ABANDONED BUT NOT FORGOTTEN: THE ILLEGAL CONFINEMENT OF ELDERLY PEOPLE IN STATE PSYCHIATRIC INSTITUTIONS

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Elderly patients are mostly kept. They are kept alive. They are kept drugged and they are kept quiet. The one thing they are not kept is involved. For the elderly, the price of this enforced passivity is their dignity, their privacy and very commonly their will to live.[1]

INTRODUCTION

In the years preceding the height of deinstitutionalization of public psychiatric hospitals, twenty-eight percent of the residents were elderly.[2] As the deinstitutionalization movement gained momentum, many elderly residents were either transinstitutionalized to nursing homes or released into the community. For a time, the percentage of elderly people in psychiatric hospitals dropped dramatically, but many elderly people remained confined involuntarily in state and county psychiatric hospitals. As the numbers of elderly people admitted to a hospital for the first time increased, the percentage of psychiatric hospital residents who are elderly rose to the point where over a quarter of all residents currently in public psychiatric hospitals are elderly.[3] Thus despite three decades of deinstitutionalization, long-term care of elderly

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1. SENATE SPECIAL COMM. ON AGING, DEVELOPMENTS IN AGING: 1987, S. REP. NO. 291, 100th Cong., 1st Sess. 29-30 (1987) [hereinafter DEVELOPMENTS IN AGING: 1987].

2. SYLVIA SHERWOOD & VINCENT MOR, *Mental Health Institutions and the Elderly, in* HANDBOOK OF MENTAL HEALTH AND AGING 854, 857 (James E. Birren & R. Bruce Sloane eds., 1980).

3. According to the most recent data available, 27% of residents of public psychiatric hospitals are elderly. Twenty-seven percent represents more than double the 12% of the elderly's representation in the general population. DEVELOPMENTS IN AGING: 1985, A REPORT OF THE SPECIAL COMMITTEE ON AGING, S. REP. NO. 242, 99th Cong., 1st Sess. 195 (1985). *See also* WALTER BARTON & GAIL BARTON, MENTAL HEALTH ADMINISTRATION: PRINCIPLES AND PRACTICES (1983) (persons over 65 consume one-quarter of all health services).

people remains one of the primary functions of the state hospital.[4]

Elderly people constitute the most rapidly growing segment of our population. Largely because of fluctuating birth rates and advances in medicine which have effectively eliminated early deaths due to contagious diseases, the number of people over sixty-five has increased threefold in the past decade alone.[5] Not only has the absolute number of elderly individuals increased dramatically in recent years, but their proportion of the general population has increased as well. In 1900, only three million people, or four percent of the population, was over sixty-five; in 1990, over thirty-one million people, or almost thirteen percent of the population, was over the age of sixty-five; and by the year 2000, that number is expected to climb to approximately thirty-five million people or one quarter of the population will be over sixty-five as the "baby boom" generation enters old age.[6] Not only are more people growing old today, but once they reach old age, they are living longer.[7] In 1950 the average life expectancy was 68.2 years. In 1985 the average life expectancy increased to 74.9 years,[8] and by the middle of the twenty-first century, it is estimated that sixteen million Americans, or slightly over five percent of the total population, will be 85 or over.[9]

When considering these statistics about the "elderly," it is important to

4. SURVEY & REPORTS BRANCH, DIVISION OF BIOMETRY & APPLIED SCIENCES, NIMH, ADDITIONS AND RESIDENT PATIENTS AT END OF YEAR, STATE AND COUNTY MENTAL HOSPITALS BY AGE AND DIAGNOSIS, BY STATE, UNITED STATES, 1984, ROCKVILLE, MD (1987). *See also* Gary Moak & William H. Fisher, *Geriatric Patients and Services in State Hospitals: Data From a National Survey*, 42 HOSP. AND COMM. PSYCHIATRY 273 (March 1991).

5. This age group will grow almost sevenfold in the next 60 years. SPECIAL SENATE COMMITTEE ON AGING, TWENTY TRENDS IN AGING, S. REP. NO. 291, 100th Cong., 2d Sess. 1-2 (1988). *See also* U.S. SENATE SPECIAL COMMITTEE ON AGING, AGING AMERICANS TRENDS AND PROJECTIONS 13-14 (1987-1988).

6. U.S. DEP'T OF COMMERCE, BUREAU OF THE CENSUS, STATISTICAL ABSTRACT OF THE U.S.: 1990 16, tbl. 18 (110th ed. 1990); *see also* TRANSPORTATION RESEARCH BOARD AND NATIONAL RESEARCH COUNCIL, TRANSPORTATION IN AN AGING SOCIETY: IMPROVING MOBILITY AND SAFETY FOR OLDER PERSONS S. REP. NO. 218, 100th Cong., 2d Sess. (1988); FOWLES, A PROFILE OF OLDER AMERICANS: 1985 (1986); Dorothy P. Rice & Jacob J. Feldman, *Living Longer in the United States: Demographic Changes and Health Needs of the Elderly*, 61 MILBANK MEMORIAL FUND Q. HEALTH & SOC'Y 362 (1983).

Statistics reveal that between 1995 and 2005, the number of people 65 and older will decline slightly because of the lower birth rates during the Great Depression. Conversely, as the baby boomers age, the number of people 65 and older will increase again. After 2030, however, the number of individuals turning 65 will decline again until the children of the baby boomers, born between 1985 and 2010 begin to age. Lawrence A. Frolik & Alison P. Barnes, *An Aging Population: A Challenge to the Law*, 42 HASTINGS L.J. 683, 688 (1991) (noting similar movement in the 65 and older age group as a result of the baby boom).

7. In 1975, 38% of the elderly were 75 or older. It is predicted that by the year 2000, 45% of the elderly population will be over the age of 75. NATIONAL INST. ON AGING, OUR FUTURE SELVES: A RESEARCH PLAN TOWARD UNDERSTANDING AGING (1978). Indeed, by the year 2000, the population over 85 years old is estimated to grow to approximately 4.6 million people. U.S. DEP'T OF COMMERCE, BUREAU OF THE CENSUS, STATISTICAL ABSTRACT OF THE UNITED STATES: 1990 16, tbl. 41 (110th ed. 1990).

8. Charles Longino, *Demography of Aging in the United States*, *in* GERONTOLOGY: PERSPECTIVES AND ISSUES 19 (Kenneth Ferraro ed., 1990).

9. Spencer, U.S. Bureau of the Census, *Projections of the Population of the United States by*

bear in mind that the term "elderly" does not define a single cohesive group.[10] The term generally applies to people over the age of sixty-five, but within that group there are vast differences. People may have little in common with others their own age and more in common with those of a different age. Further, as people get older, they may develop or lose different abilities, strengths, and interests. People who retain physical fitness or mental acuity into their sixties, seventies, or eighties, may regard the label "elderly" as an insult. But for others who eagerly anticipate benefits conferred upon them only after they reach sixty or sixty-five, the term "elderly" is a sought-after label of self-identification.

In many ways, "elderly" is a label that separates rather than unites. We choose to define certain people as elderly because it serves society's needs.[11] If a person is labeled old and suffers a hearing loss, society may excuse her for certain behaviors, rather than be annoyed by the person's failure to adhere to a police siren, for example.[12] If a person is old, she may qualify automatically

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Age, Sex and Race: 1983-2080, in CURRENT POPULATION REPORTS, Series P-25 No. 952 (May 1984).

10. I do not choose the age 65 randomly; it is the age at which a person generally begins to be considered "old" or "elderly" or a "senior citizen." Indeed, 65 is the age at which most people become eligible for benefits such as Social Security. The designation of 65 as the age requirement for these benefits can be traced back to the 1930s, when the Social Security program was enacted to remove aging people from the labor force and make room for younger workers by providing income for those no longer able to work. Now that people live — and can work — longer, the 65 age limit has been called into question.

In 1967 Congress passed the Age Discrimination in Employment Act (ADEA) to "promote employment of older persons based on their ability rather than age." 29 U.S.C. § 621(b) (1988). *See generally* Age Discrimination in Employment Act (ADEA), 29 U.S.C. § 623 (1988), 29 C.F.R. 1625 (1991). ADEA prohibits employment practices that discriminate against an employee based on the employee's age, so long as age is not shown to be a bona fide occupational qualification necessary for the normal operation of the business. 29 U.S.C. § 623(f) (1988). Further, ADEA was amended in 1978 to expressly prohibit mandatory retirement. *See* Marley S. Weiss, *Risky Business: Age and Race Discrimination in Capital Redeployment Decisions*, 48 MD. L. REV. 901, 1006-1008 (1989); Barry Bennett Kaufman, *Preferential Hiring Policies For Older Workers Under the Age Discrimination in Employment Act*, 56 S. CAL. L. REV. 825 (1983).

11. Some courts and commentators favor classifications based on age rather than individualized determinations. *See* Massachusetts Bd. of Retirement v. Murgia, 427 U.S. 307 (1976); Vance v. Bradley, 440 U.S. 93 (1979); *see, e.g.*, Michael J. Perry, *The Principle of Equal Protection*, 32 HASTINGS L.J. 1133, 1150-1156 (1981). Perry asserts, for example, that classifications based on age should be upheld under the rational review test of the equal protection clause because such a system is preferable to substituting individual determinations. However, this argument is beside the point since the typical issue is fitness "relative" to a younger person; the inquiry is not whether an older person meets specified fitness requirements but whether a younger person is generally more fit. *Id.* at 1152.

12. The issue of elderly drivers has been the subject of studies, Congressional action, and state legislation. *See, e.g.*, TRANSPORTATION RESEARCH BOARD, NATIONAL RESEARCH COUNCIL, TRANSPORTATION IN AN AGING SOCIETY: IMPROVING MOBILITY AND SAFETY FOR OLDER PERSONS, S. REP. NO. 218 (1988); U.S. DEPARTMENT OF TRANSPORTATION, NHTSA TECHNICAL REPORT, OLDER DRIVERS, THE AGE FACTOR IN TRAFFIC SAFETY, DOT HS 807 402 (1989); ALASKA STAT. § 28.15.101 (c)(5) (1989); ARIZ. REV. STAT. ANN. § 28-426.01 (A)(4)-(5) (Supp. 1990); CAL. VEH. CODE § 12814.5(e) (West Supp. 1991); IOWA CODE § 321.196 (1991); LA. REV. STAT. ANN. § 32:412B(7)(e) (West Supp. 1991).

for certain benefits, thereby avoiding the time-consuming necessity of inquiring into an applicant's particular status and situation. In short, it is easier to label individuals as old than attempt to treat them as individuals, with unique needs and abilities. As one commentator has written, "[i]f any group in our society is systematically consigned to the status of 'nonpersons,' it is the aged."[13]

Another group of people often labeled are those whose perceptions of reality differ from the majority culture. These people are labeled as mentally ill, yet do not constitute a homogenous group. They possess varying degrees of strengths and weaknesses; they function and behave differently from one another; and they vary widely in personality, background, physical health, age, and income level. What they do share in common, however, is a history of prejudice, castigation, and even abuse.[14]

The causes for mental illness remain elusive and the types of behaviors evident in people labeled mentally ill seem to change over time.[15] While the debate on the causes and types of mental illness continues, some argue that such a debate is meaningless since mental illness does not exist at all.[16] In the meantime, many people labeled mentally ill continue to suffer the pain and stigma as "mental patients" in psychiatric hospitals. Even after release from the institution to the community, many people retain this stigma and risk readmission to the state psychiatric hospital as a response to even a minor problem.

People who are considered mentally ill and elderly endure a double prejudice about who they are, what desires and needs they have, and to what sort of life they aspire. Age, per se, need not be relevant to legal issues related to mental health care, however, it is. I will now explore the legal issues affecting those elderly people who reside in psychiatric hospitals, many for years, despite changes in commitment laws and despite considerable evidence to support the effectiveness of community-based treatment.

I met Oscar Dodd in 1985 when he was a patient at St. Elizabeths Hospital, the public psychiatric hospital of the District of Columbia. Oscar Dodd was then sixty-seven years old, feeble, hearing impaired, and near-sighted, but alert. He was civilly committed in 1969 to St. Elizabeths Hospital as an alco-

13. Kenneth Karst, *The Supreme Court, 1976 Term—Foreword: Equal Citizenship Under the Fourteenth Amendment*, 91 HARV. L. REV. 1, 23 n.122 (1977).

14. *See, e.g.*, Arlene Kanter, *Homeless Mentally Ill People: No Longer Out of Sight and Out of Mind*, 3 N.Y.L. SCH. J. HUM. RTS. 331 (1986).

15. *See* AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS: DSM-IIIR (3d ed. rev. 1987). For example, prior to 1973 homosexuality was considered a mental disorder. In the 1973 revision to the DSM-II, homosexuality *per se* was removed from the classification of a mental disorder. *See* Robert L. Spitzer, *The Diagnostic Status of Homosexuality in DSM-III: A Reformulation of the Issues*, 138 AM. J. OF PSYCHIATRY 210 (1981).

16. *See, e.g.*, THOMAS SZASZ, THE MYTH OF MENTAL ILLNESS: FOUNDATIONS OF A THEORY OF PERSONAL CONDUCT (rev. ed. 1974); THOMAS SZASZ, THE MYTH OF PSYCHOTHERAPY: MENTAL HEALING AS RELIGION, RHETORIC AND REPRESSION (1988).

holic. The police brought him forcibly to St. Elizabeths when he became confused, disoriented, and unable to care for himself after his wife had left him. Mr. Dodd has never been diagnosed as mentally ill, yet he has spent over twenty years of his adult life in a public psychiatric hospital. He is angry. "I am not forgetful. I remember everything you tell me. I have committed no crime. I want out of this hospital,"[17] he demanded during an interview with a Washington Post reporter.

The hospital recommended that he be transferred to a nursing home. He had no serious physical health problems and refused to enter a nursing home where patients need "rolling chairs"—his term for wheelchairs. The hospital billed him for his care, but he refused to pay. In fact, he continually requested his accumulated social security payments from the hospital which amounted to thousands of dollars. He wanted the money to rent an apartment, but the hospital staff decided that "he's better off here." A conservator was appointed on his behalf, and even she acknowledged that "he should be able to do whatever he wants to do, and if that's to drink himself to death, then that's what he should be able to do . . . . That's a personal decision." His days have been spent on the ward, but he has refused to engage in planned activities such as basket weaving, or arts and crafts, calling them "child's stuff for crazy people"; and stating "I don't like to be hemmed up in here. It's like jail. I can't get nothing but just look at the walls and come downstairs to get a soda. And go back. And that's all."[18]

This Article explores the legal issues affecting elderly people like Oscar Dodd, many of whom have spent the majority of their adult lives in psychiatric hospitals. I will discuss their plight in the following contexts. First, I will explore who these people are and why so many of them are confined in mental hospitals, even after federal and state policies favoring deinstitutionalization have been adopted. Second, I will identify the barriers to the release of these elderly people which include legal difficulties, financial and policy considerations, and societal attitudes. I will focus particular attention on the ways in which the legal system treats elderly people differently from younger people with respect to the justifications for involuntary hospitalization and treatment.[19]

17. Benjamin Weiser, *Survival vs. Freedom: Patient Struggles in Dilemma*, WASH. POST, Sept. 28, 1987, at A8.

18. Weiser, *supra* note 17.

19. In addition to involuntary civil commitment, other legal procedures, arguably, are applied differently to elderly people than to younger people, or at least have a disparate effect on elderly people. One such procedure is guardianship, which authorizes the appointment of a guardian to make decisions for an elderly person unable to do so for him or herself. Other procedures include those under state protective services laws which authorize the involuntary removal of an elderly person from his or her home when the person is at risk of abuse, neglect, or is unable to care for him or herself. While these procedures also pose a risk of loss of liberty to an elderly person, a discussion of them and their effect on an elderly person's right to autonomy is beyond the scope of this Article. For an analysis of the guardian laws and their effect on the right of an elderly person to autonomy, see Lawrence A. Frolik, *Plenary Guardianship: An Analysis, A Critique and a Proposal for Reform*, 23 ARIZ. L. REV., 599 (1981); John Regan,

I will conclude this Article with an analysis of *Streicher v. Prescott*,[20] an example of litigation used successfully to secure the release of elderly people inappropriately confined in public psychiatric hospitals. Filed originally in 1983 as several individual *habeas corpus* petitions, *Streicher* became a class action lawsuit and established the right of elderly people confined in mental hospitals to challenge their confinements as illegal, since they had never been committed under the jurisdiction's current involuntary commitment statute. Yet *Streicher* does more than just demonstrate how one psychiatric hospital admitted elderly residents without ever proving that they were mentally ill and dangerous, as required by the current commitment law in that jurisdiction[21]—it exemplifies the plight of thousands of elderly people inappropriately committed to public psychiatric hospitals across the nation,[22] abandoned by society and the legal system.

I
WHO ARE THESE ELDERLY PEOPLE IN INSTITUTIONS?

> [T]here are two possible statuses, however uncertain their boundary: one of impaired and one of unimpaired intellect, the one lacking a right to self-direction, and the other possessing it.[23]

Many elderly people who reside in psychiatric hospitals have been residents for years, despite the changes in commitment laws and despite considerable evidence to support the effectiveness of community-based treatment for even the most resistant individuals diagnosed as chronically mentally ill.[24] One group of elderly people, like Mr. Dodd, were civilly committed prior to the 1960s, under now-illegal standards for commitment. For example, in the District of Columbia, prior to 1964, people with epilepsy and mental retarda-

Protective Services for the Elderly: Commitment, Guardianship, and Alternatives, 13 WM. & MARY L. REV. 569 (1972).

20. 663 F. Supp. 335 (D.D.C. 1987).

21. The District of Columbia's commitment law, known as the Ervin Act (named after Senator Sam Ervin, chief sponsor of the bill) was enacted in 1967 to provide essential procedural and substantive protections. For example, the law provided a right to a judicial hearing and a right to counsel for people facing commitment. *See* D.C. CODE ANN. §§ 21-525, 21-543 (1981). The law also changed the standard of commitment to mentally ill and dangerous to oneself or others. *See* D.C. CODE ANN. § 21-521 (1981).

22. In November 1990, the Washington Post ran an article entitled *Oldest Living Woman*. The woman, Carrie White, was born in 1874, during the presidency of Ulysses S. Grant, and was listed in the Guinness Book of Records as the world's oldest living person. She had been "living" since 1909 in Florida State Hospital when she was committed for "post typhoid psychosis." She was released in 1984 at the age of 110 and lived in a nursing home. WASH. POST, Nov. 20, 1990, at E3. Carrie White died in the nursing home on February 13, 1991, at the age of 116. WASH. POST, Feb. 17, 1991, at B13.

23. Daniel Wikler, *Paternalism and the Mildly Retarded*, 8 PHIL. & PUB. AFF. 377, 379 (1979).

24. *See* Leon Stein, Mary Ann Test, and Arnold Marx, *Alternative to the Hospital: A Controlled Study*, 132 AM. J. OF PSYCHIATRY 517 (1975); Mary Ann Test, *Continuity of Care in Community Treatment*, *in* NEW DIRECTIONS FOR MENTAL HEALTH SERVICES: COMMUNITY SUPPORT SYSTEMS FOR THE LONG-TERM PATIENT, No. 2 (Leonard Stein ed., 1979).

tion were routinely committed to the public psychiatric hospital. And in other jurisdictions, as well as the District of Columbia, many people were committed solely because of economic, social, or general health problems.[25]

The change in commitment laws that occurred in many states in the 1960s and 1970s was supposed to protect against the inappropriate commitment of such individuals. During the 1965 Senate hearings on a proposed revision to the District of Columbia's commitment law, Senator Sam Ervin (sponsor of the bill) observed, "[t]here is a substantial percentage among the elderly patients for whom, in the absence of some announced illness, treatment [in public psychiatric hospitals] consists largely of seeing that they have adequate food, that they are assisted in keeping clean, and things of that kind."[26]

Despite changes in the law, changes in treatment did not follow for people like Mr. Dodd; he and others remained involuntarily confined, not receiving treatment, but not able to leave. Such a situation is troubling not only from a legal or policy perspective, but on a personal level as well. The risks associated with prolonged institutionalization are enormous. Mortality rates for institutionalized elderly people are staggering and significantly higher than for non-institutionalized elderly.[27] This high incidence of mortality among institutionalized elderly people has been found to be attributable not to a resident's poor health, but to the poor quality of institutional care and the psychological impact of institutionalization.[28] Humiliation, loss of independence and dignity, and feelings of obsolescence are commonly experienced by long-term institutionalized elderly residents.[29] There is an equally pervasive passive acceptance of rules which results in detrimental changes in behavior as well.[30]

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25. *See* New York State Ass'n for Retarded Children, Inc. v. Carey, 393 F. Supp. 715 (E.D.N.Y. 1975) (class of residents of Willowbrook Institution, including many who were deaf but not mentally retarded, won their release); Texas Dep't of Mental Health and Mental Retardation v. Petty, 778 S.W.2d 156 (Tex. Ct. App. 1989), *appeal docketed*, No. 3-90-002-CV, (Tex. Ct. App. Aug. 28, 1991) (Ms. Petty was neither mentally ill nor mentally retarded, but spent over 50 years involuntarily committed to a mental hospital); Clark v. Cohen, 794 F.2d 79 (3d Cir. 1986), *aff'd*, 613 F. Supp. 684 (E.D. Pa. 1985), *cert. denied*, (Ms. Clark remained involuntarily committed to an institution for people with mental retardation for over 30 years although she was not severely mentally retarded); Thomas S. v. Flaherty, 902 F.2d 250 (4th Cir. 1990) (Thomas S. was committed soon after his birth because he was difficult to manage and remained institutionalized for over twenty years).

26. *Hearings on S.953 Before the Subcomm. on Const. Rights of the Senate Comm. on the Judiciary*, 88th Cong., 1st Sess. 41, 182 (1963).

27. SPECIAL SENATE COMM. ON AGING, MENTAL HEALTH CARE AND THE ELDERLY: SHORTCOMINGS IN PUBLIC POLICY, S. REP. NO. 38-596, 92d Cong., 1st Sess. 139-140 (1971), *quoted in* Peter M. Horstman, *Protective Services for the Elderly: The Limits of Parens Patriae*, 40 MO. L. REV. 215, 274 (1975).

28. *Id.*

29. JABER GUBRIUM, LIVING AND DYING IN MURRAY MANOR (1975); Stanislav Kasl, *Physical and Mental Health Effects of Involuntary Relocation and Institutionalization on the Elderly — A Review*, 62 AM. J. OF PUB. HEALTH 377 (1972).

30. ERVING GOFFMAN, ASYLUMS: ESSAYS ON THE SOCIAL SITUATION OF MENTAL PATIENTS AND OTHER INMATES (1961); Alan Whanger, *Treatment Within the Institution*, *in* HANDBOOK OF GERIATRIC PSYCHIATRY 465-66 (Ewald Busse & Dan Blazer eds., 1980).

Another risk of institutionalization is abuse, which is prevalent.[31] Elderly people may suffer physical abuse in mental hospitals because of their physical disabilities, impaired mobility, and bodily dysfunction. In short, they become easy targets for careless or ill-motivated staff.[32] They may also suffer from neglect since they are often viewed as unworthy of attention or rehabilitation. While the younger mentally ill person is institutionalized for the purported purpose of treatment or rehabilitation, the elderly mental patient is often ignored.[33] Indeed, some commentators have characterized the life of the long-term elderly mental patient as an extended act of dying.[34]

Those who have not been long-term residents but have been civilly committed for the first time in old age comprise a second group of elderly residents of psychiatric hospitals. According to the first and only study since deinstitutionalization which attempts to describe the care of elderly people in state psychiatric hospitals, the recent increase in the geriatric census may be the result of admission of this new group of older patients.

There is a disproportionate incidence of dementia among this older population. Dementia diminishes mental powers and is the major psychiatric disorder experienced by elders. It now affects approximately ten to fifteen percent of older adults[35] of which approximately fifty to sixty percent are thought to suffer Senile Dementia of the Alzheimer's type.[36] Alzheimer's Disease is not only the most common disease affecting the mental state of older people, it is the most common justification for the initial civil commitment of older people who had never previously suffered from a mental disorder.[37] Although Alzheimer's Disease and other forms of dementia are commonly considered mental illnesses (and generally make their victims unable to care for themselves), they seldom respond to psychiatric treatment. Therefore, for this group of elders, involuntary hospitalization may be particularly inappropriate.[38]

An additional problem for elderly people labelled mentally ill is misdiagnosis of psychiatric syndromes.[39] A diagnosis of dementia is often made merely because the patient is confused, when the confusion actually may be

31. *See Fraud and Abuse in Boarding Homes: Hearings Before the House of Representatives' Select Committee on Aging*, 97th Cong., 1st Sess. 1 (1981).

32. DEVELOPMENTS IN AGING: 1987, *supra* note 1, at 28-29.

33. *Id.*

34. *Id.*

35. Arnold J. Rosoff & Gary L. Gottlieb, *Preserving Personal Autonomy for the Elderly: Competency, Guardianship, and Alzheimer's Disease*, 8 J. OF LEGAL MED. 1, 6 (1987).

36. *Id.*; Frolik & Barnes, *supra* note 6, at 697; Michael H. Schenck, Barry Reisberg & Steven M. Ferris, *An Overview of Current Concepts of Alzheimer's Disease*, 139 AM. J. PSYCHIATRY 165, 166 (1982).

37. *See* Moak & Fisher, *supra* note 4.

38. NEW YORK STATE OFFICE OF MENTAL HEALTH GERIATRIC INPATIENT ADMISSION GUIDELINES (Aug. 8, 1980). For reference to two states, Pennsylvania and Michigan, which have addressed this issue, *see infra* note 95.

39. *See, e.g.*, L. Ralph Jones, Richard R. Parlor & Lee W. Badger, *The Inappropriate Commitment of the Aged*, 10 BULL. AM. ACAD. PSYCHIATRY & L. 29, 31 (1982).

the result of an acute physical illness. Many dementia patients have an underlying physical disorder which, when corrected, leads to substantial mental improvement. Such problems are exacerbated by the fact that routine mental examinations may not distinguish between irreversible dementia and temporary confusional states.[40] In short, people labeled with dementia or Alzheimer's disease may be civilly committed without an accurate diagnosis of mental illness.

A third group of elderly people confined in psychiatric hospitals today are those who have been the victims of "retransinstitutionalization." These older residents have spent years or even decades in public mental hospitals, only then to be transferred from a ward in the psychiatric hospital to a room in a nursing home, then back again to the mental hospital ward. This phenomenon, known as "retransinstitutionalization," has had serious consequences for elderly residents.[41]

First, elderly residents may not receive the care they require in nursing homes. Nursing home staff are not required to and usually have no training in treating people with mental illness. The physicians in charge of the residents' care often have no experience in mental health treatment and do not routinely seek the assistance of mental health professionals. This lack of training may exacerbate the demands on the nursing home personnel who may lack the time or interest to provide appropriate support and assistance to the new elderly resident. Further, the nursing home staff may perceive the transferee from the psychiatric hospital as unmanageable in the nursing home setting and mislabel the person as dangerous in order to justify the person's transfer back to the psychiatric hospital.

An elderly person who is transferred to a nursing home after years in a psychiatric hospital may have difficulties adjusting to the new surroundings, in part because the resident's consent is seldom obtained prior to such transfer.[42]

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40. *Id. See also* 11 ROCHE REPORT: FRONTIERS OF PSYCHIATRY (Jan. 1981) (citing Psychiatric Dilemmas of Caring for the Elderly); Cecil B. Kidd, *Misplacement of the Elderly in Hospital: A Study of Patients Admitted to Geriatric and Mental Hospitals*, 1962 BRIT. MED. J. 1491-1495; Jacob H. Fox, Jordan L. Topel & Michael S. Huckman, *Dementia in the Elderly - A Search for Treatable Illnesses*, 30 J. GERONTOLOGY 557 (1975); C.D. Marsden & M.J.G. Harrison, *Outcome of Investigation of Patients with Pre-Senile Dementia*, 2 BRIT. MED. J. 249 (1972); Whanger, *supra* note 30.

41. Although this Article focuses on elderly people in psychiatric hospitals, eight percent of adults residing in nursing homes in the 1970s were discharged from public mental hospitals, according to a Center for Health Statistics study of nursing home admissions. *See* Aurora Zappolo, *Characteristics, Social Contacts and Activities of Nursing Home Residents, in* VITAL & HEALTH STAT., Series 13, No. 27, DHEW Publ. No. (HRA) 77-1778 (1977). One motive for the mass movement of older residents from psychiatric hospitals to nursing homes was and is fiscal. Medicaid is not available to reimburse states for stays in mental hospitals, whereas it is available to states for reimbursement of care for elderly people with mental illness in nursing homes. GENERAL ACCOUNTING OFFICE AUDIT REPORT, RETURNING THE MENTALLY DISABLED TO THE COMMUNITY: GOVERNMENT NEEDS TO DO MORE (1977).

42. The decision to remain in the mental hospital or to transfer to an alternate facility, such as a nursing home, is often not made by the person most affected. Although there is a presumption that an adult is competent to consent to treatment unless she has been judicially

One study of a large mental health system found that only one in seven cases demonstrated a legitimate need for civil commitment—relatively transient episodes of agitation by new nursing home residents had often been accepted as "recent dangerous acts" sufficient to trigger a civil commitment order.[43] Another study has found that staff may react to difficult patients in a rejecting or punishing manner, provoking violent behavior that could be readily recognizable and manageable in a more appropriate setting.[44] A third study in Vermont found that most residents of the state's long-term care facilities who were identified as creating behavioral problems were not mentally ill at all, and that the care provided to them was provided by staff without adequate training.[45] Thus the placement of former psychiatric hospital residents into nursing homes may be even less appropriate than was their initial placement in the psychiatric hospital ward.[46]

Many elderly hospital residents require only some of the services that are offered within the institutions and could be maintained successfully in more independent settings, if such settings were available.[47] One study, for example, has indicated that in the judgment of social workers, over half of the 344

declared incompetent, this presumption may not apply with equal force to institutionalized elderly people. *See* Laurence B. McCullough, *Medical Care for Elderly Patients with Diminished Competence: An Ethical Analysis*, 32 J. AM. GERIATRIC SOC'Y 150 (1984). People who are old and have spent years in institutions are presumed to lack the capacity to make decisions about their own lives and therefore others make the decisions for them. If it is presumed that an elderly resident of a mental hospital requires a guardian and no family members or friends are available to become the guardian, treatment decisions may be made by strangers or those whose personal interests conflict with those of the elder. Further, no explicit standards exist to assist the guardian in making decisions affecting the elderly resident. *See* J. Richard Ciccone, *The Elderly and Medicolegal Trends in Consent to Treatment*, 86 N.Y. ST. J. MED. 635 (1986).

43. Jones et al., *supra* note 39, at 35.

44. *Id.* at 31. *See also* Helen E. Ross & Henry B. Kedward, *Psychogeriatric Hospital Admissions from the Community and Institutions*, 32 J. GERONTOLOGY 420 (1977).

45. Walter E. Barton, *The Place, If Any, of The Mental Hospital in The Community Mental Health Care System*, 55 PSYCHIATRIC Q. 146, 147 (1983) (citing VERMONT PROFESSIONAL STANDARDS REVIEW ORGANIZATION, INC., SURVEY OF PSYCHOLOGICAL AND BEHAVIORAL PROBLEMS IN VERMONT LONG TERM CARE FACILITIES (Sept. 1979).

46. Howard H. Goldman, Judith Feder & William Scanlon, *Chronic Mental Patients in Nursing Homes: Reexamining Data from the National Nursing Home Survey*, 37 HOSP. AND COMMUNITY PSYCHIATRY 269 (1986). To some, nursing homes were considered less restrictive than psychiatric hospitals and therefore desirable for elderly people. But much has been written criticizing nursing homes as alternative placements for elderly people with psychiatric problems. This criticism has focused on the custodial nature of nursing home care which has little or no emphasis on therapeutic treatment. For example, one researcher notes that nursing homes do not have psychiatrically trained staff, and the staff which are employed rely heavily, and often improperly, on medication for behavior control. John A. Talbott, *Taking Issue: Nursing Homes Are Not the Answer*, 39 HOSP. & COMMUNITY PSYCHIATRY 115 (1988). It has also been noted that many nursing homes provide only custodial care to psychiatric patients and are not the appropriate setting to improve or bring about a "complete reversal of symptoms." *See* Charles M. Gaitz & Roy V. Varner, *Principles of Mental Health Care for Elderly Inpatients*, 33 HOSP. & COMMUNITY PSYCHIATRY 127 (1982); *see also* Virginia T. Sherr & Maria T. Goffi, *On-Site Geropsychiatric Services to Guests of Residential Homes*, 25 J. AM. GERIATRIC SOC'Y 269 (1977).

47. *See, e.g.*, Moak & Fisher, *supra* note 4; SYLVIA SHERWOOD, DAVID S. GREER, JOHN N. MORRIS & VINCENT MOR, AN ALTERNATIVE TO INSTITUTIONALIZATION: THE HIGH-

applicants to a private nursing home were capable of functioning in the community — if the appropriate supports and living arrangements were available.[48] A similar study in the District of Columbia revealed that the vast majority of elderly residents of the public psychiatric hospital received no mental health treatment whatsoever. The only services they did receive in the facility could be obtained, less expensively, with better results and more responsive to the individual's needs, in the community.[49] Nonetheless, a disproportionate number of residents of state psychiatric hospitals are elderly and remain there, in large part, because there is no other place for them to call home.

II
WHY ELDERS HAVE REMAINED IN PSYCHIATRIC HOSPITALS

A. Civil Commitment and the Elderly

> Experience should teach us to be most on our guard to protect liberty when the Government's purposes are beneficent. Men born to freedom are naturally alert to repel invasion of their liberty by evil minded rulers. The greatest dangers to liberty lurk in insidious encroachment by men of zeal, well meaning but without understanding.[50]

In the years preceding the deinstitutionalization movement, experiences like those of Oscar Dodd were common. He was one of thousands of elderly people who were sent against their will to public psychiatric hospitals, often large, inhumane facilities in remote areas. Individuals were committed for a variety of reasons, many of which had nothing to do with the person's need for mental health treatment. Mr. Dodd, for example, was neither mentally ill nor dangerous; he was committed because he was and is an alcoholic. Many were committed following a diagnosis of "senile brain disease," an imprecise determination apparently applied to people suffering such symptoms as memory loss and depression. This diagnosis was the basis for years of civil commitment for many individuals who evidenced such symptoms not because of

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LAND HEIGHTS EXPERIMENT (1981); Elaine M. Brody, *Follow Up Study of Applicants and Non-Applicants to a Voluntary Home*, 9 THE GERONTOLOGIST 187 (1969).

48. The 1984 report by the Action Committee to Implement the Mental Health Recommendations of the 1981 White House Conference on Aging reviews a range of studies since 1971 documenting "[t]he lack of an effective outpatient service delivery mechanism for mentally ill older adults." 1 ACTION COMMITTEE TO IMPLEMENT THE MENTAL HEALTH RECOMMENDATIONS OF THE 1981 WHITE HOUSE CONFERENCE ON AGING, MENTAL HEALTH SERVICES FOR THE ELDERLY: REPORT ON A SURVEY OF COMMUNITY MENTAL HEALTH CENTERS 2 (1971). The 1985 follow-up report again noted the "gap in services, except for institutionalization." 3 ACTION COMMITTEE TO IMPLEMENT THE MENTAL HEALTH RECOMMENDATIONS OF THE 1981 WHITE HOUSE CONFERENCE ON AGING. MENTAL HEALTH SERVICES REPORT 39 (1985) [hereinafter 3 MENTAL HEALTH SERVICES REPORT].

49. 3 MENTAL HEALTH SERVICES REPORT, *supra* note 48.

50. Olmstead v. United States, 277 U.S. 438, 479 (1928) (Brandeis, J., dissenting), *overruled by* Katz v. United States, 389 U.S. 347, 352 (1967).

mental illness, but because of treatable physical conditions, including malnutrition, heart disease, and bacterial infections.[51]

After World War II, critics charged that institutions caused more harm than good, and the deinstitutionalization movement led to releases and more stringent admissions policies in most state and county psychiatric hospitals. Today, most states as well as the District of Columbia require proof of mental illness and dangerousness to justify involuntary civil commitment.[52] The primary beneficiaries of the deinstitutionalization movement have been younger residents of the state hospitals who were released into the community, some more successfully than others.[53]

Some elderly residents were also released, although more slowly. Indeed, many elderly people today live in their own homes, in retirement communities,[54] or with relatives. Many elderly people have been less fortunate. They were released to live in substandard board and care homes, foster homes, nursing homes, or perhaps even worse, not released at all, but forced to continue to live out their lives in psychiatric hospitals, where they may not have belonged in the first place. As recently as 1985, 27% of all residents of public psychiatric hospitals were elderly, while only 3.8% of admissions to outpatient psychiatric services were people age sixty-five or older.[55]

The legal justification for the State's power to commit elderly and nonelderly individuals alike lies in the *parens patriae*[56] power of the sovereign. *Parens patriae* originated with the King of England, who under English law had authority to act as the general guardian of all infants, "idiots," and "lunatics." After the American Revolution, *parens patriae* was vested with the legislatures and has developed to allow the State to act for the protection of those who are considered unable to protect and care for themselves. *Parens patriae* today provides the State with the authority to involuntarily commit an individual who is considered to pose a risk to her own safety.[57]

Parens patriae is not to be confused with the police power of the State,

51. *See* Marni J. Hall, *Mental Illness and the Elderly, in* LONG-TERM CARE: PERSPECTIVES FROM RESEARCH AND DEMONSTRATIONS (Ronald J. Vogel & Hans C. Palmer eds., 1985).

52. *See, e.g.*, CAL. WELFARE & INSTITUTIONS CODE § 5150 (West 1984); N.Y. MENTAL HYGIENE LAW § 9.39 (McKinney 1988). For a compilation of state statutes and their respective standards for commitment, see SAMUEL BRAKEL, JOHN SAMUEL PARRY & BARBARA A. WEINER, THE MENTALLY DISABLED AND THE LAW 21-176 (3d ed. 1985).

53. *See generally* Kanter, *supra* note 14.

54. Although the recently amended Fair Housing Act prohibits age discrimination in housing, residential communities that are specifically designed for and occupied by elderly people are exempted from the requirements of the Act. *See* 42 U.S.C. §§ 3604 & 3607(b) (1988).

55. *See* 2 *Developments in Aging: 1985, A Report of the Special Committee on Aging*, S. REP. NO. 99-242, 99th Cong., 2d Sess. 195 (1986); *see also* BARTON & BARTON, *supra* note 3.

56. Literally translated, "father of the country."

57. Under *parens patriae* power, the State can "protect" those who cannot or will not take care of themselves. Guardianship, like involuntary commitment, disproportionately affects the elderly. The number of guardianship petitions has increased dramatically in recent years, as the standards for involuntary commitment have become more stringent and as families have been unable to provide informal care to the elderly member of the family. *See* WINSOR C. SCHMIDT,

which provides the State with authority to act to restrict the liberty of individuals who endanger the health and safety of the community at large.[58] Under the police power, the State has authority to promote and protect the public health, safety, and welfare through the enactment of the criminal laws and social and economic legislation. It also provides the justification for the loss of liberty suffered by persons civilly committed when such persons are considered to be dangerous to others. In short, whereas the State may act pursuant to its *parens patriae* power to protect the welfare and safety of an individual or group, the State's police power may be used only as the basis to punish those who act to the detriment of others.

Because the exercise of the police power entails an enormous loss of liberty (i.e., a prison sentence), various procedural protections have been established to ensure against the mistaken punishment of "innocent" people. These protections include the right to counsel, the right to cross-examination, the right to a trial by jury, and the right against self-incrimination. Yet not all of these procedural protections are guaranteed to persons subject to civil commitment. Although there is no longer any question that the United States Constitution requires some sort of judicial hearing prior to the issuance of an order of civil commitment, questions still remain regarding the extent to which procedural due process safeguards are required at commitment hearings, when such hearings must be held, and who may participate at such hearings.[59]

One explanation advanced for the deprivation of certain procedural protections to civil committees is that commitment proceedings are benevolent in nature and pose no real harm to an individual unable to act independently. Benevolence has its victims, however. Elderly people caught up in the mental health system have frequently been such victims.[60] Indeed, the history of the

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WILLIAM G. MILLER, KENT S. BELL & B. ELAINE NEW, PUBLIC GUARDIANSHIP AND THE ELDERLY (1981).

58. The State's police power has been upheld against challenges, particularly in the area of zoning. *See, e.g.*, Village of Euclid v. Amber Realty Co., 272 U.S. 365 (1926).

59. For an impressively thorough discussion of involuntary civil commitment procedures, see 1 MICHAEL L. PERLIN, MENTAL DISABILITY LAW: CIVIL AND CRIMINAL, §§ 3.01-.60 (1989).

60. *See generally* John J. Regan, *Protecting the Elderly: The New Paternalism*, 32 HASTINGS L.J. 1111 (1981). Until the reform movements of the nineteenth century, the State avoided interfering with parental authority. Another group targeted for society's beneficence has been children. *See, e.g.*, Robert Rolfe & Anne MacClintock, *The Due Process Right of Minors "Voluntarily Admitted" to Mental Institutions*, 4 J. PSYCHIATRY & L. 333, 335-336 (1976). In response to this century's developments in psychology, states allowed parents to voluntarily commit their children, which they did. James Ellis, *Volunteering Children: Parental Commitment of Minors to Mental Institutions*, 62 CALIF. L. REV. 840 (1974). In 1974, the Supreme Court upheld this tradition by giving parents the right to involuntarily commit their children without a hearing or other due process guarantees, as permitted under the *parens patriae* power of the state. Parham v. J.R., 442 U.S. 584 (1979). In *Parham*, the Court reviewed a decision from a Georgia district court which had struck down the state's commitment statute because it failed to adequately protect the juveniles' due process rights. The Supreme Court reversed and held that the physician's exam required by the state statutory scheme was a suffi-

benevolence of *parens patriae* in the guise of protecting elderly people is well-documented.

The very first case which introduced the concept of *parens patriae* as a justification for civil commitment involved an elderly man. In 1845 the Massachusetts Supreme Judicial Court reviewed a *habeas corpus* petition of an elderly man, Mr. Oakes, who was committed to a private psychiatric facility upon his family's application. He was committed because he married a young woman of "unsavory character," a few days after his first wife's death.[61] In upholding the commitment, the court held that the *parens patriae* power justified the involuntary commitment of mentally ill people for care and treatment or protection from harm. As the court reasoned:

> The right to restrain an insane person of his liberty is found in that great law of humanity, which makes it necessary to confine those who going at large would be dangerous to themselves or others. . . . And the necessity which creates the law, creates the limitation of the law. The questions must arise in each particular case, whether a patient's own safety or that of others, requires that he should be restrained for a certain time, and whether restraint is necessary for his restoration, or will be conducive thereto. The restraint can continue as long as the necessity continues. This is the limitation, and the proper limitation.[62]

Since the court's decision in *In re Oakes*, *parens patriae* has been cited consistently by courts as the proper authority of the State to commit a mentally ill person for his or her own benefit.[63] Yet there are limits on the extent to which the State may exercise this *parens patriae* authority. In *Lessard v. Schmidt*,[64] for example, a federal district court stated that although the legislature did not define dangerousness, a finding for commitment requires

> a balancing test in which the state must bear the burden of proving

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cient due process guarantee. Then-Chief Justice Burger, for the Court, noted that "[t]he *parens patriae* interest in helping parents care for the mental health of their children cannot be fulfilled if the parents are unwilling to take advantage of the opportunities because the admission process is too onerous, too embarrassing, or too contentious." *Id.* at 605. Chief Justice Burger, however, failed to specify the basis for his speculation that parents would forego state provided hospital care if it is "contingent on participation in an adversary proceeding." *Id. See also* Bartley v. Kremens, 402 F. Supp. 1039 (E.D. Pa. 1975), *vacated,* 431 U.S. 119 (1977), *on remand sub nom.* Institutionalized Juveniles v. Secretary of Public Welfare of Pa., 459 F. Supp. 30 (E.D. Pa. 1978), *rev'd,* 442 U.S. 640 (1979); *see also* 1 PERLIN, *supra* note 59, § 3.71.

61. *In re* Oakes, 8 Law Rep. 123 (Mass. 1845).

62. *Id.* at 125.

63. According to a noted commentator on mental health care in this country, *In re* Oakes, marked the first case in which the "therapeutic justification for restraint was explicitly stated in a decision handed down by an American Court." ALBERT DEUTSCH, THE MENTALLY ILL IN AMERICA: A HISTORY OF THEIR CARE AND TREATMENT FROM COLONIAL TIMES 423 (2d ed. 1949).

64. 349 F. Supp. 1078 (E.D. Wis. 1972), *vacated and remanded,* 414 U.S. 473 (1974), *order on remand,* 379 F. Supp. 1376 (E.D. Wis. 1974), *vacated and remanded,* 421 U.S. 957 (1975), *order reinstated on remand,* 413 F. Supp. 1318 (E.D. Wis. 1976).

> that there is an extreme likelihood that if the person is not confined he will do immediate harm to himself or others. Although attempts to predict future conduct are always difficult and confinement based upon such a prediction must always be viewed with suspicion, we believe civil confinement can be justified in some cases if the proper burden of proof is satisfied and dangerousness is based upon a finding of a recent overt act, attempt, or threat to do substantial harm to oneself or another.[65]

Today, a court may only order civil commitment of an individual if it finds that the individual meets the criteria set forth in the state's commitment law. In most states, the criteria include the requirement that the individual be mentally ill and, as a result of that mental illness, dangerous to herself or others.[66] Arguably, the most dramatic change in civil commitment statutes in the past decade has been the inclusion of the "dangerousness" requirement for involuntary commitment. In 1959 only five states limited civil commitment to people considered dangerous. By 1980, virtually every state had amended its involuntary commitment law to authorize the commitment only of those who could be classified as dangerous.[67]

Some states require a recent overt act to trigger the dangerousness criterion. Other states include danger to property as a basis for hospitalization,[68] and while the dangerousness requirement in *Lessard* remains good law in Wisconsin, its overt act requirement has been rejected elsewhere.[69] California defines dangerousness as referring only to others (not oneself) while Arkansas equates dangerousness with homicidal or suicidal behavior.[70]

During the past decade, the pendulum seems to have begun to swing back slowly toward condoning the commitment of mentally ill people who are not "overtly" dangerous. This change may reflect the tenuous view that *Lessard* and its progeny have made it too difficult to provide any treatment to people who exhibit no imminent danger to themselves or others but who none-

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65. *Id.* at 1093. The court went on to state that

> [p]ersons in need of hospitalization for physical ailments are allowed the choice of whether to undergo hospitalization and treatment or not. The same should be true of a person in need of treatment for mental illness unless the state can prove that the person is unable to make a decision about hospitalization because of the nature of his illness.

Id. at 1094.

66. BRAKEL ET. AL, *supra* note 52, at 34.

67. *Id. See also* Daniel Shuman, *Innovative Statutory Approaches to Civil Commitment: An Overview and Critique*, 13 LAW, MED. & HEALTH CARE 285 (1985).

68. The application of the dangerousness requirement to danger to property has been the subject of dispute. *See, e.g.*, Suzuki v. Yuen, 617 F.2d 173 (9th Cir. 1980).

69. *See, e.g.*, United States *ex rel.* Mathew v. Nelson, 461 F. Supp. 707 (N.D. Ill. 1978) (adopting expert's view that psychiatrist may predict dangerousness, without evidence of a recent overt act); Project Release v. Prevost, 722 F.2d 960 (2d Cir. 1983) (holding overt act requirement unnecessary to guard against erroneous commitments); State v. Robb, 125 N.H. 581 (1984) (holding overt act requirement places undue burden on the state).

70. *See* BRAKEL ET AL., *supra* note 52, at 34.

theless may be in need of mental health services. As a result, some states now permit the commitment of individuals "in need of treatment," "unable to care" for themselves, or "gravely disabled."[71] The movement toward this revision of commitment laws can also be seen in the American Psychiatric Association's proposal to commit individuals who will suffer substantial physical or mental deterioration if not treated but will neither consent to treatment nor possess the capacity to make an informed treatment decision.[72] At least three states have essentially adopted this approach.[73]

Even if dangerousness *per se* is not required, a person labeled mentally disabled, elderly or young, may not be involuntarily confined in a mental hospital merely for custodial care. As the United States Supreme Court held in *O'Connor v. Donaldson*:[74]

> [A] finding of 'mental illness' alone cannot justify a State's locking a person up against his will and keeping him indefinitely in simple custodial confinement . . . there is still no constitutional basis for confining such persons involuntarily if they are dangerous to no one and can live safely in freedom . . . on their own or with the help of family or friends.[75]

The Court went on to state that "[o]ne might as well ask if the State, to avoid public unease, could incarcerate all who are physically unattractive or socially eccentric. Mere public intolerance or animosity cannot constitutionally justify

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71. The term "gravely disabled," for example, appears as a criterion for commitment in at least seven states. *See* ALASKA STAT. § 47-30.700 (1990); COLO. REV. STAT. § 27-10-105(g) (1990); CONN. GEN. STAT. § 17a-497(a) (Supp. 1991); IDAHO CODE § 66-329(c) (Supp. 1991); IND. CODE ANN. § 16-14-9.1-3 (Burns 1990); LA. REV. STAT. ANN. § 28:52.4(B) (West 1989); WASH. REV. CODE ANN. § 71.05.150(1)(A) (Supp. 1991). But each criterion for involuntary commitment seems to be applied differently in different states. In Arizona for example, a person may be in need of treatment only because she is a danger to herself or others, is persistently or acutely disabled, or gravely disabled as a result of a mental disorder. ARIZ. REV. STAT. ANN. § 36-533 (Supp. 1991). And in California, an individual may be committed as gravely disabled if she is unable to care for her own basic needs for food, clothing, and shelter. CAL. WELF. & INST. CODE § 5008(h) (West Supp. 1991).

It is interesting to note that some states are now moving in the opposite direction. In 1989, Arkansas modified its involuntary commitment law to prohibit commitment unless a person "poses a clear and present danger to himself or others" due to a mental disorder. ARK. CODE ANN. § 20-47-207(c) (Supp. 1991). Arkansas had previously allowed involuntary commitment upon showing that a person was "gravely disabled." *See* ARK. CODE ANN. § 20-47-207(b)(1) (Michie 1987). Nevada has also narrowed its involuntary commitment criteria to include only a person "likely to harm himself or others." NEV. REV. STAT. ANN. § 433A.200(2)(a) (1991). *See* NEV. REV. STAT. ANN. § 433A.200 (Michie 1986).

72. The American Psychiatric Association's proposed revised standard for commitment was presented originally in a law review article. *See* Clifford Stromberg & Alan Stone, *A Model State Law on Civil Commitment of the Mentally Ill*, 20 HARV. J. ON LEGIS. 275 (1983).

73. *See, e.g.*, TEX. HEALTH & SAFETY CODE ANN. § 573.012 (Vernon Supp. 1992); N.C. GEN. STAT. § 122c-3(11) (Supp. 1990); WASH. REV. CODE ANN. § 71.05.020(1)(b) (Supp. 1991).

74. 422 U.S. 563 (1975).

75. *Id.* at 575.

the deprivation of a person's physical liberty."[76]

The Supreme Court's decision in *O'Connor* has been followed by a majority of states which now require a showing of mental illness and dangerousness prior to involuntarily committing a person.[77] Practically, the Court's holding means that any state hospitalizing a nondangerous person against her will is violating the person's constitutional right to liberty unless the State is providing treatment to the individual.

Questions remain unanswered, however, by the Court's decision. First, how is dangerous to be defined? Although the Court did not define dangerousness, it did indicate that a person could not be considered dangerous if she is "capable of surviving in freedom" or is not "helpless to avoid the hazards of freedom."[78] Further support for a narrow reading of dangerousness can be found in the Court's opinion when it observed that Mr. Donaldson was not dangerous, because he had never "committed a dangerous act" and that "there was no evidence that [he] had ever been suicidal or been thought likely to inflict injury upon himself."[79] Second, what is meant by the term "mental illness?" The Court "assume[d]" that the "term [mental illness] can be given a reasonably precise content and that the 'mentally ill' can be identified with reasonable accuracy."[80] Finally, the Court set aside the important question of "whether mentally ill persons dangerous to themselves or to others have a right to treatment upon compulsory confinement by the State, or whether the State may compulsorily confine a nondangerous mentally ill individual for the purpose of treatment."[81]

The Court's decision has been interpreted to prohibit the confinement of people who pose no danger to themselves or others. The State is also prohibited from confining anyone for an indeterminate amount of time. The rationale for limiting the amount of time a person may be confined involuntarily, is that commitment is a significant curtailment of liberty and should be applied only in limited circumstances. In short, due process requires that the nature and duration of commitment bear some reasonable relation to the purpose for which the individual is committed.[82] As a result, most states now require

76. *Id.*

77. *See* BRAKEL ET AL., *supra* note 52, at 34.

78. *O'Connor*, 422 U.S. at 574 n. 9.

79. *Id.* at 568.

80. *Id.* at 575. This "assumption" would seem to leave open the possibility that in future cases, the reliability of psychiatric diagnoses could be challenged.

81. *Id.* at 573. Contrary to the Court's statement that the case did not decide the issue of a constitutional right to treatment, Chief Justice Burger explicitly denied such a right in his concurrence. He was, however, the only one to do so.

82. *See* Jackson v. Indiana, 406 U.S. 715 (1972). In this case, the defendant, a mentally retarded and mute man with the mental level of a preschool child, was charged with purse snatching. The trial court found him unable to show "comprehension sufficient to make his defense and ordered him committed to the state mental hospital until such time as the Department of Mental Health should certify to the court that the defendant is sane." *Id.* at 715. The defendant sought a new trial on the grounds that there was no evidence that he was insane nor that he would ever become "sane enough" to stand trial. The request was denied. The United

periodic reviews of initial civil commitment orders in order to sustain the continued involuntary confinement of an individual, thereby imposing de facto durational limits on civil commitments.[83]

The most recent court decision addressing the issue of the right of involuntarily committed people to periodic reviews occurred in a reincarnation of one of the oldest mental health cases in our history. In *Wyatt v. King*,[84] the plaintiffs alleged that the Alabama statute which provided neither a limit on the length of commitment nor an opportunity for an adversarial post-commitment periodic judicial review, violated the Due Process Clause of the Fourteenth Amendment to the Constitution. Plaintiffs presented one resident who had been involuntarily committed in 1970 and since then, had never been subjected to any formal procedure to determine whether her continued confinement was appropriate. Even though an evaluating psychiatrist noted in 1986 that foster care would be preferable for this resident, no discharge procedures were ever initiated.[85]

The court ruled in favor of the plaintiffs in *Wyatt*, holding that the Ala-

States Supreme Court reversed, finding that a defendant may not be committed indeterminately. *Id.* at 738.

83. *See generally* Charles D.H. Parry, Eric Turkheimer & Paul Hundley, *Commitment and Recommitment: Shortcomings in the Application of the Law*, 9 DEV. MENTAL HEALTH L. 25 (1989). *See, e.g.*, Clark v. Cohen, 794 F.2d. 79, 86 (3d Cir. 1986), *cert. denied*, 479 U.S. 962 (1986) ("Periodic reviews are required because if the basis for a commitment ceases to exist, continued confinement violates the substantive liberty interest in freedom from unnecessary restraint."). As these cases illustrate, support exists for periodic reviews of civil commitment orders. Questions still remain, however, whether such reviews must be automatic or whether patient-initiated reviews satisfy constitutional standards. *See* Fasulo v. Arafeh, 378 A.2d 553, 556 (Conn. 1977) (due process requires periodic judicial reviews); Doe v. Austin, 668 F. Supp. 597, 601 (W.D. Ky. 1986), *aff'd in part and rev'd in part*, 848 F.2d 1386 (6th Cir. 1988) ("there must be some judicial review, at some appropriate time, of the commitment of persons. . . ."); Johnson v. Solomon, 484 F. Supp. 278, 288-89, 313 (D. Md. 1979) (six month judicial reviews of juvenile commitments to mental retardation facilities required); *In re* Bicksler, 501 A.2d 1 (D.C. 1985) (construing D.C. ANN. CODE § 6-1985 (1981), providing periodic review of commitment of people with mental retardation); State v. Fields, 390 A.2d 574, 579 (N.J. 1978) (right to periodic review applies to civil committees and insanity acquittees); *see also* Streicher v. Prescott, 663 F. Supp. 335 (D.D.C. 1987) and the discussion *infra* nn. 153-59 and accompanying text.

84. 793 F. Supp. 1508 (M.D. Ala. 1991).

In *Lynch v. Baxley*, 386 F. Supp. 378 (M.D. Ala. 1974), a district court in Alabama found that the state's procedures for the involuntary committment of the mentally ill to state institutions did not comport with the Due Process Clause of the Fourteenth Amendment because the statutes provided for inadequate notice, allowed detention without a probable cause hearing within a reasonable period of time, did not require the person to be either committed to be present at the hearing, or represented by counsel, and provided unclear standards for commitment. As a result of the court's decision in *Lynch*, the legislature enacted new provisions to the involuntary commitment statute. *See* ALA. CODE 1975 §§ 22-52-1 to -37 (Michie 1990) (amended 1991). The constitutionality of these provisions was challenged several years later insofar as they permitted a person discharged on a "trial visit" in the community to be recommitted without a full hearing in compliance with the procedures required by *Lynch* for an initial commitment. *See* Birl v. Wallis (Birl I), 619 F. Supp. 481 (M.D. Ala. 1985); Birl v. Wallis (Birl II), 633 F. Supp. 707 (M.D. Ala. 1986).

85. Wyatt v. King, 773 F. Supp. at 1511.

bama statute violated the Due Process Clause of the Fourteenth Amendment. First, the court found that the failure to release patients who no longer meet the requirements for civil commitment implicated a liberty interest. Having concluded that persons confined involuntarily have a liberty interest in being released immediately if hospitalization is no longer necessary, the court then determined that certain process was due to ensure that the interest is not improperly curtailed. The court balanced the state interests in the civil commitment process with the interest of the residents in avoiding erroneous continued confinement and held that the state must hold post-commitment periodic judicial reviews with set procedures and standards, the reviews must be conducted within 150 days of the initial commitment, and then renewed annually thereafter.[86]

In short, since the decisions of the 1970s beginning with *Lessard v. Schmidt*[87] and *Lynch v. Baxley*,[88] most states have come a long way from the days of warehousing and confining people under vague standards and for indeterminate amounts of time. Most states require a showing that even if the person satisfies the standard for commitment (i.e., mentally ill and dangerous), the commitment itself must be the "least restrictive alternative" or the "least drastic means" for treatment available.[89] In other words, a court may sustain a commitment order, only if the person is mentally ill and dangerous *and* only if involuntary civil commitment is the "least restrictive" or "least drastic" means of providing treatment to that individual.

The "least restrictive alternative" or "least drastic means" test is now routinely applied in mental health cases, but its origin has nothing to do with mental health law. It originated in a case involving a labor dispute decided by the United States Supreme Court in 1960. In *Shelton v. Tucker*,[90] the Court invalidated an Arkansas law requiring public school teachers, as a condition of employment, to disclose annually to which organizations they belonged and to which they contributed. The Court reasoned that schools have an interest in assuring loyalty among their teachers and in promoting democracy. But the Court struggled with the question of whether the State may use any means whatsoever to achieve these goals. The Court held that the requirement to disclose all affiliations was too broad and that a legitimate state purpose cannot be accomplished by means that broadly "stifle fundamental personal liberties when the end can be more narrowly achieved."[91] The means adopted must be narrowly tailored to achieve the basic statutory purpose.

86. *Id.* at 1516-17.

87. 349 F. Supp. 1078 (E.D. Wis. 1972).

88. 386 F. Supp. 378 (M.D. Ala. 1974).

89. *See* BRAKEL ET AL., *supra* note 52, at 352-56.

90. 364 U.S. 479 (1960).

91. *Id.* at 488. While the Court's decision in *Shelton v. Tucker* is often cited as the first decision to articulate the "least drastic means" test, it appears that the Supreme Court may have introduced the concept earlier. In Anderson v. Dunn, 19 U.S. 204 (1821), the Court considered the issue of whether people who refused to testify in Congress could be held in contempt. The Court held that while Congress' interest in preserving respect for its procedures

The least restrictive principle was first applied in the area of mental health law six years later in *Lake v. Cameron*.[92] In this case, Judge Bazelon of the United States Court of Appeals for the District of Columbia held that an elderly woman who needed custodial care should not be involuntarily hospitalized until the trial court at least explored other alternatives.[93] Eight years later the District of Columbia's federal district court held that not only should alternatives to hospitalization be explored, but residents of the public psychiatric hospitals had a right, under the law of the District of Columbia, to treatment outside of the hospital in a "less restrictive alternative setting."[94]

As a result of such judicial pronouncements and legislative enactments, certain procedural and substantive safeguards have been put in place to ensure against the random institutionalization of people, including elderly people. For example, a hearing is now required prior to the commitment of any individual, and the right to a periodic review of the initial commitment is guaranteed in many states to guard against commitments which become inappropriate as the residents grow older.[95]

Despite the procedural safeguards, the imposition of dangerousness as a criterion for commitment, and the requirements of finite commitments and treatment in the least restrictive alternative settings, many elderly people remain confined in psychiatric hospitals. Apparently the standard of dangerousness necessary to justify the continued confinement of elderly people is applied differently to elderly people than to younger people who may exhibit the same behavior. For example, Mr. Oakes was committed because he married a

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was important, implementation of that policy could be achieved only in a way that "least affects individual liberties."

92. 364 F.2d 657 (D.C. Cir. 1966).

93. *Id. See also* Rennie v. Klein, 462 F. Supp. 1131 (D.N.J. 1978); Lynch v. Baxley, 386 F. Supp. 378 (M.D. Ala. 1974); Welsch v. Likins, 373 F. Supp. 487 (D. Minn. 1974), *aff'd*, 525 F. 2d 987 (8th Cir. 1975) (requiring state officials to make good faith attempts to place involuntarily committed persons in settings that are suitable and appropriate to their mental and physical needs and least restrictive of their liberties); *In re* Boyer, 636 P.2d 1085 (Utah 1981) (applying "least restrictive alternatives" analysis to the appointment of a guardian).

94. Dixon v. Weinberger, 405 F. Supp. 974 (D.D.C. 1975). Many states now impose the least restrictive alternative requirement. Arizona provides that there be "no available or appropriate alternatives to court-ordered treatment." ARIZ. REV. STAT. ANN. § 36-540(B) (1986 & Supp. 1990). Other states require that treatment in the hospital be "adequate" or "appropriate." MICH. COMP. LAWS ANN. § 330.1444 (West 1980); UTAH CODE ANN. § 62A-12-209 (1989); VT. STAT. ANN. tit. 18, § 7612 (1987); LA. REV. STAT. ANN. § 28:50 (West 1989). Maine requires a "full consideration of less restrictive treatment settings" and proof that "inpatient hospitalization is the best available means of treatment of the person." ME. REV. STAT. tit. 34-B, § 3864 (West 1988).

95. Michigan's commitment law, for example, specifically seeks to protect elderly people from inappropriate commitments. It specifies that age alone is not a basis for commitment and requires special testing for people over age 65 undergoing commitment proceedings. MICH. COMP. LAWS ANN. §§ 330.1402, .1441 (West 1980). Pennsylvania enacted the Mental Health Procedures Act, PA. STAT. ANN. tit. 50, § 7101 *et. seq.* (1976 & Supp. 1991) which requires that persons who are senile shall receive mental health treatment "only if they are also diagnosed as mentally ill." *Id.* § 7102. *See also In re* Rogers, 14 Pa. D. & C. 3d 90 (1980) (construing the statute's distinction between senility and mental illness).

younger woman of whom his family did not approve. One could not imagine the involuntary civil commitment of a twenty-five year old man today because he married a woman of whom his parents did not approve. Similarly, a young person who does not maintain an apartment would not likely be civilly committed, yet an older person who fails to keep an apartment clean runs that very risk. A recent study of elderly mental health clients revealed that one-third of the people who were transferred from community placement to an institution were transferred because of wandering or self-neglect. Such behaviors are simply not considered sufficient to sustain the commitment of a younger person.[96]

In short, the threat of doing harm to oneself has continued to provide support for a denial of the liberties of elderly people.[97] Yet a threat alone should not be sufficient for the denial of rights and liberties. People who are "normal"—not old and not mentally impaired—make decisions all the time that could risk their own interests: they impulsively enter into contracts, choose occupations for which they are unsuited, or buy the wrong stock or socks, for that matter. But they are provided with the freedom to succeed or fail at such endeavors. Thus the fact that we may not act in our own best interests is an unacceptable justification for parentalistic[98] restrictions.[99]

Courts have recognized the impropriety of confining elderly people for parentalistic reasons as "their own good":

> Consider the individual who is untreatable in the present state of medical science. Perhaps all that can be done for him under institutional tutelage is to care for his physical needs and/or subdue him through use of drugs. Unless the right to treatment be interpreted to include ineffective treatment, an anomaly in itself, the *parens patriae* rationale would seemingly fail and indeterminate institutionalization would necessarily be a purely custodial function and justifiable only by other considerations.[100]

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96. *See, e.g.*, Whanger, *supra* note 30.

97. *Compare* Bergman v. Serns, 443 So. 2d 130 (Fla. Dist. Ct. App. 1983) (upholding an elderly woman's presumptive right to live and remain in her own home and refusing to order her institutionalized since she could obtain necessary care at home) *with In re* Byrne, 402 So. 2d 383 (Fla. 1981) (court upheld forcible removal of elderly man from his home to an institution for fear of hazards to health because of "infirmities of aging"), *app. dism'd sub nom. In re* Turner, 455 U.S. 1009 (1982).

98. I use the term parentalistic rather than paternalistic since such attitudes are evidenced by men (paternalism) and women (maternalism), both of which pose serious risks to an elderly person's dignity.

99. Many types of "help" are offered to elderly people in need of assistance under the guise of *parens patriae*. Such proposals have been codified in guardianship and protective services laws, or implemented by informal guardianship by friends or relatives, trusteeships, durable powers of attorney, revocable powers of attorney, representative payees, protectorships, intervivos property transfers, insurors or guarantors, and limited bank accounts. *See* MARSHALL B. KAPP & ARTHUR BIGOT, GERIATRICS AND THE LAW: PATIENT RIGHTS AND PROFESSIONAL RESPONSIBILITIES (1985).

100. *In re* Ballay, 482 F.2d 648, 659-660 (D.C. Cir. 1973) (citations omitted). This court

Another court has recognized that a person who is elderly "may occasionally at times ask questions that may seem out of place, or he may repeat questions and conversations, and may be forgetful at times, yet it cannot be said that such are the constituent elements of and the only test of mentality."[101] Yet under such circumstances, an elderly person is considered to be unable to care for herself.

Such decisions seem to support an argument that elderly people may not be involuntarily confined under the *parens patriae* power even though they may require some sort of care. Nonetheless, many elderly people throughout the nation continue to reside involuntarily in public psychiatric hospitals although they are not dangerous, in many cases not even mentally ill, and most certainly not receiving treatment in a setting less restrictive than a mental hospital ward. A recent survey conducted by the Mental Health Law Project in Washington, D.C. revealed that well over 3,200 elderly people who are in state psychiatric hospitals have remained confined there for longer than ten years.[102]

One author has called paternalism, when applied to the elderly, "the harshest widespread application of paternalism in our society."[103] Despite the progress made with respect to society's balancing of autonomy and paternalism, elderly people remain the victims of a parentalistic system of civil commitment. This Article will now explore the financial and ageist explanations for the large number of elderly people who have remained in public psychiatric hospitals for so many years.

B. Funding for Mental Health Services: The Incentive Toward Institutional Care

The most significant reason for the continued confinement of elderly people in psychiatric hospitals is that there are no financial incentives to support community-based mental health care. It is beyond the scope of this Article to survey all possible funding sources for programs for elderly people with mental health care needs, either in terms of the money spent or the number of

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further observed that "while it is indeed deplorable that alternative facilities are unavailable, that these persons exist and need help does not strengthen the argument that treatment can serve as a justification for involuntarily committing one who is untreatable." *Id.* at 659 n.41.

101. Rhoads v. Rhoads, 163 N.E. 724, 726 (Ohio Ct. App. 1927).

102. The Mental Health Law Project, a public interest law organization based in Washington, D.C. received a grant from the Retirement Research Foundation to study the extent to which elderly people remain inappropriately confined in state mental hospitals and to design model community residential programs for these elderly people. For more information about this work, contact Leonard Rubenstein, Director, Mental Health Law Project, 1101 Fifteenth Street, N.W., Suite 1212, Washington, D.C. 20005.

103. Elias S. Cohen, *Autonomy and Paternalism: Two Goals in Conflict*, 13 LAW, MED. AND HEALTH CARE 145, 149 (1985). The author, citing U.S. SENATE SPECIAL COMM. ON AGING: 1983 (1984), observes that over 1.2 million people now reside in nursing homes. *Id.* at 150. He continues: "for only a tiny proportion does the entry into a nursing home represent an affirmative act comporting with desires, wishes or preferences, and it is only recently that some jurisdictions have begun to explore less restrictive alternatives." *Id.*

persons receiving services. The programs are numerous and each contains different eligibility requirements. Some programs provide services for all elderly people; some provide services for all mentally ill people; some provide services for elderly people with low incomes; some provide services for all low-income people; some provide services for elderly and mentally ill people; and some include elderly people and mentally ill people among the categories of people which states may elect to include in their individual programs.[104] Of the latter programs, a disproportionate number favor the elderly. As one researcher has found, since 1960 the share of the federal budget spent on programs serving the elderly has nearly doubled. At the beginning of the 1960s, less than fifteen percent of the federal budget was devoted to programs for the elderly. By 1984, the percentage had grown to twenty-eight, although a slight reduction to twenty-six percent occurred in 1986.[105]

Despite the large outlay of funds for certain classes of elderly people, however, relatively few public dollars have been spent on elderly people living in the community who may have mental health service needs.[106] In fact, funding for mental health care for elderly people outside the institutional context is severely limited.

Mental health care generally has suffered a long tradition of inadequate funding, characterized by lower reimbursement rates and greater restrictions than for other types of health care services.[107] Most of the current scarce mental health dollars are spent on institutional care which costs roughly twice that of nursing homes and four times that of psychiatric day care or private boarding home care.[108]

Government programs and fiscal policies rely primarily on institutional models. For example, the federal Medicaid program does little to promote community mental health care for people in need of mental health services. In

104. *See, e.g.*, Title 3, Older Americans Act of 1965, 42 U.S.C.A. § 3026 (Supp. 1992) and 42 U.S.C.A. § 1381-83 (1988) (Supplemental Security Income Program (SSI)) and corresponding regulations at 20 C.F.R. § 416.101-.2217 (1991)).

105. STAFF OF SENATE SPECIAL COMMITTEE ON AGING, AGING AMERICA: TRENDS AND PROJECTIONS 1987 (1988).

106. *See id.*

107. *See* Jones et al., *supra* note 39 (citing Charles Keeran, *Removing the Barriers to Mental Health Services*, HOSP., Mar. 16, 1980, at 14).

108. *See* Valery Portnoi, *Sounding Board: A Health Care System for the Elderly*, 300 NEW ENG. J. MED. 1387, 1389 (1979); J.E. Spar, C.V. Ford & E.H. Liston, *Hospital Treatment of Elderly Neuropsychiatric Patients*, 28 J. AM. GERONTOLOGY SOC'Y 539 (1980); Henry Murphy, Frank Engelsman, & Francoise Tcheng-Laroche, *The Influence of Foster Home Care on Psychiatric Patients*, 33 ARCHIVES GEN. PSYCHIATRY 179 (1976).

Surprisingly few studies have been conducted to investigate the economics of alternatives to state hospitalization. *See* Philip May, *Cost Efficiency of Mental Health Delivery Systems I: A Review of the Literature on Hospital Care*, 60 AM. J. PUB. HEALTH 2060, (1970); Jones et al., *supra* note 39, at 37. Perhaps the best known study that used a benefit-cost analysis cautioned that government policy should not be concerned with flows of money *per se* but with the uses of limited real resources that are needed to produce socially useful goods and services. *See* Burton Weisbrod, Mary Ann Test & Leonard Stein, *Alternatives to Mental Hospital Treatment II: Economic Benefit-Cost Analysis*, 37 ARCHIVES GEN. PSYCHIATRY 400 (1980).

1987, a total of 23.2 million people received Medicaid benefits; today, more than 66.9 billion dollars is spent annually on the program.[109] Because the federal and state governments share the cost of Medicaid, each state has its own version of the program and spends accordingly; Medicaid *per capita* spending in 1984 ranged from an average of $148 in New York to $52 in Wyoming.[110] Not only does the amount of expenditures vary from state to state, but the type of services reimbursable under Medicaid varies as well, often to the detriment of people in need of mental health services.

Under federal law, certain services are mandated and other services may be provided at the state's option. However, Medicaid-eligible people in need of mental health services are among the most inadequately served since mental health care is reimbursable, but only for people who are sixty-five or over or under twenty-two years of age and who reside in psychiatric hospitals. Individuals with mental illness may also theoretically obtain reimbursable services in nursing homes, but only in facilities that are not required to provide (and often do not provide) mental health care.[111] Further, regardless of a person's age, Medicaid is not available to reimburse for most services provided in the community, although such coverage is available for people with mental retardation.[112] In short, Medicaid provides no incentive to support community-based mental health care. Consequently, Medicaid funds are simply not generally available, even when community alternatives to institutional care exist.[113]

A few states, such as New York, are experimenting with programs for mental health clients, particularly elderly clients, under waivers of Medicaid requirements, granted to provide services in the community at a lower cost than institutional care.[114] But even in New York long inpatient stays often occur because alternative community placements are not available.[115] During

109. *See* Chris Koyanagi, *The Missed Opportunities of Medicaid*, 41 HOSP. & COMM. PSYCHIATRY 135 (Feb. 1990).

110. John Holahan & Joel Cohen, *Medicaid: The Trade-Off Between Cost Containment and Access to Care*, URB. INSTIT. (1986), *cited in* Koyanagi, *supra* note 109.

111. *See* Peter Fox & Steven Clauser, *Trends in Nursing Home Expenditures: Implications for Aging Policy*, 1 HEALTH CARE FINANCING REV. 65 (Fall 1980).

112. *See* Koyanagi, *supra* note 109. Certain recent changes to Medicaid have extended its coverage to outpatient hospitalization and clinic services. *See* 42 C.F.R. § 440.20(1), § 440.90.

113. The Community Mental Health Centers Act, 42 U.S.C. § 2681 *et seq.* (1963), amended as Mental Health Systems Act, 42 U.S.C. §§ 9401 *et seq.* (1988), is another federal program that allocated funds to develop mental health services for people in need of treatment, including elderly people. But despite this federal mandate, few resources have been dedicated to developing community-based services for elderly people.

114. The Medicaid Waiver program, which was established as Section 1915 of the Omnibus Budget Reconciliation Act of 1981, authorizes the waiving of Medicaid requirements in certain circumstances in order to promote community care and home care. Services not permitted to be reimbursed under Medicaid are reimbursable, once a waiver from the United States Department of Health and Human Services is obtained. *See* 42 U.S.C. § 1396n(c), § 1396n(d) (Supp. 1991).

115. *See* NEW YORK STATE OFFICE OF MENTAL HEALTH, STATEWIDE COMPREHENSIVE PLAN FOR MENTAL HEALTH SERVICES 1991-95 189 (1989).

the fiscal year 1988-89, for example, sixty-six percent of the Office of Mental Health's $2.5 billion budget was spent on inpatient facilities, while only thirteen percent of the patients annually enrolled in the state mental health system were treated in these institutions.[116] Thus in New York and elsewhere, few, if any, options other than institutional care exist for elderly mental health clients.[117] Although state mental hospitals serve less than one quarter of people considered mental patients nationwide, over half of public mental health dollars remain in the institutions.[118]

When community mental health services are available, such as those provided under the Older Americans Act, they often fail to respond to the needs and interests of elderly people.[119] Elderly people may not want to leave their homes and attend activities each day at a senior center funded by the Act, nor are they necessarily interested in learning crafts which do not draw upon the skills they have developed throughout their lives.[120] Yet programs for elderly people continue to be built around these services rather than the needs and interests of older adults.

The Medicare program, which should be a source of funding for mental health care for older people, also operates as a disincentive to the development of community programs. Medicare requires a fifty percent co-payment by the patient and severely limits the type of services and providers it covers.[121]

Similarly, the other major source of funding for community mental health services for elderly people, the Alcohol, Drug Abuse and Mental

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116. *Id.* at 17, 21.

117. Private insurance has also not been available to reimburse mental health services. Indeed, some commentators have noted that

> [t]reatment for mental disorders are not reimbursed by third party payers in the same degree or manner as general medical disorders. Although coverage of psychiatric care has improved during the 50 year history of health insurance in the United States, private insurance to cover the costs of psychiatric care is only about half as available as it is to cover general medical costs.

STEVEN SHARFSTEIN, SAM MUZSZYNSKI & EVELYN MYERS, HEALTH INSURANCE AND PSYCHIATRIC CARE: UPDATE AND APPRAISAL 1 (1984).

118. *See* Leonard Rubenstein, *Access to Treatment and Rehabilitation for Severely Mentally Ill Poor People*, 20 CLEARINGHOUSE REV. 382, 384-85 (1986).

119. Older Americans Act, 42 U.S.C. §§ 3001-3057. The reauthorized Older Americans Act, with amendments, was signed into law on November 29, 1987 as Pub. L. 100-175. Final implementing regulations were issued on August 31, 1988, 53 Fed. Reg. 33758-01 (1988).

120. Mr. Dodd, an elderly resident of St. Elizabeths Hospital and plaintiff in *Streicher v. Washington*, refused emphatically to spend his days engaged in planned activities such as basket weaving and arts and crafts, calling them "child's stuff for crazy people." *See supra* note 17 and accompanying text.

121. 42 U.S.C.A. § 1395d (1992). Prior to last year, a cap of $1,100 per year for outpatient mental health care was imposed on all recipients of mental health services, and mental health services provided by professionals other than psychiatrists were not reimbursable. However, proposals to increase or eliminate the cap and expand the covered providers have been considered by Congress every year for the past four years and last year such proposals were adopted. The cap on Medicare coverage has been eliminated and clinical psychologists and clinical social workers may now receive reimbursement for services to Medicare-eligible clients. *See* 42 U.S.C. § 1395u(b)(4)(F)(ii)(I)(1992).

Health Block Grant (ADAMH) Program, is also restricted.[122] This program, administered by the National Institute of Mental Health included the elderly as a target population for mental health demonstration programs when Congress reauthorized the ADAMH in 1985. Yet as the government's own survey has concluded, the ADAMH "fails to accommodate the specialized needs of the elderly."[123]

In sum, elderly people must compete with younger, often more visible mental health clients for whatever limited resources exist in their state for community treatment. Consequently, thousands of elderly people reside in state mental hospitals simply because few alternatives to institutionalization are funded for them.

C. Ageism and Staff Perceptions About the Abilities of Elderly People

Prejudices and misperceptions about elderly people have also impeded the placement and integration of formerly institutionalized elderly people into the community. Ageism,[124] which promotes the stereotype of an elderly person as incapable of growth and development, remains pervasive in our society as myths about older people abound. Beliefs that chronological age determines physical, mental, and emotional status are common in our society; accordingly, people who advance in years are considered confused, senile, unproductive, inflexible, disabled, or frail. Yet facts clearly dispel these myths. The vast majority of elderly people live in the community either independently or with some part-time assistance. They are capable of thinking and reasoning well, as the ability to think and reason does not decrease with age.[125] Moreover, confusion and disorientation often labeled "senility" may be a result of emotional, nutritional, or medication side effects that may be reversible.[126]

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122. 42 U.S.C. § 300x-1 (1991).

123. 3 ACTION COMMITTEE SURVEY, *supra* note 48, at 44.

124. The term "ageism" was first coined by Dr. Robert Butler in 1969 when he wrote:

> Ageism can be seen as a systematic stereotyping of a discrimination against people because they are old just as racism and sexism accomplish this with skin color and gender. Old people are characterized as senile, rigid in thought and manner, old fashioned in morality and skills . . . ageism allows the younger generation to see older people as different from themselves; thus they subtly cease to identify with their elders as human beings.

Robert Butler, *Ageism: Another Form of Bigotry*, 9 THE GERONTOLOGIST 243 (1969). He later won a Pulitzer Prize for his work, WHY SURVIVE? BEING OLD IN AMERICA (1975).

A paradox exists which is worth noting. Ageism was identified by Dr. Butler precisely at the time when government spending on behalf of elderly people began to rise. Since 1960, the share of the federal budget devoted to programs for the elderly has nearly doubled. *See* Elias S. Cohen, *Realism, Law and Aging*, 18 LAW, MEDICINE AND HEALTH CARE 183, 185 (1990).

125. *See, e.g.*, Robert Butler, *Health and Aging: The New Gerontology*, *in* HEALTH AND AGING: PERSPECTIVES AND PROSPECTS 143 (J. Schroots, J. Birren & A. Svanborg et al., eds., 1988); RICHARD MARGOLIS, RISKING OLD AGE IN AMERICA (1991); Martin L. Levine, *Introduction: The Frame of Nature, Gerontology and Law*, 56 S. CAL. L. REV. 261 (1982).

126. *See, e.g.*, Wojtek Chodzko-Zajko, *The Influence of General Health Status on the Relationship Between Chronological Age & Depressed Mood State*, 23 J. OF GERIATRIC PSYCHIATRY

Ageism also encompasses the view that an elderly person would not benefit from life in the community. It is evident in its starkest form among state psychiatric hospital staff. Physicians have been found to have accepted society's devaluation of and prejudices about the elderly and are reluctant to invest their time and energy in extended treatment that an elderly patient may require.[127] Staff may engage in "often casual and cursory [visits], reflecting pro forma compliance with minimum state requirements."[128]

These attitudes are communicated to the hospital staff who may then view their elderly clients as particularly vulnerable and become overly protective of "their" patients. Years of institutional neglect have conditioned many elderly patients to make few demands on the staff and programs. Activities, such as basket weaving and needlework, support the stereotype of them as docile and even childlike. Staff consider geriatric wards of psychiatric hospitals as the elderly resident's home, since many have spent the majority of their adult lives there. A colleague once heard a staff person remark that an elderly resident had only been on that ward a short time — five to ten years! The ease with which years of a person's life are so easily dismissed is troubling.

Given these staff perceptions, any attempt to move a long-term resident of a psychiatric hospital into the community is considered by many as unnecessary meddling at best and life-threatening at its worst. The fear of "transfer trauma" as it is known, has, by some accounts, paralyzed attempts to move long-time residents of psychiatric hospitals into the community. Yet such concerns are rarely expressed with respect to a move of an elderly person from one institution to another. And more important, research has indicated that with proper preparation and support, little disruption occurs in an elderly person who is transferred from the institution to the community. In fact, staff support has been found to be the single most important determinant of success in moving an elderly client to a community setting since "staff attitudes can reinforce institutionalized behavior."[129] Blatant ageism, as well as a combination of legal and financial considerations, seem to account for the large number of elderly people who have remained in mental hospitals, long after they may have benefited from institutionalization.[130]

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13 (1990); ALISON NORMAN, MENTAL ILLNESS IN OLD AGE: MEETING THE CHALLENGE (1982).

127. Lawrence Lazarus & Jack Weinberg, *Treatment in the Ambulatory Care Setting, in* HANDBOOK OF GERIATRIC PSYCHIATRY 427, 432 (E. Busse and D. Blazer eds., 1980); *Psychiatric Dilemmas of Caring for the Elderly, in* 6 ROCHE REPORT: FRONTIERS OF PSYCHIATRY 11 (1981).

128. *See* Portnoi, *supra* note 108, at 1388.

129. Roy Ettlinger, Norbert Binkowski & Andrey Zaiser, *A Senior Citizens Center and a Geriatric Transitional House at a State Psychiatric Hospital*, 35 HOSPITAL AND COMMUNITY PSYCHIATRY 1029, 1030 (1984).

130. Some commentators dispute whether there is any benefit at all to involuntary institutionalization. For example, one commentator has argued against involuntary commitment in any form. *See* Stephen Morse, *A Preference for Liberty: The Case Against the Involuntary Commitment of the Mentally Disordered*, 70 CAL. L. REV. 54 (1982). In Morse's view, civil commitment should be abolished for several reasons. First, he queries why commitment is

IV
THE RIGHT TO TREATMENT FOR ELDERLY INSTITUTIONALIZED PEOPLE: *STREICHER V. PRESCOTT*, LITIGATION AS A STRATEGY TO SECURE THEIR RELEASE

There is no constitutional right to treatment *per se* for any institutionalized person. The phrase "right to treatment" was coined in 1960 by Morton Birnbaum, who wrote in the American Bar Association Journal, that "[t]he purpose of this article is to advocate the recognition and enforcement of the legal right of a mentally ill inmate of a public mental institution to adequate medical treatment for his mental illness."[131]

Congress reacted to Birnbaum's article by scheduling congressional hearings about the treatment of people in state psychiatric hospitals. These hearings revealed that only a few institutionalized people actually received active therapy and that many of the beds were occupied by people with no diagnosis of mental illness.[132] The hearings showed, often in horrifying detail, that people in state institutions received no treatment, only custodial care.[133]

Following these hearings, Congress enacted the 1964 Hospitalization of the Mentally Ill Act to establish the right of institutionalized persons to treatment.[134] The first case brought under this Act was *Rouse v. Cameron*,[135] which considered whether a man committed to an institution following a ver-

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appropriate only for people labeled mentally ill. Others labeled normal also commit violent acts and may be unable to control their behavior, yet they are sent to prison, not committed. For example, a person with lung cancer who continues to smoke knowing that it will kill her, may lack the ability to control her behavior in the same way a person suffering from delusions lacks control. A "normal person" is perceived to act according to her own free will, and the normal person is let alone while the person labeled mentally ill is committed. To Morse, mentally ill people should not be legally distinguishable from "normal" persons. The person labeled mentally ill, however, is perceived to have no free will and may be hospitalized preventively, even in the absence of any evidence to support future dangerousness. Second, Morse argues that civil commitment produces unacceptable numbers of improper commitments because there is no single definition of mental disorder or dangerousness. Third, he argues that once committed, people do not receive appropriate treatment and care, and even if they do, the treatment and care will not necessarily diminish the behaviors that necessitated the original commitment, nor train the person to live in the community after release. Finally, Morse argues that involuntary hospitalization is not the best way to provide treatment to people labeled mentally ill. Better and less expensive ways exist on a voluntary basis in the community. Commitment is used, he argues, because lawyers and judges see no alternatives. Morse concludes by adopting a Szaszian view, that civil commitment should be abolished and that if people labeled mentally ill act in a way that violates society's norms, they should be incarcerated, like other people who are considered normal.

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

132. Only 50 of the 7,000 patients in St. Elizabeths Hospital were receiving individual psychotherapy. *Hearings before the Subcomm. on Constitutional Rights of the Senate Comm. on the Judiciary on the Constitutional Rights of the Mentally Ill*, 87th Cong., 1st Sess. 24 (statement of Dr. Overholser).

133. *Hearings before the Subcomm. on Constitutional Rights of the Senate Comm. on the Judiciary on a Bill to Protect the Constitutional Rights of the Mentally Ill*, 88th Cong., 1st Sess. 12 (1963) (statement of Senator Ervin).

134. D.C. CODE ANN. § 21-562 (Supp. 1966).

135. 373 F.2d 451 (D.C. Cir. 1966).

dict of not guilty by reason of insanity had a right to treatment. The court acknowledged that the purpose of involuntary commitment is treatment, not punishment, and that the 1964 Act recognized that "[a] person hospitalized in a public hospital for mental illness shall, during his hospitalization be entitled to medical and psychiatric care and treatment."[136] As a result, the court remanded the case to determine whether the individual was receiving adequate treatment. Because the court found that the plaintiff's rights under the 1964 Act had been violated, the court did not reach the issue of whether a constitutional right to treatment exists.

Since the inception of litigation on behalf of mentally disabled people, courts have been confronted with the issue of whether people in state custody have a constitutional right to treatment for mental health. Until 1982, courts seemed to acknowledge that treatment was a right of involuntarily confined people. For example, as the Supreme Court said in *O'Connor v. Donaldson*, "a state cannot constitutionally confine without more a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends."[137]

Further, in *Wyatt v. Stickney*[138] and *New York State Association for Re-*

136. *Id.* at 453 (quoting D.C. CODE ANN. § 21-562 (1964)).

137. 422 U.S. 563, 576 (1975).

138. 325 F. Supp. 781 (M.D. Ala. 1971); 334 F. Supp. 1341 (M.D. Ala. 1971), *supplemented by* 344 F. Supp. 373 (M.D. Ala. 1972), and 344 F. Supp. 387 (M.D. Ala. 1972); *affirmed sub nom.* Wyatt v. Aderholt, 503 F.2d 1305 (5th Cir. 1974).

Wyatt was the first case to recognize the rights of institutionalized people. The case began in 1970 as an obscure labor dispute and resulted in one of the most influential, if not most controversial, cases ever filed in the field of mental disability law. Filed originally as a class action lawsuit on behalf of residents of Bryce Hospital in Alabama, the complaint was later amended to include residents of two other state institutions for the mentally retarded and mentally ill. The court entered two orders, one for the treatment of people with mental illness and the other for people with mental retardation. An appendix to each of these orders set out the minimum standards necessary to achieve constitutional conditions and adequate treatment and habilitation. These standards ranged from protection of the residents' rights to privacy and dignity to specific standards regarding, for example, staff-patient ratios, the temperature of the facilities, and space between beds. They also required the creation of Human Rights Committees to guarantee the provision of constitutional and humane treatment. *Wyatt*, 344 F. Supp. at 395-408.

Although *Wyatt* has been hailed as a great victory for the rights of institutionalized people labeled mentally disabled, it has been criticized as usurping the legislature's function while leaving unresolved the seemingly insurmountable financial burden of implementing such mandates. Nor did the *Wyatt* orders address the qualitative issues relating to treatment. For example, guaranteeing certain staff-patient ratios does not ensure quality treatment nor does it address the difficult questions of whether certain patients are "treatable" or which treatments are best for which patients. *See* PERLIN, *supra* note 59, § 4.22.

Nonetheless, *Wyatt* had an enormous impact on the rights of people with mental disabilities. Congress enacted the Bill of Rights Section of the Mental Health Systems Act and many other courts were presented with similar challenges. *See, e.g.*, Halderman v. Pennhurst State Sch. & Hosp., 612 F.2d 84 (3d Cir. 1979), *rev'd in part and remanded*, 451 U.S. 1 (1981); Eckerhart v. Hensley, 475 F. Supp. 908 (W.D. Mo. 1979); Davis v. Balson, 461 F. Supp. 842 (N.D. Ohio 1978); New York State Ass'n for Retarded Children, Inc. v. Carey, 393 F. Supp. 715 (E.D.N.Y. 1975); Welsch v. Likins, 373 F. Supp. 487 (D. Minn. 1974), *aff'd*, 525 F.2d 987 (8th Cir. 1977).

tarded Children v. Carey (Willowbrook),[139] the courts acknowledged the rights of the mentally disabled to treatment or habilitation.[140] But in 1982, the Supreme Court decided *Youngberg v. Romeo,*[141] which failed to recognize a constitutional right to treatment. This was the first time the Court addressed the constitutional rights of involuntarily committed residents in a state institution. Nicholas Romeo was a thirty-three year old man who had been labeled severely retarded, with the mental capacity of an eighteen-month old child. After sustaining at least sixty injuries as a resident of Pennhurst State School, a state institution for mentally retarded people, he sued, alleging that the state officials responsible for his care had failed to prevent him from suffering injuries, had improperly physically restrained him, and had failed to provide him with appropriate care and treatment.[142] The Court, in a unanimous decision, held that the substantive rights provided in the Fourteenth Amendment define only minimum requirements and not a right to specific treatment.[143]

Although the resident had a constitutional right to training in basic self-care skills to help minimize his aggressive outbursts consistent with his liberty interest in avoiding frequent restraints, as well as a limited right to adequate food, shelter, clothing, medical care, safety, and freedom of movement, none of these rights was "absolute." Rather, these rights are subject to implementation consistent with "professional judgement."[144] The Court failed to recog-

139. New York State Ass'n for Retarded Children v. Rockefeller (Willowbrook), 357 F. Supp. 752 (E.D.N.Y. 1975) (granting preliminary injunction); New York State Ass'n for Retarded Children, Inc. v. Carey, 393 F. Supp. 715 (E.D.N.Y. 1975) (approving proposed consent judgment). Another case, Halderman v. Pennhurst, 612 F.2d 84 (3d Cir. 1979), involved the issues of whether the right to habilitation extended to people with mental retardation. Whereas the right to treatment generally refers to people with mental illness, the right to habilitation generally refers to people with mental retardation, although the terms are sometimes used interchangeably. Since mental retardation cannot be "treated," the term habilitation is used to describe the remediation of the delayed learning processes of the person with mental retardation to the point that the person may develop her maximum growth potential in terms of language, personal, social, educational and recreational skills. *See* Bruce G. Mason, Frank J. Menolascino & Lorin Galvin, *Mental Health: The Right to Treatment for Mentally Retarded Citizens: An Evolving Legal and Scientific Interface,* 10 CREIGHTON L. REV. 124, 139-40 (1976).

140. Similarly, the *Willowbrook* case involved a class of residents challenging an institution for people with mental retardation. 375 F. Supp. 752. The *Willowbrook* court rejected the *Wyatt* right to treatment theory, but nonetheless held that the residents had a constitutional right to be free from harm. As the court reasoned, "For mentally retarded people, the difference between the ability to do things for themselves within an institution and total dependence on the institution for all of their needs is as much liberty as they will ever know." *Id.* at 764. *See also Halderman,* 612 F.2d 84.

141. 457 U.S. 307 (1982).

142. *Id.* at 310-11.

143. The Due Process Clause of the Fourteenth Amendment provided Mr. Romeo with a liberty interest that required the "[s]tate to provide minimally adequate or reasonable training to ensure safety and freedom from undue restraint." *Id.* at 319. The Court reasoned that if convicted criminals are protected against cruel and unusual punishment in their conditions of confinement, "it must be unconstitutional to confine the involuntarily committed - who may not be punished at all - in unsafe conditions. " *Id.* at 315-16.

144. *Id.* at 321.

nize a *per se* right of people with mental retardation to treatment or to be treated in the least restrictive environment.

The Court rejected the *Wyatt* court's view and held that residents, at a minimum, have a constitutional right to "reasonable care and safety, reasonably nonrestrictive confinement conditions, and such training as may be required by these interests."[145] The Court found it unnecessary to decide whether institutional residents had a general right to adequate treatment and habilitation. Instead, it held only that Mr. Romeo had a right to training reasonably necessary to ensure his safety and to allow him to remain free from undue restraint.[146]

The Supreme Court has rejected the view that the Fourteenth Amendment to the United States Constitution guarantees the right to treatment for people involuntarily confined in public mental health or retardation facilities. Had the Court found such a right under the Constitution, legislatures would be more easily persuaded to devote the resources necessary to protect that right.[147]

Nonetheless, several states have now recognized the right to treatment under state statutory law. The first case to find a mandate for treatment in the least restrictive setting, *Dixon v. Weinberger*,[148] held that patients at the District of Columbia's only public mental hospital were entitled to treatment outside of the hospital, if appropriate.[149] In Arizona and New York, two state courts have upheld the right to treatment in the community under state

145. *Id.* at 324.

146. *Id.* A major question left unanswered by the Court's decision in *Youngberg* is whether there is a constitutional right to placement in the least restrictive environment. In another case decided by the Court, Halderman v. Pennhurst State Sch. & Hosp. 451 U.S. 1 (1981), the Court remained silent as to whether such a right existed. Although many courts have issued orders and consent decrees requiring a reduction in the size of institutions, most have avoided addressing the underlying constitutional issues. *See, e.g.*, Dixon v. Weinberger, 405 F. Supp. 974 (D.D.C. 1975) (decided on statutory grounds).

147. Fundamental rights under the Constitution must be protected, and, as a practical matter, paid for. For example, the fundamental right to counsel, created through the Sixth Amendment, and applied to the states through the Fourteenth Amendment, now requires the funding of court-appointed counsel programs for every defendant who is faced with a jail sentence. *See* Argersinger v. Hamlin, 407 U.S. 25 (1972). Similarly, the Supreme Court has guaranteed a defendant's right to a court-appointed psychiatrist to evaluate a defendant alleging an insanity defense. *See* Ake v. Oklahoma, 470 U.S. 68 (1985). The right to education, at the public's expense, has also been recognized, although not as a "fundamental" right. *See* San Antonio Indep. Sch. Dist. v. Rodriguez, 411 U.S. 1, 18 (1973), *reh'g denied*, 411 U.S. 959 (1973).

148. 405 F. Supp. 974 (D.D.C. 1975).

149. In *Dixon v. Weinberger*, the court based its decision on the District's Hospitalization of the Mentally Ill Act of 1964 which, in the court's view, required the "return [of] the mentally ill through care and treatment to a full and productive life in the community as soon as possible, given the patient's condition." 405 F. Supp. at 976. *Dixon* was eventually settled as a result of a consent order. Under this order, the hospital was given five years to provide the plaintiff class with mental health care in the community and appropriate residential and support services. The court also created the *Dixon* monitoring committee to monitor compliance with the court order. Even after contempt proceedings, the local government has not effectuated all the structural changes necessary to implement the decree.

laws.[150] Yet people who are labeled mentally ill or mentally retarded and who are not confined to institutions have no right to treatment, although settlement of cases such as *Brewster v. Dukakis*[151] and *Dixon v. Dixon*[152] have attempted to guarantee treatment at the public's expense.

Streicher v. Prescott[153] was a case brought to secure the right to appropriate treatment for elderly people in mental health institutions. However, the strategy was different from previous cases. Instead of seeking to vindicate their right to treatment *per se*, the *Streicher* plaintiffs claimed that they were being held illegally since the District of Columbia had never established that they were commitable under current law.[154] The plaintiffs asked the court to address two legal issues affecting the lives of elderly residents of St. Elizabeths Hospital, the District of Columbia's only public mental hospital.[155] First, for those plaintiffs who had been committed under the now-illegal commitment criteria, the court was asked to declare their commitments illegal and to order new commitment hearings. Second, for all the plaintiffs, including those whose commitments were more current, the court was asked to declare the District of Columbia's commitment law invalid because it failed to provide an automatic judicial review for all committed patients.[156]

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150. Arnold v. Arizona Dep't of Health Servs., 775 P.2d 521 (Ariz. 1989) (upholding the right of people in need of mental health treatment to such treatment under state law). In Klostermann v. Cuomo, 126 Misc. 2d 247 (1984), the court upheld the right of nine homeless people, former residents of New York State psychiatric institutions, to a treatment plan for their release, which includes housing. Such treatment was required because it was discovered that the defendants already provided such services to individuals who had less severe conditions than the plaintiffs. *Id.* at 251. The court upheld their right on equal protection arguments, but held that no federal constitutional right to treatment at public expense existed. *Id.* at 250. As the court stated, "[I]t is only confinement of that patient that triggers Federal constitutional obligation upon a state to provide him with treatment in the 'least restrictive environment.' " *Id.*

Other courts have reached similar results. In Goebel v. City & County of Denver, No. 81MG270 (P. Ct. 1984), Goebel v. Colorado Dep't of Institutions, 764 P. 2d 785 (Colo. 1988), and Assocation for Retarded Citizens of California v. Department of Dev. Services, 696 P.2d 150 (Cal. 1985), the courts held that lack of sufficient funding did not excuse the defendants from satisfying their statutory obligation to provide services to people with mental illness.

But in Mental Health Association v. Deukmejian, No. Ca. 000 540 (Cal. Super. Ct. Apr. 12, 1985) and Society for Good Will to Retarded Children v. Cuomo, 572 F. Supp. 1300 (E.D.N.Y. 1983), *later proceedings*, 574 F. Supp. 994 (E.D.N.Y. 1983), *vacated*, 737 F.2d 1239 (2d Cir. 1984), the courts did not uphold the right to treatment in the face of budget shortfalls.

151. 786 F.2d 16 (1st Cir. 1986).

152. *See* 405 F. Supp. 974 (D.D.C. 1975). Note that the defendant's name changes as the mayor of Washington, D.C. changes.

153. 663 F. Supp. 335 (D.D.C. 1987).

154. *Id.* at 336.

155. At the time the lawsuit was filed, St. Elizabeths Hospital was owned by the federal government on land leased to it by the District of Columbia. In November 1984, Congress passed legislation providing that by 1991, the hospital would be the sole responsibility of the District of Columbia government. *See* St. Elizabeths Hosp. and D.C. Mental Health Serv. Act., Pub. L. No. 98-621, 98 Stat. 3369, 3371 (1984).

Similar strategies may be employed to safeguard the freedoms and dignity of elderly people subject to guardianship proceedings. *See, e.g.*, Rosoff & Gottlieb, *supra* note 35, at 44-45.

156. *See infra* notes 84-88 and accompanying text. Most states have amended their commitment laws to provide a review of commitment orders. The law in the District of Columbia

The court has not yet ruled whether residents of psychiatric hospitals have a constitutional right to automatic judicial reviews of their commitments every six months.[157] However, the court did rule in favor of plaintiffs' rights to new commitment hearings. In a lengthy opinion, the federal district court granted plaintiffs' motion for partial summary judgment, mandating judicial hearings for a subgroup of the plaintiff class, consisting of all clients committed before 1973.[158] As the court stated, "these patients, all of whom have been detained and forcibly residing in St. Elizabeths for more than 14 years, are entitled to judicial review of their present commitment status under prevailing constitutional standards. . . . [T]he risk that these plaintiffs have been erroneously confined for 14 years or more is constitutionally intolerable."[159] This decision marks the first case to recognize the rights of long-term residents of psychiatric hospitals to be released if they no longer satisfy the current standard for commitment.

The case was brought originally as individual habeas corpus petitions and was later certified as a class action. One of the named plaintiffs, Alma Streicher, was committed in 1960. In the fall of 1959, Ms. Streicher went to a

provides for such a review, but it is not automatic and can only be triggered at the patient's written request. The *Streicher* plaintiffs claimed that such a patient-initiated review is unconstitutional. Streicher v. Prescott, 663 F. Supp. 335, 337.

157. *Id.* In O'Connor v. Donaldson, 422 U.S. 563 (1975), the Supreme Court noted that even when the original commitment order is constitutionally permissible, the confinement must end when the basis for that commitment no longer exists. *Id.* at 575. Several courts have interpreted that mandate to provide that residents of mental hospitals have a constitutional right to a periodic review of their commitment "to reestablish from time to time the basis for continued confinement." Suzuki v. Quisenberry, 411 F. Supp. 1113, 1134 (D. Haw. 1976). *See also* Dixon v. Attorney General of Pa., 325 F. Supp. 966 (D.M.D. 1971) (three-judge panel found commitment statute "almost devoid of due process" and ordered that commitment orders be limited in time, and at not more than six-month intervals); Fasulo v. Arafeh, 378 A.2d 553 (Conn. 1977) (omission of automatic periodic review provision invalidated state commitment law under state constitution); State v. Fields, 390 A.2d 574 (N.J. 1978) (equal protection requires that civil committees and pretrial detainees be accorded the right to automatic periodic reviews of their status); Nelson v. Sandritter, 351 F.2d 284 (9th Cir. 1965); Johnson v. Solomon, 484 F. Supp. 278 (D.M.D. 1979); State *ex rel.* Watts v. Combined Community Servs. Bd. of Milwaukee County, 362 N.W.2d 104 (Wis. 1985); *In re* G.K., W.M. and P.S., 514 A.2d 1031 (Vt. 1986); State v. Ballou, 481 A.2d 260 (N.H. 1984) (*per curiam*); Thompson v. Commonwealth, 438 N.E.2d 33 (Mass. 1982); State *ex rel.* Hawks v. Lazaro, 202 S.E.2d 109 (W. Va. 1974); *In re* Richardson, 481 A.2d 473 (D.C. App. 1984).

158. In 1973, the Court of Appeals for the District of Columbia Circuit declared unconstitutional the "preponderance of the evidence" standard of proof in civil commitment cases. In its place, the court required the government's evidentiary burden in civil commitment cases to be "beyond a reasonable doubt." *See In re* Ballay, 482 F.2d 648 (D.C. Cir. 1973). Six years later, in Addington v. Texas, 441 U.S. 418 (1979), the Supreme Court rejected the preponderance of the evidence standard in commitment cases in favor of the "clear and convincing evidence" standard. None of the *Streicher* plaintiffs had received any form of judicial review since their initial commitment prior to 1973. Indeed, more than half had been committed before 1965 and had never had their commitments reviewed when the commitment law was changed in 1965. *See Streicher*, 663 F. Supp. 335, 336 n.3. Thus, by ruling that all residents committed before 1973 must be provided with new commitment hearings, the Court also included specifically those residents who were committed before 1965, when the standard for commitment was changed to require mental illness and dangerousness to self or others.

159. *Streicher*, 663 F. Supp. at 336-337, 342.

police station in the District of Columbia and told police that she had killed her husband. In fact, she had not—he had died from complications of alcoholism. She said that she was responsible for his death because she had never prevented him from drinking. The police did not arrest her. They took her to St. Elizabeths Hospital instead. Twenty-seven years later, in 1987, Ms. Streicher was notified that two years earlier, a hospital psychiatrist had determined that she was doing sufficiently well to change her status from involuntarily to voluntarily committed. Alma Streicher had been a free woman for over two years, but due to a hospital "filing error," she did not even know.

A second plaintiff, Lila Wiggins (a pseudonym) is now eighty-five years old, energetic, with a beautiful smile and a fondness for gold earrings and large-brimmed hats. She was civilly committed to St. Elizabeths Hospital in Washington, D.C. in 1939 at the age of thirty-seven because she smoked cigarettes and "liked men." In the 1940s her family tried to get her released, but after several years, they gave up. In the fifty years she has remained in the hospital, Ms. Wiggins has never had a hearing to determine if civil commitment was appropriate or an evaluation to determine if she could live outside of the hospital. In May 1989, Ms. Wiggins finally had a hearing to determine whether she should remain in the hospital. At the hearing, the hospital recommended that she be released from that hospital and be placed in the community. Although she has no mental illness and takes no psychotropic medication, she is frail, has diabetes, and requires daily injections of insulin, which she cannot give to herself. Both her attorneys and the hospital staff agree that a community residence with nurses who could administer the daily doses of insulin would be perfect for her, but she remained in the hospital because the city would release her only to a nursing home, where she refused to go.

The District of Columbia in this case did not take the position that all members of the *Streicher* subclass should be confined merely because they once satisfied a now-illegal standard for commitment.[160] Rather, the District of Columbia agreed that some of the plaintiffs should be released. In fact, of the original 309 class members, less than twenty-eight percent have been recommitted as inpatients.[161]

160. In *Streicher*, 92 members of the class were confined to hospital wards and 27 members of the class were committed as outpatients. 663 F. Supp. 335.

161. Ninety-two percent of the 217 people originally listed as outpatients had their commitment status overturned. Of the 92 people originally listed as committed inpatients, 31% had their commitments overturned, and most are being placed in community programs; 28% continued as committed inpatients; 14% were found to be mentally retarded and transferred to the mental retardation system for placement in the community; 14% had not yet had their status reviewed by the court; and 13% died prior to the disposition of their case. Elizabeth Jones & Arlene Kanter, *The Rights of Institutionalized Elderly People with Mental Disabilities*, at OUR AGING SOCIETY: A COLLOQUIUM ON THE RIGHTS OF OLDER AMERICANS, N.Y.U. REV. OF LAW & SOC. CHANGE, New York (Apr. 13, 1991).

CONCLUSION

"Every human being of adult years and sound mind has a right to determine what shall be done with his own body."[162] This maxim stated by Justice Cardozo has not been applied equally to elderly people. Today, thousands of elderly people remain isolated in institutions with no right to freedom or dignity. They have been abandoned by a legal system that imposes upon them a different standard when determining the appropriateness of hospitalization. In addition, the facilities that care for them fail to provide adequate treatment. Elderly residents of psychiatric hospitals are not included in decisions about their care nor consulted with about available programs, all under the guise of caring and parentalism.

Parentalism need not be synonymous with abandonment, however. For these elderly people, advocacy must continue to strive to establish the right to treatment in and outside of a hospital setting. For people who are elderly and have been left to reside in public psychiatric hospitals for decades, presumptions about their abilities and desires should be challenged, and if necessary, litigation brought on their behalf.

The doctrine of informed consent requires that prior to any medical or psychiatric treatment the doctor must obtain an informed consent from the patient. The common law duty of the physician to obtain consent includes the physician's responsibility to provide sufficient information to the patient to enable her to make a choice regarding treatment, even a choice the physician may believe is a poor one. Although there is a presumption that an adult is competent to consent to treatment unless she has been judicially declared incompetent, this presumption has not been applied with equal force to institutionalized elderly people.[163] If it is presumed that an elderly resident of a mental hospital is unable to make decisions, then a guardian is appointed. Often the guardian is not a family member or friend. Consequently, treatment decisions may be made by strangers or those whose personal interests conflict with those of the elder. Furthermore, no explicit standards exist to assist the decision makers in reaching decisions affecting the elderly resident.[164] Unless we as a society are prepared to recognize the right of these individuals to dignity and are willing to provide them with the opportunity to live in freedom, we will continue to perpetuate the ageist attitudes of a legal system gone awry.

162. Schloendorff v. Society of New York Hosp., 105 N.E. 92 (N.Y. 1914).

163. *See* Laurence B. McCullough, *Medical Care for Elderly Patients with Diminished Competence: An Ethical Analysis*, 32 J. AM. GERIATRIC SOC'Y 150 (1984).

164. *See* Ciccone, *supra* note 42.