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One-Legged Ombudsman in a Mental Hospital:  
An Over-The-Shoulder Glance at an Experimental Project

Albert Broderick*

A leading liberal newspaper with internal and external problems names a black reporter; a major university names a member of its English department; the Department of Commerce designates a senior career official. Meanwhile, a leading labor journal recommends a new auxiliary to traditional union grievance procedure, and the Chairman of the Administrative Con-

* A.B. 1937, Princeton University; LL.B. 1941, S.J.D. 1963, Harvard; D. Phil. 1968, Oxford; Professor, Catholic University of America School of Law. William F. Fox, Jr., a 1973 graduate, and Joseph DiStefano, a 1966 graduate of Catholic University Law School (now attorney, Department of Justice), contributed significantly to this article—Mr. Fox to its final preparation, and Mr. DiStefano as associate director of the Ombudsman Project. (See text accompanying notes 57 to 95 below).


   In the fall of 1969 I became Cornell's first University Ombudsman, a position I held for two years. My major task was to hear complaints from anyone in the University . . . about the operation of the University. The Office became for me an intensive seminar in problems of university structure and functioning. I shall function here specifically on the problems of women, and mainly of professional women as I became familiar with them in my term of office as Ombudsman. It would be strange indeed if allegations of sex discrimination had not come to the Ombudsman's office.

   (Id. at 279, 280). As Dr. Cook (Professor of Industrial and Labor Relations at Cornell) makes clear in her article, they did.

   At another eastern university a faculty senate had a provision for an ombudsman in its long-considered revised statutes as a new president took office. At his informal request the ombudsman was deleted before final enactment. Within the next three years an uncommon crop of lawsuits involving faculty and students beset his administration and finally a faculty union arrived. Would an ombudsman's presence have made a difference? The president might well have later asked himself.


ference of the United States suggests a new emphasis in federal administrative justice.5

These sample "newsflashes," concerning the appointment of ombudsmen in new situations, remind us that the "ombudsman" concept, almost unknown in this country six years ago,6 is now being used by a variety of American organizations, both governmental and non-governmental, as an economical resource for resolving internal disputes, unlogging bureaucratic machinery and fostering a new sense of administrative justice.

The new, and largely American, applications of the ombudsman idea constitute what may be a definitive "Phase III" of American reaction to an institution of Scandinavian origin. Phase I was the basic introduction of the ombudsman notion to our vocabulary and understanding, almost as a study in comparative government.7 The main Phase I efforts date only from 1966. Phase II involved the wholesale proposals of ombudsman legislation both in the federal and state governments, very few of which have been implemented.8 This epoch covers roughly 1967 to the present, and is still open-ended. Phase III, I would suggest, is a distinctively American re-fashioning of the entire institution. Viewed not as a full-time official with powers which run the gamut of governmental activity, but as one operating within one limited area and often on a part-time basis, this American-style ombudsman seems on its way to becoming a popular adjunct to more traditional and cumbersome administrative procedures.

Phase III telescopes two modifications of the Scandinavian model:9 a more limited area of concern—e.g., a union, university, hospital, government department, or business organization—and the novel characteristic of "part-timeness"—the same individual who serves as ombudsman also performs other tasks.10 Before we are ready to determine the true scope and direction

7. Other writers contributing to this popularization were: ROWAT, THE OMBUDSMAN (1965; 2d ed. 1968); The Ombudsman or Citizen's Defender: A Modern Institution, 377 ANNALS (May, 1968); Frank, The Ombudsman and Human Rights, 22 AD. L. REV. 467 (1970).
9. The ombudsman concept began in Sweden in 1809 and has ultimately spread from the Scandinavian countries through much of Europe. See GELLHORN, OMBUDSMEN AND OTHERS 194-95 (1966).
10. These characteristics are separable, i.e., there could be a full-time ombudsman
of this American model of the ombudsman, we should consider two questions: First, what basic characteristics of the original ombudsman institution should the Phase III version retain while adapting to a more modest scope of activity? Second, what empirical evidence is available as to the actual workings of such a Phase III ombudsman? This article undertakes preliminary discussion of these questions about ombudsmen, American style, and proposes some partial answers.

As to the first question, we summarize the basic features of the European ombudsmen and some appraisals of their adaptability to American institutions. Second, with particular concern for the possibilities of the Phase III ombudsman—the “one-legged ombudsman”—we give attention to empirical data derived from the recent, short-lived experience of a “one-legged ombudsman” in a well-known public mental hospital. This experience has special relevance to the broad general question of the adaptability of the ombudsman concept since the mental hospital constitutes one of the areas in which there is special need to cut through a maze of procedures and administrative inertia in the interest of both individual and social justice.

I. Origin, Aims and Practices of the Ombudsman Concept

The European Experience

The ombudsman concept was first developed in Scandinavia and in its original form has remained largely a European product. However, with the exception of Sweden, even in Europe the office is relatively new. For example, the original Danish ombudsman, Professor Stephan Hurwitz, who had been in office twenty-five years, just retired in July, 1971. The first Norwegian ombudsman, Judge Andreas Schei, was appointed in 1963 and still working in a limited area. But a given area might be of such a nature that it could be handled by a part-time ombudsman with a small permanent staff. See proposal made to Administrative Conference of the United States with respect to St. Elizabeth’s Hospital. Broderick, Justice in the Books or Justice in Action: An Institutional Approach to Involuntary Hospitalization for Mental Illness, 20 Catholic U. L. Rev. 547, 681 (1971) [hereinafter cited as Involuntary Hospitalization]. Consider in this connection the recent ombudsman recommendation of the Freund Committee:

In summary, the [Study] Committee recommends . . . 3. The establishment by statute of a non-judicial body whose members would investigate and report on complaints of prisoners, both collateral attacks on convictions and complaints of mistreatment in prison. Recourse to this procedure would be available to prisoners before filing a petition in a federal court, and to the federal judges with whom petitions were filed.


12. FRANK, ABA OMBUDSMAN COMMITTEE DEVELOPMENT REPORT (unpublished manuscript dated June 30, 1972) at 3 [hereinafter cited as FRANK REPORT].
holds the position. Swedish ombudsman experience dates from 1809 and currently divides the functions of the office between two men: an ombudsman for civil affairs and another for military matters. In England, the United Kingdom ombudsman dates from 1967 and is officially called the "Parliamentary Commissioner for Administration." The European ombudsman has been defined as:

an independent governmental official who receives complaints against government agencies and officials from aggrieved persons, who investigates and who, if the complaints are justified, makes recommendations to remedy the complaints.

The prototypical European ombudsman has broad authority over virtually every phase of government and nearly plenary power to investigate. The actual enforcement of the ombudsman's recommendations, however, appears to be less a result of statutory authority and more a result of the individual prestige of the office-holder himself.

In some of the Scandinavian countries the individual serving as ombudsman has had such high personal prestige that fears have been expressed about the development of a "personality cult."

The American Experience

The Scandinavian idea of establishing a single ombudsman with broad authority over the spectrum of national governmental operations has not taken root in the United States. Criticisms of the concept range from the attitude that an ombudsman can only function along Scandinavian lines in a small

13. Id. at 7. The FRANK REPORT has noted ombudsmen or ombudsman-like institutions in sixty countries.
16. FRANK REPORT at 4.
18. In Denmark, for example, the ombudsman is elected by the Danish Parliament. Upon the retirement of Professor Hurwitz, the former Director of the Danish Prison Administration, Mr. Lars N. Nielsen, was elected. In Norway, the ombudsman is a highly respected jurist, Judge Andreas Schei. FRANK REPORT at 3, 7.
This is not to say, however, that the Scandinavian ombudsmen were immediately accepted. Professor Rowat notes that in Denmark the civil servants' reaction was mixed:

Before the (ombudsman) scheme was introduced they opposed it, but after its adoption they soon realized that the office was an aid rather than a hindrance.

For in nine cases out of ten the Ombudsman vindicated their decisions and hence increased public confidence in the civil service. . . .

homogeneous country to the notion that an ombudsman in the United States will merely add another layer of administration on an already burgeoning bureaucracy.\textsuperscript{20}

As a result, American ombudsmen, as the examples given at the outset of this article suggest, have been much more restricted and the whole concept of the office more narrowly construed. Some states have established the office either by legislative action or by executive appointment.\textsuperscript{21} In New Mexico, for example, the state legislature has given ombudsman duties to an already-established elective public office—the lieutenant governor.\textsuperscript{22} Cities,\textsuperscript{23} public school systems,\textsuperscript{24} universities,\textsuperscript{25} and correctional institutions\textsuperscript{26} have appointed individuals with ombudsman-like duties.

A unique approach on the federal level is the appointment within a federal agency of an ombudsman who has responsibility only for a specialized subject matter. On March 26, 1971, the Department of Commerce established the office of “Ombudsman for Business,” and the Postmaster General recently announced the appointment of an Office of Consumer Affairs which will function as a “Postal Ombudsman.”\textsuperscript{27} However, while numerous bills have been introduced in Congress attempting to legislate some kind of ombudsman at the federal level, none have yet been enacted.\textsuperscript{28}

Proposals have even been made for adaptation of the concept to specialized organizations such as labor unions, and even religious orders of the Catholic Church\textsuperscript{29}—not a surprising move since the first use of an ombudsman-like official in Europe seems to have been the Visitator designated in the first constitutions of the Dominican Order in 1221 A.D.\textsuperscript{30}

\begin{itemize}
  \item 20. See generally the discussion in W. Gellhorn, \textit{When Americans Complain} 212-231 (1966).
  \item 22. \textit{Id.} at 13.
  \item 23. Frank has identified three cities as having offices which could “properly be called Ombudsmen”: Dayton, Ohio; Seattle, Washington and Newark, New Jersey. \textit{Id.} at 15-16.
  \item 24. According to the \textit{Frank Report} a large number of school systems have ombudsmen, including Dallas, Texas; Montgomery County, Maryland; Philadelphia, Pa., etc. \textit{Id.} at 16.
  \item 25. While not strictly within its scope, the \textit{Frank Report} reveals that “at least 38 institutions have ombudsmen.” \textit{Id.} at 16.
  \item 26. A number of prison systems have adopted ombudsmen to help dispose of prisoners’ complaints. “Among the proposals given to the State [of New York] Correction Commissioner at Attica was a proposal for an ombudsman service.” \textit{Id.} at 17.
  \item 27. \textit{Id.} at 11.
  \item 28. See, e.g., the two bills collected at note 8, \textit{supra}.
\end{itemize}
II. The Ombudsman Concept—A Preliminary Definition

In considering a narrower scope for an ombudsman-type official, there looms a danger: that the word will be preserved without any defined content, that any suggested “Mr. Fixit”—with or without ascertainable authority or function—will be accorded the name “ombudsman.” A recent across-the-page headline in the New York Times announced the establishment of an “ombudsman” in a metropolitan school. Below the headline, the article never used the word “ombudsman”: it merely described a concerned teacher who had informally and markedly won the confidence of pupils at his school and had their interests at heart. If a word is to have any value, it must have a generally accepted content; so much the more for an embryo institution. There are minimum contours of the office we have in mind in our Phase III “one-legged ombudsman” proposal.

While there has been no agreement concerning the mode of appointment or of financing of the ombudsman, it is generally accepted that he should enjoy a certain independence of the institution within which he functions and that his effectiveness will be measured by his persuasiveness within that institution. His internal persuasiveness, in turn, rests in considerable part upon his influence outside the institution, through his access to higher administrative channels, to legislative sources which control both the purse and the legal framework of the institution, and to public opinion through professional associations and the media. This influence is often directly proportional to his own personal competence, disinterestedness, and prestige.

We start, then, with a working definition, that identifies an “ombudsman” as an administrative critic who investigates grievances within an organization and seeks in varying ways to correct malfunctions of the institutional system which give rise to them. The corollary—that he will employ external means of correction where feasible—is tempered by the realization that overstress on external pressures may limit his future effectiveness within the institution. The ombudsman, we assume throughout this article, is not an advocate in the sense of a lawyer (nor does he displace the advocate). His constituency is not primarily a specific individual, but rather the public interest in the proper functioning of a particular institution given its designated or professed objectives and its setting within the ambit of broader public concerns. His task may often be achieved in the course of seeking to correct a specific grievance; but as Professor Gellhorn insists, his real target is the correction of an administrative malfunctioning of which the specific case is but an example.31

III. The One-Legged Ombudsman In a Mental Hospital: Empirical Data

The brief ombudsman experience in St. Elizabeths Hospital, Washington, D.C., that is treated in this article, overlapped some other local ombudsman experiments which have received some public exposure.32 Reports on such projects can contribute much to the store of knowledge regarding purely local ombudsmen proposals. For this reason, the 1969-1970 Catholic University Law and Psychiatry Project [the "Ombudsman Project"] is recounted here in some detail.

The actual on-the-scene ombudsman operation at St. Elizabeths Hospital was limited to a period of six months between June and December 1969. But it is important first to examine both how the project came into being and what data was already in hand as the study began. Accordingly, our preliminary gaze is directed to a then novel legal assistance project at the Hospital in 1967-1969 and other studies of conditions at St. Elizabeths produced during the same time span.33

This legal assistance program encompassed two distinct stages in its brief existence: (1) a three-month “pilot project” (February-May, 1967), which recommended a permanent legal assistance program for mental patients; and (2) a continuation of the pilot project, with modifications, as a holding operation pending the establishment of a permanent institutionalized legal aid program at the hospital. By chance, the ombudsman project arrived on the St. Elizabeths scene at a time (June, 1969) when prospects of


The St. Elizabeths study has already provided the gist of an earlier article discussing involuntary commitment in general and the St. Elizabeths' procedures in particular. See Involuntary Hospitalization, supra note 10. For their encouragement towards fuller publication, I am indebted to Professors Walter Gellhorn, Professor Albert Reiss, Jr. of Yale University, and Professor Alexander Brooks of Rutgers School of Law.

33. In 1967, after the first "pilot program" in legal services at St. Elizabeths Hospital, the use of an "ombudsman" there was proposed to the National Institute of Mental Health (N.I.M.H.).

In November, 1968 a distinguished "ad hoc" committee composed of six psychiatrists, one behavioral scientist and one attorney who was experienced in legal psychiatry reported to N.I.M.H. on the security situation at St. Elizabeths. The committee conducted a survey of both the patient population in the various wards and the professional staffing in the wards.

Early in May 1969, Professor David Chambers of the University of Michigan Law School served as a full-time consultant to the Hospital. Both the ad hoc committee report and the Chambers Report contributed to our project's final ombudsman proposal.

Meanwhile, a proposal to N.I.M.H. was made in April, 1969 for a small grant to help sustain a project to develop a model for an ombudsman in a public mental health hospital. The grant was made by N.I.M.H. in June, 1969. The ombudsman project was the outcome of that grant.
a sustaining private sector legal assistance program had reached a vanishing point and the interim program was being phased out.84

But what sort of public mental hospital was St. Elizabeths, to provoke such a series of activities? It was, and is, indeed a special case, which warrants brief description.85

The Hospital

Some Statistics

The most important statistic about St. Elizabeths Hospital is that 5,438 persons reside there.86 With unimpressive exceptions,87 these human beings are confined by court order, either by civil commitment, after a hearing before the Mental Health Commission, or by the workings of the criminal process. The commitment by a court may be temporary (e.g., for a mental examination of persons under criminal charges to determine their fitness for trial) or for an indeterminate period (those found mentally incompetent to stand trial or not guilty of a criminal charge by reason of insanity).88

In the security sections, the patient population in 1968 was distributed as follows: John Howard Pavilion (maximum security) 395; West Side (medium security for misdemeanants and civil committees) 422; and Cruvant (female security wards and medium security ward for transfers from John Howard) 123.89 The professional staff ranged from 142 (including 117 nursing assistants and attendants) in John Howard to 59 (including 43 assistants and attendants) in Cruvant.40 It will be remembered, of course, that

34. See the summary of the earlier legal services project, text at note 53 infra.
35. There is no dearth of recent literature on St. Elizabeths. See, e.g., R. ARENS, MAKE MAD THE GUILTY: THE INSANITY DEFENSE IN THE DISTRICT OF COLUMBIA (1969); and the now classic E. GOFFMAN, ASYLUMS (1961).
37. A certain percentage (about 10%) are classed as voluntary patients although recent findings of the Judicial Conference Committee question the actual "voluntariness" in some cases. Some patients have been transferred from other federal establishments, such as hospitals or Indian reservations. See THE COMM. ON LAWS PERTAINING TO MENTAL DISORDERS, JUDICIAL CONFERENCE OF THE DISTRICT OF COLUMBIA CIRCUIT, STUDY OF THE COMM'N ON MENTAL HEALTH OF THE DISTRICT OF COLUMBIA (Nov. 13, 1969) [hereinafter cited as JUDICIAL CONFERENCE REPORT].
38. For a detailed discussion of the various methods by which patients are committed to St. Elizabeths, see the earlier article on the project: Involuntary Hospitalization 558-74.
39. These figures were developed in the NATIONAL INSTITUTE OF MENTAL HEALTH REPORT OF THE AD HOC COMMITTEE FOR THE EVALUATION OF SECURITY PROGRAMS AND FACILITIES AT ST. ELIZABETHS HOSPITAL, Nov. 1, 1968 (the report was made available to the project by official sources) [hereinafter cited as N.I.M.H. REPORT]. See supra note 33.
40. Id.
this is the total number in each ward and certain numbers of professional staff must be placed on each of three 8-hour shifts each day.

The Administrative Setting

St. Elizabeths is the largest federal mental hospital in the country; and, on paper at least, it is closely aligned with the federal mental health agencies, particularly the National Institute of Mental Health, (N.I.M.H.) under the Department of Health, Education, and Welfare.\(^{41}\) Despite its long association with these large supervisory agencies, until 1967 St. Elizabeths enjoyed a considerable measure of autonomy. This was due partly to its establishment by special act of Congress and partly to its unique mission among federal agencies.

By 1969 this autonomy was gradually changing, however, since St. Elizabeths was then placed under the Health Services and Mental Health Administration. The administrative hierarchy reads as follows: Secretary of HEW, Assistant Secretary for Health and Security Affairs, Public Health Service (Surgeon General), Health Services and Mental Health Administration, National Institute of Mental Health, St. Elizabeths Hospital.

Even though this is the format for the theoretical table of organization, the practice is that the Hospital’s major policies are no longer formulated by its Superintendent but rather by N.I.M.H. officials. One of the byproducts of the ombudsman project was the education of the project’s personnel as to where the pressure might best be applied in the administrative hierarchy to get the desired results. We discovered, and often wish we had known earlier, that the effective pressure point for change of any magnitude at St. Elizabeths is not the Hospital Superintendent’s office but the N.I.M.H. offices across town in Bethesda, Maryland.

It is freely said that this Hospital is on the verge of additional changes,\(^{42}\)

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41. An Act of Congress in 1855 established the Government Hospital for the Insane (Act of March 3, 1855, 10 Stat. 682). In 1916, the name of this federal hospital was changed to St. Elizabeths Hospital, after the geographic section of the District of Columbia in which it was located (Act of July 1, 1916, 39 Stat. 309). During this period, and until 1940, the Hospital was under the Department of the Interior. In 1939 the Federal Security Agency was established—a combination of agencies “whose major purposes were to promote social and economic security [and the] educational opportunity of the citizens of the nation . . .” and included the Office of Education, Public Health Service, Social Security Board, and U.S. Employment Service. In 1940 St. Elizabeths was transferred to the new component agency, at the same time as was the Food and Drug Administration. Reorganization Plan I, effective April 11, 1953, established the new Department of Health, Education and Welfare, which took over the component parts of the Federal Security Agency. Since 1953, St. Elizabeths has been a component of HEW.

42. A series of articles which appeared recently in The Washington Post largely confirmed the project’s observations on the inertia and lack of progress at St. Eliza-
the most drastic of which is the contemplated transfer of the Hospital from the federal government to the control of the District of Columbia.43

*The “Pilot” Project*

On December 8, 1966 a curious concatenation of events led to an unusual meeting in the maximum security building of St. Elizabeths Hospital—John Howard Pavilion. With the encouragement of Dr. Joseph Owens, clinical director, and Dr. Mauris Platkin, assistant clinical director, a “Patients Administrative Council” had recently been established at John Howard. Patients elected ward chairmen on each of the 12 wards and also elected members of a pavilion-wide administrative council. This council, and particularly its chairman, kept the pavilion directors and doctors alert to patients’ concerns. At the same time a legal assistance program had been in effect for several months at the District of Columbia Jail. In this jail project, law students, with faculty direction, assisted prisoners with their personal, non-criminal legal problems. Since there is a continuous traffic of inmates between the jail and John Howard, it was inevitable that the St. Elizabeths patients would soon ask to be included in the legal assistance program.

In Autumn 1966, having gained the approval of the pavilion administrators, the patients’ council wrote to Daniel Freed, then head of the Office of Criminal Justice, United States Department of Justice,44 asking that he consider steps toward establishment of such a program at John Howard Pavilion. The December 8, 1966 meeting was the result.

Present at the meeting were Drs. Owens and Platkin, three members of the Patients’ Administrative Council, Mr. Freed, his collaborator on the project Gerald Caplan,45 and a variety of people invited by Mr. Freed from the District of Columbia legal community: Julian Dugas, then head of the Neighborhood Legal Services Project for the District and his chief assistant, Lorenzo Jacobs; the head of the Young Lawyers Section of the District of Columbia Bar Association; John Bodner, a member of the District of Columbia bar interested in community projects; and myself, a law professor at a lo-
Ombudsman law school. Apparently most of us had nothing more than a vague notion as to the purpose of this gathering. After a presentation of the events I have related above, the invited guests agreed to collaborate on a three-month pilot program providing legal assistance on personal legal problems to the John Howard patients.

The Pre-Ombudsman Project Data

February - May, 1967

Following this meeting, from February to May, 1967 students at Catholic University Law School, supervised by John Bodner and myself, conducted the pilot project. The project's announced purpose was to determine the necessity for legal assistance—excluding habeas corpus advice—for patients at John Howard Pavilion. In the course of the three-month project, 70 patients—approximately 20 percent of the population of John Howard—were interviewed.

Each patient was initially screened as to the subject matter of his legal problem by the Patients' Administrative Council and then interviewed by law students under the supervision of the two attorneys. The students investigated each case and made preliminary recommendations as to its disposition. The two supervising attorneys then proposed disposition to a panel of volunteer attorneys from the bar association committee. The panel reviewed the interview report and the recommendations and made the final determination—placing the patients' problem in one of several categories.\(^{46}\) The students, in turn, reported the disposition to the individual patients, and the two project attorneys would arrange for either lawyer referrals or doctor interviews, as necessary, and report once again to the patients.

Of the 70 patients interviewed, 11 were referred to an outside volunteer attorney obtained by the pilot project directors. There was no further action taken beyond the initial interview for 16 of the remaining 59 patients (on a follow-up interview, these cases were given a "no action" report). In 25 cases, a consultation was arranged with the patient's administrative psychiatrist. In 16 cases, where the patient already had counsel, the attorney was advised of the interview and the patient was notified of our withdrawal from the case. In the two cases remaining, a requested contact was made with a family member and a social worker.

At the December 1966 meeting, both the hospital officials and the patient representatives stressed that the main object of the program was to provide

\(^{46}\) The categories used were: (1) refer to an outside attorney; (2) no attorney referral; (3) contact present attorney; (4) discuss with patient's psychiatrist.
civil legal assistance to patients. Matters involving habeas corpus were expressly excluded. Both the administrators and the patients’ council indicated that the chief concern among the patients was property, contract, social security, veterans benefits, or domestic relations matters. However, as it developed, the chief concerns of those interviewed were “When do I get out?” Of the 74 problems catalogued, 32 concerned proposed release from the hospital.  

June, 1967

The Pilot Project Report, prepared at the conclusion of the three-month period, recommended institution of a comparable program tied to a local law school with adequate financing and expanded beyond John Howard Pavilion to other parts of the Hospital. The Report also recommended the establishment of two part-time ombudsmen insulated from the advocacy process who could discharge the internal liaison function, such as conferring with doctors and officials inside the hospital on patient grievances.

June, 1967 - November, 1967

The legal assistance program was continued on a more limited basis through the fall of 1967. An ad hoc committee, organized to institutionalize the project, noted that financing was required if the program was to continue and expand beyond John Howard. Further, continuation of the program was fostered by the interest of the John Howard Patients’ Administrative Council and by the satisfaction with the project expressed by the chief ad-

47. Some other form of relief concerning commitment was sought by three patients (return to prison for parole, or to serve term; transfer to another hospital), and two had complaints about their attorneys. A large number of patients (24) had some complaint internal to the hospital: 13 wanted transfer to a less secure ward, 7 alleged they were receiving no treatment, 3 alleged some abuse by hospital personnel, and one proposed a legal action against the hospital. Only 13 of the 74 problems involved a civil matter of the type the program had contemplated: a conservator problem (3), a social security matter (2), a property problem (2), and a miscellany of others, including divorce, pension, veterans benefits, etc. (6).

48. The final report of the Pilot Project stated:

[We recommend] [t]he establishment of one or two Ombudsman-type independent investigators who alternatively might be responsible to the Department of Health, Education and Welfare, the Congress or the courts, and at the same time administer an interviewing and referral program based upon the experience [of the Pilot Project].

PILOT PROJECT REPORT 8 (June, 1967) (on file at Catholic University Law Review) [hereinafter cited as PROJECT REPORT].

49. The patients’ reaction was described as follows: “The project has been successful in getting detainers lifted in several cases; it has been successful in communicating with members of the Medical Staff on behalf of quite a few of our people, arranging Off-Service transfers, obtaining employment, and removing the antipathy felt by many patients towards the staff, etc. While it has not completely eliminated petitions for
ministrative official at John Howard, Dr. Platkin. Dr. Platkin, in fact, called attention to "not merely the desirability, but the need for a continuing program of legal assistance to the patients in John Howard" and endorsed the corollary proposal of a hospital ombudsman.50

December, 1967 - February, 1969

Members of the ad hoc committee met in December, 1967 and endorsed the proposal to secure funding for a permanent legal assistance program at St. Elizabeths. The committee also established a special subcommittee to follow through on drafting and funding. When initial attempts to secure funding failed, an enlarged group of interested hospital officials51 met with the ad hoc committee to discuss continuation of the program. The N.I.M.H. officials and the Hospital administrators endorsed continuation of the legal assistance program and recommended that the community ad hoc committee file a grant application for that purpose with N.I.M.H.

This application was filed on June 1, 1968 and denied in November 1968. The St. Elizabeths program had been staffed in the interim by Catholic University Law School faculty and student volunteers. Assured by N.I.M.H. that the grant application had been denied for technical reasons (absence of an adequate research component), the sponsors (this time Catholic University) filed a second application in February 1969 which was again, they were told, denied for technical reasons.52 Although they were, once again,

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50. Letter of Dr. Platkin to Daniel J. Freed, Esq., Director, Office of Criminal Justice, Department of Justice, November 27, 1967. In this letter Dr. Platkin gave his full support to a continued program: "I would certainly agree with Mr. Bodner that there is need for a fulltime lawyer stationed in the Hospital. (You are aware, of course, that in addition to John Howard there are the West Side and Cruvant Services that also house patients committed by the Court.) Because of the nature of their commitment many of these patients have numerous problems totally unrelated to, or at best, indirectly related to the particular circumstances for which they are hospitalized. Since the great majority of these patients are indigent and they are legally represented by counsel who are specifically appointed to defend them in their current charges, it is understandable that they have no, or inadequate, representation or assistance in matters other than their present charges. I believe some sort of ombudsman would be highly desirable. What is really important is that the patient have available to him legal guidance and assistance as well as representation in situations where he cannot handle his problems without such assistance."

51. The N.I.M.H. Hospital group included Drs. Bertram Brown, Louis Jacobs and Saleem Shah of N.I.M.H., Dr. David Harris, Superintendent of St. Elizabeths, and Dr. Platkin of John Howard Pavilion.

52. Unimpeachable evidence from participants in the decision-making on the two legal assistance grant applications suggests that the reasons for the rejection of the
urged to re-file, the sponsors were now fully aware that the project had no realistic chance for funding and, accordingly, began winding down the two-and-one-half year old project.\textsuperscript{53}

However, when the sponsors made their second application for the legal assistance project, almost as an afterthought they also applied for a small grant ($5,000) for a three-month ombudsman project.\textsuperscript{54} To their surprise, the ombudsman application was given serious consideration. But the granting agency would need assurance, they were told, that the Hospital was agreeable to the project. Accordingly, I conferred with Dr. Louis Jacobs, then Superintendent of St. Elizabeths, and he agreed to the plan. In June 1969, we received from N.I.M.H. both a formal rejection of the legal assistance project and an approval of the ombudsman application with the interesting proviso that the period for completion of the ombudsman project was not to be merely three months but instead from "June, 1969 to June, 1970."

\textit{The Ombudsman Project}

\textit{Methodology}

Before undertaking our work, we already had accumulated some working hypotheses as to the possible role of an ombudsman in a public mental hospital derived from the two-and-one-half years' experience in the legal services program.\textsuperscript{55} These opportunities for observation provided a reasonably sound basis for the selection of the project methodology. We decided that conventional measures were necessary for the initial framework and would include a combination of interviews, statistical research, and observation (including the fruits of the previous 2 1/2 years' experience). But it was further, and most significantly, determined that a major phase of the task remained totally unexplored as the project began. We had rarely, in the applications transcended "research techniques." One participant stated that there were strong reservations as to the propriety of N.I.M.H., which runs St. Elizabeths, funding a grant which might ultimately lead to legal actions against the Hospital itself.

\textsuperscript{53} Pending cases were reassigned to private attorneys, where they offered promise and counsel could be obtained, or closed by notification to the patients. A case summary of the two-and-a-half year legal assistance project at the Hospital is annexed, as Appendix B.

\textsuperscript{54} The ombudsman small grant application was not conceived by the sponsors as an alternative to the legal assistance grant application but as a project which could be carried on in the summer of 1969. The legal assistance program proposed a beginning date of September, 1969. A member of the committee which rejected the application stated unequivocally that his opposition, which was conclusive in the committee, was based upon the need for a larger program of full-time legal assistance rather than the part-time nature of the proposal. I concur with this judgment.

\textsuperscript{55} See the summary of the data accumulated in the legal assistance project at note 53, \textit{supra}. 
earlier legal aid project, delved into what became a central function of the ombudsman—patients' grievances against the hospital itself.\(^{56}\)

To supplement this conventional methodology, a plan was consciously adopted to act out the ombudsman role both within the hospital itself and, as necessary, in connection with those outside institutions with which the patients and the hospital had significant relations.

The project timetable was determined both by our previous experience with the Hospital and by simple economics. N.I.M.H. had granted us funds for three and one-half months, which could be completed anytime during the year from June, 1969 to June, 1970. We divided the project into two parts. Part One, which was to last five months, concerned itself primarily with the John Howard Pavilion (the maximum security section where our earlier observations had taken place). Part Two, which was contingent on receiving additional financing, would examine the medium security and civil commitment sections at St. Elizabeths. Because attempts to finance Part Two failed, our report here is primarily concerned with the results of Part One only.

The “acting out” of the ombudsman’s role within the hospital was intended to answer two basic questions: (1) is an ombudsman feasible, at least on a trial basis, in a public mental hospital, and, if so, (2) what are the necessary characteristics for such an office. Specifically, with respect to the second question, we sought answers to the following: what should be the ombudsman’s sphere of activity; what agency should finance the office; what is his constituency; what specific functions should be assigned to him; what characteristics should be sought in designating the person to fill the job; and who should designate the officeholder.

We also believed that the answers to both major questions required not only an examination of the patients’ grievances as they themselves expressed them, but also an extensive and detailed exploration of what different members of the hospital conceived their problems to be, what they saw as the

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56. In the earlier program we had been confronted with some grievances of patients against the hospital administration. However, our legal aid work had largely been confined to a patient’s “external” problems such as property claims, family affairs, social security and veterans’ benefits. We expressly restricted ourselves from giving advice on patients’ claims against the hospital. We had no concern with habeas corpus cases, although we did undertake, on occasion, to confer on a patient’s behalf with doctors as to the prospects for release. This had been done entirely unofficially and was subject to the willingness of a particular doctor to discuss his cases. At first most doctors had been willing to confer, sparked in part by an early by-product of such conferences—the decline in habeas corpus petitions. When this initial windfall became less apparent, and the habeas corpus chart soared again, these conferences became harder to obtain and, when used, were of less value. By contrast, a large part of the ombudsman project consisted of assistance on habeas corpus petitions. See the individual cases in the text at notes 60-78, infra.
best solutions to these problems, and, finally, the actual impact of an ombudsman on those external agencies which oversee and supervise the hospital's operation. We found the actual data taken to be highly relevant and invaluable to the answering of the two basic questions.  

\[\text{57}\]

The Project Begins

Administrative Support and Resistance

At the outset of the Project the ombudsmen consulted with Dr.Louis Jacobs, Hospital Superintendent, who agreed to make available whatever hospital data and staff cooperation was necessary for the completion of the task. Cooperation at John Howard Pavilion, where the major effort was initially to be made, was assured by Dr. Mauris Platkin, the Acting Director, and continued by his successor. Despite these assurances, we met with occasional lower-echelon resistance which sometimes required a return to these principal officials for further support.

The first two tasks undertaken were a complete study of the operating regulations of the Hospital (its "law in the books"), and a study of the intake and outgo functions (its "law in action"). While part of the ombudsman team was studying the Hospital regulations, another group was already examining the processing functions in the office of the Hospital Registrar. It was at the Registrar’s office that we met with our first obstacle.

The Writs

At our initial conference with the Registrar on the second day of the project, we presented the following subjects for our initial research, each covering the three-year period from July 1, 1966 to June 30, 1969:

(1) Number of admissions (per category: a) incompetent to stand trial; b) not guilty by reason of insanity; c) transfers under sentence; d) civil transfers from other federal facilities.);
(2) Number of releases (per category: a) conditional release; b) unconditional release.);
(3) Transfers (per category: a) from maximum security to less secure internal wards; b) from St. Elizabeths to other external facilities.);

\[\text{57. Perhaps the most interesting and provocative occurrence during the project was the heretofore unsuspected need for speedy response by the ombudsman to unanticipated situations, and the subsequent reaction of the hospital to these unplanned situations.}
\[\text{58. This concept of a distinction between written law and actual administrative practices originated in the writings of Roscoe Pound and has been thoroughly discussed in the earlier article on the St. Elizabeths project. See Involuntary Hospitalization 548-58.}\]
Ombudsman

(4) Habeas corpus writs (per category: a) number of writs filed; b) number of writs disposed of without filing order to show cause; c) number of writs disposed of on order to show cause filed by hospital.).

Since we had been assured that the information was readily available and at our disposal, no difficulty was anticipated at this stage. However, on the second day of research a blockage occurred requiring a further conference with the Superintendent. Meanwhile, it became apparent that much of the requested information was available at the John Howard Pavilion where the cooperation was more consistent. Fortunately, the records there proved sufficient for our purpose.

The initial writ data confirmed previous information, and there were at least five cases which required immediate attention. When inquiry proved that they could not be solved internally—i.e., the policy to insist upon “exhaustion of administrative remedies” was firm hospital policy—we referred the cases to outside volunteer counsel for testing by judicial action.

As it

59. This key subcategory was further broken down as follows: (i) with appointment of attorney, (ii) on hearing on order to show cause, attorney representing patient, (iii) on grounds of failure to exhaust administrative remedies, (iv) by court order directing release, (v) specify number of cases in category (iii) in which a hospital psychiatrist appeared.

60. The experience at John Howard Pavilion in the two preceding years had taught us that it was not easy to secure counsel for its patients, and that the quality of work on their behalf varied greatly with the individual attorney. Fortunately, Professor Richard Arens of the University of Toronto, a former colleague at Catholic University Law School and member of the District of Columbia bar with extensive mental health experience, volunteered his services for a limited number of referral cases. The Dixon matter was one of Professor Arens’ cases. He also participated in the Jones case, infra, text at notes 72 to 78, and the Williams case, infra, text at notes 66 to 72. He also helped resolve the “Thomas Smith” case as well, the case which served as a focal point for the earlier part of this study. See Involuntary Hospitalization 589-98. Since no action developed during that summer after Professor Arens filed the initial papers seeking a rehearing for Dixon as well as the other cases, in our capacity as ombudsman we sought new resident attorneys to take them. Due to the interest in the important public issues raised in these cases we were able to secure highly competent counsel in the persons of Charles Halpern who had argued and won the landmark mental health cases of Rouse v. Cameron, 373 F.2d 451 (D.C. Cir. 1966), Bolton v. Harris, 395 F.2d 642 (D.C. Cir. 1968), Covington v. Harris, 419 F.2d 617 (D.C. Cir. 1969), and Steven Rosenberg who had worked on Covington and has just completed his report for the Judicial Conference on the functioning of the Mental Health Commission in civil commitment matters. See supra note 37. Richard Sailer and Herbert Silverberg of the Covington and Burling law firm agreed to act as counsel for Donald Williams. David J. Newburger, Halpern and Rosenberg enlisted as attorneys for Alton Jones and carried on this litigation to a successful conclusion. See text accompanying notes 73-78. Thereafter, the conduct of Dixon, and the equally significant victories won in Williams and Jones were totally theirs, and their actions constitute public service in the highest traditions of the bar. This subsequent history was made largely after the ombudsman project had terminated and the report was in preparation. However, it still is part of the empirical data illustrating the type of effect a one-legged ombudsman might have if he operates, as we did, under such favorable conditions and with such strong support of the local bar.
happened, the patients whose problems were most clearly in need of attention had cases already pending in the courts or had been earlier denied judicial relief without any legal representation.

Although we later compiled extensive statistics from the hospital records, engaged in large scale interviewing of patients and staff, and maintained contact with outside agencies concerning patients' problems, the project's chief fruits were derived from the progress of these court cases. For this reason, and because they focus on the ombudsman's activities, we will discuss the court cases first.

Some Specific Cases

Three cases which resulted in court of appeals decisions favorable to the patients will be examined. We feel they are illustrative of the potential advantage of a hospital ombudsman. Each of the cases was initiated as the result of the project's initial writ research.

1. Dixon

Dennis Dixon was tried in 1964 for assault with the intent to commit carnal knowledge and murder in the first degree. He was defended by an attorney from the Legal Aid Agency (the predecessor of the Public Defender Service), found not guilty by reason of insanity, and committed to St. Elizabeths Hospital by order of the district court on December 11, 1964. Subsequently, he filed two petitions for writs of habeas corpus seeking discharge from the hospital on the ground that he had recovered his mental health. The petitions were duly opposed by the United States Attorney acting on behalf of the hospital. On each petition, counsel was appointed for Dixon and a hearing was held. Both of these early petitions were dismissed; the first on October 10, 1966, and the second on July 8, 1968.

In May 1969, Dixon was still a patient in the John Howard Pavilion, the maximum security service ward to which he had initially been assigned in 1964. Although he had undertaken some limited attempts through his physician to be moved to a less confined ward—the first step toward eventual release—he received little encouragement. As a result, in 1969, he filed a third petition for a writ of habeas corpus, drawing the petition himself with some assistance from other patients on the ward who were more adept at drafting pleadings. Since the petition made the crucial allegations that he had recovered his sanity and was no longer dangerous to himself or others (what might be termed a prima facie case for release), the district court directed the hospital to show cause why the writ should not be issued. The hospital answered on June 10, 1969, in a format that was becoming a normal
response to such petitions. It simply stated that the detention was lawful, that petitioner had two prior hearings—and received adverse decisions in each—on similar allegations, and moved to dismiss on the ground that Dixon had "failed to exhaust his administrative remedies." Without appointing counsel for Dixon or holding a hearing, the district judge dismissed the petition without explanation.

The ombudsman project was just under way and the patient who was serving as the elected head of the patients' self-government brought the matter to our attention. Our research into recent disposition of similar writs by the district courts had shown us that the court mechanically disposed of writ petitions when there had been a prior denial within the previous six months. This time period was commonly accepted by the patients and was incorporated into their pro se writ practice.

However, Dixon's case involved summary denial of his writ even though the earlier dismissal had occurred almost a full year prior to this third petition. Because the court had given no reason for its dismissal, we assumed that the basis for the denial rested on the government's assertion that Dixon had "failed to exhaust his administrative remedies." Our previous experience with John Howard patients made us aware of the use which the hospital had been making of this asserted basis for denial of the petition. The hospital claimed that there was a court of appeals requirement that patients must formally request an independent physical examination before filing a new writ petition. We were also aware that whenever a patient made such a request the hospital routinely denied it, explaining that the examination was presently unavailable to him.

After checking with various hospital officials we discovered that this procedure for dealing with writs was accepted as part of the hospital routine. Since there was no way to deal with this practice at the administrative level, the practice cut off any meaningful access to the courts for most patients. Accordingly, at Dixon's request, we referred his case to independent counsel who immediately filed an appearance on Dixon's behalf and moved for a rehearing on the petition. In keeping with our established strategy for the ombudsman project, we withdrew from the case. Henceforth, Dixon's case was to be exclusively a matter between him and his private attorney.

Rather than proceed with the motion for rehearing in the district court, Dixon's attorney filed an appeal to the District of Columbia Circuit Court of Appeals. The Court of Appeals, reversing the lower court's dismissal in an opinion written by Chief Judge Bazelon, discussed at length the entire question of the government's method of dealing with habeas corpus petitions by alleging the "exhaustion" argument and further clarified the practice fol-
owed in the district court of summarily dismissing a writ petition on grounds of abuse of the writ.\textsuperscript{61}

First, the circuit court attacked the "six-month" rule for habeas corpus petitions coming from hospital patients by requiring an examination of the merits of the petition even if its allegations were adversely resolved in an earlier writ of the patient's. Judge Bazelon took special pains to point out that, when a court is dealing with such a transitory matter as mental health and dangerousness, arbitrary time periods and summary dismissals are simply inadequate. In evaluating these petitions, the district courts failed to examine the patient's present mental condition.\textsuperscript{62} While not completely abrogating the "six month" doctrine, Judge Bazelon did comment that the lower court may hold a plenary hearing on the issues regardless of the time interval since the earlier petition "if it believes that the interests of justice would thereby be served."\textsuperscript{63}

Moreover, Judge Bazelon gave little credence to the hospital's "exhaustion" claims. To the hospital's contention that it was Dixon's duty to request a medical examination within the last six months, the court indicated that the exhaustion requirement was not the request, but the examination itself, and that the hospital was under a statutory obligation to examine its patients every six months and could not oppose a writ for reasons of its own non-feasance.\textsuperscript{64}

As for the hospital's argument that Dixon had failed to exhaust his right to be examined by an outside psychiatrist, Bazelon commented:

> The return gives no indication how such an examination might be requested, nor does it indicate that such a request, if made, would be honored. Papers filed in this court suggest that no funds are available to compensate outside psychiatrists . . . and that in consequence no such examinations are being made.\textsuperscript{65}

According to Judge Bazelon, Dixon's problems with the hospital were largely due to the inadequate methods of administration and record-keeping followed at St. Elizabeths. In a strong conclusion, the court noted this lack of established and fair procedures in the matter of patients' writ petitions and said:

> [The hospital's] reaction [in Dixon's case] was only to attempt

\textsuperscript{62} Id. at 595.
\textsuperscript{63} Id. at 597, n.22.
\textsuperscript{64} Id. at 598. The statutory provision in question is D.C. Code § 21-548 (1967):
> The chief of service of a public or private hospital shall, as often as practicable, but not less often than every six months, examine or cause to be examined each patient admitted pursuant to this subchapter . . . .
\textsuperscript{65} 427 F.2d at 599.
to avoid any review whatsoever of its action. Although it has conceded in this court—where appellant is represented by counsel—that the action below was improper, it has continued to urge the District Court to take precisely the same action on petitions filed by patients unrepresented by counsel.\(^6\)

2. **Williams**

In early August 1969, in the second month of the ombudsman project, I visited Donald Williams at West Side Service, one of the buildings on the grounds of St. Elizabeths designated as an “open” building (meaning neither maximum or medium security). Williams had been an old client from the legal assistance project when he had originally been confined in John Howard Pavilion as “incompetent to stand trial.” The mental defect upon which the district judge relied in ordering his confinement was amnesia.

In 1967, when the original pilot project was underway one of the John Howard Pavilion doctors explained to me that there were undoubtedly many difficulties presented by the Williams case. Williams was a model patient, had shown improvement in his general condition, but still persisted in asserting a lack of memory as to the events surrounding the crime for which he had been charged. The doctor could not certify that he had recovered from amnesia and thus there was “nothing the hospital could do for him.” On the doctor’s suggestion, and at Williams’ request, I discussed his case with the appropriate Assistant United States Attorney. The doctor had suggested that if Williams was in the hospital due to a verdict of not guilty by reason of insanity he would, within six months, recommend his transfer to an “outside ward”—the first step toward release.

On the other hand, if Williams remained confined as incompetent to stand trial, the present dilemma remained. Since the prosecutor insisted that he had ample objective testimony as to the offense, he refused to drop the charge. As a result, I advised Williams, and he willingly agreed, to consent to stand trial on condition that the prosecutor accept a plea of not guilty by reason of insanity. I represented Williams at his trial; he subsequently returned to John Howard and a few months later he transferred to West Side. While at West Side his performance continued to be good, but an unexpected delay developed prior to his being recommended for unconditional...

\(^6\) *Id.* at 601. Judge Leventhal dissented on various issues which appeared to focus on Dixon’s original detention by virtue of his insanity acquittal on the murder charge. “The paramount factor bearing on decision is not the interest of the patient, but rather the interests of society.” This interest, Leventhal notes, includes not confining a patient without reason or foundation. *Id.* at 601. Although the subject of an ombudsman was not under discussion in *Dixon*, Judge Bazelon’s opinion supports at least the concept. (cf. Freund Committee recommendation cited in note 10, *supra*).
release. I went to see him in August, 1969 on a social security claim we had been handling for him. He told me that his doctor advised him that the only holdup on his release was arrangement for employment. I told him I would speak to the hospital official charged with that responsibility.

The following week, as ombudsman, I interviewed the Vocational Rehabilitation officer, the hospital official in charge of seeking employment opportunities for patients ready for release, and he assured me that he expected to have a satisfactory work program ready for Williams within two weeks. On that same day, however, on returning to John Howard Pavilion, I was greeted by an attendant who said Donald Williams was back. He was confined to Ward 11, the “disturbed ward” on the top floor. The John Howard officials explained that he had been brought there by security personnel, having been identified as the person who had threatened a nurse with an ice pick in an attempted robbery a few days before. I visited Williams in my capacity as an ombudsman and he denied being involved in the incident. Further questioning led to his insistence that he had been in class at the time specified for the alleged robbery and assault.

I requested the head of John Howard and the HEW attorney who advised the hospital to grant Williams a formal hearing, arguing that this matter of reconfine ment in John Howard did not turn on a medical judgment but on an issue of fact—a pure question of identification. My request was refused and the ombudsman role had been extended to its limit, except for the final task of obtaining an attorney for Williams. At our suggestion he asked Professor Arens to represent him. After an interview, Arens presented a formal request for a hearing to the hospital authorities and was never given a reply. Since this case raised special issues requiring fuller attention than Arens was able to give, we sought additional counsel for Williams.67

The new counsel filed a petition for habeas corpus, not seeking Williams’ release from the hospital, but merely requesting a ruling that his present detention in John Howard was without due process, in that this crucial internal transfer had been made without the necessary hearing procedures. After a hearing the district court dismissed the petition. On appeal, the court of appeals reversed.

Unlike Dennis Dixon, Williams did not challenge the propriety of his detention at the hospital but merely questioned his transfer to maximum security without the benefit of a hearing. Speaking for the court, Judge Bazelon reiterated the need to limit judicial review of hospital action in the matter of treatment and internal decision making to a narrow analysis of reasonable-

67. The new counsel were Robert Sailer and Herbert Silverberg.
ness within a "broad range of discretion" and not "whether [the hospital] has made the best decision." 68

He reviewed the hospital's record-keeping as he had in Dixon, and held that the records in the Williams case were inadequate to support the actual disposition made by the hospital and inconclusive as to the reasons given for transfer. Moreover, the hospital would not be permitted to save a previously unsubstantiated decision based on incomplete data in the records by "subsequent demonstration in court." 69 Judge Bazelon commented that, had the hospital kept proper records and permitted the patient to insert his own explanation of the incident into the administrative record, "we might well be able to conclude that the patient, as well as the hospital, could be bound by the record made in the administrative proceedings." 70 Until such time as these records are regularly kept, Judge Bazelon explained that the court would continue to exercise its supervisory powers over the hospital by conducting virtually a de novo examination of the incidents complained of, rather than merely looking at the reasonableness of the hospital's action based on its own inadequate record. 71

Technically, the reversal merely remanded the case to the district court for further consideration that would permit "the government, should it desire, to introduce further hospital records that would establish the legality of appellant's transfer and retention in John Howard Pavilion." 72 No further consideration was needed, however. The hospital followed the suggestion and within weeks, Williams was given his unconditional release.

3. Jones

During the limited legal assistance project when the faculty and students from the law school were performing minor tasks for the patients in the John Howard Pavilion, one of the patients interviewed was Alton Jones. Jones was originally charged with a felony, found incompetent to stand trial, sent to St. Elizabeths, and confined to the maximum security ward. His manner was mild and his doctor soon marked him for progress out of the ward through the normal process of transfer by doctor's recommendation to a less confined service ward. Jones soon received this recommendation and was transferred to an "outside ward." While there he began keeping company with a woman patient. He was quickly returned to John Howard and advised that he had been accused of rape. To his doctor he denied any guilt.

69. Id. at 643.
70. Id.
71. Id. at 644-45.
72. Id. at 640.
Jones' psychiatrist was apparently inclined to believe him. Nevertheless, the doctor in charge of the ward where his woman friend was confined believed the female patient. Reluctant to intervene in this dispute between the two doctors as to Jones' veracity, the hospital authorities elected to leave Jones at John Howard Pavilion.

When Jones told his story to the law school interviewers, they intervened on his behalf with his doctor. Although the doctor was sympathetic with Jones' plight, he was not prepared, in light of the conflicting evidence and the strong position taken by the woman's doctor, to reopen the matter. The law students considered taking formal steps to reopen by publicly demanding a formal hearing, but decided not to press the matter by a confrontation. Jones, therefore, remained in the John Howard Pavilion. Two years later he filed a petition for a writ which was summarily denied without appointment of counsel and without a hearing. Once again, the ground cited by the judge was the failure to exhaust his administrative remedies.

When the ombudsman project commenced in the summer of 1969, Jones' original petition had been recently denied. We quickly singled out his case as one of four to be initially assigned for immediate remedial action to the independent counsel who had made his services available to us. The attorney filed a motion asking the judge to reconsider his earlier denial of the petition, but the motion was not presented for hearing during that summer. In September, new counsel was obtained for Jones. These counsel elected to discontinue the activity with respect to the recently denied petition and to file a fresh petition for a writ of habeas corpus. This second petition was similarly denied. The court ruled in accordance with its standard practice of summarily dismissing any petition when a previous petition had been filed less than six months earlier. The new counsel for Jones decided, however, to appeal this latest court order.

Before the appeal was heard by the court of appeals, the hospital recommended Jones for conditional release. Despite this recommendation, counsel pressed the appeal. The decision in the Williams case intervened,73 containing as we have seen, strong criticisms of the lack of due process within the hospital in the matter of internal transfer decisions. Subsequently, the court of appeals heard argument on the Jones appeal and established minimum procedures of due process which the hospital would be required to follow in similar cases.

Perhaps dissatisfied by the continuing reluctance of the St. Elizabeths Hospital administration to establish guidelines in internal transfer cases, the

court of appeals, in a per curiam decision in *Jones v. Robinson*, explicitly spelled out the procedures to be followed in such cases.

The court took its precedent from the recently decided Supreme Court decision of *Goldberg v. Kelly* and a particular dictum in that case which indicated that in administrative hearings elemental due process should be "tailored to the capacities and circumstances of those who are to be heard." The court quickly dismissed any notion that the hospital need conduct a full-scale trial or that legal evidentiary standards such as proof beyond a reasonable doubt need apply.

The main focus of the opinion was on the specific factual situation of Jones—the fact that a doctor, directly involved with the female complainant’s treatment, had made an *ex parte* determination that Jones had committed the rape. The court was further disturbed by the fact that the hospital had apparently fully acceded to this determination without any investigation of its own. In setting aside the transfer and the rape charge, the court outlined seven express criteria or standards which the hospital would henceforth be compelled to follow and which afforded what the court termed the "minimal protection required by due process."

1. An investigation conducted by a neutral officer (neutral meaning no prior connection with the patient, the complainant, or the incident);
2. Interviews by the investigating officer with all witnesses and the keeping of written memoranda thereof;
3. Submission of the memoranda to the accused and with an opportunity for him to respond;
4. If possible, given the *medical* circumstances of the case and those involved, allowing the accused to confront and cross-examine the witnesses;
5. Appointment of a "lay representative" for the accused at the hospital’s discretion (but a full-fledged attorney need not be appointed);
6. Preparation of detailed "informal memoranda" of the proceedings and requiring the investigator to "make findings and give reasons for his decision;"
7. Review of the decision of the investigator by the hospital superintendent.

The *Jones* decision, clearly a landmark case, was the first opinion from the D.C. Circuit which explicitly set out due process standards for patient transfer.

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76. *Id.* at 268-69.
77. *Id.* at 251.
78. *Id.* at 251-52.
It remains to be seen whether comparable standards will be applied in other analogous areas such as treatment.

**Collateral Data**

**Interviews**

One major contribution an ombudsman can make is the compiling of data that the administration may use as a basis for decision-making in place of the uneducated guess. A modest slice of even the most modest ombudsman’s budget should be set aside for some data-gathering. There is the difficult choice, often controlled by limitations of personnel and funds, between interviews and questionnaires. In the St. Elizabeths Hospital project, we combined questionnaire-type interviews—with respect to patients, ward attendants and social workers—and longer, open-ended interviews—with psychiatrists, administrators and judges. The first category included interviews with patients and ward attendants in John Howard Pavilion and with social workers throughout the hospital.\(^79\)

A 10 percent sample of John Howard patients were interviewed by project members (two law students and two social work students), using a questionnaire form with oral answers and guaranteeing anonymity to the interviewees. A 30 percent sample of ward attendants and social workers yielded interview data which was suggestive rather than conclusive, but worth noting as indicative of a function which an independent ombudsman can perform. Excerpts from these interviews are included here in Appendix A.

**“Associated” and “Interested” Agencies**

The project, as we have already noted, developed some significant contact and liaison with many of the agencies directly involved with the personal interests of the patients at John Howard. We have used the terms “associated” and “interested” in a manner which requires some clarification. The term “associated agencies” is used in the sense of other governmental agencies which have institutional contact with the primary institution—here St. Elizabeths—or whose responsibilities reach within the primary institution to affect a member—here “patient,” or, as some hospital regulations read, “inmate.” The chief associated institutions with which the one-legged ombudsman deliberately sought out contact because of problems arising within the primary institution were: the presiding officials at N.I.M.H., the parent

\(^79\). See Involuntary Hospitalization 672-80 for the interviews with judges and psychiatrists.
body; the Social Security Administration, because of persistent problems concerning benefits for patients; and the Juvenile Court, because of the purely serendipitous discovery of intermingling of juveniles with convicted felons at John Howard.

By "interested agencies," we mean other agencies or governmental activities whose range of interests includes institutions of the type of the primary institution, and their members. In our case, in addition to the courts, this category included: the Administrative Conference of the United States, because of an interest indicated by them in hospital procedures; the watchdog Senate Committee headed by Senator Sam J. Ervin, Jr. of North Carolina, author of the operative statute concerning mental hospitalization; and, by the circumstance of the Administrative Conference's interest, the mental hospital authorities in New York.

**Associated Agencies**

1. **NIMH**

To call NIMH merely an "associated agency" of St. Elizabeths Hospital is to drastically understate the real situation. In fact, as well as on the organizational chart, the significant decisions at the Hospital during our three years there—and since, it appears—have been made at the NIMH offices in Bethesda. For example, the go-ahead on the Pilot Project clearly came from NIMH officials. When there was an internal push for discontinuing the legal assistance project, the NIMH people appeared at, and participated vigorously in, the Department of Justice meeting. The strongest voice at that meeting in behalf of continuing and extending legal representation to patients was that of the psychiatrist who later became head of NIMH. The Division on Crime and Delinquency (which had been suggested by that meeting as the prospective source of grant support) is a component of the NIMH operation and the committee which passes on grants is an "independent" committee organized by NIMH.

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80. See note 40, supra.
81. See text at notes 51-52, supra.
82. During the ombudsman project, the Superintendent of the Hospital was Dr. Louis Jacobs, who had been a key member of the "headquarters staff" at NIMH. In the course of the project, he indicated that he intended to retire by the end of 1969. The ombudsman had hardly finished his work in the hospital in December, 1969 when a new "Acting Superintendent" was named and the offices of the National Center for Mental Health Services were moved from NIMH to the wing across the hall from the Superintendent. The officer in charge of the National Center, Dr. Sherman Kieffer, had been finally identified to the satisfaction of the ombudsman as "the man at NIMH charged with the responsibility for St. Elizabeths." Although Dr. Jacobs had been generous with his time and cooperation, it appeared highly desirable to secure an interview with Dr. Kieffer.
2. The Social Security Administration

A great number of St. Elizabeths patients are eligible for social security benefits. The ombudsman found, however, that only the most feeble resources were available to supply the patients with information and assistance adequate to file applications for such benefits. Only two low-level employees were in any way concerned—one, a clerk in the Registrar's office (with many other assigned duties) and the second a part-time representative from the Social Security Administration's Washington district office. There was no one either available or competent to assist the patients in pursuing complicated or uncertain claim matters through the labyrinth of procedures and remedies of the Social Security Administration.83

One of our most difficult tasks came in attempting to review the Hospital's performance in social security matters from information held by the Registrar's office. When finally completed, the review showed that less than half of the John Howard patients had even applied for disability benefits, and that less than half of those applying were eventually awarded the benefits.

Letters proved no answer to establishing contact with him. Telephone efforts did not get past his secretary. We next telephoned Dr. Bertram Brown (then Deputy Director), who had supported the earlier project. We did not reach him, but our call produced a telephone response from a very agreeable young-sounding psychiatrist who identified himself as Dr. Brown's assistant and who offered to act as "sort of an ombudsman" (his phrase) on the interview request. We explained that we were concluding the project and had been given interviews with administrators, legislators and judges without exception, save for Dr. Kieffer. We felt his views would be especially relevant as NIMH's response to the criticisms which had been made of the Hospital. Our "psychiatrist-ombudsman" explained that Dr. Kieffer had no reluctance about meeting us but that his schedule was unbelievably tight. I said this was entirely understandable, and that I merely wanted an authoritative statement (which I now had) that Dr. Kieffer could not arrange the requested interview. The N.I.M.H. spokesman summed the matter up: "You mean that you have asked for an interview and are content to report Dr. Kieffer's inability to schedule one as data." I said that was a fair statement. There was a long pause. When the "psychiatrist-ombudsman" returned to the conversation his response was: "Dr. Kieffer will meet you. I'll switch you to his secretary and you can arrange a time." The interview was promptly scheduled, and held. It was open, frank-talking, and extremely helpful to the formulation of basic conclusions of the final ombudsman report.

Like other ombudsman interviews, Dr. Kieffer's interview was given with an understanding that it would not be directly quoted or attributed. The combined impact of these various interviews demonstrated the deep misunderstandings which currently exist between legal and psychiatric professionals. It is this gap between the professions which led the ombudsman report to stress the need for continuing interdisciplinary discussion among them, perhaps along the lines of the California achievement. See Involuntary Hospitalization 617 and n.321.

83. During the earlier legal assistance project the project attorneys and the faculty-supervised law students had worked on a few of these claims. Ms. Karen Krempa, a 1971 graduate of Catholic University Law School, argued and won a substantial sum for one patient. The case eventually was reversed on intra-agency appeal, but by that time the patient had already received and spent the money. The agency accepted the reality of the impossibility of re-payment and no further action was taken.
This record led us to explore the basis for denial of the applications with the Social Security Administration directly. Our investigation illustrated that there had been an erratic history of awards and rejections on almost identical factual patterns.

Successive meetings were arranged with the Bureau of Disability and the Bureau of Hearings and Appeals. These conferences resulted in a request by the Social Security Administration for statistical data from the Hospital which would provide the basis for improving procedures within the existing statutory and regulatory framework. The ombudsman gathered this data and relayed it to the Social Security offices. But when the ombudsman project terminated, there was no one to follow through.

Our dealings with the social security problems showed us that there is a continuing, if considerably flawed, relationship between the Hospital, its patients, and the Social Security Administration. We found that, so far as maximum security patients were concerned at least, no fixed responsibility for supervising and following up benefit applications existed anywhere in the Hospital. On the other hand, there was great receptivity at the Social Security Administration for correcting an erratic situation when it was persuasively called to their attention.

3. Juvenile Court

The interviews with John Howard ward attendants in October, 1969 revealed their indignation at the presence of several juveniles in John Howard who were thrown in with an assorted adult clientele of often unsavory background. The assignment of seven boys there, aged 13 to 17, during our project brought this problem to a head. The ombudsman conferred with the superintendent immediately but his response was that no other adequately secure facilities existed in which the Hospital could keep the boys and still ensure their detention for return to Juvenile Court after their period of observation. The implication was clear: the court was aware of their detention among the adult group in maximum security, but that there would be no change in their assignment.

Having failed to reach a solution within the Hospital the ombudsman informed the Chief Judge of the Juvenile Court of the names of the young pa-

84. The initial data requested was limited to three readily ascertainable matters: (1) average length of stay of patients in John Howard Pavilion; (2) the usual statutory route of arrival (e.g., not guilty by reason of insanity, assignment from prison, civil commitment, etc.); and (3) the most common medical diagnoses. PROJECT REPORT at 88.

85. The Juvenile Court has since ceased to be a separate facility and has been absorbed in the District of Columbia Superior Court by the 1970 Court Reorganization Act. 84 Stat. 473.
tients. Neither he, nor any judge of his court, had been aware that there were several juveniles detained in John Howard. The Chief Judge pointed out that his court order specifically provided that juveniles should not be kept with adult criminals. He added that he would write the Superintendent insisting that his order be followed to the letter. On learning that two juveniles had counsel, the ombudsman advised counsel of the developments. Receiving no advice that the Hospital had changed the location of the young patients, the Chief Judge signed an order to show cause why the Superintendent should not be held in contempt for violation of the court order. This more drastic action finally led to a satisfactory resolution of the matter.

Interested Agencies

1. Legislative (Senator Ervin's Subcommittee)

The author of the District of Columbia's Hospitalization of the Mentally Ill Act, and the legislative watchdog over its functioning is Senator Sam Ervin, (D-N.C.), Chairman of the Subcommittee on Constitutional Rights of the Senate Judiciary Committee. At the time of the ombudsman project his Subcommittee was considering revisions of the statute. The Judicial Conference Report on the functioning of the Mental Health Commission in commitment matters was being completed. The one-legged ombudsman

86. Different judges of the Juvenile Court had committed different juveniles. One juvenile had been committed by the Mental Health Commission. PROJECT REPORT at 91.
87. A copy of his letter was sent to the ombudsman. It stated, in part:
I have also been informed that when a juvenile is sent to your hospital under a commitment under Title 23, Section 401 of the District of Columbia Code, that child is placed in the John Howard Pavilion where he is commingled with adult psychotic patients. Such action by your hospital and staff also directly violates the order of this court.
Such delays and commingling of juveniles with adults in violation of a court order are intolerable. It is vitally important that this practice of ignoring court orders be immediately discontinued. Set out below is a list of other juveniles who have been committed to St. Elizabeths. Will you please immediately see that the court orders on these children are obeyed?. . .
Thank you very much for your attention to this matter. If you think we should meet to discuss our mutual problems, I shall be happy to do so.
Sincerely,
MORRIS MILLER
Chief Judge"

88. An interesting sideline on this contact with an "associated agency" was a telephone message received from a newspaper reporter. The message read: "Please return call to discuss juveniles at St. Elizabeths." Since we had just completed our discussions with the Chief Judge, and believing these discussions to have been in confidence, before returning the call the ombudsman checked in at the court. The Chief Judge's secretary said, "Oh yes, I gave her your name."
90. See JUDICIAL CONFERENCE REPORT, supra note 39.
appraised Senator Ervin and his staff of data acquired by the ombudsman project and furnished formal testimony to the committee when the resulting proposals had been developed. An ombudsman at a mental hospital would find continuing contact and rapport with comparable legislative watchdogs of mental health matters both rewarding and indispensable.

2. Executive (Administrative Conference of the United States)

When the ombudsman project at St. Elizabeths Hospital was well under way and it became apparent that formulation of internal procedures there was necessary, a new opportunity for expanding the research of the ombudsman project was presented by the Chairman of the Administrative Conference of the United States. With particular emphasis upon a comparative study of hospitalization procedures in other jurisdictions, a consultanship with the Administrative Conference made possible a study of the New York Mental Health Information Service and the internal mental hospital procedures and work of ombudsmen in the mental health area in six European countries.

The interest of the then-Chairman of the Administrative Conference in the ombudsman possibility in the mental health area and the agreement of judges and officials interviewed during the project that he would be a desirably neutral figure there led to the report's recommendation that the Chairman of the Administrative Conference serve as "Administrative Commissioner for Mental Health Rights." His role was to be very much a "one-legged ombudsman." The proposal was that specific internal procedures were to be established at the Hospital and that the Chairman, aided by a small staff, would assume the experimental ombudsman role. It was urged that he could supply the prestige, expertise, and neutrality required to cope with the interprofessional and inter-institutional difficulties in the District of Columbia.

91. The Administrative Conference proposal (set out in Involuntary Hospitalization, 681-87) and the legislative proposals sent to Senator Ervin (Id. at 688-701) were transmitted in March 1970.
92. This aspect of the ombudsman report was summarized in the earlier article. Id. at 618-49.
93. Professor Jerre Williams of the University of Texas Law School. In the Summer of 1970, Williams was succeeded as Chairman by Professor Roger Crampton of the University of Michigan Law School.
94. This proposal, together with internal procedural reforms, had been scheduled for presentation to the June, 1970 meeting of the Administrative Conference. The presentation was first postponed, then, with the advent of the new Chairman of the Conference, abandoned. The notion of the Administrative Conference acting as a limited federal ombudsman had been originally suggested by Professor Gellhorn. See GELLHORN, WHEN AMERICANS COMPLAIN 94-100 (1966). It was taken up again by the new Chairman of the Conference. See R. Crampton, A Federal Ombudsman, 1972 DUKE L.J. 1.
mental commitment process that had unfolded in the course of the ombudsman project.95

Other Related Agencies and Groups

Problems involving the Veterans Administration, the United States Attorney's Office, the United States Secret Service, the United States and District of Columbia Parole Boards, and the District of Columbia jail arose during the project and its antecedents, leading, in several instances, to interviews by the ombudsman with beneficial results.

The resources of a one-legged ombudsman for mental hospitalization also include personnel from the bar, medical, psychiatric, psychological and social work associations, and from area universities. From time to time, membership of these professional groups contributed to the accomplishment of interim projects described in this article. The part-time ombudsman might himself be drawn, perhaps on a rotating basis, from these groups. In any event, a part-time ombudsman would find in this professional pool, if properly stimulated and organized, potential collaborators in his work.96

95. Psychiatrists and hospital administrators, on the one hand, and lawyers and judges, on the other, differed as to what type of person the proposed ombudsman should be. But those consulted seemed to agree that the Chairman of the Administrative Conference would be neutral enough either to serve himself or to designate and oversee a hospital ombudsman for the District of Columbia. So the project proposal was made in alternate form that either the Chairman or his designee (with the approval of the chief judges of the local courts) should serve as ombudsman on a part-time basis. (In New York the heads of the comparable Mental Health Information Service in all four state judicial departments are appointed, and supervised, by the Presiding Judge of the respective Appellate Division. (See Involuntary Hospitalization 620-632). A second major proposal for administrative change was the establishment at the Hospital of “Mental Ward Review Boards” (patterned on a Norwegian model), composed of attorneys, doctors, and non-professional persons. A panel of such persons was to be proposed by the Chairman of the Administrative Conference, in consultation with the chief judges of the local courts, and appointed by the Secretary of Health, Education and Welfare (the federal department ultimately responsible for St. Elizabeths Hospital) Id. at 682-684. The M.W.R. Boards' function was “to be regularly available to patients in the hospital with a particular concern for those who are involuntarily detained.” Id. at 682.

The ombudsman report also made five proposals for legislative change. The ombudsman and M.W.R. Board proposals (in the event they were not implemented administratively), and three others: (1) Changes with respect to the composition and jurisdiction of the Mental Health Commission; (2) Compulsory periodic reexamination by the courts of involuntarily hospitalized mental patients; and (3) Legislative direction, with adequate appropriations, to the Legal Aid Agency (soon to become the Public Defender Service) to establish a Mental Health Section to represent indigent mental patients. Id. at 688-701. (These recommendations were sent both to the Administrative Conference and to Senator Ervin’s Committee in March, 1970 in advance of publication of the ombudsman project report.)

96. In a large government center such as Washington, there is great interest among government personnel in a field such as this. For example, through the efforts of Ms. Winifred Nash, the HEW attorney then assigned to advise St. Elizabeths Hospital, a
Reception of the Ombudsman

Can an ombudsman function on a "one-legged" basis? As a partial answer there is value in recalling the obstacles as well as the cooperation received in our project. In his short career at St. Elizabeths Hospital the ombudsman found both, but happily cooperation was predominant.

Obstacles

The chief obstacles came not from the central policy-making officials, but from some division officials who had achieved a degree of autonomy and felt threatened by a transitory ombudsman. They feared, perhaps, that he was sent by higher-ups to ferret out information and to formulate criticism about them. For example, the Registrar, an official then about to retire, had long enjoyed unchallenged suzerainty regarding assignment of patients within the Hospital. Despite the approval given the project by the Hospital Superintendent, the Registrar twice halted research progress on key matters, but, in each case, later relented. The second source of resistance was at the level of administration of ward attendants at John Howard Pavilion. On one occasion, a major supervisor there stopped a very familiar project member from carrying on work she had been doing for months. On my reaching the scene, the hospital staff man relented, but only reluctantly. The same incident recurred later.

Cooperation

Save the above exceptions, the Hospital administration gave all necessary assistance to the ombudsman team. An office and intra-hospital telephone were made available at John Howard. Files and hospital records at John

Committee of the Federal Bar Association met with the ombudsman to arrange collaborative services. The acting clinical director of John Howard Pavilion also attended this meeting. This government source, of course, to an extent overlaps the professional pool, discussed above. Its availability depends on the current interpretations of department general counsel, and the Attorney General, as to restrictions on government employees acting in matters concerning other government departments.

97. The Registrar was finally mollified at a conference with the ombudsman in mid-project arranged and attended by Ms. Winifred Nash, the HEW attorney referred to in the preceding note.

98. Both the supervisors and the ward attendants had been habitually friendly to the personnel on the ombudsman project, and its predecessors, frequently citing its beneficial effect on patient morale. But when the project moved into statistics—compiling and interviewing phases—the supervisors' resistance surfaced. Alone among persons interviewed at the Hospital, the ward attendants seemed reluctant and self-consciously non-committal.

99. To this day it is not clear whether the cooperation of the hospital administration was given under a misapprehension: that the ombudsman project was authoritatively sponsored by NIMH higher-ups. It did not become clear to them, it seems, until near the end that no one in particular at NIMH was sponsoring the project.
Howard were at our disposal. Patients could be seen at will. Psychiatrists, psychologists, social workers and administrative officials were generous with their time, even to the extent of somewhat lengthy data-gathering interviews. The go-ahead had been given from A-Building (Hospital headquarters) and Hospital personnel, in general, seemed personally disposed to cooperate.\textsuperscript{100}

We should not, however, assume that a permanent ombudsman in a mental hospital would automatically receive cooperation comparable to that given to one who, as they well knew, would be gone in five months.\textsuperscript{101}

\textit{Epilog}

\textbf{III}

Three years have gone by since the ombudsman project at St. Elizabeths Hospital. Some things have improved, some are the same, and some are worse than before.

So far as the mental commitment process is concerned, the 1970 Court Reorganization legislation did far more than merely change the name of the Legal Aid Agency to “Public Defender Service” (hereinafter PDS). For the first time there is a full-fledged legal staff for patients at the Hospital. Significant progress has been made with respect to legal representation of pa-

\textsuperscript{100} It need not be overlooked that each of the constituencies in the hospital had "group-axes" to grind and viewed the ombudsman's report as a useful forum.\textsuperscript{101} The one-legged ombudsman's arrival at St. Elizabeths Hospital was the product of serendipity as much as strategy. His survival, even for five months, can be charged to a variety of circumstances, most of them unlikely to recur. When he arrived no one was quite clear who had sent him. The superintendent may have suspected his own superiors at the National Institute of Mental Health. The lesser officials at the Hospital knew his presence had the official blessing of the head of the Hospital. And, until the very last days of his stay at the Hospital, apparently the highest officials at NIMH uneasily suspected one another. Moreover, members of the ombudsman team were already favorably known for some time, at least at John Howard Pavilion, as a result of the previous two-years work there. Hadn't they been acting as ombudsman all along, some patients and officials asked them as the project wore on.

But more than such bewilderment was responsible for the cooperation the ombudsman received in many quarters. For the ombudsman offered them an opportunity, with anonymity promised, and relied on, to voice grievances felt in many quarters as to how the hospital was functioning. Psychiatrists were dissatisfied with administration and with the power of nursing assistants and ward attendants; the latter were annoyed at the central administration for routing juveniles into wards with convicted felons, and (guardedly) with non-visiting administrative doctors. Hospital administration was upset with John Howard administration and vice versa, and both were highly critical of the courts. The judges had mixed views with respect to the hospital. There was near-unanimity among all on but one point: that it would be near disaster to follow through with the rumored shift of administration of St. Elizabeths from NIMH to the District of Columbia government as long as present malfunctioning continued. (See Appendix B, in \textit{Involuntary Hospitalization}, and further discussion of above reactions at 609-612.)
tients in the civil commitment process. However, despite efforts of the PDS hospital staff, there seems slight change anywhere in the Hospital with respect to the establishment and utilization of viable internal procedures concerning treatment, internal transfer, and discharge of patients.

One hopeful sign is the beginning of a quasi-ombudsman mechanism by which the PDS may present complaints on patient matters to a Hospital liaison officer designated by the Superintendent. But when the Hospital is reluctant to move, there is no leverage available to PDS short of instituting legal action. A second favorable development is that the PDS hospital staff director and a prominent psychiatric administrator at the Hospital, with the cooperation of top hospital administration, have instituted a series of monthly conferences involving psychiatrists, lawyers, and social work professionals from inside as well as outside the Hospital. At these sessions, civil hospitalization issues, which have traditionally raised hackles among the different disciplines, are discussed in low key. While it is a bit too early in this program to risk prophecy of success in resolving basic difficulties, there is no reason for pessimism.

102. While the chief function of the 1970 legislation (D.C. Court Reform Act § 302, 84 Stat. 473), was to insure representation of patients in the commitment procedure before the Mental Health Commission, the St. Elizabeth's unit of PDS, then headed by Robert Golten, took aim on other aspects of the mental health hospitalization problem. One of his early ventures was the attempt to secure his recognition by N.I.M.H. as a true ombudsman at the Hospital. A conference with NIMH officials resulted in stopping this proposal, except for the designation of the psychiatrist serving as Assistant Superintendent as a "liaison officer" to whom the PDS might forward specific complaints—those concerning either institutional practices or individual grievances. While, at first, the measure of success of this arrangement was thought minimal, recent estimates are that, while no major policies have changed as a result of this slender "liaison" some minor irritations have been removed and a smoother working basis established.


104. Responsibility of the PDS may require action against the Hospital, and such impending actions are freely discussed both as prospective and as faits accomplis at the sessions. Most significant of all in this development, perhaps, is that the meetings are chaired by a ranking psychiatrist-administrator at the hospital; the justification for the presence of other participants is the possibility that their contributions may help the hospital better to perform its work. The contributions of the hospital PDS attorney to these meetings might well be viewed as gentle proddings of an ombudsman-type figure with respect to administrative problems which have come to his attention as a result of his office's work of representation of patients. But the sessions also offer hospital and Mental Health Commission officials an informal opportunity to air their grievances and misunderstandings on the work of the hospital PDS office, out of the climate of adversary procedure.

In the ombudsman project no attempt was made to combine, in the same person or team, the investigating and negotiating of complaints and the actual conduct of legal action against the institution. The present activities and aspirations of the PDS at St. Elizabeths seems to be undertaking such a combination. If such a combination can be carried off successfully, it will be only because of special personal qualities in a particular ombudsman-public defender. (To some extent a similar attempt has also been
Unfortunately, unlike seminars initiated in California in the 1960's in which state judges participated, the St. Elizabeths dialogues have not yet succeeded in enticing District of Columbia judges concerned with these matters to join in the discussions. The traditional reluctance of jurists to discuss issues that may later come before their tribunals is well known and appreciated. However, if the ombudsman project interviews are to be taken seriously—and they did show all the involved professionals, including judges, acknowledging their mutual difficulties in communication and understanding—there is special justification for judges in the District of Columbia (and perhaps the neighboring jurisdictions) to make an exception to the ordinarily sound practice of aloofness. Indeed, such a judicial exception in the murky field of psychiatry, law, and involuntary hospitalization is needed everywhere.

The progress made in the civil hospitalization area at St. Elizabeths has not been accompanied by similar progress at John Howard Pavilion. In this maximum security service, the legal support for patients is arguably less favorable than it was at any time during the three years spanned by the pre-project and ombudsman experiences at the Hospital.107

made in the 1st Judicial Department of New York State under its Mental Health Information Service). The characteristics required of a good defense attorney (or defense institution such as the PDS) are not the same as the investigating and negotiating qualities of an ombudsman. Furthermore, the objectives of the two institutions do not always track each other. While the data in hand does not insure an ultimate judgment that combining ombudsman and legal assistance activities is feasible, neither does it rule it out. Meanwhile the PDS unit at St. Elizabeths is making a creditable attempt at such a combination, the only option available to it under current legislation and departmental (PDS) policy.

Some preliminary efforts have been made by the PDS at St. Elizabeths to conduct surveys on the effects of certain policies of the hospital, the Mental Health Commission, and the PDS itself. This type of work was also identified as a possible function of an ombudsman both by the original Pilot Project report at St. Elizabeths, and by the Ombudsman Report. It is too early for appraisal, but regular budget allocations should be made, however modest at first, for such surveys conducted by an independent official such as an ombudsman (or PDS).

105. See Involuntary Hospitalization 609-12, and Appendix B.

106. The Association of the Bar of the City of New York Committee which did pioneer work in reforming New York law on mental health hospitalization numbered sitting judges among its members. See SPEC. COMM. TO STUDY COMMITMENT PROCEDURES, ASS'N OF BAR OF CITY OF NEW YORK, MENTAL HEALTH AND DUE PROCESS (1962).

107. The medium security services at West Side and Cruvant have been closed, and patients previously housed there are concentrated in John Howard. All court-ordered examinations—despite protests from psychiatrists elsewhere in the hospital—take place at John Howard. While the Public Defender and any attorney may visit patient-clients who have requested them by name, the regular previous availability of attorneys and para-legal personnel that characterized the pilot project and interim legal assistance project days is a thing of the past. This backward step is especially regretful in light of the change in general character of John Howard patient personnel which is the logical outcome of the revision of the Durham rule by the court of appeals in 1971.
However, in one area at least, a report of "no change" is a favorable omen. As the ombudsman project ended in 1969, the expectations—both at the Hospital and in higher government circles—were that St. Elizabeths Hospital would be transferred from the jurisdiction of the National Institute of Mental Health and the Department of Health, Education, and Welfare to the District of Columbia government. That move, which was widely viewed with alarm, seems less likely today, although the possibility continues to overhang the Hospital like Damocles' sword.

IV. An Over-the-Shoulder Glance at the Data and Some Reflections

Publication and Response

The immediate and direct written product of the ombudsman project at St. Elizabeths was a 470-page report made to NIMH, the granting source. A subsequent 154-page law review article with a broader focus made extensive reference to interview and statistical data from the report. The official court reports, of course, carried the decisions that flowed from the project—Dixon, Williams and Jones. However, beyond acknowledgement of receipt, official response to the report has been nil. Academic and professional response, on the other hand, has been encouraging and has inspired this account of the ombudsman project.

Except for three patients whose release from involuntary confinement at the Hospital may fairly be attributed to the project, there is little, if any—and the more limited criminal process hospitalization expected from the major jurisdictional change from the United States District Court to the District of Columbia Superior Court wrought by the Court Reform Act of 1970.

108. See Involuntary Hospitalization 610-12.

109. A final contribution of the one-legged ombudsman was to bring to the attention of the Secretary of Health, Education, and Welfare, as data gathered in the course of his report, the strong feelings in opposition to such a transfer. Such major decisions will always be made on higher levels of governmental authority, but an ombudsman being neutral to conflicting views of participating professionals may surely aspire to have his data given fair consideration.

110. Parts I-III (pages 1-285) of the PROJECT REPORT, dated June 28, 1971, concerned the St. Elizabeths phase under the N.I.M.H. small grant. Part IV (p. 286-470) includes recommendations to the Administrative Conference of the United States (See Involuntary Hospitalization 681-87), and a comparative study of mental health procedures and ombudsmen in six other jurisdictions. Part IV was made possible by a consultantship to the Administrative Conference.

111. See Involuntary Hospitalization.

112. See text accompanying notes 61-78, supra.

113. The full report has not been published. Reprints of the law review article have been purchased from this Review by psychiatrists, psychologists, and lawyers in about equal proportion. See note 32, supra.

114. Two were Messrs. Williams and Jones, see text accompanying notes 67-78, supra. The case of the third patient in question was fully elaborated in the earlier article as the "Thomas Smith case." See Involuntary Hospitalization 589-600.
thing, to which the project may solidly lay claim. The promised presentation of certain recommendations to the Administrative Conference of the United States did not occur. The formal recommendations for revision of District of Columbia law concerning the commitment process, for establishment of more equitable internal procedures at St. Elizabeths, and for the Chairman of the Administrative Conference or his designee to act experimentally as a limited ombudsman (“Administrative Commissioner for Mental Health Rights”) set in motion no hurly-burly of fresh activity. Perhaps this is explained by the inherent defects of the proposals. Perhaps the on-going rush of events in 1970 and 1971 in the District affecting institutional change in the mental hospitalization field\(^\text{115}\) made the report untimely, and its recommendations at odds with other forms of change preferred by the decision-makers.\(^\text{116}\)

115. One example is the transfer of primary local judicial responsibility from the United States District Court to the Superior Court of the District of Columbia pursuant to the District of Columbia Court Reform and Criminal Procedure Act of 1970, 84 Stat. 473. That court reorganization reduced the role of the Court of Appeals for the District of Columbia Circuit in the development of criminal and mental hospitalization law. That court, under Chief Judge Bazelon had produced the hospital-goading decisions referred to above and the Dixon-Williams-Jones trio of decisions emanating from the ombudsman project (cf. text accompanying notes 60-80, supra). The same court reorganization statute gave the newly-named and reconstituted Public Defender Service significant new responsibilities representing patients in court and before the Mental Health Commission, and led to the establishment of a PDS unit at St. Elizabeths Hospital for the first time. Also in the air, although few knew it at the time, was an impending reconsideration by the federal court of appeals of its historic Durham rule (Durham v. United States, 214 F.2d 862 (D.C. Cir. 1954) ). It would be changed to a variation of the American Law Institute standard for “insanity.” The local court reorganization would lead to the absorption of the former Juvenile Court into the Superior Court of the District of Columbia. Revision of management and procedures at the Mental Health Commission was impending as a result of criticism in the JUDICIAL CONFERENCE REPORT. See note 37, supra. Continuing study looking to possible revision of the Hospitalization of the Mentally Ill [Ervin] Act (see note 89, supra) was in process at Senator Ervin’s Sub-Committee on Constitutional Rights. Commencing in December, 1969, there was a new Acting Superintendent at St. Elizabeths Hospital. John Howard Pavilion was about to be placed under new, more restrictive management. The National Center for Mental Health Service had shifted from NIMH to the bank of offices across from the new Superintendent at the Hospital. Changes at the top at N.I.M.H. were in the wind, though not made until 1970. Throughout there was the uncertainty about likely transfer of control of the Hospital from NIMH and HEW to the District of Columbia government, stimulated by the recommendation to the Secretary of HEW of the Rome Report in the summer of 1970. See Involuntary Hospitalization 611.

116. Three other studies bearing on St. Elizabeths Hospital have already been referred to: N.I.M.H. REPORT (see notes 33, 39, supra); the Chambers Report on John Howard Pavilion (see note 38, supra); and the JUDICIAL CONFERENCE REPORT (see note 37, supra). In the period surrounding the ombudsman project two committees of the United States Senate were actively receiving testimony and suggestions bearing on involuntary hospitalization—the Senate Committee on the District of Columbia (engaged with the court reorganization), and Senator Ervin’s subcommittee. The House Committee on the District of Columbia was, of course, directly concerned with the new court system legislation (see note 115, supra), in formulation of which the Department of Justice was seen to be taking a leading role. In this unaccustomed
Reflections

Perhaps the fuller presentation here of the data of the project, considered together with the data of other ombudsmen's experience\(^{117}\) may yield some value to those tantalized by the attractiveness, and yet frightened by the pitfalls, of the ombudsman device. There is sore need for solid experimental data, but with the data must come reflections, and reflections on a project as hectic as this are sharpened by distance. With three years distance from the ombudsman project and its antecedents (which together spanned four years), my chief reflection is as suggested at the outset of this article: that the project experience and its implications reinforce basic conclusions set forth in the first (and really only) American think-piece on the concept of ombudsman,\(^{118}\) with just a slight modification—that the true American model for an ombudsman is not the Scandinavian career-“man for all seasons and departments,” but a part-time “public citizen” working in a limited area, with a small staff and budget, and yet with acknowledged leverage. The question of leverage is central to the adequate functioning of this limited ombudsman, and it is with the optimum sources of such leverage that subsequent reflections on the “American” ombudsman should be concerned.

The Problem of Leverage

At the ombudsman's first conference with the Hospital Superintendent both agreed “that the ombudsman must first try his luck within the hospital—by investigation, then persuasion—but that to retain credibility he can't stop there. He must have some external access or resource to which those unsatisfied grievances may be certified for further recourse. The three most obvious of these are Congress, the higher echelons of administration, and the courts.”\(^{119}\)

These obvious sources of leverage were used in the course of the project.

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\(^{117}\) See note 32, supra.

\(^{118}\) W. Gellhorn, When Americans Complain (1966). The others have been either extensive recitals of actual activity of ombudsman-like officials (e.g., D. Rowat, The Ombudsman (1965), W. Gellhorn, Ombudsmen and Others (1966),) or catalogs of fresh enlistments under the ombudsman banner (see Frank, supra note 7).

\(^{119}\) PROJECT REPORT at 71. The Superintendent thought it likely that day-to-day ombudsman-hospital relations could survive recourse to Congress or to higher administration. However, he believed that, if the ombudsman took the hospital to court, it would make effective ombudsman within the hospital unlikely. “The formula which we adopted was that of referring a case to [an outside] lawyer when the internal course had been run unsuccessfully.” Id. at 72. See note 60, supra.
Of them only the referred litigation yielded tangible result.\textsuperscript{120} The problem of more sustaining sources of leverage became acute in formulating the proposed ombudsman model. The considerations related to the broader problem—that of leverage for any ombudsman of the part-time variety. To the question of what type of person should be a mental health ombudsman, the psychiatrists unanimously said "not a lawyer." The judges said "not a psychiatrist" or hospital professional.\textsuperscript{121} There was no objection, however, to a high governmental official, removed from the immediate conflicts, such as the Chairman of the Administrative Conference of the United States (although he happened to be a lawyer). A better approach would seem to be first to ask what factors of leverage should an ombudsman possess, and then ask what type of person, in a given context, would be most apt to possess these factors, or at least an adequate number of them.

Assume that an ombudsman is without special legislative access,\textsuperscript{122} or access to higher administrative authority, or even without access to the courts, however desirable these may be. May he function successfully with lesser modes of leverage? If so, with what forms? Even the European-type ombudsman, operating with the legislative backing, stresses personal characteristics as his greatest resource.\textsuperscript{123} Access to professional groups (perhaps by virtue of his own membership in a profession—law or medicine, for exam-

\textsuperscript{120} See text accompanying notes 61-78, supra.

\textsuperscript{121} Involuntary Hospitalization 672-80. Cf. Project Report 189-122.

\textsuperscript{122} That is, beyond the general power to recommend legislative change which is inherent in any citizen.

\textsuperscript{123} The European-type ombudsman, an independent creature of the legislature, has the role of intervention with virtually all government administrative agencies. They must yield to him—in investigation, at least—and not vice-versa. Executive-type ombudsmen of broad scope, such as the Commissioner of Investigation in New York City, are often given power to investigate all executive agencies, sometimes with subpoena power. However, unlike the European type, here we have simply the executive investigating itself in the interest of better overall administration. Similarly, with ombudsmen in narrower fields (such as the University of Pennsylvania ombudsman, note 2, supra, or the ombudsman appointed by the Secretary of Commerce, note 3, supra), the officials have no scope for their reports beyond the administrator who appointed them. However praiseworthy their mission, this distorts the original concept to refer to them as "ombudsmen."

This does not mean that true ombudsmen must always be creatures of, and report directly to, the legislature. (Serious suggestion has been made that such an office would violate constitutional safeguards regulating separation of powers under the federal and many state constitutions.) However, administrative critics appointed by the executive must have some additional safeguard in order to qualify as true ombudsmen—the power to publish findings generally (satisfying the public's right to know)—or have access to higher officials or other branches. This ombudsman must also have some protection against removal from office before the end of a pre-fixed term. An additional safeguard is provided by establishing the office outside the normal promotional channels within the bureaucracy. But the crowning policy of reassurance of independence is to structure the job so that it will attract persons of independence whose judgment and thoroughness the public will respect. Without this, even a power to publicize and undisputed disinterestedness will be less than enough.
ple), access to publicity by reports and press notices, capacity for rational persuasion, disinterestedness, and personal eminence or prestige, in ascending order of importance, perhaps, are alternative sources of strength to sheer political or legal "clout."

Leverage Factors

1. Prestige. The word "prestige" is used primarily in the sense of a person who, at the time of his appointment, has already won community respect for past achievements. In a secondary sense, it would include one who has won prestige on the job. In either, the intent is that the very existence of such a person in the ombudsman office gives it leverage.

2. Publicity access. In Denmark, when the ombudsman blinks, it is newsworthy. When he criticizes it is headline material. His official reports to the legislature are taken seriously by officials in related areas who may be beyond the reach of his immediate criticism. The extent to which any ombudsman has public access is one measure of his leverage. How he makes use of his potential here is itself a resource. For instance, he might find that the possibility of publicity is an incentive to official acceptance of his suggestions, but that constant use of the press impairs his relationships within the institution.

3. Professional access. Where an ombudsman is a member of some professional group, and especially where he has won some professional recognition, he may have access to a body of vocal support, at least with respect to issues on which his profession has expertise. He may also, in special cases, be able to draw upon his professional association and its members for support and collaborative participation in aspects of his work. In addition, the professional journals would be natural avenues of publication of his data and project studies. Lesser but comparable advantages may be secured from associations and journals of professions other than his own, especially when his zone of operation is multidisciplinary.

4. Capacity for rational persuasiveness. Although this characteristic ordinarily assumes knowledge of the area in which an ombudsman is working, a capacity to learn a new area by intensive effort will suffice. If the area is multidisciplinary, such as a mental hospital, the ombudsman will be already

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124. The original Danish ombudsman, Stephan Hurwitz, who only recently retired (see text accompanying note 12), enjoyed incomparable prestige among European ombudsmen. See Involuntary Hospitalization 639.

125. In addition to press reports, note should be given to the influences of publications in scholarly journals. See text accompanying note 127, infra.

126. See, e.g., note 60, supra.

127. In the mental hospital, for example, the following professions, at least, have an interest: psychiatry, general medicine, psychology, sociology, law, and administration. See note 113, supra.
competent in one field, and getting on top of the job will require him to speedily develop understanding of, and sensitivity to, the basic points of contact of the other disciplines. Lawyers commonly believe this is their stock-in-trade, and that, therefore, they are the obvious candidates for ombudsman-like jobs. Members of other disciplines tend to disagree, some insisting that the adversary training of lawyers automatically disqualifies them from ombudsman work. In England the pride of the Parliamentary Commissioner—the British ombudsman—is that there is no lawyer on his staff. The ombudsman and his staff members are all professional civil servants—professional administrators. In investigating matters referred to them in various fields (including mental health), they seek to become sufficiently well-informed in the field to recognize difficult problems, and to ask precise questions of professionals in each relevant area.

Beyond being well-informed is the vital factor of persuasiveness. This may mean convincing an administrator by sheer dint of homework done and argument presented. More often, persuasiveness in an ombudsman role involves more: a sense of timing (not insisting on total change at once) and a sensitivity to the effect of competing pressures and professional defensiveness on the practical ability of an administrator or other official to implement a proposed solution. Persuasiveness also connotes ability to stimulate a willingness in others; once they see a change is in order, to implement change on their own responsibility—and not wait for it to be imposed from without. Perhaps it never will be imposed (or, at least, not until much later when things have gotten worse). These elements of persuasiveness, resting as they do on sensitivity, are perhaps more often inbred than made. In any event, they give a vital leverage to an ombudsman. They get his job done in the most effective way—by the administrators themselves, acting from within.

5. Disinterestedness. By disinterestedness I mean an objective capacity for fairness. The classical metaphor was "Caesar's wife," and contemporary models are the judge in court, the teacher marking examinations, and the parent allocating family resources among the children. An ombudsman should not be an official "on his way up," lest institution members' suspicions be aroused that his rise is to be at their expense. If the ombudsman belongs

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128. This was the strong feeling of many psychiatrists and social workers at St. Elizabeth's Hospital.
129. See Involuntary Hospitalization 642.
130. Id. at 643.
131. In an institutional framework involving professionals such as a hospital or university, there is a special target for an ombudsman: the professional's desire to meet the ideals or mission of their calling—a sort of yearning for "excellence." The word "profession" here has a rather broad meaning, encompassing journalism, public administration, industrial relations, to name only a few.
132. This caution, while perhaps overstated, reflects the concern of people whose
to one of the several professions at work in an institution, he should show
that, while he has professional knowledge of one discipline, he has eager
openness to the others. It is the capacity to convey this image of disinterested-
ness, rather than their legislative connection, that chiefly accounts for the
credibility of the European ombudsmen. In the context of a single-area om-
budsmen, his “part-timiness” connotes other major duties, or that he is,
perhaps, a retired official or other professional. Either possibility pro-
motes the stress on disinterested service as opposed to career-progress as his
primary motivation.

In citing these less drastic forms of leverage, I do not intend to minimize
the obvious advantages of full-bodied clout (such as access to legislatures,
higher administration, or the courts). When the “heavy weights” are availa-
ble, they give the ombudsman a stronger hand, even if they are rarely used.
I do mean that the ombudsman notion need not be dismissed when these
sanctions are not available. Furthermore, these “lesser” forms enhance the
effectiveness of even an ombudsman blessed with major support. Take, for
example, the most usual starting point of an ombudsman’s activity—the com-
plaint of some person that he is being unfairly treated by his offici
ilm dom. Statistics attest that, after investigation, the overwhelming number of such
complaints do not call for further ombudsman action, whether you call them
“dismissed,” “unfounded,” or “without basis in law, justice, or fact.” If com-
plainants accept his decision they will forego formal grievance procedures (if
available), or formal administrative or legal action. If they do so, and thus
relieve administrators of real pressures, it is only because the ombudsman
possesses leverage and credibility. Complainants do not care whether the
ombudsman gets favorable action because of personal prestige, publicity ac-

133. There may be a place for a consultant-type ombudsman who performs this
service, on a professional basis, for many clients; cf. the project report’s recommen-
dation that the Chairman of the U.S. Administrative Conference serve as ombuds-
man for St. Elizabeths. Involuntary Hospitalization 685-85. The proposal encom-
passed the alternative that the Chairman designate the ombudsman and oversee his
work in specific areas.

134. See, e.g., a retired hospital director, judge, professor, or senior governmental
career official. The dignity of the role could reach the stage that it is an eminence at
the end of the line, rather than a springboard, as a judgeship is properly conceived for
lawyers.

135. Perhaps the thinnest facade of leverage is tenure. If an executive-appointed
ombudsman does not have leverage of some other sort the mere fact that he cannot be
removed is not enough to ensure his effectiveness. At most it is negative assurance
that an executive cannot replace him for intransigency (working at the job); cf. the
“ombudsman” at the University of Pennsylvania, note 2 supra.
cess, professional access, capacity for rational persuasiveness, or disinterestedness; or whether he has delivered results because of political, administrative, or legal clout; or whether the administration itself has been unusually good-tempered, and ironed out administrative kinks ostensibly on its own motion.

Conclusion

I have argued that the ombudsman offers many benefits to an institution—to administrators (vindicating administrators' fairness, and saving them the time and expense of formal procedures) and to members (reassuring them that their complaints have been responsibly looked into). If this is so, why does the introduction of a true ombudsman—one with leverage—cause such resistance on the part of the administrators? Two of the more obvious explanations we have already discussed and can now leave aside: (1) misunderstanding of the role limitations of an ombudsman (he is not a super-administrator);\textsuperscript{138} and (2) bad experience with adversarial advocates and the assumption that an ombudsman will inevitably be a lawyer.\textsuperscript{137}

Unlike these two misconceptions, some other reasons, not based on misinformation, are understandable. For example, there is apparently a natural reluctance in any administrator to cut down on his authority, or to limit his area of discretionary action. In many, this is coupled with a confidence in his own fairness in exercising his authority. Many administrators operating in a specialized area also resist extra-professional intrusion upon their decision-making. Still others resist adding to the present number of persons who are authorized to oversee his mistakes. These are, I believe, very human reasons for waving off an ombudsman. In many areas of associational activity, it may be difficult to make a compelling argument that an ombudsman is required when present decision-makers do not see the advantages as outweighing disadvantages.

While this would appear particularly the case in most areas of private ac-

\textsuperscript{136} The Preface to the PROJECT REPORT closed with this tribute: 
\ldots I thank Professor [Walter] Gellhorn for reminders in his writings and in personal consultation that an ombudsman is no super-administrator—no threat to administration—that he operates best where sound procedures are already established; he remonstrates when they are not carried out; and he suggests procedural improvements when clogs in the machinery or procedural inadequacy become apparent in the focus of an individual case. He often absolves administrators from blame they don't deserve. And all the time he is a symbol of help for those least able to help themselves.

PROJECT REPORT at v.

\textsuperscript{137} This seems to be the fear of psychiatrists, and the expectation of lawyers (even judges). \textit{See} note 121 \textit{supra}, and accompanying text. \textit{But cf.} the English ombudsman experience, where lawyers seem to have been ruled completely off the ombudsman course in favor of career administrators. \textit{Involuntary Hospitalization} 642.
tivity, the situation is different when we consider governmental administration, especially in areas where official action has broad discretion over the personal liberty and subsistence of other human beings. Here there is particular need to inquire whether unacceptable reasons are, in fact, at the root of resistance to effective oversight of official action. In these governmental areas questions should be asked as to whether actual reasons for resistance to having an ombudsman are acceptable. Is the reluctance based on a desire to preserve a scope of arbitrary action—absence of standards in administration, a lack of consistent result in comparable cases, or a will to preserve an unchallenged inertia, a pattern of no action, or of action only under external pressure? Is the matter one of reluctance of some well-intentioned administrators to expose to criticism unsuitable subordinate co-professionals (though they are invariably a minority); or, finally, is it a willingness to camouflage a fund-shortage, or personnel-shortage, which make it impossible for the institution to perform the goals that have been set for it? Good administration, you will say, will not countenance these “reasons” for rejecting an ombudsman, in any event. The present suggestion is that the reasons are intolerable for governmental institutions that affect personal liberty or subsistence.

At the same time the resistance itself shows an obvious need for some form of external leverage, of which the ombudsman is but one (and a very mild) variety. Some advocates of reform of governmental administration reject the ombudsman notion and would have the task done by legislatures and the courts.

In his perceptive and perhaps prophetic attack on “interest group liberalism” published four years ago, Theodore J. Lowi questioned the value of the ombudsman idea for American institutions on four counts: (1) the complaint load would require a sprawling staff, adding further to the spreading bureaucracy; the inevitable size of ombudsman staffs would require a further ombudsman to police the ombudsman; (2) the ombudsman would relieve the administrative process precisely where pressure is needed to expose problems that need central agency attention; (3) the ombudsman would duplicate activities now performed by others (congressional committees, courts and political parties); and (4) “most important, he would not do the one thing the system really needs having done: He would not give agencies any more law or justification.”

The one-legged ombudsman of our experience is not recognizable as the subject of Lowi’s list of horribles. The part-time ombudsman needs but a

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139. Lowi’s thought here is that things should be allowed to get worse before they get better.
140. LOWI, supra note 139, at 303-04.
modest budget and staff—his strength comes from having an institutional legitimacy which commands respect inside and outside the unit to which he is commissioned. Where other pressure is applied "to expose problems that need central agency attention," the ombudsman will have less cause to become engaged elsewhere. Similarly, where activities within his own jurisdiction are adequately overseen by "congressional committees, courts and political parties," the ombudsman will not be offended—and surely he will not be a party to conscious duplication. The brief account we have given here on the activities of one, temporary, and undermanned ombudsman activity operating in a whirlpool of controversial professional and governmental change does seem to defuse Lowi's "most important point": whatever impact the one-legged ombudsman at St. Elizabeths may have had on the long-run functioning of that hospital, the chief identifiable product derived from the project is "more law." If there is a second dividend, it is that the ombudsman pressed the agency at least somewhat towards seeking new bases for justification of its methods.

However, Lowi's underlying objection to the ombudsman, although tied to a misunderstanding of the potential of the institution, must be taken into account. The chief thrust of his book is that American administration of government, and administrative law itself, has been overwhelmed with delegation of power. This delegation has led to a condition of government by private interest groups, and the chief present need in administration is restored legislative control whereby the legislature formulates the legal standards for governmental institutions. To Lowi, the ombudsman is tied to maintenance of simple equity within the present "disorder," and, to his thinking, this is dysfunctional. If the justification for the ombudsman were this "equity" ground alone, Lowi's objections would be well taken. However, the most prolific American spokesman for the ombudsman, Professor Walter Gellhorn, has from the outset insisted that the ombudsman is no panacea, nor is he a substitute either for good laws or for good administration.141

The problem of substantive reform, and basic procedural reforms as well, is, as Lowi and Gellhorn agree, the function of the legislature in a democracy. The ombudsman's chief contribution may well be to identify those areas most pressingly in need of legislative attention, as well as those which can be reformed from within by the particular administrative agency. Since this function can best be carried out when limited to an isolated institution, the social utility of a one-legged ombudsman should, perhaps, be the chief focus of present attention.

141. See note 136 supra.
APPENDIX A

PROJECT INTERVIEWS WITH PATIENTS, WARD ATTENDANTS AND SOCIAL WORKERS AT ST. ELIZABETHS HOSPITAL
(OCTOBER-NOVEMBER, 1969)

The ombudsman project conducted open-ended interviews with St. Elizabeths Hospital psychiatrists working in John Howard Pavilion, the maximum security service, and with a sample of District of Columbia judges (United States District Court and Superior Court). These were included, in part, in the earlier article (Involuntary Hospitalization, supra, note 10, at 672-680, 608-611.) The project also took questionnaire-type interviews with samples of patients (10%) and ward attendants (30%) at John Howard Pavilion, and with social workers throughout St. Elizabeths Hospital. Substantial excerpts from these questionnaire interviews are given here.

The interviews below were conducted by members of the ombudsman project team (Karen Krempa and James Rourke, 1971 graduates of Catholic University Law School, Kenneth Donnelly, 1972 graduate of Catholic University Law School, Richard B. Williams, Class of 1973 at Tulane University School of Law, and Ann De Lessio and Mary Elizabeth Murphy, Catholic University graduate School of Social Work) under the immediate supervision of Joseph DiStefano, associate director of the ombudsman project.

1. Nursing Assistants (Ward Attendants)

“DISCIPLINE”

What are the general discipline problems? What methods do you use to handle them? Are the methods successful? What other methods do you think should be used?

NA 1*—We don't really have much problem. Very few fights and they are usually because a patient who has been noticeably slipping has finally had to let go. The lack of trouble is because of the “togetherness” of the ward [“disturbed” ward]. The attendants allow informal visiting and conversations of patients in the office more than on some other wards. So the atmosphere is warm and congenial. As a result there is little set method for dealing with problems.

NA 2—We have stealing and a little fighting—not many problems. Our methods: talking it out. They're successful, unless it's an ornery patient.

NA 3—The main discipline problem is adjustment. We are the methods. We talk to the patient to explain the rules and regulations of John Howard Pavilion, what's our role, and what his has to be. We need strong discipline to pick up mental illness, because most patients are here because they can't follow discipline on the outside.

NA 4—For close to a year things have been running smoothly. As methods we use discussion and reconsideration. Successful.

NA 5—Some patients don't particularly like to get out of bed in the morning, and they resent our insisting. Some patients are very playful on the ward and you have to continually talk to them about that—especially the young ones. Playful younger ones say things to the older ones, or they might jump up on one of their backs. Occasionally there is profane or loud language, and we have to call them down on this. Methods depend on the seriousness of the thing we see on the ward level. For example, if there is a ward fight we talk to them and try to handle it here. Usually in most cases we transfer the aggressor. These methods succeed. If they say they can't handle their differences, we transfer them to the top floor [“disturbed” ward].

*NA's marked with an asterisk function in one of the “disturbed wards.”

#NA's marked with a # function in transient Admissions ward (30, 60, 90-day observation).
There are quite a few discipline problems because it is a disturbed ward—smoking in their rooms, stealing. If it concerns smoking, we cut him off for a few days. Sometimes we cut their coffee out for not cooperating on the ward. If there is a fight the aggressor goes into seclusion. Successful.

NA 7—Trying to smoke where not allowed (in bed), the noise level, and petty arguments. Methods: sit down discussions. Successful? Most of the time.

NA 8—Stealing, teasing, agitating; sometimes a patient is involved in another's sickness. Emergencies may necessitate transfer of an aggressor. Then the incident, and all involved around it, is discussed in group. Decisions are made on a vote of one-half plus one of all staff and patients on the ward (i.e. majority vote). Successful? Very much so.

NA 9—Fights, trading and selling personal property. We handle them by separation or discussion, or both. In many cases these methods succeed.

NA 10—Homosexual activity is No. 1; then arguments over loans, debts and cigarettes. We try to come to an understanding by discussions between the parties involved. We very rarely have to resort to seclusion; we've had maybe an hour in the last 3 months.

NA 11*—Day to day change, and borrowing and trading arguments. We try to talk to those involved to determine if they understand what they're doing, and if they do to see if they'll reconsider. When necessary we put them in the seclusion room. Sometimes it depends on the individual patient.

NA 12—Anxiety and frustration—demands for something to be done “right now” about his problem. We have a therapeutic community. We decide in meetings through the patients' own discussion how to handle a problem such as stealing. Successful. I'm answering only for my ward. I can't speak about problems and ways of coping with them in any other ward.

NA 13—Homosexual acts and contraband. On methods, if your mouth is not good then you're in bad shape. Also your experience is very helpful to you. And then you have to “con” them. Successful.

NA 14—Not much in disciplinary problems. The ward chairmen [patients] are usually guys who are pretty well liked and they keep things pretty well settled. Our methods: first we talk things out. Sometimes we have a meeting. If that doesn't work, we can send them up to Ward 12 [disturbed ward]. It is very seldom that that happens. Pretty good success with these methods.

NA 15—Arguments. We talk to the men involved to straighten it out. Successful.

NA 16—Drugs, liquor, women. We have to watch these closely. If they can get them, they will. We punish according to the crime and try to be as lenient as we can. They're already locked up; why step on them? Try to talk to them as much as possible. Successful.

NA 17—I don't think we have any on the night shift. We seclude them if they become upset, like get into an argument, or want to hurt themselves. Successful.

NA 18—Very nil here. This is a privileged ward and we don't have any disciplinary problems. Elsewhere if a patient becomes unmanageable, he is sent to the 5th floor, where they have a special treatment room. And when it's felt they are controllable, again, they are returned to their own ward. A possible escapee is sent to the 5th floor. On one ward the [attendant] personnel might be a little lax, but about 75% of the time it is effective.

NA 19—None.

NA 20*—Assaultive patients. There is a seclusion room where [such a] patient is confined. Another method is wrist manacles that can be used with doctor's permission only. Successful.

NA 21*—Fights. We talk it out with them one at a time; then both together. When the difference is settled I go along with it. Successful.

NA 22*—Fights, chips on shoulder. Methods are seclusion and physical restraint. Successful.

NA 23*—Fights and arguments; behavior problems. Our method is brute strength, if talking to the patients won't do it.
Ombudsman

NA 24*-Patients are not in bed when they are supposed to be; and bang on windows or door. Fifteen of them here ['disturbed' ward] are locked in their rooms. If the incident calls for it, we call the Supervisor. Usually handle it according to the situations. If a patient physically abuses an attendant, he has to be restrained roughly and physically. Successful.

NA 25*-Fighting, stealing and oral hygiene. Sometimes can deal with problem by suggesting and example, for example in oral hygiene. Sometimes with fighting we remove the patient from the population (temporary seclusion). The methods are adequate. I would suggest a more thorough separation of types of patients.

NA 26-We always have the problem of homosexuality. Then there is fighting, loud talking. Patients wishing to visit other patients in rooms (this isn't allowed). Smoking in bed. On this floor there aren't too many problems. Usually we just talk to them. Most of the time they listen. These methods are not successful. With this type of patient, when you ask him not to do something, he will not do it, but he will try again at a later date. There is hardly any other method except punishment by seclusion, which I do agree with.

NA 27-Fights. One patient bothering another. You just talk to the patients about it and try to find out who started the incident and send him up to the 5th floor if it's serious. While the method is successful, I'd prefer more talk with a problem patient rather than just sending him away (to 5th floor).

NA 28—Illegal smoking, loud talkers at night, loud radios, and occasionally a fight or scrap. We just give a vocal reprimand or tell them to turn the radio down. Successful.

"TREATMENT"

How often do the patients on your ward see a doctor for a psychiatric check-up; b) psychiatric treatment?

NA 1-a) Hard to say. Couldn't say because there's no set pattern; b) Only a handful—in fact maybe none now. There's no one to give it to them.

NA 2*-a) Don't know. I'm on night shift. That's handled on day shift; b) Same.

NA 3#-a) More now, hadn't been getting 6-month check-up; b) Not enough, can't venture to say.

NA 4—a) Every six months; b) Daily now.

NA 5#-a) Not too often (full-blown examination once a year); b) Not enough, can't venture to say.

NA 6*-a) Twice a month; b) None.

NA 7—a) Varies: every two months, 2 to 6 months, 1 or 2 years; b) Don't know.

NA 8*-a) Very seldom; b) They don't.

NA 9—a) Maybe once a year. The doctors don't even make the rounds many times; b) Maybe once a year.

NA 10—a) Every six months; b) In group twice a week.

NA 11—a) Don't know—night shift; b) I don't know. I don't come in contact with that.

NA 12*-a) I don't know. I'm on evening shift; b) Same.

NA 13—a) Once a week; b) Once a week.

NA 14—a) I'm on night shift, so don't know; b) Same.

NA 15#—a) No answer; b) Daily with new doctor; prior it was very irregular.

NA 16—a) I don't know—night shift; b) Same.

NA 17—a) I've never seen one. Doesn't happen; b) Only one patient here; he goes to a group twice a week.

NA 18—a) Night shift; b) Same—don't know.

NA 19—a) Every 6 months; b) Once a week in a group. Some individuals at varying times with changing frequency.

NA 20#-a) Every two months; b) Once a month.
NA 21*—a) Practically never; b) None other than religious discussion group—so—never.
NA 22—a) I'm not sure; b) Once in a while.
NA 23#—a) Some doctors consider every interview a check-up, and they've been coming weekly for the past month; b) This is an Observation Ward [i.e. Admission Patients]; so the man is in treatment twice a week.
NA 24*—a) Couldn't say—night shift; b) Same.
NA 25*—a) Varies; right now twice a year; b) Group or individual, once or twice a week.
NA 26—a) Every 6 months; b) Once a week for group meeting.
NA 27—a) At least every 6 months; b) Twice a week in groups—that's everyone. Some are in smaller groups and that's at least once a week.
NA 28#—a) Once a month. More because of the change of doctors than anything else; b) They're not really getting therapy, because this is an Observation [Admissions] Ward—30, 60, 90 days.

How many minutes does a doctor spend with the patient on ordinary visit? Do you have any influence with the doctors concerning treatment? Concerning a patient's release? Other areas?

NA 1*—15-20 minutes a visit; sometimes less. We are consulted on treatment, but the doctor makes final decisions. We do discuss release [with the doctor] and then it has to be accepted or rejected by the Superintendent.
NA 2—Visit time depends on the case. Influence with the doctors concerning treatment? Yes, I think so. They go along with us because our records show we know the patients. On release I think we have a little influence. Also regarding visiting on the grounds or at home.
NA 3*—Don't know on visiting, or if influence on treatment. None on release. But yes on patient's privileges.
NA 4—The time a doctor spends with a patient per visit varies. If the patient has a writ the doctor tries to persuade the patient to drop the writ. "Writ therapy" goes like this: if a patient files writs he is being "uncooperative"—it constitutes a challenge, for the doctors don't like to go to court. I have no influence on treatment or release.
NA 5*—Hard to say on visiting time. Influence concerning treatment? Yes, we discuss patients with doctors quite often. On release? Yes, in a way. The doctor will talk this over with us and get our opinion. In other areas? The doctor gets most of his information about a patient from us because the doctor doesn't see him enough. If we see a patient improving we could bring this to the doctor's attention.
NA 6—Visit time depends on the doctor and the problem. I don't know if it is "influence," but the doctor looks to the attendants for assistance and their information and opinion on treatment is heavily weighed. On release—well, we relay information which may just help in the decision about release. Influence on the doctor in other areas? Well, requests that patients make are often ruled upon according to what the ward staff says—about whether the request is warranted.
NA 7*—I can't really say how long the doctor spends because they're not coming because they don't have the time. We used to make recommendations to the doctors on treatment. They were considered. Now we don't have a doctor. The last doctor used to come daily, and was conscientious. On release we can only recommend, and it's a bunch of red tape that needs revamping.
NA 8#—Visiting by a doctor varies according to the patient and his problem. Roughly 10-15 minutes (giving them the benefit of the doubt). No influence [night shift].
NA 9—Visit: 15 minutes (guidelines have been set up). I have influence on treatment. They [the doctors] are more or less obligated to ask us. Same on release. In fact we have influence on the patient's overall care—whether he needs medicine started, decreased, increased, etc. Transfers involve our opinions very much.
NA 10—No set time for a visit—until the matter is cleared up. On treatment we tell the doctor our opinions and our information is considered. On release we are usually consulted, but I don't know if you'd say we have influence. Also on transfers.
NA 11—Don't know about visiting time. I've no influence on doctors on treatment and release, but the attendant in charge does.

NA 12—Visit time varies according to the problem. I have influence concerning treatment; occasionally concerning release. We are also questioned about the patient's progress and behavior.

NA 13*—Couldn't say about visit time. No influence on night shift—only influence is monthly charts.

NA 14*—Don't even know [about visits]. Influence on treatment? Yes. And also on release—as far as his behavior goes. And on movement—to courts, etc.—and on transfers too.

NA 15*—10 minutes average visit. No influence concerning treatment, but the doctor will ask me how the patient is reacting to medication and whether there's any side effects. He may ask our opinion concerning release but I don't know how much impact it has on his decision.

NA 16—I don't know about visits, but according to the patients it's a very short time. I would have had influence on treatment, but being on the night shift I haven't had. In the area of medical treatment I do have influence when a doctor is called to the ward. But not on release. But I do in the taking care of special problems, for example if a patient becomes rough and needs to be sent to the 5th [disturbed ward] floor the doctor asks our opinions. If there is a security problem, such as an escape, the doctor always listens to us and uses our opinions.

NA 17#—Visits are 15 minutes to 30 minutes—depends on the doctor and on the patient. The doctor usually asks our opinion on treatment, and I think he does take into account what we say about a patient. But on release, No! That's the court's business. Influence in other areas? If a family problem comes up you can sort of speed up the social worker.

NA 18—Visit time depends on the patient or problem. I have influence with the doctors concerning treatment and release, and rehabilitation you might add. That's about it.

NA 19—Visits vary—anywhere from 15 minutes to two hours. Doctors will consider what nursing assistants say on treatment. How much is not known. No influence on release on night shift—but if doctor makes the rounds he might ask about a certain patient.

NA 20#—Visit time varies with the nature of the problem. The present doctor spends quite a bit of time. The doctor discusses treatment with us, but the charge nursing assistant has most of the influence. On release, same thing. The doctor has final decision on both. We have influence in other areas: ward parties, transfers, sometimes even admissions. For example, a patient [scheduled] to be admitted may have a relative already on the ward.

NA 21—The doctor doesn't come. Yes, I do have quite a bit of influence with doctors concerning treatment, not release.

NA 22—[We have influence with doctors on treatment and release if a particular doctor asks us and uses our information.] . . . The doctor will ask us about it before he will give a man any privilege. The doctor will want to know if we think a patient can handle a particular privilege.

NA 23#—Visits vary—averaging 15 minutes. On treatment the doctor listens to our opinions about things. As a matter of fact in most cases this is what he has to rely on. We talk and discuss the patient on occasion. Just how much influence this has on release I really couldn't say. Then again I guess there is some.

NA 24—Forty-five minutes an average visit. I've no influence.

NA 25—Don't know about visits. Most of my contact with the doctor is in the company of the "charge man" [nursing assistant in charge] so whatever is suggested is by him. No influence on release. Recreation is the thing that the man on the low end of the totem pole (that's me) does most.

NA 26—Visits of doctors are anywhere from 15 minutes to an hour. On treatment the doctor consults me and I make recommendations. He, of course, has the final word
on decisions. On release also—the whole staff is consulted about both release and
treatment of a patient. I have influence with the doctors on transfers.
NA 27#—Visiting time depends on the patient. Influence on treatment depends on
the individual doctors. Some of them discuss everything they do with the ward per-
sonnel—others don't. I have no influence with doctors on release. But in other
areas—about his behavior, for example, request for more medication. If you have to
transfer a patient (off the ward) because two of them are fighting and might kill each
other, you call the doctor.
NA 28*—Ten-fifteen minutes a visit. Influence concerning treatment: Yes. And yes
on release too—the doctor consults attendants. In fact in all areas—transfers, etc.

"PATIENTS' PROBLEMS"

What are the most common problems of patients? Which can
you handle yourself? Where else can a patient go with problems?
What could be done to improve handling of patients' problems?
NA 1*—Why they're being kept here. I can handle some problems: writing a letter,
getting some tobacco, or just listening to their problems. They can also go directly to
the supervisor, or head of the Service, or to the social worker or minister. What we
need are more social workers.
NA 2—Property, a real problem. How long are they going to be here, and why is my
mail not going out. I handle most of their problems. If property is in the Hospital
I can handle it; if not I'll call a (property) clerk. They can also go to the charge
employee, or if he can't solve it, contact someone who can according to the needs, for
example, lawyer, chaplain, social worker. There is too much red tape going through
people for a problem you can handle yourself. It would help if there were pay phones
on the floor to handle problems, to be used at the discretion of the attendant. For ex-
ample, trouble with the girl friend—if he can call her you can get rid of his anxiety.
Problems become complicated because you can't have a simple solution for them.
NA 3*—Why are they here and how can they get out. "When will they let us go?"
I handle 90% of their problems because of staff shortage: general ward problems, and
even some concerns that could use more help. They also can go to the doctor or
nursing personnel and to the social workers (mostly family problems). We need more
staff (especially doctors), and more emphasis on mental health and academic oppor-
tunities, through the [Hospital] institution and local universities.
NA 4—Hospital status, legal matters, transfers to other wards, medications. I can
handle about 25%, such as: troubles between patients, personality conflicts brought on
by living conditions, environmental problems within the ward itself. They can also go
to the doctor, the wing nurse, and the nursing supervisor. To improve the handling we
need group therapy, more O.T. [Occupational Therapy] more doctors, and better
security facilities for visiting with families.
NA 5*—Getting out. I can handle any problem that is a ward level problem: where
to sleep, activities, clothing, canteen, etc. A patient can also go to a nurse, doctor, or
to the Superintendent of the Hospital (by letter). Improvement in handling the prob-
lems? By more staff; for individual attention is needed—though this doesn't seem a
realistic request, legal advice should be readily available—this is badly needed.
NA 6—"Time" [prison] and the courts: the way to get to court and trying to get in
touch with attorneys. I can handle very few of their problems myself: some com-
plaints about clothing, food, and recreation; just some things you can bring up for
them in a meeting with the head nurse—clothing, etc. They can go to the doctor,
social worker, chaplain, and wing nurse. We need more doctors and more social
workers.
NA 7—Something like when two or more patients are sleeping in a room and one is
snoring. Patients don't get to see the doctor often enough. I can handle all the
patients' problems. I can answer their questions, such as pertaining to not seeing a
doctor enough. I explain about the lack of staff. They understand. Patients can
also take their problems to the other person [nursing assistant] on the ward, or if he
feels it necessary I call the supervisor and ask him to come. At night that's as far as we can go.

NA 8—Getting released and when. I handle some of their problems: advice about married life, what they should do when they get out. They can also go to the chaplain, social worker, and doctors. To improve handling of patients' problems get more help!

NA 9—Discussing alcohol and drugs. These are real problems because they are what brought them in here. I can't handle any of their problems myself. They can go to the nurse, doctor, or clinical director. To improve handling problems, I'd recommend speeding up action from people we report a problem to—like the nurse. That's about all on this ward.

NA 10—Complaints against the Administration and the nursing assistants, and “when am I getting out?” I handle environmental and behavioral problems which exist on the ward. Patients can bring a problem up before the ward meeting and let the group decide whether it is valid or invalid, whether action should be taken or not. The social worker can always help. Right now the best improvement would be better communication between all staff.

NA 11—“When can I get out?” “Do I need medication?” “Can it be reduced?” Most patients here are not confused—pretty coherent. I handle some problems: as to whether patient can do without medicine. I can give the patient an opinion—also I can go to the doctor. The patient can also go to the doctor, nurse, social worker, and therapists. We need more personnel, especially social workers. This is an acute problem; we need more experienced social workers.

NA 12—Money. They know they can't have it but are always bugging you about it. Getting out, seeing their lawyer, or that the doctor doesn't come around enough. I handle such things as clothing requests, need cigarettes, they want to see the priest or chaplain. Just talking to them. Other places they can go are a priest, write a senator, write family. We have a shortage of doctors and need more contact, so that the doctors and patients have more of a relationship.

NA 13#—Charges [they make], family problems. I can't handle any of them. They can go to the administrative [ward] doctor who makes his rounds. Most patients have a lawyer of some type, court-appointed, that they can write. There is a social worker they can write. There is need for more doctors, medical and administrative [psychiatrist in charge of ward]. The administrative doctor handles the court procedures for the other doctors. There is a shortage of nursing attendants, a shortage throughout in general. Concerning nurses they are anti-woman in this Hospital. They feel when men are incarcerated for a number of years it's not fair to have a woman on the ward.

NA 14*—Mainly when the patient can see a doctor, also “getting out” or “getting to court.” I handle some problems, such as patients wanting information, patients getting to see a doctor if one is available, answering petty questions. They can also bring problems to the wing nurse, then the administrative doctor, or sometimes the supervisor before the doctor. We need more staff of the calibre that can work in a maximum security institution—attendants, doctors and social workers.

NA 15—Medicine, visiting, clothing. We're a type of father figure. We can handle clothing etc., but most problems involve other departments. At times they can go with problems to the nurse, occasionally the O.T. [Occupational Therapy] workers, or other therapists. They can write letters to any staff member. We need more doctors and more nursing assistants. Sometimes patients can't go to recreation or other places because of lack of nursing assistants.

NA 16*—Getting out. Physical needs. Very seldom anything else—they keep to themselves. I can't handle any of their problems. They can go to the doctor or the head nurse. Improve handling problems? Increase the staff.

NA 17—Can't get in touch with outside—communication. I can handle immediate needs, such as lighting cigarette, contacting social worker. Patients can also go to the psychologists—but they don't come on the ward; or to the nurse—but she is incompetent (isn't worth a damn—I've seen her once in two weeks). We need more doctors
and staff, people who will have an understanding of patients' problems—for instance we don't have one black nurse or black doctor in this building [John Howard Pavilion]. St. Elizabeth's Hospital has lots of black nurses. But none are in JHP, despite the fact that all the attendants are black.

NA 18*—Things that are happening on the street, "what's changing?" etc. I can handle most problems—except medical questions: helping them write letters, information about writs, clothing problems, etc. They can also go to the social worker and chaplain. We need more help, more money (better pay), more availability of social workers.

NA 19—Getting out. I can handle all the problems—if you include passing the buck. Especially anything to do with routines of the ward or building—as found in the memos. They can also see the doctor, nurse, wing nurse, supervisors, and social worker. For improvement we need more help.

NA 20—Mail problems, family worries, medicine cuts—and silly complaints. I can handle housekeeping problems, clothing etc. They might also write to the doctor, or catch him on the ward, or write to the social worker. We need more nursing assistants and all other personnel, especially doctors.

NA 21—Alcohol, problems with rules of Crushard [experimental ward from which men can go on grounds], wives and jobs. I can handle some problems, for example, alcohol. The patient can also go to the social worker.

NA 22—"I want to get out." "Who can I see about getting out." I can handle most of the patients' problems. The doctor has final say so on most things, but actually I have to deal with all problems, large and small, first. They can also see the nurse and the doctor—but always got to the nursing assistant first. We need more help—doctor, nurses, nursing assistants.

NA 23—I've been on the ward three or four months and haven't seen a doctor. I handle some problems in the sense that when I talk to a patient this is a way of handling problems. He can also talk to the day shift nurse, if it's an immediate problem to the night supervisor; or to the social workers or doctors. For improvement increase the staff.

NA 24—What's going to happen back in court? When is the doctor coming? Physical sickness. Carrying tales—for example, "trouble in the dorm" that doesn't really exist. I can handle about half of their problems—such as first aid advice (to write to their lawyers), discussion with them of their family problems. They can also go to the charge nursing assistant, the charge nurse, the nursing supervisor, the doctor, and the social workers. More help is one of the major things needed.

NA 25*—Their own mental difficulties [disturbed ward], sexual frustrations and depressions. Sometimes patients get up and disturb other patients. Wanting to go home when they can't. I can handle some. For example when one has depression—by conversing with him to bring up their spirits. They can go to the nurse in charge. They can't go to the doctor—lack of communication. To improve handling of patients' problems we need (1) better staffing; (2) higher wages; (3) better opportunity for promotions; (4) reorganizing of the bureaucrats in A [Administration] Building; and (5) better nursing techniques.

NA 26—"When am I going back to trial?" Lack of seeing doctors, then attorneys. I handle most ward level problems. The patient can also go to the "charge man," the wing nurse. Occasionally they stop the Supervisor, which they really shouldn't do. Also the doctor. Actually any of the ward personnel. Improvements? A larger number of staff and more regular visits of professional staff to the wards.

NA 27—Demands for attention and how to get out. The patient might ask me for my opinion or help in figuring out what he's doing wrong—if I can tell him. He can also go to the charge nursing assistant, the nurse, or the doctor. I think the system as it is now works pretty well. We refer problems to the doctor on the same day they arise.

NA 28—Patient wondering how he got into his present difficulties. Holding up mail of patient. Visitor didn't show. I handle some problems—whatever is presented to me. Patient can go to his chaplain, attendant's supervisor, social worker or nurses. Improvements? Increase the staff.
Are there regulations that tell you what to do or what not to do concerning patients' problems? Any unwritten rules? What are they? Are these regulations and rules reasonable?

NA 1—There are regulations. Unwritten rules too—for example, you don't want to tell a patient you'll do something that you know you or the hospital can't honor. Some of the rules are reasonable, some aren't. There are so many that it would be hard to go into them all.

NA 2—Regulations, yes. Memos tell you not to make phone calls, bring things in from outside, etc. Unwritten rules too: you must be quite flexible and use your own discretion about many things. Reasonable.

NA 3—There are regulations. No unwritten rules—just experience. For example, the patient comes here and he's been here for 6-8 months and wants to know when he gets out. You just play it by ear and find out and relate to him what the story is. I tell him the diagnosis and I tell him to work on it. Reasonable.


NA 5—There are regulations, such as: you cannot make phone calls (for patients), handle financial matters, carry messages outside, etc. Unwritten rules too. You must be flexible. At times it is necessary to use your own judgment about a phone call that you're not sure will be approved, and smoking rules are sometimes let up, etc., as long as not dangerous. Reasonable.

NA 6—Regulations? Yes. Unwritten rules? Yes: try not to get yourself too involved. You don't want to tie yourself in where the patient can fall back on you. Reasonable.

NA 7—There are mail regulations, phone rules, money rules, and we aren't supposed to discuss legal problems with the patients. Also unwritten rules: when families aren't visiting or writing you talk about it. If a patient can't read or write we may write a letter for him. I don't think these things are in the rules. Are the rules reasonable? I think so.

NA 8—No regulations, except to give no information from the charts. No unwritten rules.

NA 9*—Regulations? We are not to consider ourselves therapists. Otherwise no regulations. There's an unwritten rule to handle some things by vote. Regulations are reasonable—otherwise they can be thrown out by unwritten rules.

NA 10—There are regulations in the memos. There are also unwritten rules: experience helps you to handle the "con artists" and say no. Reasonable.

NA 11*—Regulations? Yes. Also unwritten rules: common sense as to the patients' personal problems. There are certain ones you can handle yourself, e.g. property, get to the doctor that it is imperative that a man make a phone call. Take patients in the Observation Wards: they are supposed to be separated from the rest of the patients, but they go out into the yard together, and to the movies together. Yet the rest of the time they are supposed to be separated. It's not natural. You lock them up, take away all privileges and then say "act normal." The observation patients should be allowed to take part in ward activities. Then the problem of money: everyone knows they keep money on them. They need it for little things. I don't mean a large amount. In this place cigarettes are money too. They should be able to keep a little of their own on them. And stamps: they should be allowed to keep their own stamps on them. It's foolish how the stamps are locked up and the nursing assistants parcel them out.

NA 12*—No regulations. Unwritten rules? Yes, we were taught how to handle certain problems.

NA 13—There are memos about things like purchases, etc. No favors. There are unwritten rules. For example, settling between us whether a patient can go to the gym or if he should have something. All of the rules are reasonable.


NA 15—There are some regulations about contacting lawyers, families, etc. No set formula (of unwritten rules)—we just do what we think is best at a particular time. The "written rules" are too reasonable, and not enforced fully.
NA 16—Yes, there is a set of guidelines. Unwritten rules? Yes: you must play by ear according to the mood of the ward. Reasonable.

NA 17*—Regulations: no phone calls allowed, etc.; nothing to be brought in from outside. To some extent there are unwritten rules: buy a pack of cigarettes for guys who have cleaned up the ward and been cooperative. Reasonable.


NA 19—There are regulations such as phone call rules, rules about family contacts, legal contacts and contraband. Also unwritten rules: getting transfers from one ward to another, handling homosexual affairs. Problems between patients are sometimes settled without the written procedures of discipline. Regulations are bent, not broken. A question of judgment. The rules are reasonable: I would say they are like handling a “family affair.”

NA 20*—Regulations? Yes. Unwritten rules? None.

NA 21*—There are regulations. And unwritten rules such as—ward management, hours for “lights out,” hours when patients can watch TV. Reasonable.

NA 22—I believe there are [regulations], but I'm not too clear. If there are I refer to charge man. There are some unwritten rules: contact the social worker to call the attorney when the patient asks the attendant to get in touch with one. On the observation ward the patient is limited in physical activities. The attendant can decide which ones can go (even though the patient is technically not supposed to). Reasonable.

NA 23*—Regulations exist: no phone calls allowed; can’t bring anything in for them, etc. No unwritten rules: things are pretty well covered in the [written] rules.

NA 24*—There are some regulations—pertaining to money transactions, giving legal advice, phone calls, gifts, etc. There are some unwritten rules—they’re necessary. Many people regularly enforce rules in a very rigid manner and this is unfortunate in dealing with patients. Generally the rules are reasonable but it’s very important to allow for flexibilities in enforcing them.

NA 25—There are regulations, but tact and common sense are important in dealing with them. I’m sure there are unwritten rules. Some policies are eventually developed into rules. This is reasonable because many of the memos and stipulated procedures are unreasonable and can’t be done without extra staff. For example, checking laundry chutes every hour.

NA 26*—No regulations. No unwritten rules.

NA 27—No regulations within the building. There are unwritten rules: not making phone calls for patients, not allowing patient to use razor blade to cut paper, or to use elevator. There are so many it’s hard to pick out some. Reasonable.

NA 28—Yes, there are kind of rigid regulations—no phone calls, letters, etc. Unwritten rules? All I can say is “I have to live with the patients.” They have to be pacified. They’re reasonable [i.e. the rules].

2. Social Workers

“DISCIPLINE”

What have you seen of hospital discipline as applied to patients? Who generally administers it? Is it administered according to some written rule, or by discretion?

SW 1—Theoretically there is no discipline, but treatment. In case of elopement [running away] restrictions depend on what the happening was. There is a standing order by the clinical director that if the nursing staff feels that seclusion is appropriate they can take the initiative, and the director will investigate later. Discipline is administered by the verbal order of the clinical director.

SW 2—The Chief of Service administers discipline. It is not administered according to written rule, but at the discretion of the Chief of Service.

SW 3—Discipliné varies from service to service and nobody goes by the book.
discipline goes as the clinical director interprets. (N.B. John Howard Pavilion is the exception). General rules there are, but the application depends on the clinical director and staff.

**SW 4**—Discipline involves such things as restriction to locked wards, loss of privileges, isolation. Administration of discipline is generally spread out among doctors, nurses or assistants, sometimes the social workers. It is not administered according to written rules, but according to the discretion of the staff member.

**SW 5**—I see more discipline that I accept than I object to. It's a matter of individual personality—such things as being crabby. Nurses generally administer the discipline. I don't know whether discipline is administered by written rules or discretion— I don't think there are any written rules.

**SW 6**—Hospital discipline involves elimination of privileges, occasional exclusion, restriction to the ward. And also the discipline that comes from the group itself. The pressures of the group are great. Generally discipline is administered by the nursing staff. I really don't know whether it is by rule or discretion. Much discretion is exercised because the staff often must move fast. But there are guidelines regarding striking of patients, etc. And this is not tolerated.

**SW 7**—I have not seen too much of hospital discipline. I don't know who administers it. I would assume the doctor and nursing staff. Rules must be observed and there would be some need for discretion.

**SW 8**—I am directly involved in administering discipline. Hospital discipline works very well, considering the number of elopements and fights. Everyone on the staff administers discipline. Regulations come from the general part of the Hospital. I would say that discipline is administered according to "standards." There is a policy leaving discipline to the policy of the particular service. There is more flexibility here, for example than in John Howard Pavilion. We let patients go off the grounds, although strictly this is a violation of hospital policy. The Hospital may be "suspicious" that our people go out. If there were dope peddling involved, for example, the Hospital would interpret the policy strictly.

**SW 9**—As discipline an in-patient would probably lose privileges, e.g. alcoholic drinking on a weekend pass would have privilege revoked. On the ward it is a combined decision in administering discipline—a combination of the staff and the psychiatric administrator. Goals are established in your own set-up, and are spelled out to patients, shared with them. So administration is not really a question of discretion. The choice of the discipline is up to the patient.

**SW 10**—In voluntary wards if a patient breaks a rule, e.g. a man in a woman's room, they are asked to leave the Hospital. Discipline is administered by the nursing staff, the nursing assistant, the nurse—whoever sees the problem. Discipline is administered according to written rule.

**SW 11**—Social workers sometimes participate in hospital discipline. Discipline is used as a move to get the patients out of the Hospital by making it less comfortable for them here. Staff people on service and social workers too administer discipline. Community conferences also administer discipline. Discipline is neither by written rule or discretion, but by joint decision at staff conferences in which the psychiatrists participate.

**SW 12**—We don't have ward discipline here. The doctor has to authorize "special treatment." Staff members present handle an immediate problem. There are no written rules.

"**PATIENTS' PROBLEMS**"

If a patient approaches you with a personal problem, such as VA benefits, social security, clothing, or personal funds, how do you handle it? What resources can you presently call on for assistance? What further resources would you like?

**SW 1**—I handle some of VA and social security (getting information), and then it is referred. Sometimes patients can handle social security. I do little concerning personal funds unless it has to do with convalescent leave. I can call for assistance on the
medical and nursing staff, Occupational Therapy, District Vocational Rehabilitation (they have an officer here), educational therapy, recreational therapy, the home arts program, and all the community resources. We would like more of all this. I'd like more social service on this Service (I'm the only one).

SW 2—VA and Social Security are referred (to A Building). On clothing and personal funds we work with the patient and his family. I can call on Public Assistance and the family service agencies in the community, District Vocational Rehabilitation and routine community agencies. We need more housing, and more foster homes and halfway houses.

SW 3—VA and Social Security are referred to the contact men in A [Administration] Building. Clothing and personal funds can be handled by the nurse. One can call on Public Assistance, Child Welfare, Vocational Rehabilitation, Parole and Probation and, when the patient is at John Howard, on Legal Aid [the program then provided by Catholic University Law School]. I would like to see more halfway houses, and more volunteer services for those not yet ready to be out in the community. Also facilities for educating the community about hiring these people.

SW 4—On VA I tell the patient how he can go about handling it. The same with social security. These are competent patients here. They bring in their own clothing. There is a $5 limit on the ward because of theft. I use follow-up agencies extensively. I would like to see a long term rehabilitation program in the Hospital and more adequate agencies in the community.

SW 5—I refer VA and Social Security matters to the representative in A Building. I take care of clothing personally, make sure they get a voucher and refer them to the Clothing Shop. I can call on such agencies and services as Work Rehabilitation, Occupational Therapy, Foster Care, Public Assistance, Child Welfare and Legal Aid. I would like to have representatives of all these agencies located right in the comprehensive center.

SW 6—I can call on all the Hospital's resources: its resources are created according to need. I can also call on the staff and on all the resources available in the community. I wish we could get comprehensive community health centers off the grounds, and that there were more domiciliary places outside for patient release placement.

SW 7—On VA and Social Security there are very few problems. Sometimes they are passed on to us. If complex they are passed on to the VA and Social Security representatives in A Building. Personal funds problems are referred. As resources I can call on Legal Aid, and the VA and Social Security representatives.

SW 8—I handle VA up to the point where the VA representative takes over. I handle social security myself. I refer patients for clothing (after checking on their financial resources). I can call for assistance on the Registrar, the VA or social security representatives, visiting nurse, welfare and community agencies. I would like there to be a lot more nursing homes that people can afford. We need more space, and arrangements for apartments with some homogeneous companionship, and more personal care homes.

SW 9—I refer VA and Social Security matters for information (to A Building). As to personal funds and clothing, sometimes I do it, sometimes the nurses. I can call on the following resources: United States Employment Services (U.S.E.S.), the nursing staff, District Vocational Rehabilitation, other professional staff, Travelers' Aid, Public Assistance, and sometimes other mental health facilities (e.g. Area C, D, etc.). I would like to see greater staffing here in the hospital, approximately two dozen volunteers, less red tape with Public Assistance, and better staffed mental health facilities outside.

SW 10—VA, Social Security, and such things as changing the name of a payee are done by me to the extent of filling out the application. Then I refer it. I can call on the following resources: the Neighborhood Legal Services Project, the VA, the Public Assistance Division of the Child Welfare Department, Travelers' Aid (to pay his fare back to the city). What I would like us to have is money: if the Hospital had funds we could, say, locate relatives of a man who lives outside the state. It is discouraging to have to feed a man out of my own pocket. We could improve what
we've got. Halfway houses are a big need, some place for a man to stay when he leaves.

SW 11—Routine matters about VA and Social Security (such as getting a card, and personal funds matters), are handled by me. There is a VA representative and a social security representative in A Building. I can also ask help from the doctor, and from Mr. Edwards, the Registrar, who has a legal background.

SW 12—I try to help them make arrangements on VA and Social Security, or they do it. On funds, the job is to find financing for their home. I use resources like neighborhood houses, churches, schools, the community at large.] I would like to see a sheltered workshop for patients, more structured recreation to meet the needs of mental patients. They should open up rooms in churches for socializing processes. The churches don't do enough.

"SOCIAL WORKERS' FUNCTIONS, OBSTACLES AND PROPOSED REFORMS"

How would you describe your work functions? What do you see as the chief obstacles to your work? Would you favor any particular reforms?

SW 1—I take case histories, participate in conferences (diagnostic and disposition), have group work with patients, individual work with patients (although there is not much in-depth therapy now), I work with families, and prepare for placements. The chief obstacles are that there is not enough staff, and we need a better trained staff. Also there are rigid personalities that block creative thinking. So much of the problem is a lack of staff that I can't think about reforms.

SW 2—I direct treatment and administration of patients, develop training programs especially for schools in the area, assist other team members in developing available resources in the community and how to use them, and coordinate on-going treatment for in-patients who will become out-patients. And I am supervisor of group work trainees. The chief obstacles are that I don't have a phone; there's not enough clerical staff; red tape forms to fill out for requisitions; the time that patients have to wait in emergency situations like public assistance. My suggested reforms would be: more communication hospital-wide so that people can share what they are doing. If other agencies could be more within physical reach, e.g. have representatives in the Hospital, it would be less frustrating. And there should be more opportunities provided for staff groups to get to know one another.

SW 3—My function is traditional social work (release plans, talking with relatives, participation in meetings). On this ward I take some administrative responsibility (as leader in ward meetings) and do a lot of work with other agencies. The chief obstacle I see is lack of firm leadership within programs. As a reform I'd like an addition, i.e. another unit in which we can have a long-term therapeutic community.

SW 4—My functions are administrative, coordinating what workers are doing—and community organization. The chief obstacles are lack of well devised community services, and staff shortages. I see need for a full-time driver-and-car person to help carry patients' things out. And more staff, in general.

SW 5—I am a member of a team, working to achieve ultimately the goal to help patients rejoin the community. Chief obstacles: not enough staff, getting bogged down in small things in moving patients out, and filing, e.g. letters. Things I would change: (1) doctors getting bogged down in paper work; and (2) wasting time making the rounds (combining the ideas of hospital and institution). Also, the Hospital should be group orientated.

SW 6—Aside from treatment functions, I see myself as an intermediary between the patient and the community (do things the patient can't do for himself). I am a job finder. I make reports to the court. The chief obstacle is understaffing—no other. An improved physical plant would increase morale.

SW 7—The chief obstacle to my work is R. M. Nixon's freeze on staff. The Congress of the United States cannot legislate human needs. It cannot cut down budgets because it cannot budget the needs of patients. Agencies in the community move too slowly to meet the needs of patients.
SW 8—I participate in diagnostic conferences, developing social data for them. I interview patients daily (about 10 a day); my case load is 30-40 and I see others outside of them. I work out plans for them for living and working in the community. Help them with marital, finance, property, VA and social security matters. What to do here to get out. How to stay out. The chief obstacle to my work is "the system" that I work in. The "system" is like a link chain, one link breaks and everything goes haywire. You spend so much time working on inanimate things—paper work, satisfying the court. The hierarchy of approval, more paper work. I would recommend revolutionizing the current routinization system, and give the hospital staff the opportunity to rehabilitate patients without legal handcuffs. The hospital shouldn't be a dumping ground for the jail, or for the community. Our job should be to help patients to return to the community.

SW 9—I am a catch-all. I feel like a liaison between the patient and the doctor. Sometimes our patients are reluctant. The chief obstacles are shortages of staff—both doctors and social workers. For reforms I would say: more doctors, more doctors' participation with patients, and more therapy (dance and recreational).

SW 10—I supervise two workers here. I am also a consultant on two other services [naming them]. I coordinate the three programs [in these services]. The chief obstacle is: not enough workers. I don't favor any reforms "as such." Things go very well in social service. There's nothing we can't do as long as we have staff.

SW 11—Primarily, I help both patients and their families regarding their social adjustment to each other. I help with family crises around the patient while he is here. I help him in his return to the community. I interpret treatment plans and take on long time case work where indicated. There is some training involvement, some administrative duties around referrals elsewhere. And I work with other disciplines in the community. My chief obstacle is lack of help. The big thing needed is more qualified staff. I feel a good deal of what's needed may already be started through the reorganization.

SW 12—My functions, as I see them, are to help patients plan realistically for certain tasks before them, e.g. leaving the Hospital, going to work, coming into the Hospital; to administer a program which involves decision-making re treatment, etc.; and some therapy. The chief obstacles are shortages in staff and community resources, delays and red tape. As to reforms: a great increase of budgets, and direction of those funds to getting more staff.

"A HOSPITAL OMBUDSMAN?"

(Note: With a view to establishing some precision of terminology the following paragraph hypothesizing one model of an ombudsman was shown to each social worker interviewed before asking the next series of questions:)

"Some people have suggested that there is a place in a public mental hospital for a hospital-wide person, officially respected, but not himself a hospital official who would receive complaints made by patients or staff, sift them out, and try to cut through the administrative machinery to correct any snags. Where necessary he would be expected to go further in search of solution, to the National Institute of Mental Health, to the Department of Health, Education, and Welfare, even to Congress. In some instances, he would help patients and staff find lawyers to take their problems to the courts".

Do you feel there is need for such an ombudsman? Why? To what extent are these functions already performed by social workers? Would such an ombudsman be merely duplicating efforts? What special recurrent problems might he be useful in solving?

SW 1—I thought we already had an ombudsman (perhaps referring to the present survey, which was often identified at the Hospital as "the ombudsman project"). It wouldn't be a bad idea. His "neutrality" would be important. Social workers handle quite a bit of this sort of problem, but there are minorities who do not want to communicate with staff. You might need more than this at John Howard.

SW 2—The ideal characteristics of an ombudsman vary from institution to institution. Here there is need to create a separate role for him. He should not be a lawyer.
He should be concerned with helping the social work profession. He would need an understanding of behavior, organization and bureaucracy. He must be aware of the dynamics of institutions: things are instituted after the condition which gave rise to the proposal no longer exists; still vested interests maintain these institutions. An ombudsman must be innovative, proposing new deals in terms of change. He must have an eye to proposing innovation in terms of patients' needs and a great awareness of patients' rights. There would be a certain percentage of duplication with what we social workers now do; an ombudsman could be a strong liaison between us and community resources.

SW 3—Although about half these tasks are performed in some measure now by social workers here, I don't feel the ombudsman would be a mere duplication. Special areas needing attention by him are: problems of patients' rights, and property outside the hospital. For example, property is sold and the social worker questions whether the patient was given the full amount; there is no one to care for the property or belongings of a patient, etc.

SW 4—When patients need legal advice social workers make referrals. There would be no duplication of efforts because things can be handled before a referral is necessary. Two special recurrent problem areas where he'd be useful are a) legal problems of patients; and b) problems involving internal workings of the hospital. Provided such an ombudsman were independent he would be a good idea.

SW 5—I see need for such an ombudsman with patients' complaints, yes, and definitely in the area of legal matters. I have some question in the area of staff. Though a great deal of these tasks are now performed by social workers I don't see an issue of duplication. He would relieve us to do "our work", and he would have a more direct line. A special area: he could get to Community Services and get us more money and workers.

SW 6—No, there is no need for such an ombudsman. He may not realize the real problem; the social worker is training to do this. This is their job and they should handle it. But you do need legal aid here—e.g. management of money for patients against the time when he leaves—the patients would complain to death. An ombudsman, unless he had very fine training, would merely duplicate. But one area where he might help is in getting commodities for patients.

SW 7—Though these functions are performed to a great extent, this would not be a duplication. Its value first of all is because such a person is not personally involved, and can be more objective, and can devote more time and explore all avenues. Two special areas are Foster Care and legal matters. (1) Foster Care: they now have to act through an intermediary in order to communicate with a patient and the story often gets distorted. There are also questions about the legality of foster homes—in terms of patients' rights. (2) Legal matters: I am not satisfied entirely with the Legal Aid services.

SW 8—That kind of person could be very helpful. Social workers do these things now to a large extent—partly because there is no one else to do it. But I don't feel an ombudsman would be a duplication.

SW 9—The neutrality factor is crucial. In some sense social workers do these things. But they only handle the problem in the particular Service. They can't go over the head of the doctors. I see no duplication. Special recurrent problem areas where he might help: (1) coordinating disputes; (2) patients' complaints; (3) staff complaints (which are now smoldering like a tinder box.)

SW 10—The work proposed above is done now to some extent by social workers here, but not very much. An ombudsman would not be merely duplicating present efforts. SW 11—At the moment I am very much in favor of it. We have great ideas and we're trying to get them within the proper channels. I prefer not to have a lawyer in this role; someone is needed with psychiatric training. I have often seen lawyers perform in service of a patient, but ultimately to his detriment. To some extent the functions are now performed, but this would not be duplication. There is need for cutting through some of the red tape involved in program planning, e.g. a plan to hire ex-addicts to work on the ward with patients has been held up by administrative red tape.
SW 12—Social workers sometimes get very involved in legal matters, though they try not to get involved so as to avoid conflict between rights of the patients and rules and regulations of the hospital. An ombudsman would duplicate some present efforts. But he would relieve us (outside our field) and do them. Even doctors now get involved in legal matters (support, committees). Special problem areas include the legal problems surrounding the patient (including such things as detainers, going back to court (when?), and the administrative area (personnel management)—here important mediation would be helpful.

3. Patients

A 10% interview sample of patients in John Howard Pavilion (maximum security) was taken by the project. A questionnaire form was used. The questions were checked beforehand for bias with behavioral science consultants. The sample was taken on a random basis. An attempt (largely successful) was made to interview at least two patients in each of the wards at John Howard Pavilion. The interviewers were two law students and two social work students at Catholic University. Three of the four had previous experience working in mental hospitals (two as members of a legal assistance project, and one as a nurse). In only three instances were the interviewers known to any of the 39 patients who were interviewed.

The patient interviewing was undertaken with an awareness of limitations on the part of patients to be expected in a maximum security ward of a mental hospital: communication limitations, bias, timidity, lack of interest and understanding. While the results of this set of interviews are, we concluded, the least valuable of the interview phase of the project, a summary here of the results seems justified. If it does nothing else it serves as data pointing in the direction of conclusions reached on more solid grounds by other phases of the project. It is also data supporting previous hypotheses that patient interviews are not likely to be productive in certain areas of inquiry (those impinging on the on-the-scene representatives of the establishment bureaucracy).

The Interviews and Interviewees

The interviewees were confirmed by other statistics to be a fair sample of the patients in John Howard Pavilion from the standpoint of years in the hospital and in JHP. The patients' high degree of coherence confirmed our experience in previous 2 1/2 year contacts in JHP. The interviewers characterized each subject at the conclusion of the interview, and graded each interview on an A to F scale. Only 6 of the interviewees were graded below C (two were not graded.) Although the “failing” grades were based solely upon lack of coherence, condition of medication, and apparent lack of understanding, it was decided to include all interviews in the final compilation to avoid bias factors that would be risked by separating out the four D's and two F's.*

The interviewers affirmatively noted in a “remarks” column their appraisal that 19 patients were “oriented,” and 4 “honest;” on the other hand they noted that 8 at times “lacked understanding,” 6 were of “low intelligence (slow),” and 2 were under heavy medication.

The planned time of the interview was 20 minutes, but it was also planned to use great flexibility here. The extremes of actual times were 10 and 55 minutes; most of the interviews (28, 72%) fell within the 11-30 minute range; 13 (33%) occupied 21-30 minutes.

The interviewees turned out to be 26 black and 12 white (with one not recorded). The interviewers were all white. Although the interviews were to be anonymous, it was likely that the various ward attendants would be aware who had been interviewed. In view of the patients’ consciousness (as brought out in the interviews) of the great influence which these attendants have on their life, this awareness may have been a deterrent towards outspokenness with respect to certain questions asked. While the interviewers only noted one patient as having “refused to interview;” only one as “evasive; non-committal,” and only one as “reluctant,” on the other hand they singled out only four affirmatively as “honest” (in the sense of forthright).

* 10 interviews were rated as A; 9 as B; and 12 as C.
The most productive aspects of these questionnaire-type interviews can be divided somewhat arbitrarily into three headings: (1) Patients' view of "treatment" as administered to them and of internal management as affecting them; (2) Patients' view of their "internal" problems; and (3) Patients' view of the "external" aspect of their problem.

(1) Treatment

As asked who were the people he usually sees, 80% of the 37 patients who answered said the ward attendant. Others "seen" followed in this order:

<table>
<thead>
<tr>
<th>Group</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family</td>
<td>20 (53%)</td>
</tr>
<tr>
<td>Doctor</td>
<td>15 (40%)</td>
</tr>
<tr>
<td>Nurse</td>
<td>12 (32%)</td>
</tr>
<tr>
<td>Minister</td>
<td>6 (16%)</td>
</tr>
<tr>
<td>Social Worker</td>
<td>4 (11%)</td>
</tr>
<tr>
<td>Friends</td>
<td>3 (8%)</td>
</tr>
<tr>
<td>Myself</td>
<td>1 (3%)</td>
</tr>
<tr>
<td>No answer</td>
<td>2 (5%)</td>
</tr>
<tr>
<td>Lawyer</td>
<td>1 (3%)</td>
</tr>
</tbody>
</table>

Here the doctors scored respectably (40%) for observed presence. However a follow up question asking how often the patient saw a psychiatrist, social worker or psychologist produced the following:

<table>
<thead>
<tr>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
</tr>
<tr>
<td>Only Once</td>
</tr>
<tr>
<td>Two Times</td>
</tr>
<tr>
<td>Three Times</td>
</tr>
<tr>
<td>Four Times</td>
</tr>
<tr>
<td>Six Times</td>
</tr>
<tr>
<td>Once a Year</td>
</tr>
<tr>
<td>Once a Month</td>
</tr>
<tr>
<td>Twice a month</td>
</tr>
<tr>
<td>Once a Week</td>
</tr>
<tr>
<td>Once a Day</td>
</tr>
<tr>
<td>Every few Months</td>
</tr>
<tr>
<td>Twice a Week</td>
</tr>
<tr>
<td>&quot;Yes&quot;</td>
</tr>
<tr>
<td>No Answer</td>
</tr>
</tbody>
</table>

Fourteen patients said they had never requested to see a psychiatrist. Others said that they had made such a request once a week (4), once a month (2), twice a month (2), once a day (1), four times (2), three times (2), twice (2), only once (1), or every few months (1). The distinction between the 40% of the patients who listed the "doctor" among those most frequently seen, and the 70% (25 of 37 answering) who claimed to see a psychiatrist no more often than every few months, if at all, does not to them represent a contradiction. The "doctor" connotes the "administrative doctor", the person they recognize as most responsible for keeping them in the hospital or paving the way for their release. (See chart under "Internal Problems" below). The question about the "psychiatrist" brings to their mind the question of "treatment," as distinguished from "detention." The "administrative doctor" and the psychiatrist are invariably, in John Howard, the very same person. They saw the "doctor" making the administrative rounds, but not the "psychiatrist" (except as noted by them in the more limited number of cases). When we asked the patients whether they were getting "treatment," 20 (54%) said "No," 17 (42%) said "Yes." We then asked the 17 in what this "treatment" consists. They answered:

<table>
<thead>
<tr>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical (drugs, medication, etc.)</td>
</tr>
<tr>
<td>Some kind of therapy</td>
</tr>
<tr>
<td>Interview with doctor</td>
</tr>
<tr>
<td>Talk over problems</td>
</tr>
<tr>
<td>A.A.</td>
</tr>
<tr>
<td>&quot;Being locked up&quot;</td>
</tr>
<tr>
<td>Can't explain</td>
</tr>
</tbody>
</table>
Succeeding questions revealed the impression of 21 patients that they were receiving "medication": and of 14 that they were not. The questions followed in this order:

Do you think you need medication?

<table>
<thead>
<tr>
<th>Answer</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>21 (57%)</td>
</tr>
<tr>
<td>Yes</td>
<td>14 (38%)</td>
</tr>
<tr>
<td>Sometimes</td>
<td>1 (3%)</td>
</tr>
<tr>
<td>No Answer</td>
<td>3 (8%)</td>
</tr>
</tbody>
</table>

Are you receiving it:

<table>
<thead>
<tr>
<th>Answer</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>21 (57%)</td>
</tr>
<tr>
<td>No</td>
<td>14 (38%)</td>
</tr>
</tbody>
</table>

It developed that of the 14 who thought they should be receiving medication, 10 were actually receiving it, and only 4 were not. But of those 21 men who thought they did not need medication, 11 were receiving it, and 10 were not.

Twenty one patients interviewed said that they had been taken "physically ill" at some time while in John Howard; 16 patients said they had not been taken physically ill and 2 did not answer. Asked what action they took when they became ill, all of the 21 who admitted past physical illness said: Go to sick call, or call the attendant. Why this reliance on the attendant? Eleven of them explained their reasons: "Takes too long to get doctor." Two others said "depends on attendant's discretion and diagnosis"; one each said "sometimes doctor won't give medication," and "attendant provides immediate assistance."

The central position of the ward attendant (nursing assistant) in the patients' life was indicated above in their account that the "attendant" was the person they most often saw. He also assigns their work, according to 23 of 37 answering (62%); 11 others (30%) said it was the ward chairman (a patient) who did so. One man (a six-year veteran) said "Myself". In the matter of "punishment" the attendant was by almost universal agreement the central figure: 32 of 37 (86%) answered to this effect. Four others said it was the doctor who "punished"—but three of these four combined the doctor with the attendant. One said the nurse did the punishing, but bracketed her with the attendant. Two patients, both in JHP for over 5 years, with pardonable reserve said simply "Don't know."

The interviews did not bring forth any significant complaints about abuses of patients. The opportunity for such expressions was furnished by the question, Is the punishment unfair? The answers were mixed, but mild:

<table>
<thead>
<tr>
<th>Answer</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sometimes</td>
<td>11 (30%)</td>
</tr>
<tr>
<td>No</td>
<td>9 (24%)</td>
</tr>
<tr>
<td>Yes</td>
<td>6 (16%)</td>
</tr>
<tr>
<td>Never</td>
<td>7 (19%)</td>
</tr>
<tr>
<td>Don't know</td>
<td>3 (8%)</td>
</tr>
<tr>
<td>No answer</td>
<td>1 (3%)</td>
</tr>
<tr>
<td>Most of the time</td>
<td>1 (3%)</td>
</tr>
</tbody>
</table>

Grouping the above answers with respect to the hospital management in regards to punishment we get this:

<table>
<thead>
<tr>
<th>Category</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Favorable</td>
<td>16 (47%)</td>
</tr>
<tr>
<td>Unfavorable</td>
<td>18 (53%)</td>
</tr>
</tbody>
</table>

Since no adverse specifications were offered, these replies are hardly conclusive, except perhaps as warranting the perils of identifiable protest.

(2) Internal Problems

The patients showed a reluctance or an inability to relate to the questions which sought to pinpoint internal problems. Or perhaps, one might argue, they just felt all was going well. Their responses isolate just one problem for significant agreement among patients—"shortage of staff", which 15 of 37 patients answering (40%) cited as the chief "problem" at John Howard Pavilion.

Others responded:

<table>
<thead>
<tr>
<th>Problem</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>No problems seen</td>
<td>9 (24%)</td>
</tr>
<tr>
<td>Lack of interest</td>
<td>2 (5%)</td>
</tr>
<tr>
<td>Hospital doesn't recognize patients' problems</td>
<td>2 (5%)</td>
</tr>
</tbody>
</table>
Can't talk to the right people
(contact problem) 1 (3%)
Staff could be more ethical 1 (3%)
Emphasis on criminal charges rather
than illness 1 (3%)

The data furnished by one possible problem area where we asked a specific question—
handling of patients' funds—reveals both a lack of concern, and general satisfaction.
Of the 23 patients answering, only one (4%) flatly stated dissatisfaction. Four (17%)
expressly found the handling satisfactory; the rest satisfied themselves by identifying
how the patients' funds were chiefly handled:

Social worker 7 (30%)
Hospital Administration 6 (26%)
Self 4 (17%)
Friends 1 (4%)

We then turned to the one question which patients at John Howard Pavilion gen-
erally agree is their most central concern: "Getting out." The first question in this
bloc indicated that some disagreement exists even here. Asked "Do you want to stay
or leave?" 8 of 38 answering (21%) said "Stay." The remaining 30 (79%) said
the more expected thing: "Leave." But "what can a patient do about leaving?"

Cooperate with doctors 12 (32%)
Nothing 11 (30%)
Get legal assistance 8 (21%)
File writs 2 (5%)

Don't know 2 (5%)
Stay out of trouble 1 (3%)
Talk to minister 1 (3%)
Break out 1 (3%)

The answers to the next question "Who are the people who can help you get out?"
show that the patients, despite their day-to-day consciousness of the ward attendants,
are under the impression that it is the "doctor" who carries the key that will get them
out "on the street." Thirty-two of the 37 answering (86%) identified the doctor here,
either alone (3), or in pairings with others (29). Others listed were:

Lawyer 20 (54%)
Attendant 15 (41%)
Nurse 8 (22%)
Family 8 (22%)
Social Worker 8 (22%)
Friends 3 (8%)
No one 2 (5%)
Supervisor 1 (3%)
Self 1 (3%)

But when asked "Are they helping?" only 8 (22%) said "Yes." Thirteen (35%)
said "No;" 6 (16%) said "Don't know;" and 10 (27%) did not answer.

We next asked the patients whether help for their getting out would come best from
the inside, or the outside of the hospital. Their answer was mixed:

Insider 14 (38%)
 Outsider 12 (32%)
 Both 8 (22%)
 No Answer 5 (14%)

We now turn to the bloc of questions which focus upon patients' view on "outside"
aspects of their problems. We singled out three for special questions: the writ of ha-
beas corpus, social security, and VA benefits.

(3) "External" problems

a) Writs of habeas corpus

Only 14 (38%) of the 37 patients who answered the question
"Have you ever filed a writ?" said "Yes." The remaining 23 (62%) said "No."
It is interesting to look at a breakdown among these two groups in terms of length
of time they have been in John Howard Pavilion.
Of those filing (14), 8 said they had an attorney; 4 said that they did not. Three of those having an appointed attorney (only one attorney was retained), said he was appointed immediately after the writ was filed (the normal practice). One patient didn’t know at what stage his attorney was appointed; one said the attorney was not appointed until just before the hearing. This last is almost impossible to conceive. It is much more likely that the attorney had been appointed at the usual time, but that the patient did not learn of his appointment until just before the hearing. These answers should be considered in conjunction with the earlier question about people the patient usually sees. Only 1 patient of 37, we should recall, included a lawyer among people most frequently seen at the Hospital.

b) Social Security

Our pre-Project experience in giving legal assistance in the Hospital showed a great concern among patients at John Howard with respect to social security. One administration official whose work concerned overseeing social security applications made clear to an attorney that John Howard was not high on his priority list. In addition, the Registrar’s office indicated that processing of social security commenced when a patient had been in the Hospital for a year, not before. The reluctance of the Administration to process applications with respect to examination patients is understandable; however, with the expanded period of examinations a patient was sometimes in JHP, jail and court, for close to a year before being returned to the Hospital again as mentally incompetent or as not guilty by reason of insanity. This was generally considered a new admission and, presumably, the Registrar’s one-year rule of thumb for social security applications was not to begin until the time of this “indeterminate” commitment. It was against this background that we included questions of JHP patients (39) about social security.

“Ever file for social security?”

<table>
<thead>
<tr>
<th>Yes</th>
<th>11 (28%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>27 (69%)</td>
</tr>
<tr>
<td>No answer</td>
<td>1 (3%)</td>
</tr>
</tbody>
</table>

Those not filing included 12 patients who had not been in JHP for a year. But it is interesting that the non-filing group also included:

<table>
<thead>
<tr>
<th>Years in Hospital</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Over 5</td>
<td>5</td>
</tr>
</tbody>
</table>

Did any of those 11 filing have an attorney?

<table>
<thead>
<tr>
<th>No</th>
<th>8</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>1 (a retained attorney; he won the case)</td>
</tr>
<tr>
<td>No answer</td>
<td>2</td>
</tr>
</tbody>
</table>

Of the 11 filing, 7 knew their grounds for social security benefits as “disability;” the other 4 did not answer.

Of the 7 disability applications, 2 patients won; 2 lost; one was pending; 2 patients did not answer this question. Overall, 5 patients said they won their social security claims; 3 patients said they had lost them (2 of them on “grounds of insufficient contributions”).

Was adequate care being taken of social security problems?
The answers were spotty—only 10 patients of 39 bothered to answer this question at all. And these answers were brief and unexplained:

Yes 4
No 6

c) Veterans Benefits

This was another area in which our interest had been sparked by experience in John Howard Pavilion prior to the Ombudsman Project. Our questions elicited that 14 of the 39 (37%) were veterans. Of the 14 veterans, 10 had actually filed for benefits; 3 had not; 1 did not answer the question. How far had the filed claims progressed? Three had been won; three were still pending; one had been lost as "not disabled."

Of those filing, 2 had attorneys; 5 had not; 3 did not answer.

Was there adequate care given veterans benefit claims at the Hospital?

Of the 14 veterans, 6 said "Yes;" 2 said "No;" NA, 5; "Self," 1.

Certain impressions are fostered by this sample of patient opinion. The patients couple an awareness of their dependence on the ward attendants as the day-in-day-out most real factor in their lives, with a belief that it is their doctor who has most practical say about their possibility of departure. They don't seem to quite suspect what the psychiatrist interviews themselves seem to confirm*—that the attendants also play a highly significant role in this decision about release.

The patients' answers, if they can be credited on this point, attest to a very heavy incidence of medication (over 50%), even among those patients who (rightly or wrongly) don't think they need it. (On the other hand there is a close correspondence between those who think they need medication and those receiving it).

The testimony of patients as to infrequent appearance of doctors "as psychiatrists" (i.e. as "healers") corroborates the interview data furnished by attendants and doctors themselves. A striking indication from this patient interview data is the lack of correspondence between the high valuation given lawyers by patients in terms of their potential for helping them "get out" (54%), and the very low marks given lawyers for an insignificant presence on the hospital scene (3%). This data corresponds with our own pre-Project observation at John Howard Pavilion: that appointed lawyers are rarely seen there by the patients after their commitment; and that patients are rarely permitted by the Hospital to retain lawyers out of their own funds.

* See, Involuntary Hospitalization, supra note 10, at 583-85.
APPENDIX B

ANALYSIS OF CASE LOAD FROM MARCH 1, 1967-JULY 1, 1969, OF CATHOLIC UNIVERSITY LAW SCHOOL LEGAL ASSISTANCE PROJECT AT ST. ELIZABETH'S HOSPITAL

As of July 1, 1969 there remained 56 active files in the legal assistance project. These were either referred to other counsel or deactivated by notice to the patients involved, as the project phased itself out during the summer of 1969. The ombudsman project analyzed the subject matter and disposition of the 188 cases (involving 231 distinct problems) in the closed files of the legal assistance project on July 1, 1969. This analysis is presented here in four categories: Attorney Problems, Release or Transfer Problems, Personal Problems, and Reasons for Closing File:

I. ATTORNEY PROBLEMS

*Contact my attorney .......................................................... 60
*Complaint about attorney .................................................. 20
I want new attorney ............................................................ 6
Do I have an [active] attorney ............................................. 11
I want attorney for private matter ....................................... 6
Get me name of my attorney ................................................. 1

*These two items were often duplicative.

II. RELEASE OR TRANSFER PROBLEMS

I want release from the Hospital ........................................ 26
  By habeas route .............................................................. 10
  By recommendation of administrative doctor ..................... 16
I want transfer to less secure internal facility (“outside ward”)—
  by recommendation of doctor ........................................... 13
I want status report on my confinement ................................ 9
I want to return to prison to resume serving sentence
  [convicted transferees] .................................................... 3
I want transfer to a Veterans Hospital .................................. 4
I want information on how I got in St. Elizabeths Hospital ........ 2
I want information on detainers pending against me in this and
  other jurisdictions ........................................................ 4
I want information on parole and probation status .................. 2
Miscellaneous (I want not to be released to jail; information on release
  procedures; name of judge who committed me; data on legality of my
  commitment; an incompetency hearing (to stand trial); to know my
  next hearing date; to have immediate trial; to block extension of ob-
  servation period; to stay at St. Elizabeths; to avoid civil commitment. 12

75

III. PERSONAL PROBLEMS

Family problems ................................................................. 7
  Contact family (wife, brother, mother) ............................... 4
  Whereabouts of wife and child ......................................... 1
  Support for children ..................................................... 1
Support for mother [by VA funds] ............................................ 1
Divorce and annulment .......................................................... 7
Veterans Benefits ................................................................. 7
Social security ........................................................................... 9
Money due from various other sources (Railroad Retirement Board, Sanitation Department, inheritance) .................................................. 8
Property (lost property, personal effects, clothes not returned, house foreclosed, will to be drawn) .............................................. 6
Miscellaneous (paternity matter, civil incompetency, appointment of a Committee, change of name) ...................................... 4
Intra-Hospital ........................................................................... 10
  No treatment ........................................................................... 4
  Handling of funds ................................................................... 2
  Miscellaneous (reinstatement for work, work release, see Rehabilitation Counselor, voluntary sign-in privilege) ................ 4

Some distinctive problems:
  Papers lost on way to court for unconditional release; patient held beyond period specified in court order; requests information on condition of his victim ............................................................. 3

IV. REASONS FOR CLOSING FILE

*Active attorney ........................................................................ 51
*Released or discharged ................................................................ 52
Obtained requested relief .......................................................... 29
Referral to newly-acquired attorney ........................................... 4
No problem we could help on ..................................................... 16
Case should not have been opened at all ..................................... 8
#Not sufficient reason in file (for closing) .................................. 15
File not clear ............................................................................ 11
Miscellaneous (eloped; trial scheduled) ....................................... 2

* These two items were often duplicative.
# Such files were reconsidered after this appraisal.