

The Right to Treatment and the Medical Establishment*

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What is the right to treatment? † What does it mean to patients and to the psychiatric establishment? How have the psychiatric establishment and the law advanced or impeded the development of that right? Such is the subject matter of my presentation.

The best way to begin is to offer you a Yiddish anecdote as a metaphor of what is to follow. An old Jew is on his way to evening services at his synagogue in the Bronx when he notices that people are running past him in the opposite direction. He interrupts his pious reverie to ask one of the racing passersby what is happening. The hurried response is, "Run for your life, a lion is loose; a lion has escaped from the zoo." Now that startling information takes the old man quite aback. It is totally outside the framework of his day-to-day comprehension of the human condition. But his survival instincts are not totally maladapted, and so he turns to hurry after the others. As he joins the frantic foot race, a characteristic thought crosses his mind: Is this good for the Jews or is it bad for the Jews?

Now in what follows the lion is the right to treatment, and the Jews are, from one perspective, the patients, and, as you shall see, from another perspective the psychiatric establishment. By the time I am finished you will understand why I choose to designate the right to treatment as a lion. During the 1960's a debate went on in liberal circles and in the national executive committee of the ACLU: Should civil libertarians attack the civil commitment laws as a deprivation of freedom without due process of law, or should they begin to beat the legal drums for improving conditions for those involuntarily confined? The strategy first adopted was to fight the very fact of civil commitment, which, as these advocates viewed it, was closer to the core issue of civil libertarians; i.e., liberty.

Thus the right-to-treatment battle, aimed at improving conditions through litigation rather than legislation, was for a long time left to the man who invented it, Dr. Morton Birnbaum, who is not a psychiatrist and who is only a part-time lawyer. Dr. Birnbaum basically argued that if the state forcibly confines someone under the benevolent theory of *parens patriae* (the state as parent), then it ought to provide treatment. He tried to build that simple moral argument into a legal and constitutional argument. Practical obstacles stood in his way during the early years. First, he is a part-time lawyer and he got little financial or scholarly support from anyone. The American Psychiatric Association gave him no support. Eventually, however, his ideas surfaced in law review articles and were at least noticed by legal scholars.

Dr. Birnbaum, of course, was not the only one to have concerns about the quality of involuntary treatment, but others were more sanguine. In 1967 the Supreme Court took a long hard look at the juvenile correctional system and its provision of treatment in the

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† Since the preparation of this article, the Fifth Circuit has upheld the right to treatment. The right, and the psychiatrist's liability as to that right, are now before the U.S. Supreme Court.

now famous case of a fifteen-year-old named Gault, who was arrested for making obscene phone calls.

The court surveyed the bankrupt state of treatment provided juveniles, and they then changed the legal procedures operating in the juvenile court, in effect to make it more difficult to incarcerate youngsters. The court made its decision at the same entry threshold as the ACLU. The decision by Justice Fortas can be read as follows: The system of treatment for juveniles is rotten; therefore, let's at least make it more difficult to get into the system by adding constitutional safeguards similar to those in the criminal courts. The *Gault* decision may have retarded the rate of growth of the juvenile "prison" census, but that census has nonetheless expanded relentlessly, and the quality of treatment and reformation is at least as horrible as it was in 1967.

Somewhere hovering in the background of the ACLU position and the *Gault* decision was a growing sense of distrust of the psychiatric establishment, which was at least in theory the leaders of the treatment enterprise. Either it was condemned because treatment was nonexistent and people were being warehoused *à la* Goffman, or it was condemned because treatment was science-fiction powerful, turning people into mindless zombies with lobotomy, shock treatment, behavior modification, and downers, *à la* "Clockwork Orange." Either of these was sufficient reason to argue for making it more difficult to get into the system.

Indeed, that kind of legal action has been happening all over the United States: courts and legislatures have been making it more difficult to enter the system of civil commitment by doing exactly what the Supreme Court did in *Gault* to the juvenile system. When you stop and think about it, the situation is really quite ironic. What the courts and legislatures are doing is imposing the criminal justice model on the civil commitment model. Does anyone really expect that imposing the procedures of one terrible system upon another will bring about any real good?

Now, I assure you that I am aware of and respect all of the important constitutional and due process arguments that can be made about our criminal justice system. But there is a critical perspective at the conceptual level to be derived from distinguishing two social functions of the criminal courts. The first is as a forum for establishing moral blameworthiness while respecting individual rights. The second is as the most powerful decision-making body in a huge bureaucracy consisting of law enforcement, the courts, and the system of corrections—a bureaucracy charged with controlling crime in modern society. It is when the system is examined from this latter perspective that its failures become most obvious; indeed, many, including judges, believe that as a bureaucracy it is counterproductive.

Perhaps this view is too cynical, but I have seen no empirical data that refute it and much that confirm it. It is my contention that the revulsion of the criminal justice system against its own ineffectiveness has led mainly to changes in the operation of the moral forum rather than to improvements in the overall bureaucracy. It is that pattern of reform which is now being applied to psychiatry and law.

But let me return to the right to treatment, which at first blush seems to be a different kind of effort, one intended to improve the lot of those who do get confined.

The right to treatment began to be articulated in courts of law in a variety of cases mostly having to do with men confined as sexually dangerous—I spare you the legal details of these early cases. The first major decision came from Judge Bazelon, who spoke to you this morning.* It was *Rouse v. Cameron*. Rouse was arrested late one night carrying a huge arsenal in a suitcase. His lawyer, rather than going through the standard and not very morally or constitutionally inspiring process of plea bargaining, decided instead to plead Rouse not guilty by reason of insanity. Doubtless the lawyer was encour-

* As indicated in the Introduction, Judge Bazelon's paper has been omitted from the *Bulletin* because it is readily available elsewhere.

aged by the expanded insanity defense, the so-called Durham decision, also created by Judge Bazelon. Unfortunately for Rouse, he was in fact found not guilty by reason of insanity and incarcerated in the John Howard Pavilion of St. Elizabeth's Hospital, where he was treated with milieu therapy and weekly group therapy.

Four years later it began to dawn on Rouse that he might have done better to cop a plea—since the maximum sentence would have been less than what he had already served. The case must have been particularly poignant for Judge Bazelon as he viewed the results of his enlightened contribution to the jurisprudence of criminal law.

At any rate, Judge Bazelon, in a now often cited landmark decision, noted that the statute under which Rouse was confined demanded treatment, and he insisted that it must be provided. Let me emphasize that the Judge did not say that Rouse had a constitutional right to treatment; he said that he based his opinion on the will of the legislature as it was decipherable in the statute. But in passing he did note that there might be a constitutional right to treatment based either on cruel and unusual punishment, or on due process arguments. Judge Bazelon did not demand cure, or even improvement, or even the best possible treatment. He simply asked for an effort in good faith and for medical records that would reflect such effort. Furthermore, he held that continued failure to provide treatment could not be justified by an insufficiency of resources.

Now, it is my view that the psychiatric establishment should have accepted that decision with gratitude and gone to the Congress and the District of Columbia to demand the resources necessary to do what the Judge had ordered. Instead, the APA immediately went to work to issue a position statement in effect rebuking the good Judge for telling psychiatrists how to treat patients. It is true that Judge Bazelon had some callous words to say about milieu therapy, but in reality the APA missed the point entirely. They reacted as if they had been attacked by the lion. "Mental hospital administrations may vary in quality as do all human institutions. It is one thing, however, for outside community agencies to render constructive criticism of the relative adequacy of a psychiatric facility, and quite another for it to interpose its judgments on the professional managerial affairs of that facility." That APA position statement is a monument to bureaucratic myopia which can be matched only by what followed.

After *Rouse*, the right to treatment became something to be talked about. But what was it? At that point it was one legal precedent articulated by a federal court of appeals based on a statute which seemed to have little relevance to other jurisdictions. But the APA did respond to the issue by forming a task force, to which I was appointed. Interestingly enough, that task force was never actually convened by its chairman. That fact, I thought, was subsequently explained when he published a paper called "The Right to Treatment: An Enchanting Legal Fiction." In it he concluded that such a right had little legal validity and no practical relevance. His views seemed to be correct in that time frame. Right-to-treatment cases had led to nothing more than the particular patient's receiving more attention, and when reformers advocated right-to-treatment legislation in the state of Pennsylvania, they were defeated because of financial concerns.

But others were more optimistic than the APA task force chairman, and they pursued the litigation route. Specifically, the Mental Health Law Project, a Washington, D.C.-based group of public interest lawyers, brought a class action suit against state hospitals in Alabama. Alabama was then 50th in per patient expenditure, and its mental hospitals resembled the Augean stables. This case is important in many respects. First, it was a class action, meaning that the hospital could not comply by borrowing from Paul's treatment to pay for Peter's. Second, it was the first right-to-treatment case brought in behalf of the typical civilly committed patients rather than the criminally insane or the sexually dangerous. Third, the case was joined by the American Civil Liberties Union, by Dr. Birnbaum, by the American Orthopsychiatric Association, and by many others—indeed, by practically every concerned organization but the American Psychiatric Association.

You may well ask how did the civil libertarians become involved in improving conditions, a strategy they had earlier rejected, and how could the APA stay out of litigation meant to improve the most egregiously horrifying situation?—a situation which involved such obscene practices as patients being hosed down with scalding water by other patients as the chief measure of cleanliness; patients who remained on penicillin for a year after treatment for pneumonia because no doctor saw them again; so-called nurses with less than an eighth grade education; and a total lack of any psychiatric treatment, with almost no trained or qualified personnel.

First, as to the ACLU: According to Dr. Birnbaum, who eventually dissociated himself from the case, the libertarians knew or gambled that Alabama would never provide adequate funds for her hospitals, and thus they saw the case as a tactic in their larger strategy: a tactic which would expose the horror of mental hospitals and eventually lead to the release of patients and the abandonment of involuntary confinement.

Now, as to the psychiatric establishment, why did it remain aloof? First, there was the problem of the APA's defensive response to *Rouse*. Second, Alabama's Commissioner of Mental Health, Dr. Stonewall Stickney, had, before the suit, called on the APA to try to help him improve conditions. The APA knew what was happening in Alabama's hospitals, but preferred to try to help Dr. Stickney persuade, rather than to resort to legal action.

Third, the psychiatric establishment had very little structural capacity to take any action, and certainly not a controversial action like naming a colleague as defendant.

These remain painful problems facing the psychiatric establishment: (a) Should it sue its own members in the effort to achieve progress? (b) How can it take any action, period? I shall have more to say about these subjects.

At any rate, Judge Johnson, who tried the case of *Wyatt v. Stickney*, articulated a clear and constitutional basis to the right to treatment:

"To deprive any citizen of his or her liberty upon the altruistic theory that the confinement is for humane and therapeutic reasons, and then fail to provide adequate treatment violates the very fundamentals of due process."

Judge Johnson, who is famous in the South for his powerful stand on civil rights, had taken another strong stand. He went further than Judge Bazelon not only by defining a constitutional right, but also by holding hearings to define the standard of treatment to be employed. Famous psychiatrists from all over America testified at those hearings as the court wrestled with something the psychiatric establishment had never been able to do—namely, to set minimum standards for such things as staff-patient ratios, etc.

Now, after the fact of *Wyatt*, a new APA task force was constituted with a new chairman. As a member of it I helped to convince the group that we should support Judge Johnson's decision, which was then being appealed to the Fifth Circuit by the State of Alabama. My strategy was to suggest that though a judge could not tell psychiatrists what was good treatment, he could tell them that treatment at a given hospital was deplorable, and that was all Judge Johnson had done. His detailed standards should be viewed as an effort, not to prescribe psychiatric treatment, but to remedy a deplorable situation. The council and trustees of the APA bought that argument (since Dr. Stickney had resigned, they may have found such action easier), and the organization's name was added to one of the amici briefs at the time of the appeal.

By this time the right to treatment was clearly more than an enchanting fiction; it was beginning to look like a lion loose in the streets.

Alabama, in its appeal of Judge Johnson's decision, made two strong arguments. The first relates to the separation of powers between the branches of government; i.e., comity. Alabama argued that treatment was a service given the citizens of Alabama, and that its legislature, rather than a judge, should set the order of priority for services. If the legislature wanted to spend money on attracting industry, or on schools, or on welfare, rather than on mental patients, that was its prerogative, and not the judiciary's.

The second argument, which was formulated in the neighboring state of Georgia in a case, *Burnham v. Welfare Department*, appealed along with *Wyatt*, was that judges couldn't possibly decide what treatment was because psychiatry is a totally amorphous discipline with different schools of thought and little objective data. That opinion, which is a scorching, ill-informed, and insulting indictment of American psychiatry, might well have been supported, however, by anyone who had attended Judge Johnson's hearings and listened to the divergent recommendations of America's famous psychiatrists. These technical legal arguments, comity and justiciability, have not yet been decided; indeed, the Fifth Circuit assembled all of its judges to hear *Wyatt* en banc, and since has sat on it for over a year without deciding it.

They are no more dilatory than the APA's task force on the right to treatment. After our initial action, a bitter wrangle developed, and we dissolved and yet a third group has been assembled.

But while the Fifth Circuit and the APA were cogitating, the legal profession was feeding the lion. A case came out of Florida which should surely terrify the psychiatric establishment once they fully understand it. In that case, Mr. Donaldson, who had been confined for fourteen years at Chattahoochee as a paranoid schizophrenic, sued his state hospital psychiatrists for money damages under the Civil Rights Act. He won that case, and the Fifth Circuit, while still holding back on *Wyatt*, has on April 26, 1974, upheld *Donaldson*, stating that the right to treatment is a constitutional right. Judge Wisdom wrote: "We hold that the 14th amendment guarantees involuntarily civilly committed mental patients a right to treatment." The 14th amendment, of course, talks about deprivation of liberty without due process of law—the legal theory of the *Wyatt* case.

If there is one patient in Florida who can bring such a damage action, do you have any doubt that there are thousands of others in the United States similarly situated? Furthermore, note that Donaldson was awarded \$38,500.

Now the lion has taken a bite out of the psychiatric establishment, and imagine the rampage which will follow if the precedent sticks and lawyers learn that money damages and therefore contingency fees are available in this field. The ACLU and the public interest law firms will be pushed aside in the rush of litigation brought by trial lawyers who are already threatened by national no-fault auto insurance.

Let me make an important distinction here. Earlier I mentioned the APA's unwillingness to sue a fellow member to achieve progress. Now I was not talking about suing for damages; rather, the class action of *Wyatt* asked Dr. Stickney to do a number of things, but it did not suggest that he personally was guilty of unjustifiably withholding treatment, as the doctors in *Donaldson* are held to be. But short of being charged with malfeasance, psychiatrists object to the harassment, to the negative publicity they receive in the media, and to the entire adversary nature of court action. Rather than helping to shape the right-to-treatment litigation, as I would have liked, the psychiatric establishment, by being "nondirective," has gotten the worst of both worlds. After *Donaldson*, the right to treatment is quintessentially the right to sue your hospital psychiatrist if he doesn't treat you.

But the *Donaldson* opinion (which, by the way, necessitated my rewriting this paper) is interesting for three reasons. First, it was the state hospital psychiatrists who argued that there was no right to treatment and that psychiatric treatment could not be defined. Of course they were defended by the Attorney General of Florida, who had his own fish to fry.

Second, because Donaldson was a single patient and no money was asked from the legislature, but only from the psychiatrist, there was no problem of comity-separation of powers. Without the problem of money, Judge Wisdom disposed of the justiciability question with dispatch. "There will be cases—and the case at bar is one—where it will be possible to make a determination whether a given individual has been denied his right to treatment without formulating in the abstract what constitutes adequate treat-

ment." Obviously I have to admire that logic, since it is similar to the argument I used with the APA: that a judge can tell when treatment is deplorable. But I had not anticipated that the argument would be used to prove damages against a psychiatrist who had sole responsibility for 600 inpatients.

Finally, the court pulled together all the relevant cases and concluded that when the state intervenes as *parens patriae* and deprives a person of freedom, the Constitution demands a *quid pro quo* of treatment. Thus, they articulated the constitutional right which Dr. Morton Birnbaum had been trying to insist upon for twenty-five years. Note that they tied the right to involuntary confinement.

Now, what does *Donaldson* mean in a practical sense? Query: Where are patients involuntarily confined and often given deplorable treatment? Answer: State hospitals. Query: What psychiatrist will be willing to work in a state hospital after *Donaldson*? Answer: Probably no one, since even now such hospitals are staffed largely by foreign-trained physicians ineligible for state licensure. Indeed, I am told that the Attorney General of Florida defended the case because he feared it would lead to wholesale resignations. Query: Does malpractice insurance cover a claim that a doctor violates a patient's civil rights? Answer: The doctors involved in *Donaldson* don't even have malpractice insurance, and they believe that if they did, it would not cover them. Remember, these are not fat-cat psychiatrists; the principal defendant is a retired state hospital superintendent living on a state pension. Query: Is this lion good for the psychiatric establishment? Answer: Obviously not. Will it be good for patients? I doubt it, for reasons which I shall now develop.

Remember that Judge Wisdom held that the right to treatment was applicable only when the patient was involuntarily confined—that is crucial. A New York case dealing with the right to treatment at Willowbrook, one of the largest institutions in America for the mentally retarded, held the following: First, conditions in the institution are horrible, but the state is not involuntarily confining these people; this is merely a service to their parents and relatives. Therefore, Judge Judd held there was no constitutional right to treatment, although he did order the state to improve some of what he felt to be dangerous and harmful conditions.

Imagine what you would do if you were a state legislature faced on one side with the prospect of class action suits on the right to treatment, and on the other side with civil libertarians who urge the abolition of involuntary confinement. The obvious solution is to save money and to look like a progressive at the same time. You accomplish that by making civil commitment more difficult, and by ordering the state hospitals to discharge everyone who isn't dangerous, whether or not adequate alternatives exist. That, of course, is exactly what is happening all over the United States. Alabama, since *Wyatt*, has cut its hospital census by at least a third. California and Massachusetts are both talking about closing down their state hospital systems.

Imagine what you would do after *Donaldson* if you were a state hospital psychiatrist and you didn't resign. You would certainly, I suspect, make the revolving door policy a spinning success. Then all that doctors would have to worry about would be malpractice suits filed because they had discharged their patients too soon and the patients had committed suicide, etc. I am dramatizing somewhat in order to emphasize the possibilities as well as the probabilities.

What will happen and what is happening already is that the right to treatment coupled with other developments is leading to an abdication of responsibility for the treatment of the chronically mentally ill in America. The ACLU strategy as described to me by Dr. Birnbaum has been a smashing success. But what has become obvious in this tragic process is that the mentally ill are not political prisoners, they are not people who have been railroaded, they are simply outcasts, persons whom nobody wants, and the right to treatment is a lion that increasingly seems at this time to be threatening the patients as well as their caretakers in the psychiatric establishment.

The federal government, in one of the nicer ironies of the situation, has, through the Justice Department, brought its own right-to-treatment suit against a Maryland institution for the mentally retarded. The complaint alleges that Maryland has not recruited adequate trained personnel, etc. It does this at the same time that HEW slashes training funds and dismantles NIMH, and at the same time that the Bureau of the Budget impounds mental health funds, and the Administration abandons the community mental health centers which were supposed to replace state hospitals.

The obvious point is that the right to treatment, if it is to be good for patients, must at some point affect the provision of mental health care—it has to make it better. That takes money, a better system, more personnel and resources.

Is there any hope for such improvements?

I have been involved in two major class action suits which attempted to achieve exactly such progress, and I shall now describe those experiences to you. Remember that we still do not know whether *Wyatt* is to be upheld, and *Wyatt* is the principal decision which requires more funds to accomplish the right-to-treatment mandate.

The first effort was an attempt to get more money for patients in state hospitals. We tried to do this by arguing two major points: (1) A mental patient eligible for Medicaid who could be admitted voluntarily to a psychiatric ward of a general hospital is entitled to \$150 per day in care, plus certain other costs. But if that same patient is too disturbed to be voluntary, and has to be committed to a state mental hospital, he gets no Medicaid. We argued that such a result was a violation of equal protection. (2) My second argument, meant to strengthen the first, demonstrated that NIMH's own statistics show that a disproportionate percentage of blacks and other minorities are involuntarily confined in the state hospital system. Thus, the Medicaid system involves racial discrimination as well as discrimination against the class of involuntarily confined patients.

That case, *Legion v. Weinberger*, was rejected by the Supreme Court with only Justice Blackmun dissenting. I prepared an amicus brief for the APA in that case, in my new capacity as Chairman of the Commission on Judicial Action. The existence of that commission suggests the APA's realization that it must take action. The APA membership, however, is not a unified voice, and I heard considerable, if minority, criticism of the position taken: first, from those who felt that I was helping state hospitals which should be allowed to die; second, from those who were unable to understand what the case was all about except that it wouldn't help them, and therefore they were against it.

The reaction to the APA's amicus participation in that case, however, was as nothing compared to my recent adventures in the class action suit, *Robinson et al. v. Weinberger et al.* *Robinson et al.* includes as a co-plaintiff the APA. Casper Weinberger *et al.*, the defendants, includes three members of the APA: Bert Brown, head of NIMH, Luther Robinson, head of St. Elizabeth's Hospital in the District of Columbia, and Jefferson McAlpine, a psychiatrist responsible, among other things, for alternative care at St. Elizabeth's. As I have been told with some heat, this suit pits brother against brother.

Let me tell you about the history of the lawsuit. When *Wyatt* was tried there was a good deal of feeling in Alabama that "Here come the carpetbaggers again," just as in the case of integration. Why don't they clean up their own back yard? Now, I, personally, am moved by that argument. A second consideration for selecting St. Elizabeth's was that it is in Washington, D.C., it has a relationship to NIMH and to Congress, and it should be a model for mental health care. Third, the APA central office is in Washington, and St. Elizabeth's is our back yard. The APA had repeatedly been consulted on conditions at St. Elizabeth's, and positive results had been decidedly slow in developing. Fourth, St. Elizabeth's is not a snakepit, it's a pretty good hospital by state hospital standards. But what we were interested in was going beyond *Wyatt* and dealing with the problem I have already described to you: the tendency to dump the mentally ill back into the community without adequate alternative treatment or care.

Think of the problem this way: There are perhaps 500,000 mentally disabled persons

in America who have spent much of their lives in institutions. They are now, in states like California and New York, being thrown out onto the streets, or else they are placed in nursing homes or other settings which are inappropriate for them. Where good alternative facilities exist, these patients overwhelm those facilities, which deteriorate. For example, there are mentally retarded persons who have languished at Willowbrook and other institutions in New York until they have reached old age. Administrators have woken up to the fact that these patients are eligible for Medicaid-Medicare, and they have started to farm them out to nursing homes to lessen their own financial burden and to comply with right-to-treatment suits. But how does a nursing home, with its staff, deal with a seventy-year-old mentally retarded person who has spent sixty-five years in an institution? How do the other elderly residents relate to that situation? The same problems occur with the aged chronic psychotic patient population.

As these hospitals disgorge their chronic residents, they compete for all the alternative services which community mental health centers and the revolving door policy at state hospitals demand. Thus, what has happened is increased demand from two sides on the limited supply of alternative treatments. All this is happening without any planning or coordination.

What is needed, then, is massive growth of these alternative services, or the right to treatment will simply further overwhelm the system of mental health care. What better place to demonstrate this problem and seek its solution than in the nation's capital? That at least is my argument in favor of having brought *Robinson et al. v. Weinberger et al.*

The complaint filed, of course, had to be built on the legal precedents. Thus, it begins by emphasizing that there is a group of patients involuntarily confined at St. Elizabeth's who don't need to be there. The NIMH had in its own study of St. Elizabeth's indicated that there was a substantial group of patients waiting outplacement, but such was unavailable. We argue that to continue to incarcerate such patients violates both the statute and the Constitution; in effect, they are not getting an adequate or appropriate *quid pro quo*. But, of course, we don't want the hospital to comply by just dumping patients; thus, we argue that it is the responsibility of the hospital and the District of Columbia to provide the least restrictive alternative to confinement which will offer adequate treatment. The complaint asks the judge to order the District of Columbia to create sufficient and adequate nursing homes, halfway houses, sheltered settings, foster care homes, day care, night care, etc., to meet the needs of this group of patients. Further, it asks that such outplacement facilities as now exist and are substandard be upgraded.

What we want to do is create a precedent about the right to treatment which requires an improvement in the provision of mental health care, which requires that community mental health concepts which have been offered as a reason for abandoning state hospitals be a reality and not just an excuse for precipitous deinstitutionalization. The lawsuit does not ask for damages against the named psychiatrists; it is an effort to remedy the flaws in the system.

Obviously it brings us right up against the problem of comity, since to accomplish what we claim the statute and the constitution demand will require money. It will force a reordering of priorities, or more tax revenue. Thus, no one can be optimistic that we will win this suit. It asks the government to go further than improving conditions within the hospital, as *Wyatt* requests. It asks that it improve treatment opportunities outside the hospital. But isn't that exactly what community mental health is all about? Aren't outplacement and outreach and community-based treatment what is supposed to replace warehousing? Community mental health concepts may be unrealistic, but without the kind of facilities sought under this lawsuit, community mental health is impossible, and quality care for the mentally ill is impossible. The whole situation is made more urgent by the federal government's plan to abandon community mental health.

Thus, whether we win or lose this suit, surely it is morally correct to bring it, and to

do so in Washington. That moral rectitude is reflected in the other organizations who are co-plaintiffs: the American Psychological Association, the American Orthopsychiatric Association, and the American Public Health Associations. The memberships of these groups, who have all too often in the past opposed each other, were together on this issue, but when the complaint was filed, all hell broke loose in the psychiatric establishment in Washington, D.C. Charges were made that the Trustees had failed to consult adequately with the membership. The people at St. Elizabeth's were doing everything they could; how could we attack them when there were so many worse hospitals in America? Lawsuits never accomplish anything anyway. Judges are going to be telling psychiatrists how to treat patients. The three psychiatrists named as defendants will be crucified in the press and their reputations will be ruined. Among all these complaints, what surfaced most dramatically was the growing anger and resentment of the psychiatric establishment in the face of adversary litigation. Much of this feeling I sympathize with. The sentiment is as follows: Here we are in the trenches, trying to do good, and you come along and sue us.

These intense feelings came to a head at the annual meeting in Detroit, earlier this month. The Assembly of District Branches, by a majority, but one not sufficient to overturn the Trustees, voted that the APA rescind its action in voting to participate as co-plaintiffs in the St. Elizabeth's suit. The Trustees, in reaction to that, reopened their consideration of the action and voted 8 to 8 on a motion to rescind. Thus the action stands, but what became very clear was that the psychiatric establishment is increasingly defensive and uncertain about litigating the right to treatment. A majority believe that the lion is threatening them, and they are not easily convinced by my argument that they must stand and tame him or the cost will be greater both to them and to their patients. Clearly something beyond *Donaldson* has to be established in the right to treatment, or else only the lawyers will have benefited from this effort at reform.

At one point I had hopes that national health insurance would make all this litigation moot. The right to treatment would come at last from the legislature. PSRO, I hoped, would set standards of treatment and thus solve the problem of justiciability. But now I have had the chance to study the Nixon bill and the Kennedy-Mills compromise, which are said to be the most likely to pass. Neither gives adequate coverage to mental health care. Nixon excludes mental health catastrophes from other health catastrophes which are covered, and Kennedy-Mills does little better. Furthermore, the Administration's bill assumes that the health care system which now exists is excellent, and that insurance will give the poor access to it. But I don't think that so much can be said for psychiatry, particularly in certain regions of America, and the elimination of training grants will surely compound that problem in the future. The national health insurance bills will not, for other more technical reasons, help the chronically mentally ill.

Thus I am left with the conviction that the psychiatric establishment cannot and must not abandon right-to-treatment litigation. That litigation must, within the limits of the law, take aim at the system of mental health care and not at those psychiatrists who are nominally responsible. On the other hand, psychiatrists in official positions must learn not to make excuses for the inexcusable. They must not become apologists for society's neglect and abuse of the mentally ill.