The Right to Effective Mental Treatment

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Within the past several years there has been increasing recognition of a right to treatment for mentally disabled persons who are involuntarily committed to mental health facilities. This right, first suggested by Birnbaum[1] and Kittrie,[2] is based upon the notion that if patients are confined for the purpose of treatment, treatment should in fact be provided. As noted by Judge Bazelon in *Rouse v. Cameron*, "Absent treatment, the hospital is 'transform[ed] . . . into a penitentiary where one could be held indefinitely for no convicted offense.' "[3]

Since the *Rouse* decision in 1966, there has been considerable support for the right to treatment among legal commentators.[4] Some courts have based this right upon such theories as due process,[5] equal protection,[6] and the avoidance of cruel and unusual punishment.[7] In

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1. Birnbaum, *The Right to Treatment*, 46 A.B.A.J. 499 (1960).

2. Kittrie, *Compulsory Mental Treatment and the Requirements of "Due Process"*, 21 OHIO ST. L.J. 28, 51 (1960).

3. 373 F.2d 451, 453 (D.C. Cir. 1966).

4. *See generally* Bassiouni, *The Right of the Mentally Ill to Cure and Treatment: Medical Due Process*, 15 DE PAUL L. REV. 291 (1965); Drake, *Enforcing the Right to Treatment*, 10 AM. CRIM. L. REV. 587 (1972); Goodman, *Right to Treatment: The Responsibility of the Courts*, in THE RIGHT TO TREATMENT (D. Burris ed. 1969); Klaber, *Persons in Need of Supervision: Is There a Constitutional Right to Treatment?* 39 BROOKLYN L. REV. 624 (1973); Note, *Civil Restraint, Mental Illness, and the Right to Treatment*, 77 YALE L.J. 87 (1967); Note, *Conditioning and Other Technologies Used to "Treat?" "Rehabilitate?" "Demolish?" Prisoners and Mental Patients*, 45 S. CAL. L. REV. 616 (1972); Note, *Wyatt v. Stickney and the Right of Civilly Committed Mental Patients to Adequate Treatment*, 86 HARV. L. REV. 1282 (1973).

5. *See, e.g.*, Wyatt v. Stickney, 325 F. Supp. 781 (M.D. Ala. 1971), *enforced in* 334 F. Supp. 373 (M.D. Ala. 1972), *appeal docketed sub nom.* Wyatt v. Aderholt, No. 72-2634, 5th Cir., Aug. 1, 1972; Donaldson v. O'Connor, No. 73-1843, 5th Cir., April 26, 1974; Nason v. Superintendent of Bridgewater State Hosp., 353 Mass. 604, 233 N.E.2d 908 (1968); *In re* Maddox, 351 Mich. 358, 88 N.W.2d 470 (1958). *See also*, Martarella v. Kelley, 349 F. Supp. 575 (S.D.N.Y. 1972).

6. *See, e.g., In re* Anonymous, 69 Misc. 2d 181, 329 N.Y.S.2d 542 (Sup. Ct. 1972).

7. *See* People *ex rel.* Kaganovitch v. Wilkins, 23 App. Div. 2d 178, 259 N.Y.S.2d 462 (1965); Martarella v. Kelley, 349 F. Supp. 575 (S.D.N.Y. 1972).

a few instances, however, courts have been reluctant to find a right to treatment; these decisions have expressed concern about the justiciability of the issue, based on an assumed difficulty in assessing the nature or quality of psychiatric care.[8]

It is understandable that courts eschew evaluating the relative desirability of various types of treatment, for this area is clearly not one of high judicial competence. But if a court assumes that such an evaluation is necessary for judicial review of the adequacy of treatment provided to patients, the court may very well decide that the issue is not justiciable. This result, which is neither necessary nor desirable, has come about through courts' and attorneys' failure to recognize a distinction between the appropriateness of various individual treatment modalities and the effectiveness of treatment generally. The central issue is the end product of treatment intervention, not the relative appropriateness of one treatment as opposed to another. The courts, then, should simply ask whether the treatment to which the patients have been subjected actually changes the behavior which led to their commitment. Their focus should be on outcome and results.[9]

Although courts and commentators frequently use the term "adequate" to describe the standard of treatment legally required for involuntarily committed patients, many other standards of treatment have also been mentioned. Among them are "permissible,"[10] "appropriate,"[11] and "responsible" treatment.[12] But treatment is not permissible, appropriate, or responsible unless it produces results compatible with the

8. *E.g.*, Burnham v. Dep't of Pub. Health, 349 F. Supp. 1335 (N.D. Ga. 1972), *appeal docketed*, No. 72-3110, 5th Cir., Aug. 4, 1972.

9. This analysis, of course, reflects the purposes inherent in the administration of involuntary commitment. It is implicit here that the primary objective of the involuntary commitment of mental patients is not their continued confinement or even their continued treatment, but rather their eventual, safe release into the community.

Of course another purpose may be to prevent patients from harming themselves or others. *Cf.*, Hodges, *Crime Prevention by the Indeterminate Sentence Law*, 128 AM. J. PSYCHIATRY 291 (1971). If the purpose of confinement is preventive detention, then this objective should be made explicit and subject to professional scrutiny, and not be disguised under the "treatment" rubric. The legality of preventive detection is not discussed herein; to the extent that the prevention of harm to patients or society justifies involuntary commitment, the protections of due process, as exemplified in criminal commitment proceedings, should serve to protect the individual's interest in freedom from wrongful incarceration. This Article addresses the test for justifying continued commitment to the extent that its rationale is the provision of treatment to mental patients. Of course, insofar as courts have required mental treatment to be afforded to those incarcerated for their own or society's protection, the upcoming analysis applies to that context as well.

10. *See, e.g., In re* Jones, 338 F. Supp. 428, 430 (D.D.C. 1972).

11. *See, e.g., In re* Clatterbuck v. Harris, 295 F. Supp. 84, 86 (D.D.C. 1968).

12. Note, *Civil Restraint, Mental Illness, and the Right to Treatment*, 77 YALE L.J. 87, 105 (1967).

purpose of its application, namely the change of patient behavior.[13] *Wyatt v. Stickney* requires that each patient be given a "realistic opportunity to be cured or to improve . . . ."[14] In other words, treatment must effectively change patient behavior to be legally adequate.

The need to provide effective treatment to civilly committed patients was alluded to by Justice Marshall in *Powell v. Texas*.[15] He noted that while penal incarceration for petty offenses such as public drunkenness is of fairly short, fixed duration, involuntary civil commitment typically lasts until one is "cured," and concluded that the classification of public drunkenness as an illness rather than an offense "might subject indigent alcoholics to the risk that they may be locked up for an indefinite period of time under the same conditions as before, with no more hope than before of receiving effective treatment and no prospect of periodic 'freedom.' "[16]

As this Article will demonstrate, Justice Marshall's caution is well-founded, because while the indefinite civil commitment of patients is premised upon an assumption that treatment can produce changes in behavior, evidence of effectiveness is lacking.

Although there appears to be a widely prevalent assumption among legislatures and courts that psychotherapeutic treatment as it is customarily practiced in institutions is generally effective in changing behavior, the available research data do not support this conclusion. If the state is providing ineffective treatment, it is engaged in an activity which should not be forced upon an unwilling, involuntarily committed patient. Furthermore, if the objective of involuntary commitment is to change the behavior of patients through treatment so that they may be safely released, then treatment which does not effectively change behavior undermines the entire operation of the commitment procedure and subverts the state's purpose. The end result is an exercise in futility with intolerable costs in personal freedom.

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13. This analysis presumes that the only valid goal in the treatment of a patient who has been committed involuntarily, either because he has committed a crime or because he has done other acts which endangered himself or others, is modification of his behavior. The science of psychiatry rightfully pursues other ends, such as aiding an individual to understand his motivations and thereby progress more effectively toward his life goals. Such ends, however, are appropriate to a voluntary relationship between an individual and his mental health professional, and cannot be justifiably thrust on the patient as a result of his encounter with the criminal law or with involuntary civil commitment. It is for this reason that this Article considers behavior modification the proper end of psychiatric intervention, and the outcome test is its proper measure.

14. 344 F. Supp. 373, 374 (M.D. Ala. 1972). *See also* Commonwealth v. Page, 339 Mass. 313, 159 N.E.2d 82 (1959); *In re* Clatterbuck v. Harris, 295 F. Supp. 84, 86 (D.D.C. 1968).

15. 392 U.S. 514 (1968) (separate opinion).

16. *Id.* at 529.

This Article attempts to explain how use of the outcome measure, or test, of effective treatment can alleviate these problems inherent in involuntary commitment. After examining the nature of an outcome measure and the questionable effeetiveness of traditional psychotherapy as typically practiced in mental institutions, the final section will consider some further implications of the outcome approach which arise from analogies with tort and contract law.

I

OUTCOME AS THE PRIMARY MEASURE OF TREATMENT EFFECTIVENESS

Traditionally three methods have been used to assess the adequacy of medical treatment (of which, of course, psychiatric treatment is a branch). One method involves a structural approach which uses criteria such as staff-patient ratios, institutional size, or per capita costs to measure treatment adequacy.[17] This is the most commonly used approach, perhaps because it is the easiest to apply.

The second major method involves a process approach where the emphasis is upon the process of treatment delivery. An assessment is made of how often or how well patients are treated by use of treatment plans, detailed records of treatment, and periodic review of patient records. One example of this approach is the "medical audit," commonly used in general medical hospitals but seldom in mental hospitals. The medical audit involves the evaluation of patient records according to a predetermined list of elements of care. These elements are usually determined by the hospital or by an outside group of experts by reference to generally accepted standards of practice.[18] An essential feature of the medical audit is the compilation from patient records of information which can be used to assess ongoing treatment practices. This information is rarely available regarding treatment provided in mental hospital settings; even when it is available, it often raises doubts about the amount of treatment actually provided. For example, through the use of a computerized record system in Missouri, it was found that the average patient in the state mental hospitals spent 14.63 hours per week in conventional forms of individual or group therapy.[19] But when this figure is adjusted to eliminate such treatment

17. A more detailed discussion of this and the other approaches to assessing treatment can be found in Schwitzgebel, *Right to Treatment for the Mentally Disabled: The Need for Realistic Standards and Objective Criteria*, 8 HARV. CIV. RTS. - CIV. LIB. L. REV. 513 (1973) [hereinafter cited as Schwitzgebel].

18. For a more extended discussion of the medical audit process, see Waldman, *The Medical Audit Study—A Tool for Quality Control*, 54 HOSPITAL PROGRESS 82 (1973).

19. Evenson, Nieuwenhnizen, Sletten & Cho, *A Computerized Survey of Treatments Used in Missouri Institutions*, 24 HOSPITAL AND COMMUNITY PSYCHIATRY 23 (1973)[hereinafter cited as Evenson].

as "spiritual counseling," the records showed that each patient received an average of only .31 hours (about 20 minutes) per week of actual psychotherapy.[20]

The collection of relevant information about the delivery of psychiatric treatment may be encouraged by present federal legislation which requires an evaluation by local Professional Standards Review Organizations (PSROs) of treatment given to patients receiving Medicare, Medicaid, and certain other federal welfare payments. Although the operation of PSROs is a matter of considerable controversy, present trends indicate that the PSROs will be composed of local physicians who will establish norms of diagnosis and treatment for specific patient populations. A committee of the American Psychiatric Association is developing a list of model criteria (elements of care) which local PSROs may use to evaluate the treatment given to psychiatric patients.[21] Tentatively, the committee is suggesting that information be kept on each patient specifying the justification for his admission, history of the problem, type of treatment, length of stay, and discharge plan. Such information collected and analyzed for groups of psychiatric patients could be very useful in determining the type and amount of treatment provided by various institutions.

The third major method used to evaluate medical treatment involves the assessment of outcome. In its simplest form, general hospitals compile statistics concerning the mortality of the patients treated. But data may also be collected on matters such as subsequent disabilities, the need for subsequent treatment, job performance, and patient satisfaction. The assessment of treatment by outcome directly measures the impact of treatment in terms of cure or recovery. It is, however, often more difficult to get outcome data than information about the structure of the hospital or the process of treatment delivery.

If structural or process measurements of treatment were highly correlated with outcome measurements, then one could use structural criteria, such as staff-patient ratios, or process criteria, such as frequency of interviews, as indicators of treatment outcome. There appear to be, however, few direct positive relationships among the measures. Of course, in some instances structural or process data might be sufficient to evaluate outcome. For example, one can assume that a very poor doctor-patient ratio, such as one physician with psychiatric training for 5,000 patients as in *Wyatt*,[22] precludes any possibility

20. These are the author's own calculations.

21. Ad Hoc Committee on PSRO, American Psychiatric Ass'n, Memorandum to District Branches (October 31, 1973).

22. Brief for Plaintiff as Amicus Curiae at 26, *Wyatt v. Aderholt*, No. 72-2634, 5th Cir., Aug. 1, 1972.

of effective treatment or even humane care. On the other hand, one psychiatrist for each patient would not guarantee a positive outcome.

If an average patient receives only 20 minutes of psychotherapy per week,[23] it is difficult, if not impossible, to justify involuntary commitment on the ground that the patient is receiving needed treatment —especially when voluntary patients in community mental health centers may receive more or more effective treatment.[24] The notion that patients are confined to state mental hospitals for intensive treatment, much as patients would be admitted to a general medical hospital for more intensive treatment than that available on an outpatient basis, has little support in fact. Reasons other than provision of psychotherapeutic treatment per se, such as the prevention of harm to oneself or others or the provision of basic care, may be the central reasons for commitment. These aspects of commitment, however, are not specifically medical matters; preventive detention and welfare are not areas in which psychiatrists have demonstrated special expertise.[25] If there is any justification for the involuntary commitment of patients for treatment, it is to be found in the total impact of the hospitalization upon patient behavior which could not have been accomplished without treatment within the institution. But does psychotherapeutic treatment as traditionally practiced in public institutions, or even within private clinics, produce demonstrable changes in patient behavior? Contrary to public opinion, the evidence is generally that such treatment does not effectively change behavior.

II

INEFFECTIVENESS OF TRADITIONAL PSYCHOTHERAPEUTIC METHODS AS MEASURED BY OUTCOME

There has long been some uneasiness about the general effectiveness of psychotherapy within the mental health professions. There are, of course, some dramatic cases of success and some spontaneous re-

23. See text accompanying notes 19-20, *supra*.

24. In a study which compared out-patient treatment with the hospitalization of patients, 90 patients were randomly assigned either to treatment during the day while living in the community or to residence in the hospital. Herz, Endicott, Spitzer & Mesnikoff, *Day Versus Inpatient Hospitalization: A Controlled Study*, 127 AM. J. PSYCHIATRY 1371 (1971). Treatment was administered in the same hospital by the same staff to both groups. The average follow-up period was slightly under two years. According to the researchers, "The results showed that, on virtually every measure used to evaluate outcome, there was clear evidence of the superiority of day treatment. Not only did the patients return to full-time life in the community and resume their occupational roles sooner, but they were more apt to remain in the community without subsequent readmission to the hospital." *Id.* at 1379.

25. *See generally* Ennis & Litwack, *Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom*, 62 CALIF. L. REV. 693 (1973) [hereinafter cited as Ennis & Litwack].

missions, but the focus of attention must be upon the majority of patients—whether they show a consistent, general pattern of improvement when therapy is used as compared with no therapy. Unfortunately, the evidence on this point tends to indicate that psychotherapy as traditionally practiced fails to produce demonstrable improvement in patient behavior, particularly among involuntarily committed patients. Some of this evidence is briefly summarized here.[26]

Beginning in the early 1950's, a noted psychologist, Hans J. Eysenck, began summarizing and reporting studies on the effects of psychotherapy with neurotic patients. After a survey of nineteen follow-up studies involving over 7,000 patients who received psychotherapy, he concluded that about two-thirds of the neurotic patients would have recovered or become much improved within two years from the onset of the illness even if they had received no treatment.[27] Although this was encouraging to the patients, it was not encouraging to the therapists. As a result of a later survey of studies which included an additional 4,000 patients, Eysenck's skepticism as to the effectiveness of psychotherapy increased. His conclusion is well known among mental health professionals interested in the empirical assessment of psychotherapy:

> With the single exception of the psychotherapeutic methods based on learning theory, results of published research with military and civilian neurotics, and with both adults and children, suggest that the therapeutic effects of psychotherapy are small or non-existent, and do not in any demonstrable way add to the non-specific effects of routine medical treatment, or to such events as occur in the patients' everyday experience.[28]

Among psychoanalytically-oriented therapists, Eysenck's conclusion was met with shock and indignation. Over the years, however, relatively little contrary evidence has been produced.[29]

If mentally ill persons tend to improve in the normal course of life events and, at the same time, they happen to be talking with therapists,

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26. Although the following studies include some patients who were not involuntarily committed, the ineffectiveness of psychotherapy is most troublesome when imposed through the commitment process.

27. Eysenck, *The Effects of Psychotherapy: An Evaluation*, 16 J. CONSULTING PSYCHOLOGY 319, 322 (1952).

28. Eysenck, *The Effects of Psychotherapy*, 1 INT'L J. PSYCHIATRY 99, 135-36 (1965). A similar conclusion was reached by Levitt in 1965 as to therapy with children. "[T]he inescapable conclusion is that available evaluation studies do not furnish a reasonable basis for the hypothesis that psychotherapy facilitates recovery from emotional illness in children." Levitt, *Psychotherapy with Children: A Further Evaluation*, 1 BEH. RES. & THERAPY 45, 49 (1963). *See also* R. STUART, TRICK OR TREATMENT: HOW AND WHEN PSYCHOTHERAPY FAILS (1970).

29. *See, e.g.*, Zetzel, *Discussions, The Effects of Psychotherapy*, 1 INT'L J. PSYCHIATRY 144 (1965).

both they and their therapists may erroneously assume that therapy rather than life events or normal healing processes produced the favorable results. The best evidence about therapeutic effectiveness therefore comes from controlled studies in which one group receives therapy and a similar "control" group receives no therapy or a different form of therapy.[30] The results of controlled follow-up studies of the effects of traditional forms of psychotherapy have been rather consistently negative.

A typical study is that by Walker and Kelly,[31] who compared 44 hospitalized schizophrenic patients receiving psychotherapy with a control group of 38 hospitalized schizophrenic patients receiving very little or no psychotherapy. Ninety days after discharge from the hospital there were no significant differences between the two groups in terms of symptoms or community adjustment. A three-year follow-up study of these same patients showed similar results: essentially no differences between the groups.[32]

To determine the effectivness of treatment it is useful to know what the normal course of the illness is without therapy. Thus one study considered 105 patients who requested psychotherapy but were placed on a waiting list instead.[33] During the follow-up period, which averaged five years and ranged from two to eight years for some patients, the study found that 41 patients received some treatment elsewhere, 5 were deceased, 4 were mistakenly diagnosed, and 55 had received no treatment. Of those patients receiving no treatment, 65 percent were generally improved and 35 percent were unimproved.[34] Of those patients receiving treatment, 78 percent were generally improved and 22 percent were unimproved. These differences are not statistically significant. With regard to specific symptoms such as depression, anxiety, and thinking disorders, the treated patients showed somewhat less improvement than the untreated patients.

The evidence of effectiveness is at least as discouraging with regard to the treatment of delinquent or criminal conduct by conventional

30. *See generally*, W. FEDERER, EXPERIMENTAL DESIGN: THEORY AND APPLICATION (1973); S. ISAAC & W. MICHAEL, HARDBOOK IN RESEARCH AND EVALUATION (1971).

31. Walker & Kelley, *Short-term Psychotherapy with Hospitalized Schizophrenic Patients*, 35 ACTA PSYCHIAT. & NEUROL. SCAND. 34 (1960).

32. Walker & Kelley, *Short-term Psychotherapy with Schizophrenic Patients Evaluated over a Three-year Follow-up Period*, 137 J. NERVOUS & MENTAL DISEASE 349 (1963).

33. Schorer, Lowinger, Sullivan & Hartlaub, *Improvement Without Treatment*, 29 DISEASES OF THE NERVOUS SYSTEM 100 (1968) [hereinafter cited as Schorer]. Most of these patients had neurotic or personality disorders rather than psychoses.

34. *Id.* This study almost exactly replicates an earlier study also showing 65 percent improvement among untreated neurotic patients. Wallace & Whyte, *Natural History of the Psychoneuroses*, BRIT. MED. J., Jan. 17, 1959 at 144. *See also* Eysenck, *supra* note 27.

forms of psychotherapy. One of the most noteworthy pieces of evidence is the Cambridge-Somerville Youth Study. A group of 650 predelinquent youths were randomly assigned to either a treatment or a no-treatment control group. The treatment, which involved the use of a wide range of individual counseling techniques, was intended to prevent delinquency as the boys went through their teenage years.[35] A three-year follow-up study revealed no statistically significant differences between the groups in terms of delinquency, but the no-treatment control group showed a slightly lower incidence of crime. Similar results were found in a study which gave intensive counseling to a group of 95 youthful parolees. The counseled parolees did not do better than two matched control groups; in fact, they did worse in terms of subsequent crime at an almost statistically significant level.[36]

The Silverlake Experiment utilized randomly selected experimental and control groups of delinquents.[37] The control subjects received the usual interventions of training school and parole. The experimental group of 140 youths went to a special residential facility much like a halfway house and participated in daily group meetings. The experimental treatment averaged about six months and emphasized a "therapeutic milieu." A one-year follow-up study indicated that 60 percent of the experimental group and 56 percent of the control group had no new arrests; the experimental program was considered no more effective than the regular program.

An exceptionally well-designed study by Kassebaum, Ward, and Wilner tested whether group counseling in a prison had an effect on the post-release behavior of the parolees as distinguished from the effects of the prison experience itself.[38] Two major forms of counseling were used. Small-group counseling involved groups of 10 to 12 inmates who met one to two hours per week under the direction of a group leader. In these groups there was an emphasis upon the discussion of feelings and attitudes and mutual acceptance among the members. The second form of counseling involved a large group of about fifty men and three leaders who met for one hour four days a week for

35. E. POWERS & H. WITMER, AN EXPERIMENT IN THE PREVENTION OF DELINQUENCY: THE CAMBRIDGE-SOMERVILLE YOUTH STUDY (1951). *See also* W. MCCORD, J. MCCORD & J. ZOLA, ORIGINS OF CRIME: A NEW EVALUATION OF THE CAMBRIDGE-SOMERVILLE YOUTH STUDY (1959) (failure still apparent) [hereinafter cited as MCCORD, MCCORD & ZOLA].

36. Schwitzgebel & Baer, *Intensive Supervision by Parole Officers as a Factor in Recidivism Reduction of Male Delinquents*, 67 J. OF PSYCHOL. 75 (1967) [hereinafter cited as Schwitzgebel & Baer].

37. L. EMPEY & S. LUBECK, THE SILVERLAKE EXPERIMENT: TESTING DELINQUENCY THEORY AND COMMUNITY INTERVENTION (1971).

38. G. KASSEBAUM, D. WARD & D. WILNER, PRISON TREATMENT AND PAROLE SURVIVAL: AN EMPIRICAL ASSESSMENT (1971).

discussions. On the fifth day the group split into three smaller groups. Of the 647 men in the study, 330 were randomly assigned to various experimental and control groups. The remaining men became part of voluntary-counseling and voluntary-control groups. There were a total of three treatment groups and two control groups. All men were exposed to at least six months of treatment in prison. A three-year follow-up study showed no significantly different outcomes among any of the treatment or control groups in terms of parole success or the frequency or seriousness of subsequent offenses. In short, the treatment had no discernible effect upon the behavior which initiated the commitment and treatment.

This result is consistent with the conclusios of two surveys of studies of correctional treatment programs. After reviewing 100 such studies conducted between 1940 and 1960, Bailey found no clear evidence of treatment effectiveness.[39] In a recent survey of treatment programs for offenders in California, Robison and Smith concluded that *"there are still no treatment techniques which have unequivocally demonstrated themselves capable of reducing recidivism."*[40]

The studies of more intensive, psychiatrically-oriented treatment of offenders are also disappointing. The first problem is the frequent inadequacy of the research design of these studies. For example, in a study of the treatability of psychopaths, LeVine and Bornstein analyzed 295 studies according to three fundamental standards of adequate research design: (1) the study must report some method of treatment; (2) it must include the use of control subjects; and (3) a post-treatment follow-up period must be used to assess results.[41] The researchers were quite lenient in applying these standards, but only 13 articles, or 4.4 percent of the total, met them. These 13 articles referred to 10 experimental studies. Eight of the ten studies claimed to have shown "positive" results; one study reported an "inconclusive" result, and one a "negative" result.[42] Two of the eight "positive" studies,

39. Bailey, *Correctional Outcome: An Evaluation of 100 Reports*, School of Social Welfare, Univ. of California, Los Angeles (1961). *See also* Miller, *The Impact of a "Total Community" Delinquency Control Project*, 10 SOCIAL PROBLEMS 168 (1962).

40. Robison & Smith, *The Effectiveness of Correctional Programs*, 17 CRIME & DELINQUENCY 67, 74 (1971). *See also* Lerman, *Evaluative Studies of Institutions for Delinquents*, in DELINQUENCY AND SOCIAL POLICY 317 (Lerman ed. 1970).

41. LeVine & Bornstein, *Is the Sociopath Treatable? The Contribution of Psychiatry to a Legal Dilemma*, 1972 WASH. U.L.Q. 693 (1972) [hereinafter cited as LeVine & Bornstein]. The researchers utilized the MEDLARS computer-based information retrieval system of the National Library of Medicine to locate psychiatric studies of treatment effectiveness.

42. "Inconclusive" results were found in Fink, Derby & Martin, *Psychiatry's New Role in Corrections*, 126 AM. J. PSYCHIATRY 542 (1971) (adult subjects) (cited in LeVine & Bornstein, *supra* note 41 at 706). "Negative" results were found in

however, did not use conventional psychotherapeutic techniques.[43] Also, LeVine and Bornstein noted several methodological problems in the remaining studies.[44] The conclusion reached by LeVine and Bornstein is equivocal:

> The data indicate that some techniques may be effective in the treatment of antisocial personality in juvenile offenders and possibly in some adults. However, the evidence from the studies reported does not permit a conclusion as to whether any one of the treatments is more effective than any other, or whether any treatment is better than none.[45]

Thus, the evidence for the effectiveness of traditional psychotherapeutic methods for the reduction of antisocial behavior is not very persuasive. In fact, the evidence in some studies points toward increased antisocial or maladaptive behavior with treatment. A study by Miller and Kenny examined the post-hospital adjustment of 175 adolescents who had been referred to the hospital by courts and others for antisocial conduct such as robbery, vandalism, truancy, and sexual offenses.[46] After periods of hospitalization ranging from two weeks to five months, the youths were released into the community. During a six-month follow-up period, those youths who refused to participate in mental health programs following release were subsequently institutionalized less often than those who participated in these programs. The investigators concluded that "[t]o date, there is nothing in the literature or practice to tell us how and no one has ever demonstrated that problems of delinquency can be successfully treated on a large scale in a psychiatric facility. We cannot treat misbehavior."[47] In other studies, the groups receiving traditional forms of psychotherapy have shown more recidivism,[48] maladaptive behavior,[49] and psychoneu-

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McCORD, McCORD & ZOLA, *supra* note 35 (cited in LeVine & Bornstein, *supra* note 41 at 706).

43. Shore & Massimo, *Five Years Later: A Followup Study of Comprehensive Vocationally Oriented Psychotherapy*, 39 AM. J. ORTHOPSYCHIATRY 769 (1969) (vocational counseling); Colman & Baker, *Utilization of an Operant Conditioning Model for the Treatment of Character and Behavior Disorders in a Military Setting*, 125 AM. J. PSYCHIATRY 1395 (1969) (token economy).

44. LeVine & Bornstein, *supra* note 41 at 707.

45. *Id.* at 710.

46. Miller & Kenney, *Adolescent Delinquency and the Myth of Hospital Treatment*, 12 CRIME & DELINQUENCY 38 (1966).

47. *Id.* at 47.

48. BUREAU OF SOCIAL RESEARCH, THE CATHOLIC UNIVERSITY OF AMERICA, FINAL REPORT IV: EXPERIMENTAL AND DEMONSTRATION MANPOWER PROGRAM FOR TRAINING AND PLACEMENT OF YOUTHFUL INMATES OF THE YOUTH CENTER, LORTON, VIRGINIA (1966); Corman, *Effectiveness of a Comprehensive Treatment Program for Antisocial Boys*, School of Education, Boston University (1973); *see also* Schwitzgebel & Baer, *supra* note 36.

49. *Cf.* Caplan, *Treatment Intervention and Reciprocal Interaction Effects*, 24 J. SOC. ISSUES 63 (1968).

rotic symptoms[50] than the control groups not receiving the treatment.

The discussion thus far has been primarily concerned with the use of traditional forms of psychotherapy which are usually based upon psychoanalytic theory and its derivatives. Since the 1950's, some newer forms of treatment have been emerging which are often, but not always, derived from learning theory and are usually practiced by professionals other than psychiatrists.[51] These newer methods tend to focus upon changing specific behaviors of particular types of individuals. There is also an emphasis upon the environment or social situation which may either facilitate or inhibit the behavior to be changed. The cause of the behavior (the "pathology" in the old view) does not lie exclusively within the head of the patient. Therefore, the situation as well as the patient is to be "treated."

In contrast to traditional methods of therapy, some of these newer forms of therapy have produced demonstrable long-term changes in behavior.[52] Often developed in psychological laboratories, these methods are only gradually being used to change antisocial or criminal behavior. Some of them, such as behavior modification using operant conditioning, have recently become a matter of considerable controversy, as they do raise acute ethical problems. This may be in part because the effects of these procedures can be readily observed; issues of freedom and control are thus much more obvious than in other forms of therapy where behavioral effects are difficult to observe, or more likely, nonexistent.

In summary, the traditional forms of psychoanalytic psychotherapy as generally practiced in public hospitals tend to show very limited effects upon behavior when patients are considered in the aggregate. Statements about the therapeutic efficacy of treatment procedures must be viewed with caution, particularly when these statements are based on data from uncontrolled or poorly designed studies. The effectiveness of traditional therapies in changing the behaviors which led to the commitment of the patients has yet to be clearly demonstrated.

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50. Schorer, *supra* note 33.

51. See discussions in A. BANDURA, PRINCIPLES OF BEHAVIOR MODIFICATION (1969); L. KRASNER & L. ULLMANN, BEHAVIOR INFLUENCE AND PERSONALITY: THE SOCIAL MATRIX OF HUMAN ACTION (1973); R. SCHWITZGEBEL & D. KOLB, CHANGING HUMAN BEHAVIOR: PRINCIPLES OF PLANNED INTERVENTION (1974).

52. See references cited in note 51 *supra*. *See also* Heap, Boblitt, Moore & Hord, *Behavior-Milieu Therapy with Chronic Neuro-Psychiatric Patients*, 76 J. ABNOR. PSYCHOLOGY 349 (1970) (token economy, patient government, behavior therapy, attitude therapy); Gove & Lubach, *An Intensive Treatment Program for Psychiatric Inpatients: A Description and Evaluation*, 10 J. OF HEALTH & SOC. BEHAVIOR 225 (1969) (distinct treatment stages, close involvement of families, development of specific treatment programs, patient's history not available to staff members, extensive patient freedom).

In a sense, these traditional forms of therapy have been living for many years on public faith and "credit" while the public, legislatures, and courts have acted in reliance upon statements of therapists which indicate that treatment can in fact change behavior. An independent accounting is now due.

III

IMPLICATIONS OF AN OUTCOME CRITERION OF TREATMENT EFFECTIVENESS

The following discussion is a frankly speculative survey of some implications of defining legally adequate treatment in terms of effectiveness and outcome. Various perspectives from which lawyers might consider the enforcement of the right to effective treatment are presented to encourage and stimulate further exploration of these ideas. Because several authors have extensively discussed the constitutional issues involved,[53] the discussion here will focus largely, but not exclusively, upon non-constitutional remedies.

Many aspects of the mental health system or its instititutions may contribute to the failure of treatment to produce demonstrable changes in patient behavior. The ineffectiveness may result, for example, from psychiatric diagnoses of low reliability[54] and validity,[55] from inadequate treatment,[56] or from a variety of other causes.[57] It is not necessary for courts to examine the various possible causes of treatment ineffectiveness under the proposed outcome test; ineffective treatment is the same as no treatment in terms of its results because both produce lengthy or unnecessary confinement. The courts need only decide that the patient has a right to some treatment as against no treatment.

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53. See note 4, *supra.*

54. The reliability of psychiatric diagnoses (degree of agreement between or among psychiatrists) has been found to be distressingly low. *See* Ennis & Litwack, *supra* note 25. Reliability is often measured by correlational techniques. The correlation coefficients of judgments between observers rating large body movements is typically quite good, with coefficients ranging from the middle to high .90's. The correlation coefficients among persons interpreting the Rorschaeh (ink blot) test has typically been quite poor, with coeffieients ranging from about .30 to .35. In a study of two groups of psychiatrists who rated 225 outpatients on an 8 point scale of "no pathology" to "extreme pathology," the correlation coefficient of reliability was found to be a remarkably low .19. Howard, Park, Lipman & Uhlenhuth, *Differential Reliability in Rating Psychopathology and Global Improvement,* 26 CLINICAL PSYCHOLOGY 320 (1970).

55. Diagnostic validity refers to the truthfulness or accuracy of the diagnosis. In this regard, see Rosenhan, *On Being Sane in Insane Places,* 179 SCIENCE 250 (1973).

56. *See, e.g.,* Evenson, *supra* note 19.

57. Another possibility is that patients who have been involuntarily committed did not require any treatment whatever. This presents serious moral issues as well as problems of due process and equal protection.

That treatment, whatever it is ought to produce demonstrable results or it is useless to the patient and leads to unconscionable deprivations of liberty. The following discussion suggests several models for enforcing the right to effective treatment using the outcome test.

A. The Res Ipsa Model

One could say, in summary of the proposed "outcome" test, that the results should speak for themselves. Good intentions and appeals to psychiatric authority should not be sufficient when contradicted by objective results.

In certain situations the courts apply the doctrine of *res ipsa loquitur* for sound policy reasons analogous to those present in the commitment situation. This doctrine, literally "the thing speaks for itself," creates a presumption affecting the burden of producing evidence. For example, in airplane accident cases, the injured party or the estate of a deceased victim may have little information about the cause of the accident; all that the plaintiff knows is a particular result or outcome—that the airplane crashed. The accident may have resulted from pilot error, a faulty altimeter, or a structural defect of the plane. The airline is in a much better position to know the circumstances surrounding the crash than the plaintiff.[58] There is a distressing analogy between passengers who are lost or disappear on a flight[59] and those patients who are "lost" in the back wards of state hospitals. The California Court of Appeal in *Cline v. Lund* appropriately noted that policy considerations favor the application of the doctrine of *res ipsa loquitur* to medical malpractice cases:

> . . . defendants therein are in a position of special responsibility to their patients and the latter are usually completely dependent upon the medical profession for treatment and care. The doctrine thus protects the dependent party from unexplained injury at the hands of one in whom, of compelling necessity, he has reposed complete trust.[60]

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58. Even when both parties are equally ignorant of the facts, the doctrine may be applied. *See, e.g.*, Haasman v. Pacific Alaska Air Express, 100 F. Supp. 1 (D. Alas. 1951).

59. *Id.*

60. 31 Cal. App. 3d 755, 762, 107 Cal. Rptr. 629, 635 (1st Dist. 1973). *See also* Frost v. Des Moines Still College of Osteopathy and Surgery, 79 N.W.2d 306, 311 (Iowa 1957): "It is difficult to see a greater justification or need for the extension of this doctrine [of *res ipsa loquitur*] to carrier passenger cases than to hospital, doctor, patient cases, especially when the one is injured while under anesthesia." The patient under anesthesia is singled out because he is unaware of his circumstances; the mental patient may well be in a similar state of disorientation and equally unable to comprehend his or her surroundings.

Such a policy should apply with equal or greater force to mentally infirm patients who may not be capable of making an informed judgment about their care or treatment.

Although the *res ipsa* doctrine has not been used frequently in medical malpractice cases in the past, its application currently seems to be increasing. In view of strong policy considerations favoring its use, some of the traditional elements of *res ipsa loquitur* have been considerably relaxed or liberally interpreted in medical malpractice cases.[61] While proper (non-negligent) practice of medicine may on occasion give rise to serious injury, there are also many injuries arising from medical negligence which is apparent even to laymen.[62] Similarly, in the case of the right to effective psychiatric treatment, it often does not require great expertise to determine that the results (or even the procedures) do not conform to what would be expected from reasonable medical practice or a "bona fide effort" to cure or improve the patient. For example, Wexler and others have reported finding a patient 78 years of age in a state institution who was committed there at the age of 19 for symptoms such as laughing and singing, being unable to sit or stand still, and talking with anyone. Her symptoms at that time were diagnosed as "only temporary." Surely a layman could reasonably conclude that treatment was not adequate or effective or possibly even necessary in this case. Fifty-nine years of "treatment" is more than enough; it is too much.[63]

One limitation on the doctrine of *res ipsa loquitur* is that it can be applied only to those events which ordinarily do not occur in the usual course of events; for example, planes do not usually crash nor do flies usually appear in coke bottles. The purpose of this limitation on the doctrine, to the extent it still exists, seems to be to prevent the jury from assuming with their limited knowledge that all outward events are the result of negligence.[64] In the operation of mental hospitals,

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61. *See* Schlegel, Silverhart v. Mount Zion Hospital: *A Re-Examination of Hospital-Patient Relationship*, 5 SW. U.L. REV. 297 (1973) [hereinafter cited as Schlegel].

62. Although the *res ipsa* doctrine in medical malpractice cases usually requires expert testimony that the defendant doctor has strayed from the proper standard of care, the doctrine can also be invoked by relying upon the layman's common knowledge of extremely unlikely injuries. *See* Wilkinson v. Vesey, 295 A.2d 676 (R.I. 1972).

63. It is not the purpose of the discussion here to go into detail with regard to psychiatric malpractice but to indicate briefly some implications of an outcome criterion of effectiveness. However, a particularly noteworthy case finding liability for the absence of treatment is Whitree v. State, 56 Misc. 2d 693, 290 N.Y.S.2d 486 (Ct. Cl. 1968). *See also* Schwitzgebel, *supra* note 17.

64. The limitation also speaks the law's concern that only certain extremely uncommon results be attributed to the defendant's negligence without the usual burden of proof on the plaintiff. As we have seen, psychiatric patients often do not receive

as in the operation of common carriers, there will be some results suitable for understanding by laymen and some which will not be. In a right-to-treatment case, the jury perhaps should not be asked to consider the rate of failure of one modality of treatment as against another, but only to consider readily apparent, overall outcomes. If many patients enter mental hospitals and do not leave, or if treated and untreated patients do equally as well, it does not require an expert to conclude that treatment is not being provided or is being negligently provided.

Hospitals sometimes defend what appears to be a poor treatment result by asserting that they are following "acceptable medical practice." But to whom is the practice "acceptable" and for what purposes? A hospital's claim that many patients show no improvement or are untreatable should generally not excuse it from liability any more than could a bottling company defend itself by asserting that flies are common in coke bottles. If ineffective treatment, as measured by results, is not an occasional accident indicating negligence but a more frequent occurrence, then perhaps a general enterprise liability ought to be considered and the social value of the entire operation reconsidered.[65]

B. The Breach of Contract Model

There may be grounds other than negligence for psychiatric liability. It is, for example, sometimes possible to bring an action for breach of contract in place of a malpractice suit. In actions based upon a contract theory, the failure to perform the promised service is at issue, and negligence need not be alleged.[66] Usually a special, written contract is required, but a physician may under some circumstances orally agree

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treatment resulting in the proper outcome. Similarly, airplanes crash more often than one would desire. The argument that the *res ipsa* reasoning be applied in the case of the patient is that ineffective treatment of involuntarily committed patients is as intolerable a result as the occasional crash of a plane, and that the law should reflect its concern for the dependent and helpless patient and passenger by altering the victim's burden of producing evidence, even though an unsatisfactory outcome is a *too* common occurence. The result should speak for itself in both cases.

65. There may be some reluctance to apply the concept of negligence to the operation of the medical profession because the notion of blameworthiness is often associated with negligence. Another approach would be the limited application of strict liability to the operation of a hospital but not to the actions of the physician, thus preserving freedom in the doctor-patient relationship. *See* Schlegel, *supra* note 61 and 304-09. Of course, the problem is most acute when an involuntarily committed patient or patient population is involved.

66. *See, e.g.*, Guilmet v. Campbell, 385 Mich. 57, 188 N.W.2d 601 (1971) (contract by surgeon for "cure" of patient; contains one of the most rousing dissenting opinions in current legal history). *Contrast* Gault v. Sideman, 42 Ill. App. 2d 96, 191 N.E.2d 436 (1963) (in spite of the existence of a contract, the complaint sounds in tort).

to perform certain services or produce a particular result if the words are very clear.[67]

Although the usual basis of consensual medical treatment involves an express or implied contract between the patient and the physician, the courts typically have not recognized or enforced the contractual basis of psychiatric treatment. Perhaps this is because psychiatry historically has been a coercive enterprise in which a psychiatrist could commit a patient to the lunatic asylum, psychopathic hospital, or mental health center against the latter's will. There is, however, some question as to whether such an authoritarian approach to the psychiatrist-patient relationship, in the absence of emergencies, is appropriate. A more contractual view of the relationship might be beneficial to both the patients and the psychiatrist.

In a pioneering article by Alexander and Szasz, some benefits of a contractual approach have been outlined.

> Many of the difficulties surrounding the contemporary practice of psychiatry—for both patients and psychiatrists—derive from ambiguities and uncertainties about the nature of the psychiatrist-patient relationship. In particular, we believe that people continue to fear and distrust psychiatrists and psychiatric institutions for a good reason: that is, not because psychiatrists are any worse (or better) intentioned than other professionals, but because they enjoy too much discretion over their client once the client places himself in their care. It seems likely—observation surely supports this impression—that individuals are often unwilling to seek psychiatric care because they do not know whether or not their psychiatrist eschews forms of treatment they do not want (for example, commitment or electroshock) . . . . This fear and mistrust is, unfortunately, perfectly well grounded in the reality of present-day mental hygiene laws. Hence, it seems likely that while more precise definitions of the psychiatrist's contractual powers and limitations would curtail some of the current psychiatrict practices, it would expand others, by removing the presently justified fears of many persons to sacrifice their autonomy and yield to the total discretion of a psychiatrist.[68]

In addition, psychiatrists might benefit from the use of clearly articulated and enforceable contracts which would protect them from liability when they are engaged in restraining or refusing to restrain pa-

67. In Nicholson v. Han, 12 Mich. App. 35, 162 N.W.2d 313 (1968), the court noted that a psychiatrist could make an express contract with a patient containing a warranty of "cure." The defendant was found not liable on contract grounds. The physician may, of course, offer therapeutic assurance to the patient without making a contract.

68. Alexander & Szasz, *From Contract to Status Via Psychiatry*, 13 SANTA CLARA LAW. 537, 555 (1973) [hereinafter cited as Alexander & Szasz].

tients.[69] Both the patients and the psychiatrists will profit from contractual protection.

With regard to the right to treatment, the substantive nature of the contract is important. It is not likely that a psychiatrist would contract to produce a "cure," although he probably could.[70] If a cure or a particular result is not warranted in the contract, the contract might expressly agree to provide treatment in keeping with recognized, explicit standards of treatment.[71] Even if there were no explicit contract, there might nevertheless be an implied contract, as in most instances of medical treatment. Also, state statutes which permit involuntary commitment expressly for "care and treatment" or similar purposes may provide the basis for a contractual relationship between the patient and the state.

Outside of psychiatry, a trend is beginning to emerge which conceptualizes experimental and therapeutic relationships in contractual terms.[72] In a mental health clinic in Florida, psychologists developed a contract method which involved developing an explicit set of treatment goals or objectives with the patient.[73] In the first interview the patient and therapist attempt to set goals and negotiate a contract. One patient came to the clinic with a complaint of "nervousness" and specific goals were worked out in the areas of drinking, finances, and work. within each of these problem areas specific objections were developed to indicate the eventual degree of success of the therapy. For example, within the area of drinking, for this patient, the "maximum level" of success predicted for the treatment was drinking on weekends once

69. *Id.* at 556. A common situation in psychiatric malpractice cases involves the restraint or lack of restraint with patients who are likely to commit suicide. The ability of incompetent persons to contract is comprehensively discussed in Alexander & Szasz, *supra* note 68. Generally, incompetent patients have been "protected" from contracting in this area. This often seems to have worked to their disadvantage. Alternatively, contracts can be made by psychiatrists with the families, guardians, or friends of patients, thus avoiding the issue of incompetency to contract.

70. In Nicholson v. Han, *supra* note 67, the court found that a psychiatrist who claimed to be treating a patient for marital problems while having sexual intercourse with her and inducing her to obtain a divorce from her husband did not make an express contract containing a warranty of cure.

71. The implied standard might be that of acceptable medical practice as measured by outcome. By analogy, in Griffith v. United Air Lines, Inc., 416 Pa. 1, 203 A.2d 796 (1964), a passenger was killed in a crash of uncertain cause. The court noted that there was no contract of "safe" carriage because the carrier is not an insurer of passenger safety. However, a high degree of care is owed to its passengers. The court concluded that there was a breach of contract of non-negligent carriage.

72. *See, e.g.*, Epstein, Suedfeld & Silverstein, *The Experimental Contract: Subjects' Expectations of and Reactions to Some Behaviors of Experimenters*, 28 AM. PSYCHOLOGIST 212 (1973); Schwitzgebel & Baer, *supra* note 36.

73. Lombillo, Kiresuk & Sherman, *Evaluating a Community Mental Health Program: Contract Fulfillment Analysis*, 24 HOSPITAL AND COMMUNITY PSYCHIATRY 760 (1973).

or twice a month. A "minimum level" of success was drinking nightly and some mornings. Lombillo, Kiresuk, and Sherman note:

> There are several practical benefits of a mutually negotiated contract of treatment goals. It provides the mental health worker with a conceptual basis on which to organize therapeutic efforts. It provides the patient with a structural framework for mobilizing his available problem-solving mechanisms and resources. It enables the patient, community caregiver, and clinic staff to establish realistic expectations of clinic intervention in the patient's life situations. And it produces valuable administrative information about the problems clinic staff are handling.[74]

Because of the certainty with which certain behaviors can be changed through the use of some of the newer forms of therapy, some psychologists are beginning to utilize explicit, written contracts with patients. These contracts may specify the behavioral outcomes to be achieved by the therapeutic intervention, for example, bedwetting is to be completely eliminated or to occur no more often under usual circumstances than three times per month within a given period of treatment. The contract may be modified by mutual agreement during the course of treatment. Sometimes the fees are contingent upon the achievement of specified behavioral objectives.[75]

The contracts just described are generally made with private, voluntary patients. Contracts, however, also offer the possibility of greatly enhancing consumer protection in the area of involuntary mental health treatment. The "consumers" who most urgently need protection are the involuntarily committed patients who presently seem unnecessarily deprived of effective services as well as legal remedies. Even though breach of an express or implied contract is not clear in individual cases, when a general pattern of inadequate treatment appears, wherein available treatment is measured only in minutes per week per patient and when there are no clearly demonstrable results, the system perpetuating such "treatment" can be seen as violating its contractual duty to society.

C. The Normative Model

Extending the contract model to admittedly extreme limits, it seems possible to make the funding of institutions contingent upon the production of certain outcomes. Because institutions are paid and staffs are employed upon the basis of the number of beds filled, it is easy to understand why administrative bed-filling activity rather than treatment occurs. Goldiamond has noted:

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74. *Id.* at 762.

75. Ayllon & Skuban, *Accountability in Psychotherapy: A Test Case*, 4 J. BEHAV. THER. & EXP. PSYCHIATRY 19 (1973).

> To get institutions to accept and care for the bedridden, Illinois Welfare pays nursing homes an allotment scaled according to degree of disability; they are paid more for supine patients than ambulatory ones. The contingencies for keeping patients bedridden are thereby neatly set up. A contingency analysis suggests that allotment might be scaled according to degree of progress toward ambulation, with so fat a bonus paid when the patient *walks* out that the institution sets up a research laboratory to develop new devices![76]

An indirect way to shift funds toward the development of more effective forms of treatment might be the use of a modified voucher system as proposed for schools. Patients would presumably purchase those treatment programs which were most effective or at least those which are associated with a high likelihood of release from the institution. As the situation exists today, non-committed patients who live in the community can purchase a variety of mental health services while incarcerated patients have little or no choice and are often forced to accept what is likely to be ineffective treatment.

D. The Experimental Model

If the effectiveness of a psychotherapeutic treatment cannot be demonstrated, then it should be placed in the same category as treatment by an investigational (experimental) drug. These drugs may be used in clinical studies or treatment only under specific, limited conditions. Before new drugs may be marketed for general use even by prescription, information must be submitted to the Food and Drug Administration regarding the drug's safety and effectiveness. This information is to include data from controlled studies. "Uncontrolled studies or partially controlled studies are not acceptable as the sole basis for the approval of claims of effectiveness . . . . Isolated case reports, random experience, and reports lacking the details which permit scientific evaluation will not be considered."[77] Ineffective psychiatric treatment may be just as dangerous, or more dangerous, than ineffective drugs. For policy reasons, there may be little value in drawing sharp distinctions between goods and services in the area of psychiatric treatment, which often involves the use of both drugs and psychotherapy.

Feinson has suggested three major goals or functions of consumer protection: (1) to insure public safety, (2) to prevent fraud, and (3)

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76. Goldiamond, Coping and Adaptive Behaviors of the Disabled, March 5-6, 1973 (paper delivered at conference on "Socialization in the Disability Process," Northwestern University, to appear in SOCIALIZATION IN THE DISABILITY PROCESS, G. Albrecht ed.).

77. 21 C.F.R. § 130.12(c) (1973).

to correct imbalances in favor of the supplier.[78] All of these goals are relevant to the protection of patients, particularly those involuntarily committed, at least while there is little information about the negative effects of treatment, very little independent review of the treatment being used, and the supplier-psychiatrist is in a position of extreme power over the consumer-patient. The *res ipsa* and contract models may serve to aid the patient and society to move toward these goals and toward meaningful and effective psychiatric treatment measured by the protections inherent in the outcome test.

In a broader perspective the limited evidence of effectiveness of the traditional forms of psychotherapeutic intervention raises the question of whether such interventions are really valid forms of treatment at all. Perhaps these interventions could be more accurately regarded as "experimental medical procedures" or "clinical research methods" which have been used over a long period of time with equivocal results and which require the protective measures usually mandated in experimental situations. Merely labeling a procedure as treatment rather than as clinical research should not disguise its fundamental nature.

Current scientific evidence does not support the assumption that the traditional forms of psychotherapy as customarily practiced in public mental institutions are generally effective in changing patient behavior. While this author believes that change of patient behavior is a legitimate state interest (at least in the involuntary commitment context), *effective* treatment needs to be guaranteed to prevent further abuses of patient rights. On the other hand, a guarantee of *ineffective* treatment is useless and, in fact, threatening to civil liberties because it can result in the long-term confinement of patients and serve as a disguise for preventive detention. Ineffective treatment must no longer be purchased with taxpayer funds and individual liberty.

Extensive precautions are now taken to protect the rights of human subjects in research. They must give their informed consent or voluntarily agree to participate. They must be aware of the potential risks and the unproven efficacy of the experimental treatment. They may not be coerced into participation. Some experimental forms of treatment show more effectiveness and no more risk than the traditional forms of treatment. To protect a relatively small number of patients from these admittedly "experimental" procedures while at the same time coercing many more patients to undergo less effective "treatment" procedures currently in vogue in standard psychiatric practice is, in terms of the old adage, straining at the gnat while swallowing the elephant.

78. Feinson, *The Need for Protection of the Consumer of Services*, 18 BUFFALO L. REV. 173, 175 (1968).