by John Parry

YOUNGBERG AND *PENNHURST* II REVISITED — PART I

In the past year, three federal courts have recognized a constitutional right to treatment or habilitation in the least restrictive setting for civilly institutionalized persons. Such recognition has occurred despite what once appeared to be formidable obstacles to the recognition of such a right articulated in the 1982 Supreme Court decision *Youngberg v. Romeo.*[1] Some other plaintiffs who have wanted to enforce a similar federal statutory or state right to treatment rehabilitation in the least restrictive setting, however, have been confounded by a second Supreme Court decision, *Pennhurst* v. *Halderman {Pennhurst II)*[2], which defined broadly state immunity under the eleventh amendment.

As a result of these two decisions, residents of civil institutions with legitimate grievances have been encouraged to rely more on forum shopping and other legal strategies and less on the merits of their claims to obtain judicial relief. What follows is a summary and analysis of the two Supreme Court cases and the subsequent case law they have spawned, particularly the numerous court decisions that have relied on *Youngberg,* sometimes with very different, even inconsistent results.

The Supreme Court Decisions

In the landmark decision *Youngberg* v. *Romeo,* all the justices except Chief Justice Burger signed an opinion that, for the first time, identified specific constitutional rights for individuals who are civilly confined in state institutions. In addition to rights to reasonably safe conditions of confinement and freedom from undue bodily restraints, Justice Powell, writing for the eight-member majority, found a right to minimally adequate training to help those who are confined take full advantage of their constitutional rights.

Justice Blackmun, writing a concurring opinion for himself and two other justices, iterated what he believed were the justification for and the minimal reaches of this new constitutional right to training. "Commitment without any 'treatment' whatsoever would not bear a reasonable relation to the purposes of the person's confinement." Each resident should receive "such training as is reasonably necessary to prevent a person's pre-existing self-care skills from deteriorating because of his commitment. . . even if respondent's safety and mobility were not imminently threatened." Chief Justice Burger, in refusing to sign the majority opinion, left no doubt about his narrow view. "I would hold flatly that respondent has no constitutional right to training, or 'habilitation,' per se." Where a person cannot exist outside an institution, even with the assistance of relatives, then "the State's provision of food, shelter, medical care, and living conditions as safe as the inherent nature of the institutional environment allows, serve to justify the State's custody." Equally important, the Court established a new standard for evaluating state actions with regard to institutional care. The state and those acting for the state meet their obligation to residents and patients if they exercise their judgment in a professional manner. In determining whether a constitutional standard of care has been met, courts must defer to reasonable professional judgment. Moreover, the state and its employees are presumed to be acting appropriately.

Two years later, in what has become known as Pennhurst II, state institutions were further insulated from judicial intervention by a 5-4 Supreme Court decision that greatly expanded the principle of and possibilities for sovereign immunity. A divided Court concluded that the eleventh amendment prohibited a federal court from ordering state officials to conform their conduct to the requirements of state law. Justice Powell, again writing for the majority, found that the judicial power in Article III, §2 of the U.S. Constitution had been circumscribed by the eleventh amendment's bar to legal claims against the state "when 'the state is the real, substantial party in interest'. . . regardless of whether it seeks damages or injunctive relief." Four dissenters led by Justice Stevens were outraged by the Court's opinion. "This remarkable result is the product of an equally remarkable misappliation of the ancient doctrine of sovereign immunity. In a completely unprecedented holding, today the Court concludes that . . . sovereign immunity prevents a federal court from enjoining the conduct that Pennsylvania [the state] itself has prohibited. No rational view. . . supports this result. To the contrary, the question. . . has been answered affirmatively by this Court many times in the past." Overlooked by the the dissenters was the fact that the rationale in *Pennhurst II,* as will be discussed later, also was applicable, in a different way, to the enforcement of federal statutes against the states.

Leading Commentary About *Youngberg*

By issuing these two opinions, the Supreme Court seemed to be limiting the right to treatment in the least restrictive setting as well as the possibility of redress against states for alleged abuses of residents and patients. As is often the situation after leading Supreme Court opinions, however, much remained to be settled by subsequent decisions.

Commentators, not surprisingly, differed in their initial interpretations of the implications of these decisions, particularly the meaning of *Youngberg*.

Perhaps the strictest *Youngberg* interpretation, other than the one put forth by the Chief Justice, came from the Department of Justice, which under the Civil Rights of Institutionalized Persons Act is supposed to intercede to protect institutionalized mentally ill and mentally retarded persons. William Bradford Reynolds, the Assistant Attorney General for Civil Rights, limited the department's obligations in this area by viewing the right to treatment as narrowly as possible.[3] He saw training as necessary only to guarantee the development of self-care during the period of confinement, rejecting any constitutional need for therapeutic interventions that would enhance a resident's "capacity, capability and competence." Even Reynolds, however, acknowledged that the Supreme Court's decision had not precluded a more expansive constitutional right to treatment.

The assistant attorney general also emphasized that the department believed "Youngberg mandates deference to the judgment of a qualified professional acting in behalf of a state in cases where injunctive relief is sought as well as in damage actions, a fact which we thought was clear from Youngberg but about which there has been some disagreement." From within the Justice Department, there hardly was unanimity regarding Reynold's interpretation. Timothy Cook, while still a trial attorney in the Civil Rights Division under Reynolds, reflected the views of a number of disenchanted lawyers within the division in an article written for the *Reporter*.[4] He indicated that there was very little reason not to find a substantive constitutional right to treatment in the least restrictive setting. Residents, Cook argued, may have a right to sufficient staff and resources to provide them with "training in life skills such as bathing, grooming, toileting, dressing, feeding and self-control, when necesary to provide reasonable care and safety. Residents also are entitled to training in such skills in order to secure greater freedom of movement." In addition, fundamental skills, such as communicating and walking, were necessary for basic self-care and, thus, the provision of speech therapy, sign language, and physical therapy for those who need such services is mandated. Such basic skills training as cleaning, shopping, cooking, or vocational and educational training might be necessary as well — anything that will enable residents "to live in settings appropriate to their needs that will diminish the injury stemming from segregation and other sources of stigma." Furthermore, if such training could not be provided successfully in an institutional setting, then it would have to be provided in an appropriate setting outside the institution.

Cook had a definitive view about courts deferring to professional judgment. While he recognized that the Supreme Court had articulated some such concept, he noted that the absence of staff and resources did not excuse inappropriate care. Courts, under his interpretation of *Youngberg*, had to step in if professionals were unable to fulfill their obligations to their clients.

James Ellis, a law professor at the University of New Mexico and a scholar in the disability law field, noted three aspects of the *Youngberg* decision that made him optimistic about the eventual expanse of institutionally based litigation.[5] First, as was also noted by Cook, the Court "'left open the possibility that the' right to habilitation includes training needed to acquire community living skills for those individuals whose release from the institution is feasible.'" Second, disagreeing with Reynolds, Ellis found a clear distinction between lawsuits in which residents seek monetary damages and those in which injunctive relief is sought. In the latter cases, budgetary] constraints should not serve as al legitimate excuse for failing to provide constitutional rights. Third, with regard to deference to professional opinion, Ellis concluded that the Supreme Court had encouraged the lower courts to scrutinize care and treatment decisions that are based on political or budgetary considerations.]

The Scope of Youngberg

Since 1982, federal courts have issued a number of opinions that define the scope of *Youngberg*. Specifically, these cases have indicated which populations and admissions statuses are covered and the legal significance of asking for injunctive, declaratory or monetary relief. No matter what rights are constitutionally protected and what standards are applied to determine reasonable professional judgment, these threshold issues of who is covered and in what context will effect every decision that attempts to apply *Youngberg*.

Although mentally retarded citizens were the plaintiffs in the Supreme Court decision, no serious debate remains over the decision's applicability to all civilly institutionalized persons, even mentally disabled persons who come through the criminal justice system. Since *Youngberg*, mentally ill persons,[6] juveniles with behavioral problems,[7] persons incompetent to stand trial,[8] and pretrial detainees in jails' all have been found to be covered by the Supreme Court's decision.

Courts also have discussed the significance of a plaintiff's admission status within an institution as a possible limiting factor. A federal court in North Dakota rejected the state's contention that due process rights were only applicable to involuntarily committed residents and not to those who were admitted voluntarily.[10] Given the plaintiffs' intellectual limitations, family pressures, and lack of alternative care, it was absurd to conclude that they had consented to their admissions. In addition, even if there had been voluntary consent, they would not necessarily lose their constitutional rights within the institution. Similarly, a Massachusetts federal court determined that involuntarily committed persons are not defined by their admission route into the institution, but rather by their status once they are inside." The question to be asked, wrote the court, is whether residents have the "will or. power independently to pursue"

their interests and assert their rights.

The Eleventh Circuit, however, decided that minors voluntarily committed by their parents do not have the constitutional right to treatment in the least restrictive environment established by the Fifth Circuit in *Donaldson* v. *O'Connor*. The rationale put forward by the Eleventh Circuit was uncomplicated: while involuntary commitment "entails a massive curtailment of liberty in a constitutional sense. . . the voluntary patient carries the key to the hospital's exit in her hand. She chooses to accept treatment or not accept it as a matter of the exercise of free will." The case is readily distinguishable since the mentally disabled plaintiff was an adolescent whose parents were actively looking after her rights. Nevertheless, a concurring opinion, concerned about the unnecessary breadth of the court's rationale, observed that "it overlooks reality to say, as the majority does, that a child admitted to a hospital by a parent is a voluntary patient and under the law, should be treated more like an adult voluntary patient than an adult involuntary patient."[12]

A third area requiring more definition after *Youngberg* was the question of whether the case applied equally to monetary, injunctive, and declaratory relief. While the Justice Department assumed that the case applied to all types of relief, the two cases that we have found on this issue are split. A federal district court judge in North Dakota rejected any suggestion that deference to professional judgment did not extend to injunctive relief, noting that the concept was founded upon a broad principle of federalism.[14] Yet, a federal magistrate in New York concluded that professional deference of the kind articulated in *Youngberg* did not govern a motion for class certification in an action requesting declaratory or injunctive relief.[15]

The New York case may be an aberration since the issue of whether *Youngberg* applies only to damage actions has not even been raised in other decisions (discussed later in this article) in which injunctive and declaratory relief were granted by federal courts. No other court we know of has supported the New York court's position.

Right to Safe Conditions of Confinement

One of the rights recognized by *Youngberg*, which had been applied in prison cases, was the basic right to safe conditions of confinement.' Subsequent interpretations of this right in the civil context have led to a number of lawsuits for damages and an expansion of the elements required for a constitutionally safe environment.

To a federal court in North Dakota, constitutionally safe conditions included adequate food, clothing, shelter, medical and dental care, fire procedures, supervision and protection from dangerous situations within the institution such as "slippery floors, crowding in the tunnels, and harmful noise levels." That court's broad concept of safety was reinforced by a subsequent Second Circuit decision that similarly identified a right to adequate food shelter, clothing, medical care, **and** protection from harm.[17] In describing the extent of these rights, the appeals court noted that residents of civil institutions must have at least the same rights as prison inmates. Specific constitutional deficiencies that were remediable by a federal court order included filth, insect infestation, clothes that were not clean and did not fit properly, injuries to residents due to improper supervision, and the feeding of residents in supine positions. The court acknowledged that even more serious injuries might occur if residents remained at home, but concluded that this fact was not persuasive since "the state must bear responsibility for unsafe conditions in the school." With the establishment of human safety as a constitutional minimum, a number of liability claims have been filed, many that turned out successfully for the plaintiffs. Without discussing the professional standards for evaluating whether liability should be sustained in each of these cases, which will be covered later on, it is interesting to note the kinds of actions that have gone forward without being subject to summary dismissal. In each of three cases that relied on *Youngberg*, the alleged safety violations led to the death of or severe injury to the resident. A federal judge in Deleware, for example, found that an institution could be liable for giving a patient too much freedom if it could be shown that the patient's freedom led to his death by suicide.[18] Similarly, a federal court in Virginia refused to dismiss a section 1983 civil rights action by an involuntary mental patient who ignited her clothes, causing third-degree burns over 35 percent of her body." In that case, it was alleged the staff failed to confiscate her cigarettes and lighter. In the third case, a federal court in Pennsylvania found that an estate of a mentally retarded resident, who had choked to death while eating lunch, had stated a proper due process claim.[20]

Right to Be Free of Undue Bodily Restraints

The right to be free of undue bodily restraints as articulated in *Youngberg* has been expanded in subsequent cases to include a range of physical and chemical restrictions on liberty that go beyond the threshold of institutionalization alone.

The right to be free of nonchemical restraints has parallel concerns with care in the least restrictive setting, a concept that will be reviewed separately in a subsequent section. In addition, this right has been held to include: reasonable opportunities to make trips into the community and live in the community;[21] freedom from any restraints that are unnecessary for safety, training, or treatment;[22] and freedom from restraints that lock ambulatory persons into wheelchairs and institutions without the use of properly equipped transportation vehicles, wheelchairs, and orthopedic carts.[23]

Right to Refuse Medication

Far more complicated and controversial is the right to refuse the chemical restrictions of medication. Three branches of law have retained or gained recognition since *Youngberg*. The first important

case was the Third Circuit's reconsideration of *Rennie v. Klein,* which reaffirmed the appeals court's original position that dangerous mentally ill mental patients who have been involuntarily committed retain a qualified constitutional right to refuse antipsychotic medication.[24] This right ended, however, where abstinence from drugs endangered the patient or other people. The decision left intact New Jersey's three-step administrative review procedure for administering medication over the refusal of a hospitalized patient. This review included separate assessments by the treating physician, the patient's treatment team, and the facility's medical director or his designee.[25]

The Second Circuit, citing *Rennie v. Klein,* also found a limited right to refuse antipsychotic medication for involuntarily committed mental patients.[26] Even though in New York a person need not be dangerous to be committed, due process was served by a three-level medical review, notifying a patient advocate, and an opportunity to have legal counsel.

In the District of Columbia, a federal court concluded that — as applied to a man who had been found not guilty by reason of insanity, dangerous and incompetent to make a rational medication decision — the due process procedures provided by St. Elizabeth's Hospital were sufficient to protect patients' qualified right to refuse psychotropic medication.[27] *Youngberg* was satisfied by adminstrative procedures requiring consultation with a patient advocate and the patient's family, and an independent administrative review of the key decision-making factors.

A fourth case that adopted the *Rennie* v. *Klein* approach was a 1984 order by a federal judge implementing a settlement agreement. Treatment with psychotropic medication met constitutional muster if: it was used to either treat the patient for the disorder that justified continued confinement or to curb the patient's violent outbreaks; and it was preceded by a two-level medical review which, if the patient was competent, included an independent psychiatric consultation.[28]

In each of these cases, the right to refuse antipsychotic or psychotropic medication was satisfied by internal administrative review procedures, usually including an independent medical evaluation. Dangerousness was a requirement in half of these decisions, but indirectly, through the commitment process.

The second theoretical branch derives from the Massachusetts litigation in the *Rogers* case. Most recently, the First Circuit upheld Massachusetts' procedures, which had allowed competent involuntary patients to make their own treatment decisions and permitted a court to make decisions for incompetent patients using substituted judgment.[29] While directing the lower court to uphold the state law because it was constitutionally protected once enacted, the appeals court noted that the procedures were more rigorous than *Youngberg* required.

The Tenth Circuit also adopted the *Rogers* model in deciding that a pretrial detainee while incarcerated in jail had a constitutionally protected interest, although not an absolute interest, in deciding whether to accept or reject the administration of psychotropic drugs.[30] The lower court, in reviewing this man's case, was instructed to make sure that the administration of medication was necessary for legitimate treatment concerns, as opposed to nonemergency concerns such as jail safety and security, and that no less restrictive alternatives were available.

Based on both common law and a state statute, the Colorado Supreme Court decided that an involuntary mental patient could not be given antipsychotic medication in a nonemergency without an adversary hearing that showed the patient to be incompetent and in substantial need of treatment, and that no less intrusive treatment was available.[31]

The third theoretical branch is represented by a federal decision that upheld a Wisconsin statute that overrides civilly committed patients' right to refuse psychotropic drugs if the drugs are administered in an acceptable professional manner.[32] Arguably, this decision does not fit within the other two branches because forcible treatment was justified by prior commitment proceedings that found the patient dangerous and incompetent to decide his own treatment. Yet, the court stated that the Wisconsin statute followed *Rennie v. Klein* and *Youngberg v. Romeo,* by giving patients the right to refuse excessive medication and establishing a grievance procedure. Moreover, it may be significant to other courts, that the plaintiff in this case was an insanity acquittee who had been committed after his criminal trial.

If this Wisconsin case signaled a third trend, it is a very narrow one indeed: civil commitment justifies fewer procedures than *Rennie,* but the commitment process must be more rigorous than the standards found elsewhere. Both this decision and the decisions following *Rennie* applied a legal analysis that evaluated the entire package of procedures rather than focusing on each individual procedure as seperate thresholds. In such a context, New York or New Jersey may have more due process after the commitment, but at the commitment hearing, Wisconsin's substantive standards are more demanding than either of those two states. The different approach comes from states like Massachusetts and Colorado that follow *Rogers* and its progeny, which insist that the Constitution requires certain substantive due process thresholds be met and that — unlike New York, New Jersey, or Wisconsin — procedural due process demands an adversary hearing.

Right to Treatment/ Habilitation/Training

The third right set out in *Youngberg* was sufficient training to allow institutionalized individuals to meaningfully exercise their other constitutional rights. Since then, several courts have expanded upon the Supreme Court's definition, in a few instances even finding a constitutional right to treatment rehabilitation.

One of the first decisions was handed down by a federal court in North Dakota that specified a number of areas of training related to the exercise of other constitutional

rights: walking, basic communication, feeding, dressing, self-control, toilet training, and any other training that would allow a resident "to maintain the minimum self-care skills that they had when they entered the institution."[33] The court, however, rejected the call for treatment or habilitation, noting that safe confinement may be constitutionally sufficient.

The Third Circuit reaffirmed an earlier decision that identified a right to adequate treatment for a man who had been committed after being found incompetent to stand trial for murder.[34] It was up to the jury to determine whether the treatment had been adequate based on reasonable professional standards.

The Second Circuit upheld a constitutional right to treatment as an essential precondition of the state's civil commitment power.[35] The determination of whether adequate treatment had been provided rested with the jury. A few months later though, the same circuit made reference to the fact, without actually deciding, that training only was required if it was needed to maintain basic skills.[36]

Right to Services in the Least Restrictive Setting

Although a right to services in the least restrictive setting was never decided by the Supreme Court, such a right might be implied from *Youngberg* and *O'Connor* v. *Donaldson* taken together. The latter decision held that a nondangerous, mentally disabled person has a right not to be confined if he is "capable of surviving safely in freedom by himself with the help of willing and responsible family members or friends."[37] Once *Donaldson* was joined with the right to minimally adequate training necessary to carry out other constitutional rights, there was a logically compelling argument that mimimally adequate treatment, habilitation, and other services were constitutionally mandated for individuals who now or in the future will be able to leave the institution.

One decision noted that while there did not appear to be an absolute right to the least restrictive services, there was a limited right that attached to the enjoyment of other basic liberty interests. Arguably, freedom from unnecessary confinement as set out in *Donaldson* would be cognizable under that rationale.

A string of opinions took a narrower view. The Eleventh Circuit found no right to treatment in the least restrictive environment, but did so only in the context of minors who had been voluntarily committed by their parents.[38] Implicitly, the appeals court recognized a constitutional right to such individualized treatment as would help or cure an adult patient's mental condition.

As part of the consent decree in the infamous Willowbrook case, the Second Circuit agreed that the residents should be deinstitutionalized as quickly and humanely as possible, but the important thing was to place them in better facilities of up to 50 beds as soon as possible, not necessarily in small, homelike facilities of 3 to 6 beds.[39] Thus, the matter was remanded to the district court to determine whether the intermediate facilities met reasonable professional standards. A year later, the Second Circuit overruled a lower court that had issued an order to deinstitutionalize 400 mentally retarded residents and place them in community residences.[40] The appeals court determined that since there was no constitutional deprivation associated with being in an institution per se, there could be no constitutional right to be in the community or in any other less restrictive setting than an institution. Citing that Second Circuit opinion, a California state court rejected the intriguing legal position that treatment in the community was constitutionally required under *Youngberg*, given the prevailing professional views about the appropriateness of community care for nondangerous mentally ill persons.

The question of whether mental health professionals, in making their judgments about patient care, must do so in the least intrusive manner possible also was put to the Third Circuit when the Supreme Court remanded *Rennie* v. *Klein."* Nevertheless, the issue remained very much in doubt as nine circuit court judges could not reach any consensus. Five of the judges thought that *Youngberg* precluded any use of the least restrictive alternative. Four other judges were incredulous that their brethren could reach such a conclusion since *Youngberg* never addressed that issue. And a tenth judge avoided taking a stand one way or the other since the question was not crucial to his resolution of the case. The first court to endorse a constitutional right to treatment in the community after *Youngberg* was a federal tribunal in North Carolina that issued a judgment detailing such a right for a mentally retarded adult.[42] In a consent decree, the plaintiff was ordered to receive, among other entitlements, a detailed treatment plan with goals and objectives, a case manager, suitable supportive services, and periodic evaluations. With only a minor modification, the decision was upheld by the Fourth Circuit, which agreed that services in the least restrictive setting were consistent with the principles articulated by *Youngberg."* The appeals court observed that the plaintiff's liberty interests in safety and freedom from bodily restraint were not dependent upon institutional confinement. Those rights existed in any social service setting. In light of Thomas' aggressiveness, attempted suicide, and other individual characteristics, it was not unreasonable professional judgment to have him transfered from the hospital to the group home.

A Pennsylvania federal court determined that the due process rights of a mentally retarded resident who had resided in a state institution for 30 years had been violated where the state repeatedly ignored her requests for a hearing on her continued confinement and failed to develop an appropriate community placement.[44] Reasonable recommendations of professionals that the plaintiff be placed in the community with proper supportive services were ignored many times as were her requests for a hearing and legal assistance. The fact that she was denied the treatment identified by the staff as necessary, for reasons unrelated to her condition,

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constituted a violation of *Youngberg*. The defendants were ordered to develop an appropriate program of community services for the plaintiff so that she could leave the institution.

Finally, in a Texas class action, a federal judge refused the state's request to modify a consent decree, finding that the plaintiffs had a constitutional right to community services, the parties had arrived at a reasonable settlement, and there had been no radical change in circumstance that would justify pulling back on the community services that had been promised.[45] The requirements of *Youngberg* had been met, since the alternative living arrangements for the plaintiffs were based on an individual assessment of each person's needs and an individualized plan that had been developed using interdisciplinary teams in accordance with professional standards.

The cases that have been discussed so far represent courts' views to date on the meaning of the rights identified by the Supreme Court in *Youngberg*. They range from a literal replication of the rights set out by the Supreme Court — which go only a little further than providing humane custodial care — to an expansion of the rights based on other precedents, which cumulatively entitle mentally disabled persons to at least some right to training, habilitation, treatment, and services both in the institution and in the community. The Supreme Court also has set a new tone for the right to refuse treatment that seems to be less absolute and that appears to have shifted somewhat toward administrative due process and away from judicial review. At the same time, the existence of some rights have been recognized, and the opportunities for plaintiffs to recover damages — for abuse, neglect, and malpractice arising out of the violation of those rights — have increased.

In the sections that follow in Part II, we will look at two potential limitations on the implementation of any of those constitutional rights by courts deferring to professional judgments and by state rights interpretations of sovereign immunity.

FOOTNOTES

1. 457 U.S. 307 (1982), 6 MDLR 223.
2. 104 S. Ct. 900 (1984), 8 MPDLR 7.
3. "Civil Rights oflnstitutionalized Persons Act," 7 MDLR 5-8.
4. Timothy Cook, "The Substantive Due Process Rights of Mentally Disabled Clients," 7 MDLR 346.
5. "Summary and Analysis," 7 MDLR 67.
6. *Gann* v. *Delaware State Hospital,* 543 F. Supp. 268 (D. Del. 1982), 6 MDLR 411.
7. *Milonas* v. *Williams,* 691 F.2d 931 (10th Cir. 1982), 7 MDLR 83.
8. *Scott v. Plante,* 691 F.2d 634 (3rd Cir. 1982), 7 MDLR 74.
9. *Bee v. Greaves,* 744 F.2d 1387 (10th Cir. 1984), 9 MPDLR 25.
10. *ARC of North Dakota* v. *Olson,* No. Al-80-141 (D. N.D. Aug. 31, 1982), 6 MDLR 374.
11. *Lombard* v. *Eunice Kennedy Shriver Center for Mental Retardation,* 556 F. Supp. 677 (D. Mass. 1983), 7 MDLR 82.
12. 493 F.2d 507 (5th Cir. 1974).
13. *Doe* v. *Public Health Trust of Dade County,* 696 F.2d 901 (11th Cir. 1983), 7 MDLR 220.
14. *ARC of North Dakota* v. *Olson,* No. Al-80-141 (D.N.D. Aug. 31, 1982), 6 MDLR 374.
15. *Rights, Equality Always at Letchworth, Inc.* v. *Cuomo,* 84 Civ. 4163 (CES) (S.D.N.Y. Nov. 1, 1985), 10 MPDLR 22.
16. *ARC of North Dakota v. Olson,* No. A-l-80-141 (D. N.D. Aug. 31, 1982), 6 MDLR 374.
17. *Society for Goodwill to Retarded Children, Inc.* v. *Cuomo, 737F.2d 1239 (2nd Cir. 1984), 8 MPDLR 462.*
18. *Gann* v. *Delaware State Hospital,* 543 F. Supp. 268 (D.Del. 1982), 6 MDLR 411.
19. *Valentine* v. *Strange,* 597 F. Supp. 1316 (E.D. Va. 1984), 9 MPDLR 127.
20. *Sabo v. O'Bannon,* 586 F. Supp. 1132 (E.D. Pa. 1984), 8 MPDLR 549.
21. *ARC of North Dakota* v. *Olson,* No. Al-80-141 (D. N.D. Aug. 31, 1982), 6 MDLR 374.
22. *Scott v. Plante,* 691 F.2d 634 (3rd Cir. 1982), 7 MDLR 74.
23. *Society for Goodwill to Retarded Children, Inc. v. Cuomo,* 737 F.2d 1239 (2nd Cir. 1984), 8 MPDLR 462.
24. 720 F.2d 266 (3rd Cir. 1983), 8 MPDLR 18.
25. *Rennie* v. *Klein,* 653 F.2d 836 (3rd Cir. 1981), 5 MDLR 322.
26. *Project Release* v. *Prevost,* 722 F.2d 960 (2nd Cir. 1983), 8 MPDLR 86.
27. *United States v. Leatherman,* 580 F. Supp. 977 (D.D.C. 1983), 8 MPDLR 104.
28. *R.A.J.* v. *Miller,* 590 F. Supp. 1319 (N.D. Tex 1984), 8 MPDLR 445.
29. *Rogers* v. *Okin,* 738 F.2d 1 (1st Cir. 1984), 8 MPDLR 528.
30. *Bee v. Greaves, 744 F.2d 1387 (10th Cir. 1984), 9 MPDLR 25.*
31. *Colorado v. Medina,* 705 P.2d 961 (Colo. Sup. Ct. 1985), 9 MPDLR 426.
32. *Stensvad v. Reivitz,* 601 F. Supp. 128 (W.D. Wis. 1985), 9 MPDLR 103.
33. *ARC of North Dakota v. Olson,* No. Al-80-141 (D. N.D. Aug. 31, 1982), 6 MDLR 374.
34. *Scott* v. *Plante,* 691 F.2d 634 (3rd Cir. 1982), 7 MDLR 74.
35. *Woe v. Cuomo,* 729 F.2d 96 (2nd Cir. 1984), 8 MPDLR 280.
36. *Society for Goodwill to Retarded Children, Inc. v. Cuomo,* 737 F.2d 1239 (2nd Cir. 1984), 8 MPDLR 462.
37. 422 U.S. 563 (1975).
38. *Doe v. Public Health Trust of Dade County,* 696 F. 2d 901 (11th Cir. 1983), 7 MDLR 220.
39. *New York ARC* v. *Carey,* No. 82-7441 (2nd Cir. March 31, 1983), 7 MDLR 226.
40. *Society for Goodwill to Retarded Children, Inc. v. Cuomo,* 737 F.2d 1239 (2nd Cir. 1984), 8 MPDLR 462.
41. 720 F.2d 266 (3rd Cir. 1983), 8 MPDLR 18.
42. *Thomas S. v. Morrow,* 601 F. Supp. (W.D.N.C. 1984), 9 MPDLR 1055.
43. *ThomasS. v. Morrow,* No. 84-2254 (4th Cir. Jan 9, 1986), 10 MPDLR 101.
44. *Clark v. Cohen,* 613 F. Supp. 684 (E.D. Pa. 1985), 9 MPDLR 246.
45. *Lelz v. Kavanagh,* No. 3-85-2462-H (D. Tex. March 4, 1986), 10 MPDLR 175. state rights interpretations of sovereign immunity.

HMO Mental Health Newsletter Published

The *Reporter* recently has encountered a new publication, the *HMO Mental Health Newsletter,* a monthly national forum devoted to mental health and substance abuse services in the prepaid health-care sector. Articles range from the practical — for example, "how to set up" an HMO department of mental health — to issues of a more legal nature — such as benefit structures and exclusions. Abstracts of current journal articles and pertinent reviews are regular features, as are listings of positions available in the mental health, substance abuse, or health education fields. The newsletter is published by Prepaid Health Publications, Inc., 1150 Griswold, Suite 1020, Detroit, MI 48226. Individual subscriptions cost $65.00 per year; single copies are $6.00 each.