1947

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Recommended Citation
ANALYSIS OF LEGAL AND MEDICAL CONSIDERATIONS IN COMMITMENT OF THE MENTALLY ILL, 56 Yale L.J. (1947). Available at: http://digitalcommons.law.yale.edu/ylj/vol56/iss7/3

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ANALYSIS OF LEGAL AND MEDICAL CONSIDERATIONS IN COMMITMENT OF THE MENTALLY ILL

Increasing psychiatric understanding of the nature of mental disease has brought to light the vast scope of the mental health problem. Mental patients now occupy over one half of the hospital beds in the country. In addition to about 600,000 institutionalized cases, it is estimated that at least 8,000,000 of our population suffer from some sort of mental disease. Total annual cost of mental illness, including loss in earning power, amounts to over a billion dollars a year.1 Pointing up sharply the extent of the drain on national re-

1. Bowman, Presidential Address, 103 Am. J. Psychiatry 1, 5 (1946); Parran, One Out of Ten, This Week Magazine, Nov. 17, 1946, p. 7. A valuable annual statistical account of patients in hospitals for mental disease is: U. S. Bureau of the Census, Patients in Mental Institutions.

The 8,000,000 of population and the billion dollars a year probably include psychoneurotics as well as psychotics. The general distinction made between these classifications of the mentally ill is that only the latter are usually fit subjects for hospitalization. The following analysis of commitment procedures will be concerned only with the hospitalization of patients afflicted with mental illness generally within the psychotic classification. Hospitalization of non-psychotic mental defectives, epileptics, alcoholics and drug
sources by mental disease is the fact that neuropsychiatric disorder was the largest single cause of draft rejections and the cause of forty-one percent of all Army medical discharges.\(^2\)

The critical nature of the problem suggested by these statistics has been recognized by the unanimous passage of the National Mental Health Act on July 3, 1946.\(^3\) This Act gives authority to the Public Health Service to extend its administration of research, grants-in-aid and fellowships to the field of mental illness and authorizes the establishment of a National Institute of Mental Health along the lines of the National Cancer Institute.\(^4\) It is ex-

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The Committee on Mental Health of the Third National Conference on Health in Colleges reported that psychiatric consultation or care is needed by fifteen percent of all college students, one third of whom are urgent cases. N. Y. Times, May 9, 1947, p. 44, col. 1.

\(^3\) 60 Stat. 421, 42 U.S.C.A. § 201 (Supp. 1946). Before the passage of the National Mental Health Act the closest Congress had come to legislating in this field was in 1848 when it was inspired by Dorothea Lynde Dix to pass a 5,000,000 acre grants-in-aid bill for the construction of mental hospitals and the treatment of the dependent insane. Only President Franklin Pierce's veto on the ground that the bill was an unconstitutional trespass of state power aborted a premature partial assumption by the nation of a duty toward its dependent classes. Tiffany, *Life of Dorothea Lynde Dix* 166-200 (1890); Deutsch, *The Mentally Ill in America* 175-9 (1937); Hurd, *The Institutional Care of the Insane in the United States and Canada* 116-20 (1916).

A great private contribution to national mental health has been made by the National Committee for Mental Hygiene, the founding of which in 1909 signified the beginning of a mental hygiene movement. Largely responsible for the success of this organization was its founder, Clifford W. Beers. See Beers, *A Mind That Found Itself* (25th Anniversary Ed. 1935) and Deutsch, *supra* at 300-30. Another national private organization, the National Mental Health Foundation, has recently been established mainly by former conscientious objectors whose present work on behalf of the mentally ill was inspired by their wartime experience as attendants in state mental hospitals. See McGinty, "Bedlam's" Answer, 106 Forum 124 (1946). These national private organizations are supplemented on the state level by privately organized mental hygiene societies in over one third of the states.

\(^4\) *Hearing before Subcommittee of the Committee on Interstate and Foreign Commerce on H. R. 2530, 79th Cong., 1st Sess. 9-14* (1945). For a full discussion of the
pected, however, that only those mental patients treated by personnel connected with teaching and research projects will be affected by federal expenditures. Mental health administration is primarily a state responsibility, and the legal procedure involved in the commitment and release of mental patients is, therefore, a subject of state legislation.

State commitment statutes, reflecting the accidents of local experience and historical influence, are varied in the extreme. Many fail adequately to integrate the different, and frequently conflicting, considerations involved in the commitment process—the right of an individual to be protected against wrongful and improper commitment; the medical interest of a mentally ill person in being handled by the best therapeutic method; and the interest of the community in being protected from irresponsible acts of a mentally ill person.

The Problem of Commitment

The problems which commitment laws are designed to meet stem directly from the nature of mental illness, as contrasted with illness of a largely organic nature. Organic illness does not principally affect the patient's orientation and emotional balance and is usually accompanied by discernible symptoms of physical disorder. On the other hand, a mentally ill person often has no discernible physical symptoms, may not realize he is sick and may not believe his physician or his family. He may "rationally" explain his disbelief by delusions, e.g., of persecution or grandeur, all of which may be a part of


6. Originally public care of the mentally ill was solely a town or county responsibility. The 19th century witnessed state participation in providing for the mentally ill and in supervising local facilities, and in 1890 New York passed the first State Care Act, making state care coterminous with public care. Craig, The New York Law for the State Care of the Insane, 48 Am. J. Insanity 171 (1891). To the extent that well-defined systems of public care have been developed, most states have followed New York; but Wisconsin and a few other states have followed the Wisconsin plan of improving mental health facilities within a framework of county care under state administrative control. Deutsche, op. cit. supra note 3, at 229–71; 1 Hurd, op. cit. supra note 3, at 163–75.

Public care as contrasted to private care accounts for about ninety-eight percent of the patients in mental hospitals. U. S. Bureau of the Census, Patients in Mental Institutions 1943 5 (1946). Considerations underlying the evolution of the public function in this field are discussed by Brownlow, Mental Health Administration As a Function of Government in Pub. No. 9 of the Am. Assoc. for the Adv. of Sc., Mental Health 362 (1939).


his illness. His lack of cooperation may be intensified by ignorant notions about mental disease, formed before his affliction and drawn from long standing popular association of mental illness with immorality, supernaturalism, criminality and pauperism. In the commitment process, as provided for by state statute, therefore, a mentally ill person may have to be taken to a hospital and detained against his will by an exercise of power authorized by law.

Assuming that the basic consideration in this process is to serve the medical welfare of the sick person, commitment would seem to be most properly handled primarily by authorized medical personnel. Yet the other, and sometimes conflicting, considerations bound up with protecting the person from wrongful and improper commitment and safeguarding the community’s interest against dangerous insane persons have generally deflected the statutory process from serving its basic function. Thus commitment has, in fact, been handled primarily by judges and county insanity commissions conducting statutory proceedings similar in their nature to criminal cases. 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.

These practices have been consistently criticized because of their anti-therapeutic effects. The patient, unable to cope with his normal surroundings and social relations, may become unduly excited and confused. His illness may be aggravated by delay in getting into a hospital environment, by inadequate treatment in jail or even at home while hospitalization is still pending, and by any suggestion in the procedure that he is an accused. He and his family also suffer from the various stigmas attached to insanity, which may be intensified by a judge’s insanity decree, or worse, by a jury’s insanity

9. For simple orientation to the nature of mental illness, see Thorman, Toward Mental Health (Public Affairs Pamphlet No. 120, 1946); Stern, Mental Illness: A Guide for the Family (1942). For specific reference to the legal effect of various mental illnesses, see Coon, Psychiatry for the Lawyer: The Principal Psychoses, 31 COll. L. Q. 327 (1946).

10. Thorman, supra note 9, at 26-7; Kempf, supra note 7, at 3. See notes 33-5 infra.

11. See, e.g., answer by the Attorney-General of Kentucky to Questionaire of the American Bar Association Special Committee on Rights of the Mentally Ill, enclosed in communication to the Yale Law Journal from Eldon S. Dummit, Attorney-General of Kentucky, March 20, 1947; Kansas Legislative Council, Psychiatric Facilities in Kansas: Objectives of a State Program 5 (1946); Myers, Commitment Laws in California, 39 Calif. & Western Medicine 313, 317 (1933); Blumer, The Commitment, Detention, Care and Treatment of the Insane in America, 50 A.M. J. Insanity 538, 539-40 (1894).

Formal court proceedings to investigate a person's mental condition are, furthermore, believed to enhance public reluctance to seek psychiatric advice at the early stages of mental illness, when possibilities of cure are greatest.\textsuperscript{14}

Introduction of less formalized commitment procedures, demanded by therapeutic considerations, has apparently to contend with two underlying public attitudes: (1) fear that a well person may be fraudulently "railroaded" to a mental hospital and (2) reliance on the court as the traditionally appropriate public authority to deprive a person of his liberty, particularly in view of the still imperfect state of psychiatric knowledge and facilities. While there have been actual cases of collusion in commitment,\textsuperscript{15} this fear has probably been exaggerated by the frequent use of "railroading" as a plot device in fictional writing and by stories of patients who blame others for their commitment—a natural turn of the mentally sick mind.\textsuperscript{16} A limited type of

Our Inadequate Treatment of the Mentally Ill, 56 PUBL. HEALTH REP. No. 40 1941, 1943 (1941).

13. See pp. 1192-3 infra.


15. The note in 145 A. L. R. 711 (1943) on actions for false imprisonment or malicious prosecution predicated upon institution of, or conduct in connection with, lunacy proceedings contains many of the litigated cases on alleged "railroading." The most famous "railroading" case was that of Mrs. E. W. Packard in 1860. For its affect on commitment statutes, see note 61 infra. It is important to realize that she was committed by her husband under a statutory provision unique among the commitment laws and obviously unconstitutional: "Married women and infants, who in the judgment of the medical superintendent are evidently insane or distracted, may be received and detained in the hospital on the request of the husband, or the woman, or parent, or guardian of the infants, without the evidence of insanity or distraction required in other cases." (Emphasis added.) Ill. Laws 1851, § 10, p. 96, 98.

16. See Ray, MEDICAL JURISPRUDENCE OF INSANITY § 613 (1871). Ray referred to an American, an English and a French insanity authority whose experiences refuted the notion of improper admissions. Psychiatrists still not only can refute it, but feel that it is necessary to do so: "I have been in psychiatry for over thirty years. . . . In all this time I have seen only two attempts at railroadings, and neither of them was successful." Bowman, supra note 1, at 11. "In my ten years in mental hospitals I can only think of two patients who were improperly committed and even in them that mistake was readily excusable. . . ." Communication to the National Mental Health Foundation from Dr. Robert A. Clark, Clinical Director of the Western State Psychiatric Institute and Clinic in Pennsylvania, April 23, 1947. In order to combat the opposition to a pending Wisconsin revised commitment statute, Senator Buchen has found it necessary to prepare a statement of seventeen points wherein the provisions of the new bill protect the patient from railroadings more effectively than the present provisions. Communication to the Yale Law Journal from Dr. Esther H. de Weerdt, Executive Director of the Wisconsin Society for Mental Health, April 4, 1947. The seventeen points are listed in the publication of the Wisconsin Society, 10 MENTAL HEALTH Nos. 1-2 13 (1947). The full force of public fear of railroadings may be realized by a comparison between public apathy toward the subhuman living conditions of the patients in some mental hospitals and public
"railroading" problem may frequently arise, however, in the case of a person whose unconventional conduct may irritate, embarrass or worry the members of his family to such an extent that they may encourage his commitment without caring whether hospitalization is what he really needs.\textsuperscript{17} Their success depends on being able to induce the concurrence of the committing authority. In any case a disinterested, publicly constituted committing authority, whether it be made up of physicians or judges, or both, will minimize the dangers of "railroading."

The relative roles played in the commitment process by expert medical judgment and the arm of the judiciary present delicate problems. In the great majority of cases the physician's opinion will be accepted, but in a borderline case the judge may assume the burden of decision. The judgment called for here is complex, involving a knowledge of the nature of the illness, and prognosis of the benefit of hospitalization, the possibilities of cure and the likelihood of the patient becoming suddenly dangerous. Where the determination emphasizes the advisability of treatment, it would seem to call for medical rather than judicial authority. In a certain type of case, however, where custodial rather than curative aspects of commitment are predominant,\textsuperscript{18} medical opinion may be deemed subordinate to the more broadly grounded judicial opinion. For example, a garrulous hitchhiker, who has been a mild nuisance to the community for some time, but who has evidenced no serious psychotic tendencies and who is not considered a fit subject for therapeutic treatment, represents a case in which the advisability of institutionalization may depend principally on a social judgment of the community on the extent of its toleration for his troublesome antics.\textsuperscript{19} Sole reliance on medical authority in the commitment process is also opposed by present inadequacies in indignation toward the alleged illegal commitment of one man or woman. \textit{Deutsch, op. cit. supra} note 3, at 418. A psychological explanation for this public indignation is that community guilt for its neglect and cruelty to the lunatic finds displacing mitigation in fancying the villainy of the medical man from whom the lunatic must be protected. Communication to the Yale Law Journal from Dr. Philip Q. Roche of Philadelphia, May 27, 1947.

17. Interview with Dr. Frederick C. Redlich, Asst. Prof. Psychiatry and Mental Hygiene, Yale University Medical School.

18. As psychiatrists find treatment cures for more and more types of mental illness, their interest is to get away from any reference to the custodial function of mental hospitals. Interview with Dr. Manfred S. Guttmacher, Chief Medical Officer of the Supreme Bench of Baltimore. But there are still many mental patients whose hospitalization may be justified merely in terms of a necessary or more beneficial environment. "In the coming years the medical profession and the public must insist that custodial care for acute cases is no longer adequate. . . . In spite of every skilled effort some mental cases will, as far as we can now see, nevertheless become chronic . . . ." \textit{Ruggles, Mental Health, Past, Present and Future} 84-5 (1934).

numbers of psychiatrists and other kinds of specially trained personnel, in psychiatric training and in mental health facilities. While, in the future, cures may be found for some of the presently incurable diseases and conditions in mental health services may be improved, procedural reforms in the commitment process should be thought of in terms of existing psychiatric limitations. But even where the judge may serve a useful purpose in the commitment process, a formalized court proceeding as in ordinary criminal cases would seem to be ill-advised.

While undue emphasis on the considerations of protection against improper commitment has occupied the center of current interest in this problem, the facts of chronological development have also been important. It is only recently that psychiatry has been able to offer any adequate empirical basis for diagnosis, prognosis and therapy. But long before psychiatry as a science offered any conception of insanity as another disease, the law had to manage the consequences of mental illness as they affected the interests of the community. When a person's derangement caused him to mismanage or abandon his property or to become a threat to his own or the public's safety, the State intervened as sovereign protector. The non-dangerous insane without property, on the other hand, merely roamed the countryside or became public charges on local communities. The first public insane asylums in the 18th century were merely extensions of local poorhouses. Special statutory procedures for admission were not generally enacted until the second half of the 19th century, and the interest of the community in self-protection

20. See notes 104 and 137 infra.
21. See Weihofen and Overholser, supra note 8, at 340-3; pp. 1192-6 infra.
22. Zilboorg, Legal Aspects of Psychiatry in One Hundred Years of American Psychiatry 511 (1944).
23. OERDROAUX, LUNACY LAWS OF NEW YORK 1 (1878); SMOOT, THE LAW OF INSANITY § 150 (1929).
24. It is important to evaluate in proper historical perspective the wholly inadequate care afforded the mentally ill by the first insane asylums, which at that time "included all that the mind of the public or of the medical profession conceived to be necessary." Hurd, op. cit. supra note 3, at 139; Zilboorg, supra note 22, at 530.
25. Among the advocates for commitment legislation were the early psychiatrists who urged the need for a minimum of legal procedure to protect themselves and public officials from damage suits. Ray, Project of a Law for Determining the Legal Relations of the Insane, 7 AM. J. INSANITY 215, 217 (1851). In the famous opinion of Van Deusen v. Newcomer, 40 Mich. 90 (1879), the judges of the Michigan Supreme Court split two to two on the question of the sufficiency of a hospital superintendent's defense of good faith, and two to two on the question of the necessity for a court proceeding in a case of doubtful insanity. See Responsibility of Asylum Superintendents, 36 AM. J. INSANITY 259 (1880). A provision still on the Mississippi statute books codifies the law generally existing before the early commitment legislation: A patient not adjudged insane may be admitted upon an application by some one in his behalf, but in all such cases asylum superintendents and trustees "shall act at their peril if the person be sane." Miss. CODE § 6917 (1942).
was at that time still the predominant consideration in commitment of the mentally ill.

**Historical Influences on Commitment**

*The Community Interest in Self-protection.* The right to restrain an insane person against his will without legal process existed at common law whenever confinement was necessary to prevent personal or property damage. It was an emergency right and could be exercised only during the time necessary to obtain legal authority. In addition, when the question of confinement did come before a judicial officer, the allegedly insane person was considered simply as a dangerous person to be at large. He might be put in a jail, poorhouse, pen, strong room or any secure place.

Reflecting the initial common law doctrine, commitment in the early statutes was limited to the dangerous insane. One of the first signs of legislative recognition that the confinement of an insane person was an incident of his medical treatment was an 1842 New York law providing for expeditious transfer of the insane from the courts, poorhouses and jails to the State Lunatic Asylum. And in 1845 Chief Justice Shaw liberalized the common law limitation of "dangerous insanity" to include a sick mind likely to commit dangerous acts, thus recognizing a curative justification for judicial restraint.

While the sole criterion for commitment in early statutes was "dangerous to be at large," the New York Commissioner in Lunacy said in 1878 that "the proper test in all cases is the dangerous nature of his disease, not the dangerous character of his demeanor alone."

The present existence of this criterion in some commitment statutes manifests itself in the following:

26. Christiansen v. Weston, 36 Ariz. 200, 284 Pac. 149 (1930); Bisgaard v. Duvall, 169 Iowa 711, 151 N. W. 1051 (1915); Look v. Dean, 108 Mass. 116 (1871); Kelterer v. Putnam, 60 N. H. 30 (1889); 1 Cooley, Treatise on Torts 313-4 (3d ed. 1905). However, the person exercising this right assumes the burden of proving the imminent necessity of restraint in a suit against him for civil damages. Crawford v. Brown, 321 Ill. 305, 151 N. E. 911 (1926); Maxwell v. Maxwell, 189 Iowa 7, 177 N. W. 541 (1920); Boesch v. Kick, 97 N. J. L. 92, 116 Atl. 796 (Sup. Ct. 1922); Notes, 45 A. L. R. 1464 (1926); 10 A. L. R. 488 (1921). The necessity, therefore, is apparent for a statutory procedure under which mentally ill persons needing immediate treatment can be summarily admitted to mental hospitals. See pp. 1196-7 infra.


31. Oronozaux, op. cit. supra note 23, at 67. See the editorial in 39 Am. J. Insanity 85 (1882) vividly pointing out the unpredictability of the line between the harmless and dangerous insane and the price sane people in society must pay for the sake of preserving the liberty of the insane.
fests the continued association of mental hospitals with dangerous insanity and tends to perpetuate the stigma of criminality attached to mental illness.\textsuperscript{32} It is this kind of attitude on the part of legislators toward mental illness that is the basis of present provisions for the arrest of mentally ill persons,\textsuperscript{33} for their confinement in jail,\textsuperscript{34} and for their being transported to the hospital by a sheriff.\textsuperscript{35} The existing criminal-like features of commitment statutes should be unconditionally repealed. The emergency case can be adequately dealt with by providing for expeditious commitment facilities in mental hospitals and expeditious legal process for cases needing immediate attention.

The Community Interest in Property Aspects of Insanity. Property considerations involved in handling the mentally ill, as they affect the community, have been another historical influence tending to deflect the commitment ma-

\textsuperscript{32} E.g., Ariz. Code § 8–301 (1939) (dangerous to be at large); Ga. Code Ann. § 49–604 (1935) (violently insane); Idaho Code § 64–209 (1932) (endanger health, person or property); Wash. Rev. Stat. § 6930 (Remington, 1932) (unsafe to be at large); Note, 158 A. L. R. 1220 (1945); Smoot, \textit{op. cit. supra}, note 23, § 135. See also Note, 19 A. L. R. 715 (1922) (on what proof of mental condition is needed to justify discharge from a mental hospital).


\textsuperscript{35} A provision where only the sheriff is designated as the person to execute the commitment order, \textit{e.g.}, N. M. Stat. § 37–208 (1941), is rare, but most states provide for execution by the sheriff and either permit a relative to go along, \textit{e.g.}, N. D. Rev. Code § 25–0313 (1943), or permit the court to designate another person than the sheriff to execute the order, \textit{e.g.}, Ohio Gen. Code § 1890–38 (Page, 1937). In 1933 both houses of the California Assembly passed a liberalized commitment statute, which was vetoed by the Governor at the request of representatives of the California Sheriffs' Association, because it contained a clause removing the function of transporting mental patients to the hospital, thus depriving the sheriffs of a liberal source of fees. Myers, \textit{supra} note 11, at 317–9. While most states do provide that a female patient be accompanied by a woman or her close relative, \textit{e.g.}, Ill. Ann. Stat., c. 91½, §6–11 (Smith-Hurd, Supp. 1946), it has been urged that more serious attention be given to the provision on transportation, since the patient's impression received at that time may play an important part in his recovery. Stern, \textit{op. cit. supra} note 9, at 39–40. The Colorado Psychopathic Hospital has not accepted patients brought in patrol wagons. Weihofen, \textit{supra} note 14, at 102. Mental patients should be accompanied to the hospital by hospital personnel especially instructed on how to carry out this duty in the best therapeutic manner; but less than half of the states provide for this service by statutory requirement, \textit{e.g.}, N. Y. Mental Hyg. Law § 81 (2), or by judicial request, \textit{e.g.}, La. Gen. Stat. § 3938.23 (Dart, Supp. 1947).
chinery from its basic function of serving the medical welfare of the sick person. This influence has operated in two opposed fact situations. In the first, indigency, the community faced the problem of making some provision for the insane person who was not capable of providing economically for himself. In the second, where the insane person had property, the state as *parens patriae* was interested in seeing that its incompetent ward did not irresponsibly squander his estate.

Pauperism in the early 19th century was a classification within which no distinction was made for treatment purposes among the sick and invalid, the well and able-bodied, the old and young, the feeble-minded and the insane. The indigent insane were cared for as were other paupers, either in private homes with state support or in the public poorhouse. Thus hobbled from the very start by "that fetich of government—Economy," insane asylums and commitment laws had their origin.

Since at first public asylums were exclusively for the indigent, the investigation of the financial status of the alleged mentally ill and those legally responsible for him logically became a vital part of the early commitment proceeding, and is still included in the commitment statutes of many states. Likewise a determination of the indigent's legal residence came to be included, so that the proper local government unit would be charged for his support. While it is still necessary to determine the paying or non-paying status of the patient, this would seem to be a matter of financial administration, to be handled most efficiently by the department which manages the state's mental

37. *Id.* at 131. "The time would fail us to mention the instances we have known, of patients removed from a hospital where they were enjoying a tolerable degree of comfort, and placed in cages or other places more or less unsuitable for the abode of any human being, because the town could save by the change, a shilling or quarter of a dollar a week." Ray, *Legislation for the Insane in Maine*, 4 **A. J. INSANITY** 211, 213–4 (1848).
38. A recent Connecticut report recognizing that the existing "support" statutes were originally written on the assumption that all public patients are indigent, urges that the rates should now be flexible and reflect the family's ability to pay. *Committee Appointed to Study the State Hospitals, Report to the 1947 General Assembly* 9 (1946).
41. A statute imposing liability upon the estate or relatives of an insane person for his support in an asylum is considered a legitimate exercise of legislative power. *Note, 48 A. L. R. 733* (1927). In some states paying patients are committed to state hospitals by a different and more simple procedure than the one by which indigents are committed, *e.g.*, Ga. Code Ann. § 35–228 (1935); Mo. Rev. Stat. § 9323 (1943). The major recommendation for a legal revision in a presently proposed program for the development of Mental Health Activities in Vermont is the equalization of commitment procedures between indigent and paying patients. *Department of Public Welfare, Report of the Committee for Mental Health* 8–10 (1946).
These determinations unnecessarily consume the court's time at the commitment proceeding and should not be prerequisites to medical care and treatment.

The origin of insanity proceedings to determine custody emphasized control of the property of a mentally unsound person. The English king, assuming the role of guardian to preserve an incompetent's estate, delegated the duty of determining incompetency to the Chancellor, and in early American experience these functions were assumed by the courts.

While the purpose of appointing a guardian or committee is to protect an incompetent person and his estate, the transfer of legal responsibility carries with it a change in his entire legal status, for his civil rights are suspended both as to person and as to property. A commitment proceeding, on the other hand, is in its nature a determination of the patient's medical status, and many patients in mental institutions are sufficiently competent to handle their business affairs so that they need not be deprived of their civil rights.

In the early formulation of commitment statutes there was a tendency to confuse incompetency with commitment, and in fact the suggestion was made

42. See Overholser, *The Desiderata of Central Administrative Control of State Mental Hospitals*, 96 AM. J. PSYCHIATRY 517, 526-7 (1939).
43. It has been suggested that the State's position of having to prove in court at the time of commitment whether the patient or his estate will reimburse the State for the cost of treatment is a primary purpose of the legal requirements for admission to a mental hospital. Kempf, supra note 7, at 2. In a few states even the transfer from paying status to indigent status requires judicial action. MO. REV. STAT. §§ 9346-7 (Supp. 1946); N. J. ANN. §§ 30:4-71 (1939); OKLA. STAT. ANN., tit. 35, §§ 68-9 (1937).
44. See People v. Janssen, 263 Ill. App. 101, 103 (1931); Weihofen and Overholser, supra note 8, at 307-8. The basic statute for this jurisdiction was *De Prerogativa Regis*, 1339, 17 Edw. II, c. 11, which divided the mentally unsound into two classes, the idiot and the lunatic. The former was deemed "a natural fool" whose mental incompetency was incurable and whose property remained in royal custody until death. The latter was deemed a "lunatick" whose guardianship terminated upon recovery. BRYDALL, *NON Compos MENTIS* (1700); ORDRONAUX, op. cit. supra note 23, at 3-4.
45. SMOOT, op. cit. supra, note 23, § 124.
46. SINGER AND KROHN, *INSANITY AND LAW* 223 (1924); SMOOT, op. cit. supra, note 23, § 240.
47. See FORENSIC COMMITTEE OF THE GROUP FOR THE ADVANCEMENT OF PSYCHIATRY, op. cit. supra note 34, at 3. For the judicial criterion of incompetency, see Notes, 17 A. L. R. 1065 (1922); 113 A. L. R. 354 (1938). A Mississippi court has made a distinction between commitment which is in the nature of a police regulation designed for the protection of the public and of the insane person and incompetency which is designed solely for the purpose of protecting the estate and person of the insane. In the latter clear and indisputable proof was said to be necessary, but in the former the protection of the community would warrant solving a doubt in favor of commitment. Baum v. Greenwald, 95 Miss. 765, 49 So. 836 (1909). Criteria for commitment and incompetency should not now be determined by marks along a line which hypothetically ends at "absolute madness." The law should recognize at least the principal classifications of psychoses, Coon, supra note 9, rather than lump all mental diseases under the heading of "insanity." Whether a mental patient is also incompetent depends upon the manifestations of his disease. See STERN, op. cit. supra note 9, at 37-8.
that incompetency status be made a prerequisite to commitment.48 This confusion is still manifest in some states, in which a decree of commitment presently amounts to a decree of incompetency. In Tennessee, for example, commitment proceedings have been held merely ancillary to an incompetency inquisition.49 If a determination of financial status reveals that a mentally ill person to be committed has an estate, in many states the appointment of a guardian is directed by a provision in the commitment statute.50 Commitment, however, should not involve suspension of civil rights, and commitment stat-

48. See Ray, Confinement of the Insane, 3 Am. L. Rev. 193, 210 (1869), refuting the suggestion on the grounds that commitment was most often of a temporary nature, that the deprivation of legal status would intensify the patient’s misery, and the prospect of this interdict status would discourage commitment at the early stages of sickness.

49. Bradford v. American National Bank, 25 Tenn. App. 413, 158 S. W.2d 366 (1941); Walker v. Graves, 174 Tenn. 336, 125 S. W.2d 154 (1939); Johnson v. Nelms, 171 Tenn. 54, 100 S. W.2d 648 (1937). The proper limitation of commitment proceedings has been recognized, however, by the courts in other states. Although a committed person may be deemed the ward of the court, this merely gives the court the power to inquire into the question of preservation of his property. Sporza v. German Savings Bank, 192 N. Y. 8, 84 N. E. 406 (1908). “Such a proceeding [commitment] has a distinct object in view, to wit, the care and treatment of the patient and the protection of the public. It is not designed as a substitute for an inquisition, and an order entered thereon does not effect an adjudication of incompetency.” Quarterman v. Quarterman, 179 N. Y. Misc. 759, 760 (Sup. Ct. 1943); Leggate v. Clark, 111 Mass. 308 (1873); In re Cook, 218 N. C. 384, 11 S. E.2d 142 (1940). Commitment status is presumptive, but not conclusive evidence upon an incompetency proceeding. Fleming v. Bithell, 56 Idaho 261, 52 P.2d 1099 (1935); State v. Bucy, 104 Mont. 416, 66 P.2d 1049 (1937); Oswald v. Seidler, 135 N. J. Eq. 490, 39 A.2d 396 (Ch. 1944), rev’d. on other grounds, 136 N. J. Eq. 443, 42 A.2d 216 (Ch. Err. & App. 1945); Leick v. Pozniak, 135 N. J. Eq. 67, 37 A.2d 302 (Ch. 1944); see Notes, 68 A. L. R. 1309 (1930); 7 A. L. R. 573 (1920). The Illinois Revised Mental Health Act provides that all committed persons be designated either as “mentally ill” or “in need of mental treatment.” ILL. ANN. STAT., c. 91½, §§ 1-5, 1-7 (Smith-Hurd, Supp. 1946). The former classification carries with it a deprivation of civil rights; the latter does not. This represents the only statutory attempt to force a separate decision on every patient’s legal status at the commitment proceeding, and the excellence of the procedure is deflected only by the confusing use of the terms “mentally ill” and “in need of mental treatment” to convey “incompetency” and “competency.”

50. E.g., ARIZ. CODE § 8-303 (Supp. 1945); COLO. STAT. ANN., c. 105, § 9 (1935); IND. STAT. ANN. § 22-1207 (Burns, 1933); WASH. REV. STAT. § 6930 (Remington, 1932). See Heckman v. Adams, 50 Ohio St. 305, 315, 34 N. E. 155, 157 (1893). After being discharged as cured, a mental patient must initiate restoration proceedings, OHIO Gen. Code § 1890-63a (Page, Supp. 1946), but a certificate of competency from the hospital superintendent should be sufficient for a court order restoring the patient’s civil rights, S. C. Code § 6249 (1942). See State ex rel. Coddin v. Eby, 223 Ind. 302, 60 N. E.2d 527 (1945) (certificate of release not stipulating that the patient was restored to mental health not sufficient); In re Pfeiffer, 10 Wash.2d 703, 118 P.2d 158 (1941) (certificate sufficient for order of accounting but not for termination of guardianship). When a patient is discharged as cured, the legal presumption of incompetency created by commitment is entirely removed. Doris v. McFarland, 113 Conn. 594, 604, 156 Atl. 52, 56 (1931); In re will of Crabtree, 200 N. C. 4, 156 S. E. 98 (1930).
utes should clearly state that the decision should have no effect on guardianship proceedings.51

The tendency to identify commitment with incompetency proceedings has also made for excessive formality in the former.52 While a procedure resulting in deprivation of civil rights may necessarily be attended with many legal safeguards,53 as has been earlier indicated, such formality is undesirable in the commitment process, which should be limited to a determination of whether a mentally sick person should be hospitalized.54

**FORMAL INVOLUNTARY COMMITMENT**

The preceding analytical discussion of the commitment process and the following review of current commitment practices are limited to what may be termed formal involuntary commitment, meaning a final order of commitment to a mental hospital for an indefinite period of time. By contrast there are, however, temporary commitments to serve the purposes of either emergency detention and treatment or observational detention and treatment, and there is a form of voluntary admission for the mentally ill person who desires hospitalization. These other forms of commitment, to be discussed under separate headings, have not been enacted in all the states and represent more recent developments in commitment legislation than formal involuntary commitment, which is the original and basic proceeding of the commitment process.

*Variety of Procedures.* A review of state statutes dealing with formal involuntary commitment reveals that the forms of proceeding are highly varied, some states even having alternative methods of procedure.56 Two main types

52. The Tennessee Supreme Court has ruled that an alleged insane has a right to a jury trial at a commitment proceeding even though the commitment statute does not provide for this right, on the ground that the North Carolina Legislature had provided for the right to a jury trial in a lunacy inquisition proceeding before 1796 when Tennessee became a state and enacted a separate constitution. Johnson v. Nelms, 171 Tenn. 54, 100 S. W. 2d 648 (1937). Failure to differentiate between lunacy proceedings and commitment proceedings is evidenced in a “due process” tirade against a 1913 Ontario commitment law which emphasized the medical interests of the patient. Coutts, *Some Unconstitutional Asylum and Insane Laws, 77 Cent. L. J. 326* (1913).  
54. For an intelligent opinion distinguishing between competency, an *in rem* proceeding fixing the status of a person, and commitment, a proceeding to justify the hospitalization of a person, *see* Leggate v. Clark, 111 Mass. 308, 310 (1873). *See also In re Dowdell,* 169 Mass. 387, 388–9, 47 N. E. 1033–4 (1897).
55. For the form of proceeding used in each state, see the chart in Appendix, p. 1209 *infra.* The American Psychiatric Association has advocated statutory uniformity. 102 Am. J. Psychiatry 266–7 (1945). The American Civil Liberties Union and the National Mental Health Foundation have formulated model commitment statutes and the American Bar Association has expressed an interest in working with the National Conference of Commissioners on Uniform State Laws. With the Federal Government playing a more
of judicial machinery are used—first, that in which the judge acts alone in making the final decision on commitment, and second, that in which the final decision is made by a local commission of which the judge or the clerk of the court is a member. In every state the proceeding is set in motion by an application from a relative, friend or reputable resident of the community in which an alleged mentally ill person resides.66

The most common procedure is a judicial hearing with the judge making the final decision after an examination report by two physicians, whose qualifications satisfy statutory requirements.67 This is the exclusive method of formal involuntary commitment in 18 states and an alternative method in five states.58 Instead of the two physicians in a few states, the judge appoints a three man commission, usually including a physician and a lawyer, which makes an examination report to him. On the other hand, the final committing authority in six states is a standing commission, of which the judge or the clerk of court is a member.69

In contrast to proceedings in which judicial and lay officials play important roles is a method used in Maryland, Louisiana, Rhode Island and Vermont, where the formal involuntary commitment order is issued solely by the certification of two physicians. Here judicial machinery is called into play only when an aggrieved party appeals directly from the certificate, as in Vermont, or by a special provision for subsequent review of the mental condition of a person already committed, as in the other three states. In Pennsylvania and New Hampshire, moreover, medical certification merely requires notarization by a public officer stipulated in the statute.60

active role in the field of mental health, the U. S. Public Health Service would likely welcome uniform commitment practices in the states. See communication to the Yale Law Journal from Dr. R. H. Felix, Medical Director, Chief, Mental Hygiene Division, U. S. Public Health Service, April 30, 1947. But in view of the close connection between commitment and the state police power, the intrastate nature of the commitment process, and the vastly different standards of care among the states, a uniform commitment law is improbable in the near future.

56. Florida's requiring the application to be made by five reputable citizens, not more than one of whom is related to the person, Kempf, supra note 7, at 17, was evidently unduly restrictive and was amended to allow the application to be made by a next of kin, a sheriff, or three reputable citizens, F.LA. STAT. ANN. § 394.20(2) (Supp. 1946), which is still more restrictive than the average requirement. New York specifically recognizes an officer of a known charitable organization and a public welfare officer among those eligible to make the application. N. Y. MENTAL HYG. LAW § 74(2).

57. The final authority to which the two physicians report in North Carolina is the clerk of the court; in Maine, a board of municipal officers; and in Delaware, the Board of Trustees of the State Hospital.

58. In eight states the procedure is the same except that an examination report is required from only one physician. See the Appendix, p. 1209 infra.

59. In North Dakota and South Dakota the standing commission is composed of the judge, a physician and a lawyer; in Iowa and Nebraska, the clerk, a physician and a lawyer; in West Virginia, the judge, the prosecuting attorney and the clerk; and in Virginia, the judge appoints two physicians with whom he joins on the commission.

60. For early approval of limiting the judicial function to notarization, see Smith,
**Legal Safeguards.** Exemplifying the undue balance in formal involuntary commitment on the side of legal safeguards to the detriment of medical considerations are such devices as the jury, compulsory personal notice and compulsory presence at the hearing. The legal safeguard most exemplary of excessive legalism in the commitment process is the jury. Compulsory jury trial enjoyed a spell of popularity following the crusade in the 1860’s of Mrs. E. P. W. Packard, a commitment victim of her husband’s conspiracy.61 It was immediately criticized as being “totally unsuitable as a means of obtaining correct results in regard to questions purely scientific.”62 Only Mississippi63 and Texas64 now provide that a jury trial is mandatory; twenty-one states provide that it may be used on demand, usually by an allegedly mentally ill person or some one in his behalf.65 The mentally ill person who has ideas of persecu-

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61. Mrs. Packard had publicly differed on religious ideas with her husband, a Calvinist preacher, who disposed of the disturbing influence by committing her, see note 15 supra. Upon her release she became the “deliverer of the oppressed” throughout the land. In Illinois she obtained the right to a jury trial for every patient already committed. In Massachusetts she caused a bill to be passed, that no person was to be regarded or treated as an insane person simply for the expression of opinions, no matter how absurd they might appear. In Connecticut she tried to have property rights equalized between husband and wife. In Iowa and Maine she was responsible for the establishment of visiting committees with female representation to inspect insane asylums. In Washington, D.C. she tried to have Congress pass special legislation to protect the postal rights of mental patients. She published a seven volume opus on “Modern Persecution, or Insane Asylums Unveiled,” and was said to have been herself on both sides of the “borderline” between sanity and insanity. 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).

62. Ray, *supra* note 48, at 212. See *Lunacy Law in Illinois*, 47 Am. J. Insanity 584 (1891). In 1893 Illinois modified the law so that a jury trial was available to the court or on demand by the alleged insane or some one on his behalf. Ill. Laws 1893, p. 140, §§ 5–7. For a criticism of the Illinois law after this modification, see Note, 6 J. Crim. L. & Criminology 764 (1916).

63. The number of jurors has been reduced from six to three. Miss. Laws 1940, c. 231, § 4576.

64. A 1913 statute setting up a commission to investigate and determine the question of commitment was held invalid as against the state constitutional provision that “the right of trial by jury shall remain inviolate” on the ground that there had been a jury trial in the commitment statute at the date of the adoption of the constitution. Loving v. Hazelwood, 184 S. W. 355 (Tex. Civ. App. 1916); White v. White, 108 Tex. 750, 196 S. W. 508 (1917). In 1935 the constitution was amended, so that the Legislature could enact a temporary commitment proceeding without the use of a jury. Tex. Const. Art. I, § 15. See Tex. Civ. Stat. § 31930–2(1) (Vernon, Supp. 1946) and *Ex parte* Giannatti, 189 S. W.2d 191 (Tex. Civ. App. 1945). There is generally, however, no constitutional right to a jury trial in a commitment proceeding, Note, 91 A. L. R. 88 (1934).

65. See Appendix, p. 1209 *infra*. This number includes Tennessee where the right of jury trial has been read into the commitment statute, see note 52 *supra*, and Califor-
tion is more likely than others to demand a jury trial, and the experience of being confronted with forensic argument invariably tends to aggravate his illness rather than prepare him for acceptance of hospital care. The use of the jury, moreover, shifts the function of weighing the evidence and reporting to the judge from the medical experts to a group of laymen, and it represents the opposite extreme from a formal involuntary commitment proceeding dominated exclusively by medical authorities. Abolition of the right to a jury trial, therefore, has been urged by both medical and legal authorities.

As with jury trial, the right of an alleged mentally ill to personal notice and personal appearance at the hearing are objectionable as excessively legalistic and detrimental to his best medical interests. Service of personal notice of pending commitment proceedings may provoke violent acts or escape; confrontation by witnesses may aggravate an affliction. But the rights of an allegedly mentally ill person to receive notice and to be present at the hearing are sometimes considered in the nature of substantive rights guaranteed by due process of law. In some states, service of notice by a warrant for arrest and presentation by a sheriff of an allegedly mentally ill person before the judge are standard statutory methods of procedure. Almost all the states require personal appearance of the committed patient or some one in his behalf. Where the jury is used, medical examination reports are still made to the court except in three states, Delaware, Illinois and Wyoming where the statute makes the jury an alternative to the two physicians. In Illinois, however, one of the six jurors must be a physician.

66. See pp. 3-4 of Comment by the Joint Interim Committee on Public Welfare Laws on Bill No. 19, S., a revision of Wisconsin's statutes relating to all types of mental patients, introduced in the State Senate, Jan. 16, 1947. The most controversial point of this pending revision is the elimination of the optional jury trial. See note 16 supra. In an Oregon case the trial judge called an advisory jury "in the spirit of fairness" to an alleged paranoiac, whose ultimate commitment by the appellate court was abetted by a brief written by him and charging that all the witnesses at the trial were in a conspiracy to persecute him. In re Fehl, 159 Ore. 545, 81 P.2d 130 (1938).

67. "[Jury trial] is about as sensible as calling in the neighbors to diagnose meningitis or scarlet fever . . . ." STEIN, op. cit. supra note 9, at 37; Weihofen, supra note 14, at 109; INTERNATIONAL COMMITTEE FOR MENTAL HYGIENE, REPORT OF COMMITTEE ON LEGAL MEASURES AND LAWS IN 1 PROCEEDINGS OF THE FIRST INTERNATIONAL CONGRESS ON MENTAL HYGIENE 61 (1932).

68. See ILLINOIS LEGISLATIVE COUNCIL, PUB. NO. 52, COMMITMENT TO MENTAL HOSPITALS 12 (1942) and cases cited note 70 infra.

69. E.g., IDAHO CODE § 64-201 (1932); KAN. GEN. STAT. §§ 59-2003 (Supp. 1945); MISS. CODE § 6909 (1942); N. M. STAT. § 37-202 (1941). State ex rel. Pollard v. Brasher, 200 Mo. App. 117, 201 S. W. 1150 (1918). "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 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
sonal notice\(^{56}\) and about half of the states require presence at the hearing.\(^{71}\)

However, it has been held that absence of an allegedly mentally ill person does not violate due process of law when it would be injurious to hear the case in his presence, providing others are given an opportunity to represent him.\(^{72}\) In line with this reasoning many states allow the judge to use his discretion or to follow the advice of the certifying physicians in excusing the presence of an allegedly mentally ill person.\(^{73}\) Similarly, several states allow dispensing with

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." Bowman supra note 1, at 12.

70. Statutes not providing for notice have been held invalid: In the Matter of Lambert, 134 Cal. 626, 66 Pac. 851 (1901); Hunt v. Searcy, 167 Mo. 158, 67 S. W. 206 (1902); People ex rel. Sullivan v. Wendel, 68 N. Y. Supp. 948 (Sup. Ct 1900) (Court implied due process defect might be cured by providing for notice to some one on behalf of admittedly mentally ill person). Cf. State ex rel. Blaisdel v. Billings, 55 Minn. 467, 57 N. W. 794 (1893); Smoor, op. cit. supra, note 23, § 157. While not invalidating the statute, other courts have strictly construed the notice provision: Hultquist v. People, 77 Colo. 310, 226 Pac. 995 (1925); Ex parte Trant, 175 S. W.2d 161 (Kan. City Ct. App. 1943); Ex parte McLaughlin, 105 S. W.2d 1020 (Kan. City Ct. App. 1937); Clark v. Mattheys, 5 S. W.2d 221 (Tex. Civ. App. 1928). On the ground that statutory proceedings must be strictly complied with, the Michigan courts have recently overemphasized due process to the detriment of medical welfare. Ex parte Sawyer, 311 Mich. 602, 19 N. W.2d 113 (1945); In re Roberts, 310 Mich. 560, 17 N. W.2d 752 (1945); Freedman v. Freedman, 303 Mich. 647, 6 N. W.2d 924 (1942); In re Ryan, 291 Mich. 673, 289 N. W. 291 (1939); In re Davis, 277 Mich. 89, 268 N. W. 822 (1936). It does not appear in any of these cases that the court was in doubt as to the patient's having a mental disease. In the Ryan case, moreover, the patient was admittedly a sex violator, but proof of his condition by an official of the Department of Welfare was disallowed on the ground that the physician was in doubt as to the patient's having a mental disease. In the Matter of Lamart, supra note 6. Similarly, several states allow dispensing with

71. E.g., ILL. ANN. STAT. c. 91 1/2, § 6-3 (Smith-Hurd, Supp. 1946); Ore. COMP. LAWS § 127-206 (Supp. 1943); S. C. CODE § 6229 (1942); WASH. REV. STAT. § 6930 (Remington, 1932).

72. Chavannes v. Priestley, 80 Iowa 316, 45 N. W. 766 (1890). Presence not required: Paul v. Longino, 197 Ga. 110, 28 S. E.2d 286 (1943) (when alleged insane examined by commission); In re Mast, 217 Ind. 28, 25 N. E.2d 1003 (1940) (when attorney appeared on behalf of alleged insane); Ex parte Higgins v. Horton 332 Mo. 1022, 62 S. W.2d 410, 91 A. L. R. 74 (1933) and McMahon v. Mead, 30 S. D. 515, 139 N. W. 122 (1912) (when due notice given alleged insane). See INTERNATIONAL COMMITTEE FOR MENTAL HYGIENE, supra note 67. But see Ex parte Scudamore, 55 Fla. 211, 46 So. 279 (1908) and Hughes v. Blanton, 120 Fla. 446, 162 So. 914 (1935) (Provision in statute requiring personal presence of alleged insane is sufficient notice to him to fulfill constitutional due process requirements).

73. E.g., KAN. GEN. STAT. § 59-2272 (Supp. 1945) (only when presence manifestly improper); KEN. REV. STAT. § 202.130 (1946) (when physicians certify presence as unsafe or unwise); MASS. ANN. LAWS, c. 123, § 51 (1942) and CONN. GEN. STAT. § 1731 (1930) (judge shall see patient or state why not); UTAH CODE § 85-7-20 (1943).
personal notice upon medical certification of its injuriousness. No deprivation of due process in any of these discretionary procedures would seem to result so long as some one on behalf of an allegedly mentally ill person is notified and given a chance to appear.

While permitting judicial discretion in the use of personal notice and presence at the hearing tends to restore the balance between medical and legal considerations in the typical formal involuntary commitment proceeding, an alternative and more extreme approach is found in Maryland. Here two qualified physicians certify the commitment of a mentally ill person, and he is forthwith committed. At any time after his hospitalization he or any one on his behalf may request in writing to the superintendent that he be discharged. If the superintendent believes the patient requires further detention, he must forthwith file a petition for court review of the patient's mental condition. The Maryland statute could be improved by providing expressly for the patient's right to appear unless the superintendent certifies that his health would thereby be injured, and for the superintendent's assisting him in communication with counsel and friends.

This procedure has been held to constitute due process, since the right to demand a determination of a patient's mental condition at any reasonable time subsequent to commitment supplies the required minimum of legal safe-


75. Chavannes v. Priestley, 80 Iowa 316, 45 N. W. 766 (1890) and other cases cited note 79 infra. In reality it is a deprivation of due process to harm a person by application of a safeguard which is traditionally intended to benefit the person. See Freund, The Police Power § 254 (1904). Provision for discretionary notice, however, in a 1941 Illinois amendment caused the Attorney General to recommend a veto, which was acted upon by the Governor. For criticism of this action, see Illinois Legislative Council, op. cit. supra note 68, at 35 and Comment, Veto of the Illinois Mental Health Bill, 36 Ill. L. Rev. 747 (1942).

76. Md. Laws Spec. Sess. 1944, c. 14. See also R. I. Gen. Laws, c. 71, § 11 (1933) (two physicians); La. Gen. Stat. § 3938.12 (Dart, Supp. 1947) (coroner's commitment, coroner and another physician); Vt. Pub. Laws § 4034 (1933) (two physicians; but should the committed person appeal from the medical certification, he cannot be held at the hospital, Id., § 4042, as amended, see note 80 infra; and the indigent insane are committed initially through a court procedure, Id., § 3982, see note 41 supra). In Maine, Legis. Doc. No. 539 (1947), was a proposal to eliminate the hearing before municipal officers, Me. Rev. Stat., c. 23, § 105 (1944), and to substitute commitment by two physicians with a right to court appeal within thirty days. It was defeated by a vote of 98-20. Communication to the Yale Law Journal from Dr. Francis H. Sleeper, Superintendent of the Augusta State Hospital, April 23, 1947.

77. In recommending such a procedure, Kempf, supra note 7, at 11-2, would seem to be incorrect in calling it a temporary commitment, for the period is indefinite. It has been called a "non-protested admission on medical certificate," Illinois Legislative Council, op. cit. supra note 68, at 26-7, 30-1.

THE RIGHT MAY BE EXERCISED BY AN APPEAL OR A SPECIAL STATUTORY PROCEEDING TO INVESTIGATE THE PRESENT MENTAL STATUS OF THE PATIENT. THE SPECIAL PROCEEDING MAY TAKE THE FORM OF AN "ENLARGED" HABEAS CORPUS HEARING WHICH INCLUDES NOT ONLY A JURISDICTIONAL REVIEW, BUT ALSO A DETERMINATION OF THE PATIENT'S PRESENT MENTAL STATUS. THE SUMMARINESS OF THE INITIAL MEDICAL COMMITMENT IN THIS PROCEDURE WOULD SEEM TO BE JUSTIFIED UNDER A PUBLIC POLICY FAVORING BOTH THE MEDICAL WELFARE OF MENTALLY ILL PERSONS AND THE PUBLIC RESPONSIBILITY OF THE MEDICAL PROFESSION.

EMERGENCY COMMITMENT

In direct contrast to the excessively legalistic attributes of formal involuntary commitment, a summary statutory proceeding without resort to the judiciary has been devised for the temporary commitment of mentally ill persons needing immediate hospitalization. Primarily important for the self-protection of the community and the mentally ill person himself, emergency commitment does not depend on a close question of the advisability of confinement and treatment, but on the existence of a clear emergency evidenced by the actions of a person dangerously mentally ill. It is proper, therefore, that

79. Hammon v. Hill, 228 Fed. 999 (W. D. Pa. 1915); Payne v. Arkebauer, 190 Ark. 614, 80 S. W. 2d 76 (1933); Chavannes v. Priestley, 80 Iowa 316, 45 N. W. 766 (1890); In re Dowdell, 169 Mass. 387, 47 N. E. 1033 (1897); In re Crosswell, 28 R. I. 137, 66 Atl. 55 (1907); cf. Ex parte Dagley, 35 Okla. 180, 128 Pac. 699 (1912); see Barry v. Hall, 98 F. 2d 222, 225 (App. D. C. 1938).

80. It was implicit in a Vermont Supreme Court holding that in order for an appeal from medical certification to constitute due process the right of appeal must be without a time limit. In re Cornell, 111 Vt. 454, 18 A. 2d 151 (1941), and see In re Cornell, 111 Vt. 525, 18 A. 2d 304 (1941). A month later the Vermont Legislature amended the appeal provision so that the right may be exercised "at any time after such certificate is made or while such person is confined by virtue of said certificate. . . ." Vt. Acts 1941, No. 62, p. 74, as amended by Vt. Acts 1945, No. 56, p. 87. Several states having judicial commitment permit appeal, e.g., CONN. GEN. STAT. § 1755 (1930); MICH. STAT. § 8901 (Mason, 1927); IOWA CODE § 239.17 (1946).

81. In Rhode Island commitment by two physicians was held unconstitutional so long as the only opportunity to contest it was not available to the committed person himself, In re Doyle, 16 R. I. 537, 18 Atl. 159 (1889); but amendments cured this defect, In re Crosswell, 28 R. I. 137, 66 Atl. 55 (1907). This requirement is satisfied in the Louisiana coroner's commitment, LA. GEN. STAT. § 3938.12 (Smith-Hurd, Supp. 1946); OKLA. REV. STAT., tit. 35, § 80 (1937); UTAH CODE § 85-7-30 (1943); WIS. STAT. § 51.11 (1945).

82. E.g., IND. STAT. ANN. § 22-1223 (Burns, 1933); N. M. STAT. § 37-219 (1941); N. D. REV. CODE § 25-0328 (1943); S. D. CODE § 30.0111 (1939).

83. See KANSAS LEGISLATIVE COUNCIL, op. cit. supra note 11, at 6 and ILLINOIS LEGISLATIVE COUNCIL, op. cit. supra note 68, at 19-20.

84. In Connecticut in spite of the fact that the emergency commitment for thirty days on the certificate of one physician is limited to patients "clearly and violently mentally ill," the emergency certificate is used for over eighty percent of all admissions. COMMITTEE APPOINTED TO STUDY STATE HOSPITALS, op. cit. supra note 38, at 4. This means that
medical certification as to the emergency be sufficient to commit the person for a temporary period of time.85

Despite the apparent need for an emergency procedure to avoid detention of a violent mental patient in jail, only twenty-two states now have statutes providing for commitment upon an application and medical certification of an emergency.86 The maximum period of confinement specified in the statutes varies from two to thirty days, during which time the patient must remain at the hospital unless discharged.87 At the end of the statutory period the patient must be discharged or his status changed by a voluntary admission, or a formal involuntary commitment initiated by the superintendent or applicant.88

CURRENT LEGISLATIVE CHANGES IN COMMITMENT

In recent years legislatures throughout the country have been occupied with the subject of commitment. From 1939 to 1946 eight states revised their commitment laws89 and thirteen states enacted substantial additions.90 In the first half of 1947 revision of commitment provisions has been enacted in Nebraska,91 Nevada92 and West Virginia,93 and defeated in Maine.94 Proposed

there has been a general violation of the law in certifying emergency patients where no manifestation of violence existed, but the amendment passed by the 1947 General Assembly, which substitutes the criterion "any person in need of care and treatment," H. B. 33 (May 26, 1947), is so broad as to eliminate any emergency element in the commitment. The result would be a temporary commitment on medical authority alone. See note 99 infra.

85. Although the statutes are divided on the requirement of one or two qualified physicians, in view of the need for speedy action and to prevent any possibility of a violent person's detention in a jail rather than in a mental hospital, the requirement of one physician would seem preferable. Several states permit this power to be exercised by a local health officer which would appear to be especially expeditious where poor persons and vagrants are concerned, e.g., KEN. REV. STAT. § 203.030 (1946); N. Y. MENTAL HYG. LAW § 72; WYO. COMP. STAT. § 51-403 (1945).

86. See the chart in Appendix, p. 1209 infra.

87. In Arkansas a patient with acute psychosis may be admitted on the certification of one physician for as long as necessary; the patient has a right to demand a hearing, but only upon thirty days notice. Ark. Acts 1943, No. 241, p. 498, §§ 4, 8.

88. A seemingly unfair burden is put upon the applicant by at least two states where, if the patient needs continued hospitalization, the applicant must initiate the formal commitment proceeding or pay a fifty dollar fine, S. C. CODE §§ 6227 (1942); TEX. CIV. STAT. § 3193f (Vernon, 1939).


90. Ariz. LAWS 1941, c. 44; Idaho LAWS 1939, c. 151; Kan. LAWS 1945, c. 236; Ken. LAWS 1944, c. 29; Md. LAWS SPEC. SESS. 1944, c. 14; Miss. LAWS 1944, c. 279; Mont. LAWS 1943, c. 157; N. M. LAWS 1939, c. 43; Ore. LAWS 1941, c. 395-7; Tenn. LAWS 1941, c. 57 and 1943, c. 69; Tex. LAWS 1943, c. 152; Va. LAWS 1944, c. 55; Wyo. LAWS 1941, c. 44.


changes are still being considered in Minnesota, Oklahoma, Vermont and Wisconsin.

Temporary Observational Commitment. While the general trend in this legislation has definitely been toward a better integration of the various considerations involved in the commitment process, the most noteworthy change is the adoption of a temporary observational commitment for a period stipulated by statute—a device designed to provide diagnostic screening of mentally ill persons. In most of the twenty-five states having temporary observational commitment procedures, the proceeding is exactly like the judicial formal involuntary commitment, except that the judge’s decree specifies a limited rather than an indefinite period of time, varying from ten to ninety days. Because the temporary nature of this type of commitment averts the stigma of a final insanity decree and postpones the prospects of a long indefinite confinement, cooperation both by the patient and his family tends to be augmented, thus facilitating early diagnosis and treatment. Consequently, under temporary observational commitment a large percentage of mental patients can be sufficiently improved to justify their release within one to three months.

Where an early discharge is foreseeable, even though it cannot be effected during the limited period of temporary commitment, it should be possible to avoid a formal involuntary commitment proceeding. Four states provide for this contingency by permitting the superintendent to apply for a renewal of the statutory period. In any event, at the expiration of the temporary commitment the patient’s affliction will have been fully diagnosed by the hospital medical staff whose recommendations then represent a maximum of medical

100. Rickles, Commitment Bill, 5 Mental Health Today No. 5 (Pub. by the Wash. Society for Mental Hygiene) 1, 5 (1946).
LEGAL AND MEDICAL CONSIDERATIONS

reliability. The final adjudication usually takes place upon the certification of the superintendent to the judge that the patient's condition warrants continued hospitalization. If this adjudication is contested, an informal hearing at the hospital provides a simple solution.102 In Delaware, New York, North Carolina and Tennessee temporary admission is a prerequisite to formal involuntary commitment of all patients, and in Montana of those patients not "dangerously disordered."103

As forward looking as are the present provisions for temporary observational commitment,104 it would seem that fullest effectuation of medical considerations in temporary commitment requires yet an additional step. It should be possible for temporary commitment to be ordered by two statutorily qualified physicians without resort to the judiciary made necessary under most of the existing provisions. This could be accomplished by medical certification with a statutory provision for judicial review at the request of the patient or some one in his behalf, following his commitment.105 Looking toward expedi-

102. Proceedings should, to the extent possible, be held not in court houses but in hospitals. When they are held in hospitals, it is a mistake to have the room in the institution set up as a court room as is now done at Bellevue Hospital. The proceedings should be informal and conducted in an atmosphere of a medical conference rather than a court. Special Commission Appointed by Governor Dewey, The Care of the Mentally Ill in the State of New York 95 (1944).


104. In the opinion of one who believes commitment of the mentally ill should be placed entirely in the hands of medical men, temporary commitments are regarded as "token compromises" which will "deteriorate to the level of meaningless rituals." Communication to the Yale Law Journal from Dr. Philip Q. Roche of Philadelphia, May 27, 1947. It should be noted that Pennsylvania is one of the few states where medical certification is sufficient for formal involuntary commitment. And Dr. Roche admits that the solution to legal formalism in commitment procedures "is a more realistic facing of the facts that the community must provide more and better doctors and better treatment." The need for temporary observational commitment is not as clear in those states where formal involuntary commitment is already handled by physicians, because to some extent the stigma of an insanity decree may be attributed to its being rendered by a court.

105. While it would seem on the surface that the stability of the temporary period of hospitalization would be subject to interruption by demands for judicial review, a psychiatrist points out that after commitment mentally ill persons—with the rare exception of certain paranoiacs—believe they must remain in the hospital and will not resist proper care and treatment. Interview with Dr. Frederick C. Redlich, Asst. Prof. of Psychiatry and Mental Hygiene, Yale University Medical School. This procedure is like that used in Maryland and Rhode Island for formal involuntary commitments: "... well over ninety percent of our patients never appear in Court and the whole procedure is handled on a medical basis." Communication to the Yale Law Journal from Dr. George H. Preston, Commissioner of Mental Hygiene, Maryland, April 1, 1947. "In practical experience, resort to the courts is not used once in four or five years." Communication to the Yale Law Journal from Dr. Arthur H. Ruggles, Superintendent of the Butler Hospital, Providence, R. I., April 10, 1947.
tion of proceedings, this reduction of legal machinery to a minimum is justified since the function of judicial safeguards relates particularly to protection against undue deprivation of liberty and gross errors of medical judgment. These dangers are at a minimum with the limited statutory period of temporary commitment. The decision is primarily medical; the more delicate social considerations arising where long term custodial confinement is involved and where the judge assumes a greater role are not presented until the question of a formal involuntary commitment is raised. Whatever dangers to the patient’s best interests may arise in a streamlined temporary commitment proceeding are adequately safeguarded by the provision for statutory review at the request of the patient or some one on his behalf.

Modernization of Terminology. Another significant recent trend in commitment legislation is the modernization of terminology. While the mere substitution of the words “mental illness” for “insanity” or “lunacy” would seem to be desirable, but relatively unimportant, actually serious injury may be done when “the patient” hears or reads that he has been officially decreed “an insane person” or “a lunatic” according to the statutory language appearing on his commitment papers. Modernization of terminology averts this danger. Words like “commitment” and “parole” are not used in New York because of their criminal connotations. “Charging the accused with insanity” identifies mental illness with crime. Principal among public duties to mentally ill persons is legislative reform which will disassociate the process of admitting patients to mental hospitals from that of committing criminals to public jails.

106. The model commitment law proposed by the National Mental Health Foundation provides for a temporary observational commitment on medical certification and for a formal involuntary commitment proceeding, where necessary, to be conducted by the superintendent of the hospital, or his authorized assistant. This novel suggestion represents an application of administrative adjudication to commitment in order to achieve the typical advantages of the administrative process—expedition and expert judgment. Submission by the Yale Law Journal of this plan to about ten mental hospital superintendents resulted, however, in general disapproval mainly because of the increased administrative burden on hospital staffs already undermanned, because placing the duties of “prosecutor and judge” on the hospital staff would be subject to public suspect and criticism, and because the all-important confidence relationships between the patient and the hospital staff would tend to be injured by issuance of the commitment order from the very authorities in whom patients are asked to place their trust.

107. Pennsylvania was the first state to substitute “mental illness” for “insanity”, Pa. Acts 1923, No. 414, p. 998. Other states have only recently followed suit: Connecticut, Illinois, Louisiana, Nebraska, Nevada, New York, North Carolina, Ohio and Oregon.

108. See Kerschbaumer, A Patient’s Reaction To A “Lunacy” Charge, 101 J. NERV. & MENT. DISEASE 378 (1945); Communication to the Yale Law Journal from Dr. Arthur H. Ruggles, Superintendent of the Butler Hospital, Providence, R. I., April 10, 1947.

109. “Certification” and “convalescent status” are the terms substituted. N. Y. MENTAL HYG. LAW §§ 72-5, 87.
Voluntary Admission

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

Provision for voluntary admission gives a person a right to be admitted to a mental hospital upon his application and its acceptance by the hospital superintendent, who must be satisfied that the person will benefit by his hospitalization. Normally the patient will have been guided to this step by his family physician or by a mental health out-patient clinic, but a physician's certificate, however, should be unnecessary, although many states require it. A voluntary patient becomes subject to all the rules and regulations of the hospital, but he may leave upon giving advance written notice, the number of days being specified by the statute. Upon his giving notice, if the hospital authorities believe his detention ought to be continued, they then should have an opportunity to initiate a formal involuntary commitment proceeding and to detain him until the decision is made. A disadvantage of the notice provision is its availability to a voluntary patient upon becoming restless and dissatisfied shortly after his admission, a difficulty solved in New York by making a patient's admission conditional upon his agreement not to give notice for the first sixty days. While the first voluntary admission law was passed by Massachusetts in 1881, six states still do not provide for this procedure and a few statutes are unsatisfactory in limiting voluntary admission to paying patients. The lack of hospital facilities, moreover, causes the non-use

110. For a list of requirements which a voluntary admission law should meet, see Kempf, supra note 7, at 5.
111. See Stern, op. cit. supra note 9, at 17-22, 33-4.
112. This is especially true in the case of alcoholics, so that voluntary admission for them is discouraged. Overholser, The Voluntary Admission Law: Certain Legal and Psychiatric Aspects, 80 AM. J. PSYCHIATRY 475, 478-9 (1924).
113. N. Y. MENTAL HYG. LAW § 71.
115. Alabama, Florida, Georgia, Mississippi, Missouri and North Dakota. See Appendix, p. 1209 infra. Ten states, Arizona, Arkansas, Idaho, Louisiana, Montana, Nebraska, Nevada, New Mexico, Tennessee and Wyoming, have enacted voluntary admission laws since 1939.
116. S. D. CODE § 30.0115 (1939) ; TENN. CODE § 4459.1 (3) (Williams, Supp. 1946) ; WASH. REV. STAT. § 6954-2 (Remington, 1932). The Washington provision, moreover, limits the admission for purposes of observation only. For criticism of this, urging the
of voluntary admission laws in some states.\(^\text{117}\) In addition to the patient's mental illness, his mental competence is considered important in voluntary admissions, for if he is not capable of understanding the nature of his acts, the admission cannot be "voluntary." Most statutes, therefore, contain a provision requiring the superintendent to satisfy himself that the patient is competent to understand his application.\(^\text{118}\) It has been suggested that the act of voluntary admission constitutes a contract between the patient and the superintendent, which could not bind an incompetent patient.\(^\text{119}\) The emphasis on legal incompetence is unfortunate. A person who is a fit subject for mental treatment and who would not object to hospitalization should not be denied the easiest method of admission merely because he may be too indecisive, weak-minded or incompetent to sign his own papers.\(^\text{120}\) The contract theory is no obstacle to an incompetent person's admission where arranged by his legal guardian or close relative. Some such procedure is provided for in four states,\(^\text{121}\) and in eight additional states a minor may be admitted on the signature of his parent or guardian.\(^\text{122}\) In order to guard against the "railroading of a wealthy uncle," especially in the

\(^{117}\) Although the statutes provide two ameliorative alternatives, namely voluntary admission and 'commitment for observation' for thirty days before the final adjudication is made as to 'sanity,' neither of these practices is encouraged, chiefly on account of the over-crowded conditions of the institutions." KANSAS LEGISLATIVE COUNCIL, op. cit. supra note 11, at 4. See Kempf, supra note 7, at 5 and Overholser, supra note 112, at 477.

\(^{118}\) E.g., ME. REV. STAT., c. 23, § 116 (1944); MD. ANN. CODE, Art. 59, § 40 (1939); MASS. ANN. LAWS, c. 123, § 86 (1942); R. I. GEN. LAWS, c. 71, § 41 (1938).

\(^{119}\) Overholser, supra note 112, at 480-3; Fenning, Voluntary Submission to Treatment and Custody In Hospitals for the Insane, 58 A. M. A. J. 1104, 1105 (1912).

\(^{120}\) In New York this type of patient, often an old person suffering from senile psychosis or cerebral arteriosclerosis, is committed on the certificate of one physician. N. Y. MENTAL HYG. LAW § 73. West Virginia has recently adopted this procedure, the committing authority being a health officer. H. B. No. 47, Art. 4, § 3-b (Feb. 10, 1947); and Oklahoma's pending revision includes a provision for commitment by two physicians, S. B. No. 122, § 20 (1947). In all three laws a prerequisite is the lack of objection on the part of the patient, but the commitment is only temporary and must be changed at the end of the statutory period by resort to certification from the superintendent to the judge.


\(^{122}\) ARIZ. CODE § 8-210 (Supp. 1945); CAL. WELF. & INSTIT. CODE § 6602 (1944); Del. Laws 1945, c. 219, § 1; MICH. STAT. ANN., c. 127, § 14.809(1) (Supp. 1946); Nev. Laws 1947, c. 257, § 16(a); N. Y. MENTAL HYG. LAW § 71; Ore. Comp. LAWS § 127-214 (Supp. 1943); Wis. STAT. § 51.10 (1945).
case of admission to a private hospital, it may be desirable to require a medical
certificate where the voluntary patient is “signed in” by some one else.

MEDICAL DUE PROCESS

Ideal Setting for Commitment. The problem of commitment can only be
seen in its proper perspective when fixed in the overall picture of the treat-
ment of mental disease. To integrate effectively streamlined commitment pro-
cedures into the fight against mental illness requires that they be implemented
with relatively new types of facilities. The full possibilities for early diagno-
sis and cure implicit in streamlined commitment procedures can only be real-
ized when there are provided adequate psychopathic facilities more readily
accessible and better integrated with the community than the conventional
state mental hospital. Such a program calls for a vast increase in the num-
ber of small community psychopathic hospitals, psychopathic wards in general
hospitals and mental hygiene clinics.

In a modern integrated community mental health program, state mental
hospitals would treat only the seriously psychotic and those incurable patients
who merely need custodial care. Mentally ill persons needing hospitaliza-
tion for the first time would be admitted to a special psychopathic hospital or
a psychopathic ward of a general hospital. These facilities would serve as
screening agents for the state mental hospitals and would accept patients by

123. Mental health services were originally limited to hospitalized patients, so that
mental hospitals were isolated from community life. A vivid example of this isolation
is reflected in the following provision of Florida’s commitment statute: “Each and every
inmate of each and every insane asylum . . . shall be allowed to choose one individual
from the outside world, to whom she or he may write . . .” (emphasis added) FLA.
STAT. ANN. § 394.13 (1943). Recently considerable effort has been made to bring the
conventional state mental hospitals into closer contact with the nearby communities. See
Wise, The Relation of the Mental Hospital to the Community, 29 MENT. HYG. 412
(1945); Jackson, The Role of a Public Mental Hospital With Reference To the Men-
tally Ill of a Community in Pub. No. 9 of the Am. Assoc. for the Adv. of Sc., MENTAL
HEALTH 331 (1939); Stevenson, Psychiatry in the Community, id. at 335; Bryan,
ADMINISTRATIVE PSYCHIATRY 20–1, 309–28 (1936).

124. See Communication to the Yale Law Journal from Dr. H. K. Petry, Superin-
tendent of Harrisburg State Hospital, Pa., April 21, 1947. Incurable patients who merely
need custodial care would always constitute a heavy burden on state mental hospitals,
unless some other provision were made for them. At present this problem is especially
critical because of the increasing numbers of old patients with senile psychosis and
cerebral arteriosclerosis. See Malzberg, The Expectation of Psychoses with Cerebral
Arteriosclerosis in New York State, 19 PSYCHIATRIC Q. 122 (1945); SPECIAL COMMISSION
APPOINTED TO STUDY STATE HOSPITALS, op. cit. supra note 103, at 85–8; CONNECTICUT
COMMITTEE APPOINTED TO STUDY STATE HOSPITALS, op. cit. supra note 38, at 4.

125. See Parsons, Administrative Practices Dealing With the Admission of Persons
to Hospitals for Mental Diseases in Pub. No. 9 of the Am. Assoc. for the Adv. of Sc.,
MENTAL HEALTH 309 (1939); ILLINOIS LEGISLATIVE COUNCIL, op. cit. supra note 63,
at 13.
voluntary admission and temporary observational commitment. Many patients would be discharged after a short residence, and those having serious psychoses demanding prolonged hospitalization would be transferred to state mental hospitals by a voluntary procedure, or, if necessary, a formal involuntary commitment initiated by the chief medical officer of the psychopathic hospital or ward. Not only would this system relieve state mental hospitals of overcrowded conditions and permit their concentration on the more serious cases of mental illness, but its association of community mental health services with general hospitals would minimize a patient's sense of being held in custody and maximize his sense of being medically assisted. At least one psychopathic ward or hospital accommodating sixty patients is said to be needed for each 300,000 of population, but there are only about one hundred existing psychopathic services in the country.

The furthest outpost of modern mental health services in the community is the mental hygiene clinic. One purpose of the National Mental Health Act is to implement the establishment of out-patient mental health clinics, where scientific research, personnel training, public education and preventive work may be accomplished. Community clinics, moreover, provide the integrating link in a total mental health program among practicing physicians, general hospitals, mental hospitals, social welfare agencies, public schools and juvenile courts. It is estimated that a minimum of 1300 clinics is needed, but on

126. For a brief statement on the operation of such existing psychopathic facilities, see Hamilton, Kempf, Scholz and Caswell, supra note 12, at 12.

127. "Except for the excellent work of diagnosis and segregation done at Bellevue Hospital the admissions to State hospitals would undoubtedly be higher. In the year 1942, 29,480 persons went through the Psychopathic Division of this hospital, of whom 8,979 were committed to State hospitals." SPECIAL COMMISSION APPOINTED BY GOVERNOR DEWEY, op. cit. supra note 102, at 83, n. 1.

128. "... during the next fifty years, with an increasing understanding of the mental hospital as a curative institution, the majority of patients will seek care in such institutions just as they do in the general hospital and be admitted upon voluntary application." RUGGLES, op. cit. supra note 18, at 82. An example of the different public attitude toward commitment to a psychopathic facility is illustrated by Mississippi's enactment of a law creating a Department for Prevention of Insanity, Miss. Laws 1944, c. 279; and whereby a patient may be admitted on written request by a health officer for an indefinite period of time to the ward of the state hospital for treatment of "neurosyphilis and/or other disease which will eventually lead to insanity."

129. Parsons, supra note 125, at 309.


131. See KANSAS LEGISLATIVE COUNCIL, op. cit. supra note 11, at 7-8; Cotton, The Scope and Purposes of the State Mental-Hygiene Clinic, 24 MENT. HYG. 177 (1940); Stevenson, Role of Community Clinics in Mental Hygiene, 96 A. M. A. J. 997 (1931). For standards of mental hygiene clinics, see 102 AM. J. PSYCHIATRY 267-9 (1945); BRYAN, op. cit. supra note 123, at 285-308. For pictorial publicity of clinics, see New Haven Sunday Register Magazine, April 20, 1947, p. 10.

the basis of one clinic for every 100,000 of population, only about twenty per cent of this goal has been achieved.\footnote{Felix, \textit{Mental Public Health: A Plan of National Scope}, Reprint of Annual Meeting Address to Mass. Society for Mental Hygiene, Jan. 24, 1946, p. 2. Thirteen states provide no mental health clinic service whatever. \textit{N. Y. Times}, April 4, 1947, p. 26, col. 5.}

In addition to relieving the stress in the commitment process, out-patient clinics and additional community mental health facilities would also serve as control centers in after-care so that hospital superintendents would be able quickly to discharge partially recovered patients whose hospitalization is no longer more beneficial than a proper extramural environment. Thus not only is the number of commitments to state mental hospitals decreased, but also the rate of discharges is increased.\footnote{In Indiana it was estimated that if the present system of community mental hygiene services were extended to cover the entire State, commitments to state mental hospitals would be reduced fifteen to twenty percent, and discharges increased about fifteen percent, thereby saving the state about \$897,892. \textit{Vogel, supra} note 12, at 1945. But the increased facilities would pay for themselves only in the long run, because of the consequent increase in the patient load. \textit{Russel, supra} note 5, at 419.}
The psychiatric social workers of community facilities would help greatly to check on the suitability of the proposed new environment and provide the necessary follow-up supervision of convalescent patients.\footnote{See \textit{French, Psychiatric Social Work} 116-60 (1940); \textit{Bryan, op. cit. supra} note 123, at 207-39.}

These facilities would also enable an expansion of the foster home care or boarding out programs for harmless patients, not sufficiently recovered to be convalescent, but who would be happier in a private home where the conditions would be suitable to the individual patient.\footnote{See \textit{Pollock, A Brief History of Family Care of Mental Patients in America}, 102 \textit{Am. J. Psychiatry} 351 (1945); \textit{Crutches, Foster Home Care for Mental Patients} (1944); \textit{Osborne, The Use of Family Care As A Treatment Procedure With the Mentally III}, 27 \textit{Ment. Hys.} 412 (1943). Before the days of social workers boarding out programs were criticized because of their placing responsibility back on the superintendents of the poor. \textit{Channing, Lunacy Legislation in New York}, 46 \textit{Am. J. Insanity} 298 (1889). For those states which have made legal provision for family care, see the chart in Appendix, p. 1209 \textit{infra}.}

The emphasis in applying public resources to the mental health problem, therefore, should be on establishment of these new community facilities rather than mainly on enlargement of conventional state mental hospitals.

But the implementation of such plans for improved mental health conditions depends ultimately on increased appropriations to raise the standards of public mental care and treatment.\footnote{There is a critical disparity between the standards for psychiatric hospitals established by the American Psychiatric Association, 102 \textit{Am. J. Psychiatry} 264-6 (1945), and the existing national average standards, Hamilton, Kemph, Scholz and Caswell, \textit{ supra} note 12, at 84-50: \textit{e.g.), The A. P. A. standard ratio of medical personnel to patients in mental hospitals is 1:150, while the national average is about 1:250. While medical understaffing in state mental hospitals may be somewhat accounted for by the fact that there are only 4000 psychiatrists among the 189,000 physicians in the United}
tions consequent inadequate treatment facilities retard discharges, causing overcrowdedness, which in itself is a practical argument against simplification of admission.° Public awareness, moreover, of unsatisfactory living conditions intensifies mistrust of mental hospitals and suppression of mental illness.° Reforms in commitment procedures may be empty legislative gestures without appropriations expressive of increased public responsibility.

Administrative Responsibility. A necessary corollary to the drive for reduction of legal safeguards in commitment is a correspondingly increased administrative vigilance over patients' welfare in mental hospitals after they have been committed. The type of administrative agency now made use of by states to control and manage their mental hospitals varies widely.° In only a few states is there a centralized, independent agency devoted solely to mental health administration.° But this field of public responsibility is so large and the problems involved are so critical that it would seem advisable, especially in the more populous states, to have a separate mental health department, headed by

States, the National Committee for Mental Hygiene significantly reports that of 900 psychiatrists interviewed on their return from the armed forces, only sixty chose to take jobs in state hospitals. Pub. Admin. Clearing House, Release No. 2, March 11, 1947. Principal among the reasons for psychiatrists' reluctance to go to state mental hospitals is the low rate of pay: e.g., the starting rate in Connecticut, one of the wealthiest states, is $2,820-$3,780 as compared with $4,169.60-$4,902.00 for a similar position in the Veterans Administration. COMMITTEE APPOINTED TO STUDY STATE HOSPITALS, op. cit. supra note 38, at 10. Low salaries cause personnel shortages and employment of incompetent personnel in all of the hospital departments: e.g., Attendants in Connecticut's mental hospitals receive $23-$27 per week take-home pay for a 48 hour week. CONN. STATE HOSP. EMPLOYEES, LOCAL 398 A. F. S. C. M. E., PAMPHLET No. 2 2 (1947).


138. "[There has been] no attempt to liberalize the procedure to make hospital admission easier, as at the present time we are overcrowded and have many persons committed awaiting admission." Communication to the Yale Law Journal from Dr. David A. Young, General Superintendent of Mental Hygiene, North Carolina State Hospitals Board of Control, April, 1947. Only nine states reported to be not overcrowded in 1938. Hamilton, Kempf, Scholz and Caswell, supra note 12, at 22.

139. Public consciousness can be awakened by accounts of these conditions, as presented by Maisel, Bedlam 1946, LIFE (May 6, 1946) p. 102, but public confidence must also be encouraged by giving wide publicity to the progressive therapy and institutional practices of the better hospitals, as presented by Deutsch, PM, June 18, 1946, pp. 12-3 and June 21, 1946, p. 15.

140. See Overholser, supra note 42, at 520-1.

a physician with long experience in administrative psychiatry. Nor should public responsibility end at state hospitals; officially unsupervised private hospitals should not be allowed to function. Yet only seventeen states now require licensing and inspection of private mental homes and hospitals. Despite centralized administrative supervision, however, the primary administrative responsibility for the patients' welfare belongs to the superintendent. He also should be a physician with experience in administrative psychiatry, whose appointment to state hospitals should not depend on political considerations and who should be removable only for good cause.

Statutory safeguards of patients' medical and civil rights are essential elements of a commitment statute. These should include: (1) the right to private visitation and correspondence with an agent of the department, the patient's attorney, physician, minister, relatives or friends; (2) the right to employment at a useful occupation depending on his condition and available facilities; (3) the right to periodic complete examinations reported to the cognizant state department; (4) the right to have the use upon him of any mechanical restraints reported to the cognizant state department; (5) the right to be discharged as soon as medically advisable; (6) the right of those patients not really incompetent to enjoy their legal prerogatives; and (7) the right of all patients to a writ of habeas corpus. Because the patient is not in a position effectively to assert these rights, his practical enjoyment of them depends primarily on alert and progressive administration at the hospital and state levels.

**Summary**

Mental illness has always taken a heavy toll of human resources. Ignorance as to its nature has frequently caused man's treatment of it to result in more
harm than good. Legislation has reflected this ignorance, especially in commitment statutes which have been overbalanced with unnecessary procedures designed to protect the public safety, the public pocketbook and the individual right to unrestrained freedom. Psychiatrists, however, have been able to demonstrate the evils in this excessively legal procedure for a long time, but not until recently have legislatures generally begun to revise commitment statutes. The principal change has been the introduction of temporary observational admissions and the continued expansion of voluntary admissions to facilitate psychiatry's attempt to treat incipient mental illness. Commitment of mental patients, like public control of venereal disease, is now primarily a problem in public education.

In working toward a change in public attitude from "committed like a criminal" to "admitted like a patient", the formal court procedure should be minimized. Prime authority in initial stages of commitment should be delegated to the physician; only where the patient's observational residence has revealed the necessity for prolonged custodial hospitalization should the judge assume more than a monitory role. Eventually with public education following closely behind advancing psychiatric knowledge, establishment of community mental health facilities, development of centralized state mental health administrations, and introduction of federal aid, the maximum potential of the nation may be brought to bear in the fight against mental illness.
## APPENDIX

### Formal Involuntary Commitment

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