

Legal Aspects of Clinical Care for Severely Mentally Ill, Homeless Persons

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The problem of widespread homelessness among mentally ill persons is often attributed to changes in mental health law. In consequence, suggestions for addressing homelessness frequently involve legal interventions, including loosening of commitment standards. A review of the limited data on the relation of legal standards to homelessness suggests that the problem is not primarily a result of statutory changes or court decisions, but stems from broader social problems, including the diminution of public psychiatric services. Simple legal remedies are, therefore, unlikely to be found. Nonetheless, there may be ways in which legal initiatives can be useful in mitigating homelessness, ranging from implementation of outpatient commitment to modification of rules concerning confidentiality, to efforts to establish entitlements to psychiatric and social services.

Homelessness in America results from a complicated web of causal factors. The restructuring of the industrial economy, the disappearance of low-cost housing, and the absence of community-based treatment and support services for mentally ill and/or substance-abusing persons have all contributed, alone and in interaction, to the current problem of homelessness.¹ The diversity of causes of homelessness is mirrored in the variety of people affected: employed and unemployed; single adults, independent adolescents, and families with children;

mentally ill persons and substance abusers; and persons with serious physical illnesses.²

A significant proportion of the homeless population have diagnosable mental disorders. A survey of existing literature suggests that approximately one-third to one-half of homeless persons suffer from severe and persistent mental illness, and another third suffer from disorders related to substance abuse. Considerable overlap exists between these two categories.³ There is dispute about how best to care for the homeless mentally ill population; advocates give different weight to the roles of housing programs, community mental health care, and psychiatric hospitalization.⁴

The role of the law in accomplishing any of these ends is a matter of some

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controversy.⁵ Systems for treating mentally ill people have always been premised on the assumption that coercive treatment may be needed, either because many mentally ill persons are incapable of making competent decisions about their need for care, or because they present serious threats to their own well-being or the well-being of others.⁶ Thus, many of the suggestions for legal initiatives to help the homeless mentally ill population involve the expansion of mechanisms for coercive care.⁷

The debate over this question tends to obscure other legal remedies. Legal doctrines establishing rights to treatment and other services for mentally ill persons may be used to compel the executive and legislative branches to establish programs in which homeless mentally ill persons may participate voluntarily. Efforts have been made, along these lines, to force recognition of governmental obligations to provide voluntary, outpatient mental health and case management services, as well as shelter and permanent housing.⁸ Other changes in the framing or interpretation of existing law might make it easier to deliver services to homeless persons.

This paper offers a critical review of certain legal remedies that might ameliorate the situation of homeless mentally ill persons. It focuses on issues related to the provision of mental health treatment, and does not consider measures related solely to shelter and housing access. Since no single remedy is likely to solve the multifaceted problems associated with homelessness, the emphasis is on identifying measures that might

make an incremental contribution to the effort.

Civil Commitment

Recent Evolution and Current Status of the Law During the late 1960s through the mid-1970s, the laws of civil commitment underwent a complete reorientation.⁹ Traditional standards for commitment, based on a potential patient's need for treatment, were criticized as overbroad and impermissibly vague.¹⁰ The state, it was argued, had no right to detain persons for the purpose of offering them ostensible benefits (i.e., treatment) they would rather avoid. Legitimate governmental intervention was limited to cases in which persons endangered others, or when they seriously endangered themselves. Moreover, the standards for involuntary confinement needed to be sufficiently precise that individual commitment decisions could be reviewed objectively by the judicial system.

Legislators prodded by these arguments (which were endorsed by the courts in many jurisdictions)¹¹ were aware of the poor conditions common in state mental hospitals and mindful of other considerations, such as potential cost savings from reducing inpatient hospitalization. As a result, legislatures replaced the familiar treatment-oriented criteria with standards for commitment based on dangerousness to oneself or others. In addition, procedural protections associated with the criminal justice process, such as adversarial hearings before judges, representation by counsel, and the right against self-incrimination,

became common.¹² Although some states subsequently made efforts to relax selected procedural rules or to broaden commitment criteria,¹³ the pattern imposed by the statutory reforms of the early and mid-1970s is still dominant.

Impact of Commitment Standards on the Homeless Mentally Ill Population

Changes in commitment laws have been blamed in part for many of the subsequent problems of homelessness among the mentally ill population.¹⁴ Critics frequently contend that the new generation of statutes makes it difficult to hospitalize severely mentally ill persons who are in need of treatment, but who fail to meet narrow dangerousness criteria, or who must be released because of technical procedural requirements. Anecdotes illustrating such cases, which often have tragic outcomes, can be found in the professional literature and the general media.¹⁵

The empirical literature on the effects of the new commitment laws, however, is less clear. Regarding the issue of whether the new laws resulted in a decrease in the number of commitments, some studies document seemingly profound effects in some jurisdictions,¹⁶ while studies in other areas find almost no impact.¹⁷ A recent effort suggests that the divergent findings are related to the length of follow-up after introduction of the new laws.¹⁸ Most studies show an immediate drop in the number of commitments within the first year, but almost every study that extends its observations beyond that period shows an increase in rates of commitment back toward the *status quo ante*.

Studies that have examined records of persons committed before and after statutory reform demonstrate little difference in demographics and diagnoses between the two groups.¹⁹ In addition, the only two studies that tried prospectively to assess whether patients in need of hospitalization were actually being excluded at the psychiatric emergency room conclude that their data did not support that assumption.²⁰ Data from several studies suggest that an important reason for these negative findings is that the dangerousness-based statutes, once thought to be restrictive and precise, allow a good deal of discretion in application.²¹ Moreover, statutory standards seem to be ignored when both clinical and judicial decision makers believe that hospitalization is necessary on some "common sense" basis.²²

If the impact of the dangerousness statutes is as limited as this analysis suggests, how can one explain the strong opinions of many clinicians and family members that they are inhibited from admitting persons in need? First, the data show *some* restrictive effects of the revised laws, albeit effects that are not as strong or as consistent as expected. Thus, the cases reported anecdotally by clinicians and families are not inconsistent with the empirical data sets. Second, commentators suggest that there may be substantial differences across jurisdictions, resulting less from the differences in the laws than from the ways in which the laws are applied.²³ In some jurisdictions, persons meeting the "common sense" standard for hospitalization will be committed, while in others, mentally

ill persons are not admitted unless rigidly defined dangerousness criteria are met.²⁴ Complaints about difficulties admitting deteriorating patients may come largely from the smaller number of more restrictive jurisdictions.

Changes in Commitment Law and the Homeless Mentally Ill Population Several categories of changes in commitment law have been proposed, with most focusing on a broadening of standards to include people who are not immediately dangerous to themselves or others, but who are suffering substantially or are likely to experience a deteriorating course. In 1979, the state of Washington was the first jurisdiction to redefine grave disability to include likely severe deterioration in the person's condition.²⁵ North Carolina broadened the definition of danger to self to include an inability to exercise self-control, judgment, and discretion in daily responsibilities or social relations; grossly irrational or inappropriate behavior, or other signs of severely impaired insight and judgment create a presumption that patients are unable to care for themselves.²⁶ By expanding their commitment criteria, the states of Alaska, Arizona, Colorado, Hawaii, Kansas, Rhode Island, and Texas made it easier to hospitalize certain classes of mentally ill persons.²⁷

The much-discussed American Psychiatric Association's model law would allow commitment if the person "will, if not treated, suffer or continue to suffer severe and abnormal mental, emotional, or physical distress, and this distress is associated with significant impairment

of judgment, reason, or behavior causing a substantial deterioration of his previous ability to function on his own." In addition, committed patients must lack the "capacity to make an informed decision concerning treatment": treatment must be available at the facility to which the patient will be sent; and commitment must be "consistent with the least restrictive alternative principle."²⁸

Although there may be reasons to push for large-scale reorientation of current commitment laws, it is difficult to justify that approach on the basis of our present knowledge about the homeless mentally ill population. The data discussed above suggest that, in practice, these laws in general are much less restrictive than is commonly believed. No data speak directly to the question of how current commitment law affects homeless persons. A recent major study of homeless persons in Baltimore, in which research psychiatrists were asked to indicate which subjects required psychiatric hospitalization, concluded that 18 percent of men and 15 percent of women fell into that category.²⁹ A Boston study of homeless persons classified seven percent of its subjects as needing psychiatric hospitalization.³⁰ It is not clear in either case, however, what percentage of these subjects would have accepted hospitalization if offered, or would have been committable under current criteria.

Factors other than the law may limit the hospitalization of homeless persons in need of treatment. The lack of available inpatient beds in many urban areas may lead clinicians to "ratchet up" their

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standards for commitment, leaving potentially committable persons on the streets.³¹ Perhaps more importantly, many homeless severely mentally ill individuals may escape evaluation by the mental health system, although they might be committable if examined. For example, when New York City established outreach teams authorized to order the transportation of homeless persons to a psychiatric emergency room for evaluation, 97 percent of the 466 patients transported in the first 1.5 years of the program were hospitalized.³²

If changes in commitment law are to be considered for the sake of the homeless mentally ill population, these changes should be supported by data indicating the nature and extent of the problem in the jurisdiction in question, the causal link between the problem identified and the current law, and the reasons to believe that statutory changes will effect the desired results. The application of these criteria to most jurisdictions at present will demonstrate the absence of sufficient justification for substantial changes. However, some places may be identified where statutory changes may be useful. Proposed changes should be considered for the advantages and disadvantages offered. But it must be emphasized that any expansion of the scope of commitment is unlikely to be effective in assisting homeless mentally ill persons unless the change is accompanied by an increase in available resources to treat the newly designated population.

Inpatient commitment is not the only area in which statutory changes are pro-

posed. Commitment to outpatient treatment is endorsed as a solution for two very different problems: affording a less-restrictive option for patients who would otherwise be committed to an inpatient facility; and breaking the cycle of the so-called "revolving door" patients, who are hospitalized, discharged, then rapidly decompensate when they stop taking medications, and subsequently are rehospitalized.³³

Outpatient commitment may have some relevance for homeless mentally ill persons, especially those who decompensate after stopping medications and perhaps those who are in need of treatment for substance abuse, in addition to treatment for their mental disorders. Psychiatrists in the Baltimore study found that 46 percent of homeless men and 64 percent of homeless women could benefit from outpatient psychiatric treatment.³⁴ However, since the target population for outpatient commitment is usually thought to be composed of patients who require medication to remain nonpsychotic, especially persons with schizophrenia and to a lesser extent bipolar disorders, the numbers who would benefit from mandatory outpatient commitment may be smaller. Only 12 percent of men and 17 percent of women in the Baltimore study had schizophrenia, with another seven percent and 8 percent respectively diagnosed with bipolar disorder.³⁵ A Los Angeles study offered comparable figures.³⁶ while a study of new entrants to New York shelters found 17 percent to have definite or probable psychosis.³⁷ These numbers offer estimates of the maxi-

imum proportions of homeless persons likely to be suitable for outpatient commitment. Some members of this group, of course, will require inpatient care.

Each outpatient commitment statute has to address two major issues: whether the eligibility criteria are the same as or broader than those for inpatient commitment, and how the commitment order should be enforced.³⁸ The answer to the criteria question depends upon the issue to be addressed. In an effort to widen the scope of their commitment laws, North Carolina and Hawaii adopted broader commitment criteria for outpatient than for inpatient commitment.³⁹ Arizona, in contrast, maintained its criteria, emphasizing the less restrictive alternative rationale.⁴⁰

Enforcement is a problem in all contexts. When broader criteria are used for outpatient commitment, hospitalization of the patient without proof that he or she meets inpatient commitment criteria is not possible. North Carolina explicitly eschews forced administration of medication to outpatients, which is another enforcement option. Nonetheless, recent data from North Carolina suggest that the majority of patients adhere to their treatment orders and that there are positive effects transcending the time period during which the outpatient commitment order is in effect.⁴¹

Despite concerns about civil liberties issues related to the proper scope of governmental intrusion,⁴² preliminary data suggest that outpatient commitment may be effective in leading patients to greater compliance with treatment. Guidelines have been developed to iden-

tify patients most likely to respond well to outpatient commitment.⁴³ Data concerning how many homeless mentally ill persons might benefit from this approach are lacking, but should be obtainable. Clearly, the efficacy of outpatient commitment in homeless populations, as in other groups, will depend largely on the resources available to monitor, track, and reach out to recalcitrant patients. Pilot projects with homeless persons in states that already have outpatient commitment statutes may be a better first option than widespread adoption of new statutes.

A final proposed change is extrastatutory. Some cities, like New York, established teams to assess homeless persons on the streets and to authorize the transport of those who are believed to meet commitment criteria to psychiatric emergency facilities.⁴⁴ A recent initiative in Congress would require states to establish such programs in order to receive federal Medicaid monies.⁴⁵ Since these projects operate within the definitions of existing law, they represent efforts to apply already agreed-upon commitment criteria to a population that is otherwise unlikely to appear at a psychiatric emergency room. These efforts are controversial,⁴⁶ but may be more acceptable to all parties than initiatives that require actual modifications of commitment law.

Competence and Informed Consent to Treatment

Recent Evolution and Current Status of the Law Until quite recently, committed mentally ill patients have been treated as exceptions to the general rules

requiring consent from patients before medical treatment takes place. The basis for this practice appeared to be the dual assumptions that most individuals seriously ill enough to require involuntary hospitalization are not competent to decide on their treatment, and that whatever justifies the state in hospitalizing patients against their will also legitimizes nonconsensual treatment.

Since the late 1970s, however, a growing number of courts have applied the doctrine of informed consent to committed mentally ill patients.⁴⁷ In many jurisdictions, committed patients, unless found to be incompetent, have the right to refuse treatment with medication. (Some jurisdictions provide review of a patient's objections to determine the appropriateness of the proposed treatment, without considering the patient's competence; this represents an incomplete application of informed consent in this context.) Conversely, once patients are found incompetent, treatment can be administered over their objections, after that decision is made according to the jurisdiction's procedures.

Impact of Competence and Informed Consent Law on Homeless Mentally Ill Persons As a patient's right to refuse treatment with medication was recognized, clinicians and families expressed concern that many patients who required treatment would be allowed to go without care.⁴⁸ In fact, a recent prospective study of medication refusal in Massachusetts demonstrated that fewer than eight percent of patients refused medication, over half of those reaccepted medication voluntarily, just under a

quarter had their refusals respected by clinicians, and the remainder had their refusals overturned in court.⁴⁹ Numerous studies confirm that nearly all cases that get to court result in treatment being imposed over a patient's wishes.⁵⁰ Most importantly, treating clinicians did not identify any patients in the Massachusetts study who clearly needed medication and who failed to receive it.⁵¹ The primary negative effects of the right to refuse treatment appear to be an increased length of hospital stay, disruption on the inpatient units leading to seclusion and restraint of patients, and the costs associated with review procedures.⁵²

Little data exist on the effects of the right to refuse medication on the homeless mentally ill population *per se*, and none address treatments other than medication. One recent study from California found that homeless persons were more likely to be found among medication refusers compared with a nonrefusing control group, but the sample size was small.⁵³ Nor do any data exist on what happens to patients who refuse treatment over the long term: for example, whether refusers who are discharged without treatment are more likely to become homeless.

Changes in the Law of Competence and Informed Consent and the Homeless Mentally Ill Population As with civil commitment, although current practices with regard to the right to refuse treatment can be questioned, the desirability of changes cannot, at this point, be linked to the situation of the homeless mentally ill population. It is not known

how alterations in treatment refusal standards or the review procedures themselves will impact this group, or might prevent entry into homelessness by other severely mentally ill individuals.

There are, however, three ways in which considerations of competence to consent to treatment may affect the homeless mentally ill population. First, the American Psychiatric Association suggests that the problem of committed patients refusing treatment be solved by including an "incompetent to decide about treatment" criterion as part of the standard for commitment.⁵⁴ The issue for any given patient, if previously judged incompetent, would be whether during the duration of the commitment the proposed treatment was appropriate.

There are reasons why an explicit competence provision is unlikely to be incorporated widely in commitment laws,⁵⁵ but where it is done (in Utah and Saskatchewan, and in more limited respects in Texas and Kansas⁵⁶) the provision forces a distinction between the competent and incompetent homeless mentally ill individual. The decision to reject treatment by those persons who are competent to make treatment decisions but are homeless may be more likely to be respected. The justification for intervening with homeless persons thought incompetent to decide about treatment may seem stronger than it does now when dangerousness is the major issue considered. A greater degree of consensus might evolve, in such a context, concerning the boundaries of appropriate interventions.

Concerns about competence to consent to treatment also may impact the homeless mentally ill population through mechanisms now used to override a patient's refusal of treatment. In some states, such as Massachusetts, a mechanism exists for adjudication of incompetence and for judicial decisions as to whether treatment should be administered for persons who are not hospitalized, as well as for those who are.⁵⁷ Determinations of the capacity of nonhospitalized persons to consent to treatment should be possible in most states. In effect, findings of incompetence and authorizations of treatment represent *de facto* outpatient commitment that does not rely on explicit outpatient commitment statutes. At least one report has been published of the use of such a process.⁵⁸

Finally, a recent decision of the U.S. Supreme Court raised, but did not resolve, the issue of whether prospective patients must be competent in order to admit themselves voluntarily to a psychiatric hospital.⁵⁹ Since evidence suggests substantially impaired decision making capacities in many newly admitted patients,⁶⁰ the adoption of such a rule might make voluntary hospitalization much more difficult, which would affect both homeless and domiciled mentally ill populations.

Competence to Make Decisions About Persons and Property

Recent Evolution and Current Status of the Law Traditionally, competence was considered an all-or-nothing phenomenon. People were either competent

to make all decisions in their lives, or incompetent to make any of them.⁶¹ In the last several decades, both the clinical and legal professions have changed their approaches to competence, recognizing that persons can be competent for some purposes and incompetent for others.⁶² Mentally ill individuals, for example, may be incompetent to manage their finances, but competent to decide about their preferred living situation. Some mentally ill individuals may be incompetent to decide about treatment because of delusions about medication, but competent to make decisions about issues unaffected by their delusional systems.

Appointing a guardian, conservator, or otherwise designated decision maker is the usual approach to assisting incompetent individuals.⁶³ Recently, these persons have been empowered to make decisions only about areas in which the subject of the incompetence finding is deemed to lack capacity.⁶⁴ For example, persons designated as representative payees can be appointed solely for the purpose of receiving and monitoring the disbursement of entitlement funds such as Social Security Disability Insurance (SSDI) payments.⁶⁵

Impact of Competence and Guardianship Law on Homeless Mentally Ill Persons Laws concerning a person's right to make decisions about their person and property constitute a double-edged sword. While these laws offer protection for the individual in the event of incapacity, they also deprive persons of important decision making powers. Little empirical research has been con-

ducted in this area, although data indicate that decisions about the determination of incompetence and the appointment of guardians are often made without many procedural protections for alleged incompetent individuals.⁶⁶

Homeless mentally ill persons may be in need of substitute decision makers for issues related to both person and property. Many homeless mentally ill individuals would qualify for entitlements related to their disabilities, including SSDI and SSI. Yet, studies in New York City, Boston, and Milwaukee indicate that only 29 percent, 21 percent, and 13 percent of homeless mentally ill persons studied were receiving any public benefits.⁶⁷ Although structural problems in the entitlement systems may be responsible in part for these figures, it is reasonable to conclude that many of these individuals, because of the effects of their illnesses, were unaware of their rights or incapable of negotiating the application process without assistance. Moreover, some proportion of those persons who do receive benefits may be so impaired in making decisions about spending their resources that they forego opportunities to secure more stable lives (e.g., shelter) for themselves.

The availability of guardians (or some equivalent) to make decisions about property might assist many homeless mentally ill persons, but the current process for appointing guardians for them is exceedingly difficult. The appointment of a guardian requires application to a court for a hearing on a determination of incompetence. An at-

torney's assistance usually is needed to file the requisite forms. A medical certificate signed by a physician who has examined the alleged incompetent individual is also required. Ordinarily, a potential guardian is suggested by the applicant, although judges can appoint attorneys who practice in their courts to serve in the absence of more appropriate choices.⁶⁸

Since this process is expensive and time-consuming, it is rarely used for people without substantial assets that require protection, and is usually initiated by someone who is personally interested in the assets not being dissipated.⁶⁹ Homeless persons are unlikely to conform to either of these desiderata. The appointment of a representative payee is somewhat simpler, but requires a person to be available to receive, disburse, and monitor payments. For many homeless persons, there is no one to fill that role.

Guardians of the person raise another set of issues with regard to the homeless mentally ill population. In some jurisdictions (such as California, where this category of guardians is called "conservators"), guardians inherently have or can be given the power to admit their wards to psychiatric facilities under the provisions of voluntary admission statutes.⁷⁰ Decisions can also be made about placement in nursing homes, board-and-care homes, and similar facilities, many of which are locked units. Other states prohibit guardians from exercising this power, or limit it to situations in which their wards have been found to meet ordinary commitment criteria.⁷¹

These powers of guardians are controversial. Some commentators regard them as a means of circumventing the commitment statutes by allowing involuntary detention of people who fail to meet commitment criteria.⁷² Others believe that guardians can play a role in stabilizing the chaotic lives of mentally ill individuals.⁷³ In any event, the practical obstacles to appointment of guardians for homeless persons noted above limit the application of these powers.

Changes in the Law of Competence and Guardianship and the Homeless Mentally Ill Population The availability of guardians for homeless mentally ill persons has the potential to make a substantial difference in their abilities to acquire and manage entitlement payments, and perhaps gain access to hospitals. Current difficulties in the appointment of guardians could be eased by the creation of public or nonprofit guardianship services. Such services, which already exist in some states,⁷⁴ could assist social workers or other outreach personnel with the filing of guardianship applications and, more importantly, provide personnel to perform the tasks required of a guardian (or an equivalent, such as a representative payee). Public guardian systems are not without their problems, but probably can be designed to work efficiently with this population, especially with regard to guardianship of property.

Some aspects of guardianship may be particularly problematic in working with the homeless mentally ill population. For example, regular contact between a guardian and a homeless person may be

difficult to maintain, and expenditures may be hard for the guardian to monitor. Nonetheless, the promise of regular income may be enough in many cases to win the homeless person's cooperation. Certainly this approach is promising enough to warrant a trial with careful evaluation. Given the deficiencies referred to above in procedural protections in many guardianship proceedings, initiatives of this type should incorporate provisions designed to protect individual rights.

The question of whether a guardian should have the power to admit a ward to a facility is more difficult. Denying incompetent persons access to hospitalization unless they meet commitment criteria differentiates them from all other people, who can admit themselves voluntarily. This is not likely to work to the advantage of a group as disabled as the homeless mentally ill population. It should be possible to design adequate protections for persons admitted by guardians, such as administrative or even judicial review of the appropriateness of the hospitalization decision (but not the person's committability) to mitigate many of the concerns in this area.

Confidentiality and the Coordination of Care

Current Status of the Law of Confidentiality As part of the general expansion of attention to patients' rights in the last two decades, rules governing confidentiality in mental health treatment have become more clearly defined.⁷⁵ Whether by statute, regulation, or common law, the general rule now is

that information communicated by patients in the course of evaluation or treatment should not be released without their consent. There are numerous exceptions to this rule, including emergency situations,⁷⁶ statutorily required reporting (e.g., of child or elder abuse),⁷⁷ information released to protect third parties from patients' violence,⁷⁸ and testimony in judicial proceedings, which is governed by testimonial privilege statutes in each state.⁷⁹ Jurisdictions differ in whether consent needs to be written or not.

Impact of the Law of Confidentiality on the Homeless Mentally Ill Population Confidentiality protects important interests of privacy. In the mental health treatment context, confidentiality, from a utilitarian point of view, serves to encourage individuals to seek treatment without fear of embarrassment, stigma, or other negative consequences that may result if the information they reveal to their therapists—or even the very fact that they are in treatment—were to become known to other people.⁸⁰ Despite these benefits, there are clearly ways in which rules governing confidentiality complicate the care of severely mentally ill individuals.

For families who want to assist mentally ill relatives who may be permanently or periodically homeless, confidentiality can be an obstacle to remaining in contact with and offering help to their family members.⁸¹ Hospitals and outpatient programs may decline to acknowledge that a particular person is admitted or enrolled, even when the family has been notified by others (e.g.,

the police) that this is the case. Similarly, families may be excluded from aftercare planning, and may not be informed when relatives are scheduled to be discharged from a facility. Similarly, caregivers in other agencies, such as outreach programs that have referred homeless persons to inpatient facilities, may not be told of post-discharge dispositions.

Changes in the Law of Confidentiality and the Homeless Mentally Ill Population The importance of confidentiality as a principle in mental health treatment means that its protections should not be abandoned lightly. However, there may be steps that treatment providers can take within existing law to ameliorate some of the problems that arise. Most of these can be accomplished if confidentiality issues are dealt with sensitively on a case-by-case basis.

For example, even when patients decline to grant permission to caregivers to reveal information to third parties, the caregiver may still meet with those parties to obtain information that may be useful in a patient's care. If the third party has learned of a patient's status from another source, the caregiver does not have to acknowledge explicitly the patient's presence in the program.⁸² Often the sense of being helpful is enormously reassuring to family members and other caregivers, and may maintain their involvement with homeless patients.

Attitudinal issues are also important. When family members' inquiries are rebuffed coldly, the implication that families do not have a right to know about their relatives may make families in-

censed with the mental health system. However, if caregivers tactfully explain rules concerning confidentiality and acknowledge the limits on communication to those interested in a patient's care, then an alliance can be maintained while respecting the patient's confidentiality.

Since confidentiality is intended to benefit patients, changes in confidentiality rules may be considered when evidence suggests that those rules may be working to the detriment of patients. Stigma may be less of a concern for a person who lives on the streets, and a desire to encourage persons to seek treatment by maintaining strict confidentiality may be less important when all care short of involuntary commitment is routinely rejected. Reasonable modification of the rules of confidentiality by legislatures or regulatory agencies can be considered. Some jurisdictions, for example, allow free exchange of information among public mental health agencies involved in a patient's treatment, even without that patient's consent. For the difficult-to-treat, severely mentally ill population, including those who are homeless, such a rule may make sense: extension to nonpublic and nonmental health agencies might also be considered.

Homeless mentally ill persons might also be asked to give prospective approval to release of information needed for treatment planning, which could then be used if hospitalization occurs. In addition, waivers of the usual rules of confidentiality could be sought for innovative programs that seek to involve family members in the care of homeless

mentally ill individuals. Cautious experimentation with altered rules of confidentiality should be considered when benefits to patients can be demonstrated.

Right to Treatment in the Hospital and the Community

Evolution and Current Status of the Right to Treatment The right to treatment for mentally ill persons has undergone many incarnations since it was first proposed more than 30 years ago.⁸³ Two parallel lines of law have evolved: one that relies on the federal constitution, and one that relies on statutes and state constitutions. The right has developed differently for hospitalized patients than for mentally ill persons in the community.

The first decision based on a federal constitutional right to treatment (arising from the due process clause),⁸⁴ the 1971 Alabama case *Wyatt v. Stickney*, was followed by numerous other cases resulting in judgments or consent decrees enforcing a right to treatment.⁸⁵ Generally, the end product was a list of staffing levels, treatment planning procedures, and patients' rights that the defendants were obliged to implement. These right to treatment cases rested on constitutional theories that a state has duties to provide treatment to persons who are deprived of liberty through involuntary hospitalization. But the idea that patients acquired a right to be treated in the least restrictive environment implied that states also could be compelled to create community-based services.⁸⁶

When the U.S. Supreme Court finally

addressed the right to treatment in *Youngberg v. Romeo* in 1982,⁸⁷ it sharply restricted the contours of the constitutional right. The Court found a right only to sufficient treatment to protect a committed patient's rights to freedom from unnecessary restraint and assault. Moreover, the Court suggested that it would not apply least restrictive alternative analysis to committed patients (thus undercutting the constitutional basis for a right to treatment in the community); instead, the Court would rely on professional caregivers' judgments of the extent to which rights needed to be limited. Although the lower courts differ in the degree to which they have followed the *Youngberg* lead,⁸⁸ and the issue of the right to treatment for inpatients remains unsettled,⁸⁹ subsequent decisions make it even less likely that the Court will support a constitutional right to services for the nonconfined population.⁹⁰

From the beginning, however, there were alternative bases for the right to treatment. The first right to treatment case, *Rouse v. Cameron*,⁹¹ was decided on a statutory basis, as was the most notable victory in creating a right to treatment in the community, *Dixon v. Weinberger*.⁹² Depending on how statutes are framed, they can convey rights that go beyond the right to treatment in the least restrictive alternative for committable patients, and include rights to treatment for the noncommittable mentally ill population. Since *Youngberg*, there have been successes,⁹³ as well as failures,⁹⁴ in using state statutes that appear to guarantee rights to treatment.

Along with state constitutional provisions, which are a relatively untapped source of law in this area, statutory approaches appear to offer the greatest hope for expansion of a mentally ill person's right to treatment in the community.

Impact of the Right to Treatment in the Community on the Homeless Mentally Ill Population Commentators are nearly unanimous in decrying the lack of community-based treatment and rehabilitation services for severely mentally ill individuals, and point to this deficit as a contributor to the problems of homelessness.⁹⁵ The creation of appropriate mental health services *per se*, even without the use of coercion to compel homeless mentally ill persons to utilize them, may significantly contribute to meeting their treatment needs. Data from different studies conflict over the proportion of homeless mentally ill persons who would accept mental health services if they were available,⁹⁶ but up to 25 percent of the population in need may be inclined to do so. Were the available services to include rehabilitation and housing, a much larger proportion would likely participate.

Changes in the Law Concerning the Right to Treatment in the Community Efforts to establish a right to treatment in the community are likely to be focused in state courts in the future, as federal constitutional rights to treatment have been strictly limited. To have a basis for suit, advocates will have to identify state statutory language that appears to guarantee treatment rights, and then weather objections that such

language was not meant to convey enforceable rights. Legislatures, more aware of the possibility of such litigation, may be more cautious in the future about appearing to promise services that they do not intend to fund. Alternatively, state constitutional provisions similar to the federal due process clause or others might be identified as a basis for litigation.

In a democratic society, there is an inherent tension in litigative strategies that seek to compel legislatures and the executive branch to create services that they previously have been unwilling to organize and fund. The countermajoritarian role of the courts has been accepted more when the courts have acted to protect powerless minorities from the majority's infringement of their negative rights rather than when there has been an attempt to create affirmative rights. Evidence for this is present in the most notable right to treatment decisions, where full compliance with court orders and consent decrees has been difficult to obtain.⁹⁷ State judges may be more reluctant than their federal counterparts to create broad remedies of the type usually sought in right to treatment cases.

Nonetheless, whatever impediments exist in theory or practice to utilizing the courts to mandate services for severely mentally ill individuals, such litigation is motivated by a stark reality. After four decades of deinstitutionalization, the promised transfer of care to the community has not taken place. Moreover, it is unclear whether services for the homeless mentally ill population will

ever be high enough on the political agenda for that to occur. Alternatives such as litigation may therefore represent the only means in many jurisdictions of obtaining meaningful assistance for the needs of this population.

Recommendations

Overview Changes in the law are no substitute for increases in funding and programs designed to provide needed services to the homeless mentally ill population. Nonetheless, as a matter of secondary concern, the law might be used to help homeless mentally ill persons take advantage of services that are available, and in some cases to increase those services.

Federal Approaches Given the primacy of state law in most matters relating to mental health, federal initiatives are best targeted at supporting needed research and developing pilot projects. Specifically, the federal government should:

1. Assist in the development of a data base that would allow informed judgments to be made as to the desirability of changes in the law. Research on the effects of current laws and proposed changes in the laws on the homeless mentally ill population should be supported and cover the following issues:

- existing and proposed commitment standards;
- involuntary transport programs; and
- rules concerning confidentiality and their impact on the coordination of care.

2. Stimulate the development of pilot

projects that either target existing statutes to the homeless mentally ill population, or that offer opportunities to test statutory modifications in selected localities by providing funding for such pilot projects, including:

- targeted use of outpatient commitment statutes with the homeless mentally ill population;
- creation of public guardian and representative payee services specifically for homeless mentally ill persons.

State and Local Approaches At this point, large-scale statutory changes affecting the homeless mentally ill population cannot be justified by what is known about this population. The states and some local governments, however, have the power to develop pilot projects to experiment with statutory alterations that might prove beneficial for this group. They also have the ability to provide funding for the enhanced services that will be necessary for almost any statutory change to have an impact. In collaboration with federal initiatives to fund evaluations of such projects, states should:

1. Develop targeted outpatient commitment systems for the homeless mentally ill population, especially in those states that already have statutes permitting outpatient commitment.

2. Establish public guardian and representative payee systems in an effort to promote access to entitlements for homeless mentally ill persons.

Public Education Approaches There may be ways in which education about alternative means of responding to legal

requirements could improve the effectiveness of groups working with the homeless mentally ill population. In particular, education is needed about confidentiality rules and their impact on the coordination of a patient's care. Clinicians should be taught how to respect patients' confidentiality while working cooperatively with family members and other care-givers.

Other Litigation concerning the right to treatment in the community—particularly if premised on state law—must originate outside of government. Advocacy groups for mentally ill individuals should examine the possibility of undertaking such litigation in appropriate jurisdictions. Nongovernmental agencies, including foundations concerned with mental health, might be able to provide the necessary funding.

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