental health expert witnesses, the attorneys should carefully consider probing such conclusory and cursory treatment evidence. The respondent's attorney may determine that no explicit alternatives were actually considered by the state.

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48. Keilitz & McGraw, supra note 19, at 98.

49. Id.

17. Court Disposition and Review

AFTER CONSIDERING THE EVIDENCE AND ARGUMENTS PRESENTED, INCLUDING THE TREATMENT PLAN FOR THE RESPONDENT, IF ANY, THE COURT SHOULD IMPOSE THE LEAST RESTRICTIVE ALTERNATIVE AS DEFINED BY GUIDELINE 1.

Commentary

Involuntary civil commitment is no longer synonymous with placement of a respondent in the maximum security ward of a state mental hospital. Techniques and settings available for assisting mentally ill individuals are increasing in number. Because of the availability of placement alternatives, because of the constitutional mandate that the nature and duration of a commitment must bear a reasonable relationship to the purpose of the commitment,[50] and because a state may not impose any greater restrictions on fundamental freedoms than is necessary to serve a legitimate state interest,[51] legislatures and courts have increasingly recognized the doctrine of the least restrictive alternative.

Paragraph (A) of this guideline is in accordance with that trend. It calls upon the court to select the least drastic means available. This does not mean that the judge must decide the appropriate dosages of the drugs to be administered, or the intensity of therapy. Rather, it requires the court to consider the types of settings (e.g., maximum security ward, non-secure ward, outpatient community mental health care), and the broad classes of therapy and services proposed, and to select the one(s) that best addresses the respondent's needs and problems, and that

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50. See, Jackson v. Indiana, 406 U.S. 715 (1972); O'Connor v. Donaldson, 422 U.S. 563 (1975).

51. See, e.g., Shelton v. Tucker, 364 U.S. 479 (1960); Lake v. Cameron, 364 F.2d 657 (1966).

intrudes least upon the respondent's freedom of action and bodily integrity.[52]

18. Outpatient Treatment and Care

(A) WHENEVER APPROPRIATE, INVOLUNTARY OUTPATIENT TREATMENT OR A COMBINATION OF OUTPATIENT AND INPATIENT TREATMENT AND CARE SHOULD BE ORDERED BY THE COMMITMENT COURT AS A LESS RESTRICTIVE ALTERNATIVE TO INVOLUNTARY INPATIENT HOSPITALIZATION.

(B) THE DIRECTOR OF THE MENTAL HEALTH CARE FACILITY PROVIDING INVOLUNTARY OUTPATIENT TREATMENT AND CARE, OR HIS OR HER DESIGNEE, SHOULD HAVE THE RESPONSIBILITY OF SUPERVISING RESPONDENTS ORDERED TO UNDERGO OUTPATIENT TREATMENT AND CARE AND MONITORING THEIR COMPLIANCE WITH THE TREATMENT PLAN. THE DIRECTOR OR DESIGNEE MAY REVOKE THE OUTPATIENT TREATMENT STATUS OF ANY RESPONDENT WHO FAILS TO COMPLY WITH THE OUTPATIENT TREATMENT PLAN.

Commentary

Most jurisdictions do not have dispositional options lying between the extremes of involuntary inpatient hospitalization and outright release of a respondent.[53] This guideline urges the consideration of less restrictive alternatives to involuntary hopsitalization whenever possible without ignoring the possibility that those alternatives may prove to be unsuccessful or become inappropriate at some future time.

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52. See e.g., Chambers, Alternatives to Civil Commitment of the Mentally Ill: Practical Guides and Constitutional Imperatives, 70 Michigan Law Review, 1107 (1972); Shapiro, Legislating the Control of Behavior Control: Autonomy and Coercive Use of Organic Therapies, 47 Southern Califronia Law Review, 237 (1974).

53. See Miller & Fiddleman, Outpatient Commitment: Treatment in the Least Restrictive Environment, 35 Hospital and Community Psychiatry 147 (1984).

In what is perhaps the most recent development of the least restrictive alternative doctrine in mental health law, some states have provided specific alternatives to involuntary hospitalization in their mental health statutes, including court-ordered treatment in community mental health centers and nursing homes, and release from involuntary hospitalization contingent on compliance with a program of outpatient treatment.[54] For example, Arizona's Mental Health Services Act, as amended in 1983, permits the court to order treatment and care in non-hospital settings. Following a judicial hearing, courts in Arizona have four dispositional options: release of the respondent if the commitment criteria have not been met by clear and convincing evidence; or outpatient treatment, inpatient treatment, and a combination of outpatient and inpatient care if the commitment criteria have been met.[55] The court must consider all available and appropriate alternatives for the treatment and care of the respondent. But it may order outpatient or a combination of outpatient and inpatient treatment only if: (a) the prescribed treatment is indeed more appropriate; (b) the respondent does not require continuous inpatient hospitalization; (c) the respondent will follow the treatment plan; and (d) the respondent is not likely to become dangerous or suffer serious health consequences as a result of following the prescribed treatment plan.[56]

The success of treatment less restrictive than involuntary intensive hospitalization and care depends, to a large extent, upon the cooperation

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54. Id.

55. Ariz. Rev. Stat. Ann. §36-540.A (19__); see also, Cal. Welf. & Inst. Code §5305 (West Supp. 1983).

56. Id. §36-540.B.

of the respondent. In Arizona, the court may order outpatient or a combination of outpatient and inpatient treatment only if it is presented with a written treatment plan,[57] which includes: (a) a statement of the respondent's needs for medication, supervision, and assistance in obtaining basic needs such as employment, food, clothing, or shelter; (b) the address of the residence where the respondent is to live and the name of the individual in charge of the residence; (c) the name and address of the responsible person or agency assigned to supervise outpatient treatment and the authority of that person or agency in carrying out the terms of the treatment plan; and (d) the conditions for continued outpatient treatment.[58]

Despite a growing emphasis on treatment and care in the least restrictive setting, outpatient treatment and care has been hampered by the reluctance of community-based treatment facilities to treat unwilling patients.[59] Also, most jurisdictions fail to adequately provide for remedial measures when less restrictive treatment and care fails.[60] Perhaps in recognition of the disinclination of community mental health facilities to treat involuntary patients on an outpatient basis and the need for monitoring and supervision of outpatient treatment, Arizona's Mental Health Services Act provides for a number of procedures aimed at assuring a continuity and linkage between the commitment court and the treatment facility. The individual assigned to supervise the treatment program must be notified at least three days before a treatment referral,

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57. Id.

58. Id. §§36-540.B.2, 36-540.01.

59. Miller & Fiddleman, supra, note 53, at 150.

60. Hoffman & Foust, supra note 1, at 116.

and the medical director making the referral and the prospective treatment supervisor must share relevant information about the respondent to provide a continuity of services.[61] The court may provide a hearing or amend its order for outpatient or a combination of outpatient and inpatient treatment if the respondent fails to comply with the treatment plan or if it is determined that the respondent needs inpatient treatment.[62] If the respondent refuses to comply with an amended order for inpatient treatment, the court may order the respondent to be taken into protective custody and transported to an inpatient facility.[63]

19. Treatment Close to Respondent's Community

> WHENEVER POSSIBLE, INVOLUNTARY TREATMENT AND CARE SHOULD BE PROVIDED IN OR BY A LOCAL MENTAL HEALTH TREATMENT AGENCY GEOGRAPHICALLY CONVENIENT FOR THE RESPONDENT.

Commentary

All other factors being equal, a treatment setting far removed from a respondent's family and community is more restrictive than one closer to the respondent's normal residence that allows the respondent to maintain his or her social ties. As important as these social ties may be to the success of a program of treatment and care, the authors of one study suggest that commitment judges "do not accord high priority to the availability of the patient's family, their attitude towards the patient, or to the proximity of the treatment facility to the patient's community or family."[64]

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61. Id. §36-540.D.3.

62. Id. §36-540.D.4.

63. Id.

64. Hoffman & Foust, supra note 1, at 1137.

Arizona and New Mexico are among only a few states that have given explicit statutory expression to the principle reflected in this guideline by requiring that an initial period of involuntary treatment be in a mental health treatment facility geographically convenient for the respondent. In Arizona, whenever a court orders a respondent to undergo involuntary treatment and care, he or she must generally be treated and cared for at least twenty-five days in a local mental health treatment agency prior to admission to the state hospital located in Phoenix, unless the respondent is already in the state hospital at the time of the court order.[65] The court may immediately hospitalize the 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 and care; (b) the state hospital provides a program specific to the respondent's needs which is unavailable in the local agency; or (c) no local mental health care facility is readily available to the respondent.[66]

New Mexico, one of five states that define the meaning of a least restrictive setting in their mental health statutes,[67] has implied the thrust of this guideline in defining the meaning of the phrase "consistent with least drastic means principle."[68] Treatment and care are to be provided "at a suitable available facility closest to the client's place of residence."[69]

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65. Ariz. Rev. Stat. Ann. §36.541 (19__).

66. Id.

67. Williamsburg/James City County Report (this volume), at note 79.

68. N.M. Stat. Ann. §43-1-3(D) (1978).

69. Id.

20. Release and Conditional Outpatient Treatment

(A) AT ANY TIME WITHIN A PERIOD OF COURT-ORDERED COMMITMENT TO INPATIENT HOSPITALIZATION, THE DIRECTOR OF THE MENTAL HEALTH CARE FACILITY PROVIDING INPATIENT TREATMENT, OR HIS OR HER DESIGNEE, MAY, IN APPROPRIATE CASES, ORDER CONDITIONAL OUTPATIENT TREATMENT OR A COMBINATION OF PROVISIONAL OUTPATIENT TREATMENT AND INPATIENT TREATMENT.

(B) THE DIRECTOR OR DESIGNEE SHOULD HAVE THE RESPONSIBILITY OF MONITORING AND SUPERVISING THE RESPONDENT. HE OR SHE MAY REVOKE THE CONDITIONAL OUTPATIENT STATUS IF THE RESPONDENT FAILS TO COMPLY WITH THE CONDITIONS OF THE OUTPATIENT PROGRAM.

Commentary

This guideline recognizes that consideration of the entire continuum of mental health and social services representing viable alternatives to involuntary hospitalization should not cease once a respondent is committed to a hospital. It applies to those respondents who may be too mentally ill to be released from the hospital without further supervised mental health care and treatment but who may no longer require continuous involuntary inpatient treatment.

Arizona's Mental Health Services Act gives statutory expression to this guideline. The medical director of a mental health care facility in Arizona may pursue conditional outpatient treatment for any respondent ordered to undergo inpatient treatment if he or she determines with a reasonable degree of medical probability that: (1) the respondent no longer requires continuous hospitalization; (2) the respondent will be more appropriately treated on an outpatient basis; (3) the respondent is likely to follow a prescribed outpatient treatment plan; and (4) the respondent is not likely to become dangerous or suffer serious physical

harm or serious illness if he or she follows the prescribed outpatient treatment plan.[70]

An objection frequently asserted against outpatient commitment is that a respondent's participation and cooperation in a treatment program less restrictive than hospitalization cannot be ensured.[71] The Arizona statute apparently counters this objection by providing for notice to interested parties of the respondent's conditional outpatient treatment program, review of the respondent ordered to undergo the program, and procedures for amending or rescinding the order for conditional outpatient care.

Before conditionally releasing a respondent previously found to be dangerous to others, the medical director must give notice to the court and any other persons with a legitimate reason for receiving such a notice to provide the opportunity for the filing of a motion for the court to determine whether the standard for conditional release has been met.[72] At least every thirty days, the medical director must receive a report about, and review the condition of, a respondent on conditional outpatient treatment and enter his or her findings in the respondent's file.[73] The medical director may amend any part of the outpatient treatment plan or rescind the order for conditional outpatient treatment altogether and order the respondent returned to an inpatient treatment

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70. Ariz. Rev. Stat. Ann. §36-540.01.A.

71. See, e.g., Hoffman & Foust, supra note 1, at 1115-9.

72. Ariz. Rev. Stat. Ann. §§36-540.01.E, 36-541.01.B.

73. Id. § 36.540.01.F & G.

program.[74] The medical director is not civilly liable for any act committed by a respondent undergoing conditional outpatient treatment if the medical director has adhered in good faith to the requirements for conditional outpatient treatment and care.[75]

21. Least Restrictive Setting Within a Hospital

> JUDICIAL COMMITMENT TO INVOLUNTARY INPATIENT CARE SHOULD NOT PRECLUDE CONSIDERATION OF THE LEAST RESTRICTIVE TREATMENT SETTING WITHIN A HOSPITAL. ALSO IT SHOULD NOT PRECLUDE MODIFICATIONS IN THE TREATMENT AND CARE CONSISTENT WITH THE LEAST RESTRICTIVE ALTERNATIVE DOCTRINE, AT ANY TIME, IF WARRANTED BY CHANGES IN A RESPONDENT'S CONDITION.

Commentary

The proper application of the least restrictive alternative doctrine to prehearing procedures and to judicial hearings should assure that only respondents in need of intensive inpatient treatment and care are the subject of involuntary hospitalization orders. However, the least restrictive alternative doctrine applies also to a respondent's treatment and care within a mental health hospital after the commitment order has been issued. This guideline urges that jurisdictions, which may have contemplated less restrictive alternatives before commitment, not ignore the application of the least restrictive alternative doctrine after commitment. As has been noted by the United States Court of Appeals for the District of Columbia:

> It makes little sense to guard zealously against the possibility of unwarranted deprivations prior to hospitalization, only to abandon the watch once the

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74. Id. § 36.540.01.H, I, K.

75. Id. § 36.540.01.L.

> 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.[76]

22. Discharge Plan

> RELEASE OF RESPONDENTS FROM MORE RESTRICTIVE TO LESS RESTRICTIVE TREATMENT AND CARE SETTINGS SHOULD BE ACCOMPLISHED IN ACCORDANCE WITH A DISCHARGE TREATMENT PLAN DEVELOPED IN ACCORDANCE WITH THE LEAST RESTRICTIVE ALTERNATIVE DOCTRINE.

Commentary

Many respondents released from hospitals may not need continued outpatient treatment and care. However, a large number could benefit from outpatient treatment while living in community mental health care facilities or with families and friends. Unfortunately, many others are simply "trans-institutionalized" by finding their way into jails, prisons, and locked wards of nursing homes where conditions may be far worse than in the hospitals from which they were released.[77] The appropriatness of the environment into which the respondent is released depends, of course, upon the availability of appropriate, less restrictive therapeutic settings but also upon the cooperation between mental health care facilities, especially hospitals and community-based facilities. In some localities this cooperation apparently meets the that needed to effect this guideline. For example, in Williamsburg-James City County, Virginia cooperation between the inpatient facility, Eastern

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76. Covington v. Harris, 419 F.2d 617, 623-24 (D.C. Cir. 1969).

77. See Stromberg & Stone, supra note 3, at 277.

State Hospital, and the community mental health center is apparently high.[78] Plans for a respondent's discharge begin immediately upon his or her admission to Eastern State Hospital. The hospital assigns the respondent a treatment team composed of a psychiatrist, a psychiatric resident, a psychologist, a social worker, a nurse, and other appropriate staff persons. The treatment team convenes an "Evaluation, Planning, and Discharge" conference shortly after the respondent is admitted to the hospital.[79] The hospital and the local community mental health center have negotiated "discharge" agreements describing the responsibilities of each agency for planning and following-up on the respondent's discharge from the hospital. A case manager of the community mental health center regularly attends the conferences on behalf of clients from the geographical area served by the community mental health center.

To both reduce its patient population and enhance successful transitions from hospital to community, Eastern State Hospital has developed a Community Support Services Program. The program began in early 1982 with the assistance of community mental health centers. Its primary mission was to create appropriate placements for patients who, because of long periods of hospitalization, would find moving back into the community very difficult.

An effective transitional program has been in use in the Bronx, New York.[80] Under this program, groups of six to eight adult inpatients

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78. Williamsburg-James City County Report (this volume), notes 176-178 and accompanying text.

79. Id.

80. See Stastny, A Comprehensive Group Resettlement Program for Psychiatric Inpatients (no date). Dr. Stastny has developed a comprehensive program that is only summarized here.

are formed within the hospital to undergo two to four-month pre-discharge treatment in prepartion for joint discharge and placement in community residences. During this time, the patients live in a transitional, open ward and participate in group and individual therapy, community visits, and vocational training. Ater discharge, the patients live together in apartments and are supervised by community agencies. The ultimate goal of the group resettlement program is integration into the community and independent living.