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HOSPITALIZATION OF THE VOLUNTARY MENTAL PATIENT

*Hugh A. Ross**

IN 1949, the last year for which accurate statistics are available, 390,567 persons were admitted to mental hospitals in the United States.¹ Total annual cost of mental illness, including loss of earnings, has been estimated to be over a billion dollars a year.² Although the problems involved in admission of the mentally ill patient to a hospital are usually thought of in terms of formal involuntary commitment proceedings, there is an increasing awareness of the desirability of provision for voluntary procedures which would encourage prompt and effective medical care. Voluntary admission is not a form of commitment, although it may have similar legal consequences.

"Voluntary admission undercuts the whole problem of commitment by altering its basic condition, involuntariness. Voluntary admission is not a *commitment* problem; it is a legal expression of the modern conception of mental illness, wherein the affliction is recognized as a disease needing special medical attention, wherein no stigma is attached to it, and wherein its cure at an incipient stage is encouraged by affording an opportunity for hospitalization involving no more red tape than admission to a general hospital."³

The increased need for and use of voluntary admission procedures parallels the major recent trend of psychiatry, i.e., the gradual ascendancy of the curative over the custodial aspects. This trend is the result of the discovery that in most cases mental patients can be cured, especially if treatment is offered at an early stage. Voluntary admission procedures are especially well-adapted to the new type of mental insti-

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¹ See Appendix, Table I, p. 390 *infra*.

² Bowman, Presidential Address, 103 *AM. J. PSYCHIATRY* 1 (1946). See also Appendix, Table I, for direct maintenance cost of public mental hospitals.

³ Comment, 56 *YALE L.J.* 1178 at 1201 (1947).

tutions developed in the past fifty years, the psychopathic hospital, the general hospital with a psychiatric ward, and the psychiatric clinic.⁴

Agitation for the adoption of adequate voluntary admission procedures is not entirely new. Massachusetts adopted the first voluntary admission law in 1881.⁵ Two years later the New York Commissioner in Lunacy urged the universal adoption of voluntary procedures.⁶ In 1930, the Committee on Legal Measures of the First International Congress on Mental Hygiene recommended that voluntary admission procedures be encouraged.⁷ The most recent expression of concern over the lack of adequate voluntary procedures is contained in the 1950 recommendations of the Council of State Governments to the Governors' Conference:

"Many states have partial provision for voluntary admission to state hospitals, but its use is limited in most states. Voluntary hospitalization saves time and money for the states and embarrassment for the patient, and it tends to reduce length of stay in the hospital. Voluntary admission procedures should be provided in all states and should be used more extensively."⁸

Although there are no comprehensive statistics available on the use of voluntary procedures for all mental hospitals, the evidence clearly indicates that in those states where adequate statutes are in existence voluntary procedures are widely used and they do result in early and successful treatment.⁹

⁴ See Appendix, p. 390 *infra*, and Table I for an indication of the present status of these new institutions (temporary-care mental hospitals) which specialize in psychiatric teaching and research and short-term intensive treatment. For the history of psychopathic hospitals, see DEUTSCHE, *THE MENTALLY ILL IN AMERICA* 291 (1937). For a functional description of modern psychopathic hospitals see Elder and Benimoff, "The Purpose of Receiving Hospitals," 47 *OHIO ST. MED. J.* 531 (1951), and Poling, "The Youngstown Receiving Hospital," 43 *OHIO ST. MED. J.* 1054 (1947).

⁵ Mass. Acts (1881) c. 272.

⁶ Smith, "Remarks on the Lunacy Laws of the State of New York," 40 *AM. J. INSANITY* 50 (1883).

⁷ 1 *PROCEEDINGS OF THE FIRST INT. CONGRESS ON MENTAL HYGIENE* 61 (1930).

⁸ *COUNCIL OF STATE GOVERNMENTS, REPORT TO THE GOVERNORS' CONFERENCE—THE MENTAL HEALTH PROGRAMS OF THE FORTY-EIGHT STATES* 5 (1950) [hereinafter cited as *REPORT TO GOVERNORS' CONFERENCE*].

⁹ As far back as 1924, when only half of the states had any kind of voluntary procedure, and most of these were inadequate, it was reported that 45% of the admissions to Iowa Psychopathic Hospital were voluntary, 22% at Michigan State Hospital, and an estimated 75% in private hospitals. Overholser, "The Voluntary Admission Law," 3 *AM. J. PSYCHIATRY* 475 (1924). See Appendix, Table 1, for number of admissions to short-term mental hospitals. Probably one half of these are voluntary admissions. For voluntary admissions to state mental hospitals (long-term care) in 1949 see *REPORT TO THE GOVERNORS' CONFERENCE*, *supra* note 8, Appendix, Table 25. A recent report on voluntary admission in the state of Washington concludes that voluntary procedures are both desirable and successful. Of the voluntary patients studied, 91% were discharged as

The Need for Voluntary Admission Laws

Granted that voluntary admission to a mental hospital is a desirable procedure, it might well be asked: what is the necessity for specific and detailed statutory authorization? Most public mental hospitals were established by statute prior to the general utilization of voluntary procedures, so the enabling legislation usually states that the hospital shall receive patients *committed* to it, by implication excluding patients not committed by a court. Even in the absence of such a statute it is unlikely that any public hospital would admit any patients except those committed, or emergency cases where commitment would follow, in the absence of express statutory authorization.

As to both public and private mental hospitals, detailed statutory authorization is needed to take care of the problem that arises where a patient asks for his discharge and the medical authorities wish to detain him, either for his own safety or that of the public. Under the common law rule, still in effect in most states, any person can detain a mentally ill person who may be dangerous to himself or others.¹⁰ The difficulty facing the hospital administrator is two-fold. First, the hospital will have to detain the patient for a short period of time after he requests release in order to determine whether or not he is dangerous. Second, even if the hospital superintendent believes the patient to be dangerous, this issue is very likely to be determined ultimately by a jury of laymen in a suit for damages for false imprisonment.¹¹

cured or improved within six months of admission. Jones and Hughes, "Washington Experience with Voluntary Admission to a State Hospital for Observation and Treatment," 50 N.W. MEDICINE 933 (1951). Statistics on the use of voluntary procedures are found in Hamilton, Kempf, Scholz and Caswell, "A Study of the Public Mental Hospitals of the United States: 1937-39," U.S. PUBLIC HEALTH REPORTS, Supp. No. 164, p. 50 (1941). In 1940 it was reported that 28.9% of patients admitted to Illinois hospitals were voluntary patients, although only 6.7% of the patients on the books at the end of the year were voluntary patients. These figures suggest both widespread use of voluntary procedures and short and successful treatment periods. ILL. LEGIS. COUNCIL, COMMITMENT TO MENTAL HOSPITALS, Pub. No. 52, p. 10 (1942). See also Bowman in 103 AM. J. PSYCHIATRY 1 at 11-15 (1946).

¹⁰ Note 11 *infra*.

¹¹ False imprisonment actions are a real danger for psychiatrists and mental hospitals. The defendant usually tries to justify the detention on the basis of the common law rule. The cases indicate some confusion as to whether or not statutory detention procedures replace or supplement the common law rule. For cases on the common law right of detention, see *Christianson v. Weston*, 36 Ariz. 200, 284 P. 149 (1930); *Denny v. Tyler*, 85 Mass. 225 (1861); and *Colby v. Jackson*, 12 N.H. 526 (1842). A recent New York case contains a discussion of the authorities on common law detention. The court held that common law detention was supplemental to the statutory process. *Warner v. State*, 297 N.Y. 395, 79 N.E. (2d) 459 (1948). Contrast *Jillson v. Caprio*, (D.C. Cir. 1950) 181 F. (2d) 523, which held that the common law rule was replaced by a statutory procedure which defendant psychiatrist failed to follow, with *Orvis v. Brickman*, (D.C. Cir.

There is a third reason for having express legislation authorizing voluntary admission and defining the status of the voluntary patient with some care. Few patients will present themselves for treatment unless the hospital admissions officer or physician can point to a statute and state definitely that the patient can be released shortly after he requests release and that hospitalization will not per se involve loss of legal competency.

In general, voluntary admission laws have been poorly drafted in that they are not comprehensive and fail to take account of many problems. Statutes in many states specifically authorize voluntary admission, but elsewhere refer to patients in mental hospitals as "those committed by a court," thus creating confusion as to the rights and status of voluntary patients. One of the recently announced objectives of the American Psychiatric Association is the drafting of an "ideal commitment law."¹² Disclaiming the ability to draft or the desirability of an "ideal" voluntary admission statute, it is my purpose to survey existing statute and case law and to point out the trouble areas with which legislators and statutory draftsmen should be concerned. Any recommendations I make should be viewed in this light.¹³

The Extent of Voluntary Admission Legislation

As has already been pointed out, voluntary admission procedures should be authorized for all public and private hospitals for the men-

1952) 196 F. (2d) 762, where the same court held that the common law rule is a good defense to a false imprisonment action, even though the detention statute was not followed, when the situation was sufficiently dangerous.

¹² Bowman, 103 AM. J. PSYCHIATRY 1 at 11 (1946).

¹³ There has been some disagreement on the desirability of uniform legislation in this area. The American Bar Association Special Committee on the Rights of the Mentally Ill concluded that the general subject of commitment does not lend itself with advantage to embodiment in a uniform state law, as few problems in the field project themselves beyond state boundaries. 73 A.B.A. REP. 297 (1948). However, other writers have not hesitated to make detailed recommendations for legislation. The increased mobility of our population, the increased incidence of multi-state property holdings and the increased number of patients in Veterans Administration hospitals, most of whom are committed under state laws, all indicate a greater need for uniformity. See for example the quite specific recommendations of the Medical Director of the U.S. Public Health Service; KEMPF, LAWS PERTAINING TO THE ADMISSION OF PATIENTS TO MENTAL HOSPITALS THROUGHOUT THE UNITED STATES, U.S. PUBLIC HEALTH REPORTS, Supp. No. 157, p. 28 (1944). The most important stimulus to uniformity was the work done in the Federal Security Agency during 1949 and 1950, which culminated in the transmittal in September 1950 of a Draft Act to all of the state governors. A DRAFT ACT GOVERNING HOSPITALIZATION OF THE MENTALLY ILL, PUBLIC HEALTH SERVICE PUBLICATION No. 51 (1951) [hereinafter referred to as the "Draft Act"]. As of the end of 1953, eight states had adopted the Draft Act in whole or in part. For comments on the drafting of the act by one of the authors see Felix, "Hospitalization of the Mentally Ill," 107 AM. J. PSYCHIATRY 712 (1951). For a detailed discussion of the Draft Act see Whitmore, "Comments on a Draft Act," 19 GEO. WASH. L. REV. 512 (1951).

tally ill.¹⁴ The Draft Act¹⁵ defines a "hospital" as "a public or private hospital or institution, or part thereof. . . ." Section 2 of the Draft Act states, "The head of a private hospital may and, subject to the availability of suitable accommodations, the head of a public hospital shall admit for observation, diagnosis, care, and treatment any individual. . . ."

Only two states, Alabama and Florida, have no voluntary admission statute for public mental hospitals. Both of these states specifically exclude admission of voluntary patients to state mental hospitals, Alabama requiring a commitment in every case and Florida requiring a commitment and a separate determination of incompetency.¹⁶

In relation to public mental hospitals,¹⁷ nine states have voluntary admission statutes that apply to all public mental hospitals.¹⁸ Twenty-five states have voluntary procedures that apply to state mental hospitals only.¹⁹ Eleven states have voluntary admission statutes that apply to state mental hospitals and to some, but not all, other public mental

¹⁴ "Mentally ill" as used in this paper refers to a person who needs care and treatment because of psychiatric disease. "Mental illness" is still referred to in the older cases and statutes as "insanity" or "lunacy." This paper does not deal with the problems of voluntary admission of mental defectives, formerly called feeble-minded, or of alcoholics or drug addicts, as these present separate although related policy issues. Throughout this paper I use the more modern terminology, i.e., "mental illness" instead of "insanity," "patient" instead of "inmate," and "mental hospital" instead of "insane asylum." See REPORT TO GOVERNORS' CONFERENCE at 47 for a discussion of terminology in commitment statutes.

¹⁵ Draft Act, §1.

¹⁶ Ala. Code (1940) tit. 45, §204; Fla. Stat. Ann. (1943) §394.25.

¹⁷ In most states, the state hospital is the only public mental hospital, although state university, city or county psychiatric hospitals, clinics and public general hospitals with psychiatric wards are becoming more common and should be provided for in the legislative scheme. All of the states except two follow the "New York plan" where public patients are cared for primarily in state hospitals. Wisconsin and New Jersey follow the "Wisconsin plan" whereby acute cases are cared for in state hospitals and chronic cases are cared for in county hospitals under state supervision.

¹⁸ Conn. Gen. Stat. (1949) §2643; Idaho Code (Supp. 1953) §66-321; Ill. Rev. Stat. (Supp. 1953) c. 91½, §1-5; Md. Ann. Code (1951) art. 59, §36; Mo. Stat. Ann. (Vernon, 1953 Supp.) §202.783; N.J. Rev. Stat. (1937) §30:4-46; N.M. Stat. Ann. (Supp. 1953) §37-229; Pa. Stat. Ann. (Purdon, 1952 Supp.) tit. 50, §1072(8); R.I. Gen. Laws (1938), c. 71, §41.

¹⁹ Ariz. Code Ann. (Supp. 1952) §8-210; Ark. Stat. Ann. (1947) §59-231; Ga. Code Ann. (Supp. 1954) §35-241; Kan. Gen. Stat. Ann. (1949) §76-1233; Ky. Rev. Stat. (Supp. 1954) §203.020; Me. Laws (1951) c. 374, §111; Mass. Laws Ann. (1949) c. 123 §§10 and 86; Mich. Stat. Ann. (Supp. 1953) §§14.801 and 14.809(1); Minn. Stat. Ann. (Supp. 1953) §525.75; Miss. Code Ann. (1942) §6909-12; Mont. Rev. Code (1947) tit. 38, §406; Neb. Rev. Stat. (1943) §83-324; Nev. Stat. (1951) c. 331, §49; N.H. Laws (1949) c. 112; N.D. Laws (1953) c. 186; Ohio Rev. Code Ann. (Baldwin, 1953) §5123.44; Ore. Rev. Stat. (1953) §426.220; S.C. Acts (1952) c. 836, art. II, §1; S.D. Code Ann. (1939) §30.0115; Tex. Civ. Stat. Ann. (Vernon, 1952) art. 3193h; Utah Code Ann. (1953) §64-7-29; Vt. Laws (1951) c. 170, §§317 and 363; Wash. Rev. Code (1951) §71.02.030; W.Va. Code Ann. (1949) §2669; Wyo. Comp. Stat. Ann. (1945) §51-402.

hospitals.²⁰ Tennessee is unique in that it is the only state with any form of voluntary admission that does not allow voluntary admission to the state mental hospital system, but does allow voluntary admission to a public psychiatric clinic.²¹

Less than half of the states have specific statutory authorization for voluntary admission to private mental hospitals.²² In general, voluntary admission statutes affecting private hospitals are not comprehensive and are more apt to be poorly drafted, although medical authorities agree that there is a real need for adequate legislation defining the legal status of the private mental hospital.²³

Of the twenty-five states that do not have voluntary admission statutes which apply to private hospitals, twenty-three states regulate private mental hospitals,²⁴ either as such, or along with other types of

²⁰ Cal. Welfare & Inst. Code Ann. (Deering, 1952) §6002 and §6602 (state mental hospital and county psychopathic hospital); Colo. Stat. Ann. (1935) c. 105, §47 and §74 (state mental hospital and Univ. of Colo. Psychopathic Hospital); Del. Code Ann. (1953) tit. 16, §5123 and §5321 (state mental hospital and government Bacon Health Center); Ind. Stat. Ann. (Burns, 1950) §§22-1301, 22-4211, 22-3001 and 22-3916 (voluntary admission to state mental hospital and to psychopathic hospital; no voluntary admission to county mental hospital or to city psychopathic hospital); Iowa Code Ann. (1949) §§225.9 and 229.41 (psychopathic hospital and state mental hospital); La. Rev. Stat. (1950) tit. 28, §51 as amended by Senate Bill No. 244 (1954) §1 (all provisions of the commitment statutes apply to all hospitals, except voluntary admission, which according to tit. 28, §51 applies only to state hospitals. But see tit. 28, §50 created by Senate Bill No. 244 (1954) which indicates that voluntary admission applies to private hospitals); 34A N.Y. Consol. Laws (McKinney, 1951) §§71, 200 and 200-a (state mental hospital, psychiatric institute in N.Y. City and psychiatric hospital at Syracuse Univ.); N.C. Gen. Stat. (1952) §§122-62, 122-73 and 122-81.1 (state, county and city); Okla. Stat. Ann. (Supp. 1953) tit. 70, §1265.6 (Univ. of Okla.) and tit. 43A, §53 (state mental hospital); Va. Code Ann. (1950) §37-19 (separate hospital for voluntary patients) and §37-113 (state mental hospital); Wis. Stat. (1953) §51.10 (state and county mental hospital).

²¹ Tenn. Code Ann. (Williams, 1952 Supp.) §4459.1(3).

²² Cal. Welfare and Inst. Code Ann. (Deering, 1952) §5750.5; Conn. Gen. Stat. (1949) §§2643 and 2655; Idaho Code (Supp. 1953) §66-318; Ill. Rev. Stat. (Supp. 1953) c. 91½, §4-1; Kan. Gen. Stat. Ann. (1949) §65-404; Me. Rev. Stat. (1944) c. 23, §146; Md. Ann. Code (1951) art. 59, §36; Mass. Laws Ann. (1949) c. 123, §§10 and 86; Mo. Ann. Laws (Vernon, 1953 Supp.) §202.783; N.J. Rev. Stat. (1937) §30:10-9; N.M. Stat. Ann. (Supp. 1953) §37-229; 34A N.Y. Consol. Laws (McKinney, 1951) §71; N.C. Gen. Stat. (1951) §122-81.1; Okla. Stat. Ann. (Supp. 1953) tit. 43A, §53; Pa. Stat. Ann. (Purdon, 1952 Supp.) tit. 50, §1161; R.I. Gen. Laws Ann. (1938) c. 71, §41; S.C. Acts (1952) c. 836, art. III, §1; Tenn. Code Ann. (Williams, 1934) §4789; Utah Code Ann. (Supp. 1953) §64-7-55; Vt. Laws (1951) c. 170, §363; Va. Code Ann. (1950) §37-61.1; Wash. Rev. Code (1951) §71.12.560; Wis. Stat. (1953) §58.05.

²³ For an example of legislative unconcern with the voluntary private patient, see the REPORT OF THE JOINT INTERIM COMMITTEE (Wisconsin) which did an excellent job on codifying and improving the commitment statutes of Wisconsin, but failed to do anything on commitment and voluntary admission to private mental hospitals. The Report is printed as a footnote to c. 51, Wis. Stat. (1947).

²⁴ Ala. Code (1940) tit. 22, §§185-190; Ariz. Code Ann. (Supp. 1952) §68-1301; Ark. Stat. Ann. (1947) §82-302; Colo. Stat. Ann. (1952 Repl.) c. 78, §21(5)(14); Del. Code Ann. (1953) tit. 16, §1102; Fla. Stat. Ann. (Supp. 1953) §395.01; Ga. Code Ann. (Supp. 1951) §99-1701; Ind. Stat. Ann. (Burns, 1950) §22-4204; Iowa Code Ann. (1949)

private hospitals. Of these states, only Iowa specifically provides that private mental hospitals cannot detain patients unless committed.²⁵ While it would be possible for these states to authorize by regulation the admission of voluntary patients and their detention for a short time after a request for release, it seems doubtful that reliance on such an administrative order would be a successful defense to an otherwise valid suit by the patient for false imprisonment.

It seems desirable that regulation, involving inspection, licensing and reports, should be done by the same agency that regulates public mental hospitals (state department of mental health) rather than the agency (usually department of health) which regulates non-mental hospitals. This would lead to a sharper focus on the problems of the private mental hospital, both on the part of the legislature and the administrative agency.²⁶

The Application for Admission

Most of the more modern voluntary admission statutes spell out in some detail the form of the application for admission and the conditions under which the procedure may be used. Generally the well-drafted statute expressly covers most or all of the following factors:

1. The patient who seeks admission must be mentally ill, supposed to be mentally ill, in need of treatment or observation, have symptoms of mental illness, or would benefit from treatment. Since one of the principal purposes of admission procedure is to encourage early treatment, the statute should authorize admission, not only of persons mentally ill, but also of those whose mental illness is in an incipient stage.

2. The application must be in writing.

§227.1; Ky. Rev. Stat. (1953) §216.400; Mich. Stat. Ann. (Supp. 1953) §14.850; Minn. Stat. Ann. (1945) §144.50; Miss. Code Ann. (1952) §7146.5-01; Mont. Rev. Stat. (1953) tit. 69, §2903; Neb. Rev. Stat. (1950) §71-2018; Nev. Laws (1951) c. 336; N.H. Laws (1947) c. 216; N.D. Rev. Code (Supp. 1949) §23-1601; Ohio Rev. Code Ann. (Baldwin, 1953) §5123.16; Ore. Rev. Stat. (1953) §441.005; S.D. Code Ann. (Supp. 1952) §27.1201; W.Va. Code Ann. (1949) §2682; Wyo. Comp. Stat. Ann. (Supp. 1953) §63-1101.

²⁵ Iowa Code Ann. (1949) §227.15.

²⁶ Most of the states which authorize the Mental Health Division to regulate private hospitals have adequate voluntary admission statutes. Most of the states which lump mental hospitals together with non-mental hospitals in the regulatory scheme have no voluntary admission procedures. Probably the best examples of integrated agencies regulating public and private mental hospitals are the New York Dept. of Mental Hygiene, 34A N.Y. Consol. Laws (McKinney, 1951) §3 and the California Dept. of Mental Hygiene, Cal. Welfare and Inst. Code (Deering, 1952) §7500.5.

3. The application must be on a form specified by the statute or by the state regulatory agency. Some states require in addition that the application must be witnessed, witnessed by a physician, acknowledged, or approved by the county or probate judge, although these requirements are probably of little value.

4. The application must be signed by the prospective patient. There are two exceptions to this rule. A few states allow the application to be signed by a relative, physician or attorney of the patient, with the oral consent of the patient.²⁷ About half of the states permit a minor (under 21) to be signed in by his parents, parent with custody, guardian of person or next-of-kin, usually in that order. The Draft Act fixes the age of consent at 16 and the authors of the Draft Act state that individuals in their later teens carry responsibilities commensurate with those of adults.²⁸ The commentary to the Draft Act also states: "It may be noted in this connection that, in cases involving the consent of a minor to the performance of surgery upon him, our courts have generally held the consent to be effective where the minor was over 15 years old and sufficiently mature to realize the dangers and benefits of the operation, although this fact has not been elevated to a rule of law."²⁹ No cases are cited and an examination of the decided cases indicates that the conclusion is at least doubtful, as most of the cases approving a minor's consent to surgery are cases where there was implied consent by the parents, or an emergency operation, where no consent was necessary.³⁰ The difficulty with the Draft Act rule is that the hospital administrator is apt to assume that since a sixteen-year-old can consent to detention without parental consent, he can also consent to major treatment (shock treatment, surgery, etc.), a position which the cases do not justify. Of the eight states which have adopted the Draft Act in the past two years, two of them have fixed the age of consent at 21 instead of 16.³¹

²⁷ E.g., Ill. Ann. Stat. (Supp. 1953) c. 91½, §4-1.

²⁸ Draft Act, 18.

²⁹ *Ibid.*

³⁰ *Luka v. Lowrie*, 171 Mich. 122, 136 N.W. 1106 (1912) (emergency); *Bakker v. Welsh*, 144 Mich. 632, 108 N.W. 94 (1906) (consent implied from circumstances). Recent cases are listed and discussed in *Bonner v. Moran*, (D.C. Cir. 1941) 126 F. (2d) 121 (consent of 15 year old boy to skin graft operation held not a valid defense to assault and battery action).

³¹ Ga. Code Ann. (Supp. 1954) §35-241 (modeled on Draft Act for voluntary patients only, age of consent 16); Idaho Code (Supp. 1953) §66-318 (Draft Act, age of consent 16); Mo. Stat. Ann. (Vernon, 1953 Supp.) §202.783 (Draft Act, age of consent 16); N.M. Stat. Ann. (Supp. 1953) §37-229 (Draft Act, age of consent 16); N.D. Laws (1953) c. 186 (modeled on Draft Act, age of consent 16); Okla. Stat. Ann. (Supp. 1953) tit. 43A, §53 (Draft Act, except age of consent 21); S.C. Acts (1952) c. 836, art. II, §1 (modeled on Draft Act, age of consent 21); Utah Code Ann. (1953) §64-7-29 (Draft Act, age of consent 16).

5. Most of the states require that the applicant be mentally competent to make his application and to understand what he is doing, on the sound theory that unless the patient is aware of what he is consenting to, the consent to detention is not voluntary. The Draft Act omits this provision, and the comment by the authors says nothing about the omission, but the requirement would probably be implied from the context. The advantages of voluntary admission should not be denied to a patient who is too incompetent to make his own application, and some provision should be made for such a patient to be admitted on the application of his guardian. However, in such a case, it is probably desirable to safeguard the patient by requiring something more than the application, such as a physician's certificate, or the consent of the probate court which controls the guardian or both. Such an admission procedure is something between voluntary admission and formal commitment and should be treated separately.

6. In all states, the hospital has wide discretion in admitting voluntary patients. Although the Draft Act says that the director of a public hospital "shall admit," this is qualified by the express exception that accommodations must be available and the implied qualification (expressly stated in most statutes) that the head of the hospital must find that the patient would benefit by hospitalization.³²

Rights of the Voluntary Patient

Consideration of the problems of release and the effect of voluntary hospitalization on legal competency will be discussed later; it is worth while now to comment on the various statutory provisions which touch on the status of the patient after he has been admitted. Some of these provisions apply only to voluntary patients while others apply to all mental patients. In some of the more recent mental health codes, and in the commentary to the Draft Act, these provisions are lumped together under a chapter heading, "Rights of the Mentally Ill Patient" or "Patients' Rights and Care." While in principle the enumeration of patients' rights may be objectionable as impinging upon the executive authority of the hospital administration, in practice they probably do not disrupt administration, and in the main reflect the present standards of care in our better-run mental hospitals. Some of the more common enumerated rights of patients are as follows:³³

³² E.g., 34A N.Y. Consol. Laws (McKinney, 1952) §71; Ill. Ann. Stat. (Supp. 1953) c. 91½, §4-1.

³³ A mental patients' "Bill of Rights" enumerating most of the rights discussed above is included in the Draft Act (Part IV—Provisions Applicable to Patients Generally); the Louisiana Mental Health Law of 1946 (Part VI, Rights of Mental Patients) La. Rev. Stat.

1. *Visitation and Communication.* The first right to receive general statutory recognition was the right of communication. Twenty-five states have some provision limiting the traditional right of the hospital staff to cut off visitation and mail service.³⁴ The older statutes authorize each patient to select a single correspondent outside the hospital to whom letters may be sent without censorship. The more recent statutes extend the privilege of mail without censorship to and from a selected class of persons and officials. Section 21 of the Draft Act states the right of communication quite broadly, giving the patient the absolute right to communicate with the central state administration and with the court which ordered his hospitalization, and a qualified right to general communication by mail and visits, together with the requirement that any restraint on these rights be entered as part of the clinical record.

(1950) tit. 28, §171; the Pennsylvania Mental Health Act of 1951 (Art. VIII—Miscellaneous Provisions Relating to Patients and Institutions) Pa. Stat. Ann. (Purdon, 1952 Supp.) tit. 50, §§1481-1484; and the statutes of the states which have recently adopted the Draft Act, note 31 *supra*.

³⁴Cal. Welfare and Inst. Code Ann. (Deering, 1952) §5751 (patient in private mental hospital can inform others of detention by mail) and §7502 (no censorship of mail to superior court, district attorney or dept. of institutions); Conn. Gen. Stat. (1949) §2678 (court may overrule hospital's decision as to visits to patient) and §2679 (mail-censorship forbidden); Fla. Stat. Ann. (1943) §§394.13 to 394.17 (no censorship of mail to one correspondent); Idaho Code (Supp. 1953) §66-346 (same as §21, Draft Act, except no right to write state dept. mental health); Ill. Ann. Stat. (Supp. 1953) c. 91½, §9-8 (no censorship of mail to governor, attorney general, court of record, state attorney, dept. public welfare, or any attorney); Iowa Code Ann. (1949) §226.13 and §229.39 (patient allowed to write once a week "what he pleases"); Kan. Gen. Stat. Ann. (1949) §76-1222 (no censorship of mail to state dept. social welfare); La. Rev. Stat. (1950) tit. 28, §171 (patient may be visited by relatives, physician and minister and may communicate in private with state dept. institutions, and his attorney); Me. Laws (1951) c. 374, §100 (no censorship of mail to state dept. institutions); Md. Ann. Code (1951) art. 59, §34 (no censorship of mail to dept. mental hygiene and one correspondent); Mass. Laws Ann. (1949) c. 123, §§97-99 (court can overrule hospital order barring visitation by attorney, no censorship of mail to dept. mental health); Minn. Stat. Ann. (Supp. 1953) §§253.11 and 253.12 (no censorship of mail to governor, public welfare dept. and one correspondent); Mo. Stat. Ann. (Vernon, 1953 Supp.) §202.847 (same as §21, Draft Act); Mont. Rev. Code (1947) tit. 38, §§112 to 116 (no censorship of mail to one correspondent); Neb. Rev. Stat. (1943) §§83-314 and 83-315 (letters must be mailed unless clearly obscene); N.H. Rev. Laws (1942) c. 17, §31 (no censorship of mail to trustees of state institutions); N.M. Stat. Ann. (Supp. 1953) §37-242 (same as §21, Draft Act); N.D. Rev. Code Ann. (1943) §25-0211 (no censorship of mail to one correspondent); Okla. Stat. Ann. (Supp. 1953) tit. 43A, §93 (substantially same as §21, Draft Act); Pa. Stat. Ann. (Purdon, 1952 Supp.) tit. 50, §1481 (reasonable visitation, private interview with attorney and no censorship of mail to dept. welfare, court, governor or attorney); R.I. Gen. Laws (1938) c. 71, §31 (no censorship of mail to dept. public welfare); S.D. Code Ann. (1939) §30.0124 (no censorship of mail to correspondent); Utah Code Ann. (1953) §64-7-48 (same as §21, Draft Act); Vt. Laws (1951) c. 170, §424 (attorney of patient allowed to visit at all reasonable times); Wis. Stat. (1953) §51.35 (no censorship of mail of patient in public hospital to governor, attorney general, court of record, district attorney, dept. of public welfare or any attorney) and §58.05 (no censorship of mail of patient in private hospital to dept. of public welfare).

Neither the Draft Act, nor the statutes of more than a few states give the patient an unqualified right to communicate with his attorney, although the courts of New York have in two cases severely castigated the Department of Mental Hygiene for denying this right.³⁵

2. *Freedom from Unreasonable Restraint.* Despite adverse publicity, the use of mechanical restraints still plays an important role in our mental hospitals, and will probably continue to do so as long as the hospitals are seriously understaffed.³⁶ The Draft Act and ten of the states provide for statutory controls on the use of restraints.³⁷ In an attempt to discourage the improvident use of restraints by ward attendants, all of these statutes require, in substance, that mechanical restraint must be prescribed for individual patients by a physician as medically necessary. In addition, most of the states require that a report of the restraint be made, together with the reasons for it, and that this report be incorporated in the clinical record of the patient.

3. *Freedom from Publicity.* As long as mental illness carries with it a stigma which does not attach to other forms of disease, patients should receive legislative protection against the social disgrace resulting from morbid curiosity. There are two aspects to the problem: protection of the hospital record and protection of the judicial record. Although the hospital record is generally kept confidential in the absence of legislation, the judicial record (involved in commitments and in proceedings relating to the expense of hospitalization for publicly-supported voluntary patients) is not, as traditionally court records are open to the public. Court records may be kept confidential both to protect the persons involved in the commitment process from the patient, and to protect the patient from adverse publicity in order to encourage early

³⁵ In *People ex rel. Jacobs v. Worthing*, 167 Misc. 702, 4 N.Y.S. (2d) 630 (1938), the court stated as dictum that the denial of a patient's right to mail letters to his attorney relative to a habeas corpus application was an unreasonable and unlawful interference with the patient's right to the Great Writ. In *Hoff v. State*, 279 N.Y. 490, 18 N.E. (2d) 671 (1939), the court held that the state was liable for damages to a patient in a state mental hospital resulting from the superintendent's failure to mail a letter to the patient's attorney, known by the superintendent to contain a petition for a writ of habeas corpus, although the statute did not give the patient an unqualified right to write his attorney, and a general order of the dept. of mental hygiene did give such a right to communicate with the department, governor, district attorneys, and courts of record.

³⁶ See REPORT TO GOVERNORS' CONFERENCE, Appendix Table 27 and Schedule G for a summary of current practices regarding the use of restraints.

³⁷ Draft Act, §20; Idaho Code (Supp. 1953) §66-345; Kan. Gen. Stat. Ann. (1949) §76-1223; Ky. Rev. Stat. (1953) §203.240; Mass. Laws Ann. (1949) c. 123, §§35-38; Mo. Stat. Ann. (Vernon, 1953 Supp.) §202.843; N.M. Stat. Ann. (Supp. 1953) §37-241; Okla. Stat. Ann. (Supp. 1953) tit. 43A, §92; Pa. Stat. Ann. (Purdon, 1952 Supp.) tit. 50, §1481.1; Tex. Civ. Stat. Ann. (Vernon, 1952) art. 3193k, l and m; Utah Code Ann. (1953) §64-7-47.

hospitalization.³⁸ A number of states now provide for sealed records, either for voluntary patients or for all patients.³⁹ Section 23 of the Draft Act requires that records be kept confidential except where consent to disclose is given, where disclosure is necessary to carry out the act, where a court may order disclosure if necessary for a pending case, or where disclosure of current medical status is sought by the patient's family or friends. A criminal penalty is attached for violation of the section.

An interesting side-light on the problem is afforded by a recent action of the Idaho legislature. Idaho adopted section 23 of the Draft Act in 1951. In 1953, the statute was amended to provide: "Nothing in this section shall preclude disclosure on proper inquiry, of any information contained in such . . . reports . . . to abstractors, title insurance companies in connection with title matters relating to title to real property in which the patient has or had some interest, lawyers. . . ."⁴⁰ While at first glance it might seem that the legislature had misconstrued one of the basic purposes of the Draft Act, i.e., the complete separation of hospitalization and incompetency proceedings, nevertheless this amendment reflects a real problem. If a patient who is a resident in a mental hospital is preparing to sell land, the vendee will certainly know about the fact of hospitalization and might require the appointment of a guardian or a judicial declaration of competency. However, where the patient is not a resident in a hospital, but on conditional release,⁴¹ the prospective vendee would probably have a legitimate interest in inquiring of the hospital as to the vendor's current status.

³⁸ A good example of both policy factors at work is illustrated by recent Wisconsin legislation. Judicial records involving both voluntary and committed patients were made confidential in 1947. Wis. Stat. (1947) §51.30. Subsequent to 1947, in two cases, released mental patients assaulted those who had petitioned for their commitment. In each case it was discovered that the patients had been in hospitals where trusted patients were allowed to assist the staff in administrative duties and thus had access to patient files. By this means word got back to the patients as to the names of those who had petitioned for their commitment. On the request of the Board of County Judges this problem was dealt with by the legislature. Wis. Laws (1953) c. 260, provides that when the county judge forwards copies of commitment records to the hospital, the names of the petitioners shall be deleted.

³⁹ Idaho Code (Supp. 1953) §66-348 (Draft Act); Ill. Ann. Stat. (Supp. 1953) c. 91½, §4-5 (hospital records of voluntary patients confidential); Iowa Code Ann. (1949) §218.22 (patient's record confidential); Mo. Stat. Ann. (Vernon, 1953 Supp.) §202.853 (Draft Act); N.M. Stat. Ann. (Supp. 1953) §37-244 (Draft Act); 34A N.Y. Consol. Laws (McKinney, 1951) §§20 and 34(9) (hospital records private); S.C. Acts (1952) c. 836, art. IV, §9; Utah Code Ann. (1953) §64-7-50; Wash. Rev. Code (1951) §71.02.250 (court records confidential); Wis. Stat. (1953) §51.30 (court records sealed, may be released if relevant to pending action).

⁴⁰ Idaho Code (Supp. 1953) §66-348.

⁴¹ Throughout this paper the term "conditional release" is used to describe a situation where the patient is carried on the books of the hospital but is not a resident. The older statutes use the terms "parole" or "furlough" while the more recent statutes use "home care," "trial visit," "convalescent leave" or "conditional release."

The Idaho exception is too broadly stated, as it is difficult to see how the title lawyer or abstractor has any real interest except in the one situation where the nonresident patient is a vendor. It should also be noted that the amendment does not require disclosure, it merely exempts the hospital authorities from criminal sanctions for making disclosure. Another apparent defect in drafting is that while title companies must be concerned with title, there is no such qualification for abstractors and attorneys. Possibly a better solution would be to require the central state authority (department of mental health), which keeps a roster of all patients, to inform attorneys and title insurance companies whether or not an individual named in the request is carried on the books of any mental hospital in the state, his current status (resident or conditional release), and how long he has been a patient.

4. *Other Rights Recognized or Created by the Legislature.* In addition to the rights already enumerated, there are a number of others, which in general are expressed in vague terms and remind one of the right to equal protection of the laws found in the United States Constitution, or the right to receive justice found in many of the state constitutions. Freedoms which have achieved legislative recognition are (1) a right to humane care and treatment in accordance with the highest standards of the medical profession, including regular physical and mental examinations;⁴² (2) the right to exercise religious freedom, including visits by a minister and participation in church services;⁴³ and (3) the right to be gainfully employed at a useful occupation where medically feasible, and to keep or sell the fruits of one's labors.⁴⁴

The Effect of Voluntary Hospitalization on Competency

1. *The Statutes.* The prospective voluntary patient is apt to be concerned with the legal effect of his admission on his competency. Does the fact of admission mean that the patient is deprived of the power to perform legally effective acts? Unfortunately, the law on

⁴² Cal. Welfare and Inst. Code Ann. (1952) §6621 (right to thorough mental and physical examination within three days of admission); Idaho Code (Supp. 1953) §66-344 (humane care and treatment); Iowa Code Ann. (1949) §225.15 (immediate medical examination); Mo. Stat. Ann. (Vernon, 1953 Supp.) §202.840 (humane care and treatment); N.M. Stat. Ann. (Supp. 1953) §37-240 (humane care and treatment); Okla. Stat. Ann. (Supp. 1953) tit. 43A, §91 (humane care and treatment, no punishment); Utah Code Ann. (1953) §64-7-46 (humane care and treatment).

⁴³ Iowa Code Ann. (1949) §218.26; La. Rev. Stat. (1950) tit. 28, §171(2); Pa. Stat. Ann. (Purdon, 1952 Supp.) tit. 50, §1481(2).

⁴⁴ La. Rev. Stat. (1950) tit. 28, §171(3)(4); Pa. Stat. Ann. (Purdon, 1953 Supp.) tit. 50, §§1481(3)(4) and 1484.

this subject is confused and uncertain, and both courts and legislative draftsmen have had a great deal of difficulty in determining the relationship between hospitalization and competency. One of the difficulties is caused by the fact that the traditional rules of competency are phrased in terms of one conclusion (incapacity) following from another conclusion (insanity), rather than from a specific set of facts. The rules say, "If a person is insane, or of unsound mind, he cannot commit a crime, serve on a jury, vote, make a contract or conveyance, etc." rather than, "If a person is a patient in a mental hospital, he cannot vote, etc." Another source of confusion is the use of a dual terminology. In the older cases and statutes, the same term, insanity, was used indiscriminately to mean the condition which justified legal loss of competency and the prerequisite for admission to a mental hospital. A third factor which has tended to perpetuate the confusion is that hospitalization and commitment laws are almost entirely statutory. Misled by the indiscriminate terminology, legislative draftsmen have generally failed to think the problem through and have introduced conflicting rules on the effect of hospitalization. On the whole, the courts have been able to work out the policy factors quite well, but all too frequently they have been handicapped by poorly drafted legislation.

Only a handful of states have attempted to work out the problem by statute. The recent Illinois Mental Health Act attacks the problem by dividing mental patients into three classes: committed "mentally ill persons" (loss of competency), committed "persons in need of mental treatment" (no loss of competency), and voluntary patients, who may be either mentally ill or in need of mental treatment. The statute provides that both classes of voluntary patients retain their competency. "No voluntary application for admission . . . and no admission . . . shall be so construed as to deprive any patient of his civil rights. . . ."⁴⁵ Ohio, Oklahoma and Washington also distinguish between voluntary patients and others, providing by statute that voluntary patients retain competency while committed patients do not.⁴⁶

The Draft Act, in enumerating the rights of mental patients in section 21(3), provides that "every patient shall be entitled to exercise all civil rights, including the right to dispose of property, execute in-

⁴⁵ Ill. Ann. Stat. (Supp. 1953) c. 91½, §4-8.

⁴⁶ Ohio Rev. Code Ann. (Baldwin, 1953) §5123.57 (no patient, except voluntary patient, is competent to make contract, conveyance, etc.); Okla. Stat. Ann. (Supp. 1953) tit. 43A, §64 (no patient in state mental hospital shall be considered legally incompetent, except those judicially committed) and Wash. Rev. Code (1951) §§71.02.040 and 71.02.650 (committed patients incompetent, voluntary patient does not suffer loss of competency by reason of admission).

struments, make purchases, enter contractual relationships and vote, unless he has been adjudicated incompetent and has not been restored to legal capacity." The Author's Commentary states, "The right to full enjoyment of personal rights as specified in paragraph (3) [of section 21] follows naturally from the fact that, under the theory of the Act, a determination that hospitalization is justified is entirely different and separate from an adjudication of incompetency. Loss of the right to vote, to dispose of property, and similar rights flows only from the latter type of judicial action."⁴⁷ The last sentence of the above seems inconsistent with the provision of section 21 that the enumerated rights are subject to the general rules of the hospital and to the restrictions which may be placed on a patient's rights by the head of the hospital. The Draft Act apparently leaves open the question of how far the hospital may go in denying the patient the exercise of his civil rights and the question of the validity of the patient's exercise of his rights contrary to the regulations of the hospital.

To date, only four states have adopted the Draft Act provision on civil rights,⁴⁸ and one state, South Carolina, adopted the Draft Act and section 21, but omitted any reference to civil rights.⁴⁹

As might be expected from the fact that it has more mental patients than any other state, New York has the most detailed provisions on competency of patients. New York seems to be the only state which by its legislative provisions recognizes that there are two separate aspects to the problem. The first problem is one of administrative control over the patients, i.e., how far can the hospital authorities go in denying a patient his normal legal rights. The second problem is essentially one of evidence. What is the value of evidence of hospitalization as a mental patient in a proceeding to avoid a contract, deed or mortgage, or to appoint or remove a guardian? Is it conclusive on the issue of lack of legal capacity? Prima facie evidence? Of some value? Or inadmissible? The New York statute does not cover the evidence problem but the statute implies that hospitalization does result in incompetency. As to the first problem of control over the patient, section 34 of the Mental Hygiene Law authorizes the hospital superintendent to act in a limited way as a guardian for any patient who has no guardian. The superintendent may receive up to \$1,000 on behalf of the patient, invest it in United States bonds, and may execute checks, receipts or other docu-

⁴⁷ Draft Act, 33.

⁴⁸ Idaho Code (Supp. 1953) §66-346; Mo. Stat. Ann. (Vernon, 1953 Supp.) §202.847; N.M. Stat. Ann. (Supp. 1953) §37-242; Utah Code Ann. (1953) §64-7-48.

⁴⁹ S.C. Acts (1952) c. 836, art. IV, §7 (same as §21, Draft Act, except ¶3 omitted).

ments for the patient. In addition, General Order No. 10 of the Commissioner of Mental Hygiene provides that no patient may accept service of process or execute a will, conveyance or contract without an order from a court of record, except that patients may cash or endorse checks of less than \$100 with the permission of the hospital director or may endorse checks for deposit with the hospital.⁵⁰

As to the other states, there are no cases or statutes on the competency of voluntary patients. A few states have statutes which state that committed patients do not lose their capacity, and these provisions would probably be extended by analogy to cover voluntary patients.⁵¹ Conversely, a number of states have provisions which imply that all patients lose their legal capacity. For example, Wisconsin Statutes (1953) section 51.13 provides that any patient may be granted a conditional release and that one year after this release is granted, the patient shall be presumed competent and his civil rights are restored. The statute makes no distinction between voluntary and involuntary patients, nor does it apply only to patients under guardianship. A court could interpret this statute to mean that a patient under guardianship is restored to competency and the guardianship is terminated one year after release (except for the ministerial acts involved in approving accounts and winding up the guardianship). However, a strong case could be made for the argument that the statute states a legislative policy that all patients are incompetent, or are prima facie incompetent. A number of other states have similar provisions implying incompetency either by providing for restoration of competency on discharge, for all patients or committed patients, or by providing a close tie-up between hospitalization and incompetency proceedings.⁵²

2. *The Cases.* Although there are no cases on the issue of competency involving voluntary patients, some idea of how the courts would be likely to handle the problem can be gained by looking at the cases

⁵⁰ General Order No. 10 is printed as a footnote to §34, in 34A N.Y. Consol. Laws (McKinney, 1953 Supp.). Section 34 applies to all patients, voluntary and involuntary, but there is some doubt as to whether or not the General Order covers all patients, or just those who are in fact mentally ill, as opposed to those voluntary patients who are "suitable for care and treatment" under §71.

⁵¹ Del. Code Ann. (1953) tit. 16, §5126 (commitment shall raise no presumption against the sanity of the person committed); S.D. Code Ann. (1939) §30.0109 (commitment has no legal effect on guardianship—only effect is to give custody of person to hospital) and §30.01A07 (Supp. 1952) (temporary commitment for observation does not affect legal capacity); Tex. Civ. Stat. Ann. (Vernon, 1952) art. 31930-1.(5) (temporary observation commitment does not affect legal capacity).

⁵² Ark. Stat. Ann. (1947) §59-235; Ind. Stat. Ann. (Burns, 1950) §22-1207; Miss. Code Ann. (1942) §6909-02; Mont. Rev. Code (1947) tit. 38, §506; Tenn. Code Ann. (Williams, 1934) §4478.

involving patients who have been committed, either for short periods for observation, or for indefinite periods. On the question of how far the hospital administrator can go in denying a patient the exercise of his normal legal rights there are very few cases and these tend to favor the patient.⁵³ On the evidence issue, the courts have ranged from one extreme to the other, saying that evidence of commitment is conclusive on the issue of competency, or that it is inadmissible, or that its effect is somewhere in between. Handicapped by poorly drafted statutes, many courts have, on the whole, failed to look at the policy problems involved so that there is a wide divergence of holdings, with a good many unfortunate decisions.

Although the problem of the effect of commitment can arise in almost an infinite number of types of proceedings, the courts of any one state generally treat all of the cases alike, with the sole exception of criminal cases. Even in those states which equate hospitalization with incompetency, the universal rule is that hospitalization is never conclusive on the issue of criminal responsibility. The courts which have passed on the problem frequently talk in terms of the time lag. The argument is that although a defendant may be judicially committed and then, before discharge, commit a crime, the time interval between the judgment and the act is great enough so that the defendant might have recovered his sanity, and therefore he cannot be conclusively presumed to be insane. However, in the one case where the time interval was cut down to seconds, and the ink on the commitment papers was literally still wet at the time of the criminal act, the California court had no real difficulty in upholding the conviction.⁵⁴

A minority of states hold, even in the absence of clear-cut statutory directions, that commitment means incompetency. These decisions are generally characterized by rigid and mechanistic application of principles without any real understanding of the policy problems involved. The courts tend to reason that insanity means commitment and insanity also means incompetency, so that commitment automatically results in total legal incompetency. Typical of this inflexible failure to differentiate between the policy issues bearing on hospitalization and those

⁵³ See note 35 supra.

⁵⁴ In *People v. Willard*, 150 Cal. 543, 89 P. 124 (1907), the defendant was taken before the superior court for a commitment hearing. After testimony of physicians that Willard was "insane, homicidal and dangerous" the judge orally adjudged him insane and committed him to the state hospital. As the judge began signing the order of commitment, Willard drew a pistol from his pocket and shot and killed the complaining witness. The conviction for murder was upheld.

bearing on competency is the Colorado case of *Rohrer v. Darrow*.⁵⁵ In 1901 Mrs. Rohrer was committed by the Denver county court to a private mental hospital. In 1903 she was conditionally released to the custody of her husband. She spent the next fourteen years working as a bookkeeper for her husband who was a banker and real estate agent. Mrs. Rohrer was a partner in some of her husband's enterprises; she purchased and sold land in her own name and was a notary public. Apparently through some oversight, she never received a formal discharge from the mental hospital. In 1917 she conveyed a parcel of land to the defendant and shortly thereafter sued to rescind the conveyance on the ground of incompetency. There was no evidence of overreaching on the part of the defendant, nor was the consideration inadequate, and the only evidence offered on the issue of incompetency was the commitment of 1901 and the lack of any discharge. The trial court authorized a compromise of the suit and the Colorado Supreme Court reversed on the ground that since the grantor was conclusively proved to be incompetent the deed was absolutely void and no compromise of her rights would be permitted.

A more recent case which illustrates the same attitude is *Sanders v. Omohundro*,⁵⁶ an action to compel the vendee under a land contract to accept a deed to the property. The vendee objected that title was defective in that the vendor had purchased from an illegally appointed guardian. The guardian had been appointed by an Arkansas probate court without notice to the ward. Apparently, the only evidence of incompetency was a letter addressed "To whom it may concern" stating that the patient was mentally ill, was confined in a private mental hospital in Dearborn, Michigan, and was incapable of caring for her person or property. The letter was signed by a physician on the hospital staff. The Arkansas court affirmed a decree of specific performance in favor of the vendor, stating that insanity is presumed from the fact of confinement. The court had no comment on the lack of notice to the ward, either of the appointment or of the sale, nor did it object to the lack of evidence of incompetency.⁵⁷

⁵⁵ 66 Colo. 463, 182 P. 13 (1919).

⁵⁶ 204 Ark. 1040, 166 S.W. (2d) 657 (1942).

⁵⁷ Other recent cases involving a conclusive presumption of incompetency resulting from commitment are *Cubbison v. Cubbison*, 45 Ariz. 14, 40 P. (2d) 86 (1935) (proof that defendant in divorce suit was committed and then discharged, but not judicially restored to competency is sufficient to vacate divorce judgment where defendant not represented by guardian ad litem); *In re Ost*, 211 Iowa 1085, 235 N.W. 70 (1931) (dictum—court states that it is improbable, if indeed not impossible, for a patient in a mental hospital successfully to force termination of guardianship prior to discharge); *Walker v. Graves*, 174 Tenn. 336, 125 S.W. (2d) 154 (1939) (four years after commitment, general guardian could be appointed for patient in mental hospital without notice to patient).

At the other end of the spectrum, a small minority holds that evidence of commitment is not only not conclusive on the issue of capacity, but is inadmissible. The two cases which are most frequently cited are *Leggate v. Clark*⁵⁸ and *Knox v. Haug*.⁵⁹ In the *Leggate* case a wife sued to avoid a deed executed by her on the ground that her husband, who joined in the conveyance, was incompetent. The trial court ruled that the order of a probate court committing the husband to a mental hospital was admissible and prima facie evidence of incompetency. The Supreme Court held the evidence to be inadmissible and ordered a new trial on the issue of incompetency, although there was other evidence which tended to prove incompetency. In the *Knox* case, the grantor deeded to the first grantee, was then committed to a mental hospital, and while on conditional release conveyed the same tract to the second grantee. The dispute was between the first grantee and the second grantee, who was fortunate enough to record his deed first. The only evidence of the incompetency of the grantor was the evidence of commitment. The court affirmed a judgment in favor of the second grantee, stating that a patient may be sufficiently unbalanced to need treatment but still be competent to dispose of his property. It is interesting to note that although the case turned on the sufficiency of the evidence, the *Knox* case has been repeatedly cited by digests, text writers and other courts as holding that the evidence is not admissible, an issue which was not before the Minnesota court.⁶⁰ The position taken in the *Leggate* case has been severely criticized by Professor Wigmore⁶¹ and by a number of courts which have passed on the issue,⁶² although it has been adopted by Nebraska and a few other courts.⁶³

⁵⁸ 111 Mass. 308 (1873).

⁵⁹ 48 Minn. 58, 50 N.W. 934 (1892).

⁶⁰ Apparently the writers have been misled by the court's headnote to the effect that commitment is ". . . not evidence of mental incapacity." This is an ambiguous statement which could refer to either admissibility or sufficiency of evidence. When the Nebraska court was faced with the issue of admissibility, it held that the evidence is not admissible, citing the *Knox* case. *Dewey v. Allgire*, 37 Neb. 6, 55 N.W. 276 (1893). The *Knox* case is cited as standing for inadmissibility and disapproved in *Martello v. Cagliostro*, 202 N.Y.S. 703 (1924) and *Maas v. Territory*, 10 Okla. 714, 63 P. 960 (1901).

⁶¹ 5 WIGMORE, EVIDENCE, 3d ed., §1671 (1940).

⁶² For an excellent discussion of the admissibility problem see *Rawson v. Hardy*, 88 Utah 109, 39 P. (2d) 755 (1935), in which the court discussed the *Leggate* case and others following it and disapproved of the rule.

⁶³ *Keely v. Moore*, 196 U.S. 38, 25 S.Ct. 169 (1904) (will contest—Supreme Court did not discuss admissibility of the fact of the testator's commitment, but did hold that the commitment papers were properly excluded, citing the *Leggate* case with approval); *Lewandowski v. Zuzak*, 305 Ill. 612, 137 N.E. 500 (1922) (will contest—reversed and new trial where commitment papers introduced); *Hicks v. State*, 165 Ind. 440, 75 N.E. 641 (1905) (commitment not admissible to impeach witness); *Wager v. Wagoner*, 53 Neb. 511, 73 N.W. 937 (1898); *Dewey v. Allgire*, 37 Neb. 6, 55 N.W. 276 (1893) (action to rescind conveyance—commitment evidence inadmissible). But cf. *Mitchell v. Mitchell*, 312

The majority of states have held that evidence of hospitalization is both admissible⁶⁴ and is entitled to some weight in proving incompetency. The most common expression is that commitment results in a rebuttable presumption of incompetency (or is prima facie evidence of incompetency) and that a final discharge from a mental hospital results in a rebuttable presumption of competency.⁶⁵ Weight of evidence is never a clear-cut thing like admissibility, and the courts shift back and forth between the language of prima facie evidence and rebuttable presumptions.⁶⁶ However, by examining in each case the amount of other evidence on incompetency, it is possible to discern a line of authority which gives greater weight to the presumption and a recent and growing trend to consider the evidence of less value. An example of this modern trend is *Finch v. Goldstein*⁶⁷ where Finch, a committed resident patient in a mental hospital, conveyed a farm to the defendant, taking back a purchase money mortgage. After the conveyance was made, a guardian was appointed for Finch. The guardian sued to foreclose the mortgage. The defendant pleaded the incompetency of the grantor and asked for rescission of both deed and mortgage and the return of his purchase price. The court held that a conveyance made prior to an adjudication of incompetency is not void, and that a judicial commitment is not such an adjudication. A number of other states are in accord, both on the proposition that evidence of commitment alone

Mass. 165, 43 N.E. (2d) 779 (1942); *Skelton v. State*, 148 Neb. 30, 26 N.W. (2d) 378 (1947).

⁶⁴ The commitment is admissible only if it is not too remote in time from the acts which are involved in the incompetency proceeding. The courts generally say that the trial courts have a wide discretion in determining the length of time that must pass before the evidence becomes immaterial. Since evidence of commitment is likely to seem quite conclusive to a jury, the jury should be carefully instructed on the weight and effect of the evidence. *Rawson v. Hardy*, 88 Utah 109, 39 P. (2d) 755 (1935); and 5 WIGMORE, EVIDENCE, 3d ed., §1671 (1940).

⁶⁵ One court has held that a final discharge is not necessary to restore the presumption of competency, and that a conditional release is sufficient. *Brewer v. Hunter*, (10th Cir. 1947) 163 F. (2d) 341.

⁶⁶ With the exception of criminal cases, most decisions on incompetency are those where the court determines both the law and the facts. Court cases are especially difficult to analyze in terms of the language of presumptions, since there is no sharp distinction between what the courts tell the jury and what the court bases its decision on. In these cases the term "presumption" is used in one or more of the following senses: (1) as a rule of procedure which changes the burden of producing evidence and results in a directed verdict if no contrary evidence is produced, (2) as an inference of fact, (3) as a label used in locating the burden of persuasion on a given issue, (4) as an authoritative principle or assumption used as a starting point in legal reasoning, and (5) as indicating a general policy disposition or attitude on the part of the court.

⁶⁷ 245 N.Y. 300, 157 N.E. 146 (1927).

is insufficient to justify a finding of incompetency⁶⁸ and on the proposition not directly involved in the *Finch* case, but implied in the decision, that the evidence is of slight weight.⁶⁹

What are the policy factors involved in deciding these issues of admissibility and weight of evidence of hospitalization? A sound argument can be made for the view that the evidence should be admissible and should be entitled at least to the status of an inference of fact, entitling the party who produces the evidence to get to the jury. Psychiatric examinations are rare enough in criminal cases and almost unheard of in civil cases, so that frequently the evidence of hospitalization is the only evidence available to the party who alleges incompetency. On the other hand, if too much weight is attached to such evidence, it will discourage patients from seeking early psychiatric assistance, a factor which is of particular importance to the voluntary patient. In any event, it seems clear that hospitalization should not result in a conclusive or even a very strong presumption of incompetency, since even judicial hospitalization for an indefinite period involves a rather summary proceeding. Another factor is the increased use of out-patient clinics, conditional release, psychiatric social case work and other recently adopted procedures which involve short periods of hospitalization and frequent discharge and re-entry, rather than a single period of long-term custodial care. A change in legal status every few weeks would clearly be psychologically harmful for these "in and out" patients, and would promote uncertainty of the law and of legal transactions.

⁶⁸ *Fetterley v. Randall*, 92 Cal. App. 411, 268 P. 434 (1928) (evidence that contract was made on same day that promisor was committed to a mental hospital held insufficient to justify finding of incompetency); *Fleming v. Bithell*, 56 Idaho 261, 52 P. (2d) 1099 (1935); *Knox v. Haug*, 48 Minn. 58, 50 N.W. 934 (1892).

⁶⁹ *Watson v. Banks*, 154 Ark. 396, 243 S.W. 844 (1922); *People v. Willard*, 150 Cal. 543, 89 P. 124 (1907); *People v. Field*, 108 Cal. App. (2d) 496, 238 P. (2d) 1052 (1951); *Livaudais v. Bynum*, 165 La. 890, 116 S. 223 (1928); *Vance v. Ellerbe*, 150 La. 388, 90 S. 735 (1922); *Quarterman v. Quarterman*, 39 N.Y.S. (2d) 737 (1943); *Sullivan v. Whitney*, 25 N.Y.S. (2d) 762 (1941); *Martello v. Cagliostro*, 202 N.Y.S. 703 (1924) (good discussion of cases on evidentiary value of commitment); *Herr v. Herr*, 56 Pa. D. & C. 421 (1946); *Ryman's Case*, 139 Pa. Super. 212, 11 A. (2d) 677 (1940); *Rawson v. Hardy*, 88 Utah 109, 39 P. (2d) 755 (1935). See *Topeka Water-Supply Co. v. Root*, 56 Kan. 187, 42 P. 715 (1895); *Fay v. Metropolitan Life Ins. Co.*, 220 Iowa 628, 263 N.W. 14 (1935). Not only is commitment not conclusive on competency, but the converse is also true, i.e., a final discharge from a mental hospital is not conclusive in a later proceeding to terminate a guardianship. In *re Pfeiffer*, 10 Wash. (2d) 703, 118 P. (2d) 158 (1941). A further indication of the trend to separate commitment and incompetency proceedings is seen in the reverse side of the *Pfeiffer* case. See *In re Zanetti*, 34 Cal. (2d) 136, 208 P. (2d) 657 (1949), which held that a judicial proceeding to "restore competency" and terminate a guardianship did not per se require the discharge of the committed ward from a mental hospital.

Release or Discharge of the Patient

Advances in psychiatry make it likely that most voluntary patients will be released as cured or improved within a relatively short time.⁷⁰ This fact indicates that carefully drawn release provisions are a very important part of the voluntary hospitalization procedure. Practically all of the states, either by express statutes or by implication, give the hospital authority the power to discharge a patient completely or to grant a conditional release. The conditional release is seldom used for voluntary patients but with the growth of out-patient clinics connected with the mental hospital, there may be some cases where the device would be desirable. In any event, the statutes should authorize its use at the discretion of the head of the hospital. Sections 15 and 16 of the Draft Act are typical of most state statutes. Section 15 provides that patients shall be examined periodically, be discharged at the discretion of the head of the hospital, and a report made to the central state mental health agency. Section 16 allows the release of a patient on condition that he continue to receive non-hospital treatment, or on other reasonable conditions. The patient can be re-hospitalized without further formalities if he fails to abide by the conditions.

Most of the difficulties over release occur where the patient desires to be released, but the hospital head feels that release is undesirable. There are two competing policy considerations to be weighed. Complete freedom to leave at any time would result in a number of patients leaving soon after admission, and this would seriously disrupt the program of treatment. Detention, however, would be difficult to justify legally and would discourage the use of voluntary hospitalization. Some compromise is necessary which will assure the patient that entry into a mental hospital is not a one-way street, and at the same time allow the hospital authorities a reasonable time to determine whether or not the patient is ready to be released. This compromise is achieved, with varying degrees of success, by the use of one or more of the following procedures:

1. The requirement, by statute or contract, that a patient must be released a specified number of days after he applies for release, or forthwith, unless commitment proceedings are started.
2. The fixing of a maximum time limit on each period of voluntary admission.

⁷⁰ Jones and Hughes, "Washington Experience with Voluntary Admission to a State Hospital for Observation and Treatment," 50 N.W. MEDICINE 933 (1951).

3. The provision for release after a hearing on the issue of need for hospitalization, either by a court or an administrative agency.

1. *Release after notice by the patient.* By far the most common is the procedure for release a short period after an application for release. Most of the statutes state that the patient "shall not be detained" for more than a specified number of days after a written request for release. A well-drafted statute would cover both aspects of the release procedure, i.e., it should specifically authorize detention during the waiting period, exempting the hospital from liability for false imprisonment, and it should specifically require release at the end of the period. The statute should also specify that if the patient is a minor, the hospital should be allowed to refuse to release him unless his parent or guardian joins in the application for release. While it is desirable to allow persons other than the adult patient to request his release, the patient's wishes should prevail in case of disagreement. Accordingly, the statute should also permit application for release to be made by a guardian, spouse or relative, but release should be conditioned on the consent of the patient.

Most psychiatrists feel that the waiting period should be about ten to fifteen days, in order to permit a complete examination of the patient and the commencement of formal judicial commitment proceedings if discharge is unwarranted.⁷¹ In the thirty-two states which have specified detention periods, the period varies from three days, which seems to be too short, to thirty-five days.⁷² In addition to the statutory detention period, three states have provisions fixing the minimum length of

⁷¹ REPORT TO GOVERNORS' CONFERENCE, 57.

⁷² Ariz. Code Ann. (Supp. 1952) §8-210 (10 days); Ark. Stat. Ann. (1947) §59-236 (30 days); Cal. Welfare and Inst. Code (Deering, 1952) §5750.5 (private hospitals—7 days), §6003 (county psychopathic hospital—7 days) and §6602 (state hospital—7 days); Colo. Stat. Ann. (1935) c. 105, §47 (3 days); Conn. Gen. Stat. (1949) §2655 (10 days); Idaho Code (Supp. 1953) §66-320 (7 days); Ill. Rev. Stat. (1953) c. 91½, §4-2 (15 days) and c. 91, §8-2 (20 days for V.A. hospitals); Kan. Gen. Stat. Ann. (1949) §76-1233 (10 days); Ky. Rev. Stat. (Supp. 1954) §203.020 (5 days); Me. Laws (1951) c. 374, §111 (state hospital—10 days) and Me. Rev. Stat. (1944) c. 23, §146 (private hospital—5 days); Md. Ann. Code (1951) art. 59, §36 (3 days); Mass. Laws Ann. (1949) c. 123, §86 (3 days); Mich. Stat. Ann. (Supp. 1953) §14.809(1) (5 days); Minn. Stat. Ann. (Supp. 1953) §525.75 (3 days); Neb. Rev. Stat. (1950) §83-324 (10 days); Nev. Laws (1951) c. 331, §51 (7 days); N.H. Laws (1949) c. 112 (15 days); N.J. Rev. Stat. (Supp. 1940) §30:4-48 (10 days); 34A N.Y. Consol. Laws (McKinney, 1951) §71 (15 days); N.C. Gen. Stat. (1952) §122-62 (10 days); N.D. Laws (1953) c. 186 (3 days); Ohio Rev. Code Ann. (Baldwin, 1953) §5123.45 (10 days); Okla. Stat. Ann. (Supp. 1953) tit. 43A, §53 (15 days); Pa. Stat. Ann. (Purdon, 1953 Supp.) tit. 50, §1162 (10 days); R.I. Gen. Laws (1938) c. 71, §41 (3 days); Tex. Civ. Stat. Ann. (Vernon, 1952) art. 3193h (3 days); Vt. Laws (1951) c. 170, §363 (5 days); Va. Code Ann. (1950) §37-114 (10 days); Wash. Rev. Code (1951) §71.02.050 (12 days); W.Va. Code Ann. (1949) §2669 (15 days); Wis. Stat. (1953) §51.10 (35 days); Wyo. Comp. Stat. Ann. (1945) §51-402 (10 days).

any one period of voluntary treatment. In addition to the Draft Act provision, Idaho has an alternate voluntary admission procedure which provides for release on two weeks notice with a minimum period of hospitalization of nine weeks.⁷³ The New York statute permits detention for the first 75 days after admission⁷⁴ and the New Hampshire statute permits detention for the first 60 days.⁷⁵

Two states, Indiana and Iowa, provide only that the application of the patient shall include an agreement that the patient shall give notice a specified number of days before asking for release.⁷⁶ It seems clear that this type of release procedure is inadequate in that it would not justify the patient's detention during the waiting period. At the most, the agreement constitutes a contract to give notice and could be the basis of an action for damages by the hospital, although it is hard to imagine what damages the hospital could recover.

The Draft Act appears to be deficient in that it does not permit a detention period after a request for release, unless in fact the hospital authority determines that the patient should not be released.

"A voluntary patient who requests his release . . . shall be released *forthwith* except that . . . if the head of the hospital, within 48 hours from the receipt of the request, files with the (*probate*) court . . . a certification that in his opinion the release of the patient would be unsafe . . . release may be postponed . . . for the commencement of proceedings for the judicial hospitalization, but in no event for more than five days."⁷⁷

Notice that detention is authorized only if the head of the hospital decides that it is unsafe to release the patient. Suppose that a patient requests his release and is then detained for 24 hours while he is examined. The physician decides that the patient can be released and he is then released. Would the patient have an action for damages for false imprisonment against the hospital? The answer to this question depends on just what the court would do with that flexible word "*forthwith*." The more recent cases indicate that in situations involving personal liberty, the term "*forthwith*" is construed to mean without delay, or a

⁷³ Idaho Code (Supp. 1953) §66-323.

⁷⁴ 34A N.Y. Consol. Laws (McKinney, 1951) §71.

⁷⁵ N.H. Laws (1949) c. 112.

⁷⁶ Ind. Stat. Ann. (Burns, 1950) §22-1301 (patient must agree to give 10 days notice of desire to leave); Iowa Code Ann. (1949) §229.41 (patient must agree to give 3 days notice prior to demanding his discharge).

⁷⁷ Draft Act, §4.

very short period of time.⁷⁸ It should also be noted that an action for false imprisonment may be grounded on an unlawful detention of momentary duration.⁷⁹

It is perhaps significant that of the eight states which have adopted the Draft Act in the past two years,⁸⁰ only New Mexico has adopted the Draft Act release provisions.⁸¹ Three of the states abandoned the "release forthwith" provision and provide for a fixed period of detention.⁸² Four of the states kept the "release forthwith" provision, but lengthened the time which the hospital has to start commitment proceedings, or lengthened the period for which release can be postponed when commitment proceedings have been started.⁸³

2. *Duty to inform the patient of his right to release.* One of the legal problems that could arise in any of the thirty-nine states which provide for release on notice is the question of how far the hospital authorities must go in advising the voluntary patient of his right to release and in assisting him in the exercise of this right. Unless the patient is informed of his right to request release and is assisted in making his request, the right of release on notice may have no real meaning. Only a few states specifically require that voluntary patients be advised of their right to request release, and these statutes require that the information be given the patient only when he is first admitted.⁸⁴ The

⁷⁸ *State v. Baker*, 3 N.J. Misc. 324, 129 A. 466 (1925); *In re Edson*, 85 Vt. 366, 82 A. 664 (1912); *State ex rel. Traister v. Mahoney*, 196 Wis. 113, 219 N.W. 380 (1928). See *In re Rose*, 90 Cal. App. (2d) 299, 202 P. (2d) 1064 (1949); *Peloquin v. Hibner*, 231 Wis. 77, 285 N.W. 380 (1939).

⁷⁹ *Parrott v. Bank of America*, 97 Cal. App. (2d) 14, 217 P. (2d) 89 (1950) (\$30,000 verdict affirmed for 3 hours detention); *Great Atlantic & Pacific Tea Co. v. Smith*, 281 Ky. 583, 136 S.W. (2d) 759 (1940) (\$2,000 verdict affirmed for one or two minutes detention); 1 TORTS RESTATEMENT §35 (1934) (false imprisonment may be for any time, no matter how short in duration).

⁸⁰ See note 31 supra.

⁸¹ N.M. Stat. Ann. (Supp. 1953) §37-231.

⁸² Idaho, North Dakota and Oklahoma. See note 72 supra.

⁸³ Ga. Code Ann. (Supp. 1954) §35-243 [release forthwith, except release can be postponed indefinitely (not 5 days) if commitment started within 30 days (not 48 hours) after request for release]; Mo. Stat. Ann. (Vernon, 1953 Supp.) §202.790 [release forthwith, except release can be postponed for 10 days (not 5 days) if commitment started within 48 hours after request for release]; S.C. Acts (1952) c. 836, §3 [release forthwith, except release can be postponed for 15 days (not 5 days) if commitment started within 7 days (not 48 hours) after request for release]; Utah Code Ann. (Supp. 1953) §64-7-31 [release forthwith, except release can be postponed indefinitely (not 5 days) if commitment started within 48 hours after request for release]. The only non-Draft Act state with a "release forthwith" provision is Louisiana, Senate Bill No. 244, §2 (1954) creating tit. 28, §98.1 of the La. Rev. Stat.

⁸⁴ In Indiana and Iowa, the only authority for detention is in the contract which the patient signs when he is admitted, and which expressly states his right to give notice. See note 76 supra. See also Ill. Rev. Stat. (1953) c. 91½, §4-2 (on admission, hospital must inform patient, and relative, guardian or attorney who accompanies him to hospital,

Draft Act does not contain any provision for informing voluntary patients of their right to request release, although it does contain such a provision applicable to patients committed by non-judicial means who may request release. "The head of the hospital shall provide reasonable means and arrangements for informing involuntary patients of their right to release as provided in this section and for assisting them in making and presenting requests for release."⁸⁵ There are only two cases on the duty to disclose the patient's right to release, both of them involving the same hospital, the Hartford Retreat, a non-profit private mental hospital. In *Boardman v. Burlingame*⁸⁶ the plaintiff alleged that she was committed on a 30-day emergency commitment, that prior to the expiration of the 30 days she was told that unless she signed a voluntary admission application she would be judicially committed for the rest of her life, and that she did sign the application. She alleged that she made frequent oral requests for release but was not informed of her right to release on a written ten-day notice. She was finally discharged five and one-half months after her admission. The court reversed a judgment for the plaintiff against the hospital and ordered a new trial on the ground that the jury had not been completely instructed on the elements of fraud and deceit. The motion of one of the defendants, the resident physician-in-chief, for judgment notwithstanding the verdict was granted.

"The claim as to Dr. Burlingame's personal liability was confined to his nondisclosure of the fact that the plaintiff could sign herself out on written notice. His contacts with the plaintiff were occasional and the circumstances were not such as to make the nondisclosure fraudulent. As stated by the defendants, nondisclosure as a species of fraud occurs only in exceptional cases."⁸⁷

The issue of nondisclosure was squarely faced several months later by the same court in *Roberts v. Paine*.⁸⁸ The plaintiff claimed that he was tricked into signing a voluntary admission application and that he

in "simple non-technical language" that patient has right to leave 15 days after notice); La. Rev. Stat. (1950) tit. 28, §51 (voluntary patient cannot be admitted unless he is fully informed of his rights under the Mental Health Act, and fully understands them); N.C. Gen. Stat. (Supp. 1953) §122-62 (application for admission contains release provisions).

⁸⁵ Draft Act, §17(b).

⁸⁶ 123 Conn. 646, 197 A. 761 (1938).

⁸⁷ Id. at 656.

⁸⁸ 124 Conn. 170, 199 A. 112 (1938).

was detained for a substantial period after an oral request for release. The trial court charged the jury:

“. . . the law did not impose upon the Retreat or its servants or agents any obligation to disclose to the plaintiff that he could obtain his discharge from the Retreat by giving notice in writing that he desired to leave. . . . Accordingly, even though you should find that the Retreat had intentionally concealed from the plaintiff the fact that he might secure his release by giving ten days' notice, that in itself gives rise to no cause of action in favor of the plaintiff in this case.”⁸⁹

Recognizing that this was a case of first impression, the court upheld a verdict in favor of the defendant and approved the charge to the jury. The court stated:

“. . . a proper regard for the purposes to be served by such an institution as the Retreat and the character of the patients it receives, who come to be cured of mental ills and who no doubt are often not in a condition to appreciate what is for their own best interests or what their real desires are, would require that it should be held that it is not the duty of the institution every time a patient expresses a desire for release to inform him that he can secure it upon written application. To impose such a duty something more than a mere expression of a desire for a release must be shown. There must be at least evidence that the circumstances under which the demand is made are such that the information is fairly called for and that a reasonable regard for the rights of the patient require that it be given. The finding is barren of any facts other than that the plaintiff made known to the officers of the Retreat his desire to leave, and this in itself is not enough to impose upon it the duty to inform him as to the method he should follow to secure his release.”⁹⁰

The decision seems unfortunate, in view of the close relationship between the patient and the hospital, and the desirability of encouraging the use of voluntary admission. Probably the best solution is to require that the notice of release be incorporated in the initial application, and, in addition, extend the Draft Act provision for reasonable access to information⁹¹ to voluntary patients.

3. *Release after a maximum period of hospitalization.* Six states provide for voluntary hospitalization for a fixed period. The patient

⁸⁹ *Id.* at 174.

⁹⁰ *Id.* at 176.

⁹¹ Draft Act, §17(b).

has no right to be released prior to the end of the period, and he must then either be released or be re-admitted for another period of treatment. Delaware provides for admission to the state hospital for a four-week period, with successive four-week periods on application of the patient.⁹² In addition to the regular voluntary procedure, cited in note 76 supra, Iowa has an alternative admission procedure which authorizes admission for a 30-day period, which may be renewed.⁹³ Montana has the longest period of hospitalization. The application must be approved by a physician and the judge of the district court. It authorizes detention in the state hospital for four months. Unfortunately, the patient must either be released or committed at the end of the period.⁹⁴ In Oregon the state hospital may admit voluntary patients for 30 days for the first period of treatment and for 90 days on any subsequent admission.⁹⁵ Tennessee authorizes detention of voluntary patients in the Gailor Psychiatric Hospital for one 30-day period, which may be extended by the superintendent up to 60 additional days.⁹⁶ Washington has two separate voluntary admission procedures for its state hospitals, both of which are apparently in effect. In addition to voluntary admission for observation and treatment for an indefinite period with release after a 12-day notice, a separate statute provides for admission for observation only for a fixed 90-day period.⁹⁷

The requirement of a re-application after a fixed period automatically solves the problem of the notice to the patient of his right to release. However, the system is probably too inflexible. Either the period is too short for effective treatment, or it is so long that it discourages use of voluntary admission.

4. *Release after a judicial or administrative hearing.* Since every detention in a mental hospital involves a deprivation of liberty, it is universally recognized that the writ of habeas corpus is available to test the legality of detention. The issue tried may be either the legality of the original detention, i. e., whether or not the patient consented to hospitalization, or it may involve the question of whether or not the patient in fact is sufficiently ill to need continued hospitalization. The courts have recognized that they bear a grave responsibility in releasing a patient contrary to psychiatric advice. The best practice would be

⁹² Del. Code Ann. (1953) tit. 16, §5123.

⁹³ Iowa Code Ann. (1949) §229.1.

⁹⁴ Mont. Rev. Code Ann. (Supp. 1953) tit. 38, §406.

⁹⁵ Ore. Rev. Stat. (1953) §426.220.

⁹⁶ Tenn. Code Ann. (Williams, 1952 Supp.) §4459.1(3).

⁹⁷ Wash. Rev. Code (1951) §§72.24.220 and 72.24.230.

to order continued restraint for a brief period in order to allow the hospital to commence proceedings for judicial commitment if the case warrants continued detention. Most courts have adopted this rule, at least where the original detention was illegal, or where there is a substantial dispute as to the sanity of the petitioner.⁹⁸ A number of states provide by statute for an alternative judicial hearing on the issue of the legality of detention. The patient has his choice of the statutory proceeding or of habeas corpus. The typical statute provides for a hearing before a probate or circuit court, the use of a court-appointed expert, and a trial by jury.⁹⁹ In only one state is the decision made by an administrative, rather than a judicial agency. The Wisconsin statutes provide that the department of public welfare may investigate detention in private mental hospitals and order the release of a patient. The hospital is absolved from liability for the detention of a patient until his release is ordered by the department.¹⁰⁰

In six states which authorize voluntary admission, some or all voluntary patients have *no* release procedures available other than habeas corpus or its statutory equivalent.¹⁰¹ In Arkansas, a voluntary patient in a state hospital may request release on a thirty-day notice, but the hospital does not have to release him at the end of the period. The

⁹⁸ *Kuczynski v. United States*, (7th Cir. 1945) 149 F. (2d) 478; *Higgins v. McGrath*, (D.C. Mo. 1951) 98 F. Supp. 670; *Ex parte Romero*, 51 N.M. 201, 181 P. (2d) 811 (1947); *State ex rel. Sullivan v. Cocke*, 167 Tenn. 253, 68 S.W. (2d) 933 (1934). See *Ekiu v. United States*, 142 U.S. 651, 12 S.Ct. 336 (1891); *Robinson v. Winstead*, 189 Va. 100, 108, 52 S.E. (2d) 118, 122 (1949). *Contra*, *Ex parte Trant*, 238 Mo. App. 105, 175 S.W. (2d) 161 (1943).

⁹⁹ Cal. Welfare and Inst. Code (Deering, 1952) §6735 (hearing before superior court and jury); Conn. Gen. Stat. (1949) §2682 (hearing before superior court with investigation by commission); Ga. Code Ann. (1935) §35-236 (hearing and jury trial); Iowa Code Ann. (1949) §229.31 (district court hearing with investigation by commission); Ky. Rev. Stat. (1953) §202.360 (county court hearing); La. Rev. Stat. (1950) tit. 28, §56 (district court hearing); Md. Code Ann. (1951) art. 59, §20 (hearing before circuit court and jury); Mass. Laws Ann. (1949) c. 123, §89 (hearing in probate or superior court) and §§91 and 92 (hearing before justice of supreme court and jury); Mich. Stat. Ann. (Supp. 1953) §14.825 (probate court hearing); 34A N.Y. Consol. Laws (McKinney, 1951) §87(3) (hearing in any court of record); N.D. Rev. Code Ann. (1943) §25-0324 (county court hearing with investigation by commission); S.D. Code Ann. (1939) §30.0112 (county court hearing with investigation by commission); Va. Code Ann. (1953) §37-123 (circuit court hearing); Wyo. Comp. Stat. Ann. (1945) §51-225 (habeas corpus proceeding in district court with investigation by two physicians and facts determined by six-man jury).

¹⁰⁰ Wis. Stat. (1953) §58.05. The department may investigate and order the release of any patient in a private mental hospital. The exemption from liability for false imprisonment applies only to committed patients or those detained at the request of a guardian or friend.

¹⁰¹ Surprisingly, the otherwise excellent Louisiana Mental Health Law of 1946 contained no release provisions for the voluntary patient. This defect has been recently corrected by Senate Bill No. 244 (1954) §2 creating tit. 28, §98.1 of the La. Rev. Stat.

statute provides that the hospital is not liable for the detention after thirty days unless continued detention is arbitrary and unreasonable.¹⁰² Mississippi and South Dakota¹⁰³ also provide for voluntary admission to state hospitals but lack any release procedure other than judicial. Kansas, Tennessee and Wisconsin provide for release for voluntary patients in state hospitals, but fail to make any provision for release of the patient in the private mental hospital.¹⁰⁴

While it seems clear that habeas corpus or its statutory equivalent is an effective way of gaining release, it also seems clear that it is not an adequate procedure where it stands alone. The lack of an alternative method is apt to place too great a burden on the hospital in a possible suit for false imprisonment, and discourages the admission of voluntary patients who do not wish to undergo the risk of the expense and publicity of a judicial trial in order to be released. Another factor which would make an incipient mental case hesitate about applying for treatment in one of the eight states listed above is that if he tries to gain release and is unsuccessful, he stands a good chance of being committed for an indefinite period and losing his civil rights.¹⁰⁵

5. *Is voluntary detention legal? The Romero case.* As we have seen, in most states an application for voluntary admission may result in involuntary detention for a limited period after a request for release. The authority for the detention may be the original application (as in Indiana and Iowa) or it may be the statute. However, in any event, the basic authority for the detention is the application, since the statute is conditioned on consent to admission. This raises an important legal issue. Can a person effectively consent in advance to being deprived of his freedom? Or, putting it another way, can a patient who has agreed to give 10 days notice before being released, change his mind and force the hospital to release him immediately?

Assume that *A*, the patient, enters the *H* mental hospital for observation, agreeing to give 10 days notice before asking for release. The hospital is located in a state whose statute provides that the hospital

¹⁰² Ark. Stat. Ann. (1947) §59-236.

¹⁰³ Miss. Code Ann. (1953) §6909-12; S.D. Code Ann. (1939) §30.0115.

¹⁰⁴ Kan. Gen. Stat. Ann. (1949) §65-404 (private mental hospital may receive voluntary patient. No release provision except habeas corpus or statutory hearing under §65-405); Tenn. Code Ann. (Williams, 1934) §4789 (private mental hospital may receive voluntary patient. No release provision except habeas corpus); Wis. Stat. (1953) §58.05(2) (private mental hospital may receive voluntary patient. No release provision except habeas corpus or investigation by department public welfare, note 100 supra).

¹⁰⁵ This defect is also present in the Montana voluntary admission for four months. At the end of the period the patient must either be discharged or committed. Mont. Rev. Code (Supp. 1953) tit. 38, §406(2).

“may detain” for 10 days after notice, and “shall discharge” the patient at the end of 10 days. Assume further that *A*'s illness is in an incipient stage, that in fact he is perfectly competent to consent and to ask for release, and that there are no grounds for committing him.¹⁰⁶ After one day of treatment *A* is notified of important business matters that need his attention, and he becomes dissatisfied with the discipline imposed on him and asks for immediate release, post-haste, forthwith and right now! Is *H* legally justified in detaining *A* for the full 10-day period?

The answer to this question depends upon how the issue of detention is brought before a court. If *A*, over his protest, is detained for 10 days, and then sues *H* for damages for false imprisonment, the detention was valid and is an effective defense to *A*'s suit. The courts have repeatedly held that a person can consent to otherwise illegal detention, and that such consent is a defense to an action for false imprisonment.¹⁰⁷ While a blanket consent to detention for an indefinite period or for detention without purpose might be invalid, here it seems clear that the consent is for a reasonable purpose and for a reasonable time. The specific issue of the validity of the consent of a voluntary mental patient has been before an appellate court only once. In *Roberts v. Paine*¹⁰⁸ the Connecticut court held that the mental hospital was justified in detaining the plaintiff patient for 10 days after he requested release. The patient's original contract with the hospital which called for 10 days notice was construed as an effective consent to the detention and an absolute defense to an action for false imprisonment.

Suppose that *A* is denied release and then seeks release on a writ of habeas corpus. Is his consent effective as a bar to the writ? Again, on this issue there is only one case. In 1947 the then existing New Mexico statute provided that voluntary patients might be admitted and detained on their own application, and could not be detained more than 10 days after written notice of intent to leave the hospital.¹⁰⁹ In 1947 Antonio Romero entered a New Mexico sanatorium as a voluntary

¹⁰⁶ I.e., *A* is not likely to injure himself or others because of illness, nor does he lack insight or capacity to make responsible decisions with respect to hospitalization. These are the alternative grounds for commitment under the Draft Act and the statutes and cases of most states. Draft Act, §9(g).

¹⁰⁷ *Erie R. Co. v. Reigherd*, (6th Cir. 1909) 166 F. 247; *Sweeney v. F. W. Woolworth Co.*, 247 Mass. 277, 142 N.E. 50 (1924); *Singerman v. Burns Detective Agency*, 219 N.Y.S. 724 (1927); *Parrish v. Boysell Mfg. Co.*, 211 N.C. 7, 188 S.E. 817 (1936); *Ryan v. Conover*, 59 Ohio App. 361, 18 N.E. (2d) 277 (1937). Cf. *Knowlton v. Ross*, 114 Me. 18, 95 A. 281 (1915); *Payson v. Macomber*, 3 Allen (85 Mass.) 69 (1861). 1 TORTS RESTATEMENT §35 (1934).

¹⁰⁸ 124 Conn. 170, 199 A. 112 (1938).

¹⁰⁹ N.M. Laws (1939) c. 43, §1. New Mexico has since adopted the Draft Act. N.M. Laws (1953) c. 182.

patient for treatment as an alcoholic. Four days after he was admitted he orally requested release. The request was denied on the ground that the hospital was, by the patient's contract, entitled to 10 days notice. Romero promptly asked the New Mexico Supreme Court for a writ of habeas corpus. The court granted the writ and ordered the petitioner released.¹¹⁰ Speaking of the contract, the court said:

"Obviously, it does not require citation of authority that one may not enforce such a contract made with a person he knows to be so disordered in mind as to require treatment in an institution for the treatment of mental diseases."¹¹¹

Apparently as an alternative ground, the court cited a number of cases holding that it is a violation of due process to commit a person to a mental hospital without a judicial proceeding, involving notice and the opportunity to be heard, and then concluded:

"We are convinced that [the voluntary admission statute] plainly violate[s] the provisions of the Fourteenth Amendment to the Constitution of the United States . . . and that the petitioner is being illegally detained."¹¹²

Although the result has been criticized,¹¹³ it seems that the result is sound, while the rationale is not. The argument that a patient who needs mental treatment is per se incompetent to consent to detention is clearly contrary to the weight of medical and legal authority and contrary to the policy expressions of the legislatures of the 46 states which have voluntary admission laws. If the court's argument is sound, then the patient's consent is never valid and would be ineffective as a defense to a false imprisonment action, a result which would wreck the whole voluntary admission program.

It is submitted that what the court could have said (and possibly what it meant in the second quotation above) was that while such a contract is valid, provided the patient is in fact competent, it would be a violation of due process specifically to enforce such a contract against *anyone*, competent or not. While there is no specific authority for this proposition, the results reached in analogous cases clearly indicate that it would be a deprivation of personal liberty without due process of law to refuse to grant a writ of habeas corpus where the voluntary patient consented in advance to detention and then changed

¹¹⁰ Ex parte Romero, 51 N.M. 201, 181 P. (2d) 811 (1947).

¹¹¹ Id. at 203.

¹¹² Id. at 206.

¹¹³ OVERHOLSER, THE PSYCHIATRIST AND THE LAW 81 (1953).

his mind. The Supreme Court has indicated that one of the principal liberties protected by the due process clause is that of freedom from bodily restraint.¹¹⁴ The point is reinforced by the numerous holdings that a court will not specifically enforce a contract of service,¹¹⁵ nor will it enforce such a contract indirectly by enjoining a breach of the contract, even where the breach is in bad faith.¹¹⁶ An even closer analogy is found in the cases involving peonage under the Thirteenth Amendment. It has been clearly held that a person cannot consent in advance to involuntary servitude, although the contract is fair and otherwise valid. Even where the employee agrees to work under guard, it is unconstitutional for a state to enforce the provision directly¹¹⁷ or indirectly by use of criminal penalties.¹¹⁸

Assuming then that on principle it would be unconstitutional to deny the voluntary patient the opportunity to change his mind and secure release by habeas corpus, does this conclusion substantially interfere with the hospital's need for time to make a pre-release examination? The answer seems to be no, that while the *Romero* case invalidates the detention provision, it does not invalidate the voluntary admission program. Although the New Mexico court held that *Romero* was being illegally detained, it made its decree effective two days after it was issued, in order to give the hospital time to examine him and to start commitment proceedings if they thought necessary.¹¹⁹ While this was less than the 10 days allowed by statute, it was probably sufficient.

Thus, referring back to our Mr. A and his release problem, we can say that he should be able to obtain release on an application for habeas corpus, and that his release will probably be delayed for a day or two after the decision, depending on the length of time which elapses between the time he asks for release and the time the court decides on his petition for a writ.

¹¹⁴ See *Meyer v. Nebraska*, 262 U.S. 390, 43 S.Ct. 625 (1923).

¹¹⁵ *Marble Co. v. Ripley*, 10 Wall. (77 U.S.) 339 (1870); *General Petroleum Corp. v. Beanblossom*, (9th Cir. 1931) 47 F. (2d) 826; *Engemoen v. Rea*, (8th Cir. 1928) 26 F. (2d) 576. See *Karrick v. Hannaman*, 168 U.S. 328, 18 S.Ct. 135 (1897).

¹¹⁶ *Arthur v. Oakes*, (7th Cir. 1894) 63 F. 310 (injunction against breach of employment contract an invasion of natural liberty and creates involuntary servitude).

¹¹⁷ *Peonage Cases*, (D.C. Ala. 1903) 123 F. 671.

¹¹⁸ *Pollock v. Williams*, 322 U.S. 4, 64 S.Ct. 792 (1944); *United States v. Gaskin*, 320 U.S. 527, 64 S.Ct. 318 (1944); *Taylor v. Georgia*, 315 U.S. 25, 62 S.Ct. 415 (1942); *United States v. Reynolds*, 235 U.S. 133, 35 S.Ct. 86 (1914); *Bailey v. Alabama*, 219 U.S. 219, 31 S.Ct. 145 (1911).

¹¹⁹ *Ex parte Romero*, 51 N.M. 201, 206, 181 P. (2d) 811, 815 (1947). Pending the determination of the case, *Romero* was not held in the custody of the hospital and was not available for examination. He was released to the custody of his wife.

Maintenance of Voluntary Patients—Ability to Pay

The Draft Act does not deal with the problem of payment for care, although the author's comment does state that access to a public mental hospital, whether on a voluntary or involuntary basis, should not be conditioned on the ability to pay, and further, that determination of ability to pay should be separated from the question of hospitalization.¹²⁰

The earliest voluntary admission laws generally permitted admission only for patients who could pay their own way. While a few states retain this policy,¹²¹ most states now permit voluntary admission of indigent patients to public hospitals at public expense.¹²² The admission

¹²⁰ Draft Act, 2.

¹²¹ Ga. Code Ann. (Supp. 1954) §35-244 (patient must pay full cost in advance); Nev. Laws (1951) c. 331, §50 (patient must pay full cost in advance); N.D. Laws (1953) c. 186 (patient must agree to pay all costs and hospital may require advance or bond); S.D. Code Ann. (1939) §30.0115 and (Supp. 1952) §30.0212 (patient must pay up to \$30 per month for treatment); Tenn. Code Ann. (Williams, 1952 Supp.) §4459.1(3) (patient must pay at least \$4 but not more than \$10 per day); Wyo. Comp. Stat. Ann. (1945) §51-406 (patient must pay full cost).

¹²² Ariz. Code (Supp. 1952) §8-210 (patient must pay full cost if able—decision made by hospital board); Ark. Stat. Ann. (1947) §59-230 and Ark. Stat. Ann. (Supp. 1953) §59-230.1 (patient or relative must pay full cost if able—decision made by hospital); Cal. Welfare and Inst. Code (Deering, 1952) §§6650-6664 (patient or relative must pay full cost if able—decision made by state department of mental hygiene); Colo. Stat. Ann. (1949 Repl.) c. 105, §47 (patient or relative must pay full cost if able—decision by county department of public welfare); Conn. Gen. Stat. (Supp. 1953) §1142c (patient or relative must pay full cost if able—decision made by state department of welfare); Del. Code Ann. (1953) tit. 16, §§5127-5130 (patient or relative must pay full cost if able—decision made by hospital board); Idaho Code (Supp. 1953) §§66-354 and 66-322 (patient or relative must pay full cost if able—decision by hospital or probate court); Ill. Ann. Stat. (Supp. 1953) c. 91½, §9-19 to 25 (patient or relative must pay full cost if able—decision by state department of public welfare); Ind. Stat. Ann. (Burns, 1953 Supp.) §§22-401, 22-403 and 22-1303 (patient or relatives must pay up to \$10 per week if able—decision by state division of mental health); Iowa Code Ann. (1949) §§225.8, 225.16 and 229.42 (patient or relative must pay full cost if able—decision by court or county commission); Kan. Gen. Stat. Ann. (1949) §§76-1234 and 76-1235 (patient must pay full cost if able—decision by probate court); Ky. Rev. Stat. (1953) §§203.080 and 203.090 (patient or relative must pay full cost if able—decision by state department of mental health); La. Rev. Stat. (1950) tit. 28, §§143 and 144 (patient or relative must pay full cost if able—decision by state department of institutions); Me. Laws (1951) c. 374, §§111 and 125 (patient or relative must pay full cost if able—decision by state department of institutions); Md. Ann. Code (1951) art. 59, §36 (patient or relative must pay full expense, unless county commissioners of county of residence agree to pay); Mass. Laws Ann. (1949) c. 123, §96 (patient or relative must pay full cost if able but not more than \$10 per week—decision by department of mental health); Mich. Stat. Ann. (Supp. 1953) §§14.809(1) and 14.818 (patient or relative must pay full cost if able—decision by probate court); Minn. Stat. Ann. (Supp. 1953) §246.47 (patient or relatives must pay full costs if able—if not able, county must guarantee payment, or patient discharged); Miss. Code Ann. (1953) §6909-13 (patient or relative must pay full cost if able—decision by hospital); Mo. Stat. Ann. (Vernon, 1953 Supp.) §§202.260 and 202.863 (patient or relatives must pay full cost if able—decision by probate court); Mont. Rev. Code (1947) tit. 38, §409 (patient or relatives must pay \$1.00 per day if able—decision by district court); Neb. Rev. Stat. (1943) §§83-322, 83-325 and 83-352.02 (patient or relative must pay full cost if able—decision by county mental health board); N.H. Laws (1949) c. 112 and N.H. Rev. Laws (1942) c. 17, §§22 to 25 (patient

of public voluntary patients is easy to justify, both on humanitarian and financial grounds. It is far less expensive for the state to admit an indigent patient and give him the best and most expensive care for a short period, than it is to wait until he is an incurable case and then care for him as a committed patient in a custodial hospital for the rest of his life.¹²³

Although state practices with respect to payment vary considerably, there is general agreement as to fundamental principles, which include the following:

1. In all states which admit indigent voluntary patients the statutes provide that where a patient is cared for in a state hospital, the patient, the guardian of his estate, or his relatives shall reimburse the state in accordance with his or their ability to pay all or part of the amounts specified.¹²⁴ The specified amount may be either the actual cost or some

or relative must pay full cost if able—decision by state commission of mental health); N.J. Rev. Stat. (Supp. 1953) §§30:4-2(c) and (d) and 30:4-3A (patient or relatives must pay full cost if able—decision by court); N.M. Stat. Ann. (Supp. 1953) §§37-248 to 37-251 (patient or relatives must pay full cost if able—decision by hospital); 34A N.Y. Consol. Laws (McKinney, 1951) §24 (patient or relatives must pay full cost if able—decision by state department of mental hygiene); N.C. Gen. Stat. (1952) §122-38 (patient must pay full cost if able—decision by hospital and county department public welfare); Ohio Rev. Code Ann. (Baldwin, 1953) c. 5121 (patient or relative must pay full cost if able—decision by state department of public welfare); Okla. Stat. Ann. (Supp. 1953) tit. 43A, §§111 to 118 (patient or relative must pay full cost if able—decision by hospital); Ore. Rev. Stat. (1953) c. 428 (patient or relative must pay full cost if able—decision by county judge); Pa. Stat. Ann. (Purdon, 1954) tit. 50, §§1361, 1363(b) and 1365 (patient or relatives must pay full cost if able—decision by court); R.I. Gen. Laws (1938) c. 71, §§41 and 43 (patient must pay full cost if able—decision by state department of public welfare); S.C. Acts (1952) c. 836, art. 4, §§16 and 17 (patient or relative must pay full cost if able—decision by state mental health commission); Tex. Civ. Stat. Ann. (Vernon, 1952) art. 3196a (patient or relative must pay full cost if able—decision by county court); Utah Code Ann. (1953) §§64-7-6, 15 and 18 (patient or relative must pay full cost if able—decision by state department of public welfare); Vt. Laws (1951) c. 170, §§384 and 406 to 419 (patient or relative must pay full cost if able—decision by court or state mental health board); Va. Code Ann. (1953) §§37-116 and 37-117 (patient must pay full cost if able—decision by state hospital board); Wash. Rev. Code (1951) §71.02.080 (patient or relative must pay full cost if able—decision by state department of institutions); W.Va. Code Ann. (1949) §2677 (patient and relatives must pay up to \$2 per day if able—decision by state board of control); Wis. Stat. (1951) §§46.10, 51.08 and 51.10(2) (patient or relative must pay full cost if able—decision by county court).

¹²³ Approximately 90% of the patients in state mental hospitals are public charges. REPORT TO GOVERNORS' CONFERENCE, Appendix, Table 14. The average maintenance cost per patient is approaching \$1,000 per year and the average duration of hospitalization is seven years. This means that the typical patient in a state hospital costs the taxpayers about \$7,000, excluding capital expenditures. On the other hand, most patients who are admitted to a psychopathic hospital are discharged within six months. The average cost per patient in such a hospital is about \$5,000 per year, or about \$2,500 for the patient's stay. The conclusion is clear. If the state will encourage, at public expense, early treatment in a hospital designed for such treatment, the state will save money in the long run, in spite of the higher costs of operating such an institution.

¹²⁴ See note 122 supra for statutory citations.

fixed maximum sum, usually about one-half to two-thirds the actual cost. A number of states provide that in determining ability to pay, the possibility that the patient might become a public charge when released, and the support obligations of the patient to his dependents shall be taken into account.¹²⁵

2. The decisions as to whether or not the patient is indigent, the part of the cost to be assessed to the patient and his relatives, and the county of his legal settlement should be made at the same time by the same agency.

3. The decisions listed above should be made after the patient has been admitted. It seems obvious that the patient should not be kept waiting while his financial status is investigated.

4. In a number of states, at the time of admission or shortly thereafter, the patient's relatives are cited to appear in a court, usually the probate court, and a hearing is held. A judicial decree then fixes liability for support.¹²⁶ The more recent trend is to leave this decision to an administrative agency, either the hospital or the state mental health agency, which makes an initial decision after investigation, but without any hearing. The hospital is then given the right to sue in any court to enforce contribution. Under both systems, the court or the hospital are usually assisted in the investigation of the financial status of the patient by some local agency such as the county welfare department or the district attorney.

5. The question of whether the state or the local unit of government should bear the financial burden is one for each state to determine on the basis of its own state-local policies, and there is no general agreement on this issue. However, there is agreement on the proposition that where a patient is unable to prove legal settlement in a specific community, the cost should be assumed by the state. A related problem is that of the patient who is not a resident of the state where he becomes mentally ill. A number of states solve this by interstate reciprocal agreements which provide for sharing maintenance and transportation costs

¹²⁵ Ark. Stat. Ann. (1947) §59.230 and Ark. Stat. Ann. (Supp. 1953) §59-230.1; Cal. Welfare and Inst. Code (Deering, 1952) §6655; Ind. Stat. Ann. (Burns, 1953 Supp.) §22-401e; N.M. Stat. Ann. (Supp. 1953) §37-250; S.D. Code Ann. (Supp. 1952) §30.0216; Ohio Rev. Code Ann. (Baldwin, 1953) §5121.04.

¹²⁶ See note 122 *supra* for statutory citations and a state-by-state indication of responsibility for the decision on financial status of voluntary patients.

between the state of residence and the state where the hospital is located.¹²⁷

In summary, the principal objective of the voluntary admission procedure is to protect and care for the patient, and issues of financial responsibility are secondary. Such matters should be determined only after the needs of the patient have been met.

Conclusion

While the principal barrier to effective treatment of the mentally ill continues to be inadequate financing, resulting in acute shortage of hospital space, equipment and trained personnel, archaic admission procedures must bear part of the blame. One of the more promising recent developments is the growth and widespread adoption of voluntary admission statutes. In order to fulfill their function of encouraging early treatment, the statutes should be carefully drawn so that both patients and hospitals will use them, rather than waiting for formal commitment. The prospective patient should be entitled to obtain the best medical care, regardless of his ability to pay, the assurance that hospitalization will not per se involve the loss of his normal civil and legal rights, and the right of release a reasonable length of time after he requests it. The hospital should be entitled to use the best methods of treatment, including those which involve a degree of interference with the patient's liberty, without fear of subsequent legal liability. Through sound legislation, a workable compromise can be achieved which will afford maximum protection to the patient, the hospital and the public.

¹²⁷ See REPORT TO GOVERNORS' CONFERENCE 65 and 66 and 106 to 133 on the general problems of payment for care of patients in public hospitals; and 220, 221 and Appendix, Exhibit Three for a discussion of interstate cooperation and a form for a reciprocal agreement.

APPENDIX

*Statistics on Mental Illness**Scope of Data:*

The purpose of this appendix is to present in tabular form the latest significant data on mental illness for the United States as a whole, and for the three states (Wisconsin, Kansas and California) for which commitment statistics are available.

Interpretation of Data:

Table I shows the mental hospital system together with statistics on patient population for the United States. The hospitals are classified in terms of length of care and further subdivided in terms of type of control.

"Prolonged-care mental hospitals" are hospitals which provide care for patients over an unlimited period. Some of them also receive patients for short periods of treatment or observation. These hospitals are subdivided in terms of control: state, county (including city or other municipal hospitals), Veterans Administration and private. Most of the county or city hospitals are in the two states with well-developed county systems of mental care, Wisconsin and New Jersey. There is only one United States mental hospital outside the V.A. system. This is classified here as a state hospital, as it serves as a state hospital for the residents of the District of Columbia.

"Temporary-care hospitals" provide observation, diagnosis and short, intensive treatment. Their high patient turnover becomes apparent by comparing admissions during the year with patients on the books at the end of the year. Temporary-care hospitals are subdivided into "general hospitals with psychiatric facilities" which function primarily as observation centers and "psychopathic hospitals" which are state hospitals, usually connected with a state medical school and which stress psychiatric teaching and research.

Statistics on types of mental disorder are not available for all mental patients. Such data are available for patients admitted to mental institutions for the first time. Table II lists the characteristics of patients admitted for the first time during 1949. Patients admitted to state mental hospitals are classified by age, sex and the most common mental illnesses.

Table III compares the number of commitment proceedings with the number of admissions to mental hospitals. The term "incidence" as used in Table III means the number of persons in the general population per each commitment or admission. For example, one out of every 605 residents of California was committed through judicial proceedings to a mental hospital during 1949.

Sources of Data:

Tables I and II are compiled from the 1949 census of patients in mental hospitals, prepared for the U.S. Bureau of the Census by the Biometrics Branch of the National Institute of Mental Health and published as PUBLIC HEALTH SERVICE PUBLICATION No. 233, PATIENTS IN MENTAL INSTITUTIONS—1949 (1952).

Population data used in Table III are taken from U.S. BUREAU OF THE CENSUS, STATISTICAL ABSTRACT OF THE UNITED STATES, 73d ed. (1952) and U.S. BUREAU OF THE CENSUS, U.S. CENSUS OF POPULATION: 1950 (1952).

Data on commitments of the mentally ill are from the following sources: BIENNIAL REPORT NUMBER 1—WISCONSIN JUDICIAL COUNCIL (1953); CALIFORNIA, 14TH BIENNIAL REPORT OF THE JUDICIAL COUNCIL (1953); and KANSAS JUDICIAL COUNCIL BULLETIN (Oct. 1951).

Recent Trends in Mental Illness:

No attempt is made to present complete tables on trends in this Appendix, but it is worth while to summarize the trends in mental care which occurred during the period 1940 through 1949. [U.S. PUBLIC HEALTH SERVICE, PATIENTS IN MENTAL INSTITUTIONS—1949 at 13 (1952)]. During this period the population increased 14.6% while the number of annual admissions to prolonged-care mental hospitals increased by 50.9%. Interesting differences are noted in the rates of admission as between different types of hospitals. In 1940, state hospitals accounted for 71.6% of annual admissions, V.A. hospitals for 6.8%, county hospitals for 5.1% and private hospitals for 16.5%. In 1949, state hospitals accounted for only 56% of annual admissions, V.A. hospitals for 18.4%, county hospitals decreased to

2.1% and private hospitals increased to 23.5% of the total. Admissions in temporary-care hospitals also increased very rapidly, i.e., about three times as fast as the population increase.

The turnover of mental patients, estimated by comparing discharges with resident population, remained constant throughout the decade. In prolonged-care institutions, the turnover is much more rapid in private hospitals than in public hospitals. The average duration of hospitalization in temporary-care hospitals is about one month, in state permanent-care hospitals about 7 years, in private permanent-care hospitals about 4 years, and in both public and private hospitals for mental defectives about 20 years.

Conclusions:

1. A glance at Table I shows that as of the beginning of the current decade there were about 700,000 persons listed on the books of our mental institutions. The public institutions alone probably cost the taxpayers \$700,000,000 during the year 1949. It is at once apparent that this is a major social and economic problem.

2. During the year in question, one out of every 372 persons in the United States was admitted to a mental hospital. If the three states studied are a representative sample, about one third of all admissions follow judicial commitment proceedings. This means that commitment proceedings probably affected about 130,000 persons during the year; certainly a sizable segment of the population and a considerable burden on our judicial system.

TABLE I
THE MENTAL HOSPITAL SYSTEM—UNITED STATES—1949

Item	Prolonged-care mental hospitals				Temporary-care hospitals		Total all hospitals
	State	Vet. Adm.	County	Private	Psycho-pathic hospitals	General hospital psychiatric wards	
(1) Number of hospitals	199	33	50	272	16	121	691
(2) Average daily patient population	471,260				458		
(3) Rated capacity of hospitals	402,822						
(4) Expenditures	\$405,107,901				\$2,481,171		
(5) Annual expense per patient	\$720				\$5,104		
(6) Full-time personnel	99,076				974		
(7) Admissions	147,955	45,744	5,764	59,532	3,710	127,832	390,567
(8) First admissions	104,365		4,072	39,315	2,747	66,186	216,685
(9) Patients discharged	83,220	44,268	2,349	54,529	3,330	84,473	272,169
(10) Patients resident in hospital, end of year	478,003	52,380	19,859	13,918	477	6,035	570,672
(11) Patients in extra-mural care, end of year	82,913	6,167	1,341	1,804	218		92,443
(12) Patients on books, end of year	560,916	58,547	21,200	15,722	695	6,035	663,115

TABLE II
CHARACTERISTICS OF MENTAL PATIENTS—UNITED STATES—1949
BASED ON FIRST ADMISSIONS TO STATE MENTAL HOSPITALS

Item	U. S.	Kan.	Cal.	Wis.
Total first admissions.....	104,356	505	9,541	1,639
Male.....	57,586	249	5,394	998
Female.....	46,779	256	4,147	641
Median age.....	49	48	45	46
Senile.....	11,252	26	946	175
Schizophrenia.....	22,212	90	2,053	375
Manic-depressive.....	5,685	75	375	139
Other psychoses.....	40,831	243	3,042	469
Total with psychoses.....	79,980	434	6,776	1,158
Alcoholics.....	7,056	15	1,747	275
Narcotics addicts.....	452	0	85	18
Psychopathic personality.....	1,323	4	74	45
Psychoneuroses.....	4,133	23	386	69
Patients without psychoses.....	13,864	48	2,281	412

TABLE III
INCIDENCE OF COMMITMENTS AND ADMISSIONS—1949

Item	U. S. ¹	Kan. ²	Cal. ³	Wis. ⁴
Per cent of admissions handled by commitment proceedings.....	—	37%	47%	28%
Incidence of admissions ⁵	372	609	285	324
Incidence of commitments ⁵	—	1,670	605	1,270
Incidence of commitments, rural counties ⁵	—	2,252	1,286	1,380
Incidence of commitments, urban counties ⁵	—	1,441	777	1,114
Total commitment proceedings.....	—	1,188	17,439	2,962
Contested proceedings.....	—	—	—	232
Petition for commitment denied.....	—	—	—	67
Petition for commitment granted.....	—	—	—	2,895

¹ Data for 1949.

² Population data for 1950. Commitment data for year ending June 30, 1951.

³ Population data for 1950. Commitment data for year ending June 30, 1951.

⁴ Population data for 1950. Commitment data for 1952.

⁵ The term "incidence" means the number of persons in the population for each commitment and is the reciprocal of the rate of commitment. There is a wide variation in rates or incidence of commitment and admission between the 48 states. Of the three states listed, Kansas has the lowest rate of admission of any of the states, California has the eighth highest and Wisconsin the ninth highest.

⁶ The figure is the average of samples based on at least ten counties per state, including counties in all parts of the state and including counties of varying size.