From Moral Treatment to Railroading Out of the Mental Hospital

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One of the great tales of human civilization is about a man, a stutterer, who heard a voice telling him to lead an enslaved people to freedom. Although hesitant and bewildered, he accepted the responsibility. He told the people, "You shall be a kingdom of priests and a holy nation." The people followed him, and with aid from above, he performed miracles in leading the way. But in the new land the people began to grumble. "What did you do? . . . Bring us out here to starve?"

The leader did not know what to do with these people. They were a petulant lot, a primitive people, of slave mentality. They could not visualize a free, a utopian society, because of their experience in slavery. They were hungry and thirsty, and they wanted immediate satisfaction. They wanted to return to slavery. The leader, again hearing the voice, was discouraged. He was told that these people had to die off; they were condemned to wander in the wilderness for 40 years.

It was apparent that these people could not be forged into a viable nation. In order to create the utopian society, the promised land of milk and honey, a new generation had to be born, one that did not have the experience of growing up in slavery.

This journey, of course, is the tale of Moses and the exodus of the Israelites from Egypt. The story teaches that the years required to forge a viable society are analogous to those necessary for the full development of the psychic structure, *i.e.*, the breaking of the umbilical cord and the gradual achievement of maturity.[1]

Given one view, the tale might also apply to current efforts to empty the mental hospitals. A chorus of voices tells us that mental hospitalization is a type of indefinite imprisonment rationalized as psychiatric treatment, and that it has dehumanizing effects. The hospital population is called "prisoners of psychiatry," and the hospital is compared to a prison as a miniature model of a totalitarian state.[2] In the name of liberty, the call has gone out to abolish the state mental hospital, and by implication the private hospital as well, with little or no regard for some kind of replacement.

The anti-hospital movement is an outgrowth of the apprehension concerning control of individuals by organized society, or at least by certain groups within society. The United States has the largest prison population in the Western world, numbering 425,000 (although that is about one-half of the estimated million in Soviet prisons and labor camps). Should for the sake of accuracy the approximately 900,000 persons in public and private mental institutions be added to the list of prisoners? Dr. Thomas S. Szasz, like Zhores and Roy Medvedev, says that psychiatry is used as "justificatory rhetoric" to exclude systematically certain groups under the guise of their being regarded as mentally ill. According to this view, mental hospitalization is the substitution of George Orwell's "Animal Farm" for the Bill of Rights. "Misguided benevolence strips the patient of adult status and generates automaton-like compliance," say critics (who include in their

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number many psychiatrists).[3] Mental impairments are exacerbated rather than alleviated in the mental hospital according to this view.

In fact, though, what is a mental hospital? Who are its inmates? How did they find themselves there? What will they do—or where will they go—when turned out? Is the mental hospital indeed a place of slavery, as some charge, as Egypt was for the Israelites under the Pharaohs? Will the inmates prosper or perish on the outside?

A type of logic generally attributed to the thinking disorder of schizophrenia is used by those who identify the mental hospital as a prison. That is, logical thinking would accept identity of two things only upon the basis of identical subjects, whereas so-called schizophrenic thinking may accept identity based upon identical predicates.[4] An example is that of a person who thought that she was the Virgin Mary. Asked why, she replied, "I am a virgin; [therefore] I am the Virgin Mary." The common predicate "being virgin" led to the identification of the two subjects.[5] With a similar logic, it is said that prisons are places without liberty; hospitals are said to be places without liberty; ergo, hospitals are prisons.

What type of loss of liberty, though, are we talking about? In one of Jules Feiffer's cartoons it is observed: "I thought school was a jail . . . until I got a job. Boy, was that a jail! Then I got married. Even more of a jail! Until I got drafted in the army. The worst jail yet! Until I got in trouble and went to jail—and learned that jail is even more of a jail than school, a job, marriage, or the army. So finally I know what freedom's all about: the right to choose which jail."

Introducing "liberty" into the discussion of mental hospitalization is attention-getting but smacks of a red herring. With liberty said to be at stake, the call has gone out for invocation of the criminal-law due-procedure requirements in the commitment process. Indeed, the premise at root is that the mental institution has no legitimacy. Aided and abetted by the writings of Dr. Thomas S. Szasz, and supported by practices in the Soviet Union, the view has spread that the population of mental hospitals is, or soon will be, composed of social or political dissidents.[6] The anti-psychiatry movement claims that "schizophrenics" are in fact social dissenters. Psychiatry is being made the villain, and the target of vitriolic assault.

Like a man looking through the wrong end of a telescope, Szasz and fellow travelers indulge in what might be called the perspective fallacy. The people in mental hospitals are not "prisoners of psychiatry"—rather, they are "casualties" as well as prisoners of society, with psychiatry often obliged to serve as warden. One example of the hospital population, Mary Parrot (a pseudonym), used to talk incessantly; she talked with a pressure of speech. To make life livable, her husband limited her to 2,000 words a day, and when she reached the 2,000, he would gag her. For a respite, he prevailed upon her to take a two-week tour of Europe. Unlike the voyages of olden times, however, it apparently was not long enough to be curative, and it brought tears to everyone in the group, some of whom had sweated and saved for the trip for years. She, her husband, and everyone else, were relieved by her hospitalization, voluntary or involuntary. This report may sound frivolous—no one, of course, should be committed for spoiling the pleasure of some tourists, even if they were retired Justices of the Supreme Court or Freudian psychoanalysts—but it may go to illustrate that music or a painting rather than words are needed to illustrate the agony of the situation. Be that as it may, she hardly qualifies as a political dissident.

And there is the person who eats his feces, or bangs his head against the wall. And then there is Willy Livelong. He lived alone, eking out an existence on his social security check. Driving an automobile, a necessity today to survive in the city, was for him not only expensive but also terribly frightening, and without other means of getting about, he was trapped, verily a prisoner. He could hardly manage to get any groceries. He found refuge in the mental hospital.

The medical model/terminology has been misleading. When we use the term "hospital,"

we naturally think of treatment. Hospitalization without treatment is an absurdity. Judge Bazelon in *Rouse v. Cameron*, the first case to talk about a right to treatment, said that the purpose of involuntary hospitalization is treatment, and concluded that the absence of treatment draws into question the constitutionality of the confinement.[7] If, however we understand by the term "hospitalization" nothing more nor less than asylum (as the mental hospital at one time was called), a place of refuge, there is no connotation of medical treatment but rather one of treatment in the broad sense as meaning "handling of" or "how we treat one another." Indeed, the first hospital in the Western world, founded at Lyons in 542 A.D., was called "Hotel Dieu" (Hospital of God), and was a charitable institution which embraced every form of aid for the poor, including an inn, workhouse, asylum, and infirmary.

The treatment of those who have been variously called "mad," "distracted," "lunatic," "insane," or "mentally ill" has fluctuated through the centuries. In some periods and in some countries, a portion at least of these people were treated with great kindness, while at the same time, others were neglected or abused. The form of the treatment has been linked to the alleged cause of the disorder. In some periods, madness was regarded as a consequence of the possession of a spirit or demon. Recourse, at times, was had to various moral means of cure. Saul was cured by the music of David, a procedure that would now be called music therapy. "And it came to pass when the evil spirit from God was upon Saul, that David took a harp and played with his hand; so Saul was refreshed and was well, and the evil spirit departed from him."[8]

Not all of the mad, though, were treated in this manner. During the Middle Ages some were burned as sorcerers or heretics. Others were beaten in order "to knock the devil out." Still others were driven forth as outcasts. Many during the Renaissance were put on ships and entrusted to mariners. "Ships of fools," as they were known, crisscrossed the seas with their comic and pathetic cargoes of passengers. The voyage, like a cruise today, was often therapeutic. Water is soothing, we know, and nothing is more soothing than the undisturbed blue of the ocean. The Romans relaxed in their baths and talked to soothsayers.

During the seventeenth and eighteenth centuries, the construction of houses of confinement replaced embarkation. In America, though, in the early part of the nineteenth century, the institutions were small, care was provided, the atmosphere was idyllic, and the results were remarkable. It is known as the era of moral treatment.

These small institutions did such a good job that pressure was brought to bear to do more. "Enlarge," was the word of the day. "Accommodate more people." "Do it on a larger scale." At the same time, it must be said that the establishment of the large mental hospital was accomplished with generosity and humanity, and overrode objections that expenditures were excessive. Palatial manors were built, at considerable expenditure, in a rustic, attractive though remote part of the state. Constructed and furnished at an expense unparalleled in the world, they were built in the hope of supplying the needs of those who were to go there.

Seeing the comfortable condition of deranged persons in the lunatic asylums, some benevolent individuals compared the deplorable situation of those confined in poorhouses. As the population increased with the influx of immigrants, the public mental hospital was turned into a welfare institution. The first issue of the *American Journal of Insanity*, published in 1844, protested a plan to build public asylums cheaply, solely for the poor and hapless. The public mental hospital thus declined from a small treatment institution with a high level of success in returning patients to a productive life to a vast place of permanent exile for the "mentally ill," where they lived by the thousands without treatment and without hope. This sad tale of social regression is described by Dr. J. Sanborn Bockoven in his publications on moral treatment in American psychiatry.[9]

The staff members of these institutions were isolated, and for mutual support they

established in 1845 the American Association of Medical Superintendents, the predecessor of the American Psychiatric Association. While doing much good in certain directions, the Association of Superintendents turned into an autocratic power. It represented the superintendents, not the patients, and it helped to keep their doings from being inspected and laid open to view. These superintendents soon became like feudal lords ruling over a fiefdom.

Curiously, in the very year (1845) that the Association was formed, the British Parliament pursued a precisely opposite policy by subjecting the English system to regulation, inspection, and responsibility to public opinion, at the hands of a "National Board of Commissioners in Lunacy." It insisted on the application in asylums, both public and private, of the same guarantees of the law that applied elsewhere. Among other things, it provided that six times a year a board, consisting of 11 persons (3 physicians, 3 lawyers, and 5 men of business), are to make an inspection of every asylum, public and private, and on each occasion "must see every patient," and must make minutes of the situation "in general and particular." It also provided that neglect or ill-treatment of a patient is to be punished as a misdemeanor.

In the United States the period from approximately the time of the Civil War to the end of World War II is the snakepit era in the history of mental hospitals. It was during this time when Mrs. E.P.W. Packard, who had been committed in Illinois upon her husband's request, crusaded for the enactment of commitment laws and laws protecting the rights of patients. These form the basis of current statutes. Mrs. Packard had receptive audiences, not surprisingly. Public sentiment on the subject is easy to stir—the fear of going mad is universal, and no one cherishes the thought of being sent to a madhouse.

In Mrs. Packard's time divorce was difficult if not impossible to obtain. Commitment to a mental hospital was one way to obtain a separation. Mrs. Packard's husband, a preacher, had her committed under an Illinois statute which provided that a married woman could be committed on the petition of her husband "without the evidence of insanity or distraction required in other cases." While commitment is not to be justified as a divorce procedure, Reverend Packard's action finds support in Albert Deutsch's book, *The Mentally Ill in America*, which describes Mrs. Packard's childhood institutionalization at the Worcester State Hospital and her psychiatric history, which showed that at one time she claimed to be the Mother of Christ and the Third Person of the Blessed Trinity. In any event, contemporary divorce laws have outmoded any need to resort to commitment in order to obtain a conjugal separation.

Two important developments followed World War II. One was the development of anti-psychotic drugs which shortened the length of hospital stays. For many, commitment no longer spelled the end of the individual's contact with the outside world. The other post-war development was in a negative direction. The quality of family and urban life deteriorated to such an extent that in comparison the mental hospital was turned into a veritable asylum or retreat.

The first development, that of medication, changed the population of the mental hospital. It now consists of two groups of patients, who are housed separately—one unit, commonly called an intensive care unit, for the short-term acute patient, and the other, for the chronic long-term or life-time patient.

Treatment of the acutely disturbed is rapid and often effective, so that the great majority of such patients are discharged within a three-week period. A study of a suburban Michigan county reveals that only 20 percent of involuntarily detained patients at the regional state hospital remain for longer than three months.[10] Drug therapy for psychosis has rapidly returned patients to the community, although with residual symptoms. Even the psychiatrist feels that healing occurs more expeditiously in the community and that hospitals may be non-therapeutic.[11] However, because of the adaptational problems or, perhaps, as a result of the natural history of the disorder, patients return again and again. Even in this era of civil liberties, urinating on the sidewalk in front of

a busy department store, shouting obscenities at passersby or disrobing before the neighborhood children are behaviors of which society has little tolerance. Gradually those who cannot be discharged and those who return year after year become separated as the chronic population, the therapeutic failures who do not engender much interest or enthusiasm among the hospital professionals. They tolerate stress poorly and avoid human relationships and stimulation. When left to their own devices, such patients seek the isolation and privacy of a bedroom. The four walls protectively circumscribe a world which they must delimit to avoid a sensory overload. These are the chronically disturbed who stand around in back wards, smiling vacuously, gesturing, talking incoherently or tilting a head toward an unseen voice.

The acutely disturbed command far more attention because they may respond. They are segregated as well, but on a ward where they receive the full therapeutic thrust of the hospital. The environment is structured. The patients are given anti-psychotic drugs and seen in group or individual psychotherapy. Time is a luxury which cost-benefit statisticians will not allow, and the pressure is ever on to shorten the stay. The state hospital superintendent with the shortest average duration of stay for his patient population wins the prize. Patients no longer complain about staying too long. Rather they more often feel prematurely catapulted back to the home, family and job, which may have brought about the disturbance which forced their hospitalization in the first place.

The long-term population also includes the elderly who cannot manage or be managed on the outside. They usually have medical problems associated with the aging process and disturbances in mental functioning attributable to hardening of the arteries to the brain or to senility. Many simply do not have the support of a concerned family and cannot survive the economic vicissitudes or physical perils of urban life. For them, the typical mental hospital can be best described in much the same terms as a home for the aged. In the absence of a social remedy for this unsatisfactory state of affairs, the one avenue left to many of the elderly, even when their major life problems are not of a medical or psychiatric nature, is to use the only living accommodations available—the mental hospital or the nursing home. The psychiatric diagnosis allows the person to gain entry to a setting that provides some type of human contact and care.

Without implying that "mental patients" are carefree or that they merrily frolic about the hospital grounds, Benjamin and Dorothea Braginsky describe the mental hospital as the "poor man's last resort."[12] Life in the hospital relieves many patients from worrying over their next meal, and their next night's shelter. For others, free movies, socializing in the canteen, or just reading in the library represent luxuries not available to them on the outside. For all of them, worry over crime and other stresses on the outside all but disappears within the hospital shelter. This helps explain why some people go to mental hospitals and some choose patienthood as a career. In Greece, some of these people (especially if they happen to be religious) go to Mt. Athos or monasteries elsewhere. The mental hospital is the only alternative (other than prison) available in the United States to lower-income persons who cannot or simply do not want to make it in mainstream society. Hospitalization thus reveals more about socioeconomic conditions than about mental conditions.

The Braginskys write: "Society neither needs nor wants poorly educated, unskilled persons; they are the surplus in an advanced, technological culture. Our society provides opportunities for dignified withdrawal from the pressures of life with resorts for the affluent, retreats for the religious, and communes for the collegiates. Some of the less affluent members of society in need of escape have discovered the resort potentials of a mental hospital. Casting these people back into society would not solve the problems that beset the ever increasing number of surplus persons who are trapped in intolerable life situations."

Ostensibly to improve the lot of the mental-hospital population, litigation has been instituted involving right to treatment, education, less restrictive alternatives, compensa-

tion for labor, rights to due process, equal protection, and freedom from cruel and unusual punishment. Judge Frank Johnson in *Wyatt v. Stickney*, setting out "minimum constitutional standards for adequate treatment of the mentally ill," called for decent and comfortable hospital facilities, among other things.[13] Following the right-to-treatment declaration, litigation has multiplied on behalf of patients. There were in early 1974, for example, lawsuits seeking damages in excess of $62 million against the Michigan Department of Mental Health.

The standards set out by Judge Johnson in *Wyatt* have been reprinted in a number of places, but the changes that the order has wrought have yet to be studied and reported. According to one report, two years after the decision, the standards remain "almost entirely unimplemented."[14] According to another account, some improvements have been made in the appearance, comfort, and safety of Alabama's institutions, but the most dramatic result of the order has been to empty the institutions of thousands of patients, approximately 4,000 to date, whose fate on the outside has yet to be told. According to the order there should be 223 doctors, nurses and psychologists at Bryce Hospital, the state's main hospital for the mentally ill, but the actual total recently was 83.[15] There are now apparently more lawyers than doctors in the house; the new commissioner of the Alabama Mental Health Department is a lawyer.[16]

A court order is a stimulus for change, but it may not necessarily be the right one. There are other means of effecting change, such as publicity and lobbying. A court order may aid in changing attitudes, but it is not a magic solution. Indeed, litigation may interfere with reaching goals in other ways. The time and energy involved in litigation, the ill feeling that it arouses, the effect on recruitment of staff, and the effect on patients and families are issues that have to be considered. Judge Bazelon at one time was thought to favor litigation as a means of solving or alleviating the problems of the mental hospital and its population, but he is reportedly skeptical about it now.

Whatever the motive of the litigation, the likely result is to make the hospital system so expensive to operate that the State will be forced to do away with it in part or whole.[17] In hard times, with money scarce, the State is not again inclined to make palatial manors of its mental hospitals, although in recent years it had been making some effort to improve their condition. It is inconceivable that the State of Alabama will improve all of its institutions, which rank next to the bottom in the country, to the standards ordained in *Wyatt*, though the standards are called minimal.

Faced with fiscal stringencies, the State will likely look most sympathetically at any justification for getting out of the mental-hospital business. That is the way Governor Reagan chose to go in California. The aggregation of fiscal demands, railroading allegations, and other anti-hospital ideology have combined to produce an impetus to close the institution and transfer the population to the community. In dollars and cents, the State is finding it cheaper to contract with private facilities in the community and it is delighted to be relieved of this care-taking function. The transfer program is, for example, saving the state of Michigan $10-$15 a day per patient; one-half of its mental hospital population at the present time are in private hospitals supported by state funds, under contract with the state. It is estimated that shortly only one-third of mental patients will be coming to the state hospital system.

In 1970, the average daily expenditure in public mental hospitals in the United States was $14.89 per individual per day, with one state spending as little as $5.80 per day. Veterans Administration hospitals spend $30 per individual per day and the better private psychiatric hospitals about $100. These amounts usually include the expenditure for medical and psychiatric treatment. (During the same period, general hospitals charged about $80 per patient per day, not including doctors' fees.) These financial facts alone account for staff shortages, poorly trained and insufficient (even though well-meaning) professional personnel, and lack of services.

The average daily expenditure of $14.89 means an annual expenditure per individual

of $5,435, or about $50,000 for a ten-year period. Instead of being cared for in the institution, some patients at the initiative of counsel are getting judgments against the State of around $50,000, on one theory or another, such as false imprisonment or involuntary servitude. Over a ten-year-period the cost to the State for institutionalization would be the same—but can the individual manage as well on the outside?

Considering all the accusations that have been made against the mental hospital, its demise would seem to be reason to rejoice. An oft-cited call for liquidation of the large mental hospital is the presidential address made in 1958 by Dr. Harry C. Solomon of the American Psychiatric Association. In this address, Dr. Solomon observed, "I do not see how any reasonably objective view of our mental hospitals today can fail to conclude that they are bankrupt beyond remedy." In his recommendation, though, to be precise, he called for liquidation "as rapidly as could be done in an orderly and progressive fashion."[18]

Shakespeare once observed, "The time is out of joint." At a time when the inner city is almost abandoned by the upper and middle classes, when it is grimy and crime-ridden, the patients are brought back. It is a cruel joke. The generation of Israelites who came out of Egypt could not manage in the new land. The inmates of a mental institution have, to be sure, far less wherewithal to cope. What is now occurring is a railroading *out* of the mental institution, and this is more fact than myth, in contrast to the allegation of railroading people *into* the institution.

Operators of community facilities say that they are not being paid enough to provide the kinds of programs required by many of the patients. As it turns out, a "nursing home" or "halfway house" is a euphemism for a proprietary place without facilities. Medicare does not cover charges of a day-care center, and in most states, neither does Medicaid.[19] Around the country, patients discharged into the community appear to be worse off than they were in a mental hospital, small or large.[20]

No state or local agency has sole responsibility for discharged patients; the agency, like the patient, is bewildered and disoriented. Responsibility is fragmented. The state throws portions of the responsibility to different agencies, and none is sure of what the others are doing. In general, state hospital employees are responsible for placing a discharged patient in a home, but they make no follow-up. County or town welfare workers send welfare checks to those eligible to addresses selected by state workers. The town building department has responsibility for housing conditions, but once a certificate of occupancy has been issued, most towns do not inspect homes again unless a complaint is received. Indeed, investigation of facilities in the community would reveal scandals more outrageous than those that have prevailed in the institutions under question.

California's bill of rights for the mentally ill, enacted in 1969, was widely hailed as legislation that would benefit both patient and society. After all, who could argue against liberating patients from snakepits? The legislation was called the "Magna Carta for the mentally ill." What has been the outcome? In an article titled "Where Have All the Patients Gone?" Janet Chase says that the time has come for a serious reappraisal.[21] Patients who are so retarded or disoriented "they can't even sign their names" are being coerced to "voluntarily" sign themselves out of the hospital. One patient pleaded, "I don't want to go out there. It's like putting a puppy on the freeway." One discharged patient, overheard in a cafeteria, tearfully put it thus: "Why did they send me out? Don't they realize how sick I am? I can't cope with it here at all. I hate to make a scene but I can't stop this madness in my head."

One of our law students encountered a middle-aged woman lying on the sidewalk kicking and screaming incoherently. Her groceries were strewn about the street in broken packages and bottles and he tried to retrieve what was probably her weekly purchase. Finally a neighbor emerged from a yard and told him that she belonged to the "crazy house" down the street. He took her "home" but commented in class that she was so

"disturbed" that he wondered how she could care for herself and avoid the muggings and rapes endemic to that neighborhood.

In all states, many former patients end up in "board-and-care homes," a term that seems to cover anything that has a roof. It applies equally to family dwellings, housing under six, to motels and convalescent hospitals that house 100 or more. Some make an attempt to provide recreational, occupational, and vocational activity, while others provide nothing in old, rundown buildings.

Many nursing homes, while they may not be snakepits, have sterile environments. The activities consist of staring up at the ceiling or down at the navel, or perhaps looking at television. Those who think, like some law students, that the third year of legal education is boring should visit a nursing home or try looking at daytime television. In many of these nursing homes, no one really cares if the patient gets up to eat or gets his medicine.[22]

A four-month investigation by *Newsday* in Suffolk County and upstate New York reports that former patients are crowded into tiny rooms, basements and garages and fed a semi-starvation diet consisting primarily of rice and chicken necks. Operators of welfare boarding houses have literally whisked patients off the steps of mental institutions and have jammed them into what can only be described as private jails, and have amassed a fortune by confiscating the welfare checks.[23]

A majority of the hospital population finds itself discharged into high-crime areas. Patients are dispersed into what are called "gray sections" of the city, the "world of furnished rooms." Many of them are mugged. The "golden years" are now the "crime victim" years for the senior citizen.[24] The community-as-jungle is depicted in one current liquor advertisement: "Tarzan comes home to his tree house one night and says to Jane, 'A martini, quick.' He downs it and asks for another, and another. 'What is it?' asks Jane. Tarzan shakes his head and says, 'It's a real jungle out there.'" One group of citizens in Oakland, California, has obtained 12-passenger vans and bodyguards trained in karate, and offers to take the elderly and the handicapped to the bank when they get their Social Security checks or shopping when they need to go.

In the big city, all too often life outside the hospital means isolated living in a dingy single-room-occupancy hotel ("SRO," as they are called). The community is a nightmare, a world of anguish. Many patients, unable to adjust to the stresses of life in the community, develop severe acute psychotic disorganization and require urgent rehospitalization.[25] Among other things, they have to adjust to their own kitchen. A number go to the cheap coffee shop for meals, or they have a little burner in their room; they cannot call "room service." Some are known as "toast and tea ladies"—they have toast and tea for meals. They get sick, and then for their physical ailments they are eligible for general city hospital care.

Many do not have the strength to stand; they need a walker, a physical aid, to move about. The University of Michigan Department of Gerontology has proposed a program for "tele-care" suggesting that volunteers check daily by telephone on elderly people living alone. It is not uncommon to discover a days' or months' old body. In many of these cases, the person could have been saved but had lain on the floor for hours or days, unable to call for help or having no one to call. While a few of the discharged patients improve their life styles upon leaving the institution, most decline to a lower standard of life and die sooner, unattended and alone.

A large number of former patients end up in jail. If adequate facilities in the community are not available or if, as the ACLU suggests, once a patient is released, he or she cannot be required to live any place, take any medication or accept supervision, then in the case of disturbing behavior, resort likely will be made to the plethora of criminal laws. The Santa Clara County Sheriff's Department reports that its jail population has at least tripled with people who require hospitalization or anti-psychotic medication. They are picked up for loitering or mischievous conduct.[26]

Is it for this that the hospital population was brought forth from bondage?

The situation brings to mind a crude but apt story of a nonconforming song sparrow. One winter this sparrow decided not to fly south. The cold, though, drove it from its nest, and as it flew, ice began to form on its wings and it fell into a barnyard. A cow wandered by and crapped on the dazed bird. The sparrow thought its end had come, but instead the cow manure warmed it. It could still breathe and its iced wings defrosted. Warm and happy, the little sparrow began to sing. A cat, happening to pass by and hearing the chirping, investigated the pile of manure. The cat found the happy bird and promptly ate it. The story has three morals: (1) everyone (the mental hospital) who craps on you is not necessarily your enemy; (2) if you are warm and happy in a manure pile (the mental hospital), keep your mouth shut; and (3) everyone who rescues you is not necessarily your friend.

California's Senator Alfred Alquist says that no one predicted or expected what has evolved from the initial idealism that preceded the passage of the Lanterman-Petris-Short Act (LPS), as the act is most often called. "There was practically no opposition from any individual or organized group. I voted for it," he says. "Everyone was just completely convinced that community care was such a fine thing. But it's not working now, and no adequate alternative programs are planned yet."[27] Those who endorsed LPS at its passage included the California Medical Association, the California Nurses Association, the California Psychiatric Association, the California Hospitals Association, the Governor, and the American Civil Liberties Union. The ACLU is not as convinced of the merits of LPS as it was four years ago. According to a recent report, the Reagan administration, in a reversal of its earlier announced position, has shelved plans to phase out California's state mental hospitals by 1982 and now plans to keep in operation for the "foreseeable future" the eleven state institutions still in existence.[28]

In the state of New York 36,000 patients have been discharged from state hospitals and 15,000 have been returned to New York City. They are caught in what the *New York Times* described as a revolving door that sends them "careening from city psychiatric wards to state hospitals to the streets or sleazy hotels and back to city hospitals." The policy of community care was established by the New York State Department of Mental Hygiene in 1968 and has resulted in thousands of chronically ill patients wandering the streets. The state institutions will not keep them, and with their civil rights intact they are shipped back and forth from agency to agency and from one level of government to another.[29]

It is necessary to rethink the concept of advocacy as applied to the mental-hospital population. In general, the way people conceptualize depends on their training and the way their economic returns come in. The criminal lawyer has traditionally looked upon his role as preventing his client from being sent to prison or getting him out of prison; he gets a gold star when he does that. For the most part, in the past, the legal profession has closed its eyes to the mental hospital. With the award of attorney fees, however—as was done in *Wyatt*—an increasing number of lawyers will get into the picture, on the principle that income lures representation. But the ethical responsibility of a lawyer to a mentally handicapped client is not very well defined.[30] Quickly enough, though, the lawyer who gets involved with handicapped persons and focuses on release soon begins to wonder whether he is performing any useful service to the client or to society. The institutionalized individual, to be sure, needs a combination of social work and legal services to take care of his property (if any), and to check on whether he is getting proper care and attention, but the allegation of railroading, with few exceptions, is fictitious.[31]

Many among the wide variety of people cannot manage in the community as it is presently constituted. Some people are fleet afoot and tireless; others are hobbled. Self-reliance and independence are ancient values, but many people can achieve adjustment

only in an institution or in certain subcultural groupings such as communes, or in the military.

Is a person to have a right *not* to be discharged against his will? Does a person have a right to *remain* in an asylum? Does a person have a right to asylum? The enunciated right-to-treatment is based on an exchange for deprivation of liberty. Thus, according to this logic, without an involuntary commitment or deprivation of liberty, there would be no right to asylum or care.

For many patients, living in some kind of institution must be a life-time proposition. If the state mental hospital has not the facilities to care for such cases, or if it is to be closed, then alternative long-term or life-time residential centers must be developed. As the Braginskys suggest, there is need for "a cooperative retreat" which might be a temporary refuge for some and a permanent residence for others and which would destroy neither self-respect nor self-esteem. These cooperative retreats would have no "degradation ceremonies," psychiatric management, or fences.[32]

The principal abuse in commitment procedures occurs not at the time of initial commitment but rather subsequently when the patient could be placed in a halfway house or foster-care home, or at home if assistance were available, but such a facility or aid is rarely available.[33] In many cases, the problem is that the patient has no family with whom he can live. He needs a fullway house, not a halfway house or a "community mental health center" as presently conceived. He needs a place where he can share community and fellowship with others.

Does a court have the power to order the establishment of various and appropriate types of institutions, or to order home assistance?[34] There is no single answer to this question. The history of American law and government shows a scope of judicial authority based on a mix of pragmatism with principle. Judge Johnson in *Wyatt* did not order the legislature to improve institutional standards; he assumed the legislature would carry out its responsibilities and honor its obligations. That is the usual assumption when a court renders an order; thus, when a court orders busing to achieve desegregation, it assumes that the legislature will purchase the buses.[35]

In many cases a family, with outside help, would be able to cope with a handicapped member.[36] A support system would help the family. In an earlier era, not only was more family time available, but many homes had some form of extended family, so that a handicapped person, or a youngster or oldster, did not have to depend solely on one or two members for attention. This reduced the pressure on the family members; they did not have to be available at all times; someone else could help bridge the gap. The family today has been reduced in size to what is called a nuclear one, and it lives in atomistic isolation. Unless outside help is given, the family today (what there is of it), in more cases than previously, will not be able to cope with the physical, emotional and economic hardships involved.[37] The handicapped person will then be thrown out entirely on society, or severely restrict the life of the family.[38] It is not to be forgotten that the family too is to have rights.

Summary

Mental patients are going from the frying pan into the fire. Under the guise of civil liberties the state mental hospital has been transported to the inner city. It is true that many persons in institutions have been dehumanized through neglect and the failure of society to meet their needs, but the second wrong of turning them back into a so-called community will not make a right. In today's world, neglect in the community dwarfs neglect in hospitals. Fundamentally, the issue that we all have to face is how we can establish programs that make a genuine effort to meet the needs of people whether they are in institutions or in the community. The rich have their resorts, the religious have their retreats, but others have no asylum. One of the often-noted anomalies of con-

temporary society is its capacity to develop extraordinary new technologies while failing to find ways to perform elementary services in a minimally decent manner.[39] In legal terms, the issue is whether the concept of adequacy of care and treatment will be expanded from the involuntarily committed to include voluntary cases as well, be they in a public or private facility.

It is necessary to look at the adequacy of all facilities for the handicapped, and not simply at the state hospital, which is only a small part of the problem. Of the approximately 20,000 places in the United States called nursing homes, most are a disgrace. In a broad view of the rights of the handicapped, it may come to pass that the elderly, as well as the young, may complain of inadequate care whether they are in a hospital, a nursing home, a care center, or even in their own home. In other words, the state may be held to have a duty to provide adequately for the needs of all its people. The state today replaces the extended family and neighbors; it is one's neighbor, so to speak.

From the viewpoint of the hospital population, short-range success is what the patient seeks because, in the long-range, he may be dead. To cast the mental-hospital population into the community seems as ludicrous as to cast a one-legged man in the role of Tarzan. Even the adequate person finds it difficult to cope in today's community. In the English comedy, "Good Evening," a reporter from the *Bethlehem Star* is interviewing Christ, and in the course of the interview, the reporter follows Christ, who walks over water. The reporter sinks to the bottom; he couldn't make it.

References

1. To be sure, the ancient struggle for freedom is a continuing one. The Hasidic masters teach that "every man must free himself of Egypt every day."
2. See, e.g., Ennis B J: Prisoners of Psychiatry. New York: Harcourt Brace Jovanovich, 1972. Goodman W: The Constitution v. the snakepit. New York Times Magazine, March 17, 1974, p 21. New York Times, March 25, 1974, p. 29. Kohring J and Page C: Mental Health Law: Crazy Until Proved Sane. Juris Doctor, March 1974, p 27
3. Eisenberg L: The human nature of human nature. Science, April 14, 1972
4. Von Domarus E: The specific laws of logic in schizophrenia. in Kasanin J S (ed): Language and Thought in Schizophrenia: Collected Papers. Berkeley, University of California Press. 1944
5. Arieti S: Interpretation of Schizophrenia. New York, Brunner, 2d ed 1974. Consider also: Hungarians are witty people; Thomas is witty; ergo, Thomas is Hungarian. It may be the case that Thomas is wholly or partly Hungarian, but he may be witty, yet Irish. Another illustration: "All the men in 'Oh! Calcutta!' are circumcised; it must be a Jewish show." Barrett R: First Your Money, Then Your Clothes. New York, Morrow, 1973, p 40
6. This is implicit in the statement by Jerome J. Shestack, chairman of a new American Bar Association Commission on the Mentally Disabled, describing his meeting with Dr. Alfred Freedman, president of the American Psychiatric Association, as one of working out cooperative approaches to prevent "the kind of situation which is developing in Russia in which a diagnosis of anti-state conduct is equated with being deviate and subject to commitment to a mental institution." Quoted in New York Post, Dec 8, 1973, p 4. There are, though, safeguards in the United States that do not prevail in the U.S.S.R. to control mental hospitalization for political purposes: the state is not the only source of employment for psychiatrists; there is judicial review; and the United States is a more open society. Chodoff P: Involuntary hospitalization of political dissenters in the Soviet Union. Psychiatric Opinion, Feb 1974, p 5
7. 373 F 2d 451 (DC Cir 1966)
8. I Samuel xvi, 16. For examples of moral treatment in ancient Greece and Rome, see Zilboorg G and Henry G: A History of Medical Psychology. New York, Norton, 1941
9. Bockoven JS: Moral Treatment in Community Mental Health. New York, Spring, 1972. See also Bettelheim B: A Home for the Heart. New York, Knopf, 1973. Foucault M: Madness and Civilization. New York, Pantheon, 1965. Grob GN: Mental Institutions in America: Social Policy to 1875. New York, Free Press, 1973. Grob GN: The State and the Mentally Ill. Chapel Hill, University of North Carolina Press, 1966
10. Morris G and Luby ED: Civil commitment in a suburban county: an investigation by law students. 13 Santa Clara Law. 518 (1973)

11. The development of medication tends to justify a simple commitment procedure for short-term (15 to 60 days) hospitalization. Timely, quick intervention in a crisis is often essential, and it would tend to lessen the use of the locked back ward. Notwithstanding the brevity of the period, however, as long as stigma and fear surround psychiatric care, emphasis of legal procedures is not surprising. Due process, though, would not seem to mandate a prior adversarial judicial proceeding; an arrest in the criminal law is made pursuant to a warrant or indictment which stems out of an ex parte proceeding.
12. Braginsky BM and Braginsky DD: Mental hospitals as resorts. Psychol Today, March 1973, p 22. See also Braginsky BM, Braginsky DD, and Ring K: Methods of Madness/The Mental Hospital as a Last Resort. New York, Holt, Rinehart and Winston, 1969
13. 344 F Supp 373, 387 (MD Ala 1972); discussed in Slovenko R: Psychiatry and Law. Boston, Little, Brown, 1973, chap 14
14. New York Times, March 10, 1974, p 53
15. Shils J: Treatment, Not Custody. Wall Street Journal, Dec 18, 1973, p 34. A classified advertisement appeared in Psychiatric News, the American Psychiatric Association newspaper, for many months seeking board-eligible or board-certified psychiatrists at Bryce Hospital at salaries negotiable upward from $33,371 and $36,792, but unlike most of the other ads in the newspaper, it went unanswered. Thereupon, the newspaper reproduced the ad in a page 2 editorial calling on the profession "to face the enormous challenge of operation of a state hospital under court decree to provide adequate care." Psychiat News, March 6, 1974, p 2
16. New York Times, Jan 20, 1974, p 64. Michigan recently cut the size of the staffs at its institutions by 934 people, for a cost saving of $5.4 million. The state's budget official contended that this is possible because the patient load is decreasing. Dr. E. Gordon Yudashkin resigned from his post as director of the State Department of Mental Health. Detroit Free Press, Feb 18, 1974, p 8
17 Malmquist CP: Book Review (B.J. Ennis, Prisoners of Psychiatry), 43 Amer J Orthopsychiatry 854 (1973). Lawrence H. Schwartz, an attorney for the Institute of Law and Social Policy, is quoted as saying that the plaintiff's goal in *Wyatt v. Stickney* was the destruction of the Alabama State Hospital system by upgrading standards to a point where it would become prohibitively expensive to continue its operation. Clayton T: Institute examines Alabama's right to treatment ruling. Psychiat News, Oct. 17, 1973
18. Reprinted in Bockoven JS: Moral Treatment in Community Mental Health. New York, Spring, 1973, p 161
19. Private (proprietary) hospitals are acceptable to Medicaid only under the not-yet-implemented section of Public Law 92-603 and in that case only for patients under age 21 and over 65, and provided the institution is accredited by the Joint Commission on Accreditation of Hospitals. Psychiat News, Jan 16, 1974, p 2
20. Mitchell WJ: Transfer program cheats mental patients. Detroit Free Press, Feb 1, 1973, p 3; New York Times, March 22, 1974, p 40
21. Human Behavior, Oct 1973, p 14
22. Every recent investigation of nursing homes has reached one basic conclusion: there is failure to enforce state and federal nursing-home standards, and over 30% of admissions could be avoided if the government offered community care. An individual in a nursing home, more likely than not, may expect food at garbage level, injury or death due to neglect, indiscriminate use of drugs, orderlies dispensing narcotics who yesterday were on skid row, and an occasional nurse who has the gentleness of a stormtrooper. The situation in board-and-care homes is even worse. Curtin S: Tender loving greed. New York Times Magazine, April 28, 1974, p 12. Gans HJ: A poor man's home is his poorhouse. New York Times Magazine, March 31, 1974, p 20. Jacoby S: Waiting for the end: on nursing homes. New York Times Magazine, March 31, 1974, p 13
23. Spencer H: Former mental patients victimized by landlord. Newsday, Dec 3, 1973, p 3
24. Clark WA and Sinclair N: Crime zeros in on Detroit's elderly. Detroit News, Jan 30, 1974, p 1
25. New York Times Magazine, April 30, 1972, p 4
26. Abramson MF: The criminalization of mentally disordered behavior: possible side-effect of a new mental health law. 23 Hosp Community Psychiat 101 (1972). Crackup in mental care. Time, Dec 17, 1973, p 74
27. Quoted in Chase J: op cit supra note 21
28. Psychiat News, Dec 19, 1973, p 1. New York State's Department of Mental Hygiene has also recently made a change in its policy by telling its hospitals that "we should not take the initiative in discharging the patient to the community." New York Times, April 28, 1974, p 1. However, the Massachusetts Department of Mental Health and the United Community Planning Corporation, in line with the current trend, have called for all mental hospitals

in Massachusetts to be phased out as state hospitals within five years. The report concludes that "much of the $80-million a year now spent on state mental hospitals should be redeployed into community-based programs; the present state hospital buildings and grounds should be used for local mental health or regional human services or other public services; and every Massachusetts citizen needing mental health services should receive such care in local community-based programs rather than in regional or state-wide facilities as is now the case for many Massachusetts citizens." Psychiat News, April 3, 1974, p 1

29. Residents in respectable neighborhoods, threatened by the prospect of a nursing home or halfway house, organize in block clubs to prevent it, relying on zoning ordinances or the law on nuisance. New York Times, Jan 10, 1974, p 39. Newsday, Jan 10, 1974, p 7. Discharge into a livable (middle or upper-class) area arouses protests, not without justification. Residents complain that the discharged patients wander helplessly in the streets, urinate and defecate in public, expose themselves before women and children, terrify apartment-house dwellers in hallways and elevators, curse pedestrians, and collapse from intoxication. The oceanside community of 34,000 residents of Long Beach, Long Island, New York, have reacted with growing anger in recent months as 300 to 800 mental patients have moved there under the release policy of the New York State Department of Mental Hygiene. (The three state hospitals there had a total in 1965 of 31,044 patients; in 1973 they had 16,769.) Proprietors of abandoned hotels and boarding houses have been eager to provide rooms for the patients, whose costs are mostly paid by the state. Strong allegations are made that the state has literally dumped these people, most of them strangers, on the small Long Beach community without providing proper aftercare. Medical World News, April 12, 1974, p 47. Newsday, Dec. 5, 1973, p 48. New York Times, Dec 9, 1973, p 50; Jan 21, 1974, p 31; Jan 23, 1974, p 35; Feb 1, 1974, p 33; Feb 2, 1974, p 28; Feb 7, 1974, p 39; Feb 24, 1974, p E-5; March 18, 1974, p 1; March 19, 1974, p 68. One cynic has suggested that patients be discharged to Disneyland; the place has a moat around it.

30. A Mental Health Advocacy Agency is urged by Andalman E and Chambers DL: Effective counsel for persons facing civil commitment: a survey, a polemic, and a proposal. 45 Miss LJ 43 (1974).

31. The American Bar Foundation, which a few years ago conducted a field investigation of mental hospitals in six states, concluded that railroading, in the sense of malicious intent, is a myth. Rock RS with Jacobson MA and Janopaul RM: Hospitalization and Discharge of the Mentally Ill. Chicago, University of Chicago Press, 1968. If railroading occurred, one would expect much greater use of the writ of habeas corpus, which is available to challenge a confinement.

32. Supra note 12.

33. Chambers DL: Alternatives to civil commitment of the mentally ill. 70 Mich L Rev 1107 (1972). The Massachusetts law specifically requires the consideration of alternatives to hospitalization in its periodic review provision, and Illinois has a similar requirement in its commitment hearings. In *Lake v. Cameron*, 364 F 2d 657 (DC Cir 1966), the D.C. Court of Appeals ruled that the trial court had an obligation to ascertain whether there were alternatives less restrictive than total confinement for the care of the appellant. The trial court was told to consider, for example, whether the appellant and the public would be sufficiently protected if she were required to carry an identification card on her person so that the police or others could take her home if she should wander; or whether she should be required to accept public health nursing care, community mental health and day care services, foster care, home health aide services, or whether available welfare payments might finance adequate private care. In making this inquiry, the trial court was advised that it might seek aid from various sources, for example, the D.C. Department of Public Health, the D.C. Department of Public Welfare, the Metropolitan Police Department, the Department of Vocational Rehabilitation, the D.C. Association for Mental Health, the various family service agencies, social workers from the patient's neighborhood, and neighbors who might be able to provide supervision. Upon remand, the trial court found that the patient (who fitted the stereotype of the little old lady in tennis shoes wandering aimlessly about the streets) needed 24-hour supervision, and that only St. Elizabeths, the mental hospital, offered it. The long proceeding ended in naught; no institution other than the mental hospital offered adequate supervision.

    Judge Burger (now Chief Justice of the United States) observed: "We can all agree in principle that a series of graded institutions with various kinds of homes for the aged and infirm would be a happier solution to the problem than confining harmless senile ladies to St. Elizabeths Hospital with approximately 8000 patients, maintained at a great public expense. But it would be a piece of unmitigated folly to turn this appellant loose on the streets with or without an identity tag; and I am sure for my part that no District Judge will order such a solution. This city is hardly a safe place for able-bodied men, to say

nothing of an infirm, senile, and disoriented woman to wander about with no protection except an identity tag advising police where to take her. The record shows that in her past wanderings she has been molested, and should she be allowed to wander again all of her problems might well be rendered moot either by natural causes or violence." 364 F 2d at 664 (DC Cir 1966)

Justice Burger dissented, however, from putting the burden on the trial court to make an investigation of alternatives. That function, he said, was reserved for social agencies. Moreover, he added, a court is not equipped to carry out a broad geriatric inquiry or to resolve the social and economic issues involved.

34. The Mental Health Law Project is also bringing suit against St. Elizabeths "for keeping people in the hospital for whom hospital treatment is not indicated and for which St. Elizabeths is not equipped or able to provide the treatment indicated," and it is simultaneously a suit against the District of Columbia attacking its "failure to provide adequate services to pick up the needs of people who need care out of the hospital." Correspondence of Jan 21, 1974, to Ralph Slovenko from Dr. Marion F. Langer, Executive Director, American Orthopsychiatric Association. In this class action, *Robinson v. Weinberger*, it is argued that the state has a duty "to provide, as alternatives to large mental institutions (to St. Elizabeths as presently constituted), such smaller, more suitable and less restrictive treatment settings or institutions, as *inter alia*, nursing homes, personal care homes, foster care homes and half-way houses." "To the extent that least restrictive alternatives consistent with treatment needs do not presently exist," it is argued, "the defendants have a duty to create new alternative facilities or upgrade existing but substandard alternative facilities so that the patient plaintiffs may be placed in alternative facilities to their benefit." It is argued that the care and treatment which the state has a duty to provide under the commitment law must be "suitable to the restoration of the patient plaintiffs to society or to the highest level of function which the patients can reasonably attain," and it is further argued that the duty also stems from the state's obligation "not to abridge the patient plaintiffs' rights to association, to travel and to liberty guaranteed by the First, Fifth, and Eighth Amendments to the United States Constitution."

The Mental Health Law Project and the New York Civil Liberties Union have also brought suit challenging the Long Beach ordinance banning released state mental patients from the city's "adult homes." New York Times, Jan 10, 1974, p 39. Newsday, Jan 10, 1974, p 7

35. See Comment, 86 Harv L Rev 1282 (1973)
36. Social workers, once called friendly visitors, cannot offer the type of assistance on an on-going and regular basis that is needed. In some cases, what is needed is a salary, perhaps also some training, for assistance by people who live nearby. There are many grandmothers who have nothing to do, and who could serve admirably as family aides. It is hard enough today for a family to survive even without a handicapped person, and it is getting harder every day, in the face of escalating pressures. The daily grind of taking care of a handicapped person can exhaust or paralyze a family.
37. See Bayle M: The community can care. New Society, Oct 25, 1973, p 207. Schumach M: Child patients not wanted by parents pose problem for psychiatric hospital, New York Times, March 4, 1974, p 31. See also Waldmer P: Family fears son will kill. Detroit News, March 15, 1974, p 10. In an inquiry into the impact of the environment on the family, Dr. Spock observes: "In simpler societies neighbors of all ages know one another, live close to one another, work together on common tasks, play together, help one another. In our industrial civilization many people work far from home, on assembly lines or in office jobs that give little or no satisfaction; and they compete with one another. They live in more or less isolated homes. They restrict their social life to those they consider their social equals. And when they need assistance they have to buy it from professional people. This is a spiritually impoverished life, compared to what our species was designed for." Spock B: Raising Children in a Difficult Time. New York, Norton, 1973. See also Clark M: Troubled children: the quest for help. Newsweek, April 8, 1974, p 52
38. Who will adopt a senile or handicapped person, when even young children go begging for attention? There are pleas on radio and in newspapers about children needing homes—for example there is a photo of Ira, 11 years old, described as "a normal, healthy, cheerful, well-educated boy who loves to play baseball." Senator Walter F. Mondale has urged governmental action, for it is badly needed to strengthen families. To date, though, social responses to the needs of both young people and the elderly have been dismal. Hearings on American Families: Trends and Pressures, 1973. Before the Subcomm. on Children and Youth of the Sen. Comm. on Labor and Public Welfare, 93d Cong., 1st Sess. (1973). Goodwin RN: The American social process. New Yorker, Jan 28, 1974, p 36
39. Illich I: Tools for Conviviality. New York, Harper & Row, 1973. Frankel C: The specter of eugenics. Commentary, March 1974, p 25