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AN EXAMINATION OF "RIGHT TO TREATMENT" STANDARDS: MENTAL HEALTH POLICY WITHIN THE CONTEXT OF THE STATE HOSPITAL SYSTEM

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ABSTRACT

This paper discusses the use of court-imposed standards for public mental hospitals as a method of improving public mental health services. The standards set out in Wyatt v. Stickney are examined, and the author concludes that if implemented nationally such standards would transform the public hospitals. In addition, implementation would alter the power structure of mental health workers, effect the allocation of state and federal funds, and influence the larger system of mental health services. Socio-economic characteristics of public mental hospital patients, and an assessment of present care in this system are presented as central issues in mental health policy and planning.

Introduction

Conditions in our nation's state hospitals* have been less than therapeutic since their establishment over a century ago. While most states report having standards and/or licensing for psychiatric facilities,[1] this cannot be taken as evidence of decent care: In 1969 Alabama reported having standards for the state mental hospitals, but the poor care and treatment received there has since been made public. Efforts by professional and lay organizations to fulfill standards which would provide adequate care and treatment have largely failed to transform the public hospitals.

Fifteen years ago the suggestion was made that adequate care and treatment of the mentally ill should be a constitutional right.[2] The grounds for such a right were developed through a number of legal actions and it was confirmed in an Alabama U.S. District Court case, Wyatt v. Stickney, in 1971.[3] In addition to declaring a constitutional right to treatment Federal Judge Frank Johnson Jr. mandated and defined adequate care and treatment. The standards set out in the Wyatt order of 1972[4] (hereinafter "the Wyatt standards") were the first such standards issued by a court, and by far the most comprehensive and ambitious set of standards issued by any body in this country. Previous standards did not approach the scope or authority of the Wyatt order. The Wyatt standards are not

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* "State hospitals," "public mental hospitals," or "public hospitals" in this paper refer to state and county hospitals for mentally ill adults.

only guiding the upgrading of services in Alabama,[5] but they serve as a model to other states struggling with the same issues.

This paper will examine the Wyatt standards as mental health policy. An overview of conditions in the public hospitals, the characteristics of the people who use them, and an analysis of the standards will be presented.

Assessing the quality of care in public hospitals

Since the beginnings of institutionalization for mental illness in the early 1800's, mental health professionals have generally agreed that outcome depends on certain factors including hospital size, staff-patient ratio, the opportunity for individual attention, and the hospital's psychological and physical environment. The most favorable outcome has been associated with hospitals no larger than one or two hundred beds where there is sufficient staff to give individualized treatment and where a comfortable, supportive environment exists.

Private hospitals* have aimed for these conditions with considerable success, while public hospitals have typically fallen far short of the ideal and in many cases have provided the antithesis of what was considered to be therapeutic care. This paper is limited to an examination of the public system of care; however, the existence of a dual system of care must be noted as a factor in standard setting and implementation. Events affecting public care occur within the larger framework of public and private systems. So long as a private system exists which provides adequate care and treatment (for those fortunate enough to have access to it) there may be little incentive for policy makers to convert the public system. The following discussion is presented with a recognition of this larger framework.

The majority of hospitalized mentally ill people in the country utilize public mental hospitals. There were 324 state and county hospitals in 1971 with about 340,000 inpatient residents at the end of the year. There were approximately 745,000 patient care episodes** in public hospitals in 1971.[6] Public hospitals are typically larger than what has traditionally been considered optimum:

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* "Private mental hospitals": operated privately by an individual, partnership, corporation, or non-profit organization; includes non-profit and for-profit hospitals.

** "Patient care episode" is a measure of utilization of facilities developed by N.I.M.H. "Patient care episodes are defined as the number of residents in inpatient facilities at the beginning of the year. . . . plus the total additions to these facilities during the year." (N.I.M.H. Utilization of Mental Health Facilities 1971. (Series B, No. 5) Dept. of Health, Education & Welfare: Washington, D.C. 1972, p. 2.)

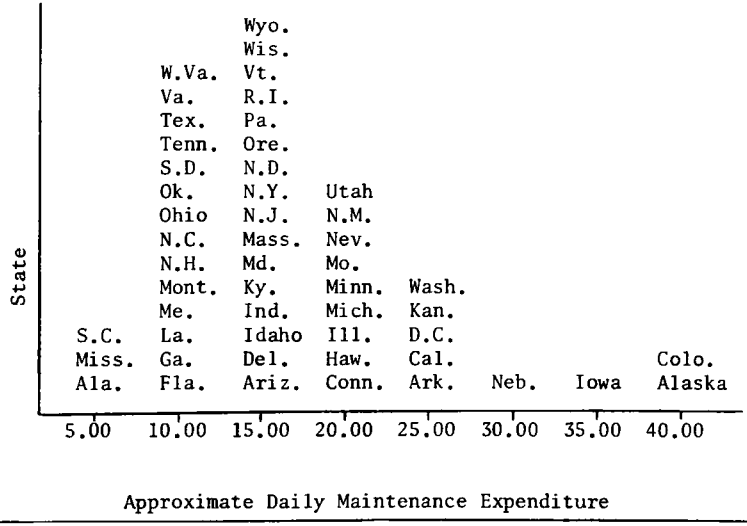
The number of residents per hospital ranged from a few hundred to over a thousand.[7] Gross overcrowding, a characteristic of public hospitals, has been reduced in recent years, but may still exist in some regions.

Staff size and composition, a critical component of care and treatment, has not been ideally determined. There is however general agreement regarding the numbers necessary to provide a minimum level of treatment, and it is generally agreed that the public hospital system falls short. Staffing patterns very widely: In 1974 the geographic region with the lowest staff-patient ratio had half the number of staff per patient population as the region with the highest ratio.[8]

Per diem costs, or "Daily Maintenance Expenditures per Resident Patient," can be one indication of the level of services offered in a hospital. Per diem costs include: clothing, room and board; all professional treatment including medical services and medication.

When Wyatt v. Stickney was initiated in 1970, the per diem cost in Alabama was $7.00 and the national average was $15.00.[9] Wyatt testimony and media coverage at that time revealed the gross neglect and destitute condition of patients in Alabama state hospitals. The following graph indicates that in 1970 fourteen states spent only about $5.00 per day more than Alabama, and sixteen spent about $10.00 more. Only four states spent $30.00 or more per day.

Figure 1.[10] Daily Maintenance Expenditures Per Resident Patient, State Hospitals (1970)

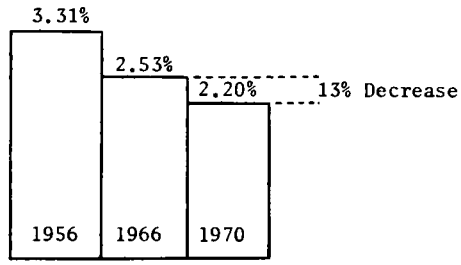


A general picture of the level of care in state hospitals can be inferred from this data.

In 1973, daily expenditures per patient ranged from $10.00 to $65.00, averaging $25.00. Twenty-four states exceeded the average--seven states spent $40.00 or more per day--and only three states (Mississippi, S. Carolina and W. Virginia) spent less than $15.00.[11]

Per patient expenditures in public hospitals have been steadily increasing, probably due to decreasing patient population,[12] increased salaries, and inflation. Despite this trend, the percentage of the total state expenditures which each state spends to maintain its public mental hospitals has decreased steadily since first measured in 1957. There has been an average decrease of 13% from 1966 to 1970:

Figure 2.[13] State Hospital Allocations As A Percent of Total General State Expenditures, U.S. Average.



While the 2.20% spent in 1970 represents more dollars than the 3.31% spent in 1956--approximately seven billion and three billion nationwide, respectively--the percentage increase in other categories (e.g., highways, education, utilities) has been much greater. It should be noted that the decrease in percentage spent on mental health has occurred at the same time as the expansion of services. Community services have been funded primarily by the federal government but required a gradually larger share from the states.

A final indicator in assessing care is mortality rate: in 1973 the mortality rate for public mental hospital patients was slightly over 7½%.[15] No comparable figures exist for private hospitals or institutions in general, but the mortality rate is slightly under 1% in the general population.[16] A possible explanation for the high rate in public hospitals is the poor medical attention resulting from 1) inadequate numbers of qualified medical personnel and 2) inability to give individual care due to staff shortages in general.[17]

Characteristics of public hospital patients

Utilization of state hospitals is similar to utilization of public psychiatric inpatient facilities in general as to socio-economic characteristics. In addition to state hospitals, public psychiatric inpatient facilities include Veterans Administration (VA) inpatient services, general hospitals, residential treatment centers for emotionally disturbed children, and Community Mental Health Centers (CMHCs). Where possible, data on state hospitals is presented separately; otherwise it is included in "all public inpatient services" data.

Public hospitals make up only 17% of all public inpatient services but account for about one third of admissions and about three quarters of resident patients in inpatient services.[18]

The most striking feature of the public hospital patient population is the racial composition. The majority of admissions are white--in 1969, 300,000 were white, 60,000 non-white.[19] However, the chart on admission rates to these hospitals (Figure 3. on following page) reveals that the non-white* rate is about one and a half times that of the white rate within each age group.

This disproportionate representation is consistent throughout public inpatient facilities (see Table A. on following page).

The disproportionate representation of non-whites in total admissions does not necessarily mean that the incidence of mental illness is higher among this group. The effect of racism on institutionalization rates, and studies of prevalence of mental illness in different racial groups,[22] suggests that race is not directly related to mental illness. Race may be related to hospitalization rates, as it is closely linked to socio-economic status. Further data reveals a close tie between hospitalization and socio-economic status.

Figure 4. (see page) illustrates marital status, sex and age characteristics of public hospital patients.

A survey of educational backgrounds of public hospital patients reveals the pattern shown in Figure 5. (see page).

Heads of "female-head" families are more likely to be hospitalized than heads of husband-wife families, and in general heads of families who are aged 18-24 have a higher admission rate than older "heads." Admission rates for persons from small families are highest, and decrease as family size increases. Adults living alone had higher admission rates than those living with friends or

*This term is loosely used in data collection and reporting, sometimes excluding Spanish-Americans and other minority groups, sometimes including them. It can be assumed that it gives a conservative estimate of minority representation.

Figure 3.[20] Admission Rates By Age, Sex, and Color, State Hospitals (1969).

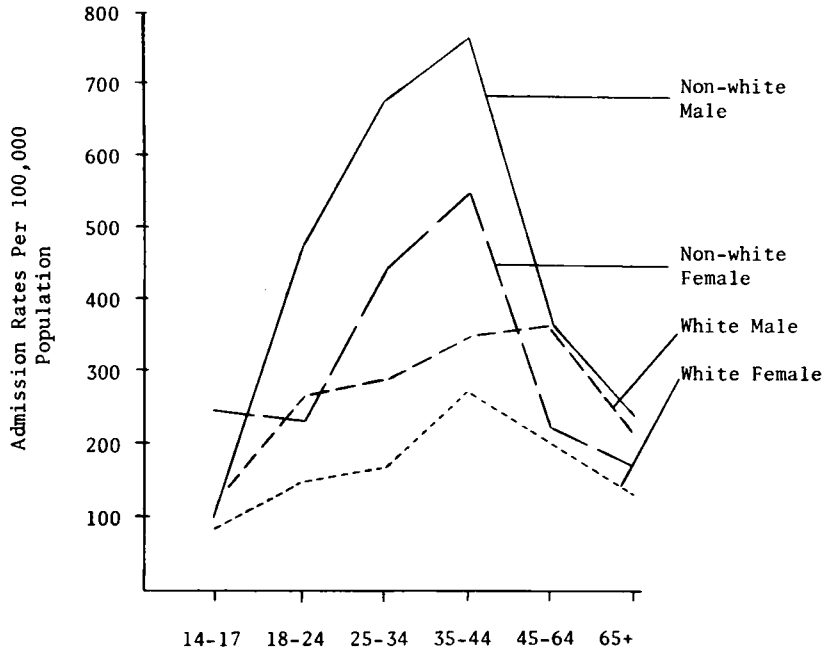


TABLE A.[21] Admission Rates Per 100,000 Population By Sex and Color, All Public Inpatient Services (1971).

	Admission Rates
White	362
Males	481
Females	248
Non-white	713
Males	930
Females	512

Figure 4.[23] Admission Rates Per 100,000 Population By Marital Status, Sex And Age, State Hospitals (1969).

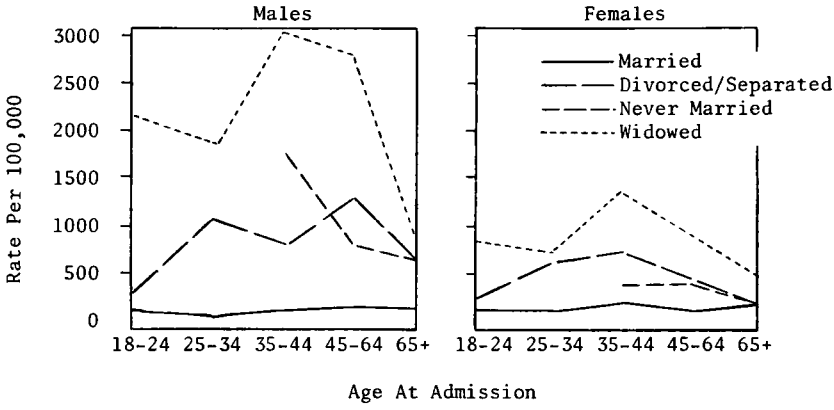
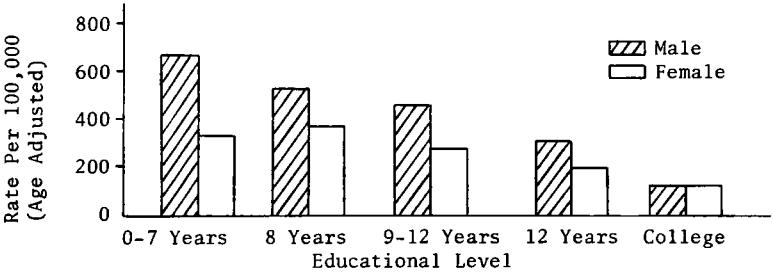


Figure 5.[24] Admission Rates Per 100,000 Population By Highest Grade Completed and Sex, State Hospitals (1969).



relatives.[25]

Diagnosis is not of itself a factor in conditions of care and treatment, although attitudes about a particular diagnostic label certainly can affect conditions. One third of all admissions to state hospitals are diagnosed Schizophrenic,[26] the most debilitating and "incurable" mental disorder.

In further regard to diagnoses, it was determined that over 1500 patients residing in Alabama state hospitals were geriatric patients who required no psychiatric treatment and should have been in nursing homes, and over 1000 patients were mentally retarded, requiring services not appropriate to the supposed purpose of mental hospitalization.[27] It is apparent that, regardless of diagnosis, some percentage of patients in public mental hospitals should not be there; that is, if the purpose of these hospitals is indeed to treat psychiatric disorders.

In summary, the data suggests that hospitalization for mental illness is closely related to race and socio-economic class. In their study of Social Class and Mental Illness, Hollingshead and Redlich have reported that of persons under treatment, both the incidence and prevalence of psychoses increases with each successively lower class.[28] They conclude that

> the excess of psychoses from the poorer area is a product of the life conditions entailed in the lower socio-economic strata of the society.[29]

However, since their sample consisted only of persons in treatment (representing only 5% of all persons needing treatment, according to the Mid-Manhattan study[30]) their conclusions apply only to people in treatment, and might more appropriately be stated thus: diagnosis and hospitalization for severe mental disorder is related to socio-economic status.

Noting that the admission rate for blacks has been double that of whites for at least forty years, NIMH suggests that the rates are affected by "the differential availability of mental health care, because of social and economic factors."[31] Private psychiatrists care for between 750,000 and 1,200,000 persons annually, yet the fact that almost 40% of public hospital admissions in 1969 reported no previous psychiatric care[32] supports the suggestion that public mental hospitals are the primary mental health facility for the lower classes.

Therefore, there exists a demonstrated--and widely recognized--need for change within the public mental hospital system and within the larger system of mental health care.

Possibilities for change prior to Wyatt

Although professionals and laymen were aware of the conditions in public hospitals, efforts to improve them have not been effective. Proposed standards--e.g., the American Psychiatric Association (APA)[33], the Joint Commission of Accreditation of Hospitals (JCAH)[34]--have had little effect on these generally impoverished hospitals: they could not meet standards so were not accredited; as a result they could not attract qualified staff, thus further lowering the quality of care. Exposes--such as Albert Deutch's classic The Shame of the States--and official reports alike changed conditions very little.

A major change, the large reduction in hospital populations in recent years, has been cited as an improvement. But community resources were not developed to meet the needs of these former patients and pre-release planning was often nil. The former patients were often worse off than when hospitalized because the communities where they were "placed" became more antagonistic toward them. The increased number of staff per patient in the hospital theoretically has benefitted the remaining population but without other improvements could scarcely transform the total system.

A second major change, the Community Mental Health Center (CMHC) movement, has no doubt affected conditions at the state hospitals, but indirectly and in a limited way. The CMHC Act--the most comprehensive federal intervention in mental health care to date--did not address the quality of care and treatment in state mental hospitals. As an alternative and preventative measure to extended care, the CMHC Act provided funding and guidelines to develop a community mental health system. Subsequent funding was granted for mental hospital programs which would "improve the quality of care and . . . provide in-service training for the personnel manning the institutions."[35] Also, as a result of the CMHC movement, hospital staffs were in some instances augmented by CMHC personnel and programs were supplemented by the establishment of CMHC units within the state hospital. These events tended to positively affect the conditions at the hospital, but were part of an effort directed at integrating hospital services into community services, not improving hospital conditions.

The CMHC Act sought to make treatment more available, earlier, and at low cost to consumers. This thrust has had considerable success according to NIMH figures: while the total number of patient care episodes has more than doubled in the past twenty years,

> state and county mental hospitals, which accounted for half of the patient care episodes in 1955, now account for only about a fifth of the yearly episodes . . . (whereas) outpatient psychiatric services . . . now account for the largest proportion of patient care episodes.[36]

However, data on persons utilizing CMHCs suggests that the hospitals and CMHCs serve slightly different groups of people: the educational level of hospital patients is lower, with only a small percentage completing high school[37] compared with about half of all CMHC clients completing high school;[38] male admission rates far outnumber female admissions to hospitals while the admission rates are about equal for men and women in CMHCs.

The enactment of Medicare and Medicaid also represented an attack on the quality of public mental health services, supposedly to upgrade services for the poor. But public mental patients under 65 were arbitrarily excluded from Medicaid benefits[39] and even patients over 65 couldn't receive benefits if the hospital in which they were "treated" didn't meet the standards set by Federal regulation. Medicare coverage is limited to 190 days--a lifetime maximum--for

psychiatric hospitalization, whereas other medical conditions may recur and be covered for each spell of illness.[40] These restrictions have served in many cases to perpetuate inadequate conditions, and have been cited as an example of racism on the part of the government due to the disproportionately high use of public hospitals by blacks.[41]

The Wyatt Standards

The Wyatt order defines adequate care and treatment as comprised of three areas: a humane psychological and physical environment; a certain number of qualified staff; and individual attention. The standards are divided into improvements in each of these three areas; in addition, the standards address what has been termed "sanism" by Morton Birnbaum, who first suggested "a right to treatment":

> Sanism is the irrational thinking, feeling and behavior patterns of response by an individual or by a society to the irrational--and too often, even to the rational behavior--of a mentally ill individual.[42]

Birnbaum emphasizes that sanism prevails no less among mental health professionals. It has been suggested that, universally,

> It is difficult to empathize with the mentally ill. It is unnatural . . . to share the feelings of someone who does not talk about the same subject at the end of a sentence as he did at the beginning, who sees and responds to things we do not see, whose mood, reason and very identity may change from moment to moment. These unfortunate people are uncanny, disconcerting, and inevitably alien to us. They invite rejection.[43]

Birnbaum observes that sanism is

> . . . An unnecessary and disabling oppressive burden that is added by our bigoted and prejudiced sanist society to the very real affliction of severe mental illness.[44]

The fact that the Wyatt standards are the only comprehensive and specific proposal with power to provide adequate care and treatment in the nearly two centuries of public care of the mentally ill supports Birnbaum's conclusions.

The Wyatt standards attack many specific manifestations of sanism that have persisted in public hospitals. Whether established for staff's convenience--e.g., the use of uniforms or communal garments for patients rather than personal clothing--or simply out of a sense of extreme indifference--e.g., the apparent assumption that mental patients don't care about their surroundings--many daily routines have degraded, restricted unnecessarily, exploited, and deprived patients. The Wyatt standards address these routines in Standards 1-20; entitled "Humane

Psychological and Physical Environment."

The Wyatt standards in general provide that any deviation from their provisions must be justified by the hospital staff and can only be of limited duration. For example, Standard 4 assures visitation rights

> except to the extent that the Qualified Mental Health Professional responsible for formulation of a particular patient's treatment plan writes an order imposing special restrictions. The written order must be renewed after each periodic review of the treatment plan if any restrictions are to be continued.

Standards 1-20 are briefly presented below:

1. Patients have a right to privacy and dignity.
2. Patients have a right to the least restrictive conditions necessary to achieve the purposes of commitment.
3. No person shall be deemed incompetent to manage his affairs . . . solely by reason of his admission or commitment to the hospital.
4. Patients shall have the same rights to visitation and telephone communications as patients at other public hospitals. . . .
5. Patients shall have an unrestricted right to send sealed mail. . . .
6. Patients have a right to be free from unnecessary or excessive medication. . . .
7. Patients have a right to be free from physical restraint and isolation. . . .
8. Patients shall have a right not to be subjected to experimental research. . . .
9. Patients have a right not to be subjected to treatment procedures such as lobotomy, electro-convulsive treatment, adversive reinforcement conditioning or other unusual or hazardous treatment. . . .
10. Patients have a right to receive prompt and adequate medical treatment. . . .
11. Patients have a right to wear their own clothes and to keep and use their own personal possessions. . . .
12. The hospital has an obligation to supply an adequate allowance of clothing to any patients who do not have suitable clothing of their own. . . . Such clothing shall be considered the patient's throughout his stay in the hospital.
13. The hospital shall make provision for the laundering of patient clothing.
14. Patients shall have a right to regular physical exercise several times a week.
15. Patients have a right to be outdoors at regular and frequent intervals. . . .
16. The right to religious worship shall be accorded to each patient who desires such opportunities. . . .

17. The institution shall provide, with adequate supervision, suitable opportunities for the patient's interaction with members of the opposite sex.

Standard 18 addresses the issue of institutional peonage, a longstanding concern of civil libertarians and many mental health workers. Institutional peonage can be defined as the uncompensated patient labor at a task which otherwise would have to be performed by a hospital employee, e.g., mopping floors, laundering clothes, etc. This labor has been defended as "therapeutic" or called "job training", and has been typically required of patients. When compensated, such work has been paid for in insufficient and degrading ways: a few cents an hour; extra cigarettes; special consideration for release; or privileged status.

Standard 18 defines the circumstances under which patient labor is appropriate, and sets out rules governing labor. The first rule sets the general limits:

> No patient shall be required to perform labor which involves the operation and maintenance of the hospital or for which the hospital is under contract with an outside organization. Privileges or release from the hospital shall not be conditioned upon the performance of labor covered by this provision. Patients may voluntarily engage in such labor if the labor is compensated in accordance with the minimum wage laws of the Fair Labor Standards Act. . . .

The second rule covers those tasks which might be deemed therapeutic; a third rule permits personal housekeeping activity; and the last rule states that payment for labor cannot be applied to hospital fees.

Standards 19 and 20 describe minimum physical facilities and nutrition which must be available to patients. Standard 19 covers various areas of patient life including sleeping quarters, lavatories, day rooms, etc., as well as the temperature and ventilation of these areas. Details such as "one tub or shower for each 15 patients" are set out, similar to JCAH standards. The overall goal of Standard 19 is that:

> facilities . . . designed to afford patients with comfort and safety, promote dignity, and ensure privacy . . . make a positive contribution to the efficient attainment of the treatment goals of the hospital.

Standard 20 states that "patients, except for the non-mobile, shall eat or be fed in dining rooms" and sets out minimum nutritional requirements.

Implementation of rights in Standards 1-20 would be very costly. (It should be noted that while most states recognize patients' rights in varying degrees,[45] implementation is not assured.) Standard 18 alone, governing patient labor,

would be enormously expensive: a Pennsylvania state official has stated that there is

> no justification for having patients work without compensation, however, institutions legitimately complain that lack of staff, lack of monies, primitive equipment and increasing admissions have necessitated patients to work.[46]

In Pennsylvania a lawsuit brought by patient-workers at various state hospitals has resulted in a consent decree specifying conditions of patient employment. In May 1974, when the lawsuit was filed, there were 6,000 patients in the state working 30 or more hours per week for little or no remuneration. By December 1974 there were 400 patient workers. Since patients are now permitted to work only 15 hours a week and must be paid at least the rate for handicapped workers, the economic effect of this legal action is indeed enormous.

The standards governing physical facilities--Standard 19--would also require large financial commitment. Most hospitals do not now provide the semi-private accomodations set out therein, and for many hospitals major renovations would be necessary to meet fire and safety requirements, maintain comfortable temperatures, and provide minimum numbers of bathroom facilities.

Some standards merely require changing hospital patterns (albeit not a simple undertaking) rather than large financial output: rights to privacy and dignity; visitation, telephone and mail use; the right to wear their own clothing; the right to be outdoors and have regular exercise; the right to interact with members of the opposite sex.

Other standards impinge on what has traditionally been defended by professionals as their exclusive domain: the use of medication (Standard 6), physical restraint (Standard 7), research (Standard 8), and treatments (Standard 9) such as lobotomy, shock, and aversive conditioning. The American Psychiatric Association, in their "Position Statement on the Question of Adequacy of Treatment" stated that "It is the responsibility of the physician to determine the appropriate treatment techniques to fit the individual patients' physical and psychological needs, assets and circumstances,"[47] and "The definition of treatment and the appraisal of its adequacy are matters for medical determination."[48] In an amicus brief filed with the Wyatt court regarding amendments to Section 9, the A.P.A. maintained this bias,[49] while other professional organizations expressed closer allegiance with Judge Johnson's intent.[50]

Standards 21-24 are entitled "Qualified Staff in Numbers Sufficient to Administer Adequate Treatment." Standard 21 requires that all professional staff meet state licensing and certification requirements. Standard 22 provides for "substantial orientation training" for non-professionals and on-going inservice training for all staff. Standard 23 requires supervision of non-professionals by professionals.

Standard 24 required the following minimum number of staff per 250 patients:

Classification	Number of Employees
Unit Director	1
Psychiatrist (3 years' residency training in psychiatry)	2
MD (Registered physicians)	4
Nurses (RN)	12
Licensed Practical Nurses	6
Aide III	6
Aide II	16
Aide I	70
Hospital Orderly	10
Clerk Stenographer II	3
Clerk Typist II	3
Unit Administrator	1
Administrative Clerk	1
Psychologist (Ph.D.) (doctoral degree from accredited program)	1
Psychologist (M.A.)	1
Psychologist (B.S.)	2
Social Worker (MSW) (from accredited program)	2
Social Worker (B.A.)	5
Patient Activity Therapist (M.S.)	1
Patient Activity Aide	10
Mental Health Technician	10
Dental Hygienist	1
Chaplain	.5
Vocational Rehabilitation Counselor	1
Mental Health Field Representative	1
Dietitian	1
Food Service Supervisor	1
Cook II	2
Cook I	3
Food Service Worker	15
Vehicle Driver	1
Housekeeper	10
Messenger	1
Maintenance Repairman	2

While the A P A , the J C A H and other standard-setting bodies have long recognized the correlation between number of staff and treatment success, they typically did not specify numbers because they recognized that minimum levels

would not be met. Instead they recommended "staff sufficient in number and skills to meet the needs of the patients and to achieve program goals."[51]

The Wyatt standards[52] would improve staff ratios in many states, although comparison with the U.S. average in selected categories indicates the following:

TABLE B.[53] Wyatt Staff Ratio Standards And State Hospital Staff Ratio, U.S. Average (1973).

	Wyatt	U.S. Average
Psychiatrists	1.4	2.4
Physicians (M.D.)	2.8	1.2
Psychologists	2.8	1.3
Social Workers	4.9	2.8
Registered Nurses	8.4	7.1

Wyatt proposes about half the number of psychiatrists as are now on staff: the number of R.N.s would increase slightly; the number of social workers would be increased by about two-fifths; the largest increase would be more than double the number of M.D.s and psychologists now on staff.

A breakdown of the U.S. average reveals a wide range of professional staff ratio, between geographic regions and within geographic regions. The highest-staffed region is compared below to the lowest-staffed region, with the range within each region also presented:

TABLE C.[54] Staff Ratio Range: Highest and Lowest Staffed Regions

	Highest Staffed Region			Lowest Staffed Region		
		Highest	Lowest		Highest	Lowest
	Region VIII	Iowa	Neb.	Region IV	Ky.	S.C.
Psychiatrists	5.9	10.6	6.7	1.0	1.4	1.1
Physicians	1.7	2.8	1.5	1.0	1.7	1.2
Psychologists	2.7	4.0	4.5	1.0	0.6	0.8
Social Workers	6.7	9.4	5.5	1.8	3.6	1.6
Registered Nurses	10.7	14.2	19.2	3.8	6.2	3.3

The range within each professional category nationwide reveals a wide disparity, the lowest existing ratio in each category being far below Wyatt, the

highest far above except for M.D.s.

TABLE D.[55] Staff Ratio Range: Highest and Lowest State In Each Staff Category.

	Wyatt	Highest Ratio	Lowest Ratio
Psychiatrists	1.4	14.3 (Colo.)	0.1 (Ala.)
Physicians	2.8	2.5 (Ariz.)	0.4 (Nev.; Haw.)
Psychologists	2.8	7.5 (Colo.)	0.3 (Miss.)
Social Workers	4.9	9.4 (Iowa)	0.7 (Miss.)
Registered Nurses	8.4	30.0 (Alas.)	3.3 (Miss.)

The magnitude of the task of meeting Wyatt staffing standards is illustrated through a comparison of Minnesota and Mississippi:

TABLE E.[56] Population, Cost, Staff: Mississippi and Minnesota.

	Miss.	Minn.
Number of Patients Under Care (1974)	10,524	13,590
Average Daily Census	4,181	4,229
Annual Number of Patient Days	1,526,045	1,543,604
Daily Expenditures Per Resident Patient	$9.99	$23.52
Full Time Equivalent Inpatient Staff	2,165	3,488

TABLE F.[57] Staff Ratio: Mississippi and Minnesota.

	Wyatt	Miss.	Minn.
Psychiatrists	1.4	0.5	0.6
Physicians	2.8	0.5	1.8
Psychologists	2.8	0.3	1.0
Social Workers	4.9	0.7	2.9
Registered Nurses	8.4	1.4	9.8

Minnesota is close to the national average ($25) in daily expenditures per resident patient, yet has about half the recommended staff ratio except for nurses. Therefore it can be conjectured that the majority of states--which spend $15.00 to $30.00 per day--would have to increase staff. That the size of increase would be substantial is indicated by comparing Minnesota to Mississippi. Though they

serve about the same number of patients, Mississippi has 1,300 less professional staff and is considerably lower than Minnesota in staff-patient ratio. Apparently, Mississippi would have to hire 1,300 new professional staff just to reach Minnesota's staffing level. Since Minnesota's staffing level is itself considerably lower than Wyatt standards (except for nurses) and would have to increase its staff as well, it is evident that thousands of additional professional personnel alone would be required to meet Wyatt standards nationwide.

Standards 25-34, "Individualized Treatment Plans," seek not only to prevent the mass treatment which has often resulted in institutionalization and neglect, but also to assure accountability for each patient. Prompt and appropriate treatment are mandated for hospital and post-hospital care, and documentation and approval is required at every step. This would entail not only increased staff and services, but decreased professional autonomy as discussed above.

Judge Johnson stipulated that upon admission the patient and her family receive a written copy of the standards, and that a copy be posted on each ward. The Court also established seven-member "human rights committees" at each state hospital and appointed the members. The Committees are responsible for reviewing research proposals and rehabilitation programs "to ensure that the dignity and the human rights of patients are preserved." The committee is also charged with assisting patients who "allege that their legal rights have been infringed or that the Mental Health Board has failed to comply with judicially ordered guidelines."

The Wyatt standards apply primarily to inpatient psychiatric services. They recognize the need for after-care (Standard 34) and continuity (Standards 26 & 27), but are limited to hospitals and do not address community care. However, Wyatt does attack practices stemming from the fact of hospitalization: even after release from the hospital, former mental patients are frequently arbitrarily restricted in many activities. Wyatt states that

> No person shall be deemed incompetent to manage his affairs, to contract, to hold professional or occupational or vehicle operator's licenses, to marry and obtain a divorce, to register and vote, or to make a will solely by reason of his admission or commitment to the hospital. (Standard 3)

Implementation would afford former mental patients greater status and greater access to goods and services.

Effects of the Wyatt Standards

The fundamental concept of adequate care and treatment established by the Wyatt standards is hardly new: humanitarians since the early 1800's have recognized the necessity of a humane psychological and physical environment, a large proportion of staff to patients, and individualized care in treating mental

illness. Private mental hospitals are modeled on this concept of treatment. Public mental hospitals, however, operating at the lowest possible cost, have provided the bare minimum in surroundings and staff, and individualized treatment is impossible under those conditions.

Prevailing attitudes toward a particular group of people are an important dynamic in policy development and implementation. Unfortunately, patients in public mental hospitals suffer doubly; discriminated against on the basis of their affliction or label, and subject to further discrimination on the basis of their racial and socio-economic backgrounds.

It appears, through the failure of previous standard-setting efforts, that adequate care and treatment in public mental hospitals can only be assured through Federal judicial and/or legislative decisions. For instance, even though Alabama has vigorously opposed compliance with Wyatt standards,[58] many changes including a substantial increase in daily maintenance expenditures[59] have occurred as a result of Federal intervention. The former Alabama mental health commissioner has stated that

> The tradition of appealing to the Constitution to expand narrow conceptions of civil rights . . . still may be the last hope of mental patients and their caregivers, against what remains in most states as continuing neglect and absurd funding priorities set by state governments.[60]

There is no doubt that national implementation of the Wyatt or similar standards would drastically change the public mental hospital system. They would alter the power structure of mental health workers and the pattern of labor distribution, effect the federal and state distribution of economic resources, and influence the role of the public hospital in mental health services.

It is feasible that a shift or redistribution of power could occur in two ways: First, as increased decision-making is given to patients, Human Rights Committees, Technical Committees, Review Committees, in-hospital legal staff, ombudsmen, etc., the mental health professional's realm of authority is reduced and their decisions subject to review and veto. Since psychiatrists have traditionally hoarded power in the hospitals, Wyatt standards could result in a greater interdependence among all staff, i.e., power once held by psychiatrists being shared by all disciplines and levels. Wyatt speaks of "mental health professional" and does not single out psychiatrists as the ultimate authority.

Second, new careers and directions may emerge: if there simply are not enough professionals available and/or willing to enable public hospitals to meet the staffing standards, there could result a strong push for paraprofessional training and utilization, and a real evaluation of this kind of contribution. This would not only result in a different staffing pattern but would open up jobs and career opportunities for non-professional staff, resulting in a change in

their status and economic situation as well. In addition or alternatively, a scarcity of professionals for public hospital positions might prompt professional training programs to re-examine their concept of service; perhaps professional care would begin to be regarded more as a national rather than a regional or otherwise restricted resource.

These possibilities exist despite the status quo stance of Wyatt in this area. The Wyatt order

> unintentionally caters to the prestige interests of medical and mental health professionals, few of whom have any interest in state hospitals anyway.[61]

Current funding on both federal and state levels would have to change in order to implement Wyatt standards. It is difficult to compare existing N.I.M.H. data on public hospital staffing with the Wyatt standards in order to determine the gap between current services and adequate services. However, it seems a reasonable estimate based on existing data that the vast majority of state and county hospitals would fall below minimum standards in some areas, and perhaps half of the hospitals would have to undertake major staffing recruitment and building renovation programs to comply. In Alabama, the state immediately had to raise a $2 million bond to correct fire hazards and hire an initial 500 employees in order to avoid court appointment of a master to oversee compliance with standards.[62]

Would the Wyatt standards eliminate or reduce the disparity between public and private hospitals? Fully implemented, they would dramatically improve the public hospitals but they would not close the gap in at least two areas: staff to patient ratio and hospital size. Since private hospitals now employ five times the number of professionals per 1,000 patients as public hospitals[63] and the Wyatt standards would primarily raise the lower-staffed public hospitals to the level of the higher-staffed public hospitals, the gap would remain.

The Wyatt standards attempt to affect the quality of life as well as availability of treatment staff: privacy, pleasant and stimulating surroundings, and adequate space are all included, but the standards are applied to existing facilities--large institutional buildings, relics of "warehousing" policies, located far from the community they serve. Wyatt takes no position regarding the size of the facility although this factor has long been recognized as crucial to treatment outcome.

Aims of Hospitalization

Further evaluation of Wyatt standards--or any policy regarding public mental hospitals--is based on the long and short term aims of hospitalization; the role of the hospital itself and the purpose of "care and treatment" in the hospital.

The status of the public mental hospital was uncertain during the first years of the CMHC movement, but seems to be generally regarded now as a necessary component in a comprehensive system. Considerable research has been done on how the state hospital can be made relevant and effective. Acceptance of the hospital is by no means unanimous: a number of groups advocate dismantling the system, and some states are moving in that direction.[64] National implementation of the Wyatt standards could terminate this debate: the mobilization of funds, labor, renovations, etc., necessary to convert the nations hospitals into treatment facilities would not only firmly establish them but may alter the direction of future planning for mental health services. A recent article regarding the Wyatt standards noted that:

> Its reordering of state fiscal and policy priorities to meet pressing needs in mental health has been appropriately hailed as an important legal precedent; its focus, however, is exclusively on the allocation and expenditure of state funds for mental health institutions. Given finite resources for mental health services, this emphasis is inconsistent with the general shift toward community-based mental health programs.[65]

The author recommends the application of Wyatt standards with appropriate modification to all mental health services as a way to "prevent the diversion of funds and resources from community mental health programs, and accomodate and promote alternatives to institutional residential care."[66]

Apropo of this issue, Judge Johnson introduced a very important treatment goal as a constitutional right in Standard 2: "the least restrictive conditions necessary to achieve the purposes of commitment." This concept has thus far not been defined, but has attracted the attention of mental health planners and lawyers active in patients rights. The implementation of this standard would cut to the core in the present contest between the public mental hospitals and CMHCs for funds and other resources.

Finally, serious consideration must be given to the dynamics determining hospitalization. Two divergent approaches to the phenomenon seem apparent: one is based on the assumption that hospitalization* is a necessary consequence of a medical/psychological condition; the other is based on the assumption that hospitalization is a consequence of a sociological condition.

According to the first approach a person is hospitalized in order to be treated for the medical/psychological condition and it is expected that hospital treatment will improve or even cure the condition. Within this "medical" framework, the racial and socio-economic characteristics of public hospital patients might be explained by pointing to the increased risk to health and mental health

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* "Hospitalization" is distinguished from "mental illness."

entailed by poverty conditions and severe emotional stress experienced by non-white and poor groups in this culture.[67]

According to the second approach to the phenomenon of hospitalization, a person is hospitalized primarily as a result of racial and/or socio-economic characteristics. The homogeneity of public hospital patients in this regard may result from a tendency to institutionalize certain groups: the former mental health commissioner of Alabama has stated that

> In Alabama, curiously, the counties that send the most patients to state hospitals are usually the same ones that send the most criminals to the state prisons. The decision about which asylum the aberrant citizen will reside in is frequently a toss-up. Demographic profiles of populations hiding out in state hospitals and in state prisons would show important properties in common: low socioeconomic, educational, and vocational levels; . . .[68]

It may be that non-institutional mental health services are not available to this group, at least not to the extent that services are available to other groups. Regardless of orientation--medical or social--policy makers cannot escape the social component of public hospital use. Yet policies have been made and implemented as if hospitalization were a purely medical decision and in fact as if hospitalization were proven to be necessary and beneficial for all those hospitalized.*

Mental health knowledge is limited particularly regarding psychosis, and current treatment of mental disorders can best be characterized as an ongoing experiment. Bruce Ennis addressed this point in the following statement regarding standards:

> Adding more psychiatrists to mental hospital staffs may confer the aura of adequate treatment, but not necessarily the substance. Perhaps it would be wiser to utilize resources for basic empirical research into the "causes" of mental illness. Only by learning more about what mental illness is can we intelligently determine which types of treatment are adequate.[69]

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* The Wyatt opinion does not challenge the medical definition of mental illness; however, diagnosis is as dependent on social, cultural, political, and economic factors as is hospitalization. For a discussion of social and medical components in the process of diagnosis, see Peter Sedgwick, "Illness-Mental and Otherwise" and Robert M. Veatch, "The Medical Model: Its Nature & Problems" in The Hastings Center Studies, Vol. 1, No. 3, 1973. A political and economic analysis of hospitalization is presented in Michael Foucault's Madness and Civilization (New York: Random House, 1973), and Andrew Scull's Decarceration: A Radical View (forthcoming book, Prentiss-Hall).

Mental health professionals have not demonstrated that hospitalization is beneficial and in fact some data and studies suggest that hospitalization is detrimental. David Rothman proposes the following:

> Enough energy has already been spent on tinkering with institutional programs for the deviant. Let us instead cast out new nets, try to devise programs not because we see the prospect of ultimate cure but because we acknowledge our ignorance and think we may be able to devise better strategies for coping with it.[70]

The conditions in public mental hospitals need attention: full implementation of standards such as Wyatt would unquestionably improve conditions for hospitalized patients. However, implementation would also push mental health services in a direction which may not be desired. Thoughtful policy planning in the area of standards is necessary if this country hopes to finally eliminate "the shame of the states."

FOOTNOTES

1. The American Psychiatric Association (APA), Standards for Psychiatric Facilities (Wash., D.C.: APA, 1969), p. 90.
2. Birnbaum, M., "The Right to Treatment," Bar Association Journal 46: 499, (1960).
3. Wyatt v. Stickney, 325 F. Supp. 781 (1971).
4. Wyatt v. Stickney, 344 F. Supp. 373, 387 (1972).
5. Mental Health Law Project (MHLP), Basic Rights of the Mentally Handicapped (Wash., D.C.: MHLP, 1973), pp. 18, 26.
6. National Institute of Mental Health (NIMH), Utilization of Mental Health Facilities 1971 (Series B, No. 5) (Wash., D.C.: Dept. of Health, Education and Welfare (DHEW), 1972), p. 20.
7. NIMH, Statistical Note 106 (Wash., D.C.: DHEW, 1974), p. 4-6.
8. NIMH, Statistical Note 109 (Wash., D.C.: DHEW, 1974), p. 2.
9. NIMH, Statistical Note 106, op. cit., pp. 19-21.
10. Ibid.
11. Ibid., p. 10.
12. Ibid., p. 15, 16.
13. Joint Information Service (JIS), Eleven Indices (Wash., D.C.: JIS, 1971), pp. 22, 23.
14. Bureau of the Census, The 1975 Fact Book: The American Almanac (Wash., D.C.: Dept. of Commerce, 1974), p. 246.
15. NIMH, Statistical Note 106, p. 7.
16. Bureau of the Census, op. cit., p. 51.
17. Furman, M., Conners, J., "The Pa. Experiment in Due Process," Duquesne Law Review, Vol. 8, No. 1 (1969 - 70), pp. 46 - 48.
18. NIMH, Utilization..., op. cit., p. 4.
19. NIMH, Socio-Economic Characteristics of Admissions to Inpatient Services of State and County Mental Hospitals, 1969 (Series A, No. 8) (Wash., D.C.: DHEW,

1971), p. 17.

20. Ibid., p. 6.

21. NIMH, Utilization..., op. cit., p. 25.

22. Kramer, M., Rosen, B., Willis, E. Racism in Mental Health (Pittsburgh: U. of P. Press, 1973), pp. 375 - 379.

23. NIMH, Socio-Economic..., op. cit., p. 8.

24. Ibid., p. 9.

25. Ibid., pp. 2 - 10.

26. 1972 data: NIMH, Statistical Note 111 (Wash., D.C.: DHEW, 1974), p. 8.

27. See Wyatt v. Stickney (1971), op. cit.

28. Hollingshead, A., Redlich, F., Social Class and Mental Illness (N.Y.: J. Wiley & Sons, Inc., 1958), p. 235.

29. Ibid., p. 242.

30. Srole, L., et. al., Mental Health in the Metropolis: The Midtown Manhattan Study (N.Y.: Harper & Row, 1975), p. 209.

31. NIMH, Socio-Economic..., op. cit., p. 7.

32. Ibid., p. 11.

33. APA, op. cit.

34. Joint Commission of Accreditation of Hospitals (JCAH), Accreditation Manual for Psychiatric Facilities (Chicago: JCAH, 1972).

35. Schulberg, H., Baker F., The Mental Hospital and Human Services (N.Y.: Behavioral Publications, 1975), p. 24.

36. NIMH, Utilization..., op. cit., p. 16.

37. See Text, above, for source of hospital data.

38. NIMH, State and Regional Data: Federally Funded Community Mental Health Centers, 1972 (Wash., D.C.: DHEW, 1974) See pp. 15 - 17 for data on CMHC.

39. Greenfield, M., Medicare and Medicaid: the 1965 and 1967 Social Security Amendments (Berkeley: U. of C., 1968), p. 110.

40. Ibid., pp. 4 - 5.

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43. Ibid., p. 108.

44. Ibid., p. 106.

45. Ennis, B., Siegal L., The Rights of Mental Patients (N.Y.: Discus/Avon Books, 1973).

46. Roth, B., "Elimination of Peonage", New Mandate (Pa. Dept. of Public Welfare), Vol. II, No. 4 (Feb., 1975), p. 7.

47. APA, op. cit., p. 103.

48. Ibid., p. 102.

49. "Amici Curiae Memorandum in Support of their Proposed Revision of Standard Nine", Wyatt v. Hardin (1974), pp. 6 - 8. Available from MHLP.

50. "Proposed Revision of Standard Nine", Wyatt v. Hardin (1974). Available from MHLP.

51. JCAH, op. cit., p. 41.

52. The Wyatt ratios were converted by the author, for comparison, to "average full time equivalent staff per 1,000 patient days" used by NIMH. Based on national averages (see Statistical Note 106, op. cit.) it was estimated that a 250 patient unit would average 200 patients on a daily basis. See Statistical Note 109, op. cit., p. 36, for formula.

53. See above and Statistical Note 109, op. cit., pp. 4 - 34.

54. Ibid.

55. Ibid.

56. Ibid.

57. Ibid.

58. Stickney, S. "Problems in Implementing the Right to Treatment in Alabama: The Wyatt v. Stickney case," Hosp. & Comm. Psychiatry, Vol. 25. No. 7 (July 1974), p. 456.

59. NIMH, Statistical Note 106, op. cit., p. 19. See also MHLP, Basic Rights..., op. cit., pp. 18 - 26.

60. Stickney, p. 460.

61. Ibid., p. 458.

62. American Civil Liberties Union, "The First Landmark: Mental Patients' Rights," Civil Liberties, No. 289 (Sept. 1972).

63. NIMH, Private Mental Hospitals (Series A, No. 10) (Wash., D.C.: DHEW, 1972), p. 11.

64. See, e.g., "Mass Study Proposes Phase-Out of State Mental Hospitals," Hospital & Comm. Psychiatry, Vol. 25, No. 7 (July 1974), p. 492.

65. Kaplan, H., "Institutions and Community Mental Health: the Paradox in Wyatt v. Stickney," Comm. Mental Health Journal, Vol. 9, No. 1 (1973), p. 36.

66. Ibid., p. 37.

67. See, e.g., NIMH, Schizophrenia: Is there an answer? (Wash., D.C.: DHEW, 1973).

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69. Ennis, B., "Civil Liberties and Mental Illness," Crim. Law Bulletin, Vol. 7, No. 2, p. 125.

70. Rothman, D., "Prisons: The Failure Model," The Nation (Dec. 21, 1974), p. 658.