

DIXON v. WEINBERGER:

A Study of the Fight to Reconstruct the District of Columbia's Mental Health System

Name Redacted

Submission for Institutional Reform Litigation/Third Year Paper requirement

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April 30, 1999

I want to acknowledge the many people who generously shared their time, their thoughts and their documents to help me understand the Dixon lawsuit. In particular: Judge Aubrey Robinson Jr., Dixon Receiver Scott Nelson, Deputy Corporation Counsel Janet Maher, Former Dixon Special Master Danna Mauch, Peter Nickles, Len Stein, Joe Bevilacqua, Len Rubenstein, Dixon coordinators Terry Hawkins and Ellen Harris, Bob Moon, Robert Washington, Elizabeth Jones, Hanna Schussheim, Laurie Davis, Barry Spodak and Michael Abramowitz.

I INTRODUCTION

“Washington ...at the time in this case was way out in front. One of the great tragedies really of the case is that when the decisions were made and when the consent decrees were entered, all around the country states and communities took to heart the basic teaching of this case -- which is that you ought to try to put back into society people who belong in society. They did so and got way out in front of the District of Columbia. And the District of Columbia became a laggard.”¹

Peter Nickles, plaintiffs' attorney

Over twenty-five years ago, attorneys for current and future patients of St. Elizabeths Hospital in Washington D.C. filed a lawsuit seeking community-based treatment for people with mental illness. In December 1975, they had their victory: a federal judicial decree firmly establishing the government's responsibility to provide community-based mental health care for people who did not require hospitalization. It was a seminal achievement for the mental health bar, one they thought would pave the way for a model program of community-based care and a new era of possibility for people with mental illness.

Yet today deinstitutionalization is as much a dirty word as a rallying cry. And nowhere more so than Washington D.C., where residents have watched the mental hospital fall into serious disrepair while promised improvements in community services remain largely unrealized. Even those who still strongly support the thrust of deinstitutionalization have little good to say about what has transpired in Washington's

¹ Interview with Peter Nickles, attorney at Covington and Burling, in Washington D.C. (Jan. 26, 1999). Unless otherwise indicated, all subsequent remarks attributed to Nickles are from this interview. I will use the same procedure when quoting other individuals who were interviewed for this paper.

mental health program in the years since the 1975 ruling.

The ever-shifting names of the Washington lawsuit tell part of the story. The case began as *Dixon v. Weinberger*, named for a longtime patient of St. Elizabeths and Casper W. Weinberger, then the head of the federal agency responsible for the hospital.² The federal names would change and ultimately disappear when the hospital was transferred to the control of the District of Columbia in the 1980s. District officials, always codefendants in the litigation, were then spotlighted in the case title through the administrations of D.C. Mayor Marion Barry, then Mayor Sharon Pratt Kelly, then Barry once again. The lawsuit continued because all these defendants were similarly unwilling or unable to meet their legal obligation to create an effective system of community-based mental health care. Today, Washington has a new mayor, Anthony Williams. Yet Williams does not run the mental health system. Instead, a court-appointed receiver is charged with bringing about the system envisioned, and decreed, almost a quarter-century ago. William Dixon, whose name remains in the case caption, died in 1992, still a patient at St. Elizabeths.³

Interestingly, the *Dixon* litigation is not a story of willful government resistance in the face of civil rights decree. Once the initial decree was handed down, the defendants rarely challenged the thrust of deinstitutionalization, and repeatedly entered into consent decrees pledging an ambitious overhaul of the city's mental health care. But neither did they embrace the cause or their legal responsibilities to the plaintiffs and the court.

The so-called *Dixon* decree fell victim to some factors unique to the case and to the

² Actually, the case was briefly called *Robinson v. Weinberger*. However, just months into the litigation the first name plaintiff withdrew from the suit and Dixon's name became the first half of the case title.

³ Melissa Warren and Robert Moon, *Dixon: In the Absence of Political Will, Carry a Big Stick*, *Law and Psychology Review*, 329, 329 (Spring 1994).

city: a mental health system divided between federal and District control and a city government crippled by weak management, limited autonomy and budget difficulties. But the case history also reveals dangers inherent to this breed of institutional reform litigation: how to keep track of what is or is not being done; controlling the budgeting for required services; how to choose among different plans for reform and the resulting political pressures. This litigation was harder still because it did not seek to reform an institution, so much as create a much broader mental health system that would serve as an alternative to the hospital. This was a daunting project beyond the scope of improving an existing facility within somewhat defined parameters. Moreover, the *Dixon* litigation took place relatively early in the move toward deinstitutionalization, before there were many models of what an effective community-based system would look like.

Throughout the case, Judge Aubrey E. Robinson Jr. made use of special tools to help tackle these challenges. Early on, he required the defendants to fund an expert monitoring committee to assess compliance and provide expertise. Later, he would appoint a mental health expert to mediate disputes between the parties and ultimately to serve as special master overseeing implementation of the 1975 decree. When even that failed to turn the District's mental health system around, the judge in 1997 appointed a receiver with sweeping powers to overhaul the system.

A year and a half into the receivership, there are signs that fundamental change is finally underway. The receiver is planning a new community services program, modeled on a model of aggressive community treatment. He has streamlined a disastrously cumbersome procurement process that repeatedly jeopardized contracts with key service providers. There are plans for a smaller and more modern mental hospital. The receiver's

progress thus far suggests that courts are able to rise to the managerial challenge posed by institutional reform. So long as the judge is willing to make use of expert assistance, sometimes going so far as a receiver, the court can be equally, and perhaps better, able to design a social service program.

That does not mean that the court's action will be seen as appropriate. In the case of the *Dixon* receiver, there are complaints from the defendants and plaintiffs alike. District officials complain about the loss of autonomy, as a non-elected official goes about making major decisions regarding a large sector of city services. Plaintiffs, for their part, are disappointed the receiver has not moved more swiftly on some matters and disagree with some of his policy inclinations. Whatever the receiver ultimately puts in place, it will not be what the parties once envisioned, either in substance or procedure. The *Dixon* litigation then, raises troubling questions not so much about the ability of courts to oversee such change, but rather the legitimacy of their actions to do so.

II. THE MOVE TOWARD DEINSTITUTIONALIZATION

While deinstitutionalization is sometimes seen as the product of a zealous and perhaps misguided civil rights bar, the effort to move people out of large state mental hospitals was well underway before the legal push for reforms in the 1970s. Instead, a combination of medical, social, economic and political factors produced the initial effort toward deinstitutionalization. One study showed that, in 1955, roughly three-fourths of all patient care episodes were handled in hospitals while one-fourth were handled in the community; 20 years later, when the civil rights push was just taking off, those

percentages had already flipped.⁴ The civil rights litigation therefore would influence not so much whether people with mental illness would leave the hospitals, but on what terms.

Prior to World War II, the people with mental illness were typically warehoused in large institutions. Many were long-term patients, including many elderly. Reform came from different directions. Several exposes helped set the stage by publicizing the demeaning and non-therapeutic conditions of state mental hospitals.⁵ The medical community began to take a more activist role in improving care for the mentally ill and the profession as a whole became more visible with the creation of the National Institute of Mental Health in 1949. Several years later, the American Medical Association and the American Psychiatric Association called for national standards governing the care of people with mental illness and Congress soon agreed to fund studies to improve mental health care.⁶ Those studies laid the groundwork for a new policy initiative by President Kennedy. Kennedy, spurred by his own experiences with a sister's mental retardation, advocated more humane treatment for the mentally disabled and his administration pushed for legislation to provide community mental health centers (CMHCs). The result was the Mental Retardation and CMHC Construction Act of 1963, which provided states with block grants to create community mental health centers. Two years later, Congress also voted money to help staff these centers. However, the money was scheduled to phase out over a number of years, with localities picking up the expense after that.

Other federal policies also created financial incentives for states to transfer patients out of large mental hospitals into smaller hospital settings and the community. Medicaid

⁴ Phil Brown, *The Transfer of Care*, 48 (1985).

⁵ Robert A. Dowart and Sherrie S. Epstein, *Privatization and Mental Health Care*, 28 (1993), noting in particular Alfred Deutsch's book, *The Shame of the States* (1948), and Mary Jane Ward's account of her own stay in such a hospital, *The Snake Pit* (1946).

and Medicare will help pay for the care of mentally ill patients in nursing homes or in the psychiatric wards of general hospitals, whereas states must fund mental hospital beds on their own. Dr. Fuller Torrey claims that this policy amounts to federal incentives for so-called “transinstitutionalization,” with the mentally ill simply being shuttled from one type of facility to another.⁷ The development of federal assistance programs, primarily food stamps and SSI, have also made it possible for former or prospective hospital patients to survive in the community.

Community treatment was also sold as cheaper than hospitalization, regardless of who was paying the bills. State mental hospital populations, and therefore costs, had been climbing throughout the first half of the century. Many hospitals were overcrowded and in poor condition, so states were facing the likely expense of building new institutions.⁸ The onset of the decline in hospitalization came just in time to head off some of that costly new construction. So fiscal conservatives had good reason to take interest in deinstitutionalization – both to take advantage of cost shifting to the federal government and to prevent the need for costly new hospitals.

Another factor fueling the move from state hospitals was the development of psychotropic drugs. These medications first came into common use in U.S. hospitals during the mid-1950s and offered new promise to many longtime hospital patients.⁹ Many psychiatrists welcomed the new medications. As one commentator describes it, “drugs appealed to psychiatrists and hospital staff because they were simple to use and paralleled the advances being made in the field of medicine, which the field of psychiatry

⁶ *Id.* at 29.

⁷ Fuller Torrey, *Out of the Shadows*, 102 (1997).

⁸ Nancy K. Rhoden, *The Limits of Liberty: Deinstitutionalization, Homelessness, and Libertarian Theory*, 31 *Emory Law Journal* 375, 381 (1982).

had so long sought to emulate."¹⁰ Moreover, these medications could be administered outside the hospital setting -- making community treatment seem far more viable. By 1961, the Joint Commission on Mental Illness and Health had concluded that psychotropic drugs were the primary factor behind reversing years of rising patient loads in state mental hospitals.¹¹

These developments coincided with the burgeoning civil rights movement on behalf of people with mental illness. At its most extreme, this movement questioned the very existence of mental illness -- seeing it as a social construction or label placed upon those who do not conform to social norms. This perception was fueled by dissenters within the psychiatric establishment itself. One of the most notable was Thomas Szasz, whose book *The Myth Of Mental Illness* posited that most "mental illness" was simply society's condemnation of behavior it finds deviant or inappropriate.

The civil rights community began to take up the cause of the mentally ill. Beginning in the early 1960s, a lawyer and physician named Morton Birnbaum pioneered the theory of a "right to treatment" for people with mental illness. His idea was that in order to justify the deprivation of liberty posed when people are confined against their will in state mental hospitals, the state must provide real treatment to these patients lest the mental hospital be a de facto prison for the "crime" of mental illness; if treatment was not provided, the patient must be released.¹² Birnbaum was not focused on establishing community treatment; rather, he hoped that the threat of forced releases would prod states

⁹ Brown, *supra* note 4, at 48.

¹⁰ John Q. La Fond and Mary L. Durham, *Back to the Asylum*, 87 (1992).

¹¹ *Id.* at 87. But see Rhoden, *supra* note 8, at 380, citing evidence that the new drugs were not the pivotal factor behind the declining caseloads, but rather simply eased the transition already underway.

¹² Morton Birnbaum, *The Right to Treatment*, 46 Amer. Bar Assn. J., 499, 503 (May 1960).

to invest in improving their mental hospitals and offering real treatment there.¹³

Other attorneys would pick up on Birnbaum's ideas, but take them in a different direction. In 1968, the American Civil Liberties Union helped create a special program focusing on mental health law. One of the founding attorneys of that ACLU office, Bruce Ennis, went on to found the Mental Health Law Project in Washington D.C. The Mental Health Law Project, now known as the Bazelon Center, was a pivotal player in the early litigation on behalf of people with mental illness as well as providing the lead attorneys in filing the *Dixon* litigation.

These reformers did not necessarily deny the reality of mental illness, although some certainly were skeptical about official diagnoses. However, they did condemn institutionalization. Activists saw hospitals as a place where patients got sicker rather than better. And they emphasized the liberty interest of people with mental illness to make their own treatment decisions whenever possible. This represented a new perspective for civil libertarians. As Szasz noted, the American Civil Liberties Union from World War II until at least as late as 1965 had backed model commitment laws rather than challenging commitment head-on.¹⁴ Ennis also tied the concerns of the mentally ill into the broader civil rights movement, noting that minorities and women were committed to mental hospitals at a greater rate than were white men.¹⁵

The 1970s witnessed a surge of legal challenges to the mental health regime. As Michael Perlin observed, the so-called deinstitutionalization cases wove together several distinct legal strands: cases challenging the validity of civil commitment statutes and

¹³ Rael Jean Isaac and Virginia C. Armat, *Madness in the Streets*, 120-21 (1990).

¹⁴ Szasz introduction to Bruce J. Ennis, *Prisoners of Psychiatry: Mental Patients, Psychiatrists and the Law*, xvi-xvii (1972).

¹⁵ *Id.* at 220-1.

seeking a constitutional right to treatment; efforts to extend the doctrine of least restrictive treatment beyond the hospital setting; and efforts to win specific recognition of a constitutional or statutory right to community treatment.¹⁶

One of the landmark cases was *Wyatt v. Stickney*,¹⁷ which challenged the mental health care practices of Alabama's state hospital. The federal district court held that the state must provide adequate transitional care for persons released from involuntary confinement as part of the constitutional right to treatment. Another constitutional case, *Lessard v. Schmidt*,¹⁸ further advanced the legal doctrine of "least restrictive alternative" for treatment decisions regarding the mentally ill. The *Lessard* court found that states had a duty to explore alternatives to commitment, including day treatment or referral to a community mental health clinic. *Dixon* was the first case to explicitly recognize an affirmative duty to create community-based mental health care, and reformers initially hailed it as a breakthrough victory for the "least restrictive alternative" principle. However, *Dixon* was decided on statutory rather than constitutional grounds, so it did not form a legal precedent applicable to other jurisdictions. The legal drive to establish a constitutional right to such care sputtered with the Supreme Court's 1982 decision in *Youngberg v. Romeo*,¹⁹ which suggested that even within the institution there was no constitutional right to treatment or habilitation beyond what is needed to promote the patients' rights of safety and freedom from physical restraint. Although the state must provide some treatment to those who are institutionalized, the court said the state has

¹⁶ Michael L. Perlin, 2 *Mental Disability Law: Civil and Criminal*, 570 (1989).

¹⁷ *Wyatt v. Stickney*, 325 F.Supp. 781 (M.D.Ala. 1971), 334 F. Supp. 1341 (M.D.Ala.), 334 F.Supp.373 (M.D. Ala)344 F.Supp. 387 (M.D.Ala. 1972), *aff'd sub nom.* *Wyatt v. Aderholt*, 503 F.2d 1305 (5th Cir. 1974).

¹⁸ *Lessard v. Schmidt*, 349 F.Supp. 1078 (E.D.Wis. 1974) *vacated and remanded*, 414 U.S. 473, *on remand*, 379 F.Supp. 1376 (E.D. Wis. 1974), *vacated and remanded*, 421 U.S. 957 (1975), *reinstated*, 413 F.Supp. 1318 (E.D. Wis. 1976).

considerable latitude over which services to provide and is not generally required to offer services in the community. This message was reinforced several years later in *DeShaney v. Winnebago County Department of Social Services*.²⁰ There, the court found that the state's duty to provide care was limited, and only triggered by the limits placed on people by institutionalization. But the deinstitutionalization movement was by then well ensconced, even if not always for the most inspiring reasons.

To say that deinstitutionalization is ubiquitous is not to say that it is beloved. Rather, there has been tremendous disappointment and anger directed at deinstitutionalization. Some critics believe the movement simply misread the ability of people with mental illness to function in the community and pushed too many people out of hospitals where they belonged. Dr. Fuller Torrey, a psychiatrist at St. Elizabeths and one of leading critics of deinstitutionalization as practiced in most communities, believes government must regain authority to institutionalize some people who need psychiatric treatment but fall short under current standards requiring that they pose a danger to themselves or others. He writes, "a large number of severely ill people cannot be involuntarily treated under present laws because they do not have enough insight to realize that they are sick and need treatment. They constitute the vast majority of the mentally ill who are homeless, in jails and prisons, or involved in acts of violence."²¹ One key shortcoming of the process has been the unwillingness of former patients to take their medication once released from a hospital. Once off medication, they may quickly lose their ability to cope in a more independent setting.

Others say the failure is not the theory of deinstitutionalization, but rather the

¹⁹ 457 U.S. 307 (1982)

²⁰ *DeShaney v. Winnebago County Department of Social Services*, 489 U.S. 189.

implementation or lack thereof. These critics claim that government and others simply failed to develop the necessary community services that are essential to people with mental illness. Many former patients need intensive and ongoing support to prevent a relapse requiring hospitalization. This type of community care is not cheap, or at least not as cheap as promised by some proponents of deinstitutionalization.

The result has been some conspicuous failures of deinstitutionalization: a rise in the number of mentally ill among homeless population, disruptive and sometimes tragic behavior by former patients who refuse to take their medication once outside the hospital, and families burdened by caring for ill relatives who are no longer receiving adequate attention from the state. Many former patients have ended up in the nation's jails, where their needs go unrecognized and they may become deeply traumatized. Nevertheless, such arrests are sometimes called "mercy bookings" that at least get these individuals off the street and into a facility where they are housed, fed, and may even receive medical treatment.

Yet these disappointments coexist with success stories of community treatment. For all his criticisms of the deinstitutionalization movement thus far, Dr. Fuller Torrey acknowledges that "the vast majority of patients say they are happier living outside hospitals than inside hospitals."²² Elizabeth Jones, a former Dixon committee coordinator and member who now runs St. Elizabeths under the receivership, said she has seen deinstitutionalization work elsewhere in the country and is beginning to see good results in Washington D.C. as well.²³ "Clients always rise to the expectations and we're having

²¹ Torrey, *supra* note 7, at 157.

²² Torrey, *supra* note 7, at 85.

²³ Interview with Elizabeth Jones, Director of St. Elizabeths Hospital and former member of the Dixon Committee, in Washington D.C. (April 2, 1999).

clients leave here and go to very successful community opportunities,” Jones said. The success stories are typically less conspicuous than the policy's failures, and therefore less publicized. However, they continue to show the promise -- in cost savings and in human fulfillment -- of community-based care for the mentally ill.

III. DIXON LITIGATION

A. Winning the Decree

It was not surprising that the mental health bar turned its attention to St. Elizabeths. With many of the movement lawyers located in Washington D.C., the hospital was a convenient and familiar target.²⁴ It was also a large target. At its height, the patient population of St. Elizabeth's reached more than 8,000. While those numbers had already begun to subside even before the de-institutionalization movement took hold, the hospital remained one of the largest mental health facilities in the nation.²⁵ In fact, Erving Goffman's book *Asylums*, one of several influential indictments of the large mental hospital, was the product of a year spent sitting among patients at St. Elizabeths.²⁶

On the legal front, Judge David L. Bazelon of the D.C. Circuit had laid some of the groundwork for the *Dixon* case, with three opinions in the 1960s interpreting the

²⁴ In fact, a list of the lawyers who have been actively involved with the Dixon case over the years reads like a who's who of the Washington D.C. legal establishment, including four federal judges (Patricia Wald, Paul Friedman, Colleen Kollar-Kotelly, Royce Lamberth), White House Counsel Charles Ruff, and Joel Klein, now head of the Justice Department's antitrust division.

²⁵ Civil libertarian Bruce Ennis noted that, despite having relatively demanding commitment standards, the District of Columbia in the 1960s had the nation's highest rate of hospitalization for the mentally ill. He traced the statistics to two factors. First, prospective patients were readily characterized as dangerous. Second, a significant number of people travel to the nation's capital to protest certain government actions or inaction and may be sent to St. Elizabeths as a " 'White House crazy.' " Ennis, *supra* note 14, at 224.

²⁶ Erving Goffman, *Asylums* (Chicago: Aldine Publishing Co. 1962). In the preface, Goffman states that he spent a year doing fieldwork at St. Elizabeths, which at the time had over 7,000 "inmates." *Id.* at ix. One writer credits Goffman's book in particular with generating interest in the plight of the mentally ill among people outside the mental health field. See Ann Braden Johnson, *Out of Bedlam: The Truth About Deinstitutionalization*, 62 (1990).

District's civil commitment law. In a 1966 case, *Lake v. Cameron*,²⁷ Bazelon concluded that the District's civil commitment law prohibited confinement in a mental hospital if the patient could be treated in the community. However, the *Lake* decision explicitly stopped short of finding an affirmative duty to create community services for people with mental illness. "We express no opinion on questions that would arise if on remand that court should find no available alternative to confinement in St. Elizabeth's."²⁸ Bazelon also rejected the suggestion that the ruling would require reexamination of commitments that had already been finalized. Instead, he wrote, "our decision does no more than require the exploration respecting other facilities to be made by the government for the indigent appellant in the circumstances of this case." In *Covington v. Harris*,²⁹ Bazelon extended this "least restrictive alternative" principle to treatment decisions within the hospital. And in a 1966 case, *Rouse v. Cameron*,³⁰ Bazelon interpreted the 1964 Hospitalization of the Mentally Ill Act (commonly known as the Ervin Act after its lead Senate sponsor) to require an actual effort to provide appropriate treatment.

At the time, St. Elizabeths Hospital was run by the federal government, specifically the National Institute for Mental Health. The District of Columbia government ran the city's modest community mental health program as part of its limited powers of home rule. In the early 1970s, the National Institute of Mental Health conducted a study indicating that almost half the patients in St. Elizabeth's did not need full-time hospital care and were eligible for treatment in the community. That was all the encouragement

²⁷ 364 F.2d 657.

²⁸ *Lake v. Cameron*, 364 F.2d 657, 662.

²⁹ 419 F.2d 617.

³⁰ 373 F.2d 451.

the mental health bar needed.³¹ A cadre of lawyers already involved in the de-institutionalization movement, headed by the Mental Health Law Project, filed a class-action lawsuit on behalf of all patients committed to the hospital or at risk of future hospitalization, with the exception of those committed through the criminal justice system.³² The plaintiffs asserted a right treatment in the least restrictive environment on constitutional and statutory grounds. The statutory argument was based on the 1964 Ervin Act, as interpreted by Bazelon. The constitutional claims cited the patients' rights to association, travel and liberty under the First, Fifth and Eight Amendments.³³

Interestingly, the lawsuit drew support from the medical community, most notably the American Psychiatric Association. The prominent association had resisted calls to join the landmark constitutional case on the right to treatment, *Wyatt*. Yet when the *Dixon* case was filed, the trustees of the APA voted to join the lawsuit as amicus curiae. Dr. Alan Stone, who was active in the association, cited several reasons for the decision in a 1974 article. The organization had had a particularly close relationship with St. Elizabeths and therefore felt more justified getting involved in the case, Stone wrote.³⁴ The group was also influenced by the hospital's location in Washington D.C. and unique relationship to the National Institute of Mental Health and Congress, all of which

³¹ Warren and Moon, *supra* note 3, at 333. According to Warren and Moon, that study indicated that 56 percent of the then 3600 patients would benefit from treatment in less restrictive setting.

³² Covington and Burling took over as lead counsel, pro bono, in 1980. *Id.* at 359 (fn 24). The class was certified by the court on February 7, 1974 as " 'all persons who are now or who may be hospitalized in a public hospital pursuant to 21 D.C. code section 504, et seq., and who need outplacement from that public hospital, as presently constituted, into alternative care facilities, such as nursing homes, foster homes, personal care homes and halfway houses, in order to receive suitable care and treatment in the least restrictive setting possible. This class includes patients who are now or who may be on convalescent leave status from the public hospital and who have been or may be placed in alternative care facilities that are not providing suitable care and treatment in the least restrictive setting consistent with the patients needs for care and treatment' " Margaret F. Ewing, "Implementing a Right to Community Mental Health Care -- Consent Order Approved in *Dixon v. Harris*," 14 Clearinghouse Review 738, 739 (November 1980).

³³ Complaint for Declaratory and Injunctive Relief, Feb. 14, 1974, at 18.

heightened its potential to set a national role model for mental health care.³⁵ Stone pointed out that deinstitutionalization was already underway nationwide, yet without the necessary community services to support the newly released patients. In his view, it was imperative to set a strong precedent for the development of these community services. Yet the decision was a controversial one within the association, where some psychiatrists saw it as an unfair attack on their colleagues at St. Elizabeths and a dangerous incursion by the legal world into their professional domain. The American Orthopsychiatric Association and the American Public Health Association also joined the lawsuit on the plaintiff's side. The Washington Psychiatric Society, however, filed a brief supporting the defendants. That group conceded the need for more community mental health services, but questioned the ability of such programs to serve the needs of many people with mental illness and cautioned against inscribing the popular push for community care as law.³⁶

The federal defendants said their responsibility was simply to provide the least restrictive treatment possible within the hospital, and to explore the availability of appropriate community placements – but not to create such community services themselves. The federal defendants also argued that community treatment would not necessarily be the least restrictive option for many patients with significant treatment needs. For its part, the District of Columbia contended that the least restrictive mandate applied only at the initial commitment phase, not to subsequent decision-making. Both defendants contended that if the court should find a legal right to community services, it

³⁴ Dr. Alan Stone, *The Right to Treatment and the Medical Establishment*, 2 *The Bulletin of the American Academy of Psychiatry and the Law*, No. 3, 165 (Sept. 1974).

³⁵ *Id.* at 165.

³⁶ See generally, Amicus Curiae Memorandum of the Washington Psychiatric Society, Oct. 29, 1975.

was the responsibility of the other defendant to provide it.³⁷

About a year later, federal district Judge Aubrey Robinson ruled for the plaintiffs on a partial summary judgment motion. The judge directed both the federal and D.C. governments to draw up a plan to transfer eligible patients from the hospital to community care. Robinson did not reach the constitutional questions, instead basing his decision solely upon the District of Columbia's civil commitment law, the Ervin Act. Robinson cited Bazelon's decision in *Rouse v. Cameron*, finding that the law required government officials to make a bona fide effort to provide treatment which is adequate in light of present knowledge and suited to the particular needs of the individual.³⁸ Robinson noted that the hospital's own clinical staff had estimated that 43 percent of the inpatients could properly receive treatment in alternative, less restrictive facilities. And he relied on legislative history, including the funding structure for St. Elizabeths, to conclude that Congress had intended that the federal and District governments share the responsibility of providing appropriate treatment for those committed under the Ervin Act. Robinson stated that alternative facilities included, though were not limited to, "nursing homes, foster homes, personal care homes and halfway houses."

³⁷ Memorandum of Points and Authorities in Opposition to Plaintiff's Motion for Partial Summary Judgment at 7-8 (May 5, 1975) (District of Columbia officials arguing that "any solution to the problem of what constitutes suitable facilities for patients of St. Elizabeths hospital, therefore, clearly remains exclusively in the hands of the United States government), and Reply to Plaintiff's Memorandum of Points and Authorities in Opposition to Defendants Motion for Judgment on the Pleadings, at 4, (July 15, 1974), (federal defendants arguing that "the duty to create and maintain alternative community facilities is the responsibility of the District of Columbia").

³⁸ *Dixon v. Weinberger*, 405 F.Supp. 974, 977 (D.D.C. 1975), citing *Rouse v. Cameron*, 373 F.2d 451, 456 (D.C.Cir. 1966).

B. Define the Players and the Goal

False Start

In his December 1975 order, Robinson gave the defendants 45 days to submit a preliminary plan and timetable to comply with his order. The outline was to include estimates of the number of individuals requiring community placements within the next 18 months, a statement of the major obstacles toward creating community placements, tentative solutions to those problems, and a proposed division of labor between the federal and District governments. The judge would review the outline, with possible input from the plaintiffs. Once the court approved the outline, the defendants would have four months to submit a final plan.

Before long, those deadlines would seem painfully optimistic. The defendants' first official submission to the court was a joint request for an extension on the deadline. The judge granted them an extra month, until March 22, 1976. On March 18th, the defendants requested another extension. Such delays were not serious and defendants did submit an outline later that spring. But the postponements were a harbinger of the many stumbles ahead. A 1979 article described some of the obstacles:

" 'In the first instance, bluntly, many of the ordered transfers never took place: although the hospital agreed during the trial that about 43 percent of the patients were ready for community living, and although clinical staff even identified nearly 1300 candidates for de-institutionalization (out of a population of 2700), hospital officials soon backtracked, claiming that only 402 of those patients were truly appropriate candidates for placement. Although many of the original targets for de-institutionalization remain in the hospital, they have been reclassified as "unacceptable for community living because of inappropriate, although not dangerous, social behavior

such as wandering, disrobing, throwing temper tantrums, and verbally abusing others." Again, the HEW [Department of Health, Education and Welfare] Assistant Secretary in charge of improving mental health services at St. Elizabeth's has repeated, 'Where are we going to put all those people?' "³⁹

Pressed to do more, the federal government proposed creating a protected area on the grounds of another hospital for hospital St. Elizabeths patients in transition to the community. But this idea was rebuffed by the plaintiffs' lawyers, who objected to concentrating former hospital patients at another site isolated from the broader community.⁴⁰

In July 1978, the plaintiffs moved for appointment of a special master and expert panel to help win enforcement of the decree, stating that "two years is long enough."⁴¹ In their brief to the court, the plaintiffs claimed that federal and District officials had made little or no progress toward crafting the needed range of community services. They said the two defendants could agree neither on a plan to transfer St. Elizabeths to the District nor on a program to finance the expansion of community services. "The federal and District governments have conflicting financial and political interests in this area and find it impossible to agree on even the most basic features of a deinstitutionalization program."⁴²

The plaintiffs requested that the judge appoint a special master to take charge of the planning process. Under their proposal, the master would be assisted by a panel of four

³⁹ Perlin, *supra* note 16, quoting Perlin, *Rights of Ex-Patients in the Community: The Next Frontier?*, 8 Bull. Am. Acad. Psychiatry & L. 33, 34, which in turn quotes, Barbara Armstrong, *St. Elizabeths Hospital: Case Study of a Court Order*, 30 Hospital and Community Psychiatry 42, 43 (1979)

⁴⁰ *Id.* at 580.

⁴¹ Memorandum of Points and Authorities in Support of Plaintiffs' Motion for Enforcement of Decree and Appointment of a Master and Expert Panel, at 13.

⁴² *Id.* at 6.

additional experts -- two nominated by the defendants and two by the plaintiffs. Together these experts would have six months to recommend an implementation plan including: patient evaluation standards, an inventory of existing services, quality standards for services and facilities, cost estimates, the redeployment of hospital staff, and an implementation timetable. The plaintiffs also proposed that this panel have authority to oversee the placement of a trial group of hospital patients in the community, and to monitor their experience with an eye toward informing the overall implementation of the 1975 decree. The plaintiffs claimed there was ample precedent for appointing a special master in such a case, citing in particular two cases involving the deinstitutionalization of people with mental retardation.⁴³ And they noted that the court overseeing a third deinstitutionalization case, involving the Willowbrook institution in New York, had made use of an expert panel along the lines being proposed by the *Dixon* plaintiffs.⁴⁴ Instead, the judge ordered the defendants to submit a plan to implement the decree by early 1979. The parties ultimately opted to negotiate an implementation agreement.

1980 Consent Decree

The negotiations that grew out of the contempt motion culminated in a 1980 consent decree negotiated by the plaintiffs' and defendants' counsel. The 1980 agreement was notable both for its substance, and for the process it put in place. The agreement had three significant aspects. First, it established certain substantive components of the

⁴³ *Id.* at 14-15, citing *Halderman v. Penhurst State School and Hospital*, 446 F.Supp. 1295 (E.D. Pa. 1978) (involving a Pennsylvania institution for the mentally retarded) and *Wuori v. Zitnay*, No. 75-80-SD (D.Me. July 21, 1978) (a Maine deinstitutionalization case)

required remedy. Second, it committed to federal and District governments to a collaborative planning process to create the new system. Finally, it established a unique monitoring committee -- to be funded by the defendants but controlled by the plaintiffs' counsel -- in order to gauge the soundness of the plans in theory and implementation.

"The *Dixon* consent order tries to institutionalize the negotiation process which produced the agreement itself," wrote one observer.⁴⁵ "Plaintiffs recognize that the court's jurisdiction in this case must terminate eventually and only to the extent that the defendant bureaucracies become committed to the negotiated plan can they expect to see it implemented in the long run. The continuing negotiation process seems to permit the defendants to incorporate the goals of the lawsuit into their own systems gradually; whether that will actually happen remains to be seen."

The plan was a combination of broad principles and specific directives. It stated that the District of Columbia's mental health law granted patients the right to treatment in the least restrictive residential environment possible, to an individualized treatment plan, and to choose where he will live and what treatment he will receive in the community. The document also evinced a commitment to developing a broad range of rehabilitative services "to encourage former in patients to live as normally as possible in the community... custodial philosophies of care have been replaced with therapeutic modalities of care." Wherever possible, the plan stated, patients would be placed in small, home-like facilities. At times, the document seemed to speak to fears about the future as much as to hopes, stating that the "transfer of psychiatric and rehabilitative care

⁴⁴ *Id.* at 19, referring to *New York State Association for Retarded Children, Inc. v. Rockefeller*, 357 F. Supp. 752 (E.D.N.Y. 1975), *aff'd* sub nom. *New York State Association for Retarded Children, Inc. v. Carey*, 393 F.Supp. 715 (E.D.N.Y. 1975)

responsibility will be phased; the hospital will not discharge its convalescent leave patients en masse."⁴⁶

The agreement specified that each patient was entitled to an individualized treatment plan or ITP to be developed by an interdisciplinary treatment team at St. Elizabeths or the community mental health center. The plan would describe the patient's capabilities, needs and goals, and determine what treatment would be provided to meet those objectives in the least restrictive manner. The plan would encompass the patient's need for social services as well as mental health services, and where necessary defendants would appoint a case manager to coordinate such support. Whenever feasible, patients were to have a right to participate in drawing up this treatment plan. If a patient objected to some feature of the ITP, he was to notify the responsible clinician or case manager who, in turn, would be required to offer the patient the help of an advocate to review the decision.

To determine how to put these principles into practice, the defendants agreed to conduct a needs assessment survey of the patients at St. Elizabeths and those being treated at the community mental health centers. That survey involved conducting a so-called Level of Care questionnaire with each patient to determine his behavioral characteristics and level of functioning. Staff would then study that data to decide precisely what services the patient would need in the community. At the same time, the defendants pledged to make an inventory of all existing mental health resources and related services. Defendants could then compare the projected need for services with available resources and assess the precise shortfall. Defendants would then be required to

⁴⁵ Margaret Ewing, *Implementing a Right to Community Mental Health Care -- Consent Order Approved in Dixon v. Harris*, 14 Clearinghouse Review, 738, 741 (November 1980).

submit an appendix to the court outlining the needed services, how they plan to create such services, and the full cost of the program.

The consent agreement also included measures to insure the quality and availability of the promised services. First, the defendants agreed to create minimum standards for a wide range of services related to the new, community-based mental health system, including homemaker services and crisis intervention. Second, the agreement created special mechanisms to generate information about the evolution of the new system and to monitor compliance with the 1980 plan -- most notably, The Dixon Implementation Monitoring Committee.

Standards: The 1982 program standards are a 90-page packet of rules, spanning issues from staffing ratios to legal rules regarding treatment, to how to advertise available services to the public. Many of the standards specify both quantitative and qualitative goals to be achieved. For instance, there are rules surrounding the initial patient assessment that is to form the basis of the individual treatment plan.⁴⁶ Some are qualitative measures relating to the ability of the staff who will conduct the assessment: i.e. psychologists must have attained a Ph.D. in clinical psychology or a closely related specialty, registered nurses must have earned a master's degree in psychiatric nursing or have formal in-service training and experience. Others are quantitative requirements specifying how much time on average members of the treatment team should spend on the assessment. The standards specify rules not only for government-run services, but also those of private agencies who are under contract to provide some of the system's

⁴⁶ Perlin, *supra* note 16, at 589.

⁴⁷ Dixon 1982 Program Standards at 20-25.

mental health services. The standards were developed by the parties, and were used in deinstitutionalization efforts elsewhere.⁴⁸

DIMC: The 1980 plan called for creating a Comprehensive Patient Information System to facilitate tracking the patient population and progress of the new system. The information system was to provide regular information on the status of the hospital population as it related to the need for various community services, as well as the extent to which the system was making use of alternative residential facilities.

However, the more significant monitoring provision was the creation of a monitoring committee that would be controlled by the plaintiffs, but financed by the defendants. The consent order implementing the 1980 plan stated: "Defendants recognize plaintiffs' right to appoint or designate an individual or group of individuals to be known as the 'plaintiff's implementation monitoring committee' (PIMC) to act as their agents to receive reports, conduct evaluations and investigations, and to assist plaintiffs' attorneys in negotiations with defendants concerning implementation of the plan."⁴⁹ The order specified that the defendants provide \$56, 716 for the first year of the committee's operation, and up to the same amount each year thereafter for up to five years. The Mental Health Law Project, now the Bazelon Center, would receive the money for the exclusive purpose of funding expenses of the monitoring committee.

Plaintiffs proposed the committee because, according to the Nickles, "one of the things that we recognized is that we didn't know what we were doing." The original members included two national pioneers in developing community mental health programs –

⁴⁸ Jones, *supra* note 23, said the standards had been used in Massachusetts, Rhode Island and Wisconsin.

⁴⁹ Dixon v. Harris, Consent Order, April 30, 1980, p. 7.

Leonard Stein, who had designed an aggressive community treatment program in Dane County, Wisconsin, and Joseph Bevilacqua, then the commissioner of mental health in Rhode Island. The committee also included a health planner, a psychiatric expert, and a mental health consumer who was part of the *Dixon* class. The membership of the committee would shift somewhat over the years, but Stein and Bevilacqua were members throughout. In addition, the committee would have two full-time staff coordinators to facilitate the panel's work and handle day-to-day contact with the defendants and class members.

There has been some ambiguity over the years whether the committee is strictly an arm of the plaintiffs, or also a resource for the judge and even the defendants. Attorney Peter Nickles described the committee as an "arm of the court." Nickles said he submitted the committee's budget to the court – to be paid by the defendants – but did not supervise their work. Judge Robinson also described the committee as a resource for the court and defendants, as well as the plaintiffs. Those comments stand in contrast to a more widespread perception that the committee was an arm of the plaintiffs. Committee members were selected by the Bazelon center, and one of its key functions was to monitor the defendants' compliance. Even so, many shared the hope that the committee's views would provide welcome expertise for all parties to the litigation. One news analysis of the consent decree concluded that the depth and breadth of the committee's membership "should produce well considered recommendations to which the defendants and court will give considerable weight."⁵⁰

⁵⁰ Ewing, *supra* note 45, at 741.

Federal vs. City Responsibility

Progress under the consent decree was severely hampered by the division between the federal and city run systems. The hospital and community providers had had little contact before the lawsuit and seemed unwilling or unable to establish a more collaborative relationship. The lack of coordination was not simply the result of two distinct bureaucracies, but also two distinct cultures. St. Elizabeths was run by the federal government's mental health experts and considered one of the leading psychiatric hospitals in the nation. In addition to ideological doubts about deinstitutionalization, some of these officials simply looked down on the mental health staff working in the District's community-based system.

In a March 1982 newspaper article on the pace of deinstitutionalization, city officials complained that hospital officials were balking at transferring clients into the community system.⁵¹ Hospital administrators, for their part, insisted that the city did not have adequate facilities in place to treat the individuals. The article found some support for both complaints. In October 1982, the court imposed a moratorium on transfers out of the hospital because community care was inadequate to support them. During this period, plaintiffs' counsel had begun pushing for a special master, but instead worked out new deals with the city.

The Dixon committee had been stressing the importance of creating a unified system and in the early 1980s this issue became a focus of the planning efforts. Several different proposals surfaced. The Department of Health and Human Services suggested

⁵¹ Kenneth Bredemeier, "Hundreds Still Needlessly Kept in Institution; Patients Held Needlessly," The Washington Post, March 28, 1983, at A1.

transferring control of both the hospital and District mental health system to an independent corporation run by presidential appointees, later to be named by the District's Mayor.⁵² Another proposal -- this one from a consultant hired by the District -- would have given the city control of the hospital's outpatient programs to be run in coordination with its existing community mental health care. But Congress settled on a more dramatic approach, choosing to transfer all responsibility for hospital and community mental health care to the District. A 1984 report by the General Accounting Office had suggested this approach, estimating savings of \$22 million over the combined expenses for the separate hospital and community systems.⁵³

Congress endorsed the provisions in October 1984, passing the St. Elizabeth's Hospital and District Of Columbia Mental Health Services Act. The act charged the District of Columbia with taking on all of the existing services at St. Elizabeths while creating a comprehensive mental health care system that would shift "the primary focus of care to an integrated community-based system." The law stated that the transfer would improve "the efficiency and effectiveness" of the existing, bifurcated mental health regime. It directed the District to have the new system up and running no later than October 1, 1993, and specified that the system should be in full compliance with the consent decree in the *Dixon* litigation. Under the legislation, the federal government would share the cost of making the transition to the new system and would be responsible for retraining hospital staff as needed.

The following month, Mayor Barry created a new office to plan the reorganization and expansion of the city's mental health responsibilities. The transfer removed one of the

⁵² Moon and Warren, *supra* note 3, at 341.

⁵³ *Id.* at 341.

major, structural obstacles towards compliance and might have marked a positive turning point in the case. This would not prove to be the case. Rather, plaintiffs' attorney Peter Nickles today says the transfer in some ways marked the end of real progress toward implementing the Dixon decree.

C. Resistance by the District of Columbia

The federal government and the District of Columbia had been tussling over St. Elizabeths hospital for years -- fighting not to get stuck with the costly, aging facility.⁵⁴ The District eventually capitulated, in exchange for a badly needed cash infusion and transitional payments by the federal government. One sweetener was the prospect of developing a portion of the St. Elizabeths campus, some of the most physically attractive real estate in the city. For years thereafter, the city floated proposals to build various commercial or residential developments on the western portion of the property.

But if the St. Elizabeths property was an enticing asset, the hospital itself was not. The aging brick buildings were costly to heat and cool, and by the 1980s often in serious need of repair. The city had to spend increasing amounts to keep the facilities in minimally acceptable condition in order to maintain accreditation. Plaintiffs' attorney Peter Nickles now concedes this dilemma was a major obstacle toward freeing up the money required to create the community programs dictated by the consent decrees.

This was not an insurmountable problem in the eyes the plaintiffs advocates, some of whom were prepared to see the city abandon a central mental hospital entirely. The city,

however, appeared never to consider such dramatic step. Politics played a role. The hospital was an important source of jobs and the union representing these workers fought against pressure to downsize the facility. In the fall of 1986, even as Mayor Marion Barry was unveiling plans to shrink the hospital and build up community care, Barry nonetheless promised that no hospital employees would be laid off -- although some might take early retirement and others would presumably be transferred to community programs.⁵⁵ This apparently represented a shift from earlier proposal that would have reduced the size of the city's mental health staff considerably. Judge Robinson cited the threat of layoffs at the hospital as a major factor in the city's resistance to implementing the Dixon decree. "St. Elizabeths Hospital provided a fertile ground for jobs for people of modest backgrounds," Robinson said. "And they all voted."⁵⁶ Some observers think city officials also inherited a philosophy that placed the hospital at the center of the mental health system. Even the budgets for the community mental health centers are channeled through the hospital, a telling organization that is apparently unique to District of Columbia.

There was some expansion of community services over the years. Yet even those providers and bureaucrats focused on community care often came up short in the eyes of the plaintiffs. To some extent, their complaints reflect problems endemic to the District: tortuous procurement systems and legendary inefficiency. And while critics are quick to cite examples of some competent and dedicated individuals within the mental health

⁵⁴ According to a 1984 newspaper article, the federal government had been trying to transfer the facility to district control since the 1960s. See Sandra Evans, *House Unit Approves Funds; St. E's May Get \$20 Million*, The Washington Post, June 15, 1984, at A1.

⁵⁵ Sandra Evans, *Plan Would Cut Size of St. Elizabeths; Hundreds of Patients Would Be Shifted to Community Homes*, The Washington Post, Oct. 2, 1986, at C8.

⁵⁶ Interview with Judge Aubrey Robinson Jr., U.S. District Court for the District of Columbia, in Washington, D.C. (March 31, 1999).

system, they say these were generally the exception within a culture of incompetence or disinterest.

For instance, in the early 1980s the Dixon committee pressured the District to send several mental health staff workers to Wisconsin to receive training at a model community treatment program there. Dixon committee member Len Stein, one of the pioneers of the Wisconsin program, said he was encouraged by the ability and attitude of the District workers he got to know during the training.⁵⁷ The staff members were being trained for one of the planned mobile outreach teams that would aggressively monitor and assist former hospital patients in the community. Yet when Stein later reviewed the experiences of these workers back in the District, he was disappointed to find little progress. According to Stein, the newly trained workers were met with suspicion and hostility from colleagues who told them to go back to the old way of doing business. "They were working too hard," Stein said. However, such characterizations do not sit well with city officials such as Deputy Corporation Counsel Janet Maher. Maher said D.C. employees worked hard to help their clients, and said those on the plaintiff's side never appreciated how difficult it was for city workers to do a good job given the city's fiscal problems.⁵⁸

Race may have been another factor complicating the city's reaction to the lawsuit. Washington is a majority black city that was long controlled by an overwhelmingly white Congress. The city was just winning limited powers of self-government in the late 1970s and was understandably touchy about taking direction from outsiders -- especially if those outsiders were white. The lawyers who initiated the *Dixon* litigation were white and

⁵⁷ Telephone Interview with Len Stein, Dixon Committee member (March 8, 1999).

⁵⁸ Telephone Interview with Janet Maher, Deputy Corporation Counsel (April 12, 1999).

did not necessarily have strong ties to the city. Former Dixon coordinator Bob Moon noted that while the monitoring committee did include several city residents, including some African Americans, all of its policy expertise came from white members from other parts of the country.⁵⁹ In retrospect, Moon says, it would have been helpful to have involved some local policy experts as well as well as involving more class members to speak on their own behalf.

System in Disarray

Whatever the precise reasons, few would dispute the discouraging trend in the District's mental health system. More than a decade after the decree that was to have led to a model system, people with mental illness were facing a rapidly declining central hospital without the promised alternative of strong community-based care.

As it became clear the District of Columbia was likely to take over running the mental hospital, a group of concerned citizens formed Friends of St. Elizabeths. The group consisted of professionals working at the hospital, family members of hospital patients as well as some consumers. It also gained support from the union representing hospital workers. The group's primary concern was maintaining quality services at hospital. A secondary interest was historic preservation of the site, situated in the Anacostia neighborhood on a bluff overlooking downtown Washington.⁶⁰ According to Hanna

⁵⁹ Telephone Interview with Robert Moon, former Dixon Coordinator (Feb. 1, 1999).

⁶⁰ Nineteenth-century social reformer Dorothea Dix persuaded the federal government to buy the land and, in 1855, create the hospital as a serene haven for the mentally ill.

Schussheim, the group had little confidence in the District's plans for the hospital.⁶¹

Schussheim says Mayor Marion Barry seemed to take a hospital under duress and had no real interest in running it, except perhaps to develop some of the grounds. Friends of St. Elizabeths, on the other hand, felt strongly that the campus should be retained as a resource for people with mental illness. Schussheim said members of the group visited a therapeutic community in Germany where people with mental illness lived and worked together in a protected environment. Some thought the District might try to develop a similar community on the grounds of St. Elizabeths, where many patients had lived for years and felt safe.

The group at one point hired a lawyer and in June 1988 sought permission to intervene in the *Dixon* litigation. Terry Lynch, an activist and advocate for the District's homeless population, was involved with that effort. Lynch believed that services had declined at the hospital and that the facility was no longer available even for some clients who wanted or needed to be there. "I felt there were *Dixon* clients who wanted the hospital," Lynch said.⁶² And he questioned whether the plaintiffs lawyers were paying attention to these class members or simply pursuing their own agenda regarding de-institutionalization: "They had a philosophical bent and they were representing that," Lynch said. Schussheim described some of the changes in a 1989 Washington Post article:

Where there was one psychiatrist to 30 patients, there is now one to 70 or 80 patients. Where there were escorts and buses to take patients needing supervision for walks or to

⁶¹ Interview with Hanna Schussheim, former president of Friends of St. Elizabeths, in Washington, D.C. (Jan. 29, 1999).

⁶² Telephone Interview with Terry Lynch (March 12, 1999).

the parks, these patients now sit day after day in locked wards with nothing to do. Where there were a variety of programs for supervised and unsupervised patients, many of the patients no longer have access to therapeutic and rehabilitative services... the library has been reduced from 45 hours a week to 16. Magazines and periodicals were cut off in October 1987. Rosenberg (then the director of the Mental Health Law Project) is trying to shut down St. Elizabeths hospital. The result of his efforts is a deteriorated life for patients.⁶³

However, Judge Robinson denied their request to join the lawsuit on September 30, 1988.

In a one-sentence ruling, Robinson cited the reasons cited by the Mental Health Law Project, which had opposed the motion on the grounds that inpatient services were not the subject of the *Dixon* litigation.⁶⁴

The plaintiffs, meanwhile, were not much happier with the state of the community programs. Since its creation in 1981, the Dixon Implementation Monitoring Committee had been chronicling the defendants' progress toward the goals of the 1975 decree and reporting continued disappointment. What follows is a sampling of their complaints excerpted from the committee's various reports to the court.⁶⁵

- 1981: very little progress toward specified transfer goals. For instance, the decree had specified that 1,000 patients on convalescent leave were to be transferred to the care of community mental health centers by October 1982. As of April 1980, only eight of these patients had been transferred. The decree also set a goal of decreasing hospital re-admissions. Yet during a six-month period in 1981, 69 percent of the 2,636 admissions were re-hospitalizations.
- 1982: after site visits to the District's community mental health centers in July 1982, the Dixon committee reported poor coordination between different pieces of the

⁶³ Cited in Isaac and Armat, *supra* note 13, at 323.

⁶⁴ *St. Elizabeths Advocacy Suit Thrown Out*, The Washington Post, Oct. 5, 1988, at D5.

⁶⁵ Excerpts taken from the Summary History of the Dixon Implementation Monitoring Committee Activities and Findings, available from the Bazelon Center.

mental health system and claimed that the services provided by the centers did not meet the needs of its clients with chronic mental illness. Moreover, the committee warned that budget policies were pushing the system backwards rather than forwards, noting that 100 staff positions had been cut from the community mental health centers budget. (This report was followed by plaintiffs motion to find defendants in contempt of court, later set aside, and it was during this period that the court had to place a moratorium on transfers due to the poor quality of community-based care.)

- 1983: the Dixon committee reported a welcome spurt of progress by the District, the outgrowth of a new agreement forged to head off the plaintiffs' contempt motion. Under that agreement, the District agreed to upgrade its crisis resolution unit and to form mobile outreach teams to work with difficult, hard to reach clients. The committee reported that initial planning and hiring for the new programs was going well.
- 1984: the committee once again expressed disappointment with the city's progress, reporting that it had failed to get the promised mobile treatment teams and crisis resolution unit up and running. The committee said community services were still too weak to warrant lifting the moratorium on transfers from the hospital. Committee members cited a lack of appropriate housing as a key barrier to community placement.
- 1986: the committee reported on its in-depth study of the crisis resolution unit, criticizing numerous aspects of the program.
- 1987: the Dixon committee reiterated numerous long-standing criticisms of the community mental health program, highlighting two shortcomings in particular -- lack of appropriate housing and inadequate outreach service for specially vulnerable class members such as homeless and the elderly.
- 1988: the committee found that the District was "seriously out of compliance" with its obligations. The panel said the District did appear to have adequate resources and knowledge of what needed to be done as well as some very committed staff members. Rather, it attributed the failure to poor financial management, including a decision to budget 88 percent of the mental health budget to hospital services even though most of the commission's clients lived in the community and should be treated there.

Dixon committee members were not the only ones sounding the alarm. In the spring of 1988, doctors within the mental health system wrote to Mental Health Commissioner Robert Washington warning that the agency's severe staff shortages were hindering its ability to provide even minimal care. " ' We feel compelled to inform you that any

continuation of this downward slide in the quality of care will likely lead to dramatically increased morbidity and mortality,' " the doctors wrote in a letter obtained and publicized by The Washington Post.⁶⁶ The letter came from doctors working both at St. Elizabeths and in the community. Soon thereafter, Commissioner Washington said the city was considering abandoning its efforts to maintain national accreditation for St. Elizabeths on the grounds that the effort would divert too much time and energy from building a community-based system. "The focus on accreditation keeps the focus on St. Elizabeths," Washington told a reporter. "We're trying to move away from that. We're trying to build outpatient facilities."⁶⁷ According to the article, the city was already at risk of losing Medicare payments for the hospital due to staffing and record-keeping deficiencies there. At the same time, the city was facing additional pressure to speed up its provision of community services. In May 1987, the federal judge in a separate lawsuit ruled that about 600 people who had been committed to the hospital before 1973 were entitled to judicial hearings to determine whether they were being held at the hospital unconstitutionally.⁶⁸ That ruling, in *Streicher v. Prescott*, raised the prospect of additional transfers that would add to the demand for appropriate community services.

City officials generally did not deny problems within the system, but said they were overstated and that the city was moving to make the needed improvements. Mental Health Commissioner Robert Washington said many employees within the commission were trying to make community-based care work during this period, although they faced

⁶⁶ Marcia Slacum Greene, *D.C. Doctors Sound Alarm on Mental Health Services*, The Washington Post, May 17, 1988, at A1.

⁶⁷ Michael Abramowitz, *City Weighs Delaying St. E's Accreditation; D.C. Health Official Raises Sensitive Issue*, The Washington Post, June 30, 1988, at D 1.

⁶⁸ Nancy Lewis, *600 Held at St. E's Granted Court Hearings; Many Patients May Have Been Illegally Confined for Decades*, The Washington Post, May 21, 1987, at A1, regarding *Streicher v. Prescott*, 666 F.Supp. 335 (D.D.C. 1987).

significant obstacles given to city's inefficient bureaucratic mechanisms and political opposition from the unions.⁶⁹ And while Washington himself grew impatient with the slow rate of progress, he said the plaintiffs lawyers exaggerated the city's deficiencies. "There was hyperbole on both sides," he said.

D. Enforce the Goal:

By the late 1980s, the plaintiffs were again growing impatient with the lack of compliance by the District and began efforts to have the city found in contempt and a special master appointed. The plaintiffs began one such go-around in 1987, only to end up with a new consent decree.⁷⁰ The same cycle began again in 1989 as the plaintiffs again called for a special master. But city officials said they would rather strike a deal and, Judge Robinson called for a consultant to be brought in to mediate between the parties. That consultant, chosen by the judge himself, was Dr. Danna Mauch. Dr. Mauch was well established in the mental health field, including having served as commissioner of mental health services in Rhode Island. She was also familiar with the *Dixon* case, working intermittently as a consultant to the Dixon monitoring committee. In her new role as mediator, Mauch helped the parties work through the outstanding issues to bring the city into compliance.⁷¹ The result was a new, 1989 consent agreement. That agreement specified that the District would create 400 new housing slots for hospital

⁶⁹ Telephone Interview with Robert Washington, former Mental Health Commissioner (April 2, 1999).

⁷⁰ See Nancy Lewis, *District Reaches Agreement on Care for the Mentally Ill; Plan Would Comply with Court Order*, The Washington Post, March 21, 1987, at C1. According to the story, that agreement included a commitment not to transfer more patients to community facilities housing more than 25 people, and to develop a timetable to move all patients into such small facilities if they request it. Peter Nickles told The Washington Post that the original decree was too general and lacked clear benchmarks to measure the city's compliance.

outpatients with appropriate support services by the end of 1991. The city also agreed to beef up staffing for community outreach programs. Mayor Barry pledged, "This is not a perfunctory agreement. I'm going to hold my staff's feet to the fire."⁷² But the Dixon Committee soon reported that the city had fallen short yet again. By the target date to transfer the first 400 patients, the committee reported that only half that number had actually been moved to community placements. With the exception of new programs for homeless class members, where new outreach programs were lauded, the Dixon panel claimed that the city was failing to meet its obligations. In 1992, the parties hammered out yet another agreement, the Service Delivery Plan or SDP.

The Service Delivery Plan represented a new phase in the *Dixon* litigation. Frustrated by the lack of progress in achieving broader goals, the plan focused sharply on the needs of the most seriously ill class members. It targeted four specific groups within the broader *Dixon* class: adults and older people currently living at St. Elizabeths (447 and 164 class members respectively), homeless individuals on the street or in shelters (estimated at 2,500), and adults at risk of readmission to the hospital (556 class members).⁷³ The agreement, reached in December 1991 and approved by the court in January 1992, set out a 5-year plan for implementation and tied the city to specific timetables for various tasks. The plan identified more than 30 services needed by class members, but specified several issues as immediate priorities including the placement of long-term hospital residents into community residential placements and services to deter re-hospitalization such as community stabilization beds and mobile outreach teams. The

⁷¹ Telephone Interviews with Danna Mauch, former Dixon Special Master (March 11 and 24, 1999)

⁷² Michael Abramowitz, *Barry Vows to Move 400 St. E's Patients by the End of 1991*, The Washington Post, June 3, 1989, at B1.

⁷³ Service Delivery Plan at 3.

agreement also called for measures to improve the capability of the mental health commission, such as staff training and an exemption from city hiring freezes.

Mauch was appointed by the court again, this time to oversee implementation of the SDP she had helped draft. Mauch said she had limited authority in this role. She described her job as offering assistance to the parties, and providing periodic reports to the court on the status of implementation. Perhaps unsurprisingly, it was not long before the plaintiffs were back asking Judge Robinson for more help, and this time he agreed. In May 1993, the judge found the defendants in violation of the Service Delivery Plan and granted the plaintiffs' motion for special master. Once more, the judge turned to Mauch.

This time around, Mauch had considerably more power. She was charged with overseeing implementation of the consent decrees, with the power to hold status conferences and ex parte meetings with the parties. Significantly, she could also make official findings of fact and issue recommendations that would be binding upon parties unless appealed to the judge and overruled. These recommendations could be quite specific. For instance, Mauch said she could tell the city to immediately fill certain vacancies or to fund a service at a given amount. However, she did not have authority over budgeting, personnel, or contracting issues. "I had to push them to use *their* authority to meet their obligations under the decree," Mauch said. The goal was to mediate issues such that the parties did not need to go to the judge for resolution.

Mauch's appointment did not sit well with city officials and then-Mayor Sharon Pratt Kelly proposed rolling back the civil commitment law underpinning decree. The proposal appeared to reflect a combination of budget pressures and resentment toward living under

the hand of the special master.⁷⁴ Given the city's dire financial situation, there was some sympathy for the mayor's contention that mental health services could not be exempted from fiscal belt tightening. For instance, the Washington Post editorial board had defended the appointment of a special master in the *Dixon* case given the city's sorry record of compliance. Yet the paper expressed support for at least debating the mayor's proposal to change the District's civil commitment law to remove the absolute commitment to provide community-based treatment. "We think the mayor is presenting the elected council with an opportunity to decide for the first time since home rule just how the city's mental health system should be run, and at what financial costs," the paper wrote.⁷⁵ However the proposal drew a political outcry, organized largely by the Bazelon Center and others involved with the plaintiffs' cause, and the repeal initiative was abandoned.

Given this bumpy start, it is perhaps unsurprising that Mauch's efforts did not turn things around. At the urging of the judge, Mauch and city officials were able to agree on many of the steps needed to bring the city into compliance with earlier consent decrees.⁷⁶ Those efforts included creating better quality assurance criteria and enforcement, getting promised mobile treatment teams up and running, and better planning for the housing needs of clients. But the needed changes remained elusive. In its June 1995 report, the Dixon committee likened the quality of the District's community mental health services

⁷⁴ James Ragland and Amy Goldstein, *Order on Mentally Ill Seems Intrusive to Kelly*, The Washington Post, May 19, 1993, at C1, and Serge F. Kovalski, *D.C. Mental Health Plan Raises Ire; Mayor Proposes Cuts to Stem Budget Woes*, The Washington Post, July 9, 1993, at D1.

⁷⁵ *Caring for the City's Mentally Ill*, The Washington Post, July 12, 1993, at A14.

⁷⁶ Memorandum Opinion and Order Implementing Final Recommendations of the Special Master, June 20, 1994 at 3.

to a box of chocolates, "you never know what you're going to get."⁷⁷ The committee did find a significant increase in the extent of community services and decreased reliance on institutionalization. However, the report cited ongoing problems including substandard services such as unsafe housing and infantilizing day programs for clients.

Mauch presented her analysis of the problem in her March 1995 report to the court:

"The special master has heard the special master's role described as one of being outside of a box containing a problem with authority to do several things around the outside of that box, (probe, push, pull and block) but without the authority to reach inside the box to directly fix the problem. In the presence of a District government evincing commitment and capacity to meet the challenge of reform, the parameters of the role of the special master would be sufficient to provoke, promote and support needed change.

However, the District has displayed a persistent pattern of non-compliance. This is a direct result of problems in commitment and capacity. The District claims that it is committed to the Dixon mandates, that adequate funds were and are available to meet the obligations of the consent agreement. If true, one is left with problems of capacity as the dominant source of non-compliance.

... Given the pending appointment of a fiscal oversight board and the poor history of federal government sponsorship of the mental health system, the special master is persuaded the compliance will not be timely achieved without further intervention by the court to direct the reform of the mental health system including: the creation of a comprehensive and integrated service delivery system, the re-balancing of the allocation of resources to support the system; and the establishment of capable leadership and a functional governance structure to sustain a clinically and cost-effective mental health system on behalf of Dixon class members."⁷⁸

⁷⁷ The Dixon Implementation Monitoring Committee's Report to the Court on the Third Year of Service Development Plan Implementation, June 15, 1995 at 6.

Mauch said she reached this conclusion before the plaintiffs were ready to accept it. The plaintiffs actually did seek to have the special master's role expanded to that of receiver around this time, in the spring of 1995. But Mayor Barry was able to forestall such action by negotiating a 120-day agreement known as the "Phase I" agreement. That agreement laid out specific steps to comply with the service development plans mandates for 1993, 1994 and 1995. The District also agreed to increase spending on outpatient mental health services by \$12 million and conduct reviews of troublesome aspects of its community mental health care.⁷⁹ The plaintiffs had some reason to think this deal might be different. The agreement had far more targeted goals and timeframes than previous consent orders, it spelled out the involvement of the special master and Dixon committee and, for the first time in the history of the case, it included fines for non-compliance.⁸⁰

Still, many were skeptical the city would make good on its promises. Even Judge Robinson expressed doubts about the newest deal. "What really disturbs me is that we have had nine consent agreements since 1980...that's all I have dealt with," Robinson said at a court hearing on the proposal. "Here we are 15 years later, talking about another agreement."⁸¹ Nevertheless, Robinson approved the new plan. The district met the requirements of the Phase I agreement, and subsequently negotiated a "Phase II" agreement for further implementation of the 1992 SDP. However, this second agreement ran into trouble and the plaintiffs once again sought the creation of receivership in December 1996.

⁷⁸ Special Master's Report to the Court, March 7, 1995, at 55.

⁷⁹ Draft Mental Health System Plan, June 1998, at 2.

⁸⁰ Plaintiffs' Motion for Appointment of a Receiver, December 17, 1996, at 3.

E. Broaden the Frame

When even a special master wielding a detailed consent agreement could not win the results they sought, the plaintiffs finally gave up on the District government and sought a court-appointed receiver to run the mental health system. With the appointment of receiver in fall 1997, the plaintiffs won the power that had eluded them throughout the many years of trying to force District officials to act. Indeed, they won power that eluded District officials themselves – namely, to break out of the bureaucratic and political logjams ensnaring many city programs. But in winning the full power of the court in service of their cause, the plaintiffs also lost control. The receiver has set out to follow the general mandates of the 1975 decree and subsequent consent orders, but on his own terms and without the service of a plaintiff-controlled monitoring committee financed by the city.

Seeking a Receiver

Once the plaintiffs concluded that negotiating with the city was futile, they did not mince words in castigating the District's performance and demanding that a receiver be given control of the mental health system. In their motion to the court, the plaintiffs described the city's overall response to its obligations as one of "paralysis and obfuscation."⁸² The request cited the city's long history of non-compliance with the 1975 decree and subsequent consent agreements. It attributed the city's failure to array of

⁸¹ Amy Goldstein, *D.C. Averts Court Takeover of Mental Health Services; Latest Deal Gives City 120 Days to Fix System*, The Washington Post, June 20, 1995, at B4.

factors: "its inability to overcome Byzantine procurement regulations, its failure to maximize available federal revenues, the continued institutional commitment to St. Elizabeths, the ongoing fiscal crisis, and a pervasive uncertainty surrounding the proper lines of authority within the District government." Yet most significant, the plaintiffs alleged, was "the complete failure of leadership within the District government."

The plaintiffs contended that the court would be well with its rights to appoint a receiver under the circumstances. Indeed, they did not have to look far for examples; among the cases cited in their brief were two recent federal court orders placing the District's child welfare system and public housing system in receivership.⁸³ The brief cites the child welfare case extensively, noting that the judge in that case found a pattern of noncompliance that closely tracked the experience of the *Dixon* litigation. "Substitute 'the mentally ill' for 'abused and neglected children' and the result is the same," the brief states.⁸⁴

The District raised a number of procedural and substantive objections to the motion. First, they questioned whether Robinson had authority to appoint a receiver: specifically, whether a federal court had authority to provide such a remedy for a violation of local law. The city also argued that its compliance was far better than the picture painted by plaintiffs and suggested they were being asked to catch a moving target. For instance, the city claimed it had met the terms of the 1980 agreement, albeit behind schedule, and was now being faulted for failing to meet goals far beyond the scope of the original litigation. Finally, they argued that if Robinson did appoint a receiver, he should not grant all of the

⁸² Plaintiffs Motion for Appointment of Receiver, December 17, 1996, at 7.

⁸³ *Id.* at 19, citing *Lashawn A. v. Kelly*, 887 F.Supp. 297 (D.D.C. 1995) (placing the child welfare system in receivership) and *Pearson v. Kelly*, No. 92-CA-14030, unreported Memorandum Opinion and Order

powers requested by the plaintiffs and – in a seeming dig at Mauch – said the job should go to someone with ties to the city. The city’s brief accused the plaintiffs of trying to circumvent the political process, noting that the special master had faulted then-mayor Barry’s proposal seeking to return St. Elizabeths to the federal government.⁸⁵

Despite a flurry of eleventh hour attempts to improve its compliance with previous court orders, the District had lost its credibility. On June 13, 1997, Judge Robinson ordered the appointment of a receiver to run the District’s mental health services. Robinson’s order first dispatched the question of whether, as a federal judge, he had authority to appoint a receiver for a violation of the Ervin Act. Robinson stated that since the federal law transferring the hospital to the District explicitly mandated compliance with Dixon decree, he had a federal authorization for full use of the court’s remedial power.⁸⁶ He then assessed the district’s history of non-compliance, concluding that the deficiencies stemmed from “incapacity, not unwillingness.” Robinson wrote of the District, “Its efforts have not been lacking, but they have been insufficient, ineffective and untimely....”⁸⁷ He concluded:

For twenty-two years, this court has witnessed the failure of the District of Columbia to provide its residents with an integrated community based mental health system. As a result, mentally ill residents of the District of Columbia are suffering. Lost, among the numerical details contained in the Court’s findings is the fact that the failure of the

dated August 18, 1994 (D.C. Sup. Ct. 1994) (placing the D.C. Department of Public and Assisted Housing into receivership).

⁸⁴ *Id.* at 20.

⁸⁵ Opposition to the Plaintiff’s Motion for the Expansion of the Powers of Special Master and Appointment of a Receiver, at 9. Mayor Barry in early 1995 proposed returning some aspects of city government, including St. Elizabeths, to federal control. Barry said that the District, in its thirst for self-government, had mistakenly agreed to take on some functions typically performed by state rather than city government and that the arrangement was doomed, at least so long as the city remained under ultimate fiscal control by Congress. See Amy Goldstein and R.H. Melton, *Barry Says Home Rule Government Unworkable, Urges U.S. Takeover of Courts, Prisons, Welfare*, The Washington Post, at A1.

⁸⁶ *Dixon v. Barry*, 967 F.Supp. 535,551.

⁸⁷ *Id.* at 540.

District of Columbia to properly treat its mentally ill citizens significantly decreases the quality of their lives and, in many cases, threatens their very existence. There is no doubt that without severe action by the Court, such suffering and loss of life will continue unabated. Accordingly, the Court has no choice but to impose a receivership on the District of Columbia's Commission on Mental Health Services. Without a receiver, the Court is convinced that mentally ill residents of the District of Columbia will never obtain the integrated community based mental health system to which they are entitled.⁸⁸

Robinson called for the appointment of a receiver with sweeping powers. The opinion authorizes the receiver to "oversee, supervise, and direct all financial, contractual, legal, administrative, and personnel functions" of the mental health commission. Specifically, it grants the receiver power to set certain personnel policies, negotiate new contracts, acquire and dispose of property, and restructure the management administrative divisions of the mental health commission. The receiver is to set the commission's budget although that budget, like all District spending, is ultimately subject to approval by Congress. The concluding paragraph of the order states that it "shall remain in effect until such time as the SDP and the orders of this court have been fully implemented, and a receivership is no longer necessary to assure the ongoing operation of the District of Columbia's mental health system in accordance with all legal requirements."

Both parties had input into selecting the receiver, proposing candidates who were narrowed to a list of three finalists. The mayor interviewed those candidates and then each side submitted its rankings to the judge.⁸⁹ Ultimately, the judge appointed Scott Nelson, who at the time headed mental health programs for the federal government's Indian Health Service and had previously run the state mental health systems in

⁸⁸ *Id.* at 554.

Pennsylvania and New Mexico.⁹⁰ Nelson was appointed to an initial two-year term with a likely extension of several additional years.

Nelson Takes Charge

Today, Receiver Scott Nelson is the District's mental health department. Moreover, his scope is broader than the initial lawsuit. The *Dixon* class did not include people committed to St. Elizabeth's through the criminal justice system. Yet as receiver, Nelson has responsibility for the care of these forensic patients as well as for *Dixon* class members voluntarily or involuntarily committed through the civil system.

The powers accompanying the office are vast, encompassing the former powers of the mental health commissioner and mayor combined. Mauch proposed such contours for the receivership in one of her outgoing reports. Judge Robinson largely followed her recommendations and those of the plaintiffs. "I think the intent was to give me as much power as possible so I could turn the system around," Nelson said, noting that he has more power as receiver than he did when acting as a state mental health commissioner.

Structurally, Nelson has set up his office in a predominantly white neighborhood in the northwest part of the city – away from city officials downtown or, for that matter, at St. Elizabeths. One of his earliest struggles was to establish his own administrative office. Nelson said this was essential to ensure real movement. "We literally went to people's desks and sorted through stacks of personnel applications to find ours and process them." However, the receivership is not free of all the city's personnel rules and other mandates.

⁸⁹ Interview with Maher, *supra* note 58.

⁹⁰ *D.C. Mental Health Receiver*, The Washington Post, Sept. 12, 1997, at B7.

Noting the limits on the court's power to reshape personnel matters within the city's mental health bureaucracy, Robinson stated, "we weren't able to sweep the rug as clean as we would have liked." There was some initial confusion about Nelson's latitude to potentially override local laws affecting his mandate. But the Court of Appeals for the D.C. Circuit, ruling in a separate case involving the city's court-appointed receiver for foster care, recently indicated that such receivers generally must abide by District of Columbia laws.⁹¹

To shape the substantive content of the new regime, Nelson has begun an elaborate planning process involving task forces on a range of topics. Technically, the 1992 service delivery plan is still the governing "law" of the case -- the remedy that the District agreed to and is legally obliged to provide. But it does not appear to be the governing document in the receiver's office. On the contrary, Nelson said he has considerable latitude to shape the details of the new system. Judge Robinson has been supportive rather than directive. "He made it very clear to me at the beginning that he was not an expert in mental health...and he was not going to get in my way," Nelson said.⁹² "I want to make my own assessment about what's needed," Nelson said. He is mindful of the previous agreements in the case but does not see his role as vindicating the demands of the plaintiffs per se.

This means far less control for the plaintiffs. One of Nelson's first acts as receiver was to indicate his desire to restructure or eliminate the Dixon monitoring committee.

According to staff at the Bazelon Center, Nelson felt it was inappropriate for the plaintiffs to monitor his activity as they had the defendants since he would be acting as an

⁹¹ *LaShawn A. v. Barry*, 144 F.3d 847 (D.C. Cir. 1998). The appeals court held that the LaShawn receiver could not violate local law to carry out a mandate premised on a violation of D.C. law. However, the court also expressed nervousness about providing receivers with such override authority even for violations of federal law. (LaShawn at 853-4).

arm of the judge. Nelson said the city indicated that it would no longer pay for the monitoring committee, since its entire mental health program was now under court authority. Nelson worked out a short-term compromise under which the committee would be formally disbanded, but the city would continue to pay for the two coordinators for one additional year. The Dixon monitoring committee went out of business in December 1998. The two Dixon coordinators will remain in place through September 1999, and the Bazelon Center is trying to find alternative funding for the positions thereafter.

And while the appointment of receiver would seem to strengthen Judge Robinson's control over the case, plaintiffs attorney Peter Nickles questions whether that is really the case. Prior to the receiver, Nickles points out, the judge commented on the record about the case during status hearings or through rulings. Now the receiver makes significant decisions on a regular basis without formal feedback from the judge. Nickles recognizes that the Dixon Committee was an expense that may not be as necessary now that the defendants are not in charge. But he worries that no one is now positioned to ensure the accountability of the receiver and his staff. Nelson said the issue of accountability came up at a recent meeting with Judge Robinson. "The judge basically said 'I'm the accountability,' " Nelson said.

Plans of Receiver: Nelson's plans to date involve establishing an aggressive community treatment system that is very much in line with what plaintiffs have been advocating. They are generally supportive of this initiative, although some believe Nelson is being too deliberate and could have gotten much farther toward implementing these ideas. His other high-profile proposal is to build a new, smaller hospital on the St. Elizabeths

⁹² Interview with Scott Nelson, Dixon Receiver, in Washington D.C. (Jan. 28, 1999).

grounds – an idea that is meeting with favorable response from some city officials but creating dismay among some of the plaintiffs' advocates. Both issues reveal the new power dynamic in the case.

Carepoints – The centerpiece of the receiver's reorganization plan is the so-called Carepoints Model. Under this model, a community-based provider or care point is responsible for helping consumers with all of their needs, such as treatment, housing, daily activities, finances and more. The care is to be available around the clock and provided wherever the consumer is located, be it in a clinic or hospital, home, shelter, or jail. There would possibly be about ten such "carepoints" throughout the city, each responsible for consumers within a fixed geographic area. One major unresolved issue is whether these providers will be run by the government, as are the existing community mental health centers, or by private providers. While there is great interest in privatizing the system, Nelson speculates that this might be too much change for the city to absorb at once given all the other restructuring of the mental health system.

New Hospital

Nelson is considering building a new, state-of-the-art hospital on the existing grounds of St. Elizabeths. In his view, it makes little sense to pour more money into the antiquated physical plant of the existing hospital. "I just think we throw huge amounts of money into repairing old system that's never going to be a very cost-effective system," Nelson told a Washington Post reporter in December 1998. His office has commissioned a study

to assess the future costs of running the existing facility, which Nelson expects will show that it makes more sense to build a new hospital. If it does, he plans to seek funding to begin work on a new hospital.

Nelson initially proposed a hospital that could accommodate between 350 and 500 patients. More than half of the beds would be for so-called forensic patients admitted through the criminal justice system, with between 100 and 250 beds available for those admitted through the civil system. Elizabeth Jones, a former Dixon Committee staff coordinator and member who Nelson hired to run St. Elizabeths, said she has helped persuade Nelson to pursue plans for a smaller hospital: about 320 beds, 250 for forensic patients and about 70 for adult civil patients and adolescents. Jones is widely described as a passionate advocate for community placement, and said she personally might prefer to see those adults who do need acute care treated in private hospitals rather than a central public mental hospital. But given that Nelson seems committed to building a new hospital, Jones said she is pleased that the proposed size has come down and believes she is helping to build a climate that will discourage unnecessary institutionalization.⁹³

But the proposal is deeply troubling to some of the people closely involved with the *Dixon* litigation and it created a considerable stir when the idea was highlighted in a December 1998 Washington Post story. No one disputes the poor condition of the existing hospital. Yet some of these critics strenuously question the need for new central facility to replace it -- at least in the case of non-forensic patients. Clients who need short-term stabilization after relapse can be treated in emergency beds in the community. Those who need longer-term hospitalization could be treated in the psychiatric wards of

⁹³ For instance, Jones said she had fired seven hospital psychiatrists she considered too resistant to the goals of community treatment.

general hospitals, rather than in a special hospital dedicated to the mentally ill. Former Dixon committee member Len Stein fears the plan would lock the District into a costly central facility at the expense of the systems community-based programs.

The other criticism is one of perceptions and emphasis. Even if there is a legitimate case to be made for new hospital, these critics say Nelson is making a large error by discussing and planning for the hospital with so much left to be done in designing the community-based system. For these critics, Nelson's proposal reveals a misguided mindset that still undervalues the potential of community treatment while elevating the role of the central hospital.

Nelson said some of the stir could not have been helped. He says he discussed many issues during the December Washington Post interview, but that the reporter chose to focus on the proposal regarding a new hospital. Moreover, Nelson said he had been discussing those plans openly and that the proposal should not have come as a surprise to anyone. Nevertheless, Nelson stands by his decision to go ahead with planning for a new hospital. He says the city will always need a central facility for the forensic caseload, as well as some number of long-term civil commitments. Moreover, Nelson says he is looking down the road regarding possible new demands, such as a facility to house and treat sex offenders.

Youth

The receiver is also focusing special planning on the needs of young people with mental illness. This group was always technically part of the *Dixon* class, but had never

been a central concern. Nelson's decision to give this issue fresh attention demonstrates the discretion he has to shape the contours of the court-ordered relief and from one view this raises questions of accountability. Yet former Bazelon Center Director Len Rubenstein noted that it also reveals the limited accountability of the plaintiff's lawyers – who might just as easily have focused on this issue but did not.⁹⁴ Members' of the plaintiffs' team seem to welcome this initiative. Nelson has outlined other areas for special attention, such as clients with dual diagnoses of mental illness and drug dependency.

IV. CONCLUSIONS

Frustrating Past – In Search of Competency

Twenty-five years after the *Dixon* lawsuit was filed, no one is hailing the case as an advertisement for the virtues of institutional reform litigation. For those who disagree with a thrust of deinstitutionalization, the case is a sad chapter in a tragic national novel. Strong proponents of deinstitutionalization, meanwhile, are dismayed that District residents with mental illness are still waiting to realize the fruits of the legal victory won in their name so long ago. Yet if there is widespread dismay at the track record of the city's mental health services, there is little consensus on what lesson should be drawn from the case.

Some critics of institutional reform litigation claim it is no surprise that lawsuits such

⁹⁴ Interview with Len Rubenstein, former director of the Bazelon Center, in Washington, D.C. (January 29, 1999).

as *Dixon* founder, arguing that courts simply lack the capacity to decree this form of complex social change. Scholar Donald Horowitz, in particular, has raised this issue of judicial competence. Faced with an institutional reform suit, Horowitz writes, a judge can view the case in terms of a relatively narrow right or may define it broadly as a social problem.⁹⁵ Horowitz believes that either choice poses serious risks: a narrow framing usually denies the complicated reality of such cases, while "casting the issue broadly risks judicial involvement in a host of issues far from those initially before the court and far from those with which most courts feel comfortable."⁹⁶ In his book, *The Courts and Social Policy*, Horowitz describes a myriad of ways in which judges, trained in the art of adjudication, may stumble in the tasks presented by litigation seeking broad social change.⁹⁷ Horowitz warns that judges overseeing such cases may be insensitive to questions of cost and limited resources,⁹⁸ may incorrectly lock in a specified remedy on the basis of premature factual assessments,⁹⁹ or may respond too slowly due to their inherently passive role.¹⁰⁰

Yet these fears do not seem borne out by the *Dixon* litigation. Judge Robinson seems to have charted a moderate course somewhere in between an activist and a laissez-faire model. People involved with the case agree that Robinson took a real interest in the case and seemed personally committed to seeing the creation of a viable system of community care for people with mental illness. Unlike most of the federal judges on the D.C. circuit, Robinson is an African-American and longtime District resident. Discussing the case, he

⁹⁵ Donald L. Horowitz, *Decreeing Organizational Change: Judicial Supervision of Public Institutions*, 1983 Duke L. Journal, 1265, 1291.

⁹⁶ *Id.* at 1291.

⁹⁷ Donald L. Horowitz, *The Courts and Social Policy* (1977).

⁹⁸ *Id.* at 34.

⁹⁹ *Id.* at 36-7.

¹⁰⁰ *Id.* at 38-9.

sometimes speaks of the District of Columbia as "we," revealing an attachment not necessarily shared by other judges on the federal judiciary's D.C. Circuit. He did not limit his input regarding the case to the official record, but rather called meetings with Dixon committee members and others and toured some of the city's mental health facilities. Mauch recalled taking the judge with her as she surveyed some of the programs, including shelters and other places where the homeless would congregate: "I had him on the streets with me at night," she said. Robinson did not typically initiate such tours, but was very willing to go if invited, she said.

At the same time, Robinson appeared extremely mindful of his judicial role. He said he sometimes felt constrained and would have preferred to gather more information independently rather than rely on what the parties brought before him. Even after 25 years, Robinson said he still has no contact with the parties beyond official communications and court appearances. Robinson also stressed the restraint and deference a court should exercise in fashioning a remedy for a claim such as that of the *Dixon* plaintiffs. "I didn't have the experience or background to lay out a plan and it's not the function of a judge to provide such a plan," Robinson said. "Most of the things couldn't be resolved in court, they had to be resolved by the parties."

This philosophy was most clearly evident in the early stages of the case. Robinson's first order directed defendants to draft their own plan for compliance with his decree. He later encouraged the parties to craft consent agreements and seems to have hoped for a collaborative process. Nickles recalls that when the plaintiffs filed one of their early contempt motions, Robinson made the point that he had never imposed orders on the city but rather had approved consent judgments city officials had helped negotiate.

His move to establish the Dixon committee also reflected this outlook; Robinson said he had hoped the panel would serve as a resource for the city, supplying expertise on community mental health that the city did not have.

At the same time, the Dixon panel signaled Robinson's willingness to employ outside expertise and creative mechanisms to handle the challenges presented by the *Dixon* litigation. Robinson said the Dixon committee was an important resource for the court, supplying needed information about the likely contours of a community-based mental health system as well as an assessment of the defendants' compliance efforts. The committee, and later the special master, provided Robinson with the type of information Horowitz feared would not reach the courts. And armed with this information, Robinson was willing to break out of an unduly passive role. On the one hand, Robinson seemed disinclined to get out in front of the plaintiffs. He did not seize the initiative to call status conferences or impose sanctions. Yet, faced with a formal request, Robinson typically ruled quickly and decisively to force city compliance "He would definitely respond, but he was not interventionist," Mauch said. Over time, Robinson would employ an escalating series of control mechanisms to counteract the defendants unwillingness or inability to implement the provisions of the Dixon decree. When the Dixon Committee proved inadequate to forge compliance, Robinson authorized a consultant or mediator, then a special master, and finally the receiver. Yet because he was patient in giving collaborative strategies a chance to work and deferential toward consent agreements, Robinson did not generate undue criticism when he moved to the more intrusive forms of court oversight. Moreover, the *Dixon* litigation does not bear out Horowitz' fear about overly rigid and quickly outdated decrees. Though some of the

mandates did become less relevant over time, the parties and Robinson repeatedly updated and adapted these initial guidelines. The Dixon Committee, and later the Special Master, helped supply the documentation and expertise needed to update requirements to fit the evolving needs of the client population, and the evolving appreciation of what was needed most. If anything, the process may have been too fluid – Maher said city officials sometimes felt they were being asked to catch a moving target.

This is not to suggest these mechanisms were not problematic. The litigation has slogged through years of undue delay that has been expensive and hurtful to a plaintiff class still awaiting promised services. Some unique factors – namely the divided federal-city responsibility and the innovative nature of the policy goal – accounted for much of the delay early in the case. Nevertheless, there is no question that the structure of the litigation has taken its toll in time, resources and good will. Perhaps the clearest insight yielded by the litigation thus far is the paramount importance of winning governmental cooperation towards reform -- and the near impossibility of succeeding in its absence. "The success of judicial reform is highly dependent on the receptivity and capability to implement reform inside the bureaucracy," said Mauch. Where suits like this have worked well she said, it is because the government, once challenged, was able to respond and "do the right thing."

One example, according to Mauch, was the deinstitutionalization litigation concerning a mental hospital in western Massachusetts.¹⁰¹ Mauch worked in the state mental health system at the time, and says she and other state employees saw the litigation as an opportunity to improve the mental health system. At times, Mauch said she would tell the plaintiff's attorneys they were not being strong enough in pushing for change. Dixon

committee member Joe Bevilacqua tells a similar story of his experience as mental health commissioner in South Carolina. When his commission was sued, Bevilacqua said they accepted it as a way to pressure the Legislature for more resources. "In a sense, we welcomed it," he said¹⁰².

By all accounts, that dynamic never developed in the *Dixon* suit. The Dixon Committee was meant to serve this purpose to some degree – at least in the eyes of some. Bevilacqua recalls that the idea was not to be drawn into the litigation per se, but to help facilitate a better accommodation between the defendants and the lawsuit: "Could we in some way soften the lawsuit to be more programmatically helpful." Yet he conceded this role was always somewhat at odds with the committee's responsibility to monitor compliance, and said the relationship with the city got increasingly adversarial over time. Robert Moon, who served as one of the staff coordinators for the committee, said his efforts to offer assistance fell flat. For instance, Moon recalled bringing in outside consultants to determine ways to improve the city's handling of crisis beds for people with mental illness – a key service to help prevent hospital readmission. Yet Moon says the city ignored the consultants' suggestions, even though most would not have required additional spending. At the same time, Moon recognizes that it may have been hard for city officials to look beyond the sometimes adversarial role of the monitoring committee: "We were the ones who could haul them back into court" by providing information about non-compliance.

It is possible a somewhat different design could have increased the committee's efficacy. As noted above, the committee was weighted toward out-of-town experts who

¹⁰¹ The litigation, known as *Brewster v. Dukakis*, produced an extensive consent decree filed in Dec. 1978.

¹⁰² Telephone Interview with Joe Bevilacqua, Dixon Committee member (March 22, 1999).

did not have established relationships or credibility with District officials. This weakness mirrored a broader problem regarding the lawsuit, which was lawyer-driven and never developed a strong community or political constituency.

The structure of the committee may also have undermined its potential influence. The committee had two full-time coordinators, who did much of the committee's legwork and maintained a constant presence for the group. Yet the presence of those staff coordinators may have lessened the role of the committee members themselves. Plaintiffs' attorney Leonard Rubenstein contrasts the Dixon monitoring committee with the expert panel appointed in the *Wyatt* case, which he said did not have staff members. As a result, Rubenstein said, the panel members got more involved in site visits and had more direct access to the judge, allowing them to be more influential overall. Bevilacqua even went so far as to say the existence of the committee may have been a mistake. The panel spent too much time finessing and repackaging different compliance strategies with the city, he said. "It became an excuse. It became an uncertainty absorber in a way."

Yet the documentation gathered by the Dixon committee was pivotal to the progress of the lawsuit and to imparting a sense of legitimacy to the court's actions. Their site visits and reports repeatedly helped bring the defendants to the negotiating table and Robinson clearly relied on their findings to inform, and justify, his rulings. In the same vein, the special master not only helped implement the *Dixon* mandates, she also provided the factual underpinning for the still greater court intervention that would follow – the receivership. "I think she opened a lot of eyes as to how many missing pieces there were," Robinson said.

Some of these interim tactics might have been sufficient had their been more

constancy within the mental health commission, and more financial stability citywide.

As it was, efforts to forge a constructive partnership between the parties never quite bore fruit. Early on, the divided responsibility between the District and federal governments complicated any possibility of such an alliance. There were occasional flickers of collaboration once the District took over St. Elizabeths, but none that truly caught fire.

Robert Washington, a community mental health professional from Chicago, was hired to run the city's mental health system after it gained control of St. Elizabeths. Washington said he believed in the goals of the *Dixon* decree and believes then-Mayor Marion Barry wanted him to move the system in this direction. Nevertheless, Washington ultimately felt undermined by Barry and other city officials who seemed unwilling to antagonize the unions or interest groups who were in competition with the mental health programs for limited city funds. Washington said he came to welcome the litigation as a potential tool to win needed resources for the community-based system. Washington was later replaced by Mayor Sharon Kelly, and the city cycled through a series of acting or permanent commissioners. There was one interval of collaboration after Barry returned to office in 1995. City officials and lawyers for the plaintiffs cooperated to submit the bills of mental health providers to the court for orders mandating payment. It was during this period that the parties also negotiated, and successfully implemented, the so-called Phase I consent agreement that many have described as a "high point" of the litigation. But this brief-lived collaboration unraveled, in part due to the city's financial crisis. A congressionally mandated control board was installed to oversee the city's finances and the board forced out human services commissioner Vernon Hawkins, who had helped engineer the agreements in the *Dixon* litigation.

Alternately, Rubenstein and others said the plaintiffs might have done better to target their litigation more precisely. The *Dixon* class was always large and somewhat amorphous; the goals of the lawsuit sweeping. Former Dixon coordinator Bob Moon believes that case might have been more effective had it defined a more targeted class and set more targeted goals.¹⁰³ Rubenstein asks himself similar questions regarding whether the litigation was too ambitious for its own good: “You feel an obligation to fix it all and to fix it in a way that’s consistent with the best thinking.”

Yet the goal of deinstitutionalization was by definition a transformative, ambitious one not easily subdivided into manageable chunks. Under this view, the critical flaw in the case was not its scope, but the defendants’ failure to buy into the new vision of what mental health care could and should be. Given the breadth of the remedy being sought – and absent the governmental cooperation seen in places like Massachusetts – it seems inevitable that the court would have to resort to interventionist mechanisms such as a special master or receiver. In retrospect, some of those involved with the plaintiffs’ effort say they should have pushed for a receiver much earlier.

This is the view of some Dixon committee members, and of Special Master Danna Mauch. And in this respect, Horowitz’s concern about the forced passivity of the court has some bearing since the judge was at the mercy of the plaintiff’s strategy. Mauch said the plaintiffs’ attorneys – the Bazelon Center and Covington and Burling -- appeared somewhat fragmented and conflicted about how hard to press the city. The plaintiffs would repeatedly file contempt motions only to back off as they negotiated new agreements with the District. It is difficult to know whether this pattern was driven by the plaintiff’s own preferences, or their perceptions of what Judge Robinson would

¹⁰³ See Moon and Warren, *supra* note 3, at 356.

prefer. Several observers said that was the plaintiffs' own strategy. Nickles, in particular, had working relationships with Mayor Barry and other city officials and was able to bring them to the table. And Mauch believes the Bazelon Center was afraid of pushing the city too hard for fear of losing the money it was using to staff the Dixon committee. But the plaintiffs' lawyers may have been responding to Robinson's perceived reluctance to take an interventionist stance. Indeed, given Robinson's outlook on the proper role of the court, it seems unlikely he would have imposed receiver without overwhelming cause to do so. The lengthy history of failed consent agreements may have been critical in this regard; when the time came, Robinson said the case for a receivership was clear because of the city's repeated failure to live up to its own promises.

Uncertain Road Ahead – The Problem of Legitimacy

Eventually, of course, the plaintiffs did seek a receivership and a frustrated Robinson sided with them over the strong objections of District officials. But in "winning" a receiver, the plaintiffs have lost considerable control. Now they must sit back and watch Nelson determine the best way to proceed.

Nelson is well versed in the issues of community mental health care and well positioned to break through the bureaucratic and ideological obstacles in the *Dixon* case. In fact, given his authority to circumvent some of the city's cumbersome governmental processes, Nelson is arguably *more* competent than District officials to compel changes in the mental health system. But in empowering the receiver with the true capacity to force change, Judge Robinson is taking risks regarding the legitimacy of the new regime.

This is the challenge Colin Diver identified in his article "The Judge As Political Power Broker: Superintending Structural Change in Public Institutions."¹⁰⁴ In Diver's view, cases such as *Dixon* inevitably require the judge to move beyond classic adjudication and make essentially political determinations about the scope and nature of a proper remedy. Yet judges must strive to conceal this truth, lest they be attacked as anti-majoritarian and illegitimate. Nor can expert committees or special masters offer a way out. Diver states:

A judge can rely on third-party mechanisms, such as masters and monitors, to perform the most explicitly 'political' tasks – conducting investigations, mediating disputes, aggressively pushing settlement, summarily resolving low-level controversies and mobilizing public opinion....[Yet] if parties resist the activities of third-party mechanisms, the judge must act personally, either by endorsing the 'extrajudicial' political behavior of his agent or by renouncing such behavior, perhaps reducing its efficacy.¹⁰⁵

Robinson thus far has not been forced to directly endorse or repudiate Nelson's work in the form of a formal motion or appeal. Yet it is clear that Nelson -- like Mauch before him-- is acting with the judge's authority and, thus far at least, his approval. It is also clear that Nelson's work is taking him into uncharted waters. Although the 1997 order establishing the receivership states that the order will remain in effect until the 1992 Service Delivery Plan has been fully implemented,¹⁰⁶ both Nelson and Robinson conceded that the particulars of that document are no longer the operative benchmarks for the case. Nelson is planning the future of the District's forensic mental health hospital,

¹⁰⁴ Colin Diver, *The Judge as Political Power Broker: Superintending Structural Change in Public Institutions* 65 Virginia L. Rev., 43 (1979).

¹⁰⁵ *Id.* at 105.

¹⁰⁶ *Dixon v. Barry*, 967 F.Supp. 535, 556.

even though those patients are not part of the *Dixon* class. And the expert monitoring committee that was meant to be a vital voice in shaping a community-based system as well as supplying timely information about city compliance, is now out of business. In other words, the remedy in the *Dixon* case has become increasingly untethered from the prior legal contours of the litigation and from the direct will of parties as reflected in the prior consent decrees.

Nelson seems to sense this and in some ways is operating as city politician might, not just an arm of the court or plaintiffs. His office issues a quarterly newsletter and holds regular public meetings about its planning efforts. Deputy Corporation Counsel Janet Maher credits Nelson with taking a more collaborative approach than some of the other court-appointed receivers operating city programs. According to Maher, Nelson attends D.C. cabinet meetings, has negotiated a detailed memorandum of understanding with new mayor Anthony Williams and generally “has made a very concerted effort to work with the government as opposed to against them.” While Nelson has authority to submit the commission budget directly to Congress, without alteration by the mayor or city council, Maher said he has tried to work cooperatively with city officials on fiscal issues. And while the Corporation Counsel’s office argued strenuously against appointing a receiver and would be involved in any future challenge to his work, the office also works cooperatively with Nelson when his office faces legal challenges from patients within the mental health system. It is striking that Maher sounds more positive about Nelson’s performance thus far than do some of those on the plaintiffs’ side. To some extent, he is repeating the model they established – trying to build “buy-in” by District officials rather than surging full-steam ahead with change as rapidly as some on the plaintiffs’ side

would like. Nelson, like Nickles and others before him, said it is critical that local administrators and staff be in a position to carry on the community-based program once court supervision ends.

On other hand, Nelson has power the plaintiffs lacked and will presumably move ahead whether or not the defendants get on board. The true test of his legitimacy lies ahead, when Nelson is ready to move decisively on key issues such as a new hospital or the nature of the proposed Carepoints. Will the parties accept his remedy as necessary or appropriate when its contours are not clearly compelled by law and do not reflect the product of their express agreement? Robinson says he gave Nelson wide berth to construct an effective community-based system as he sees fit and told him, "if you're too far off, you'll hear about it because they'll come running into court." So far, both sides seem content to hold their fire and let Nelson proceed. But Nelson, and the case, appear to be approaching a moment of truth. During the remainder of 1999, it is likely that Nelson will make key decisions about whether to go ahead with a new hospital and regarding the implementation of the carepoints initiative. If either side in the case takes issue with his choices, they are likely to mount challenges that could unravel the political and possibly the legal legitimacy of the receivership. On the other hand, should both sides be willing to accept his judgments, Nelson may be poised to produce the long-delayed promise of the Dixon decree.

The tortuous path of the *Dixon* litigation, then, has led to moment laden with both promise and peril. It is an uncomfortable place for the court, as Robinson himself is quick to volunteer. "The system's already failed if they have to bring a lawsuit" since these problems more properly belong in the political arena, Robinson said. "We really don't

have the political authority we need to have to solve this problem," he continued.

"People don't understand our limitations." Yet, there is a compelling argument that this course is preferable to the alternative. Scholar Owen Fiss identified many of the same worries that preoccupy Horowitz regarding putting courts in charge of this kind of social reform. Yet Fiss concludes the best course may well be to "live with the dilemma"¹⁰⁷ in the interests of social progress and vindicating rights. Similarly, Law professor Abram Chayes contends that courts must answer the challenge of these suits by rising to the occasion rather than by eschewing a role in the resolution of such problems. He writes, "judicial action only achieves such legitimacy by responding to, indeed by stirring, the deep and durable demand for justice in our society."¹⁰⁸

The District of Columbia presents both the best and the worst case for such intervention. On the one hand, the city's political and bureaucratic structure are widely considered so deficient that it seems legitimate for courts to step in and safeguard the rights of vulnerable groups. Robinson notes that there is rarely an effective political constituency advocating for the needs of people with mental illness as there are for more popular services, such as the police department. Moreover, Elizabeth Jones speaks of a "belief gap" among D.C. mental health employees regarding community-based care. "I've seen it can work," she says. By bringing in people who have faith in the efficacy of community-based care, the lawsuit may build a new, and lasting, foundation that the District can then build upon.

Yet courts have intervened so frequently in the District's governance that the problems of democratic accountability and disenfranchisement are magnified. Even

¹⁰⁷ Owen M. Fiss, *Foreward: The Forms of Justice*, 93 Harv. L.Rev. 1,58 (Nov. 1979).

before Nelson's appointment, the District had court-appointed officials running its public housing program, its child welfare services, and its prison health programs. Combined, those receiverships account for a large chunk of city services that are being administered by unelected officials. Indeed, the practice has arguably created a self-perpetuating regime by which programs must be under court order to have a fair chance to compete for limited funds. Maher said that for a period during the early to mid-1990s "anything in human services that didn't have some sort of special master got cut. It was robbing Peter to pay Paul." Those fiscal tradeoffs are considered less stark today. Yet the courts' interventions to run various city programs may impede the city's ability to mature into an effective bureaucracy. The receivership in *Dixon*, as well as the other court cases, is sometimes explained as necessitated by the relative immaturity and incompetence of the D.C. bureaucracy. The city was, after all, just experimenting with the early phase of home rule when faced with the mandates of the Dixon decree and subsequent consent orders. Yet will the receiverships themselves obstruct the city's efforts to create a more seasoned and effective bureaucracy? For example, Nelson may build an efficient procurement arm for mental health contracts. But will that effort serve as a model for other city programs, or simply delay the day that the city is pressed to enact citywide reforms?

Maier claims that is not the case here, and that the city – far from being disengaged—is actively working toward the day it can take over administration of the mental health system. She notes that some of the issues at stake, such as the role of privatization and managed care, are of central importance to the city's future beyond the parameters of the

¹⁰⁸ Abram Chayes, *The Role of the Judge in Public Law Adjudication*, 89 Harv L.Rev. 1281, 1316 (May 1976).

mental health program. And for all the contentiousness that led up to the receivership, there are surprising notes of consensus regarding the future of the mental health system. For its part, the city seems to be working collaboratively with Nelson and is not challenging him at every turn, even where there is ample invitation to do so. For instance, Maher said the city has agreed to let the receiver try to work out a coordinated solution including the forensic mental health program even though that topic is clearly outside the original scope of the *Dixon* case and could be promising grounds for appeal. The various sides of the deinstitutionalization debate seem closer together in other respects as well. For instance, Nelson has won widespread approval for placing Elizabeth Jones – once an active member of the plaintiffs team – in charge of St. Elizabeths. For her part, Jones said she now has more insight into the needs of clients within the mental hospital and the challenges facing many dedicated staff members working there. While Jones had long argued to shift funding from the hospital to community programs, from her new post as hospital director she now appreciates that “the money wasn’t here, it was at the layer above the clients.” Members of the Bazelon Center also seem to welcome some of the receiver’s new initiatives, such as the emphasis on youth mental health needs, even though they were not their own. Meanwhile, Hanna Shussheim of Friends of St. Elizabeths offers some positive words about community treatment, noting that many former hospital patients can do well in these settings and that the movement is in any case inevitable. Whether such convergence is because of the lawsuit or in spite of it, the fledgling consensus offers some hope for a beneficial resolution to the case.

Finally, for all the discouragement, people involved with the plaintiffs’ case still believe they did the right thing bringing the lawsuit and sustaining the struggle over the

last 25 years. Len Rubenstein believes the high cost of hospitalization would have forced patients out of St. Elizabeths soon anyway, perhaps without even the flawed community services the District has been providing. Rubenstein claims that in places such as Richmond, Virginia mental hospital patients were simply released to large boarding houses. Prior to the efforts of the *Dixon* plaintiffs, he said, "that's what deinstitutionalization meant for the District." Rubenstein says the *Dixon* litigation was able to establish an overlay of community services even if there have been serious gaps. Attorney Peter Nickles also stands by the strategy of trying to work with the city, saying he doesn't think lawsuits like *Dixon* succeed if the government is not committed to implementation. But neither does he regret pressing the lawsuit on behalf of the *Dixon* class, in spite of the District's long-term recalcitrance. "If institutional reform litigation doesn't work, then nothing will work."