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COMMITMENT OF THE MENTALLY ILL: PROBLEMS OF LAW AND POLICY †

*Hugh Alan Ross**

I. INTRODUCTION

A NUMBER of recent events makes it timely to reconsider certain aspects of the relation between psychiatry and the law. In the past decade, both the public and the legal profession have been increasingly concerned with the impact of mental illness on the law. In 1952, an outstanding text, *Psychiatry and The Law*, was published as the joint effort of a lawyer and a psychiatrist.¹ Two years later the *Durham* case laid down a new test of insanity in criminal cases, rejecting the M'Naghten rule.² Interest in the case resulted in a host of law review articles, symposiums, and a book on insanity and criminal responsibility.³ In the tort area, there is a clear trend toward recognition of mental suffering as a legitimate element of damages, either with or without preceding trauma.⁴ Another example is the recent *Bailey* case, a landmark decision in workmen's compensation law.⁵ The court said that even though a statute defined "injury" as "harm to the physical structure of the body," work-connected mental illness is compensable, since the body is a single interrelated functioning organism which includes the mind.

In the area of hospitalization and treatment, it is now generally

†This article is a part of a dissertation submitted to the Faculty of The University of Michigan Law School in partial fulfillment of the requirements for the S.J.D. degree.—Ed.

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¹Manfred Guttmacher and Henry Weihofen.

²*Durham v. United States*, (D.C. Cir. 1954) 214 F. (2d) 862.

³BIGGS, *THE GUILTY MIND: PSYCHIATRY AND THE LAW OF HOMICIDE* (1955). Symposiums on Law and Psychiatry may be found in 4 KAN. L. REV. 349 (1956); 45 KY. L.J. 215 (1957); 14 OHIO ST. L.J. 117 (1953); and 29 TEMP. L.Q. 380 (1956).

⁴Recent cases are collected in comment, 6 WEST. RES. L. REV. 384 (1955).

⁵*Bailey v. Am. Gen. Ins. Co.*, 154 Tex. 430, 279 S.W. (2d) 315 (1955), noted, 53 MICH. L. REV. 898 (1955). See also: LARSON, *WORKMEN'S COMPENSATION LAW* §42.20 (1952), and GUTTMACHER AND WEIHOFFEN, *PSYCHIATRY AND THE LAW*, chapters 3 and 7 (1952).

recognized that mental illness is the nation's number one public health problem. In 1949, the last year for which reliable statistics are available, 390,567 patients were admitted to mental hospitals.⁶ Of these, 85 percent were admitted to public hospitals. At the end of 1949, there were 663,115 patients listed on the books of mental hospitals (either as resident patients or on conditional release) and over 98 percent were accounted for by the state hospitals.⁷ These patients occupy about one-half of all available hospital beds. Despite recent developments in the use of the tranquilizing drugs, the statistics are about the same today as they were in 1949.⁸

Mental illness wastes money as well as lives. The direct cost of mental illness is borne almost entirely by the state governments, as this is one of the few important state functions which receive no federal grants-in-aid. The state hospital systems are one of the "big four" with respect to total state expenses; these are education, highways, social welfare, and mental hospitals, in that order. Although every state requires patients in state hospitals to pay for their care if able, less than ten percent of state hospital maintenance costs are recovered from patients. The state governments spend approximately \$600 million annually for capital and operating costs of mental hospitals,⁹ and the annual wage loss attributable to mental patients has been estimated at \$1,750,000,000.¹⁰ One of the most important and least recognized indirect costs of mental illness is the tremendous volume of industrial accidents caused by mentally ill workers who are accident prone. It has been estimated that ten percent of the labor force is responsible for 75 percent of the accidents, and that a substantial portion of these suffer from anxiety or hysteria neuroses.¹¹

⁶ U.S. PUBLIC HEALTH SERVICE, *PATIENTS IN MENTAL INSTITUTIONS—1949*, p. 22, Pub. No. 233 (1952).

⁷ *Ibid.*

⁸ This does not mean that the tranquilizers are ineffective. The total volume of cases remains the same, but the period of hospitalization has been reduced and more people are able to obtain psychiatric care because of the increased turnover. Silverstein, "Psychology, Mental Illness, and the Law," 60 W. VA. L. REV. 55 at 61-63 (1957).

⁹ COUNCIL OF STATE GOVERNMENTS, *BOOK OF THE STATES: 1954-55*, p. 298 (1954); COUNCIL OF STATE GOVERNMENTS, *REPORT TO THE GOVERNORS' CONFERENCE—THE MENTAL HEALTH PROGRAMS OF THE FORTY-EIGHT STATES 107* (1950) [hereinafter cited *REPORT TO GOVERNORS' CONFERENCE*]; U.S. PUBLIC HEALTH SERVICE, *PUB. NO. 233*, Table 19 (1952).

¹⁰ NATIONAL ASSOCIATION FOR MENTAL HEALTH, *FACTS AND FIGURES 3*, 9 (1952).

¹¹ James and Dickinson, "Accident Proneness and Accident Law," 63 HARV. L. REV. 769 (1950).

A. Recent Developments in the Legal Aspects of Hospitalization

During the past ten years, legislatures throughout the country have been concerned with the mentally ill and the role of the state in their care and treatment. The critical nature of the problem has been recognized by both Congress¹² and the states. At the state level this concern has resulted in a number of recent substantial revisions of both the organizational structure of the mental hospital systems and the commitment statutes.

There has been some disagreement as to the desirability of uniform legislation among the states in respect to the hospitalization of the mentally ill. The American Bar Association Special Committee on the Rights of the Mentally Ill concluded that the subject of commitment does not lend itself with advantage to a uniform state law, as few problems in the field are projected beyond state boundaries.¹³ Other writers have not hesitated to make detailed recommendations for uniform legislation.¹⁴ The impact of commitment on legal capacity to sell or contract, which affects interstate trade, the increased mobility of our population, the increased incidence of multi-state property holding, and the increased number of U.S. Veterans Administration patients, most of whom are committed under state statutes, all indicate a greater need for uniformity.

The most important stimulus to uniformity occurred in June 1949 when the Governors' Conference asked the Council of State Governments to prepare a detailed report on state programs for the care of the mentally ill. The research report, together with forty specific recommendations, was returned to the Governors' Conference in June of 1950.¹⁵ At about the same time, a working committee was formed in the Federal Security Agency, at the request of the National Advisory Mental

¹² The National Mental Health Act was passed in 1946. 60 Stat. 421, 42 U.S.C. (1952) §§201-246. The act authorized federal grants-in-aid to the states for research and education in the area of preventive mental health. No direct grants are made to the state mental hospital system. Passage of the act has done much to arouse interest in mental hygiene programs among the states and has resulted in a number of states revising the administrative structure of the state mental hospitals. See REPORT TO THE GOVERNORS' CONFERENCE 82.

¹³ 73 A.B.A. REP. 287 (1948).

¹⁴ See, for example, the quite specific recommendations of the Medical Director of the U.S. Public Health Service: KEMPF, LAWS PERTAINING TO THE ADMISSION OF PATIENTS TO MENTAL HOSPITALS THROUGHOUT THE UNITED STATES, U.S. Public Health Reports, Supp. No. 157, p. 28 (1944).

¹⁵ REPORT TO THE GOVERNORS' CONFERENCE.

Health Council, and was asked to draft a model commitment act to implement the recommendations of the Governors' Report. The work of the committee culminated in the transmittal in September 1950 of a draft act to all of the state governors.¹⁶ By the end of 1957, ten states had adopted the Draft Act in whole or in part.

The Draft Act was not designed as a uniform act, but it is intended as an aid to states which are considering revision of existing statutes. The President of the National Association for Mental Health stated:

"... nobody asserts that the Act is perfect or that all of its provisions will satisfy the needs and circumstances of any particular State. The Act is presented by the Federal Security Agency as a working model, to be adapted to local need and conditions and to be drawn upon for suggestions by those responsible for legislation in each of the States of the Union."¹⁷

Unfortunately, the newest and most complete survey of the legal aspects of mental illness has not yet been published. This is the Project on the Rights of the Mentally Ill, one of the first research surveys conducted by the recently established American Bar Foundation. The study is comparative in nature and surveys the statutes, regulations, and cases in all of the states and territories:

"The Foundation's survey of the law of mental illness is the most comprehensive examination of this topic to be undertaken in this country or abroad, and encompasses all major civil and criminal law areas relating to mental illness. The special contribution of the Foundation project to mental illness law may therefore be in the fact that it proposes to deal with the whole area in an integrated manner. No such evaluation of the interrelationships among all phases of the law has ever been attempted."¹⁸

While uniform legislation may be desirable, it is not essential.

¹⁶ A DRAFT ACT GOVERNING HOSPITALIZATION OF THE MENTALLY ILL, U.S. PUBLIC HEALTH SERVICE, PUBLICATION No. 51, rev. ed. (1952) [hereinafter referred to as the Draft Act]. A brief summary of the act, by one of its authors, is set forth in Felix, "Hospitalization of the Mentally Ill," 107 AM. J. PSYCHIATRY 712 (1951). Unless expressly stated otherwise, all references in this article are to the 1952 revised edition of the Draft Act rather than to the original 1951 edition. Both published editions include a commentary by the draftsman of the act, hereinafter referred to as "Author's Commentary."

¹⁷ Draft Act at vii (1951).

¹⁸ Kittrie, "Justice for the Mentally Ill," 41 J. AM. JUD. SOC. 46 at 48 (1957).

What is important is that state legislatures understand the problems involved in compulsory commitment, recognize the complex relationship that exists between the commitment statutes and other legal aspects of mental illness, and take advantage of the experience of those states which have recently adopted the Draft Act or other comprehensive commitment statutes.¹⁹

B. Terminology

When a mental patient is "arrested" by a "sheriff" armed with a "warrant," "charged" as a person "accused of insanity" and after "trial" committed to an "institution" as an "inmate," it is not hard to see why the terminology used acts as an emotional shock which may seriously hinder treatment and recovery. Most of the states have modernized the terminology of commitment in the past twenty years, although too many states retain a distinct criminal flavor in their statutes.²⁰

The modern statutory terminology varies from state to state. In this paper language is used as follows:

(1) The term "mental illness" is used here and in most modern statutes rather than the older terms "insanity," "lunacy" or "unsoundness of mind." "Mental illness" as used by psychiatrists refers generally to any type or degree of mental unbalance or personality disorder. Although "insanity" was formerly used to mean any serious mental illness, it is now generally used to refer to the degree of mental illness which excuses criminal responsibility.

¹⁹ For those states which contemplate revision of their statutes, one of the best sources of information consists of the research reports of some of the states which have recently overhauled their hospitalization statutes. One of the most valuable reports is that of the ILLINOIS LEGISLATIVE COUNCIL, COMMITMENT TO MENTAL HOSPITALS, Pub. No. 52 (1942). The recommendations of the Council were finally adopted as the Mental Health Code of 1951, Ill. Rev. Stat. (1957) c. 91½. See also KANSAS LEGISLATIVE COUNCIL, PSYCHIATRIC FACILITIES IN KANSAS, Parts I and II, Pub. Nos. 143 and 145 (1946); MICHIGAN JUDICIAL COUNCIL, 13th Annual Report, Part II (1943), and 14th Annual Report, Part I (1944); MINNESOTA LEGISLATIVE RESEARCH COMMITTEE, CARE AND TREATMENT OF MENTAL PATIENTS, Pub. No. 19 (1948); WISCONSIN JOINT INTERIM COMMITTEE ON REVISION OF THE PUBLIC WELFARE LAWS, GENERAL COMMENT (1947)—published as a series of footnotes to Wis. Stat. (1947) c. 51, and in Wis. Stat. Ann. (West, 1957). Foreign experience in dealing with mental illness is also available. See the recently published report of the Royal Commission on the Law relating to Mental Illness and Mental Deficiency, 1954-1957 (1957. H.M.S.O.), commented on in 21 MOD. L. REV. 63 (1958); and FOURTH REPORT OF THE EXPERT COMMITTEE ON MENTAL HEALTH, WORLD HEALTH ORGANIZATION, Technical Reports Series No. 98 (1955).

²⁰ For discussions of terminology in commitment statutes, see REPORT TO GOVERNORS' CONFERENCE 47; comment, 56 YALE L.J. 1178 at 1181 (1947).

"Incompetency" is used to refer to that degree of mental illness which renders the individual unable to take care of his property and justifies the appointment of a guardian. Unfortunately, there is no term which refers to the degree of mental illness which justifies either voluntary or compulsory hospitalization. A few writers have used "commitability" but the term seems clumsy and has not gained acceptance. Partly because of this confusion in terminology, and partly because human minds can not be measured in pounds or feet, the states have had a great deal of difficulty in defining the degree of mental illness which justifies hospitalization.

Some states have used the term "mental illness" in the definition section of the statute in a general sense and in later provisions attempted to spell out the degree of mental illness which is required to commit a person to a mental hospital. For example, the Wisconsin statute provides: "§1.001. *Definitions.* As used in this chapter: (1). Mental illness is synonymous with insanity. . . ."²¹ A later section provides that the patient must be both mentally ill and "a proper subject for custody and treatment."²²

The Draft Act also provides a general definition plus a more detailed provision for the degree of illness which justifies hospitalization. The act provides:

"Section 1. *Definitions.*—As used in this Act, terms shall have the following meanings:

(a) *Mentally ill individual.*—An individual having a psychiatric or other disease which substantially impairs his mental health."²³

A later provision states that compulsory hospitalization for an indeterminant period can be ordered by a court if the court finds that the proposed patient:

- "(1) is mentally ill, and
- (2) because of his illness is likely to injure himself or others if allowed to remain at liberty, or
- (3) is in need of custody, care or treatment in a mental hospital and, because of his illness, lacks sufficient insight or capacity to make responsible decisions with respect to his hospitalization. . . ."²⁴

²¹ Wis. Stat. (1957) §51.001.

²² Id., §51.02(5)(c).

²³ Draft Act, §1.

²⁴ Id., §9(g).

On the other hand, some states define "mental illness" so as to include the conditions which must be met before hospitalization is required. For example, New York and Pennsylvania define the term as follows:

"§2. *Definitions.* When used in this chapter, unless otherwise expressly stated, or unless the context or subject matter otherwise requires, . . .

(8) A 'mentally ill person' means any person afflicted with mental disease to such an extent that for his own welfare or the welfare of others, or of the community, he requires care and treatment. . . ." ²⁵

"§1072. *Definitions.* As used in this act, unless the context clearly indicates otherwise, the following words and phrases shall have the following meanings: . . . (11) 'Mental illness' shall mean an illness which so lessens the capacity of a person to use his customary self-control, judgment and discretion in the conduct of his affairs and social relations as to make it necessary or advisable for him to be under care. The term shall include 'insanity,' 'unsoundness of mind,' 'lunacy,' 'mental disease,' 'mental disorder,' and all other types of mental cases, but the term shall not include 'mental deficiency,' 'epilepsy,' 'inebriety,' or 'senility,' unless mental illness is superimposed." ²⁶

None of the above definitions is really adequate and some have been severely criticized as vague and loosely worded.²⁷ The phrase "necessary or advisable" in the Pennsylvania statute above is an obvious example of loose terminology. Does this almost universal ambiguity of statutory language mean that we can't do any better? Does it cast doubt on our ability to deal with the problem by statute? It seems clear that the problem must be faced and that the courts and hospital administrators should be entitled to both expert opinion directed toward the individual case and to a statutory policy statement of the prerequisites for hospitalization. In this connection it is worth noting that the Draft Act statement, which seems to be the most precise of any of the above statutes, has been criticized, but on policy grounds, rather than for am-

²⁵ 34A N.Y. Consol. Laws (McKinney, 1951) §2.

²⁶ Pa. Stat. Ann. (Purdon, 1954) tit. 50, §1072.

²⁷ See the criticism of the New York and Draft Act provisions in Whitmore, "Comments on the Draft Act for the Hospitalization of the Mentally Ill," 19 GEO. WASH. L. REV. 512 at 521 and notes 45-48 (1951).

biguity or vagueness.²⁸ However, for want of a better term, the phrase "mental illness" will be used herein essentially as it appears in the Draft Act, i.e., as indicating a general personality disorder (Draft Act, section 1a) coupled with either the situation where the patient is dangerous to himself or others, or with the situation where the patient needs hospitalization and lacks sufficient mental capacity to make responsible decisions with respect to hospitalization (Draft Act, section 9g). This paper does not deal with the problems of commitment of mental defectives, formerly called feeble-minded, or of alcoholics, or drug addicts. These groups present separate although related policy issues.²⁹

(2) The term "mental hospital" is used herein, rather than "insane asylum." There are two kinds of mental hospitals. "Temporary-care hospitals" specialize in short-term diagnostic screening and treatment and include general hospital mental facilities, psychiatric out-patient clinics, receiving hospitals, and psychopathic hospitals. "Prolonged-care hospitals" include the "regular" state hospitals and most private hospitals. Although such a hospital may also handle diagnosis and short-term intensive treatment, a great majority of patients are those who receive long-term treatment and custodial care.

(3) "Patient" is used here and in most statutes rather than the older term "inmate" which had undesirable criminal implications. The term is also used here and in most of the recent statutes to describe a person against whom involuntary commitment proceedings have been instituted.

(4) "Conditional release" describes a situation where a patient is carried on the books of the hospital but is not a resident. The older statutes use the terms "parole" or "furlough" while more recent statutes use "home care," "trial visit," "convalescent leave," etc.

²⁸ Ibid.

²⁹ The mental defective who needs institutional treatment is usually placed in a special institution, called a school, rather than in a mental hospital. The program of treatment is primarily custodial and educational, directed toward teaching the patient to live within his limitations. The narcotic addict is also treated as a special case, partly because of the close relation between addiction and the illegal drug traffic and partly because treatment in the regular mental hospitals has not been very successful. Most of the severe cases are treated in the United States Public Health hospitals which specialize in treatment and research in the narcotic field. There is a distinct trend toward treatment of the alcoholic as a separate class. Hospital treatment is rarely effective, especially in crowded state hospitals where the alcoholics are frequently housed along with other patients. The answer seems to lie in the establishment of clinics at the local level which treat alcoholics primarily on an outpatient basis.

(5) "Commitment" refers to the procedures for compulsory hospitalization. A few states use "involuntary hospitalization" or "certification." The latter term is confusing, since in some states voluntary patients must also be "certified" as in need of treatment in order to allow public funds to be used for their care.

C. Types of Hospitalization Procedures

The problems involved in the admission of a patient to a mental hospital are usually thought of in terms of formal commitment proceedings involving compulsory hospitalization for an indefinite period. There are at least six separate types of admission procedures.

1. *Voluntary Admission.* This involves a written request for admission by a patient who is competent to make such a request. A number of states also authorize the parent or guardian of a minor to make the application. In most states, the patient may be detained, either for a fixed period after admission (typically 60 days), or for a brief period after he requests release (typically 10 days).

2. *Admission by Guardian.* A number of states authorize the guardian of an adjudicated incompetent to commit the ward to a mental hospital, either with or without the consent of the court which supervises the guardian. Although some statutes refer to this as voluntary admission, it is compulsory as far as the patient is concerned and should be treated separately as a form of commitment.

3. *Non-protested Admission.* This procedure is sometimes referred to as "involuntary admission." Non-protested admission is not the same as voluntary admission, since no affirmative action is required of the patient, nor is it compulsory since a protest by the patient is effective. A number of states authorize the hospital to receive a patient who is presented for admission by a friend, relative, or physician. If he protests at the time of admission, he may not be received, and if he protests after admission, he must be discharged within a short period, or compulsory proceedings must be instituted.

4. *Emergency Commitment.* Almost every state has some authorization for compulsory commitment to a mental hospital in emergency cases, where the patient may be dangerous to himself or others and needs immediate care. The procedure is summary and permits detention only for a short period.

5. *Temporary Commitment.* This is the newest of the compulsory procedures and is primarily a device for diagnostic screening, although it is also used for short-term treatment. It developed from the older emergency procedures, but is not based on the existence of a clear emergency. The procedure is summary and authorizes detention for a limited period.

6. *Formal Commitment.* This procedure is the one most commonly used and generally involves commitment for an indeterminate period after a full-dress judicial hearing in which the prospective patient is given a chance to contest the need for hospitalization.

The purpose of this paper is to survey existing statutes and case law on formal, or indeterminate, commitment. In almost every state the other procedures exist side by side with the formal procedure, and many patients who are ultimately committed for an indeterminate period are first admitted under one of the other provisions. The relationship between these procedures has been dealt with elsewhere.³⁰

II. THE THEORY OF COMPULSORY COMMITMENT

Mental illness, as such, like any other illness, is a medical problem and is primarily of concern to the medical profession, especially to the psychiatrist who specializes in the diagnosis and treatment of mental illness, and to the clinical psychologist (not an M.D.) who deals with diagnostic and testing procedures. One of the principal characteristics of mental illness, or possibly even a definition, is the failure of the individual to adapt to the society of which he is a part. Whether the illness results from organic causes, such as paresis, or is one of the diseases for which no organic cause can be found, the symptoms of serious mental illness are essentially those of release, or regression to an uninhibited state. The social controls, including the individual's ability to work within a complex human relationship, are usually the first to suffer deterioration. This failure may result in the inability of the individual to care for himself, or it may be ex-

³⁰ Legal aspects of voluntary admissions are discussed in detail in my article, "Hospitalization of the Voluntary Mental Patient," 53 MICH. L. REV. 353 (1955). Procedures (2) through (5) and their relation to formal commitment are discussed in Ross, "Hospitalizing the Mentally Ill—Emergency and Temporary Commitments," printed in CURRENT TRENDS IN STATE LEGISLATION 1955-56, p. 461 (1957).

pressed in antisocial conduct directed at others. In either case, the problems are no longer medical, but have social and legal consequences. Thus the law, which is the most specialized and coercive of social controls, is used to regulate and channel the by-products of mental illness. The principal policy questions in the area of compulsory hospitalization are:

(1) What degree or type of social-adaptive failure should be required to justify hospitalization against the wishes of the individual?

(2) How can this standard be incorporated in legal procedures so that the policy reasons behind the standard will be effectuated, and, at the same time, the individual will be protected against unwarranted deprivation of his liberty?

(3) What effect, if any, should compulsory hospitalization have on the legal rights of the individual, other than his loss of personal liberty? Should a committed person have the power to appoint an agent, get a divorce, make a will, etc., or should hospitalization automatically result in total loss of legal capacity? This last question is discussed in Part IV.

A. *The Legal Justification for Commitment*

A careful reading of the four statutory definitions of mental illness set forth in a preceding section³¹ indicates that whatever agreement exists as to the purpose of the commitment laws, a consensus can not be found in the statutes. Just when is a patient a "proper subject for care and treatment" under the Wisconsin statute? Under many of the statutes it is not clear whether the commitment process is primarily protective, custodial, or therapeutic.

1. *The Police Power.* The clearest justification for compulsory commitment comes from the power of the state to protect itself against breaches of the peace. The police power is "... one of the most essential of powers, at times the most insistent, and always one of the least limitable of the powers of government."³² A

³¹ Notes 21-26 *supra*. The statutory provisions of all of the states are listed in Tables 1 and 3 of Appendix I *infra*. Of the 43 states which utilize judicial commitment procedures, 4 predicate commitment on danger to society, 5 on the fact that the patient needs treatment and will benefit from it, 28 states and the Draft Act allow either criteria, and in 6 states the statutes are silent on the subject. Of the 14 states using *ex parte* commitment, 3 and the Draft Act use danger, 1 need of treatment, 5 either ground, and not stated in 5.

³² *District of Columbia v. Brooke*, 214 U.S. 138 at 149 (1909).

person who is not mentally ill can be incarcerated for life if he is guilty of violence against persons or property, and the imprisonment is used both as retribution and to protect society from future violence. Can the same person be imprisoned indefinitely in order to protect society where he has not yet been guilty of a crime, but will probably commit a crime in the future? The decisions on the constitutionality of the "sexual psychopath" laws indicate an affirmative answer. While some of these statutes, such as that of Ohio, apply only to persons convicted of crime, some states do not require prior criminal conduct as a prerequisite to indeterminate imprisonment. Thus a Minnesota statute which allowed indefinite incarceration for a person adjudged a "psychopathic personality" was upheld by the Supreme Court, where the statute defined a "psychopath" as a person "irresponsible for his conduct with respect to sexual matters and thereby dangerous to other persons."³³ The court said that the element of danger is a fact which calls for proof of past (non-criminal) conduct pointing to probable future consequences, and is as susceptible of proof as many criteria constantly applied in criminal prosecutions.³⁴

The Draft Act states that a person can be committed when he is mentally ill and because of his illness is "likely to injure . . . others if allowed to remain at liberty."³⁵ Many commitment statutes contain similar language. Since the purpose of such a statute is the protection of society rather than retribution, the constitutional protections afforded in criminal prosecutions are not required. There is one obvious constitutional limitation, the requirement of an indeterminate sentence. Since the only justification for depriving such a person of his liberty is that he is dangerous to society, the restraint can last only as long as the danger exists. Presumably, commitment for a fixed term would be unconstitutional.

2. *The State as Parens Patriae.* The other major source of state authority over the mentally ill is the position of the state as *parens patriae*. Under this doctrine the sovereign has both the right and the duty to protect the persons and property of those who are unable to care themselves because of minority or mental

³³ *Minnesota v. Probate Court*, 309 U.S. 270 at 272 (1940).

³⁴ *Id.* at 274.

³⁵ Draft Act, §9(g).

illness. In England, the guardianship of those under legal disability was originally intrusted to the feudal lords, but was taken over by the Crown in the 13th century and delegated to the Lord Chancellor. In this country, the royal prerogative was inherited by the individual states and has been held to constitute part of the original inherent jurisdiction of the equity courts.³⁶ The doctrine of *parens patriae* has been the primary source of the law of guardianship³⁷ and the juvenile courts laws³⁸ and is clearly reflected in many commitment statutes. Probably the clearest example of the *parens patriae* concept is the Draft Act section which provides as an alternative ground for compulsory commitment that the patient "is in need of custody, care or treatment in a mental hospital and, because of his illness, lacks sufficient insight or capacity to make responsible decisions with respect to hospitalization."³⁹ Another part of the same section authorizes commitment where the patient is likely to injure himself if allowed to remain at large.

The gradual extension of the *parens patriae* concept to compulsory commitment raises a number of difficult policy questions which can be illustrated by the case of John S:

John S. is an elderly man, living alone on a small farm. His intellectual capacities are adequate to make a marginal living, care for his farm and get along with his neighbors. The only difficulty is that he is subject to fits of severe depression, lasting for several months. A competent psychiatrist estimates that there is a two-to-one chance that if left unrestrained he will commit suicide within the next year or two during a depressed state. John recognizes his illness as an intermittent manic-depressive psychosis, but prefers to remain on his farm and run the risk of self-destruction. Should this man, who is clearly not a danger to anyone except himself, be hospitalized against his wishes? Is this the kind of choice that should be made by the state, or should it be left to the individual?

I suspect that if this case were put to a representative group of lawyers, there would be considerable disagreement, both as to the "correct" answer and as to the additional factors to be con-

36 4 POMEROY, EQ. JUR., 5th ed., §§1303-1314 (1941).

37 MADDEN, DOMESTIC RELATIONS §151 (1931).

38 In re Turner, 94 Kan. 115, 145 P. 871 (1915).

39 Draft Act, §9(g).

sidered. The language of most commitment statutes is broad enough to allow a decision either way. Some would argue that the sanctity of human life is an absolute (except in wartime) and the state has a duty to preserve the life of its subjects. Analogous principles could be used from the law of guardianship and from the statutes which make attempted suicide a crime. Others would argue that the law should not be concerned with social non-conformity, and that everyone has a right "to go to Hell in his own way." There are other factors which may or may not be important. Should the commitment court consider the estimated cost of psychiatric care, both to the patient and to the taxpayers? Should the probability and duration of successful treatment affect the decision? Should a guardian of the property be appointed, and, if so, how can the decisions of the court which appoints the guardian be correlated with the court which is responsible for the commitment decision? In many states these are two different courts.

The justification which has been advanced for commitment of the "harmless" patient (in the sense of harmless to others) is essentially the same as the justification for guardianship. Where a patient does not have the mental capacity to make a sound decision relative to his own hospitalization, the state will step in and make it for him, even though the same individual does have capacity to make a will or a contract. This is an example of "partial incompetency."

The authors of the Draft Act have stated:

"Within the wide range of mental illnesses there are cases in which the sick individual, like the individual who is physically sick, retains sufficient capacity to make a responsible decision on the question of his hospitalization, weighing it against other factors in his life and affairs. On the other hand, without being 'dangerous,' a mentally ill individual may, because of the nature or stage of his illness, lose his power to make choices or become so confused as no longer to have the capacity to make a decision having any relation to the factors bearing on his hospitalization. It is in the latter situation that the Act permits compulsory hospitalization.

"The mentally ill individual who is found to have retained this capacity cannot be compelled to enter a hospital unless he is 'dangerous.'

"It should be emphasized that it is not a question of the individual agreeing or disagreeing with medical judgment as to

the nature of his illness or the need for hospital care, but rather of whether he is *capable* of making a responsible, not necessarily a wise, decision in the premises.

"In short, the State through its courts is here authorized to make for the individual a decision, which, *by reason of his illness*, he is incapable of making for himself."⁴⁰

Guttmacher and Weihofen have endorsed the Draft Act provision,⁴¹ but several writers from both the legal and medical professions have expressed dissent.⁴² Probably the strongest criticism that has been expressed is found in an article by Dr. Charles Whitmore.⁴³ Dr. Whitmore states that the second ground for compulsory hospitalization (that the patient needs care and because of his illness is unable to make a responsible decision with respect to hospitalization) is a radical departure from existing law and is an unsound policy decision. He argues that this provision would allow the compulsory detention of groups which have not been hospitalized in the past, such as the severe psychoneurotic. Dr. Whitmore's position seems to be overstated. The psychoneurotic is rarely benefited by hospital treatment. The few extremely severe cases would be hospitalized under the first ground stated in the Draft Act, i.e., that they are dangerous to others. Very rarely could a psychoneurotic be hospitalized under the second ground. In almost all cases the psychoneurotic recognizes his condition and is able to make a responsible decision relative to hospitalization. However, there is a large group of prospective patients who are not yet dangerous to themselves or others, who are not mentally able to realize their condition or make responsible decisions, but who need hospitalization before their condition deteriorates, as it may without treatment. This group consists of the early stage manic-depressives and schizophrenics. It is for this group of psychotic patients that the second ground for hospitalization in the Draft Act has been designed.

While the weight of both expert and legislative authority favors retention of the second ground for hospitalization, it should be understood that it is not an easy test to administer. The Draft

⁴⁰ Draft Act, Commentary, p. 28.

⁴¹ PSYCHIATRY AND THE LAW 311-312 (1952).

⁴² Curran, "Hospitalization of the Mentally Ill," 31 N.C. L. REV. 274 at 291 (1953). Cf. Szasz, "Psychiatry, Ethics, and the Criminal Law," 58 COL. L. REV. 183 at 197 (1958).

⁴³ "Comments on a Draft Act for the Hospitalization of the Mentally Ill," 19 GEO. WASH. L. REV. 512 at 522 (1951).

Act test refers to the *capacity* of the individual to make a rational choice, not the wisdom of the choice. But isn't an unwise choice evidence of incapacity? Specifically, if all the experts agree that the benefits of hospitalization for a particular individual outweigh the disadvantages (loss of personal liberty), does not the patient's failure to heed the voice of authority give rise to a strong presumption that he is incapable of making a rational choice, or is it merely evidence of non-conformity? Unfortunately, no statute can by its terms indicate just where non-conformity ends and incapacity begins.

B. *Commitment and the Decision Making Process*

One of the most fruitful ways to consider mixed issues of law and fact, such as commitment, is to consider the problem as essentially one of judicial administration, i.e., who decides the question and what kind of guides is the decision maker given.⁴⁴ The illustration given in the preceding section (John S.) illustrates some important points which go to the heart of the commitment process.

1. The decision on commitment may have to be correlated with the decision on guardianship. Should both of these functions be lodged in the same court? Clearly the trend in judicial administration furnishes an affirmative answer. The end result of this trend would be to set up a separate court to handle all matters of personal status, or to bring under one court all areas which require specialized social service assistance furnished within the court structure.⁴⁵ Thus, in some jurisdictions, guardianship, adoption, domestic relations, and juvenile problems are handled by a single court, and in a very few jurisdictions, commitment cases are handled by the same court.⁴⁶

2. The generally accepted modern view of commitment is that it is essentially a medical problem. Under the influence of this concept, most commitment statutes provide for examination

⁴⁴ A recent example of this type of thinking can be found in *Pfeifer v. Standard Gateway Theater*, 262 Wis. 229, 55 N.W. (2d) 29 (1952). The court held that in a negligence case, the issue of factual cause should be put to the jury, unincumbered by concepts of foreseeability, and in those few cases where liability ought to be limited to foreseeable (or proximate) consequences, this is a decision for the court after verdict.

⁴⁵ VIRTUE, *FAMILY CASES IN COURT*, chapters 1, 10 and 11 (1956).

⁴⁶ TWENTY-FOURTH ANNUAL REPORT OF THE DOMESTIC RELATIONS COURT OF THE CITY OF NEW YORK 13 (1956).

and report by a panel of two physicians appointed by the court. There has been a strong trend toward reliance on court-appointed experts who make the decision with very little control by the court. The same trend is observable in the criminal law where insanity is used as a defense.

There are two defects in the concept that commitment is an essentially medical judgment. In the first place, exclusive reliance upon the psychiatrist or physician arises in part from the assumption that the diagnostic aspect of psychiatry is a branch of medicine. Psychiatry is primarily an art rather than a science. When an individual is unable to adjust to society, the psychiatrist is able to formulate a theory of causation which, because of his experience and training, is more sophisticated than that of a layman. In the same sense, the sociologist can usually work out a more reliable theory on the causes of aberrant group behavior than can a banker, although possibly the sociologist will run second to the politician. The point is that mental illness is not a fact in the same sense that a broken leg is; it is a theory used to explain deviant behavior.⁴⁷

Secondly, the psychiatrist, who is trained both in medicine and in mental illness, is not necessarily the person most qualified to decide on commitments. Recall the case of John S. The "facts," meaning expert theories, guesses, and estimates of future conduct, were given as part of the problem, and are not controverted. But agreement on facts does not dispose of the issue of compulsory commitment. Commitment depends on social value judgments. In the John S. case, any decision will draw a line between the conflicting policies of individual liberty and state sanctions against self-destruction. Clearly this is not a medical or even a psychiatric judgment.⁴⁸

A recent article by a psychiatrist points out:

"The fact that court approval is usually granted routinely on the basis of medical testimony regarding the alleged need for commitment signifies that by so acting physicians fulfill a

⁴⁷ A recent article by a psychiatrist points out that the analogy between medicine and psychiatry is dangerously misleading (dangerous to both the law and to psychiatry). See Szasz, "Psychiatry, Ethics, and the Criminal Law," 58 COL. L. REV. 183 at 187-192 (1958).

⁴⁸ One of the few articles by a member of the legal profession which recognizes this problem is Dession, "Deviation and Community Sanctions," published in *PSYCHIATRY AND THE LAW*, edited by HOCH and ZUBIN (1955).

special social role, unrelated to their technical knowledge. Accordingly, by entering into this legal situation, the physician (psychiatrist) acts in the role of one of society's agents whose duty it is to enforce compliance with certain social rules. . . . [T]his may be an entirely 'legitimate' and morally defensible role, similar to the roles, for example, of policeman and judge. It is, however, scientifically misleading to equate this role with that of an 'individual therapist' vis-a-vis the patient If court action is to be determined this way, then why not conclude that the psychiatrist has nothing to contribute to the proceedings? Judge and jury are by the very definition of our democratic society the official experts in deciding which modes of behavior are socially unacceptable."⁴⁹

It might be argued that the above contention is valid only where the ground for commitment is based on *parens patriae*, but not where it is based on the police power, since danger to society is both a concept which finds greater agreement as a ground, and is also more closely related to a psychiatric prediction of the future course of the illness. This distinction is unsound. The real question is not whether the individual is dangerous to society, but how dangerous to whom, and what degree of danger can society tolerate. Certainly the latter question is essentially a policy issue. A truck driver with a mild neurosis who is "accident prone" is probably a greater danger to society than most psychotics; yet he will not be committed for treatment, even if he would be benefited. The answer lies in shifting him to a non-driving job, and the decision will probably be made by the employer rather than the psychiatrist. Even if the danger can not be alleviated, the community expects a certain amount of dangerous activity. I suspect that as a class drinking drivers are a greater danger than the mentally ill, and yet the drivers are tolerated, or punished with small fines rather than indeterminate imprisonment. Maybe our treatment of the drunken driver is not the best choice, but the point is that it is a social choice rather than a medical issue.

Once it is recognized that the medical witness, in a commitment proceeding, is acting as one of "society's agents" in determin-

⁴⁹ Szasz, "Commitment of the Mentally Ill: 'Treatment' or Social Restraint?" 125 J. NERVOUS AND MENTAL DISEASE 293 (1957). This article contains the most complete summary of psychiatric literature on the role of the psychiatrist in legal proceedings.

ing an essentially sociological question, several conclusions important to judicial administration can be drawn.

a. If impartial experts are to be used, there seems to be no reason why the panel should be limited to physicians, or even to psychiatrists. The social case worker, sociologist, or clinical psychologist knows as much about social values as the doctor of medicine, if not more.

b. In order to emphasize to the participants in the decision making process that the questions are essentially social, the statutes defining mental illness should be phrased in non-psychiatric terms⁵⁰ and the expert witnesses should be required to testify in terms of social facts and predictions rather than in psychiatric terms. Specifically, the expert should not be asked "Is this man psychotic" or "Is he a proper subject for commitment." The questions should be phrased as follows: What is the probability that this man will behave in such and such a manner in the future, specifying the sorts of situations which involve danger to himself or others? What is the possibility that such situations will occur? What is the probability of a successful cure? How long will it take?

c. While only one state still requires a mandatory jury trial, about half the states allow a jury trial on request of the patient. As a policy matter, most authorities are opposed to the use of the optional jury on the ground that the jury is not competent to determine the medical issues involved. Thus one author has stated that the use of a jury "is about as sensible as calling in the neighbors to diagnose meningitis or scarlet fever."⁵¹ If the decision is based on sociological values, the cross-section of the community may be the best agent, not to diagnose mental illness, but to apply the diagnosis of the experts to the social context in which the patient exists. A recent Wisconsin statute explicitly recognizes the policy-making function of the optional jury by requiring a special verdict. The jury is asked two questions: Is the patient mentally ill? If so, should he be committed?⁵²

⁵⁰ Psychiatrists discourage the use of technical terms in the statutes, as the classification of mental illness is still in a state of flux. Group for the Advancement of Psychiatry (Report No. 9, Committee on Forensic Psychiatry) p. 1 (1949).

⁵¹ STERN, MENTAL ILLNESS: A GUIDE FOR THE FAMILY 37 (1942). For other criticisms of the optional jury, see Draft Act, Commentary, p. 26; GUTTMACHER AND WEIHOFEN, PSYCHIATRY AND THE LAW 299 (1952); comment, 56 YALE L.J. 1178 at 1192 (1947).

⁵² Wis. Stat. (1957) §51.03.

d. The points listed above are arguments in favor of limiting the role of the medical witness to the presentation of expert opinion, with decision on the policy issues being left to a judge or jury, and the purpose of this limitation is to further the decision process. There is an additional purpose to be served by such a limitation—the encouragement of effective psychotherapy. Reliance on the psychiatrist to make the commitment decision has two adverse effects on the psychiatrist—it damages him psychologically, and damages his future effectiveness as a healer. As to the first point, the psychiatrist is trained to identify with his patient. He is therapy-oriented and trained to think of his prime obligation as that to his patient. When he is making a commitment decision, he is forced to identify with the community, a conflicting role which may cause trouble. One psychiatrist has indicated that there is a widespread reluctance in the psychiatric profession to enter into the commitment process, and suggests that this role-conflict may be part of the cause.⁵³ Secondly, the practice in a few states is to allow commitment by the superintendent or staff physician of the same state hospital to which the patient will be committed. In other states, the patient whose indefinite commitment is being sought may already be in the hospital as a voluntary patient or under an emergency order, and the doctor who has been treating him is called on to participate in the commitment process. This practice should be avoided. Not only does placing the duties of “prosecutor and judge” on the hospital staff lead to public criticism, but more important, it breaks down the vital relation of trust and confidence between the patient and his therapist. One of the most difficult problems faced by the psychiatrist in treatment is persuading the patient to think for himself, a problem which is rendered more difficult if the same therapist is “the law” to the patient, with final authority to commit and discharge.⁵⁴

III. COMMITMENT PROCEDURES

Proceedings for the compulsory commitment of a patient to a mental hospital must not violate the constitutional provisions that no person may be deprived of his liberty without due process

⁵³ Szasz, “Commitment of the Mentally Ill: ‘Treatment’ or Social Restraint?” 125 J. NERVOUS AND MENTAL DISEASE 293 at 305 (1957). See also Dession, “Deviation and Community Sanctions,” in HOCH AND ZUBIN, *PSYCHIATRY AND THE LAW* 10 (1955).

⁵⁴ Szasz, “Psychiatry, Ethics, and the Criminal Law,” 58 COL. L. REV. 183 at 198 (1958); comment, 56 YALE L.J. 1178 at 1200, n. 106 (1947).

of law. However, what may be needed to satisfy the constitutional requirements may vary with the circumstances, and nowhere is this principle more aptly illustrated than in the conflicting decisions on due process in commitment cases.

The precise requirements of due process are hard to state in any area of the law, and especially so in the field of commitments for the following reasons:

(1) A glance at the statutes discussed in this article reveals a wide variety of enactments, many of them loosely worded. The procedural aspects of commitment are the subject of continuous legislative experimentation and there is a bewildering array of commitment methods. As a result many judicial decisions have turned on narrow questions of statutory interpretation and there are few reported judicial decisions in which the result rested on constitutional issues. Many of these procedures have remained on the statute books for years with little or no constitutional litigation.

(2) An additional factor which creates uncertainty in the constitutional area is the fact that many of the decisions which are reported are relatively old. Since they were rendered, there have been substantial changes in both psychiatric and legal understanding of the problems of mental illness. It is by no means certain that a modern court would adhere without qualification to the views expressed during the latter half of the nineteenth century.

This basic disagreement as to the minimum constitutional requirements has led to a bewildering variety of procedures. An additional factor which has produced the same result is disagreement as to the feasibility of procedural safeguards over and above those imposed by the constitution. The legal profession has emphasized the need to guard against "railroading" by the use of procedures adopted from criminal or civil trials. A fair hearing on notice, the right to counsel, and the right to a jury trial are not mere "technicalities," but represent principles of justice in dealing with human rights which have evolved over the centuries.

"The terms 'star chamber' and *lettre de cachet* describe no imaginary evils dreamed up by cautious lawyers, but very real practices current not so many hundreds of years ago, and hardly exceeded in arbitrariness, tyranny and injustice by practices rampant in Germany and elsewhere in our own times.

"Safeguards designed to guarantee fair procedure and

to prevent the abuse of commitment laws . . . are therefore not mere technicalities and formalities to be lightly brushed aside in favor of some summary commitment procedure."⁵⁵

The reported cases indicate that occasional abuses do crop up, and they are abuses which could be prevented by a rigid adherence to traditional legal procedures.⁵⁶

On the other hand, it is clear that legal formalities may do positive harm to the mental patient. A person who is already mentally disturbed should not be forced to sit through a public hearing and listen to his family and physician testify to his infirmities. The president of the American Psychiatric Association had this to say on commitment procedures:

"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 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."⁵⁷

The defects in the ordinary forms of judicial procedure when applied to the determination of mental illness are now widely recognized. Fortunately, many states have attempted to devise procedures which would protect the sane and provide minimum interference with the treatment process.

Although procedures vary widely, two basic methods predominate. The most common, referred to as "judicial commitment," involves a hearing before a court or a quasi-judicial ad-

⁵⁵ Weihofen and Overholser, "Commitment of the Mentally Ill," 24 *TEX. L. REV.* 307 at 337 (1946).

⁵⁶ For a good example of a "railroading" case, see *Shields v. Shields*, (W.D. Mo. 1939) 26 F. Supp. 211.

⁵⁷ Bowman, Presidential Address, 103 *AM. J. PSYCHIATRY* 1 at 12 (1946).

ministrative body. Ex parte commitment, used in fourteen states, permits indeterminate commitment without a hearing. The commitment order is issued by a physician, public health officer or judge, and a hearing is held only if the patient appeals the order.

The specific procedures for both methods and the statutory references for the 49 states are set forth in Tables 1 to 4 of Appendix I *infra*, and the text of the judicial commitment section of the Draft Act is reprinted in Appendix II. Particular aspects of commitment procedure have been discussed in detail elsewhere.⁵⁸ The purpose of this section is to summarize the existing statutes and to identify the major problems and the recent trends in commitment procedure.

A. Judicial Commitment

1. *Pre-hearing Procedures.* In all of the 43 states which utilize judicial commitment the action is initiated by a pleading, often called an application, petition or complaint, which usually must be verified. In most states any person can make such an application. In a few states the right to initiate proceedings is limited to certain select groups, such as the guardian of the patient, a physician or public official. Presumably, the reason for limiting the applicant to members of a specified class is the same reason for the requirement of verification: to discourage the groundless application.

A more effective method of preventing unnecessary proceedings is the requirement that a physician's report accompany the application. The report, made after a personal examination, serves another purpose: the provision for medical evidence at the hearing. In 34 states the statute requires that the court order a medical examination by one or more doctors appointed by the court. With the exceptions of Alaska, Kansas, and Rhode Island, all states require either one of these procedures, thus insuring that some medical evidence is available for the court. It is surprising that even three states would permit commitment without any medical examination.

⁵⁸ On procedural due process generally, see the sections on the Fifth and Fourteenth Amendments in CORWIN, *CONSTITUTION OF THE UNITED STATES ANNOTATED* (1953). On jury trials in commitment proceedings, see Williams, "Public-Law Adjudications of Mental Unsoundness and Commitability in Texas: Jury Trial Policy," 1 *BAYLOR L. REV.* 248 (1949). On notice, hearings and evidence, see the references cited in note 19 *supra*; and articles in 24 *TEX. L. REV.* 307 (1946); 13 *ROCKY MT. L. REV.* 99 (1941); 3 *STAN. L. REV.* 109 (1950).

Some states, and the Draft Act, require both medical examinations. This duplication seems to be unnecessary in light of the fact that approximately 90 percent of commitments are uncontested. Probably the best procedure would be to require a medical certificate with the application in all cases and require a separate examination only in those cases which are contested by the patient. Generally, the pre-hearing examination is conducted by physicians, or, if they are available, psychiatrists. Minnesota has an interesting and worthwhile provision, which is one of the few statutory recognitions that the need for commitment is both a medical and a social issue. The Minnesota court may appoint a social worker or welfare agency to conduct a social case work investigation. Oklahoma also has an interesting innovation and one which appears desirable. A pre-hearing examination is held by two doctors and one attorney. The physicians advise the court on the extent of mental illness and the attorney advises the court on the need for concurrent guardianship proceedings.⁵⁹

2. *Notice of the Hearing.* Most statutes are deficient with respect to a major part of the hearing process—the provision for adequate and timely notice. The function of the notice is to provide an opportunity for the patient who wishes to contest the commitment at the hearing the chance to prepare for the hearing. Measured by this standard, most of the statutes are defective in one or more of the following respects:

(a) In many states the notice is served only two or three days prior to the hearing. This short period is not adequate for a contested hearing and is probably utilized because the statutes were drawn up when commitment was used mainly for dangerous patients who were held in jail pending a hearing. Today there is no necessity for a quick hearing, since many patients can be treated on an out-patient basis while waiting for a hearing, and the dangerous patient can be hospitalized pending the hearing under one of the emergency admission procedures.

(b) Ideally, the notice should do more than inform the patient of the time and place of the hearing. Too many statutes set forth a notice form phrased in complex legal terms. The notice specified by the recent Texas Mental Health Act is a model of simplicity and completeness. In laymen's language it tells the patient what

⁵⁹ Okla. Stat. (Supp. 1957) tit. 43A, §54.

the hearing issues will be and advises him of his right to a jury trial, his right to counsel, and how these rights can be exercised.⁶⁰

(c) Many of these statutes require notice to the patient, but do not provide for any notice to others who may be interested in his commitment. A carefully drawn statute, such as the Draft Act, would also require notice to a guardian, if any has previously been appointed, to the spouse, and to close relatives. These persons should be notified, if their location is known, even though they are outside of the state.

(d) Most states wisely provide that if the medical examiners certify that notice to the patient would be harmful, the court can omit personal notice. However, few states provide an adequate substitute for personal notice when it has been omitted. The Washington statute is the only one which is really adequate in this respect. Notice to the patient can be dispensed with for medical reasons only when the notice is served on a court-appointed guardian ad litem who must be an attorney.

3. *The Hearing.* The hearing is customarily held in either the probate court or in the general trial court, although in seven states the hearing is held by a specialized quasi-judicial agency with judicial powers. The hearing is mandatory, except that four states provide that the hearing will be held only if the patient requests it. In the uncontested case, the commitment decision is made on the written record which consists of the petition and the medical report. At first glance the optional hearing procedure seems desirable, since most commitments are uncontested and the provision for a hearing only when requested does result in a substantial saving of time and effort. However, there are too many important auxiliary decisions for the hearing to be dispensed with. Specifically, the hearing ought to reveal the need for a legal guardianship, which is a decision which can not be made on the record alone. In three of the four states which do not hold hearings in all cases, the commitment order does not result in automatic incompetency. In the uncontested case the patient is hospitalized, legally capable of executing deeds and contracts, and no consideration is given to the need for protection of his estate from his own improvident acts. In a state such as New York where commitment does result in incompetency, the patient may be placed in the anomalous posi-

⁶⁰ Tex. Civ. Stat. Ann. (Vernon, 1958) art. 5547-44.

tion of being denied legal capacity, and yet having no substitute appointed to protect his estate from dissipation. Also, in many states, the question of the liability of the patient's estate and his relatives for the expenses of hospital care is made at the time of commitment, which, of course, requires a hearing in almost every case.

4. *Jury Trial.* The obvious disadvantages of the mandatory jury trial have been recognized by all of the authorities, and today only Kentucky and Alaska require a jury in every case.⁶¹ The majority of states have completely dispensed with the jury system, although in 13 states it is available in contested cases where requested by the patient. Personal observation indicates that the jury trial is rarely used where it is available, mainly because the patient is rarely informed of its availability. Most medical authorities state that the optional jury trial is unnecessary to protect the sane and is undesirable because a jury can be fooled by a paranoiac who can be lucid and convincing during the trial. The answer to both of these points lies in better presentation of the medical evidence, and neither objection seems a valid indictment of the jury system per se. As previously indicated in Part II (B), the question of commitment is often more of a social problem than strictly medical, indicating that the jury trial may be worthwhile. Probably the best system would be to permit a jury trial where the patient or his guardian ad litem specifically request it but to require that a special verdict be used, as is done in Texas and Wisconsin.⁶²

5. *The Informal Nature of the Hearing.* It is widely recognized that when the formal hearing is conducted in public with the patient compelled to be present the cumulative effect of the whole procedure is often medically harmful. The paranoiac is already suffering from the feeling that society is conspiring to punish him. If he is required to sit in a courtroom and listen to his physician and family testify against him, the experience will confirm his suspicions and make psychiatric treatment much more difficult.

⁶¹ Several authors have recently stated that no state today requires a jury. See GUTTMACHER AND WEIHOFEN, *PSYCHIATRY AND THE LAW* (1952) at 300. The only exception listed is Texas, which amended its Constitution in 1953 to permit waiver of a jury. Apparently, in reading the Kentucky statute, the authors have been misled by the section title "Jury Trial may be had unless waived." The body of the statute requires a jury in every case. Ky. Rev. Stat. §202.080. Section titles are not part of the law in Kentucky (§446.140) and the attorney general has ruled that the jury is mandatory. Ky. Op. Atty. Gen. 39, 583 (1957).

⁶² Tex. Civ. Stat. Ann. (Vernon, 1958) art. 5547-51; Wis Stat. (1957) §51.03.

Most commitment statutes, either expressly or by implication, no longer require the physical presence of the patient. A number of states also provide that the court may exclude all persons who do not have a legitimate interest in the hearing, and permit the court to hold the hearing at any place, including the home of the patient or a medical facility. The Draft Act expressly provides for all of the above, and, in addition, provides that the court is not bound by the technical rules of evidence, but can admit any relevant evidence for whatever weight it has. This last provision is very common in juvenile court and workmen's compensation acts, but as yet is not common in commitment statutes.

All of these provisions are desirable and permit considerable variation between the degrees of formality required for contested and uncontested hearings. The major defect is that in most states there is no requirement that the patient be informed of his rights to be present or to require a formal hearing in open court. The recent Texas Act is a major improvement over many statutes in this respect. The statutory notice spells out in simple language the right to have a jury, an attorney, and the right to be present.⁶³

6. *Representation by Counsel.* As indicated in Appendix I, twenty-five states now expressly provide that the patient can be represented by counsel and nineteen require that the court must appoint counsel if the patient requests it. The primary purpose of allowing counsel to a patient is, of course, to insure that the patient has a real chance to contest the case. Many of the statutes on court-appointed counsel are defective in one or more of the following aspects: (1) In most states, appointed counsel is either not compensated at all, or a low fee is set by the statute. The result is that counsel is not encouraged to prepare adequately for the hearing. (2) In some states counsel is appointed on the day of the hearing. The aid of counsel tends to become a mere formality unless the attorney is appointed early enough so that he can consult with his client and gather the evidence. (3) Most of the states which do provide for appointed counsel do so only on request of the patient, and yet there is no provision requiring that the patient be informed of his right to counsel.

Since the traditional role of counsel has been thought of in terms of the prevention of "railroading" by designing relatives, the statutes of most of the states contemplate participation by

⁶³ Note 60 *supra*.

counsel only in the contested cases. There are other functions which can and should be served by counsel in all cases of long term hospitalization, whether the case is contested or not. In some jurisdictions the court can commit the patient without loss of legal capacity, or can commit as incompetent. Where this choice is possible, counsel should assist the court in reaching a desirable decision. Furthermore, in many states there is no choice and every long term commitment order automatically results in legal incompetency, but no provision is made for the automatic appointment of a guardian. The patient is thus left in the peculiar position of being deprived of the right to deal with his property and having no responsible person appointed to substitute for him. In such a case the appointed counsel can be of great help by investigating the need for a separate guardianship action.

B. *Ex Parte Commitment*

Short-term commitment, without any hearing, is available in almost all of the states, either where the patient is dangerous and must be restrained until the formal proceedings can take place, or where the patient is committed for observation and diagnosis pending a formal hearing.⁶⁴ In fourteen states, the procedure is available for indeterminate commitment, and in six states it is the only available procedure. The typical statute permits compulsory hospitalization on the certificate of two physicians who must make a personal examination. In several of the states the commitment order is approved by a judge, but the function of the judge is limited to determining whether the papers are in order. In a few states the committing doctors must report the fact of commitment to the relatives of the patient and to the state mental health agency.

1. *The Policy Basis of Ex Parte Commitment.* The justification for ex parte commitment is that most cases are uncontested, and it is inconvenient and costly to require a hearing in every case. In the few cases where the patient wishes to contest the commitment order, an appeal is available, either by a statutory appeal from the commitment order with a trial de novo, or by means of an independent habeas corpus action. Since the procedure is not based on the existence of an emergency or dangerous

⁶⁴ Emergency and temporary observation commitment on an ex parte basis is discussed in Ross, "Hospitalizing the Mentally Ill—Emergency and Temporary Commitments," in *CURRENT TRENDS IN STATE LEGISLATION 1955-56*, p. 401 (1957).

situation and is not subject to any initial public control, substantial constitutional issues are raised. These will be discussed in the next section. For the same reasons, there is a greater possibility of abuse of the procedure. In order to prevent possible misuse of the process, most of the statutes include one or more of the following safeguards:

(1) The admission formalities are greater than in the case of emergency or short term observation commitment. Instead of allowing commitment on the certificate of one physician, as is common in the emergency case, the approval of two or more physicians, or of a designated public official, such as a health officer or coroner, is required.

(2) In several states, the *ex parte* procedure is available only for use by the state hospital system. The state hospitals, usually overcrowded and understaffed, retain a veto power over the commitment decision and are not likely to accept a borderline case.

The decision on whether or not *ex parte* commitment is wise is not easy to make. There are arguments in favor of the procedure:

(1) The average layman thinks of a criminal trial when he thinks about law. A hearing before a black-robed judge, with lawyers, witnesses, bailiffs, and all the other trappings of a formal trial, is very apt to be confused with a criminal prosecution, especially by the disturbed patient who already feels that society is conspiring against him. The psychiatrists are almost unanimous in decrying the traumatic effects of a judicial hearing.

(2) The provision for a trial *de novo* or an appeal from the commitment order is an adequate safeguard for the few contested cases. To provide an initial hearing in all cases, contested and uncontested, is a waste of time and effort, both for the court and for the medical witness.

Most of the arguments against the *ex parte* procedure have already been mentioned elsewhere in this paper, and can be summarized as follows:

(1) There are serious doubts as to the constitutionality of *ex parte* commitment.

(2) The traumatic effects of a judicial hearing can be lessened or completely dissipated by the use of the flexible hearing procedures discussed in the previous section of this article, such as the abolition of the mandatory presence of the patient, the release

of the harmless patient to his family pending the hearing, and others.

(3) When a patient is hospitalized without any judicial intervention, there is apt to be no consideration given to the need for legal guardianship.

(4) No matter how well drafted, the statutory release procedures are seldom adequate in fact. The patient who is already in a hospital and wishes to contest the decision of the committing doctor is often unable to find an attorney who can handle his petition for release. It is generally agreed that the state hospital systems of New York and California are among the best in the country, yet there are three cases from these states in which a patient's request to communicate with his attorney in order to file a habeas corpus petition was refused by the hospital authorities.⁶⁵

(5) Placing the primary responsibility for commitment on the medical profession can injure the relation of trust between the patient and the psychiatrist who will be treating him. Where the patient suspects that all society is against him, the role of the law as a scapegoat may help the doctor, who does bear ultimate responsibility for the patient, to suggest that "I'm on your side."

My own conclusion is that the best results can be achieved by improving the judicial hearing rather than discarding it. While the *ex parte* hearing seems to work in the states that have adopted it, there is no strong trend in this country to dispense with the judicial hearing. The Draft Act did not incorporate the procedure, but concentrated on other areas.

If a particular state does decide to adopt the *ex parte* process, the draftsmen should avoid simply copying the existing statutes from states which already use *ex parte* procedures. Examination of the statutes reveals two common defects:

(1) Of the fourteen states listed in Tables 3 and 4 of the Appendix, in one state commitment results in automatic legal incompetency and in four states the law is not clear on this point. The lack of automatic consideration of the need for guardianship is especially important in these five states and could cause considerable hardship where the patient is legally unable to deal with his property and no substitute is appointed.

⁶⁵ *In re Hofmann*, 131 Cal. App. (2d) 758, 281 P. (2d) 96 (1955); *People ex rel. Jacobs v. Worthing*, 167 Misc. 702, 4 N.Y.S. (2d) 630 (1938); *Hoff v. State*, 279 N.Y. 490, 18 N.E. (2d) 671 (1939).

(2) In several of the states there is no specific release provision. In such a state, the only method of gaining release is the writ of habeas corpus. The habeas corpus procedure does not contain many of the built-in safeguards, such as the right to appointed counsel, that are contained in the more recent statutes which establish a specific hearing procedure for commitment. The commitment hearing statute is tailor-made to fit the needs of the mental patient.

To meet the objections listed above, it is suggested that if *ex parte* commitment is used:

(1) The procedure should be used only for the state hospitals, and preferably only after an initial period of short-term observation commitment;

(2) The patient should not be considered as legally incompetent;

(3) The patient should be informed of his right to appeal, both by the examining physicians and by the hospital;

(4) The statute which establishes the appeal process should be essentially the same as a well-drawn statute which governs initial judicial commitment.

As a final note on *ex parte* commitment, conversations with a number of psychiatrists and mental hospital administrators have revealed that most of them are under the impression that the Draft Act provides for *ex parte* commitment on the certificate of two physicians, as an alternative to the judicial commitment found in section 9. The source of this misconception is the ambiguous wording of section 6-A. This section provides that a mentally ill individual may be admitted to a hospital on the certificate of two doctors. This section authorizes admission, not commitment. The section provides for what is usually called "non-protested admission," but fails to provide expressly that admission depends on acquiescence, rather than compulsion. Part B of section 6 and the commentary to the act make it clear that compulsion can not be used unless the procedure is also an emergency situation.⁶⁶ Misunderstanding would be avoided if the effect of a protest were expressly stated, as it is in most states with similar statutes.⁶⁷

⁶⁶ Draft Act, at 24.

⁶⁷ For example, California Welfare and Institutions Code (Deering, 1952; Supp. 1957) §§6610.1 to 6610.4.

2. *The Constitutional Problem.*⁶⁸ A fairly recent constitutional development is the principle that in certain cases due process requires no more than one opportunity to be heard, and if the full hearing is available at some stage, preliminary action need not meet any formal requirements. Most of the cases in the United States Supreme Court have involved the taking of property without a hearing. Thus when a condemnation statute contains an adequate provision for payment of compensation without unreasonable delay, the taking may precede the compensation.⁶⁹ The taking may be contested by an appeal de novo or by allowing the owner to sue the government in a separate action and either kind of proceeding will justify the prior administrative seizure. In a recent case the court indicated that the due process clause will be satisfied where property is seized prior to the judicial hearing, even though the burden of proof in the hearing is placed upon the owner.⁷⁰

The Supreme Court cases have concerned the taking of property rather than liberty, and it is not clear just how far the court would go in upholding the deprivation of a person's liberty by an order which did not follow a hearing, where adequate review was provided for at a later date. In the *Falbo* case the Court held that a selective service registrant could be punished for failing to report for induction, even though the induction order may have been invalid.⁷¹ In this case the Court indicated that some liberty could be curtailed by administrative order, and the proper remedy for the registrant was to report to the induction center and at that point contest the order in a court.

The principle has been extended to commitment cases by the state courts, and ex parte commitment for an indefinite time has been upheld where the patient could obtain a full hearing reasonably soon after commitment.

It is clear that if ex parte commitment is to be sustained, the

⁶⁸ There is very little writing on the constitutional aspects of ex parte commitment. In spite of its title, the article "Constitutionality of Nonjudicial Confinement," 3 STAN. L. REV. 109 (1950) is concerned solely with commitment after a hearing before an administrative or quasi-judicial agency.

⁶⁹ *Bailey v. Anderson*, 326 U.S. 203 (1945); *Utey v. St. Petersburg*, 292 U.S. 106 (1934); *Am. Surety Co. v. Baldwin*, 287 U.S. 156 (1932); *Missouri ex rel. Hurwitz v. North*, 271 U.S. 40 (1926); *Samuels v. McCurdy*, 267 U.S. 188 (1925); *Braton v. Chandler*, 260 U.S. 110 (1922); *Hays v. Seattle*, 251 U.S. 233 (1920); *Bragg v. Weaver*, 251 U.S. 57 (1919); *Am. Cold Storage Co. v. Chicago*, 211 U.S. 306 (1908); *Lawton v. Steele*, 152 U.S. 133 (1894).

⁷⁰ *Societe Internationale v. Brownell*, 357 U.S. 197 at 210-212 (1958).

⁷¹ *Falbo v. United States*, 320 U.S. 549 (1944).

statutes must furnish adequate procedures by which the patient may test his detention after he is admitted. Habeas corpus is not always adequate because some states use it to test only the legality of the original detention and do not inquire into the mental illness of the petitioner at the time the writ is requested. However, most states now provide by statute for a full judicial hearing on request of a patient to determine present mental illness, or by statute have enlarged the habeas corpus proceeding so that it performs the same function. The two leading cases which uphold summary commitment both emphasized that any due process defects in the original commitment would be cured only by an unlimited right to full review by habeas corpus or other proceeding in the nature of an appeal.⁷² A number of other states are in accord,⁷³ although there are some courts which have held otherwise.⁷⁴ Most of these latter decisions can be distinguished on the ground that adequate review procedures were not available.

The conflicting views are illustrated by the two most recent decisions. In both cases adequate review procedures were provided, and yet the courts reached opposite results, in both cases by a unanimous bench. In *Hiatt v. Soucek*⁷⁵ the Iowa court held that indeterminate ex parte commitment was valid, even though the statute failed to provide expressly for an appeal. The court conceded that if habeas corpus was limited, as it was at common law, to testing the legality of the original detention, the commitment would be unconstitutional. However, the court held that the Iowa habeas corpus statute was broad enough to permit a determination of whether the plaintiff is in fact a proper subject for

⁷² In re Dowdell, 169 Mass. 387, 47 N.E. 1033 (1897); In re Crosswell, 28 R.I. 137, 66 A. 55 (1907).

⁷³ Payne v. Arkebauer, 190 Ark. 614, 80 S.W. (2d) 76 (1935); In re Mast, 217 Ind. 28, 25 N.E. (2d) 1003 (1940); In re Bryant, 214 La. 573, 38 S. (2d) 245 (1948).

⁷⁴ Barry v. Hall, (D.C. D.C. 1938) 98 F. (2d) 222. See Rivers v. Munson, (D.C. Cir. 1941) 125 F. (2d) 393. The Barry case is the most recent one in which a court flatly states that the Dowdell and Crosswell cases, note 72 supra, were wrongly decided, and that an ultimate hearing was not sufficient to avoid due process defects. The Barry case may be distinguished on the grounds that the federal habeas corpus statute does not afford a complete rehearing. Also, the statement was dictum, as the statute involved was not a commitment statute. One court has indicated that although indeterminate commitment on an ex parte order might be defective, detention for a limited time is permitted without a hearing. In re Allen, 82 Vt. 365, 73 A. 1078 (1909). A later case held in effect that if adequate appeals provisions are provided, indeterminate commitment is in reality only provisional, and due process would not require an initial hearing. In re Cornell, 111 Vt. 525, 18 A. (2d) 304 (1941).

⁷⁵ 240 Iowa 300, 36 N.W. (2d) 432 (1949).

detention.⁷⁶ The Missouri Supreme Court reached a contrary result on the constitutional issue in *State ex rel. Fuller v. Mullinax*⁷⁷ where it was held that the release provisions of the Draft Act, no matter how adequate, could not cure the defects inherent in summary commitment. Apparently, the court was bound by earlier Missouri cases which held that a defect in commitment is not cured by a right to full review by habeas corpus.

In conclusion, the majority of cases have held that summary commitment is valid and that the due process of law is satisfied where an adequate appeal provision is included. An additional point is that this principle can not be extended to allow summary action which involves serious irreparable injury. Corporal punishment, for example, once inflicted can not be undone and no appeal could cure the lack of an initial hearing. Thus a statute which permits *ex parte* commitment and provides that the patient becomes legally incompetent and a guardian can be appointed for his estate without notice to him is probably unconstitutional.

"Whether commitment to a mental hospital is such 'irreparable injury' depends largely on the point of view. A court imbued with the feeling that commitment of a person to a 'lunatic asylum' stamps him with the stigma of insanity, and degrades him in public estimation,' may well refuse to allow such serious action to be taken without first giving him his day in court. A different result might be expected from a court which sees no logical or scientific basis for differentiating mental from physical ills so far as the propriety or need of hospital care is concerned, which does not regard a scientific examination by experts as a 'summary' procedure or as less likely than a judicial verdict to reflect a correct result on a question of this kind, and which is convinced of the psychiatric wisdom and sound public policy of sparing the mentally ill from the harmful effects of formal judicial notice and hearing insofar as it is safe to do so."⁷⁸

⁷⁶ Iowa Code (1958) §229.37 provides: "All persons confined as insane shall be entitled to the benefit of the writ of habeas corpus, and the question of insanity shall be decided at the hearing." The Draft Act contains a provision (§22) which preserves the right of habeas corpus, without indicating whether the court can inquire into the present justification for detention, as in Iowa, or is limited to the propriety of the original commitment. South Carolina, which has adopted most of the Draft Act, including §22, has recently held that the reference to habeas corpus in the commitment statute did not impliedly repeal the common law rule that the issue of the petitioner's present sanity could not be determined in a habeas corpus action. *Douglas v. Hall*, 229 S.C. 550, 93 S.E. (2d) 891 (1956).

⁷⁷ 364 Mo. 858, 269 S.W. (2d) 72 (1954).

⁷⁸ Weihofer and Overholser, "Commitment of the Mentally Ill," 24 TEX. L. REV. 307 at 347 (1947).

IV. THE MEDICAL AND LEGAL RIGHTS OF THE COMMITTED PATIENT

The first part of this article has been devoted to the procedures for admission or commitment. Post-admission provisions are also important and are frequently incorporated in the commitment statutes. After the patient is admitted to the hospital, his principal concern is the quality of psychiatric care which he will receive. This, of course, is a medical problem beyond the scope of this paper. It is important to note, however, the various statutory provisions which affect the legal status of the patient during his hospitalization. Some of these statutes involve limits on the patient's exercise of his normal civil rights and others are more directly concerned with the medical treatment which he receives.

Some of these provisions apply only to the short-term patient, while others apply to all mental patients. The patient's right to release or to contest the need for compulsory hospitalization is one of the most important of his rights. Release procedures have been discussed as part of the commitment procedure, and are therefore excluded from this section.

In some of the more recent mental health codes, provisions which affect the civil and medical rights of the patient are grouped together in a single chapter or section entitled "Patients' Rights and Care" or "Rights of the Mental Patient." Part IV of the Draft Act, "Provisions Applicable to Patients Generally,"⁷⁹ has been referred to by one author as a "Patients' Bill of Rights."⁸⁰ Similar codifications of the patients' rights are found in the 1946 Louisiana Mental Health Law,⁸¹ the 1951 Pennsylvania Mental Health Act,⁸² and the 1957 Texas Mental Health Code.⁸³

While in principle the enumeration of patients' rights may be objectionable as impinging upon the executive authority of the hospital, in practice they probably do not interfere with orderly administration, and in the main reflect the present standards of care in our better-run mental hospitals. The author's Commentary to the Draft Act states: "Some of the individual rights specified would seem to be necessarily implied from the function of a mental hospital. The creation of a sympathetic

⁷⁹ Draft Act, §§19-26.

⁸⁰ GUTTMACHER AND WEIHOFEN, *PSYCHIATRY AND THE LAW* 314 (1952).

⁸¹ La. Rev. Stat. (1950) tit. 28, §171.

⁸² Pa. Stat. Ann. (Purdon, 1954) tit. 50, §§1481-1484.

⁸³ Tex. Civ. Stat. Ann. (Vernon, 1958) arts. 5547-68 to 5547-87.

public attitude toward the operation of this Act will, however, be facilitated by express provisions guaranteeing such rights."⁸⁴

*A. The Relationship Between Commitment and Legal Capacity**

The terms "capacity" or "competency" refer to the ability of a person to perform acts which the legal order will recognize as effective. Although there are special restrictions applied to aliens and those who have been convicted of crimes, the general rule is that all adults are treated alike in their capacity to make deeds, contracts, gifts, etc.⁸⁵ The principal exception to the rule involves those who are considered legally incompetent by reason of mental illness. The usual statement of this exception is that legal transactions will be ineffective if the individual did not have sufficient mental capacity to understand the nature and effect of the particular transaction. The rule is easy to state but difficult to apply, partly because of the difficulty of determining the fact of incompetency, and partly because the law must strike a balance between the interests of incompetents and the interests of businessmen and others who deal with them. The courts are generally agreed that where an individual has been adjudicated incompetent by a court, and a guardian appointed, the legal acts of the individual are void. The courts will usually not inquire whether the individual was in fact mentally incompetent as long as he is under an active guardianship. The more frequent and much more difficult problems arise where the individual is not under guardianship, but where other evidence, including evidence of hospitalization as a mental patient, is introduced in a suit to set aside a deed, contract, will, etc.

The prospective patient, his family and friends, are apt to be concerned with the legal effect of hospitalization on his compe-

⁸⁴ Draft Act, at 34.

* The problem of legal capacity in contract law is discussed in a special student study, "Mental Illness and the Law of Contracts," p. 1020 *infra*.—Ed.

⁸⁵ Most of the cases involve the capacity of a person to make a deed, contract or will, but the problem of mental incompetency is coming up in other contexts with increasing frequency. Thus mental incompetency of a parent may justify the adoption of the child without consent of the parent. *Nebstedt v. Barger*, 3 Ill. (2d) 511, 121 N.E. (2d) 781 (1954). A person who is incompetent can not bring a divorce action, either in person or by his guardian [*Shenk v. Shenk*, 100 Ohio App. 32, 135 N.E. (2d) 436 (1954)], but can bring a separation action in person [*Sengstack v. Sengstack*, 4 N.Y. (2d) 502, 151 N.E. (2d) 887 (1958)]. See also on the divorce problem: *Turner v. Bell*, 198 Tenn. 232, 279 S.W. (2d) 71 (1955). On mental incompetency as a defense to a divorce action, see HARPER, PROBLEMS OF THE FAMILY 706 (1952).

tency. The problem is of special concern to the borderline patient who is admitted at an early stage of his illness. Does the fact of admission mean that he is deprived of the power to perform legally effective acts? Unfortunately, the law on this subject is confused and uncertain, and both courts and legislatures have had difficulty in determining the relationship between hospitalization and competency. The difficulties have been caused primarily by three factors:

(1) The traditional rules of incompetency are phrased in terms of one conclusion (incompetency) following from another conclusion (insanity), rather than from a specific set of facts; i.e., the rules say, "If a person is insane, he cannot serve on a jury, vote, make a deed or will, etc." rather than, "If a person is a patient in a mental hospital, he cannot vote, etc." The basic source of confusion is the use of a dual terminology. In the older statutes and cases, the same term "insanity" was used indiscriminately to mean the condition which justified the loss of legal capacity and the prerequisite for admission to a mental hospital.

(2) A factor which has tended to perpetuate the confusion is that commitment procedures are almost entirely statutory. Misled by the indiscriminate terminology, legislative draftsmen have generally failed to think the problems through and have occasionally introduced conflicting rules on the legal effect of hospitalization. On the whole, the courts have been able to work out the policy factors quite well, but all too frequently they have been handicapped by poorly drafted legislation.

(3) Most courts and legislatures have failed to recognize that there are two separate aspects to the problem of the relation between hospitalization and incompetency. The first problem is one of administrative control over the patient, i.e., how far can the hospital authorities go in denying the patient his normal legal rights. The second problem is essentially one of evidence. What is the value of evidence of hospitalization as a mental patient in a later proceeding to appoint a guardian or to avoid a deed, contract, or will? Is the evidence conclusive proof of the patient's lack of capacity? *Prima facie* evidence? Of some slight value? Or inadmissible and of no value?

Before considering in detail the relation between commitment and incompetency, it is helpful to outline briefly the effect of guardianship on incompetency. The two areas are analogous, partly because the policy problems are similar, and partly because

in many states commitment results in some form of guardianship.

1. *Guardianship and Incompetency.* The simplest problem is the one where the individual is incompetent in fact. The legal effects of incompetency are generally clear cut in any given jurisdiction and the existence of a court decree of commitment or guardianship does not change the result. Generally, a contract or conveyance made by an incompetent is voidable at his option. The rules on avoidance, and the policy justifications, are the same as those which allow the minor to disaffirm. Both the minor and the incompetent are liable in quasi-contract for necessities, and this common law rule has been carried into the Uniform Sales Act.⁸⁶ The one area where the incompetent has been treated with less leniency than the minor is in the requirement of restitution. In most jurisdictions the infant can disaffirm although he is unable to restore the status quo, but the contract will bind the incompetent if he is unable to make restitution and the other party to the transaction dealt with him without knowledge of his incompetency.⁸⁷

A problem which is less frequent, but much more difficult for the law to handle, is the effect of deeds or contracts by a person who is under guardianship, but who may be competent in fact at the time of the transaction. The legal results can be summarized as follows:

(1) A substantial group of courts hold that the appointment of a guardian is an *in rem* proceeding which gives constructive notice to the whole world of the incompetency of the ward, and that this status continues until the guardian is discharged.

(2) Probably a numerical majority have concluded that appointment of a guardian is conclusive on the issue of incompetency only at the time of the appointment, and a contract made by the ward at a later date is valid if he is in fact competent.⁸⁸

These are the policy arguments:

(1) Favoring the rule that guardianship is conclusive on incompetency. The guardian, and the court which appointed him,

⁸⁶ Uniform Sales Act, §2.

⁸⁷ The cases are cited and analyzed in Virtue, "Restitution from the Mentally Infirm," 26 N.Y. UNIV. L. REV. 132 (1951).

⁸⁸ See annotations in 7 A.L.R. 568 (1920), supplemented in 68 A.L.R. 1309 (1930). A careful reading of the cases shows that in most of the cases which hold that the appointment of a guardian is conclusive, the statement is dictum, because the third party had actual knowledge of the appointment of the guardian.

are primarily charged with the responsibility for protecting the property of the ward. This duty would be rendered very difficult if the ward were left free to convey away property or make contracts which could be enforced against his property, and the issue of incompetency in fact were to be relitigated in each action.

(2) Favoring the rule that guardianship is not conclusive on incompetency. If a person is in fact competent, the third person who deals with him in good faith and is unaware of the fact of guardianship ought to be protected. Realistically, the "constructive notice" that is given the world of business by the court decree of guardianship is no notice at all, since most states do not maintain central records of guardianship decrees, and it is very possible for a person to be adjudicated incompetent in one county and have his business or property in another county.

There are several methods by which the competing policy claims can be compromised. One method is reflected in a line of cases from Ohio which hold that the appointment of a guardian is conclusive evidence of the ward's incapacity to make a contract or conveyance which directly conflicts with the authority of the guardian, but as to matters which do not conflict with his authority, the adjudication is not conclusive. Thus the making of a will or a contract of marriage would be valid if the ward were in fact competent.⁸⁹ Another method is to extend protection by statute to specific groups or individuals who are apt to deal with incompetents at a distance, and who would be unlikely to discover the fact of guardianship. Thus several recent corporation code revisions provide that a corporation and its stock transfer agent are protected if they permit a stockholder of record to exercise voting or ownership rights, unless the corporation has actual notice of a court decree of incompetency or guardianship.⁹⁰ The Ohio statute goes so far as to protect the corporation regardless of any actual notice.

2. *The Case Law.* As most of the problems concerning the legal status of the patient after commitment are not dealt with by statute, investigation seems most easily handled by first analyzing the existing common law background, and then attempting to

⁸⁹ *Jordon v. Dickinson*, 10 Ohio Dec. Reprints 147 (Superior Court 1887); *Lee v. Stephens*, (Ohio App. 1942) 50 N.E. (2d) 622.

⁹⁰ E.g., 1953 Wisconsin Corporation Code (Wis. Stat. §180.851), 1955 Ohio Corporation Code (Ohio Rev. Code §1701.28).

determine how far the common law has been modified by the various statutes.

On the question of how far the hospital administrator can go in denying a patient the exercise of his normal legal rights, there are very few cases, and these tend to favor the patient. The view of the courts is well illustrated by three recent New York cases.

In *People ex rel. Jacobs v. Worthing*⁹¹ the court said as dicta that the denial by a mental hospital of a patient's right to mail letters to his attorney was an unreasonable and unlawful interference with the patient's rights.

In *Hoff v. State*⁹² a general order of the Department of Mental Hygiene provided that every patient had the right to communicate free of censorship with the department, the governor, district attorneys, and courts of record. The order further provided that all other mail could be forwarded by the superintendent of the hospital to the patient's guardian. Hoff, a patient in a state hospital, executed a petition for a writ of habeas corpus and mailed it to his attorney. The superintendent, knowing what the letter contained, forwarded it to Hoff's guardian, who apparently suppressed it. After gaining his release, the patient sued the state. The court held that the superintendent could not rely on the general order, his act was a tort, and the state was liable for damages.

In re Alexieff's Will involved the question of the legal effect of a patient's attempt to exercise a right in violation of a hospital regulation. A general order of the Department of Mental Hygiene provided that ". . . no patient shall be permitted . . . to make a will . . . except upon the order of the commissioner or a judge of a . . . court of record. . . ."⁹³ A patient executed a will without attempting to gain the required consent. The court held that assuming the order were valid, violation of the order did not affect the validity of the will. There was evidence that the patient was in fact competent, and the will was admitted to probate.⁹⁴

On the evidence issue, the courts have ranged from one ex-

⁹¹ 167 Misc. 702, 4 N.Y.S. (2d) 630 (1938).

⁹² 279 N.Y. 490, 18 N.E. (2d) 671 (1939).

⁹³ General Order No. 10, printed as a footnote to 34A N.Y. Consol. Laws (McKinney, 1951; Supp. 1958) §34.

⁹⁴ 94 N.Y.S. (2d) 32 (1949), *affd.* 277 App. Div. 790, 97 N.Y.S. (2d) 532 (1950), leave to appeal denied, 277 App. Div. 901, 98 N.Y.S. (2d) 582 (1950).

treme to the other, saying that evidence of commitment is conclusive on the issue of competency, or that it is inadmissible, or that its effect is somewhere in between. Handicapped by poorly drafted statutes, many courts have, on the whole, failed to look at the policy issues involved, so there is a wide divergence of holdings and many unfortunate decisions.

Although the problem of the effect of commitment can arise in almost an infinite number of types of proceedings, the courts of any one state generally treat all of the cases alike, with the sole exception of criminal cases. Even in those states which equate hospitalization with incompetency, the universal rule is that hospitalization is never conclusive on the issue of criminal responsibility. The courts which have passed on the problem frequently talk in terms of the time lag. The argument is that although a defendant may be judicially committed, and then, before discharge, commit a crime, the time interval between the judgment and the act is great enough so that the defendant might have recovered his sanity, and therefore he cannot be conclusively presumed to be insane. However, in the one case where the time interval was cut down to seconds, and the ink on the commitment papers was literally still wet at the time of the criminal act, the California court had no real difficulty in upholding the conviction.⁹⁵

A minority of states hold, even in the absence of clear-cut statutory directions, that commitment is conclusive evidence of incompetency. These decisions are generally characterized by rigid and mechanistic application of principles without any real understanding of the policy problems involved. The courts tend to reason that insanity means commitment and insanity also means incompetency, so that commitment automatically results in total legal incompetency. Typical of this inflexible failure to differentiate between the policy issues bearing on hospitalization and those bearing on competency is the Colorado case of *Rohrer v. Darrow*.⁹⁶ In 1901, Mrs. Rohrer was committed by the Denver county court to a private mental hospital. In 1903, she was con-

⁹⁵ In *People v. Willard*, 150 Cal. 543, 89 P. 124 (1907), the defendant was taken before the superior court for a commitment hearing. After testimony of physicians that Willard was "insane, homicidal, and dangerous" the judge orally adjudged him insane and committed him to the state hospital. As the judge began to sign the order of commitment, Willard drew a pistol from his pocket and shot and killed the complaining witness. The conviction for murder was sustained.

⁹⁶ 66 Colo. 463, 182 P. 13 (1919).

ditionally released to the custody of her husband. She spent the next fourteen years working as a bookkeeper for her husband who was a banker and real estate agent. Mrs. Rohrer was a partner in some of her husband's enterprises, she purchased and sold land in her own name and was a notary public. Apparently through some oversight, she never received a formal discharge from the mental hospital. In 1917, fourteen years after her discharge from the hospital, she sold a parcel of land to the defendant and shortly thereafter sued to rescind the deed on the ground of incompetency. There was no evidence of overreaching on the part of the defendant, nor was the purchase price inadequate, and the only evidence offered on the issue of incompetency was the commitment of 1901 and the lack of any discharge. The trial court authorized a compromise of the suit and the Colorado Supreme Court reversed on the ground that the lack of a hospital discharge was conclusive proof of legal incompetency, the deed was absolutely void, and no compromise of her rights would be permitted.

A more recent case which illustrates the same attitude is *Sanders v. Omohundro*,⁹⁷ an action to compel the buyer under a land contract to accept a deed to the property. The buyer objected that title was defective in that the seller had purchased from an illegally appointed guardian. The guardian had been appointed by an Arkansas probate court without notice to the ward. Apparently, the only evidence of incompetency was a letter addressed "to whom it may concern" stating that the patient was mentally ill, was confined in a private mental hospital in Dearborn, Michigan, and was incapable of caring for her person or property. The letter was signed by a physician on the hospital staff. The Arkansas court affirmed a decree of specific performance in favor of the seller, stating that insanity is presumed from the fact of confinement. The court had no comment on the lack of notice to the ward, either of the appointment or of the sale, nor did it object to the lack of evidence of incompetency. Several other states have also adopted the view that commitment is conclusive on the issue of legal incompetency.⁹⁸

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

⁹⁸ *Cubbison v. Cubbison*, 45 Ariz. 14, 40 P. (2d) 86 (1935) (proof that defendant in divorce action was committed and then discharged, but not judicially restored to competency is sufficient to vacate a divorce judgment when defendant was not represented by a guardian ad litem); *Walker v. Graves*, 174 Tenn. 336, 125 S.W. (2d) 154 (1939) (four years after commitment, general guardian could be appointed for patient in a mental

At the other end of the spectrum, a small minority hold that evidence of commitment is not only not conclusive on the issue of capacity, but is inadmissible. The two cases which are most frequently cited are *Leggate v. Clark*⁹⁹ and *Knox v. Haug*.¹⁰⁰ In the *Leggate* case, a wife sued to set aside a deed executed by her on the ground that her husband, who joined in the deed, was incompetent. The trial court ruled that the order of a probate court committing the husband to a mental hospital was admissible and prima facie evidence of incompetency. The Massachusetts Supreme Court held that the evidence was inadmissible and ordered a new trial on the issue of incompetency, although there was other evidence which tended to prove incompetency. In the *Knox* case, a Minnesota decision, the owner of land deeded it to A, was then committed to a mental hospital, and while on conditional release sold the same tract to B. The dispute was between A, the first buyer, and B, the second buyer, who was fortunate enough to record his deed first. The only evidence of the incompetency of the seller was the evidence of commitment. The court affirmed a judgment in favor of B, stating that a patient may be sufficiently unbalanced to need treatment, but still be competent to dispose of his property. It is interesting to note that although the case turned on the sufficiency of the evidence, the *Knox* case has been repeatedly cited by digests, text writers, and other courts as holding that the evidence was not admissible, an issue which was not before the Minnesota court.¹⁰¹ The position taken in the *Leggate* case has been severely criticized by Professor Wigmore¹⁰² and by a number of courts which have passed on the issue,¹⁰³

hospital without notice to him). See *In re Ost*, 211 Iowa 1085, 235 N.W. 70 (1931) (court stated that it is improbable, if indeed not impossible, for a patient in a mental hospital successfully to force termination of guardianship prior to discharge).

⁹⁹ 111 Mass. 308 (1873).

¹⁰⁰ 48 Minn. 58, 50 N.W. 934 (1892).

¹⁰¹ Apparently the writers have been misled by the court's headnote to the effect that commitment is "... not evidence of mental incapacity." This is an ambiguous statement which could refer to either admissibility of evidence or sufficiency of evidence. When the Nebraska court was faced with the issue of admissibility, it held that the evidence was not admissible, citing the *Knox* case. *Dewey v. Allgire*, 37 Neb. 6, 55 N.W. 276 (1893). The *Knox* case is cited as standing for inadmissibility and disapproved in *Martello v. Cagliostro*, 122 Misc. 306, 202 N.Y.S. 703 (1924) and *Maas v. Territory*, 100 Okla. 714, 63 P. 960 (1901).

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

¹⁰³ For an excellent discussion of the admissibility problem, see *Rawson v. Hardy*, 88 Utah 109, 39 P. (2d) 755 (1935) in which the court discussed the *Leggate* case and others following it and disapproved of the rule.

although it has been adopted by Nebraska and a few other jurisdictions.¹⁰⁴

The majority of states have held that evidence of hospitalization is both admissible¹⁰⁵ and entitled to some weight in proving incompetency. The most common expression is that commitment results in a rebuttable presumption of incompetency (or is *prima facie* evidence of incompetency) and that a final discharge from a mental hospital results in a rebuttable presumption of competency.¹⁰⁶ Weight of evidence is never a clear-cut thing like admissibility, and the courts shift back and forth between the language of *prima facie* evidence and rebuttable presumptions.¹⁰⁷ Some of the states treat the presumption as a true presumption and require little or no additional evidence of incompetency. There is a more recent and apparently growing trend to consider the evidence of hospitalization of less weight. This recent line of authority is hard to recognize, because the courts continue to talk

¹⁰⁴ *Keely v. Moore*, 196 U.S. 38 (1904) (will contest—Supreme Court did not discuss admissibility of the fact of the testator's commitment, but did hold that the commitment papers were properly excluded, citing the *Leggate* case with approval); *Lewandowski v. Zuzak*, 305 Ill. 612, 137 N.E. 500 (1922) (will contest—reversed and new trial where testator's commitment papers introduced as evidence); *Hicks v. State*, 165 Ind. 440, 75 N.E. 641 (1905) (evidence of prior commitment not admissible to impeach witness); *Wager v. Wagoner*, 53 Neb. 511, 73 N.W. 937 (1893); *Dewey v. Allgire*, 37 Neb. 6, 55 N.W. 276 (1893) (action to rescind conveyance—commitment evidence inadmissible). But cf. *Mitchell v. Mitchell*, 312 Mass. 165, 43 N.E. (2d) 779 (1942); *Skelton v. State*, 148 Neb. 30, 26 N.W. (2d) 378 (1947).

¹⁰⁵ The commitment is admissible only if it is not too remote in time from the acts which are involved in the subsequent incompetency case. The courts generally say that the trial courts have a wide discretion in determining the length of time which must pass before the evidence becomes immaterial. Since evidence of commitment is apt to seem quite conclusive to a jury, the jury should be carefully instructed on the weight and effect of such evidence. *Rawson v. Hardy*, 88 Utah 109, 39 P. (2d) 755 (1935) and *WIGMORE, EVIDENCE*, 3d ed., §1671 (1940).

¹⁰⁶ One court has held that a final discharge is not necessary to restore the presumption of capacity, and that a conditional release is sufficient. *Brewer v. Hunter*, (10th Cir. 1947) 163 F. (2d) 341.

¹⁰⁷ With the exception of criminal cases, most decisions on incompetency are equity cases to set aside deeds, wills or contracts, etc., where the court determines both the law and the facts. Court cases are especially difficult to analyze in terms of the language of presumptions, since there is no sharp distinction between what the court tells the jury and what the court bases its decision on. In these cases the term "presumption" may have any one or more of the following meanings: (1) as a rule of procedure which changes the burden of producing evidence and results in a directed verdict if no contrary evidence is produced; (2) as a rule of procedure which results in the issue being put to the trier of fact, even where no supporting evidence is introduced; (3) as a permissive inference of fact; (4) as a label used in locating the burden of persuasion on a given issue; (5) as an authoritative principle or assumption used as a starting point in legal reasoning; and (6) as indicating a general policy disposition or attitude on the part of the court.

of hospitalization resulting in a presumption. However, the results reached by the courts show that either substantial additional evidence of incompetency is required to justify a conclusion of incapacity, or that very little rebutting evidence is required to overcome the presumption.

An example of this modern trend is *Finch v. Goldstein*¹⁰⁸ where Finch, a committed resident patient in a mental hospital, sold a farm to the defendant, taking back a purchase money mortgage. After the sale was made, a guardian was appointed for Finch. The guardian sued to foreclose the mortgage. The defendant pleaded the incompetency of the grantor and asked for rescission of both deed and mortgage and the return of his purchase price. The court held that a deed and mortgage made prior to an adjudication of incompetency is not void, and that a judicial commitment is not such an adjudication. A number of other states are in accord, both on the proposition that evidence of commitment alone is insufficient to justify a finding of incompetency,¹⁰⁹ and on the proposition not directly involved in the *Finch* case, but implied in the decision, that the evidence is of slight weight.¹¹⁰

3. *The Statutes.* Only a handful of states have attempted to work out the problem by statute. Many of the statutes are poorly drafted and create as many difficulties as they settle. Most of the state statutes which deal with the problem provide in general that hospitalization as a voluntary or short-term patient does not

¹⁰⁸ 245 N.Y. 300, 157 N.E. 146 (1927).

¹⁰⁹ *Fetterley v. Randall*, 92 Cal. App. 411, 268 P. 434 (1928) (evidence that contract was made on same day that promisor was committed to a mental hospital held insufficient to justify finding of incapacity to make contract); *Fleming v. Bithell*, 56 Idaho 261, 52 P. (2d) 1099 (1935); *Knox v. Haug*, 48 Minn. 58, 50 N.W. 934 (1892).

¹¹⁰ *Watson v. Banks*, 154 Ark. 396, 243 S.W. 844 (1922); *People v. Willard*, 150 Cal. 543, 89 P. 124 (1907); *People v. Field*, 108 Cal. App. (2d) 496, 238 P. (2d) 1052 (1951); *Livaudais v. Bynum*, 165 La. 890, 116 S. 233 (1928); *Vance v. Ellerbee*, 150 La. 388, 90 S. 735 (1922); *Quarterman v. Quarterman*, 179 Misc. 759, 39 N.Y.S. (2d) 737 (1943); *Sullivan v. Whitney*, 25 N.Y.S. (2d) 762 (1941); *Martello v. Cagliostro*, 202 N.Y.S. 703 (1924) (good discussion of evidentiary value of commitment); *Herr v. Herr*, 56 Pa. D. & C. 421 (1946); *Ryman's Case*, 139 Pa. Super. 212, 11 A. (2d) 677 (1940); *Rawson v. Hardy*, 88 Utah 109, 39 P. (2d) 755 (1935); and *Western State Hospital v. Winger*, 196 Va. 300, 83 S.E. (2d) 446 (1954). See *Topeka Water Supply Co. v. Root*, 56 Kan. 187, 42 P. 715 (1895); *Fay v. Metropolitan Life Ins. Co.*, 220 Iowa 628, 263 N.W. 14 (1935). Not only is commitment not conclusive proof of incompetency, but a final discharge from a mental hospital is not conclusive proof of competency, so as to justify termination of a guardianship. In *re Pfeiffer*, 10 Wash. (2d) 703, 48 P. (2d) 158 (1941). The converse is also true. A judicial order which restores competency and terminates a guardianship does not per se require that the committed ward be discharged from a mental hospital. In *re Zanetti*, 34 Cal. (2d) 136, 208 P. (2d) 657 (1949).

involve loss of capacity, and either remain silent or specifically provide that long-term patients do lose their legal capacity.

The Draft Act has attempted to give express recognition to the difference between hospitalization and the status of legal incompetency. One of the fundamental principles of the act is that a patient who needs hospitalization is not necessarily legally incompetent, and a person who is legally incompetent does not necessarily require hospitalization. The preface to the act states:

"A statute having to do with the mentally ill is necessarily one which deals with individuals who as a class are peculiarly in need of the protective forces of society; public provision of hospital care for the mentally ill generally is itself a recognition of this need. Decision as to hospitalization in the individual case, however, is one which as a rule needs to be made in the light of the individual's entire situation, including the availability of alternatives which may be sufficient or preferable, even from the medical point of view, in the particular case. In those cases in which a guardian of the person has previously been appointed, the guardian should be helpful and will have a more or less authoritative role, depending on the law of the State, in arriving at decisions in the interest of the sick individual. Appointment of a guardian by the court may frequently be a desirable first step in meeting problems growing out of the individual's mental condition of which his need for hospitalization may be only one.

"The Act, however, does not deal with guardianship as such, nor does it make the status of incompetency a prerequisite to, or a consequence of, hospitalization. . . . [I]t is desirable that jurisdiction for both types of proceedings should be in the same court. . . . Procedurally, however, the determination that hospitalization is justified should be separated from the adjudication of incompetency and the appointment of a guardian. It is a fundamental theory of the Act that an order of hospitalization decides no more than the question of hospitalization."¹¹¹

Specifically, section 21 of the Draft Act provides:

"(a) Subject to the general rules and regulations of the hospital and except to the extent that the head of the hospital determines that it is necessary for the medical welfare of the patient to impose restrictions, every patient shall be entitled . . .

¹¹¹ Draft Act, p. 2.

"(3) to exercise all civil rights, including the right to dispose of property, execute instruments, make purchases, enter contractual relationships, and vote, unless he has been adjudicated incompetent and has not been restored to legal capacity.

* * *

"(c) Any limitations imposed by the head of the hospital on the exercise of these rights by the patient and the reasons for such limitations shall be made a part of the clinical record of the patient."

Looking at the preface, the commentary, and the act as a whole, several conclusions are apparent:

(1) It is clear that hospitalization under the act does not result in total loss of legal capacity.

(2) It is also clear that the act does not guarantee the patient the full exercise of his normal legal rights. The commentary to the act mistakenly concludes that the act does guarantee the full enjoyment of personal rights and that the loss of such rights can result only from a guardianship proceeding.¹¹² This conclusion is incorrect, as limitations may be imposed by the hospital. However, the patient is protected against abuse by the requirement that the limitations must be either by general rule or regulation, or be incorporated in his clinical record. Thus the act apparently leaves open the question of how far the hospital may go in denying the patient the exercise of his civil rights, and also the question raised in the *Alexieff* case,¹¹³ on the validity of the patient's exercise of his rights contrary to the restrictions imposed on him by the hospital.

(3) The Draft Act does not settle the evidence problem. It would seem that the act does indicate a legislative policy which requires that evidence of hospitalization is not conclusive and entitled to slight weight in a proceeding where legal capacity is an issue.

To date, of the six states which have adopted the Draft Act,¹¹⁴ four have adopted the Draft Act provision on civil rights.¹¹⁵ South Carolina adopted section 21 of the act, which contains a general

¹¹² *Id.* at 35.

¹¹³ *Alexieff's Will*, note 94 *supra*.

¹¹⁴ Idaho, Missouri, New Mexico, Oklahoma, South Carolina, Utah. For citations, see Appendix I *infra*.

¹¹⁵ Idaho, Missouri, New Mexico, Utah.

enumeration of patients' rights, but omitted sub-paragraph (a) (3) which is the civil rights part of section 21.¹¹⁶

The lineup of the 49 states is given in the last section of Tables 2 and 4 in Appendix I *infra*. The tables are only partly accurate. Where there is no express statute on the subject, but where there are references to the appointment of a guardian in the commitment process, or where the statute indicates that a discharge from the hospital will restore capacity, the state is listed as merging commitment and capacity. Where there is no statute or case law on the capacity of patients, the state is listed as not merging commitment and capacity, although a court might so hold.

The statutes of some of the states which have accorded express legislative recognition to the problem are summarized or quoted as follows:

(1) The states which go the farthest in separating commitment and capacity are Delaware and North Carolina. "Commitment . . . shall not raise any presumption against the sanity of the person . . . committed."¹¹⁷

(2) Wisconsin has enacted what is probably the majority rule at common law. "Hospitalization under this chapter . . . is not an adjudication of legal incompetency, but merely raises a rebuttable or disputable presumption of incompetency while the patient is under the jurisdiction of the hospital authorities."¹¹⁸

(3) Illinois and Texas are unique in that the court is required to consider the issue of competency, and has the alternative of committing as competent or incompetent.¹¹⁹

(4) In New York, the statute is silent on the evidence problem, although it seems to imply that hospitalization results in incompetency. However, the New York courts have generally considered evidence of commitment of slight weight in a subsequent case involving incompetency.¹²⁰ On the issue of ad-

¹¹⁶ S.C. Code (Supp. 1958) §32-950.12. A later section implies that all patients lose legal capacity. "The regular discharge of any person shall ipso facto restore to him all his legal rights." §32-950.28.

¹¹⁷ Del. Code Ann. (1953) tit. 16, §5126. *Accord*, N. C. Gen. Stat. (1958 repl.) §122-46.

¹¹⁸ Wis. Stat. (1957) §51.005(2).

¹¹⁹ Ill. Rev. Stat. (1957) c. 91½, §§1-8, 1-9; Tex. Civ. Stat. Ann. (Vernon, 1958) art. 5547-51.

¹²⁰ See the New York cases cited in notes 108 and 110 *supra*.

ministrative control over the patient, the statutes contain detailed provisions. The Mental Hygiene Law authorizes the hospital superintendent to act in a limited way as a guardian for any patient who has no guardian. The superintendent may receive up to \$1,000 on behalf of the patient, deposit funds in a bank or invest in United States bonds, and may execute checks, receipts or other documents for the patient.¹²¹ In addition, General Order Number 10 of the Department of Mental Hygiene provides that no patient may accept service of process or execute a will, conveyance, or contract without an order of a court of record, except that patients may cash or endorse checks of less than \$100 with the permission of the superintendent.¹²²

(5) Florida, Georgia, Indiana, and Oklahoma expressly provide in general terms that patients who are hospitalized for an indeterminate period are incompetent.

(6) One of the most specific statutes is that of Ohio:

"... no patient in a hospital . . . or a patient on trial visit therefrom, shall be competent to enter into any agreement or execute a contract, deed, or other instrument unless it has been approved and allowed by the court committing him by an order entered on the journal of said court. A certified copy of such order of the court shall be attached to such contract, deed or instrument.

"The discharge of a patient shall not operate as a discharge of a legally appointed guardian of the person or estate of such patient."¹²³

In the *Seabold* case, the Ohio court held that a marriage contracted in Ohio by a patient on convalescent leave from an Ohio mental hospital would be void, as an "agreement, contract, deed or other instrument" prohibited by the statute, but a marriage contracted outside of Ohio was valid if the patient was competent in fact.¹²⁴

4. *Summary.* It seems clear that none of the statutes discussed above adequately handles the problem of control by the hospital over the patient's affairs. As a practical matter, the hos-

¹²¹ 34A N.Y. Consol. Laws (McKinney, Supp. 1958) §34(14).

¹²² General Order No. 10 is printed as a footnote to 34A N.Y. Consol. Laws (McKinney, 1951; Supp. 1958) §34. See also text at notes 93 and 94.

¹²³ Ohio Rev. Code (Baldwin, 1958) §5123.57.

¹²⁴ *Seabold v. Seabold*, 84 Ohio App. 83 (1948). See also 1956 Ohio Atty. Gen. Op. #7106, p. 656.

pital will have to exercise a substantial degree of control. On the other hand, most authorities would agree that it is unwise to equate hospitalization with complete loss of competency. Probably the Draft Act and New York provisions are the best available, as they recognize the need for control but provide some safeguards for the patient.

Only three of the statutes spell out in specific terms the answer to the evidence problem. On policy grounds it seems clear that evidence of hospitalization should not be treated as conclusive proof of incapacity. A sound argument can be made for the view that the evidence should be admissible and should be entitled at least to the status of a presumption which entitles the party who produces the evidence to get to the jury. Psychiatric examinations are rare enough in criminal cases and, except in a few states, are almost unheard of in civil cases, so that frequently the evidence of hospitalization is the only evidence available to the party who alleges incompetency. On the other hand, if too much weight is attached to such evidence, it will discourage patients from seeking early psychiatric assistance. Another factor is the increased use of out-patient clinics, conditional release, psychiatric social case work, and other recent procedures which involve short periods of hospitalization and frequent discharge and re-entry, rather than a single period of long-term custodial care. A change in legal status every few weeks would be psychologically harmful to these "in and out" patients, and would produce uncertainty of the law and of legal transactions. In any event, it seems clear that hospitalization should not result in a conclusive or even a very strong presumption of incompetency. Even formal commitment is a relatively summary process compared with the usual guardianship proceeding, and each procedure may involve medical and social questions which are not relevant to the other proceeding.

My own conclusions are as follows:

- (1) The problem is one which ought to be handled by statute.
- (2) The Wisconsin statute is probably the best answer to the evidence question, but it should be modified so that the presumption of incompetency applies only to the patient in the hospital, and not to the patient on convalescent leave.
- (3) The committing court should be required to consider the problem of incompetency and the need for guardianship, as the courts of Illinois and Texas are required to, with the

help of a social case work investigation as in Minnesota, or with the advice of a disinterested attorney, as in Oklahoma.

(4) The statutes should extend maximum protection to innocent third parties who deal with incompetents or those who might be incompetent, whether they are hospitalized or under guardianship. There are two methods, both of which could be used. First, extend specific protection to classes of third parties who are likely to deal with the incompetent at a distance, and without knowledge of any facts which might indicate incompetency. The recent corporation codes of Wisconsin and Ohio are examples of this type of statute,¹²⁵ and the same principle should apply to banks and insurance companies, as well as stock transfer agents and securities brokers. Secondly, the guardianship laws should be amended so as to lessen the possibility of an innocent third party dealing directly with a person under guardianship. Specifically, the statutes should provide for a court decree transferring title to the ward's realty to the guardian, which decree could be recorded in every county where the realty is located. The same statute would provide that in the absence of such recording, the good faith buyer from the ward would get good title.

B. The Patient's Right to Communication

While in theory the patient's right to unrestricted communication is a part of his general civil rights, to be protected or not under the cases and statutes discussed above, in fact, this specific right and a few others have been treated separately in detailed statutes. The right of communication was the first right to receive recognition and is the only right which is guaranteed by the statutes of most states.

Some of the early legislation was enacted as a result of the "anti-railroading" crusade of Mrs. E. P. W. Packard, a movement which attracted wide popular and legislative support in the 1860's and 1870's. Mrs. Packard was the commitment victim of her husband's conspiracy. She differed publicly with her husband, an Illinois preacher, on religious issues. He won the argument by committing her under a convenient and obviously unconstitutional statute which provided that a married woman

¹²⁵ See text at note 90.

could be committed on the petition of her husband "without the evidence of insanity or distraction required in other cases."¹²⁶ On her release, she began a vigorous and highly vocal campaign to prevent unwarranted commitment. She was responsible for the adoption in a number of states of the mandatory jury trial, state inspection of private hospitals, and other legal safeguards against "railroading," although she failed to persuade Congress to guarantee the postal rights of mental patients. It is generally agreed that her objective of obtaining legal safeguards against the abuse of commitment proceedings was a worthy one. It is unfortunate that her principal means used was the mandatory jury trial involving a public trial whether the patient wants it or not.¹²⁷

Although a few modern statutes appear to recognize that a patient's rights of communication are worth protecting as such, most statutes clearly indicate that these rights are ancillary to the right to release. The power of the hospital to supervise or deny the patient visitation or postal rights may be misused as a means of holding the patient incommunicado. An example of the abuse which is possible even in a modern state mental hospital is found in the recent case of *People ex rel. Jacobs v. Worthing*.¹²⁸ Jacobs was held in a New York state hospital for four years. During all this time he sought release on a writ of habeas corpus. The hospital regulations denied the patient the right to correspond with his attorney or with any attorney, and the hospital rigidly enforced the prohibition. After four years, he finally succeeded in getting in touch with an attorney by smuggled mail. The Supreme Court stated that the evidence overwhelmingly favored his release and then severely castigated the hospital for its unreasonable restraint of his rights.

The older statutes authorize the patient to designate a correspondent outside of the hospital. Mail addressed to the correspondent must be forwarded without examination.¹²⁹ The more

¹²⁶ Ill. Laws (1851) p. 98.

¹²⁷ The Packard case and its impact on state legislation is reviewed in a detailed article, Dewey, "Lunacy Legislation in Illinois," 69 AM. J. INSANITY 751 (1912). See also DEUTSCH, *THE MENTALLY ILL IN AMERICA* 423 (1946).

¹²⁸ 4 N.Y.S. (2d) 630, 167 Misc. 702 (1938). See also the Hoff case, discussed in the text at note 92.

¹²⁹ Fla. Stat. (1957) §§394.3 to 394.17; Mont. Rev. Code (1954) §§38-112 to 38-116; N.D. Rev. Code (1943) §25-0211; S.D. Code (1939) §30.0124.

recent statutes extend the privilege of mail without censorship to and from a selected class of persons or public officials. The Draft Act provision is typical. Section 21 provides that subject to the general rules of the hospital, and except to the extent that restrictions are deemed necessary for the patient's welfare, the patient shall be entitled "to communicate by sealed mail or otherwise with persons, including official agencies, inside or outside the hospital; to receive visitors. . . ." ¹³⁰ An additional paragraph provides that: "Notwithstanding any limitations authorized under this section on the right of communication, every patient shall be entitled to communicate by sealed mail with the (central administration) and with the court, if any, which ordered his hospitalization." ¹³¹

Thus the act creates qualified privileges of correspondence and visitation. The rights may be restricted by a general rule of the hospital, or by an order of the hospital administrator, which must be entered in the patient's records. The act also creates an absolute right to communicate with the central state mental health agency and the committing court. Criminal penalties are provided for a denial of the patient's rights. ¹³² All of the six states which have adopted the Draft Act have adopted its provision on the right of communication. ¹³³ A number of other states provide for a similar absolute privilege of correspondence with designated officials or persons. ¹³⁴ The Draft Act and most of the other statutes

¹³⁰ Draft Act, §21.

¹³¹ *Ibid.*

¹³² *Id.*, §26.

¹³³ Idaho Code Ann. (Supp. 1957) §66-346 (same as Draft Act, except no absolute right to write state department of mental health); Mo. Stat. Ann. (Vernon, Supp. 1958) §202.847 (same as Draft Act); N.M. Stat. (1953) §34-2-15 (same as Draft Act); Okla. Stat. (Supp. 1957) tit. 43A, §93 (substantially same as Draft Act); S.C. Code (Supp. 1958) §32-950.12 (same as Draft Act); Utah Code Ann. (1953) §64-7-48 (same as Draft Act).

¹³⁴ Cal. Welfare and Inst. Code Ann. (Deering, 1952) §7502 (no censorship of mail of patient in state hospital to superior judge or district attorney); Ill. Rev. Stat. (1957) c. 91½, §9-8 (no censorship of mail to governor, attorney general, court of record, state attorney, dept. of public welfare or any attorney); Kan. Gen. Stat. Ann. (1949) §76-1222 (no censorship of mail to dept. social welfare); La. Rev. Stat. (1950) tit. 28, §171 (no censorship of mail to state dept. institutions or attorney); Me. Laws Rev. Stat. (1954) c. 27, §100 (no censorship of mail to the state dept. institutions); Md. Code Ann. (1957) art. 59, §35 (no censorship of mail to one correspondent or dept. mental hygiene); Mass. Laws Ann. (1957) c. 123, §98 (no censorship of mail to dept. mental health); Minn. Stat. (1957) §253.11 (no censorship of mail to governor, public welfare dept., or one correspondent); N.H. Rev. Stat. (1955) c. 135, §33 (no censorship of mail to trustees of state institutions); Pa. Stat. Ann. (Purdon, 1954) tit. 50, §1481 (no censorship of mail to governor, dept. of welfare, court or attorney); R.I. Gen. Laws (1956) §26-3-20 (no censorship of mail to dept. public welfare); Wis. Stat. (1957) §51.35 (no censorship of mail

appear to be unduly restrictive in that the absolute privilege applies only to mail to public officials. The New York court, in the *Jacobs* case discussed above, pointed out that public officials may be unable or unwilling to act, and that the patient's attorney should be included. The New York Department of Mental Hygiene, after being severely criticized in the *Jacobs*¹³⁵ and *Hoff*¹³⁶ cases, both of which involved denial of mail privileges in habeas corpus proceedings, changed its regulation. The present regulation is detailed and complete and would be an ideal model for a state which wishes to incorporate the communication privilege in its statutes. The regulation creates a qualified privilege as to all mail and an absolute privilege relative to officials, attorneys, and habeas corpus pleadings.¹³⁷

A few states have adopted a qualified privilege statute, providing that mail privileges may be restricted under certain specified conditions.¹³⁸ A number of states have similar statutes on the rights of visitation.¹³⁹ In only two states does the patient have an absolute statutory privilege of writing to anyone without censorship.¹⁴⁰

C. *Freedom From Publicity*

As long as mental illness carries with it a stigma which does not attach to other forms of disease, patients should receive legislative protection against possible social disgrace resulting from publicity. The problem is especially important to the borderline patient in an early stage of mental illness. The natural reluctance of the patient's physician and family to expose "private family troubles" in a court room open to the public often causes postponement of early treatment. The result is that many who could have

of patient in public hospital to governor, attorney general, dept. of public welfare, district attorney, court, or attorney) and §58.05 (no censorship of mail of patient in private hospital to dept. of public welfare).

¹³⁵ See text at note 91.

¹³⁶ See text at note 92.

¹³⁷ N.Y. Codes, Rules and Regs. (4th Supp. 1949), Dept. of Mental Hygiene General Order No. 11.

¹³⁸ Cal. Welfare and Inst. Code Ann. (Deering, 1952) §5751; Neb. Rev. Stat. (1958) §§83-314, 83-315.

¹³⁹ Conn. Gen. Stat. (1958) §17-189; La. Rev. Stat. (1950) tit. 28, §171; Mass. Laws Ann. (1957) c. 123, §99; Pa. Stat. Ann. (Purdon, 1954) tit. 50, §1481; Vt. Stat. Ann. (1959) tit. 18, §2512.

¹⁴⁰ Conn. Gen. Stat. (1958) §17-190 (censorship of mail prohibited); Iowa Code (1958) §§226.13, 229.39 (patient allowed to write once a week "what he pleases" to any person).

benefited by prompt treatment are not hospitalized until their condition is incurable.

There are two aspects to the problem—protection of the hospital record and protection of the judicial record. The hospital record and the records of physicians or health officers who participate in the commitment process are generally kept confidential in the absence of legislation and in accordance with medical ethics. The judicial record, however, is traditionally considered a public record and in the absence of express legislation the hearing, if any, and the resulting records are available to all. Court records may be kept confidential both to protect the persons involved in the commitment process from the patient, and to protect the patient from adverse publicity. Experience under recent Wisconsin statutes is a good example of both policy factors at work. Judicial records involving all patients were made confidential in 1947.¹⁴¹ Subsequent to 1947, in two cases, released mental patients assaulted those who had petitioned for their commitment. In each case, it was discovered that the patients had been in hospitals where trusted patients were allowed to assist the staff in administrative duties and thus had access to patient files. By this means, word got back to the patients as to the names of those who had petitioned for their commitment.¹⁴² On the request of the Board of County Judges the problem was dealt with by the 1953 legislature. The present statute provides that when the county judge forwards copies of the commitment records to the hospital, the names of the petitioners must be deleted.¹⁴³

The Draft Act provides that judicial hearings may be held in a non-public session in the discretion of the court.¹⁴⁴ A number of states have similar provisions.¹⁴⁵ Possible constitutional difficulties would be avoided if the statute expressly stated that the patient may require that the hearing be public. The Draft Act also makes confidential the records of courts, health officers, and hospitals involved in the commitment process. The act provides:

¹⁴¹ Wis. Laws (1947) c. 485.

¹⁴² Letter to the author, dated July 1, 1954, from the Hon. George Kroncke, Jr., County Judge, Dane County, Wisconsin.

¹⁴³ Wis. Stat. (1957) §51.06(2) and §51.30.

¹⁴⁴ Draft Act, §9(f).

¹⁴⁵ E.g., Tex. Civ. Stat. Ann. (Vernon, 1958) art. 5547-49; Wis. Stat. (1957) §51.02(2).

"Section 23. *Disclosure of Information.*—

"(a) All certificates, applications, records and reports made for the purpose of this Act and directly or indirectly identifying a patient or former patient or an individual whose hospitalization has been sought under this Act shall be kept confidential and shall not be disclosed by any person except insofar

"(1) as the individual identified or his legal guardian, if any (or, if he is a minor, his parent or legal guardian), shall consent, or

"(2) as disclosure may be necessary to carry out any of the provisions of this Act, or

"(3) as a court may direct upon its determination that disclosure is necessary for the conduct of proceedings before it and that failure to make such disclosure would be contrary to the public interest.

"(b) Nothing in this section shall preclude disclosure, upon proper inquiry, of any information as to his current medical condition, to any members of the family of a patient or to his relatives or friends.

"(c) Any person violating any provision of this section shall be guilty of a misdemeanor and subject to a fine of not more than \$500 and imprisonment for not more than 1 year."

The Draft Act provision has been adopted in five states¹⁴⁶ and somewhat similar provisions exist in five other states.¹⁴⁷

An interesting side-light on the problem is afforded by a recent action of the Idaho legislature. Idaho adopted section 23 of the Draft Act in 1951. In 1953, the statute was amended to provide: "Nothing in this section shall preclude disclosure upon proper inquiry, of any information contained in such . . . reports . . . to abstractors, title insurance companies in connection with title matters relating to title to real property in which the patient has or had some interest, lawyers. . . ." ¹⁴⁸ While at first glance it might seem that the legislature had misconstrued one of the basic purposes of the Draft Act, i.e., the complete separation of hospitalization and incompetency proceedings, nevertheless this

¹⁴⁶ Idaho Code Ann. (Supp. 1957) §66-348; Mo. Stat. Ann. §202.853 [repealed, Laws 1957, p. 672, §1]; N.M. Stat. (Supp. 1957) §34-2-17; S.C. Code (Supp. 1958) §32-950.14; Utah Code Ann. (1953) §64-7-50.

¹⁴⁷ Ill. Rev. Stat. (1957) c. 91½, §4-5; Iowa Code Ann. (1949) §218.22; 34A N.Y. Consol. Laws (McKinney, 1951) §§20, 34(9); Wash. Rev. Code (1953) §71.02.250; Wis. Stat. (1957) §51.30.

¹⁴⁸ Idaho Laws (1953) c. 264, §4, Idaho Code Ann. (Supp. 1957) §66-348.

amendment reflects a real problem. If a patient who is a resident in a mental hospital is preparing to sell land, the buyer will certainly know about the fact of hospitalization and might require the appointment of a guardian or a judicial declaration of competency. However, where the patient is not a resident in a hospital, but on conditional release, the prospective purchaser would have a legitimate interest in inquiring of the hospital as to the seller's current status. The Idaho exception is too broadly stated, as it is difficult to see how the abstractor has any real interest. It should also be noted that the amendment does not require disclosure; it merely exempts the hospital authorities from criminal sanctions for making disclosure. Another apparent defect in drafting is that while title companies must be concerned with title, there is no such qualification for abstractors and attorneys. Possibly a better solution would be to require the central state authority (department of mental health), which keeps a roster of all patients, to answer questions from attorneys and title insurance companies as to whether or not an individual named in the request is carried on the books of any mental hospital in the state, his current status (resident or conditional release), and how long he has been a patient.

D. *The Patient and His Medical Rights*

1. *In General.* A few writers have discussed briefly the topic of proper medical care and the patient's right to such care. One author has used the term "medical due process."¹⁴⁹ The problem is one which by its very nature cannot be solved by passing a law. The principal barriers to effective treatment are inadequate financing, an acute shortage of hospital beds and equipment,¹⁵⁰ in some states a poorly designed administrative structure for the state hospital system,¹⁵¹ and most of all, lack of trained personnel.¹⁵²

The Draft Act and the more modern commitment codes indirectly secure some elements of proper medical care by eliminat-

¹⁴⁹ Comment, 56 YALE L.J. 1178 at 1203 (1947).

¹⁵⁰ The U.S. Public Health Service estimates that in 1950, 725,000 hospital beds were needed for mental patients. Only 462,000 beds were available, and 63,000 of these were sub-standard. Felix, "Hospitalization of the Mentally Ill," 107 AM. J. PSYCHIATRY 712, n. 78 (1951). See also REPORT TO THE GOVERNORS' CONFERENCE 134.

¹⁵¹ REPORT TO THE GOVERNORS' CONFERENCE 70.

¹⁵² Id. at 149.

ing admission procedures which are harmful to the patient. More directly, section 19 of the act lists as one of the patient's "rights":

"Every patient shall be entitled to humane care and treatment and, to the extent that facilities, equipment, and personnel are available, to medical care and treatment in accordance with the highest standards accepted in medical practice."¹⁵³

In addition, the act imposes on the hospital a duty to examine each patient at least once every six months.¹⁵⁴ As already indicated, adequate personnel and equipment do not exist today and could not be created overnight, even if funds were available. The Draft Act provisions for the best medical care are relatively meaningless at the present time and are little more than pious expressions of hope. Section 19 is a statement of an ideal and certainly does no harm, but it might better be included as a general policy expression at the beginning of the act.¹⁵⁵ To date, provisions similar to section 19 have been adopted by eight states, either as general policy statements or as part of the "rights of patients" chapter in the commitment statute.¹⁵⁶

In addition to the general provisions on medical care, there are two specific aspects of treatment which have received separate legislative attention. One of these involves legal control over the degree of mechanical restraint which may be imposed, and the other involves legal control over the use of major and potentially dangerous methods of treatment, such as surgery or shock therapy.

2. *Regulation of Restraint.* Of the many controversies in the psychiatric profession during the last half of the nineteenth century, none was more heated than the question of "restraint" versus "non-restraint."¹⁵⁷ Eventually the advocates of non-restraint carried the field and their ideas were written into the laws of a number of states. Despite adverse publicity, the use of mechanical restraints still plays an important role in our mental hospitals and

¹⁵³ Draft Act, §19.

¹⁵⁴ Id., §15.

¹⁵⁵ This has been done in Oklahoma. Okla. Stat. (Supp. 1957) tit. 43A, §2.

¹⁵⁶ Cal. Welfare and Inst. Code Ann. (Deering, 1952) §6621; Idaho Code Ann. (Supp. 1957) §66-344; Iowa Code (1958) §225.15; Mo. Stat. Ann. (Supp. 1958) §202-840; N.M. Stat. (1953) §34-2-13; Okla. Stat. (Supp. 1957) tit. 43A, §§2, 91; Tex. Civ. Stat. Ann (Vernon, 1958) art. 5547-70; Utah Code Ann. (1953) §64-7-46.

¹⁵⁷ The restraint controversy and the arguments on both sides is treated in detail in DEUTSCH, *THE MENTALLY ILL IN AMERICA*, c. XI (1946).

will probably continue to do so as long as they are seriously understaffed.¹⁵⁸ The Draft Act and ten of the states provide for statutory controls on the use of restraints.¹⁵⁹ All of these require in substance that mechanical restraints may be used only when prescribed for individual patients as medically necessary, thus attempting to discourage the improvident use of restraints by ward attendants. In addition, the Draft Act and most of the states require that a report of the restraint and the reasons for its use be incorporated in the clinical record of the patient. In addition to statutory controls, many states have administrative regulations on the use of restraints. Perhaps the best of these is the recent and carefully-drafted New York provision.¹⁶⁰

3. *Legal Control of Potentially Dangerous Treatment.* The administrators of mental hospitals are faced with the difficult problem of how far they can go in administering serious or major treatments which may involve some danger to the patient. Surprisingly, the issue has received little or no attention in legal or medical literature.

The legal rules relating to surgery in a non-mental hospital are fairly well defined.¹⁶¹ Except in the case of an extreme emergency, the physician may not operate without consent. An unauthorized operation is a technical assault and makes the physician liable in damages. The required consent must be given by the patient or, if he is a minor, by his parents or guardian. The administration of the rule presents very few problems, as the patient is almost always willing to consent or, if he is a minor, the parents are willing to consent and are immediately available to give their consent.

Serious difficulties, however, are presented by the special characteristics of the mental hospital and its patients. The hospital administrators work on the assumption that the consent of the

¹⁵⁸ Current practices regarding the use of restraints are summarized in REPORT TO THE GOVERNORS' CONFERENCE 100, 303, and 354.

¹⁵⁹ Draft Act, §20; Idaho Code Ann. (Supp. 1957) §66-345; Kan. Gen. Stat. (1949) §76-1223; Ky. Rev. Stat. (1959) §203.240; Mass. Laws Ann. (1957) c. 123, §§35-38; Mo. Stat. Ann. (Vernon, Supp. 1958) §202.843; N.M. Stat. (1953) §34-2-14; Okla. Stat. (Supp. 1957) tit. 43A, §92; Pa. Stat. Ann. (Purdon, 1954) tit. 50, §1481.1; Tex. Civ. Stat. Ann. (Vernon, 1958) art. 5547-71; Utah Code Ann. (1953) §64-7-47.

¹⁶⁰ The regulation is substantially the same as the Draft Act provision, except that means of restraint and maximum periods of restraint are limited. N.Y. Code, Rules and Regs. (5th Supp. 1949) Dept. Mental Hygiene General Order No. 7.

¹⁶¹ See cases collected in HOYT AND HOYT, LAW OF HOSPITAL, PHYSICIAN AND PATIENT 168 (1947).

patient is of no value, since a court might hold that he is mentally incapable of giving effective consent. Most patients in the state hospitals are public charges. Having no estate, most of them have no guardian who could give consent. Many patients become estranged from their families and, in addition, many patients are hospitalized away from their own communities. Thus the hospital may have a great deal of difficulty in locating the relatives and convincing them to grant consent. Some of these cases are covered by the emergency exception to the consent rule. However, the emergency doctrine has been strictly limited by some courts to cases where the operation is immediately necessary to save the patient's life.¹⁶²

Some hospital administrators contend that the provisions for treatment of a committed patient in a public mental hospital may be distinguished from the legal rules governing patients in medical hospitals. The argument is that mentally ill persons are considered wards of the state. The state as *parens patriae* must provide necessary care and treatment. The care and treatment of mental patients is a governmental function and the basic consideration in the exercise of this function is the patient's welfare, not what the patient or his relatives believe to be in his interests. Thus, consent is not legally required for the patient in a public mental hospital. Although there are no cases squarely in point on the issue of surgery without consent, there is one attorney general's opinion. Basing his conclusion on the above arguments, the Vermont Attorney General concluded that the state mental hospital performed a governmental function in treating patients and:

"... it is my belief that you may administer in your own sound discretion such treatment [including surgery] . . . as is indicated after diagnoses as being necessary or proper for his welfare. As to the matter of securing the consent of the inmate's relatives, it is my belief that such is not necessary as a matter of law, but where it can be obtained, it is my feeling that such a course is one to be commended."¹⁶³

The Vermont conclusion is buttressed by the language of most commitment statutes to the effect that patients are committed "to the state hospital for care and *treatment*"¹⁶⁴ or that the state

¹⁶² *Id.* at 176; REGAN, DOCTOR AND PATIENT AND THE LAW, 2d ed., §11 (1949).

¹⁶³ Vt. Atty. Gen. Rep. 207-208 (1944-1946).

¹⁶⁴ E.g., Draft Act, §5.

hospital has "exclusive custody and control of all patients."¹⁶⁵ A few states have specifically dealt with the problem by statute. Illinois is the only state which apparently provides that surgery may be used in all non-emergency cases without consent. The statute provides that the various forms of admission, including voluntary and non-protested admission and emergency and formal commitment "shall constitute the authority for the Superintendent . . . for giving such standard treatment including surgery as may be necessary for the welfare of the patient, or of the public."¹⁶⁶ The statute applies to all mental hospitals, including private hospitals, a fact which might cause constitutional objections. It might be held that the doctrine of *parens patriae* could not be stretched to authorize a private hospital to operate without consent. On the other hand, it could be argued that the care of all of the mentally ill is essentially a governmental function and that the superintendent of a private mental hospital is in effect a state or quasi-state agent in the exercise of this function. A similar Iowa statute applies to the state psychopathic hospital only. The statute authorizes the physician in charge to ". . . proceed with such observation, medical or surgical treatment, and hospital care as in his judgment are proper and necessary."¹⁶⁷

Ohio and Oklahoma have almost identical statutes which provide that except in emergency cases, the hospital may not perform a major operation until the hospital notifies the guardian or relative of the patient, if such information is in the patient's records.¹⁶⁸ Note that the statute requires notice rather than consent. Under a literal interpretation of the statute, the hospital could notify the relatives and then disregard a protest.

The Draft Act does not cover the problem of consent to surgery nor do the statutes of any of the other states, although almost every state has some general provision giving the hospital authority to both detain and care for the patient. These provisions

¹⁶⁵ E.g., Okla. Stat. (Supp. 1957) tit. 43A, §95; N.H. Rev. Stat. (1955) §17-33; Utah Code Ann. (1953) §64-7-9.

¹⁶⁶ Ill. Rev. Stat. (1957) c. 91½, §§4-8, 5-18, 6-3.

¹⁶⁷ Iowa Code (1958) §225.15. No such provision exists for the regular state mental hospital. But see *id.*, §226.6(1). The 1957 Texas Mental Health Act has a provision similar to Iowa Code §225.15; Tex. Civ. Stat. Ann. (Vernon, 1958) art. 5547-70. Sterilization and prefrontal lobotomy is specifically prohibited unless consent is given by a guardian. Tex. Civ. Stat. Ann. (Vernon, Supp. 1958) art. 3174b-2.

¹⁶⁸ Ohio Rev. Code (Baldwin, 1958) §5123.03; Okla. Stat. (Supp. 1957) tit. 43A, §96.

could be liberally interpreted to allow the hospital to treat without consent.

The statutes discussed above all relate to the problem of surgery. In recent years, another problem has plagued mental hospital administrators: the legality of the use without consent of major types of non-surgical treatments. Specifically, these treatments are the shock and fever therapies. The electro-shock treatment has been widely adopted since it was introduced into this country from Italy in 1939, and is the most widely used of the shock therapies. The treatment results in the patient losing consciousness and experiencing convulsions and violent muscular contractions. Although fractures were common when the therapy was first used, the present incidence of complications is less than one percent. The effectiveness of the treatment is now well recognized for certain mental disorders, especially the manic-depressive psychoses. Some state hospitals do not use such special therapies without the consent of the relatives. It is felt that the treatments are sufficiently dangerous that the rules of consent which apply to operations should be applied here. Other hospitals do not require consent, although they do make some effort to obtain it. There are no cases or statutes which specifically cover the point, although the Illinois statute discussed above is probably broad enough to include shock therapy. The only detailed discussions of the medical and legal aspects of the problem are contained in two 1948 attorney general opinions, one from Pennsylvania and one from Wisconsin. Both opinions conclude that neither voluntary nor committed patients in a state hospital, nor their relatives or guardians, have any control over the type of treatment used. Under its police power, the state may advance the medical and psychiatric welfare of a patient by means of electric shock or other well-recognized therapies, including prefrontal lobotomy, without first obtaining consent.¹⁶⁹

E. Conclusions

Primarily for historical reasons, our hospitalization statutes have stressed the procedural problems involved in getting the

¹⁶⁹ Pa. Ops. Atty. Gen. 120 (1948); Wis. Ops. Atty. Gen. 502 (1948). See also Ohio Ops. Atty. Gen. No. 7106, p. 656 (1956), which holds that a patient admitted under a short term ex parte commitment can be given only emergency treatment, unless valid consent is present.

mental patient into a hospital, and have almost completely ignored the legal problems which may arise after the patient is admitted. On some of the minor details, such as protection of the patient's postal rights, or protection against unwarranted mechanical restraint, substantial agreement has been reached and is generally embodied in legislation. However, on the broader and more fundamental problems involving the effect of hospitalization on legal capacity and the types of treatment which may be administered without consent, there is no general policy agreement and most of the statutes are silent. These more basic problems are difficult to solve and no ready-made policy determinations are presented here. What is important is that the state legislatures recognize that there are policy questions to be decided. When the nature of the problems are understood, then the psychiatrists, hospital administrators, and probate judges can be called in and asked to help to provide specific solutions.

APPENDIX I
STATUTORY PROVISIONS
Table 1. Indeterminate Judicial Commitment—Pre-Hearing Procedures

	Court	Justification for Commitment		Application Sup- ported by Medi- cal Certificate	Notice of Hearing			Pre-Hearing Medical Exam Ordered by Court
		Danger	Needs Treatment		Relative	Guardian	Patient	
Draft Act Public Health Serv. Pub. No. 51 (1951)	not specified	X	X	X	X	X	(1)*	by 2 specially qualified physicians
Ala. Code (1940) tit. 45	probate	X	X					1 physician
Alaska Comp. Laws Ann. (1949) c. 51-4	probate	not stated	not stated					1 physician
Ariz. Rev. Stat. (Supp. 1958) tit. 36, c. 5	superior	X					(1)	2 physicians
Ark. Stat. (Supp. 1957) §59-234	probate	X		X	X	X	X	
Cal. Welfare and Inst. Code Ann. (Deering, Supp. 1957) Div. 6	superior	X	X		X		(1)	2 physicians
Colo. Rev. Stat. (Supp. 1957) c. 71, c. 124-3	county	X	X	X				2 physicians ⁽¹⁾
Conn. Gen. Stat. (Rev. 1958) tit. 17, c. 306	probate	X	X		X		X	2 physicians
Fla. Stat. (1957) tit. 27, c. 394	county	X	X		X		X	1 citizen and 2 doctors
Ga. Code Ann. (Supp. 1958) c. 35-2, c. 49-6	ordinary	X	X	X	X			2 physicians
Idaho Code (Supp. 1957) tit. 66	district or probate	X	X	X	X	X	X	same as Draft Act
Ill. Rev. Stat. (1957) c. 91½	any court of record	X	X	X (optional)	X		X	only when application not supported by med- ical certificate
Ind. Stat. Ann. (Burns, 1953 repl.) tit. 8; (Supp. 1957) tit. 22, c. 47	circuit or superior	X	X	X			X	2 physicians

*The numbers in parentheses refer to the notes following this table.

Iowa ⁽⁸⁾ Code (1958) §§225-229	insanity commission		X			X		1 physician
Kan. Gen. Stat. (1949; Supp. 1957) c. 59-20, 22	probate	X	X				X	1 physician (optional)
Ky. Rev. Stat. (1959) c. 202	circuit	not stated	not stated		X		X	2 physicians
La. Stat. Ann. (1950; Supp. 1957) tit. 28	district		X	X			X	coroner and one physician
Me. Rev. Stat. (1954) c. 27, §110	municipal board of examiners or probate court	X	X				X	2 physicians
Mass. Laws Ann. (Supp. 1958) c. 123	superior or district	X	X		X	X	X	1 physician and 1 psy- chiatrist if available
Mich. Stat. Ann. (Supp. 1957) §14.811	probate	not stated	not stated		X		(1)	2 physicians
Minn. Stat. (1957) c. 525	probate		X					2 physicians ⁽⁷⁾
Miss. Code Ann. (1942; Rec. 1953) tit. 4, c. 2 and tit. 25, c. 3.	chancery	X	X		X	X		2 physicians
Mo. Stat. Ann. (Supp. 1958) c. 202	probate	X	X	X	X	X	X	2 physicians
Mont. Rev. Code (Supp. 1957) tit. 38 and tit. 91	district	X			X		X	2 physicians
Nev. Rev. Stat. (1957) c. 433	district		X					2 physicians
N. J. Stat. Ann. (Supp. 1958) tit. 30, c. 4	county domestic relations or juvenile	not stated		X	X		X	
N. M. Stat. (1953) c. 34-2	district	X	X	X	X	X	(2)	
34A N.Y. ⁽⁹⁾ Consol. Laws (McKinney, Supp. 1958)	any court of record	X	X	by 2 specially qualified physicians	X		(2)	1 physician
N.D. Rev. Code (Supp. 1957) tit. 25	(8)	X	X	X	X	X	(1)	1 physician

Table 1, Continued

	Court	Justification for Commitment		Application Sup- ported by Medi- cal Certificate	Notice of Hearing			Pre-Hearing Medical Exam Ordered by Court
		Danger	Needs Treatment		Relative	Guardian	Patient	
Ohio Rev. Code (Bald- win, Supp. 1958) c. 5123	probate	X	X		X		(1)	1 physician
Okla. Stat. Ann. (Supp. 1957) tit. 43a	county	X	X		X		X	2 physicians
Ore. Rev. Stat. (1957 Repl.) tit. 35	probate	X	X				X	2 physicians
Pa. Stat. Ann. (Purdon, 1954) tit. 50	common pleas	X(8)	X(8)	by 2 physicians			X	
R.I. Gen. Laws (1956) tit. 26	district or supreme court	X(4)	X(4)				X	
S.C. Code (Supp. 1958) tit. 32	probate	X	X	X	X	X	(1)	2 physicians
S.D. Code (1939) tit. 30; 1953 Laws, p. 187	(8)	not stated	not stated		X			1 physician
Tenn. Code Ann. (Supp. 1957) tit. 33	probate	X	X				X	2 physicians
Tex. Civ. Stat. Ann. (1958) tit. 92	probate	X	X	X	X	X	X	
Utah Code Ann. (1953; Supp. 1957) tit. 64, c. 7	district	X	X	X	X	X	(1)	2 physicians
Va. Code (Supp. 1957) tit. 37	circuit corporation or trial justice	X	X				X	2 physicians
Wash. Rev. Code (Supp. 1955) tit. 71; 1957 Laws 87	superior	X			X	X	(9)	2 physicians
W. Va. Code Ann. (1955; Supp. 1958) c. 27	(10)	not stated	not stated				X	2 physicians
Wis. Stat. (Supp. 1958) c. 51	county or district		X				(1)	2 physicians

Wyo. Comp. Stat. (Supp. 1957) c. 51	district	X	X				(1)	2 physicians
Summary: 43 States	Probate: 16 Trial Court: 16 Trial Court or Probate: 7 Administrative Agency: 4		Danger: 4 Needs Treatment: 5 Either Ground: 28 Not Stated: 6	Mandatory: 16 Optional: 1	24	12	Mandatory: 22 Discretionary: 12	Mandatory: 34 Discretionary: 3

¹Court has discretion to omit notice to patient if notice would be meaningless or harmful to patient because of his mental condition.

²Court commitment is for 60 days. Court order becomes an order for indeterminate detention on certificate of hospital.

³Statute refers to "necessary or advisable for him to be under care," but court held that only justification for commitment is danger. *Commonwealth v. Noyes*, 83 Pa. D. & C. 311 (1952).

⁴Commitment statute allows commitment of either group, but discharge statute requires discharge of non-dangerous patient on application for habeas corpus. §26-3-10.

⁵There are two types of judicial commitments in Iowa, plus ex parte commitment. The proceedings referred to in the table above and in Table 2 involve a hearing before a quasi-judicial agency, the county insanity commission, which consists of an attorney, a physician, and the clerk of court. This procedure is used for commitment to any mental hospital (state, county, private or United States veterans' administration) excepting only the psychopathic hospital at the state university medical school. A separate and exclusive procedure is provided for the psychopathic hospital, involving a hearing with optional jury before the superior or district court.

⁶The hearing is held by the panel of two doctors who make a personal examination and also hear witnesses. The court commits the patient if it approves the findings of the panel.

⁷Court may also appoint one psychologist and may appoint welfare agency to make a social case study investigation.

⁸The hearing is held by the mental health board, a quasi-judicial agency with judicial powers (immunity, subpoena, etc.), consisting of the county judge, one attorney, and one physician.

⁹Notice to patient may be dispensed with if notice would be harmful and if guardian ad litem appointed.

¹⁰Hearing before quasi-judicial commission consisting of judge, prosecuting attorney and clerk of county court.

Table 2. Indeterminate Judicial Commitment—Hearing Procedures

	Mandatory Hearing	Right To Be Represented by Counsel	Court-Appointed Counsel	Jury Trial	Reference to Hearing Commission	Does Commitment Automatically Result in Incompetency?
Draft Act	X	X	X		optional—1 referee	no—except that restrictions may be imposed for medical reasons
Alabama	X			(4)*		no—except that guardian can be appointed for committed patient without notice to him [§36-214(E)]
Alaska	X	X	X	mandatory	forbidden	yes—(Laws, 1957, c. 164)
Arizona	X	X	compensated			(5)
Arkansas	X					no
California	(6)	X	compensated by state	X		no—but public guardian may be appointed without notice to patient
Colorado	X	X	compensated by county	(8)	mandatory(8)	yes
Connecticut	X	X				no
Florida	X	X	compensated by county			yes(9)
Georgia	X				mandatory reference to panel of 2 physicians and 1 attorney. Commitment is by court	yes—commitment and guardianship are one proceeding
Idaho	X	X	compensated by county		optional—referee	same as Draft Act
Illinois	X			6 jurors—1 a physician	optional reference to panel of two physicians	committing court must designate patient as competent or incompetent
Indiana	X	X	X			yes(7)
Iowa	X	X	X			yes
Kansas	X	X	X	6 jurors—1 a physician	optional reference to panel of two physicians	yes—guardian may be appointed in commitment order
Kentucky	X	X	X	mandatory(8)		yes—but no provision for automatic guardianship
Louisiana	(8)				optional reference to panel of one physician and coroner	no

Maine	X					no
Massachusetts	(⁹)	X				no
Michigan	X			X		yes—public guardian appointed for every committed patient
Minnesota	X					no
Mississippi	X				hearing may be held by commissioner or clerk	yes—guardian may be appointed for patient without notice to him
Missouri	X	X	X			same as Draft Act
Montana	X			X		yes—guardian may be appointed as part of commitment procedure
Nevada	X					no—but committing court shall appoint guardian on application of any interested person
New Jersey	X	X		discretionary with court	optional	no
New Mexico	X	X	X		optional	no—Draft Act provision
New York(²)	(¹)			X	testimony may be taken before referee	yes—by administrative order No. 10
North Dakota	X	X	compensated		optional—referee	no—Draft Act provision
Ohio	X				optional—referee	yes
Oklahoma	X			X	(¹⁰)	yes—guardian appointed by committing court
Oregon	X	X	X			yes—Ore. Rev. Stat. §426.305
Pennsylvania					testimony may be taken before panel of 2 physicians and 1 attorney	not stated
Rhode Island	X		compensated		testimony may be taken before 3 commissioners	no
South Carolina	X	X	X			not clear
South Dakota	X	X				no
Tennessee	X					
Texas	X	X	X	(¹¹)		no—but committing court is required to determine if patient is competent

*The numbers in parentheses refer to the notes following this table.

Table 2, Continued

	Mandatory Hearing	Right To Be Represented by Counsel	Court-Appointed Counsel	Jury Trial	Reference to Hearing Commission	Does Commitment Automatically Result in Incompetency?
Utah	X	X	optional with court		optional—referee	no—Draft Act provision
Virginia	X	X			hearing held by panel of judge and 2 physicians	no
Washington	X	X		X		yes
West Virginia	X	X	compensated			yes—guardian appointed for every committed patient
Wisconsin	X	X	optional	X	expressly forbidden	no—results in rebuttable presumption of in- competency
Wyoming	X			X		yes—guardian appointed in commitment pro- ceeding
Summary 43 States	Not stated: 1 Mandatory: 38 If asked for: 4	25	21	Mandatory: 2 Discretion of court: 2 If demanded: 11		No: 23 Yes (in whole or part): 18 Not stated: 2

¹Hearing required if a friend or relative of patient demands it.

²Court order is for 60-day commitment. Order becomes an indeterminate commitment on certificate of hospital.

³Hearing is before commission of two physicians but commitment is by the court. If patient objects to findings of commission, he can demand jury trial.

⁴Hearing is ex parte, no notice to or presence of patient is required. Use of jury is in discretion of court, not the patient.

⁵Committing court must designate patient as competent or incompetent, and if incompetent may appoint guardian. Ariz. Rev. Stat. Ann. (Supp. 1958) §§36-514(D).

⁶Judicial commitment and incompetency proceeding are merged in one action. If court finds incompetency, it may or may not commit.

⁷Commitment is equivalent to adjudication of incompetency and guardian may be appointed at time of commitment, or if guardianship is asked for in subsequent proceeding, fact of continued hospitalization plus physician certificate of incompetency is conclusive on fact of incompetency. §§8-120.

⁸Ky. Op. Atty. Gen. 39, 583 (1957).

⁹No hearing unless requested by patient.

¹⁰Hearing is before court, but preliminary hearing is held before panel of two physicians and one attorney who make findings as to both incompetency and need for hospitalization.

¹¹Jury trial mandatory unless expressly waived by patient or relative and attorney ad litem.

Table 3. Ex Parte Indeterminate Commitment-Admission Procedures

	Commitment by	Approved by	Justification for Commitment		Admission Reported to	Patient Informed of Right To Appeal
			Danger	Needs Treatment		
Draft Act Public Health Serv. Pub. #51 (1951)	2 physicians	judge or health officer	X		state mental health agency	X

†Ark. (1) Stat. Ann. (Supp. 1957) c. 59-2	1 physician		X			
Conn. Gen. Stat. (Rev. 1958) §17-181	physician, attorney and one other person	superior court	not stated	not stated	state mental health agency	
†Del. (1) Code Ann. (Supp. 1956) c. 16-51	2 physicians		not stated	not stated		
Fla. Stat. (1957) §394.21	2 physicians	county judge	X			
Iowa (6) Code (1958) c. 227	2 physicians		X	X		
†Md. Code Ann. (1957), art. 59	2 physicians		not stated ⁽²⁾	not stated ⁽²⁾		
Miss. (1) Code Ann. (1942; Rec. 1953) §6909-12	2 physicians	director of state hospital	X	X		
†Neb. Rev. Stat. (1958) c. 83(3)(b)	(8)			X		
†N.H. Rev. Stat. (1955) c. 135	2 physicians	probate judge	not stated	not stated	state board of health	
†N.C. (1) Gen. Stat. (1958 repl.) c. 122	state hospital ⁽⁴⁾	clerk of superior court	X	X		
Pa. Stat. Ann. (Purdon, Supp. 1957) tit. 50	2 physicians	hospital superintendent	not stated	not stated		
S.C. (1) Code (Supp. 1958) §32-912	2 physicians	probate court	X	X		X
Utah Code Ann. (Supp. 1957) tit. 64, c. 7	2 physicians	judge or health officer	X	X		X
†Vt. Stat. Ann. (1959) tit. 18, c. 61	2 physicians	magistrate	X			
Summary: 14 states In 6 states ex parte commitment is only method.			Danger: 3 Needs treatment: 1 Either ground: 5 Not stated: 5			

†In these states, ex parte commitment is the only procedure available for indeterminate commitment.

¹Ex parte commitment is only to state hospital.

²Court test is M'Naghten test (right-wrong) or danger. *Salinger v. Supt.*, 206 Md. 623, 112 A. (2d) 907 (1955).

³There are two forms of ex parte commitment: by a county board of mental health consisting of attorney, physician, and court clerk; or by two physicians.

⁴Initial commitment to state hospital is for 60-day observation period, made by clerk of court after hearing. Final commitment is made ex parte by clerk on certificate of hospital.

⁵Ex parte commitment can be used only for county hospitals, private hospitals, or general hospital psychiatric wards. See note 5 to Table 1.

Table 4. Ex Parte Indeterminate Commitment—Post-Admission Provisions

	Appeal to	Right to Be Represented by Counsel on Appeal	Court Appointed Counsel	Jury Trial on Appeal	Does commitment automatically result in incompetency?
Draft Act	court	X	X		no—except that restrictions may be imposed by hospital for medical reasons
Arkansas	*				no
Connecticut	superior court or habeas corpus				no
Delaware	chancery court			mandatory	no—and commitment raises no presumption of incompetency
Florida	county court	X	compensated		no
Iowa	district court	X	X	X	yes
Maryland	law courts			X	no
Mississippi	chancery court or habeas corpus				not stated
Nebraska	district court or habeas corpus				no
New Hampshire	superior court				no
North Carolina	habeas corpus in superior court				no—commitment raises no presumption of incompetency
Pennsylvania	habeas corpus in superior court				not stated
South Carolina	probate court	X	X		not clear
Utah	district court	X	optional		no—draft act provision
Vermont	probate court			X	not stated
Summary: 14 states		4	3	mandatory: 1 optional: 3	no: 9 yes: 1 not stated: 4

* There is no appeal provision, but patient can bring habeas corpus in any court of record.

APPENDIX II

The Judicial Commitment Section of the Draft Act

Sec. 9. *Hospitalization upon court order; judicial procedure.*

(a) Proceedings for the involuntary hospitalization of an individual may be commenced by the filing of a written application with the (probate) court by a friend, relative, spouse, or guardian of the individual, or by a licensed physician, a health or public welfare officer, or the head of any public or private institution in which such individual may be. Any such application shall be accompanied by a certificate of a licensed physician stating that he has examined the individual and is of the opinion that he is mentally ill and should be hospitalized, or a written statement by the applicant that the individual has refused to submit to examination by a licensed physician.

(b) Upon receipt of an application the court shall give notice thereof to the proposed patient, to his legal guardian, if any, and to his spouse, parents, and nearest known other relative or friend. If, however, the court has reason to believe that notice would be likely to be injurious to the proposed patient, notice to him may be omitted.

(c) As soon as practicable after notice of the commencement of proceedings is given or it is determined that notice should be omitted, the court shall appoint two designated examiners to examine the proposed patient and report to the court their findings as to the mental condition of the proposed patient and his need for custody, care, or treatment in a mental hospital.

(d) The examination shall be held at a hospital or other medical facility, at the home of the proposed patient, or at any other suitable place not likely to have a harmful effect on his health. A proposed patient to whom notice of the commencement of proceedings has been omitted shall not be required to submit to an examination against his will, and on the report of the designated examiners of refusal to submit to an examination the court shall give notice to the proposed patient as provided under paragraph (b) of this section and order him to submit to such examination.

(e) If the report of the designated examiners is to the effect that the proposed patient is not mentally ill, the court may without taking any further action terminate the proceedings and dismiss the application; otherwise, it shall forthwith fix a date for and give notice of a hearing to be held not less than 5 nor more than 15 days from receipt of the report.

(f) The proposed patient, the applicant, and all other persons to whom notice is required to be given shall be afforded an opportunity to appear at the hearing, to testify, and to present and cross-examine witnesses, and the court may in its discretion receive the testimony of any other person. The proposed patient shall not be required to be present, and all persons not necessary for the conduct of the proceedings shall be excluded, except as the court may admit persons having a legitimate interest in the proceedings. The hearings shall be conducted in as informal a manner as may be consistent with orderly procedure and in a physical setting not likely to have a harmful effect on the mental health of the proposed patient. The court shall receive all relevant and material evidence which may be offered and shall not be bound by the rules of evidence. An opportunity to be represented by counsel shall be afforded to every proposed patient, and if neither he nor others provide counsel, the court shall appoint counsel.

(g) If, upon completion of the hearing and consideration of the record, the court finds that the proposed patient

(1) is mentally ill, and

(2) because of his illness is likely to injure himself or others if allowed to remain at liberty, or

(3) is in need of custody, care or treatment in a mental hospital and, because of his illness, lacks sufficient insight or capacity to make responsible decisions with respect to his hospitalization, it shall order his hospitalization for an indeterminate period

or for a temporary observational period not exceeding 6 months; otherwise, it shall dismiss the proceedings. If the order is for a temporary period the court may at any time prior to the expiration of such period, on the basis of report by the head of the hospital and such further inquiry as it may deem appropriate, order indeterminate hospitalization of the patient or dismissal of the proceedings.

(h) The order of hospitalization shall state whether the individual shall be detained for an indeterminate or for a temporary period and if for a temporary period, then for how long. Unless otherwise directed by the court, it shall be the responsibility of the (local health authority) to assure the carrying out of the order within such period as the court shall specify.

(i) The court is authorized to appoint a special commissioner to assist in the conduct of hospitalization proceedings. In any case in which the court refers an application to the commissioner, the commissioner shall promptly cause the proposed patient to be examined and on the basis thereof shall either recommend dismissal of the application or hold a hearing as provided in this section and make recommendations to the court regarding the hospitalization of the proposed patient.

(j) The head of the hospital admitting a patient pursuant to proceedings under this section shall forthwith make a report of such admission to the (central administration).