LEGAL PROBLEMS INVOLVED IN IMPLEMENTING THE RIGHT TO TREATMENT*

by

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I. Introduction

Within the last twelve years, the concept of a legally enforceable "right to treatment" for institutionalized mental patients has been asserted. The "right to treatment" advocates argue that if a mentally ill person has been hospitalized by the state involuntarily because he needs mental treatment, the state has an obligation to furnish that treatment. Even if the individual has been institutionalized as "dangerous to himself or others" instead of "in need of care and treatment," since there has been involuntary confinement without a finding of guilt of a crime, and without rigorous criminal process safeguards, it is a duty of the state to make that confinement as short as possible, by providing adequate treatment. Stated in these simple terms, few lawyers and few psychiatrists are opposed to the principle of a "right to treatment."

It seemed as if members of our two great professions had finally found an issue upon which they could agree and that the iron curtain of icy silence existing between us might melt into meaningful dialogue. However, the difficult problems involved

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in defining and implementing the right to treatment have quickly returned us to the Cold War. What constitutes adequate treatment? Who should determine adequacy? Are courts competent to enforce a right to treatment? Is release of an inadequately treated, but dangerous patient appropriate? What is adequate treatment for an untreatable patient? These are but a few of the important, and as yet, unresolved issues.

As Legal Counsel to the Michigan Legislative Committee to Revise the Mental Health Statutes, I have examined the existing Michigan legislation on the right to treatment--what little there is of it--and the relevant court decisions construing the right. My preliminary work on the subject has been completed and has been reviewed by the Legislative Committee and by the Governor's Mental Health Program and Statute Review Commission. Undoubtedly, there will be substantial modification of my position and my recommendations before legislation is introduced next year.

II. General Policy Issues

The first two problems involving the right to treatment are interrelated, and should be discussed together. The first issue is, "Who determines adequacy?" and the second issue, "Adequacy for whom?" In attempting to resolve these issues, we must examine the short historical context in which the right to treatment has been asserted.

The concept of a legally enforceable right to treatment was first asserted in 1960 by Dr. Morton Birnbaum.[1] A basic

tenet of the right, as he viewed it, was enforcement through petitions to the court by confined patients for the remedy of release in situations where the state had not fulfilled its treatment obligations.

The "right to treatment" concept received its major judicial impetus in the landmark case of Rouse v. Cameron[2] decided by the United States Court of Appeals for the District of Columbia Circuit in 1966. In that decision, Chief Judge David Bazelon, writing for the majority of the court, declared that since the purpose of involuntary hospitalization is treatment, not punishment, the hospital has a duty to furnish treatment, and the patient has a legal right to receive that treatment. This right to treatment, said Judge Bazelon, is enforceable by a writ of habeas corpus. In other words, if a patient is not receiving adequate treatment, he has a right to secure his release from the mental hospital even though he remains mentally ill. Judge Bazelon and others have indicated that grave constitutional problems involving due process and cruel and unusual punishment would arise if involuntarily hospitalized persons could be retained in the institution without affording them adequate treatment.[3]

Thus, within the first six years of the "Right's" existence, the answers to the two questions were (1) the courts determine adequacy, and (2) the determination of adequacy is made for the individual aggrieved patient who sues for his release from confinement.

However, this resolution of the issues was not without controversy. The American Psychiatric Association questioned

the competence of the courts to determine adequacy, and in an official policy statement, asserted: "The definition of treatment and the appraisal of its adequacy are matters for medical determination."[4] The psychiatrists were not the only critics. Even the judges sitting in the same court as Judge Bazelon differed in their views as to the appropriate treatment standard required by the right. Judge Bazelon in Rouse phrased the test in terms of suitable and adequate treatment for the particular individual in the light of existing medical knowledge. In a subsequent case in the District of Columbia,[5] Judge Edgerton required only treatment which is selected by a reasonable and permissible decision on the part of the hospital within a broad range of discretion. And in a third case,[6] Judge Burger, now Chief Justice of the Supreme Court of the United States, wrote a concurring opinion in which he intimated that simply any treatment at all satisfies the right to treatment requirements.[7]

Additionally, the method by which a patient raised the issue of adequacy of treatment, i.e., a writ of habeas corpus seeking release from the institution, has been questioned. Although many lawyers, schooled as they are to represent the interests of their own individual clients, have viewed the right to treatment as a device to obtain their client's freedom, some attorneys have viewed the right in a broader context. As one attorney recently wrote, "Habeas corpus appears to be an inadequate vehicle for meaningful reform because even successful litigation will limit relief to one individual. A single patient might be discharged from an institution or begin to receive

treatment, but the institution would continue to function basically unchanged."[8]

Even that great judicial activist, Judge Bazelon himself, seemed willing to throw the ball into someone else's court, when he admitted:

> I, of course, believe the judiciary can play a role, but I will be the first to admit that, in most instances, the legislature can do a better job. A court can only lay down broad policy outlines, but the legislature can create specific procedures and institutions to implement the right to treatment.[9]

However, in most states, the legislatures simply have not done a better job. For example, while existing Michigan statutes mention treatment and indicate that standards of treatment are to be established, there is no Michigan statute explicitly recognizing that mental patients have a judicially enforceable right to receive treatment that is adequate and appropriate for their particular needs. Several bills have been introduced in the Michigan Legislature which announce the right of patients to receive "adequate treatment" and state that "failure to provide adequate treatment is sufficient grounds for immediate release despite the severity of a patient's illness." However, these bills still fail to resolve the problems raised above.

When the answer to the question: "Who determines adequacy?" shifted to "the legislature" instead of "the courts," the answer to the other question: "Adequacy for whom?" shifted to "all the patients in the institution--collectively" instead of "the individual aggrieved patient." To the extent that legislatures focused on the problem at all, they focused on the generalized problem of treatment for <u>all</u> institutionalized patients.

However, what I feel is needed is an articulated legislative standard of treatment which judges can apply in individual cases to curb inappropriate or nonexistent treatment without unduly straightjacketing the medical profession. In my opinion, both the legislature and the courts have a role in determining adequacy--the legislature in establishing meaningful standards applicable to all patients, and the courts in determining whether adequate treatment has been accorded in individual cases. Similarly, my answer to the second question is that both the patient as an individual and as a part of the collective patient body have to be considered in establishing adequate treatment plans. My recommendation[10] for a "Right to Treatment Law," insofar as it deals with the issue of determining appropriate standards of treatment, is derived from and patterned after a comprehensive bill introduced in, but not enacted by, the Pennsylvania Legislature.[11] I chose that model because I recognized my inability as a non-mental health professional to prescribe standards of treatment. Within very broad guidelines, the approach I adopted provides for a determination of adequate treatment standards by mental health professionals.

The bill establishes a Mental Treatment Standards Committee composed of a psychiatrist, a nonpsychiatrist physician, a psychiatric social worker, a clinical psychologist, a psychiatrist who is a superintendent of a mental hospital, a psychiatric nurse, and the Director of Mental Health. The members of the Committee are appointed by the Governor. The Committee is charged with the preparation and adoption of a "Manual of Minimum Standards for

Treatment of Mentally Ill Patients in State Mental Institutions." "Treatment" is defined as those forms of therapy from which a patient can gain sufficient benefit to substantially aid in his adjustment for his return to society, in the reasonable belief of a psychiatrist. Custodial care does not constitute treatment within the meaning of my proposal. The bill directs the Committee to specify within its standards,

(1) the number of professional and non-professional staff per patient population, including the maximum number of patients for each psychiatrist, physician, psychologist, social worker, industrial therapist, nurse, and attendant;

(2) the minimum qualifications for each professional and non-professional staff position;

(3) the minimum number of individual consultations between patient and psychiatrist and other professional personnel in each thirty-day period;

(4) the frequency and extent of general physical examinations,

(5) requirements for the maintenance of individualized treatment plans for each patient, including (i) the initial diagnosis, (ii) the manner in which the facilities and programs of the particular institution can improve the patient's condition, (iii) the treatment goals, and (iv) the treatment regimen that is planned to accomplish these goals. There is also a requirement that individualized treatment plans be periodically reviewed and updated. Six months after its appointment, the Committee is required to complete its Manual Of Minimum Standards, and one year after presentation of the standards to the Governor, the

standards shall go into effect. The Committee is charged with periodic review of the standards and is empowered to make such changes as it deems necessary.

Obviously, a similar Committee should be established to provide standards of education and training for the institutionalized mentally retarded.

While I feel that the task of delineating treatment standards applicable to all patients is largely within the province of the mental health professional, the task of assisting the individual patient in achieving his full measure of adequate treatment falls within the bailiwick of the lawyer. The difficult and delicate problem is to provide a way in which the patient can effectively enforce his right to treatment, without necessarily impairing the therapeutic relationship existing between the patient and treating personnel.

A non-mentally disordered individual who has a question or problem concerning his legal rights normally consults a lawyer. However, attorneys have not as yet become involved to any great extent with mental patients' problems. There are many reasons why this situation exists. Generally, patients' rights have not been recognized statutorily to date. Patients may not seek out lawyers to aid them in contesting alleged violations of their rights due to a lack of sophistication or mental competence. Lawyers lack expertise in this neglected area. Statutory duties for the attorney are virtually nonexistent, and lawyers who have worked in the civil commitment area often act only in a ceremonial

manner. Additionally, patients' legal problems are often financially unprofitable to an attorney. A lawyer who services many clients may find that the occasional mental patient-client, whom he must visit in an institution rather than in his own office, consumes too much of his working time over inconsequential, though complex, matters. However, these reasons do not justify a continuance of the existing situation.

Recent statutory developments in New York suggest a workable solution to the problems involved in enforcing patients' right to treatment and other related rights. In 1965, new laws modifying mental hospitalization procedures went into effect. A special service was created at that time, and Mental Health Information Service, in each of the four Judicial Departments of the State, responsible to the Appellate Division of each Department. The Mental Health Information Service is staffed primarily by lawyers, and its function is to review the status of involuntary patients, inform them of their rights under the law, including the right to be represented by legal counsel and to seek independent medical opinion, assemble information for the court whenever a hearing is requested, and advise patients when they seek aid. Statewide, the Mental Health Information Service is authorized to employ 11 persons in supervisory positions and 43 in staff positions.[12] Many of the staff workers are stationed within the mental hospitals themselves.

Although there are differences between each of the four Services, they have generally proved to be an invaluable asset

in aiding patients, without unduly hampering administration of the institutions. Contrary to the fears of some hospital personnel, the presence of specially trained mental health lawyers in the institutions themselves has resulted in less conflict and less litigation. Lawyers who work full-time on mental patients' problems and who continually observe the difficulties involved in working in and administering the institutions themselves, develop an expertise in avoiding rather than promoting litigation. Only in the most extreme situations do competent attorneys utilize the formalized relief provided by judicial intervention. A psychiatrist at Bellevue Hospital, where seven to eight full-time Mental Health Information Service attorneys are stationed, recently reported:

> The trend toward out-of-court settlement is largely an artifact of the new law and the presence of lawyers is undoubtedly the key to this phenomenon. Furthermore, the increasing trend in recent years seems to indicate both a stepped-up effort by these lawyers and their effectiveness in avoiding a court hearing. However, in settling the "disagreement" between psychiatrist and patient, these lawyers apparently exert pressure not only on psychiatrists but also on patients. When advising the patient to accept hospitalization, the lawyer could be doing so because of his "calculation" that he cannot make a good case for discharge in court or because of his judgment that the patient does need hospitalization.[13]

The desire of Service workers to reach a negotiated settlement of a dispute--a settlement which satisfies both the psychiatrist and the patient--has been attested to repeatedly.[14] In one major New York hospital, court commitment hearings were reduced from an average of 40-50 per week prior to the existence of the Mental Health Information Service to 8 per week after the Service came into existence.[15]

It should be remembered that the New York Mental Health Information Service deals primarily with legal problems involved in civil commitment. However, such an agency could easily be assigned the role of counseling patients and insuring protection of their legally recognized interests.

The poor in our society are increasingly becoming entitled to free legal services in all matters, civil and criminal. The mentally disordered, confined in mental institutions, should not be deprived of such benefits. Ideally, a "Mental Health Information Service" type of lawyer should act as a personally retained house counsel for mental patients, advising and representing them in all their legal disputes.

I have proposed that a new state-wide agency, called the Mental Patients' Legal Assistance Service be created as an autonomous agency independent of the mental institutions and of the Department of Health. The Service should have the function of protecting the legal rights of mental patients, including the right to treatment. Service personnel should perform this function by fulfilling the following duties:

1. Inform and advise patients of their legal rights;

2. Study and review all patient records to determine whether patients' rights are being observed;

3. Investigate any violations of rights which appear on patients' records and any and all other violations which are complained of or observed;

4. Determine whether a patient's voluntary and informed consent has been obtained for any therapy, prodecure or operation requiring patient consent;

5. Act informally to correct any violations of patients' rights;

6. Counsel and represent patients in court in all legal disputes in situations where Service personnel determine that a right has been violated and the violator refuses to stop the violation, subject to a patient's right to retain independent legal assistance.

The Service should be staffed primarily by full-time attorneys who receive such training and such psychiatric and other assistance as is necessary to perform their duties. Service personnel should be stationed in and available to patients at state mental institutions.

III. Specific Treatment Problems and Specific Treatment Rights.

The above stated proposals attempt to create a framework for establishing minimum treatment standards that can be applied to all mental patients in the state mental hospitals, and an agency to enforce an individual patient's rights to receive treatment as required by those standards. However, there are major treatment problems that may involve only some patients and which cannot be dealt with by proclaiming generalized treatment standards. At this point in my presentation, I will explore some of these problems and the role of the Mental Treatment Standards Committee, if any, in resolving them.

A. The Voluntary Patient

In Rouse v. Cameron, Judge Bazelon reasoned that if the state involuntarily deprives a person of his liberty and confines

him because he is in need of treatment, it has the obligation to accord him that treatment or to release him. This is logical in a situation where an individual has brought a writ of habeas corpus and is attempting to obtain his release from confinement. But to what extent is the right to treatment approach appropriate to the voluntary patient, the one who seeks not release from confinement, but rather treatment for his condition?

For example, let me focus on the aged and their need for rehabilitative programs. Should an elderly person have to be involuntarily confined in a mental institution before he can claim that he is not receiving adequate treatment? It seems senseless to so restrict the right to treatment. The voluntary aged mental patient should be accorded the right to complain of inadequate treatment as well. And what of the elderly person in a nursing home? Should he not also be entitled to complain of inadequate programs and services? And finally, what about the elderly person who still maintains his own home, or who lives with his children--does the state not owe him access to rehabilitative programs which he may want to voluntarily attend?

It seems to me that the ultimate goal of a right to treatment philosophy is a requirement that the state provide more treatment; i.e., adequate treatment to meet the medical needs of its citizens. An approach such as that suggested in Rouse v. Cameron, would permit the state to simply release all involuntarily confined mental patients and completely avoid the obligation to provide adequate treatment, is deficient.

Realizing the practicality of the situation--that the public would be frightened to death--the right to treatment advocates know full well that the states will not release all mental patients into society. Notwithstanding, they may be attempting to capitalize upon this fear by attempting a squeeze play; i.e., if you fail to provide more money for mental health programs, we will release all of the "crazy" people. Unfortunately, this squeeze play offers no solace to those individuals who actively and voluntarily seek services, whether mental treatment, physical therapy programs or day care programs for the elderly. A much broader approach must be taken to insure adequate services for all those who desire them.

B. Institutional Alternatives

The push for additional therapeutic programs and services leads to an additional problem. If such programs become more readily available, there is a very real danger of coercion and a corresponding need to safeguard the individual's liberty--his freedom of choice in deciding whether to participate in beneficial programs. As Dr. Thomas Szasz so accurately describes, it is so easy to coerce when we are trying to "do good" for the other person. This danger is even more acute when we think we have the available means to "do good." It is for this reason that I think Judge Bazelon's opinion in Lake v. Cameron[16] is of even greater significance than Rouse. Lake involved an elderly lady who suffered from a chronic brain syndrome associated with cerebral arteriosclerosis, and who, as a result of her condition, exhibited occasional lapses of memory. The lower court decided that her mental condition warranted involuntary institutionalization in a

mental hospital under the applicable District of Columbia statute. However, the Court of Appeals for the District of Columbia reversed the decision and held that there was a duty on the part of the trial court to explore alternatives to this deprivation of liberty and to satisfy itself that no less onerous disposition than involuntary confinement of the individual was available. The court also held that the individual cannot be required to carry the burden of showing the availability of alternatives. That burden rests on the state. In exploring alternative courses of treatment, Judge Bazelon stated that the trial court may consider, for example:

> whether the individual 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; 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. Every effort should be made to find a course of treatment which (the individual) might be willing to accept.[17]

No matter how much staffing, facilities, and treatment programs within the public mental hospitals are improved, the fact remains that involuntary institutionalization involves imposition of physical restrictions on the individual. The principle enunciated in Lake v. Cameron should be embodied in a statute as a basic treatment right of the individual; the right of a mentally ill person whose mental condition meets the criteria for involuntary hospitalization to demand that the state explore less restrictive alternatives to institutionalization that are acceptable to him.

The decision in Lake is certainly laudable. Yet, a feeling of satisfaction is premature. On remand, the trial court found that Mrs. Lake needed twenty-four hour supervision for her own safety and found that the only facility currently available to her affording that type of continuous supervision was a mental hospital.[18] While the trial court's inquiry into alternatives showed the need to establish a new type of facility to handle persons who have problems like Mrs. Lake, the court would not, and perhaps could not, order its creation.

Even if alternatives to institutionalization become more available, and even if courts become more willing to order their use instead of institutionalization, there are nevertheless certain dangers involved. Although the court's approach in Lake is designed to increase personal liberty for those individuals who might otherwise be involuntarily confined, a decrease of liberty might actually result from an improper use of such half-way measures. For example, where previously a court may have been unwilling to completely restrict personal liberty by ordering involuntary hospitalization, now that same court might be more willing to partially restrict personal liberty by requiring attendance at day-care programs. These problems are in need of further exploration. Perhaps the Mental Treatment Standards Committee may have a legitimate role to play in establishing minimum standards for voluntary patients, both inside and outside the institutional setting. Such efforts may enable the concept of "continuity of quality services" to become more than a mere lofty goal.

C. Special Treatment Measures for Dangerous Patients

The difficult problem presented by the dangerous or allegedly dangerous patient is worth specific mention at this point. During a psychotic episode when a patient acts in a manner that threatens serious bodily harm to himself, other patients, or staff, he must be restrained temporarily. There is no time to seek a court order authorizing such restraint. While I recognize this, I feel that statutory safeguards are necessary to prevent misuse or overuse of restraint or seclusion. I have proposed a statute to provide:

> Patients admitted to mental institutions shall have the right to be free from mechanical or physical restraint or seclusion. Restraint or seclusion shall not be used as punishment, nor shall patients be threatened with restraint or seclusion.
>
> When a patient acts in a manner that threatens serious bodily harm to himself, other patients, or staff of the institution, he may be temporarily restrained by ward personnel only until a physician can be immediately summoned. The physician shall determine and order the minimal restraint that is necessary to prevent the patient from committing the destructive acts. The decision to temporarily restrain a patient and a physician's decision to order restraint or seclusion shall be recorded on the patient's clinical record, together with an explanation justifying the decision. No physician's order for restraint or seclusion shall be for a period of time longer than twenty-four hours. Any subsequent necessity for restraint or

seclusion shall be determined by a physician after a personal examination of the patient while under restraint or seclusion. Subsequent orders for restraint or seclusion shall be recorded as above. The patient may contest the physician's decision to order or reorder restraint or seclusion.

The use of tranquilizing drugs has reduced the incidence of and need for physical restraints. However, there is a danger presented by the potential overuse of drugs to achieve the same result as physical restraint. The Mental Treatment Standards Committee may be the appropriate body to examine the use of tranquilizing drugs in the institutions and to establish guidelines as to their appropriate use.

On rare occasion, a patient's dangerous propensity to commit destructive acts cannot be adequately controlled by temporary use of tranquilizers, restraint, or seclusion. In any situation where a patient's alleged "dangerousness" or any other circumstance warrants a substantial restriction on either that patient's rights as a patient or restrictions on "typical" or "normal" treatment opportunities afforded other patients generally, judicial intervention is necessary to scrutinize the propriety of such deprivation.

The Mental Treatment Standards Committee should be empowered to establish guidelines on what constitutes a substantial restriction on treatment opportunities afforded patients generally. For example, mere placement of a patient in a locked ward may not, in

and of itself, constitute a substantial restriction on a patient's treatment opportunities. However, transfer to a locked ward for an indefinite length of time with a restriction on movement of the patient to occupational or other therapeutic programs, might constitute such restriction. If such a standard was established, the institution would be called upon to justify in a court hearing, a proposed placement of this restriction on any patient.

D. The Right to Decline Certain Treatments

Currently, a person involuntarily committed to a mental hospital is, by virtue of his status, considered subject to treatment. Dr. Jay Katz, the eminent Yale psychiatrist, recently wrote:

> "The right to treatment will sooner or later be tested in the courts with allegations that some forms of treatment are 'cruel,' inferior,' 'experimental,' 'unsuccessful' or that persons have not 'consented' to their administration. Surely it will be argued that a patient's right to treatment encompasses a right to select and reject certain kinds of treatment or, in the alternative, that a duty to be treated does not necessarily preclude his participation in the selection of treatment.
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> . . .In the context of a right or duty to be treated, the presently unrestricted option to impose any treatment, particularly experimental procedures, therapeutic techniques with uncertain predictive consequences, and treatments which aim for social control, can no longer be left to the sole discretion of the mental health profession."[19]

While as yet no definite answer can be given or even suggested as to the extent of the patient's right to refuse treatment or his duty to accept treatment, an attempt should be made to formulate some workable principles in this area. The

rules relating to the administration of treatment by non-mental hospitals are well settled. Except in emergency cases, before a physician administers treatment or performs an operation, he must obtain the consent of the patient, or if the patient is a minor, he must obtain the consent of the patient's parent or guardian. Absent in adjudication of incompetency of a mental patient, these rules should apply to him as well--at least as to those therapies that involve significant danger to the physical or mental well-being of the patient. I have proposed a statute to provide:

> Therapies or procedures involving any significant degree of danger to the physical or mental well-being of the patient and all surgery except those operations performed on an emergency basis to save life, limb, sight or hearing, shall require the written, voluntary, and informed consent of the patient prior to their administration or performance. If the patient is a minor or is mentally incapable of executing a valid consent, the written consent of the guardian of the patient shall be substituted for the consent of the patient. Additionally, therapies, procedures, or operations requiring consent shall be permitted only by order of the patient's physician and only when no less dangerous therapy can achieve the necessary and therapeutically desirable result. The decision to order such therapy, procedure, or operation shall be recorded on the patient's clinical record prior to its performance together with an explanation justifying

> the decision. Prior to its performance, the patient shall have the right and opportunity to contest the necessity to perform such therapy, procedure, or operation or the necessity to substitute another's judgment for his, or the validity of the written consent obtained from him.

Lobotomy and other psychosurgery, aversive conditioning therapies, and clinical investigations, research, experimentation or testing of any kind seem to be obvious examples of procedures involving a significant degree of danger to the physical or mental well-being of mental patients. Occupational therapy, recreational therapy, group therapy and other psychotherapies do not seem to involve such risks. Electro-convulsive therapy involves certain dangers, although the risk of injury has been reduced in recent years.[20] The Mental Treatment Standards Committee is the appropriate body to examine these and other therapies and to determine which therapies involve the degree of danger necessary to invoke the requirement of consent.

Two other issues involving the patient's right to decline treatment should also be mentioned. A statute similar to the following Missouri statute should be considered in Michigan: "Admission of a patient does not authorize any form of compulsory medical treatment of any person who is being treated by prayer in the practice of the religion of any church which teaches reliance on spiritual means alone for healing."[21]

The right of a mental patient to be treated by the physician he had been seeing prior to institutionalization is in need of further study. If it can be accomplished without undue administrative burden, the use of outside physicians to treat patients within the institutions seems to be a desirable goal that should be encouraged.

E. The Chronic Patient--The Imposition of a Time Limit to Treatment

In discussing existing treatment within Pennsylvania mental hospitals, Senator Reibman, a sponsor of the Right to Treatment bill in that state, wrote:

> In reality, a choice is made as to who should not receive care. The members of the profession would rather use the words selection and priority, but what it all boils down to is that the choice is made not to treat these large numbers of chronically ill patients in the mental institutions in this State.[22]

It is well-known that a mental patient receives a more intensive treatment program upon initial admission to a mental hospital than after he has remained for a time and been assigned to a "continued treatment" ward. There are significantly fewer patients per physician in admissions wards than in continued treatment wards. The problem is not one of willful withholding of treatment to patients who have been institutionalized for a time, but rather, the problem of allocating inadequate numbers of treating personnel where they will do the most good. But if the goal of treatment remains the same (rehabilitation of the individual to the extent that he is able to function adequately outside the Institution), a patient's need for treatment opportunities does not necessarily decrease with a continuing increase in length of stay.

Pursuant to the legislation I have proposed, the Mental Treatment Standards Committee should establish minimum standards to be utilized in admissions or intensive care units. It would be unrealistic for me to propose that continued treatment wards be expected to meet those standards. However, it is undesirable to propose the establishment of "lesser-than-minimum-standards" that would satisfy the treatment requirement for continued treatment wards. I feel that the proper approach is as follows:

1. A patient should be retained in an intensive care ward that meets the minimum treatment standards established by the Mental Treatment Standards Committee until he can be released to the community as sufficiently rehabilitated, or until he has received the maximum benefit from such treatment. A patient should be permitted to allege that he has received the maximum benefit from treatment.

2. Continued confinement of the individual after he has received the maximum benefit from treatment can not be justified on a "need for treatment" basis.

3. If a patient is to be retained thereafter, some other basis to justify the commitment must be utilized. A new hearing with the requisite procedural safeguards should be held at this time. An appropriate placement in a new institutional setup or release should be ordered accordingly.

For example, indefinite commitment of individuals with sociopathic personalities who have not responded to mental hospital treatment can be justified only as preventive detention. If the

real basis for the commitment is alleged dangerous to society and not "need for treatment," and if this justification is legally sufficient and socially desirable, the individual should be accorded a trial with stringent criminal process safeguards. Accuracy of the prediction of dangerousness should be required. If committed, the individual should be placed in a detention facility, not a hospital. Similarly, if there is justification for retaining chronic schizophrenics because of their inability to care for themselves, a new hearing should be required to establish this, and placement should be in an extended care facility, not a hospital.[23]

IV. Conclusion

No discussion of the Right to Treatment would be complete, at this point of time, without some mention of the case of Wyatt v. Stickney.[24] The article by Birnbaum in 1960, the opinion of Bazelon in the Rouse case in 1966, and the order of United States District Court Judge Frank M. Johnson in Wyatt issued in the spring of 1972 are the three significant landmarks of the emerging right to treatment. And Judge Johnson's order may be the most consequential of the three.

Originally, the Wyatt case involved a lawsuit brought on behalf of all the patients at one of Alabama's mental hospitals--a class action alleging inadequate treatment.[25] In March 1971, Judge Johnson determined that the programs of treatment in use at the hospital were scientifically and medically inadequate and deprived patients of their constitutional rights. The court

ordered the defendants to prepare a specific plan whereby appropriate and adequate treatment would be provided to the patients of the hospital. Thus, the court accepted the class action approach to the right to treatment, and announced a constitutional basis for the right.

Subsequently, the class of plaintiffs was enlarged to include all involuntarily confined mentally ill and mentally retarded individuals in the State of Alabama.[26]

After reviewing the standards proposed by the parties to the case and by amici, Judge Johnson issued a decree establishing and ordering the implementation of standards which he felt to be medical and constitutional minimums.[27] He commended those who had submitted briefs amicus curiae, including the American Orthopsychiatric Association, the American Psychological Association, the American Civil Liberties Union, and the American Association on Mental Deficiency.[28] It is obvious that these groups supplied the expertise necessary for the court to formulate the standards that were ultimately adopted.

The standards ordered by Judge Johnson encompass most aspects of patient life. He issued thirty-five standards for the mentally ill designed to establish a humane psychological and physical environment, to provide qualified staff in numbers sufficient to administer adequate treatment, and to ensure individualized treatment plans. He also issued forty-nine standards for the mentally retarded designed to provide for adequate habilitation of residents.

Most of the standards are not mere generalizations of desired goals, but, quite the contrary, are specific as to their requirements. For example:

"The number of patients in a multi-patient room shall not exceed six persons. There shall be allocated a minimum of 80 square feet of floor space per patient in a multi-patient room. Screens or curtains shall be provided to ensure privacy within the resident unit. Single rooms shall have a minimum of 100 square feet of floor space. Each patient will be furnished with a comfortable bed with adequate changes of linen, a closet or locker for his personal belongings, a chair, and a bedside table."[29]

The following staffing ratios per 250 mental patients were ordered:

Classification	No. of Employees
Unit Director	1
Psychiatrist (3 years' residency training in psychiatry)	2
MD (Registered physicians)	4
Nurses (RN)	12
Licensed Practical Nurses	6
Aide III	6
Aide II	16
Aide I	70
Hospital Orderly	10
Clerk Stenographer II	3
Clerk Typist II	3
Unit Administrator	1
Administrative Clerk	1
Psychologist (Ph.D.) (doctoral degree from accredited program)	1
Psychologist (M.A.)	1
Psychologist (B.S.)	2
Social Worker (MSW) (from accredited program)	1
Social Worker (B.A.)	5
Patient Activity Therapist (M.S.)	1
Patient Activity Aide	10
Mental Health Technician	10

Classification (cont'd.)	No. of Employees	
Dental Hygienist	1	
Chaplain	.5	
Vocational Rehabilitation Counselor	1	
Volunteer Services Worker	1	
Mental Health Field Representative	1	
Dietitian	1	
Food Service Supervisor	1	
Cook II	2	
Cook I	1	
Food Service Worker	15	
Vehicle Driver	1	
Housekeeper	10	
Messenger	1	
Maintenance Repairman	2	30

And let me reiterate, the 84 standards ordered by Judge Johnson were stated to be medical and constitutional minimums. The judge also ruled "that the unavailability of neither funds, nor staff and facilities, will justify a default by defendants in the provision of suitable treatment for the mentally ill."[31]

The court retained jurisdiction of the case and did not rule out the possibility of affirmative action, including appointment of a master and professional advisory committee to oversee the implementation of the court-ordered standards if the state did not fulfill its court-ordered treatment obligations.[32]

Judge Johnson did more than merely recognize a constitutional right to treatment; he did more than say that adequate treatment standards will be developed by a panel of experts; he went the extra step and actually announced the standards for adequate treatment. He indicated that courts, at least his court, are not unwilling to establish the specific parameters of the right to treatment and to fashion whatever remedies are necessary to

ensure compliance with the standards. And whether legislatures or other courts agree with the specific standards he laid down, at least in the future they will be discussing those standards and modifications of those standards, rather than merely focusing on the issues of whether a right to treatment exists in the abstract, and whether adequacy of treatment is a meaningful term. For this giant step, I salute Judge Johnson.

In concluding, let me give you my appraisal of where we now stand in the development of the right to treatment. The situation is analogous to the D-Day invasion of June 6, 1944. The decision of Judge Johnson in the Wyatt case established a firm beachhead. And in the words of Sir Winston Churchill, reviewing the events on Normandy Beach on that historic day:

> "This is not the end;
> this is not the beginning of the end;
> this is the end of the beginning."

APPENDIX A

PROPOSED RIGHT TO TREATMENT LAW

Section 1. Short Title. -- This act shall be known and may be cited as the "Right to Treatment Law of 1972."

Section 2. Establishment of Mental Treatment Standards Committee.

(a) A committee shall be appointed by the Governor within ninety days after the effective date of this act which shall be known as the Mental Treatment Standards Committee.

(b) The Mental Treatment Standards Committee shall be composed of seven members as follows:

(1) A licensed non-administrator psychiatrist who is a member of the American Psychiatric Association;

(2) A licensed physician who is not a psychiatrist and who is a member of the American Medical Association;

(3) A psychiatric social worker who is a member of the Committee of Psychiatry of the National Association of Social Workers and who has had at least five years experience in institutional psychiatric social work;

(4) A clinical psychologist holding a Ph.D. and who is a member of the Clinical Psychologists of the American Psychological Association;

(5) A licensed psychiatrist who is a member of the National Association of Medical Superintendents of Mental Hospitals and who has had a least five years of experience as a mental institution administrator;

(6) A registered professional nurse who is a member of the Psychiatric and Mental Health Division of the American Nurses Association; and

(7) The Director of Mental Health.

(c) The Director of Mental Health shall serve on the committee in an advisory capacity only and shall have no vote in the adoption of minimum mental treatment standards. He shall obtain and make available to the committee any data, statistics and information relating but not limited to State mental institutions, personnel and patients that the committee requests in the course of its research and preparation of minimum standards.

(d) The Governor shall request the presiding officer of each of the appropriate professional associations named above to recommend to him the names of three persons who would be willing to accept appointment and the Governor shall appoint each member from the three names recommended to him by these associations.

(e) The committee members shall be appointed for six year terms except that the first appointed members shall serve staggered terms.

(f) No member shall be appointed who was employed or retained by the State of Michigan or any of its subdivisions or any agency thereof at any time during the three year period immediately preceding appointment, nor may any member be so employed or retained while he is a member of the committee, nor for five years thereafter: Provided, however, that these

restrictions shall not apply to the psychiatrist who is a member of the National Association of Superintendents of Mental Hospitals.

Section 3. Preparation and Adoption of Minimum Standards.--

(a) The Mental Treatment Standards Committee shall prepare and adopt a "Manual of Minimum Standards for Treatment of Mentally Ill Patients in State Mental Institutions," which shall, in the opinion of the committee, be acceptable to the professional associations named in Section 2 and represented by the members of the committee. "Treatment" is defined as those forms of therapy from which a patient can gain sufficient benefit to substantially aid in his adjustment for his return to society, in the reasonable belief of a psychiatrist. Custodial care shall not constitute treatment within the meaning of the act.

(b) These standards shall be prepared and adopted in accordance with the definition of "treatment" and shall specifically include, but not be limited to the following matters:

(1) The number of professional and non-professional staff, whose responsibilities are directly related to patient population, including the maximum number of patients for each psychiatrist, physician, clinical psychologist, social worker, industrial therapist, nurse and attendant or aide;

(2) The required minimum qualifications for each professional and non-professional staff position, referred to in clause (1) of subsection (b) of Section 3, including

degrees, licensure, certification, apprenticeship, and experience;

(3) The minimum number of individual consultations each patient shall have with a psychiatrist and other appropriate professional personnel and the minimum number of hours of such individual consultations each patient shall have in each thirty day period;

(4) The frequency and extent of general physical examinations, and,

(5) Requirements for maintenance of the individualized treatment plans for each patient which shall include but not be limited to: (i) the initial diagnosis, (ii) the manner in which the facilities and programs of the particular institution can improve the patient's condition, (iii) the treatment goals, and (iv) the treatment regimen that is planned to accomplish these goals, subject to the limitation provided in subsection (e) of Section (3).

(c) Individualized treatment plans shall be periodically reviewed and updated at no greater interval than every three months.

(d) The minimum standards for numbers and qualifications of staff and number of individual consultations shall be no lower than the standards established by the American Psychiatric Association; and they shall also include requirements that all psychiatrists and medical practitioners must have the qualifications that are required to obtain Michigan licensing for private practice.

(e) The committee shall not include in its standards any requirements relating to selection and conduct by individual psychiatrists, physicians or clinical psychologists of their treatment methods or procedures, nor the judgment, skill or care used by these practitioners. The standards promulgated by the committee shall be expressed in objective terms so far as possible in order to minimize the necessity for subjective evaluation of departmental and institutional compliance, in judicial review.

(f) The committee shall present to the Governor within six months after its appointment the completed "Manual of Minimum Standards for Treatment of Mentally Ill Patients in State Mental Institutions" and the minimum standards as promulgated by the committee and set forth in such manual shall be the minimum standards of treatment for all patients confined in State mental institutions in Michigan, beginning one year after such presentation, and such manual shall be a public document.

(g) The Governor shall immediately upon receipt of said manual from the committee furnish to the Director of Mental Health and the Superintendent of each State mental institution copies of the manual and shall allocate sufficient resources necessary for the State mental institutions to be able to provide at least the minimum staffing standards;

(h) The Department of Mental Health shall make studies to determine the additional personnel necessary to meet the requirements of this act. A report shall be prepared and

be presented to the Legislature within one year from the effective date of this act, giving cost and other appropriate data.

(i) The Mental Treatment Standards Committee shall periodically review the minimum treatment standards manual and shall make such changes as it decides are necessary. Once every two years the committee shall submit to the Governor a list of all such changes, and these changes shall become amendments to the "Minimum Standards." The manual shall be amended accordingly, the Governor shall forthwith furnish copies to the Director of Mental Health and the Superintendent of each State mental institution. Such amendments shall become effective and patients' legal rights to such amended minimum standards of treatment shall vest within three months after the committee has forwarded the amendments to the Governor.

Section 4. Patients' Legal Right to Minimum Standards of Treatment.

(a) Beginning one year after the presentation of the manual to the Governor, every person who is then or at any time thereafter confined, voluntarily or involuntarily, in a State mental institution, shall have the legal right to receive at all times while so confined at least minimum treatment as herein defined.

(b) The decisions of the Mental Treatment Standards Committee reflected in the standards adopted in the manual are subject to judicial review in the same manner as are rules of other administrative agencies.

(c) The right to minimum standards of treatment provided by this act shall not include the right to have reviewed the judgment, skill or care used by individual psychiatrists, physicians or clinical psychologists. Any such rights and remedies existing by common law or other statutes shall not be hereby impaired.

FOOTNOTES

1. M. Birnbaum, The Right to Treatment, 46 A.B.A.J. 499 (1960).

2. 373 F.2d 451 (D.C. Cir. 1966).

3. Bazelon, Rights of Mental Patients to Treatment and Remuneration for Institutional Work--Prior Court Decisions and Legislation, PA. BAR ASSN. Q. 534, 544 (June 1968); Note, Civil Restraint, Mental Illness and the Right to Treatment, 77 YALE L.J. 87, 97-104 (1967).

4. Council of the American Psychiatric Association, Position Statement on the Question of Adequacy of Treatment, 123 AM. J. PSYCHIATRY 1458 (1967).

5. Tribby v. Cameron, 379 F.2d 104 (D.C. Cir. 1967).

6. Dobson v. Cameron, 383 F.2d 519 (D.C. Cir. 1967).

7. See P. Marschall, A Critique of the "Right to Treatment" Approach, 37 at 49-51 in G. MORRIS, ed., THE MENTALLY ILL AND THE RIGHT TO TREATMENT (1970) for a discussion of these three cases.

8. J. Drake, Enforcing the Right to Treatment: Wyatt v. Stickney, 10 Am. Crim. L. Rev. 587, 595 (1972).

9. Bazelon, supra note 3, at 544.

10. My proposal is reprinted as Appendix A.

11. Senate Bill No. 816, General Assembly of Pennsylvania, 1969 Session.

12. Zitrin, Herman, and Kumasaka, New York's Mental Hygiene Law--A Preliminary Evaluation, 54 MENTAL HYGIENE 28, 31 (Jan. 1970).

13. Kumasaka, Process of Involuntary Hospitalization 5 (unpublished manuscript 1970).

14. Zitrin, Herman, and Kumasaka, supra note 25, at 33-34; Rozensweig, Compulsory Hospitalization of the Mentally Ill, 61 AM. J. PUBLIC HEALTH 121, 123-34 (Jan. 1971); Gupta, Mental Health Information Service: An Experiment in Due Process 5 (unpublished manuscript).

15. Chayet, Legal Neglect of the Mentally Ill, 125 AM. J. PSYCHIATRY 785, 790 (1968).

16. 364 F.2d 657 (D.C. Cir. 1966), cert. denied, 382 U.S. 863 (1966).

FOOTNOTES (cont'd.)

17. Id. at 661.

18. Lake v. Cameron, 267 F. Supp. 155 (D.D.C. 1967).

19. Katz, The Right to Treatment--An Enchanting Legal Fiction, in THE MENTALLY ILL AND THE RIGHT TO TREATMENT (Morris, ed.) 27, 30 (1970).

20. Persons temporarily detained pursuant to Mich. Comp. Laws §330.19, Mich. Stat. Ann. §14.809 may receive "medical or psychiatric treatment excluding shock treatment." This appears to be at least some statutory recognition of the danger involved in shock therapy.

21. Missouri Revised Statutes, Section 202.807(7) (1969).

22. Reibman, Rights of Mental Patients to Treatment and Remuneration for Institutional Work--Pending Mental Health Legislation, PA. BAR ASSN. Q. 538, 539 (June 1968).

23. I do not at this time express any opinion as to whether these non-treatment confinement arrangements are legal or desirable.

24. 344 F. Supp. 373; 344 F. Supp. 387 (M.D. Ala. 1972).

25. Wyatt v. Stickney, 325 F. Supp. 781 (M.D. Ala. 1971).

26. Wyatt v. Stickney, 334 F. Supp. 1341 (M.D. Ala. 1971).

27. Wyatt v. Stickney, 344 F. Supp. 373; 344 F. Supp. 387 (M.D. Ala. 1972).

28. Id. at 375, n. 3.

29. Id. at 381-82.

30. Id. at 377.

31. Id. at 377.

32. Id. at 378.