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The Pennsylvania Experiment in Due Process

*Marian Schwalm Furman**
*James A. Conners, Jr.***

. . . nor shall any State deprive any person of life, liberty, or property, without due process of law; nor, deny to any person within its jurisdiction the equal protection of the laws.[1]

I. Due Process for Mental Patients: Evolution of a Remedial Concept.

The purpose of this paper is to present and describe a unique legislative prescription, an untried approach to the long-standing and vexing problem of insuring that each patient confined in a public mental institution will be insured at least a minimum standard of treatment. Such legislation, embodying the concept of state responsibility for treatment and offering a method for assumption of that responsibility, has been introduced in the 1969-1970 Pennsylvania legislative session.[2]

Originally introduced in the 1967-68 session, primarily as a basis upon which to have public hearings, it was known as the "Right to Treatment Law."[3] In the hearings conducted in March 1968 before the Pennsylvania Joint House and Senate Committees on Public Health and Welfare,[4] this measure's basic provisions were examined and discussed by an array of outstanding experts in the mental health field. Considerable testimony was offered at these Joint Committee hearings on the extent and quality of institutional care of patients in Pennsylvania and in the nation. These witnesses,[5] from various parts of the

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1. U.S. Const., Amend. XIV, § I.
2. Senate Bill 158 the "Right to Treatment Law of 1969" General Assembly of Pa., session of 1969, introduced by Senator Jeanette Reibman, Feb. 4, 1969, see Appendix Exhibit II, P. 67.
3. Senate Bill 1274 and House Bill 2118 "The Right to Treatment Law of 1968," General Assembly of Pa. session of 1967, were introduced in both Houses simultaneously.
4. *Hearings on S. B. 1274 and H. B. 2118, "The Right to Treatment Law of 1968" and S. B. 1275 and H. B. 2117, "Institutional Peonage Abolishment Act,"* before the Joint House and Senate Committees of the General Assembly of Pa. of Public Health and Welfare, 152nd Regular Session (1968) [hereinafter cited as *Penna. Joint Hearings*].
5. Arlin M. Adams, Philadelphia attorney and former Pennsylvania Secretary of Public Welfare (1963-67); Mark David Altschule, M.D., Assistant Clinical Professor of Medicine, Medical School, Harvard University; Chief Judge David L. Bazelon, U.S Court of Appeals,

country, several of national prominence and representing not only mental health, but also law, general medicine, government, religion and labor, uniformly deplored the pitiable, substandard levels of care in most state institutions.

A. *Tranquilizers in State Policies*

It is surprising to discover that, although legal periodicals, medical journals, statutes and court decisions have traditionally manifested considerable concern over "due process" in the commitment of persons to mental institutions, there has been little voiced concern until recently on the equally important right to adequate care and treatment inside the institution. It is incredible but true that while commitment statutes contain provisions for judicial review before commitment or legal remedy in case of improper commitment,[6] not one state law establishes a judicial remedy for deprivation of treatment once a person has been committed. Only recently have a few writings appeared that show any concern for patients' legal rights to receive actual treatment while involuntarily confined.[7] This muted expression of concern is less understandable, when it is realized that all the professionals with a working knowledge of public mental health facilities are aware that many patients do not receive any type of treatment.

District of Columbia Circuit; Pennsylvania State Representatives Milton Berkes, James J. A. Gallagher, and Robert Gerhart, Jr.; Morton Birnbaum, LL.B., M.D., New York; Harry Boyer, President, Pennsylvania AFL-CIO; Gilbert Cantor, Attorney, Chairman, Mental Health Committee, American Civil Liberties Union, Greater Philadelphia Branch; Walter Fox, M.D., Superintendent and Area Director of Mental Health, Mental Health Institute, Mt. Pleasant, Iowa; Donald J. Jolly, M.D., Commissioner of Mental Retardation and Joseph Adelstein, M.D., Deputy Secretary for Mental Health, Department of Public Welfare, Pennsylvania; Frederic D. Justin, President, Pennsylvania Mental Health, Inc., Philadelphia; George M. Leader, former Governor, Commonwealth of Pennsylvania (1955-59); Jesse D. Reber, D.D., General Secretary, Pennsylvania Council of Churches; Pennsylvania State Senator Jeanette F. Reibman; Irvin D. Rutman, Ph.D., Executive Director, Horizon House, Inc., Philadelphia; Gloria Shipley, Senior Supervisor, Temple University Mental Health Center and Assistant Professor of Social Work, Department of Psychiatry, School of Medicine, Temple University; Charles F. Taylor, M.D., President, Pennsylvania Psychiatric Society; Francis Tyce, M.D., President, Association of Medical Supervisors of Mental Hospitals, Rochester, Minnesota; David J. Vail, M.D., Medical Director, Department of Public Welfare, Minnesota; Lucie S. Young, R.N., Ph.D., President, Pennsylvania Nurses Association. Pennsylvania Joint Hearings, *supra* note 4.

6. AMERICAN BAR FOUNDATION, THE MENTALLY DISABLED AND THE LAW, Tables II B through II G, 49-72 (1961).

7. Birnbaum, *Some Comments on the Right to Treatment*, 13 ARCHIVES OF GENERAL PSYCHIATRY 34 (July, 1965); Comments, *Civil Restraint, Mental Illness, and the Right to Treatment*, 77 YALE L.J. 87 (1967); Bassiouni, *The Right of the Mentally Ill to Cure and Treatment: Medical Due Process*, 15 DEPAUL L. REV. 291 (1966); Ross, *Commitment of the Mentally Ill: Problems of Law and Policy*, 57 MICH. L. REV. 945 (1959). See also Dr. Birnbaum's testimony at *Hearings before the Subcommittee on Constitutional Rights of the Committee on the Judiciary, United States Senate, 87th Cong., 1st Sess. (1961)* on Constitutional Rights of the Mentally Ill, Part I Civil Aspects at 273-305.

Involuntary mental institution confinement is amenable to constitutional due process considerations, in that it constitutes imprisonment or deprivation of liberty.[8] Both persons involuntary committed and persons voluntary committed who are subsequently restrained from leaving the institution come directly within the ambit of the 14th amendment to the Federal Constitution:

> . . . nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.[9]

Popular reaction to mental hospitalization as "imprisonment" may be somewhat mitigated, because this confinement is not considered punishment since it is intended for the disabled person's treatment as well as for the protection of himself and others. As long as the decision to confine (hospitalize) is made, not by the disabled person, but by others, however, it is a deprivation of liberty and is as entitled to judicially enforced safeguards as is confinement in prison.[10]

Although the commitment usually occurs through the initiative of a private party, the proceeding is a public one. It is a state process; the police power of the state is invoked to accomplish the restraint of liberty.[11] There are generally two statutory conditions under which a mentally ill person may be confined in a public mental institution against his will: if restraint is necessary to prevent the allegedly mentally disabled person from inflicting harm on himself or others and if confinement is necessary for, or will be conducive to, his restoration to health.

Most state laws authorizing involuntary confinement use both bases, either conjunctively or in the alternative.[12] The "need for treatment"

8. For discussion of the historical development of constitutional due process concepts and their application to institutionalization of the mentally ill, see Kittrie, *Compulsory Mental Treatment and the Requirements of Due Process*, 21 OHIO ST. L.J. 28 (1960).

9. See discussion by Bassiouni, *supra* note 7, at 308-311.

10. Hinchman v. Richie, 1 Brightly 143 (Penna. 1849); Matter of Josiah Oakes, 8 Law Rep. 122 (Mass. 1845).

11. See Kittrie, *supra* note 8, at 32-33 for discussion of the three bases of the state's authority to confine mentally ill persons without their consent: the police power, the sovereign's position as parens patriae, and the authority and duty to provide for the indigent.

12. A 1959 survey of state commitment procedures indicated that 43 states and the District of Columbia had statutes authorizing involuntary hospitalized custody of the mentally ill. Forty of these laws, including the District of Columbia, delineated the protective and treatment bases underlying that judicially imposed commitment. Thirty of these statutes used the two bases mentioned above. In five states the sole test was whether the person was dangerous to himself or others, and need for proper care or treatment was the only criterion in five others. A half dozen other state laws failed to establish such a

basis could be said to encompass the "danger to himself or others" basis, since anyone so disabled is obviously in need of treatment. Even those states whose commitment statutes do not include a need for treatment basis do in fact commit and hold many persons on this theory, since most patients are not dangerous.[13]

Regardless of the enumerated statutory justifications for the exercise of the state's police power to forceably confine persons in mental institutions, the fundamental concepts on which the constitutional due process requirements of the 14th Amendment are based would seem to dictate that the state is obligated to furnish adequate treatment to persons so confined. Only insensitivity to the most elementary concepts of justice could explain the failure of the state to assume the legal obligation to provide such treatment; and most of them at least express this purpose or intent, if not the obligation, through their commitment statutes.

That the obligation to provide treatment, as distinguished from mere custodial care, is legally assumed, once the state restrains a person against his will in a mental institution, is often recognized. The Pennsylvania Mental Health and Mental Retardation Act of 1966[14] provides that if a person is believed to be mentally disabled and, after petition to the court and examination, is found to be in need of institutional care, the court may order the commitment of such per-

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criterion, presumably leaving the courts to determine who should be hospitalized. In the balance of the states the courts were substituted by administrators or physicians who enter into the commitment process through the statutory standards already mentioned. See Ross, *Commitment of the Mentally Ill: Problems of Law and Policy*, 57 MICH. L. REV. 945, Table I, at 1008-1011 (1959).

13. Albert Deutsch, author of THE SHAME OF THE STATES and THE MENTALLY ILL IN AMERICA, former welfare research associate with the New York Department of Social Welfare, and journalist specializing in social welfare problems, testified in the *1961 Senate Judiciary Committee hearings, supra* note 7, at 46:

> . . . I am not advocating that all the so-called insane be loosed on the community, but I am convinced that all but a small proportion of the civil insane need not be subjected to degrading commitment proceedings and then locked up in custodial institutions. We can no longer tolerate the paradox of depriving mental patients of their civil rights in the name of hospital treatment when we know that it is not only unnecessary for security but harmful to potential recovery.

At the same hearings Dr. Szasz, professor of psychiatry at the Upstate Medical Center, Syracuse, N.Y., testified, at 271:

> By empirical definitions of mental illness I mean such things as for example defining those inside of mental hospitals as mentally ill, and those outside as not; or those who go to psychiatrists for help as mentally ill, and those who do not as not ill. These may not be good definitions, but if we insist on talking about mental illness, we have got to have some measures for defining it. Now, if we define mental illness in some such ways as these, then I say there is not a shred of evidence that the mentally ill are more dangerous than the mentally healthy.

14. 1966 Spec. Sess., No. 3, Oct. 20, P.L. 6, Art. IV, Sec. 406; 50 P.S. 4406.

son for care and treatment.[15] Thus, *care and treatment* are assumed to be inseparable.

Statutory expressions of this kind scattered throughout earlier Pennsylvania mental health legislation are apparently in conformity with early judicial expressions of the required bases for forcible restraint in mental institutions. In an interesting mid-19th century Pennsylvania case, which was treated by the court as a case of first impression in that state, the court in referring to the propriety of forcible mental institution confinement said:

> If wrong has been done, they [mental institutions] are open to the examination of the civil courts, and the question will be, in each particular case, whether the safety of the person himself, or that of his family or friends or neighbors, required that he should be restrained for a time, *and* whether restraint is necessary for his restoration or will be conducive thereto . . . and if confinement or restraint, with regular medical treatment, are necessary for the restoration of such a person to a perfectly sound mind, they are the best friends of the person who enforce it.[16] [Emphasis added.]

Treatment of the mentally disabled has thus been recognized as a basic governmental responsibility for over a century.[17]

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15. See, however, Comment, *Hospitalization of the Mentally Disabled in Pnnsylvania: The Mental Health—Mental Retardation Act of 1966*, 71 DICK. L. REV., 300 (1967), at 345-348. The author states that this act was drafted with the conscious intent *not* to provide a guarantee of active treatment for patients, and to this end the words care *or* treatment were deliberately used throughout the act. In spite of this apparent intent, the statute does include the cited provision, which grants judicial authority to order confinement for treatment as well as care.

16. Hinchman v. Richie, 1 Brightly 143 (Penna. 1849).

17. The Pennsylvania Hospital was established in 1756 as the first general hospital in the U.S. also receiving mental patients. A. DEUTSCH, THE MENTALLY ILL IN AMERICA, 117. (1949).

Dr. F. Lewis Bartlett, psychiatrist at Haverford State Hospital, Haverford, Pennsylvania, in a paper presented at the annual meeting of the American Psychiatric Association, Atlantic City, N.J., May 12, 1966, pointed to the increasing trend among the states to relax licensure requirements for state hospital staff employment. He listed four states that had lowered their requirements in the immediately preceding year (Arizona, California, Oklahoma and Washington).

Ironically, while state standards are being lowered, non-state revenue sources of support for mental hospital care have been increasing significantly. Federal medicare and VA payments, private medical insurance payments, other benefits to which patients are entitled, such as retirement and disability pensions and family resources subject to liability for care have increased significantly. Michael Johnson, Vice President of the Pennsylvania AFL-CIO, testified before *Pennsylvania Joint Hearings, supra* note 4, at 282 that

> during the past five years alone and particularly in the past three years, the increase in revenue through these various sources has tripled and quadrupled. . . . I would like to point out to you, Senator, that when you increase this revenue without increasing the expenditure for which there has been demonstrated such a great need as in the testimony today, we are in effect reducing the state's responsibility which admittedly is low enough as it stands.

Between 1960 and 1965, the number of public mental hospital physicians per resident

Inexplicably, although government provision of medical treatment apparently has been rather consistently assumed (both statutorily and judicially) to be legally inseparable from confinement and care, until recently the patient's statutory right to legal redress against the state where involuntary confinement is not in fact accompanied by treatment has not been recognized. There is one recent exception.[18] The explanation may lie in a depressing factual situation that is common to most of the states—a case of de facto and de jure being so far apart that for de jure to take cognizance of de facto could cause governmental, indeed political, reverberations of unpredictable dimensions.

Judicial remedy is available to test the propriety of commitment in contrast to the absence of such judicial remedy for lack of treatment.[19] Although the statutory provisions governing petitions for writ of habeas corpus in these cases are not completely satisfactory,[20] the right to redress is at least recognized. If the need for treatment has generally been assumed as a prerequisite condition of the right to commit and if the furnishing of such treatment is directed by legislation, why, then, has there been no legal remedy available to the person restrained but not treated?

It is submitted that the answer lies in the almost universal failure of public mental institutions to provide even minimum standards of treatment.[21] The responsibility for this dereliction lies, however, not

state mental institution patients dropped 36%. FIFTEEN INDICES, *infra*. note 64, at 11.

18. The District of Columbia 1964 Hospitalization of the Mentally Ill Act, D.C. Code §§ 21-562 (Supp. V, 1966), affirmatively provides that every public mental hospital patient shall be entitled to psychiatric and medical treatment. It does not expressly provide for judicial remedy.

19. In many states there are rather formal hearing requirements, including in some the right to demand a jury trial, as part of the pre-commitment proceedings. About 15 states do not provide for patient right to pre-commitment hearing, but these grant habeas corpus or other post-commitment remedies to review the propriety of commitment. AMERICAN BAR FOUNDATION, *The Mentally Disabled and the Law*, *supra* note 6.

20. See Comment, *supra* note 15, at 339-343, for instance, on the problems associated with the various Pennsylvania habeas corpus statutes.

21. Bassiouni, *supra* note 7, at 298, alleges, "We are satisfied with segregating and literally 'parking away' thousands of mental patients with no more than tranquilizers." He quotes Schmideberg, *The Promise of Psychiatry, Hopes and Disillusionment*, 57 NEV. L. REV. 30, 22 (1962);

> According to a recent survey, eighty per cent of mental institutions are purely custodial, providing no treatment of any significance even to their law-abiding patients. . . . A good portion of the remaining twenty per cent provide adequate treatment only for well-paying private patients.

Deutsch, in his testimony before the *1961 Senate Judiciary Committee Hearings on The Constitutional Rights of the Mentally Ill*, *supra* note 13, at 43:

> That is, we send them to these institutions without their approval or against their will. We do so on the implicit or explicit premise or promise that they will be treated with a view toward aiding their recovery. But what happens?
>
> Recent studies—notably those of Drs. Erving Goffman, William Caudill, and Ivan Belknap, based on prolonged ward observation—attest to the continuance of the

with the hospitals' medical staffs, but with the state legislatures and administrations who lack the moral courage to invest sufficient public funds for the staffing needed to furnish even minimal treatment standards.

B. *Judicial Evolution*

Before the courts mental patients deprived of treatment have historically been in a position comparable to victims of non-profit general hospital negligence and victims of police brutality. The charitable immunity and sovereign immunity doctrines, which have deprived these victims of remedy, have outlasted their utility in many jurisdictions primarily because the courts have viewed these issues as more properly within the jurisdiction of legislative forums. Jurists, with their ingrained sense of obedience to *stare decisis*, find it difficult to rationalize the abolition of these doctrines even when they fully recognize the injustice of continuing the doctrines.

The justiciable right to public institutional treatment suffers an additional impediment, however, that deserves sympathetic consideration. That is the practical difficulty of judicially ascertaining what constitutes "adequate treatment" as related to each case and of effectuating enforcement of an order to furnish such treatment.[22]

In spite of these impediments, courts in a few jurisdictions have begun to recognize the right to treatment as a justiciable one,[23] and a variety of remedies have been granted. These decisions follow a growing body of cases which have developed the fairly well defined principle that in order for involuntary confinement statutes to be classified as nonpenal, thereby avoiding the constitutional requirements surrounding criminal proceedings,[24] they must base the state's mental institution

stripping of the patient, loss of his individuality, and dignity, depersonalization, and demoralization. The chronically acute shortage of physicians in most wards makes the term 'psychotherapy' a hideous mockery for most patients. In most public mental hospitals, the average ward patient comes into person-to-person contact with a physician about 15 minutes every month—not a day or even a week, but a month . . . .

22. See Comment, 77 YALE L.J. 87, *op. cit.*, 104-114 for discussion of some of the difficulties encountered when the task of fixing and measuring required medical treatment standards is foisted on the courts.

23. Whitree v. State of New York, 56 Misc. 2d 693, 290 N.Y.S.2d 486 (Ct. Cl. 1968); Nason v. Supt. of Bridgewater State Hospital, 339 Mass. 313, 233 N.E.2d 908 (1968); Commonwealth v. Page, 159 N.E.2d 82 (1959); Rouse v. Cameron, 373 F.2d 451 (D.C. 1966); Anderson v. State, 48 Misc. 2d 1061, 266 N.Y.S.2d 703 (Ct. Cl. 1966).

24. The 6th, 8th and 13th Amendments to the Federal Constitution are generally considered applicable, referring to rights of accused in criminal prosecutions, prohibition of cruel and excessive punishments, and prohibition against involuntary servitude except for crime whereof the party shall have been duly convicted, respectively.

commitment authority on the remedial purpose of treatment.[25] Some of these cases hold further that unless confinement pursuant to these statutes is in fact accompanied by treatment the statutes still run into the constitutional roadblocks, in their application.[26] Under these holdings, only if the state's confinement procedures meet both tests (statutory expression of remedial purpose and actual provision of treatment) can they be classed as civil commitments. Even when the commitments are classed as civil, the continued confinement is subject to review for 14th amendment due process and equal protection requirements vis-a-vis adequate treatment.[27]

In reviewing the cases it becomes apparent that judicial recognition of public mental institution patients' legal rights to adequate treatment does not dispose of the problem. Once the right is established, what remedies should be recognized as appropriate? Money damages, mandamus, mandatory injunction, habeas corpus?[28] Each of these carries practical limitations that need to be recognized. Examining the limitations prepares a basis for developing workable legal procedures that are adaptable to the different situations presented in individual cases.

In May of 1968 the Court of Claims of the State of New York awarded a former Matteawan State Hospital inmate, Victor Whitree, $300,000 in damages, the exclusive legal basis being that he was deprived of adequate treatment during his 14 years' confinement.[29] One of the elements of damages was false imprisonment for over 12 of those years.

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25. One of the earliest cases to condition the propriety of forceable confinement of mentally disabled persons on the remedial purpose of the confinement was the Pennsylvania case of Hinchman v. Richie, 1 Brightly 143 (1849). *Cf.* Matter of Josiah Oakes, 8 Law Rep. 122 (1845 Mass.). Contemporary cases include Sas v. State of Maryland, 334 F.2d 506 (4th Cir. 1964); Miller v. Overholser, 206 F.2d 415 (D.C. 1953).

26. Sas v. State of Maryland, 334 F.2d 506 (4th Cir. 1964); Whitree v. State of New York, 56 Misc. 2d 693, 290 N.Y.S.2d 486 (Ct. Cl. 1968); Nason v. Supt. of Bridgewater State Hospital, 339 Mass. 313, 233 N.E.2d 908 (1968).

27. Darnell v. Cameron, 348 F.2d 64, at 67-68 (D.C. Cir. 1965); Nason v. Supt. of Bridgewater State Hospital, 339 Mass. 313 at 317, 233 N.E.2d 908 at 913:

> 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. As we said in the *Page* case, 339 Mass. 313, 317, 159 N.E.2d 82, 85, of a statute permitting comparable confinement, "to be sustained as a nonpenal statute . . . it is necessary that the remedial aspect of confinement . . . have foundation in fact."

28. The legal propriety, as distinguished from the practical utility, of these remedies was touched on by the court in Miller v. Overholser, 206 F.2d 415 at 420 (1953):

> We think that the doctrine of the *Bonner* case applies to our present problem. Appellant's complaint did not arise until after his commitment and so was not available to him upon an appeal from the order of commitment. Mandamus or injunction might also lie, but they would not preclude habeas corpus where illegal detention is involved.

29. Whitree v. State of New York, 56 Misc. 2d 693, 290 N.Y.S.2d 486 (Ct. Cl. 1968).

The testimony established that, had he received psychiatric treatment, he could have been discharged after two years. The failure to provide treatment cost the state not only the 12 years of unnecessary custodial care but (unless the decision is successfully appealed) $300,000 in damages plus the cost of litigation extending over many years.

It does not require any precise mathematical computations to realize that these huge sums could have paid for substantial psychiatric services for many patients.[30]

Just three months before the *Whitree* decision was issued, the Supreme Judicial Court of Massachusetts, recognized the legal grounds of a habeas corpus petition brought by an inmate of Bridgewater State Hospital who alleged that he was receiving inadequate treatment and was therefore being deprived of the equal protection of the laws and of due process.[31] The court further found that the petitioner had failed to receive adequate treatment during his six years of confinement. Since the petitioner was considered extremely dangerous, the court undoubtedly had difficulty selecting an appropriate remedy. It therefore held that if adequate treatment was not provided the petitioner within a reasonable time, the legality of his further confinement could be presented to the county court for review. The court's frustration over the irreconcilable factors was apparent—unconstitutional deprivation of liberty versus the absolute need to continue that confinement, the latter probably due to the failure of the "parens patriae" to carry out the purpose for which petitioner was committed.

Two earlier Massachusetts cases, decided less than a year apart, in June 1959 and March 1960, respectively, are interesting as illustrations of the salutory effect courts can have on laggard institutions. In the first case[32] an inmate of the Massachusetts Correctional Institution at Concord was in the process of being transferred to the treatment center of that institution for an indefinite period after his sentence as a sex offender had expired. The defendant excepted to the commitment proceedings, claiming that the treatment center was no treatment center in fact; that it was substantially indistinguishable from the remainder

30. Money damages "after the fact" does not, of course, help the mentally disabled person to obtain necessary treatment. Further, it is not likely that medical testimony will often be available as to how much the hospitalization time could have been shortened had psychiatric treatment been available.

31. Nason v. Superintendent of Bridgewater State Hospital, 339 Mass. 313, 233 N.E.2d 908 (1968).

32. Commonwealth v. Page, 339 Mass. 313, 159 N.E.2d 82 (1959).

of the correctional institution, and that, since this was so, the commitment statute as applied was unconstitutional and inoperative.

The appellate court, reversing the lower court, upheld the petitioner's exceptions. It found that the center as constituted had practically no indicia of being a bona fide treatment center. It said:

> . . . to be sustained as a nonpenal statute, in its application to the defendant, it is necessary that the remedial aspect of confinement thereunder have foundation in fact. *It is not sufficient that the Legislature announce a remedial purpose if the consequences to the individual are penal.*" [Emphasis added.][33]

The court held that the commitment was invalid and that even if the treatment center had been properly constituted after his commitment, it would not have validated the commitment retroactively.

In a subsequent March 1960 case reviewed by the same court,[34] it was revealed that within three weeks and four days after the earlier decision, the Massachusetts Department of Mental Health had established a true treatment center at the correctional institution. In dismissing this petitioner's appeal, the court noted that the center had acquired general medical and psychiatric staff; had arrangements with a nearby hospital for staff consultation; was now separated from the general prison sections of the institution; in other words, it had acquired the attributes of a true treatment center, all within less than a month after the court's earlier decision.

The speedy response of that state's Department of Mental Health to the appellate court's refusal to uphold confinement under the prevailing conditions suggests that much of the universal administrative handwringing over inability to acquire adequate staff is somewhat exaggerated. Undoubtedly, there are not nearly enough psychiatric treatment personnel to give adequate attention to all the mentally disabled. A more pertinent observation, however, is that there are many psychiatrists who are not tempted to substitute time in dreary, uninspiring public institutions for even part of their private office practices, often composed of many affluent neurotics whose need for treatment is not serious.[35] The psychiatrists cannot be blamed too

33. Commonwealth v. Page, 339 Mass. 313 at 315, 159 N.E.2d 82 at 85.
34. Commonwealth v. Hogan, 341 Mass. 372 170 N.E.2d 327 (1960).
35. Typical is the Pennsylvania situation. According to the 1968 edition of FIFTEEN INDICES, published by the Joint Information Service of the American Psychiatric Association and the National Association for Mental Health, Pennsylvania in 1965 ranked 11th in the nation in ratio of psychiatrists to general population. It ranked only 45th, however,

much, when the administrative atmosphere is one of resignation, instead of militant determination to at least approach acceptable standards of treatment.

Probably the most frequently cited case on the right to treatment is the District of Columbia U.S. District Court of Appeal's *Rouse* v. *Cameron* decision of 1966.[36] A St. Elizabeths Hospital patient, confined since 1962, attacked the legality of his confinement, asserting, among other things, that the hospital failed to provide adequate treatment. The trial judge, in denying the petition, had stated: "My jurisdiction is limited to determining whether he has recovered his sanity. I don't think I have a right to consider whether he is getting enough treatment."[37] On appeal, he was reversed.

Chief Judge Bazelon, reversing the District Court, noted that although many states include in their mental health statutes expressions of state obligation to provide care and treatment to persons confined in their mental institutions,[38] none provide the patient with a judicial remedy. Congress in 1964 passed legislation for the District of Columbia which expressly granted a legal right to every public mental hospital patient to receive adequate treatment.[39] The statute further required the maintenance of hospital records detailing psychiatric treatment and the furnishing of these records, upon the patient's request, to his attorney or personal physician, thus affording the possibility of judicial remedy.[40]

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in ratio of physicians, serving full-time in public mental institutions, to patient population. To make matters worse, practically none of the serving physicians were licensed psychiatrists.

Dr. Bartlett, in his article, *Present-Day Requirements for State Hospitals Joining the Community* (*infra* note 73) said:

> Although staffing state hospitals with qualified physicians has always been declared impossible the fact remains that the proposition has never been tested.
>
> Today [1966] when membership in the American Psychiatric Association exceeds 15,000 there are fewer members working full time in state institutions than when the membership was 4,000. The reasons for this are readily apparent: since World War II, psychiatric leadership has made the attractions of practice, largely with self-designated patients, more rewarding than the professional treatment of the severely ill; and, conversely, practice in a state hospital is less rewarding, for a doctor's position is socially and professional denigrated by low professional standards and by appropriately low pay scales. Furthermore, hospital professional procedures are dictated by anachronistic policies necessitated by traditional staffing deficiencies. Gresham's Law applies: poor doctors and poor procedures drive out good doctors and good procedures.

36. 373 F.2d 451 (D.C. 1966).
37. Rouse v. Cameron, 373 F.2d 451 at 452.
38. *Id.* at 455.
39. The 1964 Hospitalization of the Mentally Ill Act, D. C. Code Sec. 21-562 (Supp. V. 1966).
40. Rouse v. Cameron, 373 F.2d 451 at 454.

Judge Bazelon referred to some of the background of the 1964 statute. Congress had considered a draft act prepared by the National Institute of Mental Health which contained the following provision: "Every patient shall be entitled to humane care and treatment *and, to the extent that facilities, equipment and personnel are available,* to medical care and treatment in accordance with the highest standards accepted in medical practice."[41] [Emphasis original.] Since the italicized language was omitted in the act as passed, Judge Bazelon held, on the basis of this admission, that continued failure to provide treatment could not be justified by lack of staff or facilities.[42]

The constitutional issues presented by involuntary, indefinite confinement including those of due process, equal protection, and cruel and unusual punishment, were also discussed. The presence of the D.C. Statute made resolution of the Constitutional issues unnecessary in order to determine the legality of confinement without treatment.

Judge Bazelon also touched on some of the problems connected with judicial determination of adequacy of treatment. Referring to the uncertainty of the present state of knowledge and therapy, he noted that lack of finality cannot relieve the court of its duty to render an informed decision.[43] He also mentions in a footnote[44] the desirability of administrative review procedures, noting that these would not only permit remedy by the hospital, but would also provide a record which might assist in the disposition of any resulting litigation.

The direction of the preceding cases should be a signal to state legislatures that sooner or later the right of every public mental institution inmate to adequate treatment may be expressly placed within the 14th amendment due process and equal protection requirements by the highest courts of the state or even the U.S. Supreme Court. The result could be temporary chaos, panic and astronomic state expense. The staggering liability that could ensue from damage suits alone is most sobering.

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41. Id. at 457.
42. At least ten states have adopted portions of the NIMH Draft Act, including the quoted provision, above, conditioning patients' entitlement to humane care and treatment and personnel. This expression of good intent begs the issue, and foreseeably, has not been effective to guarantee treatment rights. The major obstacle is, of course, lack of availability of facilities, equipment — and most of all, personnel. Until state administrations are required to furnish them, all too many patients will continue to deteriorate and die in the public mental institutions.
43. Rouse v. Cameron, 373 F.2d 451 at 457.
44. Id. at 456. See fn. 22.

Effective legislative action will not be cheap.[45] Just as a run-down, neglected home costs much more to bring into a satisfactory standard of repair, so too the years of deterioration in the treatment standards of most mental institutions will necessitate extra investment. Carefully devised legislative prescriptions (together with necessary appropriations, of course) can effect the transition to maintenance of decent treatment standards on a planned and orderly basis, through coordination among legislative, administrative and judicial forums.

II. The Ailment: A Chronic, Endemic, and Critical Problem

In June 1966 the Pennsylvania House of Representatives directed, by formal resolution,[46] that a bipartisan House Committee visit all the state mental hospitals and schools for the mentally retarded, after earlier investigations by a small bipartisan group of legislators had turned up disquieting conditions at several institutions. The Committee was charged with submitting a report to the House of its findings and recommendations.

After personal visitations to all 29 state hospitals and schools, the Committee issued a formal report in 1967.[47] It included in its findings the following serious problems: overcrowding, obsolete facilities, lack of trained personnel, high turnover of help due to poor pay, frustrating business red tape and failure to provide the best therapeutic treatment. The Committee members all concurred that the single most significant contribution of the visitations was the awareness it brought the lawmakers. They saw for themselves what leaders in the mental health field have been alleging with great concern: that public mental hospitals are largely custodial warehouses for human beings.

The Honorable George M. Leader, former Governor of Pennsylvania (1955-59), who was associated with advances in the mental health field during his tenure, reviewed in his testimony before the Committee a list of indices of care and treatment levels, pointing out Pennsylvania's low ranking in most indices.[48]

45. Dr. Adelstein, Deputy Secretary for Mental Health, Pennsylvania Department of Public Welfare, stated in the *Penna. Joint Hearings* (*supra* note 4, at 120) that the cost of bringing staffing levels up to the American Psychiatric Association standards would cost $25,825,374 for fiscal 1968-69. He stated that this expenditure would be offset by reducing the length of stay of patients.

46. H.R. 82, General Assembly, Commonwealth of Pennsylvania, adopted June 15, 1966.

47. Special House Committee Report on Resolution No. 82, *Id.*

48. *Penna. Joint Hearings, supra* note 4, at 79, 80.
In considering the number of resident patients, on an average, per 100,000 civilian

However narrowly the basic public welfare responsibility of government is construed, it is scarcely open to question that mentally disabled persons confined in public institutions are about the most vulnerable of any class that is dependent on the proper execution of that public welfare responsibility.

Historically, superstitions and ignorance about the nature and origins of mental disability; the lack of adequate facilities within which to hospitalize the mentally ill; failure of medical science until recently to render mental disability amenable to treatment on any consistent, predictable basis;[49] and limited recognition that provision of medical care to the medically indigent is a basic public welfare responsibility have served to allow the public conscience to remain dormant. Consequently, public mental institution patients' legal remedies for lack of treatment, as distinguished from the obligation it is generally assumed the state accepts to provide treatment, have been never statutorily defined nor seldom judicially enforced. These past deterrents can no longer justifiably be proffered as excuse for continued dereliction.

A. *Hospitalization Minus Treatment Equals Death Trap*

At the close of 1966, there were 1,229,068[50] mental patients in state, federal and county mental hospitals and clinics and over 30,000[51] in private and general hospitals and institutions. Mental patients alone

population, in 1956, we ranked 11th, and in 1966, we ranked 7th. This does not mean that we now have more patients per 100,000 citizens. This means that we have not reduced our resident patient population as quickly as have other states. In 1956, Pennsylvania was spending $3.06 per resident patient in our hospitals. Our rank was 29th. In 1966 we were spending for the same maintenance per patient, $7.01, and our rank was 35th. . . . In 1956, Pennsylvania ranked 32nd in terms of ratio of full-time doctors to resident patients. In 1966 that ranking was 45th. . . . In 1956, in terms of the ratio of full-time employes to resident patients, Pennsylvania's rank among the states was 21st. In 1966, our rank was 36th.

49. "Though human mental illness is ages old virtually everything known today about its physical treatment has been learned in the last twenty years." Martin, "Inside the Asylum," SAT. EVE. POST, Nov. 10, 1956, at 130.

50. This figure includes 452,329 resident patients and 450,020 in out-patient clinics of state and municipal hospitals; 62,000 resident patients and 73,922 in outpatient clinics of Veterans Administration hospitals; 190,797 in public institutions for the mentally retarded. NATIONAL INSTITUTE OF MENTAL HEALTH, U.S. DEPT. HEALTH, EDUCATION AND WELFARE, Current Facility Reports (1967), PROVISIONAL PATIENT MOVEMENT AND ADMINISTRATIVE DATA, STATE AND COUNTY MENTAL HOSPITALS, UNITED STATES, Series MHB-H-11, at 7; PROVISIONAL PATIENT MOVEMENT DATA, OUTPATIENT PSYCHIATRIC CLINICS, UNITED STATES, Series MHB-J-1, at 8, 10; PROVISIONAL PATIENT MOVEMENT AND ADMINISTRATIVE DATA, PUBLIC INSTITUTIONS FOR THE MENTALLY RETARDED, UNITED STATES, Series MHB-1-11, at 7.

51. BUREAU OF THE CENSUS, U. S. DEPT. OF COMMERCE, STATISTICAL ABSTRACT OF THE UNITED STATES, (1968), PATIENTS IN MENTAL HOSPITALS, OUTPATIENT PSYCHIATRIC CLINICS, AND INSTITUTIONS FOR THE MENTALLY RETARDED, Table No. 98; ADMISSIONS AND RELEASES OF MENTAL PATIENTS AND MENTALLY RETARDED, Table No. 99, at 74.

occupy 45.6%[52] of all hospital beds reported in the United States. Monopolistically, the responsibility for providing psychiatric care and facilities resides with the states, which provide for 87%[53] of all mental patients in 245[54] state hospitals.

It is axiomatic that the longer mental illness is prolonged by lack of care, the more public revenue is expended and the more lives are wasted. States' mental health programs constitute one of the "big four" in proportion to the total state expenditures, following education, highways, and public welfare.[55] The total expenditures of state and county governments constitute over one billion dollars annually for capital and operating costs of mental hospitals.[56] The annual wage loss attributed to these mental patients could well be estimated over $2 billion.[57] What are the chances of discharge for a patient from a public mental institution?[58] An even more sobering question is—what are your chances of remaining alive, if you should become mentally ill and be committed to a mental institution because this is "necessary" for your care and treatment? Data published by the National Institute of Mental Health reveal the shocking disparity between public mental institution death rates and general population death rates.[59] If you were lucky enough to be hospitalized in Hawaii, where there were only 778 patients confined in public mental institutions in 1966, you would have had a better chance of survival than if you had been free to enjoy surfing or touring volcanoes.[60] If, on the other hand, you became mentally disabled and were confined in a Pennsylvania public mental institution in 1966, your chances of becoming a death statistic were at least *seven*

52. In 1965, there were approximately 767,024 mental patients in federal, state, county, private and general hospitals and a total availability of 1,678,658 beds in all hospitals in the United States. SOCIAL SECURITY ADMINISTRATION, U.S. DEPT. HEALTH, EDUCATION AND WELFARE, *Social Security Bulletin*, (Jan. 1967).

53. Approximately 7.1% are in Veterans Administration hospitals; 3.3% in county and municipal hospitals; 2.6% in private hospitals. *supra* notes 50, 51.

54. NATIONAL INSTITUTE OF MENTAL HEALTH, PUBLIC HEALTH SERVICE, U.S. DEPT. HEALTH, EDUCATION, AND WELFARE, PATIENTS IN MENTAL INSTITUTIONS 1965, PART II STATE AND COUNTY MENTAL HOSPITALS, Number of State and County Mental Hospitals in 1965, Table A, at 9. In 1965 there were county hospitals distributed as follows: Maryland 1, New Jersey 6, Tennessee 1, Wisconsin 37.

55. BUREAU OF CENSUS, U.S. DEPT. OF COMMERCE, STATISTICAL ABSTRACT OF THE UNITED STATES (1968), REVENUE, DEBT, AND EXPENDITURES OF STATE GOVERNMENTS BY STATES FOR 1967, Table No. 596, at 421.

56. *Supra* note 54, Table No. 10, at 53.

57. In 1965, there were 767,024 hospitalized mental patients in all hospitals. *Supra* note 52. In 1965, the per capita personal income of all individuals in the United States was $2,760. *Supra* note 55, Table 468, at 322.

58. See Appendix Exhibit I.

59. Exhibit I, *Ibid.*

60. Exhibit I, *Ibid.*

times higher than if you had not been so confined. Even worse *ratios obtain in* many states.[61]

The incredibly high mental institution resident death rates bear evidence that such confinement represents a high likelihood of deprivation of life as well as liberty.[62] There has been created in many states a situation where the processes of law and the direct powers of the state are invoked ostensibly for the welfare of the helpless, but in fact they result in increased chances of death for the recipients.

The precise reasons for the startlingly higher death rates in public mental institutions are not known with certainty.[63] Statistics obtained from the measured indices of care and treatment lead to conclusions, however, that are difficult to ignore.[64] Sample: in 1965 while Pennsylvania ranked 8th in the nation in ratio of psychiatrists to general population, it ranked 45th in the ratio of doctors to patients in public mental institutions, not quite 6 doctors for each 1,000 patients.[65] Not too surprisingly, Pennsylvania ranked 50th in ratio of patients discharged (alive) to average patient population.[66] It may come as a shock to some unfamiliar with public mental institution staffing deficiencies to learn that the staffs of several of Pennsylvania's larger institutions have included not one licensed phychiatrist, and only very few have even one resident psychiatrist.[67]

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61. Exhibit I, *Ibid.*

62. Dr. Fox, testified before the *Pennsylvania Joint Hearings, supra* note 4, at 54-55 that mental hospitalization increases chances of death, that a random patient in a given age group in a mental hospital has a much greater chance of dying than his brother in the home, office, and on the highways.

> The high death rate in hospitals as compared to the general population is alarming when it is coupled with the knowledge that 'mental illnesses are chronic illnesses for the most part, but they seldom kill.' 10 GEO. WASH. L. REV. 512, note 7, at 513 (1951).

63. Dr. Fox, *supra* note 63, at 55.

64. THE JOINT INFORMATION SERVICE OF THE AMERICAN PSYCHIATRIC ASSOCIATION AND THE NATIONAL ASSOCIATION FOR MENTAL HEALTH, FIFTEEN INDICES, REVIEWING STATE AND LOCAL MENTAL HEALTH PROGRAMS (1968 ed.).

65. *Ibid.* Table 6, "Number of Psychiatrists per 100,000 Population," at 19 and Table 2, "Number of Resident Patients per Public Mental Hospital Physician," at 11.

66. See Exhibit 1, "Net Releases From Hospital Per Year 1000 Average Resident Patients." Pennsylvania with 228.5 per 1000 average resident patients ranks the lowest of all the states in the number of releases, as can be observed from comparing all other states in the column. The ranking may be distorted by the different methods used among the states for handling and reporting releases. Pennsylvania does not usually "discharge" patients at the time of their release, but furloughs them for a certain period of time, and only "discharges" after a successful interim furlough. Therefore, a furloughed, later readmitted, still later discharged patient would be counted as one "release," whereas in many states this would be counted as two separate releases.

67. Pennsylvania Department of Public Welfare, Office of Planning and Research Document O.M.H. 4.5, released Oct. 31, 1967, covering June 30, 1966, to June 30, 1967.

> Comment, *supra* note 15, at 334-335, n. 174, reports that as of June 30, 1966, there were only 180 full-time equivalent psychiatrists employed in Pennsylvania's 18 State mental

Public mental health administrators acknowledge that many, many chronic patients are not seen by a general medical practitioner for years on end.[68] Since the mentally ill are not very articulate in communicating medical complaints, the lack of periodic consultation and examination undoubtedly contributes significantly to the inordinately high death rates.

B. *"Parens Patriae"—Humane Care or Cruel and Unusual Punishment*

Ordinarily, an otherwise normal person with a respiratory disease or bone fracture has the availability of a hospital and the ministrations of a physician and can not only reasonably be assured his ailment is being treated, but is able to determine that he is receiving proper treatment. Similarly, a paretic or paranoid in open society has access to medical facilities and professional resources for treatment. He may not be able to ascertain that he is receiving proper care, but neither are persons with cancer or heart disease who do not possess sufficient knowledge of their illness to know what type of medical care is best for them. In the latter instance their ignorance is not due to their illness. However, in both cases it is likely that someone can be present to see that the care and treatment accorded is conducive to their recovery.

Consequently, a generally overlooked component of the deprivation of liberty, *and* sometimes life, suffered by the patient confined in the state mental institution, is that he is removed from the possibility of obtaining even that amount of medical treatment which he could have received, and probably would receive, were he outside the institution. He is deprived not only of an ideal or average standard of care, for which the exact degree of public responsibility may be susceptible to somewhat variable determinations, but he is actively deprived by State-

institutions; that 31 of these were administrators (superintendents or assistant superintendents) and 43 of them were psychiatric residents who spend much of their time in training rather than in patient care; thus leaving only 106 psychiatrists actually engaged in the care of an average daily patient population of 34,920, or a ratio of 1 psychiatrist for each 330 patients.

68. Rep. Kaufman, member of the Pennsylvania House Committee on Public Health and Welfare, commented during the Joint Committee hearings, *supra* note 4 at 125:

> Now I have been in some state institutions where the superintendent admits to me that there are patients in back wards that haven't been seen by a physician in maybe five years.

Senator Reibman, who testified before the *Penna. Joint Hearings,* in presenting some detail on lack of staff, commented:

> I know of some instances of doctors being assigned to the psychiatric care of as many as 300 or 400 patients and in some instances as many as 500 or more. . . . As a practical matter, many patients are never even seen by a doctor at all.

imposed confinement of the actual care he could get in his own community. This amounts to a quarantine, not for public protection (if he is not dangerous and is not afflicted with a contagious disease) but from available treatment.

Clinics, hospital outpatient departments, and counseling services are increasingly available to indigent and low-income persons as well as to those able to pay, and rural family physicians are noted for dispensing medical services by way of their own private charity. Public assistance recipients in most states are legally entitled to medical services. Pennsylvania recipients living in their own homes, unlike those patients in mental institutions, are entitled to regular visits to the doctor of their choice for chronic ailments and to as many visits as are necessary in any given period of time for acute illnesses.[69] Any prescribed medications, except possibly the most esoteric, are paid by the state.

Many mentally disabled persons, a good number of them receiving public assistance, live in their own communities and manage to function adequately, with some personal supportive help. Relatives or friends check in on them occasionally, take them to the doctor, if necessary, or help them with perplexing business matters. Their general medical care, with counseling added in some cases, allows them to manage satisfactorily. In most cases the factor governing whether or not a mentally disabled person will be confined in an institution is the presence or absence of minimum supportive services from friends or relatives. In respect to medical treatment, the person "humanely" confined against his will in the mental "hospital" fares much worse than his counterpart who is left to his own devices in the community.

Since most mental institution patients are neither dangerous to others nor even dangerous to themselves in a direct or immediate sense, the avowed official purpose of their commitment is to provide necessary care (room and board plus supportive personal care) and treatment which presumably they are unable to obtain for themselves. The involuntary commitment procedure and enforced hospitalization are sanctioned by statutory authority and public approval, because they appear to be humane and pursuant to governmental duty to provide for the welfare of the helpless.

69. Pennsylvania's public assistance law has included the right to payment for medical care for assistance recipients since 1939. Act of June 24, 1937, P.L. 2051, as amended by Act of Sept. 14, 1938, P.L. 31, No. 10.

Whether we respond more readily to the personal testimony of mental health personnel who report their own bleak observations[70] or the more dispassionately presented data from reported indices of treatment standards,[71] the verdict is the same—confinement results in serious deprivation of care—not the humane treatment for which the involuntary confinement is legally justified. If one were to reflect which is the more serious deprivation of civil rights—involuntary hospitalization when treatment is not needed or involuntary confinement that produces deprivation of needed treatment—one's conclusion might cause disturbing reflections on the total lack of legal remedy for the latter situation.

That this most vulnerable group of citizens still suffers unbelievable deprivation of care and treatment in most states is acknowledged by practically all practitioners and administrators familiar with the state mental institutions. The medical-legislative-judicial complex has never been able to fuse in any state a momentum sufficient to overcome this hiatus in the protection of the basic civil rights of life and liberty.

III. A Modern Prescription: Pennsylvania's "Right To Treatment" Draft Act[72]

The proposed Pennsylvania legislative experiment evolved from the ideas of Dr. F. Lewis Bartlett,[73] Michael Johnson,[74] Executive Vice

70. The witnesses before the *Penna. Joint Hearings, supra* note 4, and witnesses appearing before the U.S. Senate Judiciary Committee in 1961, *supra* note 7, sounded distressingly near unanimous in their bleak assessment of treatment standards throughout the U.S.

71. Fifteen Indices, *supra* note 64; National Institute of Mental Health, Public Health Service, U.S. Dept. Health, Education, and Welfare, *Provisional Patient Movement and Administrative Data* etc., *supra* note 50.

72. The "Right to Treatment" bill, currently introduced as S.B. 158; in the 1967-68 legislative session identified as S.B. 1274 and H.B. 2118.

73. Graduate, University of Vermont Medical School; internship, St. John's Hospital, Tulsa, Oklahoma; training in psychiatry, University of Louisville and University of Pennsylvania; former member of staff of Eastern Pennsylvania Psychiatric Institute, Philadelphia. Presently a psychiatric physician, Haverford State Hospital, Pennsylvania; Author, *Institutional Peonage: Our Exploitation of Mental Patients,* Atlantic, Vol. 214, No. 1, July, 1964; paper, *Present-Day Requirements for State Hospitals Joining the Community,* presented at the Annual Meeting, American Psychiatric Association, Atlantic City, New Jersey, May 12, 1966, and published, 276 New England Journal of Medicine 90, (1967); *The Third Mental Health Revolution and The State Hospital Superintendents,* address to the Annual Meeting, The Association of Medical Superintendents of Mental Hospitals, Washington, D.C., Sept. 30, 1968.

74. Executive Vice President, Penna. AFL-CIO since 1962; Director, Pennsylvania Mental Health, Inc., since 1956; Member and former Director, National Association of Mental Health; served on numerous advisory committees during tenure of Penna. Governors George M. Leader (1955-59) and David L. Lawrence (1959-63).

President of Pennsylvania AFL-CIO and Morton Birnbaum.[75] These three men directed their efforts to establishing a legally enforceable "right-to-treatment" with an accompanying rationale. In early 1965 the Pennsylvania AFL-CIO had the authors of this article formulate their ideas into a legislative solution and legal approach for discussion.[76] The result, the Pennsylvania "Right to Treatment" bill, utilizes a classic pattern in the manner in which it defines the cooperative roles of legislature, administrative agency and judicial forum. It adopts this pattern to the problem in a manner totally different from any other approach either now being utilized or suggested.

There are no known suggested, model, or draft acts that confront and work through the admittedly difficult problems, as the Pennsylvania "Right to Treatment" bill does. Since it is "sui generis," more or less, at least so far, it appears worthwhile to present the bill's philosophy, discuss its mechanisms, and invite comment in the anticipation that its basic provisions can be utilized as a model act.

A. *Basic Ingredients*

Several objectives were pursued by the authors of this article in drafting the "Right to Treatment Law:"

1. To create a "procedure" for developing defined standards that

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75. Engaged in both the general practice of medicine and the general practice of law. A member of the New York Bar, he has advocated before the courts judicial recognition of an enforceable right to treatment for mental patients. See, for example, People *ex rel.* "Anonymous" v. La Burt, 27 Misc. 2d 584, 211 N.Y.S.2d 963 (1961) petition for writ of habeas corpus denied; direct appeal denied, 9 N.Y.2d 794, 215 N.Y.S.2d 507, N.E.2d 165 (1961); *aff'd,* 14 A.2d 560, 218 N.Y.S.2d 738 (1961); leave to appeal denied; 10 N.Y.2d 708 (1961); *cert. denied,* Mr. Justice Douglas dissenting, 369 U.S. 428 (1961).

Author: *Some Questions that a Lawyer May Ask a Psychiatrist Concerning the Psycopath Before the Law,* 261 NEW ENG. J. MED. 1220 (1959); *Right to Treatment,* 46 AMER. BAR ASSOC. J. 499 (1960); *Eugenic Sterilization,* 175 J.A.M.A. 951 (1961); Book Review, *Social Class and Mental Illness: A Community Study,* Hollingshead, A.B. and Redlich, F.C., (1958), 47 A.B.A.J. 81 (1961); *Some Comments on The Right to Treatment,* presented to Nervous and Mental Diseases Section, Amer. Med. Assoc. 113th Annual Meeting, June 24, 1964; printed 13 ARCH. GEN. PSYCHIAT., 34, July 1965.

Witness: Constitutional Rights of the Mentally Ill, Part I, Civic Aspects, *Hearings before the Subcommittee on Constitutional Rights of the Committee on the Judiciary,* U.S. Senate, 87th Cong., 1st Sess. 273-305 (1961); Public Hearings on S.B. 1274 and H.B. 2118 (The Right to Treatment Law of 1968), Joint House and Senate Committees on Public Health and Welfare, General Assembly. Commonwealth of Pennsylvania, pp. 178-205 (1968).

Advanced Studies: Post doctoral fellow 1958-59 in Harvard University training program for social scientists in medicine and a research fellow in the Department of Social Relations of Harvard University.

76. In 1967, 2,500 delegates to the Eighth Annual Constitutional Convention of the Pennsylvania AFL-CIO unanimously adopted a resolution obligating 1.5 million members to strive for eventual enactment of the first statutory guarantees of "right-to-treatment" for mental patients.

would be simultaneously objective (i.e. measurable) and yet be adaptable to changing concepts within the medical disciplines (the details of such standards are developed more flexibly outside the rigid confines of a statute and more objectively outside the administrative milieu responsible for execution);

2. To specify administrative procedures for achieving the treatment standards and for reviewing and correcting patient complaints that would fit into existing state administrative organization but also operate with a minimum of red tape and patient confusion;
3. To provide judicial remedies that are precise, certain and effective and are available to every patient in case of administrative failure to meet the required treatment standards.

Several drafting principles had to be carefully adhered to. When an individual's civil rights are to be protected through procedures carried out within the framework of a large state government bureaucracy, the statutory directives cannot avoid touching bases in the administrative ball park. Similarly, when judicial remedies are being provided by statute, the failure, through a misguided attempt to retain literary informality, to employ the terms of art consistently used in existing law for identical procedures and concepts often creates unanticipated problems. On the other hand, too many statutory schemes for ameliorating social problems flounder by entangling the intended beneficiaries in bureaucratic maze and at the same time overwhelming an already overburdened bureaucracy.

Our approach was to keep each statutorily prescribed step as close as possible to the ultimate objective—the guarantee of treatment reaching at least the defined minimum level for each mental institution patient.

Assuming that a state, as a matter of public policy, is prepared to recognize each institutionalized mental patient's right to treatment as a legally enforceable right, exactly what is it the patient should have a right to have enforced? Remembering that each legal right imposes a correlative legal obligation on someone else, the necessity for a reasonably precise definition and delineation of the *legally enforceable* treatment standards becomes obvious.

To date, substantial difficulties inherent in formulating treatment standards and procedures appropriate for both departmental applica-

tion and judicial enforcement have probably been major obstacles to official recognition of this right in any state.[77]

The Pennsylvania experiment may finally establish a workable formula. Its approach is completely unique, minimizing required ancillary red-tape, record keeping, etc., and maintaining a direct route between delineation of enforceable standards and judicial redress for failure to receive treatment.

B. *A Detailed Prognosis and Diagnosis*

Basically the Pennsylvania draft legislation provides:

1. A formal structure and procedure for establishing, defining, and delineating enforceable institutional treatment standards;
2. Direction, with fixed initial time limits, for implementing the standards;
3. Internal departmental procedures for protecting the patient's rights through: (a) required notices to the patient and maintenance of proper treatment records, (b) patient recourse to a departmental review board, (c) opportunity for adjustment by the institution after departmental review;
4. Patient rights to the judicial remedies of mandamus or mandatory injunction or habeas corpus, and, in any event, the absolute right to the remedy of psychiatric treatment by independent practitioner of patient's choice, whether or not the patient is released from the institution as a result of his judicial appeal.

77. Judge Bazelon's comments on the roles of court, legislative and administrative agencies in his testimony on the Penna. "Right to Treatment" bill before the *Penna. Joint Committee* (*supra*, note 4) gives perspective to the interrelationship of the bill's procedural provisions (p. 231):

> Many people argue that it is the business of the legislature and not the court to establish and define the right to treatment. I, of course, believe the judiciary can play a role, but I will be the first to admit that in most instances, the legislature can do a better job. A court can only lay down broad policy outlines as to whether or not the procedure violates the constitution, but the legislature can create specific procedure and institutions to implement the right to treatment.
>
> For example, in my opinion in *Rouse v. United States,* I suggested that St. Elizabeth's Hospital, with 500 patients, should establish internal administrative procedures to oversee the adequacy of treatment, and I have continued to make this point in subsequent opinions. But, I could not require the hospital to set up administrative review boards and to the best of my knowledge they have not yet done so. Your bill, on the other hand, expressly provides for internal administrative procedures. These procedures will enable the hospitals to examine their own actions and practices and thereby to decide before a case goes to court whether its actions should be corrected or defended. These procedures will insure that fewer cases come to court and that the cases which do come are ripe for proper consideration and decision.

In Pennsylvania the maintenance and supervision of public mental institutions is under the jurisdiction of the Bureau of Mental Health, Department of Public Welfare. The Pennsylvania "Right to Treatment" draft act calls for two structural entities to effect the intradepartmental responsibilities to patients. First is the Mental Treatment Standards Committee,[78] charged with promulgating a manual of minimum treatment standards. The second vehicle is the Patient Treatment Review Board,[79] whose responsibility is to review patient complaints alleging failure to receive adequate treatment.

The seven-member Treatment Standards Committee is to be composed of a non-administrator psychiatrist, a psychiatrist who is a mental institution administrator, a physician, a psychiatric social worker, a clinical psychologist, a nurse, and the Commissioner of Mental Health, who is to serve in an advisory capacity only. Each member is to be selected by the Secretary of Public Welfare (with the advice of the Pennsylvania Advisory Committee for Mental Health) from three names submitted to him by the appropriate statutorily designated national professional association. The designation of national rather than state associations is deliberate, to obtain the advantage of greater variety of experience in institutional programming. Except for the administrator-psychiatrist, no member of this committee may have been retained in any capacity by the Commonwealth of Pennsylvania, or any of its subdivisions or agencies, during the three-year period preceding the appointment, nor may he be otherwise employed by the state while he serves on the Committee nor for five years after his committee tenure expires. This restriction is deemed advisable in order to minimize potential state administration influence on committee members to adopt weak standards.[80]

The Committee must be appointed within 90 days after the act's effective date; must have its manual of minimum standards completed within six months after it has been appointed (Committee receipt of compensation is contingent on completion of the standards manual within the specified time). The Committee-adopted minimum standards become the mandatory standards for departmental implementation and also the basis for each patient's legally enforceable treatment right.[81]

78. Penna. S.B. 158, "Right to Treatment Law of 1969," Sec. 3. See Appendix Exhibit II, P. 67.
79. Penna. S.B. 158, Sec. 6.
80. Penna. S.B. 158, Sec. 3(f).
81. Penna. S.B. 158, Sec. 3(a) and Sec. 4.

Although the Committee is a permanent one (its members serving staggered six year terms), it is expected to meet and serve only periodically and is to be compensated on a contractual basis. It is charged with periodic standards review and with making such changes as it deems necessary once every two years, thus guaranteeing flexibility in adopting required standards to actual institutional needs and to advances in medical knowledge.[82]

Special factors have to be dealt with in developing a statutory prescription for implementing patient rights. Among these are the special nature of the disability requiring protection, the institutional setting, the governmental-administrative envelope around the institution, the kinds of legal remedies available, and the kinds of obligations and liabilities created for those charged with implementing the legally required treatment standards.

Establishing enforceable treatment standards for the mentally disabled in public institutions is a different proposition from setting standards for private treatment of other medical infirmities such as broken bones or pneumonia. The term mental illness encompasses many different kinds of disability ranging from the generalized degenerative processes of old age, to disorientation caused by the various more localized origins of chemical imbalance or organic damage, to malfunctioning produced by unbearable stress of environmental or personal life problems. Different forms of treatment are called for, depending on the nature and origin of the disability.

Practitioners differ as to the appropriate treatment approaches in many cases. Even diagnosis remains a more imprecise art than for the more strictly physical ailments. Circumstances outside but related to the individual usually have a more intimate relationship to both the disability and the treatment process. Given these circumstances, attempts to set standards in terms of type and quality of each individual treatment would be foolhardy.

There are some who feel the statutory right to treatment should include the right to review the quality of treatment methods employed by institutional practitioners and the judgment, care and skill employed in their individual treatment relationships. The common law right to redress for practitioner negligence in diagnostic and treatment procedures exists, of course, and is at least theoretically available to

82. Penna. S.B. 158, Sec. 4(i).

any patient. This common law right is expressly saved from any interference by the statutory provisions. It was concluded, however, that, mainly for the reasons stated here, the draft act should also expressly exclude review of the level of skill, care and judgment employed by practitioners from the scope of the statute's application.

The extensive incidence of deplorable lack of care and treatment in public mental institutions throughout much of the United States is rarely the result of individual practitioners' negligence. It is generally a matter of legislative-administrative-institutional inertia in relation to providing the wherewithal and then obtaining adequate numbers of trained personnel and facilities. By comparison with the private sector, if standards safeguarding against insufficient staffs, overcrowding, inadequate medical care, patient records, and physical examinations, improper food, lack of safety and hygienic conditions, that are legislatively imposed on non-profit and proprietary nursing homes for the welfare of the aged and ill, were administratively applied as the test for adequate care and treatment for the states' mental hospitals, many would be in open violation of the law.[83]

The Treatment Standards Committee is directed by the draft act to include in its standards coverage of such matters as maximum permitted staff-patient ratios; required minimum qualifications of staff, including degrees, licensure, certification, apprenticeship and experience; minimum number of individual psychiatric consultations for each patient per given period of time; frequency and extent of physical examinations; and maintenance of individualized treatment plans.[84]

What standards, if any, should be written into the draft act itself turned out to be the most vexing drafting problem to confront the authors. What elements were so crucial they should not be left to

83. For example, regulations for non-profit and profit nursing homes require for each patient the medical supervision of a state licensed physician; a yearly physical exam; privacy for each person's personal dignity during physical exams, treatment, toileting and bathing, a plan of care based upon medical examinations to provide staff direction to rehabilitation needs; a complete periodic, medical record and physician's progress record from admission to discharge. In addition, required is 24 hour nursing service by a registered nurse for each 20 patients; a day duty registered or practical nurse-patient ratio of 1:8 to 1:20 at night; a minimum average of two general nursing hours per patient per day; beds in multi-bed rooms shall have four feet of open space between adjacent beds with no more than four beds per room and no more than eight beds per infirmary room; a bathtub for each 10 patients; 1 toliet to 6 patients. PENNA. DEPT. OF WELFARE, OFFICE OF THE AGING, *Rules and Regulations Pertaining to Infirmary Units and Nursing Homes of Nonprofit Homes and Rules and Regulations pertaining to Nursing Homes operated for a profit,* effective Dec. 1, 1967, pursuant to PUBLIC WELFARE CODE, P.L. 21, June 3, 1967.

84. S.B. 158, Sec. 4(b), (c), (d).

chance or to committee discretion? The temptation was overwhelming to write in certain "absolute minimums," such as requiring a certain number of consultations per year, etc. One general and two specific requirements were finally included (but only after much debate):

> the minimum standards for numbers and qualifications of staff and number of individual consultations shall be no lower than the standards established by the American Psychiatric Association; and they shall also include requirements that all psychiatrists and medical practitioners must have the qualifications that are required to obtain Pennsylvania licensing for private practice.[85]

The other specific requirement is that individual treatment plans must be maintained.[86]

The general statutory outline of standards coverage concentrates mainly on the institutional staff who have a direct responsibility to the patient. It is based on the premise that the important medical judgments at the root of meaningful hospitalization should be made by persons who have actually acquired, through appropriate training and experience, the expertise necessary to treat mentally disabled patients.

The deliberate direction to the Treatment Standards Committee to promulgate minimum standards only, not average or ideal standards, takes into account the present inadequacy of facilities, equipment and personnel which makes adherence to high medical standards for those most in need difficult if not impossible.

After the Treatment Standards Committee has adopted a set of standards, they become the official state standards for mental institution treatment. The Department of Welfare and each institution is then charged with the responsibility of obtaining the personnel and implementing the changes necessary to meet the designated standards. The Department is given another year and three months (two years from the act's effective date) to bring the institutions' staffs and practices up to the adopted standards.[87] At the end of this period patients acquire the enforceable legal right to treatment which meets the adopted standards.[88]

In the meantime the Department is also charged with the duty (while the committee is completing its manual) to make studies sufficient to

85. S.B. 158, Sec. 4(c).
86. S.B. 158, Sec. 4(b)(5).
87. S.B. 158, Sec. 4(f).
88. S.B. 158, Sec. 5(a).

report to the Legislature within one year of the act's effective date (or three months after the committee's work completion date) cost and other appropriate data pertinent to implementing the statutory requirements.[89] The Legislature will need this data in order to plan for sufficient appropriations and to take steps that will encourage increased availability of professional institutional personnel in Pennsylvania.

While patients' mental disabilities vary widely, the impaired ability of many to understand their rights and to measure them against actual institutional performance requires special attention. Stringent notice requirements are deemed necessary and are provided for. Notice must be given also to the guardian, legally liable relative or next friend. These required notices must include a brief but specific synopsis of the minimum standards, a statement that the patient has the legal right to have these standards met, and a statement of the legal remedies available to the patient, including his right to engage a private psychiatrist and an attorney to present his appeal to the court.[90]

The first tribunal to review a patient's formal complaint is the Patient Treatment Review Board. In contrast to the Standards Committee, the Review Board is a continuing, full-time board employed under the Civil Service merit system. It hears, investigates, decides and issues rulings on patients' petitions alleging lack of adequate treatment. The board is to consist of two psychiatrists, two physicians and one lawyer. They are to be provided with staff; and their procedures for handling patient petitions are to be governed by departmental regulations.[91] Each patient has the right to appear before the board and be heard, if he desires. But there is no requirement that a hearing be held if the petitioner does not request one. He may also be represented by an agent, who may be, but need not be, an attorney. Also, since a patient may lack sufficient insight or capacity to make responsible decisions due to his illness, the petition for review need not be brought by the patient himself, but may be brought on his behalf by a guardian, relative or friend. Proceedings before the board are not to be conducted as adversary proceedings.[92]

Informality at the board review level is considered desirable to prevent inhibiting patients from seeking redress, to minimize adverse

89. S.B. 158, Sec. 4(g).
90. S.B. 158, Sec. 5(c).
91. S.B. 158, Sec. 6(a) through (d).
92. S.B. 158, Sec. 7.

psychological reaction, to avoid having evidence that might be helpful excluded, and to make it easier for the institution and the petitioner to work together toward better treatment after the board's review. Adversary proceedings might tend to discourage post-review cooperation.

In each case in which the board finds that a patient's care and treatment does not meet the adopted standards, the institution, if the superintendent concurs in the finding and agrees to improve the treatment, is given a three-month probationary period to improve treatment to the required level. In all other instances, petitioners have the right to take court action after the board has issued its findings or upon the board's failure to issue a finding within a month from the date of the petition.[93]

In lieu of court action by the patient (in a case in which a patient is entitled to petition the court), the board may, in its discretion, and with the agreement of the institution and the patient, certify to the Department of Welfare the patient's medical eligibility for treatment by a private psychiatrist. In every case of such certification the patient becomes entitled to obtain private psychiatric treatment, paid by the Commonwealth.[94]

The Pennsylvania bill has been criticized as not going far enough to ensure review of severely disabled patients' treatment. It has been suggested that the Treatment Review Board should be required to review these cases on its own initiative.[95] The criticism is probably warranted, particularly since a surprisingly large number of patients have no one outside the institution who maintains contact or is actively concerned about the patient's welfare. There are, however, pitfalls in such a statutory requirement. When no one is actively representing the possibly aggrieved person, investigations have a tendency to become pro forma and ultimately become an actual deterrent to appropriate action.

Upon appeal to court a patient is entitled to both a psychiatrist and a lawyer of his choice (subject to the practitioner's willingness to be engaged) to present his case,[96] either de novo or on the record only, according to petitioner's preference.[97] The psychiatrist will be in the

93. S.B. 158, Sec. 7(a)(3).
94. S.B. 158, Sec. 8(m).
95. See, Judge Bazelon's testimony before the *Penna. Joint Hearings supra* note 4, at 234.
96. S.B. 158, Sec. 8(g) and (h).
97. S.B. 158, Sec. 8(f).

nature of an expert witness, presenting technical testimony on the patient's needs,[98] as well as the institution staff levels and adherence to required procedures.

Although the relative informality of the proceedings before the Patient Treatment Review Board may fail to produce a completely satisfactory record for court review, when review is on the record only, it is deemed necessary to allow the patient (or petitioner) this choice on appeal, because of the expense and other practical difficulties of presenting all evidence again as if there had been no board preceeding. Therefore, the petitioner has the choice, on appeal, of presenting the evidence de novo or appealing on the record only, from the review board.

The petitioner may seek several remedies in the alternative. Habeas corpus, mandatory injunction, or mandamus are the choices, with the right to private psychiatric care paid by the Commonwealth being absolute in every case where the court finds treatment did not meet the statutory standards.[99] Since it is anticipated that many patients placed in institutions as an outcome of criminal proceedings will petition for habeas corpus and be denied the writ because of their status in relation to the previous criminal proceedings, the right to petition in the same proceeding for either mandamus or mandatory injunction provides a possible remedy. The draft act gives the courts the discretion, in a habeas corpus proceeding, where the patient is in the institution as a result of some form or stage of criminal proceeding, of if he is demonstrably dangerous to himself or others, to order the patient transferred to another institution where he will receive adequate care. In all other cases where the petitioner requests a writ of habeas corpus and the court finds he did not receive adequate treatment, habeas corpus must be granted.[100]

In every case where the court finds the patient did not receive the statutory standard of treatment, the patient has an absolute right (whether or not he requests it) to have the court order the Department to provide payment for treatment by a private psychiatrist of the patient's choice, whether the patient remains in an institution or is released. The patient is entitled to one half hour consultation per week if he remains in the institution and two half hour consultations a week

98. S.B. 158, Sec. 4(b)(3) and (5).
99. S.B. 158, Sec. 8(c).
100. S.B. 158, Sec. 8(c)(2).

if he is released.[101] Just as the "almshouse" concept was long ago discarded for indigent persons who could function without extensive supportive services, so the time has come to free mentally disabled persons from the death trap of institutional vegetation.

The patient or anyone legally liable for his support is liable for reimbursement to the Commonwealth on the same basis as liability exists for reimbursement of regular institutional care. The Commonwealth must provide payment in the first instance, however. Many patients do not recognize that they need treatment and would not obtain it if payment were denied on the grounds that legally liable relatives are able to pay.

Public payment for private psychiatric treatment may disturb traditionalists who will view it as yet another "socialized welfare scheme." In reality, however, it is merely an alternative mechanism (one that has been estimated by some mental health specialists as ultimately less costly than the present institutional milieu) for meeting one of the earliest assumed public welfare obligations. The *Whitree* case is a good example.[102] New York State paid for 12 years of custodial care that would have been unnecessary had it furnished this patient with psychiatric treatment for two years or less. The procedural mechanisms for handling public payment of private practitioner services are by now well established, and can be comfortably adapted to this need.

Experience has demonstrated universally that the changes needed to bring about an acceptable minimum level of treatment are not likely to occur by relying on administrative discretion.[103]

Public institution regime presents many dynamics absent in private treatment relationships. The various specialties that are at least potentially available for any one patient's care—psychiatrist, psychologist, social worker, therapist, nurse, attendant, etc.—demand an intra-institutional coordination that is delicately balanced according to many considerations. Administrative stresses, housekeeping functions, security

101. S.B. 158, Sec. 8(j).

102. 56 Misc. 2d 693, 290 N.Y.S.2d 486 (Ct. Cl. 1968).

103. Dr. David J. Vail, Medical Director, Department of Public Welfare, Minnesota, in his appearance before the Pennsylvania Joint Committee, *supra* note 4, commented at page 141 on this part of the Draft Act:

> I think this bill goes a long way toward defining treatment in the sense that it creates a procedure to do so, and this is the crucial first step. What I like about it is the clear rule of law requiring that the definition be made and the standards be laid down as a mandate to the public agency complete with deadline, and the matter is not left to the good intentions of the porfessionals in the field, who so far on their own devices have not done very well . . . .

considerations, legal obligations connected with trusteeship of incompetents and custody of persons under the jurisdiction of the criminal courts exert unavoidable influences on the total treatment configuration. This configuration is even further controlled by the placement of the institution somewhere in the government administrative bureaucracy, with its inevitable regulations, statutes, and budgetary strictures.

The patient's legal right to a certain standard of treatment creates the custodian's legal obligation to provide that standard. It becomes important, therefore, not only that the patient or someone on his behalf can determine in concrete, measurable terms what that right is, but also that those responsible for his care can determine what their legal obligation is. The sensitivity of this side of the equation becomes more apparant when it is realized that the individuals charged with this obligation are representatives and employees of the sovereign state and are not free to act as they personally might deem necessary in order to discharge their obligations.

These factors have to be taken into account in developing a statutory formula for ensuring an enforceable patient right to treatment. They were resolved in the "Pennsylvania Right to Treatment" bill in a number of ways: by devising a procedure for setting the standards that combined medical expertise, independent of the bureaucracy, with at least one representative of the state administration and one public institution administrator; by requiring that the scope of the required standards remain objective rather than subjective—i.e., that the standards be easily definable and observable instead of wandering into the realm of treatment techniques; by requiring stringent notice requirements; by providing as much leeway as possible for adjustments *before* a patient appeals to the courts; by providing institution administrators with the option of arranging for private treatment if they are unable to provide the required standard of care.

IV. Conclusion

This article is neither designed to cause embarrassment nor place blame for the deplorable plight of the mentally disabled on any person, profession, administration, court or legislative body. There is plenty of blame for everyone in today's society to bare and share with preceding generations who likewise tolerated these conditions. The history of suffering of that long line of hapless and helpless mentally ill, that

stretches back through the ages, can neither be rewritten to please us nor blotted out to hide our shame. The hope of this article is in offering a constructive program, with a view from the past, to reduce the suffering of that long line of disabled, the living and unborn, that will reach forward in the years to come.

A prescription is offered by the Pennsylvania "Right to Treatment" draft act for escaping the terrible dilemma of most states—neither their courts nor their legislatures dare recognize the basic rights of their public mental institution patients to adequate treatment, because of the fear they would be inundated with suits seeking redress for inevitable neglect. Yet they know that sooner or later their patients' constitutional rights are likely to be decreed from some source over which they have no control, with the sudden cost then totally unpredictable. They know, too, that their general, well-intended policy edicts have been ineffective to cause administrative raising of standards to levels that could ease consciences.

The draft act sets a date in the future after which patients' rights to treatment henceforth cannot be thwarted. It provides, however, an interim period of grace for planned departmental action to meet objective, measurable standards. It offers a relatively independent vehicle and an orderly procedure for establishing the treatment standards, preventing the necessity for ad hoc judicial development of mandated medical standards.

Perhaps most salient, it grants leverage and possible escape for administrative officials if, in spite of reasonably adequate funding, they cannot find sufficient personnel or, for whatever other reasons, they cannot meet the required standards; and yet the patients are assured of access to treatment, whether or not they leave the institution.

Colonial Pennsylvania pioneered in early humanitarian attempts to provide crude maintenance for the "qyut madd" in "private cages and strong rooms." Later, the Commonwealth stood in the forerank to establish legal due process for "lunaticks" incarcerated in "asylums." Today, the State's General Assembly is poised on the threshold of a new era for the "mentally ill"—granting them medical due process through an enforceable "Right to Treatment" in true "mental hospitals."

For the mentally disabled, the gorge separating their mere commitment from meaningful treatment has stood as a deep barrier through-

out the ages. But for State legislators, the distance is only a step across. The Pennsylvania "Right to Treatment" bill has been characterized by nationally recognized jurists and mental health experts alike as a "historic document"[104] "that can become a model for the nation."[105] The concept and workable procedure embodied in this experiment in medical due process are now in the public domain, available to any legislative forum that has the courage to meet this obligation to an increasing and mute constituency.

104. Dr. Francis Tyce, *Penna Joint Committee*, *supra* note 4, at 50.

105. Judge Bazelon, in his testimony before the Penna. Joint Committee, *supra* note 4, (at 230): characterized the "Right to Treatment" bill in this way,

> S.B. 1274, your right to treatment bill, is a major advance in the mental health field. I am sure that it will become a model for similar legislation throughout the nation.

EXHIBIT I

MENTAL PATIENT RELEASE AND DEATH DATA — 1966
STATE AND COUNTY MENTAL HOSPITALS

Including:
A) Net live releases per 1,000 average patient resident population.
B) Deaths per 1,000 average resident patients.
C) Deaths per 1,000 general population.
D) Ratio of patient deaths/general population deaths.

State	Resident Patients Beginning of Year	Resident Patients End of Year	Average Yearly Resident Patients	Net Yearly Hospital Releases: Total	Net Yearly Hospital Releases: Per 1000 Average Resident Patients	Deaths Per Year: In Mental Hospitals	Deaths Per Year: Per 1000 Average Resident Patients	Deaths Per Year: Per 1000 General Population	Ratio
United States	476,401	452,329	464,365	311,827	671.5	42,644	91.8	9.5	9.7:1
Alabama	7,691	7,715	7,703	3,884	504.2	352	71.7	9.3	7.7:1
Alaska	310	303	306	351	1147.1	9	29.4	4.8	6.1:1
Arizona	1,690	1,469	1,580	2,126	1345.6	218	138.0	8.3	16.6:1
Arkansas	2,779	2,353	2,566	4,692	1828.5	188	73.3	9.9	7.4:1
California	30,318	26,658	28,488	29,726	1043.5	1,789	62.8	8.5	7.4:1
Colorado	3,934	3,655	3,794	4,802	1265.7	231	60.9	8.4	7.2:1
Connecticut	7,908	7,273	7,590	8,492	1118.8	953	125.5	9.0	13.9:1
Delaware	1,667	1,596	1,632	1,341	821.7	156	95.6	9.6	10.0:1
District of Col.	6,131	5,924	6,028	1,883	312.4	456	80.6	13.5	6.0:1
Florida	9,992	9,855	9,924	4,081	411.2	921	92.8	10.8	8.6:1
Georgia	11,823	11,289	11,556	6,166	533.6	1,151	99.6	8.6	11.6:1
Hawaii	765	790	778	420	539.8	39	5.0	5.4	0.9:1
Idaho	740	719	730	769	1053.4	84	11.5	8.3	1.4:1
Illinois	30,837	28,315	29,576	21,450	725.2	3,206	108.4	10.3	10.5:1
Indiana	11,048	10,942	10,995	4,296	390.7	754	68.6	9.6	7.1:1
Iowa	2,220	1,717	1,968	5,601	2846.0	151	76.7	10.8	7.1:1
Kansas	2,622	2,432	2,527	3,167	1253.3	139	55.0	9.7	5.7:1
Kentucky	4,887	4,744	4,816	5,094	1057.7	606	125.8	10.0	12.6:1
Louisiana	6,449	5,949	6,199	6,774	1092.8	383	61.8	9.1	6.8:1
Maine	2,819	2,755	2,787	1,629	584.5	305	109.4	11.2	9.8:1
Maryland	8,731	8,259	8,495	9,276	1091.9	1,012	119.1	9.6	12.4:1
Massachusetts	17,253	16,199	16,726	11,549	690.5	1,660	99.2	11.4	8.7:1
Michigan	18,711	17,079	17,895	9,368	523.5	1,031	57.6	8.9	6.5:1
Minnesota	6,592	5,906	6,249	6,169	987.2	519	83.0	9.4	8.8:1

State	Resident Patients Beginning of Year	Resident Patients End of Year	Average Yearly Resident Patients	Net Yearly Hospital Releases: Total	Net Yearly Hospital Releases: Per 1000 Average Resident Patients	Deaths Per Year: In Mental Hospitals	Deaths Per Year: Per 1000 Average Resident Patients	Deaths Per Year: Per 1000 General Population	Ratio
Mississippi	5,584	5,446	5,515	3,801	689.2	359	65.1	9.8	6.6:1
Missouri	10,466	9,933	10,200	6,283	616.0	782	76.7	11.6	6.6:1
Montana	1,518	1,413	1,466	1,980	1350.6	173	118.0	9.7	12.2:1
Nebraska	3,327	3,096	3,212	2,540	790.8	289	90.0	10.2	8.8:1
Nevada	516	568	542	776	1431.7	30	5.5	7.6	0.7:1
New Hampshire	2,239	2,170	2,204	1,326	601.6	202	91.6	10.4	8.8:1
New Jersey	19,428	18,746	19,087	10,722	561.7	2,291	120.0	9.4	12.8:1
New Mexico	890	695	792	1,292	1631.3	71	9.0	6.7	1.3:1
New York	86,775	83,834	85,304	30,806	361.1	9,030	106.4	10.3	10.3:1
North Carolina	9,334	8,819	9,076	12,423	1368.8	1,126	124.1	8.5	14.6:1
North Dakota	1,479	1,424	1,045	1,362	1303.3	93	89.0	8.9	10.0:1
Ohio	21,830	21,439	21,634	17,409	804.7	1,860	86.0	9.6	9.0:1
Oklahoma	5,454	4,729	5,092	5,503	1080.7	390	76.6	9.9	7.7:1
Oregon	2,855	2,577	2,716	4,122	1517.7	282	103.8	9.7	10.7:1
Pennsylvania	35,966	35,071	35,519	8,116	228.5	2,500	78.8	10.9	7.2:1
Rhode Island	3,164	2,280	2,722	2,762	1014.7	235	87.4	10.6	8.2:1
South Carolina	6,406	6,119	6,262	3,095	494.3	546	87.2	8.5	10.2:1
South Dakota	1,648	1,548	1,598	1,321	826.7	153	95.7	9.6	10.0:1
Tennessee	7,767	7,366	7,568	8,123	1073.3	671	88.7	9.8	9.0:1
Texas	15,652	15,714	15,683	13,326	849.7	1,295	82.6	8.1	10.2:1
Utah	592	532	562	1,015	1806.0	64	113.9	6.9	16.5:1
Vermont	1,207	1,175	1,191	642	539.0	145	121.7	11.4	10.7:1
Virginia	11,544	11,370	11,457	5,518	481.6	1,109	96.8	8.1	11.9:1
Washington	3,820	3,498	3,659	3,657	999.5	359	98.1	9.7	10.1:0
West Virginia	5,060	5,005	5,032	2,644	525.4	498	99.0	10.9	9.1:1
Wisconsin	13,315	13,277	13,296	7,592	571.0	1,132	85.1	9.7	8.8:1
Wyoming	648	589	618	565	914.2	63	101.9	8.1	12.6:1

(1) Calculated from existing data.

SOURCE: Dept. of Health, Education, and Welfare, Public Health Service, National Institute of Mental Health, Provisional Patient Movement and Administrative Data, State and County Mental Hospitals, U. S. Series MHB-H-11, (1966), p. 7.

EXHIBIT II

Section 1. SHORT TITLE.—This act shall be known and may be cited as the "Right to Treatment Law of 1969."

Section 2. DEFINITIONS.—As used in this act:

(1) "Board" means the Patient Treatment Review Board.

(2) "Committee" means the Mental Treatment Standards Committee.

(3) "Department" means the Department of Public Welfare.

(4) "Manual" means the "Manual of Minimum Standards for Treatment of Mentally Ill in State Mental Institutions" prepared by the committee.

(5) "Minimum standards" means those standards prepared and adopted by the committee and contained in the manual.

(6) "Secretary" means the Secretary of Public Welfare.

Section 3. ESTABLISHMENT OF MENTAL TREATMENT STANDARDS COMMITTEE.—(a) A committee shall be appointed within ninety days after the effective date of this act by the secretary, with the advice of the Pennsylvania Advisory Committee for Mental Health which shall be known as the Mental Treatment Standards Committee.

(b) The Mental Treatment Standards Committee shall be composed of seven members as follows:

(1) A licensed non-administrator psychiatrist who is a member of the American Psychiatric Association;

(2) A licensed physician who is not a psychiatrist and who is a member of the American Medical Association;

(3) A psychiatric social worker who is a member of the Committee of Psychiatry of the National Association of Social Workers and who has had at least five years experience in institutional psychiatric social work;

(4) A clinical psychologist holding a Ph. D. and who is a member of the Clinical Psychologists of the American Psychological Association;

(5) A licensed psychiatrist who is a member of the National Association of Medical Superintendents of Mental Hospitals and who has had at least five years of experience as a mental institution administrator;

(6) A registered professional nurse who is a member of the Psychiatric and Mental Health Division of the American Nurses Association; and

(7) The Commissioner of Mental Health of the Department of Public Welfare.

(c) The Commissioner of Mental Health shall serve on the committee in an advisory capacity only and shall have no vote in the adoption of minimum mental treatment standards. He shall obtain and make available to the committee any data, statistics and information relating but not limited to State mental institutions, personnel and patients that the committee requests in the course of its research and preparation of minimum standards.

(d) The secretary shall request the presiding officer of each of the appropriate professional associations named above to recommend to him the names of three persons who would be willing to accept appointment and the secretary shall appoint each member from the three names recommended to him by these associations.

(e) The committee members shall be appointed for six year terms except that the first appointed members shall serve staggered terms as follows:

(1) The registered professional nurse—two years;

(2) The psychiatric social worker—two years;

(3) The clinical psychologist—three years;

(4) The physician—four years;

(5) The psychiatrist-administrator—five years;

(6) The psychiatrist recommended by the American Psychiatric Association—six years.

(f) No member shall be appointed who was employed or retained by the Commonwealth of Pennsylvania or any of its subdivisions or any agency thereof at any time during the three year period immediately preceding appointment nor may any member be so employed or retained while he is a member of the committee, nor for five years thereafter: Provided, however, That these restrictions shall not apply to the psychiatrist who is a member of the National Association of Superintendents of Mental Hospitals.

(g) The committee shall be compensated for its services on a contractual basis by the Department of Welfare, but shall be compensated only if it performs the services herein specified within the time limits specified.

Section 4. PREPARATION AND ADOPTION OF MINIMUM STANDARDS.—(a) The Mental Treatment Standards Committee shall prepare and adopt a "Manual of Minimum Standards

for Treatment of Mentally Ill in State Mental Institutions," which shall, in the opinion of the committee be acceptable to the professional associations named in section 3 and represented by the members of the committee.

(b) These standards shall specifically include, but shall not be limited to the following matters:

(1) The number of professional and non-professional staff, whose responsibilities are directly related to patient treatment or care, per patient population, including the maximum number of patients for each psychiatrist, physician, clinical psychologist, social worker, industrial therapist, nurse and attentant or aide;

(2) The required minimum qualifications for each professional and non-professional staff position, referred to in clause (1) of subsection (b) of section 4, including degrees, licensure, certification, apprenticeship, or experience;

(3) The minimum number of individual consultations each patient shall have with a psychiatrist and other appropriate professional personnel and the minimum number of hours of such individual consultations each patient shall have in each thirty day period, taking into account, if deemed appropriate, varying standards for the following categories: (i) immediately after admission and for diagnostic purposes, (ii) treatment as indicated by individual conditions and need, (iii) pre- and post-institutional release period for home, occupation, and community adjustment, including continuing therapy after the patient leaves the institution, if not provided by other mental health facilities;

(4) The frequency and extent of general physicial examinations; and

(5) Requirements for maintenance of the individualized treatment plans for each patient which shall include but not be limited to: (i) the initial diagnosis, (ii) the manner in which the facilities of the particular institution can improve the patient's condition, (iii) the treatment goals, and, (iv) the treatment regimen that is planned to accomplish these goals, subject to the limitation provided in subsection (d) of section 4.

(c) The minimum standards for numbers and qualifications of staff and number of individual consultations shall be no lower than the standards established by the American Psychiatric Association; and they shall also include requirements that all psychiatrists and medical practitioners must have the qualifications that are required to obtain Pennsylvania licensing for private practice.

(d) The committee shall not include in its standards any requirements relating to selection and conduct by individual psychiatrists, physicians or clinical psychologists of their treatment methods or procedures, nor the judgment, skill or care used by these practitioners. The standards promulgated by the committee shall be expressed in objective terms so far as possible in order to minimize the necessity for subjective evaluation of departmental and institutional compliance, in judicial review.

(e) The committee shall present to the secretary within six months after its appointment the completed "Manual of Minimum Standards for Treatment of Mentally Ill in State Mental Institutions" and the minimum standards as promulgated by the committee and set forth in such manual shall be the minimum standards as promulgated by the committee and set forth in such manual shall be the minimum standards of treatment for all patients confined in State mental institutions in Pennsylvania, beginning two years from the effective date of this act, and such manual shall be a public document.

(f) The secretary shall immediately upon receipt of said manual from the committee furnish to the superintendent of each State mental institution copies of the manual; shall allocate sufficient resources necessary for the State mental institutions to be able to provide at least the minimum staffing standards; and shall provide advice and assistance to such institutions in their preparation to meet the minimum standards as set forth in the aforesaid manual.

(g) The department shall make studies to determine the additional personnel necessary to meet the requirements of this act. A report shall be prepared and be presented to the General Assembly within one year from the effective date of this act, giving cost and other appropriate data.

(h) Each State mental institution shall be responsible for maintaining complete and accurate records of treatment furnished persons confined therein. The record of treatment for each patient may be kept in his individual case record and is not required to be otherwise recorded or compiled. The records shall be maintained, however, in such manner that determination can be made at any time whether minimum standards of treatment are being furnished to any particular person confined therein. Each patient's records shall be fully available at any time to his independently engaged psychiatrist or attorney and to the Patient Care Review Board hereinfter designated.

(i) The Mental Treatment Standards Committee shall periodically review the minimum

treatment standards manual and shall make such changes as it decides are necessary. Once every two years the committee shall submit to the secretary a list of all such changes, and these changes shall become amendments to the "Minimum Standards." The manual shall be amended accordingly, and the secretary shall forthwith furnish copies to the director of each State mental institution. Such amendments shall become effective and patients' legal rights to such amended minimum standards of treatment shall vest within three months after the committee has forwarded the amendments to the secretary.

Section 5. PATIENT'S LEGAL RIGHT TO MINIMUM STANDARDS OF TREATMENT.—(a) Beginning immediately upon the expiration of two years from the effective date of this act, every person who is then or at any time thereafter confined, voluntarily or involuntarily, in a State mental institution, shall have the legal right to receive at all times while so confined at least minimum treatment as herein defined.

(b) The right to minimum standards of treatment provided by this act shall not include the right to have reviewed the judgment, skill or care used by individual psychiatrists, physicians or clinical psychologists. Any such rights and remedies existing by common law or other statutes shall not be hereby impaired.

(c) Beginning immediately upon the expiration of two years from the effective date of this act, every person then confined in any State mental institution and every person thereafter admitted to any such institution and each such person's legal guardian or designated responsible relative or friend shall be furnished with a brief but specific synopsis of the minimum standards of treatment, together with a statement of the patient's legal right to such minimum standards henceforth, and the legal remedies available if such patient fails to receive such treatment, including the patient's right to be represented by a psychiatrist and an attorney of his choice (subject to the consent of any psychiatrist or attorney to be retained by the patient) in the pursuit of his legal remedies. Said synopsis shall be in plain and simple language and shall be in printed form large enough to be easily read.

Section 6. PATIENT TREATMENT REVIEW BOARD.—(a) The secretary shall appoint a Patient Treatment Review Board, consisting of two licensed psychiatrists, two licensed medical practitioners and one attorney, who shall not serve the Commonwealth or any of its agencies or subdivisions in any other remunerative capacity, whose tenure and duties shall begin immediately upon the expiration of two years from the effective date of this act.

(b) These board members shall serve on a full-time basis and be employed under the merit system in accordance with the act of August 5, 1941 (P. L. 752), known as the "Civil Service Act."

(c) Adequate staff shall be provided to assist the board in its duties and adequate facilities shall be provided.

(d) The duty of the board shall be to receive, hear and investigate petitions filed on behalf of patients who allege they are not receiving minimum standards of treatment, and to issue findings thereon.

(e) The secretary shall promulgate and issue procedural regulations, not in conflict with the provisions of this act, which shall guarantee to petitioners proper notice, fair procedure, and prompt dispositions of petitions.

(f) Three members of the board shall constitute a quorum for transacting business.

Section 7. PATIENTS' LEGAL REMEDIES.—(a) Any person confined in a State mental institution, or his legal guardian or designated responsible relative or friend, who, at any time after the expiration of two years from the effective date of this act or after three months subsequent to the date of his admission to the institution, whichever is later, believes he is not receiving minimum treatment as defined in this act, shall have the right to take action according to the procedure hereinbelow provided:

(1) Petition the board for a formal determination of whether in fact the patient has failed to receive the minimum treatment to which he is legally entitled, as provided in this act; (i) the petition shall be in writing, addressed to the board and be signed by the patient or his legal guardian or designated responsible relative or friend; (ii) the petition shall contain a resume of the reasons it is believed the patient is not receiving the minimum treatment to which he is legally entitled; (iii) the patient may be represented by an agent designated by him or his legal guardian or designated responsible relative or friend, in writing. Such agent may be, but is not required to be, an attorney; but in no event may such designated agent be an employe of or engaged in any capacity by the Commonwealth or any of its agencies or subdivisions. Such designated agent may personally represent the patient in any hearings, investigations, or correspondence, and all institutional and departmental records relating to the issue of adequate treatment

shall be fully available to such agent. Whether or not any such designated agent is an attorney, the proceedings before the Patient Treatment Review Board shall not be conducted as adversary proceedings nor with adherence to technical rules in the presentation of evidence.

(2) The board shall review the petition, hold hearings, make such investigation as appears appropriate and confer with the superintendent of the State mental institution where the petitioner is confined; (i) the board shall personally review each petition en banc; (ii) the board shall, within one month after receipt of any petition, issue a written finding, stating whether or not the patient has failed to receive minimum treatment, whether the superintendent of the State mental institution concurs in the finding; and, when the finding is that the patient has not received minimum treatment and that the superintendent concurs in this finding, whether or not the superintendent agrees to furnish forthwith said minimum treatment; (iii) the finding shall specify in what respect, if any, the treatment has failed to meet the minimum standards; (iv) a copy of said findings shall be forwarded to the petitioner and if petitioner is the person confined in a State mental institution, then a copy also to petitioner's legal guardian or designated responsible relative or friend; (v) a copy shall also be forwarded to the superintendent of the State mental institution.

(3) If the State mental institution superintendent concurs in a finding that minimum treatment has not been received and agrees to furnish such minimum treatment, a probationary period of three months shall ensue; (i) immediately at the end of the three month probationary period the board shall forward a simple inquiry to the petitioner as to whether the patient on whose behalf the petition was filed has been receiving minimum treatment during the probationary period; (ii) if the inquiry is returned within two weeks, signed by the petitioner and witnessed by two persons not associated in any way with the State mental institution, indicating that minimum treatment is being received, the review shall be concluded. The response to the inquiry shall be made a permanent part of the petitioner's records with the board; (iii) if the board does not receive a response from the petitioner that minimum treatment is being received, it shall make such further investigation as it deems appropriate and issue a final finding.

(b) Any patient may file or have such a petition filed on his behalf once in any six months period but no oftener.

Section 8. RIGHT TO PETITION COURT.—(a) In any of the following instances any petitioner may personally or by an attorney of petitioner's choice (subject to the agreement of the selected attorney to serve as petitioner's counsel) take court action in accordance with subsections (f) to (n) of section 8 of this act, in respect to the alleged lack of minimum care:

(1) If the board issues a finding that the person on whose behalf the petition was filed is receiving minimum treatment, and the petitioner does not agree;

(2) If the board finds that the person on whose behalf the petition was filed has not been receiving minimum treatment and the superintendent of the institution does not concur in the finding or the superintendent concurs but does not agree to furnish minimum treatment forthwith;

(3) If the board finds that the person on whose behalf the petition was filed has not been receiving minimum treatment and the superintendent concurs and agrees to furnish at least such minimum treatment forthwith, but at the end of the three month probationary period or any time within three months thereafter the petitioner or the person on whose behalf the petition was filed believes that minimum treatment has not been received subsequent to said final finding of the board;

(4) If the board has failed to notify the petitioner of any finding at the end of one month from the date of the patient's petition;

(5) If the patient seeks an appeal from the findings of the Patient Treatment Review Board as provided in subsection (o) of section 8.

(b) Any patient whose petition to the board has been concluded in one or more of the alternatives cited in subsection (a) of section 8, may petition a court for appropriate relief, personally or by his guardian or responsible relative or next friend.

(c) The following remedies shall be available: the common law writ of habeas corpus as modified herein; writ of mandamus; mandatory injunction; order requiring the Commonwealth to permit, to help arrange for if necessary, any to pay for private psychiatric care, either while the patient remains in the institution or after he is released.

(1) Petitioner may petition for any one of the above remedies exclusively; or, he may petition simultaneously for writ of habeas corpus and either writ of mandamus or mandatory injunction.

(2) If a petitioner requests a writ of habeas corpus and the court finds that petitioner did not receive the minimum standard of treatment as defined in this act, the only grounds on which the writ of habeas corpus may be denied, in proceedings brought pursuant to this act, shall be if the court finds, upon proper evidence that: (i) the patient is demonstrably dangerous to himself or others if released; or (ii) the patient has been acquitted of a crime by reason of insanity; or (iii) the patient has been convicted of a crime and his sentence has not expired; or (iv) the patient has been charged with a crime and has not yet been tried; or (v) the patient has been convicted of a crime and committed to a mental institution in lieu of sentence.

(3) The court may in its discretion, on a habeas corpus petition, if it finds any of the above, order the patient transferred to another suitable mental treatment facility where at least minimum standards of treatment as defined in this act will be furnished.

(4) In any habeas corpus proceeding the burden of proof shall be on the defendant to show that its treatment met the minimum standards as defined by this act.

(d) The defendants named in any such action shall be the superintendent of the institution in which the patient is confined and the secretary.

(e) The petition may include a request for payment of treatment on a private consulting basis, as specified in subsections (i) to (l) of section 8.

(f) Any petitioner proceeding under this act shall have the right, but shall not be required, to have all evidence presented de novo before the court, and shall have the right of appeal from any adverse order of the court, as in other such cases.

(g) Each person confined in a State mental institution who believes that he is not receiving minimum treatment and intends to petition for a finding may engage a psychiatrist of his choice for an independent evaluation (subject to the selected psychiatrist's agreement to be so retained). The psychiatrist so engaged shall have the right to present evidence and testimony to the board and to the court in any legal proceeding hereunder. If the patient is indigent, he shall have the right to have the Commonwealth compensate such psychiatrist with a reasonable fee for such services.

(h) Each person confined in a State mental institution or his legal guardian or designated responsible relative or next friend initiating court action on his behalf shall have the right to counsel of petitioner's choice (subject to the attorney's agreement to be so retained). If the person on whose behalf the petition is filed is indigent, he shall have the right to have the Commonwealth compensate such council a reasonable sum for such services.

(i) Any patient shall have the absolute right, in the event the court shall find that he has not received minimum treatment as defined in this act, to treatment furnished by a private licensed psychiatrist on a private consulting basis, said treatment to be paid by the Commonwealth at the rate of twelve dollars and fifty cents ($12.50) for each half hour consultation.

(j) Such patient shall have the right to have payment furnished for no more than two private one-half hour consultations per week if the patient is released from the institution on a writ of habeas corpus and to have payment furnished for no more than one private one-half hour consultation per week if the patient remains in an institution. The patient shall have the right to choose his psychiatrist, subject to the requirement that the psychiatrist so selected must meet the same professional standards as are set forth in the manual referred to in this act and further that the psychiatrist shall not be employed on the staff of the institution where the patient is confined.

(k) The court shall order the defendants, as part of its order or decree, when it finds that the patient has not received minimum treatment as defined in this act, to furnish payment as specified in this act, for such treatment; and also to aid the patient in arranging for such treatment if the patient remains in the institution.

(l) Payments to psychiatrists so engaged shall be in accordance with regulations promulgated by the Department of Public Welfare and shall be reimbursable to the extent of the patient's ability to pay, on the same basis as liability for reimbursement is determined by law and regulation for mental institutional care generally.

(m) In the event that a patient who is entitled to petition a court for relief as specified in subsections (a) and (b) of section 8 of this act, shall be willing to accept treatment on a private consulting basis, in lieu of petitioning a court for relief, the board may, with the approval of the superintendent of the mental institution, certify to the department the medical eligibility of the patient to receive such treatment and the patient shall thereafter have the right to have payment for such treatment furnished by the Commonwealth, on the same basis and subject to the same requirements as specified in

subsections (i) to (l) of section 8 of this act. In such event the superintendent of the mental institution shall aid the patient in arranging for such treatment.

(n) In each case where payment is furnished by the department for patient treatment on a private consulting basis, the superintendent of the mental institution where the patient was confined shall have a review made every year of the patient's continued need for treatment, unless the patient shall be discharged from treatment by his psychiatrist before any annual review. In any such annual review the appropriate mental institution staff and the patient's private psychiatrist shall jointly confer in determining the patient's need for continued treatment.

(o) In case the patient's psychiatrist and the superintendent of the institution disagree on the patient's further need for treatment, the mater shall be referred to the Patient Treatment Review Board by the patient, or his private psychiatrist, or someone on his behalf. Appeal shall be available from the findings of the Patient Treatment Review Board as provided in clause (5), subsection (a) of section 8, as applicable.

Section 9. REPEALER.—All acts and parts of acts insofar as they are inconsistent with the provisions of this act are hereby repealed.

Section 10. SEVERABILITY.—If any provision of this act or the application thereof to any person or circumstance is held unconstitutional the remainder of the act and the application of such provision to other persons or circumstances shall not be affected thereby, and to this end the provisions of this act are declared to be severable.

Section 11. APPROPRIATION.—The sum of one hundred thousand dollars ($100,000), or as much thereof as may be necessary, is hereby appropriated to the Department of Public Welfare for the fiscal year 1969-70 for the purpose of carrying out the provisions of this act.

Section 12. EFFECTIVE DATE.—This act shall take effect January 1, 1970.