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Henry Weihofen
University of New Mexico

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HOSPITALIZING THE MENTALLY ILL*

Henry Weihofen†

It is hard for lawyers and doctors to see eye to eye on the fundamental problem of how to eliminate needless legalistic formality in hospitalization procedures and at the same time maintain adequate legal safeguards against error and abuse.

Lawyers are inclined to emphasize the need to guard against "railroading" sane persons into institutions without giving them a chance to prove their sanity. They therefore stress the importance of a fair trial, with adequate notice and a chance to be heard before being deprived of one's liberty. As a special committee of the American Bar Association said a few years ago, these are "fundamental principles of justice which cannot be ignored. Without them no citizen would be safe from the machinations of secret tribunals, and the most sane member of the community might be adjudged insane and landed in a madhouse. It will not do to say that it is useless to serve notice upon an insane person. . . . His sanity is the very thing to be tried."[1]

Medical men, on the other hand, are likely to be impressed with the harmful results of too much legal formality, and to demand informal procedures designed to minimize the psychic traumatization which a judicial trial frequently entails. They want to eliminate the use of archaic legal phraseology carrying connotations of criminal prosecution and guilt, and to set up methods which will get maximum patient participation in treatment.[2]

Their answer to the lawyers' concern over proper procedure has been well stated by Dr. Bowman, speaking as president of the American Psychiatric Association:

> "Not long ago in California a wife decided that her husband was mentally sick. He was depressed and had delusions that persons were trying to kill him. Following the regular legal procedure she swore out a warrant, the sheriff arrested the patient, and he was taken to the county jail, there to await a hearing before the

* The substance of this article will appear in a forthcoming book on *Psychiatry and the Law* by the author and Dr. Manfred S. Guttmacher, Chief Medical Officer of the Supreme Bench of Baltimore.—Ed.

† Professor of Law, University of New Mexico.—Ed.

1 Report of the Special Committee on the Rights of the Mentally Ill, American Bar Association, 72 REPORTS OF THE AM. BAR ASSN. 289, 293 (1947), quoting from In re Wellman, 3 Kan. App. 100 at 103 (1896).

2 Forensic Committee of the Group for the Advancement of Psychiatry, Report on Commitment of Mentally Disordered Persons to Hospitals (1947).

> judge. That night he hanged himself in the jail. To those sticklers for legal procedure and defense of the legal rights of the patient, I would point out that his legal rights were well preserved. He was arrested on a warrant by a sheriff; he was not sent to a hospital without due process of law and a chance to appear before the judge. Perhaps if he had, he might be alive today. The point I wish to make is that the public is so obsessed with the legal point of view and the alleged infallibility of legal procedure that they insist on protecting the so-called legal rights of the patient without thinking of what his medical rights are."[3]

The problem is to devise procedures that will protect the sane without needlessly subjecting the sick to heartless and harmful mental torture. This is not impossible. But it is necessary first for lawyers and psychiatrists each to understand the essential soundness of the other's position.

The impatience of medical men with unduly formalized commitment procedures is understandable. It is worth remembering, however, that these procedures represent the application of principles of fairness and justice in dealing with human rights that have been established by generations who saw and suffered the effects of more summary methods. It is a precious heritage that enables us to insist that a man be served with notice of the pendency of any legal action in which his rights may be affected, and that he have opportunity to be present, to confront and cross-examine the witnesses against him, and to introduce any testimony he may have in his own defense, instead of having his rights decided in a secret star chamber proceeding and his life or liberty taken by a *lettre de cachet* calling for his confinement or liquidation without notice or hearing. The terms "star chamber" and *lettre de cachet* describe no imaginary evils dreamed up by overcautious lawyers, but real practices rampant not so many hundreds of years ago and hardly exceeded by practices current in various parts of the world in our own time.

On the other hand, it is necessary for lawyers to recognize that commitment to a mental institution involves peculiar considerations not present in ordinary legal cases. A sane person can usually be left to decide for himself whether he needs hospital care for his physical ills. But a mentally ill person may not realize that he is ill; he may rationalize all his symptoms and explain the urgings of his family and physician as evidence of a gigantic plot against him. For the same

[3] Bowman, Presidential Address, 103 AM. J. PSYCHIATRY 1 at 12 (1946).

reason that he is incapable of reaching a decision to be hospitalized voluntarily, he may be unable to avail himself of legal safeguards such as notice and hearing, and may only be harmed by them. Present practices in many states are not only heartless and harmful, but cumbersome and expensive, without having any demonstrable justification as safeguards against arbitrariness or error.

Formal Commitment

Although it is possible in most states today to obtain temporary hospitalization for observation and for emergency cases, most of the 600,000 or more patients in the mental institutions of the United States are there under formal order of commitment for an indeterminate period. In most states, the order is issued by a court, but the trend is toward allowing hospitalization upon informal administrative proceedings.

The procedure varies so much from state to state that generalization is difficult, but three basic methods predominate:[4]

a. A judicial hearing before a judge, after an examination by two physicians. This is by far the most common procedure, and is found in twenty-three states. In eight others, the procedure is the same except that an examination report is required from only one physician. A jury trial is permissible in about half of these states on demand or in the discretion of the judge. In Texas, the law requires trial before a jury of six, and does not require examination by physicians.

b. A hearing before a commission, of which the judge or the clerk of court is a member, the other members usually being two physicians or a physician and a lawyer. This is the method used in Iowa, Nebraska, North and South Dakota, Virginia and West Virginia.

c. Commitment on certification by physicians, without prior hearing. A hearing is had only if the person appeals from the certification. Variations of this method are found in Delaware, Iowa, Louisiana, Maine, Maryland, New Hampshire, Pennsylvania, Rhode Island and Vermont. This is an interesting and promising device, about which we shall have more to say later.

The lack of uniformity in procedure among the several states is due to the fact that commitment of mental patients under the Federal

[4] The classification of state procedures is taken from the chart appearing as an appendix to comment, 56 YALE L.J. 1178 at 1191, 1209 (1947). Some changes have occurred since that comment was written. Thus, Mississippi in 1948 abolished mandatory jury trial. Miss. Laws 1948, c. 394.

Constitution is left to the states. Congress has no control over the matter except in the District of Columbia.[5] A certain degree of uniformity has been achieved with respect to commitment of veterans. The Uniform Veterans' Guardianship Act, as revised in 1942, authorizes state courts to commit eligible veterans to the Veterans' Administration or other agency of the United States Government under the same procedure as that by which commitment to the state hospitals is effected. Commitments by courts of other states are recognized, thus permitting transfer of the patient from a federal hospital in one state to one in another. This uniform act has been enacted in whole or in part in all states except Delaware.

In spite of local variations, commitment by judicial procedure follows a general pattern:

Proceedings are usually set in motion by a sworn petition of relatives, friends or certain officials. A certificate by one or more physicians that the person is mentally ill and in need of commitment must accompany the petition. The person sought to be committed must be notified of the proceedings and usually is required to be present at the hearing. In most states, the court appoints physicians to examine the person; this examination is usually very informal, and is held at the person's home or wherever he may be, before the formal hearing.

The major shortcomings of present-day commitment laws have been summarized by one writer as follows:

> "The allegedly mentally ill person may be arrested by a sheriff with a warrant, charged with insanity by a judge, detained in a jail pending the hearing, tried in open court before a jury, remanded to jail pending a vacancy in a mental hospital, and finally transported to the hospital by a sheriff. While this procedure in each detail may not be followed by any jurisdiction, it represents a pattern of existing practices which are especially objectionable."[6]

It is worth while to examine each of these objectionable practices more fully.

The Analogy to a Criminal Charge. Historically, commitment was merely one solution for the general problem of pauperism and vagrancy.

[5] In 1854 Congress passed a bill which had been sponsored by Dorothea Lynde Dix, making a grant of 10,000,000 acres of public lands to the several states, the gross proceeds from the sale of which were to be invested by the states and used for the maintenance of the indigent insane. The bill was vetoed by President Pierce as unconstitutional. 5 RICHARDSON, MESSAGES AND PAPERS OF THE PRESIDENTS 247 (1903). It is probable that such legislation today would be held a valid exercise of Congress' power to appropriate for the general welfare.

[6] Comment, 56 YALE L.J. 1178 at 1181 (1947).

When persons of property became mentally ill, the early law concerned itself primarily with the administration of the estate, leaving care and custody to be provided privately. The poor and indigent insane, on the other hand, were not differentiated from other paupers or vagabonds. No distinction was made between the mentally or physically ill, those too young or too old or infirm to work, and the able-bodied unemployed. All these unwanted social liabilities roamed at large, starved and naked, "warned out" of town after town. When they were too dangerous to be allowed at large, the primary concern was to dispose of them with the least expense; pauperism was a burden to the impoverished communities of 18th century England and colonial America. To save towns from being saddled with the support of undue numbers of such public charges, strict settlement laws were adopted, fixing a definite term of residence before a person became the town's obligation if he thereafter became a public charge. Many lawsuits between New England towns were litigated over which one was liable for the support of certain paupers. And sometimes towns attempted to avoid such controversies by quietly taking mentally ill paupers to neighboring towns by night and leaving them there. The general public attitude is reflected in the title of the Massachusetts statute passed in 1699: "An Act for the Suppressing and Punishing of Rogues, Vagabonds, Common Beggars, and other Lewd, Idle and Disorderly Persons; and also for Setting the Poor to Work."[7]

In the first part of the 19th century the principal methods of disposition were provision in the persons' own homes (usually granted when only partial or temporary support was required); auctioning off the poor to the lowest bidder, i.e., the person willing to undertake their support at the lowest cost to the community; or contracting with a single individual for the support of all paupers at a fixed price. Only if they were too dangerous or too weak to be contracted out to labor were they locked up in jails, pens or almshouses.

Commitment to an institution became the normal solution to the problem of the insane only gradually. Until the close of the colonial period, there was no hospital in all America where the mentally ill might be kept. The first general hospital in the land, the Pennsylvania Hospital, was established in 1756. Mental patients were received here along with others. The first "asylum" exclusively for mental patients was opened in 1773 in Williamsburg, Virginia. It remained the only

[7] 1 Mass. Acts & Resolves (1699-1700) p. 378. See DEUTSCH, THE MENTALLY ILL IN AMERICA (1937); CREECH, THREE CENTURIES OF POOR LAW ADMINISTRATION (1936); RUGGLES, MENTAL HEALTH, PAST, PRESENT, AND FUTURE (1934).

state hospital of the kind for fifty years, although several private institutions were opened in this period. It was only after 1830 that the conviction became widespread that mental disease was curable, and that commitment was proper not only for the safety of society or of the person himself, but also if it might be conducive to his restoration to health. That provision for the insane was a state duty became accepted only around 1850, thanks very largely to the untiring efforts of Dorothea Lynde Dix, an ex-school-teacher reared in the social idealism of the Unitarians. Horrified by the filth and dirt, the neglect and the brutality she saw when she went to teach Sunday school at the East Cambridge, Massachusetts, jail one Sunday in 1841, she dedicated her life to the cause of the insane and became one of the great social reformers of her age.

The use of the term "hospital" in referring to the early institutions may give a misleading impression of the extent to which they devoted themselves to treatment or cure. The problem of administration was limited to guarding the inmates and preventing their escape. Whipping, chaining to the wall or floor, and restraint in handcuffs, bed-harnesses, leg irons, or in the strait jacket or "madd-shirt" were the generally used devices of the time. No systematic effort was made to discover and treat the disorder at an early stage when treatment might have cured or arrested its progress. The problem was faced only when the condition was already incurable.

While psychiatrists have come to be much more interested in the therapeutic purposes of commitment than in the merely custodial, our statutes all too commonly still reflect the older attitude, that an order of commitment to a mental institution is analogous to conviction of crime or at least of vagrancy, and that persons ordered committed are presumably dangerous. This explains the pattern still found in too many states where the petition is denominated a "charge" and is served by a sheriff, armed with a warrant to "apprehend" the defendant and take him into custody.[8] A rationale of this practice has been offered by the Alabama Supreme Court: "The wise policy of the statute," said the court, "is to bring the alleged lunatic notice by restraining him of his liberty, so that if he has any mind at all he will realize that he must

[8] In Texas, "it is clear that medical treatment is at best a secondary object of the lunacy statute." Williams, "Public-Law Adjudications of Mental Unsoundness and Commitability in Texas: Jury Trial Policy," 1 BAYLOR L. REV. 248 at 255 (1949). In a number of states, the person is arrested on a warrant by a sheriff. Colo. Stat. Ann. (1935) c. 105, §3; Idaho Code (1949) §66-402; Kan. Gen. Stat. (Supp. 1947) §59-2272; Minn. Stat. (1945) §525.751; Mont. Rev. Code (1947) tit. 38-201; N.M. Stat. (1941) §37-202; Ohio Laws 1945, p. 423, and §1890-24 at p. 432.

defend in order to remove this restraint, and, if not, persons interested in his freedom and his property rights may come to his aid. Anything short of this cannot be approved as due process of law."[9]

The "wise policy" of the Alabama statute has not recommended itself to states having the most modern and carefully drawn commitment laws. The latter states act instead on the sound assumption that a person who cannot by other means be made to understand that proceedings have been instituted to commit him probably will not be enlightened by being taken into custody by a sheriff. Indeed, in most of the states the detention of the mentally ill in jails or lockups is strictly forbidden by statute.

In New Mexico, a person who is unfortunate enough to need commitment is not only "charged" with being insane and a peace officer ordered to "apprehend and detain" him under a "warrant of apprehension," but the "defendant" is thereupon "arraigned" before a judge, who is required to "inform him that he is charged with being insane [!] and inform him of his rights to make a defense to such charge," etc.[10] All that is lacking is a finding of "guilty," but the connotation is certainly there, and is not lost upon the mind of the victim, who is very likely already burdened with feelings of imagined guilt and public hostility.

Notice. The purpose of notice is to enable the person to appear at the hearing and protect his interests. This is so fundamental to procedural fairness that notice and a chance to be heard are held to be guaranteed by constitutional prohibitions against depriving any person of "life, liberty or property without due process of law."[11]

The abuses possible where this principle is not recognized are vividly illustrated by history. Until only a century ago, patients were committed with an ease and informality which would amaze a twentieth century lawyer. If the relatives and the family physician agreed that a person should be committed, nothing more was asked. Committed he was, and objections on his part only served to make his lot in the institution harder.[12] But once in a while the victim convinced the hospital authorities of his sanity and was released or in some other manner managed to get the matter aired, and physicians, hospital au-

[9] Fowler v. Fowler, 219 Ala. 453 at 455, 122 S. 440 (1929).
[10] N.M. Stat. (1941) §§37-202, 37-203.
[11] Supreme Council v. Nicholson, 104 Md. 472, 65 A. 320 (1906); Ussery v. Haynes, 344 Mo. 530, 127 S.W. (2d) 410 (1939); Hunt v. Searcy, 167 Mo. 158, 67 S.W. 206 (1902); Matter of Blewitt, 131 N.Y. 541, 30 N.E. 587 (1892).
[12] DEUTSCH, THE MENTALLY ILL IN AMERICA 62-63 (1937).

thorities and relatives were sometimes held guilty of conspiracy or of false imprisonment. In Pennsylvania, in 1849, one Hinchman sued and recovered heavy damages from everyone connected with his commitment—relatives, physicians at the asylum and those who signed the certificate—even though according to Dr. Isaac Ray, the outstanding leader of forensic psychiatry during the second and third quarters of the 19th century, the man was actually "violently and dangerously insane."[13] Such cases made it clear that legislation setting forth the proper procedure to be followed in committing patients to mental institutions was needed not only to protect the patient but also to protect the physicians and others involved. New York enacted a law governing commitment procedure in 1827, and other states soon followed suit.

Typically, the statutes simply incorporated the traditional legal concept of notice, without any attempt to adapt this concept to the peculiar needs of the mentally ill. But where the person is mentally incapable of understanding the nature of the proceeding or preparing therefor, or is so deranged that notice would do him harm, the purpose of protecting his interest can be more effectively accomplished in some other way than by serving him with legal papers. It is difficult to see what useful purpose is served by requiring, as one court has required, formal service of notice upon a person who was conceded to be a helpless idiot from his birth, unable to hear, speak or take care of himself.[14]

The better mental hospitals try to spare patients the psychic trauma of having the sheriff actually serve, or having the patient hear read, legal papers that only produce anxiety and confusion in a sick mind. The papers are sometimes left with the hospital staff, and one of the doctors then orally explains their nature to the patient, perhaps making a gesture toward compliance with the legal requirement of personal service by waving the paper vaguely in front of him. Even in England, where they have a reputation for more scrupulous regard for legal niceties, we are informed by a superintendent of one of the hospitals there that it is customary for one of the staff to accompany the sheriff to the patient's side, and as soon as the paper is placed in the patient's hand to extract it with the comment, "You don't want to be bothered with that, now." If this be trifling with the majesty of the law, who will condemn doctors for trying to circumvent a hurtful legal formality which more progressive states have long since eliminated? The same

[13] Hinchman v. Richie, Brightly 143 (Pa. Nisi Prius 1849). See also Van Deusen v. Newcomer, 40 Mich. 90 (1879).

[14] Evans v. Johnson, 39 W.Va. 299, 19 S.E. 623 (1894).

hospital staff doctors who use subterfuges to mitigate the harm done by serving of papers are likely to be the most scrupulous in seeing that patient's requests for habeas corpus are delivered.

Where the court, upon the physician's certificate or otherwise, concludes that service of notice on the patient would be harmful to him, it should be lawful to have service made on a next friend or relative, other than the person who signed the petition. This is permitted under the law of New York and half a dozen other states,[15] and the more modern cases hold that such a provision is constitutional.[16] Where the person is in fact seriously disordered, notice to the next of kin or friends, some at least of whom may be supposed to be interested in his welfare, is likely to be more valuable for his protection than the service upon him of a paper which he cannot deal with or adequately comprehend.[17]

[15] Cal. Welfare & Instit. Code §5050.7 (1944); Mich. Comp. Laws (1948) §330.21; Nev. Stats. 1947, c. 257, §9; N.Y. Mental Hygiene Law (McKinney, 1951) §74 (3); Ohio Code Ann. (Throckmorton, 1948) §1890-25; Okla. Stat. Ann. (Supp. 1951) tit. 43A, §22; Wis. Stat. (1949) §51.02 (1).

[16] Ex parte Scudamore, 55 Fla. 211, 46 S. 279 (1908); Paul v. Longino, 197 Ga. 110, 28 S.E. (2d) 286 (1943); Georgia Railroad Bank & Trust Co. v. Liberty Nat. Bank & Trust Co., 180 Ga. 4 at 10, 177 S.E. 803 (1934); In re Mast, 217 Ind. 28, 25 N.E. (2d) 1003 (1940); Chavannes v. Priestly, 80 Iowa 316, 45 N.W. 766 (1890). *Contra:* Hunt v. Searcy, 167 Mo. 158, 67 S.W. 206 (1902) [statute (Mo. Rev. Stat. 1879, c. 116, §5789 at 1133) providing for notice "unless the probate court order such person to be brought before the court, or spread upon its record of the proceedings the reason why such notice or attendance was not required," held invalid because of the qualification of the right to notice]. And see Matter of Blewitt, 131 N.Y. 541, 30 N.E. 587 (1892) (proceeding to have person declared incompetent; held, notice should be served on alleged lunatic unless a very clear showing is made that giving such notice would be improper or unsafe). Also Supreme Council v. Nicholson, 104 Md. 472, 65 A. 320 (1906).

Some of the cases holding that notice to the patient himself is essential involve a determination of incompetency and appointment of a guardian or committee to manage his property, and not merely commitment to a hospital. See, for example, Evans v. Johnson, 39 W.Va. 299, 19 S.E. 623 (1894). The distinction between a legal determination of incompetency and mere hospitalization should not be disregarded.

The Missouri Supreme Court has been rather strict regarding notice. In Ussery v. Haynes, 344 Mo. 530, 127 S.W. (2d) 410 (1939), it was held that although the statute did not provide for notice, notice was constitutionally required. The notice had in fact been read to the patient twice, but no copy was served on her. There was no showing that she was not actually put on notice by the reading, but the court held that the constitutional requirement is that a copy be served. That an attorney was appointed for her and appeared at the hearing is not enough, for that was not her doing. See also Ex parte McLaughlin, (Kans. City Ct. of App. 1937) 105 S.W. (2d) 1020, where a patient was ordered discharged because the commitment judgment was not worded so as to show proper notice, although it was conceded that the patient had actually been served with notice in full compliance with the law.

[17] See In re Electra Myers, 73 Mich. 401, 41 N.W. 334 (1889), where notice of guardianship proceedings had been served on the alleged lunatic and one daughter, but not on any of the three sons living in the vicinity. Although the statute in terms did not require notice to anyone but the alleged incompetent himself, the court held that the notice in this case was inadequate, and said, at p. 403: "If the person sought to be declared an incompe-

The only possible objection to allowing such substituted service is that sane persons might be "railroaded" into an institution. There have been cases where sane persons have been committed to institutions, sometimes through error, sometimes through the intrigue of "friends" or relatives and unscrupulous owners of proprietary institutions. But the danger has been grossly exaggerated by writers of sensational fiction and more sensational "exposés." Under the proper kind of statutory procedures found in the more progressive states, safeguards against "railroading" are quite adequate:

1. No one can be committed without the certification of at least one or two medical examiners or of a "commission in lunacy." These are either appointed by the court, or are certified by a state board, or at the very least have their professional standing and reputation to consider. It is not to be presumed that they would abuse their authority or act improperly.

2. If the examiners should lend themselves to conspiracy, they would be subject to suit for damages, along with everyone else participating in the plot.[18] In addition, making a false affidavit or a false certificate is, at least in some states, specifically declared a crime, punishable by fine and imprisonment.

3. It is not likely that the medical examiners could make the personal mental and physical examination which the laws of most states require, without the patient's being aware, if he actually is sane, of what is going on.[19]

tent person, and put under guardianship of person and property on this account, is, as claimed, incompetent, a notice served upon her alone can be of but little use, even in protecting her rights in the premises; and she is therefore entitled, for her own protection, to have her next of kin notified of the proceedings, as it is naturally to be supposed that at least some of them, above all other persons, will be interested in her welfare."

[18] Zinkham v. District of Columbia, (D.C. Cir. 1921) 271 F. 542; Crawford v. Brown, 321 Ill. 305, 151 N.E. 911 (1926); Sheean v. Holman, 6 N.J. Misc. 346, 141 A. 170 (1928); Boesch v. Kick, 97 N.J.L. 92, 116 A. 796 (1922); Hinchman v. Richie, Brightly 143 (Pa. Nisi Prius, 1849); Lindsey v. Woods, (Tex. Civ. App. 1930) 27 S.W. (2d) 263; 9 Tex. L. Rev. 115 (1930). But a physician is not liable for making a false certificate of mental condition if he acted in good faith and on probable cause. Christopher v. Henry, 284 Ky. 127, 143 S.W. (2d) 1069 (1940); Niven v. Boland, 177 Mass. 11, 58 N.E. 282 (1900); Bradshaw v. Miami Retreat Foundation, 155 Fla. 76, 19 S. (2d) 574 (1944).

[19] Ex parte Scudamore, 55 Fla. 211 at 228, 46 S. 279 (1908); Hughes v. Blanton, 120 Fla. 446, 162 S. 914 (1935); Georgia Railroad Bank & Trust Co. v. Liberty Nat. Bank & Trust Co., 180 Ga. 4 at 10, 177 S.E. 803 (1934); Chavannes v. Priestly, 80 Iowa 316, 45 N.W. 766 (1890). Matter of Lambert, 134 Cal. 626, 66 P. 851 (1901), apparently contra, is perhaps distinguishable. There the court in striking down the statute said that under its provisions the medical examiners might so conduct their examination that the person might not know why they were examining him or even making an examination of him. The same criticism has been made of the Vermont statute: In re Allen, 82 Vt. 365 at 369, 73 A. 1078 (1909).

4. If through error or malice a sane person should be committed, the hospital authorities would release him as soon as the fact became apparent. State mental hospitals, like most public institutions, are overcrowded; they are not anxious to hold anyone who can safely be released. (Ironically, our over-legalistic procedure to protect persons from railroading is strictly applied only to public institutions, where it is least needed, and largely unenforced as to private institutions where if anywhere railroading is possible.) All state hospitals are inspected regularly by state medical officers. Seventeen states provide for inspection of private hospitals as well.[20]

5. If the hospital authorities deliberately or through negligence fail to recognize his sanity, the patient can always petition the courts for release on a writ of habeas corpus. This right to obtain a hearing on habeas corpus is itself sufficient to satisfy the requirement of a chance to be heard.[21] Hospital authorities who prevent or interfere with a patient's efforts to petition a court for a writ—even when they act in good faith—may be personally liable for damages.[22]

Presence at the Hearing. In accordance with the legal principle that a person whose legal rights are being adjudicated has a right to appear and defend himself, the allegedly insane person is generally required to be present at the hearing. Unfortunately, the compulsory observance of this "right" may do more harm than good. In many cases of mental illness, especially the paranoic types, the patient is already suffering from the feeling that people dislike him and from delusions of persecution. Requiring him to sit in a court room and listen to his

[20] California, Connecticut, Illinois, Kansas, Maryland, Massachusetts, Michigan, Minnesota, New Hampshire, New Jersey, New York, North Carolina, Ohio, Oregon, Pennsylvania, Rhode Island and Vermont. Six other states provide authority or power to supervise private institutions, but inspections are apparently not had regularly: Iowa, Louisiana, Maine, Utah, West Virginia and Wisconsin. See STERN, MENTAL ILLNESS: A GUIDE FOR THE FAMILY 101 (1943). See also comment, 56 YALE L.J. 1178 at 1209 (1947).

[21] Hammon v. Hill, (D.C. Pa. 1915) 228 F. 999; Payne v. Arkebauer, 190 Ark. 614, 80 S.W. (2d) 76 (1935); In re Mast, 217 Ind. 28, 25 N.E. (2d) 1003 (1940); People ex rel. Morriale v. Branham, 266 App. Div. 476, 42 N.Y.S. (2d) 761 (1943); Ex parte Dagley, 35 Okla. 180, 128 P. 699 (1912); People ex rel. Peabody v. Chanler, 133 App. Div. 159, 117 N.Y.S. 322 (1909), affd. 196 N.Y. 525, 89 N.E. 1109 (1909); In re Petition of Simon Crosswell, 28 R.I. 137, 66 A. 55 (1907). *Contra:* Barry v. Hall, (D.C. Cir. 1938) 98 F. (2d) 222 [this case can perhaps be distinguished in that it involved the federal habeas corpus statute, 28 U.S.C.A. 451 et seq. (1926), which contains no provision for a hearing of insanity question on the merits.]

Federal courts have refused to disturb commitments made pursuant to state statutes which include provisions for appeal or for determination of the insanity question in a hearing under a writ of habeas corpus. Hammon v. Hill, supra; Hall v. Verdel, (D.C. Va. 1941) 40 F. Supp. 941; Shapley v. Cohoon, (D.C. Mass. 1918) 258 F. 752.

[22] Hoff v. State, 279 N.Y. 490, 18 N.E. (2d) 671 (1939); 38 MICH. L. REV. 103 (1939).

trusted physician and his nearest and dearest relatives testify to the facts regarding his mental condition is likely to confirm his worst suspicions. The result may be dangerous to them as well as injurious to him. If not restrained, either because the court fails to appreciate the seriousness of his disorder or for any other reason, he may attempt to kill those who have thus "betrayed" him.

These dangers are recognized by the law in only a minority of states (e.g., Connecticut, Kentucky, Massachusetts, New York, Utah). These states provide that the person need not attend where the court or commission decides that his presence may be detrimental to his health.[23] Such provisions have been held constitutional, at least where the person has had actual notice of the hearing.[24] Appearance by attorney has been held sufficient to satisfy the right to appear and be heard.[25]

Trial by Jury

Since it is the most public and most elaborate form of judicial proceeding, the jury trial is the worst example of the unfortunate concomitants of formal judicial procedure. The objections to jury trial for commitment cases have been so often stated[26] that it is proper here merely to summarize them.

1. The traumatic effects on the patient of having to sit through a trial which to a layman carries many of the earmarks of a criminal prosecution have been mentioned above. There is hardly a more powerful device conceivable for convincing an already unstable mind that his suspicions are true than subjecting him to a jury trial.

2. The natural reluctance of patients' relatives to expose "private troubles" before a jury, and their sense of shame or disgrace, cause

[23] See, for example, Conn. Gen. Stat. (1949) §2645; Ky. Rev. Stat. (1948) §202.130; Mass. Ann. Laws (1942) c. 123, §51; Utah Code (1943) tit. 85-7-20; similar provisions are found in a number of other states.

[24] Simon v. Craft, 182 U.S. 427, 21 S.Ct. 836 (1901); Chavannes v. Priestly, 80 Iowa 316, 45 N.W. 766 (1890); Ex Parte Higgins v. Hoctor, 332 Mo. 1022, 62 S.W. (2d) 410 (1933); McMahon v. Mead, 30 S.D. 515, 139 N.W. 122 (1912).

[25] In re Mast, 217 Ind. 28, 25 N.E. (2d) 1003 (1940). However, where, although served with notice, the person is restrained in an institution and is not allowed to attend the hearing, there is a denial of due process, and the fact that an attorney was appointed by the court to represent him at the hearing does not cure the defect. Shields v. Shields, (D.C. Mo. 1939) 26 F. Supp. 211.

[26] SINGER AND KROHN, INSANITY AND LAW: A TREATISE ON FORENSIC PSYCHIATRY 224 (1924); INTERNATIONAL CONGRESS FOR MENTAL HYGIENE, REPORT OF COMMITTEE ON LEGAL MEASURES AND LAWS, 1 PROCEEDINGS OF FIRST INT. CONGRESS ON MENTAL HYGIENE 61 (1932); Kerschbaumer, "A Patient's Reaction to a 'Lunacy' Charge," 101 J. NERV. & MENT. DIS. 378 (1945); Parker, "The Determination of Insanity in Criminal Cases," 26 CORN. L.Q. 375 at 382 (1941); Weihofen, "Commitment of Mental Patients: Proposals to Eliminate Some Unhappy Features of our Legal Procedure," 13 ROCKY MT. L. REV. 99 (1941).

postponement of early treatment, with the result that many who with prompt care might have been restored are allowed to sink into hopeless conditions. As long ago as 1893, Dr. G. Alder Blumer of Utica State Hospital said, "There is a vastly greater number of persons utterly lost to society and deprived of the capabilities of ordinary life by the shameful neglect and hindrance of those who should know better in the first and early stage of this disease than by all the mistakes or the undetected evil intentions of improper commitment that were ever known."[27] The backwardness of our legal procedures makes this statement almost as true today as when it was first said.

3. Upon recovery, the patient is subjected to considerable emotional stress as he prepares to return to the community in which he had been so publicly subjected to the social stigma which commitment frequently entails. Yet this home community should provide the best environment for readjustment.

4. A lay jury is obviously not well qualified to pass upon a question calling for a highly specialized medical diagnosis. Americans have a sentimental predilection to regard trial by jury as a great safeguard of personal liberties; and so it is in some situations, such as political crimes. But in cases involving questions such as that of mental condition, there is no evidence whatever to support the idea that juries make fewer mistakes than judges or boards of medical experts. During the twenty-five years that Illinois used the jury trial for all commitments (1867-1893), more sane persons were declared insane by juries, as shown by the reports of the state institutions, than were ever wrongfully committed under the earlier method.[28]

Use of the jury owes a large part of its popularity to the crusading efforts during the 1860's of Mrs. E. P. W. Packard of Illinois. The wife of a preacher, she had differed with her husband on religious questions and he had resolved the dispute by having her committed under a convenient Illinois law permitting married women and infants to be detained in a state hospital "without the evidence of insanity or distraction required in other cases." Released at the end of three years, Mrs. Packard started on a campaign to "expose" the asylums. Her writings created a sensation and fostered the growth of sentiment for legal safeguards against "railroading." She was a woman of forceful personality, although probably a "borderline" case, and she succeeded

[27] BLUMER, THE COMMITMENT, CARE AND TREATMENT OF THE INSANE (a report of the 4th Section of the International Congress of Charities, Correction and Philanthropy, 1893) 153 (1894); also in 50 AM. J. INSANITY 538 (1894).

[28] Dewey, "The Jury Law for Commitment of the Insane in Illinois (1867-1893), and Mrs. E. P. W. Packard, Its Author," 69 AM. J. INSANITY 571 (1913).

in inducing the Illinois legislature in 1867 to pass a law prohibiting the commitment of any person to an insane institution without a trial by jury. Her agitation also gave strong impetus to demands for changes in the commitment laws of other states.[29] Her objective of obtaining legal safeguards against error and abuse was a worthy one; but it was unfortunate that she turned to jury trial as the device for attaining it.

Abolition of the right to a jury trial has been urged by almost all the authorities, both medical and legal.[30] A mandatory jury trial has been abolished everywhere except in Texas, where attempts at abolition have been defeated by an unduly restrictive interpretation of the state constitution.[31] But in about a dozen states, jury trial is still permissible, either on demand or in the discretion of the court, and in a number of others, a jury trial may be had upon appeal from the determination of the committing tribunal.[32]

[29] Ibid.

[30] See note 26 supra.

[31] The Texas Constitution, Art. I, §15 (1926) merely provides that "The right of trial by jury shall remain inviolate." In White v. White, 108 Tex. 570, 196 S.W. 508 (1917), the Texas Supreme Court held—contra to the weight of authority in other states—that this entitled persons "charged with insanity" to a jury trial. In 1925, the legislature attempted to substitute a permissive jury trial for the mandatory one, but a state district court held this unconstitutional. Ex parte Fisher, No. B47701, 57th Jud. Dist. Ct. of Bexar County (1927). This again was contrary to the weight of authority, which holds that even where a clear right to a jury exists, it may be waived. However, no appeal from this decision was taken, and the Attorney General later ruled in accord with this interpretation. OP. ATTY. GEN. TEXAS, No. 2924 (1933). The 1925 act has since been regarded as unconstitutional—a modest and reasonable piece of legislation vetoed by judicial and administrative lawmakers.

The Texas situation is fully reviewed in an article by Professor Percy Williams, Jr., "Public-Law Adjudications of Mental Unsoundness and Commitability in Texas: Jury Trial Policy," 1 BAYLOR L. REV. 248 (1949). Professor Williams marshals the objections against the use of jury trials in commitment proceedings, but concludes, at p. 275, surprisingly, that since "in the few ill-designed cases which proceed to trial a jury verdict would seem to be one safeguard against a court order based on collusion . . . it seems unwise to consider elimination of the jury altogether." He therefore recommends making jury trial optional instead of mandatory. No evidence is offered to support the suggestion that jury trial is a safeguard against collusion or against any other kind of error. On the contrary, Professor Williams assembles strong authority for the conclusion that juries are not qualified to reach correct conclusions in such cases, and says, at 275, note 156, that "the possibility of an erroneous commitment by means of such collusion would seem almost non-existent . . . under a commitment law requiring investigation and report to the committing judge by medical and legal personnel appointed by the court." Since it will apparently require a constitutional amendment to make any change in Texas procedure, it is to be hoped that the amendment adopted will not be a narrow one perpetuating the use of the jury whenever a patient demands it—a procedure condemned by authorities most familiar with the problem, and which therefore would already be outmoded at the time it was adopted. Most states have not found it necessary or politic to incorporate detailed specifications for commitment proceedings into their constitutions.

[32] For citations to the state statutes, see Williams, "Public-Law Adjudications of Mental Unsoundness and Commitability in Texas: Jury Trial Policy," 1 BAYLOR L. REV. 248 at 282, notes 167-169 (1949). See also comment, 56 YALE L.J. 1178 at 1209 (1947).

Making jury trial optional instead of mandatory has the merit of at least eliminating this clumsy, harmful and expensive procedure in cases where nobody wants it. But why allow it at all? The person most likely to demand a jury trial is the mentally ill person with a persecution complex. And if such person is articulate and quick-witted, as such types very frequently are, he may convince a jury that his story of a nefarious plot to "railroad" him into an insane asylum is true. The truly sane person should have no greater difficulty in convincing a judge or a commission of physicians of his sanity than in convincing a jury. The insane, on the other hand, is much more likely to fool a jury than he is the experts. Persons unskilled in psychiatry usually do not realize that a patient requiring hospital treatment may not exhibit his symptoms at all times. Especially on such an occasion as a trial, he may reach a pitch of tension which enables him to overcome his basic delusions or other symptoms and appear quite normal. Only the psychiatrist who has observed him over a period of time may know that he has all the characteristic symptoms of a major psychosis, in spite of his normal appearance in court.

There are still many people today with Mrs. Packard's narrow focus on commitment *procedure*, as contrasted with Dorothea Dix's broader concern with the physical care and medical treatment of the insane—people who become disturbed only at the thought of someone sane being railroaded into an insane asylum. As Albert Deutsch eloquently put it,

> "Let thousands of mental patients in the public hospitals of a state exist under terrible conditions of overcrowding; let them be fed with bad food; let them be placed under all sorts of unnecessary restraints; let them lack adequate medical care due to poor therapeutic equipment or an understaffed personnel; let them be housed in dangerous firetraps; let them suffer a thousand and one unnecessary indignities and humiliations, and more likely than not, their plight will attract but little attention. The newspaper will maintain a respectful silence; the public will remain ignorant and indifferent. But once let rumor spread about a man or woman illegally committed to a mental hospital, and newspaper headlines will scream; the public will seethe with indignation; investigations and punitive expeditions will be demanded."[33]

This fixation on illegal commitment, to the exclusion of all of the many other tragedies connected with the insane, is but another instance of man's neurotic self-interest. Most people defensively feel that

[33] DEUTSCH, THE MENTALLY ILL IN AMERICA 418 (1937).

insanity can never come to them. An old term for insanity, "alienation," clearly portrays this. It is remote like some decimating plague in distant India. But they can conceive of normal people like themselves being unjustly committed. What may happen to *me* is more important than what is happening to others.

Determination of Ability to Pay. Since historically commitment of the mentally ill was simply one means of disposing of paupers, the determination of whether the person was in fact a pauper was an important part of early commitment proceedings. Today, we do not think of commitment to a state mental institution as a proceeding reserved for the indigent or believe that access to mental hospital facilities should be conditioned on ability to pay. But the law in several states still requires a determination of the person's financial status and of his legal residence as part of the commitment proceedings.[34] The question of ability to pay should be separated procedurally from the question of mental condition. The administrative department in charge of operation of the state hospital can determine whether the patient's estate or his relatives can be charged with the cost of treatment in whole or in part, and this is the way the matter is handled in some states.[35] This is not only less cumbersome than judicial procedure, but insofar as there is reason to fear abuse, an administrative agency, by hiring a few investigators, probably can do a more efficient job of checking financial condition than a court, which has no investigative machinery at its command but must rely on sworn statements.

Transportation to Hospital. In a number of states, an order of commitment is carried out as if it were an order sentencing a convict to a penal institution. The sheriff is ordered to take the person into custody and convey him to the designated hospital. Sometimes the patient must first spend some time in jail, while arrangements are made for his admission to the hospital. A study made in 1937 revealed

[34] See, for example, Ala. Code (1940) tit. 45, §212; Colo. Stat. Ann. (1935) c. 105, §6; Kan. Gen. Stat. (Supp. 1947) §59-2003; Minn. Stat. (1945) §525.752; Mont. Rev. Code (1947) tit. 38-214.

[35] See, for example, N. M. Stat. (1941) §37-213: "The estate and property of an insane person shall be liable to pay for his care and maintenance while confined in said asylum... and it is hereby made the duty of the directors of the New Mexico Insane Asylum to make collection of all said costs and charges from his said estate and property in the hands of any person having charge of the same, including any guardian who may have been appointed to the care and custody of said estate. . . . Following the admission of a patient into the asylum the directors thereof shall cause an investigation to be made to determine what estate or property, if any, said patient may have and whether he has a duly appointed and acting guardian. . . ."

that out of 18,459 admissions to 26 state hospitals, 64% were taken to the hospital by a sheriff or police officer, and 29% were lodged in jail pending transportation.[36] While the incidence of such practices has perhaps since been reduced, they have certainly not been wholly eliminated. One way for hospital authorities to make clear the objectionable character of these practices is to refuse to accept patients brought to the hospital in patrol wagons, handcuffed, or in the custody of uniformed officers. In about one-third of the states, attendants from the hospitals are available to transport the patients. More than half the states require that female patients be accompanied by a husband, blood relative or a female attendant, and there is no reason why similar consideration should not be shown all patients. The sick person's family and friends should be allowed to transport him to the hospital by private means, and, if necessary, to call upon the local health authorities for transportation.

Commitment without Judicial Trial. The only argument made in favor of full hearing in these cases is that sane persons might otherwise find themselves committed. But since no one would suggest that more than a small percentage of commitment cases involve anything improper, it seems a blunderbuss method to require elaborate formalities in all cases, in order to avoid abuse in a few. Easy and informal admission is the most humane to the patient and least expensive for the taxpayer. The relatively rare cases where the patient wants to contest the commitment order could be handled by allowing a full hearing on appeal.

This is the device which a growing number of states have adopted. In Maryland, for example, if two physicians certify to the need for commitment, the person is forthwith committed. At any time thereafter, he or any one on his behalf may request in writing that he be discharged, and the superintendent must thereupon either discharge him forthwith, or file a petition for court determination of his mental condition. Thus commitment is had with a minimum of formality, but full judicial hearing is available upon any claim of error. Iowa and Rhode Island have similar procedures.[37]

[36] Bevis, W. M., paper presented before the American Psychiatric Association, 1937, (unpublished).

[37] Md. Laws Spec. Sess. 1944, c. 14; Iowa Code (1946) c. 228; R.I. Gen. Laws (1938) c. 71, §11. Iowa uses two alternative procedures: (1) county commissions composed of the clerk of the district court, a physician and a lawyer; (2) a state-wide commission composed of the medical director, assistant medical director and one other staff member of the state Psychopathic Hospital. See 33 IOWA L. REV. 390 (1948).

In Delaware, the patient is examined by two physicians, and their certificate, together with the petition, is sent to the superintendent of the state hospital. The patient is placed in the observation clinic, and if he is found to require continued hospital care, the superintendent so reports to the board of trustees. A jury of six is called if demanded by the patient or a relative, but if no such demand is made, the board appoints a commission of two qualified and licensed physicians to make an examination and file a written report. The board acts on this report. The patient has a right of appeal to the chancellor of the state.[38]

In Louisiana, commitment may be ordered by the coroner on certificate of himself and another physician; in Vermont, by two physicians, subject to appeal; in Maine, by town officers on examination by two physicians.[39]

It is reported that in 1949 all commitments in Delaware, Iowa, Maine and Nebraska were made without court order, or by voluntary admission.[40] Such provisions are constitutional; the right to obtain a hearing on appeal with reasonable promptness after commitment is sufficient to satisfy the requirements of due process.[41]

Voluntary Admission

Whereas commitment connotes a legal command by which a person is placed in an institution, voluntary admission signalizes recognition of the newer conception of "insanity" as a form of illness calling for medical care. Such a conception was of course impossible so long as commitment was resorted to only as a means of confining the dangerous insane. But after the view became accepted, legally as well as medically, that commitment might be proper not only where it was necessary for the safety of the public or of the patient, but also where it might

[38] Del. Rev. Code (1935) §3074.

[39] La. Gen. Stat. (Dart. Supp. 1947) §3938.12; Me. Rev. Stat. (1944) c. 23, §105; Vt. Pub. Laws (1933) §3757 and §3761.

[40] COUNCIL OF STATE GOVERNMENTS, THE MENTAL HEALTH PROGRAM OF THE 48 STATES 298 (1950).

[41] Payne v. Arkebauer, 190 Ark. 614, 80 S.W. (2d) 76 (1935) (statutory and constitutional provisions for appeals from probate to circuit court); Ex parte Scudamore, 55 Fla. 211, 46 S. 279 (1908) (statutory provision for filing a bill in equity by relative or friend); The County of Black Hawk v. Springer, 58 Iowa 417, 10 N.W. 791 (1882) (statutory provisions for appeal and new trial in circuit court and for appointment of new commission after confinement and for habeas corpus); Peff v. Doolittle, 235 Iowa 443, 15 N.W. (2d) 913 (1944) (similar); In re Dowdell, 169 Mass. 387, 47 N.E. 1033 (1897) (written application to justice of supreme judicial court); In re LeDonne, 173 Mass. 550, 54 N.E. 244 (1899). See comment, 3 STANFORD L. REV. 109 (1950).

be conducive to his restoration to health,[42] it was inevitable that we should come to regard mental illness as not essentially different from physical illness, and to believe that a person able to realize that he is mentally ill should be able to obtain hospital treatment as easily and as informally as he can for physical illness.

Almost every state today provides for voluntary admission, and there is no need to belabor the need or the wisdom of such provisions. It is worth while, however, to point out the features which should be included if such provisions are most effectively to achieve the two primary objectives of reducing the traumatization which compulsory procedures so often induce, and encouraging early action, not only by the patient himself but by his family. For admission to a public institution, it is of course necessary to provide that application must be accepted by the hospital authorities, after they determine (1) that there is room, and (2) that the person will benefit by hospitalization. The law should expressly define this concept of "benefit" to allow admission not only of those who are clearly ill, but also those who have some symptoms of mental illness and whom it would be useful to admit for observation and diagnosis. If the person is found eligible, no physicians' certificates or other such prerequisite should be demanded. Ability to pay should not be made a condition of admission. Payment might be required of those able to pay but as already said the determination of whether such ability exists should be left to administrative agencies. Statutes commonly contain a provision requiring the superintendent to satisfy himself that the patient understands his application.[43] However, there is sound practical reason for extending the voluntary admission procedure to persons who are too senile, indecisive or weak-minded to make a clear-cut decision, by allowing the application to be signed by the next of kin or guardian, and under the laws of a few states this is made possible.[44] Minors and persons for whom a legal guardian has been

[42] The first case adopting the newer viewpoint seems to have been a habeas corpus proceeding for the release of Josiah Oakes, 8 Law Rep. 122 (Mass. 1845), where Chief Justice Shaw held that confinement of an insane person was justifiable not only if the safety of the patient or of others requires it, but also if it is necessary or conducive to his restoration to health. The same view was adopted a few years later in Hinchman v. Richie, Brightly 143 (Pa. Nisi Prius, 1849).

[43] See, for example, Ky. Rev. Stat. (1948) §203.020; Me. Rev. Stat. (1944) c. 23, §116; Md. Ann. Code (1939) art. 59, §40; Mass. Ann. Laws (1942) c. 123, §86; R.I. Gen. Laws (1938) c. 71, §41.

[44] Ark. Stat. Ann. (1947) §59-231; Ill. Rev. Stat. (1949) c. 91½, §4-1; Ohio Code Ann. (Throckmorton, 1948) §1890-50. In Virginia, although the application may be made by another, the patient must be able to understand it. Va. Code (1946 Supp.) §1031.

appointed should be admissible upon application of the parent or guardian, but surprisingly few states so provide.[45]

With regard to provisions for release, two opposing considerations must be weighed. On the one hand, complete freedom to leave the hospital at any time will almost certainly lead a number of patients to leave a few days after being admitted, for restlessness and dissatisfaction with the restraints of hospitalization are common and natural, especially during the first period of adjustment. This makes the admission a complete waste of time and money. On the other hand, refusal to release a voluntary patient on demand would not only be difficult to justify legally but would be highly undesirable, because resort to voluntary admission will be discouraged unless it is made quite clear that a patient may change his mind and leave. Most voluntary admission statutes meet the problem by providing that a voluntary patient shall be released within a specified number of days after he gives written notice of his desire to leave, unless in the meanwhile the hospital authorities start proceedings to have his status changed to that of involuntary patient. It has been held that detention for a reasonable number of days after written demand for release is proper,[46] although a refusal to release, without legal proceedings being taken, is illegal and may be ground for claiming damages for false imprisonment.[47]

New York has added another sanction to prevent premature demands for release by requiring an applicant for admission to sign an agreement that he will not give notice for a least sixty days.[48] If a patient nevertheless demands release before that time, it seems dubious whether this provision would justify holding him, although it presumably would at least in theory subject him to liability for damages for breach of contract. The written agreement, however, no doubt has moral if not legal effect in discouraging demands for release.

Here, as in so many other situations, passing a law does not necessarily mean that a problem is solved, and we must guard against the too easy assumption that if a state has a voluntary admission law on the

[45] Ariz. Code (Supp. 1951) §8-210; Ark. Stat. Ann. (1947) §59-231; Cal. Welfare & Instit. Code (1944) §6602; Del. Laws (1945) c. 219, §1; Ill. Rev. Stat. (1949) c. 91½, §4-1; Mich. Comp. Laws (1948) §330.19a; New York Mental Hyg. Law (McKinney, 1951) §71; Ore. Comp. Laws (Supp. 1943) §127-214; Wis. Stat. (1949) §51.10.

[46] Roberts v. Paine, 124 Conn. 170, 199 A. 112 (1938). *Contra:* Ex parte Romero, 51 N.M. 201, 181 P. (2d) 811 (1947).

[47] Cook v. Highland Hospital, 168 N.C. 250, 84 S.E. 352 (1915).

[48] N.Y. Mental Hyg. Law (McKinney, 1951) §71.

books, voluntary admission is possible. Because of the crowded condition of existing hospital facilities, the voluntary admission laws of some states are not used at all, or are used only for paying patients.[49]

Most of the voluntary admission statutes apply only to public institutions on the wholly sound theory that legislation is not necessary to enable any person of mature years and sufficient mind to contract, to enter any hospital that is willing to admit him. However, it might be well for the law to cover private hospitals as well, for their own protection and benefit, and to make it clear that such hospitals may receive and detain patients on the same terms as public hospitals.[50]

Emergency and Temporary Procedures

The police and other agencies sometimes are called upon to take custody of mentally ill persons who are likely to injure themselves or others if not promptly restrained. In most states, unless there is justification for arresting such person on a criminal charge, there is no clear legal authority to act. [There is in fact authority at common law for any officer or private person to restrain a person dangerous to be at large, but this (1) is limited to the dangerous insane, (2) puts the burden of establishing such dangerousness on the officer or person doing the restraining if the person later complains that the restraint was illegal, and (3) not being specifically authorized by statute may not be regarded by the officers as law.] Specific authority should therefore be conferred to take charge of such persons and convey them to a public or licensed private hospital. The protection against abuse would be the same as now exists against unlawful arrest: the officers should be required to record the reasons for believing that the person is dangerous and the circumstances under which he was taken in charge. Where the action was clearly unjustified, the officer would be liable for false imprisonment. The legal wrong of false imprisonment

[49] In Kansas, voluntary admission is not encouraged because of overcrowded conditions. KANSAS LEGISLATIVE COUNCIL, PSYCHIATRIC FACILITIES IN KANSAS: OBJECTIVES OF A STATE PROGRAM (1946) #4. In Vermont, in practice only paying patients are admitted. VT. DEPT. OF PUBLIC WELFARE, REPORT OF THE COMMITTEE FOR MENTAL HEALTH 8 (1946). Iowa's voluntary commitment law, Iowa Laws 1947, c. 128, §§2, 3, has so far been of little effect because it provides that no voluntary patients may be accepted unless the hospital has adequate staff and facilities to accommodate them. Since the state's mental hospitals are overcrowded and understaffed, it is unlikely that the law can be used for some time to come. Note, 35 IOWA L. REV. 270 (1950).

[50] Report of the Special Committee on the Rights of the Mentally Ill, 72 REPORTS OF THE AM. BAR ASSN. 289 at 294 (1947).

includes not only actual locking up but any illegal restraint of a person's liberty.

Such a procedure is necessary not only where a person is found to be violent, but for vagrants and persons unknown in the community or having no friends or relatives who could sign an application and obviously in need of care and custody. This form of admission should be for not more than ten or fifteen days, to allow time for more formal action to be taken.

For cases somewhat less pressing, admission should be possible upon the certificate of a physican that he has examined the person and that there is reason to believe that unless immediately hospitalized, he is likely to cause serious injury to himself or to others. Designated health officers, if they are licensed physicians, should be among those authorized to issue such certificates. The certificate should be valid only to allow prompt action—within two or three days—and should authorize holding the person for only ten or fifteen days, unless more formal action is instituted within that time.

Such emergency provisions would avoid cases such as that which occurred in the District of Columbia recently. A psychiatric physician, called by a husband who said his wife had been threatening to kill him and their child, after talking with the woman called the police and had her forcibly removed to Gallinger Hospital for mental examination. She was discharged ten days later as not then insane, although there was evidence that members of the Mental Health Commission who examined her shortly after she was taken to the hospital thought her then to be mentally ill. She then sued the doctor for false imprisonment, and the Court of Appeals for the District of Columbia held that these facts stated a cause of action, because under the laws of the District, arrest without a warrant is permitted only if the insane person is found in a public place or if affidavits have been signed by two or more responsible residents and examination has been made by two physicians.[51] Under the court's interpretation, the District statute did not authorize either the doctor or the police to act, even though the woman appeared dangerously insane and likely to kill a member of her own family unless immediately restrained.

"Observation commitment" is now possible in more than half of the states. This permits adequate diagnosis under hospital conditions, without the stigma of an indeterminate commitment, and encourages

[51] Jillson v. Caprio, (D.C. Cir. 1950) 181 181 F. (2d) 523.

earlier action by the patient and his family. Most of the states providing for such observation commitment require the same judicial formality as for indeterminate commitment. This seems unnecessary, for this is a much less serious step. Application by a responsible relative, accompanied by the certificate of two specially qualified physicians, ought to be deemed sufficient. Protection against abuse could be afforded by entitling the patient to release on demand, unless more formal proceedings were promptly instituted.

The Model Act Governing Hospitalization of the Mentally Ill

A committee of psychiatrists and lawyers working under the auspices of the National Institute of Mental Health, of the federal Public Health Service, has drafted a model act dealing with the problem of commitment and hospitalization of the mentally ill.[52] This draft represents the most modern thinking on the subject, translated into very concrete legal procedures.

To avoid so far as possible the traumatic effects of public formal hearings and the subjection of sick people to popular prejudices about mental illness, the draft permits hospitalization in the great majority of cases without judicial proceedings. Not only emergency cases, but any person may be admitted to a hospital upon application by someone on his behalf, plus certification by two "designated examiners" (i.e., physicians registered as specially qualified under standards to be established by the state administrative agency) that upon medical examination the person appears to be mentally ill and either likely to injure himself or others if allowed to remain at liberty, or in need of hospital care and treatment and without sufficient insight or capacity to make application therefor.

A novel but sensible distinction is made between involuntary commitment and actual compulsion. Commitment proceedings may be involuntary in the sense that they are initiated by someone other than the patient himself, and yet the patient may accept the judgment of the doctors and of his family and upon certification go to the hospital without protest. However, if he objects, the draft would not permit taking him by force, except where there is danger that he will injure himself or others, and even in that case, the certificate must be endorsed by the head of the local health authority or by a judge. The judge's function

[52] A DRAFT ACT GOVERNING HOSPITALIZATION OF THE MENTALLY ILL, U.S. FEDERAL SECURITY AGENCY, PUBLIC HEALTH SERVICE, Publication No. 51 (1951).

in such a case, however, is not based on a trial, but is rather analogous to that of a magistrate issuing a warrant for arrest upon a showing of "probable cause."

A judicial hearing is required only for compulsory hospitalization where there is no emergency and no danger of injury. Notice of the action must be given the person himself (unless there is reason to believe it would be harmful to him) and also to his nearest known relative or friend.

The court then has the person examined by two designated examiners. If the examiners report that the individual is not insane, the judge may terminate the proceedings without further action; otherwise, he is required to hold a hearing, at which all relevant and material evidence offered is to be received. The individual is entitled but is not required to be present. The hearings are to be conducted "in as informal a manner as may be consistent with orderly procedure and in a physical setting not likely to have a harmful effect on the mental health of the proposed patient."

If the court finds that the person is ill and is either likely to injure himself or others or is in need of hospital care but lacks sufficient insight or capacity to make a responsible decision with respect to hospitalization, it may order him hospitalized, either for an indeterminate period or for a temporary period of observation not to exceed six months. A person not found to be dangerous or incapable of making a rational decision for himself, even though he may not be wholly sane, retains the freedom to choose for himself whether to go to a hospital or not. Not even the court, let alone any other person, can put such an individual in a hospital against his will.

In adopting this limitation, the draftsmen of the act were required to exercise a political judgment. To those who believe that a benevolent government will know best whether or not a person needs care, it may seem proper to accept the judgment of the authorities upon a fair and trustworthy examination and not allow the patient to refuse needed treatment. But the right to live one's life in one's own way, even in a way that seems foolhardy to others, is an important aspect of liberty —perhaps the very essence of liberty. This liberty may not be carried to the point where it threatens the correlative liberty or rights of others, and so there can be no question of the propriety of committing a person without his consent if he is dangerous to others. And since the life and health of an individual is a matter of social concern as well as of private concern to himself, society has a legitimate interest in pro-

tecting a person even against himself. For the same reason that it is proper for the state to prohibit suicide or self-mutilation, so it may properly commit involuntarily a person who is dangerous to himself. It also would seem beyond cavil that when a person is so mentally unsound as to be incapable of making a rational decision whether to accept hospitalization or not, no real freedom of choice is possible, and it is proper for the state, as *parens patriae*, to make the choice for him. But when, although hospitalization is needed, the person is not dangerous and is able to exercise a responsible judgment of his own and he objects to being hospitalized, is the state justified in compelling him? The draftsmen decided no, and their judgment is no doubt politically wise. This much, however, might be said for going farther: granting that we do not want the state to infringe personal liberty except in vindication of an overriding social interest, society may have a very real interest in insisting on hospitalization, if the individual's refusal to accept treatment now is likely to result in his condition becoming worse, so that he may eventually either become dangerous, or cause the state greater expense because treatment was delayed too long. Political judgment in this field depends in part on how long a view we take of social interests.

In emergency cases, admission is made possible without waiting for the examination by two designated examiners. Where a physician on examination finds that a patient is mentally ill and is likely to injure himself or others unless immediately restrained, hospitalization may be had upon the doctor's certificate. Police and health authorities are also authorized, as a safety measure, to take disordered and dangerous individuals into custody and place them in a hospital, subject only to a requirement that the application set forth the circumstances and the reasons for the officer's belief that it would be unsafe for the person to go unrestrained pending examination.

All involuntary patients are required to be examined by the hospital staff promptly after being admitted, and emergency cases, admitted merely upon the certificate of one physician or without any medical certification at all, are to be examined by a designated examiner within five days. If not so examined, or if the examiner fails to certify that the person is mentally ill and likely to injure himself or others if allowed at large, the person must be immediately discharged.

To reduce the harmful effects of compulsory hospitalization and at the same time encourage obtaining care at an early stage, the act increases the scope and effectiveness of voluntary admission. Not only

those actually ill, but those showing some symptoms of mental illness could apply, the latter for observation and diagnosis. Admission to public hospitals would be without regard to ability to pay, subject only to availability of accommodations. Children under sixteen and persons under guardianship could be committed on application of the legal guardian.

The act imposes on the hospital staff the duty to examine every patient at least once every six months to determine whether involuntary hospitalization is any longer justified. It is recognized that the adequate performance of this obligation would be difficult without adding to the staffs of some hospitals. Release may be made conditional upon receiving out-patient or non-hospital treatment or on other reasonable terms.

Involuntary patients not under court order may demand release at any time, and on such demand, must be released within forty-eight hours unless the hospital applies to a judge for postponement, supported by a certification that release would be unsafe for the patient or for others. Judicial proceedings are then held. Patients under court order may also obtain re-examination of their cases by applying to the court. Abuse of this privilege is forestalled by limiting the right to one application per year.

The periodic six-month examination requirement would almost certainly require adding to the staffs of most hospitals, already seriously under-staffed. To offer more than merely custodial care, a mental hospital should have one psychiatrist for every 30 acute patients and one for every 200 chronic patients. Since there are 650,000 patients in psychiatric hospitals in the United States and only 6,000 psychiatrists—including those *not* on hospital staffs—the shortage is critical.

The draft act covers all cases involving psychiatric or other disease substantially impairing mental health, and is intended to include sexual and other psychopaths and chronic alcoholics, but not the mentally defective. The draftsmen of the act state, "It is questionable, however, whether there is a compelling need for separate statutory provision for the mentally defective and whether procedures suitable for hospitalization of the mentally ill would not be equally suitable for the mentally defective." This act could be extended to cover defectives simply by broadening the definition of "mentally ill individual."

The legal safeguards which the draft provides are amplified and particularized in a novel "bill of rights" for patients. This sets forth not

only general rights, such as the right to "humane care and treatment" and to the highest standards of medical care possible with the facilities and personnel available, but also the right to communicate by sealed mail, to receive visitors, and to exercise civil rights, including the right to dispose of property, make contracts, and to vote, except insofar as one may have been declared incompetent to exercise such rights.[53] Mechanical restraints are not to be applied except where found necessary by the head of the institution, and every use of such a restraint and the reasons therefor is to be part of the clinical record of the patient. Right to the writ of habeas corpus is specifically preserved.

The act also deals with such aspects of commitment procedure as detention in jail pending conveyance to the hospital and the method of transportation. While recognizing that detention in jail is among the worst of current practices, the draft realistically faces the fact that situations will arise where no alternative exists. It provides that, pending removal to a hospital, the patient may be detained in his home, in a licensed foster home, or in some other suitable facility under conditions fixed by the local health authority, but shall not be detained in a jail "except because of and during an extreme emergency." To avoid the unfortunate effects of transporting mental patients by police officers in conveyances used for criminals, the draft permits the family or friends to arrange for transportation by private means, or to request the local health officers to arrange for transportation.

This model act offers an immense improvement over traditional legal procedures. It is ingeniously devised to allow voluntary or involuntary hospitalization without needless legal red tape, and yet to provide the fullest kind of judicial hearing in any case where the person wants it. The New Mexico legislature has already been called upon by the state conference on social welfare to adopt it to replace that state's monstrously criminalistic procedure, and similar movements are under way in other states.

[53] Most states today recognize that commitment to a hospital does not of itself constitute a determination of incompetency or a deprivation of civil rights. However, to avoid the possibility of misconstruction arising from failure to distinguish between commitment and incompetency proceedings, it is well for statutes specifically to provide that commitment should not entail incompetency or deprivation of civil rights. An example of the effect of failure to differentiate between commitment and incompetency is Johnson v. Nelms, 171 Tenn. 54, 100 S.W. (2d) 648 (1937), holding that the right to jury trial applies to commitment proceedings, because jury trial was employed in North Carolina in lunacy inquisition proceedings prior to 1796, when Tennessee became a state.

Discharge from Hospital: Habeas Corpus

There is widespread belief that patients once committed are rarely discharged as cured. Unfortunately, this is more true than it should be. Too many state institutions are so niggardly supported that thousands of patients who could be cured with proper treatment are allowed to deteriorate into hopeless conditions because the hospitals are not equipped to do more than to keep them confined. Albert Deutsch, in his two books, *The Mentally Ill in America* and *The Shame of the States,* has done much to publicize the tragic conditions in which these wretched unfortunates are maintained. Apart from any humanitarian considerations, it is short-sighted economy to deny the institutions the funds necessary for therapeutic work, with the result that patients who could be cured and discharged after a relatively short time have to be kept for the rest of their lives.

Nevertheless, for every three patients admitted each year, two are discharged.[54] Some of these have to be returned later, but the fact remains that even with the little therapeutic work now being done, there is reason to expect that most of the patients admitted will be improved sufficiently to be discharged within a relatively short time.

Where the patient was admitted voluntarily, or for temporary or emergency care, the discharge is final, but regularly committed patients are frequently released conditionally, or on temporary visit or "parole," in order to provide a period of readjustment to community living.[55] In a few states, the patient may be boarded out with a private family. Originating in Massachusetts in 1885, this "family care" arrangement was adopted in several other states during the depression of the 1930's.[56] The patient so boarded out is considered in the constructive custody of the institution and may be returned thereto without further legal process.[57]

[54] Census figures for 1943 showed that while approximately 250,000 persons were admitted, about 160,000 were discharged, not including those who died or were transferred to other hospitals. BUREAU OF CENSUS, PATIENTS IN MENTAL INSTITUTIONS 1943 (1945).

[55] The right to impose conditions on release has been upheld "for obvious reasons of public policy." Murray v. Murray, 313 Mass. 8, 45 N.E. (2d) 933 (1943). Modern statutes avoid the use of terms with criminal overtones, such as "parole." See N.Y. Mental Hygiene Law (McKinney, 1951) §87, as amended N.Y. Laws 1946, c. 732, which refers to "convalescent status."

[56] POLLOCK, FAMILY CARE OF MENTAL PATIENTS (1936). See for example Va. Code (Supp. 1946) §§1037a to 1037d.

[57] Dodrer v. Dodrer, 183 Md. 413, 37 A. (2d) 919 (1944).

The administrative head of the institution is usually given the power to discharge, without reference to the committing authorities. This is as it should be. Fitness to be released is best determined by the hospital authorities who have the patient under daily supervision. There is little danger that hospital administrators will misuse this power to detain persons who can safely be released. The public institutions are practically all crowded and therefore under pressure to release as many patients as possible. Any abuse that may occur is subject to correction by the official supervisory bodies which exist in almost all states for the public institutions. Less than half the states subject private sanatoria to official supervision, and it is here, if anywhere, that the possibility of improper detention for pecuniary gain exists. Any patient may write to the supervisory board, under seal and without censorship, and his mail must be forwarded by the institution. The boards typically review all admissions, and interview all patients. Not only may the board on its own initiative order the release of any patient it deems proper, but the patient is frequently given the right to an administrative appeal. In some jurisdictions, statutes permit application to the courts for release, and even without such specific provision, there is always the universally recognized right to petition for release on habeas corpus.

Habeas corpus in Anglo-American jurisprudence is available to any person who claims he is being restrained of his liberty illegally, and this includes anyone restrained in a mental hospital. And since even formal commitment is ordered to continue only so long as the person needs care and custody, it is always open to him to petition for the issuance of a writ on the ground that he is now sane and so entitled to release. In only a few jurisdictions are there any restrictions imposed on the frequency with which application may be made, and these usually extend only to persons committed after being acquitted of crime by reason of insanity.

Resort to habeas corpus in mental cases may give rise to one of two questions: first, whether the proceedings for the commitment of the patient were in accordance with law and were carried out in a tribunal of competent jurisdiction and, second, if the commitment procedure was legal, whether the patient has been restored to mental health and should therefore be released.

In some states the writ is resorted to almost not at all by mental patients, whereas in other jurisdictions, the number of petitions has at

times attained such proportions as to call for judicial attention and correction. In the District of Columbia prior to 1945, petitions for the writ were used, as the Court of Appeals for the District found, "not only as they should be to protect unfortunate persons against miscarriages of justice, but also as a device for harassing court, custodial and enforcement officers with a multiplicity of repetitious, meritless requests for relief." During a period of less than five years one person had presented fifty petitions, another twenty-seven and still another twenty-four. A total of 119 persons had presented an average of five petitions each during that period. The court laid down a rule that the trial judge, although convinced of the sanity of an applicant for habeas corpus, does not have power to release him forthwith, and can do no more than order the original inquiry reopened with the Commission on Mental Health participating.[58] Five years later, in 1950, the court overruled that decision, on the ground that it was not justified under the statute, but it confirmed the view that it is desirable for the judge to utilize the expert services of the commission, even though he is not required to do so.[59] It is to be hoped that the relaxation of the rule in force from 1945 to 1950 will not lead to a repetition of the sort of incident which occurred a few years before 1945, when a mental patient shot and killed the lawyer who a few days before had won his release on habeas corpus!

Other courts have also stated that trial judges should exercise caution in ordering the release of persons as sane who the superintendent of the hospital believes require continued custody. Where the petition is based on the ground of alleged defect in jurisdiction or procedure, the United States Supreme Court and other federal courts have held that the petitioner should not be ordered discharged, notwithstanding such defect, if the evidence indicates that he is not actually insane, but his continued restraint should be ordered until proper proceedings can be had.[60]

Commitment of Feebleminded

Because special problems are deemed to be involved, most states make separate statutory provision for certain groups, such as the feeble-

[58] Dorsey v. Gill, (D.C. Cir. 1945) 148 F. (2d) 857, cert. denied 325 U.S. 890, 65 S.Ct. 1580 (1945).

[59] Overholser v. Boddie, (D.C. Cir. 1950) 184 F. (2d) 240; see also Stewart v. Overholser, (D.C. Cir. 1950) 186 F. (2d) 339.

[60] Ekiu v. United States, 142 U.S. 651, 12 S.Ct. 336 (1892); Kuczyniski v. United States, (7th Cir. 1945) 149 F. (2d) 478.

minded, sexual psychopaths and alcoholics. The group most commonly so dealt with are the feebleminded. A feebleminded, or mentally defective, person may for legal purposes be just as "insane" as a person suffering from an acquired mental disease; that is, he may be unable to understand the nature of a criminal act he committed, or may be incompetent to make contracts or manage his affairs, or may need hospital care and treatment. However, such persons are usually simple, quiet people who are not dangerous. In so far as they are likely to commit crime or do other dangerous acts, it is probably because of their suggestibility or childish inability to foresee consequences. The emphasis in commitment of defectives, therefore, is primarily on training and education, rather than on protection of the public against dangerous persons, and the institutions for their care are more often referred to as schools than as hospitals. Although the same general principles govern as in commitment of the insane, the procedure is frequently in a different court, namely, the probate court, which traditionally has jurisdiction of such matters as guardianships, orphans, etc. In some states, a parent may sign an application for the admission of a feebleminded minor for admission to an institution.

There are more than 110,000 mentally defective persons in American institutions. Probably every public institution for such persons is overcrowded and has a waiting list. Experts estimate that there are at least ten times as many mental defectives who need institutional care as are now actually receiving such care. Albert Deutsch, in his book, *The Shame of the States,* tells of a case where the family had to wait *thirty years* before a feebleminded son could be admitted.[61] This happened in Ohio, where conditions are no worse than in most states. The nervous and financial strain on families burdened with the care of low-grade mental defectives in the home, and the effect on normal brothers and sisters, is a tragic and costly price which lack of institutional facilities entails.

Commitment of Alcoholics

"To the public, an alcoholic presents a picture of a bleary-eyed, bulbous-nosed, shaky creature, disheveled and uncombed, often in the hands of a burly policeman who is ushering him none too gently into the depths of a patrol wagon."[62] Actually, more than half of the

[61] DEUTSCH, THE SHAME OF THE STATES 123-127 (1948).
[62] STRECKER AND CHAMBERS, ALCOHOL, ONE MAN'S MEAT 21 (1938).

alcoholics come from the professional, white collar and skilled worker classes.[63] The skid-row derelict is more conspicuous on our public streets and on the police blotters, but he is only the lesser part of the problem. It was estimated that there were over 3,000,000 excessive users of alcohol in the United States in 1945, of whom 750,000 were chronic alcoholics. The figures are probably higher today.[64] The cost to society—the direct monetary cost alone—is probably more than one billion dollars annually.[65]

Traditionally, we have tried to meet the problem of alcoholism by penal law. But there is probably no drearier example of the futility of using penal sanctions to solve a psychiatric problem than the enforcement of the laws against drunkenness. Every night in every town and city the police pick up drunks on the streets and lock them up in the "drunk tank." In the morning they are released or sentenced to a short term in jail, only to be picked up again soon after their release. It is not unusual for some of these chronic drunks to have records of fifty arrests or more. No one defends this futile procedure, but it goes on, day after day, in every city in the land. This in spite of the fact that it has been recognized for a century, in certain circles at least, that inebriety is a medical rather than a criminal problem. Writing in 1877, Sir Arthur Mitchell stated unequivocally, "It should be at once understood that alcoholic intoxication, i.e., ordinary drunkenness, is really a state of insanity."[66] In 1914, Thomas Davidson Crothers, at the close of a lifetime devoted to the study of the relationship of alcoholism to

[63] Of 145 men and 29 women at two clinics, 7.5% were professional or executive, 17% white collar, 35.5% skilled, 32.4% unskilled and 7.6% others. Jellinek, "Notes on the First Half Year's Experience at the Yale Plan Clinics," 5 Q.J. OF STUDIES ON ALCOHOL 279 at 298 (1944).

[64] Jellinek, "Recent Trends in Alcoholism and in Alcohol Consumption," 8 Q.J. OF STUDIES ON ALCOHOL, 1 at 22, (1947). Cf. ENGLISH AND PEARSON, EMOTIONAL PROBLEMS OF LIVING 356 (1945), estimating the number of alcoholics in the United States at 1½ million, and RENNIE AND WOODWARD, MENTAL HEALTH IN MODERN SOCIETY (1948), who say (p. 138), "There are a million chronic alcoholics in this country."

[65] In 1940, the three million alcoholics then in the United States cost the country over $778,000,000 made up of the following items: $12,000,000 for care in mental hospitals; $18,000,000 for cost of illness over the normal; $188,000,000 as the cost of crimes in large part referable to alcoholics; $89,000,000 in injuries and property damage accidentally committed; $25,000,000 for maintenance of "drunk tanks" in county jails; $21,000,000 for support of families of alcoholics by private welfare agencies (expenditures of public agencies, not here included, probably are even larger); $431,000,000 in lost wages.

See comment, 2 STANFORD L. REV. 515 at 516-517 (1950).

[66] Quoted in Christie, "Intoxication in Relation to Criminal Responsibility," Scots. L.T. News 75 at 80 (1919-1920).

mental disorder and crime, said: "Each new advance in the physiology of the brain and in psychology gives new conceptions of the nature of criminals and their repression and control, and at no distant time the present treatment of inebriates and alcoholics will be considered very much as the efforts of our forefathers to suppress witches."[67]

Most states now make it possible to commit chronic alcoholics to a state mental institution.[68] But mental hospitals, already over-filled with psychotics and others suffering from serious disorders, understandably do not want to give any of their limited facilities to cases which they are not in a position to treat effectively, and for which the prospects of permanent rehabilitation seem dim. Because of crowded conditions, the hospitals are usually unable to segregate the alcoholics from other patients, and without segregation the effectiveness of hospitalization is much reduced.

Beginning with New York in 1858, a number of states have from time to time undertaken to set up special institutions for the care of persons addicted to the excessive use of alcohol or of narcotic drugs. With the possible exception of the United States Public Health Service hospitals for drug addiction, these institutions do not seem to have achieved conspicuous success, and some of them have been abandoned.[69] The alcoholic typically does not show immediate symptoms of disorder, and after a period in the institution without access to liquor, he may make an excellent appearance. Unfortunately, experience shows that he is very likely to suffer a relapse. He may go a year or more after his release without touching a drop, and then on some special occasion be persuaded that he can take "just one"—and go off on another bout.

The search for the proper methods of care and treatment has led a number of states to establish inebriate colonies, or farms. California adopted a law for the establishment of state inebriate colonies in 1939,[70] but no funds have ever been appropriated for these colonies. However, the City of Oakland has a farm to which drunks picked up by the police may be sent, and it seems to be doing effective work.

Voluntary admission of alcoholics is permitted in some states where the statutes providing for voluntary admission of the mentally ill are

[67] Crothers, "Criminality from Alcoholism," 4 J. CRIM. L. 859 at 866 (1914).

[68] NAT. COMMITTEE FOR EDUCATION ON ALCOHOLISM, BULLETIN ON LEGISLATION (1949).

[69] BACON, THE ADMINISTRATION OF ALCOHOLISM REHABILITATION PROGRAMS 20, 34-35 (1949).

[70] Cal. Welfare and Inst. Code (Deering, 1944) §7100 et seq.

broad enough to include alcoholics. But experience with voluntary admission has been unsatisfactory, primarily because the constraint and the deprivation of alcohol is more than the voluntary patient is able to bear, and he therefore demands his release. In consequence, voluntary admission has largely fallen into disuse.

Notwithstanding our failure to achieve notable success to date, there is reason to believe that a majority of alcoholics could be cured and readjusted to normal living, under proper care and treatment.[71] A number of states are now embarked on programs of study, investigation and public education, and enlightened laws for the treatment of alcoholics have been adopted in Connecticut, the District of Columbia, New Hampshire and several other states.[72] A comprehensive program should include the following features:[73]

1. The program should be blocked out by the legislature in broad and flexible terms, leaving specific methods and procedures to be formulated by a central administrative agency. We have too little certain knowledge in this field for the legislature to lay down many specific rules. The state agency should supersede or at the very least should co-ordinate as far as possible the work of local governments.

2. Drunks picked up by the police and alcoholics for whose commitment petitions are presented by relatives or by public welfare officers should be sent to a receiving station or screening center for mental and physical examination. They should be retained here for a reasonable number of days, until diagnosed and classified and recommendation for disposition arrived at.[74] A program such as here envisioned, if adequately financed, could do much to add to our understanding of the various forms of alcoholism.

[71] Bacon, "The Mobilization of Community Resources for the Attack on Alcoholism," 8 Q.J. OF STUDIES ON ALCOHOL 473 (1947). San Francisco's alcoholic clinic has reported successful rehabilitations in 50% of its cases. SAN FRANCISCO DEPT. OF PUBLIC HEALTH, ALCOHOLIC CLINIC REPORT (1949).

[72] NAT. COMMITTEE FOR EDUCATION ON ALCOHOLISM, BULLETIN ON LEGISLATION (1949). Connecticut has appropriated 9% of liquor revenues for the study and treatment of alcoholism; the District of Columbia, 10%. A number of other states have made appropriations of over $100,000 for the purpose.

For examples of recent laws for treatment of alcoholics, see Conn. Gen. Stat. (Rev. 1949) §2725 et seq.; N.H. Laws 1949, c. 313; N.C. Sess. Laws 1949, c. 1206; Ore. Laws 1949, c. 552; Va. Code (1950) §32-365 et seq.; Wis. Stat. (1949) §51.40 et seq.

[73] An excellent proposed program with particular reference to California is found in a comment, 2 STANFORD L. REV. 515 (1950).

[74] Types of alcoholics are discussed in LANDIS AND BOLLES, TEXTBOOK OF ABNORMAL PSYCHIATRY 182-187 (1947); Bowman and Jellinek, "Alcohol Addiction and its Treatment," 2 Q.J. OF STUDIES ON ALCOHOL 98 at 104-105 (1941).

3. Commitment proceedings should be instituted in those cases where the agency so recommends. Whether commitment should be by a judicial or an administrative tribunal is a question we have already discussed in connection with commitment generally. Medical men would certainly favor having the matter handled by a panel of experts, which could be part of the administrative agency in control of the program. Adequate safeguards could be thrown around the action of the panel to assure against arbitrariness. However, if this seems too radical a departure from traditional concepts of due process, a procedure could be provided which retained ultimate control in a court, but with the actual hearing before a panel, as in the model act governing hospitalization of the mentally ill sponsored by the National Institute of Mental Health. Or judicial procedure could be used for commitment of those found to be actually psychotic or otherwise committable as mentally ill, with other alcoholics committed administratively. Even if judicial control is retained, jury trial should not be used. What has been said above regarding the undesirability of using a jury in commitment proceedings applies equally to commitment of alcoholics.[75]

Commitment should be for an indeterminate term. This is less drastic in the case of alcoholics than in most forms of mental illness, for rehabilitation can in most cases be effected in a year or two. The authority should be empowered to release on "convalescent status"; a probationary period after release is helpful in bridging the gap between hospital life and freedom and in keeping the alcoholic sober during this difficult readjustment. Continued psychiatric treatment could be provided during this period on an out-patient basis.

4. In a large percentage of cases, no commitment would be found necessary. Many, perhaps most, alcoholics could be treated on an out-patient basis alone. Others would be encouraged to join Alcoholics Anonymous and to obtain the help of other social welfare organizations. Cooperation with such groups and education of the patient's family to obtain their enlightened cooperation would be among other activities of the agency.

[75] Proceedings for commitment of alcoholics are parental and not punitive in character, and therefore constitutional provisions entitling persons accused of crime to a jury trial do not apply. Barry v. Hall, (D.C. Cir. 1938) 98 F. (2d) 222; Matter of Application of O'Connor, 29 Cal. App. 225, 155 P. 115 (1915); In re Hinkle, 33 Idaho 605, 196 P. 1035 (1921); In re Noble, 53 Idaho 211, 22 P. (2d) 873 (1933). In Illinois, New York, Virginia and some other states, the statutes permit jury trial on demand. Ill. Rev. Stat. (1949) c. 91½, §6; N.Y. Laws 1948, c. 32; Va. Code (1942) tit. 12, c. 46, §1071.

5. In its provincial form, Alcoholics Anonymous is sometimes anti-scientific, putting its trust in a vulgarized Jehovah. The agency could provide guidance to help such groups avoid letting their potentialities drift into shallow waters.

The cost of such a program would be considerable, but it would be less than the cost we now pay for alcoholism. It could be financed if only part of the revenues now derived from liquor taxes were devoted to the purpose.