

## Editorial: "Beleagued"

JONAS R. RAPPEPORT, M.D.

In recent years we have seen a great wave of concern in our society for the rights of all individuals. None of us would argue against this concern, but to many of us in the mental health professions this human rights movement has brought new problems and responsibilities.

Whenever mental health professionals get together these days, the conversation is bound to include mention of patients' rights. Almost every issue of the APA News contains an article about a court decision, a new law suit, or a discussion of a legal issue. We are so inundated with concerns for patients' rights that we may look upon ourselves as the beleaguered mental health professions, or, to create a neologism, the "beleagued" mental health professions.

In 1966 the *Rouse* decision in the District of Columbia recognized a patient's right to treatment.<sup>1</sup> Other decisions followed, including, prominently, the *Wyatt* decision in 1971 on the right to treatment,<sup>2</sup> the *O'Connor v. Donaldson* decision in the Supreme Court in June, 1975, with reference to involuntary commitment and treatment,<sup>3</sup> *Dixon v. Weinberger* on the least restrictive alternative,<sup>4</sup> *Lessard v. Schmidt* on commitment,<sup>5</sup> and *Bartley v. Kremens* on the commitment of minors.<sup>6</sup> And these are but a few. I'm sure that many of you are familiar with these decisions and have been involved with their implications in one way or another.

What hath all of this litigation wrought? In 1977 a mental health professional's *dossier* should list, besides his publications, the number of times he has been named in a human rights suit. Today one must be sure that he has his own malpractice insurance, whether or not his employers say they will cover him. Today one must be sure he has read the latest court decision before he talks to a patient. Today it is more important to be sure that one's pen has ink in it than to be sure that the pharmacy has enough phenothiazines or the ECT machine is calibrated. Today, one must warn the patient, and possibly scare him before ministering to him. Today, one must spend one-fourth to one-third of his time meeting paper requirements or attending hearings rather than treating patients. Today, we psychiatrists must discharge patients before we believe they are ready to leave, often only to re-admit them a few weeks later. Today, in some jurisdictions we may not be able to treat a disturbed patient if he refuses treatment until he has had his hearing or we get a court order. Yes, we are truly "beleagued."

Is all of this responsibility undesirable? Undoubtedly some of it is, certainly for those myopic souls who resist *any* change. For most of us, however, it is painful but challenging. Can these changes really improve the care our patients receive? I believe that in some ways they can and already

have. Patients, when able, are now participating more actively in their treatment — a maturing experience. Families have been forced to accept more responsibility for their relatives and not to use the hospital or community mental health center as a dumping ground. Many patients who can manage adequately outside of hospitals have left; we are no longer jailers. The responsibility is the courts', not ours. In some understaffed facilities, at least the patient is seen once a month when his individual treatment plan is reviewed. Patients may use the phone and are thus less isolated. In many circumstances additional funds have been forthcoming and services have improved.

In the *Wyatt* decision, Judge Frank Johnson stated that Alabama's treatment programs were deficient in three fundamental areas. The programs failed to provide "a humane psychological and physical environment, qualified staff in numbers sufficient to administer adequate treatment and individual treatment plans."<sup>7</sup> He then ordered the state to establish rigid treatment plans, staffing ratios, specific housing conditions, human rights committees in the hospitals, etc. The state authorities responded. First, they discharged a large number of patients, returning them to communities which lacked adequate facilities. They attempted to hire staff, and they have succeeded in hiring a few. They increased the budget of the hospital, but not nearly as much as Judge Johnson wanted. Judge Johnson's routines were established — his paper work and his due process. Alabama's hospitals were "beleagued."

What has happened as a result of the right to treatment movement in other states? Some states have agreed that their services were inadequate and have participated in consent agreements, even agreeing to do what they cannot possibly do. New York, in the Willowbrook case, is a good example.<sup>8</sup> Some states took action before suits were filed, establishing individual treatment plans, enlarging patients' personal rights and increasing treatment services. So some good was accomplished for many patients.

The right to refuse treatment, which, in a sense, develops from the right to treatment, has been a very thorny problem for which, as yet, there is no easy solution. The APA Task Force on the Right to Treatment made some suggestions but recognized the need for further study. Patients should have a right to refuse treatment *if they are competent to make such decisions*. Unfortunately, in mental illness the decision-making mechanism, the ego, the mind, is not in control, and the psychotic individual does not have a free will out of which to make decisions. The general medical patient refuses treatment, and if competent, he is discharged from the hospital. With the committed patient we may not always do this. Even with a voluntary patient our humanitarianism will not always allow us to do this. Thus we are caught on the horns of a dilemma. Perhaps we are too humanitarian and too paternalistic. We need to think about the possible advantages of discharging the refusing patient. Might not then his family accept their responsibility and somehow get him to accept treatment? Might not the community decide to establish some standard of competency which will not harm the patient, delay his treatment, or require so much of our time at hearings that the patient suffers more? Might not he, after some further suffering, decide to accept help? These are new problems, both for law and for mental health,

requiring a totally new approach. We must devote our efforts to trying to resolve the issue in a manner which will be acceptable, both to the law and to ourselves, and which will still benefit the patient.

Is the least restrictive alternative a true alternative if the patient is not better off within it? He may be better off in terms of freedom, but he may be worse off in the quality of the life he lives within this freedom. While community facilities can handle a large majority of the mentally ill, they are still inadequate in numbers and quality.

While my association with the law has left me with tremendous respect for it, I have come to realize that there are many reasons why the statue of justice wears a blindfold. I have also come to realize that truly satisfactory communication and mutual understanding between law and medicine may never be possible. I find myself constantly reevaluating, reconsidering and, at times, altering my position. I have seen many developments which I recognize as good, right, proper and helpful. Yet I have seen many other developments that I realize may not be so good; they may, in fact, create more problems than benefits and may cause increased suffering for us if not for our patients.

Courts stress the concept of liberty and freedom and have a great deal of difficulty in recognizing illness, particularly when an individual does not appear bizarre. The law tends to look at things in a different way from ours and is more willing to take an individual at face value. This places upon us the burden of learning how to communicate our ideas and concepts to the court, learning to organize our information in an orderly, concise, appropriate fashion and to present this information clearly. It means not relying on the lazy man's technique of using conclusory terms, such as "psychosis" or "depression", but clearly indicating to the court what is wrong with this individual's thinking and why in this particular case the least restrictive alternative is a hospital.

Darrel Treffert speaks of "patients dying with their rights on."<sup>9</sup> Yet we have suicides in our hospitals. Dangerousness is the key factor. When the concept of dangerousness was in our hands we had no problem. However, when the law interprets dangerousness we have trouble. Fortunately, in time and with experience, judges and hearing officers are developing clinical judgment. One of our jobs is to furnish them and ourselves with follow-up. Let them know when they were right and when they were wrong; judges ordinarily receive even less follow-up than we do. Even though we cannot confidently predict that someone is likely to commit a dangerous act in the distant future, certainly we can say whether a person has homicidal or suicidal tendencies *now* or cannot *now* adequately care for himself, and we can demonstrate our judgment by describing his behavior. Freedom and liberty are cherished rights, but the courts don't want people to suffer any more than we do.

If we really look at the basic problem it is the bottom line — it is money. The human rights movement has failed in this respect. While funding has increased somewhat, much of the new money has been used for hearing officers, trials, lawyers, public defenders, individual treatment plans, and other paper procedures.

Our forefathers declared their independence. I am not proposing that we

declare our independence from the law, because I think the law is both friend and foe. I am suggesting, however, that we declare a type of independence from the law, that we declare our individuality, that we declare the rationality of our treatment programs and the rationality of our need to commit some patients to hospitals, that we demand that commitment laws fit the needs of patients, not abstract concepts, and that we demand our right to treat patients in the best possible facilities and in the best manner according to our professional judgment without costly and wasteful legal trappings.

The challenge is for us to learn to speak clearly and loudly – to explain understandably what we know, what we can do and how we can best do it, and most importantly, what resources we need. Perhaps then we will no longer be “belegaled.”

### References

1. *Rouse v. Cameron*, 373 F. 2d 451 (D. C. Cir. 1966)
2. *Wyatt v. Stickney*, 325 F. Supp. 781 (M. D. Ala. 1971)
3. *O'Connor v. Donaldson*, 422 U. S. 563 (1975)
4. *Dixon v. Weinberger*, 405 F. Supp. 974
5. *Lessard v. Schmidt*, 349 F. Supp. 1078 (E. D. Wis. 1972)
6. *Bartley v. Kremens*, 402 F. Supp. 1039
7. *Op. cit.*, n. 2
8. *New York State Association for Retarded Children v. Carey*, 393 F. Supp. 715 (E. D. N. Y. 1975)
9. Treffert DA: Dying with your rights on. Presented at 127th Annual Meeting of the American Psychiatric Assn., Detroit, May 6-10, 1974