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Treating the Untreatable—A Critique of the Proposed Pennsylvania Right to Treatment Law

Aaron D. Twerski*

Dr. Birnbaum has presented in a most eloquent fashion his case for the right to treatment.¹ His position is simple and is easily understood. No person should be involuntarily confined to a mental institution if he will not receive meaningful treatment. To do otherwise would be to deprive one of liberty without due process of law.² Dr. Birnbaum's position that substantive due process requires substantive treatment it seems to me is irrefutable. If we assume that the patient who is confined against his will is not "dangerous" to society in the strictest sense of that word,³ then the only defensible reason⁴ for depriving him of his

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1. See Birnbaum, *The Right to Treatment*, 46 A.B.A.J. 499 (1960); Birnbaum, *A Rationale For The Right*, 57 GEO. L.J. 752 (1962) for a full exposition of Dr. Birnbaum's position.

2. The substantive constitutional dimensions of the "right to treatment" are explored by Goodman, *Right to Treatment: The Responsibility of the Courts*, 57 GEO. L.J. 680. For some judicial thought on the relevance of the constitutional question, see *Rouse v. Cameron*, 373 F.2d 451 (1966); *Millard v. Cameron*, 373 F.2d 468 (1966); *Nason v. Superintendent of Bridgewater State Hospital*, 233 N.E.2d 908 (Mass. 1968) and *Sos. v. Maryland*, 334 F.2d 506 (4th Cir. 1964). The author of some of the leading decisions in this area, Chief Judge David F. Bazelon of the District of Columbia Court of Appeals, has commented on the constitutional problems in his testimony to a Pennsylvania legislative committee. His remarks are to be found in 39 PA. BAR ASSOC. QUAR. 543 (1968).

3. It is not suggested that there is an easily ascertainable standard as to who is dangerous enough to be confined against his will. The problem is most complex since it requires society to make judgments as to (1) the seriousness of the behavior which it fears the mentally ill may indulge in and (2) the likelihood that the mentally ill may commit such acts. The scope of this problem has been explored by Goldstein and Katz, *Dangerousness and Mental Illness: Some Observations on the Decision to Release Persons Acquitted by Reason of Insanity*, 70 YALE L.J. 225 (1960). See text accompanying footnotes 24 & 25. Also see, Livermore, Malmquist and Meehl, *On The Justifications for Civil Commitment*, 117 U. PA. L. REV. 75, 81 (1968).

4. Although others have suggested that in cases where one is a gross nuisance society may have grounds for limited confinement, this author doubts the validity of this category for almost any sort of involuntary commitment. See Malmquist, *supra* note 3 at 83, 91. Also see *Lake v. Cameron*, 304 F.2d 657 (1968). In the case of a gross nuisance to the family or neighborhood the law should permit the dynamics of the situation to operate. This most often will result in the mentally ill person being unable to live in his surroundings. These unfortunate people should have the option of open institutions where they can live and receive care for their personal human needs and where they can retain their basic freedom of movement.

The most troublesome class of cases in the "nuisance" category are the senile. For the vast majority of senile people involuntary commitment is unnecessary. They seek only to have a place where they can live with relative comfort. Relatives are today being forced

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liberty is to treat him so that he can rejoin society as a useful and productive person.⁵ To confine him in the hospital; throw away the key and pay no attention to whether the substantive grounds for his confinement are being met is indeed a cruel hoax. To date the United States Supreme Court has yet to act to recognize this right; but, surely after the decision of *In re Gault*,⁶ in which the Court recognized that a jail is a jail regardless that the juvenile has been placed there under a civil rather than criminal procedure,⁷ the day when this right shall be given legal recognition is not in the distant future.⁸

Agreeing as I do with Dr. Birnbaum that the situation which presently exists in which patients are held against their will for years on end without treatment is a shocking and scandalous one, it grieves me that I must take issue with his proposal to remedy the situation. What Dr. Birnbaum proposes is that state mental institutions should be required by appropriate legislation to meet minimal staffing requirements.⁹ A state administrative agency would be established to formulate these standards and oversee their implementation.¹⁰ Any patient who is involuntarily confined in a state mental hospital and who believes that he is not receiving treatment would bring his case before a review

to use the commitment process to receive basic care for them. Though many statutes exclude the senile from involuntary commitment this is easily subverted by claiming there is a psychotic overlay to the senility problem. In many instances, this is a pure fabrication.

5. The assumption is that society makes the judgment that the person requires treatment. Whatever the philosophical justifications for this judgment, it will be made whenever society is concerned that the subject is not exercising proper reasoning because his reasoning faculties are impaired. When society makes the decision that treatment will lead significantly to improve the subject, it will be unconcerned with the subject's present or past views as to the desirability of treatment. Although at times this may seem to be officious intermeddling and violative of the individual's right to choose his own destiny, this author is not terribly concerned with the problem. Cf. Malmquist, *supra* note 3 at 94, case 8. As a political judgment there is little question that society will choose bona fide treatment even if faced with serious civil liberties questions, let alone trivial ones.

6. 387 U.S.1 (1967).

7. *Id.* cit. 27.

8. Although in *re Gault* concerned itself with procedural due process, the willingness of the court to look to the realities behind the walls of an institution be it hospital or jail is of great significance. Once a court decides to pierce the veil of institutionalism it may be forced to consider a whole host of other constitutional problems. Not only may it have to consider procedural safeguards assured to those who are dealt with by the criminal "punitive" process; but it then must focus on the question as to whether the subject may constitutionally be punished.

For an interesting twist to this question, see *Powell v. Texas*, 392 U.S. 514 (1968) in which Justice Marshall decided to keep the criminal process in operation for chronic alcoholics because he saw no practical treatment solution available. For an interesting comment on his decision, see Goodman, *supra* note 2 at 699.

9. Dr. Birnbaum took part in the discussions which led to the drafting of Pennsylvania's Right to Treatment Law of 1968. Although he has now expressed some reservations about the bill, he is substantially satisfied with the legislative scheme. Birnbaum, *Rationale for the Right*, *supra* note 1 at 764. The full text of the Right to Treatment Law of 1968 is reprinted in 8 *Duquesne L. Rev.* 67 (1969) and in 57 *Geo. L.J.* 811. (1969).

10. Right to Treatment Law of 1968; Section 4.

board.¹¹ If a hospital failed to meet the standards established for minimal treatment¹² the patient would be able to enforce his right to treatment by either seeking release through habeas corpus, or through forcing the institution to provide the necessary service by mandamus or mandatory injunction.¹³ This, in essence, is the heart of the Birnbaum proposal and it has been incorporated in the proposed Pennsylvania Right to Treatment Law.

My reasons for opposing this approach to resolve this most serious problem are several. First, the proposal as outlined by Dr. Birnbaum envisages the continuation of long term confinement of the mentally ill.¹⁴ It seeks only to make sure that patients who are confined for long periods of time in a mental hospital receive appropriate treatment. In fact, under the proposed legislation no patient can raise the issue that he is receiving inadequate treatment until the passing of three months in a state mental hospital.¹⁵

I believe that it is time that we face up to some very hard facts. There are many patients in mental hospitals today who do not belong there—for the very simple reason that nobody has a method of treatment for them. Now, note I do not contend that they are not mentally ill. I have no doubt that we can all admit that their behavior is aberrational. I do not agree with Dr. Thomas Szaz that there is no such thing as mental illness.¹⁶ My contention is that they do not belong in a mental hospital because they are untreatable, and they are untreatable because the state of the art of psychiatry is such that a psychiatrist will simply shake his

11. *Id.* Section 11

12. Although the theory of the "Right to Treatment Law" is that the proper method for insuring the "right to treatment" is to focus on proper staffing requirements (macro-statistics), there are serious ambiguities in the Act on this point. It appears that the drafters could not resolve the problem of how to deal with the patient in a properly staffed hospital who was receiving inadequate treatment. See Halpern, *A Practicing Lawyer Views The Right To Treatment*, 57 *Geo. L.J.* 782, 808, 809 (1969).

For example, the bill contains a provision Section 8 (g) which permits a patient confined in a state mental institution who believes he is receiving inadequate treatment the right to engage a psychiatrist of his choice for an independent evaluation. If the Patient Treatment Review Board is not to check the quality of treatment it is difficult to understand the function of the independent evaluation. See section 4(d). Apparently, Dr. Birnbaum has recognized this contradiction in the Right To Treatment Law. See Birnbaum, *A Rationale for the Right*, *supra* note 1 at 764, footnote 34.

13. Section 8(c)(1).

14. The very recognition that two standards of staffing are to exist—one for the patient requiring intensive treatment (ratio of 1 doctor to 30 patients) and another for continued care patients (1 doctor to 150 patients) is an indication of the policy decision to permit state mental hospitals to continue to exist as custodial care institutions. Birnbaum, *Rationale for the Right*, *supra* note 1 at 754, 755.

15. Section 7(a).

16. SZAZ, *LAW, LIBERTY AND PSYCHIATRY* (1963).

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head and say—"there is little or nothing I can do for him." If they are being kept in a state hospital for a purpose other than treatment I suggest that we ask what that reason is. It would seem that the answer to that question is fairly clear—we (society) are putting the mentally ill out of sight so that they do not annoy us. The mentally ill are troublesome to us and give us a feeling of discomfort. To cure this problem and at the same time put our consciences to rest we tell ourselves that we have put them in a hospital; that we are being humane and just in putting them in an environment where they can receive help. But, can we lull ourselves into this sense of smugness when we treat a patient for five, ten, twenty or thirty years? It seems patently absurd to say that we are treating someone for this period of time. Yet, the proposed Right to Treatment Law would not expose this most serious of deprivations of human liberty by assuring proper staffing of state mental hospitals. Admittedly, state mental institutions are understaffed but the problem I describe to you will not be solved by adequate staffing. *No Right to Treatment Law will solve the very real problem of treating the untreatable.*¹⁷

At this point I should like to digress for a moment to meet an oft made objection with regard to question of treatability. To many psychiatrists the concept of treatment means more than returning the patient to society; it includes the concept of relieving the patient of suffering. Thus even if a patient cannot be returned to normalcy the doctor feels it his duty to relieve the patient's anxiety. The argument then is that by keeping the patient in a tranquil environment and com-

17. In *Rouse v. Cameron*, *supra* note 2, the court in footnote 28 addressed itself to this question in a noncommittal fashion. It said:

We need not now resolve the implications of the "right to treatment" for a patient who is demonstrated by the hospital to be "untreatable" in the present state of psychiatric knowledge, if such a patient exists. See Statement of Dr. Winfred Overholser, then Superintendent of Saint Elizabeth Hospital, *1961 Hearings* at 594:

I do not believe we should write off any patient as incurable In other words, we are going to try our hand at treating any patient that is sent to us.

This author is somewhat puzzled by the above statement by the court. It appears to go to the heart of the problem. In fact the court itself seemed to sense that the problem of long term commitments is essentially a problem of treatability. The court said at 458 and 459.

In determining the extent to which the hospital will be given an opportunity to develop an adequate program, important considerations may be the length of time the patient has lacked adequate treatment, the length of time he has been in custody, the nature of the mental condition that caused his acquittal, and the degree of danger, resulting from the condition, that the patient would present if released. Unconditional or conditional release may be in order if it appears that the opportunity for treatment has been exhausted or treatment is otherwise inappropriate. It is unnecessary to detail the possible range of circumstances in which release would be the appropriate remedy.

binning this with drug therapy we are relieving him of real anguish. The argument is not frivolous, but in my opinion it is wrong—deadly wrong. What it presupposes is that an unwilling patient shall be confined in an institution and have his anxieties relieved—not because the patient so desires—but because the doctor knows what is best for him. This kind of decision making on the part of psychiatrists would seem to me to be antithetical to the concept of a free society. Whether the individual wants to suffer should be his decision, especially when the decision to relieve his anxieties requires the total deprivation of his freedom of movement.

Dr. Birnbaum in his address presented a challenge to those who oppose his plan to come up with something better. Mere negativism will not suffice. In response I should like to lay before you a plan which I have suggested in an article published earlier this year in conjunction with Dr. Abraham Twerski.¹⁸ It is our contention that we must admit that there is a real need for some form of involuntary commitment of the mentally ill. In those instances in which enormous benefit can inure to the patient from short term commitment it seems cruel to say that under no circumstances should a patient be committed to a mental institution against his will. The problem is not the short term commitment for treatment. Although, there is a deprivation of liberty the benefits which can and do accrue to the patient are so great that society will demand that the patient receive treatment even against his will. But, as time passes there must come a point when we admit that the treatment aspect of his confinement has taken a back seat and that what we are really doing is keeping the patient away from society for a purpose which is no longer compatible with his basic right to freedom.

We thus propose a return to the involuntary commitment procedure whereby two doctors can commit a patient to a mental hospital for a period of sixty days for treatment.¹⁹ This would require only that the doctors state that they believe that they can provide therapy which will

18. Dr. Abraham Twerski is clinical director of psychiatry at St. Francis Hospital in Pittsburgh, Pennsylvania. The legislative scheme is presented in full in the Duquesne Law School magazine, *JURIS*, Vol. 3, No. 4. (May, 1970) and is reprinted in the *PITTSBURGH LEGAL JOURNAL*, Vol. 118, No. 7 (July, 1970) in an article entitled *Court Scrutiny of Mental Commitment: Collusion on Delusion*. The sum and substance of these proposals have been adopted by the Pittsburgh Neuropsychiatric Association in a position paper. They have testified before a State Mental Health Subcommittee considering revision of the civil commitment procedure, *PITTSBURGH PRESS*, November 9, 1970.

19. The former two doctor involuntary commitment procedure was an indefinite commitment. *PA. STAT. ANN.* tit. 50 § 404. There was serious question as to its constitutionality and its use has been effectively suspended in the commonwealth of Pennsylvania.

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be highly beneficial to the patient.²⁰ The patient should be immediately provided with counsel so that if he desires he can test the bona fides of the commitment by habeas corpus.²¹ However, a lawyer counseling such a patient would advise him that the only grounds for his release in the sixty day period would be that the doctor has insufficient grounds to substantiate his belief that the patient can be effectively treated.

After the first sixty day commitment period has run out, if the psychiatrist has not been able to convince the patient to remain voluntarily for further treatment, a court or a review board should be able to authorize a further commitment for an additional 120 days, if there is a substantial case made out for continued involuntary treatment. The burden should be on the petitioner to prove that there is very substantial hope that the additional period of hospitalization will lead to effective treatment of the patient and to a meaningful adjustment upon his return to society.²²

At some point we will have to call it quits. At some point we shall have to recognize that we are not dealing with treatment but with confinement and custodial care. I suggest that six months is the maximum period for involuntary commitment designed to facilitate treatment. I make no apologies for an arbitrarily established time limita-

20. The present procedure in which psychiatrists spend large portions of their work day testifying in court on civil commitment cases benefits nobody. The courts rarely challenge the psychiatric finding that the patient is mentally ill. The psychiatrist becomes the formal adversary of the patient thus damaging the doctor-patient relationship. The family is forced to relate embarrassing personal relationships in open court thus complicating the family relationship with a patient who will return home after short term treatment.

21. There is, of course, a serious problem as to how one can account for a sixty day deprivation of liberty without a court determination of the patient's mental status. Presently, California has passed a statute which provides for a 14 day involuntary commitment for intensive treatment. The Lanterman-Petris-Short Act provides for such commitment without a prior court procedure. WEST CALF. CODE ANN., Welfare & Institutions, § 5250.

The constitutionality of the act was under review in *Thorn v. Superior Court of San Diego County*, 83 Cal. Rptr. 600, 464 P.2d 56 (1970). The court recognized that the concepts of due process must take into account the enormous complexities of the particular problem faced. A unanimous court upheld the non-judicial commitment if the patient was made aware of his rights to seek habeas corpus. The court approved a wide range of procedures to accomplish this purpose.

This author believes that the 14 day treatment period in the California statute is inadequate. It is far too short to accomplish intensive therapy in the average situation. The 60 day period has been chosen since it reflects practical treatment needs.

22. Rather than focus on the appropriateness of the treatment and its suitability to a particular patient, the focus of this proposal is to limit civil commitments to a specific period of time. My concern is not with giving broad discretion to a psychiatrist to make the treatment determination, but giving him unchecked discretion as to *how long* he can treat the patient involuntarily. Professor Davis has pointed out that the absence of limits and checks on discretion, not the exercise of discretion, is the problem behind much arbitrary governmental action. KENNETH CULP DAVIS, *DISCRETIONARY JUSTICE* (1969).

tion; for the failure to establish some rational time limit will lead us back into the present system of indefinite commitments.

Perhaps a brief explanation is necessary as to why I am unwilling to recommend indefinite involuntary commitment for treatment purposes. If we assure the patient a "right to treatment" and limit the length of his confinement by excluding custodial care from the scope of "treatment," have we not effectively safeguarded the patient from indefinite involuntary commitment? I believe not. My reasons are several: First, it is clear that the concept of treatment and treatability are complex ones. The creation of a vague legislative standard will not significantly change the pattern of custodial commitments because we simply will engage and embroil the courts in a complex controversy which in the interim will permit the long term commitment to go on. Secondly, the tendency of lawyers to focus on word changes to accomplish substantive results is oft an erroneous one. As long as the method for incarcerating society's undesirables exists under the guise of "treating the patient" we must expect that it will be used. Professor Dershowitz has pointed out that commitment practices do not vary significantly between jurisdictions which have statutes which permit commitment "when the patient is dangerous to himself or others" and those which permit commitment when the "patient is in need of care or treatment."²³ The reason is not difficult to comprehend. Once the method for disposing of those with undesirable qualities is available to society under the guise of humane motives it will be used. The only way to beat the system is to change it. And the only way to change it is to effect the abuse of discretion by limiting it realistically.

Finally, if society decides that behavior of some mentally ill patients is so irrational that society is endangered by their presence in our midsts, I suggest that we address ourselves to that problem. Dr. Birnbaum has suggested that there is little evidence to support the thesis that mentally ill people are particularly dangerous.²⁴ Others have suggested that those who are dangerous have usually evidenced their danger to society by overt antisocial acts which could provide sufficient grounds for their commitment.²⁵ But, in the absence of such acts I do not believe that we have a right to confine them.

23. The author awaits with anticipation Professor Dershowitz's forthcoming book on the subject of preventive detention. Until its publication the author will rely on his memory of Professor Dershowitz's excellent lectures on the subject of civil commitment given in November 1969 at the Duquesne Law School.

24. Birnbaum, *Right to Treatment*, *supra* note 1 at 765-767.

25. WEST CALF. CODE, ANN. ART 6 entitled Post Certification Procedures for Imminently Dangerous Persons, §§ 5300-5306.

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One final observation about the Right to Treatment Law, which I consider of great importance. One cannot propose legislation without considering legislative priorities. It is not my intention to criticize this bill on the grounds that it is more important to spend our tax dollar for projects of greater importance. However, there is today a real problem of resources to deal with mental health problems even if the financial problems were to be resolved. The number of doctors available to the public practice of psychiatry is extremely limited. It would seem that what we are doing is draining these precious resources to serve the state mental institutions to satisfy the staffing requirements of the proposed bill. I seriously question this legislative judgment.

The past few years have seen the development of community mental health services which are designed to diagnose and treat the mentally ill at the earliest of stages of their illness. This treatment is preferably to take place at outpatient clinics. By legislatively requiring the adequate staffing of mental hospitals and mandating this requirement by the injunction process, we may effectively draw the few resources available to us away from early treatment programs into the acute treatment programs. It is as if we were to legislatively mandate that all doctors are to treat terminal cancer patients before turning their attention to those who have a better prognosis for recovery.

Now, if this places me in the position of arguing for inadequate staffing of mental hospitals I can only respond by saying that if we are making a legislative judgment which concerns priorities I suggest that we take an honest look at the judgments we are making. Furthermore, I do not believe that by increasing the salary picture somewhat we shall draw psychiatrists from the private practice of psychiatry. The disparity of potential salaries between the public and private sectors are so great that we cannot expect that slight upward shifts in public salaries will significantly alter the present situation.

In light of my opposition to the Right to Treatment Law as presently written and with the offer of a reasonable, and in my opinion, a better alternative, it might be unwise to offer amendments to the Act to help meet my objections. However, the need for change in this area is so great that one has no right to be chauvinistic. As indicated, it is my contention that the major fault in the Act is that it makes no distinction between commitment for treatment purposes and custodial confinement. To cure this fault I propose the following definition of the term "treatment":

Treatment shall include those forms of therapy which lead a psychiatrist to a reasonable belief that the patient can gain sufficient benefit through such therapy to substantially aid in his adjustment for his return to society. Long term custodial care shall not constitute treatment within the meaning of the act.²⁶

Although, there is the very significant chance that a patient will be held for many years under the language of the above statute, the proposed amendment does recognize that the long term patient can be considered custodial and has a right to release.

After a century of benign neglect the mentally ill have found champions for their cause. It behooves us to weigh the alternative approaches to the problems seriously and then act. However, the need for action overtakes the need for reflection. It is in this spirit that the above critique is offered.

26. The author's dissatisfaction with the vagueness of the language contained in the amendment should be self-evident from the discussion throughout this article. It is suggested as a starting point for discussion leading to the amendment of the Right to Treatment Law to limit commitment to short term intensive therapy situations.

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