

APPLICATION OF THE FAIR LABOR STANDARDS ACT TO PATIENT WORK PROGRAMS AT MENTAL HEALTH INSTITUTIONS: A PROPOSAL FOR CHANGE†

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In 1973, a federal district court held in *Souder v. Brennan*¹ that patients in mental health institutions must be considered employees and paid the minimum wage required by the Fair Labor Standards Act of 1938² ("FLSA") whenever they perform any activity that confers an economic benefit on the institution where they are located. In its decision, the court excluded from consideration whether the activity has therapeutic value for the patient. The court also did not consider whether the work activity is undertaken in the interest of the patient or in the interest of the institution.

The court in *Souder* was reacting to a pernicious set of circumstances. The plaintiff in whose name the suit was brought worked a sixty-six hour week in the kitchen of a state institution for the retarded, and he received two dollars a month for his efforts. The court, however, went too far in applying the provisions of the FLSA to all patient work activities that confer any economic benefit on the institution where the patient is located. As a result of the *Souder* decision, and the regulations adopted by the Department of Labor ("DOL") in response to it,³ mental health institutions have eliminated, curtailed or declined to establish patient-work programs which would otherwise serve substantial therapeutic and rehabilitative purposes.

After setting forth a brief history of patient-work programs as they existed in this country prior to the *Souder* decision, this article will describe in more detail the decision itself and its effect on patient-work activities. The article will then discuss the need for work programs as essential means of treatment and demonstrate why the decision, and the DOL regulations, have substantially interfered with the operation of such programs. Finally, the article will discuss the need to differentiate between the exploitive programs which led to the *Souder* decision and truly therapeutic and rehabilitative activities which should not be subject to the FLSA. This article will propose a set of criteria for distinguishing work treatment from the "institutional peonage" involved in *Souder v. Brennan*.

I. A BRIEF HISTORY OF PATIENT WORK PROGRAMS IN AMERICAN PSYCHIATRY

Work as a form of psychiatric treatment has occupied a significant place in the history of American institutional psychiatry. So, too, has work as a form of institutional

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¹ 367 F. Supp. 808 (D.D.C. 1973). For a discussion of the facts of *Souder*, see *Souder v. Brennan: Impact on the Courts*, HOSPITAL AND COMMUNITY PSYCHIATRY 107 (Feb. 1976).

² 29 U.S.C. § 201 (1982) [hereinafter cited as "FLSA"].

³ 29 C.F.R. § 529.1 (1985).

peonage. The line between these two facets of patient work has never been a simple one to draw, but the distinction is a critical one to make.

A. From Moral Treatment to Custodial Confinement

Before 1800, the few mentally ill persons who were institutionalized at all were committed primarily to poorhouses and, to a lesser extent, to jails. Those individuals unable to work languished in idleness and, not infrequently, in chains. Those persons able to work were made to labor on the grounds of the institution — and at times were even auctioned out to the highest bidder. Undoubtedly, working was considered good for those required to perform it. In a world in which insanity was believed to be impervious to human intervention, however, the work assignments had a great deal to do with economics and virtually nothing to do with treatment of the mentally ill.⁴

The early years of the nineteenth century brought a new approach to the treatment of insanity.⁵ Proponents of "moral treatment," as the movement came to be called, viewed the mentally ill as people who were sick, who could be treated and who could be cured. Moral treatment proponents called for the abolition of chains and other mechanical restraints, and they recommended instead the construction, generally in isolated and bucolic settings, of hospitals, or asylums, specifically intended for the residential care of the mentally ill.⁶

From the beginning, work played a central role in moral treatment. The movement traced its origins to Philippe Pinel, who freed the insane of Paris from chains and recommended instead a prescribed program of "physical exercise and manual occupations,"⁷ and to Samuel Tuke, an English Quaker whose York Retreat replaced the hitherto accepted practices of corporal punishment and manacled restraint with "every kind of rational and innocent employment."⁸

⁴ See generally A. DEUTSCH, *THE MENTALLY ILL IN AMERICA* (2d ed. 1949); L. HAAS, *PRACTICAL OCCUPATIONAL THERAPY FOR THE MENTALLY AND NERVOUSLY ILL* 6-15 (1944); *OCCUPATIONAL THERAPY: PRINCIPLES AND PRACTICE* 3-7 (W. Duntton & S. Licht ed. 1950) [hereinafter cited as *OCCUPATIONAL THERAPY*]; *OCCUPATIONAL THERAPY SOURCE BOOK* (Licht ed. 1948), [hereinafter cited as *Licht*]; Dain, *From Colonial America to Bicentennial America: Two Centuries of Vicissitudes in the Institutional Care of Mental Patients*, 52 *BULL. N.Y. ACAD. MED.* 1179-96 (Dec. 1976).

⁵ See generally R. CAPLAN & G. CAPLAN, *PSYCHIATRY AND THE COMMUNITY IN NINETEENTH-CENTURY AMERICA* (1969); A. DEUTSCH, *supra* note 4; M. GREENBLATT, R. YORK & W. BROWN, *FROM CUSTODIAL TO THERAPEUTIC PATIENT CARE IN MENTAL HOSPITALS: EXPECTATIONS IN SOCIAL TREATMENT* 407-27 (1955) [hereinafter cited as *FROM CUSTODIAL TO THERAPEUTIC CARE*]; L. HAAS, *supra* note 4; *OCCUPATIONAL THERAPY*, *supra* note 4; Licht, *supra* note 4; D. ROTHMAN, *THE DISCOVERY OF THE ASYLUM: SOCIAL ORDER AND DISORDER IN THE NEW REPUBLIC* (1971); Bockoven, *Moral Treatment in American Psychiatry*, 124 *J. NERVOUS AND MENTAL DISEASES* 167-94 (Aug. 1956), 292-321 (Sept. 1956) [hereinafter cited as *Moral Treatment*]; Bockoven, *Some Relationships Between Cultural Attitudes Toward Individuality on Care of the Mentally Ill: An Historical Study*, in *THE PATIENT AND THE MENTAL HOSPITAL* 517 (M. Greenblatt, D. Levenson & R. Williams ed. 1957); Curran, *Legal Psychiatry in the 19th-Century*, 4 *PSYCHIATRIC ANNALS* 8 (Aug. 1974); Dain, *supra* note 4; Dain, *The Chronic Mental Patient in 19th-Century America*, 10 *PSYCHIATRIC ANNALS* 323-27 (Sept. 1980) [hereinafter cited as *The Chronic Mental Patient*]; Tournay, *Psychiatric Therapies: 1800-1968*, in *CHANGING PATTERNS IN PSYCHIATRIC CARE* 3-42 (T. Rothman ed. 1970).

⁶ R. CAPLAN, *supra* note 5, at 3-11, 26-38; A. DEUTSCH, *supra* note 4, at 88; L. HAAS, *supra* note 4, at 6-11; Dain, *supra* note 4, at 1184; *Moral Treatment*, *supra* note 5, at 175.

⁷ *Medical Philosophical Treatise on Mental Alienation* (1801), in Licht, *supra* note 4, at 19.

⁸ *Description of the Retreat, an Institution Near York for Insane Persons*, in Licht, *supra* note 4, at 54.

Beyond their role as a humane alternative to the enforced idleness and immobilization of the insane, work programs were meant to be an active treatment intervention and an integral part of institutional life. Residents of the asylum, like their predecessors in the poorhouse, were expected to work; and the asylum, like the poorhouse, reaped much of the fruit of its inmates' labors. Work programs, in fact, were often expressly designed to benefit the institution, and patients did a good deal of the work on its grounds. The patient, however, and not the hospital, was the focus of the program, for useful and productive activity was considered an essential part of the treatment process.⁹

The successes of moral treatment encouraged other reformers, most notably Dorothea Dix, to press for the creation of a system of state hospitals to care for the thousands of mentally ill still committed to poorhouses and prisons.¹⁰ The new institutions tended to be much larger than the earlier asylums, however, and state governments made liberal use of their police power to commit disproportionate numbers of the poor, the immigrant, the vagrant and even the criminal. They also incorporated hospital jobs into their spoils systems and thereby precipitated a marked decline in the professional status and caliber of hospital employees.¹¹

By the time of the Civil War, institutional conditions, fueled by skepticism over the results of moral treatment, had helped revive public doubts about the possibility of treating mental illness at all.¹² New psychiatric theories were concurrently challenging the premises of moral treatment by emphasizing the physiological and hereditary causes of insanity. These new psychiatric theories made mental illness appear to be either an intractable disease or one whose remedy lay in surgical rather than environmental treatment.¹³

The changes inevitably led to a very different perception of the asylum. Once a place for treating the curable, the asylum became a place for categorizing the untreatable. Originally insulated from society to protect and restore the patient, the mental institution was now an overcrowded and isolated repository for the chronically ill, the politically defenseless and the socially undesirable.¹⁴

Such custodial institutions had little interest in work programs whose principal aim was patient therapy rather than hospital economy. To a staff more concerned with keeping order than providing treatment, work tools seemed potentially dangerous weapons and work assignments invitations to escape.¹⁵ Therapeutic work programs, which

⁹ L. HAAS, *supra* note 4, at 6-11; OCCUPATIONAL THERAPY, *supra* note 4, at 6-9; Licht, *supra* note 4, at 13; D. ROTHMAN, *supra* note 5, at 144; *Moral Treatment*, *supra* note 5, at 188; McLEAN HOSPITAL, 1835 ANNUAL REPORT (1835) (available in McLean Archives); Letter from Samuel Tuke to Thomas Eddy (July 17, 1815), *quoted in* A. DEUTSCH, *supra* note 4, at 101. See also A. DEUTSCH, *supra* note 4, at 58-63.

¹⁰ A. DEUTSCH, *supra* note 4, at 166; Curran, *supra* note 5; Dain, *supra* note 4, at 1185; *Moral Treatment*, *supra* note 5, at 115; *The Chronic Mental Patient*, *supra* note 5, at 324.

¹¹ R. CAPLAN, *supra* note 5, at 72-87, 98-105; D. ROTHMAN, *supra* note 5, at 270; *Moral Treatment*, *supra* note 5, at 176-86.

¹² On the claims of moral practitioners, see R. CAPLAN, *supra* note 5, at 88-97; A. DEUTSCH, *supra* note 4, at 132. On recovery rates, see *id.* at 136-37; *Moral Treatment*, *supra* note 5, at 173-74.

¹³ R. CAPLAN, *supra* note 5, at 126-42; A. DEUTSCH, *supra* note 4, at 276; D. ROTHMAN, *supra* note 5, at 268-69; *Moral Treatment*, *supra* note 5, at 187-89; Dain, *supra* note 4, at 1185.

¹⁴ R. CAPLAN, *supra* note 5, at 149; A. DEUTSCH, *supra* note 4, at 368; D. ROTHMAN, *supra* note 5, at 283-86; *Moral Treatment*, *supra* note 5, at 169, 316.

¹⁵ R. CAPLAN, *supra* note 5, at 151-52; Dain, *supra* note 4, at 1185; *Moral Treatment*, *supra* note 5, at 169.

required planning, active supervision, equipment, supplies and space, also fell victim to the economies of state legislators, who did not consider institutions housing social outcasts to be pressing budget items.¹⁶

Ironically, the absence of patient work programs did not mean the disappearance of patient-workers. In spite of testimony to the incompetence of patient labor, the fiscal realities of state hospitals for the mentally ill dictated the extensive use of those patients who could perform productive work with a minimum of supervision. Over the course of the next century such hospitals became increasingly dependent on resident labor. Although many administrators and clinicians continued to pay lip service to earlier beliefs in the therapeutic and rehabilitative value of patient work and many of the work assignments appeared at least superficially similar to those of the past, in fact, a fundamental shift in the focus and purpose of institutional work activities had taken place. Work had been transformed from treatment to peonage and patients in work programs had become employees, albeit unpaid ones, of the hospital.¹⁷

The most basic change occurred in the context in which the work programs were administered. In hospitals where patient work had had a therapeutic function, staff members had believed in the curability of mental illness and had perceived its role as the provision of active treatment. Many appear to have identified with the patients sufficiently to have tried to instill in the hospital a sense of community, in which all were engaged in the common purpose of making the patients well.¹⁸

In the therapeutic hospital, work was an integral part of the mission in helping patients recover, and work assignments were based on a belief in their value as treatment. Work programs were one of a series of activities available as part of an overall treatment.¹⁹ The aim of work activities was therapeutic, intending to prepare the patient for something beyond the hospital job itself.²⁰ While the programs often did result in some savings, the focus remained on the patient, rather than the institution,²¹ and there is evidence of patient consent to participation in the programs.²² The programs were supervised by clinicians,²³ who emphasized the importance of the process of work, rather

¹⁶ R. CAPLAN, *supra* note 5, at 162-68; A. DEUTSCH, *supra* note 4, at 253-54; L. HAAS, *supra* note 4, at 12-13; D. ROTHMAN, *supra* note 5, at 265-66, 283-86; Dain, *supra* note 4, at 1185; *The Chronic Mental Patient*, *supra* note 5, at 324.

¹⁷ R. CAPLAN, *supra* note 5, at 160-68.

¹⁸ A. DEUTSCH, *supra* note 4, at 93-94; *Moral Treatment*, *supra* note 5, at 303. See also R. CAPLAN, *supra* note 5, at 76; Dain, *supra* note 4, at 1184.

¹⁹ Kirkbridge, *On the Construction, Organization and General Arrangements of Hospitals for the Insane*, in Licht, *supra* note 4, at 73; *Moral Treatment*, *supra* note 5, at 302. See also R. CAPLAN, *supra* note 5, at 34-35; *Occupational Therapy*, *supra* note 4, at 8-9.

²⁰ R. CAPLAN, *supra* note 5, at 38.

²¹ R. CAPLAN, *supra* note 5, at 161; A. DEUTSCH, *supra* note 4, at 139; D. ROTHMAN, *supra* note 5, at 146; *Moral Treatment*, *supra* note 5, at 192-94.

²² While many of the moral-era clinicians believed in the benefits of almost all labor, and farming was the most readily available kind, see A. DEUTSCH, *supra* note 4, at 445, Pinel's belief that "[i]ntelligent treatment must be based on the individual behavior and thought of the patient," Licht, *supra* note 4, at 23, was echoed by others. See Kirkbridge, *supra* note 19, at 255-56.

²³ The issue of consent in a mental institution is an extremely delicate one, and we do not maintain that such consent was formally obtained, nor that the practice of consulting the patient's preferences was universal. There are indications, however, that the wishes of the patient and of the patient's family were at least considered. See, e.g., R. CAPLAN, *supra* note 5, at 161; *Moral Treatment*, *supra* note 5, at 191, 194. In addition, there are published complaints about those, particularly the rich, who refused to work, Bockoven, *supra* note 5, at 190, about American patients who demanded

than the value of its product.²⁴ The work programs did not foster that clear division between working and idle patients that characterizes institutions where peonage prevails.²⁵ Finally, according to the reports of those who administered them, the programs provided effective treatment.²⁶

In the custodial hospital, by contrast, work programs focused on the job to be done, rather than on the needs of the inmate. Work assignments were determined by the value of the activity to the hospital, rather than its benefit to the patient. With a large, captive and unpaid labor pool, such institutions could selectively choose their work force and they could afford to put up with its inefficiencies. Those patients who mastered particular jobs were valued for their productive contribution to the hospital, and their supervisors were consequently reluctant to see them transferred or released. A great many other patients did little or no work, however, and hospital populations became divided between those who toiled and those who did virtually nothing.²⁷

B. The Reemergence of Therapeutic Patient-Work Programs

Over the course of the next hundred years the failure of the custodial hospital became widely acknowledged.²⁸ Some critics advocated a revival of therapeutic work programs as an antidote for patient idleness and a more humane alternative to the growing reliance on mechanical restraints and tranquilizing drugs.²⁹ Particularly in state hospitals, however, economics dictated against both the revival of work treatment and the termination of peonage.³⁰ Moreover, prior to World War II, widespread clinical

to be paid, Licht, *supra* note 4, at 9, and about families who refused to allow hospitalized members to engage in work programs. F. Leuret, *On the Moral Treatment of Insanity*, in Licht, *supra* note 4, at 67. More generally, Caplan compares moral treatment to modern milieu therapy and argues that coercion was kept to a minimum. For an indication that consent was at times circumscribed, see R. CAPLAN, *supra* note 5, at 172; A. DEUTSCH, *supra* note 4, at 202.

²⁴ R. CAPLAN, *supra* note 5, at 70; D. ROTHMAN, *supra* note 5, at 144. That clinicians in this period emphasized the process of the work rather than the value of its product can be deduced from: (a) evidence of the assignment of patient-workers based on their need for the work rather than on their ability to do it; (b) evidence that patients moved among different jobs; (c) evidence that the goal of the work assignment was progression either toward a cure of the illness or training for employment and, in either case, release from the hospital; and (d) some indication that the demands of the work assignment differed from those of the marketplace. See, e.g., Reil, *Rhapsodies on the Psychic Treatment of the Insane*, in Licht, *supra* note 4, at 25; Kirkbridge, *supra* note 19, at 74. See also R. DUNTON, JR., *PRESCRIBING OCCUPATIONAL THERAPY* 62 (2d ed. 1945).

²⁵ See *Moral Treatment*, *supra* note 5, at 168; Reid, *Ergotherapy in the Treatment of Mental Disorders*, in Licht, *supra* note 4, at 82.

²⁶ L. HAAS, *supra* note 4, at 6-13; *OCCUPATIONAL THERAPY*, *supra* note 4, at 3-11.

²⁷ R. CAPLAN, *supra* note 5, at 167; D. ROTHMAN, *supra* note 5, at 266. See also Chapple & Esser, *Workshops in State Hospitals*, 38 *PSYCHIATRIC Q. SUPP.* 317-22 (1964); Forrer, *Work Therapy Program at Northville State Hospital*, *AM. OCCUPATIONAL THERAPY* 154 (1955).

²⁸ Bockoven, *supra* note 5, at 182; R. CAPLAN, *supra* note 5, at 179. Nor were only state hospitals affected. See D. ROTHMAN, *supra* note 5, at 277; Bockoven, *supra* note 5.

²⁹ R. CAPLAN, *supra* note 5, at 255-56; Blumer, *The Medical and Material Aspects of Industrial Employment for the Insane*, in L. HAAS, *supra* note 4, at 11. See also L. BRIGGS, *OCCUPATION AS A SUBSTITUTE FOR RESTRAINT IN THE TREATMENT OF THE MENTALLY ILL* (1923); Carroll, *The Therapy of Work*, 14 *J. AM. MED. A.* 2032-35 (June 18, 1910); Licht, *supra* note 4, at 14 (summary of early twentieth century experiments by Harvard); Meyer, *The Philosophy of Occupational Therapy*, 1 *ARCHIVES OCCUPATIONAL THERAPY* 1-10 (Feb. 1922).

³⁰ See, e.g., *OCCUPATIONAL THERAPY*, *supra* note 4, at 9-10 (comments of Dr. Frank Crampton Hoyt, Superintendent of Iowa State Hospital).

support for patient-work programs was lacking, particularly in America, where "psychodynamics" became the treatment of choice even in institutions primarily for the chronically and psychotically ill. Work programs consequently tended to be viewed not as activities worthy of a physician's personal oversight, but as tasks to fill the idle hours between treatment or regular jobs to be assigned in overcrowded institutions for chronic patients with little hope of release.³¹

After World War II, the concept of therapeutic work began to establish itself in the United States once again. Various reasons can be advanced to explain this revived interest in work programs. The number of draftees disqualified on nonphysical grounds, together with the war's psychiatric casualties, had underscored the problem of mental illness, and government programs of physical rehabilitation were extended to include psychiatric disabilities.³² Theoretical inquiries into the significance of work and its value as a treatment reappeared in the literature.³³ The influence of Europe, where work programs had maintained a much more vital tradition, the emergence of social treatments, and the introduction on a wide scale of antipsychotic medication all challenged both the commitment to psychodynamics that prevailed in private hospitals and the custodialism that characterized many state institutions.

One of the greatest spurs to the revival of interest in work programs was the mounting dissatisfaction with the lives that chronic patients were forced to lead on the back wards of the large state hospitals. Psychiatric and sociological studies both stressed the role of the institutional environment in fostering handicaps that worsened or prolonged the original illness.³⁴ While many of these studies condemned the existence of peonage, they generally focused their attacks on the plight of patients whose lives were characterized by boredom, idleness and inertia. "Enforced idleness" was viewed as the major cause of institutional deterioration, which was itself seen as often more perma-

³¹ For the late 19th century, see Bockoven, *supra* note 5, at 188-89; McLEAN HOSPITAL, 1893 ANNUAL REPORT (1893) (available in McLean Archives). For the 20th century, see M. GREENBLATT, M. SHARAF & E. STONE, DYNAMICS OF INSTITUTIONAL CHANGE: THE HOSPITAL IN TRANSITION 108-09 (1971); H. LAMB & ASSOCIATES, COMMUNITY SURVIVAL FOR LONG-TERM PATIENTS 96 (1976); Bockoven, *supra* note 5, at 303; Olshansky & Unterberger, *The Meaning of Work and its Implications for the ex-Mental Patient*, 47 MENTAL HYGIENE 139-49 (Jan. 1963).

³² Kissin & Carmichael, *The Rehabilitation of Psychiatric Patients*, 21 REHABILITATION LITERATURE 142-50 (May 1960); VOCATIONAL REHABILITATION AD. (HEW), REHABILITATING THE MENTALLY ILL (Report of Planning Conference, October 1964) (Government Document 11765, Washington, D.C. July 1965); Rubin, *Community Psychiatry*, 20 ARCHIVES GEN. PSYCHIATRY 498 (May 1969).

³³ NEFF, WORK AND HUMAN BEHAVIOR (1968); *Work as Integration*, 160 MED. REC. 735-39 (Dec. 1947); Hendrick, *Work and the Pleasure Principle*, 12 PSYCHOANALYTIC Q. 311-29 (1943); Lantos, *Work and the Instincts*, 24 INT'L J. PSYCHO-ANALYSIS 114-19 (1943); Loias, *Metapsychological Considerations on the Concept of Work*, 33 INT'L J. PSYCHO-ANALYSIS 439-43 (1952); Menninger, *Work as Sublimation*, 6 BULL. MENNINGER CLINIC 170-82 (Nov. 1942); Oberndorf, *Psychopathology of Work*, 15 BULL. MENNINGER CLINIC 77-84 (May 1951); Neff, *Psychoanalytic Conceptions of the Meaning of Work*, 28 PSYCHIATRY 324-33 (1965); Olshansky & Unterberger, *supra* note 31.

³⁴ R. BARTON, INSTITUTIONAL NEUROSIS (3d ed. 1976); I. BELKNAP, HUMAN PROBLEMS OF A STATE MENTAL HOSPITAL (1980); H. DUNHAM & S. WEINBERG, THE CULTURE OF THE STATE MENTAL HOSPITAL (1960); E. GOFFMAN, ASYLUMS (1961); O. SIMMONS & H. HUGHES, WORK AND MENTAL ILLNESS (1965); A. STANTON & M. SCHWARTZ, THE MENTAL HOSPITAL (1954); J. TALBOTT, THE DEATH OF THE ASYLUM (1978); J. WING & G. BROWN, INSTITUTIONALISM AND SCHIZOPHRENIA (1970); D. VAIL, DEHUMANIZATION AND THE INSTITUTIONAL CAREER (1966); Goffman, *Characteristics of Total Institutions*, in SYMPOSIUM ON PREVENTIVE AND SOCIAL PSYCHIATRY 43-84 (1957); Wing, *Institutionalism in Mental Hospitals*, 1 BRIT. J. SOC. AND CLINICAL PSYCHOLOGY 38-51 (Feb. 1962).

nently debilitating than the original illness, and work activities were recommended to ameliorate symptoms and to prepare for discharge.³⁵

Several post-war treatment methods consequently incorporated work programs as important components. Social psychiatry or milieu therapy, which was in some ways a modern version of moral treatment, sought to create a sense of community in which patients were encouraged to accept responsibility for themselves, their fellows and their environment.³⁶ One means of fostering this spirit was through common work projects undertaken for the common good. Somewhat later, behavior therapists advocated a system of "token economies," in which work assignments were central features of broader programs aimed at modifying maladaptive behaviors.³⁷

There were also a great many experimental programs that focused more directly on work. In England,³⁸ other parts of Western Europe,³⁹ and the Soviet Union,⁴⁰ industrial therapy programs played a central role in psychiatric care. In the United States,

³⁵ GUIDES TO PSYCHIATRIC REHABILITATION 30 (B.J. Black ed. 1963). See also BARTON, *supra* note 34, at 20; Bickford, *Treatment of the Chronic Mental Patient*, THE LANCET 924-28 (May 1, 1954); M. Catstairs, *Industrial Work as a Means of Rehabilitation for Chronic Schizophrenics*, in SECOND INTERNATIONAL CONGRESS FOR PSYCHIATRY, CONGRESS REPORTS 99 (1959); Esser, *Workshops in State Hospitals*, 38 PSYCHIATRIC Q. SUPP. 317-22 (1964); Gutterson, *Changing Treatment Concepts*, 40 MENTAL HOSPITALS 8-9 (Dec. 1953); Walker, *Mistreatment of the Mentally Ill*, 121 AM. J. PSYCHIATRY 215-20 (Sept. 1964); Wexler & Scoville, *The Administration of Psychiatric Justice: Theory and Practice in Arizona*, 13 ARIZ. L. REV. 1-259 (1971); Wing, *supra* note 34.

³⁶ D. CLARK, SOCIAL THERAPY IN PSYCHIATRY (1975); FROM CUSTODIAL TO THERAPEUTIC CARE, *supra* note 5; M. JONES, SOCIAL PSYCHIATRY: A STUDY OF THERAPEUTIC COMMUNITIES; M. JONES, SOCIAL PSYCHIATRY IN PRACTICE (1968); Abrams, *Defining Milieu Therapy*, 21 ARCHIVES GEN. PSYCHIATRY 555-60 (Nov. 1969); Brooks, *Rehabilitation of Hospitalized Chronic Schizophrenic Patients*, in CHRONIC SCHIZOPHRENIA 248-57 (L. Appleby, J.M. Scher & J. Cumming ed. 1960); Gunderson, *A Reevaluation of Milieu Therapy for Non-Chronic Schizophrenics*, 6 SCHIZOPHRENIA BULL. 64-69 (1980); Jones, *Social Rehabilitation with Emphasis on Work Therapy as a Form of Group Therapy*, 33 BRIT. J. MED. PSYCHOLOGY 67-70 (1960).

³⁷ T. AYLLON & N. AZRIN, THE TOKEN ECONOMY (1968); G. PAUL & R. LENTZ, PSYCHOSOCIAL TREATMENT OF CHRONIC MENTAL PATIENTS (1977); Zimmerman, Stuckey, Garlick & Miller, *Effects of Token Reinforcement on Productivity in Multiple Handicapped Clients in a Sheltered Workshop*, 30 REHABILITATION LITERATURE 34-41 (Feb. 1969).

³⁸ See especially the works of J. Wing, G. Carstairs, M. Jones, D. Early and D. Bennett. For a comparison of institutional psychiatric practices in England and the United States, see Sargant, *Psychiatric Treatment — Here and in England*, THE ATLANTIC 88-95 (July 1960).

³⁹ For example, Lothar B. Kalinowski wrote:

Active treatment is applied everywhere. Neither the somatic treatments nor formal psychotherapy are [sic] the 'number-one' approach. The treatment applicable and actually applied — to every patient, young or old, acute or chronic, is 'work therapy,' which has largely replaced the former unproductive type of occupational therapy. This deep belief in work therapy is common to all European institutional psychiatrists Work consists of any type of occupation in and for the hospital, and it may be added that no complaints of exploitation of patients are feared. The public has been made to understand with the help of the press that the mental patient is in urgent need of occupation and work.

Kalinowski, *Advances in Management and Treatment in European Mental Hospitals*, AM. J. PSYCHIATRY 552 (Dec. 1956).

⁴⁰ J. WORTIS, SOVIET PSYCHIATRY (1950); Hein, *Social Psychiatric Treatment of Schizophrenia in the Soviet Union*, 6 INT'L J. PSYCHIATRY 346-62 (Nov. 1968); Kline, *The Organization of Psychiatric Care and Psychiatric Research in the Union of Soviet Socialist Republics*, 84 ANNALS NEW YORK ACAD. SCI. 147-224 (Apr. 22, 1960).

veterans' hospitals pioneered in both industrial subcontracting and paid hospital work,⁴¹ and more conventional sheltered workshops were adapted to the needs of the mentally disabled.⁴²

Many of these programs offered monetary payments to the patients engaged in them. Workshops under contract to local industries generally paid piece rates for the work performed. Within the hospital, clinicians who regarded nonessential work as counter-therapeutic had patients perform jobs that benefitted the institution. Because such work would otherwise have been done by hired employees, it seemed both economically and therapeutically just that the patient-workers be paid.⁴³

The issue of compensation, however, proved extremely complex. In determining pay levels, work programs were faced with such issues as overhead and clinical costs, the productivity of patient-workers and taxes. While some practitioners advocated minimum or prevailing wages,⁴⁴ in most programs, including subcontract work where industrial piece rates prevailed by law, individual payments were very low.⁴⁵ Beyond the economic issues, in most programs the work was intended to provide treatment rather than employment. The compensation, therefore, was intended to serve as an incentive or a reinforcer rather than "to represent the material value of the work."⁴⁶

Because neither the payment nor the work assignment was meant to be an end in itself, some clinicians were concerned that the monetary reward would become the primary object of the patient-worker or that fully compensated hospital employment would tend to encourage dependency and inhibit the patient from seeking discharge.⁴⁷

⁴¹ See the numerous articles on Member/Employee Programs by Peter A. Pfeffer, Reuben J. Margolin, J. Edward Conners, James F. McCourt, Bernard F. Stotsky, and others; and on Community Hospital Industrial Rehabilitation Programs (CHIRP): by Robert Walker, William Winnick, Earl S. Frost, and others.

⁴² See the work of Bertram J. Black, Herman C.B. Denber, C.H. Patterson, and others.

⁴³ W. QUERY, *ILLNESS, WORK AND POVERTY* (1968); Berrington, *Re-socialization: Undoing the Damage*, 12 INT'L J. SOC. PSYCHIATRY 85-97 (Spring 1966); Denber & Rajotte, *Problems and Theoretical Considerations of Work Therapy for Psychiatric Patients*, 7 CANADIAN PSYCHIATRIC A.J. 25-33 (Feb. 1962); Kott, *Wage Payments for Mentally Retarded Residents of Public Institutions*, MENTAL RETARDATION 161 (June 1963); Stotsky, *A New Look at Rehabilitation*, 3 AM. ARCHIVES REHABILITATION THERAPY 22-27 (Mar. 1955); Watson & Maddigan, *The Effects of a Paid-Work Program on Chronic and Short-Term Patients*, 23 HOSP. AND COMMUNITY PSYCHIATRY 376-78 (1972).

⁴⁴ Brennan, *Standard Pay or Token Pay for Rehabilitation of Mental Patients?*, 34 J. REHABILITATION 26-27 (Mar.-Apr. 1968); Rubin & Roessler, *Guidelines for Successful Vocational Rehabilitation of the Psychiatrically Disabled*, 39 REHABILITATION LITERATURE 70-74 (Mar. 1978).

⁴⁵ W. BARTON, *ADMINISTRATION IN PSYCHIATRY* 157-61 (1962); Baker, *Factory in a Hospital*, THE LANCET 278-79 (Feb. 11, 1956); Carstairs, O'Connor & Rawnsley, *Organization of a Hospital Workshop for Chronic Psychotic Patients*, 10 BRIT. J. PREVENTIVE AND SOC. MED. 136-40 (July 1956); Durling, *State Hospitals Make a New Start in Vocational Rehabilitation*, 44 MENTAL HYGIENE 105-10 (1960); Kidd, *Industrial Units in Psychiatric Hospitals*, 111 BRIT. J. PSYCHIATRY 1205-09 (1965); LaFave & Cohen, *Intensive Rehabilitation for Chronic Patients*, 6 MENTAL HOSPITALS 279-81 (1965).

⁴⁶ Burr, *Group Work-Therapy in Holland*, THE LANCET 1083 (Nov. 19, 1955). For other views that compensation was intended to serve as an incentive see Evje, Bellander, Gibby & Palmer, *Evaluating Protected Hospital Employment for Chronic Psychotic Patients*, 23 HOSP. AND COMMUNITY PSYCHIATRY 204-08 (1972); Fanning, *Compensated Work Therapy Provides Hope for a Patient's Return to the Community*, 22 AM. ARCHIVES REHABILITATION THERAPY 173-78 (1974); Pfeffer, *Money: A Rehabilitation Incentive for Mental Patients*, 110 AM. J. PSYCHIATRY 84-92 (1953).

⁴⁷ Barbee, Berry & Micek, *Relationship Of Work Therapy to Psychiatric Length of Stay and Readmission*, 33 J. CONSULTING AND CLINICAL PSYCHOLOGY 735-38 (1969); BARTON, *supra* note 45, at 59; Berrington, *supra* note 43, at 91.

Compensation, however, did not always prove a valuable therapeutic intervention. In some experiments, it was found to have little or no effect on patient performance.⁴⁸ In others, involving paranoid schizophrenics, it actually resulted in a decline in productivity.⁴⁹

At its core, the concern about payments to patients engaged in work treatment was that wages would fundamentally misconstrue the nature of the therapeutic activity. Maxwell Jones, the English psychiatrist credited with originating milieu therapy, wrote:

There is a danger that paid incentives will become a part of every work programme. Before patients become "trade unionized" should we not question the wisdom of a step which once taken is difficult to reverse, and which tends to confuse the process of hospital treatment with outside employment?⁵⁰

Most programs were intended to prepare patients for discharge as well as to improve their institutional behavior. In fact, the two objectives were intimately related. By nurturing an atmosphere of idleness, nonproductivity and dependence, the custodial hospital did not merely fail to plan for discharge; it actually required from its patients an adjustment that was inimical to that demanded by life outside. After years in the hospital, many patients found themselves unequipped to deal with the world and desperately afraid to leave their protected and familiar environment.⁵¹ By providing skills, confidence in accomplishment and a simulation of reality outside the hospital, work programs could play a vital role in the difficult transition back to the community.⁵²

Beginning in the mid-1950's, the extensive use of antipsychotic drugs accelerated the trend toward markedly shorter hospital stays and the corresponding release of large

⁴⁸ Hamilton & Salmon, *Psychological Changes in Chronic Schizophrenics Following Differential Activity Programmes*, 108 J. MENTAL SCIENCE 505-20 (1962); O'Connor & Rawnsley, *Incentives with Paranoid and Non-Paranoid Schizophrenics in a Workshop*, 32 BRIT. J. MED. PSYCHOLOGY 133-43 (1959); O'Connor, Heron & Carstairs, *Work Performance of Chronic Schizophrenics*, 30 OCCUPATIONAL PSYCHOLOGY 153-64 (1956); Thorpe, *The Response of Chronic Female Schizophrenics to Monetary Incentives*, 1 BRIT. J. SOC. AND CLINICAL PSYCHOLOGY 192-98 (1962); Topping & O'Connor, *The Response of Chronic Schizophrenics to Incentives*, 33 BRIT. J. MED. PSYCHOLOGY 211-14 (1960); Wing & Freudenberg, *The Response of Severely Ill Chronic Schizophrenic Patients to Social Stimulation*, 118 AM. J. PSYCHIATRY 311-22 (1961).

⁴⁹ Topping & O'Connor, *supra* note 48; Thorpe, *supra* note 48; Wing & Freudenberg, *supra* note 48. See also Wadsworth, Scott & Wells, *Employability of Long-Stay Schizophrenic Patients*, THE LANCET 593-95 (Sept. 9, 1961).

⁵⁰ Jones, *Social Rehabilitation with Emphasis on Work Therapy as a Form of Group Therapy*, 33 BRIT. J. MED. PSYCHOLOGY 70 (1960). See also Berrington, *supra* note 43; Ethridge, *Work — A Treatment Media for All Disabilities*, 17 AM. J. OCCUPATIONAL THERAPY 16-18 (1963).

⁵¹ LUDWIG, *TREATING THE TREATMENT FAILURES* (1971); Anderson & Kuncze, *Stresses of Discharge for the Mental Patient*, 28 J. REHABILITATION 121-22 (1962); Baker, Thorpe & Jenkins, *Social Status After Five Years in a Mental Hospital*, 30 BRIT. J. MED. PSYCHOLOGY 113-18 (1957); Ludwig & Farrelly, *The Code of Chronicity*, 15 ARCHIVES GEN. PSYCHIATRY 562-68 (1966); Margolin, *The Mental Patient Who Wants to Fail*, 4 REHABILITATION REC. 34-39 (1963).

⁵² T. RENNIE, T. BURLING & L. WOODWARD, *VOCATIONAL REHABILITATION OF PSYCHIATRIC PATIENTS* (1950); Berrington, *supra* note 43; Brooks, *Rehabilitation of Hospitalized Chronic Schizophrenic Patients*, in *CHRONIC SCHIZOPHRENIA* 248-57 (L. Appleby, J. Scher & J. Cumming ed. 1960); Stern, *Operation Rip Van Winkle*, THE LANCET 162-63 (July 25, 1959); PUBLIC HEALTH SERVICE, *THE PREVENTION OF DISABILITY IN MENTAL DISORDERS*, (Publication No. 924) (Richard H. Williams ed. 1962).

numbers of long-term patients.⁵³ This trend led to a decline in the quantitative need for work programs for chronic patients, precisely the kind of program that had proved most susceptible to institutional abuse, and made more imperative the need to train patients for post-discharge performance.⁵⁴ An essential component of the deinstitutionalization movement was the emergence of rehabilitation — which stressed building functional skills, rather than relieving symptoms — as a vital part of treatment that must begin as soon as possible.⁵⁵ In response to the new demands, traditional occupational therapy departments shifted their focus away from crafts and recreation and toward work and community adjustment. Similarly, rehabilitation professionals sought to develop training devices for independent living patient-work programs which had too often become little more than labor pools for institutional economy.⁵⁶

Even as such programs were experiencing a resurgence of interest on the part of both psychiatrists and rehabilitation specialists, they were coming under attack in the courts. Yet evidence indicates that, in their new consideration of work treatment for patients, hospital staffs were also addressing the issue of peonage and the "institutionalism" of which it was a part.⁵⁷ This is not the contradiction it may at first appear. Whether a patient spends hours scrubbing a floor or sitting on a bench, he or she is being deprived of treatment, and in that sense, peonage and idleness are but two sides of the single coin of custodial care. By emphasizing the importance of meaningful, contributory and productive activity, the new programs were intended, not just to fill the patients' idle hours or the hospital's maintenance needs, but to be active treatment interventions. The history of patient-work programs has demonstrated the clinical importance of keeping very clear the distinction between work as treatment and work as peonage. Difficult as that line has been at times to draw, work has proved too valuable a treatment modality either to abuse or to discard.

⁵³ Ozarin, Redich & Taube, *A Quarter Century of Psychiatric Care, 1950-1974: A Statistical Review*, 27 HOSP. AND COMMUNITY PSYCHIATRY 55-59 (1976); Redlich & Kellert, *Trends in American Mental Health*, 135 AM. J. PSYCHIATRY 22-30 (1973).

⁵⁴ Brown, Carstairs & Topping, *Post-Hospital Adjustment of Chronic Mental Patients*, THE LANCET 685-89 (Sept. 27, 1958); Linder & Landy, *Post-Discharge Experience and Vocational Rehabilitation Needs of Psychiatric Patients*, 42 MENTAL HYGIENE 29-44 (1958); Stotsky & Weinberg, *The Prediction of the Psychiatric Patient's Work Adjustment*, 3 J. COUNSELLING PSYCHOLOGY 3-7 (1956).

⁵⁵ M. GREENBLATT, M. SHARAF & E. STONE, *supra* note 31; REHABILITATION OF THE MENTALLY ILL: SOCIAL AND ECONOMIC ASPECTS (Greenblatt & Simon ed. 1959); Burling, *The Vocational Rehabilitation of the Mentally Handicapped*, 20 AM. J. ORTHOPSYCHIATRY 202-07 (1950); DuBois, *Rehabilitation and Occupational Therapy*, 115 AM. J. PSYCHIATRY 635-40 (1959); Jones, *Rehabilitation: Concept and Practice*, 18 BRIT. J. INDUS. MED. 241-49 (1961).

⁵⁶ G. FIDLER & J. FIDLER, *OCCUPATIONAL THERAPY* (1963); E. MACDONALD, *OCCUPATIONAL THERAPY IN REHABILITATION* 25 (2d ed. 1964); Bickford, *The Rehabilitation of Schizophrenics*, THE LANCET 1082-84 (Nov. 11, 1961); Kissin & Carmichael, *supra* note 32; Linn, *Occupational Therapy and Other Therapeutic Activities*, in 2 COMPREHENSIVE TEXTBOOK OF PSYCHIATRY 2003-09 (Freedman, Kaplan & Sadock 2d ed. 1975).

⁵⁷ B. BLACK, *PRINCIPLES OF INDUSTRIAL THERAPY FOR THE MENTALLY ILL* (1970); M. GREENBLATT, M. SHARAF & E. STONE, *supra* note 31; G. PAUL & R. LENTZ, *supra* note 37; Bickford, *supra* note 35; Brooks, *Vocational Rehabilitation*, in THE CHRONIC MENTALLY ILL (J.A. Talbott ed. 1981); GITTELMAN & BLUMBERG, *Rehabilitation*, in MENTAL HEALTH: THE PUBLIC HEALTH CHALLENGE 77-81 (E.J. Lieberman ed. 1975); Hartlage & Tatum, *A Survey of Industrial Programs*, 16 MENTAL HOSPITALS 190 (1965); LANDY & RAULET, *The Hospital Work Program*, in REHABILITATION OF THE MENTALLY ILL 71-87 (1959).

II. THE *SOUDER* LITIGATION AND ITS EFFECT ON PATIENT-WORK PROGRAMS

Prior to 1966, the FLSA exempted from its coverage service establishments, including hospitals for the mentally ill, so long as more than fifty percent of the establishment's sales were made in the state where it was located.⁵⁸ In a 1966 amendment, Congress extended the FLSA to institutions engaged primarily in the "care of the sick, the aged, [or] the mentally ill or defective who reside on the premises of such institutions . . ."⁵⁹ By enacting this amendment, Congress clearly intended to establish that hospitals for the mentally ill are engaged in commerce within the meaning of the FLSA. The legislative history of the amendments, however, left unresolved the issue of whether Congress also meant to extend coverage of the FLSA to the patients of such institutions.⁶⁰

In light of this uncertainty, the United States Department of Labor ("Department" or "DOL") took conflicting positions with regard to the applicability of the FLSA to patients in mental health institutions. A 1968 release stated that participation in a patient work program for up to three months would not constitute an employment relationship, provided that: (1) the tasks performed by the patient had medically adjudged treatment value; and (2) the patient did not displace a regular employee or otherwise impair the employment opportunities of nonpatients.⁶¹ Shortly after issuing this release, however, the Department decided that it would take no enforcement action with respect to patients in institutional work programs until it had completed a departmental review.⁶² This was the status of the applicability of the FLSA to patients of mental health institutions when the *Souder* litigation was brought against the Department of Labor in 1973.

The *Souder* litigation was part of a broader movement which sought to enlarge the rights of the psychiatrically disabled. In particular, the litigation questioned the efficacy of large state institutions that provided protracted or permanent custodial confinement rather than patient treatment. Critics of "institutional peonage" focused on the role of chronic patients in maintaining a system from which they often derived little benefit — indeed, from which they often suffered.

Nelson Souder was a patient who suffered from this institutional peonage. At the time he brought his suit, Souder had spent thirty-three of his forty-seven years in a state hospital for the mentally retarded. In 1973, he was working sixty-six hours each week in the hospital kitchen and another eight hours doing house and yard work for retired state employees. For the latter, he received about ten dollars a month. His hospital pay was less than one cent an hour.

Nelson Souder was not an isolated case. With institutional budgets inadequate to hire sufficient numbers of regular employees, a great deal of the work at state hospitals across the country was being performed by residents. Patients were clearly being used

⁵⁸ Fair Labor Standards Act, ch. 676, § 13, 52 Stat. 1067 (1938) (current version at 29 U.S.C. § 201 (1982)).

⁵⁹ Fair Labor Standards Act, Amendments of 1966, Pub. L. No. 89-601, § 102, 80 Stat. 831-32 (1966).

⁶⁰ See S. Rep. No. 1487, 89th Cong., 2d Sess. 1, 8, 22-23 (1966), reprinted in 1966 U.S. CODE CONG. & AD. NEWS 3002; H.R. Rep. No. 1366, 89th Cong., 2d Sess. 3, 11-12, 15, 16-17, and 18 (1966).

⁶¹ Department of Labor Release G-874, reprinted in *Souder v. Brennan*, 367 F. Supp. 808, 815-16 (D.D.C. 1973).

⁶² *Souder v. Brennan*, 367 F. Supp. 808, 816-17 (D.D.C. 1973).

to reduce the costs of their own hospitalization, and those persons who were good workers were likely to be valued more for the services they provided than for any progress they might be making toward discharge.

As the representative of a class of patients who were clearly being exploited, Souder presented a situation that cried out for judicial intervention. In its deliberations, however, the court did not focus on either the extreme nature of the work activities required of Souder or on their lack of therapeutic value. Instead, the *Souder* court focused almost exclusively on the FLSA, holding that the language of the statute was broad enough to apply to any situation in which an institution derived any "economic benefit" from the activities of a patient, regardless of any therapeutic value the activities might have for the patient.

Starting from the premise that a "basic canon of statutory construction is that when statutory language is clear on its face and fairly susceptible of but one construction, that construction must be given to it," the court held that "[t]he words of the statute here in question say simply that 'employ' means 'to suffer or permit to work,' [and] that 'employer' specifically includes 'a hospital, institution or school' for residential care of the mentally ill."⁶³ The court further stated that:

[e]conomic reality is the test of employment, and the reality is that many of the patient-workers perform work for which they are in no way handicapped and from which the institution derives full economic benefit. So long as the institution derives any consequential economic benefit the economic reality test would indicate an employment relationship rather than mere therapeutic exercise. To hold otherwise would be to make therapy the sole justification for thousands of positions as dishwashers, kitchen helpers, messengers and the like.⁶⁴

In a footnote the court added:

The fallacy of the argument that the work of patient-workers is therapeutic can be seen in the extension to its logical extreme, for the work of most people, inside and out of institutions, is therapeutic in the sense that it provides a sense of accomplishment, something to occupy the time, and a means to earn one's way. Yet that can hardly mean that employers should pay workers less for what they produce for them.⁶⁵

The *Souder* court seemed untroubled by the absence of any legislative history indicating Congressional intent to apply the FLSA to the patients of mental health institutions as distinct from the employees of such institutions. Indeed, the court declared that:

[e]ven where there is legislative history in point, albeit ambiguous or contradictory, it is unnecessary to refer to it and improper to allow such history to override the plain meaning of the statutory language. Most certainly, then, the absence of any legislative history in point should not outweigh the words of the statute.⁶⁶

Furthermore, in both the wording of the FLSA itself and in Labor Department policy, the *Souder* court purported to find evidence of intent to include patient-workers.

⁶³ *Id.* at 813 (citations omitted).

⁶⁴ *Id.* (citations omitted).

⁶⁵ *Id.* at 812 n.21.

⁶⁶ *Id.* at 812-13 (citations omitted).

With regard to the latter, the court concluded from the 1968 release that "the Department's initial and consistent interpretation . . . of the Act has been to recognize its application to patient-workers."⁶⁷ The *Souder* court failed to address the fact that the release had specifically exempted tasks performed by a patient as part of a program of activities which had been determined, as a matter of medical judgment, to have therapeutic or rehabilitative value. Nor did the court consider important the Department of Labor's subsequent determination not to apply the FLSA to the patients of mental health institutions pending a fuller review.

With regard to the FLSA itself, the *Souder* court noted that Section 14 of the Act established a procedure for certifying workers with impaired productivity and paying them at competitive rates. While conceding that application of Section 14 of the FLSA to patient-workers throughout the country might be both costly and time-consuming, the court concluded that "administrative burden is no excuse for failure to implement the statutory mandate."⁶⁸

The statutory mandate, however, was not as clear as the court indicated. In fact, as other courts had previously noted, the FLSA definitions of employment and employ are essentially circular and do *not* provide precise and unambiguous guidelines for determining the existence of an employment relationship.⁶⁹ As a result of this lack of clarity in the statute, the United States Supreme Court has stated that the "primary consideration in the determination of the statutory [definitions] is whether effectuation of the declared policy and purposes of the Act comprehend securing to the individual the rights guaranteed and protection afforded by the Act."⁷⁰

It is unlikely that any closer attention to the underlying purpose of the FLSA would have altered the result in *Souder v. Brennan*, for it is certainly arguable that the FLSA was intended to stop the type of exploitation that was involved in that case. Rather than simply addressing the inappropriate nature and extent of *Souder's* work assignments, however, the court adopted a literal approach to the statute. According to the *Souder* court, as long as the patient was performing any work activity, it was irrelevant whether the work had any therapeutic value to the patient or even whether the costs incurred by the institution in making the activity available to the patient exceeded any benefits the institution received as a result of the activity. In adopting this literal approach to the statute, the court departed from previous judicial decisions in this area.⁷¹

The Department of Labor did not appeal the *Souder* decision. Indeed, it promulgated a comprehensive set of regulations considerably more rigid than its 1968 release. The new regulations provided that an employment relationship:

generally arises whenever a patient is suffered or permitted to work. The total facts surrounding a given situation, other than those factors specifically

⁶⁷ *Id.* at 814.

⁶⁸ *Id.*

⁶⁹ *See, e.g.,* *Rutherford Food Corp. v. McComb*, 331 U.S. 722, 728 (1947) ("As in the National Labor Relations Act and the Social Security Act, there is in the Fair Labor Standards Act no definition that solves problems as to the limits of the employer-employee relationship under the Act.").

⁷⁰ *United States v. Silk*, 331 U.S. 704, 713 (1947).

⁷¹ *See, e.g.,* *Walling v. Portland Terminal Co.*, 330 U.S. 148, 152-53 (1947) (Although noting that the FLSA definition of employee applied literally to participants in on-the-job training course for railroad brakemen, the court held that statute could not reasonably be interpreted "so as to make a person whose work serves only his own interest an employee of another person who gives him aid and instruction.").

excluded in this subsection, determine whether the test is satisfied. A major factor in determining whether or not an employment relationship exists under this Part is whether the work performed is of any consequential economic benefit to the institution. Generally, work shall be considered to be of consequential economic benefit if it is of the type that non-handicapped workers normally perform in whole or in part, in the institution or elsewhere [D]etermination of an employment relationship does not depend on the level of performance of the patient or whether the work is of therapeutic value to the patient.⁷²

This definition of employment, like that of the *Souder* decision to which the Department was responding, is manifestly overbroad. In reality, the definition does not exclude any form of patient work from the reach of the FLSA, since no matter what the work is, nonhandicapped workers presumably could be found performing something similar. Despite the problems inherent in this definition, the Department has made clear that it will enforce the new regulations.

The combined effect of the *Souder* decision and the subsequent DOL regulations was dramatic. Within a year of the decision, over half the states had either reduced their work programs or discontinued them altogether.⁷³ In keeping with the economic basis of the decision, some states made economic responses to the ruling. Virginia, for example, removed about 1,000 patients from nonpaying jobs, while a dozen of the most productive workers, who probably should at least have been considered for release, were kept on at the full minimum wage.⁷⁴ A budget crisis caused Georgia to reduce all of its work programs, remove the least productive patient-workers, and make its own labor needs the sole criterion for placement.⁷⁵

Many private hospitals likewise either abandoned work programs or else restricted them to only a few patients working a small number of hours for a limited period of time. A few institutions went to great effort and expense to get a Department of Labor waiver from the regulations, while others retained programs of questionable legal standing. But these are isolated instances. Although *Souder* apparently was meant to encourage work programs, the overall result has been a significant retreat from patient-work activities.⁷⁶

III. THE CONTINUING NEED FOR PATIENT-WORK PROGRAMS

As repugnant as were the images of forced labor that sparked *Souder v. Brennan* and other "institutional peonage" suits, more prevalent were the descriptions of the back wards of large state institutions where patients deteriorated in an environment characterized by "overpowering boredom."⁷⁷ As one critic wrote in 1969:

Traditionally in the care of the mentally ill in America, patients defined as sufficiently sick to require institutional care were defined as too deteriorated

⁷² 29 C.F.R. § 529.2(d) (1985).

⁷³ *From Peonage to Pay*, BEHAVIOR TODAY 331-32 (Dec. 16, 1974), 337-39 (Dec. 23, 1974), 344-46 (Dec. 30, 1974), 351-53 (Jan. 6, 1975), 364-66 (Jan. 20, 1975), 372 (Jan. 27, 1975).

⁷⁴ 8 PSYCHOLOGY TODAY 17 (1975).

⁷⁵ BEHAVIOR TODAY, *supra* note 73.

⁷⁶ J. Blaine, *Patient Work Programs a Decade After Souder v. Brennan: A Survey of Selected Private Psychiatric Hospitals* (Private Paper on file at McClean Hospital).

⁷⁷ Wexler & Scoville, *supra* note 35, at 196.

to perform in work roles. Instead, patients were frequently allowed to sink into apathetic stupor while their work skills atrophied. Although in recent years the attitude toward the work of mental patients has become more reasonable, persons receiving hospital care continue to be regarded as too sick to pursue meaningful task activities; and there is a very limited scope of meaningful activity available to the patient in such treatment contexts. Yet, the ability to continue performing meaningful tasks while under treatment can do much to raise the patient's confidence in himself and to encourage persistence in coping efforts. The assumption that mental illness is totally incapacitating is reinforced by programs that fail to keep active those aspects of social functioning that can be sustained.⁷⁸

The *Souder* case raised an issue of real abuse which demanded serious and creative thinking about the role of patient work programs in institutions for the mentally ill — something that had been absent in many custodial institutions for a long time. The problem, however, is that the language of the *Souder* court and the response of the Department of Labor threw the baby of treatment out with the bath water of peonage. In so doing, the *Souder* decision terminated, abridged or impeded the inception of numerous beneficial programs which addressed the diagnostic, therapeutic and rehabilitative needs of many long- and medium-stay patients. It is doubtful that these needs can be met in any other way.⁷⁹

The importance of work programs for the institutionalized mentally ill is now widely accepted. In a recent survey of clinical and rehabilitative professionals at selected private psychiatric hospitals, ninety-eight percent of the respondents affirmed the value of work programs for at least some patients, and virtually all of these respondents believed that such programs occupy a special niche which cannot be filled by another type of activity.⁸⁰ Furthermore, other available evidence demonstrates that patients like structured work programs and recognize their benefits.⁸¹

The benefits of work programs to institutionalized patients are varied and come under seven different but related headings such as: structured constructive activity, therapy, rehabilitation, work-adjustment, diagnosis, research, and cost savings. The first benefit work programs provide is a *structured and constructive activity*. For almost two centuries work programs have been advocated as humane alternatives to the often

⁷⁸ Mechanic, *Sociological Issues in Mental Health*, in *PROGRESS IN COMMUNITY MENTAL HEALTH* 62 (L. Bellak & H. Barton ed. 1969).

⁷⁹ G. PAUL & R. LENTZ, *PSYCHOSOCIAL TREATMENT OF CHRONIC MENTAL PATIENTS* (1977); Kapp, *Resident Labor in Public and Private Institutions: A Disparity in the Law*, 30 *HOSP. AND COMMUNITY PSYCHIATRY* 414-15 (1979); Lebar, *Worker-Patients: Receiving Therapy or Suffering Peonage?*, 62 *A.B.A. J.* 219-21 (1976); Sharfstein, Clark, Turner & Clark, *Financing Issues in the Delivery of Services to the Chronically Mentally Ill and Disabled*, in *THE CHRONIC MENTAL PATIENT* 148 (J.A. Talbot ed. 1978). See also Walsh & Sookoos, *Impact of Souder v. Brennan on the Profoundly and Severely Retarded*, 14 *J. PSYCHIATRIC NURSING AND MENTAL HEALTH SERVICES* 14-18 (1976).

⁸⁰ Blaine, *supra* note 76.

⁸¹ Bolin & Scott, *Patient Industry and the Workers' Attitudes Toward Their Jobs*, 115 *AM. J. PSYCHIATRY* 246-47 (1958); Hartlage & Hartlage, *Practices Contributing to Successful Rehabilitation*, 51 *MENTAL HYGIENE* 231-35 (1967); Malhotra & Olgiati, *A Survey of Therapists' Attitudes Toward Psychiatric Patients as Hospital Volunteers*, 28 *HOSP. AND COMMUNITY PSYCHIATRY* 345-46 (1977); Schmidt, *Patient as Volunteer: An Assault on Chronicity*, 30 *HOSP. AND COMMUNITY PSYCHIATRY* 404-06 (1979); *Work: The Patients' View*, 27 *HOSP. AND COMMUNITY PSYCHIATRY* 102 (1976); Egan & Sovchen, *Being Paid and Being a Patient* (1976) (unpublished research results; available in Dixmont State Hospital, Sewickley, Pa.); interview with Dr. Paul M. Howard, in Belmont, Massachusetts.

repressive idleness of institutional life. They provide meaningful activity within a structure that is at once familiar and formal, yet flexible enough to accommodate individual needs. By encouraging patients to adopt a role other than that of patient and to engage in a more normal life within the hospital, work activities help to combat idleness, dependence, apathy and the stripping away of the ordinary life functions that are both cause and effect of institutional deterioration.⁸²

The second benefit of work programs to institutionalized patients is *therapeutic*. Work programs do much more than occupy otherwise idle time. They bind the individual to reality and help to build or rebuild self-image, self-confidence and self-esteem.⁸³ Work encourages sublimation and, particularly in its more physical forms, it provides a release for the frustrations and aggressive urges that tend to build up in a confined setting.⁸⁴ For patients who need help with interpersonal skills, work programs provide a natural social setting.⁸⁵ On the other hand, those patients who feel intimidated by interpersonal relationships can concentrate on and build from the neutral and nonthreatening work task itself.⁸⁶ While not denying the fact of illness, the worker role provides the patient with an alternative self-perception which emphasizes the healthy part of the ego; and one thing that virtually all work programs instill in their participants is the feeling that they have identities as productive people who are both useful and needed.⁸⁷ Programs designed so that the patient is the only beneficiary of his or her efforts do not, of course, address this therapeutic need. Yet these types of programs are the only kinds which the Souder court and the Department of Labor appear willing to regard as treatment.

The third benefit of work programs is *rehabilitation*. Many work programs are specifically designed to teach social and vocational skills and to alter inappropriate behaviors, rather than to address the psychodynamic aspects of a patient's condition. The intent of such programs is less to "cure" the patient, or even to ameliorate the symptoms of the illness, than it is to prepare the patient to function outside the hospital.⁸⁸

⁸² H. LAMB, *TREATING THE LONG-TERM MENTALLY ILL* (1982); Barton, *Occupational Therapy for Psychiatric Disorders*, in *OCCUPATIONAL THERAPY*, *supra* note 4, at 177-96; Denber, *Work Therapy in Psychiatry*, in 5 *CURRENT PSYCHIATRIC THERAPIES* 228-34 (J. Masserman ed. 1955); Blaine, *supra* note 76.

⁸³ M. GREENBLATT, M. SHARAF & E. STONE, *supra* note 31; Cohen, *Work as a Therapeutic Tool in the State Mental Hospital*, 49 *MENTAL HYGIENE* 358-63 (1965); Denber & Rajotte, *supra* note 43; Mackota, *Using Work Therapeutically*, in H. LAMB, *COMMUNITY SURVIVAL FOR LONG-TERM PATIENTS* 96-114 (1976); Oseas, *Therapeutic Potentials in Work*, 4 *ARCHIVES GEN. PSYCHIATRY* 622-31 (1961); Strauss, *Chronicity: Causes, Prevention, and Treatment*, 10 *PSYCHIATRIC ANNALS* 328-32 (1980); Thompson, *The Effects of Industrial Therapy Upon Personality and Behavior* (1960) (unpublished Ph.D. Dissertation, University of Colorado); Blaine, *supra* note 76.

⁸⁴ Barton, *Occupational Therapy for Psychiatric Disorders*, in *OCCUPATIONAL THERAPY*, *supra* note 4; Menninger, *supra* note 33; Neff, *supra* note 33; Olshansky & Unterberger, *supra* note 31; Blaine, *supra* note 76.

⁸⁵ *HUMANIZING THE PSYCHIATRIC HOSPITAL* 45-51 (A. Gralnick ed. 1975); Luzzi & Shapiro, *Work, Personhood and Rehabilitation*, 20 *AM. ARCHIVES REHABILITATION THERAPY* 102-10 (1972).

⁸⁶ Mackota, *supra* note 83; Azima & Azima, *Outline of a Dynamic Theory of Occupational Therapy*, 13 *AM. J. OCCUPATIONAL THERAPY* 215-21 (Sept.-Oct. 1959).

⁸⁷ Freed, Fazzato, Hall & Haugen, *A Meaningful Work Assignment for Patients in a Psychiatric Hospital*, 20 *AM. ARCHIVES REHABILITATION THERAPY* 91-95 (Sept. 1972); Lehrer & Lanoil, *Natural Reinforcement in a Psychiatric Rehabilitation Program*, 3 *SCHIZOPHRENIA BULL.* 297-302 (1977); Mackota, *supra* note 83; Richman & Zinn, *Work as a Central Focus in Therapy*, 13 *MENTAL HOSPS.* 603-09, (Nov. 1962); Singer & Burstein, *Work as a Therapeutic Agent*, 21 *HOSP. AND COMMUNITY PSYCHIATRY* 235-37 (July 1970); Blaine, *supra* note 76.

⁸⁸ A. GOLDSTEIN, *PSYCHOLOGICAL SKILLS TRAINING* (1981); G. PAUL & R. LENTZ, *supra* note 79;

Work programs need not focus exclusively on job-related skills, and they have far broader applications than in the workplace alone. The goal of work activities is to maximize the patient's potential for independent living. Even for those who may never hold competitive employment, the acquisition of constructive work habits may make an enormous difference in their ability to live at home or with others outside the hospital setting. Because such institutional attributes as dependency, lack of motivation or a sense of inadequacy are more easily acquired in the hospital than they are discarded upon release from it, it is imperative that patients receive counteractive treatment as early as possible in their hospital stays.⁸⁹

Work adjustment is the fourth benefit of some work programs. Work is a complex social rite as well as an economic necessity, and a substantial number of the psychiatrically disabled must be taught how to work.⁹⁰ Many people are hospitalized as a result of work-related problems.⁹¹ Others have never been exposed to the world of work and they need to discover what that world is and how they can cope with it. They can also acquire, in a supportive setting, the work record and references which a potential employer is likely to require.⁹²

There is no better — and often no other — way for the psychiatrically disabled to learn the things that are necessary to get and hold a job than to participate in a work program in a simulated and sheltered climate. In a setting which reproduces as closely as possible an actual work environment, yet which can be controlled for treatment purposes, patients can be taught the skills they will need to find and hold a job, and they can be assisted through a graded continuum of opportunities aimed at their transition to the outside world.⁹³ Clearly, hospitals for the mentally and emotionally disabled can no longer ignore the social and vocational needs of their clients. The decline in the duration of inpatient status has increased the importance of rehabilitation and work-

Anthony, *A Rehabilitation Model for Rehabilitating the Psychiatrically Disabled*, 24 REHABILITATION COUNSELLING BULL. 6-21 (1980); Anthony & Margules, *Toward Improving the Efficacy of Psychiatric Rehabilitation: A Skills-Training Approach*, 21 REHABILITATION PSYCHOLOGY 101-05 (1974); Braceland, *Rehabilitation*, 5 AM. HANDBOOK PSYCHIATRY 687 (Arieto 2d ed. 1975); Lamb, *Essential Concepts*, in REHABILITATION IN COMMUNITY MENTAL HEALTH 2 (Lamb ed. 1971); Mackota, *supra* note 83; Olshansky, *Changing Vocational Behavior Through Normalization*, in THE PRINCIPLE OF NORMALIZATION IN HUMAN SERVICES 150-63 (W. Wolfensberger ed. 1972); Wing, *Social and Psychological Aspects of Rehabilitation of the Disabled in the United Kingdom*, 53 REHABILITATION (London) 11-21 (Apr.-June 1965).

⁸⁹ Allen & Velasco, *An Inpatient Setting: The Contributions of a Rehabilitation Approach*, 24 REHABILITATION COUNSELLING BULL. 108-17 (Sept. 1980); Blaine, *supra* note 76.

⁹⁰ Kline & Hosiington, *Placing the Psychiatrically Disabled: A Look at Work Values*, 24 REHABILITATION COUNSELLING BULL. 365-69 (May 1981); Walls, *Modification of the Employment Handicaps of Psychiatric Patients by Behavioral Methods*, 30 AM. J. OCCUPATIONAL THERAPY 487-90 (Sept. 1976).

⁹¹ Strauss, *supra* note 83, at 328-32.

⁹² Anthony & Jansen, *Predicting the Capacity of the Chronically Mentally Ill*, 39 AM. PSYCHOLOGIST 541 (May 1984); Ciardiello & Bingham, *The Career Maturity of Schizophrenic Clients*, 26 REHABILITATION COUNSELLING BULL. 3-9 (Sept. 1982); Paquette & LaFave, *Halfway House*, 64 AM. J. NURSING 121-24 (1964); Affidavit of Shervert H. Frazier, M.D., Psychiatrist-in-Chief, McLean Hospital, March 17, 1975, on file at McLean Hospital in Belmont, Massachusetts.

⁹³ Anthony & Jansen, *supra* note 92, at 541; Burke & LaFave, *Rehabilitation: Comprehensive and Inexpensive*, 24 DISEASES NERVOUS SYS. 612-15 (1963); Hursh & Anthony, *The Vocational Preparation of Chronic Psychiatric Patients in the Community*, in PRINCIPLES OF TREATMENT 235 (1983); Lang, Richmand & Trout, *Project Outreach: Volunteer Transitional Employment*, 15 PSYCHIATRIC HOSPITAL 75-80 (1984).

adjustment programs for psychiatric patients, who must learn more quickly than ever the skills with which to cope with life outside the hospital.⁹⁴

The fifth benefit is *diagnosis, assessment and prediction*. An integral component of work programs is their ability to help the therapist diagnose problems, assess strengths and measure results. "Work not only provided structured activity beneficial to individuals with disordered cognition," wrote two clinicians, "but also provided an accurate and quick appraisal of skills and cognitive abilities."⁹⁵ For patients readying themselves for discharge, work programs may be the only means of detecting vocational problems and determining work readiness, particularly in such areas as on-the-job behavior and the ability to endure a working day. The low employment and high recidivism rates of ex-patients indicate how much in these areas is yet to be done.⁹⁶

The sixth benefit is *research*. In spite of its long history and its recognized value, a good deal remains to be learned about the uses and applications of therapeutic and rehabilitative work programs. Like all treatment modalities, patient-work activities need experimental flexibility. While limitations must be placed on institutional work programs, those limits should restrict as little as they legitimately can the development and application of treatments that may produce positive results and thus, help some patients to get better.⁹⁷

The final benefit is *cost savings*. There is an economic argument to be made on behalf of therapeutic and rehabilitative work programs, but it is not that of institutional savings. The value of the work performed by patients in such programs rarely matches the cost of their care. On the other hand, the cost of mental illness to society, and to the patient, is enormous. A 1974 study estimated its annual cost in the United States to be almost thirty-seven billion dollars.⁹⁸ Another study indicated that the inability of discharged schizophrenics to find sustained employment costs the economy three to four times more than all of their active treatment costs combined. The author of a recent report concluded that the best hope for schizophrenic patients is the provision of a structured, long-term environment in which treatments that increase work productivity play a crucial role.⁹⁹ The restoration of mental health patients to productive activity will benefit not only the individual patients, but society as a whole.

⁹⁴ R. CLASSCOTE, *REHABILITATING THE MENTALLY ILL IN THE COMMUNITY* (1971); Brooks, *Vocational Rehabilitation*, in *THE CHRONIC MENTALLY ILL* (J.A. Talbot ed. 1981); BOSTON UNIVERSITY, FARKAS & ANTHONY, *THE DEVELOPMENT OF THE REHABILITATION MODEL AS A RESPONSE TO SHORTCOMINGS OF THE DEINSTITUTIONALIZATION MOVEMENT* (Monograph No. 1, Center for Rehabilitation Research and Training in Mental Health (Apr. 1981)).

⁹⁵ Allen & Velasco, *An Inpatient Setting: The Contributions of a Rehabilitation Approach*, 24 *REHABILITATION COUNSELLING BULL.* 109 (1980).

⁹⁶ Anthony, Buell, Sharratt & Althoff, *Efficiency of Psychiatric Rehabilitation*, 78 *PSYCHOLOGICAL BULL.* 447-56 (1972); Mikel, Cohen & Vitalo, *The Measurement of Rehabilitation Outcome*, 4 *SCHIZOPHRENIA BULL.* 365-83 (1978). See also Wilson, Berry & Miskimins, *An Assessment of Characteristics Related to Vocational Success Among Restored Psychiatric Patients*, 18 *VOCATIONAL GUIDANCE Q.* 110-14 (1969).

⁹⁷ G. PAUL & R. LENTZ, *supra* note 79; Neff, *supra* note 33; Olshansky, *Some Assumptions Challenged*, 4 *COMMUNITY MENTAL HEALTH J.* 153-56 (1968).

⁹⁸ Sharfstein & Clark, *Economics and the Chronic Mental Patient*, 1 *SCHIZOPHRENIA BULL.* 319-414 (1976). See also Conley, Conwell & Arrill, *An Approach to Measuring the Cost of Mental Illness*, 124 *AM. J. PSYCHIATRY* 755-62 (1967).

⁹⁹ Gunderson, *Cost Considerations in Treatment of Schizophrenia* (Apr. 20, 1982) (paper presented at the Conference on Cost Considerations, Washington, D.C.). See also R. CONLEY, *THE*

IV. THE DIFFICULTIES INVOLVED IN TREATING PATIENTS WHO PARTICIPATE IN WORK/TREATMENT PROGRAMS AS EMPLOYEES

Neither the court's decision in *Souder v. Brennan* nor the resulting regulations issued by the Department of Labor actually prohibit institutions from operating work programs for patients. Under *Souder* and DOL regulations, patients who perform any activity which confers economic benefit on an institution are employees under the FLSA. Thus, patients in such programs must be paid the minimum wage or, alternatively, the institution must obtain one of the certificates authorized by Section 14 of the FLSA and pay a wage that is commensurate with that paid others in the institution or industry for the same or similar work. On its face, this requirement seems reasonable because it appears only to demand that the institution pay a fair wage for each of the patient services it obtains.

The matter, however, is not that simple. While the *Souder* litigation exposed destructive abuses, psychiatric patients are legitimately assigned to work programs, not as a means for the hospital to obtain low-cost services, but for the purposes of treatment and rehabilitation. For example, a patient who is nearing discharge may be asked to perform tasks under "work-like" circumstances to determine how the patient will respond to the pressures of the workplace and whether he or she is ready for competitive employment. In any such case, the formulation of the patient's work assignment must be dictated by his or her treatment needs, not by the economic needs of the institution. The patient continues to be a patient and the hospital continues to have both an ethical and a legal duty to act, not in its own interest, but in that of the patient.¹⁰⁰ In such cases, the mere fact that the assignments carried out by the patient may have some incidental value to the institution should not be the sole determinant of whether an employment relationship has, as a matter of law, arisen between the patient and the hospital.

A patient participating in a bona fide work-treatment program at a mental institution is not an employee of the institution, regardless of whether he or she can and does perform work tasks either just as well or almost as well as an employee might perform them. The patient is not in the hospital in order to have minimum- or commensurate-wage employment, and it is not the function of the hospital to provide such employment to its patients. The situation of the patient simply is not comparable to that of the employee, and it is a destructive legal fiction to assume that it is.

Apart from the fundamental distinction between the hospital-patient relationship and that of employer and employee, there are numerous administrative difficulties for a hospital attempting to comply with the Department of Labor regulations. Primarily, there is the problem of determining precisely what to pay the patient. The simplest alternative is to pay the minimum wage. Paying minimum wage, however, may be neither required nor economically reasonable if the patient's ability to perform the work in question is substantially impaired by a mental or physical handicap. In that case, the institution could apply for one of the four certificates that would allow it to pay a commensurate wage based on the productive capacity of the patient-worker.¹⁰¹

The receipt of a certificate from the Labor Department, however, does not necessarily exempt an institution from paying patients in a work program at least the minimum

ECONOMICS OF VOCATIONAL REHABILITATION (1965); Gunderson & Mosher, *The Cost of Schizophrenia*, 132 AM. J. PSYCHIATRY 901-06 (1975).

¹⁰⁰ See generally *Wyatt v. Stickney*, 325 F. Supp. 781 (N.D. Ala. 1971).

¹⁰¹ 29 C.F.R. § 529.4 (1985).

wage. For example, if an institution pays its cafeteria workers eight dollars an hour, the commensurate pay for a patient whose productivity is seventy-five percent of the norm would be six dollars an hour, considerably more than the minimum wage. If the institution elects instead to pay the minimum wage, it may be vulnerable to a charge of impermissible handicap discrimination, since it is paying the patient-worker substantially less than it pays other employees for what appears to be substantially similar work. Although no patient seems yet to have asserted such a claim, many handicap-discrimination statutes are relatively new.¹⁰² More to the point, so long as patient-workers are legally considered to be employees within the meaning of the FLSA, any institution that pays them less than it pays other employees for the same or similar work will be putting itself at risk under the various state and federal employment discrimination statutes.

Once having determined what to pay its patients for activities that could arguably be construed as work, the institution must then withhold social security and state and federal income taxes, report the withholdings to the proper government agencies and furnish a W-2 form to the patient. The institution must also maintain workers' compensation coverage for all patients to whom it pays wages.¹⁰³ The institution will incur all these expenses and administrative burdens — which are an integral part of any employment relationship and which do not take into account the clinical and diagnostic costs of implementing a patient-work program — even though its relationship with and responsibilities to its patients differ fundamentally from those it has with its regular employees.

It is hardly surprising, then, that many institutions have adopted the path of least resistance by cutting back or discontinuing their work programs. Principally because of the sweeping language of the *Souder* decision, there is simply too much uncertainty and too much risk involved in operating a work program for patients. An institution which runs afoul of the regulations or the underlying statute can be sued, not just for lost wages, but for liquidated damages as well. In addition, personal liability can be imposed on its officers, directors and trustees. Since all that needs to be shown for such extraordinary damages is that the hospital knew the FLSA was "in the picture," there are strong incentives to avoid doing anything that might arguably be said to violate the regulations.¹⁰⁴ The result is a form of paralysis which few institutions have been able to surmount.

Apart from the fiscal and administrative difficulties, treatment considerations impinge on an institution's ability and willingness to pay minimum or commensurate wages to patients engaged in work treatment programs. Some critics of institutional peonage have argued that the payment of wages would of itself both protect the patient from exploitation and improve the provision of treatment.¹⁰⁵ This argument fails to distinguish

¹⁰² For example, the Massachusetts employment discrimination statute, G.L. c. 151B, was amended in 1984 to prohibit handicap discrimination. MASS. GEN. LAWS ANN. ch. 151B, § 4 (West Supp. 1986).

¹⁰³ E.g., there is no exemption in the Massachusetts worker's compensation statute, G.L. c. 152, for patients of hospitals or mental health institutions. MASS. GEN. LAWS ANN. ch. 152 (West 1982). There is an exemption for such patients in the Massachusetts unemployment compensation statute. See MASS. GEN. LAWS ANN. ch. 151A, § 6(t) (West 1982).

¹⁰⁴ *Coleman v. Jiffy June Farms, Inc.*, 458 F.2d 1139, 1142 (5th Cir. 1971), cert. denied, 409 U.S. 948 (1972). For liability of officers and directors under FLSA, see, e.g., *Donovan v. Agnew*, 712 F.2d 1509 (1st Cir. 1983).

¹⁰⁵ Friedman, *Thirteenth Amendment and Statutory Rights Concerning Work in Mental Institutions*, in

between two different ends. The payment of wages to patients engaged in nontherapeutic work — that is, peonage — clearly helps protect them against exploitation, but it does not thereby convert the work activity into treatment. The justification for an institutional work program should not merely be that it does not exploit the patient, but that it performs an essential treatment function on his or her behalf.¹⁰⁶

This is not to argue that the payment of patients for participating in work treatment is necessarily inappropriate. In a bona fide program, however, payment itself is a treatment decision. For example, many clinicians strongly believe that any wages paid in such a program should reflect the reality of individual achievement, rather than some externally imposed standard. It is, they argue, both unrealistic and counter-therapeutic to pay wages that are not based on performance. By allowing patients to engage in regularly paid work under conditions of less than normal competitiveness and stress, wage payments could actually encourage the very dependency they were intended to alleviate.¹⁰⁷ The purpose of work treatment, after all, is not the provision of sheltered employment, but preparation for the highest possible level of independent living.

More generally, work-treatment programs require the flexibility to manipulate the work environment in the interests of the patient.¹⁰⁸ A great tragedy of peonage programs was that, by definition, they did not do this. Programs required to conform to general wage and hour standards are also inhibited in their ability to respond to individual patient needs. Where applicable, for example, monetary payments may serve as a reinforcement, instill a sense of self-worth or simulate as closely as possible the conditions of employment in the wider society. They are not meant to convert the patient recipient into an employee of the hospital, nor to relieve the hospital staff of its responsibility for patient treatment. In work-therapy programs, in other words, payment is an adjunct of the treatment, not compensation for the labor.

Thus, for treatment as well as administrative and economic reasons, hospitals understandably want to avoid the establishment of an employment relationship, which places the institution in a position of at least potential conflict of interest with regard to a patient who is simultaneously a recipient and a provider of hospital services. If the purpose of a work program is patient treatment rather than institutional maintenance, then the hospital cannot simply treat the patient as a regular employee. On the contrary, the hospital is obligated to respond to the treatment needs of the patient rather than the economic requirements of the job.

In apparent recognition of this difficulty, the Department of Labor has attempted to give some relief to hospitals for the mentally and emotionally disabled. In its Field

2 LEGAL RIGHTS OF THE MENTALLY HANDICAPPED (Ennis & Friedman ed. 1973); Perlin, *The Right to Voluntary, Compensated, Therapeutic Work as Part of the Right to Treatment: A New Theory in the Aftermath of Souder*, 7 SETON HALL L. REV. 298-339 (1976).

¹⁰⁶ See generally Wyatt v. Stickney, 325 F. Supp. 781 (N.D. Ala. 1972). See also Bartlett, *Institutional Peonage*, THE ATLANTIC 1169 (July 1964). Compare Bickford, *Treatment of the Chronic Mental Patient*, THE LANCET 924-27 (May 1, 1954) with Bickford, *Economic Value of the Psychiatric Inpatient*, THE LANCET 714 (Mar. 30, 1963).

¹⁰⁷ Interview with Shervert H. Frazier, M.D., currently Director of the National Institute of Mental Health. See also Barbee, Berry & Micek, *Relationship of Work Therapy to Psychiatric Length of Stay and Readmission*, 33 J. COUNSELLING AND CLINICAL PSYCHOLOGY 755-58 (1969); Berrington, *supra* note 43; Lamb, *supra* note 88, at 23-24 ("[t]he more rewards [a person] gets from illness and disability, the more difficult the rehabilitation process may be.").

¹⁰⁸ G. PAUL & R. LENTZ, *supra* note 79; Oseas, *supra* note 83.

Operations Manual ("Manual"), the circumstances under which patients can engage in work treatment programs without an employment relationship being deemed to exist are broadly defined. In addition to personal housekeeping chores and some bona fide volunteer activities, the Manual states that no employment relationship will be found where work activities are performed in connection with evaluation and training programs, provided that the patient engage in the activity for no more than one hour a day, no more than five hours a week, and for a period not to exceed three months.¹⁰⁹

Within the context of the recent history of deinstitutionalization, these guidelines have met the needs of most patients. But it is imperative to emphasize that, even where they have proved adequate, the guidelines leave the hospital at considerable risk. First, the guidelines do not appear in the underlying Department regulations on which the Manual is supposed to be based. More importantly, they have not been approved by any court, and do not appear in the *Souder* decision. A hospital, thus, cannot safely rely on an interpretation of the FLSA by the Department of Labor. The Department gave tacit approval to the institutional conditions that existed prior to 1973, and it subsequently found itself the defendant in *Souder v. Brennan*.

Aside from the issue of their legitimacy, the Department guidelines are simply not adequate for many psychiatric patients, whose treatment has consequently suffered. The most obvious category is that of long-term patients. Despite the reduction in their numbers over the past three decades, many of the chronically ill continue to require institutional care.¹¹⁰ By making less accessible an activity that has in the past proved extremely valuable to such patients, the *Souder* decision, whatever its intention, victimized once again the most powerless and vulnerable segment of the patient population. For example, an organically brain-damaged twenty-one-year-old patient recently spent four years at a reputable private psychiatric hospital. Only when she was able to work in the patient library did she show any marked improvement. Her psychiatrist strongly believed that if she could have increased the time she spent in the work-therapy program she would have made faster progress, he would have been more sure of her readiness for discharge, and she would have left the hospital sooner and with a greater probability of success.¹¹¹

The guidelines establish an outside limit on a patient-work program of approximately sixty-five hours.¹¹² This is not enough time to prepare many patients for discharge. At one hospital a twenty-two-year-old schizophrenic, who had been institutionalized for half his life and who had proved unable to function outside an institutional setting for more than a few weeks, responded positively to a work program. His interest was not in earning money but in feeling productive and in learning a skill. Yet the hospital was very much hampered in its ability to provide him the cumulative and extended work experience he needed to develop the tools and the confidence necessary

¹⁰⁹ DEPARTMENT OF LABOR, FIELD OPERATIONS HANDBOOK ¶ 64 § 01 (1980).

¹¹⁰ G. PAUL & R. LENTZ, *supra* note 79; Becker & Bayer, *Preparing Chronic Patients for Community Placement: A Four-Stage Treatment Program*, 26 HOSP. AND COMMUNITY PSYCHIATRY 448-50 (1975); Sharfstein, Clark, Turner & Clark, *supra* note 79; Wexler, *Token and Taboo: Behavior Modification, Token Economics and the Law*, 61 CALIF. L. REV. 81-109 (1973).

¹¹¹ Notes of interview conducted as part of Blaine survey, *supra* note 76. See also Rosenberg & Wellerson, *A Structured Pre-Vocational Program*, 14 AM. J. OCCUPATIONAL THERAPY 57 (1960).

¹¹² The guidelines permit only one hour per day, five days per week for a three-month period. This totals approximately 65 hours.

for success. Issued on behalf of patient rights, the *Souder* decision actually curtailed this patient's access to a program which he had deemed important to his own recovery.¹¹³

The constraints imposed by the *Souder* decision are by no means limited to long-term patients. The shorter hospitalizations and declining inpatient populations have made increasingly important the provision of intensive programs to prepare patients for the highest possible level of independent living. Yet, even to consider the optimum result — that is, competitive employment — both staff and patient must have an idea of how the latter will perform on a work site. "It is very easy to trick yourself," said the Director of Activities Therapy at a private psychiatric hospital, "if you only work a one-hour day."¹¹⁴

Scheduling and other administrative problems may limit even that hour. At one hospital, the recommendation to place an adolescent patient in the beauty shop ran afoul because the shop was only open one day a week. Thus, the patient's vocational training was restricted to one hour a week, a time limit that made the program virtually valueless.¹¹⁵

There are not many solutions to such cases. Some hospital staffs have considered referring patients to programs outside the hospital. This, however, presents a host of medical, ethical and other problems. One problem is that the hospital cannot send a patient off its grounds until the staff is certain that the patient can cope with the new setting. The irony is that one of the functions of a work program is to prepare the patient for just such a transition. Other patients, for example, those institutionalized under a court order or those considered dangerous to themselves or others, may not be legally allowed to leave the premises. In other cases, it is feared that third-party payers may balk at such an arrangement.¹¹⁶

Even those who are discharged from inpatient status and enrolled in an outpatient work-treatment program on the hospital grounds are not exempt from the reaches of the *Souder* decision, which continues to apply. This brings us full circle to those chronic patients who have been discharged but neither cured nor rehabilitated. For them, the back ward has been replaced by the back alley. Clearly, the treatment needs of such people are not being met, and the constraints of the *Souder* decision only make it more difficult to meet them.¹¹⁷

¹¹³ Blaine, survey interview, *supra* note 76. See also Douzinas & Carpenter, *Predicting the Community Performance of Vocational Rehabilitation Clients*, 32 HOSP. AND COMMUNITY PSYCHIATRY 409-13 (1981); Goldberg, *Hospital Work and Family: A Four-Year Study of Young Mental Hospital Patients*, 112 BRIT. J. PSYCHIATRY 177-96 (1966); Wing, *Rehabilitation and Resettlement of the Mentally Ill*, 75 PUBLIC HEALTH 85-89 (1961); Wing & Freudenberg, *The Response of Severely Ill Chronic Schizophrenic Patients to Social Stimulation*, 118 AM. J. PSYCHIATRY 311-22 (1961).

¹¹⁴ Notes of interview conducted in connection with Blaine survey, *supra* note 76.

¹¹⁵ *Id.*; see also Esser, *Regular Work Availability*, 14 AM. ARCHIVES REHABILITATION THERAPY 17-26 (1966).

¹¹⁶ Notes of interview conducted in connection with Blaine survey, *supra* note 76.

¹¹⁷ Arnhoff, *Social Consequences of Policy Toward Mental Illness*, 188 SCIENCE 1277-81 (June 27, 1975); Aviram & Segal, *Exclusion of the Mentally Ill*, 29 ARCHIVES GEN. PSYCHIATRY 126-31 (1973); Dellario & Anthony, *On the Relative Effectiveness of Institutional and Alternative Placement*, 37 J. SOCIAL ISSUES 21-33 (1981); Scheri & Macht, *Deinstitutionalization in the Absence of Consensus*, 30 HOSP. AND COMMUNITY PSYCHIATRY 599-604 (1979); Schwartz & Goldfinger, *The New Chronic Patient: Clinical Characteristics of an Emerging Subgroup*, 32 HOSP. AND COMMUNITY PSYCHIATRY 470-74 (1981); Spivack & Siegel, *The Long-Term Patient in the Community: Life Style Patterns and Treatment Implications*, 33 HOSP. AND COMMUNITY PSYCHIATRY 291-95 (1982); Talbot, *Deinstitutionalization: Avoiding the Disasters of the Past*, 30 HOSP. AND COMMUNITY PSYCHIATRY 621-24 (1979).

It is little wonder, then, that in the recent survey of clinical and rehabilitative staff members at private psychiatric hospitals, almost four times as many interviewees felt that *Souder v. Brennan* had had a negative impact as felt it had had a positive effect. Nor should it be a cause for surprise that more than seventy-five percent of the respondents wanted the ruling reinterpreted to allow for expanded work opportunities for patients.¹¹⁸ It seems clear, at least in retrospect, that the *Souder* decision hampered the very creative thinking about work programs and patient needs that it was meant to encourage and appeared to demand.

V. A PROPOSAL FOR A MORE FLEXIBLE APPROACH TO PATIENT-WORK PROGRAMS

The intent of the Fair Labor Standards Act is to eliminate "labor conditions detrimental to the maintenance of the minimum standard of living necessary for health, efficiency, and general welfare of workers."¹¹⁹ Thus, if the purpose of the patient-work activity is to provide therapy or rehabilitation to the patient, rather than to perform essential functions for the institution, and if the patient, in performing the activity, does not displace a regular employee or otherwise impair the employment opportunities of others, then the patient-work activity cannot lead to the type of detrimental labor conditions that the FLSA was intended to prohibit.

For example, a hospital might operate a gift or coffee shop to provide therapeutic or rehabilitative work opportunities for its patients. In such a case, the hospital would need to provide close clinical as well as operational supervision, and it would need to structure the activity to accommodate the needs and schedules of its patients, rather than to maximize its revenues. The shop would not produce a net financial gain for the hospital and thus would only be operated to provide therapeutic or rehabilitative work opportunities for patients. Where the purpose of the activity is to provide treatment, and where its operation neither yields to the institution a financial gain, nor relieves it of the need to perform any essential functions, there is no reasonable basis for asserting that the underlying policies of the FLSA are implicated. The amount paid for the activity cannot have an effect on prevailing labor conditions or the general welfare of workers because, by its nature, the activity is treatment, not work, and its only reason for being is to provide such treatment to the institution's patients.

While, in some sense, all work may be therapeutic as the court stated in *Souder*, not all hospital-work programs constitute patient treatment. The *Souder* court's declaration that no distinction can be drawn between work and treatment for the purposes of the FLSA is erroneous. The distinction between work and treatment for purposes of the FLSA lies in whether the activity is undertaken in the interest of the patient, either to provide therapy or rehabilitation, or in the interest of the institution, either for its financial benefit or to enable it to provide essential services for less cost than it would otherwise incur. This necessity to distinguish between the interests being served has been successfully asserted in other areas, for example, with respect to student activities in schools,¹²⁰ and it should be no more difficult to draw with respect to patient activities at mental health institutions.

The following six criteria could be utilized to differentiate work from treatment in mental health institutions:

¹¹⁸ Blaine, *supra* note 76.

¹¹⁹ 29 U.S.C. § 202(a) (1982).

¹²⁰ See, e.g., *Bobilin v. Board of Educ. of Hawaii*, 403 F. Supp. 1095 (D. Hawaii 1975).

1. The knowledge of patients or their guardians, prior to admission, of both the existence of patient-work programs as part of the hospital's treatment philosophy and practice and of the rules governing participation in those programs.
2. The existence of a coherent and individualized treatment plan, supported by a body of medical evidence, for each patient.
3. The assignment of the work activity by a qualified clinical professional who is responsible for the treatment plan of the assigned patient, and the entry of the assignment on the patient's chart.
4. Direct and regular supervision of the work activity by a clinically trained staff person who is aware of how the work assignment fits into the overall treatment plan of the patient, and the entry of the supervisor's report on the patient's chart.
5. Evidence that the institution incurs a greater cost to provide the activity than it receives as a result of the activity.
6. Evidence that the institution maintains at least as many nonpatient employees as it would if the activity were not performed.

Where all of these criteria are met, the activity should be deemed treatment that is not subject to the FLSA, regardless of whether the activity continues for more than one hour a day, more than five hours a week, or more than three months. The time limits established in the DOL regulations have no legal standing and any institution that adopts them does so at some risk. More importantly, the DOL regulations are wholly arbitrary and mark no consequential dividing line between work and treatment, for they provide no meaningful benchmark for determining when the activity is being conducted in the interest of the patient and when it is being conducted in the interest of the institution. The six criteria listed above, however, mark the consequential dividing line between work and treatment.

CONCLUSION

The determination of whether an employment relationship exists for the purposes of the FLSA "does not depend on . . . isolated factors, but rather upon the circumstances of the whole activity."¹²¹ In *Souder v. Brennan*, the court departed from this established and reasonable precedent and held that the FLSA applied whenever a patient at a mental health institution took part in a work program which involved activities that nonhandicapped workers performed at the institution or elsewhere. In arriving at this position, the court specifically excluded from consideration whether the primary purpose of the activity is to benefit the patient rather than the institution and whether the overall cost of the activity to the institution exceeds any financial gains it might receive from it.

As a result of the *Souder* decision, and the regulations the Department of Labor adopted in response to it, public and private mental health institutions have been severely restricted in their ability to provide work-treatment programs to those who need them. Clearly, these restrictions are not in the best interests of the patients they were intended to benefit. The time has come to draw appropriate distinctions between patient activities that should be subject to the FLSA and those that should not. This article has suggested six criteria which should be applied to determine the applicability of the FLSA to patient-work activities.

¹²¹ *Rutherford Food Corp.*, 331 U.S. at 730.

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