Right to Treatment

IVAN COHEN, M.D., NANCY L. COHEN, ESQ.,
AND ROBERT L. SADOFF, M.D.*

I. The Problem of Adequacy

In the case of *O'Connor v. Donaldson*[1] the Supreme Court has recently held that "a State cannot constitutionally confine without more a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends."

The court did not feel that this case was a proper one for deciding the issue of a constitutional right to treatment because Donaldson was not dangerous and had received no treatment. Justice Stewart implied in his opinion that the question of whether a mentally ill person who is dangerous to himself or to others has a right to treatment and whether the state can involuntarily confine a nondangerous mentally ill person for treatment are issues which the court may be called upon to decide in the future.[2]

Thus it is possible and even likely, as indicated by the trend in court decisions over the last ten years, that the Supreme Court will find a constitutional right to treatment for some subgroup of psychiatric patients. If the court affirms such a right, it will have to set standards for adequate treatment or provide a mechanism for setting such standards. To affirm that a right to treatment does exist, but to set no standards for such treatment would be a meaningless decision in view of the barely adequate custodial care which now passes for treatment in some state hospitals.

The problem of adequacy can be approached in two ways. The first is by looking at the treatment of individual patients. For example, why have specific therapeutic modalities been used or not used? Is there a reason given for employing group therapy and not providing individual therapy? Are therapeutically justifiable reasons found in the patient record for denying passes?

The second approach is by determining conformity to institution-wide standards. What are the staff-to-patient ratios? What are the frequency and duration of physician, social worker, occupational therapist, and nurse contacts with patients? What is the frequency of chart notes? What are the physical characteristics of the institution?

Before the judicial and psychiatric advantages and disadvantages of each of these approaches are explored, it is appropriate to review how adequacy has been measured in key right-to-treatment cases. Initially the courts wrestled with trying to generate adequate treatment for individual patients. The first of these cases was *Rouse v. Cameron*.[3] The Court of Appeals for the District of Columbia ruled that treatment had to be individually prescribed for each patient. The hospital records of Rouse were examined and specific reasons for the use or non-use of a given therapy were sought. Rouse had refused group therapy and the hospital had offered no alternative therapy. The court examined the record for reasons why group therapy was deemed the only appropriate therapy.

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* Dr. Cohen is Associate, Department of Psychiatry, University of Pennsylvania; Ms. Cohen was counsel to the Philadelphia Association for Retarded Citizens, and is now in private practice; Dr. Sadoff is Assistant Professor of Psychiatry and Director, Center for Studies in Social-Legal Psychiatry, University of Pennsylvania, and a past President of the Academy.

In this case the court got into matters of psychiatric management beyond its proficiency. In effect the court said that it was a proper judicial function to rule on whether every treatment decision was appropriate. The court could have been forced to spend inordinate amounts of time meticulously examining the care received by a succession of plaintiffs from psychiatric hospitals.

In two subsequent cases, *Tribby v. Cameron*[4] and *Covington v. Harris*,[5] the U.S. Court of Appeals for the District of Columbia seems to have realized that it had overstepped the bounds of practicality and of its competency, and that the issue of adequacy should be determined by the psychiatric community acting in uniformity with general guidelines set down by the court.

In *Tribby v. Cameron*[6] the Court of Appeals stated:

> We do not suggest that the court should or can decide what particular treatment this patient requires. The court's function here resembles ours when we review agency action. We do not decide whether the agency has made the best decision, but only make sure that it has made a permissible and reasonable decision in view of the relevant information and within a broad range of discretion.

In *Covington v. Harris*[7] the Court of Appeals gave further guidelines for the evaluation of adequacy by defining what it meant by "relevant information." Covington had requested transfer from a maximum security facility at St. Elizabeth's Hospital to a less restrictive ward. The hospital had not granted his request, basing its refusal on Covington's dangerousness.

The court agreed that dangerousness was certainly a relevant issue, but that the treatment needs of the patient must also be considered in making a decision. Specifically they asked whether Covington would be more likely to improve or to recover on a more open unit. The court was saying that, of the many factors which are relevant in making a treatment decision, the paramount one is the question: what does the patient need to improve or recover?

The cases of *Rouse*, *Tribby*, and *Covington* can be seen in combination as a judicial attempt to define for the psychiatric community a process for making treatment decisions which would guarantee that individual patients would receive adequate treatment. There followed a group of cases in which the courts stopped dealing with individual treatment decisions and began to try to secure adequate treatment by dealing with institution-wide standards.

In the first of these cases, the *New York State Association for Retarded Children, Inc. v. Nelson Rockefeller*,[8] the District Court for the Eastern District of New York found that, for treatment to be adequate, mentally retarded inmates of Willowbrook State Hospital had to be protected from harm at the hands of other patients or staff members and that their surroundings must meet basic standards of human decency. Toward these ends, the court declared that a large number of ward attendants, nurses, physical therapists, and medical doctors were to be hired and that residents of Willowbrook had to receive outside activity, adequate heat, working toilets, adequate medical and surgical care, and freedom from seclusion.

The most important case concerning right to adequate treatment was *Wyatt v. Stickney*,[9] later known as *Wyatt v. Aderholt*.[10] This case was the first to enunciate that treatment was a constitutionally guaranteed right for the involuntarily committed psychiatric patient. Initially the suit was brought as a class action on behalf of the inmates of Bryce State Hospital in Tuscaloosa, Alabama; however, it was later changed to include all of the inmates in the Alabama state facilities for the retarded, the aged, and the mentally ill. The fact that the care provided in these institutions was grossly inadequate was uncontested. For the 5,000 inmates at Bryce State Hospital there were seventeen medical doctors, only three of whom were involved in direct patient care, and only one of whom was board-eligible in psychiatry. There were no board-certified

psychiatrists. The U.S. District Court in Alabama found that "the purpose of involuntary hospitalization for treatment purposes is treatment and not mere custodial care or punishment."[11]

The court stated that the treatment program is "to give each of the treatable patients . . . a realistic opportunity to be cured or to improve his or her mental condition."[12] It then went on to spell out exact numerical standards with which the state facilities had to comply. The court wanted to know the number of treatment teams at Bryce State Hospital, the number of patients on each team, the number of staff on each team, and the number of patients getting individual care from some member of the treatment team. The court mandated that staffing be in accordance with the standards of the Department of Health, Education, and Welfare, and that for each patient records had to be kept detailing the treatment the individual was receiving.

In *Welsch v. Likins*[13] the U.S. District Court for Minnesota added two more requirements for adequacy. First, patients had to be in the least restrictive environment in which proper treatment could be provided. The court, by enunciating this doctrine of least restrictive alternative, was stating that in addition to large central institutions states had to provide community facilities. Secondly, the court stated that restraints and tranquilization could be used only for specific therapeutic indications. Adequate treatment was precluded if restraint or sedation was used to provide control which was needed because of understaffing.

It had been hoped that *O'Connor v. Donaldson*[14] would add some clarity to exactly what courts consider proper treatment to be. But by deciding the case on the grounds of denial of liberty, the court completely side-stepped the issue of adequacy. It is noteworthy that adequacy is mentioned only in passing in the court's decision.

If in a future case the Supreme Court should rule that a right to treatment exists and then has to define adequate treatment, it is unlikely that it will go against the grain of judicial experience and set individual standards for adequacy. Only in the case of *Rouse v. Cameron*[15] have individual treatment standards been made a necessity to adequacy. The courts soon found it very difficult to administer and to assess compliance with these standards. Thus in two subsequent cases, *Tribby v. Cameron*[16] and *Covington v. Harris*,[17] the court had to step back and grant a great deal more autonomy to the psychiatric community in defining adequacy.

Individually based standards for adequacy would require any individual patient who felt he was not getting adequate treatment to bring suit personally in order to secure adequate treatment. Such standards would thus be primarily helpful to patients with the emotional, intellectual, financial, and familial resources to bring suit. This group of patients, capable of asserting their needs and planning steps to secure them, is a miniscule minority compared to the thousands of passive, chronically ill inmates of state hospitals. Of course, in the best of all possible worlds, where there would be an infinite number of attorneys willing to represent such patients, an infinite number of judges trained in psychiatry, and a superabundant well-trained staff in all state hospitals, individually based standards for adequacy would be appropriate. In the real world of limited psychiatric and legal resources, however, such standards seem to be an impossibility.

For the pragmatic reasons of ease of definition and ease in monitoring compliance, the Supreme Court would be wise to set institution-wide standards, with perhaps some caveats regarding individual treatment plans and amount of patient-staff interaction. Such institution-wide standards might be similar to those suggested by Morton Birnbaum.[18] Birnbaum proposed that all institutions should meet the standards of the Joint Commission for the Accreditation of Hospitals, and that they should qualify for Medicare and Medicaid funds through certification by the Social Security Administration. This qualification guarantees minimal standards for record-keeping, staffing, and utilization. The institutions should meet the American Psychiatric Association's standards for physical

facilities and patient-to-staff ratios. Finally he proposes that all physicians working in state institutions be fully licensed. At the present time, many of the physicians serving in state hospitals have restricted licenses which allow them to practice medicine only within the confines of a state hospital. The result of this licensing procedure is that patients in state hospitals receive not only inadequate psychiatric care but also second-class medical care which is not felt to be adequate for the citizens who reside outside the state hospital.

Institution-wide standards for adequacy would be of great benefit to those non-verbal, regressed, passive patients who cannot bring their needs for adequate treatment to judicial notice. It would not be necessary for a patient to go through lengthy litigation to prove that the care and treatment he or she was getting were not adequate. The patient would have to demonstrate only that staff ratios or physical facilities were not in accord with the minimal standards set by the above-named bodies. And the courts would not have to get involved in complex issues about exactly what is adequate treatment for a given patient.

II. Adequacy and the Individual Practitioner

If in the future the Supreme Court should affirm that a certain group of patients, perhaps those who are committed because they are dangerous to themselves or to others, or those who cannot function outside of a hospital, has a constitutional right to adequate treatment, that decision would have a great impact on the individual practitioner of psychiatry. Most of what would happen would be beneficial for patients and psychiatrists, but certain other results might be very difficult for psychiatrists to accept. The key difficulty will be that psychiatric decisions will be open to public scrutiny. Some psychiatrists may resent their decisions' being judged by courts or regulatory bodies.

Psychiatrists have spent many years of arduous training becoming specialists in the diagnosis and treatment of psychiatric illness. They are doctors trained in making important decisions and in assuming responsibility for the well-being and frequently for the very lives of their patients. They feel comfortable with and enjoy this responsibility. They will not look benevolently on anyone from outside their profession who questions the adequacy of their therapeutic approach.

Doctors are human and heir to all the shortcomings of others. As Judge Bazelon stated in *Covington v. Harris:*

> Not only the principle of judicial review, but the whole scheme of American government, reflects an institutionalized mistrust of any such unchecked and unbalanced power over essential liberties. That mistrust does not depend on an assumption of inveterate venality or incompetence on the part of men in power, be they Presidents, legislators, administrators, judges, or doctors. It is not doctors' nature, but human nature, which benefits from the prospect and the fact of supervision. Indeed, the limited scope of judicial review of hospital decisions necessarily assumes the good faith and professional expertise of the hospital staff. Judicial review is only a safety catch against the fallibility of the best of men; and not the least of its services is to spur them to double-check their own performance and provide them with a checklist by which they may readily do so.[19]

Psychiatric decision-making will be demystified as the process is reviewed by others and as standards are applied to evaluate the adequacy of psychiatric care. What a psychiatrist does will be seen less as an unintelligible, magical undertaking and more as a logical process based on hard data and following specific rules for arriving at the best therapeutic course for a given patient.

Of course, many psychiatrists may fear that setting specific guidelines for therapeutic decisions will lead to cookbook care for patients and take the essence out of the therapeutic process. But it must be remembered that the Supreme Court will probably set

institution-wide standards for adequacy. Such standards will continue to leave much latitude for the individual psychotherapist in determining care for his patients, while assuring that psychiatrists and patients alike will have adequate resources for the therapeutic endeavor.

From the judicial opinions already discussed it becomes apparent that courts are no longer willing to accept the opinions of psychiatrists as automatically the best decisions. Instead, courts show a readiness to accept the fallibility of psychotherapists and the fact that they can make decisions not in the best interests of their patients. Because of this realization, courts are demanding that records be kept detailing how treatment decisions are made. In *Rouse v. Cameron*[20] the hospital record contained no justification for group therapy, so Rouse's refusal of group therapy was not deemed by the court as the end of the hospital's responsibility to provide adequate treatment.

The same kind of judicial fact-finding is apparent in *Covington v. Harris*.[21] The Court of Appeals wanted to know where in the written hospital record Covington's dangerousness was balanced against the possible therapeutic benefits that he would receive from being on a less restrictive ward.

In *Tribby v. Cameron*,[22] in *Covington v. Harris*,[23] in *Dixon v. Pa.*,[24] in *Burnham v. Ga.*,[25] and in an article by Judge David Bazelon,[26] it has been made clear that courts are reluctant to take, and feel incapable of taking, the responsibility for assuring adequate treatment. The courts are willing to set general, institution-wide standards, to set guidelines that psychiatric decision-making must conform to, and as a last resort to intervene directly in the therapeutic process to protect the rights of patients. But it will be the responsibility of psychiatrists, as spokesmen and leaders in psychiatric care, to assure that patients receive adequate care. The situation will offer another example of the need for self-policing to make sure that adequate care is, in fact, being delivered.

Monitoring the deliverance of adequate care could be done in at least two ways. First, simply having professional standard review organizations active in psychiatry would go a long way toward making sure that adequate care was being delivered. A more formal system, proposed in legislation in the Pennsylvania House[27] several years ago but never passed, provided for the establishment of Mental Treatment Standards Commissions which would promulgate objective standards for adequate care. The bill would also have established a Treatment Review Board. Patients could have come before this board with grievances about the treatment they were receiving, and if the board had found the grievances justified, it could have provided remedies.

Birnbaum[28] has pointed out that our society stigmatizes the mentally ill. His meaning is that hospitalized psychiatric patients are discriminated against in many ways and regarded as second-class citizens. Birnbaum has raised a point which may be very important in improving the care given to our hospitalized patients. There is no question that these patients are neglected, receiving inadequate treatment in inadequate physical facilities, from physicians not fully licensed. The reason for this deplorable state of affairs is that state legislatures have not been pushed by their constituencies to appropriate adequate funds for state psychiatric institutions.

But if the Supreme Court in the future rules that there is, in fact, a constitutional right to adequate treatment, psychiatrists, others on the therapeutic team, and organizations such as the National Association for Mental Health will be able to go to the legislatures and the citizens of a state and say "You are depriving some of your citizens of a right guaranteed to them by the Constitution of the United States." Psychiatrists will have to insist that the treatment needs of those in state hospitals cannot be ignored and forgotten, but must be met through adequate treatment and habilitation.

As legislatures are forced to allocate money for the adequate treatment of psychiatric patients, it will no longer be possible for society to deposit its deviant and bizarre members in state hospitals for inexpensive custodial care. Since it will be expensive to hospitalize patients, state legislatures will be forced into the alternative of maintain-

ing and providing psychiatric care for patients in their communities. The individual psychiatrist working in a community setting will be called upon to see large numbers of people with serious psychiatric illness as out-patients.

If the doctrine of least restrictive alternative as promulgated in *Welsch v. Likins*[29] is accepted by the Supreme Court as a condition for adequate treatment, then individual community psychiatrists may find that a large range of facilities such as half-way houses and sheltered workshops will have to be provided for patients who may need the structure and guidance that such facilities provide. The community psychiatrist will be asked to plan, to take part in the management of, and to provide care in these treatment resources.

An affirmation by the Supreme Court that adequate psychiatric care is a right will rescue psychiatrists from a conflict that is intrinsic in an understaffed state hospital. Psychiatrists in these institutions have long had to balance the needs of their patients for personal freedom against the necessity of controlling agitated or destructive patients with inadequate numbers of often poorly trained staff.

In *Welsch v. Likins*[30] the use of physical restraints as tranquilization for non-therapeutic reasons was considered cruel and inhuman punishment. Thus, psychiatrists can now go to state legislatures and declare that if inadequate funds are provided for psychiatric care in state hospitals, the psychiatrists will then be forced to use restraints in violation of the law. State legislatures have been able to avoid doctors' pleas for more financial support for psychiatric care for many years, but it would be most difficult to circumvent the law in this regard.

The Supreme Court has not ruled on the very important malpractice issues raised in *O'Connor v. Donaldson*.[31] The Court of Appeals has upheld the jury's award of $28,500 in compensatory and punitive damages to Donaldson because Dr. O'Connor, acting as a state official under color of law, was found to have maliciously deprived Donaldson of his civil liberties. The Supreme Court, however, sent the issue of damages back to the Court of Appeals for further litigation. In the psychiatric community there has been a great deal of alarm about the financial award made to Donaldson. In the *amicus* brief[32] filed by the American Psychiatric Association, the fear is stated that if Dr. O'Connor is found financially responsible for Donaldson's inadequate care, doctors will flee the state hospital system in droves, with the result that care in state hospitals will actually become even less adequate.

This reasoning is faulty for two reasons. First, if the financial award to Donaldson is eventually upheld, it will give doctors working in state hospitals a tremendous weapon to use against financially recalcitrant state legislatures. They will be able to say that they cannot continue to work in state hospitals without adequate financial support. The state certainly will not be able to run its institutions without doctors or to close them. The public would not tolerate the mass release of the hundreds of thousands of patients now in state hospitals.

The second and key reason why the psychiatric community should not become alarmed if Donaldson wins his suit for damages is that a careful reading of the case will show that Donaldson's doctors were not acting in good faith. They seem to have acted capriciously and willfully in denying him adequate treatment or release from the hospital. During his fourteen-year hospitalization, both an organization, Helping Hands, and an old college friend tried to get Mr. Donaldson released from the hospital. His doctors erected one barrier after another, finally prohibiting his release. As soon as his friend or the organization met one condition imposed by the hospital and the plaintiff's physicians, another one was erected. They both finally gave up trying to get Donaldson out of the hospital.

Donaldson's doctors were not culpable for errors in decision-making or lack of success with reasonable treatment, but are accused of acting in bad faith in their denial of adequate treatment or release to Donaldson. For this reason Donaldson was awarded

both compensatory and punitive damages. Dr. O'Connor may be found financially liable not merely because he worked in a state hospital and therefore could not deliver adequate treatment, but because he did not do the best with the resources available. Thus, it is unwarranted alarmism to feel that every doctor doing a conscientious job in a state hospital will immediately be assaulted by innumerable law suits alleging that he is responsible for delivering inadequate care.

Conclusion

Affirmation by the Supreme Court of a constitutional right to adequate treatment for at least some segment of the psychiatric in-patient population will be of great benefit to the patients included. State hospitals will no longer be able to function as storehouses for the bizarre, the deviant, and the chronically ill. We do not yet know how to restore all these unfortunate patients to a full and productive life, but we can do much more for them, if only in terms of creature comforts and basic needs of decent living. And with intensive and early intervention many patients of the future can be spared the agony of life-long institutionalization.

For the psychiatric community a constitutional right to adequate treatment will present opportunity and challenge. The opportunity will be to do more for the patients in state hospitals than has ever been previously possible. The challenge will be to accept and to learn to live with the necessity of judicial, regulatory body, and public scrutiny of professional psychiatric decisions.

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