

IN THE UNITED STATES DISTRICT COURT
NORTHERN DISTRICT
EASTERN DIVISION

ALLYN RONE, et al.
Plaintiffs,

vs.

BARRY I. FIREMAN, et al.
Defendants.

CASE NO. C75-355A

Judge Contie

BRIEF OF THE AMERICAN
PSYCHOLOGICAL ASSOCIATION
AS AMICUS CURIAE

PRELIMINARY STATEMENT

The American Psychological Association (APA), the major association of psychologists in the United States, was founded in 1892 as a non-profit professional organization. The Association numbers almost 45,000 members and includes a vast majority of the psychologists holding doctorate degrees from accredited schools in this country. The Association's purpose as set forth in the bylaws, is to "advance psychology as a science and as a means of promoting human welfare by the encouragement of psychology in all its branches in the broadest and most liberal manner." Professional psychologists are licensed or certified by statute in all fifty states and the District of Columbia to evaluate and treat emotional and mental disorders and deficiencies in behavioral coping skills.

The Association is deeply concerned about the quality of care and treatment given to persons with mental problems in this country and, in particular, to those persons confined in state mental hospitals. The implementation of the concept of treatment in the least restrictive setting is critical to the preservation of civil liberties and to improvement in the care and services afforded to such individuals throughout the country and, specifically, to the patients of Western Reserve Psychiatric Habilitation Center (WRPHC).

The Association believes that patients who are confined because of a failure to behave in appropriate ways either toward themselves or in interaction with others must receive treatment that is directed toward improving their skills of coping with the behavioral demands of society. The concept

procedures be directed toward improving behavioral effectiveness and that the treatment environment be as unrestrictive and as integrated with the community as possible. Only in this manner can opportunity be afforded for maintenance and consolidation, through practice, of the appropriate behavior that will allow patients to successfully return to community living.

STATEMENT OF FACTS¹

There is minimal effort to treat patients at WRPHC in "the least restrictive environment consistent with the treatment plan." Sec. 5122.27(f)(1), Ohio Rev. Code. Few patients are given the freedom to make decisions about their own life or the freedom to implement those decisions. Even the most basic living patterns are dictated to the patient. For example, for most patients, housing arrangements are imposed; mealtime is established; diet is centrally determined; passage to and from the dining halls is organized. Staff determine when patients will sleep, watch television, and have recreation. Efforts to provide treatment settings outside the hospital have also been insufficient for the large number of patients who could benefit from such less restrictive settings. The variety of treatment settings both within and without the hospital presently used by Defendants is much too limited to permit effective treatment of patients' problems.

A high percentage of the patients have suffered extensive physical and mental deterioration as a result of Defendants' failure to provide humane custodial care and therapeutic treatment services, and as a result of their long exposure to an institutional environment. As it now stands, patients are being summarily released ("dumped") from the hospital having received little or no therapy designed to assist them in learning community living skills or acceptable behavior for coping with their mental problems so that they might eventually be able to function successfully in the community. Nor have most patients received any remedial care and treatment that would help them overcome the regressive effects caused by their long confinement in an institution by putting them in the mental and physical conditions they would presently enjoy had they been properly cared for and effectively treated during their confinement in the hospital.

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The American Psychological Association's statement of facts is based on a review of depositions taken in this case and of evidence which will be

I. PATIENTS HAVE A RIGHT TO RECEIVE TREATMENT IN THE LEAST RESTRICTIVE SETTING APPROPRIATE TO THEIR NEEDS.

The constitutional and statutory bases for a right to be free from harm,² a right to receive effective treatment,³ and a right to receive treatment in the least restrictive setting⁴ while a patient in a public mental hospital have been extensively set forth by Plaintiffs in their several briefs before the Court. Amicus will not repeat in this brief those arguments which go to the existence of such rights. Instead, this brief will focus on the nature of the rights to be free from harm, to effective treatment, and to treatment in the least restrictive setting and, in particular, the need to provide care and services, both within and without the hospital setting, aimed at enabling a hospital patient to successfully return to and remain in the community.

A. Implementation of the "Right to be Free from Harm" Requires the Development of Less Restrictive Settings for the Treatment of Mentally Disordered Persons.

In New York State Association for Retarded Citizens v. Rockefeller, 357 F.Supp. 752 (E.D.N.Y. 1973), later opinion sub nom. New York Association for Retarded v. Carey, 393 F.Supp. 715 (E.D.N.Y. 1975), the court noted that

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The constitutional bases for the right to be free from harm are the Eighth Amendment (prohibition against cruel and unusual punishment) and the Fourteenth Amendment (right to due process) to the U.S. Constitution, as well as the constitutionally-based right to treatment. The statutory bases lie in Sections 5122.27 and 5122.29 of the Ohio Revised Code. A number of cases have held that there is a right to be free from harm while in the State's custody. See, e.g., Brenneman v. Madigan, 343 F.Supp.128 (N.D. Cal. 1972); Inmates of Suffolk County Jail v. Eisenstadt, 360 F.Supp.676 (D.Mass. 1973), aff'd 494 F.2d 1196 (1st Cir. 1974), cert. denied 419 U.S. 977 (1974); New York Association for Retarded v. Rockefeller, 357 F.Supp. 752 (E.D.N.Y. 1973), later opinion sub nom. New York State Association for Retarded v. Carey, 393 F.Supp. 715 (E.D.N.Y. 1975).

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Several cases have held that there is a constitutional right to adequate treatment. See, e.g., Davis v. Watkins, 384 F.Supp. 1196 (N.D. Ohio 1974); Welsch v. Likins, 373 F.Supp. 487 (D.Minn. 1974), aff'd in part, remanded in part on other grounds, 550 F.2d 1122 (8th Cir. 1977); Wyatt v. Stickney, 325 F. Supp. 781 (N.D. Ala. 1971), on submission of proposed standards by defendants, 334 F.Supp. 1341, enforced, 344 F.Supp. 373, 344 F.Supp. 387 (1972), aff'd sub nom. Wyatt v. Aderholdt, 503 F.2d 1305 (5th Cir. 1974). The statutory basis is in Sec. 5122.27, Ohio Rev. Code.

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The right to receive treatment in the least restrictive setting is based upon the constitutional principle that the state, when interfering with an individual's fundamental rights, must do so in the least restrictive manner possible. See, e.g., Welsch v. Likins, supra. Section 5122.27, Ohio Rev. Code, provides a statutory basis for the right in Ohio. In the District of Columbia, statutory language was interpreted to require "a

"harm can result not only from neglect but from conditions which cause regression or which prevent development of an individual's capabilities." 393 F. Supp. at 718. While confinement in an inhumane physical and psychological environment is, in itself, harmful, long-term confinement alone is enough to cause deterioration in a patient's mental and physical well-being.

Studies have shown that the environments of large mental hospitals have negative influences on the behavior patterns of long-term patients.⁵ The term "institutional neurosis" has been coined to describe a disorder separate from the one responsible for bringing the patient to the hospital. It is a "disease produced by methods of looking after people in mental hospitals and is not part of the mental illness preceding and sometimes existing with it."⁶ In long-term patients, "institutional neurosis" is characterized by apathy, lack of initiative, loss of interest, submissiveness, lack of expression of feelings of resentment at harsh or unfair orders, loss of individuality, and a resigned acceptance of things as they are.

Many patients at WRPHC have been confined to the hospital for years because there was no treatment within the hospital to help them change their behavior so as to be able to live in the community, and because the support services and treatment within the community needed by such patients were inadequate or non-existent. Patients have thus in many ways been subjected to needless harm by virtue of the Defendants' failure to provide treatment alternatives to hospitalization and, within the hospital, treatment programs which maximize personal freedom and decision-making⁷ and which bring the patient into contact with the community so as to prepare the patient to return to

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See, e.g., J.K. Wing, Institutionalism in Mental Hospitals, 1 Brit. J. Soc. Clin. Psychology 38 (1962); E. Goffman, Asylums (1961); R. Sommer & G. Witney, The Chain of Chronicity, 118 Am. J. Psychiatry 111 (1961); E. Gruenberg et al., Objective Appraisal of Deterioration in a Group of Long-Stay Hospital Patients, 40 Milbrook Mem. Fund Q. 90 (1962).

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R. Barton, Institutional Neurosis 15 (1966).

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The importance of personal freedom and decision-making was demonstrated in a study by Langer and Rodin in which it was shown that elderly nursing home patients who were permitted to make a greater number of choices and to feel more control and responsibility for day-to-day events had sustained beneficial effects with regard to health, mortality and other indicators. J. Rodin & E. Langer, Long-Term Effects of a Control-Relevant Intervention With the Institutionalized Aged, 35 J. Personality & Soc. Psychology 897 (1977).

living in the community. In order to protect the Plaintiffs from such harm in the future, the Court should order the establishment of treatment settings within the hospital and settings completely separate from the hospital.

See discussion infra at Part B.

In addition to devising an order designed to protect Plaintiffs from harm because of needless institutionalization, the Court must also focus on the Defendants' present practice of summarily discharging, or "dumping", patients who are ill-prepared for community living; such a practice causes additional harm, indeed, sometimes death. Patients who exhibit the adverse effects of long-term institutionalization (i.e., apathy, resignation, dependence, release anxiety) as well as the effects of substandard custodial and therapeutic care should not be released without special assistance in overcoming those adverse effects. Special assistance should include care and treatment in less restrictive settings, when appropriate.

B. The Implementation of the "Right to Treatment" Must Include an Emphasis on Treatment Aimed at Enabling a Hospital Patient to Successfully Return to and Remain in the Community.

In ensuring that patients receive care and therapy of such quantity and quality as are required by the right to treatment, the Court must focus on the purpose behind hospitalization, the goals of treatment programs which are acceptable to that purpose, and determine what treatment settings must be established in order to carry out those goals. Such an approach, which requires that the means be directly related to the desired end result, was followed in Jackson v. Indiana, 406 U.S. 715, 738, 92 S.Ct. 1845, 1858 (1972), where the Court, in considering Indiana's commitment statutes, stated that, "[a]t the least, due process requires that the nature and duration of commitment bear some reasonable relation to the purpose for which the individual is committed."

Persons are often hospitalized not only because of their mental disorders, but also because of their inability to cope with their mental disorders.⁸ Therefore, a major purpose of hospitalization is to provide such treatment as will restore to patients their ability to behave appropriately and effectively toward themselves and others so that they may resume community

living.

If a purpose of hospitalization is to alter that unacceptable behavior which necessitated hospitalization, then a goal of treatment should be to treat persons so as to permit them to return to the community as soon as possible and enable them to remain there as long as possible. Defendants presently rely almost exclusively on hospital treatment directed solely toward mental "illness". Such treatment, which combines drug therapies with benign custodial seclusion, when carried on over periods of months and years may further erode patients' coping skills through disuse and thereby aggravate rather than enhance the primary cause of the initial withdrawal from community life.⁹ Social and behavioral skills need stimulation, through use. Just as the physically impaired patient must be ambulated from bed rest as soon as possible, so too must the behaviorally impaired patient be "ambulated" to the least socially restrictive environment as soon as possible. In order to satisfy acceptable treatment goals, Defendants should provide a continuum of treatment settings which not only address the underlying mental-disorder, but which also help people return to and successfully remain in the community.

The continuum of treatment settings should start from the point of intensive hospitalization, such as is presently provided by the Defendants. As a patient begins to emerge from an acute symptomatic stage, he/she should be gradually eased back toward the community. In order to begin this part of the process, the hospital can, for example, establish wards which provide varying levels of assistance in everyday living skills, such as daily shopping trips, use of public transportation, etc.¹⁰ A patient can be graduated from one ward to the next as a patient's condition improves, until such time as the patient is ready for a community experience.¹¹ In addition to establishing

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See note 5 supra, and accompanying text.

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The concept of placing a patient in a less restrictive setting within the hospital environment has been recognized in Covington v. Harris, 419 F.2d 617 (D.C.Cir. 1969), where a patient confined to the maximum security division sought his transfer to an area of the hospital permitting greater personal freedom. The court there held that the principle of less restrictive alternative is applicable within the confines of a hospital and that a hospital may not impose unwarranted deprivations of liberty upon a civilly committed patient.

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While a few such wards presently exist at WRPHC, they lack fully qualified staff and have not been systematically organized and implemented.

a variety of ward settings, a hospital can also create group or semi-independent living settings on the grounds of the hospital itself, with case management, treatment and program services provided by the hospital. The same treatment settings can be used in the return of chronic patients to community living.

The continuum of mental health care must extend into the community,¹² for the success with which a person returns to the community and avoids further need for hospitalization will be largely dependent on the improvement of the person's skills in coping with social demands, the location of the person in a benign and supportive community environment, the assistance the person receives in making the transfer and the help he/she receives once in the community.¹³ Studies have shown that an unstructured release back into the community without referral to community aftercare and involvement with community-based services will result in a predictable and substantial increase in the rate of re-hospitalization.¹⁴

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There is a precedent for ordering the Defendants to provide transitional services to discharged patients. In Davis v. Watkins, 384 F. Supp. 1196, 1205 (N.D. Ohio 1974), the court entered a preliminary order providing that,

The Department of Mental Health and Mental Retardation and its agents have an affirmative duty to provide adequate transitional treatment and care for all patients released after a period of confinement to Lima State Hospital. Transitional care and treatment possibilities include, but are not limited to, psychiatric day care, treatment in the home by a visiting therapist, nursing home or extended care, outpatient treatment, and treatment in a psychiatric ward of a general hospital.

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There have been many descriptions of "transitional group living programs" all of which include small group living units, regularly scheduled staff visits, and group therapy as well as appropriate domestic and job skill training. See, e.g., G.W. Fairweather et al., Community Life for the Mentally Ill (1969); G. Shean, A Social Learning Approach to Community Living for Chronic Mental Patients, Procdgs. of the 81st Ann. Conv. of the Am. Psychological Ass'n, Montreal, Canada 457 (1973); J. DeLeon, "Treatment of Mental Patients in Residential Settings", unpublished address before the 80th Ann. Conv. of the Am. Psychological Ass'n, Honolulu, Hawaii (1972).

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See, e.g., H. Freeman & O. Simmons, The Mental Patient Comes Home (1963); Zollik et al., Hospital Return Rates and Pre-release Referrals, 18 Archives Gen. Psychiatry 712 (1968). The importance of community resources in preventing hospitalization was demonstrated by Lipsius. Alternative treatment programs such as outpatient psychotherapy, half-way houses, day treatment, night hospitalization, family counseling, home care, and sheltered workshops were seen as potential deterrents to hospitalization. S. Lipsius, Judgments of Alternatives to Hospitalization, 130 Am. J. Psychiatry 892 (1973). In another study the importance of community treatment (as contrasted with community placement) was shown to be critical to the successful return of hospital patients to the community. The study concluded that:

...chronic schizophrenics, in order to remain successfully in the community, must have continuous supervision and medication. They and their families must receive social services and psychological support to allow them to

The key to the operation of the concept of least restrictive setting is that of appropriateness to individual needs and individual abilities. The right to treatment has not been satisfied where a person needing program support within the community, for example, to improve basically inadequate coping skills, is simply discharged from the hospital and instructed on where to look for a bed. At the same time, discharging all hospitalized patients into a community-based setting does not satisfy the right to treatment in the least restrictive setting appropriate to needs, when some of those hospitalized patients do, in fact, need hospital care of varying duration. Care that extends from the hospital through transitional, less socially restrictive facilities back into the community, with continuing professional community supports, will reduce the frequency of, or eliminate, the repeated re-hospitalization of such patients. This in turn will reduce the high cost in both human and economic terms of the present system of inadequate treatment at WRPHC.

Presently, at WRPHC, patients either remain in confinement for years on a chronic ward because there are minimal treatment programs geared to helping them return to community living and/or insufficient community support to enable them to survive in the community, or patients are discharged shortly after they have emerged from a psychotic episode, with little or no assistance in making an adequate adjustment to community life. In neither instance have the Defendants effectively "treated" patients. Many patients have thus been denied their right to receive treatment for the deficiencies in social coping behavior that were the explicit bases for their hospitalization.

The Court should fully implement the right of patients to receive effective treatment. By focusing on the relationship between purpose of hospitalization and goals of treatment programs, it will be necessary for the Court to order that a variety of settings less restrictive than intensive hospital confinement that is isolated from all regular community activities be created and used, including community-based settings, and that professional help to overcome deficiencies in social and personal coping skills be provided, as appropriate, to treat the individual needs and abilities of each patient.

- C. Defendants Have a Duty to Plaintiffs to Provide Post-Hospital Care and Services Until Such Time as Plaintiffs Are Able to Overcome the Regressive Effects of the Inhumane Environment Which Has Existed at WRPHC for Years.

Defendants have failed to protect Plaintiffs from harm and must therefore provide them with an adequate remedy. The care at WRPHC has been so substandard as to cause the physical and mental deterioration of patients confined within. In addition, many patients have been needlessly exposed to a total institutional environment when they could have been treated in settings less restrictive in nature. This failure to use less restrictive treatment settings has caused harm to patients in that they have become apathetic, resigned to their life situation anxious about living outside an institution, and unable to cope with life outside a hospital. The Defendants have further harmed Plaintiffs by "dumping" them into the community without adequate preparation. Defendants have also failed to treat effectively Plaintiffs' mental problems in that treatment programs have not, by and large, centered on returning the patient to the community as quickly and as successfully as possible. Defendants have a duty to Plaintiffs to remedy these past failures by providing such care and services as are needed to put Plaintiffs in the position they would enjoy today had they not been harmed and denied effective treatment. In order to fulfill this duty, Defendants must provide special care and services not only within the hospital, but outside the hospital as well.

Defendants' obligation to provide remedial care and services derives from their duties to protect Plaintiffs from harm and to provide effective treatment in the least restrictive alternative appropriate to needs. Their failure to properly perform these duties requires them to not only begin meeting these responsibilities, but also to remedy the effects of their past failures. It is within the Court's equitable powers to fashion an order which is both prospective and remedial in nature. "The essence of equity jurisdiction has been the power of the Chancellor to do equity and to mould each decree to the necessities of the particular case." Hecht Co. v. Bowles, 321 U.S. 321, 329, 64 S.Ct. 587, 592, 88 L.Ed. 754, 760 (1944); Bowles v. Skaggs, 151 F.2d 817 (6th Cir. 1946).

This case is similar to school desegregation cases. In those cases, federal district courts have often found that a school system has failed to perform its duty of providing education in a non-segregated fashion, causing certain kinds of harm to students. The courts have ordered the systems to halt the further use of segregated practices and to remedy the harm so caused by instituting specific programs. See, e.g., Miller v. School District Number 2,

Clarendon, S.C., 256 F.Supp. 370 (D.S.C. 1966); Hart v. Community School Board of Brooklyn, 383 F.Supp. 699 (E.D.N.Y. 1974), aff'd 512 F.2d 37 (2d Cir. 1975).

The United States Supreme Court has reviewed the propriety of ordering remedial programs in the school desegregation context in Milliken v. Bradley, ___ U.S. ___, 97 S.Ct. 2749, ___ L.Ed. 2d ___ (1977). There, the Court upheld a district court order that was generally prospective in nature but that also included the requirement that the Detroit School Board provide remedial programs in four areas: reading, in-service teacher training, testing, and counseling and career guidance. The Court outlined three factors to be considered before a court resorts to its remedial powers: (1) the nature and scope of the constitutional violation, and the extent to which the remedy will relate to the constitutional violation; (2) whether the order carries with it the possibility of restoring the victims of the discriminatory conduct to the position they would have enjoyed had there been no constitutional violation; (3) the interests of state and local authorities in managing their own affairs, consistent with the Constitution. 97 S.Ct. at 2757. With regard to the third point, the Court noted that:

Once involved, "the scope of a district court's equitable powers to remedy past wrongs is broad, for breadth and flexibility are inherent in equitable remedies." 97 S.Ct. at 2757, citing Swann v. Charlotte-Mecklenburg Board of Education, 402 U.S. 1 (1971) at 15.

Thus, while local authorities have the initial responsibility for dealing with a problem, the courts may become involved if local authorities fail to carry out their responsibilities.

In the present case the Court is asked to issue an order which will not only address the practices and conditions within the hospital which have resulted in patient harm and ineffective treatment, but to also order the creation of such programs and treatment services and settings, including programs and settings outside the hospital, as will remedy the damage caused Plaintiffs by Defendants' failures. It is most appropriate for this Court to fashion such an order. All three tests in Milliken are satisfied here. First, the constitutional violations presented in this case are of the most serious nature. Defendants have failed to protect Plaintiffs from harm and to provide effective treatment in the least restrictive setting while Plaintiffs were confined within Defendants' institution. As a result, Plaintiffs have suffered undue physical and mental deterioration, including an inability to cope with community

living. A remedial order designed to help Plaintiffs overcome the harm caused them and to help them adjust to life in the community again would thus be in order. Second, the goal of such an order would clearly be remedial in nature: to restore Plaintiffs to the position they would presently enjoy had they been properly cared for and treated. Third, Defendants have had ample opportunity to address the problem of hospital conditions and care, as well as the opportunity to assist patients who have regressed as a result of their hospitalization to overcome such negative effects. Defendants' efforts in this regard have either been non-existent or grossly inadequate.

It is proper for this Court not only to fashion an order which is remedial in nature, but to use great breadth and flexibility in designing the remedy. Alternatives less restrictive than hospital confinement, where appropriate to patients' needs, should be used in order to help patients overcome the negative effects of the WRPHC environment, so as to enable them to return to community living. Such remedial programs should be ordered for all patients presently at WRPHC and all patients who will be at WRPHC until such time as the inhumane conditions and care are brought up to constitutional standards.

D. Defendants Should Provide Post-Hospital Care and Services to All Discharged Patients Until Such Time as Needed to Prevent the Erosion of Therapeutic Benefits Gained in the Hospital.

Presently, because of the failure to protect Plaintiffs from harm and to provide effective treatment, the Defendants have a duty to provide remedial care and services to Plaintiffs, including care and services administered in a community setting. The improvements mandated by this Court as to hospital conditions and as to effective treatment programs should eventually result in the creation of a truly therapeutic mental health care system. Since the creation of such effective treatment programs will necessarily include treatment settings and programs outside the hospital environment, the question arises as to how long the Defendants' involvement with a patient must last once the patient is discharged from the hospital into a community treatment setting.

While the Defendants' responsibility to a discharged patient might not last indefinitely, Defendants' involvement should continue at least as long as needed to stabilize the patient within the community and to prevent erosion of

those benefits gained from the in-hospital therapy.¹⁵ This standard for Defendants' responsibility is derived from their duty to effectively treat patients and the idea that effective treatment must have as its goal the return of the patient to the community as quickly and as successfully as possible. Absence of post-hospital follow-up of a patient after a heart attack or an ulcer operation would be unthinkable. Absence of post-hospital care and treatment of a patient with a mental disorder should be just as unthinkable and should be enjoined by court order.

II. THE COURT SHOULD TAKE AN ACTIVE AND VIGOROUS ROLE IN CORRECTING ANY INHUMANE CONDITIONS AT WRPHC AS WELL AS INADEQUATE SERVICES PROVIDED BY DEFENDANTS.

The American Psychological Association urges the Court to take an active and vigorous role in correcting any inhumane conditions at WRPHC as well as the inadequate services provided by Defendants. The Court should not step lightly in acting to ensure that specific tasks are undertaken and objectives met. The Court should actively seek the advice and expertise of professionals knowledgeable in the area of improvement of coping skills as well as the treatment of mental disorders. Once received, however, the Court should move decisively and as independently as needed in order to bring an end to the tragic and needless destruction of human lives.

CONCLUSION

The American Psychological Association as amicus curiae, urges the Court to order the Defendants to provide Plaintiffs less restrictive settings appropriate to their individual treatment needs and to emphasize the development of effective social coping skills as a primary goal of treatment.

Respectfully submitted,

Sarah L. Baker

SARAH L. BAKER
Ohio Legal Rights Service
8 East Long Street - 5th Floor
Columbus, Ohio 43215
(614) 466-7264

ATTORNEY FOR AMICUS CURIAE