ARTICLES

LITIGATING FOR TREATMENT: THE USE OF STATE LAWS AND CONSTITUTIONS IN OBTAINING TREATMENT RIGHTS FOR INDIVIDUALS WITH MENTAL ILLNESS

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I. INTRODUCTION

Advocates for the mentally ill have litigated in pursuit of a right to treatment for more than three decades.[1] Motivated by the widespread failure of state institutions to provide adequate treatment or habilitation for the mentally disabled, advocates began going to court in the late 1960s to demand that residents be released or provided with minimally adequate care.[2] This pursuit of a legal right to treatment continued throughout the next several decades and helped to spur significant improvements in the level of care provided to the institutionalized mentally ill.[3] It has, however, encountered significant setbacks in more recent decades, as several of the major legal premises on which it was based have become obsolete or have been undermined by adverse decisions in the federal courts.[4]

The failure of many of the major legal premises forwarded by the right-to-treatment movement has clearly been caused at least in part by the conservative turn in the federal judiciary. Since the inception of the right-to-treatment movement, advocates have focused primarily on federal law claims.[5] This initial focus of advocates on federal, as opposed to state law, claims is unsurprising. At

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* J.D. Expected, Yale Law School, 2004. Many thanks to Steven Wizner, Tom Behrendt, Ray Brescia, Heather Barr, Isaac Wheeler, Galia Benson-Amram, and Fernanda Torres for their generosity in commenting on drafts of this article and in sharing their perspective as practitioners.

1. *See* Rouse v. Cameron, 373 F.2d 451 (D.C. Cir. 1966) (finding a statutory right to treatment for an individual who had been involuntarily committed after being acquitted by reason of insanity). The statute at issue in *Rouse* was ultimately construed as conferring treatment rights on all mentally ill individuals hospitalized in the District of Columbia. *See* Dixon v. Weinberger, 405 F. Supp. 974 (D.D.C. 1975).

2. *See generally* 2 MICHAEL L. PERLIN, MENTAL DISABILITY LAW § 3A-2–3A-3.3 (2d ed. 1999).

3. *Id.* at § 3A-2.1.

4. *See infra* Section II.

5. *See, e.g.*, Youngberg v. Romeo, 457 U.S. 307 (1982); Pennhurst State Sch. & Hosp. v. Halderman, 451 U.S. 1 (1981).

the time that treatment rights for the mentally ill began to be litigated intensively, federal courts were generally perceived to be a friendly forum for institutional reform (and other social change) plaintiffs.[6] Furthermore, the increased efficiency of successful federal claims made (and continues to make) them an attractive vehicle for impact litigators seeking to effect widespread change. However, this focus on federal claims has rendered the movement highly vulnerable to the shifting political tenor of the federal judiciary. While there are a few federal statutes that continue to hold promise as a means of obtaining broader and more accessible treatment for the mentally disabled, most of the major legal premises on which the initial right-to-treatment movement was predicated have been rejected or fatally weakened by the Supreme Court.[7]

While the legal premises on which the movement was based have foundered in recent decades, the need for legal advocacy has not. Despite decades of litigation, individuals with mental illness continue to be poorly provided for in most locales.[8] While right-to-treatment litigation, coupled with other legal, societal, and medical developments, has fueled a major move towards deinstitutionalization of individuals with mental illness,[9] this transition to community-based care has not been an unqualified success. Most states and locales have clearly and dramatically failed to provide an adequate system of community treatment, even for those individuals with the most serious mental disorders.[10] For example, recent estimates suggest that nationwide a majority of individuals

6. Burt Neuborne, *Parity Revisited: The Uses of a Judicial Forum of Excellence*, 44 DEPAUL L. REV. 797, 797 (1995) (noting a consensus on the superiority of federal courts as a venue for constitutional litigation in the 1960s and 70s).

7. *See infra* Section II.

8. *See, e.g.*, HEATHER BARR, CORR. ASS'N OF N.Y. & URBAN JUSTICE CTR., PRISONS AND JAILS: HOSPITALS OF LAST RESORT (1999); Thomas Uttaro & David Mechanic, *The NAMI Consumer Survey Analysis of Unmet Needs*, 45 HOSP. & COMMUNITY PSYCHIATRY 372 (1994); U.S. PUB. HEALTH SERV., MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL (1999), *available at* http://www.surgeongeneral.gov/library/mentalhealth/toc.html.

9. It is likely that the right-to-treatment movement itself, by requiring adequate treatment and other improvements in the level of care provided by state hospitals, helped spur the move towards deinstitutionalization by significantly increasing the cost to the state of providing long-term institutional care for mentally ill individuals. Additional significant factors in deinstitutionalization have included the development of effective psychotropic drugs (which allowed individuals to function better in the community); limitations on Medicaid and other federal funding reimbursement for treatment in institutions (which typically make it impossible for the state to get reimbursement for costs associated with patient care in state hospitals (Institutions of Mental Disease or IMDs)); changes in civil commitment standards (which have limited the grounds for involuntary commitment); and an overall shift in the philosophy of preferred treatment modalities among psychiatric care providers. *See e.g.* Nancy K. Rhoden, *The Limits of Liberty: Deinstitutionalization, Homelessness, and Libertarian Theory*, 31 EMORY L.J. 375, 379–87 (1986) (discussing factors contributing to deinstitutionalization). *See generally* Jeffrey L. Geller, *The Last Half-Century of Psychiatric Services as Reflected in* Psychiatric Services, 51 PSYCHIATRIC SERVICES 41 (2000).

10. *See, e.g.*, Gen. Accounting Office, Mental Health: Community-Based Care Increases for People with Serious Mental Illness, GAO #01-224 (Fed. Document Clearing House 2000); BARR, *supra* note 8; U.S. PUB. HEALTH SERV., *supra* note 8.

with schizophrenia do not receive adequate treatment and support services.[11] Due in part to the widespread dearth of adequate services and treatment, "treatment in the community" has meant either homelessness[12] or incarceration for a substantial minority of the mentally ill.[13] Even among those who have managed to avoid these two fates, the level of treatment and services available to them is very often inadequate.[14] Given the failures of the current system, there is an obvious need for continued legal advocacy. There is, therefore, a need to explore alternative legal bases for obtaining treatment rights for the mentally ill.

There are reasons for believing that state laws might provide such a basis. Although there has been extensive state-law-based right-to-treatment litigation in a few states, in most jurisdictions state laws remain an underutilized if not totally untested potential means of obtaining relief.[15] Furthermore, unlike most of the federal judiciary, the judiciaries of many (although clearly not all) states have remained or have become increasingly receptive to the claims of reform-oriented plaintiffs.[16] Finally, and probably most importantly, states continue to be the primary entities responsible for the care of the mentally ill. Unlike subsistence benefits and low-income medical care in which the federal government has come to play a very substantial role, the care and treatment of the mentally ill continues to be very highly state controlled and funded.[17] As a consequence, there are simply far more state-level laws that address the care of the mentally ill than exist at the federal level.

The following sections will evaluate the viability of utilizing state laws and constitutions from several perspectives. In order to provide a background referent, Section II will briefly examine the primary federal claims that the right-to-treatment movement has raised. Section III will provide a survey of state-law-based right-to-treatment cases throughout all state jurisdictions, and will discuss general conclusions that can be drawn from examining that litigation on a macro level. Section IV and Section V will provide more detailed analyses of the history of state-law-based litigation in the two states (New York and Connecticut) with the highest prevalence of state law right-to-treatment litigation brought on behalf of the mentally ill. These sections will also provide an overview of state

11. U.S. PUB. HEALTH SERV., *supra* note 8.

12. According to recent estimates, approximately one in twenty adults with serious mental illness is homeless. The comparable figure for adults without serious mental illness is one in 530. GEN. ACCOUNTING OFFICE, *supra* note 10; U.S. Census Bureau, 2001 Population Estimate, *at* http://quickfacts.census.gov/qfd/states/00000.html.

13. GEN. ACCOUNTING OFFICE, *supra* note 10; BARR, *supra* note 8; U.S. PUB. HEALTH SERV., *supra* note 8.

14. U.S. PUB. HEALTH SERV., *supra* note 8.

15. *See infra* Appendix B.

16. *See* William B. Rubenstein, *The Myth of Superiority*, 16 CONST. COMMENT. 599 (1999); Harold A. McDougall, *Lawyering and the Public Interest in the 1990s*, 60 FORDHAM L. REV. 1 (1991).

17. *See generally* Jeffrey L. Geller, *Excluding Institutions for Mental Disease from Federal Reimbursement for Services: Strategy or Tragedy*, 51 PSYCH. SERVICES 1397 (2000).

law provisions in those states that have not been fully litigated (or that have not been litigated at all) and will discuss what possibilities might exist for future litigation based on those provisions. Finally, Section VI will discuss the implications of both the survey of all jurisdictions and the more detailed case studies for the likely viability of state law claims nationwide.

II.
A BRIEF HISTORY OF FEDERAL RIGHT-TO-TREATMENT CLAIMS

The right-to-treatment movement has raised a number of federal claims on behalf of mentally disabled individuals.[18] Primarily, these claims have fallen under one of three categories: 1) substantive due process claims; 2) claims under the Developmental Disabilities Bill of Rights[19] and/or Mental Health Rights and Advocacy Bill of Rights;[20] and 3) claims based on the Americans with Disabilities Act[21] and/or the Rehabilitation Act.[22] Each of these categories of claims is discussed briefly below.

A. Substantive Due Process

For most of the duration of the right-to-treatment movement, the core legal claims raised on behalf of the mentally disabled have centered on a substantive due process right to treatment.[23] Substantive due process claims initially proved quite successful legally and were also highly influential in modifying the public perception of the legitimacy and purposes of involuntary institutionalization.[24] However, they ultimately proved to be an extremely weak basis for seeking widespread legal treatment rights.[25] Multiple factors contributed to the failure of these claims, including both legal setbacks and shifts in the demographics of the mentally ill.

The logic of a substantive due process right to treatment was first specifically delineated by Morton Birnbaum, a doctor and legal academic, in

18. Although the primary focus of this article is treatment rights for the mentally ill, the discussion of case law throughout the article will include a discussion of claims brought on behalf of the mentally retarded and developmentally disabled. Although clearly these populations are not identical, and jurisdictions may have varying statutes governing the care and treatment of each population, as a general matter, the types of statutes and constitutional provisions governing the care of each subgroup are quite similar, and are interpreted by the courts in comparable ways.

19. 42 U.S.C. § 6010 (1994) (repealed 2000). This original bill of rights was replaced with the language now codified at 42 U.S.C. § 15009 (2000) in 2000. *See* Developmental Disabilities Assistance and Bill of Rights Act of 2000, Pub. L. No. 106-402, Title IV, § 401(a), 114 Stat. 1677, 1737 (2000).

20. 42 U.S.C. § 9501 (2000).

21. 42 U.S.C. § 12101 (2000).

22. 29 U.S.C.A. §§ 791, 793–794 (West 1999 & Supp. 2002).

23. *See* 2 PERLIN, *supra* note 2, at § 3A-2.

24. *Id.*

25. *Id.*

1960.[26] Noting the abject failure of mental institutions as providers of therapeutic care, he argued that the Due Process Clause should be conceptualized as prohibiting the institutionalization of mentally disabled individuals without treatment.[27] Specifically, he argued, "substantive due process of law does not allow a mentally ill person who has committed no crime to be deprived of his liberty by indefinitely institutionalizing him in a mental prison."[28] Absent the provision of adequate treatment, institutionalization provides no hope of recovery, and amounts to a substantive violation of the Due Process Clause.[29]

This theoretical framework was adopted in substantially identical form in many of the early right-to-treatment cases and became the central legal basis on which a right to treatment was thought to rest.[30] The leading case in which the theoretical right to treatment was legally affirmed, *Wyatt v. Stickney*,[31] refined Birnbaum's framework, stating:

> The purposes of involuntary hospitalization for treatment is *treatment* and not mere custodial care or punishment. . . . To deprive any citizen of his or her liberty upon the altruistic theory that the confinement is for humane therapeutic reasons and then fail to provide adequate treatment violates the very fundamentals of due process.[32]

Subsequently, the *Wyatt* court proceeded to delineate three fundamental requirements that public institutions must fulfill in order to ensure that adequate treatment was provided to involuntarily hospitalized patients: 1) a humane psychological and physical environment;[33] 2) adequate staffing;[34] and 3) individualized treatment plans.[35]

Wyatt had a substantial impact, both internally, on the right-to-treatment movement, and more broadly on public perception of the rights of involuntarily institutionalized individuals with mental illness.[36] Internally, the resounding success of substantive due process claims in *Wyatt* helped to secure the primacy of such claims among right-to-treatment advocates.[37] For the broader public, the case vividly highlighted the inadequate treatment of institutionalized individuals

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26. *See* Morton Birnbaum, *The Right to Treatment*, 46 A.B.A. J. 499, 503 (1960).

27. *Id.*

28. *Id.*

29. *Id.*

30. *See* 2 PERLIN, *supra* note 2, at § 3A-2.

31. 325 F. Supp. 781 (M.D. Ala. 1971), *aff'd sub nom.* Wyatt v. Alderholt, 503 F.2d 1305 (5th Cir. 1974).

32. *Wyatt*, 325 F. Supp. at 784, 785. For further developments in the *Wyatt* litigation see *Wyatt v. King*, 803 F. Supp. 377 (M.D. Ala. 1992), *supplemented*, 811 F. Supp. 1533 (M.D. Ala. 1993), *aff'd* 985 F.2d 579 (5th Cir. 1993).

33. Wyatt v. Stickney, 344 F. Supp. 387, 399 (M.D. Ala. 1972).

34. *Wyatt*, 344 F. Supp. at 406.

35. *Wyatt*, 344 F. Supp. at 397.

36. *See* 2 PERLIN, *supra* note 2, at § 3A-3.2b.

37. *Id.* at 3A-3.2d.

with mental disabilities, and helped to provide the political impetus that would ultimately lead to the passage of many state-level laws providing increased protections for the mentally disabled.[38] Indeed, many of the specific requirements for humane care first delineated in *Wyatt*'s various opinions would eventually become part of state-level laws guaranteeing adequate treatment for institutionalized individuals.[39]

Unfortunately, despite its widespread influence, *Wyatt*'s legal premises have not fared well in more recent decades. Approximately a decade after *Wyatt*, the Supreme Court addressed for the first time in *Youngberg v. Romeo*[40] the question of whether a substantive due process right to treatment exists. While the Court found that such a right does exist, they found it to be considerably more limited than the right articulated in *Wyatt*. Finding that involuntarily institutionalized individuals were only entitled to "minimally adequate or reasonable training to ensure safety and freedom from undue restraint,"[41] the court effectively limited the applicability of a due process right to treatment to the most egregiously apparent denials of care. Furthermore, the court held that in determining whether adequate or reasonable treatment had been provided the courts were generally to defer to the judgment of professionals, including the very professionals charged with providing inadequate care.[42] Although some courts have construed *Romeo* broadly or creatively, the decision has unquestionably significantly diminished the utility of due process right-to-treatment arguments.[43]

The utility of substantive due process claims has been further limited by the deinstitutionalization of many individuals with mental illness. As noted above, state and county institutions dramatically depopulated during the course of the latter half of the twentieth century.[44] Today, therefore, many treatment accessibility issues focus on the availability of community care.[45] The substantive due process right-to-treatment argument relies conceptually on the due process implications of the deprivation of liberty of institutional residents. Therefore, it typically has not been interpreted as providing a basis for asserting

38. *Id.* at § 3A-14.2. *See also The* Wyatt *Standards: An Influential Force in State and Federal Rules*, 28 HOSP. & COMMUNITY PSYCH. 374 (1977).

39. 2 PERLIN, *supra* note 2, at § 3A-14.2.

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

41. *Id.* at 319.

42. *Id.* at 323.

43. For an expansive interpretation of *Romeo* see, for example, *Thomas S.* ex rel. *Brooks v. Flaherty*, 902 F.2d 250 (4th Cir. 1990) (applying *Romeo* standard rigorously, and finding that where state had broadly failed to provide the treatment recommended by its treating professionals plaintiff class was entitled to relief). For opinions adopting a more restricted reading of *Romeo* see, for example, *Hanson* ex rel. *Hanson v. Clarke County*, 867 F.2d 1115, 1120 (8th Cir. 1989) (plaintiff entitled only to minimally adequate treatment, not optimal treatment), and *Society for Good Will to Retarded Children v. Cuomo*, 902 F.2d 1085 (2d Cir. 1990) (reversing district court ruling for plaintiffs and setting high standard for showing violation of substantive due process).

44. *See* Geller, *supra* note 9, at 45–46.

45. *Id.* at 47–50.

that the state must provide released institutional residents or other community individuals in need of treatment with care.[46] As a result, the functional significance of substantive due process in seeking treatment rights is fairly limited.

B. Developmental Disabilities and Mental Health Patients Bills of Rights

In addition to pursuing a substantive due process right to treatment, advocates for the mentally disabled have explored the possibility of securing substantive treatment rights via the Developmental Disabilities Bill of Rights (enacted in 1975)[47] and the Mental Health Rights and Advocacy Bill of Rights (enacted in 1980).[48] Unfortunately, these efforts proved fairly short-lived; the initial Supreme Court pronouncement on the issue, *Pennhurst State School and Hospital v. Halderman*,[49] was largely definitive and adverse. Although some subsequent litigation has occurred involving each of the statutes, it is clear subsequent to *Pennhurst*, and courts have fairly consistently held, that neither act provides a basis for legally enforceable treatment rights.[50]

Both the Developmental Disabilities Bill of Rights and the Mental Health Rights and Advocacy Bill of Rights were enacted in conjunction with grant programs providing funding for states to improve their systems of developmental disabilities and mental health care.[51] They provided, respectively that, "[p]ersons with developmental disabilities have a right to appropriate treatment, services, and habilitation,"[52] and that a "person admitted to a program or facility for the purpose of receiving mental health services should be accorded . . . [t]he right to appropriate treatment and related services."[53] Both further provided that

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46. *See, e.g.*, Philadelphia Police & Fire Ass'n For Handicapped Children v. City of Philadelphia, 874 F.2d 156, 166–68 (3d Cir. 1989) (finding that plaintiffs had no due process right to treatment, since the state had not deprived them of liberty); Alessi by Alessi v. Pennsylvania, Dep't of Public Welfare, 893 F.2d 1444, 1448 (3d Cir. 1990) (finding that plaintiff had no substantive due process right to placement in treatment, even where she was urgently in need of services).

47. Developmentally Disabled Assistance and Bill of Rights Act, Pub. L. No. 94-103, 89 Stat. 486 (1975) (repealed 2000). The current version of the bill of rights, enacted in the Developmental Disabilities Assistance and Bill Of Rights Act Of 2000, Pub. L. No. 106-402, 114 Stat. 1677, is codified at 42 U.S.C. § 15009 (2000).

48. Mental Health Systems Act, Pub. L. No. 96-398, § 501, 94 Stat. 1564, 1598 (codified at 42 U.S.C. § 9501 (2000)).

49. 451 U.S. 1 (1981).

50. *See, e.g.*, Monahan v. Dorchester Counseling Ctr., 961 F.2d 987, 994–95 (1st Cir. 1992) (so holding for Mental Health Rights and Advocacy Bill of Rights); Clift by Clift v. Fincannon, 657 F. Supp. 1535, 1543 (E.D. Tex. 1987) (Developmental Disabilities Bill of Rights).

51. *See* Developmentally Disabled Assistance and Bill of Rights Act, Pub. L. No. 94-103, 89 Stat. 486 (1975); Mental Health Systems Act, Pub. L. No. 96-398, 89 Stat. 486 (1980). The provisions of the Mental Health Systems Act (although not the Bill of Rights), were largely repealed the following year in the Omnibus Budget Reconciliation Act of 1981, §§ 902(e)1, 902(f)1, 902(f)(20), Pub. L. No. 97-35, 95 Stat. 357, 560 (1981).

52. 42 U.S.C. § 6010 (1994) (repealed). The current version is identical except that it substitutes the word "[i]ndividuals" for "[p]ersons." 42 U.S.C. § 15009 (2000).

53. 42 U.S.C. § 9501 (2000).

all treatment and services should be provided in the least restrictive setting appropriate to treatment needs.[54]

The Supreme Court, however, addressing the Developmental Disabilities Bill of Rights, found that it was not intended by Congress to impose substantive obligations on the states.[55] Noting that, if construed literally, the treatment rights purportedly created by the act would impose tremendous new financial burdens on the states, the Court found it more plausible that Congress merely intended to articulate unenforceable policy preferences.[56] This holding was subsequently applied to the Mental Health Rights and Advocacy Bill of Rights by lower courts[57] and has effectively nullified the potential utility of the federal "Bill of Rights" statutes as a means of seeking substantive treatment rights.

C. Americans With Disabilities Act and Rehabilitation Act

Federal disabilities anti-discrimination statutes have provided the third major source of claims raised by right-to-treatment advocates. Unlike the other two major sources of right-to-treatment claims, the Americans with Disabilities Act (ADA)[58] and Rehabilitation Act[59] have continued to provide the basis for successful claims into the present decade. Both statutes, furthermore, continue to hold promise as a means of further improving the quality and accessibility of care provided to the mentally disabled.[60] However, the nature of the claims that

54. 42 U.S.C. § 15009; 42 U.S.C. § 9501 (2000).

55. Pennhurst State Sch. & Hosp. v. Halderman, 451 U.S. 1 (1981).

56. *Id.* at 18–19.

57. *See, e.g.*, Monahan v. Dorchester Counseling Ctr., 961 F.2d 987, 994–95 (1st Cir. 1992); Croft v. Harder, 730 F. Supp. 342, 350–51 (D. Kan. 1989).

58. The relevant provision of the ADA for treatment rights litigation purposes is codified at 42 U.S.C. § 12132 (2000). Relevant regulations are at 28 C.F.R. §§ 35.101–35.164 (2002).

59. The Rehabilitation Act's prohibition on discrimination in government services is codified at 29 U.S.C.A. § 794 (West 1999 & Supp. 2002). Relevant regulations are at 28 C.F.R. § 42.503 (2002), as well as several other places in the CFR (separate Rehabilitation Act regulations have been promulgated by many of the agencies awarding grants to the states).

60. For the purposes of this discussion, analysis of the potential utility of the Rehabilitation Act and Americans with Disabilities Act is collapsed. It should be noted however, that there are certain significant differences between the Rehabilitation Act and the ADA. Most notably, the Rehabilitation Act is spending clause legislation, and therefore only applies to state departments that have accepted federal funds. Additionally, the Rehabilitation Act is substantively somewhat less broad in scope than the ADA, although the degree to which this is true is not entirely clear. For cases seeking injunctive relief (a category that presumably includes most broad treatment rights litigation) this distinction is immaterial, since the broader ADA will always apply. However, for cases seeking damages (for example, for failure to provide treatment appropriate under the ADA), these distinctions may be important, as the ADA will not always be available. At present, at least one circuit has held that plaintiffs may never, consistent with the Eleventh Amendment, sue a state for damages under Title II of the ADA. *See* Reickenbacker v. Foster, 274 F.3d 974 (5th Cir. 2001) (finding that Title II did not validly abrogate state sovereign immunity). Another circuit has upheld the right of action under Title II in its entirety, and a few have hewed a middle road, finding that damages suits against the states are appropriate, but only where there is some level of elevated showing of animus or other egregious conduct. *See* Hason v. Medical Board of California, 279 F.3d 1167 (9th Cir. 2002) (upholding Title II in its entirety); Garcia v. S.U.N.Y. Health Sciences

can be raised under the ADA and the Rehabilitation Act is somewhat limited in scope and generally does not go to the overall level of care provided by the state. For reasons discussed further below, this creates substantial limitations in using either statute as an independent means of seeking broad treatment rights for individuals with mental illness.

The most significant victory secured by treatment rights advocates under the ADA or the Rehabilitation Act came in the 1999 case of *Olmstead v. L.C.*[61] In *Olmstead*, the Supreme Court held that "[u]njustified isolation . . . [of people with mental disabilities] is properly regarded as discrimination based on disability."[62] As a result, the Court found that the failure to provide individuals with community-based treatment could constitute a violation of the ADA under certain circumstances.[63] However, the Court went on to clarify that failure to provide such treatment would not constitute a violation of the ADA where "taking into account the resources available to the State and the needs of others with mental disabilities," provision of community treatment would constitute an undue burden on the state.[64] *Olmstead*, therefore, bestows some rights to community treatment and services, but only to the extent that they can be balanced with the other competing mental health services provided by the state.

This limitation significantly mitigates the usefulness of the *Olmstead* decision as a basis for seeking broad treatment rights, as it means that *Olmstead* will not require that states provide any particular level of treatment and services for individuals with mental illness. This is not to say that *Olmstead* did not constitute a major victory for individuals with mental disabilities. Inasmuch as it holds that the states are compelled to ensure that the balance between the availability of community and institutional treatment is appropriate to the needs of state residents, it is indeed a major victory. However, it does not ensure that adequate treatment will be provided for the many who are currently underserved or who are altogether shut out of the states' systems of mental health care. Because the decision provides states with a defense to ADA claims that are predicated on under-funding, as opposed to a misallocation of resources, it is not

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Center, 280 F.3d 98 (2d Cir. 2001) (holding that only Title II claims predicated on disability related animus can provide a valid basis for the abrogation of state sovereign immunity). The Supreme Court recently granted certiorari to decide the question of Title II's validity and will therefore soon definitively address whether Title II can be used to abrogate state sovereign immunity. *See* Tennessee v. Lane, 2003 WL 21180382 (June 23, 2003) (granting certiorari).

61. Olmstead v. L.C. by Zimring, 527 U.S. 581 (1999).

62. *Id.* at 597.

63. *Id.* at 587.

64. *Id.* at 607. Justice Stevens did not join the portion of the majority opinion discussing the limitations on the state's obligations to provide for community care, and would have voted to uphold the lower court's more stringent evaluation of what the ADA required. These limitations are, therefore, not technically part of the Court's opinion (which was overall five to four). However, eight of nine justices would have applied the limitation outlined by Justice Ginsburg or a more restrictive standard. Therefore, it is clear that litigants will at a minimum be subjected to this limitation.

likely to provide a significant asset in expanding the scope, as opposed to the nature, of treatment and services that are available.

There are currently a number of second-generation *Olmstead* suits proceeding in the lower courts that will flesh out more clearly the scope of the rights conferred by that decision.[65] In particular, these suits will clarify the degree to which *Olmstead*'s balancing approach renders it an ineffective means of securing community treatment rights. Unfortunately, initial results suggest that the chronic underfunding of many states' systems of mental health care may well provide them with a defense to *Olmstead* claims.[66] This issue, however, has not yet been addressed extensively at the appellate level, so there is still some possibility that the decision may ultimately be construed more broadly in favor of treatment advocates.[67]

In addition to these *Olmstead*-type suits, there are a number of other claims that are currently being raised under the ADA and Rehabilitation Act which may hold promise for further improving the quality of care provided to the mentally ill. For example, advocates have raised claims challenging the inaccessibility of social services and public medical assistance to individuals with psychiatric disabilities.[68] Often, the inaccessibility of such services contributes to the inability of mentally disabled individuals to survive and receive adequate treatment in the community.[69] A determination that states are required to provide mentally disabled individuals with adequate accommodations and assistance in accessing *existing* services and treatment resources could, therefore, provide

65. *See, e.g.*, Frederick L. v. Department of Public Welfare, 217 F. Supp. 2d 581, 593 (E.D. Pa. 2002) (denying plaintiffs' claims for relief because defendants were acting reasonably in allocating limited financial resources).

66. *See id.* Discouragingly, advocates have suggested that they have been in fact *less* likely to prevail in ADA community treatment rights cases since the *Olmstead* decision. Interview with Ilene Shane, Executive Director, and Robert Meek, Managing Attorney, Disabilities Law Project, in Philadelphia, Pa. (Dec. 20, 2002).

67. *See, e.g.*, Makin *ex rel.* Russell v. Hawaii, 114 F. Supp. 2d 1017 (D. Hawaii 1999) (acknowledging that some balancing must occur under the *Olmstead* decision, but not reading balancing approach as superseding "fundamental alteration" standard, and therefore requiring the state to show more than just a shortage of funds).

68. For an interesting example of this type of litigation, see Administrative Complaint, *People with Psychiatric Disabilities v. New York City Human Resources Admin.*, filed with the U.S. Department of Health and Human Services, Office for Civil Rights (Apr. 2, 2002), *available at* http://www.urbanjustice.org/litigation/index.html (last visited Nov. 14, 2002). *Cf.* Henrietta D. v. Giuliani, 119 F. Supp. 2d 181 (E.D.N.Y. 2000) (finding that city defendants had denied individuals with AIDS and HIV-ill individuals meaningful access to social services where they failed to make such services accessible in light of the specific limitations imposed by AIDS and HIV-related illnesses), *aff'd sub nom.* Henrietta D. v. Bloomberg, 331 F.3d 261 (2d Cir. 2003). *But see* Rodriguez v. City of New York, 197 F.3d 611 (2d Cir. 1999) (rejecting argument that failure to provide safety monitoring services denied individuals with mental disabilities meaningful access to Medicaid personal care services).

69. For numerous examples of the ways in which the inaccessibility of social services and medical assistance contributes to the inability of individuals with mental illness to secure adequate treatment and services see *Administrative Complaint*, *supra* note 68.

significant benefits in terms of the actual availability of community care.[70] Like *Olmstead*, however, this and other innovations on the part of advocates seem unlikely to substantially address the fundamental inadequacy of the level of care available in most states.

D. Conclusions

As a general matter, the federal claims advanced by the right-to-treatment movement have not ultimately proved to be successful. Two classes of claims—substantive due process claims and statutory claims brought pursuant to the federal developmental disabilities and mental illness "bills of rights"—have been explicitly rejected by the courts or otherwise rendered largely ineffective. The remaining class of claims, those brought under the ADA and Rehabilitation Act, have had some success and continue to hold some promise as a means of improving the services and treatment provided to individuals with mental illness. They are highly unlikely, however, to provide the basis for claims to a higher, legally mandated, baseline level of care. As a result, a state-law based right to substantively adequate treatment and services for the mentally ill remains a distinct and necessary legal entitlement. The following section will survey cases that have attempted to secure this type of entitlement using state law and will discuss the broader implications of the outcomes of those cases.

III.
A SURVEY OF STATE-LAW BASED TREATMENT LITIGATION

A broad survey[71] of cases reveals that state laws and constitutions have formed the basis for right-to-treatment claims in a number of jurisdictions.[72] Taken together, these cases suggest that, when utilized, state law may often provide a far more extensive source of substantive rights for the mentally disabled than that which the courts have inferred under federal constitutional and statutory provisions. Even those state law provisions that are textually quite similar to the federal provisions discussed above have often formed the basis for successful claims to substantive and enforceable treatment rights. While state

70. In addition, these types of lawsuits could serve an important educational function. Creating disjointed and complex eligibility procedures for social services may, for the mentally disabled, often be the equivalent of requiring an individual with mobility impairments to apply for benefits in an inaccessible building. Despite the fact that these two situations are often equally prohibitive in terms of their impact on an individual's ability to access benefits, an understanding of the equivalence between architectural obstructions and complicated and antagonistic procedures as discriminatory obstacles is not well entrenched in the public (or judicial) understanding of what constitutes disability discrimination. Claims that emphasize the discriminatory impact that the failure to provide coordinated and supportive social services has on individuals with mental disabilities could, therefore, begin the important process of modifying public perceptions even if they are not ultimately successful.

71. For a discussion of the methodology used and which categories of cases were excluded from the analysis see Appendix A, *infra*.

72. For a list of all right-to-treatment cases located see Appendix B, *infra*.

law claims have not been uniformly successful, they provide a promising basis for seeking broad treatment rights for individuals with mental illness. The following section will begin by discussing the success rates of the various types of state law right-to-treatment claims and the articulated reasons for failure where state law claims have not proven to be successful. It will then discuss in greater depth several of the systemic treatment rights claims that have been made pursuant to state law.

A. Statutory and Constitutional Bases For State-Law-Based Claims and Their Success Rates

There are a number of different legal bases on which state law right-to-treatment claims have been predicated. Most commonly, the efforts of advocates have focused on one of two broad categories of claims: 1) statutory claims brought pursuant to a state law mental disabilities "bill of rights" or statement of rights (hereinafter "patients' bill of rights")[73] and 2) claims seeking enforcement of the statutory responsibilities of the state departments of mental health, mental retardation and/or developmental disabilities (hereinafter "DMH/DMR statutes").[74] In addition to these two common categories of claims,[75] advocates have less frequently pursued claims under state constitutional provisions,[76] anti-discrimination laws,[77] commitment statutes,[78] and general social services/ medical assistance statutes.[79]

Among those cases that have raised patients' bill of rights or DMH/DMR statutory claims, a substantial proportion have ultimately proved successful (approximately 70% of all claims raised under DMH/DMR statutes and 69% of all patients' bill of rights claims).[80] Although many of these claims were brought on behalf of individual claimants, and therefore did not result in systemic change, in several cases claims brought pursuant to patients' bills of rights or DMH/DMR statutes ultimately resulted in court-ordered reform of non-trivial aspects of the state's system of mental health (MH) or mental retardation

73. *See, e.g.*, Ass'n for Retarded Citizens v. Dep't of Developmental Servs., 696 P.2d 150 (Cal. 1985); Mullins v. N.D. Dep't of Human Servs., 483 N.W.2d 160 (N.D. 1992); E.H. v. Matin, 284 S.E.2d 232 (W.Va. 1981).

74. *See, e.g.*, N.J. Ass'n for Retarded Citizens v. N.J. Dep't of Human Servs., 445 A.2d 704 (N.J. 1982); Love v. Koch, 54 N.Y.S.2d 595 (App. Div. 1990); Schmidt v. County of Allegheny, 429 A.2d 631 (Pa. 1981).

75. It should be noted that these two categories of claims can overlap. Sometimes, the rights of individuals with mental illness or other mental disabilities are articulated in the code as part of the obligations of the DMH or DMR. For the purposes of simplicity, I have grouped such cases with the DMH/DMR statutory claims, unless they explicitly are styled as a MH/MR bill of rights.

76. *See, e.g.*, Klostermann v. Cuomo, 463 N.E.2d 588 (N.Y. 1984).

77. *See, e.g.*, Foti v. Richardson, 620 A.2d 840 (Conn. App. Ct. 1993).

78. *See, e.g.*, *In re* Hamil, 431 N.E.2d 317 (Ohio 1982).

79. *See, e.g.*, Arnold v. Ariz. Dep't of Health Servs., 775 P.2d 521 (Ariz. 1989).

80. For a listing of decisions surveyed, see Appendix B, *infra*.

(MR) treatment.[81] Indeed, when one counts only those cases where the plaintiffs sought or were awarded some form of systemic relief, the proportion of successful cases brought under bill of rights statutes actually increases substantially to 80%.[82] It appears, therefore, that both DMH/DMR statutes and state-level bill of rights statutes may frequently provide an effective basis for securing widespread treatment rights for the mentally disabled.

It is far more difficult to evaluate the potential utility of other types of state law claims. Although advocates have raised claims across a broad variety of types of statutes and constitutional provisions, the number of cases decided in each of the sub-categories of claims is simply too small (often only two or three cases) to evaluate the likely utility of any one kind of claim.[83] Therefore, while it is useful to bear in mind that there are a broad variety of potential types of state law claims that can be made, surveying existing cases reveals very little regarding the likely viability of state law claims outside of the most commonly utilized categories of claims.[84]

B. Reasons for Failure of State Law Claims

Courts have articulated two broad reasons for the failure of state law treatment-rights claims. First, courts have found that the statutory provisions cited by advocates were only intended as a statement of policy or regulatory

81. *See Arnold*, 775 P.2d at 522; Ass'n for Retarded Citizens v. Dep't of Developmental Servs., 696 P.2d 150 (Cal. 1985); Goebel v. Colo. Dep't of Insts., 764 P.2d 785 (Colo. 1988); Dixon v. Weinberger, 405 F. Supp. 974 (D.C. 1975); N.J. Ass'n for Retarded Citizens v. N.J. Dep't of Human Servs., 445 A.2d 704 (N.J. 1982); Heard v. Cuomo, 578 N.Y.S.2d 417 (App. Div. 1992), *summarily aff'd*, 578 N.Y.S.2d 417 (App. Div 1992), *aff'd in part*, 610 N.E.2d 238 (N.Y. 1993); City of Philadelphia v. Pennsylvania., 562 A.2d 271 (Pa. Commw. Ct. 1989); E.H. v. Matin, 284 S.E.2d 232 (W. Va 1981).

82. When one looks at cases seeking or awarding systemic relief, the proportion of successful cases brought under DMH/DMR enabling statutes decreases to 62%.

83. *See infra* Appendix B.

84. For example, the degree to which state constitutional provisions may provide a viable source of state law treatment claims remains extremely uncertain given the relatively low number of treatment rights cases that have been litigated using such claims. This lack of constitutional claims is rather surprising given the preference of institutional reform litigants for constitutionalizing claims. However, there are several plausible explanations for this phenomenon. First, in some cases, courts have declined to reach constitutional issues where they have found that statutory claims were likely to provide an adequate basis for relief. *See, e.g.*, *Goebel*, 764 P.2d at 809–10. Second, the vast majority of states that have constitutional provisions directly addressing the care of individuals with mental disabilities or mental illnesses have not been the site of state-law-based right-to-treatment litigation. *Compare* ARK. CONST. art. XIX, § 19; IDAHO CONST. art. X, § 1; MICH. CONST. art VIII, § 8; MISS. CONST. art IV, § 86; MONT. CONST. art XII, § 3; WASH. CONST. art XIII, § 1 *with* Appendix B, *infra*. Finally, it may well be, as several authors have suggested, that state constitutional provisions are simply underutilized as a potential source of legal claims in right-to-treatment litigation. *See, e.g.*, Michael Perlin, *State Constitutions and Statutes as Sources of Rights for the Mentally Disabled*, 20 LOY. L.A. L. REV. 1249, 1264–65 (1987); Alan Meisel, *The Rights of the Mentally Ill Under State Constitutions*, 45 LAW & CONTEMP. PROBS. 7, 9 (1982).

structure and did not create legally enforceable entitlements.[85] Second, courts have determined that any rights the statute created were implicitly or explicitly limited by the availability of sufficient appropriations.[86] Most commonly, however, courts have relied on both of these types of justifications when rejecting treatment rights claims.[87]

Courts have articulated a few other reasons for the failure of state claims. Most of these reasons are either extraordinarily rare, or of limited applicability in seeking broad treatment rights. For example, in individual litigation seeking appropriate placements, where courts have rejected claims it has often been because they found that the lower courts exceeded their authority in ordering individuals placed in private or out-of-state facilities.[88] While this implied limitation on the scope of placements available under the MH/MR code is certainly significant for individual litigants seeking adequate placements, it is of less relevance to class-wide litigation. As a practical matter, therefore, the primary concerns for broad state law right-to-treatment claims are limited to whether the provisions in question create substantive rights and whether those rights are wholly or partially contingent on available funding.

C. Systemic State Law Right-to-Treatment Cases

While many of the state law treatment rights cases brought under DMH/DMR statutes and patients' bills of rights statutes have been successful, a substantial minority have not. Given these varying results, it is important to understand what factors may influence the likelihood that a given statute will provide the basis for successful claims. The survey discussed above suggests at least two factors that are likely to be significant: 1) whether or not funding limitations are explicitly written into the statute at issue and 2) whether or not the statute contains indications that it was intended merely as a policy statement. In order to evaluate whether these factors are relevant to the likelihood of success, and to get a better understanding of what other factors may influence the likelihood of success, a few of the systemic cases where DMH/DMR statutes and/or patients' bills of rights have provided the basis for claims are discussed below. Four systemic cases were selected for closer examination—two of these had primary claims under DMH/DMR statutes and two had primary claims under MH/MR bills of rights.[89] One of the cases in each of these categories resulted in broad relief, whereas in the other all claims proved to be unsuccessful.

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85. *See, e.g.*, McWilliams v. Catholic Diocese of Rochester, 536 N.Y.S.3d 285, 286 (App. Div. 1988).

86. *See, e.g.*, Pet. of Brenda Strandell, 562 A.2d 173 (N.H. 1989); J.D. *ex rel.* D.D.H. v. N.J. Div. of Developmental Disabilities, 748 A.2d 613 (N.J. Super. Ct. App. Div. 2000).

87. *See, e.g.*, Y.A. *ex rel.* Fleener v. Bayh, 657 N.E.2d 410 (Ind. Ct. App. 1995); Williams v. Sec'y of the Executive Office of Human Servs., 609 N.E. 447 (Mass. 1993).

88. *See, e.g.*, *In re* Hamil, 431 N.E.2d 317 (Ohio 1982); R.I. Dep't of Mental Health & Hosps. v. Doe, 533 A.2d 536 (R.I. 1987).

89. In the interest of space and clarity, other claims raised in the cases discussed here which

i. Patients' Bill of Rights Claims

The two illustrative MH/MR bill of rights cases are *Dixon v. Weinberger*[90] and *Dixon Association for Retarded Citizens v. Thompson.*[91] The statutes at issue in the two cases were quite similar,[92] providing respectively that a "person hospitalized in a public hospital for a mental illness shall, during his hospitalization, be entitled to . . . psychiatric care and treatment,"[93] and that a "recipient of services shall be provided with adequate and humane care and services . . . pursuant to an individual services plan."[94] Despite these similarities, *Weinberger* resulted in a court order awarding plaintiffs broad relief, whereas in *Thompson*, the plaintiffs did not prevail on their claims and were ultimately denied all relief.[95]

Given the similarities in the statutes at issue, there is relatively little that can be learned from comparing the two cases regarding the likelihood that specific variations in statutory language will influence the success rates of claims. Other differences in the cases, however, do help to demonstrate non-textual factors that may play an important role in determining the success of bill of rights claims. In particular, the differences in the factual backgrounds of the cases suggest that targeting areas of acknowledged inadequacy in the state's system of mental health care may increase the potential for success.

In *Weinberger*, the plaintiffs, who were hospitalized in St. Elizabeth's Hospital, sought to challenge the District of Columbia's and federal government's[96] failure to provide community care.[97] The District's health professionals had acknowledged that a substantial proportion of the patients hospitalized in the D.C. hospital would be better treated in community facilities, but neither the District nor the federal government had developed facilities for community care.[98] The court awarded broad relief,[99] ordering the creation of numerous community

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did not rest on DMH/DMR statutes or MH/MR bills of rights will not be discussed in this section. However, it should be noted that most cases raised significant other claims, some of which were successful and others of which were not. In all cases, the overall result of the case (i.e., whether or not relief was awarded) correlated with the success of the primary DMH/DMR statutory or MH/MR bill of rights claims.

90. 405 F. Supp. 974 (D.C. 1975).

91. 440 N.E.2d 117 (Ill. 1982).

92. *See* D.C. CODE ANN. § 21-562 (1973); 91½ ILL. REV. STAT. 2-102 (1977).

93. *See* D.C. CODE ANN. § 21-562 (1973).

94. *See* 91½ ILL. REV. STAT. 2-102 (1977).

95. *See Weinberger*, 405 F. Supp. at 979–80; *Dixon Ass'n*, 440 N.E.2d at 125.

96. At the time of the *Weinberger* case, the federal government and the District of Columbia had joint responsibility for the provision of mental health care to mentally ill D.C. residents. The federal government relieved itself of its mental health care obligations to D.C. residents in the mid-80s. *See* Mental Health Services Act, Pub. L. No. 98-621, 98 Stat. 3369 (1984) (codified as amended at 24 U.S.C. §§ 225–225g).

97. *See Weinberger*, 405 F. Supp. at 976.

98. *Id.* at 977.

99. Despite the broad relief awarded by the court in *Weinberger*, administrative incompetence and inertia prevented the effective implementation of the court's orders for more than twenty years.

facilities and the provision of additional services necessary for adequate community care.[100] Despite the fact that the statute on its face applied only to the hospital itself, the court found that the underlying purpose of the statute was the provision of adequate care and reintegration in community life, and that this construction of the statutory requirements was most consistent with the broad statutory purpose.[101]

In contrast, in *Thompson*, the state's health professionals had developed and were implementing a plan that they felt adequately provided for the plaintiffs' and plaintiffs' children's treatment needs.[102] The state in *Thompson* had decided to close a residential treatment MR facility.[103] The plaintiffs, who were residents of the facility and parents of residents of the facility, sought to enjoin these efforts, as they felt that the state's plans for transferring patients to other facilities did not adequately account for their treatment needs.[104] The court rejected the plaintiffs' arguments, finding that the protections conveyed by the statute were limited, and that decisions of the state's professionals should be deferred to unless they substantially departed from accepted professional standards.[105]

The courts in *Weinberger* and *Thompson*, therefore, approached very similar statutory language in very different ways. While the court in *Weinberger* looked to the underlying statutory purpose and extrapolated from that a broad statutory meaning, the court in *Thompson* read the protections of the statute narrowly, and created a presumption of validity of the status quo that would be difficult for plaintiffs to overcome. It is not at all clear, however, that the courts' respective methods of statutory analysis, rather than the differing factual situations, were the determinative factors in each of the cases. For example, it seems unlikely that the court in *Weinberger* would have ordered such sweeping relief (or perhaps any relief) had the District and/or the federal government had a plan in place whereby hospital residents better served by community care were being gradually transferred to community facilities. Similarly, had the state in *Thompson* intended to close the facility with no plans at all for transferring residents to appropriate facilities, it seems probable that the court would have granted at least some form of relief.

A comparison of *Weinberger* and *Thompson*, then, highlights the potential significance of having one or both of two factual contexts: 1) a situation in which

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In 1997, the court finally placed the D.C. mental health system in receivership in order to ensure that defendants were in compliance with the court's orders. *See* Dixon v. Barry, 967 F. Supp. 535 (D.C. 1997). This is an extreme and depressing example of the ways in which legally favorable results can be effectively nullified by resistant government actors.

100. *Weinberger*, 405 F. Supp. at 979–80.

101. *Id.* at 978.

102. Dixon Ass'n for Retarded Citizens v. Thompson, 440 N.E.2d 117, 119 (Ill. 1982).

103. *Id.* at 119.

104. *Id.*

105. *Id.* at 124–25 (citing Youngberg v. Romeo, 457 U.S. 307, 323 (1982)).

state professionals have specifically recommended treatment options that are not being provided and/or 2) a situation in which there is no plan or a patently inadequate plan in place for the state to provide the requested care. This may seem like a somewhat unremarkable conclusion; that courts will generally be more willing to award relief where the state acknowledges its failure to fulfill its obligations or is not even attempting to fulfill its obligations is intuitively obvious. However, this conclusion bears remembering in the context of litigation planning, and suggests the utility of looking for sources of information that may reveal acknowledgement on the part of the state of the inadequacy of levels of care.[106]

As a final note, it is interesting to observe that although the courts in *Weinberger* and *Thompson* arrived at different results, neither suggested that the language of the statute at issue might be merely precatory. This is somewhat surprising given that the statutory language at issue in *Weinberger* and *Thompson* was quite similar to that utilized in the federal Developmental Disabilities and Mental Illness Bills of Rights.[107] The fact that these courts found that the statutory language was mandatory, and not merely permissive or a statement of policy, is encouraging inasmuch as it suggests that state courts may be more inclined than their federal counterparts to assume that bill of rights statutes were intended to impart at least some form of substantive treatment rights to the mentally disabled.

ii. DMH/DMR Statutory Claims

The two illustrative DMH/DMR statutory cases are *Arnold v. Arizona Department of Health Services*[108] and *Y.A.* ex rel. *Fleener v. Bayh*.[109] In contrast to the MH/MR bill of rights cases examined above, the underlying statutory bases for the claims in *Arnold* and *Y.A.* were distinct in substantive ways.[110] Interestingly, however, the differences in the statutes' text appear again not to have been dispositive of the cases' different outcomes. Rather, the difference in outcomes appears to have been based on the courts' very different approaches to

106. For example, states often create commissions to evaluate the inadequacies in their mental health care systems. The reports and recommendations of these commissions, could, in some cases, provide valuable evidence of the state's own understanding of where its mental health system is not providing appropriate treatment and services. Similarly, in many states there are record keeping and/or discharge planning requirements that can provide a record of the state professionals' treatment recommendations for various individuals, including recommendations that individuals be placed in particular types of community residences. Inasmuch as those treatment and placement recommendations systematically remain unfulfilled, they may provide a strong basis for arguing that granting relief does not interfere with the deference due to the executive branch.

107. For a discussion of the federal Developmental Disabilities and Mental Illness Bills of Rights see Section II, *supra.*

108. 775 P.2d 521 (Ariz. 1989).

109. 657 N.E.2d 410 (Ind. Ct. App. 1995).

110. *Compare* ARIZ. REV. STAT. §§ 11-251, 11-291, 36-104, 36-204, 36-511, 36-550 (1988) *with* IND. CODE §§ 12-21-1-1, 12-21-2-3, 12-21-2-4, 12-21-5-1-1.5, 12-24-19-1, 12-24-19-4 (1995).

particular provisions that were quite similar. An examination of DMH/DMR statutory cases, therefore, similarly suggests that non-textual factors may play a substantial role in the success or failure of state law right-to-treatment claims.

In *Arnold*, the plaintiffs sought and were awarded broad relief in the form of a court order directing the state to provide a comprehensive and integrated system of mental health care.[111] The plaintiffs raised two primary claims under the DMH/DMR statutes: 1) that Arizona's mental health statutes required Arizona State Hospital (ASH) to function as an integrated part of the state's system of mental health care; and 2) that the state Department of Health Services (DHS) was statutorily obligated to provide community-based services for the chronically mentally ill.[112] The court agreed with the plaintiffs' assertions that, taken together, the statutory provisions required that the state provide a coordinated and comprehensive system of mental health care.[113] Accordingly, it upheld the decision of the Superior Court ordering a broad overhaul of Arizona's system.[114]

In contrast, in *Y.A.*, the court found that "the legislature did not intend to provide the comprehensive residential services demanded by the plaintiffs."[115] Like the plaintiffs in *Arnold*, the plaintiffs in *Y.A.* relied on statutory provisions outlining the duties of the Department to create a system of community care.[116] The court, however, found that the legislature had explicitly limited mental health services to those available under existing appropriations, and denied all relief for the plaintiff class.[117]

The court in *Y.A.* specifically distinguished several treatment rights cases brought in other states, including *Arnold*, on the grounds that the underlying statutes at issue in the other cases did not include appropriations limitations.[118] Although the statutes at issue in *Arnold* were different from the statutes at issue in *Y.A.* in certain substantive ways (most notably, the statutes in *Arnold* were significantly more comprehensive and detailed), they did in fact include appropriations limitations, providing that community mental health care should be provided or contracted for only to the extent of "funds identified and available for the seriously mentally ill."[119] The defendants in *Arnold*, furthermore, had raised this provision as a defense, and it had been explicitly rejected by the Arizona Supreme Court.[120] What appears to account for the different outcomes, then, is not the differences in the statutory texts at issue, but rather the different

111. *See Arnold*, 775 P.2d at 522.
112. *Id.* at 531.
113. *Id.*
114. *Id.* at 538.
115. *See* Y.A. *ex rel.* Fleener v. Bayh, 657 N.E.2d 410, 416 (Ind. Ct. App. 1995).
116. *Id.* at 415.
117. *Id.* at 416.
118. *Id.* at 417.
119. ARIZ. REV. STAT. § 36-550.03 (1988).
120. *Arnold*, 775 P.2d at 530, 533–34.

approaches of the respective courts to the question of how statutory limitations based on available appropriations should be treated.

The court in *Arnold* treated the statutory limitation as a defense that must be proven in order to prevail.[121] As the state had not demonstrated the impossibility of compliance within the bounds of existing appropriations, the Supreme Court rejected the state's arguments that the provision shielded them from being subjected to injunctive relief.[122] In contrast, the court in *Y.A.* treated the statutory provisions at issue as determinative without any showing of actual impossibility on the part of the defendants.[123] The court therefore denied relief on the basis of the state's bare allegations that they lacked sufficient funds to provide the services mandated by the statutory scheme.[124]

A comparison of *Arnold* and *Y.A.* thus suggests that the existence of an appropriations limitation in the statute need not be determinative, but can be tempered by the manner in which it is framed by the plaintiffs and by the court. This hypothesis is substantially borne out by other successful class-based litigation that has been brought under state DMH/DMR statutes. In many of the cases where the plaintiffs have raised class-wide state law right-to-treatment claims, the statutes at issue have contained indications that the legislature intended services to be subject to available appropriations.[125] In most of those cases, however, the funding limitations did not pose a bar to relief.[126] In addition to the strategy utilized in *Arnold* (i.e., framing lack of funds as a defense that must be proven),[127] other courts have effectively eliminated the bar posed by such limitations by finding that the limitations cannot alter the substance of the other provisions of the DMH/DMR code.[128] Therefore, courts have found that

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121. *Id.* at 533.

122. *Id.* at 533–34.

123. *See Y.A.*, 657 N.E.2d at 417.

124. *Id.* at 418. Clearly, this is a troubling outcome, since it suggests that any statutory conditions regarding the availability of appropriations divests the state's DMH of any duty to provide statutorily required treatment and services. In effect, requiring no evidentiary showing allows the state an impenetrable defense against claims of lack of compliance with its statutory duties.

125. *See, e.g.*, Goebel v. Colorado Dep't of Insts., 764 P.2d 785 (Colo. 1988); City of Philadelphia v. Commonwealth, 564 A.2d 271 (Pa. Commw. Ct. 1989).

126. *See, e.g., Goebel*, 764 P.2d at 810; *City of Philadelphia*, 564 A.2d at 276.

127. *See, e.g., City of Philadelphia*, 564 A.2d at 275 (finding that state could not rely on their compliance with a statutory provision delineating procedures to be followed in the event of shortfalls in appropriations where they had consistently made budget *requests* that fell far short of the amount anticipated to be necessary in order to provide the statutorily mandated services and treatment). *See also In re* C.H., 559 A.2d 694 (Vt. 1989) (allowing for interlocutory appeal of question of whether the Commissioner of Mental Health was required to prove a defense of inadequate appropriations).

128. *See, e.g., Goebel*, 764 P.2d at 798 (finding that statutory appropriations limitations did not alter substantive rights but rather made implementation subject to availability of appropriations); Colorado v. Pena, 855 P.2d 805, 810–11 (Colo. 1993) (applying *Goebel* principle to another section of the code to find that explicit appropriations limitation did not affect substantive rights); Ass'n for Retarded Citizens v. Dep't of Developmental Servs., 696 P.2d 150 (Cal. 1985) (refusing to imply appropriations limitations affecting rights to services where insufficient funds

states were not relieved of their substantive obligations, and were required to seek further funding from the legislature in the event that their efforts to fully comply with their obligations led them to exhaust already appropriated funds.[129]

On a final note, it should be observed that it is possible that the textual differences in the statutes at issue in *Arnold* and *Y.A.* did in fact play some role, albeit not a clearly defined one, in the differing outcomes in the two cases. Although the court in *Y.A.* does not focus on this issue, its fundamental reason for denying the plaintiff's relief —that the statutes at issue did not demonstrate an intent on the part of the legislature to provide a comprehensive system of mental health care—is supported by the relative lack of specificity and breadth of coverage of the Indiana statutes.[130] Therefore, it is conceivable that the court's reading of the legislature's limitations on appropriations was colored by the fact that the provisions governing required treatment and services were themselves limited to certain populations and did not cover all contexts in which care might be required.[131] Textual differences in specificity and comprehensiveness of coverage, therefore, may be worthy of examination as potentially relevant factors in evaluating the viability of DMH/DMR statutes as a basis for seeking relief.

D. Conclusions

Surveying existing state law treatment-rights litigation provides significant information regarding both the likely viability of state law claims and the various impediments that may arise in specific cases. Most significantly, the success rates of cases brought pursuant to state MH/MR bills of rights and DMH/DMR enabling statutes suggests that both types of statutes may provide a highly effective basis for seeking broad treatment rights for the mentally ill. In addition, a survey of case law reveals numerous other potential bases for state law claims that should be explored, including constitutional provisions, anti-discrimination statutes, and general social services/medical assistance statutes.

Surveying state law litigation also highlights the key factors that may make state law rights litigation ineffective. Overwhelmingly, where such litigation has

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had been appropriated in a given year).

129. *See, e.g., Ass'n for Retarded Citizens*, 696 P.2d at 156. In some sense this is a risky strategy since the legislature could fail to provide additional appropriations, a resource allocation decision that would be beyond the scope of the court's remedial powers to challenge. *Goebel*, 764 P.2d at 801. In the contexts in which it has been used, however, it appears to have been largely successful, with legislatures appropriating additional funds as a result of the litigation. *See, e.g.*, An Act Concerning a Supplemental Appropriation to the Department of Health Care Policy and Financing, ch. 308, 1996 Colo. Sess. Laws 1961 (appropriating funds specifically for the purpose of implementing the *Goebel* order).

130. *Compare* IND. CODE §§ 12-21-1-1, 12-21-2-3, 12-21-2-4, 12-21-5-1-1.5, 12-24-19-1, 12-24-19-4 (2002) (setting out relatively limited requirements for the provision of community care), *with* ARIZ. REV. STAT. §§ 11-251, 11-291, 36-104, 36-204, 36-511, 36-550 (1993) (setting out requirements for the provision of community care in broad and sweeping terms).

131. IND. CODE §§ 12-21-1-1, 12-21-2-3, 12-21-2-4, 12-21-5-1-1.5, 12-24-19-1, 12-24-19-4 (2002).

failed, the provisions at issue have been read as not creating substantive rights and/or as being explicitly or implicitly limited by the availability of appropriations. A closer examination of specific cases reveals, however, that the outcomes in individual cases may not necessarily be contingent on differences or limitations in the statutory text.[132] Instead, such an examination suggests that outcomes may be contingent on variations in interpretation, and highlights the importance of encouraging the court to frame issues in a particular way, and of selecting favorable factual predicates for claims.

Altogether, the state law right-to-treatment litigation that has been conducted to date suggests that state law often may provide a valuable source of treatment rights claims. The following two sections will examine in greater detail the range of possible claims, as well as likely limitations on the availability of relief in the context of the two jurisdictions that have had the most extensive state law treatment rights litigation brought on behalf of the mentally ill: New York and Connecticut.

IV.
NEW YORK

In order to fully evaluate the utility of state law treatment rights claims, it is necessary to evaluate in greater detail the viability of such claims in the context of specific states' laws. New York State provides an ideal focus for this type of in-depth evaluation, as it has been the site of the most extensive state-law-based right-to-treatment litigation of any jurisdiction.[133] Despite this extensive litigation, New York still has numerous statutory and constitutional provisions that have not yet been tested in litigation but could potentially form the bases for claims for relief. As a result, an examination of New York law can provide valuable insights into how state law right-to-treatment litigation has progressed, as well as what statutory and constitutional provisions may, as a general matter, be available to provide the bases for right-to-treatment claims. This section will examine New York's history of right-to-treatment litigation, the constitutional and statutory bases for claims used in that litigation, and possible bases for future claims. From this, conclusions will be extrapolated regarding the possible range

132. This assertion may be somewhat overstated due to the limited number of cases surveyed. All of the statutes at issue in the specific cases evaluated in detail used mandatory "shall" language rather than permissive "may" language. In addition, in none of the cases examined were the statutes at issue styled or titled as a statement of policy, preamble, or other non-substantive statutory form. It is entirely possible that if these types of textual differences had been at issue they would in fact have made a difference in the outcome of the cases, as they go to the existence of *any* obligation, enforceable or not, on the part of the state to provide the requested treatment and services. *See generally* Lopez v. Davis, 531 U.S. 230, 238–43 (2001) (discussing distinction between mandatory and permissive statutory language); Pennhurst State Sch. & Hosp. v. Halderman, 451 U.S. 1 (1981) (rejecting assertion that a provision styled as "Congressional findings" imposed substantive obligations).

133. Thirty percent of all state law litigation seeking treatment rights for individuals with mental illness to date has been brought in the state of New York. *See infra* Appendix B.

of types of treatment rights claims that may be available under state law, as well as possible barriers that may arise to the availability of relief.

In order to provide for a cohesive framework, in the subsections below New York's prior litigation and state laws are examined within the framework suggested by the conclusions of the nationwide survey of right-to-treatment litigation. First, the two primary types of claims that have been brought in nationwide right-to-treatment litigation—claims based on the mental health statutes and claims based on patients' bills of rights—are discussed in the context of the New York statutory scheme and litigation history. This is followed by a discussion of some of the other types of claims that have been or could be brought under New York law. Finally, the implications of New York state law for broader state-law-based treatment rights litigation are discussed.

A. Mental Health Statutes

New York's mental hygiene code spans hundreds of pages, includes extensive provisions governing mental health treatment and services, and has provided the primary basis for state-law-based treatment rights litigation in New York. As discussed below, this litigation, although not uniformly successful, has had some remarkable successes. In addition to establishing certain substantive rights, it has established transsubstantive principles that are critical to New York treatment rights litigation, such as the justiciability of claims challenging the state's compliance with its obligations under the mental health code. Given the scope of the code, there are numerous areas of the New York mental health laws that have not yet been fully litigated and that therefore continue to provide a potential basis for successful claims. Below, various classes of claims that have been or could be brought under the mental hygiene code are discussed. This discussion is coupled with an examination of the limitations of the New York mental hygiene code from a litigation perspective.

i. Discharge Planning/Section 29.15

The discharge planning provisions of New York's Mental Hygiene code have been extensively litigated over the past two decades. The primary relevant provision, § 29.15, imposes explicit and detailed obligations on state and local actors regarding how they must discharge mentally ill inpatients to the community.[134] Specifically, it provides that the patient must be discharged in accordance with a written discharge plan, that state facilities must assist the patient in locating proper services and applying for benefits, that state facilities must follow up to ensure that the discharged patient is living in adequate conditions and receiving necessary services, and that the local social service district and/or local government unit to which the patient is discharged must

134. *See* N.Y. MENTAL HYG. LAW § 29.15 (McKinney 2002).

cooperate in implementing the comprehensive services suggested at discharge.[135] Perhaps unsurprisingly given its detailed and mandatory language, § 29.15 has been, and continues to be, the subject of the most extensive treatment rights litigation of any provision of the Mental Hygiene code. This litigation has established substantive rights to specific discharge planning and follow-up procedures. In addition, and perhaps more importantly, many of the broad principles that apply generally to litigation under the Mental Hygiene code have been clarified by New York's appellate courts during the course of § 29.15 litigation. Both the general litigation principles and specific substantive discharge planning rights that have resulted from § 29.15 litigation are described below.

1. Klostermann v. Cuomo[136]

The first major case to raise successful claims[137] under the discharge planning provisions of the New York Mental Hygiene code was *Klostermann v. Cuomo*.[138] Although the plaintiffs in *Klostermann* raised additional claims under various provisions of the mental hygiene code, New York and federal constitutions, and federal statutes, the "crux of [their] complaint [was] an asserted right . . . to receive residential placement, supervision, and care upon release from a State institution" pursuant to the provisions of § 29.15.[139] The plaintiffs' claims were initially dismissed by the lower court as raising non-justiciable policy questions.[140] The state's highest court, the Court of Appeals, reversed, finding that "plaintiffs have properly petitioned the courts for a declaration of their rights . . . . [T]o the extent that plaintiffs can establish that defendants are not satisfying nondiscretionary obligations to perform certain

135. *Id.*

136. For the purpose of simplicity, I refer only to *Klostermann v. Cuomo*, 463 N.E.2d 588 (N.Y. 1984), throughout this section. The Court of Appeals opinion in *Klostermann* also addressed another case that was joined for the purpose of appeal which raised very similar claims pursuant to § 29.15. As *Klostermann* was the lead case, and the two raised similar issues, this other case is omitted from discussion here. *See Klostermann*, 463 N.E.2d at 592 (discussing claims brought under *Joanne S. v. Carey*); Joanne S. v. Carey, 498 N.Y.S.2d 817 (App. Div. 1986) (reversing order granting joinder of city defendants on the grounds that primary responsibilities for discharge planning would run to the state).

137. Claims had been brought previously under the discharge planning provisions of the code in the case of *Bowen v. State Board of Social Welfare*, 390 N.Y.S.2d 617 (App. Div. 1976), *rev'd sub nom.* Jones v. Beame, 380 N.E.2d 277 (N.Y. 1978). In *Bowen*, the Appellate Division held that the City of Long Beach could bring suit to seek state compliance with the provisions of § 29.15. 390 N.Y.S.2d at 621. The Court of Appeals reversed, finding that the question of the state's compliance with the discharge planning provisions of the code was a policy question and therefore was nonjusticiable. *Beame*, 380 N.E.2d at 279–80. This result was reversed in *Klostermann*, 463 N.E.2d at 596. While the court in *Klostermann* offers an argument for distinguishing the two cases, it is unconvincing, as an examination of the basis of the claims in *Bowen* reveals that the two were indistinguishable in virtually all relevant respects. *See Bowen*, 390 N.Y.S.2d at 619–20.

138. 463 N.E.2d 588 (N.Y. 1984).

139. *Id.* at 591.

140. *Id.* at 590.

functions, they are entitled to orders directing defendants to discharge those duties."[141]

On remand, the defendants were granted summary judgment on several of the plaintiffs' claims.[142] Although the court did not grant summary judgment on the plaintiffs' claims under § 29.15, [143] the plaintiffs apparently did not proceed to trial as there are no subsequent published decisions in the case. *Klostermann*, therefore, did not directly address the question of the entitlement of mentally ill plaintiffs to treatment or services under § 29.15. However, it provided important and positive precedent regarding the appropriateness of ordering injunctive relief to remedy noncompliance with non-discretionary duties imposed by existing state law. Given that the two primary reasons for rejecting state law right-to-treatment claims have been their nonjusticiability as policy matters and their inapplicability wherever the state alleges that they lack sufficient funding to comply, *Klostermann* constituted a very important first step towards establishing an enforceable right to treatment under New York state law.

2. Heard v. Cuomo

Heard v. Cuomo[144] was initiated a few years after the final decision in the *Klostermann* litigation, and raised similar claims of entitlement to discharge planning, follow-up and community-based services and treatment under § 29.15. In a very broad decision, the lower court found after trial that the defendant, New York City's Health and Hospitals Corporation (HHC),[145] had violated its duty "to see that the residences in which its discharged patients are living are adequate and appropriate to their needs,"[146] and ordered compliance with the statute. Although the language of the order was not entirely clear on this point, it was construed by the parties as requiring the city to build appropriate community residences where such residences were not otherwise available.[147]

The Court of Appeals rejected this construction, finding that "the statute . . . [does not] impose[] upon HHC an explicit duty to build, create, supply or fund

141. *Klostermann*, 463 N.E.2d at 596.

142. Klostermann v. Cuomo, 481 N.Y.S.2d 580 (Sup. Ct. 1984).

143. *Id.* at 585.

144. 567 N.Y.S. 2d 594 (Sup. Ct. 1991).

145. The state was also a defendant in the *Heard* litigation, but was dismissed from the suit after trial as the court found them to be in substantial compliance with the mandates of § 29.15. *See* Heard v. Cuomo, 567 N.Y.S.2d 594, 599 (Sup. Ct. 1991). The Appellate Division (which summarily affirmed all parts of the Superior Court judgment, Heard v. Cuomo, 578 N.Y.S.2d 417 (App. Div. 1992)) only granted leave to appeal to the city defendants, and, as a result, the final order in *Heard* applies only to the City of New York. *See* Heard v. Cuomo, 610 N.E.2d 348, 349 (N.Y. 1993). It should be noted, however, that under the statute, the state's discharge planning obligations are even more extensive than those ascribed to localities such as the city. *See* N.Y. MENTAL HYG. LAW § 29.15 (McKinney 2002); Heard v. Cuomo, 567 N.Y.S.2d 594, 596 (Sup. Ct. 1991).

146. Heard v. Cuomo, 567 N.Y.S.2d 594, 598 (Sup. Ct. 1991).

147. Heard v. Cuomo, 610 N.E.2d 348, 351 (N.Y. 1993).

such [community-based] housing."[148] Given the lack of language in the statute mandating that the city provide community-based housing, the court found that the manner in which the city chose to fulfill its discharge planning obligations must be left to its discretion.[149] They upheld, however, the lower court's determination that the city was obligated to provide discharge planning services as detailed in § 29.15.[150] Finding that the language of § 29.15 "at its core 'import[s] duty, not discretion,'"[151] the Court of Appeals held that

> the statute requires that HHC take concrete steps to prescribe in the discharge plan the specific type of adequate and appropriate housing necessary for the about-to-be-discharged mentally ill patients; to assist in locating such adequate and appropriate housing before the patients are discharged from inpatient care; to discharge the patients in accordance with their individual written service plans that include the recommended housing; and to coordinate the effectuation of those efforts among the responsible entities.[152]

The outcome in *Heard* was, therefore, disappointing inasmuch as it held that localities are not required to provide the services specified under individual discharge plans. However, it did establish a right to comprehensive discharge planning and coordinated transitioning for New York residents who are leaving a city or state psychiatric facility. This entitlement has provided some important benefits. For example, it has allowed advocates to effectively prevent the previously common practice of involuntarily discharging hospital residents to homelessness.[153] In addition, it has resulted in some increased compliance with the discharge planning requirements of the statute.[154] Nonetheless, the limitations inherent in the city and state not having a responsibility to provide services have diminished the effectiveness of such planning. Subsequent rulings have confirmed that the lack of responsibility on the part of the city and state to actually provide services and housing makes it extremely difficult to ensure that their discharge planning obligations are in fact implemented.[155] Therefore,

148. *Id.*

149. *Id.*

150. *Id.* at 350.

151. *Id.* (quoting Jiggetts v. Grinker, 553 N.E.2d 570, 574 (N.Y. 1990)).

152. *Id.* at 351.

153. Interview with Ray Brescia, Director, Community Development Project, and Heather Barr, Staff Attorney, Mental Health Project, Urban Justice Center, in New York, N.Y. (Jan. 11, 2002) [hereinafter Brescia & Barr Interview]. While the ability to prevent hospitals from involuntarily discharging patients to shelters or the streets is highly useful in those cases where inpatients more urgently desire to stay off the streets than to leave the restrictive setting of an inpatient ward, long wait times for placement in community residences often result in many inpatients leaving voluntarily prior to their placement at an appropriate community facility. *Id.*

154. *Id.*

155. *See, e.g.*, Adriane A. v. Cuomo, 624 N.Y.S.2d 7 (App. Div. 1995) (finding that because under *Heard* city agencies were not statutorily obligated to build or fund housing, they were not obligated to discharge patients to appropriate residences within any fixed period of time); Koskinas

while *Heard* has resulted in some improvements in the system for the release of patients to the community, it has not provided a broad mandate for the provision of community care.

3. Prospects for the Further Extension of Heard*:* Brad H. v. City of New York

Litigation under § 29.15 is ongoing, and in 2000, the case of *Brad H. v. City of New York*[156] resulted in the issuance of a preliminary injunction against the city and other responsible agencies to prevent them from inappropriately discharging seriously mentally ill prisoners without discharge planning.[157] Noting that the broad language of several of the provisions of § 29.15[158] applies to segregated treatment units, forensic HHC psychiatric wards, and other city forensic mental illness facilities, the court found that irreparable harm to the plaintiff prisoners had been demonstrated, and that they were entitled to a preliminary injunction.[159] The court rejected the defendants' contention that discharge planning might delay the release of prisoners beyond their release date, noting simply that "as Plaintiffs . . . have a constitutional and statutory right to be released when the date thereof becomes due, discharge planning will have to occur in a manner that does not hold up the release of Plaintiffs."[160]

This opinion was subsequently summarily and unanimously affirmed by the Appellate Division.[161] If the case ultimately results in a permanent injunction or other appropriate relief, it may provide an important extension of the right to discharge planning to a group of individuals who are among the most marginalized of the mentally ill. Furthermore, given that city officials are limited by the time constraints of prisoner release dates, an injunction requiring effective discharge planning may actually prove more effective in ensuring that dischargees are released promptly to appropriate residences than the current requirements for discharge to appropriate residences from inpatient hospital psychiatric facilities. If advocates are able to obtain a favorable ultimate dis-

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v. Carillo, 625 N.Y.S. 2d 546 (App. Div. 1995) (discussing lack of effective implementation of the *Heard* decree). *See also* Brescia & Barr Interview, *supra* note 153.

156. 712 N.Y.S. 2d 336 (Sup. Ct. 2000).

157. Prior to the issuance of the preliminary injunction, it had been the policy of the City and its responsible agencies to discharge inmates receiving health care for serious mental illnesses "to the Queen [sic] Plaza subway station between 2:00 A.M. and 6:00 A.M. . . . [with] $1.50 plus two subway tokens." *Id.* at 339.

158. For example, § 29.15 applies to all "psychiatric inpatient services subject to licensure by the office of mental health." N.Y. MENTAL HYG. LAW § 29.15 (McKinney 2002). Mental Hygiene Law § 31.02 specifies the broad range of facilities subject to such licensure, including, among others, community residences, general hospitals, and residential care centers that provide services to the mentally disabled. N.Y. MENTAL HYG. LAW § 31.02 (McKinney 2002).

159. *Brad H.*, 712 N.Y.S. 2d at 344.

160. *Id.*

161. Brad H. v. City of New York, 716 N.Y.S.2d 852 (App. Div. 2000).

position coupled with adequate monitoring provisions,[162] Brad H. could hold significant promise as a means of furthering the goal of ensuring that mentally ill individuals have access to community facilities and services as required by New York state law.[163]

ii. Other Mental Hygiene Code Provisions

In addition to the discharge planning provisions of the New York code, there are numerous provisions of the New York Mental Hygiene and Social Services codes that address the obligations of the state and localities to provide care and assistance to individuals with psychiatric disabilities. Unfortunately, with few exceptions, these provisions fail to provide a clear and coherent mandate for any entity, local or state, to provide services and treatment to individuals with mental illness. There are, however, some more limited arguments that can be crafted under existing statutes regarding the obligations of state and/or local actors to provide services and treatment for the mentally ill. While prior litigation suggests that these arguments are unlikely to be successful if the state and/or localities are making even moderately effective attempts to comply with their obligations, they may well be viable where localities or the state have manifestly failed to provide adequate housing, services and treatment. Below, several of the provisions which might provide the basis for community treatment rights claims are discussed, together with the prior relevant case law.

1. Powers and Responsibilities of the Department of Mental Hygiene and Office of Mental Health

The most significant potential source of broad treatment rights in the New York Mental Hygiene code are the provisions governing the general powers and responsibilities of the Department of Mental Hygiene (DMH) and Office of Mental Health (OMH).[164] These provisions, which span two Articles of the

162. According to advocates, in addition to the structural problems posed by the *Klostermann* decision, the absence of effective monitoring provisions in the final judgment has hampered their ability to ensure compliance with the decision. They hope to obtain a more stringent monitoring framework if they prevail on their claims in *Brad H.* *See* Brescia & Barr Interview, *supra* note 147.

163. A proposed settlement agreement between the City and the plaintiff class in *Brad H.* was entered into on January 8, 2003. The settlement agreement must now be submitted to members of the plaintiff class for comment, and will be subject to a public hearing prior to final approval. If approved, it will provide an entitlement to extensive discharge planning services for mentally ill inmates. In addition, the agreement includes the type of provisions for monitoring and enforcement of defendant compliance that advocates had sought. *See* Stipulation of Settlement, Brad H. v. City of New York, Index No. 117882/99 (N.Y. Sup. Ct. 2003), *available at* http://www.urbanjustice.org/litigation/index.html; Press Release, Office of Council Member Margarita Lopez, *Lopez Highlights Settlement Agreement Between City and Members of Class Action Suit* (Mar. 24, 2003), *available at* http://www.council.nyc.ny.us/pdf_files/newswire/lopezandclarkebradhcase.pdf.

164. The OMH is a subdivision of the DMH, which also includes offices that deal specifically with mental retardation and addiction services. N.Y. MENTAL HYG. LAW § 5.01 (McKinney 2002).

code, include several sections that would seem to impose specific obligations on the state to provide appropriate services and treatment, at least as a service provider of last resort.[165] For example, § 7.07 provides that "[t]he Office of Mental Health shall have the responsibility for seeing that mentally ill persons are provided with care and treatment [and] that such care, treatment and rehabilitation is of high quality and effectiveness."[166] Section 7.07 additionally provides that the OMH "shall provide appropriate facilities" for the care, treatment, and rehabilitation of the mentally ill.[167] These mandates are mirrored in the policy statement provisions of § 7.01,[168] and in the Article 5 provisions setting out the overall duties of the DMH.[169]

Under a plain meaning reading, this language appears to impose broad obligations on the OMH to provide treatment and services to the mentally ill and to create facilities for those purposes where required. Similarly broad language in other states' statutes has been so construed in several instances,[170] and there are no mitigating factors in the New York language (e.g., specific funding limitations, or permissive "may" language) that would suggest that it should be read as anything other than mandatory. However, prior case law, as well as other aspects of the Mental Hygiene code, suggest that the provisions of Articles 5 and 7, standing alone, may not provide an effective basis for seeking treatment rights in most circumstances. The circumstances in which they may provide such a basis, as well as the specific reasons why they may not in all circumstances, are discussed below.

2. Savastano v. Prevost *and the Scope of OMH/DMH Discretion*

The most significant Court of Appeals decision that has addressed the scope of the DMH's duties outside of the context of § 29.15 litigation is *Savastano v. Prevost*.[171] In *Savastano*, which was brought on behalf of several mentally retarded individuals inappropriately housed in mental illness facilities, the plaintiffs claimed that they had a right to immediate transfer to an appropriate Office of Mental Retardation and Developmental Disabilities (OMRDD)[172]

165. *See generally* N.Y. MENTAL HYG. LAW, ch. 27, tit. A, art. 5 (McKinney 2002); N.Y. MENTAL HYG. LAW, ch. 27, tit. B, art. 7 (McKinney 2002).

166. N.Y. MENTAL HYG. LAW § 7.07 (McKinney 2002).

167. *Id.*

168. *See* N.Y. MENTAL HYG. LAW § 7.01 (McKinney 2002).

169. *See* N.Y. MENTAL HYG. LAW § 5.05 (McKinney 2002).

170. *See, e.g.*, Arnold v. Ariz. Dep't of Health Servs., 775 P.2d 521 (Ariz. 1989) (finding obligation on the part of the county to provide community mental health services based on language that is even broader and less specific than that found in New York Mental Hygiene code); *In re* Schmidt, 429 A.2d 631 (Pa. 1981) (finding a duty on the part of the state to find or develop an appropriate placement for an individual with mental retardation based on virtually identical statutory obligations to those found in the New York code).

171. 485 N.E.2d 213 (N.Y. 1985).

172. OMRDD is one of three subdivisions of the DMH. There is also an office of mental health and an office of alcoholism and substance abuse. *See* N.Y. MENTAL HYG. LAW § 5.01

facility pursuant to the terms of the Mental Hygiene code.[173] In support of their allegations, they cited several general provisions setting out the duties of the DMH and OMRDD, as well as the state patients' bill of rights.[174] Finding that the state was acting within its discretion, the Court of Appeals observed that "[t]here is no contention that respondents have failed to formulate *any* plan for the transfer of patients from OMH to OMRDD."[175] Concluding that the cited provisions could not be read as mandating an immediate transfer, the court held that the plaintiffs were not entitled to relief.[176]

Although several of the provisions relied on in *Savastano* were specific to the Office of Mental Retardation and Developmental Disabilities, rather than the Office of Mental Health or overall DMH, they were sufficiently similar to equivalent mental health provisions in the New York code that the case provides relevant precedent in the mental illness area.[177] *Savastano* therefore suggests that Article 5 and Article 7 claims are unlikely to prevail unless the state itself lacks a plan for correcting the alleged deficiency[178] or has otherwise manifestly failed to provide the requested treatment or services.[179] While there are certainly likely to be contexts in which this is true, *Savastano* limits significantly the scope of Article 5 and Article 7 claims that are likely to succeed.

(McKinney 2002).

173. *Id.* at 214.

174. *Id.* at 215.

175. *Id.*

176. *Id.*

177. The Court in *Savastano* does not specifically list all of the provisions under consideration, making it difficult to assess whether it may be distinguishable in certain circumstances. *See Savastano*, 485 N.E.2d at 215 ("Petitioners cite various provisions of the Mental Hygiene Law, including Sections 5.05(b), 13.01, and 33.03(a)...."). It is plausible, therefore, that *Savastano* may be distinguishable in some circumstances in the mental illness arena. For example, if the obligations imposed under § 7.07 exceed any obligations imposed by the provisions at issue in *Savastano*, the question of whether liability exists under § 7.07 should not be controlled by the outcome of *Savastano*.

178. It should be noted that the New York statutes impose significant planning requirements on the DMH and OMH, a factor which may prove both an asset and a drawback in treatment rights litigation under the Mental Hygiene code. *See, e.g.*, N.Y. MENTAL HYG. LAW §§ 5.07, 7.05 (McKinney 2002). If the reports that the Department is required to formulate reveal significant deficiencies in services, they may provide a valuable litigation tool. However, to the extent that the Department has set out a plan to rectify deficiencies in these mandatory reports, it may be difficult to challenge them under the provisions of Article 5 or Article 7.

179. This hypothesis (i.e., that the Department is likely to be vulnerable where it has manifestly failed to provide certain basic needed treatment and services) is supported by the case of *Love v. Koch*, 554 N.Y.S.2d 595 (App. Div. 1990). The Court in *Love*, while finding that the Mental Hygiene Law did not mandate the provision of community care and housing, found that the plaintiff's situation (homeless and mentally ill) might constitute extraordinary or emergency circumstances, rendering it appropriate for the courts to intervene. *Id.* at 597. Effectively, the court held that where the Department has failed to provide services to an extent that creates extraordinary or emergency circumstances, it does not constitute an inappropriate invasion into OMH discretion to intervene despite the lack of explicit and specific statutory mandates. *Id.*

3. Article 41 and the Community Treatment Obligations of Localities and the State

In addition to the unhelpful precedent provided by *Savastano*, there are features of the New York Mental Hygiene code itself which undermine arguments for a literal and broad reading of Article 5 and Article 7's provisions. In particular, Article 41, which delineates in extensive detail the organizational and substantive requirements governing the provision of community-based care, militates against a broad reading of the mandates of Article 5 and Article 7.[180] Not only does Article 41 discuss in far more specific detail than the earlier sections the question of community care and services, it does not, in most cases, ascribe responsibility for the provision of such care to the OMH.[181] While there are certainly plausible arguments that the mandates of Article 5 and 7 should be read in conjunction with Article 41 to require the state to serve as a provider of last resort in the area of community care, Article 41, like *Savastano*, is likely to have a limiting effect on the ability of advocates to make broad claims pursuant to Articles 5 and 7.[182]

However, Article 41 is not completely detrimental to right-to-treatment claims. Article 41 itself imposes certain obligations on both the state and localities related to the provision of community-based treatment and services. In particular, § 41.13 and 41.47 together provide that either localities or the state[183] must be responsible for providing community support services to the mentally ill.[184] Community support services are defined to include "case management services, advocacy services, clinic services, day treatment, day training, continuing treatment, homemaker services, housekeeping services, on-site rehabilitation services, sheltered workshop and other vocational programs, psychosocial clubs, neighborhood drop-in centers, transportation services, non-residential crisis services, outreach services, and other services approved by the

180. *See generally* N.Y. MENTAL HYG. LAW, ch. 27, tit. E, art. 41 (McKinney 2002).

181. *See id.*

182. Article 41 creates an opt-in system whereby localities can receive funding from the state for the provision of community services and treatment. A plausible argument can be made that Article 41 should be read jointly with the broad treatment obligations imposed by § 7.07, and that, therefore, the state should still be compelled to serve as a service provider of last resort where localities have either opted not to participate in the provision of mental health care or have provided inadequate service coverage. The main problem with this argument is that the New York courts are still likely to find § 7.07 to be too broad to impose specific duties on the state absent an absolute failure on the part of the OMH to provide needed services.

183. Under § 41.47, localities may choose to provide community support services, but need not provide such services. If they do opt to provide community support services, the services provided are completely reimbursable by the state. If they do not, the state is responsible for providing community support services in that locality. N.Y. MENTAL HYG. LAW §§ 41.13, 41.47 (McKinney 2002).

184. *See id. See also* N.Y. COMP. CODES R. & REGS. tit. 14, § 575.5 (2001) (setting out obligations to provide community support services for localities that opt generally to provide such services); N.Y. COMP. CODES R. & REGS. tit. 14, § 575.8 (2001) (obligating the state to fill gaps in service provision).

commissioner."[185] Effectively, this definition includes all community care services except for residential care/supportive housing itself. Given the importance of residential care and/or supportive housing to the ability of many individuals with mental illness to survive in the community, this is a significant omission.[186] Nevertheless, securing effective provision of the many support services and treatment modalities described in § 41.47 would clearly be a significant step forward in terms of access to community-based treatment and services.

Unfortunately, § 41.47 specifically indicates that "[n]o provision of this section shall be interpreted to create an entitlement for any individual to receive community support services."[187] Therefore, claims brought pursuant to § 41.47 are unlikely to succeed as simple statutory claims. However, as discussed at greater length below, it seems likely that this specific limitation is violative of the social services requirements of New York State's Constitution. As a result, a claim brought challenging this limitation under the state Constitution and seeking broad provision of community services might well prove successful.

4. Assisted Outpatient Treatment/Section 9.60

The only class of mentally ill individuals in New York for whom there is a clear statutory entitlement to prompt and comprehensive community-based services, housing and treatment is the class of involuntary recipients of the benefits of the mental health system. New York's "Assisted Outpatient Treatment" (AOT) law clearly mandates that any services included in a court-ordered treatment plan shall be provided to individuals subject to the plan, including treatment, supportive services, and residential care.[188] All persons subject to AOT orders must be provided with a case manager or Assertive Community Treatment team.[189]

Clearly, AOT cannot, standing alone, provide the basis for broad treatment rights claims. Plaintiffs who voluntarily seek treatment are, in the absence of an existing court order, by definition not eligible for AOT services.[190] However, as in the case of § 41.47, there are potentially viable legal arguments under the New York State Constitution that the AOT's program's restrictions on eligibility are not valid. As discussed in greater length below, if AOT limitations based solely on desire for services were declared unconstitutional, it would at a minimum

185. N.Y. MENTAL HYG. LAW § 41.47(b) (McKinney 2002).

186. Community residential services for the mentally ill are provided for in another section of the code, the terms of which are clearly permissive. *See* N.Y. MENTAL HYG. LAW § 41.44 (McKinney 2002) (providing that "[t]he commissioner of mental health is authorized, within appropriations made therefore, to establish a continuum of community residential services for the mentally ill.").

187. N.Y. MENTAL HYG. LAW § 41.47(l) (McKinney 2002).

188. N.Y. MENTAL HYG. LAW §§ 7.17(f), 9.47, 9.60 (McKinney 2002).

189. N.Y. MENTAL HYG. LAW § 7.17(f)(iii) (McKinney 2002).

190. *See* N.Y. MENTAL HYG. LAW § 9.60 (McKinney 2002).

allow those who are most gravely disabled[191] to have access to prompt and comprehensive community services and care.

B. *Patients' Bill of Rights*

Like many other states, New York State has a patients' bill of rights.[192] As noted above, bill of rights provisions have, in several states, formed the basis for successful and broad treatment rights claims. New York's provision includes language similar to that of most bill of rights statutes, providing that "[e]ach patient in a facility and each person receiving services for mental disability shall receive care and treatment that is suited to his needs . . . ."[193] This provision would seem, therefore, an obvious choice for pursuing treatment rights litigation under New York state law.

Existing precedent suggests, however, that New York's patients' bill of rights is not likely to be interpreted broadly by the New York courts. In particular, the adverse result in *Savastano* suggests that the New York courts may be unwilling to apply the bill of rights stringently, even where it most clearly applies.[194] As discussed earlier, the plaintiffs in *Savastano* were not even housed in a facility that was appropriate to their mental disorder. It seems highly unlikely, therefore, that they were receiving care that could be described as "suited to [their] needs."[195] Nevertheless, the Court of Appeals found that the patient's bill of rights, § 33.03, did not mandate their immediate transfer to a more appropriate facility.[196]

Despite the existence of this adverse precedent, it may be worthwhile to pursue at least some further claims under § 33.03. Given that the provision applies not only to "patients" but more broadly to any "person receiving services for mental disability," its potential coverage is very wide.[197] As a result, any holding indicating that § 33.03's mandates are not simply precatory would represent a significant advance in treatment entitlements for individuals with mental illness who live in New York. Although *Savastano* does not provide encouraging precedent, it is probably distinguishable in many cases, and there-

191. The statutory requirements for AOT are such that only the gravely disabled would be covered even if the involuntariness requirement were invalidated. In addition to requirements prohibiting the issuance of AOT orders where the individual will voluntarily comply with treatment, the statute requires that the individual be "unlikely to survive safely in the community without supervision" and that she be likely to cause harm to herself or others if she does not receive appropriate treatment. N.Y. MENTAL HYG. LAW § 9.60 (McKinney 2002).

192. N.Y. MENTAL HYG. LAW § 33.03 (McKinney 2002).

193. *Id.*

194. *Savastano v. Prevost*, 485 N.E.2d 213 (N.Y. 1985).

195. N.Y. MENTAL HYG. LAW § 33.03 (McKinney 2002).

196. *Savastano*, 485 N.E.2d at 215.

197. N.Y. MENTAL HYG. LAW § 33.03 (McKinney 2002).

fore should not pose a total bar to future attempts at seeking enforceable treatment rights pursuant to § 33.03.[198]

C. *Other Bases for Relief*

As discussed earlier, while DMH/DMR statutes and MH/MR bills of rights have provided the most frequently utilized basis for securing treatment rights pursuant to state law, a number of other types of state law claims have been raised on behalf of mentally ill individuals. Below, several of these types of claims are explored in the context of New York state law. Potential claims arising under the social welfare provisions of New York State's constitution are discussed fairly extensively, followed by a brief discussion of New York's anti-discrimination law and equal protection clause, as well as its general social services and medical assistance statutes.

i. Social Welfare Provisions of the New York State Constitution

Unlike the United States Constitution, the New York State constitution includes numerous provisions addressing the social welfare and affirmative entitlements of New York State residents. Most of these provisions were enacted in 1938, in response to the Great Depression, and they address a range of subjects from institutions for the care of the mentally disabled[199] to the provision of free education for New York school age children.[200] Most of these provisions have been minimally litigated in the mental disability context, if at all, and several could provide useful support for a state-law based right to treatment or other services. Below, each of the provisions that seem likely to provide support for treatment rights claims are discussed.

1. Article XVII, Section 4

The provision of the New York State constitution that most obviously applies to mental illness related litigation is Article XVII, § 4 .[201] Unfortunately, Article XVII, § 4 employs only permissive language, providing that "[t]he care and treatment of persons suffering from mental disorder or defect . . . . may be provided by state and local authorities and in such manner as the legislature may from time to time determine."[202] Although the Court of Appeals in the case of

198. There is surprisingly little additional precedent beyond *Savastano* interpreting § 33.03 as it applies to treatment rights. While there has been fairly significant litigation of § 33.03's import in the area of forced treatment, there remains very little in the way of clear determinations of § 33.03's significance in ensuring adequate treatment. There are, therefore, significant possibilities for distinguishing *Savastano* that have yet to be explored and that could potentially prove fruitful.

199. N.Y. CONST. art. XVII, § 4. (providing for care and treatment of persons suffering from mental disorder or defect).

200. N.Y. CONST. art. XI, § 1.

201. N.Y. CONST. art. XVII, § 4.

202. *Id.*

Kesselbrenner v. Anonymous[203] suggested in dicta that treatment rights might be found in § 4, this has never been squarely affirmed in subsequent litigation. Given the extremely permissive language utilized in § 4, and the many years that have passed since the time of the *Kesselbrenner* decision, it seems highly unlikely that this dictum will be affirmed in the future. Therefore, while it may be worthwhile to include Article XVII, § 4 where other state constitutional claims are being raised, § 4 seems unlikely, in and of itself, to provide a basis for securing treatment rights.

2. Article XVII, Sections 1 and 3

In contrast to Article XVII, § 4, both § 1 and § 3 of Article XVII of the New York Constitution impose clearly mandatory duties on the state, and seem likely to provide a valuable tool in treatment rights litigation. Article XVII, § 1 provides in relevant part that "[t]he aid, care and support of the needy are public concerns and shall be provided by the state . . . in such manner and by such means, as the legislature may from time to time determine."[204] Similarly, § 3 provides that "[t]he protection and promotion of the health of the inhabitants of the state are matters of public concern and provision therefore shall be made by the state . . . in such manner, and by such means as the legislature shall from time to time determine."[205] The Court of Appeals has interpreted these provisions[206] to impose social services obligations not only on the executive branch of New York government,[207] but also on the legislature itself.[208]

Most significantly, the Court of Appeals has repeatedly held that the legislature may not, consistently with § 1, impose eligibility criteria for social services programs that are not related to need.[209] So, for example, the court has

203. 305 N.E.2d 903, 905 (N.Y. 1973).

204. N.Y. CONST. art. XVII, § 1.

205. N.Y. CONST. art. XVII, § 3.

206. There is very little jurisprudence discussing the interaction between § 1 and § 3 and the degree to which their mandates overlap. Existing case law implies, however, that § 3's mandates may be entirely subsumed in the mandates of § 1. *See, e.g.*, Aliessa v. Novello, 754 N.E.2d 1085, 1092–93 (N.Y. 2001) (finding that the exclusion of legal aliens from Medicaid eligibility violated § 1, and declining to reach the issue of whether it would also constitute a violation of § 3); Hope v. Perales, 634 N.E.2d 183, 188 (N.Y. 1994) (finding that neither § 1 nor § 3 mandated the provision of certain medical services as there was no indication that the class at issue was "needy" within the meaning of § 1). Nevertheless, the New York courts have not explicitly so held, and it remains, therefore, an open issue. Because existing jurisprudence suggests that § 3's mandates may be subsumed within § 1's mandates, and because there is very little case law clarifying what independent significance § 3 may have, the two are discussed jointly here.

207. *See, e.g.*, Jiggetts v. Grinker, 553 N.E.2d 570 (N.Y. 1990) (finding that the Department of Social Services' shelter grant schedule violated § 1 because it was not reasonably calculated to conform with the statutory mandate that such grants be "adequate").

208. *See, e.g.*, Tucker v. Toia, 371 N.E.2d 449, 452 (N.Y. 1977) (finding that legislature had violated § 1 by enacting a statute that denied aid to those classified as needy).

209. *See id.* (finding that law prohibiting payments to individuals under age twenty-one who were living apart from legally liable relatives prior to the disposition of proceedings seeking to compel support from those relatives violated § 1). *See also* Lee v. Smith, 373 N.E.2d 247 (N.Y.

struck down provisions of New York state law excluding disabled individuals from receiving Home Relief[210] and has eliminated statutory bars on the receipt of Medicaid by legal aliens.[211] In striking down non-need based requirements, the court has observed that

> section 1 of Article XVII imposes upon the state an affirmative duty to aid the needy. Although our Constitution provides the Legislature with discretion in determining the means by which this objective is to be effectuated . . . it unequivocally prevents the legislature from simply refusing to aid those whom it has classified as needy.[212]

As noted above, it seems likely that this prohibition could be usefully applied in seeking broader treatment rights under New York state law. In particular, the restrictions included on the breadth of the availability of community services and treatment under § 41.47, as well as some of the restrictions included in the Assisted Outpatient Treatment statutes, seem likely to be violative of § 1's mandates.[213] Below, the restrictions included in each of these statutory programs are discussed in the context of § 1's requirement of aid to the needy.

3. Community Services and Treatment/Section 41.47

As discussed above, § 41.47 and § 41.13 together provide that either localities or the state must be responsible for providing community support services to the mentally ill. Section 41.47 goes on to broadly define the support services to be provided, and to delineate detailed eligibility requirements for the

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1977) (finding that barring Social Security recipients from eligibility for Home Relief violated § 1 because it might result in the aged, blind and disabled receiving lesser overall support than the non-disabled needy); *Aliessa*, 754 N.E.2d at 1088 (N.Y. 2001) (finding that the exclusion of legal aliens from Medicaid eligibility violated § 1 of the New York Constitution).

210. *See Lee*, 373 N.E.2d at 252.

211. *See Aliessa*, 754 N.E.2d at 1099.

212. *See Tucker*, 371 N.E.2d at 452.

213. It should be noted that developments under the education clause of the New York Constitution suggest that it should be possible to bring an action directly under § 1 or § 3 where the provision of basic needed services and treatment is, taken as a whole, manifestly inadequate. In particular, the 1995 case of *Campaign for Fiscal Equality v. State of New York*, 655 N.E.2d 661 (N.Y. 1995), indicates that where the failure of a section of government to fulfill a very broadly defined duty is manifest and cannot be construed as a matter of policy judgment, the courts may be willing to intervene. In *Campaign for Fiscal Equality*, the Court of Appeals held that where the state has failed to provide minimally acceptable educational services and facilities, a valid cause of action will lie directly under the education clause. *Id; see also* N.Y. CONST. art. XI, § 1. If §§ 1 and 3 and the education clause are subject to similar analysis (and the similarity of the text of §§ 1 and 3 to that of the education clause suggests that they should be), the outcome in *Campaign for Fiscal Equality* seems to dictate that a direct claim should similarly be viable in certain circumstances under §§ 1 or 3. *Cf. Campaign for Fiscal Equality*, 655 N.E.2d at 682 (Simons, J., dissenting in part) (noting that because of the similarity in language between the education and social welfare clauses of the New York Constitution "I know of no legal answer for those who will contend [based on the holding in *Campaign for Fiscal Equality*] that we must resolve similar questions challenging compliance with the Social Welfare Article . . . .").

receipt of services.[214] Despite this apparently mandatory language and need-based structure, § 41.47(l) states that "[n]o provision of this section shall be interpreted to create an entitlement for any individual to receive community support services."[215]

It is likely that this attempt to disclaim creation of an entitlement is invalid under Article XVII, § 1 of the New York Constitution. As noted, § 41.47 includes detailed eligibility requirements that are clearly designed to track the need of recipients for services, requiring, for example that eligible individuals' ability to remain in the community "be seriously jeopardized without the provision of support services"[216] and that individuals be "functionally disabled as a result of mental illness."[217] Furthermore, localities and the Department of Mental Heath are required to implement fee schedules for community support services that are calibrated to the individual's ability to pay.[218] As a result, any individual qualified to receive community mental health services pursuant to § 41.47 will be clearly clinically in need of such services, and will already be paying to the extent of their ability.

Under these circumstances, the insertion by the legislature of a qualification that § 41.47 does not create an entitlement program seems like a textbook violation of Article XVII, § 1. The legislature has unambiguously classified certain individuals as needy of services under § 41.47's statutory scheme, but has, just as clearly, declined to provide that they are entitled to support. This attempt to avoid responsibility for providing what the legislature itself has defined as necessary services runs contrary to the mandate of Article XVII, § 1. As a result, it seems likely that the entitlement qualification in § 41.47(1) would not be enforceable were advocates to bring statutory claims for broad enforcement of § 41.47's mandate.

4. Assisted Outpatient Treatment/Section 9.60

As discussed above, persons who are subject to an AOT order are the only class of New York State residents who are entitled to receive prompt and comprehensive community-based mental health treatment and services. This means that individuals who are equally gravely disabled by their mental illness, and

214. *See* N.Y. MENTAL HYG. LAW § 41.47 (McKinney 2002). *See also* N.Y. COMP. CODES R. & REGS. tit. 14, § 575.6 (2001) (specifying eligibility criteria for community support services in even greater detail).

215. N.Y. MENTAL HYG. LAW § 41.47(l) (McKinney 2002).

216. N.Y. MENTAL HYG. LAW § 41.47(c)(2) (McKinney 2002).

217. *Id.* Functional disability is defined in the regulations governing community support services as a "severe, chronic" disability. N.Y. COMP. CODES R. & REGS. tit. 14, § 575.4 (2001).

218. For requirements that localities charge fees calibrated to ability to pay see, for example, N.Y. MENTAL HYG. LAW § 41.25 (McKinney 2002) (discussing setting of fees schedules by localities) and N.Y. COMP. CODES R. & REGS. tit. 14, § 100.4 (2001) (excluding from state reimbursement all "[e]xpenditures for services furnished to patients who are financially able to pay for private care."). For requirements that the state charge calibrated fees where it is the service provider see, for example, N.Y. MENTAL HYG. LAW § 43.01 (McKinney 2002).

equally likely to cause serious harm to themselves or others in the near future, are treated differently depending on their desire to access services and treatment.[219] Individuals who do not desire community services and treatment are entitled to receive them and are subject to coercive measures to ensure that they do.[220] In contrast, individuals who *do* desire community services and treatment have no entitlement to receive them.[221] As a result, individuals who want to prevent harm to themselves or others and who seek treatment in order to do so may be compelled to hospitalize themselves in order to receive care.

As in the case of § 41.47, this outcome seems contrary to Article XVII, § 1's mandates that the legislature "care for the needy" and not impose eligibility criteria that are unrelated to need. Although there may be a reasonable basis for assuming that individuals who are likely to cause harm to themselves or others are more in need of services treatment than others, and that, similarly, the most gravely disabled are those most in need, there is no reasonable basis for assuming that those who do not want to receive services and treatment are categorically more in need of treatment than those who do. As a result, the crafting of AOT in § 9.60 as a system of involuntarily imposed treatment and services would seem to run counter to the mandates of Article XVII, § 1. Although removal of the involuntary facets of the AOT system would not open up community treatment and services on a broad basis, given that other program requirements mandate that individuals be very seriously disabled by their illness, it would provide an entitlement to prompt and comprehensive care and treatment for the most seriously incapacitated individuals residing in the community.[222]

5. Conclusions

There are, therefore, viable claims that can be raised pursuant to New York's social welfare constitutional provisions. In particular, limitations in the mental hygiene code on access to services that are predicated on non-need based factors, for example, desire to access services, or the state's need to save money, are likely to be invalid, and challengeable pursuant to Article XVII, §§ 1 and 3. If these restrictions were indeed invalidated, the scope of community treatment and services available to mentally ill individuals in New York would be expanded considerably.

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219. *See* N.Y. MENTAL HYG. LAW § 9.60 (McKinney 2002).

220. *Id.*

221. *See id.*

222. As in the case of all community health services, individuals subject to Assisted Outpatient Treatment orders are subject to a system of fees calibrated to their ability to pay. *See* N.Y. MENTAL HYG. LAW §§ 41.25, 43.01 (McKinney 2002). *See also In Re* Arden Hill Hospital, 703 N.Y.S.2d 902, 906 (Sup. Ct. 2000) (stating that "if the respondent [individual subject to an AOT order] has financial resources . . . [he] should be responsible for the costs of his or her own treatment and for the costs of obtaining that treatment."). Typically, however, the most gravely disabled of the mentally ill are likely to be financially needy in any event, given their inability to engage in substantial gainful employment.

ii. Social Services and Medical Assistance Statutes

In addition to the New York Constitution's social welfare provisions, there are a number of general social services and medical assistance statutes in New York State that could be construed as requiring the provision of some form of community care and/or treatment for mentally ill individuals.[223] By far the most promising of these sections are the statutes and regulations governing the provision of protective services for adults (PSA) by social services officials.[224] By the terms of the statute, officials "shall provide protective services . . . to . . . individuals without regard to income who, because of mental . . . impairments, are unable to manage their own resources, carry out the activities of daily living, or protect themselves from . . . active, passive or self neglect . . . or other hazardous situations without assistance from others."[225] This definition would include many of those who are seriously disabled by mental illness and residing in the community without adequate treatment and/or mental health support services.

The statutes and regulations proceed to define very specifically the protective services that must be provided to any eligible adults as needed. These services include: 1) "arranging for medical and psychiatric services . . . to safeguard and improve the circumstances of those with serious impairments;"[226] 2) assisting individuals to "move from situations which are, or are likely to become, hazardous to their health and well-being;"[227] and 3) "assisting in the location of social services, medical care and other resources in the community, including arrangement for day care in a protective setting,"[228] as well as other relevant and needed assistance.[229] Furthermore, an investigation of the circumstances of the at-risk individual must be initiated within seventy-two hours of a referral to the Department.[230] A referral is defined broadly and can be made by any individual simply by providing the Social Services district with written or verbal notice that an individual within its jurisdiction is "apparently in need of PSA."[231]

While in most circumstances the PSA statutes and regulations do not require the Social Services department to itself become the provider of needed care,

223. *See, e.g.*, N.Y. SOC. SERV. LAW § 131.2 (McKinney 2003) (social services officials are required insofar as funds are available to cooperate with the directors of mental hygiene facilities in ensuring that patients transition smoothly to the community); N.Y. SOC. SERV. LAW §§ 250–259 (McKinney 2003) (certain support services shall be provided to disabled individuals).

224. *See* N.Y. SOC. SERV. LAW § 473-473-e (McKinney 2003); N.Y. COMP. CODES R. & REGS. tit. 18, § 457.1-457.16 (2001). *See generally* 88 N.Y. JUR. 2D *Public Welfare and Old Age Assistance* § 174 (1990).

225. N.Y. SOC. SERV. LAW § 473.1 (McKinney 2003)

226. *Id.*

227. *Id.*

228. N.Y. COMP. CODES R. & REGS. tit. 18, § 457.1 (2001).

229. *See id.*; N.Y. SOC. SERV. LAW § 473 (2003).

230. N.Y. COMP. CODES R. & REGS. tit. 18, § 457.1 (2001).

231. *Id.*

these provisions could be highly beneficial in assuring prompt attention to the needs of seriously mentally ill individuals who are entering the community or who already reside outside of an institution. Indeed, virtually all seriously mentally ill individuals who are not discharged to appropriate facilities and services in accordance with the provisions of § 29.15 are likely to be in need of PSA services.[232] Simple notification of the appropriate social services district triggers their obligation to promptly provide evaluation and support services.[233] In addition, departments are then required to follow up at minimum regular intervals to ensure that the needs of the PSA services recipient continue to be adequately met.[234] To the extent that PSA services can be utilized broadly to serve a case management and supportive monitoring function for individuals with serious mental illness who reside in the community, they may provide a valuable resource in assisting such individuals in accessing those treatment and services that are available, or to which they are otherwise legally entitled.[235]

iii. Anti-Discrimination Law and Equal Protection

As disclosed in the nationwide survey of state-law right-to-treatment litigation, advocates have sometimes made use of state law equal protection and anti-discrimination guarantees in seeking treatment rights for individuals with mental disabilities.[236] New York has both a state law equal protection clause[237] and a state law anti-discrimination statute covering people with disabilities.[238] Unfortunately, both have textual limitations or have been construed in ways that are likely to render them essentially useless as a means of making treatment rights claims. New York's anti-discrimination law does not prohibit disability discrimination in the provision of government services, and is, therefore, simply not applicable to most cases involving the availability of government provided

232. Where neither friends, family, nor a governmental entity has taken responsibility for ensuring that individuals with serious mental illness have access to needed care, virtually all such individuals will come under the eligibility criteria for PSA. "Self neglect," one of the primary categories under which one becomes eligible for PSA services, is defined very broadly as

> an adult's inability, due to physical and/or mental impairments to perform tasks essential to caring for oneself, including but not limited to, providing essential food, clothing, shelter and medical care; obtaining goods and services necessary to maintain physical health, mental health, emotional well-being and general safety; or managing financial affairs.

N.Y. SOC. SERV. LAW § 473.6 (2003).

233. N.Y. COMP. CODES R. & REGS. tit. 18, § 457.1 (2001).

234. N.Y. COMP. CODES R. & REGS. tit. 18, § 457.5 (2001).

235. It is interesting to note in this regard that as a component of protective services, social services districts are required to provide "advocacy and assistance in arranging for legal services to assure receipt of rights and entitlements due to adults at risk." N.Y. COMP. CODES R. & REGS. tit. 18, § 457.1 (2001).

236. *See infra* Appendix B.

237. N.Y. CONST. art. I, § 11.

238. N.Y. EXEC. LAW §§ 290–301 (McKinney 2002).

treatment and services.[239] Similarly, New York's equal protection clause has been construed as coextensive with the federal equal protection clause, which itself provides basically no protections in the area of treatment rights claims.[240] Therefore, neither provision is likely to be of significant use in seeking broader treatment rights for individuals with mental illness.

D. Conclusions

A detailed survey of New York state law lends support to several of the conclusions that were suggested by broadly surveying prior right-to-treatment litigation. It also, however, highlights the wide degree of variability in the potential legal bases and barriers to success of right-to-treatment litigation that are likely to exist from state to state. Finally, it suggests several additional litigation factors that one may want to consider in assessing the viability of right-to-treatment litigation in any given state.

As discussed in Section III, courts have, to an overwhelming degree, relied on either 1) implied or explicit funding limitations or 2) the lack of a mandatory duty on the part of the state in denying right-to-treatment claims brought pursuant to state law. The prevalence of these factors is to some extent reflected in New York's prior right-to-treatment case law; in most of the cases in which advocates have been partially or wholly unsuccessful the court has justified its denial of relief on the grounds that there was no mandatory duty on the part of the state to provide the requested treatment or services.[241] However, funding limitations, which are so frequently utilized to deny relief in other jurisdictions, appear not to be a major concern in New York. When the New York courts have found a mandatory duty on the part of the state, they have seemed relatively unconcerned about ordering broad relief that might require the expenditure of substantial additional funds.[242] This suggests that the degree to which such limitations are a concern may vary considerably from state to state.

Similarly an examination of viable claims in New York provides some support for the hypothesized importance of bill of rights and mental health statutory claims, while also suggesting the importance of searching beyond those two categories in seeking out possible treatment rights claims. As surveying prior litigation suggests, the mental health statutes in New York are an important

239. *Compare id.* (not prohibiting disability discrimination in the provision of government services), *with* 42 U.S.C. § 12132 (2000) (broadly prohibiting discrimination on the basis of disability in the provision of government services).

240. *See* Under 21 v. City of New York, 482 N.E.2d 1, 7 n.6 (N.Y. 1985) (stating that New York's equal protection clause "is no broader in coverage than the Federal provision."). *See also* City of Cleburne v. Cleburne Living Center, 473 U.S. 432 (1985) (finding that laws involving people with mental disabilities are subject to only rational basis review under the federal equal protection clause).

241. *See, e.g.*, Savastano v. Prevost, 485 N.E.2d 213, 215 (N.Y. 1985).

242. *See* Heard v. Cuomo, 610 N.E.2d 348, 351 (N.Y. 1993); Brad H. v. City of New York, 712 N.Y.S.2d 336, 345 (Sup. Ct. 2000).

source of right-to-treatment claims. However, they are clearly not the only source of such claims. Furthermore, New York's patients' bill of rights, which prior litigation suggests might be of substantial value, seems unlikely to provide an effective basis for bringing broad treatment rights claims. Instead, constitutional provisions and social services statutes, both of which have been rarely used in other states' right-to-treatment litigation, appear likely to provide a critical supplement to the possible claims that can be brought under the mental health statutes in New York.

Finally, surveying New York State treatment rights litigation in detail strongly reemphasizes the importance of the factual context in which litigation is brought to the statutory interpretation that results. Repeatedly, in treatment rights litigation in New York, when the state or locality disclaimed responsibility for providing the services or treatment sought by advocates, they were compelled to provide at least partial relief.[243] In contrast, when the state had a plan for the provision of services that was being even moderately effectively implemented, statutes were typically found not to require them to provide any greater relief.[244] This reinforces the importance of looking for obligations that have been implemented in a manner that is manifestly inadequate or, ideally, that remain totally unimplemented by the state.

In addition to providing clarification and support for many of the observations deduced from a broad survey of jurisdictions, New York state law suggests numerous additional factors that should be considered in contemplating the viability of right-to-treatment litigation under a given state's laws. For example, an examination of New York State statutes and jurisprudence suggests that more detailed code provisions dealing with the obligations of the state may not always be preferable as a basis for seeking relief. Indeed, New York's laws suggest that inasmuch as more detailed statutory provisions do not clearly ascribe responsibility for treatment and/or services to the state, they may even undermine less specific statutory mandates.

Similarly, surveying New York state law suggests the importance of searching broadly for claims and of being aware of their potential interplay along various dimensions. Mirroring the overlapping and complementary obligations of state actors, it is likely that various statutory provisions and regulations will sometimes need to be joined in order to create an effective claim. In addition, the potential claims under New York law strongly suggest that the effect of constitutional requirements on statutory mandates should be considered, since statutory provisions which would not, standing alone, provide a basis for relief may sometimes do so when coupled with constitutional mandates.

Finally, a detailed survey of New York state law highlights the basic importance of strategic litigation planning over time in bringing state-law-based treatment rights claims. Given that in some cases (as in New York) the only

243. *Id.*

244. *See Savastano*, 485 N.E.2d at 215.

possible treatment rights claims may be partial and not holistic, it is important to approach the ordering and joining of claims strategically. Advocates' experience with the implementation of discharge planning rights, in particular, suggests that the effective implementation of established rights may often be contingent on the preexistence of obligations in another arena.

A survey of New York state law, therefore, confirms the likely viability of utilizing state laws and constitutions in seeking treatment rights. It suggests, however, that such litigation will often not be neat or easy; the claims available may be partial and may require successive and strategic litigation in order to secure effective relief. In order to provide additional insight into the likely viability of various types of state law claims, and the difficulties that may arise in bringing such claims, the following section surveys Connecticut law in detail.

V.
CONNECTICUT

Like New York, Connecticut has been the site of comparatively extensive state law mental illness right-to-treatment litigation.[245] Most of this litigation, however, has been limited to a single Connecticut statute, and has been individual, rather than class-based, litigation. As a result, despite comparatively intensive litigation of state law claims, there remain numerous questions of law that have not been definitively decided by the Connecticut courts. An examination of Connecticut law can, therefore, provide the opportunity both to explore in depth prior right-to-treatment litigation and to evaluate potential alternative grounds for treatment rights claims.

Below, Connecticut's litigation history, as well as the potential treatment rights claims that may exist under Connecticut state law, are evaluated in the context of Connecticut's statutory and constitutional scheme. First, the two primary types of claims that have been brought in nationwide right-to-treatment litigation—claims based on the mental health statutes and claims based on patients' bills of rights—are discussed. This is followed by a discussion of some of the other potential types of claims that have been or could be brought under Connecticut law. Finally, the implications of Connecticut state law for broader state-law-based treatment rights litigation are discussed.

A. Patients' Bill of Rights

The vast majority of right-to-treatment litigation that has been brought in the state of Connecticut has focused on the Connecticut patients' bill of rights.[246]

245. Twenty-two percent of all state law litigation seeking treatment rights for individuals with mental illness that has occurred to date was brought in Connecticut. *See* Appendix B, *infra*.

246. CONN. GEN. STAT. § 17a-540 (2003). *See, e.g.*, Mahoney v. Lensink, 569 A.2d 518 (Conn. 1990) (finding that state hospital residents have a right to adequate treatment under the patients' bill of rights); Wiseman v. Armstrong, No. 02-0821661S, 2003 WL1227567 (Conn. Super. Ct. Feb. 27, 2003) (finding that patients' bill of rights applies to psychiatric unit of Conn-

Although very little of this litigation has reached the appellate level, that which has has resulted in successful decisions.[247] Despite its success, this litigation has apparently not resulted in systemic change,[248] due in part to the fact that so little of it has reached the appellate level, and due in part to the fact that all of the litigation has been in the form of individual claims. Below, prior litigation under the patients' bill of rights is discussed, and further possibilities for raising treatment rights claims under the statute are explored.

i. Right to Treatment and Mahoney v. Lensink

Connecticut's patients' bill of rights secures a number of rights to patients within the mental health system, including personal autonomy, respectful handling, and, significantly, effective treatment.[249] The relevant provisions of the statute provide that

> [e]very patient treated in any facility for treatment of persons with psychiatric disabilities shall receive humane and dignified treatment at all times .... Each patient shall be treated in accordance with a specialized treatment plan suited to his disorder. Such a treatment plan shall include a discharge plan which shall include, but not be limited to, (1) reasonable notice to the patient of his impending discharge, (2) active participation by the patient in planning for his discharge and (3) planning for appropriate aftercare to the patient upon his discharge.[250]

The Connecticut Supreme Court has interpreted these sections to require the provision of adequate treatment to patients at facilities within the mental health system. In 1990, in the case of *Mahoney v. Lensink*,[251] the court found that the plain language of the patients' bill of rights bestowed an affirmative right to some form of active treatment. The court rejected the defendants' argument that

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ecticut correctional facility); Harris v. Scott, No. 99-0090121, 2000 WL 1022873 (Conn. Super. Ct. July 10, 2000) (rejecting claim of patient at Whiting Forensic Division that he was denied adequate treatment); Zigmond v. Leone, No. 99-0088949, 2000 WL 486853 (Conn. Super. Ct. Apr. 7, 2000) (rejecting claim of patient at Whiting Forensic Division that he was denied adequate treatment); Bradley v. Central Naugatuck Valley Help, 25 Conn. L. Rptr. 178 (Super. Ct. 1999) (finding community residences to be "facilities" within the meaning of the patients' bill of rights); Sheehan v. Superior Ambulance Co., No. 95-59460S, 1998 WL 951041 (Conn. Super. Ct. Dec. 30, 1998) (finding that question of fact existed as to whether defendants had complied with their discharge planning duties under the patients' bill of rights); Pfadt v. Greater Bridgeport Cmty. Mental Health Center, No. 326263, 1996 WL 166410 (Conn. Super. Ct. Feb. 26, 1996) (finding that pleadings did not allege violation of patients' bill of rights where they did not allege violations rising above negligence, but allowing for refiling of amended complaint); Lafleur v. Hogan, No. 89-0371070S, 1993 WL 426155 (Conn. Super. Ct. Oct. 13, 1993) (rejecting claim of patient at Whiting Forensic Division that he was denied adequate treatment).

247. *See, e.g.*, *Mahoney*, 569 A.2d at 531.

248. Interview with Tom Behrendt, Legal Director, Connecticut Legal Rights Project, in Middletown, Conn. (March, 2002).

249. CONN. GEN. STAT. §§ 17a-540 to 550 (2003).

250. CONN. GEN. STAT. § 17a-542 (2003).

251. 569 A.2d 518 (Conn. 1990).

the statute provided a guarantee of only minimally humane and adequate care.[252] Rather, it found that the history of the provision and the statutory text suggested an intent on the part of the legislature to bestow a right to treatment that incorporated "'active intervention of a psychological, biological, physical, chemical, educational, or social nature. . . . [that] is felt to have a reasonable expectation of improving the patient's condition.'"[253] While noting that it could not be expected in every case that such treatment would ultimately prove effective, the Court found that a patient's entitlements under the statute were nevertheless judicially discernable and exceeded minimally humane custodial care.[254]

Unfortunately, the lower court opinions that have followed *Mahoney* have not tended to read its mandate expansively.[255] The lower courts have generally rejected plaintiffs' claims of inadequate treatment, noting that the actions of the defendant institutions did not rise to a level that would constitute a violation of the bill of rights.[256] However, none of those cases have proceeded beyond the Superior Court level and several have clearly relied on faulty legal grounds for their decisions.[257] These faulty cases transposed the standard set by the Supreme Court for claims under a *different* section of the patients' bill of rights to right-to-treatment claims, for which the Court had articulated a separate and much easier to meet standard.[258] Thus these cases would likely have been overturned had they been appealed.[259]

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252. *Id.* at 526.

253. *Id.* at 527 (quoting R. SADOFF, LEGAL ISSUES IN THE CARE OF PSYCHIATRIC PATIENTS: A GUIDE FOR THE MENTAL HEALTH PROFESSIONAL 32 (1982)).

254. *Id.* at 528.

255. *See* Harris v. Scott, No. 99-0090121, 2000 WL 1022873 (Conn. Super. Ct. July 10, 2000) (rejecting claim of patient at forensic facility that he was denied adequate treatment); Zigmond v. Leone, No. 99-0088949, 2000 WL 486853 (Conn. Super. Ct. Apr. 7, 2000) (same); Lafleur v. Hogan, No. 89-0371070 S, 1993 WL 426155 (Conn. Super. Ct. Oct. 13, 1993) (same). *See also* Pfadt v. Greater Bridgeport Community Mental Health Center, No. 326263, 1996 WL 166410 (Conn. Super. Ct. Feb. 26, 1996) (finding that pleadings did not allege violation of patients' bill of rights where they did not allege violations rising above negligence, but allowing for refiling of amended complaint). *But see* Wiseman v. Armstrong, No. 02-0821661S, 2003 WL1227567 (Conn. Super. Ct. Feb. 27, 2003) (finding that patients' bill of rights applies to psychiatric unit of Connecticut correctional facility); Bradley v. Central Naugatuck Valley Help, 25 Conn. L. Rptr. 178 (Super. Ct. 1999) (finding that question of fact existed as to whether defendants had complied with their treatment duties under the patients' bill of rights).

256. *See Harris*, 2000 WL 1022873 at *3; *Zigmond*, 2000 WL 486853 at *2; *Lafleur*, 1993 WL 426155 at *4.

257. *See* Harris v. Scott, No. 99-0090121, 2000 WL 1022873 (Conn. Super. Ct. July 10, 2000); Zigmond v. Leone, No. 99-0088949, 2000 WL 486853 (Conn. Super. Ct. Apr. 7, 2000); Lafleur v. Hogan, No. 89-0371070 S, 1993 WL 426155 (Conn. Super. Ct. Oct. 13, 1993); Pfadt v. Greater Bridgeport Community Mental Health Center, No. 326263, 1996 WL 166410 (Conn. Super. Ct. Feb. 26, 1996); Bradley v. Central Naugatuck Valley Help, 25 Conn. L. Rptr. 178 (Super. Ct. 1999).

258. *See Harris*, 2000 WL 1022873 at *3; *Zigmond*, 2000 WL 486853 at *2. Both of these cases appear to be applying the legal standard adopted by the court in *Mahoney* for consideration of claims arising under § 17-206b (now codified at CONN. GEN. STAT § 17a-541 (2003)), rather than §

There remains, therefore, a substantial basis for asserting claims under the Connecticut patients' bill of rights. In addition to further individual claims that could flesh out the scope of mandated treatment rights, class-wide litigation might well prove successful under the provision, particularly if applied to those parts of Connecticut's mental health system which chronically provide inadequate care. Although the provision facially does not extend to those who are totally excluded from the Connecticut mental health care system, it has been construed quite broadly thus far, and it seems plausible that it might even be interpreted to require the restructuring of the system of care *a la Dixon v. Weinberger*[260] were it raised in the context of class-wide claims.[261]

ii. Discharge Planning Under the Connecticut Patients' Bill of Rights

The Connecticut patients' bill of rights also includes discharge planning requirements that are in some respects similar to those included in the New York statutory scheme.[262] Although not laid out in terms as detailed and obligatory as New York's discharge planning requirements, the discharge planning require-

17-206c (now codified at CONN. GEN. STAT § 17a-542 (2003)). Both make specific reference to the necessity of making a showing exceeding negligence, with one case requiring that the plaintiff allege "wanton, reckless or malicious" action on the part of the defendants. *Harris*, 2000 WL 1022873 at *3. However, the court in *Mahoney* only required a showing that exceeded negligence with regard to § 17-206b, not § 17-206c. *Compare Mahoney*, 569 A.2d at 530 (requiring for § 17-206b that there be a showing exceeding negligence), *with id.* at 528 (requiring for § 17-206c only that "the plaintiff must allege and prove that the hospital failed initially to provide, or thereafter appropriately to monitor, an individualized treatment suitable to his psychiatric circumstances."). While the *Mahoney* court did indicate that the standard under § 17-206c "does not sound in negligence," other parts of the opinion make clear that the court meant simply to distinguish § 17-206c from common law tort causes of action and did not intend to require a showing of willful or malicious misconduct. *See id.* at 520, 522. On the contrary, although the court's opinion is not totally clear on this point, it appears that they held the opposite—that is, that not even a showing of negligence is required in order to state a valid claim under § 17-206c. *See id.* at 522 (upholding that part of the Appellate Court's decision which rejected the defendant's contention that "because a merely negligent failure to afford proper treatment does not constitute a cause of action under 42 U.S.C. § 1983[,] § 17-206c similarly requires allegations rising above negligence.").

259. It is perhaps a cynical observation, but it may be significant that all of the cases in which claims were dismissed or in which defendants were granted summary judgment involved patients at Whiting Forensic Division, a facility for those convicted of crimes or found not guilty by reason of insanity. Given the general hysteria that often surrounds mentally ill criminal offenders, it is possible that this factor colored the outcome of the cases.

260. 405 F. Supp. 974 (D.C. 1975).

261. In *Dixon*, discussed at length in Section III, *supra*, a statute with facially *more* limited applicability than the Connecticut Patient's Bill of Rights was construed by the court as requiring the creation of a system of community treatment and services. The court's reasoning—that the statute required appropriate treatment for all patients, and that community treatment was indicated for many of the hospitalized patients who had brought the suit—would apply equally to the Connecticut patients' bill of rights. If the Connecticut courts did give the bill of rights this type of broad construction, it could provide a very valuable tool in seeking community care, as it would impose an *indefinite* obligation on the state to provide adequate mental health treatment once an individual has entered any branch of the state's system of mental health care.

262. *Compare* CONN. GEN. STAT. § 17a-542 (2003) *with* N.Y. MENTAL HYG. LAW § 29.15 (McKinney 2002).

ments included in Connecticut's patients' bill of rights facially compel some planning for appropriate aftercare, and coordination with the patient in determining the residence to which they will be discharged.[263] Although there are, as of yet, no appellate court decisions affirmatively holding that the discharge planning provisions of the Connecticut patients' bill of rights impose substantive obligations, it seems likely, given the construction of other parts of the statute by the court in *Mahoney*, that they will be found to bestow some kind of affirmative rights.[264] The few lower-court opinions that have ruled on the issue have generally affirmed that effective discharge planning is mandated by the statute, and have allowed actions to proceed where the plaintiff has alleged harm as a result of an inadequate release plan.[265]

Unfortunately, it is likely that the discharge planning provisions of the bill of rights, standing alone, will not provide an entitlement to community care itself, as their requirements are explicitly limited to appropriate planning. However, they could, in requiring the state to effectively plan for placement of dischargees, provide a significant hook into accessing community services and treatment, particularly if, for example, the state supreme court were to find the treatment rights provisions of the patients' bill of rights to be broadly enforceable and applicable on a continuous basis subsequent to the entry of an individual into the mental health system.

B. General Mental Health Statutes

Unlike New York, Connecticut does not have particularly extensive statutes governing the provision of mental health care. Instead, the Connecticut statutes address the question of services and treatment for the mentally ill in a confusing and piecemeal fashion, and generally fail to impose affirmative treatment obligations on the state Department of Mental Health, even on a very general level.[266] As a result, the provisions of the mental health code (with the exception of the patients' bill of rights) have not been the subject of treatment rights

263. CONN. GEN. STAT. § 17a-542 (2003).

264. The one appellate court case to address the discharge planning requirements of the statute dealt solely with the question of whether or not a patient (and her advocate) had a right to actively participate in the process of discharge planning. *See* Phoebe G. v. Solnit, 743 A.2d 606 (Conn. 1999) (finding that patient had a right to participate in discharge planning process and that meaningful discharge planning could not take place without patient input).

265. *See, e.g.*, Sheehan v. Superior Ambulance Co., No. 95-59460S, 1998 WL 951041 (Conn. Super. Ct. Dec. 30, 1998) (finding that question of fact existed as to whether defendants had complied with their discharge planning duties under the patients' bill of rights).

266. *Compare* N.Y. MENTAL HYG. LAW § 7.07(c) (McKinney 2002) (mandating that the New York Office of Mental Health see that "mentally ill persons are provided with care and treatment, [and] that such care, treatment and rehabilitation is of high quality and effectiveness"), *with* CONN. GEN. STAT. § 17a-450(a), (b) (2003) (prescribing only general duty for the Department of Mental Health and Addiction Services to operate facilities and treatment programs).

litigation, and seem unlikely to be of substantial use in future right-to-treatment litigation.

The one possible exception to this is § 17b-232 and § 17b-509. These two interconnected provisions of the code indicate that the state must pay for the cost of community board and care where the director of a state-operated facility transfers a patient to a "private boarding home for mental patients, group home, chronic and convalescent hospital or other residential facility."[267] Under § 17a-509, however, the director's decision to transfer a patient is entirely discretionary, rendering the provisions of little use as a direct legal claim.[268] However, in the event of a successful legal claim (for example under the patients' bill of rights) requiring the directors of state-operated facilities to transfer large numbers of patients to community residences, these provisions would provide a compelling rationale for requiring continued state funding of services.

C. *Other Bases for Relief*

Like New York, several of the potentially viable claims under Connecticut state law arise under provisions that have not been frequently utilized in prior treatment rights litigation. Specifically, it appears possible that successful treatment rights claims might be brought pursuant to the Connecticut State Constitution and Connecticut's anti-discrimination laws. These two potential bases for claims are discussed in turn below.

i. Obligations Under the Connecticut State Constitution

The Connecticut Constitution lacks the kind of affirmative social welfare mandates found in the New York Constitution. As a result, arguments that the state is constitutionally obligated to provide a specific baseline level of services and treatment are considerably more difficult to make in Connecticut than they would be in New York. And indeed, where advocates have attempted to read substantive obligations into some of the Connecticut Constitution's more ambiguous provisions, the Connecticut Supreme Court has generally rejected their efforts, finding no obligation on the part of the state to provide even minimum subsistence-level assistance.[269]

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267. CONN. GEN. STAT. § 17a-509 (2003). *See also* CONN. GEN. STAT. § 17b-232 (2003) (providing that "[where t]he state. . . . authorize[s] the transfer of a resident to a private boarding home for mental patients, group home, chronic and convalescent hospital or other residential facility as provided by section 17a-509, [it] shall pay the cost of the board and care of such mentally ill person".)

268. The statute provides that

> [t]he superintendent or director of any state-operated facility . . . may place any person with psychiatric disabilities committed to such state-operated facility, if such person is no longer in need of active psychiatric treatment in such state-operated facility, in a private boarding home for mental patients . . . or a chronic or convalescent hospital.

CONN. GEN. STAT. § 17a-509 (2003)

269. *See, e.g.*, Hilton v. City of New Haven, 661 A.2d 973 (Conn. 1995) (finding that the

This is not to say, however, that the Connecticut Constitution is insignificant in seeking treatment rights on behalf of the mentally ill. It appears likely that either or both of Connecticut's two equal protection clauses may provide a basis for raising treatment rights claims on behalf of the mentally ill. Both have wording that is substantially distinct from that included in the United States Constitution, and both give rise to plausible textual arguments for treatment rights in the community for the mentally ill. These provisions are discussed in turn below, and evaluated in the context of prior litigation.

1. Article 1, Section 1

The first of Connecticut's equal protection clauses, Article 1, § 1 reads, "[a]ll men when they form a social compact, are equal in rights; and no man or set of men are entitled to exclusive public emoluments or privileges from the community."[270] Clearly, there is a textual argument for differentiating this clause from the equal protection clause of the Fourteenth Amendment and inferring from it more expansively defined rights. Underlying the bar on providing a public emolument or privilege to only a subgroup of state citizens would appear to be the premise "'not only that everyone enjoy equality before the law or have an equal voice in government but also that everyone [should] have *an equal share in the fruits of the common enterprise.*'"[271]

This "equal benefits" interpretation would be considerably broader than the protections bestowed by the Fourteenth Amendment and suggests that Article 1, § 1 might be applied to the disparate treatment of the seriously mentally ill as compared to other groups of comparably situated individuals in the Connecticut statutory scheme. As discussed above, the regulatory scheme established in the Connecticut mental health statutes is patently inadequate; the provisions discussing mental health treatment are scattered, piecemeal, and do not provide the framework for an effective regulatory structure.[272] In contrast, the needs of

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Connecticut Constitution does not impose an obligation on the state to provide shelter for homeless persons); Moore v. Ganim, 660 A.2d 742 (Conn. 1995) (finding that the Connecticut Constitution did not create affirmative obligations for the state to provide basic subsistence level support, and upholding statute providing for termination of public assistance benefits after nine months). *But cf.* Doe v. Maeher, 515 A.2d 134 (Conn. Super. Ct. 1986) (finding a constitutional obligation for the state to fund abortions in some circumstances). The precedential value of *Doe* in the area of constitutionally mandatory social welfare benefits is probably fairly limited. Although the court did find that the state had a constitutional obligation to fund medically necessary abortions for indigent women, the case was never appealed beyond the Superior Court level. In addition, the court in *Doe* explicitly declined to rule on the issue of whether or not the Connecticut Constitution created an independent right to minimally adequate medical care. Instead, the court based its ruling on both statutory grounds and on state constitutional guarantees of due process (privacy) and equal protection (pregnancy/sex discrimination). *See id.* at 148, 162.

270. CONN. CONST. art. I, § 1.

271. Baker v. State, 744 A.2d 864, 875 (Vt. 1999) (quoting W. ADAMS, THE FIRST AMERICAN CONSTITUTIONS 188 (1980) (emphasis added by author of opinion)). *See also* note 279, *infra.*

272. *See generally* CONN. GEN. STAT. tit. 17a, ch. 319i (2003) ("Persons with Psychiatric Disabilities"); CONN. GEN. STAT. tit. 17b (2003) ("Social Services").

other groups that require similar services, such as the elderly and the mentally retarded, are addressed in the Connecticut statutes in terms that are clearly mandatory, and that far more directly lay out the framework of community supports, services and housing to be provided.[273] Appropriations are reflective of this disparity, with funding for community placements for individuals with mental retardation alone amounting to more than half of the total budget of the Department of Mental Health.[274]

Unfortunately, existing Article 1, § 1 jurisprudence suggests that the courts are unlikely to construe it very expansively.[275] The vast majority of statutorily enacted programs that have been challenged under Article 1, § 1 have been deemed acceptable.[276] And indeed, given the profusion and complexity of state-

273. *See, e.g.*, CONN. GEN. STAT. tit. 8, ch. 128 (2003) (Parts VI and VII) (public housing for the elderly); CONN. GEN. STAT. § 17b-4 (2003) ("Department of Social Services: Duties and services provided. Elderly and aging persons"); CONN. GEN. STAT. § 17a-218 (2003) (programs of community-based residential facilities and respite care and emergency placement for persons with mental retardation in residential facilities); CONN. GEN. STAT. § 17a-226 (2003) (day services for adults with mental retardation).

274. *See* CONN. OFFICE OF POLICY & MGMT., GOVERNOR'S MIDTERM BUDGET ADJUSTMENTS C-1 (FY 2002–2003), *available at* http://www.opm.state.ct.us/budget/2003MidTerm/MidTerm Home.htm. As a general matter, the Connecticut Department of Mental Health and Addiction Services (DMHAS) is severely underfunded as compared to the Connecticut Department of Mental Retardation (DMR). According to the DMR figures for 2001, there are an estimated 33,500 people in Connecticut who have mental retardation, of whom approximately 18,500 receive services from the DMR. CONN. DEP'T OF MENTAL RETARDATION, QUEST FOR EXCELLENCE: ANNUAL REPORT (2001) (on file with the author). In contrast, according to the estimates of the state's Blue Ribbon Commission on Mental Health, there are approximately 135,000 people in Connecticut with serious mental illness (not defined in the report, but typically including serious disorders such as schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, and obsessive compulsive disorder); there are also approximately *an additional* 66,000 people who are severely and persistently mentally ill (again, not defined in the report, but typically meaning those who have a serious mental illness that has resulted in frequent contacts with the mental health system and which prevents them from undertaking basic self-care activities like working or applying for public benefits). *See* REPORT OF THE GOVERNOR'S BLUE RIBBON COMMISSION ON MENTAL HEALTH (July 2000), *available at* http://www.dmhas.state.ct.us/blueribbonreport.htm. Counting *all* estimated individuals with mental retardation who reside in Connecticut, the average per-person budget of the Department of Mental Retardation is $21,774. In contrast, counting only those who are seriously or severely and persistently mentally ill, the average per-person budget of the Department of Mental Health and Addiction is $2,217.

275. *See, e.g.*, State v. Angel C., 715 A.2d 652 (Conn. 1998) (rejecting claim that Article 1, § 1 rendered unconstitutional a statute allowing for only discretionary transfers of juveniles charged with felonies from the criminal docket to the juvenile docket, and treating federal and state standards the same for the purposes of equal protection analysis); Moore v. Ganim, 660 A.2d 742 (Conn. 1995) (rejecting argument that statute terminating public assistance after nine months was unconstitutional under Article 1, § 1). *But see* Carilli v. Pension Comm'n of City of Hartford, 220 A.2d 439 (Conn. 1966) (finding city firefighters' pension plan to be unconstitutional because it arbitrarily benefited certain individual firefighters without any concomitant public benefit); Warner v. Gabb, 93 A.2d 487 (Conn. 1952) (finding that act providing retirement credit for WWII veterans who were in the employ of the city prior to WWII, but not for WWII veterans who became employed by the city after the war, violated Article 1, § 1, because it benefited a sub-class arbitrarily).

276. *See e.g.*, *Angel C.*, 715 A.2d at 671; *Moore*, 660 A.2d at 750.

conferred benefits that exist today, it is difficult to imagine that one might construe Article 1, § 1 as requiring equal benefits for all sub-groups of citizens without creating significant legal complexities. However, such a claim might succeed if it were framed as a challenge to the inability of the seriously and persistently mentally ill to have access to the type of supportive housing that has already been created to serve other populations.[277] The plausibility of this type of claim is supported both by the Connecticut courts' willingness to read § 1 more expansively than the federal analogue on a number of occasions,[278] and by the fact that the Vermont courts have given a similar reading to their own textually similar "common benefits" clause.[279] However, although there is some possibility of gaining more expansive rights to community services and treatment under Article 1, § 1, the likelihood of such claims succeeding seems slim.[280]

2. Article 1, Section 20

The second equal protection clause of the Connecticut Constitution, Article 1, § 20, is textually far more similar to the Equal Protection clause of the Fourteenth Amendment than is Article 1, § 1. It provides that "[n]o person shall be denied the equal protection of the law nor be subjected to segregation or discrimination in the exercise or enjoyment of his or her civil or political rights because of religion, race, color, ancestry, national origin, sex or physical or mental disability."[281] This has been interpreted to require strict scrutiny of classifications based on disability (unlike the federal equal protection clause, under

277. It is troubling that there is a Connecticut appellate decision rejecting precisely this type of logic. *See* Foti v. Richardson, 620 A.2d 840 (Conn. App. 1993). However, the plaintiff in *Foti* had raised claims only under Article 1, § 20, which is textually distinguishable from Article 1, § 1 in significant ways. *See* CONN. CONST. art. I, § 1; CONN. CONST. art. I, § 20.

278. *See, e.g., Carilli*, 220 A.2d at 442; *Warner*, 93 A.2d at 488.

279. VT. CONST. CH. 1, ART. 7 (providing that "government is, or ought to be, instituted for the common benefit . . . of the people, . . . and not for the particular emolument or advantage of any single person, family or set of persons."). Most strikingly, the Vermont Supreme Court found that Vermont's common benefits clause prevents the exclusion of gays and lesbians from the benefits associated with state-recognized marital status. Baker v. State, 744 A.2d 864 (Vt. 1999). Although they ultimately decided to allow the legislature the discretion to create a separate institution in lieu of providing full access to the institution of marriage itself, the court did require that the associated state-conferred benefits, privileges and responsibilities be equivalent. *Id.* at 886.

280. It should be noted that irrespective of whether Article 1, § 1 provides a viable legal claim, there may be countervailing considerations that militate against the framing of a claim whose central premise is the unconstitutionality of the disadvantaging of the mentally ill vis-à-vis other disabled or disadvantaged populations. Unless such a claim can be framed in a positive non-zero-sum manner (i.e., as a claim where the requested relief would result in the addition of community services and housing for the mentally ill, not siphoning off of resources from existing populations' services and housing), it might create divisions and acrimony that are not productive to the long term goals of advocates for individuals with mental illness. While it might be possible to frame such a claim positively, it is important to consider whether claims under Article 1, § 1 constitute a productive approach to advocacy.

281. CONN. CONST. art. I, § 20.

which disability classifications are subject only to rational basis review).[282] In addition, the Connecticut Supreme Court has found that the provision's specific concern with *segregation* is significant, and at times requires that the state take far greater measures to prevent the segregation of protected groups than would otherwise be required by the United States Constitution.[283]

Although the importance of the use of the term "segregation" in Article 1, § 20 has not yet been addressed in the context of disability discrimination, the implications of the expansive interpretation that it has been given by the Connecticut Supreme Court in other contexts are clearly highly positive. To the extent that services, treatment and housing for persons with mental illness are provided primarily in the setting of a state hospital, there is a compelling argument for the proposition that such methods of service provision constitute unconstitutional segregation of the mentally disabled by the state.[284]

This argument is buttressed by the fact that Article 1, § 20 was only amended to include physical and mental disability in 1984.[285] While this was prior to the passage of the Americans with Disabilities Act, it was well after the passage of the Rehabilitation Act, which required (and currently requires) that state services be provided in the most integrated setting possible.[286] Therefore,

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282. *Compare* Daly v. Delponte, 624 A.2d 876 (Conn. 1993) (finding that textual differences between state and federal constitutional equal protection clauses justified application of strict scrutiny to classification on the basis of disability), *with* City of Cleburne v. Cleburne Living Ctr., 473 U.S. 432 (1985) (finding that discrimination on the basis of mental retardation was only subject to rational basis review under the federal Equal Protection clause).

283. The most striking instance of this is the court's opinion in *Sheff v. O'Neill*, 678 A.2d 1267 (Conn. 1996). In *Sheff* the court found that the state had a responsibility to remedy de facto racial segregation of the state's schools resulting from factors such as segregated residential patterns. However, it is important to note that the court in *Sheff* specifically observed that it was evaluating the import of Article I, § 20 in light of the specific service at issue, education. *Id.* at 1283. Given that the Connecticut Constitution includes a provision explicitly addressing rights to public education, it is not clear how broadly applicable *Sheff's* finding with regard to Article I, § 20 will be.

284. The Connecticut Constitution's prohibition on mental disability discrimination could be productively applied to other Connecticut state statutes, though a full discussion of these possibilities is beyond the scope of this article. For example, despite its articulated commitment to prohibiting discrimination on the basis of mental disability, Connecticut has a statute that creates an exception to the use of affirmative action to remedy employment discrimination on account of a mental disorder (or a history of mental disorder). *See* CONN. GEN. STAT. § 46a-61 (2003) ("Discriminatory employment practices: Mental disorder exception"). This facially discriminatory provision would have the effect of preventing what are, in other areas (e.g., race and sex), normal measures ordered to remedy systemic or pervasive discrimination on the part of an employer. For example, no matter how pervasive an employer's discriminatory actions were, a court would be barred under § 46a-61 from ordering the employer to make special recruitment efforts aimed at mentally ill (or formerly mentally ill) workers, to implement training programs or support services designed to make the workplace more accommodating to individuals with psychiatric disabilities (beyond the case's actual plaintiffs or plaintiff class), or to order any other non-individual relief.

285. CONN. CONST. art. XXI (adopted November 28, 1984).

286. *See* 28 C.F.R. § 42.503 (2003) (entitled "Discrimination prohibited") (defining what practices constitute discrimination for the purposes of the Rehabilitation Act). The Rehabilitation Act was passed in 1973, Pub. L. No. 93-112, 87 Stat. 355 (1973); the Americans with Disabilities

the amendment's drafters were almost certainly cognizant of the significance of segregation in the context of disability discrimination, and the fact that unnecessary segregation of the disabled can constitute per se discrimination.

Accordingly, there is a substantial basis for arguing that limiting services and treatment primarily to an institutional setting constitutes impermissible and unconstitutional segregation on the part of the state. The implications of this type of finding are complicated, and do not necessarily mandate a right to treatment and services for all individuals with mental illness. They are discussed at greater length below in the context of Connecticut's anti-discrimination statute. However, it is important to observe that there is the potential to make constitutional arguments of this type, and that such arguments may provide an important component of claims for community treatment rights for individuals with mental illness.

ii. Obligations Under Connecticut Anti-Discrimination Laws

In addition to Connecticut's constitutional bar on discrimination on the basis of disability, there are a number of statutory provisions in Connecticut that specifically prohibit disability discrimination. The primary three provisions of this kind are § 46a-71 (prohibiting discriminatory practices by state agencies)[287], § 46a-76 (prohibiting discrimination in the allocation of state benefits)[288], and § 46a-77 (requiring state agencies to comply with the ADA).[289] All three of these provisions may prove useful in seeking treatment rights for mentally ill individuals in Connecticut, particularly rights to treatment and services in a community setting. Below, the types of claims that might be brought pursuant to these statutes are discussed, as are the likely advantages and limitations of any such claims.

Although Connecticut's anti-discrimination provisions contain wording that differs from the wording of the federal ADA and Rehabilitation Act, their thrust appears to be largely the same; discrimination based on disability is prohibited, and is defined or has been construed to include segregation, unequal access, and other forms of disparate treatment and impact.[290] As a result, it is likely that right-to-treatment claims available under Connecticut's anti-discrimination laws will be similar in kind to those available under the ADA and Rehabilitation Act.

Act was passed in 1990, Pub. L. No. 101-336, 104 Stat. 327 (1990).

287. CONN. GEN. STAT. § 46a-71 (2003).

288. CONN. GEN. STAT. § 46a-76 (2003).

289. CONN. GEN. STAT. § 46a-77 (2003).

290. *See* CONN. GEN. STAT. § 46a-71 (2003) (stating that discriminatory practices by state agencies prohibited); CONN. GEN. STAT. § 46a-76 (2003) (stating that state agencies must comply with the ADA). *See also* CONN. GEN. STAT. § 46a-51 (2003) (indicating that discrimination "includes segregation and separation"); Levy v. Comm'n on Human Rights & Opportunities, 671 A.2d 349 (Conn. 1996) (holding that disparate treatment and disparate impact theories of liability can be pursued under Connecticut's state anti-discrimination laws).

This means that *Olmstead*-type[291] claims, arguing that the failure to provide community treatment leads to discriminatory segregation of the mentally disabled, are likely to prove viable and to provide the primary basis for raising community right-to-treatment claims under Connecticut's anti-discrimination laws. Secondly, claims challenging the inaccessibility of social services and medical assistance programs may also be viable, and could provide a substantial basis for seeking community treatment and support services, as they would allow individuals with mental illness to better take advantage of existing resources.[292]

Since the claims available under § 46a-71, § 46a-76, and § 46-77 are likely to be similar if not identical to those already being brought under federal anti-discrimination laws, it is not immediately apparent why it would be advantageous to utilize state, rather than federal law. There are two primary reasons for preferring Connecticut's state anti-discrimination statutes: 1) given the specifics of Connecticut's anti-discrimination statutes, they will always provide at least as extensive protections as the ADA; and 2) Connecticut's state anti-discrimination laws can be read contextually in a way that the ADA cannot be. As discussed below, these two advantages could provide significant benefits in bringing claims.

Section 46a-77 of the Connecticut code requires that agencies comply with the ADA wherever it is interpreted to provide greater protections than those otherwise provided for by state law.[293] As a result, protections under Connecticut's state statutes can never fall below the baseline set by federal courts' interpretation of the ADA's mandates. On the other hand, Connecticut courts are free to construe their state statutes to *exceed* the protections offered by the ADA; therefore, Connecticut's anti-discrimination statutes have a greater potential for positive growth than the federal ADA. While none of Connecticut's anti-discrimination provisions have been subject to extensive litigation as of yet, it is certainly plausible that they may be construed to offer significantly broader protections.

The likelihood that Connecticut's anti-discrimination statutes will be construed broadly is enhanced by the fact that they can be read contextually as reinforcing, and being reinforced by, other complimentary provisions of the Connecticut code. For example, Connecticut state social services law expresses a clear preference for coordinated and integrated provision of social services.[294]

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291. *See supra* notes 65–70 and accompanying text.

292. *See supra* Section II for a more extensive discussion of advantages and limitations of these types of treatment rights claims under the ADA and Rehabilitation Act.

293. *See* CONN. GEN. STAT. § 46a-77(c) (2003) ("Each state agency shall comply in all of its services, programs and activities with the provisions of the Americans with Disabilities Act (42 USC 12101) to the same extent that it provides rights and protections for persons with physical or mental disabilities beyond those provided for by the laws of this state.").

294. *See, e.g.*, CONN. GEN. STAT. § 4b-31(e) (2003) ("Human services shall be provided, wherever feasible, through collocated sites that promote accessibility and integration of services . . . ."); CONN. GEN. STAT. § 17b-3 (2003) ("The commissioner [of Social Services] shall have the power and duty to . . . act as advocate for the need of more comprehensive and co-

In this context, claims under the state anti-discrimination law seeking the provision of accessible and coordinated services and treatment are buttressed by the state's existing statutory preference. Similarly, the anti-segregation mandate of the state's anti-discrimination laws is nicely complemented by the patients' bill of rights' requirement that all individuals be provided with treatment that is suited to his or her particular needs, including, in many cases, community treatment.[295]

It is therefore likely that successful claims to improved treatment and services, particularly community treatment and services, could be brought pursuant to Connecticut's anti-discrimination laws. Connecticut's laws are by definition at least as expansive as the ADA, and could be read as significantly broader. It should be noted, however, that Connecticut's anti-discrimination laws are unlikely to be construed so broadly as to totally eliminate the major limitation of the federal anti-discrimination statutes, namely their failure to address the baseline inadequacy of the level of treatment and services provided by the state.

D. Conclusions

A detailed survey of Connecticut's state laws both 1) confirms several of the conclusions that were suggested by a nationwide survey of treatment rights litigation, and 2) highlights the degree of likely variability from state to state in the available legal bases for claims. Most notably, the primacy of Connecticut's state bill of rights statute reinforces the conclusion that in many states, bill of rights statutes or DMH/DMR statutes will be the most effective legal weapons available to litigators. However, the other potential legal claims available under Connecticut state law (i.e., anti-discrimination and equal protection claims) have not been commonly utilized in other states and reinforce the need to search broadly for potential legal bases for claims.

These anti-discrimination and equal protection claims additionally highlight the fact that in certain instances available claims under federal and state law will overlap. As a result, litigators will be faced with making strategic choices regarding the preferability of state law claims as compared to federal law claims. Connecticut law suggests that even where facially similar, such laws may have different substantive scope. In addition, it suggests that other factors, such as the availability of supporting arguments from the jurisdiction's other statutory or constitutional provisions, should be considered in determining the viability of claims.

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ordinated programs for persons served by the department . . . ."); CONN. GEN. STAT. § 17b-606 (2003) ("The Department of Social Services shall be the lead agency for services to persons with physical or mental disabilities and shall coordinate the delivery of such services by all state agencies servicing people with disabilities.").

295. *See generally* CONN. GEN. STAT. § 17a-542 (2003).

In the following section the implications of Connecticut right-to-treatment law are considered jointly with the implications of the broad survey of treatment rights cases and the survey of New York state law. All of these surveys are evaluated together in order to suggest conclusions regarding the likelihood that state law may prove to be broadly viable as a means of seeking treatment rights for individuals with mental illness.

VI.
CONCLUSIONS

Despite decades of litigation focused on federal law, most states continue to lack adequate treatment and services for individuals with mental illness. It is clear, therefore, that new approaches to seeking treatment rights for the mentally ill are required. The most obvious potential alternative approach is to make increased use of the broad body of state law that has so far remained relatively underutilized in treatment rights litigation. This article has evaluated the potential viability of this state law approach by surveying prior state-law right-to-treatment litigation, and by performing detailed evaluations of state law grounds for claims in two states, Connecticut and New York. All three areas evaluated suggest that, in many cases, state law claims will provide a more effective litigation tool than currently available federal alternatives. An examination of the three together also suggests some of the reasons why this may be so, as well as some of the difficulties that are likely to be encountered in raising state law claims.

There are numerous reasons why, in many jurisdictions, state law claims are likely to provide an improved basis over federal law claims for seeking treatment rights for the mentally ill. Most notably, state laws simply deal in far more extensive detail with issues that are pertinent to treatment rights claims. Most states, for example, have extensive statutes setting out the duties and powers of the state Department of Mental Health. These statutes can provide a rich basis for asserting legal claims, as they often impose obligations on the state to provide treatment and services in a variety of settings. Similarly, some states have constitutional and/or statutory social services obligations that are unparalleled in federal law and which can provide a significant basis for asserting treatment rights claims.

Furthermore, even inasmuch as state law claims substantively mirror previously or currently utilized federal claims, prior treatment rights litigation suggests that they may nevertheless provide a far more extensive basis for asserting treatment rights claims. This is most clearly demonstrated by the overwhelming success of claims brought under state mental illness bills of rights. Many states' mental illness bills of rights have formed the basis for highly successful claims, even providing the legal foundation for a significant overhaul of some states' systems of mental health. In contrast, the federal mental illness bill of rights has not formed the basis for successful claims.

It appears, therefore, that state law claims are likely to provide a strong basis for seeking treatment rights in many jurisdictions. Just how strong a basis will vary, obviously, by state. While a survey of case law suggests that there are a few primary types of statutory provisions that are likely to be available in many states (most notably, claims based on the mental health statutes and patients' bill of rights), many other types of statutory and constitutional provisions are specific to a certain sub-class of jurisdictions or to a single jurisdiction. Furthermore, as demonstrated by prior right-to-treatment litigation, state courts often treat even textually similar statutes and constitutional provisions quite differently. For example, there has been a high degree of variability in the degree to which state courts have interpreted similar provisions as permissive or mandatory, and in the treatment of similar explicit funding limitations.

Impact litigators who have the luxury of selecting fora and fact patterns can, of course, maximize their chances of success by carefully examining the relevant statutory, constitutional and case law landscape in any potential forum. The history of state-law treatment-rights litigation suggests that several factors may be of particular importance in evaluating the benefits of a given jurisdiction. In particular, an examination of whether state courts have found social service rights-creating language (inside or outside the mental health context) to be mandatory or precatory, and how the courts have treated funding limitations as a defense, may provide an important insight into the likely success of claims.

Other litigation-framing tactics may help to maximize the success of claims wherever brought. First, prior case law suggests that claims are most likely to succeed when the state's professionals have recommended treatment or services that are not being provided, or when the state has failed to implement a plan to provide the requested treatment or services. In contrast, where the state is making some affirmative attempts to provide the requested treatment or services, courts are far more likely to afford it some leeway and find that it is acting within its range of discretion. Second, the ordering or joining of claims may be very important in determining the viability of the claim and the scope of relief. Basing claims on multiple, intersecting statutory and/or constitutional provisions may succeed where more discrete claims would fail or provide only piecemeal relief.

Finally, where a state has raised an appropriations-based defense, the burden of proof should be vigorously litigated. Where claims of insufficient funds are treated as a defense that must be proven by the state, they will be less likely to succeed. There are strong arguments why these claims should always be treated as defenses that must be proven, most notably that accepting a state's assertions at face value would allow it to violate any and all affirmative statutory mandates at will. Similarly, arguments can be made that limitations in appropriations should not, of themselves, be able to alter the substance of statutory mandates: rule of law values strongly support disallowing any alteration in the substance of statutory obligations as a result of funding limitations.

There are, then, substantial reasons for believing that state law claims may provide a strong basis for treatment rights claims brought on behalf of individuals with mental illness. Although there is likely to be significant variation from state to state in the availability and likely viability of such claims, prior state law litigation suggests numerous ways to mitigate the impact of this variation. Given the breadth of relief awarded in prior state-law-based right-to-treatment litigation, state law claims are clearly worth evaluating in most jurisdictions, and in many jurisdictions, are likely to provide a far stronger basis for right-to-treatment claims than federal law.

APPENDIX A:
METHODOLOGY AND EXCLUSIONS FOR SURVEY OF STATE LAW LITIGATION

Four primary methods were utilized to locate state-law-based right-to-treatment claims. First, major sources such as law review articles, treatises and American Jurisprudence sections were surveyed in order to obtain an initial list of relevant cases.[296] Following that, Westlaw and LEXIS searches were conducted of all state court decisions using common keywords and phrases found in right-to-treatment litigation. From the initial list of cases obtained from these two survey methods, additional cases were located by examining cases cited in and citing to major right-to-treatment decisions. Finally, the West key number digest system was utilized to locate decisions that were classified similarly to major treatment rights decisions.

Certain categories of decisions were then excluded from this broad group of cases. The major exclusions were: 1) decisions in cases involving mentally disabled populations whose treatment rights are typically governed by distinct and non-comparable statutory provisions and/or case law (e.g., non-dually-diagnosed substance abusers and sexually dangerous predators);[297] 2) decisions in cases involving juveniles, unless the basis for claims was explicitly extendable to adult populations;[298] 3) federal court decisions[299] interpreting state laws;[300] 4)

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296. Major sources surveyed in order to obtain an initial list of relevant cases included: 53 AM. JUR. 2D, *Mentally Impaired Persons* §§ 107, 110 (2d ed. 1999); SAMUEL JAN BRAKEL, JOHN PARRY & BARBARA A. WEINER, THE MENTALLY DISABLED AND THE LAW (3d ed. 1985); MICHAEL L. PERLIN, MENTAL DISABILITY LAW (2d ed. 1999); Paul S. Appelbaum, *Resurrecting the Right to Treatment*, HOSP. & COMMUNITY PSYCH. 703 (1987); Jonathan P. Bach, *Requiring Due Care in the Process of Patient Deinstitutionalization: Toward a Common Law Approach to Mental Health Care Reform*, 98 YALE L.J. 1153 (1989); Latisha R. Brown, *The McKinney Act: Revamping Programs Designed to Assist the Mentally Ill Homeless*, 33 COLUM. J.L. & SOC. PROBS. 235 (2000); Alan Meisel, *The Rights of the Mentally Ill Under State Constitutions*, 45 LAW & CONTEMP. PROBS. 7 (1982); Michael Perlin, *State Constitutions and Statutes as Sources of Rights for the Mentally Disabled: The Last Frontier?*, 20 LOY. L.A. L. REV. 1249 (1987); Nancy K. Rhoden, *The Limits of Liberty: Deinstitutionalization, Homelessness, and Libertarian Theory*, 31EMORY L.J. 375 (1982); Sidney D. Watson, *Discharges to the Streets: Hospitals and Homelessness*, 19 ST. LOUIS U. PUB. L. REV. 357 (2000); Antony B. Klapper, Comment, *Finding a Right in State Constitutions for Community Treatment of the Mentally Ill*, 142 U. PA. L. REV. 739 (1993); Robin Cheryl Miller, Annotation, *Construction and Application of State Patient Bill of Rights Statutes*, 87 A.L.R. 5TH. 277 (2001).

297. *See, e.g.*, *In re* Clinton Royal, 495 S.E.2d 404 (N.C. Ct. App. 1998); McGraw v. Hansbarger, 301 S.E.2d 848 (W. Va. 1983).

298. *See, e.g.*, *In re* Ellery C., 300 N.E.2d 424 (N.Y. 1973); *In re* Frederick F., 583 A.2d 1248 (Pa. Super. Ct. 1990).

299. The only two exceptions to this exclusion rule are cases from the District of the District of Columbia and D.C. Circuit decided at the time when the federal government and the D.C. government had joint responsibility for the provision of mental health care to District of Columbia residents. These cases were included in the analysis, as the federal courts had a jurisdictional basis lacking in other federal court cases interpreting state law.

300. *See, e.g.*, Pennhurst State Sch. & Hosp. v. Halderman, 465 U.S. 89 (1984); Ass'n for Retarded Citizens of N.D. v. Olson, 713 F.2d 1384 (8th Cir. 1983); Rone v. Fireman, 473 F. Supp.

minor procedural decisions that were a part of larger litigation addressing state right-to-treatment claims;[301] 5) decisions that mention state law right-to-treatment issues, but that were not ultimately decided on those grounds;[302] and 6) decisions where the legal basis on which the court rested its judgment is not at all clear.[303]

While the author attempted to be as thorough as possible in locating state-law-based cases, it is likely that there were cases that were missed in this survey, particularly unappealed lower or intermediate court decisions, or cases in which state law treatment claims were only a minor part of the litigation. In addition, it should be noted that the survey was conducted in February of 2002, and is only current as of that date.

92 (N.D. Ohio 1979).

301. *See generally* footnotes in Appendix B, *infra*.

302. *See, e.g.*, Kesselbrenner v. Anonymous, 305 N.E.2d 903 (N.Y. 1973).

303. *See, e.g.*, Nason v. Superintendent of Bridgewater State Hosp., 233 N.E.2d 908 (Mass. 1968).

APPENDIX B:
STATE LAW RIGHT-TO-TREATMENT CASES

The first parenthetical following the case citation indicates the types of state law claims that were raised in the case. Claims that were clearly not reached by the court are omitted. Types of claims are coded as follows: MH = mental health or mental retardation statutes; BR = bill of rights statutes; SS = social services or general medical assistance statutes; AS = anti-discrimination statutes; CS = social welfare constitutional provisions; CO = all other constitutional provisions; C = commitment statutes; O = other or legal basis for decision unclear.

Cases marked with an (S) are "successful" state law cases. In general, decisions on motions for summary judgment and motions to dismiss were considered to have been "successful" if the major questions of law raised regarding the enforceability of at least one of the state law treatment rights claims went in the plaintiffs favor. Decisions where the issue was a purely factual evaluation of whether plaintiffs were entitled to relief under previously established treatment rights claims were considered "successful" if the plaintiffs prevailed on the factual determination.

Cases marked with an (I) ("indeterminate cases") are those cases where any success achieved by the plaintiffs was too limited to consider the decision a success, but which were not properly classifiable as unsuccessful either. Typically these cases were cases where either: 1) the court ruled against the plaintiffs on some point of law but reaffirmed the vitality of a previously established treatment rights claim, and left open the possibility that the plaintiffs would prevail on that claim on remand; or 2) the decision had been mooted by the time of the appeal due to the state's decision in the interim to provide the requested services or treatment.[304]

ALABAMA
None

ALASKA
None

ARIZONA
Arnold v. Arizona Dep't of Health Services, 775 P.2d 521 (Ariz. 1989) (MH/SS) (S)

304. These cases were excluded from the calculation of the proportion of successful claims. *See supra* Section III.

ARKANSAS

None

CALIFORNIA

Ass'n for Retarded Citizens v. Dep't of Developmental Services, 696 P.2d 150 (Cal. 1985) (MH/BR) (S)

Clemente v. Amundson, 70 Cal. Rptr. 2d 645 (Ct. App. 1998) (MH/BR) (S)

Williams v. Macomber, 276 Cal. Rptr. 267 (Ct. App. 1991) (MH/BR) (S)

COLORADO

Goebel v. Colorado Dep't of Insts., 764 P.2d 785 (Colo. 1988)[305] (MH) (S)

CONNECTICUT

Mahoney v. Lensink, 569 A.2d 518 (Conn. 1990) (BR) (S)

Cameron v. Alander, 664 A.2d 332 (Conn. App. Ct. 1995) (MH)

Wiseman v. Armstrong, No. 02-0821661S, 2003 WL1227567 (Conn. Super. Ct. Feb. 27, 2003)[306] (BR) (S)

Harris v. Scott, No. 99-0090121, 2000 WL 1022873 (Conn. Super. Ct. July 10, 2000) (BR)

Zigmond v. Leone, No. 99-0088949, 2000 WL 486853 (Conn. Super. Ct. Apr. 7, 2000) (BR)

Bradley v. Cent. Naugatuck Valley Help, 25 Conn. L. Rptr. 178 (Super. Ct. 1999)[307] (BR) (S)

Foti v. Richardson, 620 A.2d 840 (Conn. App. Ct. 1993) (AS/CO)

Sheehan v. Superior Ambulance Co., No. 95-59460 S, 1998 WL 951041 (Conn. Super. Ct. Dec. 30, 1998)[308] (BR) (S)

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305. For additional proceedings in *Goebel* not counted separately for the purposes of the survey see *Goebel v. Benton*, 830 P.2d 995 (Colo. 1992) (overruling denial of plaintiffs' motion for recusal of trial judge, and finding that recusal was required as a matter of law) and *Goebel v. Colorado Dep't of Institutions*, 830 P.2d 1036 (Colo. 1992) (finding that class as certified by the trial court was defined too narrowly).

306. For additional proceedings in *Wiseman* not counted separately for the purposes of the survey see *Wiseman v. Armstrong*, No. 02-0821661S, 2003 WL 1908939 (Conn. Super. Ct. Mar. 21, 2003) (denying reconsideration of original decision).

307. For additional proceedings in *Bradley* not counted separately for the purposes of the survey see *Bradley v. Central Naugatuck Valley Help*, No. 95-0126436S, 1997 WL 112770 (Conn. Super. Ct. Feb. 20, 1997) (denying motion to dismiss claims against individual defendants in their official capacity).

308. For additional proceedings in *Sheehan* not counted separately for the purposes of the survey see *Sheehan v. Superior Ambulance Co.*, No. 95-59460S, 1998 WL 951041 (Conn. Super. Ct. Nov. 19, 1996) (granting state hospital's motion to dismiss third party plaintiff Superior Ambu-

Pfadt v. Greater Bridgeport Cmty. Mental Health Ctr., No. 326263, 1996 WL 166410 (Conn. Super. Ct. Feb. 26, 1996) (BR)
Lafleur v. Hogan, No. 89-0371070 S, 1993 WL 426155 (Conn. Super. Ct. Oct. 13, 1993) (BR)

DELAWARE
None

DISTRICT OF COLUMBIA
Covington v. Harris, 419 F.2d 617 (D.C. Cir. 1969) (BR) (S)
Rouse v. Cameron, 373 F.2d 451 (D.C. Cir. 1967) (BR) (S)
Tribby v. Cameron, 379 F.2d 104 (D.C. Cir. 1967) (BR) (S)
Dobson v. Cameron, 383 F.2d 519 (D.C. Cir. 1967) (BR) (S)
District of Columbia v. In the Matter of H.J.B., 359 A.2d 285 (D.C. 1976) (BR) (I)
Dixon v. Weinberger, 405 F. Supp. 974 (D.C. 1975)[309] (BR) (S)
In Re Henry Jones, 338 F. Supp. 428 (D.C. 1972) (BR) (S)

FLORIDA
None

GEORGIA
None

HAWAII
None

IDAHO
None

ILLINOIS
Dixon Ass'n for Retarded Citizens v. Thompson, 440 N.E.2d 117 (Ill. 1982) (BR)

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lance Co.'s complaint as Superior Ambulance Co. could not invoke bill of rights waiver of sovereign immunity as a non-patient).

309. For additional proceedings in *Dixon* not counted separately for the purposes of the survey see *Dixon v. Barry*, 967 F. Supp. 535 (D.C. 1997) (placing the D.C. mental health system in receivership as a result of chronic non-compliance with the court's orders in the litigation) and *Dixon v. Kelly*, CA No. 74-285, 1993 U.S. Dist. LEXIS 6511 (D.C. 1993) (ruling on motion for contempt).

INDIANA
Y.A. by Fleener v. Bayh, 657 N.E.2d 410 (Ind. Ct. App. 1995) (MH/CS)

IOWA
Baker v. Webster County, 487 N.W.2d 321 (Iowa 1992) (MH)

KANSAS
None

KENTUCKY
None

LOUISIANA
None

MAINE
None

MARYLAND
None

MASSACHUSSETS
Williams v. Sec'y of the Executive Office of Human Servs., 609 N.E.2d 447 (Mass. 1993) (MH/CO)
In the Matter of McKnight, 550 N.E.2d 856 (Mass. 1990) (O) (S)

MICHIGAN
None

MINNESOTA
None

MISSISSIPPI
None

MISSOURI
None

MONTANA
None

NEBRASKA
None

NEVADA
None

NEW HAMPSHIRE
Petition of Brenda Strandell, 562 A.2d 173 (N.H. 1989) (BR)
State v. Brosseau, 470 A.2d 869 (N.H. 1983) (BR) (S)
Chasse v. Banas, 399 A.2d 608 (N.H. 1979) (BR) (S)

NEW JERSEY
P.F. and B.F. on Behalf of B.F. v. New Jersey Div. of Developmental Disabilities, 656 A.2d 1 (N.J. 1995) (MH) (S)
Mr. And Mrs. J.E. on Behalf of G.E. v. New Jersey Dep't of Human Services, 622 A.2d 227 (N.J. 1993) (MH) (S)
New Jersey Ass'n for Retarded Citizens v. New Jersey Dep't of Human Servs., 445 A.2d 704 (N.J. 1982) (MH) (S)
Application for Writ of Habeas Corpus by D.D., 285 A.2d 283 (N.J. 1971) (BR) (S)
J.D. by D.D.H. v. New Jersey Div. of Developmental Disabilities, 748 A.2d 613 (N.J. Super. Ct. App. Div. 2000) (MH)
S.I. by G. and S.I. v. New Jersey Div. of Developmental Disabilities, 626 A.2d 466 (N.J. Super. Ct. App. Div. 1993) (MH) (I)
Rosen by Rosen v. New Jersey Div. of Developmental Disabilities, 607 A.2d 1030 (N.J. Super. Ct. App. Div. 1992) (MH) (S)
T.L. v. New Jersey Div. of Developmental Disabilities, 580 A.2d 272 (N.J. Super. Ct. App. Div. 1990) (MH) (S)
In the Matter of the Commitment of B.R., 494 A.2d 333 (N.J. Super. Ct. App. Div. 1985) (MH) (I)
In the Interest of R.G.W., 366 A.2d 1375 (N.J. Juv. & Dom Rel. Ct. 1976) (MH/BR) (S)

NEW MEXICO
None

NEW YORK
Savastano v. Prevost, 485 N.E.2d 213 (N.Y. 1985) (MH/BR)

Klostermann v. Cuomo, 463 N.E.2d 588 (N.Y. 1984), on remand, Klostermann v. Cuomo, 481 N.Y.S.2d 580 (Sup. Ct. 1984)[310] (MH/CS/CO) (S)

Koskinas v. Carillo, 625 N.Y.S.2d 546 (App. Div. 1995) (MH) (I)

Adriane A. v. Cuomo, 624 N.Y.S.2d 7 (App. Div. 1995) (MH)

Love v. Koch, 554 N.Y.S.2d 595 (App. Div. 1990) (MH/CS) (S)

McWilliams v. Catholic Diocese of Rochester, 536 N.Y.S.2d 285 (App. Div. 1988) (MH)

Bowen v. State Board of Social Welfare, 390 N.Y.S.2d 617 (App. Div. 1976), *rev'd sub nom.* Jones v. Beame, 380 N.E.2d 277 (N.Y. 1978) (MH)

Brad H. v. City of New York, 712 N.Y.S.2d 336 (Sup. Ct. 2000), *summarily aff'd*, Brad H. v. City of New York, 716 N.Y.S.2d 852 (App. Div. 2000)[311] (MH) (S)

Alexander L. v. Cuomo, 588 N.Y.S.2d 85 (Sup. Ct. 1991) (SS) (S)

Heard v. Cuomo, 567 N.Y.S.2d 594 (Sup. Ct. 1991), *summarily aff'd*, Heard v. Cuomo, 578 N.Y.S.2d 417 (App. Div. 1992), *aff'd in part*, Heard v. Cuomo, 610 N.E.2d 238 (N.Y. 1993)[312] (MH) (S)

Besunder v. Coughlin, 422 N.Y.S.2d 564 (Sup. Ct. 1979) (MH) (S)

Renelli v. Dep't of Mental Hygiene, 340 N.Y.S.2d 498 (Sup. Ct. 1973) (MH) (S)

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310. For additional proceedings in *Klostermann* and in a companion case, *Joanne S. v. Carey*, that are not counted separately for the purposes of the survey, see *Klostermann v. Carey*, 467 N.Y.S.2d 1025 (N.Y. 1983) (granting motion for leave to appeal); *Joanne S. v. Carey*, 457 N.E.2d 802 (N.Y. 1983) (granting motion for leave to appeal); *Joanne S. v. Carey*, 498 N.Y.S.2d 817 (App. Div. 1986) (overruling order granting joinder of city defendants on the grounds that the primary responsibilities at issue in the lawsuit ran to the state); *Joanne S. v. Carey*, 462 N.Y.S.2d 808 (App. Div. 1983) (summarily affirming the decision of the Supreme Court); *Klostermann v. Carey*, 458 N.Y.S.2d 190 (App. Div. 1982) (summarily affirming the decision of the Supreme Court); *Joanne S. v. Carey*, No. 777 (N.Y. Sup. Ct. February 1, 1983) (dismissing action as non-justiciable); and *Klostermann v. Carey*, No. 571 (N.Y. Sup. Ct. October 14, 1982) (dismissing action as nonjusticiable).

311. For additional proceedings in the *Brad H.* litigation that are not counted separately for the purposes of this survey see Brad H. v. City of New York, 729 N.Y.S.2d 348 (Sup. Ct. 2001) (Plaintiff's motion for discovery granted).

312. For additional proceedings in the *Heard* litigation that are not counted separately for the purposes of this survey see *Heard v. Cuomo*, 581 N.Y.S.2d 259 (App. Div. 1992) (defendant's motion for leave to appeal to the Court of Appeals granted); *Heard v. Cuomo*, 554 N.Y.S.2d 234 (App. Div. 1990) (holding that where report prepared by plaintiffs regarding compliance of the city and state with discharge planning requirements was based on redacted service plans revealed through discovery, it was not a breach of confidentiality to release the report to the public); *Heard v. Cuomo*, No. M-2107, 1989 N.Y. App. Div. LEXIS 7799 (App. Div. May 23, 1989) (denying motion to vacate stay or for alternate interim relief); *Heard v. Cuomo*, 531 N.Y.S.2d 253 (App. Div. 1988) (reversing denial of request for order requiring production of representative sample of discharge plans on the grounds that there was a "public necessity" for them to be disclosed); and Heard v. Cuomo, 526 N.Y.S.2d 760 (Sup. Ct. 1988) (denying request for an order requiring production of a representative sample of discharge plans by the state).

Usen v. Sipprell, 336 N.Y.S.2d 848 (Sup. Ct. 1972), *rev'd in part*, 342 N.Y.S.2d 599 (App. Div. 1973) (O) (S)
In the Matter of David M., 354 N.Y.S.2d 80 (Fam. Ct. 1974) (O) (S)
In the Matter of Leopoldo Z., 358 N.Y.S.2d 811 (Fam. Ct. 1974) (O) (S)
In the Matter of Graham S., 356 N.Y.S.2d 768 (Fam. Ct. 1974) (MH/CS) (S)

NORTH CAROLINA
None

NORTH DAKOTA
Mullins v. North Dakota Dep't of Human Servs., 483 N.W.2d 160 (N.D. 1992) (BR) (I)
In the Interest of J.A.L. v. J.A.L., 432 N.W.2d 876 (N.D. 1988) (BR)

OHIO
In re Hamil, 431 N.E.2d 317 (Ohio 1982) (C)
In re Blackman, 627 N.E.2d 1049 (Ohio Ct. App. 1993) (O) (S)

OKLAHOMA
None

OREGON
None

PENNSYLVANIA
In re Schmidt, 429 A.2d 631 (Pa. 1981) (MH) (S)
City of Philadelphia v. Pennsylvania, 564 A.2d 271 (Pa. Commw. Ct. 1989) (MH) (S)
In re Sauers, 447 A.2d 1132 (Pa. Commw. Ct. 1982) (MH) (S)

RHODE ISLAND
Rhode Island Dep't of Mental Health, Retardation & Hosps. v. Doe, 533 A.2d 536 (R.I. 1987) (C)

SOUTH CAROLINA
None

SOUTH DAKOTA
None

TENNESSEE
None

TEXAS
None

UTAH
None

VERMONT
In re Judicial Review of C.H., 559 A.2d 694 (Vt. 1989) (C) (S)
In re R.A., 501 A.2d 743 (Vt. 1985) (C) (S)
In re V.C., 505 A.2d 1214 (Vt. 1985) (C)
In re M.G., 408 A.2d 653 (Vt. 1979) (C) (S)

VIRGINIA
None

WASHINGTON
None

WEST VIRGINIA
E.H. v. Matin, 284 S.E.2d 232 (W.Va. 1981)[313] (BR) (S)

WISCONSIN
In the Matter of D.E.R. v. La Crosse County, 455 N.W.2d 239 (Wis. 1990) (BR/C) (S)

WYOMING
None

313. For additional proceedings in the *E.H. v. Matin* litigation that are not counted separately for the purposes of this survey see *E.H. v. Matin*, 432 S.E.2d 207 (W. Va. 1993) (ordering continued court monitoring of overhaul of state mental heath system) and *E.H. v. Matin*, 428 S.E.2d 523 (W. Va. 1993) (reversing order granting injunction preventing construction of a new mental hospital).