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# Debate, The Right to Treatment: Encounter and Synthesis

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## Debate: The Right to Treatment— Encounter and Synthesis

### A SUMMARY OF DR. BIRNBAUM'S INITIAL REMARKS\*

Dr. Birnbaum first noted that the judicial history on the right to adequate care and treatment in public mental hospitals is brief and limited to mere recognition. In 1966 the United States Court of Appeals of the District of Columbia held that a criminally-committed person had the right to adequate treatment, based on a mental health statute.<sup>1</sup> In 1968 the foundation for the right to treatment seemed to be expanded to the constitutional due process level.<sup>2</sup> Finally in 1971, a further expansion occurred when a federal district court in Alabama clearly said that a civilly-committed patient had a constitutional right to treatment.<sup>3</sup>

Birnbaum noted that American courts have been reluctant to allow the release of patients from mental hospitals where poor treatment is given. He discussed at length the case of Kenneth Donaldson, an involuntary inmate of Florida State Hospital, Chatahoochee, Florida. Donaldson was committed in 1956 as a paranoid schizophrenic with no record of arrests or convictions. Acting as his own attorney, Donaldson petitioned the Florida courts for a writ of habeas corpus on the grounds of inadequate care and treatment. His petition was denied. Thereafter, he continued to present his claims to the Florida courts, federal courts, and the United States Supreme Court. Four times the Supreme Court refused to grant certiorari, from 1960 to 1970. The fourth time, Dr. Birnbaum was Mr. Donaldson's attorney, and the primary claims were: one, unconstitutional commitment; two, unconstitutional denial of counsel in the lower Florida courts; three, unconstitutional denial of a judicial hearing on the issue of his hospitalization; and four, unconstitutional denial of his right to adequate care and treatment. As a result of various courts' reluctance to even hear the case, Donaldson remained in

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\* Dr. Birnbaum's opening address essentially paralleled a paper he had previously written for the Alabama Law Review, Birnbaum, *Some Remarks on "The Right to Treatment,"* 23 ALA. L. REV. 623 (1971). For purposes of illuminating issues and criticisms raised in response to Dr. Birbaum's initial presentation, however, his remarks are summarized.

1. *Rouse v. Cameron*, 373 F.2d 451 (D.C. Cir. 1966).

2. *Nason v. Superintendent of Bridgewater State Hospital*, 353 Mass. 604, 233 N.E.2d 908 (1968).

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

Florida State Hospital for almost fifteen years before he was finally released.<sup>4</sup>

According to Dr. Birnbaum, American society has an outdated concept of the legal protections to be provided for the mentally ill. Under the present scheme of things, a substantive inquiry is made as to the existence of a mental illness, and then a procedural question of voluntary or involuntary confinement arises. The inquiry and concern of society seems to end for the most part at this point. Dr. Birnbaum proposes that society must stop rejecting the mentally ill at this point and inquire into the adequacy of the treatment provided.

The incentives for making such an inquiry are the present need and the resulting benefit to be gained. Annually, 400,000 persons are inmates in public mental hospitals, and 800,000 are treated for mental illness each year.<sup>5</sup> In the states of Alabama, Connecticut, and Florida, the physician-patient ratio is 1/800 or 1/900, and the ratios in other states are not much better. To illustrate conditions in such institutions, Dr. Birnbaum related the story of a Maryland mental hospital where visiting supervisory psychiatrists noticed that a patient was suffering from pellegra—a vitamin deficiency that can in itself cause mental illness. A dietary solution was provided, but hospital officials noted that budgetary problems might mean the reappearance of pellegra.<sup>6</sup>

To establish the right to adequate care and treatment in public mental hospitals, Dr. Birnbaum proposed that objective standards be used. The standards are to be applied on a macro-scale by observing the institution as a whole rather than observing and calculating the particular therapy received by each individual. According to Birnbaum's analysis, this latter approach would evoke more problems than it would solve. By compelling hospital staffs to spend long periods of time attending hearings to determine the adequacy of each individual's therapy, anti-therapeutic effects would result. More simply, from a practical and procedural standpoint, it is difficult to administer.

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4. Birnbaum observed that four times during the last decade the Supreme Court refused to grant certiorari to review lower court decisions that had declined to openly state whether a constitutional right to treatment exists. *Donaldson v. O'Connor*, 400 U.S. 869 (1970); *Donaldson v. O'Connor*, 390 U.S. 971 (1968); *Donaldson v. Florida*, 371 U.S. 806 (1963); *In re Donaldson*, 364 U.S. 808 (1960).

5. NATIONAL INSTITUTE OF MENTAL HEALTH, DEPT. OF HEALTH, EDUCATION AND WELFARE, *PATIENTS IN STATE AND COUNTY MENTAL HOSPITALS 1967* (Public Health Service Pub. No. 1921, 1969).

6. *Psychiatric News* (official newspaper of the American Psychiatric Assn.) May 5, 1971, at 18, col. 4.

Instead, Dr. Birnbaum proposes seven objective, institution-wide standards that would raise the general level of treatment for all patients.

1. Hospitals should be accredited by the Joint Commission on Accreditation of Hospitals, which has been established by the American Hospital Association, the American Medical Association, the American College of Physicians, and the American College of Surgeons. Most of the general hospitals in the United States are accredited by the Joint Commission, whereas only 100 out of the 300 public mental hospitals could meet the minimum standards of the Commission. The standards include a satisfactory physical plant, provisions for a pharmacy and a laboratory, minimum cleanliness, and minimum records.<sup>7</sup>

2. Hospitals should be accredited by the Social Security Administration. The Social Security Administration, upon request, will investigate a hospital to determine whether or not it meets its standards, such as medical record requirements and base staffing requirements.<sup>8</sup> If a hospital has the accreditation of the Joint Commission on Accreditation of Hospitals and meets the standards of the Social Security Administration, then it can qualify for federal funds, without a separate investigation.

Dual accreditation by both the Joint Commission and the Social Security Administration would insure that public mental hospitals meet minimum levels of care and treatment and that they would receive federal funds.

3. Hospitals should be accredited by the American Psychiatric Association.<sup>9</sup> This association adds specific requirements to the general ones supplied by the Joint Commission on Accreditation of Hospitals and the Social Security Administration. For example, the latter two agencies establish physical plant standards of fire controls and sanitation; the American Psychiatric Association sets up minimum space standards for physical facilities.

4. Hospitals should meet personnel-patient ratios.<sup>10</sup> For example, in 1956 the American Psychiatric Association first advocated minimum personnel-patient ratios for public mental hospitals, such as one physician for 30 patients on the admission ward and one physician for every 150 patients on the continued care ward. In contrast, the present physician-patient ratio in public mental hospitals is 1/800 or 1/900.

5. Hospitals should employ only state-licensed professional per-

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7. For an elaboration of the standards, see JOINT COMMISSION ON ACCREDITATION OF HOSPITALS, ACCREDITATION MANUAL FOR HOSPITALS (1971).

8. 20 C.F.R. § 405 (1971) sets forth the standards which hospitals are required to meet for eligibility for funds under Medicaid and Medicare programs. 42 U.S.C. §§ 1395-96 (1970).

9. AMERICAN PSYCHIATRIC ASSOCIATION, STANDARDS FOR PSYCHIATRIC FACILITIES 64-66 (1969).

10. See AMERICAN PSYCHIATRIC ASSOCIATION, STANDARDS FOR HOSPITALS AND CLINICS 44 (rev. ed. 1958). The American Psychiatric Association, it should be noted, no longer advocates these personnel ratios.

sonnel. There is a prevalent state policy of permitting foreign-trained personnel, not licensed by the state, to treat the mentally ill. An attack must be made on the philosophy of creating one standard for the population in general and creating a substandard for the mentally ill. Dr. Birnbaum made clear that this attack is not made upon the foreign-trained personnel themselves, but upon a society willing to apply a double standard to the care and treatment of the mentally ill.

6. Hospitals should require periodic progress reports on each patient. Dr. Birnbaum's own vast experience in federal, state, and city hospitals has made him aware of a "civil-service" mentality of getting all and doing nothing in return. If regular reports were required there would be the assurance of examinations and consultations, *e.g.*, once a week for the first two months and at least once a month thereafter. Thereby, patients would not be ignored, and the personnel would maintain a high level of performance.

7. Intermediate facilities must be established to ease the patient transition back into society. The patients should not always be presented with the choice of confinement or no confinement when what they need is a helping step of a halfway house. Families are not always available or willing to assume this responsibility, and both patients and society in general stand to benefit from halfway houses.

Dr. Birnbaum believes that all seven objective proposals can and should be implemented into our 300 public mental hospitals, so as to raise the level of treatment. Furthermore, he proposes legal sanctions to insure their implementation. Dr. Birnbaum argues that the current legal machinery of mandamus or a civil suit for damages does not solve the dilemma of a patient who is receiving or has received inadequate treatment in a public mental hospital. The current legal machinery is time-consuming, cumbersome, and ineffective. Under the Birnbaum system, the immediate relief of discharge would occur. The two-part system for solving the problem of inadequate care and treatment through the courts if the public mental hospital is unable to prove that it has met required objective institution-wide standards is:

- 1) discharge of voluntary patients upon request; and
- 2) discharge of involuntary patients after a habeas corpus procedure or some sort of simplified administrative procedure.

Dr. Birnbaum believes the right to adequate care and treatment in public mental institutions is a problem that society can no longer afford to ignore. He argues that public mental hospitals can be upgraded

through definite, objective means, and that patients who are given sub-standard treatment must have an opportunity to voice their disapproval. He maintains the age-old excuses of money and personnel are meaningless to an era that has seen medical personnel recruited into armies—such as during World War II when 50 percent of the medical population served 10 percent of the general population without any disastrous effects on national health care. The suggestion that time will provide some sort of medical plan is similarly meaningless, when one considers that none of the competing medical plans—Nixon, Kennedy, American Hospital Association, or American Medical Association—allocate funds for confined in public mental institutions. Dr. Birnbaum concludes then that affirmative action is needed to end the total rejection of the mentally ill—a rejection that is political, economic, and even professional.

#### PROFESSOR TWERSKI'S OPENING REMARKS

Ladies and gentlemen, I must say that I'm always very interested in what I'm going to say. After listening to somebody get up and talk about the right to treatment and setting forth why that right to treatment is so important, it's really going to be enlightening to find out how I could be opposed to it. I think it's the equivalent to being opposed to motherhood or the American flag or apple pie or something of the sort. But I'm reminded of a situation I had when I was a student in seminary. We had an old Talmudist who was a very, very fine teacher. I remember one day asking a question. Apparently the question was quite incisive and the teacher looked at me. He said, "Twerski, you're a hundred percent right, but I'll show you where you're wrong." I'm afraid that I'm going to have to take the same position here with Dr. Birnbaum—whom I, of course, greatly admire for the work he's done in the area. Dr. Birnbaum, I believe, is 100 percent right, but I think I can show him where he's wrong.

First of all, we have to take a good look at what a typical civil commitment case looks like today. Dr. Birnbaum has set forth the right to treatment in a way that we're going to have objective standards. That means we're going to look at a hospital and find out if we have a 1/30 ratio per doctor-patient for new admissions and 1/150 doctor-patient ratio for long continued care patients. We will then determine on that basis whether or not the hospital should be or is an appropriate place

to commit a patient. A court or administrative agency will look at those statistics and decide. If the hospital doesn't meet that standard, then obviously the patient can no longer be committed and he has a right to go free.

If Dr. Birnbaum is correct, we're going to do away with subjective evaluation. That means that we will not examine every patient and find out what his mode of therapy is. The problem is that we're going to have to do it at an earlier stage in the game. Although Dr. Birnbaum's proposal doesn't address itself to the subjective evaluation question, we have the problem with us and we're going to have to face it. Let's take a typical civil commitment case today. Take, for example, a woman with post-menopausal depression and the husband wants to commit her. The status of the law today is such that if you want to commit that kind of patient you have to go to court. The patient can, of course, sign herself into the hospital voluntarily; but if we assume that this woman is depressed enough so that she doesn't want to sign herself in voluntarily, we're going to have to go to court. Now what takes place? Go downtown to Orphan's Court on any given day and you can witness a very interesting show. The patient is brought into court. The doctor from a state mental hospital who is servicing these one to five hundred (or one to six hundred or one to seven hundred) patients is spending the morning down at court testifying why a particular patient ought to be committed, rather than treating a couple of patients where he can do some good (in the process he may alienate the patient). We go through a very elaborate procedure to get a certain class of patients into a mental hospital. These are the facts today.

If we work with involuntary commitment—and I'm afraid that for a certain category of patients we will continue to have to work with involuntary commitment—we are going to go through a subjective evaluation. We cannot avoid asking the question in such a procedure whether a particular patient is "crazy enough" or has sufficient mental illness or mental disability, which ever way you want to define it, to be able to be confined. Perhaps it is not a critique of Dr. Birnbaum's proposal that he doesn't address himself to that problem, because he admits that he doesn't address himself to that problem. But I think I will indicate to you, a little bit later on, why that is a very significant part of the problem and why we're going to have to solve it. If we don't solve it we're going to rob very, very scarce psychiatric personnel from mental hospitals today to get the patients committed through court procedures—and to

do an awful lot of harm to the doctor-patient relationship in the first instance.

Dr. Birnbaum has challenged those who disagree with him to come up with a better proposal and I have accepted the challenge.<sup>11</sup> Whether the proposal is better or not you will have to judge for yourself. At this stage of the game let me point out (and I hope you will keep this in the back of your mind) that subjective evaluation at the present date is going to continue to operate. It is going to operate, because in order to get the patient in, we have to have the one-to-one case that Dr. Birnbaum dislikes.

How is the Birnbaum proposal supposed to work? It has been basically incorporated in the proposed right to treatment law that is presently pending before the Pennsylvania legislature. It works something like this. You set up the minimum standard. There's 1/30 and 1/150 doctor-patient ratio for appropriate classes of patients. We find out whether the hospital has a sufficient laboratory and all the other facilities that a good hospital ought to have. Then we set up a patient treatment review board. This essentially means that the patient who feels that he is not getting appropriate treatment can come to the review board and say:

I want out because I'm not being adequately treated and I'm not being adequately treated because the hospital doesn't have sufficient facilities. They don't have the appropriate doctor-patient ratio. I'm supposed to get so many visitations per month. I didn't get those number of visitations per month and I want out.

In order to test the validity of Dr. Birnbaum's proposal I have jumped five, ten, or fifteen years ahead and hoped that we've reached the best of all possible worlds—the world in which Dr. Birnbaum's proposal has come true. In fact, let us suppose a world exists where we have the appropriate doctor-patient relationships of 1/30 for admissions and 1/150 for custodial care patients. Let's see how that looks.

Dr. Birnbaum mentioned the *Donaldson* case. Donaldson was essentially a paranoid schizophrenic who was committed to one of the Florida State Mental Hospitals. He was there for fifteen years. The doctor-patient relationship was 1/900. What will happen if the doctor-

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11. See Twerski, *Treating the Untreatable—A Critique of the Proposed Pennsylvania Right to Treatment Law*, 9 DUQ. L. REV. 220 (1970). Professor Twerski's legislative scheme was presented in full in the Duquesne Law School magazine, 3 JURIS, May, 1970, at 8 and was reprinted in an article entitled *Court Scrutiny of Mental Commitment: Collusion on Delusion*, 118 P.L.J. 10 (July, 1970). See also this debate, pp. 562-65 *infra*.

patient relationship is 1/150 for a custodial care patient or one who is a continued care patient? Donaldson is still going to be there. You know why? Because there's no place else to go. We have set up our mental institutions such that they deal with long-term custodial care patients. They're designed to do it. Society is obviously uncomfortable with the mentally ill. They're funny; they talk different. The analogy that it's a little bit uncomfortable to talk to people who start the sentence with a predicate and end with a subject is true. We are put into a very serious sense of discomfort with the mentally ill. Their families don't want them, and people who deal with mentally ill all the time know that even when a patient is "releasable," there is no one there to release him to. That was the problem with Donaldson—because they would have released him if they had a place to do it. But you see what happened was that the mental institution was set up to take care of long-term custodial care patients.

The Right to Treatment Act is presently pending before the Pennsylvania legislature. As important as it is, it will not solve that problem, because it continues the very same institutional framework. The institutional framework remains long-term custodial care institutions. That means that Donaldson would be there for twenty years. Whether a hospital has an appropriate doctor-patient relationship is irrelevant. It may very well have it. Assuming the hospital has it, we're going to still keep him there because society wants to tell us that they're going to treat him. And the hospital is going to treat him for one year, two years, three years, five years, ten years, twenty years.

I'm reminded of the story of the fellow whose wife was very sick and was hospitalized. Every day when the doctor came, he asked the doctor, "How's my wife doing?" The first day she was there the doctor replied, "Well, she's improving." The patient's husband came back the second day and asked, "How's my wife doing?" The doctor answered, "Well, she's improving." The third day she was improving and the fourth day she was improving. Finally on the fifth day she died. As the husband left the hospital someone came up to him and said, "I'm sorry to hear that your wife died." And he said, "What did she die of?" The husband answered, "The best I can tell, she died of improvement." I have a feeling that is what we're going to talk about. The patient will die of improvement because he's going to be treated for twenty years on end and that won't change anything. It won't change anything because the institutional framework is set up all wrong.

I disagree with Dr. Birnbaum because I don't think that his approach will solve the institutional problem. How do you go about solving the institutional problem? I believe that we're going to have to have involuntary commitments. The American Civil Liberties Union, every now and then, comes out with some noise about doing away with involuntary commitments and begins drawing analogies to political oppression in Soviet Russia—suggesting people are being made political prisoners and being sent to mental institutions and things of that sort. In my humble opinion, it's nonsense. I don't think people are railroaded into mental institutions. I believe that people who go to mental institutions in this country are sick, are mentally ill. I don't agree with Dr. Szasz that there is no such thing as mental illness. I think that it's a very real thing, and when we can help a patient, I believe we ought to be able to commit him. But I think that we have to change the entire psychology of the way the commitment process works.

I have suggested after lengthy discussions with my brother, Dr. Abraham Twerski, who is Chief of Psychiatry at St. Francis Hospital, that we set up a simple commitment procedure.<sup>12</sup> Rather than the court asking how sick the person is or whether he should be committed, I believe we must let the psychiatrist evaluate and decide. I have full faith that psychiatrists in this country are not in the business of committing people for no good reason. I believe they will commit someone when they believe that he is very seriously mentally ill and they can help him. I think, however, we're going to have to put realistic time limits on the time allowed for treatment. I don't think that twenty years is a realistic time limit; nor do I think that ten years is a realistic time limit, nor five.

I would like to see us set up a commitment procedure which works for approximately 60 days. You commit somebody to a mental hospital for 60 days. For that time interval, the doctor doesn't have to go to court to get the commitment. The two doctor involuntary commitment rule, which was known in Pennsylvania before as the 404 rule,<sup>13</sup> should remain valid. Once that patient is in the hospital, the doctor has the right to treat him or her for those 60 days. If the patient wants to test the commitment by habeas corpus, all right. But that won't happen, because by and large the only way the patient can go out is by challeng-

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12. See Juris, *supra* note 11.

13. Although *Dixon v. Attorney General of Pennsylvania*, 325 F. Supp. 966 (M.D. Pa. 1971) declared long term involuntary commitments without a hearing unconstitutional, a scheme can arguably be developed involving two-doctor commitments which will pass constitutional muster (as, for example, by providing for shorter duration commitments and immediate judicial review).

ing the doctor's belief that the patient is treatable. Then the commitment will stand. I doubt that there are going to be complex court procedures challenging such time-limited commitments. The maximum period of time for the commitment would be 60 days. In very extreme cases I would be willing to renew the commitment for another 60 days or another 120 days. But at some point we're going to have to admit to ourself what we're doing. We are no longer treating; we're becoming a custodial care institution.

I was charmed by Dr. Birnbaum's statement about how doctors treat: "They cure rarely, relieve often, and comfort always." That sounds nice, except when you think we're comforting a patient who doesn't want to be comforted. If the patient wants out, it seems to me that he has the right to get out, and we ought not, at any stage of the game, say commitments can last for an indefinite period of time just because we have the appropriate doctor-patient ratio. And that is what is going to go on under, it seems to me, Dr. Birnbaum's proposal.

I think the tactical effect of such a change could be very, very strong indeed. First of all, such a change would set up a dichotomy between the two kinds of institutions—treatment institutions and custodial care institutions. Mental hospitals would lose the stigma of being long-term prisons. You may not be aware of the fact that the voluntary commitment rate at a private hospital, at least prior to the *Dixon* decision, was something like 80-85 percent. In the state hospitals it was something like 20 percent. The reason for the disparity was quite simple. State hospitals have the image of being long-term prisons—which in fact they were. This is not because the doctors wanted to serve as wardens, not because doctors were bad people, and not because they wanted to hurt the patients. It is because society has forced upon the mental hospitals a role that is not appropriately theirs.

It seems to me that the role of the mental hospital, both private and public, is primarily a treatment institution. Conceivably you can treat a patient for a year or five years or for ten but, it seems to me from a civil libertarian point of view, one has to say in effect, "Let's talk about a realistic time for treatment, limit it at that point, and call it quits." What happens after that? If involuntary commitment cannot last after more than 60 days or 120 days, we will get change. The change will come about not because these patients will go home, because they are not wanted at home. But what can happen is that by limiting the commitment rate one can force the institutional change to halfway houses, to

open living institutions for those who are mentally ill and who are chronic patients.

I said in my article that no right to treatment bill would solve the very real problem of treating the untreatable.<sup>14</sup> I think that the statement is accurate. I don't think that the untreatable can be treated, and I don't think that we ought to make the illusion. The longer we continue on with the illusion, the longer we enforce a mental image of a mental hospital, as a custodial care institution. It's wrong the law has helped to commit people for tremendously long periods of time in mental institutions with the illusion that they are going to be treated (when even if they had proper staffing requirements they wouldn't be).

One other problem can arise by requiring minimum staffing. It is no great secret throughout the country that there is what is known as paper staffing. If you want to face up to it, all right, if you want to bury your head in the sand, that's all right too. But there's a tremendous amount of paper staffing going on in many mental hospitals and it is a national problem. Everybody recognizes it. Now what happens when we get the right to treatment bill? We are going to check the staffing requirements for the hospitals. How are we going to check them? We'll go through the hospital records and find out what the staffing requirements are. They are going to be beautiful! That doesn't mean the doctors are going to be there, because the doctors are going to be out in private psychiatry, earning the kind of money they can in private psychiatry. I don't agree, as a very practical matter, with Dr. Birnbaum that we're going to get the change because I don't think the state of Pennsylvania or any other state is going to be ready to pay a private psychiatrist \$75,000 to \$100,000 a year (which he can get on the outside), to come into a public mental institution. I think that's daydreaming and it's very unrealistic. What we're going to have is part-time staffing in mental hospitals, as we have today, with a tremendous amount of paper staffing. There will be no way to police the right to treatment act that Dr. Birnbaum proposes.

I come back to my proposal. Let's change the institutional structure. If we can change the institutional structure by limiting mental hospitals to short-term intensive therapy and move the other patient population out to halfway houses, to the sort of situation where we have social workers, we will get a phenomenal percentage of voluntary commit-

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14. Twerski, *Treating the Untreatable—A Critique of the Proposed Pennsylvania Right to Treatment Law*, *supra* note 11.

ments. We will not need the involuntaries. Second, the involuntary commitment I have proposed is not a court procedure and it would not require the subjective evaluation that goes on today. I would rather hope that if my legislative proposal would go through, that when we ask the question of the psychiatrist in the future, "Are you your brother's keeper?" he could answer realistically, "No, I am my brother's healer."

DR. BIRNBAUM'S REPLY

Frankly, I have no disagreement with Professor Twerski's comments and suggestions. I prefer not to comment about them, because he's talking about apples and I'm talking about oranges. I wouldn't care if he suggested that a patient be committed for only six months. All I'm saying—and what I can't seem to make clear in my writing—is that if you're in this hospital for one day, for one year, or for ten years, you should get certain minimum standards of treatment. He's talking about apples and I'm talking about oranges.

There used to be a saying, "The light of many candles leaves no shadows." I'm not saying that I have the only solution. Right to treatment is a partial solution to what is realistically an unsolvable problem—how to handle difficult-to-handle people. All I'm saying is that if you talk about conditions where there is one physician to a thousand patients, one nurse to a thousand patients, and a total absence of clinical psychologists, the solution I offer would be an improvement.

What do you do with patients after you send them out after one year or six months, whichever solution Professor Twerski suggested? What happens after that time? They'll be out on the streets, and they might come back to the hospitals again. Otherwise you do as we do in the advanced state of New York where I come from. We're emptying our mental hospitals. Do you know where we're emptying them to? The streets. I'm seeing now (for the last few years) what I've never seen before on Broadway and 63rd Street. The typical deteriorating state hospital schizophrenic can be found looking into garbage cans. If you know Broadway in that area (where the state hospitals are discharging these patients), two cops don't walk into these types of buildings at one time. When you call the police, if they ever do come, the police call two cars and walk in four at a time. Yet they expect a sixty-year old lady or man to walk in by himself.

Now what did I see the other day on Broadway? A man walking naked down the street at 4:00 in the afternoon. So I asked the police officer, "Why don't you take this man to a hospital?" He said, "Why, he doesn't want to go." This is reality in New York.

The *New York Times* wrote an article about all these people. They're sleeping in the streets on Fifth Avenue at night. They have rooms in a welfare hotel because New York State has emptied its patients from the state hospitals and put them on the welfare roles. That's progress? I mean, everybody has his own evaluation.

What I'm pointing out again is that I'm offering *a* solution, not *the* solution to a really very difficult-to-handle problem. Whatever solution you offer is really not 100 percent perfect. What I'm offering, what I'm suggesting, are minimum standards for these hospitals, not optimum standards. I admit that professional medical personnel will still control who will be hospitalized through a subjective evaluation. But this has nothing to do with what I'm discussing. I'm just saying that you need objective standards to determine whether a patient is receiving adequate treatment. The courts have never acted in this area. I think they should crawl before they walk, walk before they run. The issue is where the courts will act in the future in an area where they don't act now. As far as I'm concerned, the courts do not involve themselves, if they can possibly avoid it, with the rights of the civilly committed.

#### PROFESSOR TWERSKI'S REPLY

When Dr. Birnbaum started out he said that he doesn't disagree with me. I think that it's only fair to say that in substance, in terms of what we're both looking for, we're looking for very much the same thing. But I'm afraid that the analogy to apples and oranges won't stand. You see, what's going to happen here is very simple. The legislature is going to have to do one thing or the other. They are going to take up the problem when we finally knock enough heads together.

Let me say something about the legislative process at I view it. We do not in this country have active legislative revision. When a legislature gets to the job of writing a piece of legislation they write a law. It is intended to stay indelibly in the statute books for close to all time. They change it sometimes after a terrible, terrible catastrophe and then only sometimes. Look at gun legislation. Now you may be pro or con but in light of all that has gone on in the past years, gun legislation is still a

dream. We in this country have, for better or for worse, a distaste of government. We were weaned in this country on laissez-faire government—that meant that government stays out of our business. And that means that when government finally does get into the business by writing a law, you can expect that it's going to stay there for a long, long time.

What I'm concerned with is that after the legislature pats itself on the back by writing the right to treatment law (and I have no objections to the right to treatment law *per se*—I have no objections to somebody saying that a mental hospital ought to be properly staffed), nothing will change institutionally. The institutional framework will remain what it presently is and that is long-term custodial care. The image of mental institutions will, in short, remain precisely what it is today—and that grieves me greatly.

Furthermore, I think that when we talk about why the Supreme Court denied certiorari in the *Donaldson* case four times<sup>15</sup> and in all these other cases (and by the way it's a scandal—I couldn't agree with Dr. Birnbaum more), we ought to ask ourselves realistically why they didn't hear these cases. I think the answer is probably quite simple. The medical profession in this country has an aura all of its own. Doctors don't make mistakes. Doctors are there to help the patient. The doctors have an immunity. Now we've been cutting it down somewhat. Doctors are now altogether aware that malpractice is in the picture, but it's a fairly recent innovation. A malpractice suit is still even today an oddity.

Now what the Supreme Court was saying in *Donaldson* is, "How do you expect us to get involved in telling doctors how to treat patients when the doctors say that they are treating them?" It is the medical profession and the psychiatric profession that is at fault (and they're at fault because they make the illusion that they are treating in a real sense long-term custodial care patients and it's time to stop the lie). It's time to tell it like it is. The patients that are in the hospital for twenty years are getting food, they're getting sleep, a place to go to sleep, but they're not getting realistic treatment. It is time, it seems to me, for the medical profession to say that realistic treatment in any real substantive sense is an illusion. When that happens, I think that we can get certiorari in these cases, because the medical profession will then have told the court that all they are doing is acting as sophisticated prisons. And I say this again without any malice toward the medical profession—they've

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15. See note 4, *supra*.

been forced by society to do a job which is not theirs. They have been forced to take on a role which is not the role that the medical profession should have.

Doctors should primarily treat and they shouldn't be wardens. What has happened in the vast number of state mental institutions is that doctors have sadly become wardens. I meant it very seriously that the entire role change is of great importance here. We can't get society to respond until we begin facing the problem of long-term custodial care patients. I agree with Dr. Birnbaum—the specter of having someone walking naked down Broadway is very upsetting. It's terribly upsetting. But the only way we're going to begin forcing the answer to that problem is not by releasing patients from mental institutions, because they should not be released "out to the streets." That's cruel. It's probably cruel and unusual punishment if I may borrow a phrase from the Constitution. It's a terrible thing.

If we want proper staffing, and if we want to change the institutional structure, I suggest we address ourselves to the legislature by telling them what the problem is. The problem is partially a problem of staffing, but also a problem of medical impossibility. When we face that fact, it seems to me we can get the kind of institutional change that will really be meaningful.

#### MORNING FISHBOWL DISCUSSION<sup>16</sup>

##### *Panelist Question and Comment:*

*Walter W. Stelle*

I'd like to address myself to a couple of assumptions made by Professor Twerski. They are unfortunate assumptions, I think. Professor

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16. The participants in the morning Fishbowl discussion included: Dr. Morton Birnbaum; Professor Twerski; Dr. Joseph J. Baker, Chief of Psychiatry, Neurology, and Psychology, Veterans Administration Central Office; Dr. Eugene M. Caffey, Jr., Chief of Psychiatry, Veterans Administration Central Office; Dr. Charles A. Stenger, Psychologist, Veterans Administration Central Office; Delwin Anderson, Chief of Social Work, Veterans Administration Central Office; Daniel J. Parent, Chief Attorney for the Pittsburgh regional office of the Veterans Administration; Mary D. Baltimore, Social Worker and Assistant to the Honorable K. Leroy Irvis, Pennsylvania State House of Representatives; Gladys Bolling, Chief of Social Work, Leech Farm Road Veterans Hospital; Ruby Holozs, Chief of Nursing, Leech Farm Road Veterans Hospital; Nathaniel Young, Psychology Aid, Leech Farm Road Veterans Hospital; Walter W. Stelle, Psychology intern, Leech Farm Road Veterans Hospital and doctoral candidate in psychology, University of Pittsburgh; and Dr. Robert Hickey, Chief of Psychology, Leech Farm Road Veterans Hospital. The Fishbowl discussion group was conducted in an informal manner. Audience participation was encouraged. It should be assumed that any speaker not identified in published portions of the Fishbowl was a member of the audience.

The *Review* would like to thank Dr. Robert Hickey for his help in identifying different speakers on the program and their corresponding remarks.

Twerski has stated that lower patient-personnel ratios will not change the institutional structure of our mental hospitals—which have been designed primarily and historically as custodial care institutions. I think this is incorrect, because if anything, high ratios encourage custodial care. If the ratios were lowered you would have more personnel who could be involved with rehabilitation efforts for the patients they are serving.

It is also interesting to note that psychiatry hasn't been in the mental hospital business for all that long. As a matter of fact, the medical profession didn't enter into the mental hospital situation until about 100 years ago. Prior to that most of the mental institutions—there were not many—were cared for by church-related agencies. At this time there was a kind of therapy known as moral therapy—which involved low ratios between personnel and patients, which involved a lot of work and occupational therapy, and which involved an attempt to relocate these people in their communities. This kind of moral therapy is now the new thing in our mental hospitals today, so I think that it is incorrect to assume that lower ratios will definitely continue custodial care. I think we can treat the custodial care problem by lowering our ratios.

My second point is that Professor Twerski has made the assumption that after 60 days a patient should be removed from a treatment facility to what, in fact, amounts to a custodial care institution or non-treatment facility. This is making the assumption that there are some mental patients who can be treated and others who can't be treated. I think this is very unfortunate because there is treatment for *any* person. First of all, what Professor Twerski seems to be saying is that there is a large majority of patients who cannot be helped. What this means is that these patients will be relegated to back wards, will be cared for in a custodial fashion, and may in fact suffer from nutritional deficiencies, *ad infinitum*. Also what might happen is that research funding would stop for an attempt to find cures for chronic illnesses if the assumption in the law books is that there is nothing you can do.

Thirdly, I think that things can be done for chronic patients and I believe what Dr. Szaz says—that mental illness is a myth. Mental patients do not have some kind of biological disease. They do not have some kind of bug that they have caught like a cold. They are people who cannot live effectively in the outside world. They are brought into the hospital because they have failed to live adequately in the community. Their

behavior is what brings them into the hospitals. They're unproductive; their behavior is abhorrent and crazy, or bizarre.

All behavior is learned. We know this to be fact. If behavior is learned, it can be unlearned. Look at our chronic mental patients as people who need to relearn new skills, who need to unlearn poor habits. By applying modern psychological techniques to modify this behavior, changes can be made in the chronic patients. Examples of this are the Token Economy Programs which are going throughout the country and which are helping chronic patients to a great extent. Maybe these chronic patients in your Token Economy Wards are not out on the street holding down a nine-to-five job. But they're not sitting in a chair anymore vegetating and dying at a young age. They're involved in the hospital community. They have part-time jobs. They're going downtown. They are living a much more productive life. If we do away with the disease model and look at our patients as being people who need relearning or re-education, and that our institutions should not be mental hospitals but learning facilities, then we have made a big step. But if you make the assumption that some people cannot be helped, then you are guaranteeing that they will never be helped. And it's similar to someone saying sixty years ago that a machine heavier than air will never fly.

*Professor Twerski*

That's a rather tall order to respond to. First of all, I think that there's an assumption in your comments that I am unwilling to deal with the backlog problem in any realistic fashion. The problem that you are discussing, it seems to me, is primarily a backlog problem of institutions that were not responsive for fifty years. With regard to people who have become institutionalized, who have been in institutions for ten, fifteen, or twenty years, all the more power for anything that you can do. And whatever the program is, I'm obviously open to it since I will have to deal with the backlog problem in some realistic fashion. There is no question of that.

Secondly, I am not concerned primarily with the voluntary patient. It seems to me that if the institution becomes a learning institution, and if you're dealing with a patient who comes in today, do you need him in the mental hospital as an involuntary patient for more than 60 days? My suggestion is that if you need him there for more than 60 days as an involuntary patient, something is wrong with the hospital.

## Observations on the Right to Treatment

### *Panelist Question and Comment:*

*Dr. Robert H. Hickey*

First of all, the approach that the previous questioner was talking about, the model that he was talking about, isn't just appropriate for chronic patients, for the backlog. It's being used with active duty soldiers at Walter Reed and it's being used at the Robert F. Kennedy Training School for Juvenile Delinquents. It has been used with the retarded and the severely retarded as well.

Furthermore, I think all of us in the field who work with people and have seen people who are making slow, fairly steady progress, often do not believe six months is enough. I'll give you an example. A young fellow in his late twenties was constantly plagued by hallucinations and voices telling him to kill, to strike out—he put his fist through windows, broke his fist on doors and walls, and set himself on fire. He was under observation. The nurse turned her back for a second and he soaked his clothes in lighter fluid, lit a match, and went up like a torch. This fellow has spent two and a half years on the Token Economy Program. In the best of possible worlds, maybe we would have had some way to get him out in six months. It took us two and a half years, step by painful step. Because there is no steady progression, it took him really two and a half years of constant reinforcement and strengthening of constructive or healthy kind of behaviors. More important in his case, was demonstrating to him that he was a worthwhile person—to give him the confidence to try things out, to get him out living on his own in a Halfway House. But we could only accomplish these things over a long period of time during which we needed the authority of an involuntary long-term commitment.

*Professor Twerski*

Dr. Hickey, I suggest that you've made the best case for my argument. The problem is now that you have set up a very difficult alternative. Theoretically you could have treated this man for ten years. It would have taken ten years of reinforcement. The image of your hospital, therefore, would have been a long-term institution. I think you're going to have to face up to that problem and make a decision. You may lose a patient now and then who ought to stay. We're not working with anything closer than good percentages anyway.

I'm under substantial attack for my sixty day proposal. I figured I

would be, but let me say again that what I'm concerned with is the involuntary commitment for sixty days. The other thing that I'm concerned with is that one of the reasons we may not be getting the alternatives in terms of community services is because we've been passing ourselves off in the wrong direction. If we begin dealing with the hospital as a treatment facility, as a learning facility, rather than as a long-term custodial care institution, we may be able to generate the other types of necessary services. But as long as we insist on continuing on the present model, we're not going to get them because we're doing the job. We're keeping the mentally ill people off the streets, and we're doing what society wants us to do. I am willing to live with 90 days, 120 days, or some realistic figure—but I would like the treating facilities in this country to limit themselves in some realistic fashion consistent with the concept of treatment.

*Dr. Birnbaum*

My comment on the 60 day period is that I think that 60 minutes is too long in the wrong facility. I simply don't think you should even be allowed to enter a hospital that isn't set up properly. I am reminded of a situation I was involved in in New York three years ago. When I first started in a state hospital I left one patient at 5:00 and I said, "Good day, I'll see you." And he looked at me and said, "Is he going to leave me here with all these crazy people? It's terrible here. You can't do that to me. Look, they're hitting me and everything." Often 60 seconds can be too long in the wrong facility. Also I am reminded of the story of two doctors in New York City a few years ago. Somebody called and wanted to get out of Bellevue. These doctors without a second thought would go down and sign anybody out. Their attitude was that no matter how bad it was in the streets, it's worse in Bellevue.

*Panelist Question and Comment:*

*Dr. Eugene M. Caffey*

I'd like to remind you that the mental hospital evolved not only from the church but from the old term asylum. And this is really a beautiful word. We've loused it up by the connotations we gave it. I think anyone who's worked around psychiatric hospitals, state hospitals, or others recognizes that there is a certain population that needs asylum. Asylum is an important function. Whether we like it any longer as part of the

## Observations on the Right to Treatment

present day mental health operation, it is an important need. We still have patients, persons whom we identify as patients, who would probably be better served in a different kind of setting entirely, whether it's a nursing home, a halfway house, whatever you want to call it. I don't suppose we'd ever call the treatment institution an asylum again though. On this point I don't think we are sentencing certain categories of patients to no treatment or to a hopeless status. If we recognize a certain class of patients as primarily needing asylum and then set out to provide this in the best way, the most humane way, the kind of way that keeps them most involved in planning their own activities and doing their own, there is no need to fault our efforts. What we have to do is come up with some kind of asylum for some people that won't destroy them.

### *Panelist Question and Comment:*

*Dr. Joseph J. Baker*

I have misgivings though about the possibilities that adequate treatment can ever be institutionalized and codified into law. I don't think that standards alone or ratios of personnel can really impart the flavor of what we're trying to do here. You can't measure it, you can't quantify it anymore than you can quantify the depths of a depression. There is just no way to measure the kinds of encounters that go on in a hospital—and this is what makes the difference between a treatment program or a good therapeutic program. You just can't measure these intangible factors. This is why I have misgivings every time I hear Dr. Birnbaum—though no one could be against the basic hypothesis that every person has a right to be helped who needs it.

### *Panelist Question and Comment:*

*Gladys V. Bolling*

I am a social worker, and I have been interested in human beings and the right to treatment—not particularly to the Right to Treatment Act (or legislation) but the right to treatment as a human being. I think this has to be done on all levels—on many levels—and legislation is only one. I was struck with the term Professor Twerski used this morning, “the distrust of government.” I think our problem is not only distrust of government, legislation, and politics, but is also a mistrust of each other. Society is really not yet able to cope and grapple with any prob-

lem that causes unrest or anything that shakes up their stability—whether it's civil unrest, racial unrest, or whether it's mental illness. We're just not yet to the point of dealing with these things. Until we grapple with that personally and individually, we can't expect that institutions are going to be any different.

*Professor Twerski's Concluding Remarks*

I view the legal structure as an important one. I think that the legal structure—how we go about setting up the institutional level and the role that the law has in the institutional level—is vital. Law is a magnificent educator. *Brown v. Board of Education*<sup>17</sup> had a lot to do with changing societal attitudes toward how we were going to treat our black brother. There was a revolution. We have a long way to go in the mental health area, but I retain my faith in the law as a magnificent educator.

I would like to begin structuring legal institutions (*i.e.*, the legal response to the mental health problem) to deal realistically with the problem as I think we around the table view it. I think we will all struggle with the discussion of alternatives as being one of the most important problems. And I would like to see the legal structure define the role of the mental hospital so that we can begin looking at the other alternatives.

*Dr. Birnbaum's Concluding Remarks*

I think certain comments that have been made only serve to reinforce what I've said from the beginning. The right to treatment doesn't only improve conditions in the hospital; it helps the extra-hospital view of these patients. Put yourself in the place of an institutionalized patient. If I or a member of my family were in a hospital, what do I want from the day I enter? I would like to know that I can have my case reviewed after 60 days. But even more basically from the day I enter, I'd like to know there is adequate treatment. In light of these considerations my proposals for objective standards are not radical. Ask the man you meet in the street. Does he think there should be a minimum doctor-patient ratio? Does he think there should be 100, 200, or 300 patients to a doctor? He'll say yes.

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17. 347 U.S. 483 (1954).

AFTERNOON FISHBOWL DISCUSSION<sup>18</sup>

*Panelist Comment:*

*Marian Schwalm Furman*<sup>19</sup>

The background of the proposed legislation which has been in the last several sessions of the Pennsylvania Legislature is briefly as follows. Three very dedicated and committed men who seemed to be thinking along the same lines came together and realized they were thinking along the same lines. The three men were Dr. Birnbaum, Dr. Bartlett of Haverford State Hospital, and Michael Johnson, Executive Vice-President of the Pennsylvania AFL-CIO. These men recognized that in no state in the union until very recently was there a judicially recognized, legally enforceable right of patients in mental hospitals to treatment. Many state statutes, like Pennsylvania, contained directory but not mandatory language—to the effect that the purpose of commitment will be care and treatment and the mental health bureau shall provide the care or treatment. But what if this didn't happen? There was no remedy for the patient. Conditions in mental hospitals have been and are pretty deplorable. Legislative task forces have visited the institutions, have recognized the problem, and have wrung their hands. But nothing too much has ever happened. The goal was to draft legislation that would give patients a remedy—so that somehow we would require that there be treatment of some sort in the state mental institutions. The premise on which the bill was drafted is that a violation of the fourteenth amendment due process occurs when persons involuntarily committed to hospitals receive no or totally inadequate treatment.

The next problem that arose was finding a way to fit any kind of remedy into the existing administrative structure or hierarchy of the particular political jurisdiction. In Pennsylvania the responsibility for the state mental institutions resides with the Department of Welfare. Under the proposed bill the Department of Welfare would appoint a committee (which we call The Treatment Standards Committee) com-

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18. The Right to Treatment: Implications for the Commonwealth of Pennsylvania. The format of this Fishbowl followed that of the morning session, see note 16 *supra*. The participants were: Marian Schwalm Furman, Attorney, framer of the proposed Pennsylvania Right to Treatment law; Mary Baltimore, Assistant to the Honorable K. Leroy Irvis; Dr. Robert H. Hickey, Chief of Psychology, V.A.H.; Daniel J. Parent, Chief Attorney, V.A. Regional Office, Pittsburgh; J. Stephen Kreglow, Editor-in-Chief, Duquesne Law Review.

19. See Furman and Connors, *The Pennsylvania Experiment in Due Process*, 8 Duq. L. Rev. 32 (1969). For a text of the proposed Pennsylvania Right to Treatment law see *Id.* at 67-72.

posed of seven people representing certain interested disciplines. The disciplines include psychiatrists, administrative psychiatrists, physicians, social workers, etc.

This committee would then take six months to develop a set of standards appropriate as minimum standards of treatment for the state mental institutions. We wrestled long and hard in the skull sessions that Dr. Birnbaum, Dr. Bartlett, and Michael Johnson had as to whether the legislation itself should speak to what the standards should be. We agreed, for the most part, that we should not be tempted to try to put these standards into the statute itself—leaving such matters for the committee. In this way we believed that the regulatory process could be flexible as needed.

Time limits would then be set and the department would be given standards. The department would have a certain length of time to notify all of the hospitals what the standards were going to be. In this way the hospitals would have an idea of what would be involved in the way of additional personnel and facilities—so an idea of the cost involved could be attained. Two years after its passage the legislation would become effective. The patients would then begin having the right—an enforceable right to treatment.

Under the operative procedure there would be a Review Board made up of two psychiatrists, two attorneys, and two physicians. Every patient in the hospital would then be given in clear, simple language a résumé of what the minimum standards are and what his rights are. His legally responsible relative or best friend outside the institution would also be given a copy of the same document. If a patient felt that he was not receiving this minimum standard of care he could (or his representative could) file a petition with the Review Board. The Review Board would hear the patient and the patient could be represented by an attorney or by anyone else.

*Professor Twerski*

I have one question to ask. I found out a very interesting statistic this week and I'd like you to consider it. I visited one of the state hospitals the other day and I asked them in light of the changes that have been going on in the voluntary and involuntary commitment area, what percentages are they running in voluntaries and involuntaries. They said on the whole they are running 80 percent voluntary. They're running 80 percent voluntaries, not because these institutions have become beau-

## Observations on the Right to Treatment

tiful, but because chronic patients have no other place to go now that they're free to go. We're back to the problem we talked about this morning. I'd just like to raise this question in light of the *Dixon* change, which has essentially turned the major portion of mental patients in the state into voluntaries. The only enforcement procedure left in the act is the fact that the patient can seek release by habeas corpus. He is free to go today.

*Marian Schwalm Furman*

But that's not giving him treatment.

*Professor Twerski*

Yes, but we're giving him the right to leave and from what I've been told this last week he's free to leave if he desires. Can a patient force the right to treatment? Can the patient say, "You have to give me a doctor?"

*Marian Schwalm Furman*

Yes. This bill gives the patient an absolute right to treatment.

*Professor Twerski*

That's very interesting. Do I have the right, assuming I'm outside and have anxieties, to the services of a psychiatrist? Do I have the right to go to the state and say, "I would like to have a psychiatrist to treat me." I have read the bill very carefully and I think we have created a very novel thing here. If I read the bill carefully, if we're not talking about the purely institutionalized patient, right to treatment legislation gives every single member of the community a right to a psychiatric consultation once a week.

*Marian Schwalm Furman*

That's not as funny as it seems because provisions in the bill tie the medical need into public assistance requirements. In other words, if the patient himself or his family can pay, that treatment is to be reimbursed. If they're not able to pay, a determination is made of eligibility for payment for medical treatment under assistance generally.

*Question from the Audience*

I have a very simple question. If you're going to give me the right to treatment, I'd like to know how you plan to deliver it—especially in light of the fact there may not be enough staff to handle it?

*Mary Baltimore*

There are those who say that most psychiatrists, presently cater to the wealthy neurotic, and that if we had a different atmosphere in connection with state mental hospitals, we could entice many more psychiatrists away to give more of their time to the patients who really need help. I'm not in a position to say but that is what has been said by many. To respond to your question, "How are we going to deliver it?" is a difficult task. I think all the ramifications of the right to treatment bill are going to have to be clearly and explicitly explained to every legislative front. Even after you explain it, I'm not sure that they're going to go for it. Is this a very realistic thing? You can talk about the Act and the right to treatment and hospitals taking responsibilities and how we're going to deliver it, but if you get an Act and it gets passed, it has to go through legislature. And at the rate it's going, I don't think it's going to make it—because I don't think that's where the priorities are. Unless you sell them on it, all of the talk here and elsewhere will be in vain.