Part III:

AFTER COMMITMENT: THE ARIZONA STATE HOSPITAL

Commitment in Arizona ordinarily entails a period of confinement at the Arizona State Hospital in Phoenix, a facility established in 1887 and currently housing a resident population of about 1,200. At the hospital, the general psychiatric patients reside in various semi-autonomous treatment divisions organized on a geographical basis: there is a Maricopa *I* Division, a Maricopa *II* Division, a Pima Division, and a Twelve County Division (housing general psychiatry patients from all counties other than Maricopa and Pima). Organizing those units on a county basis presumably permits the hospital staff to familiarize itself with available treatment facilities in the counties, thereby making possible some semblance of a thoughtful community aftercare program for released patients. In addition to the geographical units, there are specialized wards for geriatric, pediatric, mentally deficient and maximum security patients.

To gain information for this section, the project combed several of the state hospital annual reports, made visits to the hospital, interviewed the superintendent, nurses, social workers, mental health technicians, and patients, and observed various meetings and proceedings on the hospital grounds. Finally, as discussed below, the project worked closely with a group of clinical psychology graduate students who, with the approval of the hospital administration, spent a few days posing as mental hospital patients. For discussion purposes, the analysis of Arizona State Hospital is subdivided into three sections: "Life at the Hospital," "Rights of Patients," and "The Right to Treatment."

LIFE AT THE HOSPITAL

Because it lays the groundwork for a discussion of patients' rights and the right to treatment, a description of life at the hospital seems to be a particularly appropriate starting point for bringing into focus questions of psychiatric justice at the Arizona State Hospital. The following description of hospital life was prepared by clinical psychology graduate

students who, with permission from the hospital administration, studied the hospital as participant-observers for 3 days during February, 1971. Initially, at least, the patients and staff were unaware of the students' true identities. With the exception of certain deletions and minor editorial changes, the report prepared by the psychology students of their experiences is reproduced *in haec verba*.[1] Comments made to the project by the hospital administration regarding the report have been inserted in footnotes.

PATIENT *I*

I am sure that most of you are familiar with the physical description of a mental hospital. But very few of you, perhaps none of you, have seen it the way a new patient sees it during the first few days there. However, the five student writers of this report have experienced the indoctrination processes of a state mental institution, and this is our special perspective as we describe our experience of being patients at the Arizona State Hospital.

Our experience with the Arizona State Hospital began about 3 weeks before we actually spent our 2½ days there. Twelve first-year graduate students from the University of Arizona Clinical Psychology Department were interested in experiencing a mental hospital from the patient's point of view. After discussing our desire with the Department, we made arrangements through the chief psychologist at the state hospital, who was aware of our desire that neither staff nor patients know our real identity. We wanted to be treated as patients. Some ward chiefs agreed to our wishes; others felt that their staff should know. Then, less than one week before we were to go, we were told that only six of us would be allowed to go and that on one ward, the patients as well as the staff would know who we were. We unanimously refused to stay on that ward because we felt the experience would be too contaminated. As it was, five of us went on the wards of the hospital; we did not go through the admission unit procedures.

We were put on three different wards. On two wards there were two of us together, while our fifth colleague was by himself on the third ward. Patient *V* and I were on the same ward, which was later described to us as the most progressive in the hospital. At no time during our stay on that ward were we given an orientation as to where the bathroom was, which technician was assigned to us, or whether there was some activity for us to become involved in.[2] We were simply assigned

1. The report was prepared by Lawrence P. Percell (Patient *I*), James P. McHugh (Patient *II*), Val Farmer (Patient *III*), Gregory K. Berg (Patient *IV*), and Allan W. Duprey (Patient *V*).

2. The hospital concedes the problem of laxity in explaining procedures to incoming patients.

a bed and told that lunch was in the main dining hall from 11 a.m. to 1 p.m.

Our beds were in a very large dormitory where all 47 male patients on our ward slept. My mattress reeked of urine. On the second night, when I went to the dormitory to retire, there was a patient in my bed. I can understand how this would happen in such a large room. There were no lockers near our beds in which to secure our belongings; there was only a wooden cabinet without doors for a closet and a drawer without a lock at the foot of our beds.

The toilets on our ward were atrocious. There were no seats on them, and one of the stalls was even without a door. On another ward, on which Patient *V* and I attended a dance, there was a urinal directly across from the nurses' station; thus, each man could have special attention over his urinary habits. I would only ask: Does this help a man maintain or regain self respect?

The dining hall is a separate building on the hospital grounds. Most of the patients eat there, and I was impressed with the trust put in the patients and also with the fact that meals were served for 2 hours, which allowed for some decision making on the patients' part in choosing when they wished to go to meals. During my first meal, a patient sat at the table next to mine. He placed his tray on the table, sat down, and proceeded to vomit all over himself, his lunch and the floor. No one, staff or patient, came to his aid. The reason for this became clear later: there were no staff members present, and most of the patients do not involve themselves in helping a fellow patient or in preventing a fight, because it is assumed that those functions are reserved for the staff. All that is required of a patient is that he make his bed, take his medication, and not cause any trouble.

My most memorable experience occurred on our second evening at the hospital, and is described fully in the report of Patient *V*. Briefly though, we returned to our ward from a dance at about 10 o'clock. A few minutes later, I was called into the medicine room and was told that the ward where the dance was held had called and said we had caused trouble during the dance and should be sedated. I was then told to pull down my pants and to bend over for a shot of Thorazine.[3] There were about eight to ten people, including two hospital police and some nurse-trainees, in the room watching this. It was later explained to me that so many people were present for my shot because patients often become aggressive and refuse to take the medication. Does it take ten people to insure this? Again, I would ask: Does this help a man maintain or regain self respect?

3. Thorazine is a trade name of chlorpromazine, a psychotherapeutic drug of the phenothiazine group. It may be either injected or ingested and its use is wide-

PATIENT *II*

I was assigned to a sort of experimental ward for only chronic patients. Previously, the psychologist had explained that chronic patients who had a tendency to "blend into the woodwork" had been selected for this ward in order to give them more intensive treatment. My experience was that these patients were either too drugged or too regressed to carry on any sort of interactions with other patients. When I first entered, I sat in a chair in the middle of a large day-room which connected the men's and women's sleeping dormitories. Most of the patients sat in chairs around the room or paced a section of floor tiles. One girl approached me, sat next to me and asked my name. I told her, and we talked for a few minutes. She spoke infrequently and softly, and seemed sad. During my stay, I had conversations with a number of other patients in much the same way. Aside from my attempts to communicate with selected patients, I never saw any other patients converse for more than 15 seconds.

On the ward, patients alternated between nervous sitting, agitated pacing and apparently random anxious behavior. This behavior, after a day on the ward, seemed (introspectively) due totally to boredom. To me, the word "boredom" is the characterization par excellence of the ward.[4] I soon found myself watching the clock along with the rest of the patients, praying for the relief of mealtime, and planning my periods of pacing and sitting, interspersed with periodic trips to the water fountain.

There were a few magazines, well earmarked and dated, for the patients' pleasure. Also, there was a small snooker table with one cue and one ball, providing an opportunity for a stimulating, if somewhat short, game of snooker.

The situation was summarized for me dramatically in a statement made by a 28-year-old woman, the most lucid of any of the patients on the ward. She said most emphatically: "I'm tired of the ward, I'm tired of the staff, I'm tired of the patients, I'm tired of the food, I'm tired of nothing, I'm tired of not having anything to do, I'm tired of nothing, I'm tired of everything."

During the first day, there were no meaningful patient-staff interactions more complex than an occasional chuckle by a staff member at some humorous patient verbalization. My first experience with the staff as a patient occurred the first evening when I was collected along with the other male patients and showered. We were required to strip, then

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spread in mental institutions. PSYCHOLOGY TODAY: AN INTRODUCTION at Table 221 (1970).

4. The tremendous boredom and inactivity is also conceded by the hospital to be a major problem.

were guided by the staff into a multi-nozzled shower stall and were expected to wash all over. Afterwards, we were given an inspection (which included staff rubbing of the patients' hair to make sure it was clean), were given fresh underwear, and were put to bed. During this process, I carefully suppressed my flaming indignation, not only at my own dehumanization, but at that of many of the patients who were clearly capable of taking showers. Moreover, helping patients to accomplish acts which are well within their capabilities obviously reinforces the retreat from reality which characterizes mental illness, and is sure to result in further regression.

The second day I observed for the first time genuine staff interactions with the patients. Two young men came from the nurses' station and began enlisting patients for a game of catch. Unfortunately, the only ball available was a 20-pound medicine ball. Most of the patients seemed quite frail, so the game was rather short-lived. I hesitate to criticize the use of the medicine ball, since the only exercise the patients get is pacing and walking to and from the cafeteria. Nevertheless, many patients clearly indicated that they had never seen such a ball before, and the sight of a 100-pound woman attempting to catch a ball one-fifth her weight suggested rather clearly to me the need to start a little less ambitiously.

Later in the day, two basketballs were obtained and a game of catch was begun that lasted over an hour. The last day, minutes before I left, patients were playing with clay. I asked the patients after each of the activities how frequently such events occurred. All patients that I spoke with indicated the events occurred quite infrequently, and I suspect that my presence may have had some influence in the matter.

My own more personal involvement with the staff began late on the second day. About 3:30 p.m. I was awakened from an afternoon siesta and told to report for medicine. I complained to the licensed practical nurse (LPN) that I hadn't seen a doctor and asked what had been prescribed. She said Thorazine had been prescribed for me by the doctor that morning, and that while I hadn't seen him, he had seen me on his rounds! I took the pill, but later flushed it down the commode.

Later, after dinner, I talked to a patient from another ward. He was young and intelligent, nervous but quite well maintained. He said that in the year and a half he had been at the hospital, he had seen a doctor only twice—both in the first week, and both times for less than 15 minutes.[5] The only other therapy of any sort that he had received had been a period of schooling, working towards his GED.

5. The hospital noted that it felt the students often took patients' remarks too literally. On the other hand, however, it also noted that perhaps a greater problem is in the staff not listening enough to what patients say.

After dinner, the LPN had another pill for me, which I disposed of as before. Then I went to a dance on another ward. After I had been there about an hour, I was called back to get a shot. The LPN explained that she had inadvertantly given me twice as much Thorazine as I was supposed to have, and that I therefore needed an anti-phenothiazine shot. For this I was required to drop my pants and touch my toes in the presence of the nurse, the entire ward staff, and anyone in the male dormitories.

Because I wished to return to the dance, I explained to the nurse who I was and that I was rational enough to leave the dance if I felt the medicine affecting me. I don't know if she knew who I was—by this time, the ward staff knew or had a pretty good idea. In any case, I quite adequately demonstrated my knowledge of psychology and of university life (she was currently a university student). Nevertheless, her last statement was "I'm sure your delusions are very real to you, but . . . ." Having been forbidden to return to the dance, I retired.

About 2:00 a.m., I woke up wrestling with a man who claimed I was in his bed. The staff came in, and after a short inquiry, came to the decision to put me in seclusion. I later found out that the man who attacked me was a staff member and the whole episode was staged for my benefit. I still do not understand why.[6]

The seclusion room was about 8 by 12 feet, completely bare except for a mattress with a blanket but no sheet. There was a potty chair in one corner and a urine-soaked roll of toilet paper in another. Urine was standing in small puddles. Obviously, the smell was sickening. The blanket on the bed had a number of dark stains, which, from the smell, I took to be dried feces.[7] I was given a sedative, and my outer clothes were taken. I was told that the staff would return with sheets, but after 15 minutes, I knew I had been deserted. The light was on continually,

6. The hospital pointed out that because of various factors the true identity of the students generally became known after awhile. Then, some of the college-aged mental health technicians (MHTs) began to "haze" their "patient" peers. The superintendent apparently attributes the hazing in part to a "slothfulness" that infects the entire hospital environment, including the staff. "It [slothfulness] affects the staff and an astonishing thing here is that we have imported . . . a whole bunch of energetic, idealistic college students to take care of the mentally ill . . . . They come here idealistic, they are bright, they've got long hair, you know, and they think they're doing something for people, and you can put them on the wards with these patients for 2 or 3 months and they turn slothful too, and you go around and look at it. The liveliest thing they did lately was to harass the psychology students."

7. The hospital acknowledges the problem of sanitation, particularly in some of the male wards. It cautioned, however, that the hazing efforts by the MHTs may have included the creation of a little extra filth for the benefit of the students. Yet, even the psychology students who were not themselves placed in seclusion noted and confirmed the condition of the seclusion rooms. And on another occasion, members of the law school project saw on one ward a seclusion room housing a somewhat elderly woman; the floor of the room contained only a mattress and a puddle of urine.

but I managed to sleep somewhat. I was released from seclusion about 6:30 that morning.

PATIENT *III*

> The chief marks of the informed outsider's view on almost anything important are these: that a very great deal is attacked as wrong, and very drastic and speedy action is said to be needed to avert disaster. The mark of the insider's view is his awareness of the harsh necessity of choice. No government can ever do a lot quickly. Since resources are always limited, and their possible uses unlimited, policy-makers and administrators have constantly to choose, or in other words, to decide which alternatives have priority.[8]

The perspective of this writer is that of the "informed outsider," and perhaps the tone and content will even appear harsh and unyielding. People affiliated with the Arizona State Hospital and those acquainted with the political processes and the allocation of resources may be justifiably indignant with regard to the opinions expressed here. However, it is hoped that the comments expressed may offer something of value to those who bear the weighty burden of being "insiders."

On Ward K-2, we were exposed to one personal experience of patient-staff interaction. We were told to sit and wait in a large day-room while our admission on the ward was being processed. About 20 minutes later, a technician approached us and asked if we were aides or patients. He then inquired as to where we were from, and upon hearing "Tucson," he firmly insisted we were in the wrong place, opened a nearby door, suggested firmly that we leave and closed the door behind us. It took him all of one minute to throw us off the ward with no inquiry into the legitimacy of our status on his ward and with no direction or supervision as to where we were to go.[9] In the process of getting back on the ward, the staff was informed as to our true identity.

For the most part, we were ignored by the staff during our stay, the fact of which suited our purposes. Our subsequent observations involved patient-patient interactions and staff-other patient interactions, with the staff aware of our presence.

Two things struck my attention immediately. One was the amount of undisturbed "crazy" behavior occurring on the ward. The other was the first exposure of the captivating, deadening influence of the television.

I call the abnormal behaviors exhibited on the ward "undisturbed" in the sense that no effort was made by staff or patients to terminate ongoing behaviors unless the behaviors involved interpersonal aggressive-

8. THE CONSCIENCE OF THE CITY 335 (M. Meyerson ed. 1970).
9. See note 2 *supra.*

ness. Even in these latter instances, the patients did not interfere with physical scuffles in their immediate vicinity. They either ignored the trouble or summoned loudly for the technicians. One notable exception was the president of the patient council who seemed to function as an ancillary staff member. He had specific charge of the most troublesome patient and quickly acted to preserve the peace of the ward. The patients had a live-and-let-live attitude. They did not infringe on the isolation or bizarreness of their fellow patients unless it threatened them personally. Patient *IV* and I quickly became aware of which patients to avoid. It was the most pressing matter of new learning we needed in our new environment. It was within the first hour on the ward that a particular bizarre patient placed his head on Patient *IV's* lap and, while singing loudly and kicking his feet in rhythm to his sing-song words, proceeded to place his hands in a vice-like grip around his neck and pulled Patient *IV* towards him. As psychology students, the experience was unsettling enough, and had we been new patients coming to our home, we would have been terrified completely. This was not the only instance of being personally confronted by bizarre behavior. At bedtime, Patient *IV* was greeted by a schizophrenic sermon on hellfire and damnation by our bunkmate. At 2:45 a.m. we were rousted out of our sleep by our bunkmate on the other side. He loudly expressed his displeasure at the putting on of his pants and shirt. He cursed the difficulty of putting on his shoes and carried on a conversation with his mother about whether he could or could not put on his shoes. Sleep was hard to come by and an hour later our preacher awoke and began his own diatribe. The scene was repeated the next evening as our patient began putting on his shirt and pants, cursing loudly when he found his shoelaces in knots and engaged in a conversation with his mother as to whether he was a "bawl-baby." I wondered if the staff realized why there were so many people sacked out in the afternoons. Among the group getting their afternoon sleep was my noisy bunkmate!

I was expecting abnormal behavior during the day, but not at night. I thought at the time of the feelings of despair I would feel were I a patient with no indication of when I might leave.

The ostensible purpose of the institution is to help people with "psychological" difficulties, but the covert purpose seemed to be that of custodial care. The bizarreness and the depressive nature of the living conditions would seem to contravene beneficial effects. The passage of time would result in "spontaneous recoveries" for some, but the powerful influence of the environment is towards chronicity.

What is the nature of this environment? It is overpowering boredom. The daily routine consists of watching television punctuated by meals and occasional ward meetings and activities. Our first impression was of 40 men watching Romper Room, or a program with a similar

format, with crazy behavior occurring at the periphery of the room. Whatever is on is watched. Nobody cares what is on the other channels. The news is watched about five times a day along with the Matinee Movie, "As the World Turns," and so on—ad nauseum. Once the sound went off for a 30-minute period during a movie entitled "Oliver Cromwell." Nobody adjusted the set and we all watched a soundless screen until the sound miraculously returned. The effect at the end of the day was similar to the numbness felt following the fourth football game on New Year's Day. Why did we watch it? Well, there were four magazines on the ward, three of which were philosophical religious publications. The dorms were available for more earnest escape in the afternoon. At mealtime, the entry of the president of the patients' council signaled the beginning of service and a line of ex-TV viewers formed immediately, regardless of the Nielsen rating of the program.

One patient told me that a place to stay was what this place was all about. Then he added, "Eat, sleep and be happy. If that's not what they are selling, I'm in the wrong place." In addition to food, coffee and cigarettes enjoyed heightened stimulus value. The amount of cigarettes bummed and smoked and the gusto with which patients lined up for meals of marginal taste appeal indicated the extent to which ordinary stimulations became the *raison d'etre.*

The staff used bribes of cigarettes and coffee to get volunteers for some of the work around the ward. While the fights looked aggressive enough on the surface, they consisted of a lot of non-injurious yelling and shoving that added occasional social stimulation. Each person is essentially alone in his TV watching. There is no pressure to interact with others. The patients value the privacy of their own thoughts and this helps the staff to run a smooth ward. The TV is a God-send to patient and staff alike. Arizona State Hospital should publish an account of its TV therapy, except its practice wouldn't be news to anyone. The cover of the report should have a surrealistic scene of a large number of men facing an elevated TV set, separated by a wall from an equal number of women facing them—also watching a TV screen.

Adding to the total picture is a set of dehumanizing and depersonalizing experiences. We were not oriented to procedures and important physical facilities, such as the shower. The fact that we were known to the staff probably contributed to this. A loudspeaker periodically paged in our domitory for doctors and announced hospital business. We had no place to put personal possessions except at the foot of our bed. We were victimized several times by the local kleptomaniac. At least we knew where to go to retrieve our belongings. We were never informed as to a change of clothes, shaving, toothpaste, etc. The one obvious bathroom was filthy beyond belief, with the urinal in full view of the nursing station. The stalls had no doors. The windows were

permanently open and one could get a nice view of the dining area or vice-versa. I didn't feel the full significance until I had an early morning diarrhea attack and sat captive in the face of some pretty cold air.

The staff seemed young and well-meaning. One staff member became perturbed when his chess game was interrupted several times by patient demands. There was quite a bit of time spent by the staff in the nurses' station and they seemed to enjoy each other thoroughly. One patient said, "I'm a little man, I don't have any keys." The staff had access to a great deal of power in the "P.R.N." (*pro re nata*, or "as circumstances may require") orders of medication. During a therapeutic community meeting, one patient expressed his displeasure over the conduct of one of the members of the patient council. He became increasingly agitated during the discussion and the patient council took a silent vote and asked him to leave, which he did. I thought, "Wow, the sanction of the group has real power to control behavior." Later, I learned the patient was also administered a shot of Thorazine following the meeting. It seemed inconsistent to allow "free interaction" and then punish behavior that occurred in that context.

The dorms were locked from 7 a.m. to 1 p.m. to "prevent patients from returning to bed," but also to permit clean-up and to preserve the cleanliness. By coincidence, the shower room was in the locked area and patients having gotten up for breakfast could not return to clean up or retrieve any personal items until 1 p.m.

We were introduced as new patients at roll call and it was suggested that ward members make our acquaintance. Nobody came up to us after the meeting. We talked to a number of patients about the ways to leave legitimately or otherwise. One man said he knew how to leave but didn't have any place to go. I wonder how many share his position. The people just do not meet the criterion of having someone who wants them or who will put up with them. The state has thrown itself into the breach and is providing a place for them.

In conclusion, I believe there is a hidden value preserving the status quo and maintaining a "tolerable" environment for the patients in the state's charge by intercepting aggressive and socially disrupting behaviors. Maybe this is the only realistic goal with the resources available. The patients concur and must feel, "Well, if nothing else, give us at least this."

PATIENT *IV*

I was the last of the five to decide to make the trip to Phoenix. For various reasons, I was a bit hesitant at the prospect of spending 2½ days and 2 nights with a group of people less sane than myself. But through coercion and social pressure, the other four members of our en-

tourage were able to convince me of the value of such an experience; besides, it was a legitimate chance to escape from the books for a few days.

Now, using hindsight, I can honestly say that I am grateful for my colleagues' persistence. The stay was very meaningful for me and has become more so with the passage of time. I was able to learn much about the institutions our society sets aside for the care of those with emotional or "mental" difficulties, as well as something about the inhabitants of these institutions.

My initial encounter with one of the patients was rather dramatic. I had been sitting, in the sitting room appropriately, less than 15 minutes when "Joe," a strange-looking patient with food smeared over his face, came over, laid his head in my lap and began to sing and stomp his feet. To make matters worse, Joe decided to mix music and wrestling: perhaps attracted by my longish locks, he reached up and put a vice-hold on my neck. By the time the other patients had torn old Joe off of me, I had turned blue—more from fear than from lack of oxygen. The incident raises an important point: If I, a relatively stable individual possessing the knowledge that my stay would be temporary, could be shaken out of my wits by such an experience, how much more damaging would a similar incident be for someone already under emotional strain? And Joe was not an isolated case. A great deal of aberrant behavior went on day and night at the hospital.

My defense for the very real fears I was feeling was to become more or less catatonic. Since I was on a ward which did not permit grounds passes until the fourth day, I could not escape physically from my surroundings. So I escaped within myself. I probably would have degenerated to the state of many of the young patients I observed, had it not been for the saving knowledge that I was a short-term visitor and not a semi-permanent resident. As it was, I found myself trying to become more and more like the other patients, trying not to be different in any way. As an example of how I was modeling the patients, let me relate an incident which occurred during breakfast of the second day. The main course was a choice of two alternatives: gooey oatmeal or bran flakes. Needless to say, I wanted the bran flakes. Not seeing any displayed, I asked the kitchen attendant if there were any more. She had been eyeing me pretty critically during the previous two meals I had eaten (probably because I really didn't have the "look" of a completely assimilated patient) and she asked me who I was. "I'm a patient," I told her. "Where do you live?" she asked suspiciously. "Over there," I said, in a dull voice, pointing across to the wing of the hospital where I had been assigned. That seemed to satisfy her, for she didn't ask any more questions as I shuffled down the line.

My ward was a good one for patient-patient interaction. I was able to speak at length with several of the patients. I also wrote a letter for one of the patients and was involved in several card games. By the time the second day arrived, I was almost enjoying the place, having accepted the role of patient and the total lack of responsibility that goes with it. How far I had come toward being assimilated into the institution was made clear to me at lunch the second day when the other three fellows from our group dropped in unexpectedly on Patient *III* and me. They were a bit concerned as they had not seen us since admission and not knowing we were confined to our ward, they came to check us out. The experience was most anxiety-provoking. They were in no way trying to act like patients, and I found myself caught between trying to talk to them as one of them on one hand, and trying to maintain my impersonation of a patient on the other. I became extremely nervous—so much so that I was unable to talk. I remember being very concerned at the prospect of the staff finding out about me, as they were watching us closely. I was so shaken up by the visit that it took me about an hour to calm down after they left.

The point I wish to make in all of this is that I did become very much assimilated into the institution and could easily conceive of myself staying for a long period of time. Although I am certain that I would become bored with the dullness of the daily routines after an extended stay at the institution, I found that the longer I was exposed to its environment, the more I was able to adapt to the way of life which existed there. With three meals and absolutely no responsibilities to go along with unlimited TV and occasional card games, the place became more and more enticing to me each day. If such a thing could so easily happen to me, how much more easily could it happen to someone having some kind of difficulty or to someone with no place to go. It would seem that an institution that could be so inviting and attractive could not in any meaningful way be therapeutic to its inhabitants, but instead would be a dead-end custodial service for the unwanted and emotionally disturbed of our society.

PATIENT *V*

It has been over a month since our experimental trip to the Arizona State Hospital, and I should begin to record my impressions of that stay. The physical effects of the trip have not been hard to remember for just yesterday I was sent to St. Joseph's Hospital to find out why it was becoming increasingly difficult to move my left hip. Two X-rays revealed that the shot I had been given some 5 weeks ago had struck the pelvic bone and had torn up much of the surrounding tissue, causing the pain. The circumstances of that shot will be discussed later. Suffice it to say now that the memories of our stay are still fresh on my mind and body.

My initial impression of the idea of going to the state hospital was one of excitement coupled with a sense of realistic caution; excitement because I felt that it could prove to be an immensely fruitful learning experience and caution because of my slight familiarity with some large state institutions in the East, particularly in Chicago. Upon arriving at the hospital, however, my sense of excitement was overwhelmed by my sense of caution and even fear. All five of us met Dr. Levy, with whom we had planned the trip, and she began to take us to the wards where we would be staying. As we approached the first ward, she said that two of us would be staying there and that the others should go sit on the bench outside the front door. I found myself running to the bench, grabbing for a last minute of freedom before plunging into this place that I began to realize I knew nothing about. Of course, my reprieve was only a momentary one, and I soon found myself on the Pima County ward, Flamenco *IV*.

I was introduced to the social worker of the ward, then taken into the dorm area and assigned a bed. The mattress of the bed was my first shock, for it was so filthy as to be unrecognizable as the gray that it was. Of course, the pillow was equally colorful—*i.e.*, black. I was quite relieved to see that at least the sheets were starched and quite clean.

Then began my first day. First, I made my bed. Noticing that there were no drawers or closets where I could leave my things, I simply left them on the bed, hoping they would not be missing upon my return.

I walked out to the dayroom of the ward where people were mingling around, apparently aimlessly, or watching TV. It soon became obvious that these were the two primary activities open to the patients: wandering aimlessly or watching TV. We were fortunate on our ward in that we also had a pool table. In what was to become a rather common irony of the place, however, the equipment was barely in working order. It crossed my mind that if someone was going to take the time and effort to install a pool table, at least it ought to be more than a reminder of what the patients could *not* do. I spent the rest of the morning observing the general level of boredom or agitated distress and then went to lunch. I might add that I was allowed "privileges," or to leave the immediate area of the dorm, so I was free to go over to the cafeteria to get lunch. The quality of the food was such, however, that I ate only enough to sustain me until dinner and quickly left.

I went from there on a small tour of the grounds which I found to be quite pleasant. There were benches scattered over the grounds which would have made good meeting places for other patients. But the benches were seldom used, reinforcing a later idea that patient-patient interaction was rather minimal, and that even when it did occur, it was not particularly therapeutic.

I saw a doctor later in the day who asked if I might need sleeping pills. I assured him that I would not, and that was the extent of my seeing any doctors. However, later in my stay, I was given what was supposed to be Thorazine, upon the recommendation of this or some other doctor, whom I had seen for approximately 5 minutes!

Thus far, the stay was quite uneventful and I began to regret offering 3 days of my time merely to have the experience of being bored in a different environment from home or school. This feeling was to prove to be extremely inaccurate, however, as my first meeting with the technicians was to reveal.

It was about one o'clock in the morning before the technicians were finally able to sit down and talk with me. I began by telling them who I was and why I was there. Nothing had prepared me for their response: "Tell us more about your delusions!" In my initial shock, I became obviously and overtly confused, merely adding more to the "clinical picture" of their newest patient. I began to be filled, indeed swept, with all kinds of feelings. First was a paranoia about my own state. If the technicians really thought I was a patient, perhaps I would have difficulty getting out, a point about which Dr. Levy had been particularly reticent. But even more was an anger combined with a sense of disbelief and pity for those who really were there. I had done nothing throughout the day to allow the technicians to suspect even remotely that I had any psychological problems *except present myself to the hospital.* And it suddenly occurred to me that this was the ultimate criterion: if you were here in a mental hospital, there must be something wrong with you. But, not only was there not enough wrong with me to require hospitalization, there was equally little wrong with many of the patients that I saw on our ward. One patient was there because he was an epileptic, yet he had not had a seizure in 2 years. And so it is with all those who are there for all the other non-psychiatric reasons of no job, no family, no home. There may very well be nothing wrong with these people, but by virtue of their admission to the state hospital, they had to have something wrong with them, in these technicians' minds, even if the technicians had to manufacture it.

This then was the first real clue that I had regarding the nature of the psychological environment of the hospital. It is an environment that operates under the premise that all who are there are sick, which allows the staff to maintain a very tight role structure, which both the patients and the staff were aware of but not so aware to see its irrationality. This was made explicitly clear in a remark of profound insight by one of the patients on my ward: "We couldn't leave here, you know, because then the technicians would be out of a job." This social symbiosis is among the most distressing things of the hospital. It says to the

staff that "We are good" and to the patients that "If we simply don't rock the boat, we'll get three meals a day, a bed, and all the television we want." Yet nowhere in this arrangement is there recognition that a therapeutic community ought to foster more than a mere maintenance of the psychological and political status quo.

I went to bed the first night tired and angered by my first real encounter with what it's like to be a patient in a large state hospital. But the best learning experience, yet the worst personal experience, was to come tomorrow. Had I had any idea as to what it was to be, I should not have slept nearly so well.

The day began about 6 o'clock when all the lights on the ward were turned on. I made my way over to breakfast, the only meal I felt at all comfortable about because there was little that the kitchen staff could do to an unpeeled banana or to an unopened box of cereal. I spent the morning alternately playing pool, watching TV, and talking to other patients. One young woman interested me and I attempted to learn something about her. This soon became a very futile attempt, however, for I found that she was apparently so drugged that she found it difficult to carry as much as a single sentence in her thoughts before totally losing what I had said. I did learn that she had been in and out of this hospital for 3 years.

Lunch was another experience, but I attempted to tolerate as much as I could, knowing from the previous day's experience that dinner would be the same thing simply cut differently and warmed over. It did in fact turn out to be an accurate assessment.

The afternoon was spent in the same way—playing cards, pool, and trying to talk with the patients. Conversing with patients was extremely difficult, however, due to the many who were on such strong doses of drugs.[10] It appeared that the average stay on our ward was about 1½ years, and the average visiting time with a doctor was one or two 15-minute sessions during the *first week* the patient was there. It was also during the afternoon that I was informed that new medicine had been prescribed for me, something I thought at the time to be patently absurd. I was to learn differently later that evening.

After dinner (warmed-over hot dogs) there was a dance on the outer counties ward, Kachina. After getting written permission from one of the technicians to attend, Patient *I* and I made our way over to the dance. It was the second attempt we had witnessed of some sort of staff directed patient-patient interaction. The first was on our first night there when the movie, *Incident at Owl Creek Bridge*, was shown. The movie, for those who are not familiar with it or the short story from

10. The hospital feels that many of the patients who appear to be heavily sedated are simply very regressed psychologically.

which it is taken, concerns a man about to be hung during the Civil War. The platform he is on is released and he falls. The rope holding his neck breaks, whereupon ensues an hour of chaos wherein he tries to escape. The movie ends with the man falling into the arms of his wife, only to have the viewer made vividly aware that it was all fantasy, as the hanging body swings back and forth on the screen. The therapeutic value of such a movie on a normal population is dubious, and in this situation seems simply ludicrous. So the dance appeared to have to be better than the previous night's fare, and I looked forward to it.

It proved to be one of the few really pleasurable hours of my whole stay. The patients for the most part actively participated and all seemed to have a good time. I was also anxious to go to the dance to check my own physical reactions, for before we left, I was given what was allegedly 150 mg. of Thorazine, which, needless to say, surprised me; the more so since the night before, I had asked Dr. Levy to allow me to experience a small dose of the dreaded drug to see what it was like but she had refused. Thus, throughout the evening I was attempting to monitor any changes in my own state and have none to report. This first medication was the first of many harassments which were to follow later that night, our last night there. After the dance, we went back to the ward where we were informed that the technicians on Kachina had just called and stated that we had been unruly at the dance. Our own technicians then told us that we were going to get another dose of Thorazine to calm us down. The shot was administered in a small room, with about 10 people milling around. There were two or three security policemen present who, I was told in a very unsubtle way, were to offer any assistance in case a patient refused to take his shot quietly. This shot was apparently administered with such vigor that even now, 5 weeks later, I can still feel its effects. We were told to stand in the middle of the room and to drop our trousers. I was getting increasingly disturbed over their little game, for by now it was apparent that the technicians at least did know who we were and were just doing all this to hassle us. But considering that I felt they were probably hoping we would do something to give them an excuse for further harassment, I merely submitted to the process of unveiling myself in front of eight to ten strangers. We were then told that the drug would take effect in about 10 minutes and we should go straight to bed. We did not, and 3 hours later, except for one very painful hip, I had noticed no other effects of the shot. The giving of this shot also taught me something about the hospital, but there was an even better lesson to come.

As I finally made my way to bed about 1:30 a.m., two patients across the ward were arguing over something, probably over the property rights of a given bed, a frequent occurrence with so many patients drugged into the states that they are in. At any rate, the technicians

came down and straightened it out. At this time, I was sitting up in bed attempting to observe this occurrence of typical hospital behavior. The technicians then came over to me and told me that I had started the whole thing and they would have to put me in seclusion. I knew that this was coming and all I could do was try to control a rapidly growing rage. Somehow I let them take me there without a fight on my part.

Seclusion was something I had seen other patients thrown into but I simply was not prepared for what followed. The physical area of the room is about 6 by 12 feet. There are windows but they are screened off with a thick wire mesh. In the middle of the room there was a metal bed on which there was a vinyl-covered mattress. In order to get to the bed, I had to step over a puddle of urine. As I reached the bed, I became aware that the spots on the mattress were constituted of dried blood and feces, in varying amounts throughout the surface of the mattress.

The technicians took my wedding ring, my watch, my glasses, and my college class ring. They made me lie down on the mattress, with no sheet under me or any other covering under me, placing my head in the middle of a pool of dried blood. They proceeded to strap my hands and feet to the bedposts. They put a sheet and a blanket over me and then left. The blanket was necessary as it was quite cold. But the cold room falls far short as an explanation as to why I was trembling so hard. I tried to sleep but found that my right arm was strapped in such a position that it kept falling asleep so that the "pins-and-needles" effect would awaken me every 10 minutes or so and I would have to attempt some isometrics to restore circulation to my arm. As I drifted in and out of sleep this way, and in and out of consciousness, the whole experience took on an eerie quality, something out of the bitterest writings of Sartre, of Camus, or of Kafka. I could imagine myself standing at the door and looking in at this pathetic figure tossing and turning, and being filled with rage . . . and, too, a profound sorrow. A sorrow marked by the fact that however terrible it was for me, as it indeed was an experience of terror, how much more so for those who experience it not knowing that they really won't be there tomorrow; not knowing that they are free to return to people who love them and miss them.

In retrospect, what is to be said about our state hospital? It seems to me that there are two important points which lead to a final conclusion.

The first was already mentioned, that the hospital operates under the mental set that everyone there has some kind of psychiatric disorder. This, although certainly unhealthy, is probably going to be the case in any such institution. The second is far more damaging and is that, in spite of all the rhetoric of a "therapeutic community," the main goal and all

the energies of this hospital were directed at merely maintaining the status quo; that is, allowing everyone to function *as they are.* As long as a patient played the role of patient quietly, everything was fine. However, any attempts to break out of the mold, any attempt to induce some individuality to one's role is met at first with a hypodermic needle and finally with the seclusion room. This is the *real* psychological environment.

I feel that a word here is in order about the technicians on our ward and in general. The technicians on our ward, as evidenced by the deliberate attempts to give us as difficult a time as possible, were hardly the kind of healthy models we should expect patients to imitate. The technicians' role, however, gives me much trouble, as does their actual functioning. If we give all the real power to run this kind of an institution to people who are not very well selected, trained, or paid, can we really be surprised that they do such a poor job of it? The role of a technician is supposed to be one of the patient's friend and assistant. But because the roles of patients and staff are so limited, and because there is really no room in this institution for a patient-technician relationship, the technicians are reduced to the role of maintainer of law and order, peace and quiet, wanting as little as possible to do with the real problems of the patients who are there. This role is tremendously reinforced by the P.R.N. drug orders. Who decides when it is necessary to give a drug to a patient outside of regular prescribed times? The technicians, of course. On what basis do they make this decision? Whenever a patient becomes unruly, whenever a patient tries to break out of the mold of patient. So it becomes a vicious circle. A young, idealistic person signs on to help other people who need help. But finding himself up against the whole institution, and seeing all the other models acting differently, he soon gives up this attempt to help and joins the rest of the team as a practicing member. Is it any wonder that our technicians were gleeful at the chance to take out some of their own frustrations on us?

These points cannot help but lead us to a final conclusion, and it is this: that a therapeutic community at the Arizona State Hospital is a contradiction in terms, and under these kinds of settings, where we take people away from their own communities, call them sick and treat them that way, it is a virtual impossibility.

RIGHTS OF PATIENTS

As the preceding section indicates, life in the total institution of a mental hospital inherently raises questions regarding rights of the resident population. Rights of patients are ordinarily classified in two categories: the right to treatment, which will be discussed in the following section,[11] and "other" rights of patients. For organizational clarity, that dichotomous classification will be employed here, but not without some hesitation. Though this section will deal with rights of patients "other" than the right to treatment—such as the right to live in an open ward, to receive mail, to have visitors, to handle money, etc.—these residual rights ought not to be viewed as clearly distinct from the question of treatment, for a deprivation of these and related rights and responsibilities surely contributes to the secondary problems of institutional neurosis and dependency exhibited by all too many hospitalized mental patients.

Studying British mental hospitals and patients, J. K. Wing has provided some interesting scientific support for the assertion that hospital social conditions can be correlated with the clinical states of patients.[12] Wing selected three hospitals (*A*, *B*, and *C*) known for their different reputations for according rights to long-term schizophrenic patients, and verified their differences by comparing them on various social indices. The indices included, among others, restrictiveness of ward security, percentage of patients permitted to have matches, staff supervision of patients in matters such as bathing, and the number of patients who were permitted to have (or be supplied with) certain personal possessions. Hospital *A* proved to accord its patients far more liberty than did Hospital *C*, and Hospital *B*—which was in a state of organizational improvement—fell somewhere between the other two. With respect to the percentage of patients permitted to possess various items, for instance,

> it is fairly clear that far more long-stay patients in Hospital *A* owned personal possessions of all kinds than in Hospital *C*. Seventy-nine percent owned a handbag, for example, compared with 42 percent at Hospital *C*. A woman seems far

11. See "The Right to Treatment," pp. 228-36 *infra*.

12. Wing, *Evaluating Community Care for Schizophrenic Patients in the United Kingdom*, in COMMUNITY PSYCHIATRY 138, 147-57 (Anchor ed., L. Roberts, S. Halleck & M. Loeb eds. 1969).

> less feminine without a handbag, and these . . . facts . . . illustrate the process of institutionalism. Conditions in Hospital *B* were intermediate between conditions in the other two. In rather obvious things, such as outer clothing, patients were as well off as those in Hospital *A*. In less obvious possessions, such as face powder or a toothbrush, they came about halfway between the other two groups. But they were not allowed to possess items that might have been harmful, such as scissors or a mirror, any more than patients in Hospital *C*.[13]

Wing then correlated the clinical states of the patients—measured by an operationalized social withdrawal score—by the length of the patients' stay in each of the three hospitals. Significantly, the clinical states of the patients closely paralleled the liberty generally accorded the patients.

> Patients in Hospital *A* were markedly less withdrawn, whatever their length of stay, than patients in Hospital *C*, while those from Hospital *B* varied according to how long they had been in the hospital: long-stay patients were as withdrawn as if they had been in Hospital *C*, but relatively short-stay patients were as lively as those in Hospital *A*. Clinical state measured at a psychiatric interview confirmed these results. For example, the proportion of mute or almost mute patients in the three series, *A*, *B*, and *C*, was 6, 14, and 24 percent, respectively.[14]

It is apparent, then, that the rights of incarcerated patients should be cast not only in a conceptual framework of the appropriate limits of administrative discretion, but also in a framework tied closely to the emerging constitutional right to treatment discussed in the following section. Against this theoretical backdrop, we may proceed to consider the rights of patients at the Arizona State Hospital.

In investigating rights of patients at the hospital, the project was fortunate in being permitted to conduct a taped interview with a professional social worker attached to one of the units. The following presentation—a slightly edited version of that interview—presents rather richly a description of patients' rights,[15] at least on that particular semi-autonomous ward.

INTERVIEW REGARDING RIGHTS OF PATIENTS

When and how may patients exercise religious practices?

There is a chapel of all faiths and it includes Mormon services, Jewish services, Catholic services, and Protestant services. Patients can go to that chapel at scheduled church services and in addition the chapel is open during the day for patients to go over and meditate without being scheduled.

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13. *Id.* at 148.
14. *Id.* at 149-51. *See also* E. GOFFMAN, ASYLUMS 41 (Anchor ed. 1961).
15. The interview does not, of course, cover the entire gamut of patients' rights.

Are all patients entitled to attend the chapel services?

Yes, unless their behavior is so out of contact that they would not be getting anything from the services and they would be disruptive to other people that were attending.

Can a patient use the chapel privileges if he does not have ground privileges?

I think that if the staff coverage permits, sometimes a staff member will take a group over to the church, and those patients taken over by a staff member would not have to have ground privileges.

Do ministers ever come and visit patients?

Yes.

What about patients who want to refuse drug treatment on religious principles?

I do not recall that this has ever come up. We do have patients who do not take drugs because of their paranoid feelings or because they do not make them feel good or something. We can either give them concentrate medication in orange juice or something, or you can give them long-acting intramuscular shots, or you can respect the wishes of the patient and see what happens.

Who makes that decision?

The doctor.

Has the situation ever arisen where a patient believes that a certain religious practice or following the doctrines of a certain faith will help him, and has he been allowed to pursue that?

I know of one interesting example of this, but it does not happen

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For example, possible right to privacy problems, highlighted by the dormitory sleeping arrangements and by other factors noted in the psychology students' report, *supra* pp. 192-206, are not explored in the interview. *See* Commonwealth v. Wiseman, 356 Mass. 251, 249 N.E.2d 610 (1969), *cert. denied*, 398 U.S. 960 (1970), *noted in* 83 HARV. L. REV. 1722 (1970). Other areas and problems regarding patients' rights were investigated at the hospital apart from the interview. It was learned, for instance, that in at least one unit, administrative policy forbids patients, whether or not they have been declared legally incompetent, to have in their possession more than $5 in cash per week. Certain other aspects of patients' rights—such as ward transfers and disciplinary proceedings—are discussed in the text following the interview. *See also* LINDMAN & MCINTYRE, THE MENTALLY DISABLED AND THE LAW 142-82 (1961) (chapter titled "Rights of Hospitalized Patients"); Comment, *Compulsory Commitment: The Rights of the Incarcerated Mentally Ill*, 1969 DUKE L.J. 677.

very often. There was an Indian from the reservation and both she and her family thought that if they had a sing for her up on the reservation that this would be the cure. So the doctor, who was a young, vigorous, open-to-any-idea kind of person, allowed the patient to have a pass, go back up to the reservation with the family and see if the ceremonial sing would cure her. Unfortunately for everybody, the patient came back sicker than before.

May patients mail outgoing letters?

Yes, letters—incoming or outgoing—are no longer censored. Except that once in a while a patient persists in sending very irrational, kind of troublesome, letters to the same correspondent and the correspondent sends the letter back unopened to the staff. This has happened on our ward. We have a patient who thinks she is in love with one of the clergy in her home town. The love letters that she sends out —maybe two a day—are terribly upsetting to this clergyman. There is no basis for her amorous feelings towards him. These we intercept. We tell the patient, however, that it just does not make good sense to send these, and we are not going to send them. But she gets a lot of pleasure out of writing them. She goes through beautiful fantasies while she is writing them. We do not send them, but sometimes they get through.

How does the mail system work? Do the patients give the mail to staff members?

There is a post office right on the grounds and patients can buy their own stamps and mail their letters themselves. They prefer the system of just dropping their sealed addressed envelopes in the outgoing mail bag, however, and having them sent for free. That is how we know what mail is going out. There are instances of patients going out on passes and mailing letters outside.

Are pencils and paper free to the patients?

Yes.

When patients' mail is censored, who does that? Is that a staff decision?

The patient with a particular delusion—at least on this ward—becomes a matter of common knowledge. We do not have any cut and dried way of assigning the task of censoring mail to anybody, but once the mail of such a patient is in the mail-out basket, the person who sees that the mail gets to the mailman just takes it out. I guess the clerk usually does it.

When was the practice of censoring all mail discontinued?

About 4 years ago.

Can patients also receive uncensored incoming mail? Is there any problem with incoming mail?

None. Occasionally a bright-eyed clerk—and we have bright-eyed clerks—will have a question about mail that might look, for some reason, kind of suspicious or as if it might have some implications that some staff member should know about—from social security or welfare or something. He might ask a worker to take a look and decide whether the patient should have the mail first or whether a staff member should be with them when they open it or something like that, just so that information the staff should have might help the patient.

Are patients encouraged to communicate by mail?

Yes. I myself have a patient that is very inactive, keeps very poor contact with relatives, and I think it is therapeutic for her to acknowledge Christmas presents and gifts. I encourage her to respond to such contact as part of the process of getting better.

Are notations ever made in a patient's file as to kinds of letters either sent or received?

A progress note may include a notation that a patient is still delusional about her relationship with, in the case I mentioned, the clergyman; an indication of the patient's delusional system; and occasionally in the chart you will find on the correspondence side a copy of a letter that has either come in or been mailed that would significantly describe the patient's thought process, or the relationship between the patient and relatives. I myself have never made a copy of a letter, but I have seen photo-copies of letters signed by patients and addressed to patients from the old days, apparently before they quit censoring.

Can patients receive and make telephone calls?

By and large, yes. We have public telephones outside, and if they have a dime there is nothing to prevent anyone who has the privilege of roaming the grounds from making a call. Often staff members are willing to help patients make calls from the office—with the exception of patients whose relatives have reported that the calls are becoming a harassment, or they do not want to be bothered at their work—"please keep my wife from calling every half hour"—or something like this. Then we only try to help the patients curtail their calls—by trying to help them use better judgment; but no one has to ask permission to make a

phone call, if they have a dime. Sometimes they can get a dime by borrowing.

Do you inquire as to the purpose of the call or whom they are calling if they ask to use office phones?

That usually never comes up because I always happen to know the purpose of the call. They openly discuss the reason for the call. I usually sit right here and listen to the call. Not for any particular reason, but because I happen to be here—if the patient asks for privacy I would leave the room. My approach, however, is not necessarily typical of the approach of other staff members.

What are some of the other approaches?

I have observed that some social workers say that the telephone is for business purposes and the patient is not to use it. That is not a hospital policy, that I know of. If it is, I break it.

Or they might say, "I'll make the call for you," or "I'm too busy"; some dodge because they do not want the patient to take advantage of this kind of thing.

Are there any hospital policies generally on any of the matters we have discussed so far?

Yes, about the mail. There is a hospital policy that mail should not be censored. This was a change from the way it used to be when I first came. Then the mail was opened when it came in and also when it left.

What kind of mechanical restraints are used on the ward?

They have padded leather belts which go around the waist and are then looped around the wrists so that a patient that has to be restrained from either harming himself or others has some slight movement with his hand but not enough to harm anyone.

I have seen some people in the same kind of leather belts around the ankles—they call those ankle cuffs. This is what the nurses do. As a social worker, I have never put restraints on people. All I can say is that I have observed the nurses or technicians using them.

One time a patient who felt suicidal, or at least that she wanted to harm herself—she used to swallow pins and needles—asked to have the wrist cuffs put on her. Another time a patient was absolutely impossible to keep on the ward. She would break out and run out. The only way to keep her here was to put the ankle cuffs on her so she could not get away.

Sometimes a patient is very hostile and has no impulse control and is a threat to the other population, but they sometimes would rather have this person on the ward with these cuffs on than put him in seclusion.

Have you ever seen mechanical restraints used as punishment?

No.

What about seclusion?

The crisis committee, which is a part of our [therapeutic] community, is made up of patients, with staff supervision. It offends the patient population very much if a patient is put into seclusion without having the situation discussed with the crisis committee. Sometimes the crisis committee will say about a patient who has been having a lot of acting-out difficulty, "In the future if you knock somebody down or hit out at somebody you will go into seclusion without any formalized discussion with the crisis committee." That gives the personnel the right to put him in seclusion without any further ado.

How long is a person in seclusion?

It varies with the situation. Twenty-four hours is often the rule. It used to be stated that if a patient is away from the hospital without permission that he could expect to be put into seclusion for 24 hours. A patient that I have been working with recently was threatened with seclusion for 24 hours. It seems to be the rule.

What did this patient do?

This patient has been out of control, hostile, knocking people down. I had told the rest of the team that I didn't want my patient in seclusion, because it was bad for her self-esteem. So, sure enough, she hit out at somebody. In the crisis committee, with my encouragement, they kept her from going into seclusion, and told her that if she came to the crisis committee as a member every morning she would not have to be put into seclusion. But if she failed to do so, she would have to be put into seclusion. She forgot to go to a meeting, they had to carry out the agreement, and put her into seclusion for 24 hours. The result was that when she got out of seclusion she was in better shape than when she went in.

Is much shock therapy used?

With depressed patients. But it is not used willy-nilly on this ward. It is used with discretion, and by and large with the patients who are very suicidal and with whom contact cannot be made because they are so withdrawn and so depressed. When it seems like the only way to get

them into a state where treatment can proceed on a verbal level, you give them shock treatment. The doctor makes that decision.

What formalized procedure is there for administering a patient shock therapy?

There is a preliminary physical workup which includes skull X-ray, EEG and tests that assure the doctor there would be no physical harm resulting from shock therapy. The procedure then is to go to the little nursing room where the shock is administered. This is off the ward. And they give them a shot so that the only thing the patient remembers is the shot. It is not very traumatic for the patient to have shock treatment.

Are you a believer in shock therapy?

I have watched it and it horrifies me just because it looks frightening to see the patient going through these sort of convulsive movements. So I do not like the idea of it at all. But if this is necessary and the doctor feels it is necessary, I discount my own tender, misplaced, sentimental prejudices in favor of the treatment.

Have you ever seen any bad effects from shock therapy?

Not so much any more. Sometimes you get a patient who has been hospitalized many times in the past and has had series of treatments—maybe 300 shock treatments throughout their hospital experience. By that time it seems that often their memory is somewhat impaired and their thinking processes perhaps are not so sharp. You kind of wonder if the shock treatment may have been a little damaging to them.

How many times a year is shock treatment administered to patients on this ward?

At the present time, no one is getting shock treatment. In the last 3 months, we have had two people that have had shock treatment. By and large, in the whole hospital, shock treatment is administered pretty judiciously throughout.

What jobs are assigned to the patients and what work do the patients do in the wards?

On the ward, there is cleaning and there is a job called a runner, where the patients carry things, except charts, from one building to the next. They monitor the door. Although we have an open door system, where the doors are not locked, we still ask patients to be responsible

to see that the people who cannot manage ground privileges do not walk out the door.

In cleaning they have certain responsibilities to aid the housekeepers. There are at least four housekeepers assigned to keep this ward clean. They do the waxing, for example, and the patients are helpers with tasks like dusting a certain area and that sort of thing. In our therapeutic community we have a committee called the work committee, made up of patients who volunteered. They are responsible for organizing the clean up part of the ward maintenance. They either do it themselves or maybe pick some other patients to help out.

If a particular patient has the "I can't" syndrome and no one thinks it is either physically or emotionally valid—that she is much more capable than she would like to have the rest of us believe—we try to encourage her to do something to help. She would answer "I can't" if you would ask her to eat an ice cream cone.

Are there any other jobs?

We do have a dining room committee. Most of our patients do not eat on the ward anymore, but there is the serving of the trays and the cleaning up of the tables.

We have what we call a "goody room," which is a place where tobacco and toiletries and so forth are available to the patients. A patient is assigned to it and is the storekeeper for a certain period of the day, which is usually only half an hour or an hour.

There is also the clothing room. The state provides clothing for patients who do not have their own or cannot keep up their own, and patients are assigned to organize the clothing in the proper bins and hand the clothing out.

What about clothes?

The purchasing department buys all these dresses that are made the same and look the same. We like to have patients use their own clothing, but our laundry is such an impersonal kind of operation that personal laundry cannot go to the laundry but state-issue clothing can. So those patients who cannot wash and iron and keep up their own things use the state clothing.

Do the patients work off the ward?

There are jobs off the ward that patients are involved in. Those include landscaping, laundry, some clerical work and some are receptionists.

How are they compensated?

There is a fund that is given to the housekeeping department. People who do housekeeping work on the ward get such a minimal amount that it is merely a token of appreciation rather than an actual pay. It is ridiculously low—they might get a dollar for working all week.

Those patients who work off the ward are usually assigned jobs by the rehabilitation department which wants the assignment to be a part of one's therapy—usually to test out whether a patient has what it takes to be trained, to have money expended for their training, and if they are employable. I do not think they are even paid by and large for that kind of thing because it is part of their therapy. They are assigned these tasks through a joint effort between the department of vocational rehabilitation—which merely has a representative that comes out here once in a while—and the people in job evaluation in our rehabilitation department that are hired by the hospital. It is kind of a complicated thing. There is no way of forcing the patient to take on a job that he does not want to do. It is the professional's job to motivate them, to see that the end result will be meaningful to the patient; and if the patient is not ready for that kind of acceptance, if he cannot see it through, then he just does not do the job until he is more ready to do so.

Is the mixing of sexes a problem?

The problem arises sporadically depending upon the patients that we have. When you were here before it happened that we had some young people and some people whose cultural standards made that part of their life—the sexual acting out. You might call it "acting out" since it is against the rules of the hospital. Again it is handled by the crisis committee, because it is a violation of the rules to have sexual intercourse on the ward. It does occur occasionally.

What about visitor privileges?

Unless contra-indicated by the emotional problem of the patient, everyone has a right to have visitors from 8 a.m. to 8 p.m. every day of the week. Sometimes, because of an individual situation, it might be deemed detrimental to the patient's health to have interaction with somebody that is terribly distressing to them. If the allowance of visitors all during the day has to be changed, it is only on an individual basis.

Where do the patients exercise?

Over in the rehabilitation department they have specified times and special classes, body building, etc., and we have a field where we have

ball games occasionally, but generally we do not have exercise classes. We have punching bags and balls and we do get patients together to toss the ball around. We should do more of it; it is only because it is our fault that we do not have the patients exercise as much as they should.

Do the patients use the art room freely?

They have to use it under supervision. Some of our MHTs [mental health technicians] are taking education courses in school and they do have art classes three times a week—in ceramics, painting, and drawing.

OTHER ASPECTS OF PATIENT RIGHTS

As indicated by the preceding interview, rights are generally accorded Arizona State Hospital patients not by legislation, as is the case in some states,[16] but rather by overall hospital policy or, more often, by the action of the patient's residential treatment unit. Some treatment units, in turn, often arrive at decisions by the action of their patient-staff governing bodies, better known as "therapeutic communities."

In units where therapeutic communities are operative, the communities meet at least several times a week, and even daily in some units.[17] During their meetings, which usually run one or two hours, a patient seeking a privilege will stand and state his request, whereupon the community will discuss the request and render a decision. Typical requests relate to passes—to use the grounds, to leave the grounds for 2 hours to shop at a nearby market, to leave the hospital for a weekend—as well as to other matters, such as the right to be put on self-medication.[18]

Though Maxwell Jones' concept of extended patient participation[19] has been widely applauded for its therapeutic value in patient self-development,[20] the concept poses some troubling questions when applied to the meting out of privileges to fellow patients. In addition to the possible incursions on privacy[21] entailed in having patients' personal problems laid bare before the entire ward, ward government may open the door

16. For a discussion of some of the pertinent statutes, see LINDMAN & MCINTYRE, *supra* note 15, at 142-82.

17. The therapeutic community concept at the Arizona State Hospital is described in the Phoenix Gazette, Mar. 18, 1971, at 22, col. 1. For other articles on the hospital, see *id.* at 1, 22 & 23.

18. *Id.* at 22. The operation of the therapeutic community in this manner was also confirmed by project field research conducted at the hospital.

19. M. JONES, THE THERAPEUTIC COMMUNITY (Basic Books ed. 1953).

20. *E.g.*, Greenblatt & Levinson, *Mental Hospitals*, in HANDBOOK OF CLINICAL PSYCHOLOGY 1343-51 (B. Wolman ed. 1965).

21. During a therapeutic community meeting witnessed by the project, in at least two instances the relationship of a patient to his family was discussed and was the basis for action taken by the community. In both cases the patient had requested a pass to visit his family, and in both cases the pass was denied based on information revealed during the meeting regarding disharmony in the patient's family.

to needlessly restrictive decision making particularly if, as some suggest, the patients "are often more strict with each other than the staff would be."[22] And if patients are likely, more so than the staff, to deny requests on the basis of seemingly improper criteria—as where a pass to shop at a Safeway Market was presumably disapproved by one patient because the applicant "gobbles his words"[23]—ward government may in many instances violate the principle that hospital patients ought not to be unnecessarily deprived of living with as much freedom as is feasible.[24]

Troubling though it may be to have privileges and rights rest with a therapeutic community, the situation of obtaining favorable action on requests is even further compounded for those patients—not insubstantial in number—who are on "special classification," and whose requests for privileges must accordingly be approved not only by their residence unit but also by a "Special Classification Committee" (SCC) and by the superintendent. Patients on special classification include those on criminal commitment (such as those found incompetent to stand trial or not guilty by reason of insanity),[25] those transferred from the Department of Corrections,[26] juveniles under the equivalent of a criminal commitment,[27] all persons in the Maximum Security Unit regardless of their technical legal status, civilly committed persons with criminal detainers,

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22. Phoenix Gazette, Mar. 18, 1971, at 22, col. 5 (remarks of Dr. Lois Breen). Whether patients or staff are stricter in these matters is, of course, subject to empirical inquiry. *Cf.* H. KALVEN & H. ZEISEL, THE AMERICAN JURY (1966) (study of the comparative leniency of judges and juries).

23. Phoenix Gazette, March 18, 1971 at 22, col. 4.

24. Covington v. Harris, 419 F.2d 617 (D.C. Cir. 1969). *Cf.* Lake v. Cameron, 364 F.2d 657 (D.C. Cir. 1966) (appeal from remand of 331 F.2d 771 (D.C. Cir. 1964), *cert. denied*, 382 U.S. 863 (1965)). This is not to suggest, of course, that the staff always adheres to the *Covington* principle. In fact, one notable Arizona State Hospital instance of staff departure from the spirit of *Covington* occurred when the therapeutic community in one unit began to falter because of increasing patient apathy. Concerned that the program might collapse, the unit head imposed a "freeze" on the entire community, restricting all patients to the ward until the therapeutic community could be rejuvenated. Unfortunately, the technique backfired and led to acting-out behavior on the part of some patients, whereupon the freeze was lifted.

As an interesting aside, it should be noted that one staff member on the Pima County unit emphasized that patient government on that ward was far more effective in the days prior to the Pima County Combined Program, which emphasizes community care rather than state hospitalization for the bulk of mentally disturbed patients from Pima County. Before the Combined Program, apparently, many patients sent to the Pima unit were very much in contact and performed well in roles of democratic leadership. But now that the Combined Program has kept most of the in-contact patients at home and sent to the state hospital only the more disturbed persons, patient performance in the therapeutic community has plummeted.

25. See discussion at pp. 149-53, 165-68 *supra.*

26. See discussion at pp. 176-83 *supra.*

27. Mental health laws and the juvenile justice system present an area clearly deserving of study, but one beyond the scope of the instant project. *See, e.g.*, Popkin & Lippert, *Is there a Constitutional Right to the Insanity Defense in Juvenile Court?*, 10 J. FAM. L. 421 (1971) (the authors are members of a District of Columbia Bar Association project studying mental illness and juvenile justice).

and a residual category of persons civilly committed but placed on special classification by "Superintendent's Directive."

The SCC, composed of seven staff members selected by the superintendent,[28] was instituted by the hospital administration to provide centralized control over advances in privileges afforded to the "special" types of patients described above. Apparently, such a system of control was thought necessary by hospital administrators who were ultimately responsible for lower-level decisions regarding patient privileges.

Procedurally, matters are brought to the attention of the SCC in the following manner: Upon the recommendation of the therapeutic community or on the initiative of a staff member, a request form (RO-7) is completed by the staff and transmitted to the committee. The completed form contains the requested action and provides a summary of the patient's history, present behavior, medication, and present privileges. Formerly, the SCC acted on the basis of the information in the RO-7 form alone. Now, however, the SCC also sometimes interviews the subject patients. The committee then meets[29] to grant or deny the applications, which involve requests to transfer to a less restrictive ward;[30] to go to church, rehabilitation, swimming or other activities on a 1:1 or 1:5 staff-patient basis; to receive grounds privileges; off-grounds passes; and related matters. Action taken by the SCC is not final until approved by the superintendent.

Some hospital staff members interviewed by the project expressed disappointment over what they termed the SCC's conservatism in granting privileges. Even in the face of a strong recommendation by those in closest contact with the patient, the privilege may be denied by the

28. The committee consists of doctors, nurses, a security officer and other professionals. To insure reasoned decision making, however, the superintendent has chosen as committee members persons who are not involved in day-to-day affairs of the patients. The committee is further described in Arizona State Hospital, Regulations & Procedures No. 708 (Nov. 23, 1970).

29. A project member was permitted to attend an SCC meeting and to peruse several applications filed with it.

30. The SCC is sometimes baffled by civil commitment orders containing language to the effect that the patient is "to be held in the Maximum Security Ward." A problem arises when the SCC is faced with a patient's request to transfer out of Maximum Security and at the same time with a commitment order containing the above language. In such a case the SCC does not know whether it is bound to follow the order—in which case it is easier to discharge the patient than to change his ward—or whether the committing court has exceeded its authority, in which case the SCC could, with legal impunity, disregard the superfluous language if it felt treatment could be appropriately carried on in a ward other than Maximum Security. Since the pertinent statute speaks merely of ordering a patient confined in the state hospital, ARIZ. REV. STAT. ANN. § 36-514(C) (Supp. 1970-71), the latter course of action by the SCC would seem permissible. In any case, committing courts should refrain from attempting to tie the hospital's hands with respect to the appropriate ward of confinement. This is particularly so in view of the fact that few judges are sufficiently acquainted with the facilities of the hospital to recognize, for example, that tight security is available not only in the Maximum Security Unit (Encanto Hall), but also in a slightly less restrictive ward (Hermosa Hall), and that even the general population wards do not grant grounds privileges to all patients.

seven members of the SCC who probably know little about the patient[31] and his therapeutic circumstances. Staff members indicated that the supposed SCC timidity is most apparent when the request involves patient contact with the community at large, such as with respect to off-grounds passes or contemplated discharges.

Because of the additional deprivation of liberty involved,[32] the decision to place a patient—particularly a civilly committed patient—on special classification ought to be one made with some degree of formality and with some opportunity for the subject patient to air his views. Yet, the actual determination to place a civil patient on special classification pursuant to the "Superintendent's Directive" is apparently made unilaterally by the staff and administration, without officially hearing from the affected patient. Often, a telephone call from a law enforcement agency—including the Secret Service with respect to "White House cases"[33]—is sufficient to trigger the special classification machinery. Since the resulting restriction on liberty—quite analogous to punishment—can be effected on the basis of flimsy evidence and without the opportunity for the patient to controvert the facts in issue, the "Superintendent's Directive" procedure may raise due process and equal protection problems and deserves to be re-thought by the hospital, perhaps along the lines discussed below.

Unpleasant as it may be to be placed on special classification, that consequence is probably viewed as merely ancillary by those patients who receive special classification status by virtue of being transferred from a general population ward to the Maximum Security Unit.[34] For them, the dismal life on the latter ward[35] is probably far more troubling than is mere special classification status. Yet, even decisions of ward transfers may apparently be made at the Arizona State Hospital without the benefit of a due process framework. Though there are published hospital regulations governing transfers to the Maximum Security Unit,[36] they simply insure that the decision is made by an appropriate official, and do not deal with other procedural or due process considerations, such as the right of the subject patient to be informed of the precise accusations and to present his version of the facts.

31. See note 15 *supra.*

32. The additional deprivation of liberty may well be unnecessary. *See* the section on prison-to-hospital transfers, pp. 174-88 *supra. See also* Covington v. Harris, 419 F.2d 617 (D.C. Cir. 1969).

33. Persons who travel to see the President or who write disturbing letters to him are often committed and watched carefully by the Secret Service. The problem is, of course, most severe in the District of Columbia, and many such cases are confined to St. Elizabeth's Hospital located there. *See* Arizona Daily Star, May 2, 1971, at B-11, col. 6.

34. As noted above, all patients on the Maximum Security Unit are automatically placed on special classification. See discussion at p. 208 *supra.*

35. See the discussion of the Maximum Security Unit in the section on prison-to-hospital transfers, pp. 186-88 *supra.*

36. Arizona State Hospital, Regulations & Procedures No. 413 (Feb. 22, 1971).

Despite the absence of general hospital policy regarding procedural safeguards in ward transfers, it is of course possible that the individual treatment units might themselves provide for certain safeguards in the matter. Although the project did not observe any ward transfer proceeding per se, some of its members did witness a disciplinary proceeding resulting in temporary revocation of ground and visiting privileges—a consequence severe enough to qualify as a conceptual analogue to transfer to a more restrictive ward.

The observed proceeding was of a "crisis committee," a patient-staff committee of the particular treatment division's therapeutic community.[37] The crisis committee ordinarily meets every morning to discuss current matters, but the particular meeting observed was an unscheduled "emergency" session called in the afternoon after the subject patient—a young man of 19 or 20—was allegedly seen smoking marijuana at the rehabilitation building.

Since the meeting was called in an emergency context, only two patient members were located. The room was filled, however, by five or six staff members. The staff member who had supposedly seen the patient smoking at Rehabilitation was for some reason unable to attend the meeting, and she sent in her stead another staff member. This individual offered hearsay testimony to the effect that the first woman, who is able to detect the smell of marijuana, noted the distinct odor coming from the area in which the patient was sitting and noted that he was at the time smoking a hand-rolled cigarette. The patient denied smoking the contraband, noted that several patients were present in the rehabilitation room at the time, and claimed that many patients smoke roll-your-own cigarettes containing state-issued tobacco.

The staff, however, was unconvinced. The subject patient, though under a civil commitment, had a sheriff's hold on him for illegal possession of dangerous drugs, and the staff suspected that he had a cache of drugs secreted on the premises, perhaps brought to him by his wife who had visited him a week earlier. Someone had also apparently seen the patient put his hand over the Maximum Security wall and hand a cigarette to a patient on the other side. Though the subject patient once again claimed it to be an ordinary cigarette, staff suspicion was not dispelled.

At this point in the proceedings, one patient committee member noted that the only evidence against the subject patient was speculation, suspicion, and hearsay. A high-ranking staff member interrupted, agree-

37. Under the therapeutic community's constitution, patients, to be eligible for service on the crisis committee, must have first demonstrated their responsible character by serving as members of other community committees, such as the door (opening and closing ward doors), buddy, recreation and clean-up committees. It would seem that such a requirement might result in a very selective type of patient membership on the crisis committee.

ing that the evidence was flimsy, but emphasizing that the ward was having a drug problem and that something had to be done about it. The patient committee member then responded to the effect that, "I'm not saying we shouldn't do something; I'm simply pointing out that anything we do will be based on suspicion and not on evidence."

With that said, the committee began to think about the possible due process implications of its proceeding, and turned to the legally trained project member observers for advice. But because the project members were in attendance only as observers, they told the committee they felt their interference at that time would be inappropriate. The committee proceeded to ask the patient whether he would accept being confined to his ward without visitors for the period of a week until "we can straighten things out and get them under control." When the patient did not raise any strong objections, the meeting was adjourned.

The project members left the proceeding with a feeling of ambivalence, obviously disturbed by the equation of suspicion and guilt, and yet impressed at the way in which the disposition was informally negotiated, apparently without engendering any noticeable animosity in the subject patient—a point that probably cannot be gleaned adequately from a "cold" report of the proceedings. The project was impressed, too, by the fact that the staff was obviously groping for some type of legal guidelines for fairly conducting disciplinary hearings.

In the context of a case involving the transfer of a St. Elizabeth's Hospital patient to the hospital's Maximum Security Unit for allegedly committing a rape, the United States Court of Appeals for the District of Columbia Circuit has recently specified due process guidelines for disciplinary ward transfers that may well serve as a procedural framework for hospital disciplinary decisions in general.[38] That court, noting that a "full dress trial" is hardly required, nevertheless held in *Jones v. Robinson*[39] that minimal due process mandates:

> (1) That the officer conducting the inquiry be neutral, in the sense that where possible he have no prior connection with the accused patient, his alleged victim, or the incident under investigation. . . . A doctor, an administrative assistant to the superintendent or similar personnel of the hospital could serve in this capacity.
>
> (2) That the investigating officer interview all the witnesses himself, including those suggested by the accused patient,

38. Jones v. Robinson, 440 F.2d 249 (D.C. Cir. 1971). *Jones* recognizes, however, that transfers for *medical* (rather than disciplinary) reasons may involve different considerations. *See also* Williams v. Robinson, 432 F.2d 637 (D.C. Cir. 1970). Disciplinary decisions in prison settings have recently received much play in the courts and in the periodicals. *See, e.g.*, Sostre v. McGinnis, 442 F.2d 178 (2d Cir. 1971). *See also* Jacob, *Prison Discipline and Inmate Rights*, 5 HARV. CIV. RIGHTS-CIV. LIB. L. REV. 227 (1970); Kraft, *Prison Disciplinary Practices and Procedures: Is Due Process Provided?*, 47 N.D.L. REV. 9 (1970).

39. 440 F.2d 249 (D.C. Cir. 1971).

and make a written memorandum of each interview. In this way the same fact finder can judge the credibility of all witnesses.

(3) That copies of these memoranda be made available to the accused patient and that he be given an opportunity to respond to the allegations contained therein.

(4) Where the hospital authorities believe that confrontation and cross-examination will not adversely affect the patients involved, including the witnesses, confrontation and cross-examination to the extent indicated should be permitted.

(5) That a lawyer to represent the accused patient is not required, but the hospital authorities may conclude that a lay representative assigned to the accused patient may be in the interest of justice.

(6) No court reporter or transcript of the proceedings would ordinarily be necessary, but detailed informal memoranda should be kept by the investigating officer who shall also make findings and give reasons for his decision. . . . These memoranda, together with his findings and reasons, should become a part of the permanent records of the hospital.

(7) That while the investigating officer may determine whether the evidence is sufficient to justify a transfer of the accused patient to [maximum security], to be effective that judgment must be affirmed by the superintendent of the hospital after a review of the record.[40] (citations omitted).

Behavioral theory may suggest, of course, that overattention to due process considerations in disciplinary hearings can be counterproductive and can reinforce acting-out behavior by the formal attention paid to that behavior and by the ensuing relief from boredom entailed by the convening of a disciplinary committee. A similar concern has been expressed by the Second Circuit in a case involving prison disciplinary proceedings,[41] but even that court recognized that there is a crucial distinction between overattention to due process considerations and such basic safeguards against arbitrariness as adequate notice, an opportunity for the prisoner to reply to charges lodged against him, and a reasonable investigation into the relevant facts.[42] The Arizona State Hospital regulations ought to be revised to provide for those basic safeguards, and the regulations as revised ought to be adhered to closely.[43]

40. *Id.* at 251-52.

41. See Sostre v. McGinnis, 442 F.2d 178, 197 (2d Cir. 1971):

It would be mere speculation for us to decree that the effect of equipping prisoners with more elaborate constitutional weapons against the administration of discipline by prison authorities would be more soothing to the prison atmosphere and rehabilitative of the prisoner or, on the other hand, more disquieting and destructive of remedial ends. This is a judgment entrusted to state officials, not federal judges.

42. *Id.* at 198-99.

43. In addition to individual unit procedures (for instance, those described in the interview, pp. 213 *et seq. supra*, regarding one unit's use of a crisis committee to approve seclusion decisions), the hospital does have a formal regulation regarding

CONCLUSION

Unlike many other jurisdictions,[44] Arizona has not cast its rights of patients in statutory language. Though it is not a simple task, perhaps some thought should be given to legislation in that area. At the very least, the hospital itself should, in its internal regulations, elaborate more fully the rights of its patients. In so doing, attention should be paid to some of the procedural considerations discussed in this section and to some of the substantive rights enumerated in statutes of other jurisdictions.[45]

The most extensive and clearly the most far-reaching published proposal of statutory patients' rights comes from a draft act recently prepared by the Center for Study of Responsive Law.[46] The draft act was prepared by the Center at the request of Senator Ervin's Senate Judiciary Subcommittee on Constitutional Rights, which is considering revamping the District of Columbia commitment law.

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the use of seclusion, Arizona State Hospital Regulations & Procedures, No. 502 (Sept. 24, 1968), but it has not proven satisfactory in operation.

The regulation permits seclusion for a maximum of 24 hours, though all seclusion orders are supposed to be discontinued at 10 a.m. each day unless reordered. As a general rule, according to the regulation, a physician is required to write any order for seclusion or restraint, but the rule is clearly capable of being swallowed by its exceptions, which permit P.R.N. (*pro re nata*, or "as circumstances may require") orders for seclusion and permit seclusion to be effected without a physician's order in emergencies, so long as a physician writes the order "as soon as possible thereafter."

According to interviews conducted at the hospital, the formal regulation is in fact often circumvented. In the Admissions Unit, for example, standard practice apparently entails the automatic issuance of a one-time P.R.N. seclusion order for each incoming patient, authorizing immediate seclusion should the patient become disruptive. The formal regulation, moreover, is neatly avoided on the general wards as well. Since seclusion is generally ordered at night, when the staff is reduced and when it accordingly becomes exceptionally difficult to manage disruptive patients, mental health workers are the ones who ordinarily invoke the seclusion room. The mental health worker will then go to see a physician. Though it is assumed that a physician ought to *see* the patient before writing a seclusion order, the regulation does not specifically so provide, and physicians sometimes write the orders on the mere say-so of mental health workers, without conducting examinations of the subject patients.

The superintendent believes that the seclusion room could be dismantled if the hospital created a "disturbed ward" which would be highly staffed and which would care for disturbed patients on a short-term basis. But because many staff members view even the term "disturbed ward" as a step backward in mental health care, such a ward has never come into being, and the seclusion room remains.

Even if seclusion rooms continue to be used, there is much that can be done to control their abuse. Seclusion should, for example, be temporary; after a patient has been placed in seclusion and medicated, he may well be removed within an hour or so, but hospital officials agree that such a time schedule is not often followed. See also the statutory proposal of the Center for Study of Responsive Law, reprinted in the text at pp. 225-27 *infra*.

44. *E.g.*, CAL. WELF. & INST'NS CODE § 5325 (West Supp. 1971); D.C. CODE ANN. §§ 21-56 to -565 (1967); MASS. GEN. LAWS, ch. 123, § 23 (Supp. 1970).

45. *Id.*

46. *Hearings on Constitutional Rights of the Mentally Ill Before the Subcomm. on Constitutional Rights of the Senate Comm. on the Judiciary*, 91st Cong., 1st 2d Sess. 396-97 (1970) [hereinafter cited as *1970 Hearings*].

Rights of Person[s] during Emergency Detention and after Commitment

All the rights in this section shall also apply to persons voluntarily admitted to a mental institution except when the reference is specifically to committed persons.

Any person in a mental institution shall have the right—

(1) to refuse drugs.
(2) to refuse electric shock.
(3) to refuse insulin shock.
(4) to refuse lobotomy.
(5) to remain silent.
(6) to remain fully clothed.
(7) to be allowed access to toilet facilities upon request.
(8) to refuse to participate in any research projects.
(9) to be given a copy of the statute under which he is being held upon request.
(10) to apply for habeas corpus and to be given detailed written instructions on how to apply for it.
(11) to refuse to be photographed or fingerprinted.
(12) to vote.
(13) to hold a driver's license.
(14) to refuse to work for the institution. If the person works voluntarily he must be paid the minimum legal hourly wage.
(15) to send and receive uncensored and unopened mail, and to be given adequate writing paper, pencils, envelopes and stamps.
(16) to have access to a telephone between the hours of 9 a.m. and 9 p.m. Local calls shall be allowed without charge and the person shall be allowed long distance calls if he can pay the institution for them or can charge them to another number.
(17) to receive any visitors between the hours of 9 a.m. and 9 p.m.
(18) to be allowed to have unlimited access to his own money unless a conservator has been appointed, and to keep as much money in his personal possession as he deems necessary.
(19) to wear his own clothes and keep his own toilet articles.
(20) to have adequate private storage space for his personal effects.
(21) to be allowed to purchase personal articles such as variety store items.
(22) to be allowed at least two hours of physical exercise each day outside of his ward and, if the weather permits, outside of a building.

No person shall be placed in seclusion or in mechanical restraints or otherwise forcibly retrained unless such placement or restraint is applied within ten minutes after the person without reasonable provocation overtly attempts or inflicts physical harm upon the person of another or upon himself. No person

shall be placed in seclusion or mechanical restraints or otherwise forcibly restrained for longer than two hours. Whenever a person is placed in seclusion or mechanical restraints, or otherwise forcibly restrained a certificate shall be filed with the Board of Enforcement within 48 hours by the institution stating who ordered the seclusion, restraint, or force, who applied the seclusion, restraint, or force, and what specific and detailed acts were the basis under this section for the seclusion, restraint, or force. If the certificate contains insufficient information under this section the Board of Enforcement shall issue a citation to the person signing the certificate. The Board of Enforcement shall investigate the application of seclusion, restraint, or force within 72 hours after the certificate is filed and issue appropriate citations or make appropriate arrests if this statute has been violated. The results of the investigation shall be made available to the person to whom seclusion, restraint, or force was applied for his use in a civil suit if he requests.

No person or anyone legally responsible for him shall be required to pay the costs of an involuntary commitment.

No person involuntarily committed may be transferred out of the District except by being brought before a District judge and requesting his own transfer.

Every person voluntarily entering a mental institution shall be given a separate written notice of release procedures and [be] orally informed of release procedures. Detailed release procedures for voluntary persons shall be permanently and prominently displayed on every ward. All persons voluntarily in the institution, regardless of age, shall have the right to immediately sign themselves out [discharge themselves] upon request.

No records of any sort concerning any person alleged to have a mental disorder shall be made available to anyone except authorized personnel employed in the mental institution in which the person is placed who are expressly authorized by the director of the institution, members of the Board for the Review of the Presence of Mental Disorder, the Enforcement Board and the person's attorney. Any person shall be subject to civil and criminal penalties for releasing information without the person's [patient's] written consent.

Every person brought or admitted to a mental institution shall have a civil cause of action for assault and battery, false arrest, or false imprisonment if he is unlawfully taken into custody or unlawfully detained or restrained after admission or commitment. He may also file a criminal complaint.

Any violation of a person's civil rights under this act shall give him a cause of action for the greater of the following amounts: (1) $1,000 or (2) three times the actual amount of damages. It is not a prerequisite to such an action that the plaintiff suffer or be threatened with actual damages.

None of these rights may be suspended for any cause. A list of these rights shall be provided to a person upon entering into a mental institution and shall be posted prominently on

all the wards in the institution so that all the persons on that ward may easily see the list.[47]

As the Center proposal recognizes, even a detailed panoply of statutory rights would be to no avail if the patients and staff were unaware of them.[48] To that end, any Arizona legislation or regulations regarding patients' rights should call for the posting—in Spanish as well as in English[49]—of all rights, including rights regarding re-examinations, rehearings, and release.[50] But perhaps the only way of insuring adequate protection of patients' rights is through the establishment of an effective legal services project on the hospital grounds. Such a project could take the form of a law school clinic, a matter currently being explored by the state hospital and the University of Arizona College of Law.[51] Were such a clinic available, patients could receive broad assistance in their civil-legal problems—which must obviously gnaw at their psyches and contribute to their emotional conditions—as well as with matters relating to criminal holds, release from the hospital, and rights while in the hospital—including the rather pervasive right to treatment, considered immediately below.

47. *Id.* § II.J.

48. In this regard, it is noteworthy that the Arizona State Hospital does not have available many copies of its own internal regulations and procedures.

49. Bilingual publication is statutorily required in California. CAL. WELF. & INST'NS CODE § 5325 (West Supp. 1971).

50. Arizona law provides for commitment rehearings, but the provisions have been largely ignored, perhaps due to ignorance on the part of the patients. ARIZ. REV. STAT. ANN. § 36-516 (Supp. 1970-71). Statutory law for the District of Columbia provides that each patient be given a written statement regarding that and other rights. D.C. CODE ANN. § 21-565 (1967).

51. Such clinics are now commonplace in prisons. *See, e.g.*, Jacob & Sharma, *Justice After Trial: Prisoners' Need for Legal Services in the Criminal-Correctional Process*, 18 KAN. L. REV. 493 (1970); Wexler, *Counseling Convicts: The Lawyer's Role in Uncovering Legitimate Claims*, 11 ARIZ. L. REV. 629 (1969) (discussing the work of the University of Arizona Post-Conviction Legal Assistance Clinic); Wexler & Silverman, *Representing Prison Inmates: A Primer on an Emerging Dimension of Poverty Law Practice*, 11 ARIZ. L. REV. 385 (1969).

THE RIGHT TO TREATMENT

In 1960, when Morton Birnbaum first advocated it,[52] many observers must obviously have been doubtful whether the "right to treatment" for involuntarily committed mental patients would ever gain a respectable foothold in American law. But it is now, of course, beyond question that the right has received appropriate legal recognition.

Six years after Birnbaum's thesis was published, Judge Bazelon, speaking for the District of Columbia Circuit in *Rouse v. Cameron*,[53] converted the thesis into binding precedent within the nation's capital. Though the *Rouse* court acknowledged that the Constitution was close to the surface of its decision,[54] the case was actually disposed of by recognizing the applicability of a local statutory right to treatment.[55]

Rouse spawned its expected share of commentary in the legal literature,[56] including an interesting piece in this *Review*.[57] But by far the most significant post-*Rouse* development is the recent decision in *Wyatt v. Stickney*,[58] where a federal district court in Alabama squarely held the right to treatment to be constitutionally compelled.[59]

The fact that the right to treatment is now recognized does not, however, mean that its constitutional contours are at all precise. In-

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52. Birnbaum, *The Right to Treatment*, 46 A.B.A.J. 499 (1960).
53. 373 F.2d 451 (D.C. Cir. 1966).
54. *Id.* at 453. *See also* Nason v. Superintendent, 353 Mass. 604, 612, 233 N.E.2d 908, 913 (1968) ("Confinement of mentally ill persons, not found guilty of crime, without affording them reasonable treatment also raises serious questions of deprivation of liberty without due process of law."). *Rouse* also recognized that "[i]ndefinite confinement without treatment of one who has been found not criminally responsible may be so inhumane as to be 'cruel and unusual punishment.'" 373 F.2d at 453.
55. D.C. CODE ANN. § 21-562 (1967).
56. *E.g.*, THE MENTALLY ILL AND THE RIGHT TO TREATMENT (G. Morris ed. 1970) (containing original articles as well as some reprinted from a collection of articles in 36 U. CHI. L. REV. 743, 755, 784 (1969)); THE RIGHT TO TREATMENT (D. Burris ed. 1969) (reprinting a symposium originally appearing in 57 GEO. L.J. 673 (1969)); Note, *The Nascent Right to Treatment*, 53 VA. L. REV. 1134 (1967); Note, *Civil Restraint, Mental Illness, and the Right to Treatment*, 77 YALE L.J. 87 (1967).
57. Dix, Book Review, 11 ARIZ. L. REV. 822 (1969).
58. 325 F. Supp. 781 (M.D. Ala. 1971).
59. The opinion does not make perfectly explicit whether the court was employing a due process or a cruel and unusual punishment rationale.

deed, many basic questions have yet to be finally resolved, including the scope of the remedy[60] and the definition of the right itself. With respect to the latter, Professor Dix recognizes five possible definitions of the right,[61] but properly contends that, at the moment, only two of them are worthy of serious consideration: a right to have the detaining institution meet certain minimum standards, and a right to a course of treatment that is theoretically adequate.[62]

THE ARIZONA SITUATION

Only 425 of the 1,443 patients admitted to the Arizona State Hospital during the fiscal year ending June 30, 1970 were voluntary admissions.[63] In other words, 1,018 admissions—or 71 percent—represent patients being held against their will, clear candidates for the right to treatment. In Arizona, the right to treatment could quite clearly be held to have a statutory base,[64] but, particularly in view of the perennial problem of inadequate legislative appropriations to the hospital and the possibility of a reversal of legislative intent, the emerging constitutional claim is obviously more potent than its statutory counterpart.

A look at the Arizona State Hospital in relative statistical terms can provide a starting point, however crude, for evaluating the extent to which the mental health care provided by the institution compares to that provided by other institutions across the country. Data from the National Institute of Mental Health[65] for the fiscal year ending June 30, 1969, which is portrayed in Table XIV, permits comparison of Arizona's

60. The Supreme Court of Massachusetts has held that mandamus would not lie to compel adequate psychiatric treatment, Nason v. Commissioner, 351 Mass. 94, 217 N.E.2d 733 (1966), but that the legality of confinement without treatment could be tested by a writ of habeas corpus. Nason v. Superintendent, 353 Mass. 604, 233 N.E.2d 908 (1968). The obvious but drastic remedy of release was avoided by the court in *Wyatt v. Stickney*, 325 F. Supp. 781 (M.D. Ala. 1971), where the court held instead that "a failure on the part of the defendants to implement fully, within six months from the date of this order, a treatment program so as to give each of the treatable patients committed to Bryce facility a realistic opportunity to be cured or to improve his or her mental condition, will necessitate this Court's appointing a panel of experts in the area of mental health to determine what objective and subjective hospital standards will be required to furnish adequate treatment to the treatable mentally ill in the Bryce facility." *Id.* at 6. *Cf.* Note, *Receivership as a Remedy in Civil Rights Cases*, 24 RUTGERS L. REV. 115 (1969).

61. Dix, *supra* note 57, at 824-26.

62. Rejected by Dix as impractical definitions of the right, given current knowledge, were a right to be cured, a right to the most appropriate course of treatment, and a right to regular executive or legislative evaluation of adequacy of facilities. *Id.* at 826-28.

63. Arizona State Hospital, 1969-70 Annual Report 22 (Aug. 14, 1970).

64. ARIZ. REV. STAT. ANN. § 36-202(A) (Supp. 1970-71) reads in part: "A state hospital for the mentally ill shall be maintained for care and treatment of persons adjudged mentally ill and other mentally diseased persons who are admitted thereto in accordance with law." And the statute is embellished by *id.* § 36-202(B) which, among other things, specifies that "[t]he hospital shall have adequate facilities and equipment for enlightened and scientific treatment of nervous and mental diseases in accordance with approved methods of mental therapeutics."

65. NATIONAL INSTITUTE OF MENTAL HEALTH, MENTAL HEALTH STATISTICS—

TABLE XIV: FUNDING OF MENTAL HOSPITALS

State	Daily Expenditures Per Resident Patient		Daily Expenditures Per Patient Under Treatment		Ratio of Patients to Full-Time Staff*	
	Amount	Rank	Amount	Rank	Ratio	Rank
National Average	$12.59	—	$ 5.31	—	1.73	—
Alabama	5.82	50	3.31	47	3.39	51
Alaska	38.93	1	12.40	1	.72	3
Arizona	*$13.63*	*24*	*$ 5.29*	*19*	*1.52*	*22*
Arkansas	16.75	15	5.23	20	1.01	7
California	19.30	9	5.03	22	1.43	18
Colorado	29.70	2	7.52	7	.66	1
Connecticut	17.16	13	4.66	29	1.43	17
Delaware	13.79	22	4.97	24	1.32	14
Dist. of Columbia	20.40	8	11.07	2	1.36	15
Florida	8.60	44	5.05	21	1.89	35
Georgia	10.07	37	4.53	33	2.11	43
Hawaii	18.43	12	4.78	28	1.39	16
Idaho	15.20	19	5.54	16	1.20	10
Illinois	19.14	10	7.80	5	1.25	13
Indiana	12.04	31	5.00	23	1.75	28
Iowa	29.60	3	5.68	15	.68	2
Kansas	21.70	6	6.72	9	.89	5
Kentucky	12.86	25	4.18	36	1.60	24
Louisiana	11.05	34	3.84	39	2.00	41
Maine	8.14	45	3.63	40	2.41	48
Maryland	12.50	29	3.88	38	1.63	25
Massachusetts	12.84	26	4.62	31	1.76	30
Michigan	16.02	16	7.74	6	1.75	29
Minnesota	17.00	14	5.46	17	1.43	19
Mississippi	5.40	51	2.51	51	2.55	49
Missouri	18.86	11	6.20	13	.97	6
Montana	9.81	40	4.65	30	2.06	42
Nebraska	20.94	7	7.52	8	.84	4
Nevada	24.83	4	6.22	12	1.13	8
New Hampshire	9.74	48	4.42	35	2.00	40
New Jersey	11.94	38	6.08	14	1.65	26
New Mexico	15.67	17	4.87	27	1.17	9
New York	11.25	33	6.46	11	1.93	39
North Carolina	10.06	39	3.33	46	1.90	37
North Dakota	12.12	30	3.95	37	1.78	31
Ohio	10.07	38	3.29	48	2.13	44
Oklahoma	10.74	35	3.55	41	1.52	21
Oregon	13.84	21	3.47	42	1.75	27
Pennsylvania	12.58	28	8.15	3	1.80	33
Rhode Island	14.59	20	4.92	26	1.90	36
South Carolina	6.75	49	3.42	45	2.76	50
South Dakota	9.76	41	4.54	32	1.53	23
Tennessee	9.31	43	3.08	50	1.82	34
Texas	8.06	46	3.09	49	2.29	45
Utah	15.44	18	4.52	34	1.25	12
Virginia	7.23	48	3.47	43	2.36	46
Vermont	10.47	36	4.95	25	1.79	32
Washington	21.81	5	7.94	4	1.22	11
West Virginia	7.27	47	3.43	44	2.37	47
Wisconsin	13.59	27	6.67	10	1.93	38
Wyoming	13.78	23	5.44	18	1.51	20

* Computed by average daily census over full-time equivalent in inpatient staff.

performance against the performance of other states in providing funds and facilities, as measured by expenditures per patient and by the ratio of patients to full time staff.

According to the report from which the data was taken, the amount of *daily expenditures per resident patient* is the most commonly used measure for comparing mental hospital expenditures, the major limitation being that "it does not adequately take into account the number of [new admissions] for which a large share of the expenditure is required."[66] A ranking of the states by this measure indicates that Alaska ranks highest, with a daily expenditure of $38.93 per resident patient. Mississippi is the low, with an expenditure of $5.40. The national average is $12.59, and Arizona ranks 24th with an expenditure of $13.63, slightly above the national average.

The amount of *daily expenditures per patient under treatment* is yet another measure for comparing mental hospital expenditures but it suffers from somewhat the same limitation since it weights both admissions and resident patients equally, and a larger proportionate share is required for the care of admissions.[67] Ranking by expenditures per patients under care reveals that Alaska is still the highest in the nation with an expenditure of $12.40 per patient. Mississippi is still lowest with an expenditure of $2.51. The national average is $5.31 per patient, and Arizona ranks 19th with a daily expenditure of $5.29 per patient under care.

The *ratio of patients to full-time in-patient staff* has obvious limitations since no consideration is given to the nature or the quality of the staff, but it nevertheless provides a rough basis for comparison. Six states have a ratio of patients to staff less than 1:1. Colorado, with a patient-to-staff ratio of 0.66:1 (slightly less than two staff members for every patient), has the highest ratio of staff members to patients. Ten states have patient-to-staff ratios greater than 2:1, with Alabama having the highest at 3.39:1 (one staff member for every 3⅓ patients). The national ratio is one staff member for each 1.73 patients, and Arizona ranks 22nd with a ratio of one staff member for each 1.52 patients. While these criteria are no real indicia of adequacy,[68] and are pre-

CURRENT FACILITY REPORTS: PROVISIONAL PATIENT MOVEMENT AND ADMINISTRATIVE DATA, STATE AND COUNTY MENTAL HOSPITALS, JULY 1, 1968-JUNE 30, 1969 (Series MHB, No. H-79, 1969) [hereinafter cited as 1968-69 STATISTICS].

66. *Id.* at 13.

67. *Id.*

68. Five years ago, the *Rouse* court remarked that "[i]n the opinion of the American Psychiatric Association [APA] no tax-supported hospital in the United States can be considered adequately staffed." 373 F.2d at 458. Nevertheless, the court in *Rouse* cited the APA "staffing tables" as one of the sources against which adequacy of treatment, in terms of staff-patient ratios, could be gauged. *Id.* at 457 n.33. For physicians, for example, the standards specified a ratio of 1:30 for the Admission and Intensive Treatment Service, 1:150 for the Continued Treatment Service, 1:150 for the Geriatric Service, etc. For clinical psychologists, the standards specified a ratio of 1:100 for the Admission and Intensive Treatment Service and 1:500 for the Continued Treatment Service. AMERICAN PSYCHIATRIC ASSOCIA-

sented for comparison purposes only, it is significant to note that Arizona ranks favorably in all three categories.

In gauging Arizona's performance, however, it is probably more profitable to focus on the Arizona State Hospital itself and on its programs. The hospital, which recently received its first full, 2-year accreditation from the Joint Commission on Accreditation of Hospitals,[69] reorganized several years ago by decentralizing clinical departments and by organizing along treatment division lines, whereby patients are assigned to treatment units according to their area of residence rather than according to their clinical diagnosis. The purpose of the unit approach in general is, apparently, to permit the hospital personnel to develop relationships with the outlying communities, including the family doctors, who are often helpful in keeping the hospital informed with respect to discharged pa-

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TION, STANDARDS FOR HOSPITALS AND CLINICS 59-62 (Rev. ed. 1958). *See* Comment, *Involuntary Civil Commitment and the Right to Treatment in Pennsylvania*, 15 VILL. L. REV. 951, 959 n.60 (1970), for an analysis of the extent to which Pennsylvania's mental hospitals comply with the APA standards.

For a variety of reasons, including the fact that the Arizona State Hospital has only had an Admissions and Early Discharge Unit since December 1970, the project has been unable to compute meaningfully the extent to which Arizona conforms to the 1958 APA staffing standards. But data from Tables 5(B) & 7(B), NATIONAL INSTITUTE OF MENTAL HEALTH, MENTAL HEALTH STATISTICS: STAFFING PATTERNS IN MENTAL HEALTH FACILITIES 168 at 59, 71 (Series B, No. 2, 1968) [hereinafter cited as 1968 STATISTICS], provides the following noncomparative staffing figures for the 1,200 patients at the Arizona State Hospital:

PROFESSIONAL POSITIONS	
Psychiatrists	8
Physicians (Nonpsychiatric)	11
Psychologists	8
Social Workers	16
Professional Nurses	40
Other Professionals	47
Total Professionals	130
NONPROFESSIONAL POSITIONS (Full and Part Time)	
Practical and Vocational Nurses	14
Aides, Attendants, Assistants, Technicians	204
Other Nonprofessional Mental Health Workers	183
All Other Nonprofessional Positions	193
Total Nonprofessionals	594
TOTAL STAFF	724

It is interesting to note that, not long after *Rouse*, the American Psychiatric Association (APA) revised its standards, and its "staffing tables" were conspicuously absent from the revised draft, which explained in a footnote that "the Task Force was aware that the staffing tables . . . were often regarded as highly useful guidelines. In spite of this, it was felt that such staff-patient ratios could no longer be meaningfully updated for general application." AMERICAN PSYCHIATRIC ASSOCIATION, STANDARDS FOR PSYCHIATRIC FACILITIES 29 (1969). One can only speculate, of course, on the extent to which *Rouse* was responsible for dequantifying the revised APA standards, but to the extent that it was, it is indicative of the troubling fact that the law, by taking cognizance of professional standards, may induce understandably gun-shy professionals to refrain from formulating explicit standards. *Cf.* Hirschkop & Millemann, *The Unconstitutionality of Prison Life*, 55 VA. L. REV. 795 (1969) (proposing that the courts, in evaluating mistreatment complaints by prisoners, look to the published standards of the American Correctional Association and of the Federal Bureau of Prisons).

69. Arizona State Hospital, 1969-70 Annual Report, 8 (Aug. 14, 1970).

tients and in insuring that discharged patients maintain their needed medication. With the exception of mentally deficient, geriatric,[70] pediatric, "forensic psychiatry" and certain chronic patients, who are kept on specialized wards, the entire hospital is structured along treatment division lines.

As indicated previously,[71] many of the treatment divisions have sought to establish "therapeutic communities,"[72] partly to democratize decision-making and partly to serve the therapeutic purpose of drawing the patients out and encouraging their participation in interpersonal activities. Apart from the overall therapeutic community approach, the hospital has been instituting certain specialized treatment programs.

The superintendent is apparently most pleased with the pediatric program, which has changed markedly in recent years. Not long ago, children at the hospital experienced rather long stays, often up to a year. Now, with a better staff, better organization, a good school program and dedicated efforts at finding suitable community placements, the average stay has dropped to 3 to 5 weeks.[73]

Some strides have seemingly also been made in the geriatric division, where the goal of returning to independent living consists of a program stressing "continence, independence, socialization, recreation, and even gainful occupation when possible."[74] But the most ambitious effort is being made with the chronic, long-term patients, who have now been brought together for treatment on a specialized ward.[75] For these patients, all of whom have been at the hospital for a minimum of 3 out of the past 5 years,[76] discharge is so remote that, the hospital believes, having them reside on a treatment unit tied to their county of residence makes little sense. Instead, the program, emphasizing behavior modifi-

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70. With regard to geriatric and mentally deficient patients at the state hospital, consider the following pertinent remarks of the federal district court in Wyatt v. Stickney, 325 F. Supp. 781, 784 (M.D. Ala. 1971):

> Included in the Bryce Hospital patient population are between 1,500 and 1,600 geriatric patients who are provided custodial care but no treatment. The evidence is without dispute that these patients are not properly confined at Bryce Hospital since these geriatric patients cannot benefit from any psychiatric treatment or are not mentally ill. Also included in the Bryce patient population are approximately 1,000 mental retardates, most of whom receive only custodial care without any psychiatric treatment. Thus, the evidence reflects that there is considerable confusion regarding the primary mission and function of Bryce Hospital since certain nonpsychotic geriatric patients and the mental retardates, and perhaps other nonmentally ill persons, have been and remain committed there for a variety of reasons.

71. See "Rights of Patients," pp. 207-27 *supra.*

72. M. Jones, THE THERAPEUTIC COMMUNITY (Basic Books ed. 1953).

73. The pediatric program was described to the project in an interview with the superintendent.

74. Arizona State Hospital, 1969-70 Annual Report, 8 (Aug. 14, 1970).

75. Unfortunately, the program is located on a second floor ward, thereby automatically excluding from participation any patient unable to climb stairs.

76. Many have been in the hospital for as long as 12 years.

cation techniques,[77] brings the chronic patients into common quarters and stresses the development of ordinary life behavior—such as the use of eating utensils, proper dressing techniques, and proper patterns of social interaction involved in recreational game playing and in off-grounds group trips. Shortly, the experimental program plans to institute a "token economy,"[78] whereby tokens can be earned as rewards for demonstrating normal behavior and can be spent to purchase various items at certain hospital stores not yet in operation. Because the experimental program for chronic patients is not yet fully operational, it is, of course, impossible to evaluate it at this time. But it can be said already that the program represents an honest attempt to depart from the inertia of a custodial care program and to explore the possibility of helping, along theoretically adequate lines, even the most difficult of cases.[78a]

At least as significant a development as the experimental program for chronic patients is the recent creation at the Arizona State Hospital of a separate Admissions and Early Discharge Unit. That unit, which first opened in December 1970, seeks to screen and evaluate incoming patients and to provide immediate intensive treatment to those deemed capable, with appropriate therapy, of an early departure. According to figures supplied by the hospital, an average of 22 percent of incoming patients have to date been selected for treatment by the Early Discharge Unit.[79]

Most of the therapy on the 25-bed Early Discharge ward is conducted by three treatment teams. Each team generally consists of a mental health technician, a nurse, and a specialist such as an occupational therapist. The teams provide treatment in conformity with treat-

77. *See, e.g.*, Kalish, *Behavior Therapy*, in HANDBOOK OF CLINICAL PSYCHOLOGY 1230 (B. Wolman ed. 1965).

78. PSYCHOLOGY TODAY: AN INTRODUCTION 656-59 (1970).

78a. As this project went to press, the token economy became operative. Though the token economy method of behavior modification holds much promise, it also poses serious legal questions, such as the propriety of denying chronic patients various basics unless they are able to purchase those basics with earned tokens. For instance, one sign posted on the chronic ward states: "MONDAY BED RENTAL NIGHT: 5 Tokens Buys You A Bed for a Week."

79. The hospital report:

ENTRIES* TO EARLY DISCHARGE DIVISION VS. THE BALANCE OF THE HOSPITAL**—DECEMBER 1970-APRIL 1971

	Early Discharge		*Balance of Hospital*		*Total*	
	No.	*Percent*	*No.*	*Percent*	*No.*	*Percent*
December 1970	31	29	75	71	106	100
January 1971	25	22	89	78	114	100
February 1971	19	19	82	81	101	100
March 1971	23	18	102	82	125	100
April 1971	26	23	87	77	113	100
Total	124	22	435	78	559	100

* Not including re-entries from unauthorized absence.

** Does not include admissions to Maximum Security or Children's Division but does include some patients with a re-entry within 6 weeks who did not go through the Admissions Center.

ment programs prepared for each patient by a psychiatrist and mental health technician. Each afternoon, a staff conference is held to discuss the various patients and treatment programs. The average stay on the unit is 2 to 3 weeks, though some patients are released within a day or two.[80]

Yet, despite the recent developments, the picture at the hospital remains relatively bleak. As the previous section relating to "Life at the Hospital" demonstrates, the true daily existence for the bulk of the patients is one of idleness and inactivity, occasionally sprinkled with staff and other patient contact.

Some patients, of course, have it even worse than others. It is worth repeating[81] in this section, for example, an excerpt from the last Annual Report of the Arizona State Hospital describing the plight of the "forensic psychiatry" patients:

> Maximum Security . . . continued to labor with the realities of obsolete crowded buildings, lack of proper treatment facilities, critical staff shortages, and the pressure of time. Idealistic program planning had to be put second to the demands for processing; mere management took precedence over treatment because of the dual problems of the patients who are, for the most part, mentally ill and under criminal charges.
>
> . . . .
>
> But, overall, conditions must be reported as discouraging. Staff turnover has been high in the face of frustrating obstacles. Recreation for patients is limited, industrial therapy is not available, and an educational effort proved abortive due to improper facilities. Court testimony consumes psychatrists' time away from the unit. Under these conditions the primary medical treatment is chemotherapy. Appropriate rehabilitation, counseling, and education cannot even be attempted.[82]

Clearly, the conditions and inadequacy of treatment are most severe in the Maximum Security Unit, but the hospital paints no illusions even with respect to the care received by the general patient population. For instance, the hospital commented as follows:

> Even with careful use of the 1970-71 appropriation it will be possible to employ only 781 persons at the Arizona State Hospital. To meet reasonable requirements for patient care, there should be at least 977. There is no solution to this problem other than by increased appropriations for more persons, or by some reorganization of the entire mental health sys-

80. A discharge after 1 or 2 days almost certainly indicates the impropriety of the patient's commitment. It is important to recognize, however, that even patients discharged after 2 or 3 weeks should probably not have been committed to a state hospital to begin with, though they might well have been in need of short-term inpatient treatment in the community. In many ways, therefore, the Early Discharge Unit of the Arizona State Hospital is performing the function that ought to be performed by an active county hospital.

81. See "Prison-to-Hospital Tranfers," pp. 174-88 *supra*.

82. Arizona State Hospital, 1969-70 Annual Report 9 (Aug. 14, 1970).

> tem of the State which would effectively reduce the number of patients in the State Hospital. Unfortunately, such is not yet in view.
>
> In the meantime, we are operating the only institution in the State for the care of the mentally ill with critical and costly staff shortages in nearly every area—critical, in that needed care, which we know how to provide, is at best hindered and at worst simply not available; and costly in that delay or absence of treatment works to impede the patients' return to independent living.[83]

It is apparent, then, that patients at the Arizona State Hospital are being denied the right to treatment to which they are constitutionally due. As the above quotation from the Annual Report suggests, apart from short-circuiting the problem altogether by somehow reducing the hospital population,[84] the situation can best be altered by increased legislative appropriations. Moreover, given the constitutional base of the right to treatment, the problem will not evaporate in the face of legislative inertia, for the courts are capable of enforcing the right by fashioning imaginative and drastic remedies, including, if need be, ordering the release of untreated patients.[85] Indeed, the court in *Wyatt*, paraphrasing *Rouse*,[86] has put the matter bluntly: "The failure to provide suitable and adequate treatment to the mentally ill cannot be justified by lack of staff or facilities."[87] Prompt fulfillment of the right to treatment is, then, very much in order.

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83. *Id.* at 7.

84. See "General Conclusion," *infra*, and sections discussing community mental health and less drastic means, pp. 118-46 *supra*.

85. See note 60, *supra* p. 229.

86. Rouse v. Cameron, 373 F.2d 451, 458 (D.C. Cir. 1966):

> We are aware that shortage of psychiatric personnel is a most serious problem today in the care of the mentally ill. . . . We also recognize that shortage cannot be remedied immediately. But indefinite delay cannot be approved. 'The rights here asserted are . . . *present* rights . . . and, unless there is an overwhelmingly compelling reason, they are to be promptly fulfilled.' (citation and footnote omitted).

87. Wyatt v. Stickney, 325 F. Supp. 781, 784 (M.D. Ala. 1971).