Impact of *Davis v. Watkins* on Ohio Forensic Hospital Practice

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The writer has for the past year been carrying out consultation at certain of Ohio's mental health facilities in consequence of an Affiliation Agreement between the Ohio Department of Mental Health and the Department of Psychiatry of Wright State University. One of these facilities, Lima State Hospital (LSH), the state's single forensic hospital, has been the object of civil rights litigation. Events there are absorbing and have profound implications not only for forensic but indeed for all of psychiatric practice. These events need reporting. Some of them are taken up in this paper with an attempt to analyze the consequences of the legal impact upon clinical practice and psychiatric professionalism.

Davis v. Watkins

The state in the course of its defense in this case, *Davis v. Watkins*, stipulated agreement in principle to the right-to-treatment issue. After joint motions by both the plaintiffs and defendants on relatively broad areas of stipulated agreement, a partial summary judgment was made in an Interim Order issued in September, 1974.[1] In this order the Judge of the Federal District Court of Northern Ohio imposed *Wyatt*-type standards[2] by specific reference and quotation and went on to spell out further particulars in great detail. The legal standards of *Wyatt* were now applied to a forensic hospital. Moreover, the Judge appointed a Special Master for on-going surveillance of compliance.

Left after the stipulated agreement were a group of disputed complaints now referred to as "the twenty-three litigated issues." The content of this group of issues will be examined later. In the meantime, matters for the State took a grave turn when the Judge issued in January, 1977, a civil contempt citation against the hospital for non-compliance. The citation credited general good faith and cooperative effort on the part of the state, and no sanctions were actually imposed. But the threat for continued non-compliance specified in the contempt order is a fine of $100 per day per issue per patient. Given the obvious difficulties in achieving compliance, the potential of large fines is perceived as great, but what strikes special fear in the hearts of state officials is the realization that fines could be assessed against any one of them, personally.

One fortuitous event occurred early this year. Lima State Hospital regained JCAH accreditation. Hope was kindled briefly that this achievement

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would enable the state to end involvement of the Court in LSH operations. That hope faded very quickly with the realization that the potential impact of accreditation on the litigation is moot and might conceivably have a paradoxically negative effect on the State case. As is well known, JCAH accreditation notices pursue ideal levels of service delivery and always contain a lengthy list of critical commentaries under the rubric of "Recommendations." In the case of LSH there are (by no means unusually) five pages of "Recommendations" – three pages of items of "substantial compliance," most of two pages of "partial compliance," and only one relatively minor item of "non-compliance" – in all, a favorable report. In the adversary process, however, the intentionally critical "Recommendations" lend themselves too readily by distortion or exploitation to become an indictment of the hospital program through the accreditation statement itself. Furthermore, it may be argued that JCAH Accreditation Standards do not address themselves basically to the right-to-treatment issue.

At the present time, therefore, the Interim Order, Contempt Citation, and compliance surveillance by the Court Master all continue along with the "twenty-three litigated issues," with no clear end in sight.

It should be added parenthetically that there is another continuing area of litigation in the *Davis v. Watkins* case. The plaintiffs in the original complaints had raised the issue of the constitutionality of various Ohio commitment statutes. By the rules of the Federal District Court then pertaining, this part of the action required hearing and ruling by a three-judge panel. For one reason or another this aspect of the litigation has remained in abeyance to this time. Action on the single-judge issues, which have been summarized above, has waxed and waned over the past five years, evidently according to the limits of available resources and energies of all parties involved. In the meantime the state made moves – by administrative changes and by legislating statutory changes – which have been intended to reduce or erase substantively the three-judge issues. There is some indication at this time that this part of the *Davis* action may be moving toward resolution soon on the basis that pragmatically and currently the issues no longer exist.

The standards of the *Wyatt* decision have been summarized as covering three broad areas: "humane physical and psychological environments, improved quality and quantity of staff, and individualized treatment plans for all residents."[3] And the standards set for the hospital by *Davis* have been summarized as "written in great detail, covering specific requirements on a wide range of issues, such as privacy in bathrooms, the provision of staff on various work shifts, the use of seclusion, the nature of educational and recreational programs, standards for record keeping, and procedures."[4] But these summaries don't catch the flavor of the experience and its impact on those clinical professionals and administrators whose job it was or is, during the adversary proceedings, to respond to the searching inquiries into all areas of practice, or to carry on day-to-day implementation of the resulting Court orders.

Consider the sweep of the searching legal inquiry in these examples taken from "the twenty-three litigated issues":

Whether patient self-government in considering recommendations to staff of deprivation of privileges for certain patients should allow the accused patient the due process right to call, confront, cross-examine accusers or other witnesses, or whether recommending punishment deprives the affected patient of the right to treatment.

Whether patients have a constitutional right to prior consent to the administration of medication, or to participation in other treatment modalities.

Whether patients have a right to legal representation at "Staffings."

Whether mail privileges can be limited regardless of the interests of security.

Whether the use of intelligence testing is discriminatory and violates constitutional rights.

Whether literacy tests in assessment of educational and vocational programs meet constitutional standards.

These examples are not meant to be deprecated, much less held up to ridicule. They are also not meant to, and do not necessarily, portray the central and serious issues of the right to treatment under incarceration. Most mental health professionals are humanists and civil libertarians who have themselves been appalled by the conditions in the institutions under question. All mental health professionals have to bear individual and collective responsibility for ever having allowed such conditions to develop or to continue unabated. Many of the issues posited above may be in fact knocked down in the adversary process. The Court, it is hoped, will have no difficulty in understanding that the clinical process of treatment is something different from the legal process. What is meant to be conveyed here is the experience of having to justify everything from the bottom up, with nothing being taken for granted. In many matters, sometimes crucial matters, it's a case of "back to the drawing board" for the professional clinician. For many professionals, if they stick with the institutions to practice under the newly imposed legal standards, the psychological experience may be new and strange as they become unsure, frustrated, and overcome finally by the sense of powerlessness.

It was ten years ago that the Cleveland *Plain Dealer,* one of the state's major newspapers, undertook an exposé of the conditions at LSH. Over these years have appeared frequent articles characterizing LSH as a "pest hole" and alleging brutality in treatment of patients. Early in this decade such allegations began to be referred to a Grand Jury, which eventually indicted thirty-one attendants on charges involving physical and in some cases even sexual abuse of patients. Only one case came to trial. Upon evidence, the judge in that case directed the jury to acquit the attendant of the charges. There were no further trials. Eventually the matter ended when the charged attendants, whose number was finally reduced to twenty-four,

elected to plead guilty to reduced charges of misdemeanors and accepted probation. In the course of civil service processes, however, all who wished to return to their jobs were allowed to do so provided they went through some training and a period of probation. Some are still on the current attendant staff, and it is fair to say that some have become effective, even highly effective, in their positions. But it is also fair to say that the acrimonies engendered by the charges and indictments are a persisting legacy, not effaced by time or improvement in performance by some attendants.

About the time of the indictments of the attendants, individual cases of patient complaints were coming to the attention of the U.S. District Court on petitions of *habeas corpus.* Assignment of legal assistance gravitated to one particular lawyer in Toledo. When the number of such cases increased beyond the capacity of the one lawyer acting in private capacity to represent the growing number of plaintiffs, the Judge of the Federal District Court called upon a group of lawyers calling themselves "Advocates for Basic Legal Equality" (A.B.L.E.), who were involved in various public law litigation. This group at first collaborated with the private attorney but later took over advocacy for the plaintiffs when the class action strategy was developed. *Davis v. Watkins* was the resulting litigation, with the Civil Rights Division of the Justice Department joining the action with an *amicus curiae* brief in support of the plaintiffs.

The Impact of the Court Order

The Federal Court decision, coming upon the series of events which had convulsed the Lima institution and left it reeling from internal and external problems, and requiring sweeping changes, in and of itself had an unsettling effect. The boat was being rocked in a new way. One of the endemic factors which helps make LSH the kind of institution it is, rather than the ideal someone or some group wants it to be, is the very real potential for explosive catastrophe at any time, any day, every day. At times, following the decision, the day-to-day survival of the institution was in question. Gradually the administration and staff began to surmount the difficulties and to gain a measure of control. First a new Superintendent and later a new Medical Director provided the strength, capability, and leadership which have succeeded in achieving a fair degree of stability. At least continuity of the institution can be reliably expected. Yet this accomplishment, which is from one perspective very real and deserving of high commendation, counts for naught when selected specifics of single cases are argued.

One of the most important products of *Wyatt* is the articulation of the concept of the Qualified Mental Health Professional, the "QMHP" as it very soon became in practice parlance.* By this judicial act Judge Johnson "licensed" members of a group of different mental health disciplines with responsibility in common for implementing programs providing treatment according to legal standards, and in some respects he created a peer relationship between members of different mental health disciplines – psychiatry, clinical psychology, psychiatric nursing, and psychiatric social

*At LSH the term has been given a vocalization 'QiMHP" to become a generic term pronounced "Quimp." We are told that this word is a take-over from usage at Bryce Hospital.

work. Organized psychiatry, the American Psychiatric Association, erred profoundly in its early stand on the right to treatment issue and most specifically in its failure to respond to the *Wyatt* case with an *amicus curiae* brief. Dr. Alan Stone picks up on this error in his excellent article, "Overview: The Right to Treatment," in which he quotes from *Wyatt*, Standard 24, that "qualified mental health professionals trained in particular disciplines may in appropriate situations perform services or functions traditionally performed by members of other disciplines."[5] Some critics hold that Judge Johnson created instant, homogenized professional responsibility, and by so doing lowered standards of professional qualifications. Some pragmatists consider that he provided a practical solution to the problem of inadequate psychiatric staff.

At LSH by court order the QMHP concept has been applied with a few modifications. By administrative determination no nurses of the hospital staff have qualified to meet the criteria for Nurse-QMHP. Whether Ph.D. level psychologists solely or also licensed psychologists at the Master's degree level qualify as QMHP is a litigated issue.

The medical staff feels undercut, perhaps emasculated. At this time there are ten full-time equivalent M.D.'s on the medical staff, among whom are six fully trained and experienced psychiatrists, five of whom are board-eligible but none board-certified, plus two who are partially trained and well experienced in psychiatry; the rest are non-psychiatric physicians. Six of the M.D.'s are considered to qualify as staff QMHP's. Admissions with full psychiatric and physical examination, medical orders, and discharges are exclusively medical responsibilities carried out only by physicians. But the unit or ward and activity programs are the province of multidisciplinary teams consisting of QMHP's and other professional and non-professional staff. Only one physician is a leader of a unit team. For the most part the physicians feel that their ability to influence the therapy provided by the teams is severely limited. Psychiatrists provide evaluations for the courts, of course, but such evaluation may be and is, at times, done by non-medical QMHP's. Occasionally, on a given patient's case, a team QMHP may render to the court an evaluation which is at variance from that of the psychiatrist, who has persistent medical responsibility but may not be a member of the team.

The court orders treatment responsibility placed in the hands of QMHP's. Tradition of hospital practice and JCAH requirements place ultimate responsibility for treatment on the practice privilege of physicians. The JCAH survey team was careful to stick to its own precepts and only informally inquired into the workings of the Court Order. It advised, informally again, that if treatment were carried out according to standard hospital practices, the concerns of the court would take care of themselves. But LSH staff found such advice grossly unrealistic. The privilege of time to remedy or perfect standard treatment practices is not given. The imperative of the court order is *now!*

Within the institution, there are three somewhat independent groups who in fact affect patient management and treatment. The doctors do admissions, discharges, and medical-psychiatric work-ups, and prescribe medications. They make reports to and testify in the courts. QMHP's plan and implement

treatment in other respects and are responsible for such critical aspects of patient management as seclusions and restraints. The attendants feel that they are the ones on the firing lines, working with the patients around the clock, all the time. By their sheer numbers, the extent of their time involvement, and the fact that plans and orders are often carried out through them, these attendants are in a critical position to affect what actually happens, both in treatment and in management. One of the points of the Contempt Citation based on the report of the Court Master was that attendants blocked the carrying out of orders so that patients were handled with excessive restraint. Attendants have been administratively incorporated into the multidisciplinary unit teams. But integrating them has had variable success, given the institution's history and complex operational conditions.

Not all the complications are internal. The Central Office at departmental headquarters in Columbus has been fending off attacks for the last ten years or more. In understandable efforts to shore up and secure the situation, bureaucratic controls have increased. Executive orders seek to set standards and to control practice in such areas as behavior modification, restraints of patients, and aspects of psychopharmacological treatment. Such central controls necessarily limit local initiative, autonomy and prerogative, and turn the affected professional staff member into more of a functionary.

Given the conflicts in philosophy as to what constitutes proper management and treatment and who decides; given the confusion and diffusion of staff roles and assignments; given the erosion of professional prerogative and local autonomy, frustrations for staff are beyond the call of duty. Under such circumstances, staff demonstrates remarkable endurance. Nevertheless, burnout has to and does occur.

Another area of centrally imposed control has been genericized in the word "compliance." Especially since the contempt citation, a compliance mechanism has been set up, with authority centralized in Columbus but with an on-site member at LSH to monitor the documentation of compliance activity. The invocation of the word "compliance" is enough to stop any staff member in his or her tracks and evoke from him or her various highly regimented responses. On the one hand, compliance along with its documentation is a vital issue. On the other hand, it is also a paradoxical problem. It frequently becomes more nearly the end than the means. Serious staff estimates show that "compliance" exhausts 50-90% of staff time and energy. In this way compliance actually competes with, and ultimately interferes with, the clinical and legal objective, treatment. At one time the whole range of compliance and its documentation was concretized in a check list of 128 items to be scored by various staff, including compliance clerks, on each patient as often as daily.

Senior departmental as well as LSH staff complain bitterly of the confusion of trying to meet the specifications and expectations of the court order. First there is ambiguity in the order itself. Then there is difficulty if not total frustration in achieving clarification. Finally there is the confusion of shifting and escalating demands under plaintiff pressures and evolving attitudes of the court. Under adversary conditions the defendant staff is convinced that they are repeatedly subjected to Kafka-esque experiences. Plaintiff advocates counter that the defendants are not forthcoming and have

to be prodded and forced to deliver what the order calls for. In simple truth the court is beyond its competence in trying to specify the end of treatment and the process by which treatment is to be delivered. Within mental health professionalism in the matter of treatment and proper means to treatment, the achievement of conventionality is difficult enough. In the judicial process under adversary conditions it becomes impossible. Hence, the court's dicta cannot be other than ambiguous, as they are.

One of the imperatives of the court order was the developing of specialized treatment of young adult patients as inspired by *Wyatt.* Among many experienced in forensics, this requirement strikes a note of horror, since in their opinion the very fact of segregating this patient group is asking for trouble. They see it as concentrating these young patients – ages taken arbitrarily at LSH as eighteen to twenty-two, since there was no judicial specification – until they become a critical mass with explosive potential. Failure to act expeditiously on this requirement, specialized treatment for young adults, was also one of the points of non-compliance of the contempt citation.

Since this patient population is seen by the staff as notoriously negative and uncooperative, the program designed for them at first involved behavioral technique to deal with patient resistance through a program called "Reality Therapy." In this program, patients are put into a situation of few privileges with the opportunity of working out of the situation by doing the "right" things, by participating in "desirable" activities. Such might be to attend education classes to remediate the gross deficiencies so many of this group have. The intent in such cases would be to deal with the common and vexatious problem among these young patients of refusing to go to classes.

This Reality Therapy met criticism and attack. Under question of constitutional acceptability, this element of the treatment program was abandoned. The staff has been working feverishly on developing a more "positive" treatment approach that eliminates the risk of having an element of treatment judged "harsh" or "intrusive."

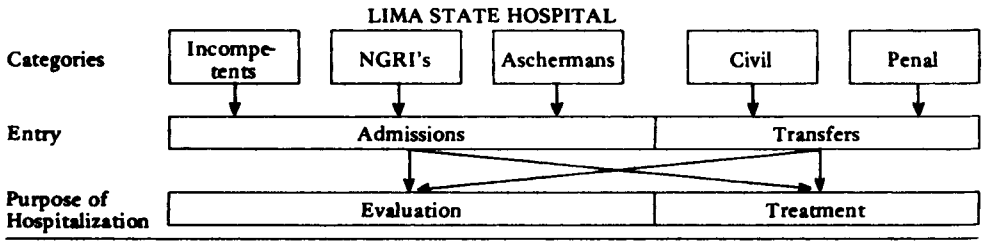
Categories of Patients

In order to understand further the effects of *Davis v. Watkins* on patient careers at LSH, we must first look at the kinds and number of patients who get sent there. First, all patients are involuntary and are legally committed in one manner or another. The largest number get into the hospital as "Admissions," which is local technical parlance to distinguish those coming into the forensic hospital directly from the communities. Most "Admissions" come through the criminal justice system by judicial commitment. A small number, infrequently, come in by judicial civil commitment. The judicial commitment in a criminal case is in large part in regard to the twin psychiatric questions of the criminal justice system – "competency to stand trial" and "legal insanity" – those to be evaluated or those to be treated in relation to the one or the other of the two questions. Another class of criminally adjudicated "Admissions" is the so-called "Ascherman" cases, after the eponym for the statute which is the basis for psychiatric treatment partially or totally in lieu of prison sentence for certain adjudicated criminals such as psychopathic or sexual offenders, as a discretionary option given to

the sentencing judge.

Patient entry into LSH also includes a second category designated in the same local technical parlance as "Transfers." These are already-institutionalized individuals, convicted criminals from correctional institutions who develop the need for the psychiatric hospital treatment ("penal transfers") and civilly committed individuals from civil mental institutions ("civil transfers") for reasons of violence or dangerousness. "Transfers" include some retardates. "Transfers" are entered into LSH by an inter-departmental or intra-departmental administrative process of state government. The usage of "Transfers" is a carry-over from the days when the Department of Mental Health and Mental Retardation, which now operates LSH through its Forensic Division, was until 1971 the combined Department of Mental Hygiene and Correction.

Gross heterogeneity in patient population, in patient status, and in service objectives are some of the givens at LSH and the sources of complexity in its manifold practices.



Separations of patients from the hospital follow a similar process in reverse, with some variations. The Transfers-in are transferred out administratively. The admissions by commitment from criminal courts have to be referred back to the courts of jurisdiction for ultimate separation. LSH cannot itself directly discharge these patients when staff determines that the need for further hospitalization no longer exists. For NGRI's, however, separation requires by statute agreement of any two of a panel of three consisting of the superintendent of the hospital, the alienist (the statutory term referring to the evaluating psychiatrist), and the criminal court judge. Penal transfers, when hospital treatment is accomplished, are returned to the correctional institutions. They may be discharged on parole if they qualify and if psychiatrically indicated. If psychiatric hospital treatment is still indicated when the criminal sentence expires, by due process the patient may be transferred by commitment to a civil hospital.

Table I shows the variations among the categories of admission. Evaluation cases were a very large proportion of total admissions in 1970 and 1971, almost three-quarters, and have been diminishing in proportion to about one-quarter in 1978. The reduction in number of evaluation cases from 1970 to 1978 is drastic, to about 16%.

At the same time the Ascherman admissions show a sharp reduction by 40-50%. But the admissions for treatment of "Incompetents" and "NGRI's" show a triple increase during the same period. Between increase in number of "Indefinites" as commitments for treatment and radical reduction of observation cases, a shift emerges from a predominantly evaluation service to

a growing treatment service for a growing number of "Incompetent" and "NGRI" cases.

There have always been a number of questions concerning the Ascherman cases at LSH. Discussion becomes academic as the State has just recently changed its policy and has adopted new legislation which eliminates the Ascherman category entirely from forensic hospital treatment.

TABLE I
LSH – ADMISSIONS

Year	*Temporary (%)	Indefinite **Incomp. or NGRI (%)	***Aschermans (%)	Total
1970	690 (74.3)	88 (9.5)	151 (16.3)	929
1971	669 (73.6)	86 (9.5)	154 (16.9)	909
1972	350 (68.0)	100 (19.4)	65 (12.6)	515
1973	225 (54.6)	108 (26.2)	79 (19.2)	412
1974	325 (62.5)	113 (21.7)	82 (15.8)	520
1975	204 (48.2)	144 (34.0)	75 (17.7)	423
1976	229 (48.6)	153 (32.5)	89 (18.9)	471
1977	184 (38.2)	213 (44.2)	85 (17.6)	482
1978	108 (23.1)	277 (59.3)	82 (17.6)	467

*Temporary – committed for observation and evaluation for definite, short periods or for short renewable periods with frequent reevaluation, in regard to questions of competency, NGRI, potential Ascherman cases, or dangerousness.

**Indefinite (Incomp. or NGRI) – committed for indefinite period for treatment following adjudication as "Incompetent" or "NGRI."

***Indefinite (Aschermans) – adjudicated criminal offenders committed for treatment for reasons of mental illness, mental retardation, or psychopathic disorders for periods limited by length of criminal sentence, right to parole, or other technicalities.

TABLE II
TRANSFERS (IN)

Year	Civil	MR	Corrections	Total
1970	43	10	71	124
1971	43	4	116	163
1972	22	7	83	112
1973	19	4	59	82
1974	19	3	83	105
1975	12	2	81	95
1976	18	2	73	93
1977	4	1	62	67
1978			98	98

Table II shows the trends in the categories of the "Transfers." Civil transfers are considered professionally and legally inappropriate for treatment in the forensic hospital. The table shows the trend toward elimination of these, which has been achieved totally more recently.

During 1975 and after, unquestionably as a consequence of the *Davis* suit, the frame of reference of civil transfers shifted. Such transfers by the purely administrative process were eliminated, so that in the latest fiscal year all the transfers were penal ones from the correction institutions. A small number of formerly civil transfer cases still get into LSH, but now in the formal admissions category, by due process by specific judicial commitments.

Severe MR cases are also considered not professionally or legally appropriate for LSH and have been virtually eliminated by policy. At this writing it is reported that there are two such cases at LSH as anomalies, for lack of alternative, with awareness and consent of all interested authorities.

In the MR category the less severe cases are left as possible transfers for LSH treatment. The tables show that the MR group has never been numerous as civil transfers and is clearly phasing out. Mild to moderate retardation cases are to be noted among the Aschermans.

Juveniles, always occasional and exceptional, have been eliminated.

Transfer from Corrections has always been the major component of the transfer group, and is now becoming preponderantly so. Since 1976, coincident with another class action suit, *Register v. Denton,* focusing on medical and psychiatric services for state prison inmates, the number of Transfers from Corrections has shown a sharp rise, reversing a trend of seven years, to the highest number since 1971.

Deaths are the final category terminating hospitalization. They were formerly commonplace at LSH, as high as twenty-three a year, but have been decreasing dramatically to one only for the fiscal year ended June 30, 1978. The decrease as a ratio of Average Daily Resident Population (ADRP) is less dramatic but still very significant.

TABLE III
LSH – DEATHS

Year	Deaths	Death/ADRP* %
1970	19	1.5
1971	23	1.8
1972	14	1.3
1973	13	1.4
1974	11	1.4
1975	6	1.1
1976	2	.54
1977	2	.57
1978	1	.29

*Average Daily Resident Population

Trends in In-Hospital Population

The recorded all-time peak of Average Daily Resident Population* of patients was 1475 in 1960. During the decade of the 1960's it ranged along a plateau around 1300. A remarkable decline started in 1971 and ran its course as the ADRP began to plateau again in the last couple of years. Then, during the past six months, for the first time in seven years, additions have begun to exceed separations again, as most other factors have stabilized while penal transfers have been rising sharply. During recent months, the patient population trend has reversed and shown increases again.

TABLE IV
REDUCTION IN ADRP

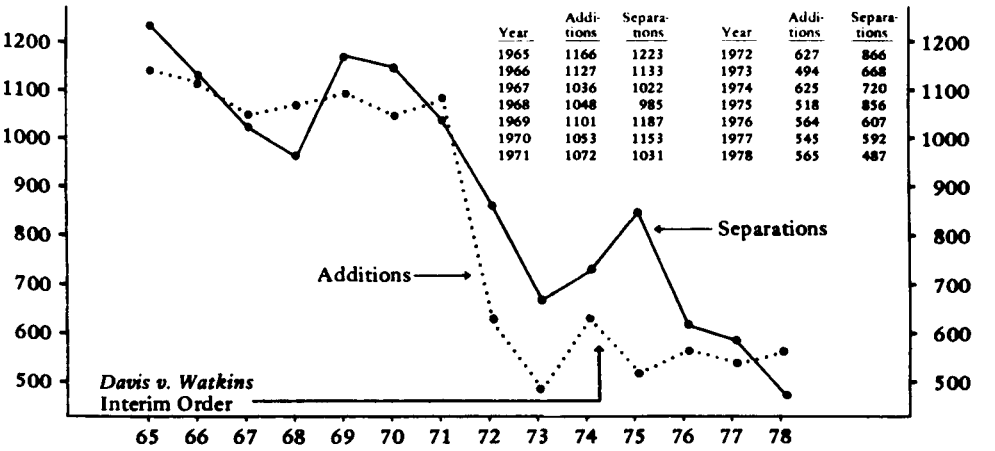
Year	ADRP	♦ in ADRP from Previous Year
1971	1280	1
1972	1115	165
1973	929	186
1974	770	159
1975	532	238
1976	372	160
1977	350	22

♦1971-74 – 510 prior to *Davis*
♦1974-77 – 420 after *Davis*

*ADRP is a slightly different datum from Enrolled Patients, as there is always a variable small number of patients on trial leave, etc.

Additions and separations (see curves on graph) were close together and intertwined up to 1971. Hence the plateau in ADRP during that time. Additions and separations moved apart and stayed apart more widely than before from 1971 until the past year. Since separations exceeded additions, the ADRP kept decreasing consecutively and continually during this extended period. Then recently additions crossed and exceeded separations for the first time since 1971. With this change, patient population has been rising again.

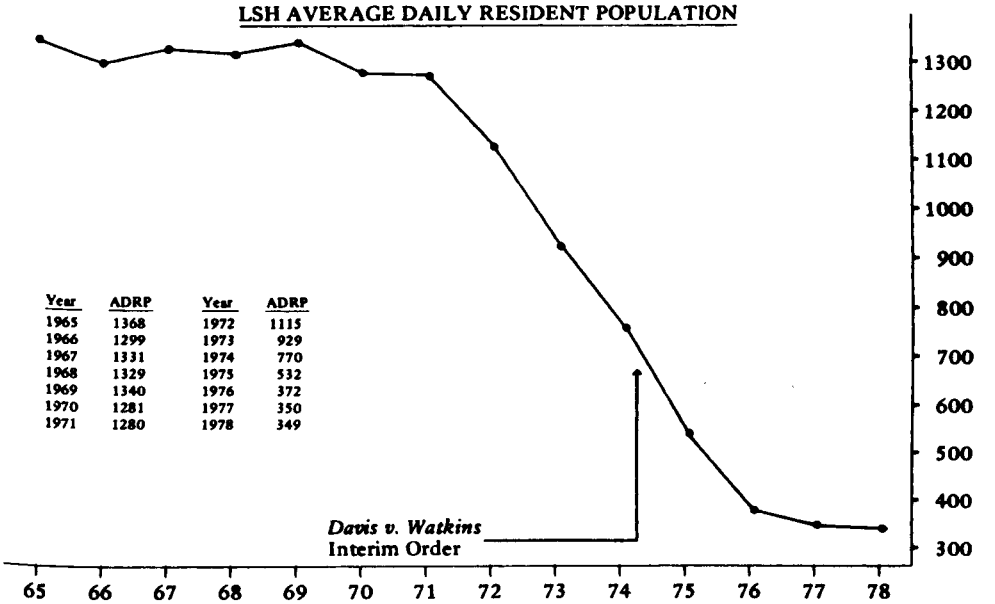
LSH PATIENT POPULATION



Year	Additions	Separations	Year	Additions	Separations
1965	1166	1223	1972	627	866
1966	1127	1133	1973	494	668
1967	1036	1022	1974	625	720
1968	1048	985	1975	518	856
1969	1101	1187	1976	564	607
1970	1053	1153	1977	545	592
1971	1072	1031	1978	565	487

(Each year of the above table and of all subsequent tables is a fiscal year ending June 30 in the year indicated)

LSH AVERAGE DAILY RESIDENT POPULATION



Year	ADRP	Year	ADRP
1965	1368	1972	1115
1966	1299	1973	929
1967	1331	1974	770
1968	1329	1975	532
1969	1340	1976	372
1970	1281	1977	350
1971	1280	1978	349

Most who observe the phenomenal reduction in patient population at LSH assume uncritically that it is a result of the impact of the *Davis* court order. The facts show clearly that this is simply not so. The depopulation of

LSH started a full three years before *Davis*, and was well established before the *Davis* decision became a reality on September 9, 1974, early in the 1975 fiscal year. The reduction in ADRP, 510 patients, for the three fiscal years* prior to *Davis* exceeded the reduction, 420 patients, for the three years following *Davis*. *Davis* merely accentuated modestly what was already in progress and might have continued anyway. We may estimate the quantity of accentuation but first should examine another matter.

In Article II of the Appendix of the Interim Order, the judge directed as the first task the evaluation on a crash basis of every single then patient at LSH to determine, according to legal definition, whether he or she were mentally ill and dangerous and required the security of that hospital. A colleague of the writer has published his experiences as one of a multidisciplinary group of thirty mental health professionals from all parts of the state who came together on successive weekends for over two months at the end of 1974 to carry out these evaluations.[6] Dr. Arnold Allen reported his personal involvement with his team in evaluating 111 of some 750 patients in the hospital at that time and finding that 80% "were seen as not meeting the criteria for hospitalization in a maximum security setting."

Of course, we can't say for sure, but assume that these 111 patients were a sample of the total patient population. The court order gave specific directions for each category of patient who might then be at LSH – paroled prisoners, civil transfers, Ascherman cases, penal transfers, "Incompetents," "NGRI's" – to carry out a process to insure separation from the hospital of all cases not requiring its restrictive setting (or in some cases, requiring no further hospitalization at all). But it appears that no massive separation of patients, nothing approaching the order of 80%, took place. One wonders, why not?

A close examination of the records reveals two facts. First, LSH services always were, until recent years, predominantly evaluative. The record further shows a progressive reduction in entrees** for evaluation both absolutely and in proportion to total entrees. These patients are processed in a finite short period for the main purpose of evaluation and are discharged from the hospital.

Data on length of hospital stay (LOS) of discharged (separated) patients show a heavy majority of short stay, three months or less, 80% in 1971 but decreasing to 50% by 1976. The graph would be bimodal with a minor but definite second peak at one to two years from 1970 to 1973, following which this peak disappeared. Comparing the proportion of patient entrees for evaluations only to the proportion of discharged patients with length of stay less than one year reveals that evaluation cases are decreasing and becoming a smaller proportion of short stay patients.† The conclusion is that short stay patients derive from both evaluation and treatment cases, and that the increased component of the latter started in the years before *Davis*.

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*Ending June 30, 1974; *Davis* came early in the fiscal year ending June 30, 1975.

**"Entrees" as used here is meant as the class of all those who enter LSH as patients, embracing both "admissions" and "transfers."

†It is understood that the population of patients entering the hospital in a given period is not exactly comparable to the population of patients separating from the hospital during that time, but the intervening variables cannot practically make significant differences.

TABLE V

Year	Entrees for Eval./Tot. Entrees	%	LOS < 1 Yr. (%)
1970	690/1053	65.5	75.9
1971	669/1072	62.4	82.0
1972	350/627	55.8	57.8
1973	225/494	45.5	45.2
1974	325/625	52.0	60.1
1975	204/518	39.4	55.1
1976	229/564	40.6	69.3
1977	184/545	33.8	**
1978	108/565	19.1	**

The final conclusion is that at any given time a majority of patients are progressing toward early discharge. Therefore, since it is a majority, the difference between this group, whatever its exact size might happen to be, and the 80% figure of Dr. Allen's evaluation team, cannot be radical.

We have a satisfactory answer, then, for what the record indeed shows, that *Davis* caused no radical departure from the trends already in progress, but for the most part, just an accentuation of them. The ADRP shows a sharp, consistent drop from 1971 to 1974 and a somewhat sharper downward break for the three years thereafter. Projection of the average slope of decrease from 1971 to 1974 would suggest that the impact of *Davis* in 1975 resulted in an additional decrease of perhaps seventy patients. Re-examination of the separations and additions curves shows that they were going hand-in-hand, similar forms but at different levels. But in 1975 there was a change out of character with the trend. Separations and additions diverged, separations increasing suddenly while additions were decreasing. From this portion of the information we might estimate additional separations of over 100 cases in fiscal 1975, the year of *Davis,* due to *Davis.*

Still nothing changes the broader perceptions. The die was cast early in the decade, and a similar end point likely would have been achieved, probably at a slightly later time. The state had then undertaken a policy of discouraging utilization of LSH while pressing for use of any and all alternatives. This policy and later programs to implement the policy were undertaken by the state on its own initiative.

There were, to be sure, pressures on the state. There was the newspaper notoriety. The LSH staff then included only three psychiatrists, who were spending an exorbitant and preemptive amount of time testifying all around the state in the various common pleas courts of Ohio's criminal justice system. In this is revealed the value system giving first priority to serving the courts through the alienist function, as Ohio still legally calls the psychiatrist in this role. In self-defense, the state undertook to develop a system of alternatives to LSH for providing evaluations to the state courts. These programs are the Area Forensic Centers (AFC's), which provide local outpatient evaluation service.

A few of these centers had been in existence for years. They formed the nucleus of what now numbers thirteen AFC's blanketing the greater part of the state. However, a number of the new centers did not start until 1972,

**All statistical data given in this paper were supplied by the Record Department of LSH or by the statistical service of the Department of Mental Health and Mental Retardation in Columbus. The latter compiles extensive tabulation by computer printouts some time following the end of each fiscal year. These printouts are routinely not yet available for the fiscal years ended June 30, 1977 and 1978. Therefore, data regarding LOS for these years have not been made available at this time.

1973, and 1974, and some even later. Even before they materialized, the judges were formally exhorted to use every available means to reduce the pressure on LSH. This development was almost certainly the basis for the depopulation of LSH which clearly started in 1971 and continued practically in a straight line for six years. The ADRP dropped from 1280 to 350. The record tells that in the process of reduction of resident patients, the first and foremost reduction was in admissions. Reducing admissions was obviously more effective than increasing pressure for discharge of patients already there. The datum denoting the largest single one-time change is in additions to LSH, a drop of 445 in the one year from 1971 to 1972. Three hundred fifty-seven of these were a reduction in cases committed by criminal court judges.

An interesting sidelight is worth reporting, since it portrays the mindless operation of legal demands as clinical staff is separated from the Court by a cushion of bureaucracy and legal representation. A special unit of a dozen beds was set up at LSH to continue to provide evaluations for that portion of the state not covered by AFC's. Since the cases were admitted for evaluation only, they did not have treatment plans as demanded by the Interim Order. "Each patient shall have an . . . individualized treatment plan." As cases without recorded treatment plans, they showed up on the delinquency lists as instances of non-compliance with the court order, a matter of no little gravity. The involved staff endured the frustrations but were deeply vexed by the senselessness of the situation and the lack of effective recourse. Finally they took the matter into their own hands. With considerable trepidation, by fiat, they announced a few months ago that these evaluation cases would henceforth be handled on an out-patient basis only, by one-day, same-day evaluation, and would no longer be admitted as in-patients. This particular issue of non-compliance was instantly and permanently solved.

By policy, in the same instant, another portion of LSH involvement in evaluations was eliminated. Likewise by policy, civil and MR transfers have been eliminated – forty-three and four such additions, respectively, occurred in 1971, and none in the fiscal year ended June 30, 1978. MR transfers, and juveniles also no longer admitted, never added up to significant numbers.

Currently LSH concentrates its services on treatment cases in four categories – indefinitely adjudicated "Incompetents" and "NGRI's" and criminally adjudicated "Ascherman" cases and "Penal Transfers." By change in legal statute the "Ascherman" category has been repealed. The number of "Incompetents" and "NGRI's" admitted for treatment has been increasing. As a result of legal pressure for psychiatric services in the prisons, "Penal Transfers" have also increased.

Other Effects of the Changing Hospital Scene

Resources affording the level of individual patient care have increased very significantly. Expenditures have more than doubled from 1970 to 1977. One should note, however, that the increases in dollar amounts of expenditures are approximately equal, comparing the post-*Davis* years to the pre-*Davis* years.

TABLE VI

LSH	Expenditures	Tot. Ann. Pt.-Days	Ann. Cost/Pt.	Cost/Pt.-Day
1970	$4,897,204	467,560	$ 3,876	$10.62
1971	5,227,669	467,463	4,080	11.18
1972	5,855,997	397,832	5,453	14.90
1973	7,391,054	338,960	7,789	21.34
1974	7,575,567	281,289	9,826	26.92
1975	8,401,737	193,951	15,822	43.35
1976	8,582,060	136,095	23,070	63.03
1977	10,225,686	127,721	29,216	80.04

Through increase in fiscal dollars and even more so through radical reduction in patient population, the average cost per patient-day has risen several fold. Since fiscal 1977 the amount has reached $100 per patient per day. In the state mental institutional system the increase in support of patient services has been much greater in forensics, 716% from 1971 through 1977, compared to 393% in mental retardation and to 330% in civil mental health. Even with a correction for six years of inflation, the increase in support of cost for patient services is impressive.

TABLE VII

Cost/Pt.-Day	1971	1977	↑ '71-'77
M.H. Division	$14.32	$47.30	330%
M.R. Division	9.75	36.34	393%
LSH	11.18	80.04	716%

Although in the same period the number of employees has risen only somewhat, the significant improvement is in relation to ADRP from less than one employee per two patients to two employees per patient.

TABLE VIII

LSH	Employees/ADRP	Ratio
1970	535/1281	1/2.39
1971	550/1280	1/2.33
1972	585/1115	1/1.91
1973	587/929	1/1.58
1974	581/770	1/1.33
1975	606/532	1/ .88
1976	541/372	1/ .69
1977	675/350	1/ .52

In special areas the improvement is even more significant. Staff have increased from three physicians to the equivalent of ten, five of whom are board-eligible psychiatrists; from nine licensed psychologists to twelve, including two Ph.D.'s; from sixteen nursing staff to forty-five; from fourteen teachers to twenty-one, of whom twelve are certified for the educable mentally retarded.

A mail survey was done to collect comparative data on costs of patient care in other state level forensic hospitals.[7] These data indicate that LSH has the fourth highest daily cost per patient in the country, exceeded by such anomalous instances as one in a non-contiguous state and another in the nation's capital. Eighty dollars per patient-day of over a year ago exceeded by far the average of approximately $58 for comparable forensic hospitals, and at more than $100 per day, more recently, the comparison appears to be even more favorable.

Traditionally LSH has been viewed as a maximum security institution. Only a minority of patients are now subject to strict internal security. Security is still "maximum" at the perimeter, which is guarded and patrolled around the clock and fitted with electronic sensor devices set in high, double, barbed-wire-topped chain-link fences. Internally many patients are housed on wards unlocked during the day and have privileges to move about more or less freely, with access to the central quadrangle activity and recreational area at given times. On some occasions select patients may be given extra-mural privileges with staff escort. Without question the life space of most patients has been grossly expanded.

The life sphere of patients also includes greatly increased interpersonal contacts, especially with staff, and with other patients and visitors. Opportunities for a variety of activities exist, in marked contrast to past years.

Life space and interpersonal contact are but aspects of the psychological sphere generally. In addition to greater freedom and avenues of movement and expression, patient morale is buoyed by a number of sources of advocacy. The patients are, of course, very rights-conscious. There are three staff ombudsmen who daily hear patient complaints. Patients have other champions both within and outside the institution. They have their class action advocates, the ABLE lawyers. They have the court through its Master. They have the press with its unfailing pipeline for instant intelligence on inside LSH happenings.

The staff therefore operates in a fish bowl with all kinds of limitations and inhibitions. The system requires the staff to document good and sufficient reasons for applying patient restrictions, seclusion and restraints. Close surveillance of restrictions and frequent reevaluation for continued restriction are the orders of the day – every day – with the staff always facing the requirement for meticulous documentation of clearly stated reasons. The philosophy and, to some extent, the decision-making parameters as to what constitutes excessive restriction or restraint are taken out of the hands of staff, who have to face the challenge of the plaintiff advocates, the court, and even within the defendant group, the policies and directives of the central office.

The physical environment at LSH, upon surface inspection, is also considerably improved. The physical plant is large, sprawling, drab and antiquated. The perimeter corridors are a mile in length. One problem in maintaining any contracting institution built for a capacity of several times its residual residents is the keeping up of the central core of the physical facility and its services, which cannot be contracted. Much effort and cost go into sprucing up, cleaning, and polishing the old premises. Even so, a factor in the contempt citation was the failure to meet the physical facility standards of the Interim Order. And even after all the cost and effort in maintenance, decorations, and appointments, the premises remain drab.

There can be absolutely no question that the lot of patients has improved in very many ways. Similarly there is no question that the opportunity for hard-handed measures for patient control by staff has been grossly reduced in a systematic way. But it cannot be said that in implementation excesses don't sometimes happen. There are instances of honest difference of

opinion. There are instances of technical deficiency, lack of documentation. And it is alleged, more assertively by advocate opinion, but also at times by others, that subversion of the system still occurs, resulting in unwarranted repression of patients in subtle or covert ways.

The indices of how well or badly the institution works for its constituents, staff and patients, are the untoward events, the extremes of which are attempted or successful suicides, escapes, outbreaks of violence and riots, and injuries to patients or personnel. Knowledgeable old-timers among the staff and patients are in unanimous agreement that all such indices are grossly reduced in incidence and are anxious to give anecdotal detail to give point to the dark past compared with the brighter present. More perceptive members of the staff volunteer the question whether the reduction is more apparent than real, whether it is any greater than the reduction in patient population (75%). Unfortunately, comparative data are not available. Despite the question and the lack of data, prevailing opinion is that the rate of untoward patient events is really greatly reduced.

The official record of patient deaths by suicide supports the impression that they have become rare to non-existent.

TABLE IX
PATIENT SUICIDES

1970	3	15.8% of all patient deaths
1971	2	8.7%
1972	2	14.3%
1973	1	7.7%
1974	3	27.3%
1975	1	16.7%
1976	0	0%
1977	0	0%
1978	1	100%

But certain adversaries impugn the reliability of this official record. While we cannot support with greater knowledge the reliability of either the official record or challenging adversary opinion, the truth is that the latitude for manipulation of fact has grown slim since deaths of patients from all causes in the more recent of these years are but one or two.

Routine data collection on LSH patient services contains demographic, legal, and clinical variables. The system of data collection has varied little for many years. It betrays a historical preoccupation with the legal variables characterizing the services of the hospital to the state criminal justice system.

Careful observation leads to the conclusion that patient progress through LSH is governed more or less by legal variables. At first glance this might seem like a trivial realization, nothing more than the difference between definite and indefinite commitment. Evaluations are committed for short, definite periods, ninety days or less. Staff members report that commonly evaluation cases are also treated with effective results of remission or improvement in a short period, but when, as happens from time to time, some of these same cases return to LSH under indefinite commitment as NGRI, the hospital course characteristically becomes extended for a long period of time. In such cases the patient serves as his own control in comparison of one treatment context with another.

It should not be assumed too readily that the above described, a rather

paradoxical clinical course of events, is unique to forensic practice. It is but one instance of a general truism, that the development, treatment, and course toward possible chronicity are materially influenced by social systems factors in any mental health system, forensic or civil.

Again in the matter of the impact of the *Davis* decision, the numbers of patients being admitted and of those in residence are but fractions of the corresponding numbers in former times, and the repertory of service is being simplified with increasing concentration on treatment. Yet, study of each individual parameter reveals that the changes were initiated independently and earlier, before the advent of *Davis*.

Perspectives

A forensic hospital necessarily concentrates a population of society's most difficult deviants. An institutional mentality not too different from that of a prison reigned typically at LSH without much question by anybody until only the last ten years. This psychology still affects elements of both staff and patients bilaterally. LSH surely looks like a prison – double fences, armed guards, bars, locks, gate inspection – and the legal process is not totally different from one leading to sentencing to a correctional institution. For the component of transferred adjudicated prisoners, and perhaps Ascherman cases as well, it is *de facto* their prison.

The affected elements of staff and patients become implacably polarized in conflict, each convinced of the villainy of the other, repeatedly finding reasons to reinforce their convictions. Stringent controls, seen as vital to the protection of society at large and essential to safety of life and limb of members of the institutional society, staff and patients alike, produce, in pressure-cooker fashion, extraordinary tensions. The real life situation within the walls of the hospital is difficult to reform. It is bigger than individuals or groups of individuals. It is convenient for more enlightened and genteel staff and other critics to impugn other staff who resist or defeat reform and persist in repressive abuses, to imply a lack of sophistication among these other staff, and perhaps ignorance or inherent meanness. These allegations in individual cases may or may not be right. The overriding factor is personal safety and survival. An individual staff member may, unrealistically or not, exaggerate or minimize the sense of danger, but for most staff it's always there. Methods of patient control considered vital to personal security and survival are not easily changed.

In the larger sense we cannot fully understand the behavior of an individual by personal, intrapsychic insights alone. But the institutional protagonists do not perceive that their respective behaviors are both shaped by their conflict. With a fixed belief system, with personal security at stake, the repertory of behavior styles is narrow and predictable. The behavior of each antagonist fulfills the prophecy of the other.

Workmen's Compensation cases are some measure of work-related injuries to staff, though not differentiated as to injuries suffered at the hands of patients. However, injuries incurred in dealing forcibly with patients are not uncommon, though admittedly they are not all necessarily inflicted by patients. These figures run ten to fifteen per cent of the average work force, at a rate which contributes certainly to the feeling and to some extent to the

fact that to work (or to be incarcerated) at LSH is hazardous. Yet, according to the verbal report of a senior member of the security staff, there have been no homicides, either patient-patient or patient-staff, in the last ten years.

TABLE X
WORKMEN'S COMPENSATION CASES

1974	68
1975	97
1976	74
1977	92
1978	64

There can be no doubt that LSH is an institution in which, with very great effort, very considerable progress has been made and is being made. Unquestionably patient experiences are much more wholesome than before. There can be no doubt either that something of the past repression survives and manages to feed on undercurrents which keep it alive. The legal adversaries will each assert a selective partisan perspective. To some extent both will be right, and both wrong.

LSH has historically been the institution the state has wanted it to be, combining security with evaluation and treatment services. The priorities were in that order, except that previously the most desirable "treatment" from the standpoint of the legal, social system was custodial.

Forensic services interface with a variety of social systems – health, law, corrections, government, body politic. A finely honed equilibrium has been worked out over the years reconciling the objectives of these diverse interests. Displacement of the equilibrium is disruptive on all sides. The complex system, moreover, has the capacity for enough inertial resistance to dissipate the impact of the uniquely legal demand.

The legal establishment has come to understand the difficulties of achieving institutional reform by judicial decree in public law litigation. The mental health bar has apparently also sensed the judicial problems in implementation. Its members have prepared a model statute on Mental Health Standards and Human Rights[8] to be adopted by the several states. Such action would take the judges off the hook in transferring to legal statute and bureaucratic regulation the principles of the judicial decisions. The model statute is long on civil rights and short on clinical content. In dealing with clinical matters it is mainly proscriptive, with a list of "thou shalt nots" of forbidden areas of clinical practice, but containing little positive recommendation for what clinical practice should be. The potential benefit of transferring the determination of clinical proprieties from the professional-clinical process to political regulation is, from the standpoint of the prejudice of this writer, at least questionable.

An outstanding study by the Harvard Law Review makes a number of telling points:[9]

> Despite the doctrinal advances, the implementation record in mental health litigation has not been impressive. . . .
>
> A key observation is that complexity of large organizations is at least as important a factor in the difficulty of implementing change as are

incompetence and deliberate resistance. . . .

Most important to recognize is the fact that this . . . complexity reflects a wide variety of goals, perceptions and needs among the relevant entities (with which the mental health institution interrelates) – from internal organizational units to allied external systems. . . .

. . . given intense conflicts of interest, lack of cooperation among the necessary parties, shortage of resources, and the complexities of control and unresponsiveness that characterize organizations, the probability of full implementation of reform policies is apt to be quite low. . . .

The cases have produced ringing judicial rhetoric and 'stunning paper victories' but less impressive results in the real world.

The Harvard Law Review article follows its extraordinary analysis with a prescription for remediation of the judicial process. All the points of the above excerpts and of the entire analysis of the study are exquisitely demonstrated in the implementation experience of *Davis.* The problem as perceived by this writer from the experience of *Davis* and a number of analagous cases is the inevitable sequelae of an attempted uni-system solution to a multi-system problem.

In such context, it is worth taking note of a similar critical study done from the economic point of view, edited for publication by Jeffrey Rubin of the Economics Faculty and Disability and Health Economics Research Section of Rutgers University.[10] "Failure to understand the implications of resource limitations, the determinants of demand and supply and the benefits and costs of their activities has led the legal and mental health advocates to behavior which is inefficient, excessively costly and perhaps, if taken too far, contrary to the best interests of the mentally disabled."[11] The problems of competition for scarce fiscal and person-power resources, of paradoxical consequences in satisfying the legal process rather than the end of patient-care, of "the lack of consensus with respect to a definition of 'adequate' care"[12] are among those discussed in this study. Another point touched upon is the starkly highlighted conflict between the use of the mental health system for social control and the mental health treatment function.[13]

As a mental health advocate, Robert Plotkin, Attorney of the Mental Health Law Project in Washington, D.C., a contributor to the same economic study, takes stock after six years in the *Wyatt* era.[14] "Legal challenges to the mental health system are only small battles in a much larger war – the problem of delivery of all human services. . . . At the least, we can now agree that the mentally disabled are citizens, entitled to the protection of the Constitution." Plotkin is content that class action has accomplished its purpose, and to grapple with the problem of implementation, the legal activism he projects is a shift from class action to dramatic increase in "individual damage action . . . to hold accountable those people responsible for implementing those rights" against individual administrators and professionals. These legal actions will shift also from federal to state courts.

The powerful question about the role of judicial activism in mental health litigation has apparently pulled upon Judge Johnson himself. The instance of a jurist defending his decision, in this case of *Wyatt v. Stickney,* is exceptional in judicial history. In a public address early this year, Judge Johnson spoke of "the duty of protecting the health and well being of our citizens," and when the legislative and executive branches of government, through "callousness and neglect, fail to perform their role in securing these rights and leave them endangered, it is the constitutional duty of the judiciary to step in and fill this dangerous void."[15] Having reaffirmed the duty to rule as he did, Judge Johnson proceeded to discuss the *terra incognita* for the judiciary of implementation of the court order, acknowledging that results in this respect are less than totally successful. To measure the impact of his decision, the Judge adduced data showing an eight-fold increase over the pittance of $6.50 *per diem* that Alabama was spending per patient in 1972 when the *Wyatt* decision was rendered, a reduction in hospitalized patients of 50%, an improvement of staff-to-patient ratio from .47/1.0 to 1.4/1.0, and concluded that by "all reports, the quality of care . . . has been dramatically improved." Johnson reiterated the three basic conditions for effective treatment: (1) humane psychological and physical environment, (2) qualified and sufficient staff, and (3) individualized treatment plans. He reviewed the required elements of the minimal legal standards he imposed by order to assure the conditions for effective treatment – a bill of rights for patients assuring privacy and dignity, and treatment under least restrictive conditions, among others.

Judge Johnson appears to take clear satisfaction from deinstitutionalization, enrichment of the hospital programs for the remaining patients, and humanization in handling of these patients. Judge Johnson is joined by many in these evaluations. Accomplishments such as these in regard to Bryce and other mental hospitals in Alabama are more than matched by LSH in Ohio. One must not forget, however, that in Ohio the accomplishments are not necessarily to be credited to *Davis.* The economic study referred to above also questions in a similar way the accomplishment of *Wyatt* in Alabama, suggesting that deinstitutionalization would have come about there also, anyway, enabling enrichment of programs and humanization of patient care.

Patient care and management have an effect upon and play a role in treatment, of course, but even as essential ingredients, they do not in the larger sense in or of themselves constitute treatment. Pragmatic wisdom may urge support of the view that treatment has been substantially achieved, in order to help the judiciary disentangle itself and withdraw graciously.

At LSH, there have been undeniably vast improvements – in the physical plant, in psychological environment, in enrichment of program support and staffing. Arguments continue about proper standards by which to measure progress, and admittedly deficiencies do exist, here and there, now and then. When the *Davis* decision hit the institution, the traditional expectations of the state were still in place, primarily that LSH should serve the courts with evaluations and testimonies. Treatment was a secondary, perhaps even tertiary objective. The state has moved aggressively to change all that. The majority of patients admitted to LSH now, for the first time in its history,

are there for treatment. The professional staff can concentrate on treatment and come to grips with treatment responsibility as it never could before.

Whither Now?

In the course of its defense in the *Davis* case and in planning the future of forensics service, the Forensic Division of the Ohio Department of Mental Health determined that, because it would be too costly to modernize the physical facility at LSH, among other reasons, LSH should be phased out and replaced by three smaller regional forensic hospitals. Promises to this effect were made to the court. LSH is to be closed when the new facilities become operational. Construction is already in progress for the first of the three, being built at Dayton Mental Health Center (DMHC) and scheduled for completion by early 1980.

Task forces have been organized to plan the programs for these new forensic hospital units. The DMHC Task Force began its study by taking note of the commentary of the JCAH survey team in carrying out its task of evaluating the accreditability of LSH. The survey had to be done on the basis of Standards for General Psychiatric Facilities. There are no standards for forensic hospitals. The task force has taken as its first task, then, the development of standards for forensic practice upon which to structure its service program.

In approaching the promulgation of standards there are obvious issues and conflicts to face in attempting to provide a professional mechanism for dealing with problems and at best solving them. At the head of the list is the need to clarify the identity of the forensic hospital as a mental health facility with the objective of rendering treatment to individuals. How do problems of security conflict with or complicate individual treatment? The problem follows of reconciling legal standards, with their proper interest in civil rights, with professional-clinical standards of responsibility for quality treatment with humanity and dignity. There is the problem of legal proscriptions of treatment, whether they do not in some instances go too far, or whether they are the necessary or best way, or even a reliable way, to safeguard patients from unwarranted methods of therapy. There is the need to restore to professional staff a role offering constructive leadership with commensurate authority to fulfill clinical responsibility to fashion the treatment organization, to select the methods, and to supervise and participate in delivery of treatment services. There is a need to define the forensic treatment hospital as one element in a comprehensive treatment system. There is a need to define the relationship between the forensic treatment system and other social systems with which it must interact. There is the need to define the roles of staff members of the different professional disciplines, in recognition of the thrust of the times, and to define the relationships between them.

Clearly the professional staff in practice find themselves at severe disadvantage in dealing with legal imposition in the adversary process. Professional staff are thrown off balance and function to a large extent defensively. Professional staff need to be set upright again to make their unique and probably incomparable contribution to the delivery of treatment.

One legal advocate in the *Davis* case expressed disappointment that in the now more than four years since the Interim Order the professional staff of some of the other mental health disciplines has not demonstrated the way to fulfill treatment as a right according to ideal standards. Invidious comparisons of virtue or ability among the professional disciplines should be avoided as neither necessary nor helpful. Suffice it to say that a number of LSH staff have demonstrated altruism, dedication, and ability, but have achieved no revolutionary break-through. Under prevailing circumstances it is naïve to expect that any one or group of professionals could achieve the wished-for ideal. The social systems factors outweigh the intrinsic virtues and abilities of whatever species of professionalism; all are hemmed in alike.

Psychiatry, along with other mental health professions, has to bear the guilt of past neglect. Psychiatrists and other mental health professionals, if they are to continue to be involved, must recognize that they face now escalating demands for responsible performance. We are put on notice that the demands for professional responsibility will be reinforced if necessary, painfully, economically, by the strategy of individual damage suits. The professionals must take into their own hands the fashioning of the ground to stand on if they are to meet the demand with stability and strength.

Psychiatry has no natural or rightful monopoly among the mental health professions. Whichever can do the job best, reliably, economically, deserves the mandate to do it, and deserves the support of all psychiatrists as citizens as well as professionals.

In the historical evolution of forensic practice, treatment has not been the long suit. This is so simply and mainly because treatment has not been the main objective of the forensic institutions. Models for forensic treatment are scarce or non-existent. In all mental health, and perhaps more so in the forensic area, the state of the art of treatment is evolving. The professions need individuals in a receptive climate of operation to demonstrate, explore, and advance the art and science of treatment.

One disadvantage of legal standards is that they tend to be fixed and concrete. What is more appropriate to the need are standards for process whereby evolutionary progress can be made, whereby the system is adaptive to change.

Public law litigation in the forensic field is an experiment in striving for institutional change. LSH has provided a field laboratory experience in one instance of imposition of legal standards demonstrating both positive and paradoxical results. It remains now for professionalism to come forward, put its shoulder fully to the wheel, and fulfill its responsibility of public trust.

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