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# HOSPITALIZATION OF THE MENTALLY ILL

WILLIAM J. CURRAN\*

## I. INTRODUCTION

Few other phases of the medical care and treatment of the individual members of our society are so closely supervised by the state as is mental health. Approximately 97.5% of the mental patients hospitalized in this country are in government institutions.<sup>1</sup> Since mental illness is one of the most serious health problems in the United States today,<sup>2</sup> this virtual monopoly of the state in psychiatric facilities makes it imperative that these facilities be made available to the general public on the broadest possible basis.

However substantial the facilities may be, they must be put *within the reach* of the individual if they are to accomplish their objectives. This aspect of the mental health program of the states is governed entirely by law, the so-called "commitment laws." These are the statutes governing admission, detention, and discharge from the mental institutions.

In the past and in many of the states at present these procedures have accorded unnecessarily inhumane treatment to the mentally ill. In recent years some of the states have made attempts to mitigate the harshness of these laws. Some of the legal aspects of the present commitment laws and the problems presented in reforming them will be examined in this article.

## II. HISTORICAL BACKGROUND

The ignorance and apathy of the general public concerning mental illness and the mentally ill were a part of our social structure until only about one hundred years ago. It was naturally reflected in the law.

In colonial times an "insane person" (only the acutely disturbed,

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<sup>1</sup> Approximately 84.7% are in state hospitals; 9.3% are in Veterans Administration hospitals; 3.5% are in county and municipal hospitals. See *Mental Health Statistics*, Series IMH-B53, No. 1, F. S. A., Dec., 1952; *Patients in Mental Institutions, 1949*, F. S. A., 1949.

<sup>2</sup> Over 600,000 patients were hospitalized in institutions for the prolonged care of mental cases in 1950. *Mental Health Statistics*, *supra* note 1. Mental patients now occupy one half of the hospital beds in the country. One out of every 18 persons in the United States is suffering from some form of mental illness, and it is estimated that one out of every ten persons will need psychiatric care at some time in his life. See Parren, *One Out of Ten*, This Week, Nov. 7, 1946, p. 5; *Statistics Pertinent to Psychiatry in the United States*, Report No. 7, G.A.P., March, 1949; Bowman, *Presidential Address*, 103 AM. J. PSYCHIATRY 1 (1946); Barton, *Hospital Services for the Mentally Ill*, 286 ANNALS 107 (1953).

violent and dangerous, were recognized as such) could be confined in any available place. There were no hospitals where the mentally ill were accepted. They were disposed of as criminals or paupers, confined in jails, poorhouses, in private cages or strong-rooms.<sup>3</sup>

During the early years of the Republic when special legislation began to appear in which these "furiously mad" creatures were mentioned, such laws were statutes relating to the "suppression of Rogues, Vagabonds, Common Beggars and other idle, disorderly, and lewd persons."<sup>4</sup>

When the early asylums were established, commitment could be achieved with great ease. Institutionalization was confined to the indigent insane, however. If private funds could provide a sturdy cage for the unfortunate creature the state would concern itself no further. Even as the state mental hospitals for universal care were established and psychiatry became a part of the science of medicine, these easy practices of admission and discharge continued. There was little concern for the personal rights of the individuals committed. It is notable, however, that the legal order had long had elaborate provisions for the disposition of the *property* of the insane.<sup>5</sup>

As the humanitarian movement for the decent care and treatment of the mentally ill began to achieve some success in the middle of the nineteenth century, the amazing void in the law concerning commitment came to public attention.

A sensationalist writer of the time, Charles Reade, published a book called *Hard Cash* which made its appearance in America in 1860. It told the lurid tale of a rich young man who was committed to an insane asylum by his business associates who had designs on his fortune. Of course, the perfectly sane hero eventually obtained his release and all was made right, but not before Mr. Reade's point was made. The law under which the young man was committed gave him little protection. The novel was highly successful and a public clamor for safeguards in the law against wrongful commitment was raised throughout this country and England.<sup>6</sup>

Of even greater significance than the Reade novel were the efforts of Mrs. E. P. W. Packard, who led a public crusade for strict commitment laws throughout the country in the 1860's and 1870's. Mrs. Packard had been confined to a mental institution in Illinois on the petition of her husband. She protested her sanity to all who would hear

<sup>3</sup> DEUTSCH, *THE MENTALLY ILL IN AMERICA* 421 (2d ed. 1949).

<sup>4</sup> Mass. Laws 1797, c. 73 (copied almost verbatim from a New York Law passed in 1788 which followed identically an English law of 1744).

<sup>5</sup> England had them in 1324. 17 EDW. 11, c. 10. They were known in Ciceronian Rome. DEUTSCH, *op. cit. supra* note 3, at 40.

<sup>6</sup> The novel was used in support of arguments for strict commitment laws as late as 1913. Coutts, *Some Unconstitutional Asylum Laws*, 77 CENT. LAW J. 326, 332 (1913).

her, claiming to be the victim of her husband's plot to be rid of her.<sup>7</sup> She finally succeeded in procuring her release after three years in the institution through habeas corpus proceedings.

Upon her release she immediately began her vigorous campaign for more effective legal protection against wrongful commitment.<sup>8</sup> She traveled throughout the country lecturing to huge audiences and appearing before state legislatures. Mrs. Packard is credited with directly influencing legislation in Illinois, Iowa, and Massachusetts, and she was instrumental in the formulation of laws in many other states.

The Packard movement placed great confidence in the judicial process, in the procedure of the criminal trial, to safeguard the individual from wrongful commitment. The bulwark of her "personal liberty bill" was the trial by jury for the person "charged" with insanity.

As the years have passed, this confidence in the criminal law procedures has been weakened considerably. The jury trial has been abandoned in many states. It is mandatory today only in Texas. The function of an untrained jury considering the "facts" and weighing highly technical medical testimony became increasingly impotent. The system added little to the protection of the individual. In fact, it is interesting to note that in Illinois, where Mrs. Packard's bill was most successful, the jury trials resulted in more commitments of sane persons than had ever been the case under any other procedure.<sup>9</sup>

The use of the court procedures with their accompanying harsh treatment for the person involved has received the almost universal condemnation of the medical profession and others working in the field of mental health. Under the court procedure the person "charged" with insanity is usually arrested and brought before a judge in a courtroom to be tried. He is forced to sit and listen while his relatives, friends, and doctors testify that he is insane. He is usually in the custody of police throughout this procedure.

It is little wonder that such a process results in harmful effects on the individuals who must undergo it. They may be made to feel that they are being persecuted by their relatives and friends. They often feel that they have done something morally culpable, that they are shunned

<sup>7</sup> The medical history of Mrs. Packard lends some support to the action of the mental hospital in accepting her as a patient. She had been a patient at Worcester State Mental Hospital in Massachusetts as a child. She at one time imagined herself to be the Third Person of the Blessed Trinity and the Mother of Christ. DEUTSCH, *op. cit. supra* note 3, at 424.

<sup>8</sup> Mrs. Packard published a series of books which received wide circulation and greatly aided her campaign. Among them: MRS. PACKARD'S PRISON LIFE (1867); INSANE ASYLUMS UNVEILED (OR, THE PRISONER'S HIDDEN LIFE) (1868); MODERN PERSECUTION (1877). Note the assimilation to criminal incarceration.

<sup>9</sup> Dewey, *The Jury Law for Commitment of the Insane in Illinois*, 69 AM. J. OF INSANITY 571 (1913).

by society as unclean or as criminals. The traumatic effects of this procedure, which is intended to protect them, may require a great deal of care and treatment to overcome.

And yet wrongful commitments must be guarded against. The confinement of an individual in a mental institution against his will is a deprivation of his liberty, per se, and must therefore conform to the constitutional requirements of due process of law. Due process has been held by the Supreme Court of the United States to require that the person be given notice and an opportunity to contest the commitment.<sup>10</sup> The striking of a balance between the requirements for legal safeguards and medical discretion in medical matters is the great dilemma in the commitment laws today.

### III. HOSPITALIZATION PROCEDURES

#### A. *Voluntary Admission*

We begin our examination of the hospitalization procedures with the simplest and least controversial, the voluntary admission. It is easily described and understood and is substantially uniform throughout the country. Admission is similar to hospitalization for any other illness. The patient presents himself for treatment and signs admission papers. Admission is at the discretion of the hospital officials. The patient may leave whenever he wishes, though a few days' advance notice may be required.

The voluntary admission procedures enjoy the unique position of being favored by nearly all groups actively interested in influencing legislation in this field. They are stressed by the medical profession and others who desire less formal procedures, since they involve a minimum of court action.<sup>11</sup> They are favored also by those advocating strict legal safeguards against wrongful commitment, since these groups consider the dangers to exist only in involuntary procedures.

The unanimity of approval has been beneficial. The movement to enact voluntary admission laws has been the most striking development in the commitment laws in the United States in the last decade. Only eight states are now without voluntary admission procedures,<sup>12</sup> and it is generally expected that these will soon follow the trend.

Despite this favorable attitude toward the laws, only about 10% of

<sup>10</sup> *Simon v. Craft*, 182 U. S. 427 (1901).

<sup>11</sup> The medical profession recommends them: First Int. Congress on Mental Hygiene, 1930, Recommendations of the Committee on Legal Measures and Laws, Rec. One; Report No. 4, Committee on Forensic Psychiatry, Group for the Advancement of Psychiatry, April, 1948; FACT SHEET, MODEL LAW FOR THE HOSPITALIZATION OF THE MENTALLY ILL, Rec. (1), p. 3 (F.S.A. Pub. Health Serv. Pub. No. 51, Rev. 1951).

<sup>12</sup> Alabama, Florida, Missouri, North Dakota, Georgia, Tennessee, New Mexico (where it is unconstitutional), and Mississippi (where hospitals act at their peril in accepting patients should they be sane).

the admissions to mental hospitals each year are through the voluntary procedures.<sup>13</sup> There are many reasons for this disuse of the procedures that seem the most salutary of the laws. First of all, voluntary admissions will account for only a small percentage of the total admissions as long as the personal initiative of the patient is required for hospitalization. Only a small percentage of the mentally ill are capable of the volition required. In addition, few of these people recognize their own mental condition. Unless the class of persons deemed capable of procuring the voluntary admission of patients is broadened to include such persons as the parents or guardians of minors,<sup>14</sup> for example, the numbers of voluntary admissions will probably remain relatively small.

The constitutionality of the voluntary admissions procedures has been challenged successfully in only one state.<sup>15</sup> In that case, the New Mexico voluntary admission statute was declared unconstitutional as a violation of due process of law along with its emergency commitment law. The procedures were found invalid for failure to provide notice and a hearing to the patient before commitment. In considering the voluntary procedure, it seems that the court was of the opinion that a mental patient could not have the capacity to make application for hospitalization.

No doubt the New Mexico court has strong backing for such an opinion. Many mental patients do not have the capacity to make application for commitment. The recent federal Model Act specifically recognizes that fact.<sup>16</sup> However, the law has always recognized the existence of the "lucid interval" in criminal cases, and it would seem that a person could be mentally ill and yet be capable of the rational act necessary to obtain hospitalization. In these cases the voluntary admission procedures should be valid. The argument in favor of validity is that the admission is similar to any hospitalization in that the person enters of his own volition, without force, and is free to leave at his own request. This privilege, or right, to leave the mental hospital at his own request is set out in the statutes, though a short advance notice may be required.

<sup>13</sup> THE MENTAL HEALTH PROGRAMS OF THE 48 STATES, 1950, 298, Council of State Governments (1950).

<sup>14</sup> Illinois, New York, and Massachusetts have such procedures: ILL. ANN. STAT. c. 91½, § 4-1 (Supp. 1952); N. Y. MENTAL HYG. LAW § 71; MASS. GEN. LAWS c. 123, § 86A (1932) (for minors under sixteen). The procedure is recommended in the Federal Model Act for minors under sixteen: DRAFT ACT GOVERNING HOSP. OF THE MENTALLY ILL, Pt. II, § 2 (F.S.A. Pub. Health Serv. Pub. No. 51, Rev. 1952).

<sup>15</sup> *Ex parte* Romero, 51 N. M. 201, 181 P. 2d 811 (1947).

<sup>16</sup> In the Model Act hospitalization under the involuntary procedures can be obtained if such is the condition: DRAFT ACT GOVERNING HOSP. OF THE MENTALLY ILL, Pt. III, §§ 6(C) and 9(g) (3) (F.S.A. Pub. Health Serv. Pub. No. 51, Rev. 1952).

The factor of free release is one of the reasons behind the small percentage of admissions under this procedure. A voluntary patient may become restless after a few days or weeks at the institution. This is particularly true of certain psychotic patients who enter the hospital during one stage of their illness and express a desire to leave as they pass into another stage of their unbalance.<sup>17</sup> This is true also of alcoholics and drug addicts. The hospital staff is faced with the dilemma of discharging such patients before their treatment is completed, or of instituting court procedures to have them involuntarily committed. Neither alternative is a good one. The hospital doctors do not wish to discharge the uncured patient, nor do they like to put the patient through the distasteful and often traumatic experience of a courtroom involuntary commitment.

A compromise has been suggested of requiring the voluntary patient to sign an agreement on application for admission that he will not request release for a specified time, usually ten to fifteen days, during which at least some diagnosis and prognosis can be made. The procedure was declared constitutional in an Attorney General's Opinion in New York as a valid contractual agreement,<sup>18</sup> but such a provision in the New Mexico law was found unenforceable.<sup>19</sup>

Another reason for the relatively small number of voluntary admissions can be traced to one of the grave problems in mental health today—overcrowding in the institutions. In most states voluntary patients are admitted at the discretion of the hospital superintendent, while court-committed patients *must* be accepted. It may be expected that the number of voluntary patients accepted will be small as long as the present laws and institutional overcrowding are with us.

### *B. Commitment for an Indefinite Period*

This is the area of conflict and dilemma. This is what is often called "involuntary commitment" or "court commitment." The term "involuntary" is not adopted here because of the impression it conveys that in each case the person is committed against his will. This is true in only a limited number of cases where the patient or someone on his behalf actually *contests* the commitment. In the remaining cases the court procedures are used because the person lacks the mental capacity to obtain voluntary admission, or the voluntary admission procedures are not available for some other reason. This is an essential distinction. Once it is realized, reforms in the law are made easier. The simple term "commitment" is used here to indicate that the hospitalization

<sup>17</sup> Overholser, *The Voluntary Admission Law*, 3 AM. J. OF PSYCHIATRY 475, 479 (1924).

<sup>18</sup> N. Y. OPS. ATT'Y. GEN. 332 (1923).

<sup>19</sup> *Ex parte* Romero, 51 N. M. 201, 181 P. 2d 811 (1947).

is obtained through state action and not through individual action, regardless of whether the person involved is passive or opposed to the state's action.

The cases testing validity of the commitment procedures have concluded that notice and an opportunity to contest the commitment are required.<sup>20</sup>

*Personal Notice:* The traumatic effect of personal notice of commitment action on a person who is mentally ill has been decried by numerous psychiatrists. It often throws the patient into violence.<sup>21</sup> Not only is the notice often harmful, but it is often useless for the protection of the individual.

For these reasons seven states have provided for the elimination of personal notice where it would be injurious to the health of the patient.<sup>22</sup> All provide for a substituted notice to the person's relatives, guardian, or friends.

The humanitarian motive behind these attempts to mitigate the hardships of the personal notice requirement is laudible. They have the support of the medical profession. In the learned writings on the subject in the law journals many authors seem to feel that the substituted notice provisions are constitutional.<sup>23</sup> Their arguments are based on the same line of decisions used to sustain the non-judicial commitment procedures which would eliminate notice and a hearing before hospitalization. It is argued that liberal provisions for appeal to the courts to obtain release after commitment make the procedures constitutional,<sup>24</sup> by thus providing the person's "day in court." The decisions are the basis for the commitment laws in at least two states.<sup>25</sup>

These cases are a very weak foundation for the argument for substituted notice and non-judicial commitment. Many deny the applicability of the due process clause or were decided before the Supreme Court of the United States passed on the matter and required notice and a hearing before commitment.<sup>26</sup> None of the cases cite the Supreme

<sup>20</sup> *Simon v. Craft*, 182 U. S. 427 (1901); *Barry v. Hall*, 98 F. 2d 222 (D. C. Cir. 1938); *In re Wellman*, 3 Kan. App. 100, 45 Pac. 726 (1896); *State v. Billings*, 55 Minn. 467, 57 N. W. 206 (1894).

<sup>21</sup> Kerschbaumer, *A Patient's Reaction to a Lunacy Charge*, 101 J. OF NERVOUS AND MENTAL DISEASES 378 (1945).

<sup>22</sup> California, Michigan, Nevada, New York, Ohio, Oklahoma and Wisconsin.

<sup>23</sup> *Weihofen and Overholser, Commitment of the Mentally Ill*, 24 TEXAS L. REV. 307, 340 (1946); *Comments*, 36 ILL. L. REV. 747 (1942), 47 NORTHW. U. L. REV. 100 (1952), 56 YALE L. J. 1178, 1194 (1947).

<sup>24</sup> *Hiatt v. Soucek*, 240 Iowa 300, 36 N. W. 2d (1949); *In re Dowdell*, 169 Mass. 387, 47 N. E. 1033 (1897) (case cites as authority *Miller v. Horton*, 152 Mass. 540, 26 N. E. 100 (1891), in which Justice Holmes upheld the validity of summary action to kill a diseased horse to stop the spread of contagious disease, clearly asserting that this was valid only in an emergency situation); *In re Crosswell*, 28 R. I. 137, 66 Atl. 55 (1907).

<sup>25</sup> Rhode Island and Iowa.

<sup>26</sup> The line of Iowa cases, none of which cite the Supreme Court decision, traces



Court decision. It is highly questionable whether the procedures for commitment without notice and a hearing before hospitalization are valid for anything but emergency situations.<sup>27</sup>

The substituted notice provisions may stand on their own merit, however, without reference to these questionable arguments. The procedure has been used in New York since at least the beginning of the nineteenth century and may have been used in England in Chancery in cases where notice to a "furiously mad" person would be "improper or dangerous" (referring probably to the danger to the process-server, not the person). New York chancery cases sustaining the validity of the substituted notice date back to 1829.<sup>28</sup> It is possible that the Supreme Court would find that the procedure satisfies due process of law, if the substituted notice and other safeguards in the law are found sufficient to insure protection of the person's rights.

It should be noted, however, that one of the latest efforts to install the substituted notice provisions in the law was frustrated on this point. The Revised Mental Health Act of Illinois was vetoed by Governor Green on the advice of the attorney general that the substituted notice was unconstitutional.<sup>29</sup> In the Act as passed "reasonable notice" must be given the person concerned.<sup>30</sup>

#### (1) Arrest

Some states still provide for the arrest of the individual concerned at the time notice is given and for placing him in the custody of the sheriff for transport to a jail, court, or hospital.<sup>30a</sup> The method has been approved in a 1929 decision in Alabama as a "wise policy" in regard to the "alleged lunatic" to bring him notice and make him realize he must defend himself.<sup>31</sup>

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back to *Chavennes v. Priestley*, 80 Iowa 316, 4 N. W. 766 (1890) and *Black Hawk Co. v. Springer*, 58 Iowa 417, 10 N. W. 791 (1891), both of which deny the applicability of the due process clause to lunacy commitments. See also *Hammon v. Hill*, 228 Fed. 999 (W. D. Pa. 1915), which agrees with *Chavennes v. Priestley*, *supra*, that the due process clause does not apply.

<sup>27</sup> *Simon v. Craft*, 182 U. S. 427 (1901); *Barry v. Hall*, 98 F. 2d 222 (D. C. Cir. 1938); *Payne v. Arkebauer*, 190 Ark. 614, 80 S. W. 2d 76 (1935); *In re Lambert*, 134 Cal. 626, 66 Pac. 851 (1901); *In re Wellman*, 3 Kan. 100, 45 Pac. 726 (1896); *State v. Billings*, 55 Minn. 467, 57 N. W. 206 (1894); *Ex parte Romero*, 51 N. M. 201, 181 P. 2d 811 (1947); and see *Ex parte McGee*, 105 Kan. 574, 185 Pac. 14 (1919); *Miller v. Horton*, 152 Mass. 540, 26 N. E. 100 (1891).

<sup>28</sup> In the matter of *Tracy*, a habitual drunkard, 1 Paige 580 (N. Y. 1829); In the matter of *E. Petit*, a lunatic, 2 Paige 173 (N. Y. 1830); *Matter of Blewitt*, 131 N. Y. 541, 30 N. E. 587 (1892).

<sup>29</sup> *Veto Messages of Dwight H. Green, Gov. of Ill.*, p. 92, 62d Gen. Ass., 1941.

<sup>30</sup> ILL. ANN. STAT. c. 91½, §6-3 (Supp. 1952).

<sup>30a</sup> Alabama, California, Idaho, Mississippi, Missouri, New Mexico. North Carolina permits arrest and detention in the county jail if the medical certification is to the effect that the person's condition is such as to "endanger himself or others." N. C. GEN. STAT. § 122-44 (1943, recompiled 1950).

<sup>31</sup> *Fowler v. Fowler*, 219 Ala. 453, 455, 122 So. 440, 442 (1929).

In the majority of the states this harsh and unnecessary treatment has been abandoned. It had its origin in early times when only the violently insane were recognized as mentally ill. They were arrested for disturbing the peace and were incarcerated, not for their own benefit, but to prevent them from bringing harm to others. Today arrest and restraint in a jail is not necessary to bring the mentally ill "notice." Detention in jail is still permitted in most of the states, but only in cases where the police are forced to restrain a violently disturbed person. To prevent the necessity of the use of the jails even in such emergency cases, the states should adopt procedures under which the police can obtain the temporary emergency commitment of violent patients to a mental hospital or to the psychopathic ward of a general hospital. In all other cases, vehicles provided by the mental hospitals themselves should be used for the transportation of patients.

## (2) *Presence*

One of the most objectionable features of the commitment laws in many states is that concerning the compulsory presence of the prospective patient at the hearing which "determines" his "insanity" and need for treatment. The traumatic effect of the hearing on the patient is readily apparent. He is forced to sit and listen while his relatives, friends, and physicians testify that he is insane and in need of treatment in a mental institution. This testimony is given before a court or a commission. The patient is often held in the custody of police or court officers during the "trial." It is little wonder that the patient is often made to feel that he is being persecuted by these people and shunned by society—that he has done something morally culpable. It may take considerable time for the hospital psychiatrists to overcome the effect of this experience.

Since the actual presence of the person at the hearing is not required for due process of law as long as he has had notice and an opportunity to contest the commitment,<sup>32</sup> the requirement is difficult to defend. Compulsory presence is a part of the law in about half the states. It would seem in the best interests of more humane treatment to dispense with the requirement of compulsory presence. Personal presence of the individual adds little to the case, since the conclusion of the court must rest largely on medical testimony. The courts are well aware that a person can present a perfectly normal appearance during a brief court hearing and can yet be suffering from some mental illness.

It is said in the law that the presence of the "accused" is necessary so that he may conduct his defense and confront the witnesses against

<sup>32</sup> *Simon v. Craft*, 182 U. S. 427 (1901).

him. Consequently, presence should be necessary only when a "defense" is going to be conducted, that is, when the commitment is contested.

### (3) *Jury Trial*

Another objectionable feature of the present commitment laws is the jury trial to determine sanity. The use of a lay jury to determine such a highly technical medical question has been compared to calling in the neighbors to diagnose meningitis or scarlet fever.<sup>33</sup> The strong flavor of a criminal trial lent to the proceedings by the use of a jury is most unfortunate for the person concerned. It has not even proved effective for the single motive behind its adoption, the prevention of wrongful commitments.<sup>34</sup>

Today a jury trial is compulsory only in Texas.<sup>35</sup> It is optional in some other states<sup>35a</sup> and is actually used in only a very small percentage of cases. Since it is not required in due process of law,<sup>36</sup> the procedure should be eliminated from the commitment laws.

### (4) *Psychiatric Examination.*

Emphasis on the above elements in the cases and writings in the field may convey the impression that commitment is accomplished without the requirement of adequate medical basis. This is not the fact. In all of the states indefinite commitment petitions must be accompanied by the medical certification of qualified physicians that the person is mentally ill and in need of treatment.<sup>37</sup> In the majority of the states certification is by two physicians, while in others only one is required. Even the so-called non-judicial commitment procedures used in some states for indefinite commitment in non-emergency cases, though of doubtful constitutionality because of the lack of notice and a hearing before commitment, all require medical certification before hospitalization. It can be seen, therefore, that the bulk of the responsi-

<sup>33</sup> STERN, *MENTAL ILLNESS: A GUIDE FOR THE FAMILY* 37 (1942).

<sup>34</sup> See Dewey, *supra* note 9.

<sup>35</sup> TEX CONST. Art. 1, § 5. Jury trial is mandatory for detention over ninety days. For recent criticism of the requirement, see Williams, *Public Law Adjudications of Mental Unsoundness in Texas: Jury Trial Policy*, 1 BAYLOR L. REV. 248 (1949).

<sup>35a</sup> Alabama, Arkansas, California, Colorado, Delaware, Florida, Georgia, Illinois, Iowa, Kansas, Kentucky, Massachusetts, Michigan, Missouri, Montana, New Jersey, New Mexico, New York, Oklahoma, Rhode Island, South Dakota, Washington, Wisconsin, and Wyoming.

<sup>36</sup> *Wagner Electric Co. v. Lyndon*, 262 U. S. 226 (1922). State constitutions should not bar elimination of the jury trial in these procedures except in Texas. See note 35 *supra*. See also *Clough v. Clough*, 10 Colo. App. 433, 51 Pac. 513 (1897); *People v. Niesman*, 356 Ill. 322, 190 N. E. 668 (1934); *In re Brewer*, 224 Iowa 773, 276 N. W. 766 (1937); *In re Moynihan*, 332 Mo. 1022, 62 S. W. 2d 410 (1933); *People ex rel. Scheinberg v. McDermott*, 179 N. Y. Misc. 89, 37 N. Y. S. 2d 69 (City Ct. 1942). *But see* *Sporza v. German Savings Bank*, 192 N. Y. 8, 84 N. E. 406 (1908).

<sup>37</sup> See Kempf, *Laws Pertaining to the Admission of Patients to Mental Hospitals Throughout the United States*, Pub. Health Rep., Supp. 51, 1944.

bility for commitment is on the medical profession, where it belongs. In the last analysis there is little to fear from "wrongful commitments" with competent and honest psychiatrists.

### (5) *Appeal and Habeas Corpus*

It has been seen that some states provide for commitment on medical certification without prior notice and a hearing. These states attempt to "cure" this defect by providing liberally for appeal and a broadened habeas corpus after hospitalization.<sup>38</sup> Doubts have been expressed in this article concerning the constitutionality of such procedures for anything but emergency commitments. It would seem that due process of law requires an opportunity to contest *before* commitment in non-emergency cases if the person or someone on his behalf so desires.<sup>39</sup>

Appeal provisions and habeas corpus should be available in any case, however, no matter what the original method of commitment. Commitment is never a *final* determination. Hospitalization by law is valid only as long as the patient is mentally ill and in need of treatment. The commitment is therefore open to examination at all times. This is an important point. No matter what the form of appeal to the court, the only important question is the present mental condition of the patient. His condition on initial hospitalization or the procedure under which he was committed is of no consequence as far as disposition of the individual is concerned, since he will not be released unless he is sane.<sup>40</sup>

### C. *Temporary Observational Hospitalization*

Provisions for temporary hospitalization of patients for observation and diagnosis in cases where mental illness is indicated, but which are not so serious as to require the more drastic step of indefinite commitment, are essential to an adequate mental health program. Without such provisions, indefinite commitment would be used, or an "emergency" might be simulated, or the patient would have to be treated in some out-patient or home-office system. The latter form of treatment is useful, but by sending the patient to a hospital, the doctor is assured that the patient will receive expert attention and the constant care and observation so essential to proper diagnosis, prognosis, and therapy in mental cases.

Well over half of the states have temporary observational hospitaliza-

<sup>38</sup> See notes 24 and 25 *supra*.

<sup>39</sup> See note 27 *supra*; An Attorney General's Opinion gives this effect to a non-judicial commitment provision in New York: N. Y. OPS. ARRY. GEN. 332 (1923), concerning N. Y. MENTAL HYG. LAW § 72.

<sup>40</sup> *Payne v. Arkebauer*, 190 Ark. 614, 80 S. W. 2d 76 (1935); *Paul v. Longino*, 197 Ga. 110, 28 S. E. 2d 286 (1943); *Matter of Josiah Oakes*, 8 Law Rep. 122 (Mass. 1845); *Ex parte Romero*, 51 N. M. 201, 181 P. 2d 811 (1947); *Ex parte Shaeffer*, 177 Okla. 464, 60 P. 2d 1037 (1936). *Contra*: *Barry v. Hall*, 98 F. 2d 222 (D. C. Cir. 1938); *Okerberg v. People*, 119 Colo. 529, 205 P. 2d 224 (1949).

tion procedures, but most of these require court action. Only nine have such procedures not requiring court action.<sup>41</sup> For these short term hospitalizations court action should not be necessary unless the patient protests. Certification by a physician is required here as well. This, in addition to the integrity of the receiving hospital, should be a sufficient safeguard.

#### *D. Emergency Hospitalization*

Procedures for summary hospitalization without court action are essential in emergency situations. Otherwise the unfortunate individual is confined to a jail for disturbing the peace or is without hospitalization until the time-consuming court procedures can be followed.

The majority of states have non-judicial emergency admission procedures,<sup>41a</sup> but many of them are too narrowly drawn to accomplish their objectives. Many require the medical certification of two physicians. In view of the fact that hospitalization is only temporary and requires speedy action to prevent the violent and dangerous patient from being retained in jail, certification by one physician should be sufficient. Some states allow certification by a local health officer.<sup>42</sup> In Massachusetts, a police officer can obtain hospitalization of a person in a mental institution in an emergency for a ten day period if the hospital superintendent finds the person in need of immediate care.<sup>43</sup>

The latter type of non-judicial emergency hospitalization procedures should be encouraged. They are the best means of preventing detention of violent mental cases in the jails. They are a necessary step in eliminating the stigma of criminality from mental illness.

#### IV. COMPARATIVE LEGISLATION

In more recent times, mental health has become a topic of popular attention and consideration. State legislatures have begun to take remedial action in the field. Since the basic problems are the same in every state, an examination of some of the legislative solutions will be of interest.

In 1923, Pennsylvania made the first comprehensive attempt at improving the commitment laws in any state since the Packard movement in the middle of the nineteenth century had built them to resemble criminal statutes.<sup>44</sup> The term "mentally ill" replaces the terms "insane" and

<sup>41</sup> North Carolina, Delaware, Connecticut, Illinois, Wyoming, New York, Ohio, Pennsylvania, and Oklahoma.

<sup>41a</sup> Arkansas, California, Connecticut, Delaware, Illinois, Kentucky, Louisiana, Massachusetts, Michigan, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Utah, Vermont, Virginia, Washington, Wisconsin and Wyoming.

<sup>42</sup> Massachusetts, New York, Kentucky, and Wyoming.

<sup>43</sup> MASS. GEN. LAWS c. 123, § 79 (1932).

<sup>44</sup> PA. STAT. ANN. tit. 50 (Purdon 1931).

"lunatic." The term "mental defective" is used in place of "feeble-minded," and "inebriate" is used to include the alcoholic and drug addict.

The use of the more progressive and humane language sets the tenor of the act. The procedures are set out in single sections in simple non-technical language. There is a provision for voluntary admission. Hospitalization on the application of a relative or friend accompanied by the certificates of two physicians is provided for without the requirement of a judicial hearing. Admission is obtained merely by having the certificate affirmed before a judge who must be satisfied as to the qualifications and reputation of the examining physicians and the genuineness of their signatures. There is another procedure requiring court action. The hearing may be in such place as the judge prescribes, and presence of the person concerned is at the discretion of the court. The act provides for emergency hospitalization and for temporary care on certification of one physician. No court procedure is necessary. The language of the section is particularly apt for temporary care in that it may be used for "any person who is, or is thought to be, suffering from mental illness."<sup>45</sup>

There are separate procedures concerning hospitalization of mental defectives and inebriates. There is a section entitled *Rights of Patients* wherein are contained guarantees of the right to communicate with counsel, and other rights of communication, religious freedom, habeas corpus, discharge, and medical attention.

Though it was a pioneer attempt, the Pennsylvania system has proved to be one with few inadequacies. Later reforms adopted in other states have not equalled it in its comprehensive treatment of the subject and in its admirable simplicity of language.

The most recent attempts at installation of wholly new mental health programs have been in New York and Illinois. The New York Act<sup>46</sup> is very thorough, covering most of the situations in which state action is taken in commitment. There are five procedures for commitment of the mentally ill, three for mental defectives, and separate procedures for epileptics and inebriates.

The language adopted in the New York Act is excellent. There are no "commitments"; they are called "certifications." This is no mere interchange of words. Certification, or psychiatric examination, is the core of each procedure. Court action is necessary only if the patient requests it. The other four procedures are non-judicial.

The Revised Mental Health Act of Illinois, passed in 1945, is an example of a well considered minimum of procedures. There are only

<sup>45</sup> PA. STAT. ANN. tit. 50, § 45 (Purdon 1931).

<sup>46</sup> N. Y. MENTAL HYG. LAW (passed in 1946).

three methods of commitment, called in order: Voluntary Application, Emergency Admission, and Court Commitment. The Act relates only to the mentally ill, however, specifically excluding mental defectives and epileptics.

In its formulation, with articles on each procedure and short paragraph sections, the Act presents a fine example of statutory architecture. However, the procedures themselves are complicated and confusing. In the court commitment, there are *nineteen sections* actually providing three different methods of commitment.

As was noted previously, the Act was vetoed in its original and more salutary form. In this atmosphere it was revised and made to contain many of the "legal safeguards" so often objected to in commitment procedures. The jury trial is continued at the request of the person or someone on his behalf. A commission hearing is one of the three procedures which may be used for court commitment, but the commission's findings are not final. This renders its deliberations a useless and expensive gesture, if we may judge from the experience in other states. The Act requires personal notice and presence of the person concerned at the hearing. No procedure for temporary observational admission is provided.

In spite of the inclusion of these questionable "safeguards," there is no adequate provision for the most effective weapon against wrongful commitment, competent psychiatric examination. The Act requires examination by a "duly qualified physician" and defines the phrase in Article One as any person licensed to practice medicine in the state. No requirement as to knowledge of psychiatry or experience in the field or even in general practice is included.

The above are the only comprehensive state programs which will be examined. In most of the states the procedures have "just grown" like Topsy without rational order. In the further examination of state laws a review of some of the particular procedures used in various states will be presented.

At the First Mental Hospital Institute Convention of the American Psychiatric Association in April, 1949, psychiatrists from all over the United States and Canada gathered to discuss their common problems. There was a general agreement that the admission laws should allow maximum freedom of access to the hospitals. Much concern was expressed at the continued public prejudice against such proposals.

The comment of Dr. K. M. Bowman, Medical Superintendent of Langley Porter Clinic in San Francisco is exemplary:

In some states, the patient has to be brought before a judge and is charged with being insane. The whole setting is that of

a criminal trial. I remember in Boston Psychopathic (Hospital) when patients were committed to the State (Mental) Hospital, they were transferred by a representative of the court. He would come up to the ward. When he looked at the patient and decided the patient was not safe, he would pull out a pair of handcuffs and take the patient along. We remonstrated with him and told him he could have waited until he got outside the ward and not in sight of other patients. These things are sources of trauma to the patient—they are really terrible.<sup>47</sup>

The only doctors recorded as expressing satisfaction with the admission laws in their jurisdictions were from Rhode Island, Delaware, Pennsylvania, and Ontario, Canada.

The types of commitment laws approved are those generally described as non-judicial. Under these laws hospitalization is accorded on medical certification without court order, liberal provisions for appeal after hospitalization being provided. In the states with such provisions the public has been educated to the use of the procedures, and they have been highly successful. They have been found constitutional in Rhode Island,<sup>48</sup> though doubts have been expressed in this article concerning their validity where no opportunity to contest is afforded before commitment in non-emergency cases.

As noted, the procedures are used in these states quite to the exclusion of any others. There has not been a court commitment in Delaware in over thirty years, though the machinery still exists.<sup>49</sup> In Ontario, Dr. Stevenson asserted that 90% of the admissions are received directly from the physicians.<sup>50</sup> In Pennsylvania most of the admissions are under the non-judicial procedure.<sup>51</sup> Rhode Island has had much the same experience.<sup>52</sup>

Maryland, Louisiana, Vermont and New Hampshire have similar procedures. In New York and California non-judicial admission is possible where the party or someone on his behalf does not demand a court hearing.

In Maryland a new program for the care and treatment of the mentally ill is being developed. The non-judicial admission provision enacted there in 1944 is particularly interesting.<sup>53</sup> Under it the patient may be admitted on the certification of two qualified physicians. The

<sup>47</sup> *Better Care in Mental Hospitals*, Proceedings of the First Mental Hosp. Inst. of the Am. Psych. Assoc., p. 133, April 1949.

<sup>48</sup> *In re Crosswell*, 28 R. I. 137, 66 Atl. 55 (1907).

<sup>49</sup> *Better Care in Mental Hospitals*, *supra* note 47, at 135.

<sup>50</sup> *Id.* at 132.

<sup>51</sup> *Id.* at 41.

<sup>52</sup> Comment, 56 YALE L. J. 1178, 1183 (1947).

<sup>53</sup> MD. ANN. CODE GEN. LAWS art 59, § 34 (1951).



petition for admission may be made by a relative, friend, or an officer of a charitable institution or agency. The patient must be released on request of the patient or anyone on his behalf. The hospital must institute proceedings for court commitment in order to retain the patient.

As a general conclusion it can be said that the trend in the laws in the states is toward some type of non-judicial commitment procedure. It is significant that the newer non-judicial procedures are being adopted in the states as more adequate facilities for the care and treatment of the mentally ill are made available. Proper care and treatment move hand in hand with more humane commitment laws. Non-judicial commitment laws are more readily accepted by the people as their confidence in the mental hospitals and psychiatry grows. As the Medical Director of the U. S. Public Health Service, Dr. Grover A. Kempf, put it, "It is a fact that the states with the best mental hospitals have the most favorable commitment laws."<sup>54</sup>

#### IV. SUGGESTIONS FOR GENERAL IMPROVEMENT

##### A. Nomenclature

The great influence of language on the human thought process, the degree to which the words we use determine our attitudes, is well known in our modern world.

In the field of mental health the proposals for the use of proper terminology are a prime force in the movement to divorce mental illness from social and criminal stigma. Much of the battle can be won if the language of the criminal law is eliminated from the mental health laws. Archaic phraseology left over from a past when mental illness was regarded with suspicion and fear should be purged from the laws. Statutory language has influence on the language of the official forms of the administration, on the attitudes of public officials, on the members of the community affected by the laws. Proposals for reform should be examined from this perspective.

The first suggestions which come to mind are those concerned with the terminology for describing the various types of mental abnormality. Words and phrases offered as substitutes for such terms as "insanity," "feeble-mindedness," "lunacy," etc. could be paraded before the reader in almost unlimited variety. Some have made their appearance in the statutes.

The technical terms of psychiatry are the most obvious suggestions. The initiate as well as the novice leans heavily on the language of medical science. For "insanity" and "lunacy," which have no medical meaning, the term "psychotic" is proposed. There is justification for this in the literature of psychiatry, where the latter is frequently used as a

<sup>54</sup> Kempf, *supra* note 37, at 27.

generic term to describe the more serious and prolonged mental disorders such as dementia praecox and manic-depressive psychosis. In the reports of psychiatric examination of patients submitted to the courts by psychiatrists the question "Is he insane?" is taken in most instances to mean "Is he psychotic?" and is answered accordingly. It can be seen, however, that the term has a restricted meaning in psychiatry and cannot be used for the commitment of persons who have not reached the more serious stages, or for mental defectives.

The psychiatrists themselves discourage the use of the technical language of psychiatry in the statutes.<sup>55</sup> The language is still very much in a state of flux. The adoption of a particular technical term in a statute might tend to hinder its further dynamic development, or merely add to the confusion if the meaning changed in medical circles.

Other suggestions for terms to replace "insanity" and "lunacy" have been offered. The most popular has been the phrase "mentally ill." It embodies the connotation which the community should be conditioned to accept. It has replaced the term "insanity" in the commitment laws of nine states.<sup>56</sup>

At this point the difficulty becomes not so much the term as the *definition* of the term. In most legislation the new terminology replaces only "insanity" or "lunacy" and not the other categories such as mental deficiency, epilepsy, psychopathic personality, or alcoholism, though the F.S.A. Model Act would encompass all except the mental defective.<sup>57</sup> In the wording of the definition other legal problems may occur. The language should not be so loose as to be meaningless as identifying anything but mental incompetence. Commitment to a mental institution should not of itself deprive a person of the right to manage his affairs, though it may be *prima facie* evidence of his incompetence.<sup>58</sup>

Other problems may occur when the definition is broadly worded so as to cover cases other than those in which the person is likely to be dangerous to himself or to others. The original basis for jurisdiction to confine the mentally ill was the police power, which covered only situations involving actual danger to the public or to the person should he

<sup>55</sup> Report No. 9, Committee on Forensic Psychiatry, Group for the Advancement of Psychiatry, p. 1, May 1949.

<sup>56</sup> Pennsylvania, New York, Illinois, Connecticut, Iowa, Nebraska, Nevada, Ohio, and Oregon. The F.S.A. Model Act also adopts it. North Carolina adopted the term "mentally disordered" to replace "insane" in 1947.

<sup>57</sup> DRAFT ACT GOVERNING HOSP. OF THE MENTALLY ILL, Pt. I, § 1(a) and the first paragraph of the *Scope of the Act* at p. 1. (F.S.A. Pub. Health Serv. Pub. No. 51, Rev. 1952.)

<sup>58</sup> See Weihofen and Overholser, *supra* note 23, at 323-324. See also ILL. ANN. STAT. c. 91½, §§1-8, 1-9 (Supp. 1952). The former section defines a "mentally ill person" and would render the person committed incompetent. The latter section defines a "person in need of mental treatment" and would not render the person incompetent. This is the only state attempt at separate treatment.

remain at large.<sup>59</sup> In 1845 Chief Justice Shaw liberalized the common law basis for commitment to include those persons likely to become dangerous and to whom restraint would be conducive to recovery.<sup>60</sup> Shaw thus added a curative element to the justification for commitment laws. Cases following the Shaw decision are cited today for the validity of the present commitment laws in many states where only the curative element is mentioned, no reference being made to the likelihood of danger should the person remain untreated. Doubts have been expressed concerning the validity of restraint and confinement under these broadly worded laws.<sup>61</sup> They are difficult to sustain under the police power.<sup>62</sup> They would seem to have validity only under the state's capacity as *parens patriae*, but whether this authority extends to any but the incompetent is questionable.<sup>63</sup>

Substitutes for other archaic and harsh terms in the commitment laws are more readily agreed upon. For "feeble-minded" the term "mental defective" is an excellent choice. It is a term used by the medical profession which is easily adaptable to the statutory scheme. For the term "dipsomaniac" such terms as "alcoholic" and "inebriate" are adequate substitutes.

Next the controversy over the term "commitment" should be noted. Quite a few of the professional groups working in the field urge it be dropped from the language of the mental health laws because of its association with the criminal procedures. Some would adopt the term "admission," others "hospitalization."<sup>64</sup> Only New York has entirely eliminated the word from its statutes, replacing it with "certification."<sup>65</sup>

Other phraseology adopted from the criminal law could well be dropped from the mental health laws. The mentally ill should not be "charged with lunacy." They should not be addressed as "the accused" and be "arrested" and "tried." When allowed to leave the hospital temporarily, they should not be recorded as "on parole." All of these terms are common in the language of the mental health laws today. They color mental illness with ridicule, criminality, fear, and suspicion.

### B. *The Stigma of Criminality*

In the previous section the present subject was examined in relation

<sup>59</sup> 1 COOLEY, TORTS 313-314 (3d ed. 1906).

<sup>60</sup> Matter of Josiah Oakes, 8 Law Rep. 122 (Mass. 1845).

<sup>61</sup> See cases cited at note 27, *supra*; COMMENT, 19 GEO. WASH. L. REV. 512, 522 (1951).

<sup>62</sup> This would require an element of danger or likelihood of danger to the public or to the person should the person be allowed to remain at liberty. See cases cited at note 27 *supra*.

<sup>63</sup> Under old English law, jurisdiction in regard to the insane where they had no guardian and could not care for themselves was in the Court of Chancery. STORY, EQUITY JURISPRUDENCE § 1362 (13th ed. 1886); N. Y. Laws 1813, c. 30, p. 147, *Sporza v. German Savings Bank*, 192 N. Y. 8, 84 N. E. 406 (1908).

<sup>64</sup> The term is adopted in the F.S.A. MODEL ACT, *supra* note 16.

<sup>65</sup> N. Y. MENTAL HYG. LAW, §§ 70-82.

to its appearance in statutory language. Often discussions about divorcing mental illness from the stigma of criminality begin and end with suggestions for changes in nomenclature. This should not be the end of the matter.

In early times mental illness *was* assimilated to crime because it occasioned public notice only when the person became violent and disturbed the peace. From ancient times to the not too distant past the mentally ill were believed to be morally culpable, possessed of devils or witches.<sup>66</sup>

In more recent times the language of the criminal law is found in the commitment laws largely due to the fact that most of the states have modeled the procedures for commitment after criminal law procedures. We are now moving away from the ill-advised belief that a criminal trial is the only proper weapon against wrongful commitment. As we move away, as the procedures themselves are improved, the stigma of criminality and the language of the criminal courts should drop away as well.

The use of police officers and police patrol cars for transportation of patients to and from mental institutions should be discouraged. Transportation should be furnished by the hospitals themselves. Eight states now prohibit the use of police transportation for mental patients.<sup>67</sup> Thirteen states do not allow detention of mental patients in jails or prisons.<sup>68</sup> Emergency commitments for temporary periods to mental hospitals, psychopathic hospitals, and the psychopathic wards of general hospitals should be authorized to prevent the use of the jails for the restraint of emergency cases.

### C. *The Fear of Wrongful Commitment*

No amount of statistics has been sufficient to convince some elements of the community that a wrongful commitment very, very seldom appears in the admissions to the mental hospitals of this country. Protests against the undue fear of wrongful commitment and the effect such fear has on the commitment laws can be found in legal periodicals as early as 1869.<sup>69</sup> In 1901 Dr. A. B. Richardson of the Government Hospital for the Insane, Washington, D. C., said:

Far more damage is done to both patient and society by impediments to ready commitment of the insane than by their unnecessary or unjust confinement. In an experience of a

<sup>66</sup> DEUTSCH, *op. cit. supra* note 3, at c. 1.

<sup>67</sup> Maryland, Nevada, New York, Oregon, Rhode Island, Virginia, Wisconsin, and Wyoming.

<sup>68</sup> Connecticut, Delaware, Maine, Maryland, Massachusetts, Minnesota, Mississippi, New Hampshire, New Jersey, New York, Oregon, Tennessee, and Vermont.

<sup>69</sup> Ray, *Confinement of the Insane*, 3 AM. L. REV. 193 (1869).

quarter of a century, embracing perhaps 10,000 cases, a number of habeas corpus proceedings have resulted in the release of the patient, but there has not been a single well established case in which its future history did not give sufficient proof that the original commitment had been justifiable.<sup>70</sup>

It suffices to say that the medical profession has consistently asserted that wrongful commitments are very infrequent, that they are in the main imaginary fears played upon by Sunday-supplement sensationalist writers. Even a psychological explanation is offered. It is said that such an expressed fear is a defense mechanism to rationalize our wretched neglect of those actually mentally ill.

Members of the medical profession express the hope that the public will one day come to realize its fears are unfounded. Their hopes were shared in 1912 by a leading member of the legal profession in these words:

Some day we hope to have the public at large accept the belief that hospitals for the insane harbor only the insane and that the sane man is released from such hospitals as promptly and with the same facility as the man whose fever has subsided and is discharged from the typhoid ward.<sup>71</sup>

And yet the legitimate *possibility* of wrongful commitment must be guarded against. A recognition of this should not, however, mean that arrest and a criminal trial procedure must precede each commitment. It has been amply proved that this mechanism does not prevent wrongful commitments in itself and does produce undesirable traumatic effects on the person who must undergo it. It would seem to be worthwhile, then, to examine the other elements of the situation to discover the most efficacious methods of preventing wrongful commitments.

### (1) *The Causes of Wrongful Commitment*

Little consideration has been given in the literature on commitment to the basic causes of wrongful or unjust commitments. Why would any human being want another sane human being placed in a mental institution?

The classic example from fiction, the unscrupulous person moving to have a rich relative or business associate committed in order to get his money, seems extremely unlikely today. The readily available machinery for appeal, habeas corpus, and freer access to and from mental institutions militates against it. The wealthy person will usually

<sup>70</sup> Richardson, *The Mental Hospital*, 62 ALBANY LAW J. 441, 442 (1901).

<sup>71</sup> Fenning, *Voluntary Submission to Treatment and Custody for the Insane*, 58 A. M. A. J. 1104, 1105 (1912).

have the resources to obtain release. There is little temptation to attempt to commit a person if he will be released quickly. Criminal and civil action against the wrongdoer will be another deterrent.<sup>72</sup>

But what of the person without money? The greatest temptation to wrongful commitment in the present day is the commitment of the *unwanted*. The unwanted will hardly ever be rich.

Who are the unwanted? The largest group are the elderly members of the community, particularly those without independent incomes. Other tragic cases are found among persons with criminal records, juvenile delinquents, sexual deviates, alcoholics, drug addicts, and others.

For the aged the medical profession is acutely aware of the danger, and special care is taken in the reception of aged persons at the mental hospitals.<sup>73</sup> The problem is actually becoming more acute daily, as America's population is growing old.<sup>74</sup>

There is an encouraging awareness in America of the problems of the older part of our population. We now have the social security and other programs. Community activities are being organized for elderly people. Two great wars have proved the worth of the older worker.

All of these programs aid in preventing commitment of aged persons unnecessarily. They help to make the aged financially independent of the bounty of relatives. Community activities and gainful employment help to keep them in the stream of active life.

The problems concerning the commitment of the other classes mentioned are far more difficult of solution. As old age will visit us all, self interest directs much of the campaign to prevent the evils of it. However, few people are interested in those persons who step across the moral line into crime. Many of these are unwanted in the true sense of the term. Here we have the defective delinquents,<sup>75</sup> sexual deviates,<sup>76</sup> drug addicts, alcoholics, and habitual criminals. It often

<sup>72</sup> Many states provide specific criminal sanctions against wrongful commitment. For example, see MASS. GEN. LAWS c. 123, §110 (1932); ILL. ANN. STAT. c. 91½, §12-1 (Supp. 1952). See also F.S.A. MODEL ACT, *supra* note 16, Pt. IV, § 26.

<sup>73</sup> *The Problem of the Aged Patient in the Public Mental Psychiatric Hospital*, Report No. 14, Committee on Hospitals of the Group for the Advancement of Psychiatry, August 1950.

<sup>74</sup> Average life span in the United States has risen from 47 to 68 years in the past 25 years. By 1970 it is estimated that there will be sixteen and one half million persons 65 years of age and over. Of particular importance in the increase of mental cases among the aged is the fact that at present the average life expectancy at the age of 65 is nearly thirteen years. See *Id.* at 1.

<sup>75</sup> See Harris and Gordon, *An Investigation and Critique of the Defective Delinquent Statute in Massachusetts*, 30 B. U. L. REV. 459 (1950).

<sup>76</sup> See PLOSCOWE, *SEX AND THE LAW* (1951); *The Habitual Sex Offender*, New Jersey Legis. Comm. Rep. 1951; *Report of the Governor's Study Commission on the Deviated Sex Offender*, Michigan, 1951; *Psychiatrically Deviated Sex Offenders*, Report No. 9, Committee on Forensic Psychiatry of the Group for the Advancement of Psychiatry, May 1949; Curran, *Commitment of the Sex Offender in Massachusetts*, 37 MASS. LAW Q. 58 (1952).

seems easier to commit these persons and be rid of them than to attempt rehabilitation and cure.

There is much laudable work being done to help these unfortunate people. The work of all of these groups aid in the prevention of wrongful commitments.

## (2) *The Examining Physician*

The strongest bulwark against wrongful commitment is in the last analysis the medical profession itself. The integrity of the profession as a whole can hardly be doubted in this present day. Active policing within the profession is the best and most effective force in exposing unscrupulous practitioners.

And yet, if medical certification is required in every case, wrongful commitments must pass through a doctor's hands. The temptation to commit irregularly must not be made attractive. There are criminal and civil sanctions against it. The doctor is liable to lose his right to practice medicine. Since psychiatry is a lucrative calling, this is a strong deterrent in itself.

There are other deterrents. In most cases two physicians must make the certification. Opportunities for corruption are lessened with an increase in numbers. The cooperation of the hospital staff would have to be assured in any case, further reducing the likelihood of success.

Most of these are after-checks, however. What can be done *before-hand* to prevent unscrupulous medical certification? The states have devised a series of possible methods. Minimum standards for physicians eligible to make certification can be established. Most of the states merely require that the examiner be licensed to practice medicine in the state. Others require some years of at least general experience. The requirement of experience or training in psychiatry is rare.<sup>77</sup> The very fact of the scarcity of psychiatrists, particularly outside the larger cities, militates against requirements of this type.<sup>78</sup>

<sup>77</sup> In Massachusetts the court is authorized to require that one of the examining physicians (two are required for involuntary commitment) be a diplomate of the American Board of Psychiatry and Neurology, Inc. where practicable in the jurisdiction. MASS. GEN. LAWS c. 123, § 53 (1932). In New York the court can in some cases demand examination by "certified psychiatrists" registered by a state licensing board, but this is generally limited in practice to criminal cases. N. Y. MENTAL HYG. LAW § 27. Certification for admission to the mental hospitals under the regular procedures is made by "certified examiners" who must meet the same basic requirement as under Massachusetts law. N. Y. MENTAL HYG. LAW, § 19.

<sup>78</sup> Of the approximately 7700 psychiatrists in the country, 4100 are in private practice. Of these the ratio of those practicing in cities of over 100,000 population to those in other areas is 3 to 1. In the New England, New York, New Jersey area 1400 psychiatrists are practicing in cities of over 100,000 population while only 394 are practicing outside of these cities. In the southern states (southeast and southwest) only 191 psychiatrists are in private practice, and of these 143 are in cities of over 100,000 population. See Blain, *Private Practice of Psychiatry*, 286 ANNALS 136, 144-146 (1953).

There have been suggestions that the state keep a list of psychiatrists and physicians eligible to make certifications. The list would have to be a liberal one for the reasons pointed out above. There are not enough psychiatrists to do the job themselves. The list would be an administrative burden to the state and might lead to abuses in its use. The value of a listing would probably be found more in preventing physicians of doubtful reputation from making certifications rather than in inducing any positive action.

### (3) *The Mental Hospitals*

Groups working to prevent wrongful commitments concentrate on building high walls of legal requirements around entrance to the mental institutions. And yet it is *after* admission that the major part of the psychiatric examination of the patient begins. If the hospitals are genuinely working to achieve adequate care and treatment of patients, wrongful commitments are all but impossible for anything beyond temporary confinement. Those not needing treatment will be quickly discharged, and the wrongdoer will be punished. All statistics indicate that the mental hospitals are making great progress in the care, treatment, and rehabilitation of the mentally ill.

The obstacles to extended confinement of a sane person in a mental hospital are very great. The motive for unjust confinement would be profit—a bribe. Present conditions make this prohibitive. We have seen that the vast majority of the mental hospitals of the country (97.5%) are government operated. They are also very much overcrowded. Fees for care would not be an incentive to commitment. If bribery were used, an entire hospital staff would have to be corrupted. The hospital would have to keep close check on the patient to prevent communication with persons not connected with the conspiracy.

The dangers in regard to smaller private hospitals are perhaps greater, but even these are often visited and licensed by the state.<sup>79</sup> Improvement in state machinery for inspection and licensing of private hospitals and nursing homes where mental patients are detained should be encouraged.

The periodic examination and re-examination of patients and the rapid discharge of patients no longer needing care should be an integral part of the administrative program of every mental institution. The F.S.A. Model Act recommends it as a statutory requirement.<sup>80</sup>

<sup>79</sup> Private mental hospitals are inspected and licensed by the state in California, Connecticut, Illinois, Iowa, Kansas, Maine, Maryland, Massachusetts, Michigan, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Vermont, Virginia and West Virginia.

<sup>80</sup> DRAFT ACT GOVERNING HOSP. OF THE MENTALLY ILL, Pt. III, § 15 (F.S.A. Pub. Health Serv. Pub. No. 51, Rev. 1952) (periodic examination required at least every six months).



(4) *Mental Hygiene*

Effective mental hygiene programs and psychiatric research are an essential part of our country's mental health program. This has been graphically recognized in the unanimous approval of the National Mental Health Act by Congress in 1946. Under it the National Institute of Mental Health was established. Under the Act grants-in-aid are made to the states and private agencies for the training and education of psychiatric personnel, for the conduct of research, and for aid to community psychiatric services outside of the mental hospitals themselves.

The mental hygiene programs aid in preventing wrongful commitments. Along with prevention of mental illness, and care and treatment of the mentally ill, they provide a "screening process" for possible unjust commitments. Wrongful commitment is made even less an incident of the mental health programs as the patient passed through more and more way stations on the road to recovery.

#### V. THE BASIC REQUIREMENTS OF AN ADEQUATE AND HUMANE HOSPITALIZATION LAW

Too often in the past hospitalization of the mentally ill has been accompanied by inhumane treatment of the people involved. The causes of this are basically of two types: (1) fear and ignorance regarding mental illness and assimilation of it to criminality, and (2) harsh procedures adapted from the criminal law designed to prevent wrongful commitments. The first should be entirely eliminated. The second cause, prevention of wrongful commitments, will remain, but its effects in producing harsh treatment can be eliminated without increasing the risk of wrongful commitments. Materials in the previous sections of this article were designed to aid in this program.

For an adequate program for hospitalization of the mentally ill, the following procedures should be adopted:

- (1) A Voluntary Admission Law.
- (2) Commitment for an Indefinite Period on Medical Certification (with notice to the patient required and a hearing *before* commitment if the patient or anyone on his behalf requests it).
- (3) Temporary Observational Commitment on Medical Certification Without Court Order.
- (4) Temporary Emergency Commitment Without Court Order.
- (5) Liberal Judicial Appeal and Habeas Corpus Procedures.

Each of the above is discussed in detail in an earlier part of this article. In addition to these, state legislation should provide for reasonable communication by patients with relatives and friends and unrestricted communication with their attorneys. Religious freedom should be accorded all patients. Mechanical restraints should be prohibited. Transportations of patients should be provided for by the hospitals themselves and use of police and police transportation should be avoided wherever possible.

The primary responsibility for commitment must be on the medical profession itself. Certification of psychiatric examination for admission to the mental hospitals should be the responsibility of physicians trained in psychiatry whenever practicable in the jurisdiction. The staffs of the hospitals as well as other state officials and private physicians should encourage this. All should be watchful for certification by unscrupulous physicians and psychiatrists.

Periodic examination and re-examination of patients should be required in all institutions to promote the prompt discharge of patients no longer requiring care and treatment.

It should not be forgotten that the present widespread programs for the construction of more and better mental hospitals and other facilities, aid and encouragement in the education and training of psychiatric personnel, the mental hygiene and clinic programs, and research activities are all a part of the program to prevent wrongful commitments. They are all a part of the progress of the country toward better mental health.