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HOSPITALIZATION OF THE MENTALLY ILL IN WISCONSIN: A NEED FOR A REEXAMINATION*

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Public institutional care of the mentally ill is a problem of significant size in Wisconsin. At the end of April, 1966, 13,192 patients were hospitalized in state and county mental institutions, while 742 others were on conditional leave from these facilities.[1] During the year ending June 30, 1965, 2,803 patients were admitted to these facilities under "voluntary admissions" while 4,764 were received under various forms of involuntary admission.[2] It is evident that the admission and retention in public mental health facilities touches a large portion of the state's population; the legal implications of the process, then, are subjects of personal concern to a large number of the state's residents.

It has, for several reasons, become apparent that the time is ripe

*The concern here will be only with admissions to mental hospitals in a civil context. This is not to imply that important problems are not presented where mental illness arises in a criminal context; such matters are, however, beyond the scope of this paper.

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The resesarch for this paper was done while the author was employed as a professional assistant by the Comprehensive Mental Health and Mental Retardation Planning Program of the Wisconsin Department of Public Welfare. Much of the information used herein was obtained in personal interviews with medical and judicial personnel directly involved in the hospitalization process. Opinions expressed in this paper do not, of course, represent the views of the state agency or anyone affiliated with it.

[1] State Dep't. of Public Welfare, Monthly Population Report of State and County Mental Institutions (April, 1966). Wisconsin is one of the few states with a dual system of mental health facilities, one on the county level, the other on a state basis. County hospitals have traditionally been largely custodial and for "chronic cases"; the state institutions, Mendota State Hospital (hereinafter MSH) and Winnebago State Hospital (WSH) have been the primary treatment facilities. For the development of the Wisconsin "county care" system, see DEUTSCHE, THE MENTALLY ILL IN AMERICA, 262-67 (1949). For a detailed discussion of the development of Wisconsin mental institutions, see Hardy, Mental Hygiene Institutions (unpublished paper prepared for the Wisconsin Legislative Council, March, 1956, on file in the Legislative Reference Library, Madison, Wisconsin). As the county institutions obtain better facilities and staffs, this difference between the state and county hospitals is becoming less meaningful.

[2] State Dep't. of Public Welfare, *1965 Annual Population Report—Mental Institutions,* Table 2 STATISTICAL BULLETIN MH 40, Dec. 22, 1965. For a more detailed breakdown of admissions for the years 1960 through 1965, see the appendix.

for a thorough revision of the existing Wisconsin statutory provisions dealing with the hospitalization of the mentally ill. First, the basic features of the present statutory scheme were formulated in 1897.[3] Continuing changes in attitude and knowledge regarding mental illness[4]

[3] See note 7, *infra.*

[4] Perhaps the most significant change has been the realization that the "need" for hospitalization is not necessarily based only on a pathological condition of the individual but also on friction between the individual and his environment which may be "caused" as much by environmental factors as by illness of the individual:

> The traditional notion has been that a person comes to a [mental] hospital because he is sick, mentally ill . . . or, in another interpretation, he is involuntarily committed to a hospital because persons around him consider him psychotic, dangerous to himself or others, or in need of hospital care even though he does not acknowledge this himself.
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> Recently . .. it has been suggested . . . that patients are entering and leaving mental hospitals not on the basis of amount of psychopathology or change in mental illness alone, but rather in response to the ebb and and flow of acceptance and toleration in their own family and community, the availability of a particular role in the family and the nature of their social group or class.

Mahren, *The Psychodynamics of Psychiatric Hospitalization,* 135 J. OF NERVOUS AND MENTAL DISEASES, 354 (1962). See also Breggin, *Book Review,* 141 J. OF NERVOUS AND MENTAL DISEASES, 388 (1965). Those behavior characteristics that in practice lead to hospitalization may have only an indirect causal relationship to the mental illness. Mechanic, *Therapeutic Intervention: Issues in the Care of the Mentally Ill,* 37 AM. J. OF ORTHOPSYCHIATRY 703, 706 (1967) points out:

> [Much] of the disability suffered by [mental] patients is not necessarily the result of the natural history of illness itself, but it is often a consequence of the manner in which the patient has been dealt with by associates, treatment personnel and the community. . . . [T]he factors producing psychiatric disorders may be very different from those which lead to social intervention and care.

One commentator has gone so far as to deny the existence of "mental illness" as a medical fact. What is regarded as "mental illness," he argues, is actually no more than behavior deviation from a norm which must be defined in ethical rather than medical terms. SZAZ, LAW, LIBERTY AND PSYCHIATRY, 14-15 (1963). But compare Ausubel, *Personality Disorder Is Disease,* MENTAL ILLNESS AND SOCIAL PROCESSES (Scheff ed. 1967).

Contemporary sociologists tend to avoid the problem. They acknowledge (or at least do not challenge) that a legitimate "medical" concept of mental illness based on a theory of pathology (i.e., the unconscious response of the personality to anxiety and tension) exists and that medical personnel attempt to differentiate the "mentally ill" from the rest of the population on the basis of symptoms which they reasonably theorize arise from this pathological condition. But, the sociologists argue, as a practical matter it is a different definition of "mental illness"—that applied by the individual's family, his associates and he himself—which determines for most purposes whether he is treated as being "mentally ill." This non-medical definition is based primarily on the appropriateness of the person's behavior—whether he responds to situations and other persons in a manner which the family, the associates or the person himself deem appropriate (or "right" or "convenient")—and there is no attempt made to causally relate the behavior to any pathological condition. In many cases where an individual has been "diagnosed" as "mentally ill" by his family or associates, he is rejected by them as "sick" and "in need of hospitalization." He can thus be turned away by mental health facilities only to face an outside world in which he no longer has any place. For obvious humanitarian reasons he is often absorbed into the hospital system with little regard for whether he meets the medical criteria. Where this absorption is accomplished by civil commitment, it is argued, both courts and medical personnel tend to ignore the failure of the patient to meet the medical criteria because of the absence of any other solution to his problem. But this means that full-time mental hospitals accommodate many that the community has

suggest that procedures and criteria developed under ideas of nearly seventy years ago should be periodically reexamined in light of subsequent developments. Moreover, the fact that the statutory scheme is, in practice, often not followed suggests that it no longer corresponds to the practical needs related to the problem of hospital treatment of the mentally ill. The need for a reexamination of the matter is also supported by the fact that a number of jurisdictions have recently reworked their own provisions dealing with the subject.[5]

While the treatment of mental illness is a medical problem properly entrusted in large part to those with expertise and training in the area, the decision to permit the medical treatment experts to invoke the coercive power of the law to compel their patients to undergo treatment involves the weighing of a prospective patient's medical "right to treatment"[6] against rights essentially legal in nature: his right to freedom of choice and to a procedure designed to accurately determine the factual justification for invoking legal coercion. A reexamination of the statu-

diagnosed as "mentally ill" but who do not meet *medical* criteria of "mentally ill." For these—often the aged, the indigent and others who for various reasons can collectively be described as the "unwanted"—the hospital serves little more than a custodial function. See generally Mechanic, *Some Factors in Identifying and Defining Mental Illness,* MENTAL ILLNESS AND SOCIAL PROCESSES (Scheff ed. 1967).

One result of this more sophisticated view of the dynamics of mental illness has been an emphasis on community education in an attempt to encourage the early identification of those who are "medically" mentally ill and to stimulate development of alternative methods of meeting the needs of the "unwanted" who do not meet medical definitions of mental illness. Another result—and one more important for our purposes—has been a shift in the emphasis in treatment provided for those already identified (often under non-medical criteria) as mentally ill. Clinical means of treatment have been supplemented by programs designed to assist a person diagnosed as mentally ill in adjusting to his environment. Out-patient clinics, night or day hospitals (in which the individual functions in the community for a portion of the day) and similar facilities are being used to provide what is closely akin to social casework assistance. See generally, e.g., Gorwitz, *Changing Patterns in Psychiatric Care in Maryland,* PSYCHIATRIC RESEARCH REPORTS OF THE AM. PSYCHIATRIC ASSN., PSYCHIATRIC EPIDIMOLOGY AND MENTAL HEALTH PLANNING (Monroe, Klee and Brody ed. 1967).

[5] New York (L. 1964, ch. 738); Illinois (L. 1963, p. 1645); District of Columbia Act of Sept. 15, 1964, Pub. L. 88-597, 78 Stat. 944 (Pub. L. 88-597, 78 Stat. 944, Sept. 15, 1964); Minnesota (L. 1967, ch. 638). See also Note, *The Need for Reform in the California Civil Commitment Procedure,* 19 STAN. L. REV. 992 (1967) discussing the far-reaching recommendations of the Subcommittee on Mental Health Services of the California State Legislature, and the report of the Legal Studies Unit of the Massachusetts Special Commission on Mental Health, Kenefick, et. al., *The Massachusetts Commitment and Hospitalization Laws for the Mentally Ill: Analysis and Proposals for Change,* 2 PORTIA L. J. 19 (1967). It is not likely that the statutory revisions have—or that they will—

No attempt will be made here to duplicate the survey of statutory provisions by the American Bar Foundation in, THE MENTALLY DISABLED AND THE LAW (*Lindeman and McIntyre* ed. 1961), which contains an exhaustive discussion of the Draft Act for the Hospitalization of the Mentally Ill and all state statutes. For another classical discussion, see Ross, *Commitment of the Mentally Ill: Problems of Law and Policy,* 57 MICH. L. REV. 945 (1959).

[6] Stating that a mentally ill person has a "right to treatment" in the absence of his recognition of the need for it assumes the legitimacy and desirability of the exercise of the state's parens patriae power. But this statement of the problem—and its implications—may be misleading; see text at page ...., *infra.*

tory provisions, then, is only in part a medical problem. The purpose of this article is to examine a number of problems related to the hospitalization of the mentally ill as to which no satisfactory solution can be achieved without a consolidation of legal and medical knowledge and values.

I. PRESENT WISCONSIN STATUTORY SCHEME[7]

The basic procedure contemplated by the present statutory provisions can be summarized briefly. A petition for a judicial inquiry into a prospective patient's mental condition is filed with the county court by three

[7] In the period immediately after statehood, the county judge had care and custody of all insane persons and was directed to "provide for their safekeeping and maintainance." WIS. STAT. §63 (1848). In 1858, the county judge was authorized (if "public safety" so required) on the petition of a local governmental unit to require the sheriff to confine any insane person in a "proper place" where he was to receive "such care, attention and treatment as the judge may deem proper and necessary." Wis. Laws 1858, ch. 71.

In anticipation of the opening of the first state mental hospital (the insane had previously been cared for in county almshouses or "poorhouses"; see note 34, *infra*) the following year, the legislature in 1859 provided for admission to the new facility upon the certification of a "respectable physician" that he had examined the prospective patient and found him insane. The right to habeas corpus was expressly preserved and in such proceedings the issue of sanity was to be determined by the court after a hearing. Wis. Laws 1859, ch. 218.

A provision apparently for voluntary admissions was enacted in 1860, authorizing such admissions upon the recommendation of two physicians. Wis. Laws 1860, ch. 263 sec. 12.

In 1871 a somewhat more complex procedure was prescribed. Upon receipt of information that there were "insane persons within the county needing care and treatment," the county judge was authorized to have the sheriff summon two physicians to examine the persons. Although this is not entirely clear, the statute apparently intended an independent evaluation by the court of the justification for commitment. Wis. Laws 1871, ch. 82. This ambiguity was cleared up in 1878 when the examining physicians were directed to "certify the results" of their examination to the judge, who "after such further inquiry as he shall deem just and necessary" was to determine the issue of sanity. Wis. Laws 1878, ch. 32.

This procedure was apparently an alternative to that contained in Wis. Laws 1872, ch. 176 which provided for admission on the written request of the patient's friends, relatives or guardian plus a certification by two physicians. No independent judicial action was required.

In 1897 the statutory provisions underwent a thorough revision; the result was essentially the scheme that exists today. Provisions for involuntary admission without judicial action were eliminated. After application to the court had been made, the prospective patient could demand a jury trial (but only if a reasonable doubt as to insanity existed). Before commitment, a finding by either the court or a jury that the individual was insane and "a fit subject to be sent to the hospital or asylum for the insane" was required. Specific provision was made for observational detention for the time necessary to "afford sufficient opportunity to determine the necessity of committing such person." Wis. Laws 1897, ch. 319.

Specific provision for "voluntary admission" was also made. Such an admission required a certificate to two physicians and was to be at the discretion of the hospital superintendent. Five days' notice was required before the patient had a legal right to leave the institution, Wis. Laws 1897, ch. 263 sec. 8.

An extensive revision of a "housekeeping nature" was made in 1947, but no fundamental changes in procedure or substance were made. Wis. Laws 1947, ch. 485. See generally Comments of Interim Committee, 1960 Wis. Ann. at 318.

Statutory provisions for hospitalization, then, became more precise as facilities for the mentally ill became available. Although the early provisions

persons, one of whom must bear a close relationship to the prospective patient.[8] The court then appoints two physicians, one a psychiatrist, to examine the patient.[9] The physicians conduct the examination, "satisfy themselves as to his mental condition and make a written report."[10] For purposes of the examination, the court may compel the subject to be present at a specified time and place.[11] A time is then set for a hearing and notice of this is served on the patient.[12] A judicial hearing is held; its significance is explained to the patient[13] and a guardian *ad litem* may be appointed for him.[14] If notice is given in advance, the patient may "examine" the physicians;[15] he may also demand a jury trial.[16] The court (or the jury, if one is demanded) determines whether the prospective patient "is mentally ill and should be sent to a hospital for the mentally ill."[17] If it is determined that he meets these two criteria, the court then formally commits[18] him to a state hospital or, if his illness is diagnosed as chronic, to a county hospital.[19]

The statutes also provide for a number of variations in this procedure, although the overall scheme clearly contemplates that the variations are to be used only in exceptional situations where a specific justification for abandoning the normal procedure exists.

A prospective patient who is "irresponsible and dangerous to himself or others" may be detained by a law enforcement officer for five days simply on the application of one physician and two other individuals; a judicial proceeding must be initiated as soon as possible.[20] Or, if "safety requires it," a court may order a prospective patient detained up to ten

required independent court action only if habeas corpus was brought, since 1897 the courts have had the responsibility of making an independent evaluation of the justification for hospitalization in all cases. The vague "fit subject" criteria has remained substantially unchanged since 1897.

[8] WIS. STAT. §51.01(1) (1965).

[9] WIS. STAT. §51.01(2) (1965).

[10] WIS. STAT. §51.01(2)(b) (1965). The form for the report, set out in the statute, is in summary terms. WIS. STAT. §51.01(4) (1965).

[11] WIS. STAT. §51.01(2)(a) (1965).

[12] WIS. STAT. §51.02(1)(a) (1965). The court has discretionary authority to have notice served on "such other persons as it deems advisable." It may also issue an attachment of the person to compel the patient's attendance at the hearing. WIS. STAT. §51.02(1)(a) (1965).

[13] WIS. STAT. §51.02(2) (1965).

[14] WIS. STAT. §51.02(4) (1965).

[15] WIS. STAT. §51.02(1) (1965).

[16] WIS. STAT. §51.03 (1965).

[17] WIS. STAT. §51.05(1) (1965).

[18] Mental health personnel argue that the term "commitment" should be abandoned in favor of a term with less of a criminal flavor, such as "involuntary hospitalization." The danger is that by giving the process a benign label, the fact that it represents a significant deprivation of liberty may be obscured. Here "commitment" will be used interchangeably with "involuntary hospitalization."

[19] WIS. STAT. §51.05(2) (1965). The same procedural sections are used for determination of mental infirmity (usually senility) and mental deficiency (but see alternative procedure, WIS. STAT. §51.065 (1965). This undoubtedly causes some confusion between "mental illness" and other afflictions for which institutionalization may be obtained.

[20] WIS. STAT. §51.04(1) (1965).

days pending a judicial hearing.[21] Both provisions are obviously designed to permit pre-hearing detention of an individual who is potentially dangerous to himself or others.

If no psychiatrist is available to assist in the medical examination, two "reputable" physicians may conduct the pre-hearing examination.[22]

After the report of the examiners has been received, but before the hearing, the court may order the patient detained in a "designated institution" for up to thirty days; upon application, this may be extended to ninety days.[23] When this is to be done is not made clear by the statute, but the overall scheme clearly implies that the provision is to be used only in unusual situations where the pre-hearing examination is inconclusive. Where the provision is invoked, there is no formal opportunity for the patient to protest his confinement before the end of the ninety-day period.

Notice of the hearing need not be given to the patient if "it appears to the satisfaction of the court that the notice would be injurious or without advantage to the patient by reason of his mental condition."[24] The patient himself need not be present at the hearing;[25] the criteria for excusing his presence is not spelled out, but it is reasonable to assume that his attendance may be excused if the court is convinced that his presence would be useless or injurious because of his mental condition.

Finally, if after the hearing the judge is still in doubt as to the patient's mental condition, he may, before deciding whether the patient should be committed, order him detained for up to ninety days for "medical observation."[26] During this time, treatment may be administered if the superintendent of the hospital believes it necessary.[27]

A patient may also be admitted to a mental hospital on a "voluntary" basis. A superintendent may, at his discretion, admit any person who requests admission and presents a certificate of one physician, based on personal examination, supporting the person's claim that he is suffering

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[21] WIS. STAT. §51.04(2) (1965). In addition, if a patient is "brought to or applies for admission to" a hospital without a commitment or a voluntary application or under a "void or irregular" commitment or application, he may be detained by the superintendent for no more than ten days for the purpose of procuring a valid commitment or application or "for observation." If the superintendent decides the patient needs hospitalization, he may himself begin involuntary commitment proceedings. Wis. Stat. §51.05(4) (1965). This broad authority would permit the development of a practice whereby ten day hospitalization could be routinely accomplished with no judicial intervention whatsoever; there is some indication that it has been so used.

[22] WIS. STAT. §51.01(2) (a) (1965).

[23] WIS. STAT. §51.04(3) (1965).

[24] WIS. STAT. §51.02(1)(a) (1965). The commitment is to show whether notice was in fact served and, if no such service was made, the reason for the failure to do so. Wis. Stat. §51.05(1) (1965).

[25] WIS. STAT. §51.02 (1965). If the patient is not present, however, the court must personally observe him.

[26] WIS. STAT. §51.02(5)(b) (1965).

[27] WIS. STAT. §51.04(5) (1965).

from mental illness.[28] The patient admitted under this provision is to be released five days after he gives notice of an intention to leave.[29] If, however, the superintendent believes the patient needs further hospitalization, he may detain him up to thirty-five days during which time involuntary commitment proceedings may be begun.[30]

Once hospitalized under an indeterminate commitment, a patient may secure release in only two ways. The superintendent of the hospital may grant him a "conditional release." During the year following such release the patient may be summarily returned if "it becomes unsafe or improper to allow him to remain at large."[31] (The superintendent of a *state* hospital may, with the approval of the Department of Public Welfare, also unconditionally release a patient.)[32] In the alternative, a patient (or a friend or relative) may petition the court for a re-examination.[33] The procedure followed is much like that of the original commitment: an examination by two physicians is conducted, notice is given, a hearing is held (and a jury is available). A judicial determination is then made of the propriety of further detention. A patient is entitled to one re-examination per year as of right but the court may in its discretion order one at any time.[34]

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[28] WIS. STAT. §51.10(1) (1965). Some screening is performed in the exercise of this authority. The superintendent of one state institution indicated that if the patient was an inebriate (special provisions for the admission of alcoholics appear in WIS. STAT. §51.09 (1965), if he was trying to avoid criminal liability or if he had been misled as to the consequences of admitting himself, the request for a voluntary admission would be refused. Only if a patient was "grossly incompetent" would he be refused admission on grounds of his incapacity to surrender his future liberty. At any stage of the involuntary proceeding, a prospective involuntary patient may become a voluntary patient by signing an application for voluntary admission *in the presence of the judge.* Wis. Stat. §51.10(4) (1965).

[29] WIS. STAT. §51.10(2) (1965).

[30] *Ibid.* There is some indication that the state institutions begin commitment proceedings to retain a voluntary patient who gives notice of his intention to leave only if the patient is considered "dangerous." There is no proof that this is uniformly observed, nor are there any safeguards against its misapplication in a specific case.

A patient may also be admitted as a transfer from a correctional institution; see appendix. This presents special problems beyond our concern here. See Comment, 50 MARQ. L. REV. 120 (1966).

[31] WIS. STAT. §51.13(1) (1965).

[32] WIS. STAT. §51.12(4) (1965).

[33] WIS. STAT. §51.11(1) (1965).

[34] It is undoubtedly true that in Wisconsin as elsewhere the elaborate safeguards surrounding involuntary hospitalization are partially traceable to the custodial nature and atrocious conditions of early institutional facilities for the mentally ill. In 1870, for example, although the State Hospital for the Insane had 300 patients, many of the mentally ill were still being "cared for" in county almshouses or poorhouses, along with the epileptics, blind, mentally deficient and other social misfits. The State Board of Charities and Reform made the following report concerning the Dane County Poor House:

> One insane woman was confined with a chain in the room with the female paupers. . . . Two insane men were confined in a building, erected for the purpose, adjoining the wood house, and a little distant from the main building. One of the men is demented, and remains in his cell all the time simply covered with a blanket. The other is badly

II. Present Practice In Hospitalization Proceedings

While the precise extent to which the statutory scheme is observed in practice is a matter of dispute, it is clear that in a significant number of cases the basic procedure is not followed.[35] In some situations the statutory "exceptions" have become the general practice; in others no statutory justification whatsoever for routine practices can be found.

Although the statutory scheme apparently contemplates that the county court will usually be the initial official agency coming into contact with a potential patient, this may be true in practice. In many cases, the behavioral symptoms are such that the police are the first official agency to come into contact with the prospective patient; this fact raises troublesome questions as to the willingness and ability of law enforcement agencies to rapidly identify the mentally ill and to present them to a proper facility for treatment.[36] In other cases, help may initially be

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deformed, his knees being drawn up to his chin and his limbs stiff in that position. He has no clothing other than a blanket thrown over him. 1870 Report of the State Board of Charities and Reform 61 (1870).

Where the facilities have been transformed from custodial to treatment institutions and physical conditions have been improved, however, the result of an unjustified commitment is less burdensome. The patient is unlikely to be retained for a long period if he does not in fact meet the criteria, and his confinement is not as unpleasant as it would have been in earlier years. Procedural safeguards developed when the above conditions were prevalent may, therefore, no longer be reasonable in light of the risks presently involved.

Yet despite the improvements, ex-patients regard their stay in the institutions with little favor. Miller, *et al., Aftermath—The Community Readjustment of Post-Hospital Mental Patients,* 40 Psychiatric Quarterly Supplement 244, 252 (1966) reported that when patients were interviewed eight years after their release from such institutions, nearly one-third indicated that hospitalization was either a harmful or a negative experience; only one-fourth regarded it as therapeutic or helpful. Despite modern facilities and treatment techniques, it seems clear that hospitalization in a mental facility is generally regarded as less beneficial and more uncomfortable than a stay in a facility for treatment of a physical illness.

[35] Accurate field data on commitment procedures is difficult to obtain. Extensive field research on commitment procedures in Wisconsin has been done by Thomas J. Sheff under a grant from the State Mental Health Advisory Committee, but his results and conclusions are not available in final form. But see Sheff, *The Societal Reaction to Deviance,* 11 Social Problems 401 (1964), based on research in an unidentified "midwestern state," concluding that prehospitalization screening by medical examiners and courts is "usually prefunctory." Janopaul, *Problems in Hospitalizing the Mentally Ill* (no. 31, American Bar Foundation Research Memorandum Series, 1962) describes the extensive field studies conducted in seven states by the American Bar foundation; no published final report of this project is available. Miller and Schwartz, *County Lunacy Commission Hearings: Some Observations of Commitments to a State Mental Hospital,* 14 Social Problems 26 (1967) critically discusses procedures observed in an unidentified state (probably California).

[36] A recent study reported that over 76 percent of a sample of Negro male patients in a Baltimore state hospital had arrived at the institution through the police and the city jail; the report indicated that the police agencies had failed to recognize pre-existing mental illness of these patients despite frequent earlier contacts with them. Brody, Derbyshire and Schliefer, *How the Young Adult Baltimore Negro Male Becomes a Maryland Mental Hospital Statistic,* in Psychiatric Research Reports of the Am. Psychiatric Asso., Psychiatric Epidemiology and Mental Health Planning (Monroe, Klee and Brody, ed., 1967). But the sword cuts two ways. While there is the danger that law enforcement agencies will not recognize an individual's need for mental treatment and thereby delay treatment, well-meaning police officers may also assist in

sought from nearby hospitals; in at least one county, current practice is to detain patients brought directly to the hospital for a significant time before any judicial action whatsoever is taken (or sought).[37]

In a number of counties, pre-hearing detention has become standard practice through the issuance of an order for detention whenever an application is filed. Often the patient is held in a local hospital, but in some cases a jail is used. In most cases, this pre-hearing detention is relatively short, often approximately a week or ten days.

The medical examination also differs from county to county. Especially in predominantly rural areas, physicians with formal psychiatric training are often not available, but in some cases even where trained psychiatrists are available they are not used. The reliability of an examination by one without formal training in the mental health field is, of course, open to severe question. The actual examination itself is sometimes brief and cursory; it may be conducted in the judge's chambers at the time of the hearing itself. (Where the patient is being detained in a hospital, the examination is likely to consist of a number of interviews conducted by a psychiatrist and in some cases also by a social worker or other hospital staff member.) But it seems clear that in a number of cases, the medical examination cannot be regarded as providing the court with a careful and reliable evaluation of the need for long-term hospitalization.

The procedure followed in the hearing itself is a little more consistent. Pre-hearing notice is sometimes routinely omitted or may consist of no more than service of a formal document, a process apt to mean little to a confused and disturbed individual. The hearing itself varies in degree of formality and location. In some counties it is held in the courtroom with the judge on the bench, while in others (especially where the patient has been detained prior to hearing), it is an informal consultation at the hospital, perhaps even in the patient's room. Often a procedure of intermediate formality—a hearing in chambers—is conducted. A guardian *ad litem* may be appointed only infrequently or if appointed, may make only a perfunctory appearance.

Seldom is any meaningful challenge made to the conclusions of the medical examiners. The physicians may not be present at the hearing—the judge may have only a report phrased in terms of conclusions. The

unnecessary hospitalization. See Yelk v. Seefeldt, 35 Wis.2d 271, 151 N.W.2d 4 (1967), where two police officers who had arrested a wife after responding to a domestic disturbance call signed applications for an inquiry at the urging of the husband and his pastor; only after several days of hospitalization was it determined that the wife was not in fact mentally ill.

[37] The simple matter of getting information as to the procedure for obtaining treatment for the mentally ill may be extremely difficult. See the experience of the American Bar Foundation researcher who was unable to obtain a coherent description of the available alternative procedures despite telephone calls to the police, a hospital emergency service and a hospital psychiatric receiving center. Janopaul, *Problems in Hospitalizing the Mentally Ill*, p. 8-9 (No. 31, AMERICAN BAR FOUNDATION RESEARCH MEMORANDUM SERIES, 1962).

patient almost never has contradictory medical testimony, and the guardian seldom provides vigorous cross examination of the court appointed examiners. In some cases, then, the hearing may become merely a rubber stamp of the medical examiners' conclusion and therefore be of little functional value.[38]

The absence of a meaningful pre-hearing medical evaluation of the need for long-term hospitalization may be partially offset by routine use of the observational commitment: a patient may be routinely sent to a mental hospital on a thirty-to-ninety day "observational commitment." Where this is done, the hospital's recommendation as to the need for further hospitalization, *i.e.*, an indeterminate commitment, may be followed without any formal opportunity for the patient to respond.

Once an indeterminate commitment has been made, a patient may be unaware of—or unable to effectively implement—his right to periodic redeterminations of the justification for his retention. If released conditionally, he may be returned to the hospital without effective opportunity to question the legitimacy of the action.

This is not the place to evaluate these questionable practices. To the extent that they occur, they may offend values to which legally-trained individuals are particularly sensitive. But they may also represent a necessary accommodation to local conditions and facilities. The fact that the practices find no justification in the present statutory provisions suggests that both the practices and the statutes should be carefully examined. A convenient way to lay the groundwork for such an examination is to investigate the alternatives to the existing statutory provisions.

III. Potential Changes in the Statutory Provisions

To the extent that present statutory provisions and actual practices do not correspond to modern medical knowledge or do not strike an acceptable balance between the right to individual freedom and the necessity of providing proper treatment, a change in either the statutes or the practice—or perhaps both—is indicated.

Some potential changes can be given only passing mention here. Thus, the recently enacted definition of "mental illness,"[39] which uses

[38] The statutory right to a jury determination is almost never exercised. There is, in fact, some indication that if a patient requests a jury proceeding, active steps are taken to prevent his following through. One judge suggested that when such a demand is made, an attorney is appointed and the attorney manages to "work things out" without a jury trial. This illusory right to invoke the protection of the jury has such strong emotional roots, however, that as a practical matter its elimination is an impossibility. For that reason, the issue will be given no more attention here.

[39] The new definition was enacted as part of the Interstate Compact on Mental Health. Wis. Laws 1965, ch. 611, sec. 1. This repealed the old definition, obviously antiquated, which equated mental illness with insanity, defined, in turn, as including "every idiot, non compos, lunatic and distracted person." Wis. Stat. §990.01(16) (1965). It substituted, for purposes of Chapter 51, the definition contained in the Interstate Compact:

> " 'Mental illness' means mental disease to such extent that a person so

only the conclusory term "mental disease" to describe the requisite mental condition but continues to attempt to define mental illness in terms of need for treatment, may be more confusing than helpful.[40] The presumption of incompetency raised by hospitalization[41] (whether voluntary or not) which continues through the period of conditional release has, the authorities agree, little basis in fact and often constitutes a serious inconvenience for patients and their families.[42]

There are a number of matters, however, which demand more extensive discussion.

True Voluntary Admission Procedure

Under the present provisions there is no way by which a patient may be received in a mental hospital on a truly voluntary basis, *i.e.*, where he may be assured of the legal right to leave when and if he desired to do so. There are a number of arguments in favor of the availability of such a procedure. The coercive aspects of admission to a mental hospital under the present provisions may deter some who would otherwise voluntarily seek institutional help—the availability of institutional care without the aura of legal coercion would encourage

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afflicted requires care and treatment for his own welfare, or the welfare of others, or of the community."
WIS. STAT. §51.001(1) (1967).

[40] Whether or not so intended, this definition tends to confuse the criteria for involuntary hospitalization. Under existing statutory criteria, an individual is subject to involuntary hospitalization if he is "mentally ill" *and* "a proper subject for custody and treatment." Yet under the newly-enacted definition of mental illness, he is not mentally ill unless he is so afflicted with "mental disease" that he "requires care and treatment for his own welfare, or the welfare of others, or of the community." There is significant doubt that a meaningful definition of "mental illness" can be drafted for statutory purposes. Compare Weihofen, *The Definition of Mental Illness*, 21 OHIO ST. L. J. 1 (1960) with Schwartz, *"Mental Disease": The Groundwork Legal Analysis and Legislative Action*, 111 U. PA. L. REV. 389 (1963). The same definitional problem creates difficulties in the formulation and administration of the defense of non-responsibility in the criminal arena. See, e.g., Livermore and Meehl, *The Virtues of M'Naghten*, 51 MINN. L. REV. 789, 825-29 (1967). But it is clear that whether a person is "mentally ill" is a far different question from whether the effects of his illness are such as to justify *requiring* him to undergo treatment and perhaps full-time hospitalization. Weihofen, *supra* at 2.

It may be that whether an individual is so afflicted with mental disease that he requires care and treatment is a different inquiry than whether he is a proper subject for *custody and* treatment. An individual could require treatment for his own welfare yet it might not be necessary that the treatment be administered while he remains in custody. But the existing statutory provisions are confusing and it would seem that if no meaningful medical definition of mental illness can be drafted, the definition is best left vague; eligibility for voluntary and compulsory forms of treatment should explicitly be set out in proximity to the statutory provisions dealing with the specific treatment facilities rather than in the definitional section.

[41] WIS. STAT. §51.005(2) (1965).

[42] E.g., Crawfis, *Discharge from State Hospital in Relation to Competency*, 113 AM. J. PSYCHIATRY 448 (1956); Mezer and Rheingold, *Mental Capacity and Incompetency: A Psycho-Legal Problem*, 118 AM. J. PSYCHIATRY 827 (1962). But see Ross, *supra* note 5 at 944 who characterizes the Wisconsin presumption (if modified so as not to apply to a patient on conditional release) as the "best answer."

these individuals to seek help at an early stage of their illness. Moreover, the present "voluntary" procedure as applied to some individuals is constitutionally suspect: if a patient is in fact incompetent, he may well lack the capacity to "contract away" his liberty by voluntarily admitting himself and thereby surrendering for up to thirty-five days the right to release.[43] If this is true, the only method by which institutional care

[43] In Ex Parte Romero, 51 N.M. 201, 181 P.2d 811 (1947) the petitioner had signed a written application for voluntary admission. The statute authorized the hospital to detain a voluntary patient not more than ten days after notice in writing of intent to leave was given. When the hospital refused to release him immediately after he gave oral notice of intent to leave, petitioner brought habeas corpus. The New Mexico Supreme Court held that the voluntary admission statute (and another statute permitting hospitals to detain persons for thirty days upon the certificate of one physician that immediate institutional care was required) violated the Fourteenth Amendment of the Federal Constitution and Art. 2, Section 18 of the New Mexico Constitution. Responding to the hospital's assertion that by applying for admission the petitioner had contracted to remain for ten days after written notice, the court declared:

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

51 N.M. at 204, 181 P.2d at 813. Section 71 of the New York Mental Hygiene Law, which provides for voluntary admissions pursuant to which a patient may be detained for ten days after giving notice of intent to leave (see text at note 45, *infra*) has come under attack by several lower New York courts. Section 71(5) specifically provides that "no requirement shall be made . . . as a condition to admission and retention . . . that any person applying for admission shall have the legal capacity to contract." In People *ex rel* Kaminstein v. Brooklyn State Hospital, 49 Misc.2d 57, 266 N.Y.S.2d 916, 922-23 (Supreme Court, 1966) the court commented:

> [Section 71] assumes that although a mentally ill patient may lack legal capacity to contract, he nevertheless has the legal capacity to agree to deprive himself, by agreement with the hospital authorities, of the rights which are accorded to "involuntary" patients.
>
> It is, of course, familiar law that mental incapacity . . . will avoid a contract for lack of consent. But in cases other than those involving contract, the act of one mentally ill may also be disaffirmed, i.e., an act of retirement from the public school system while mentally incompetent [citation omitted]; a wife's abandonment of the husband [citation omitted]; an attempted marriage by one mentally incapacitated [citation omitted].
>
> . . . [S]ince a person admitted and detained as mentally ill is unable to make sound judgments, the law should be especially solicitious for his welfare and not, as here, encourage its officials to induce or beguile such a patient, in the midst of his confusion and agony, to make judgments of doubtful integrity.
>
> . . . [The voluntary status] is directly contrary to the whole purpose and spirit of [the Mental Hygiene Law. It] . . . is of doubtful constitutionality. The requirement that hospital officials should encourage and induce patients to accept that unjust classification is most unworthy.

In re Buttonow, 52 Misc.2d 687, 276 N.Y.S.2d 771 (Supreme Court, 1966) set aside the conversion of a patient from involuntary status to voluntary status on the ground that Section 71 violated due process and equal protection. The court took notice of the statutory directive that capacity to contract not be required, but it observed that there is also a requirement that the patient be "suitable and willing." This implies, the court indicated, a requirement that the patient have at least "simple understanding." In addition, the court noted that although a voluntary patient has a theoretical right to release on ten days' notice of intent to leave, testimony established that if the medical staff did not regard him as ready for release, involuntary proceedings would be begun upon the receipt of such notice from the patient. This factor, coupled with the absence of any provision for judicial review of continued retention of the vol-

for such individuals can legitimately be provided is through the complex procedure of involuntary commitment.

In any case, the availability of a true voluntary procedure for admission would minimize the need for coercion either by encouraging a prospective patient to seek help before he becomes so ill that he no longer recognizes his need for treatment or by permitting his admission without the deprivation of liberty inherent in the present alternatives.

There is also evidence which indicates that within a mental hospital, those patients who are known to be voluntary admissions are regarded more favorably by the staff, other patients and family members. This may affect the patient's relationship with these individuals and ultimately his response to attempts to treat his illness.[44] Medical as well as legal considerations argue in favor of the use of voluntary procedures wherever possible.

A model for a true voluntary procedure is the New York statute which provides for both "voluntary admissions" (pursuant to which a patient may be detained for a limited period of time)[45] and "informal admissions" (under which a patient may leave the hospital at any time he desires).[46] The "informal admission," then, is essentially the same as the familiar mode of entry to non-mental hospitals.

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untary patient and the failure to provide for *compulsory* involvement by the Mental Health Information Service in the hospitalization and retention of voluntary patients led the court to conclude that the voluntary admission provision "in effect has established an underpriviledged class of patients [subject to disabilities similar to those of involuntary patients but] . . . without the protection of the law afforded to involuntary patients." 52 Misc.2d at ...., 276 N.Y.S.2d at 775. This, it was held, constituted a violation of the rights to due process and equal protection guaranteed by both the New York and the federal constitutions.

The decision in *Buttonow* (and the dicta in *Kaminstein*) rested on the factual conclusion that voluntary patients were as a practical matter subjected to a potentially more serious deprivation of liberty than a ten day waiting period for release and the legal conclusion that this demanded that they be accorded more protective aspects of the Mental Hygiene Law than are presently applied to them. In neither case did the court discuss whether enforcement by a hospital of the ten day waiting period against a person who was mentally ill at the time of his admission would, without more, constitute a deprivation of liberty without due process of law. It seems clear that a number (probably most or almost all) of voluntary patients do, at the time of admission, have sufficient mental capacity to intelligently consider whether to submit themselves to this procedure; but it is also likely that some do not possess capacity to contract or the mental capacity courts have traditionally required for an effective waiver of constitutionally guaranteed rights. The New York cases strongly suggest that detention pursuant to such an "agreement" would, where there is no assurance that the patient did in fact have the capacity to waive his rights, be subject to question. The potential success of such a challenge would be greatly reduced if the proof showed a regularized administrative practice of screening applicants for voluntary admissions and refusing to accept those where it appeared possible that because of family or other pressures and/or the applicant's mental condition, the patient's action did not meet the "legal" test for a waiver of constitutional rights.

[44] Dezin and Sptizer, *Patient Entry Patterns in Varied Psychiatric Settings*, 50 MENTAL HYGIENE 257, 261 (1966).

[45] N. Y. MENTAL HYGIENE LAW §71(1) (McKinney, 1965).

[46] N. Y. MENTAL HYGIENE LAW §71(2) (McKinney, 1965). See also ILL. REV. STAT. ch. 91½, §4-1.

To assure that patients in such categories are aware of their right to leave, some states require careful explanations to the patients of their status; New York requires that such explanations be made every 120 days.[47]

Merely inserting such a provision in the statutes will not, of course, limit the use of involuntary methods to those cases where coercion is absolutely necessary. Only the enthusiastic implementation of voluntary and informal admission procedures by those working with prospective patients (for example, county judges, family physicians and social workers) can make the statutory provisions into an effective means of minimizing the use of commitments.[48] But the objective of restricting involuntary commitment to those cases where its use is absolutely necessary can be recognized, and perhaps its achievement stimulated, by a provision similar to that adopted in New York: "It shall be the duty of all state and local officers having duties to perform relating to the mentally ill to encourage any such person suitable therefore and in need of hospitalization to apply for admission as provided in [the informal and voluntary admission] . . . section."[49]

Procedure for Involuntary Hospitalization

It is apparent from the brief discussion above that in a number of situations the statutory procedure for commitment is not being carefully followed. Where it is not, any reshaping of the statutory provisions

[47] N. Y. MENTAL HYGIENE LAW §71(4) (McKinney, 1965).

[48] Maximum use is not being made of the existing provisions for voluntary admissions, imperfect though they may be. The following table contains ratios calculated by placing the number of voluntary admissions over the number of indeterminate commitments; in 1960, for example, Mendota State Hospital had 2.5 voluntary admissions for every indeterminate commitment.

Table 1: Trends in Use of Voluntary Admissions in Wisconsin Mental Hospitals—1960-1965

	1960	1961	1962	1963	1964	1965
Mendota State Hospital	*2.5* / 1	*3.3* / 1	*3.6* / 1	*4.6* / 1	*3.8* / 1	*4.2* / 1
Winnebago State Hospital	*0.85* / 1	*0.90* / 1	*0.91* / 1	*0.96* / 1	*0.96* / 1	*1.05* / 1
Non-Milwaukee County Hospitals	*0.12* / 1	*0.15* / 1	*0.12* / 1	*0.38* / 1	*0.53* / 1	*1.10* / 1

Milwaukee County is not included because the number of indeterminate commitments is so small as to be negligible; see appendix.

In all three categories of institutions, the trend is towards increased use of the voluntary admission, but the progress is uneven. By 1965, Winnebago State Hospital lagged behind even the county institutions which have shown rapid progress since 1963; both, however, were far outdistanced by Mendota State Hospital. While it may be argued that the county hospitals have inadequate staffs to undertake the sometimes time-consuming task of encouraging voluntary admissions and that many of what now show up as commitments would, were such an admission available, be non-protesting admissions of elderly and senile patients, no reason for the difference between the two state facilities, other than a difference in effort and emphasis, appears.

[49] N. Y. MENTAL HYGIENE LAW §71(5) (1965).

should involve a factual investigation of the reasons for the noncompliance and the substitution of provisions that are realistic (in the sense that they provide for necessary accommodation to local situations that cannot be altered by legislative mandate), but yet provide an assurance that a procedure meeting minimum requirements of fairness will be followed.

Two potential changes can be discussed in detail, however, even with the meager quantitative information available at this point.

A. Pre-hearing Detention

Especially in rural counties with limited mental health facilities, the prevailing practice often is to have the sheriff take a prospective patient to the county hospital as soon as an application for a judicial inquiry into his mental condition has been filed. The patient is then detained there until a physician (often a local psychiatrist who spends one day per week at the hospital) conducts a thorough examination. At the time of the hearing, the patient will almost always have been detained for a week or more; so that even if it is determined at the hearing that commitment is not warranted, the patient will have already undergone a significant deprivation of liberty.

The formal statutory provisions invoked differ, but usually the ten-day detention on court order (to be used, according to the terms of the statute, if "safety requires it") is used.[50] In some cases, the "safety" requirement is completely ignored; in others, the concept of "dangerousness" required for detention is stretched and/or the family's assertion that the patient needs immediate detention is uncritically accepted by the county judge.

The practice is defended on several grounds. Many localities have such limited psychiatric facilities that any examination by a trained psychiatrist is allegedly impossible unless the patients are readily available at a central location during the limited time the psychiatrist is available. Even where this is not the case, however, it is argued that only during a period of relatively long term observaton can a reliable

[50] The provision in WIS. STAT. §51.04(3) can also be used for pre-hearing detention, although by its specific terms this provision is not legitimately available until after the examination by the court-appointed physicians. Some idea of the extent of pre-hearing detentions can be obtained by noting the number of "temporary detentions with court order" in the appendix.

Use of statutory provisions intended for occasional "emergency" detentions as a means of developing a general practice of pre-hearing detention is not unique to Wisconsin. See, e.g., Note, *Hospitalization of the Mentally Ill in Utah: A Practical and Legal Analysis*, 1966 UTAH L. REV. 223, 229-30 and Grace, *et. al., Screening the Mentally Ill Before Court Commitment*, 16 CALIFORNIA DEPARTMENT OF MENTAL HYGIENE, 1965. But consider for comparison the policy reflected in the TEXAS MENTAL HEALTH CODE, ART. 5547-47 (1958):

> Pending the hearing on the Petition for indefinite commitment the proposed patient may remain at liberty unless he is already a patient in a mental hospital or is placed under protective custody.

A similar provision relates to the procedure for short-term hospitalization. TEXAS MENTAL HEALTH CODE, ART. 5547-35 (1958).

diagnosis on which to base the commitment decision be made.[51] By a period of pre-hearing hospitalization, the medical staff can thoroughly observe the patient and make a meaningful diagnosis on which the court may confidently rely.

If these arguments are valid, there is obviously a conflict between two present statutory directives: no patient is to be deprived of his liberty before a judicial hearing unless there is a danger of physical violence, and the court is to have available at the time of the hearing a reliable medical evaluation of the prospective patient's condition. If this conflict does exist (as seems likely), a compromise might be made by providing that if those applying for a judicial inquiry make a "prima facie case" for a medical need for immediate hospitalization, the court, after making a finding that a reliable medical examination cannot be obtained without detention of the patient, might authorize a limited period of observational detention, to be followed by a judicial hearing on the need for further hospitalization.

It is also argued that the limited pre-hearing detention sometimes enables a mentally ill individual to be treated without further invoking coercion.[52] During the period of pre-hearing detention, the medical staff has an opportunity to persuade a patient to voluntarily admit himself. In some cases where full time hospitalization is not necessary, judicial proceedings are suspended on condition that the patient uses private or public out-patient facilities.

Before the need for pre-hearing detention is accepted, however, it might be wise to study in detail the practice which has developed in Madison. Under this procedure, which has been reported as successful in the majority of cases, a prospective patient is merely served with a notice to report to a local hospital at a given time for a mental examination; if he does not do so, he is taken into custody and an examination and judicial hearing are held almost immediately. In most cases, however, the prospective patient voluntarily presents himself for examination and later at the hearing for disposition of the application.

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[51] Several recent studies cast severe doubts on the reliability of single-interview psychological evaluations. Clinical concepts, taken for granted as being universally understood, are sometimes in fact unclear, and even if examiners agree on the significance of an observed fact, the difference in techniques among psychiatrists may result in different observations. Stoller and Geetsma, *The Consistence of Psychiatrists' Clinical Judgements,* 137 J. NERVOUS AND MENTAL DISEASES 58 (1963); Rosenweig *et al., A Study of the Mental Status Examination,* 177 AM. J. PSYCHIATRY 1102 (1961). But compare Jones and Kahn, *Dimensions and Consistency of Clinical Judgement,* 142 J. NERVOUS AND MENTAL DISEASES 19 (1966).

[52] This seems to have been the conclusion of the Subcommittee on Mental Health of the California State Legislature, which recommended the abandonment of the present involuntary hospitalization system and the substitution of "Emergency Service Units" in each community. These Units would have authority to detain *dangerous* persons up to—*but not exceeding*—seventeen days. This proposal is subject to serious criticism; see Note, *The Need for Reform in the California Civil Commitment Procedure,* 19 STAN. L. REV. 992, 1005-08 (1967).

While the success of the Madison program may be due to the availability of numerous psychiatrists at the University of Wisconsin or to the efforts of the full time social worker dealing with mental health problems, the practice deserves further consideration as an alternative to the practice of routine pre-hearing detention for diagnostic purposes.[53]

B. Initial Judicial Participation in Involuntary Hospitalization

Wisconsin's basic procedure for involuntary hospitalization is one of "admission by court order." Except in emergency situations, it is contemplated that no deprivation of liberty will take place before a judicial determination of the existence of a mental illness and the justification for requiring the patient to submit to full-time hospitalization. As was pointed out above, however, in practice effective judicial involvement often comes, if at all, only after a significant deprivation of liberty has already taken place.

It is arguable that full judicial participation prior to any deprivation of liberty is an unrealistic and undersirable goal.[54] The report of the medical examiners may be little more than an impressionistic conclusion drawn from a cursory interview with the patient; the patient himself generally lacks the knowledge and ability to effectively challenge the conclusion, and in many cases also lacks the initiative to do so. Where the hearing is really an *ex parte* application for hospitalization on the understanding that the hospital will make a thorough and reliable evaluation of the patient and determine for itself whether the patient does in fact need full time hospitalization, the hearing may perform no useful function.

In addition, it is argued, subjecting a mentally ill individual to the judicial hearing procedure may lessen his ability to benefit from subsequent treatment. Requiring—or permitting—a mentally ill individual to listen to detailed testimony regarding his ailment serves to emphasize to him that he is seriously ill. In response, the patient may overreact in either of two ways: he may reject the assertion that he is actually ill, and consequently also reject his need for treatment, thereby making any attempt to help him more difficult. On the other hand, he may become so depressed by the seriousness of his condition that he loses

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[53] Cf. the proposal in Comment, *Liberty and Required Mental Health Treatment*, 114 U. PA. L. REV. 1067, 1077 (1966) that "neighborhood service centers" (combination mental health clinics and social service agencies) be used for initial psychiatric interviews where immediate custody of the prospective patient is not necessary.

[54] There is, of course, a constitutional question as to whether hospitalization prior to a judicial hearing (where no "emergency" exists) violates due process. Compare State *ex rel* Fuller v. Millinax, 364 Mo. 858, 269 S.W.2d 72 (1954) with In the Matter of Coates, 9 N.Y.2d 242, 173 N.E.2d 797 (1961). The problem has been discussed adequately elsewhere. See, e.g., Kadish, *A Case Study in the Significance of Procedural Due Process—Institutionalization of the Mentally Ill*, 9 WESTERN POLITICAL QUARTERLY 93 (1956); 75 HARV. L. REV. 847 (1962); Lindman and McIntyre, *supra* note 5 at 34; Ross, *supra* note 5 at 976-978.

confidence in his ability to recover and may, for that reason, reject attempts to treat him.

As a result, critics of routine early judicial participation assert that a judicial proceeding can serve a useful purpose only where the patient may reasonably be expected to raise some issue regarding the propriety of his detention. To require such a proceeding in *all* cases, including those where no reasonable expectation of any such objection exists, severely hampers attempts to treat the mentally ill with no compensating advantage.

Other medical authorities argue, however, that in very few cases does attendance at such a hearing cause severe discomfort or lasting adverse effects on a patient. To the contrary, some argue that requiring a patient to go through a well-defined procedure before he is deprived of his liberty may be advantageous from a therapeutic point of view. If a patient believes he has been arbitrarily deprived of his liberty or that he has been confined with no opportunity to protest this loss of freedom, he may react with fear or resentment. This reaction may color his attitude towards his "captors" and make him less responsive to attempts to treat him. Even patients who have apparently lost contact with reality are sometimes found to have been more aware of their situation than was at first supposed. In any case, these authorities conclude, the risk of any significant damage by a relatively informal judicial hearing is small and the potential benefits—from the medical as well as the legal point of view—are sufficient to justify routine initial judicial participation.

There are a number of jurisdictions which have minimized early judicial involvement in the procedure. Some proposals, such as the procedure traditionally urged by the medical profession, would permit hospitalization upon the certification of two physicians that the prospective patient is mentally ill and meets the criteria for involuntary hospitalization.[55] This would limit judicial participation to those cases where the patient actively demanded it as by bringing a petition for a writ of habeas corpus. Given the prevailing attitudes on the part of the Wisconsin public and judiciary (as well as large portions of the medical community), such a procedure has no realistic chance of adoption. But in view of the acceptance of the informal practices which have developed in many counties, a procedure similar to the "admission by certification" provided for in Article VII of the Illinois Mental Health Code is worthy of consideration. In many cases, it would merely legitimize what is already standard practice.

[55] E.g., Committee on Psychiatry and the Law, Group for the Advancement of Psychiatry Laws Governing Hospitalization of the Mentally Ill 153 (1966). It is true, however, that many psychiatrists are sincerely concerned with the danger of improper use of coercion and are willing to work within a fairly structured system to minimize the risk of abuse of the power.

Under the Illinois provision, a patient may be admitted to a mental hospital (under coercion, if necessary) on the certification of two physicians that he is mentally ill and meets the criteria for involuntary hospitalization.[56] Within twenty-four hours, the patient is to be given written notice setting forth his rights in clear and simple language.[57] "As soon as practicable," but never more than five days after admission, the patient is to be seen by a magistrate who conducts informal "consultations" at the hospital itself.[58] The magistrate's duties at this consultation are carefully spelled out: he is to identify himself, explain the patient's rights to him (including his right to a full judicial hearing at any time), "ask the patient to make a statement regarding the reasons for his presence in the hospital" and specifically ask the patient if he desires a hearing concerning his further detention.[59] If the patient indicates "in any manner" that he desires a hearing—or if the magistrate himself finds reason to doubt the propriety of the patient's detention—a hearing must be held within five days.[60]

The patient may be detained for only sixty days under this procedure; at any time he may request and obtain within five days a full judicial hearing.[61] At the end of the sixty-day period, the patient (if he has not admitted himself to the facility on a voluntary basis) must be released or a regular involuntary commitment proceeding must be begun.[62]

The procedure is obviously a compromise. It recognizes that in many cases a full hearing accomplishes little and may cause significant harm. But it also attempts to stimulate any latent objection a patient might have to his hospitalization and encourages him to raise it. If such an objection is raised, the patient is accorded the full procedural benefits of a judicial hearing. The ultimate objective is to restrict formal judicial participation during the first sixty days of hospitalization to those cases where a judicial proceeding may be expected to serve some functional purpose.

In some Wisconsin counties, the normal procedure is similar to that contemplated by the Illinois statute: hospitalization is routinely ordered upon application; the "hearing" is an informal meeting at the hospital (sometimes in the patient's room) where the judge does little more than informally converse with the patient. If this procedure represents the best possible accommodation to local conditions, it would seem wise to legitimize it by adoption of a provision similar to that in the Illinois statute. This would also have the advantage of formalizing

[56] ILL. REV. STAT. ch. 91½, §7-1 (1965).
[57] ILL. REV. STAT. ch. 91½, §7-2 (1965).
[58] *Ibid.*
[59] *Ibid.*
[60] *Ibid.*
[61] *Ibid.*
[62] *Ibid.*

the duties of the judge at the "consultation" and the patient's right to a more structured proceeding if he so desires.

A strong argument in favor of the use of such a procedure is that it may, in the long run, minimize the total coercion exerted over an individual. After a short period of hospitalization, a patient will often recognize his need for further treatment and, after discovering that hospitalization is not as unpleasant as he may have anticipated, will voluntarily admit himself or remain in the facility. Commitment is then, of course, unnecessary.

Encouraging voluntary admissions in this manner is largely a function that only hospital staffs can perform. The treatment of the patient during the initial "crisis period" of his illness often determines his subsequent willingness to undergo further treatment on a voluntary basis.[63] But by providing the medical personnel with an opportunity to demonstrate to the patient the effectiveness and reasonableness of treatment in a mental hospital, the statutes may make the performance of this function much easier.

It might be wise, however, to restrict the use of this procedure to those cases where the prospective patient has been under the care of a physician for a significant period. In such cases the physician, because of his contact with the situation, can reasonably be expected to recommend hospitalization only where he knows, on the basis of his extended observations, that the patient meets the statutory criteria. Perhaps in these cases (as contrasted with those where the physician's diagnosis is made on the basis of a single interview) the medical evaluation will, as a general rule, be sufficiently reliable to justify postponing judicial participation to the limited extent provided for in the Illinois-type procedure.[64]

Non-Protesting Admission Procedure

In response to assertions that the complex hearing procedures often serve no useful function, a number of states have adopted non-protesting admission procedures. These are designed to provide summary methods of admitting patients who cannot or will not admit themselves but who will make no objection to admission if someone else takes the initiative to secure their hospitalization.

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[63] Chafetz, *The Effect of a Psychiatric Emergency Service on Motivation for Psychiatric Treatment,* 140 J. NERVOUS AND MENTAL DISEASES 442 (1965).

[64] Pre-detention judicial involvement may also serve the valuable function of insulating from civil liability medical personnel and others involved in the detention of the allegedly mentally ill. In Yelk v. Seefeldt, 35 Wis.2d 271, 151 N.W.2d 4 (1967) a judgment for damages against two police officers who had signed an application for an inquiry had been obtained on a malicious prosecution theory. In reversing, the court held that there was insufficient evidence to support the jury finding of actual malice; it was noted explicitly that once the application was "executed," the responsibility for the procedure (and the detention) falls almost entirely on the court. See generally, Note, *Civil Liability of Persons Participating in the Detention of the Allegedly Mentally Ill,* 1966 WASH. U. L. Q. 193.

Under the Washington, D.C. provision, a prospective patient is merely presented at a hospital for admission; unless the need for hospitalization is apparent to the admitting physician (a member of the hospital staff), the patient must have a referral from a practicing physician.[65] The hospital physician examines the patient and if he determines that hospitalization is indicated asks the patient to sign a statement to the effect that he is being hospitalized and must be released upon request.[66] Under somewhat similar provisions in New York and Illinois, a patient may be admitted upon an application by a member of the family and the certificate of one physician "if such person does not object to hospitalization."[67] At the end of a short period, however, if the patient has not become a voluntary admission and involuntary admission proceedings have not been begun, the patient may no longer be retained in the hospital.[68]

It is clear that there is a difference in purpose between the provisions. The Washington, D.C. procedure is designed to permit long-term hospitalization of those lacking the capacity or incentive to admit themselves. The New York and Illinois provision, on the other hand, are designed as temporary measures to provide for a limited period of hospitalization during which the patient may be convinced to submit voluntarily to treatment or restored to a condition where he has the capacity to do so under the applicable procedures.

Non-protesting procedures may serve a valuable function in permitting the hospitalization of those patients (especially older and senile individuals) who are proper subjects for full-time hospital care but who lack the initiative or willingness to admit themselves. The danger, of course, is that such a person's will is particularly subject to family or other pressures and the patient's apparent acquiescence may be only a submission to informal but overwhelming pressure. In such a case, by-passing the procedural safeguards of a regular commitment creates a significant danger of unjustified hospitalization. This danger could be minimized, perhaps, by making non-protesting admissions also available only where the prospective patient has for a significant period of time been under the care of a physician who, on the basis of his extended contact with the situation, can certify that no undue pressure has been placed on the individual to submit to hospitalization.

Limited Period of Commitment

Under existing statutory provisions, a court which finds that an individual should and may be hospitalized has no formal choice but to order an indeterminate commitment. In practice this lack of a less

[65] D. C. CODE §21-513 (1966 Supp.).
[66] *Ibid.*
[67] N. Y. MENTAL HYGIENE LAW §73; ILLINOIS REV. STAT., ch. 91½, §6-1. These provisions are titled "Admission on certificate of one physician."
[68] *Ibid.*

drastic alternative is often compensated for by routine use (or abuse) of the "observational commitment."[69] It seems clear, however, that this provision was intended for use only in exceptional cases where after the hearing the court remained in doubt as to the need for hospitalization.

A routinely available short-term commitment has the important advantage of minimizing the need for indeterminate commitments. This is true for two reasons. In many cases, at the end of a short period of hospitalization a patient has received sufficient treatment so that he is ready for release from full-time hospitalization.[70] In other cases, by the end of such a period the patient has recognized his need for further treatment and will voluntarily submit to further hospitalization. In either case, indefinite commitment with its inherently more serious deprivation of liberty and danger (however slight) of retention beyond the time the patient needs full time hospitalization is rendered unnecessary.

Additional long-term advantages might be realized if short-term hospitalization under a limited commitment was provided in a local facility. As the county hospitals improve facilities and treatment resources, it may become feasible to provide substantially all short-term intensive treatment in these institutions. This would permit the patients to remain in the general community area and avoid extended separation from family and acquaintances. It would facilitate the increased use of part-time hospitalization and out-patient treatment as an alternative to full-time hospitalization earlier in the treatment program, and would also make easier family-oriented treatment programs during full-time hospitalization. If effected, this would reverse the situation developed

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[69] Perhaps the best developed system is that of Milwaukee County where a close working relationship has developed between the mental health facilities and the county court. Almost never is the indeterminate commitment used before a period of shorter detention; in fact, the indeterminate commitment is almost never used at all (see appendix). It is clear that the temporary detention is for the purpose of intensive short-term treatment rather than diagnosis.

[70] Short term intensive treatment must not be regarded as a "cure all." Given the limited state of scientific knowledge of mental illness, "cure" in this context is probably a meaningless term. JOINT COMMISSION ON MENTAL ILLNESS AND MENTAL HEALTH, ACTION FOR MENTAL HEALTH 54-55 (1961). The aim of treatment is perhaps best described as "to resettle the patient in a normal domestic setting and in work appropriate to his talents." Goldberg, *Rehabilitation of the Chronically Mentally Ill in England,* 2 SOCIAL PSYCHIATRY 1, 1-2 (1967). While this must be accomplished primarily by working with the patient in his domestic and employment environment, occasional short periods of hospitalization are often necessary to provide treatment and/or restraint during acute episodes. Just as release from full time hospitalization cannot be regarded as evidence that the patient is "cured," then, rehospitalization cannot be regarded as evidence that treatment has failed.

This can be illustrated by a statistical view of the Milwaukee system. The acute hospital (Milwaukee North) in 1965 admitted 1,996 new patients and had 1,603 former patients return. The median stay for patients in the acute facility was short; in 1964 it was only 0.5 months. This did not differ significantly between those patients released and those transferred (many to the chronic facility, Milwaukee South). It is clear that Milwaukee North serves as a short-term intensive treatment hospital where a patient is either released after short-term treatment or is transferred to a chronic facility. For many patients released, however, subsequent rehospitalization becomes necessary.

under the county-care system: the county institutions (which have traditionally provided primarily custodial care for chronic patients) would become oriented to providing intensive short-term treatment for acute patients; the state institutions (now the principle acute treatment facilities) would provide primarily custodial care or treatment for patients with chronic disorders where extended separation from the family and community is often unavoidable and more intensive treatment for those patients whose disorder requires separation from the family or community before clinical treatment is feasible.

An excellent example of a statutory provision authorizing short-term commitment is the Texas provision which requires that initial commitments be for a limited period not exceeding ninety days.[71] Only if temporary hospitalization does not produce adequate results may a petition for an indeterminate commitment be filed; if this second step is invoked, the statute provides for a specific procedure to determine the need for the indeterminate commitment.[72]

Any such provision should deal specifically with several matters. First, care should be taken to make clear that the purpose of the short period of hospitalization is not observation, but primarily short-term intensive treatment. Second, a procedure should be provided for the patient to effectively contest a subsequent imposition of an indefinite commitment. Too often, under present practice, the hospital recommends after an observational period that the patient be retained under an indefinite commitment and this is followed without any hearing or other formal opportunity for a patient to be heard on this additional and more serious deprivation of his liberty.[73]

Overall Procedural Scheme

In the process of providing for alternative means of admission, care must be taken in the combination of alternatives that are made available.

[71] TEX. REV. CIV. STAT. art. 5547-38 (1957).
[72] TEX. REV. CIV. STAT. art. 5547-40 to art. 5547-57 (1957).
[73] The new Minnesota procedure requires that the initial commitment be for a sixty-day period. It then provides:

> Within 60 days from the date of the commitment order the head of the hospital shall file a written statement with the court . . . and a copy thereof with the commissioner and the patient's attorney, setting forth findings as to the condition of the patient; a diagnosis of the patient; whether the patient is in need of further care and treatment; whether such care and treatments, if any, must be provided in a hospital and if so what type; whether the patient must be committed to a hospital; and whether the patient is dangerous to the public.

L. 1967, ch. 638, sec. 253.37 (23). If this statement describes the patient as in need of further institutional care and treatment, the court is directed to "consider" this finding and make a final disposition, which may be an indefinite commitment. Only if the statement also describes the patient as "mentally ill and dangerous to the public" does the statute provide for a hearing (upon the patient's request) prior to the final disposition. *Id.* at Sec. 253.37 (26). It is difficult to justify the failure to provide for equal hearing opportunity for those patients who are not dangerous to the public but are to be deprived of their liberty for an indeterminate period because they are in need of treatment.

First, if a true voluntary admission is provided (such as the New York "informal admission"), it is not clear whether the present provision which provides for a limited period of detention after notice of intent to leave is given should be retained or not. If the two are available as alternatives, the admitting hospital must determine at the time of admission whether there may be a subsequent need to retain the patient; if it determines that there is a sufficient probability that this may be necessary, the hospital would, of course, insist on the patient admitting himself under the provision now used. An overcautious admissions policy might severely impede attainment of the objectives of voluntary admissions. Yet it also seems clear that in some cases the hospital could not legitimately admit a patient knowing they have no legal right to detain him should he subsequently decide to leave. If a voluntary admissions procedure permitting limited detention is not available, the hospital would have no choice but to insist that the patient be subjected to commitment even though he is willing and capable of admitting himself on a voluntary basis.

Second, if an Illinois-type of certification provision is adopted, the present provision for admission by court order may be unnecessary or unwise. Illinois has retained the alternative of admission by court order; New York (with an analagous certification procedure) has not. If it is true, as the Madison experience suggests, that pre-hearing detention is not routinely medically "necessary," the best solution would seem to be to retain both procedures and require for use of the certification alternative that the physician attest to a medical need for *immediate* hospitalization.

The result (if the suggestions above are also implemented) would be that where no immediate danger of violence existed, a patient might be hospitalized without a full judicial hearing only if (1) a physician with extended contact with the situation certified that the patient met the criteria for involuntary hospitalization and that he had a medical need for immediate hospitalization, or (2) the family (or friends) established a prima facie case of such a medical need for immediate hospitalization *and* the court specifically found that a medical determination of this need could not be obtained without pre-hearing observational detention. A general policy of pre-hearing liberty should, however, be set out in the statutes.

Third, if an Illinois-type certification procedure is adopted, it is not clear whether non-protesting procedures need also be provided. The danger is that by making available the less formal non-protesting procedure, the safeguards of the other procedures will too often be bypassed. On balance, it seems that the certification procedure is sufficiently flexible that no serious inconvenience would be caused by requiring its use in the *initial* admission of all non-voluntary patients (unless

admission by court order is used). After the initial period of hospitalization, however, non-protesting procedures could legitimately be made available as a means of permitting the patient to remain in the hospital.

Finally, a careful choice should be made between making a limited period of hospitalization available as an alternative to indefinite commitment and making it a prerequisite to any indeterminate commitment as Texas has done. Under the Texas-type combination, there is greater assurance that the indeterminate commitment will not be used unless its necessity has been demonstrated, but it also seems to require an unnecessary series of procedural steps in those cases where the need for an extended period of hospitalization is obvious from the time of initial hospitalization.

The best solution would be to make both available but to require for an initial indeterminate commitment a medical determination based on extended observation that long-term treatment is necessary. In other words, an indefinite commitment where no short-term commitment had previously been imposed would be proper only where the patient had been under pre-hearing detention for some reason, e.g., emergency detention or diagnostic detention.

Criteria for Involuntary Hospitalization

Under the existing statutory provisions, an individual is subject to involuntary hospitalization if he is found to be "mentally ill" and "a proper subject for custody and treatment."[74] This criteria is obviously vague and gives no indication of what specific characteristics are to be taken as sufficient justification for requiring an individual to submit to treatment.

A number of states have after consideration retained equally vague criteria which do not reflect any policy decision as to the degree of illness or symptoms which are to be considered sufficient to justify depriving a mentally ill individual of his right to choose what, if any, treatment to take. New York, for example, requires for initial hospitalization only that an individual be mentally ill and "suitable for care and treatment"[75] and for continued retention only that the condition of the patient require his continued retention in a hospital.[76] While it is arguable that this reflects a legislative determination that any individual who is mentally ill and whom the medical authorities are willing to

[74] WIS. STAT. §51.02(5), 51.03 (1965). While there is some confusion as to the effect on this criteria of the new definition of "mental illness" (see note 39, *supra*), it is doubtful whether the definitional section affects the substance of the basic criteria set out in these sections.

[75] N. Y. MENTAL HYGIENE LAW §72.

[76] N. Y. MENTAL HYGIENE LAW §73. In a jury proceeding to review a court order authorizing continued retention, the only jury question is apparently whether the patient is mentally ill. N. Y. MENTAL HYGIENE LAW §74.

The New York provisions have been severely criticized by Chaikin, *Commitment by Fiat: New York's New Mental Law,* 1 COLUM. J. OF LAW AND SOCIAL PROBLEMS 113 (1965) as inadequately reflecting the legislative decision that need for custodial care is not sufficient justification for commitment.

accept as a patient may be compelled to submit to hospitalization, the statute does not reflect the express grant of authority which one would expect in such a drastic delegation of authority to the medical profession. It is more probable that the vagueness represents an abdication by the legislature of its responsibility of framing the criteria for the exercise of coercion over the mentally ill.

Washington, D. C. has gone to the opposite extreme by restricting involuntary hospitalization to those "likely to injure [themselves] . . . or others if allowed to remain at liberty."[77] While the apparent objective of this provision is to permit the use of coercion to administer treatment only where the lack of such treatment creates a relatively clear and immediate danger of physical violence, broad construction of the "danger" which will justify hospitalization may make this criteria less restrictive than it seems at first glance.[78]

Perhaps a more satisfactory test would emphasize the ability of the individual to make a rational decision as to his own need for treatment. Thus, the statute might permit involuntary hospitalization of those who are determined to be "mentally ill" and who, because of their mental illness, "pose an immediate threat to the safety of themselves or others, or who do not have the capacity to make a rational decision as to their need for hospitalization."[79] Such a test assumes, of course,

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[77] D. C. CODE §21-541(1) (1966 Supp.).

[78] See Cantor and Sherman, *Hospitalization of the Mentally Ill in the District of Columbia,* 15 AM. U. L. REV. 203 (1966). For support of such a criteria, see Comment, 107 U. PA. L. REV. 668, 683 (1959).

There are a number of practical problems in applying a "dangerousness" criteria. First, it is by no means clear what conduct is "dangerous." Will, for example, the traumatic effect on a family of the bizarre behavior of one of its members make the conduct "dangerous?" Second, it is not clear what certainty that the dangerous activity will be performed is necessary. Does "likely to" mean "may possibly" or does it imply a probability of 25, 50, 76 or 97 percent? It is unlikely that medical examiners would be willing to express their diagnosis in terms of percentage probability. See generally, Goldstein and Katz, *Dangerousness and Mental Illness, Some Observations on the Decision to Release Persons Acquitted by Reason of Insanity,* 70 YALE L. J. 224, 230-39 (1960).

[79] The Draft Act suggests, in addition to a "likely to injure himself or others" test, that a patient be subject to involuntary hospitalization if he is "in need of care or treatment in a mental hospital, and because of his illness, lacks sufficient insight or capacity to make responsible application therefore." See Lindman and McIntyre, *supra* note 5 at 20-21. This has been criticized as too broad on the assumption that it would permit involuntary hospitalization of even severe neurotics and psychoneurotics. Whitmore, *Comments on a Draft Act for the Hospitalization of the Mentally Ill,* 19 GEO. WASH. L. REV. 512 (1951). The most telling criticism, it seems, is the ambiguity of "insight or capacity to make responsible application for hospitalization." While it would seem to include those without the capacity to "contract away" their liberty, it also includes some—but how many is not clear—who have not become incompetent but who are considered incapable of making a decision as to their need for hospitalization.

A somewhat similar proposal was made in Note, 79 HARV. L. REV. 1288, 1295 (1966) which suggested authorizing commitment of "persons who, because of mental illness, would be likely to make decisions about their own interests which would result in substantial damage to their mental or physical well-

that a person could rationally decide to forego treatment despite the risk of deterioration of his mental illness and the possible development of tendencies towards violence directed at himself or others. We have in the field of physical illness recognized an individual's right to refuse treatment despite near certainty that such refusal will mean harm to the individual himself and those associated with him (as, for example, his family's loss of support).[80] There is no logical basis for differentiating those situations where the illness is mental, if the afflicted individual has not lost the capacity to weigh for himself the alternatives.

In evaluating the alternative criteria, two factors are of primary importance. The first is the philosophical justification being invoked for the exercise of force.[81] If the state's police power provides the authority, it necessarily follows that no individual may legitimately be hospitalized who does not present a significant threat to society or other individuals. It is arguable, however, that among the threats to society which may be considered is the loss of the patient himself and those things which he contributes to society. The decision to hospitalize, in any case, is a balance between the social interest in protecting society from the effects of this specific individual's illness and the individual's interest in being free from interference with his own decisions.

If, on the other hand, the justification asserted is the state's *parens patriae* power and responsibility to protect and make decisions for an individual who is considered unable to make decisions as his own best interests dictate, a different situation is presented. To society's interest in the balancing process must be added the individual's own interest in being treated if treatment would in fact be in his own best interest—in other words, there can be added a mentally ill person's "right to treatment" irrespective of whether he himself recognizes the need for that treatment. To the extent that the exercise of the *parens patriae* power is accepted as a legitimate and desirable function of government, a broadening of the criteria for the exercise of coercion can be justified.

The second important factor is the role which the facilities to which the patient is committed play in the overall treatment program for the

being." The ambiguities here are considerable: "Likely to," "substantial damage," "mental or physical well-being."

It seems that a person who is mentally ill could rationally decide to forego treatment despite substantial risk to his "well being" or that of others. No sufficient reason has yet been suggested why a patient with a mental illness should not be allowed the same prerogative as one with a physical illness—that of weighing the "cost" of treatment (in terms of loss of liberty, financial burden, and personal preference) against the risks of non-treatment. Perhaps under the two tests described above if a decision is a rational weighing of the alternatives, it is not "because of" mental illness. But this should be made clearer. The emphasis should be on the individual's mental process, not on the result he reaches through that process.

[80] Cf. *In re* Brooks' Estate, 32 Ill.2d 361, 205 N.E.2d 435 (1965). *But see* Application of President and Directors of Georgetown College, Inc., 331 F.2d 1000 (D.C. Cir.), *cert. denied*, 377 U.S. 978 (1964).

[81] See generally Ross, *supra* note 5 at 954-60; Note, 79 HARV. L. REV. 1288 (1966).

mentally ill when viewed in light of other treatment resources. It has been suggested that full-time hospitalization is now—or soon will be—obsolete as a means of treating mentally ill individuals who are not suicidal or homicidal.[82] If true, this suggests that involuntary commitment should be limited to those mentally ill persons who pose a physical danger to themselves or others, and that some other means should be found to stimulate other mentally ill persons to use other available facilities such as out-patient clinics and part-time hispitals. But, especially in view of the limited number of alternative resources available, the prevailing view is that full-time hospitalization is still a valuable stage in the treatment of many non-violent mentally ill persons.[83]

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[82] Recent refinements in the treatment of psychoses have given rise to serious question as to whether psychiatric hospitalization is truly necessary for an individual, no matter how ill he may be. Improvements in psychotherapy, new drugs, group and family therapy, day and night hospitals, halfway houses, and foster care represent some of the new therapeutic techniques utilized in attempts to avoid hospitalization of the severely ill patient.

These recently developed approaches to treatment arose out of two major trends of the past several decades: first, the more effective treatment of psychoses through psychotherapy and somatic therapies, and second, recognition of the tendency of traditional mental hospital settings to aggrevate and protract illness. Not only have all of these new modalities been useful in treatment of specific types of psychotic patients, but they have now been proposed as alternatives to hospitalization, in fact, as opening the way to elimination of the 24-hour hospital experience.

Mechanick and Nathan, *Is Psychiatric Hospitalization Obsolete?* 141 J. NERVOUS AND MENTAL DISEASES 378, (1965).

For an optimistic forecast arising out of a three year experimental program conducted in Jefferson County, Kentucky, see Pasamanick, Scarpitti and Dinitz, Schizophrenics in the Community 248 (1967): "The project demonstrated in a most conclusive way that home care under drug medication with systematic public health nursing care is quite feasible for . . . schizophrenic patients. Even the minimal type of home care provided proved in every respect at least as effective, and in most respects, clearly superior, to treatment in a hospital. . . . It is . . . a reasonable inference that other categories of the mentally ill may be successfully treated in this way." In selecting patients for the study, however, the authors carefully eliminated all suicidal or homicidal patients and restricted participation to those with a family (or an equivalent) willing to accept and supervise the patient in the home. Unfortunately, not all of the mentally ill are as fortunate as those who met the criteria for inclusion in the study.

At least where the only defined problem of a "mentally ill" person is not essentially pathological but rather one of symptomatic inability to cope with family or other environmental situations, isolated clinical treatment is quite clearly inappropriate. Thus a recent study of married patients in a state mental hospital concluded that their problems originated in "severe and longstanding marital conflict. Yet a stay in a state mental hospital without the use of family-oriented therapy would seem to execerbate the problem rather than improve the patient's mental health." Miller and Barnhouse, *Married Mental Patients in Crisis: A Research Report,* 124 AM. J. PSYCHIATRY 364, 369 (1967).

[83] "We now see [the full-time mental hospital] . . . in its true perspective as a hospital for selected patients, mostly with good prognosis, but needing a special treatment and conditions which cannot be provided by an outpatient service." Carse, Panton and Watt, *A District Mental Health Service: The Worthington Experiment,* 1 LANCET 39, (1958). Mechanick and Nathan conclude that full-time hospitalization remains a valuable stage in the treatment continuum for any persons whose behavior does not need control; hospitalization must, they caution, be viewed as a "therapeutic maneuver in the course of a treatment program rather than a final step." Mechanick and Nathan, *supra* note 82 at

In practice, commitment is more than a means of compelling an individual to submit to full-time hospitalization. Most patients spend only a short time in a full-time hospital.[84] But the possibility of return to the full-time facility often serves as a motivation for a partially-recovered person to make maximum use of other treatment resources. It is also true that the decision as to whether a patient must be retained in a full-time hospital for an extended period or whether he may be permitted relative freedom while he receives out-patient care is a decision in most cases best left to medical personnel. The crowded condition of many mental hospitals and the lack of adequate staffs suggests that medical authorities will not permit an individual to remain hospitalized beyond the point where they feel he can function adequately elsewhere and still receive adequate care. The ability of a hospital to release a patient as soon after commitment as the staff deems desirable provides sufficient flexibility to make involuntary commitments in reality commitments to a treatment continuum, only one part of which involves full-time hospitalization.

This argues in favor of broader criteria. Commitment may legitimately be used to require a patient to submit to a program of treatment which involves significantly less deprivation of liberty than would full-time hospitalization. The less the deprivaton of liberty involved, the less need be the social interest invoked to justify bringing legal coercion into play.

It would be possible to authorize the courts to order a patient to submit directly to treatment resources other than full-time hospitals without first being admitted to the full-time hospital.[85] If this is a

382. See also Haun, *Chronicity and the Mental Hospital,* 39 PSYCHIATRIC QUARTERLY SUPPLEMENT 18, 24 (1967), who agrees that as a general rule only if a patient fails to respond to short periods of hospitalization in a local facility should he be removed to a large mental hospital, but who also observes that in some situations "therapy can never proceed until community and even family ties are severed by full time hospitalization in a large institution removed from the patient's environment. . . ."

[84] The median length of stay of patients released from all county and state hospitals in 1964 was 1.3 months. Wisconsin Dept. of Public Welfare, *Trends in Length of Stay at Wisconsin State and County Mental Hospitals* 1960-64, 9 STATISTICAL BULLETIN MH—41, May 1966. (Comparable figures for patients dying in the instituitons were significantly higher. *Id.* at 10. Most deaths, however, occurred in county hospitals.) As might be anticipated, the length of stay varied with diagnosis. Patients diagnosed as "mental deficiency" averaged 8.0 months in 1964, followed by those with schizophrenic reactions, other psychotic disorders and diseases of the senium. Patients diagnosed as suffering from psychoneurotic reactions and personality disorders averaged only 0.5 months in 1964. *Id.,* Table 5 (all figures are medians).

[85] See generally Bleicher, *Compulsory Community Care for the Mentally Ill,* 16 CLEV. MARSH. L. REV. 93, 112-15 (1967) who proposes the establishment of a mental health treatment board with supervisory powers over local counselors. This board would advise a committing court as to the best program of treatment for a patient found to meet the criteria for involuntary treatment; this might involve initial full-time hospitalization of the patient or his placement in the custody of a counselor who would supervise his treatment in outpatient facilities.

The District of Columbia statute authorizes the committing court to "order

practical possibility, the criteria for commitment to full-time hospitalization could be made more restrictive while that for "supervised outpatient treatment" could legitimately be much broader. California has done this by authorizing the release of a prospective patient to the care of the counselor in mental health[86] if he does not meet the criteria for involuntary commitment but is found to be "mentally disoriented and bordering on mental illness but not dangerously ill."[87]

In practice, the same result is often accomplished informally in Wisconsin. A judicial inquiry is sometimes suspended on the condition that the patient receive treatment from designated public or private resources. In other cases, a commitment is made but the patient is retained for only a short period in the full-time facility and conditionally released subject to return should he fail to make use of designated treatment resources or respond satisfactorily to them. This system, of course, is subject to the criticisms made of many informal sub rosa procedures: the criteria on which the decision to require out-patient treatment is made is not open to evaluation or criticism, and there are no safeguards to assure that it is applied uniformly.

But formalizing the practice by permitting the court to order, as an alternative to full-time hospitalization, that the patient submit to other forms of therapy poses serious problems. In view of the limited value of presently-available pre-hearing diagnoses, it is probably not feasible for a court to obtain (without full-time hospitalization) sufficiently reliable information on which to base a choice among alternative treatment procedures. It would be more realistic to make such a disposition available as an alternative to further full-time hospitalization after a limited period of hospitalization pursuant to a short-term commitment. But there is still significant doubt that the decision as to when a patient can and should be treated other than in a full-time facility is properly a judicial one. Like the decision as to whether society is justified in requiring non-voluntary treatment, social as well as medical factors are involved; but in view of the predominance of medical factors in the decision as to the treatment program, deference to the expertise of hospital personnel seems advisable. Moreover, effective supervision of individuals under court order to make use of treatment facilities other than a full-time hospital would pose a difficult problem to a court which

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hospitalization . . . or order any other alternative course of treatment which the court believes will be in the best interests of the person or of the public." D.C. CODE §21-545(b). In Lake v. Cameron, 364 F.2d 657 (D.C. Cir., 1966), the court (sitting en banc) reversed a district court's denial of an application for a writ of habeas corpus by a patient in Saint Elizabeth's Hospital. Noting that the patient was dangerous only in the sense that she was apt to wander about the streets, the court remanded to the district court for an inquiry into "other alternative courses of treatment." Under the District of Columbia statute, it is clear, a patient may have a "right" to treatment in the community.

[86] See text at n. 107, *infra*.

[87] CAL. WEL. AND INST. CODE §5568.

did not have available personnel devoted to mental health matters. Full-time hospitals, while certainly not adequately equipped for such a task, are presently more likely to have available personnel professionally equipped to provide such supervision.

Thus, in the absence of a professional court-attached staff devoted to coordinating non-institutional treatment resources and over-seeing the use of such facilities by patients under court order, it seems wise not to expand the dispositional alternatives beyond commitment to a full-time hospital. Hospital authorities must, of course, retain sufficient flexibility to release each patient when he is deemed ready and when appropriate outside treatment resources are determined to be available. Authority to supervise the patient's activities for a period of time must also be retained. There is no apparent means of enforcement available other than return to full-time hospitalization. The use of the contempt power, backed by the ultimate sanctions of imprisonment or fine, is obviously inappropriate in view of the therapeutic objective. Nevertheless, it might be wise to provide a procedure whereby approval of the committing court could be obtained for post-release treatment programs. The fact that the "obligation" is one imposed by court order rather than by doctor's directions might, in some cases, effectively encourage compliance.

In any event, the possibility of reducing the number of mentally ill who are hospitalized around the clock by establishing a coordinated system of supervised out-patient facilities constitutes a strong argument in favor of court-attached social service agencies devoted to mental health matters.

Role of the Attorney in Hospitalization Procedures

The present statutory provisions are extremely vague as to the right of a prospective patient to the assistance of legal counsel. The only provision bearing on the question merely authorizes the court, at any point in the proceedings, to appoint a guardian *ad litem* "if it determines that the best interests of the patient require it."[88] In view of the current emphasis on the right to representation in the criminal and juvenile justice fields, the role of legal counsel in involuntary hospitalization proceedings seems a problem deserving serious consideration.

The constitutional right to representation, if it exists, is not well established. The United States Court of Appeals for the District of Columbia in 1957 established a requirement that in hearings before the Commission (which may or may not be followed by a judicial hearing under the procedure followed in the District of Columbia) a prospective patient have either a guardian or counsel appointed, even if he does not desire such assistance.[89] In view of the fact that a guardian need

[88] WIS. STAT. §51.02(4) (1965).
[89] Dooling v. Overholser, 243 F.2d 825 (D.C. Cir., 1957).

not be an attorney, however, the court expressly observed, "We have not decided . . . that an alleged insane person must be represented by an attorney at hearings before the Commission."[90]

One commentator has recently taken the position that there is a constitutional right to counsel in mental commitment proceedings and that this right includes access to assigned counsel.[91] This view is substantiated by a recent decision of the New York Court of Appeals holding that "an indigent mental patient, who is committed to an institution, is entitled, in a habeas corpus proceeding (brought to establish his sanity), to the assignment of counsel as a matter of constitutional right."[92] This, of course, implies a similar right in the original hospitalization proceeding. In view of the potentially serious deprivation of liberty involved and the importance of an accurate factual determination of the justification for this deprivation of freedom, it seems almost certain that the constitutional right to assistance of counsel does—or soon will—extend to involuntary hospitalization proceedings.

A number of statutory provisions have dealt with the problem. Washington, D.C. requires that "the allegedly mentally ill person shall be represented by counsel in any proceeding before the Commission or the court, and if he fails or refuses to obtain counsel the court shall appoint counsel to represent him."[93] Under the Illinois provision for hospitalization pursuant to court order, the court must ask at the hearing whether the prospective patient desires counsel and must then comply with any request for counsel.[94] But under the Illinois provision for short-term hospitalization without a judicial hearing, if the patient indicates a desire *for a hearing,* the court must arrange for appointment of counsel.[95] Under the Texas statute, in each case "the county judge . . . shall appoint an attorney *ad litem* to represent the proposed patient."[96]

Since in Wisconsin a guardian *ad litem* must, by statute, be an attorney,[97] the constitutional requirement would probably be met by a provision for the appointment of a guardian in every proceeding. But in the absence of a clear definition of the role of the guardian this would

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[90] *Id.* at 828 (supplemental opinion).
[91] Cohen, *The Function of the Attorney and the Commitment of the Mentally Ill,* 44 TEX. L. REV. 424, 438 (1966).
[92] People *ex rel* Rogers v. Stanley, 17 N.Y.2d 256, 217 N.E.2d 636 (1966). A strong dissent was registered by Judge Bergan who observed, "Thus, the adversary trial of medical issues implicit in the universal and compulsory assignment of counsel . . . seems at once unwise and injudicious." 17 N.Y.2d at 263, 217 N.E.2d at 638.
[93] D.C. CODE §21-543 (1966 Supp.).
[94] ILL. REV. STAT. ch. 91½, §8-22. Specific provision has been made for appointed counsel for an indigent patient. ILL. REV. STAT. ch. 91½, §8-22.1.
[95] ILL. REV. STAT. ch. 91½, §7-2.
[96] TEX. REV. CIV. STAT., ART. 5547-43 (1957). See also the new Minnesota provision. L. 1967, ch. 638, Sec. 253.37(15), requiring appointment of counsel at the time the medical examiners are designated.
[97] WIS. STAT. §256.48 (1965).

probably be no more than a pro forma compliance with the constitutional mandate.

In present practice, it seems clear that in almost all cases where a guardian is appointed he sees his role not as an advocate for the prospective patient but as a traditional guardian whose function is to evaluate for himself what is in the best interests of his client-ward and then proceed, almost independent of the will of the client-ward, to accomplish this. This attitude is encouraged by some county judges who see the introduction of an attorney (if he performs in any other way) into the proceeding as turning the informal hearing into an adversary trial, thereby destroying the valuable flexibility and damaging the patient by subjecting him to a traumatic "trial" experience.

In most cases, performance of the role of a traditional guardian is probably all that can realistically be expected of an attorney since in the majority of cases the patient does not wish to protest the hospitalization or, if he does, has no real basis on which to do so. The danger, of course, is that by making no real advocate available the occasional patient with a legitimate objection may find no one available to help him effectively assert it.

Perhaps the problem can be partially solved by inserting in the statutes a clear definition of the proper duties of a guardian *ad litem.* Compliance with the constitutional mandate requires that if the prospective patient wishes to actively contest his hospitalization (as by challenging the factual data on which the need for hospitalization is based), the guardian must perform essentially an adversary's role in presenting the patient's objection to the court. It seems equally clear that if the attorney feels strongly that it would be in the best interests of his client-ward to submit to hospitalization, he may indicate this to the client-ward and attempt to persuade him to admit himself to a hospital or not to oppose the proceeding. He must, however, be extremely careful not to take advantage of the coercive atmosphere of the usual pre-hearing situation and the confused condition of many prospective patients to subtly coerce the individual into acquiescense. The line between counseling and coercion can only be drawn by each attorney for himself in the specific situation; but he must be aware that the line needs to be drawn.

In the majority of cases, where the prospective patient does not desire to contest the proceeding or has no basis on which to do so, the attorney can perform a different role somewhat analagous to his function in "plea bargaining." He can investigate alternatives to full-time hospitalization and explore with the prospective patient the possible use of these facilities or the possibility of voluntary admission. At the hearing stage itself, he can see that all relevant facts are carefully presented to the court and require the medical examiners to elaborate sufficiently on their findings to assure that they have made a reliable diagnosis.

Spelling out the role of the guardian *ad litem* in this manner would encourage the observation of the spirit as well as the letter of the constitutional mandate and would help the legal profession to perform a constructive function in the numerous proceedings where their adversary talents are otherwise of little use.[98]

Periodic Review of Commitments

Under the present provisions, a patient once committed has no formal right to a review of the justification for his continued retention unless he (or someone in his behalf) takes affirmative action to secure a judicial re-examination. Once put into motion, the re-examination procedure is almost as detailed as the original commitment.[99] While there would be little reason to eliminate this provision, it might be wise to consider an additional requirement for a less complex re-evaluation to be made routinely, i.e., without an affirmative action on the part of the patient.

Such a requirement would have two primary advantages. First, some patients may be unaware of their right to judicial re-examinations. While there is now less danger of a patient under involuntary commitment languishing in a hospital simply because no one in a position of authority has re-examined his need for continued retention, even the remote possibility that such a condition might exist (most likely in some of the less well-staffed county facilities) constitutes a strong argument for such a requirement. Second, it is likely that some patients remain hospitalized not because of an "illness" in any medical sense, but because they lack the initiative to request release and arrange for a new life in the outside world. Routine re-examination of their status might stimulate them into taking the initiative necessary to make a successful transition from the institution to the community. Such re-examinations might also serve to emphasize to hospital staffs the number of patients whose medical condition does not require their continued hospitalization and per-

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[98] A related question concerns the services of an attorney for those *seeking* involuntary hospitalization of a relative or friend. No statutory provision specifically authorizes such participation by an attorney; WIS. STAT. §51.02(3) (1965) provides that the District Attorney is to assist in the proceedings if requested to do so by the judge. In many cases, the District Attorney does, upon the request of a family or the judge, perform the mechanics required to begin a judicial proceeding. At least one county court has adopted a strict requirement that any family (or individual) seeking involuntary hospitalization procure the services of a private attorney. The judge feels that only by having both sides represented by counsel can he maintain the detachment that he feels is essential to an impartial fact-finding process and also assure adequate presentation of all relevant facts. In those counties where a court-attached social service agency exists, this agency often assumes the burden of performing the mechanical tasks of bringing a judicial proceeding; this would undoubtedly be another advantage to more widespread use of such agencies. Compare the provision in the new Minnesota statute: "In all commitment . . . proceedings the county attorney shall appear and represent the petitioner." Minn. L. 1967, ch. 638, Sec. 253.37(15).

[99] WIS. STAT. §51.11 (1965).

haps stimulate them into a more active program of arranging for releases by finding the patient a place in the community.

A number of provisions have been adopted by other states to achieve these objectives. Some require only that each hospital examine each patient periodically to determine whether he should still be retained in the hospital.[100] Others require more; Illinois directs that after each such examination, written reports "setting forth the reasons supporting the need for further hospitalization of the patient" be filed and that notice of the decision to retain the patient (plus a reminder of the right to obtain a hearing on the need for continued retention) be given to the patient, his relatives, the person who applied for his commitment and any person designated by the patient to receive such reports.[101] New York hopes to achieve similar results by abolishing indefinite commitments and substituting limited terms (the initial period is sixty days; the second is six months; the next for up to one year; all subsequent periods may be for up to two years);[102] if the hospital determines that the patient needs further hospitalization notices similar to those required in Illinois are sent out. If no hearing is demanded by anyone concerned, the commiting court may order a further limited term of commitment without a hearing.[103] It is unlikely that where no hearing is held the court makes any real independent evaluation of the need for continued retention.

It is probably unrealistic to expect that any such procedure could result in independent re-evaluations by the courts of the need for continued retention. Even if the county courts had sufficient time (which seems doubtful), the reports could probably not be detailed enough to permit such re-evaluations. The objective of such a requirement should be not to secure outside review of a hospital's decision that patients need further hospitalization but rather the development of an internal procedure which assures that the hospitals routinely re-examine the status of each patient in light of any changes in his condition. If a provision for informal "consultations" with a magistrate at the hospital is adopted (the Illinois-type procedure), it might be feasible to require periodic "consultations." This would be the closest that it would seem possible to come to providing for a judicial supervision of the decision to retain committed patients.

Care must also be taken to emphasize that re-evaluations are certain not to produce a mass exodus from mental health facilities. It is distressingly clear that many patients presently under commitment do not "need" full time hospitalization in any medical sense. Inability or

[100] Lindman and McIntyre, *supra* note 5 at 150-51.
[101] ILL. REV. STAT., ch. 91½, §7-7.
[102] N. Y. MENTAL HYGIENE LAW §73(1), (3).
[103] N. Y. MENTAL HYGIENE LAW §73(1). The court must be "satisfied," however, that the patient requires retention.

unwillingness of families and communities to accommodate the inconvenience of caring for and providing treatment for a mentally ill person explains the continued presence of a significant number of mental patients in full-time facilities. No periodic re-evaluation of their status can enable hospital authorities to return them to the community. Only an increased awareness and understanding of the problems of mental illness on the part of communities and families can solve this problem.

Court-Attached Social Service Agency

Under existing practice, most Wisconsin county courts handle hospitalization matters without any special facilities to assist them in such matters. Applications for judicial inquiries are in many cases taken by individuals whose primary function relates to other aspects of the county court's jurisdiction: the register in probate, the court reporter or the district attorney. If an early attempt (before detention or hearing) is made to screen out those cases in which there is no merit to the application or where measures short of commitment might be adequate, this is usually done by the busy county judge or those who accept the application. In any case, this preliminary check is seldom performed by anyone with a professional background in the field of social work or mental health.

Several states have attempted to remedy this type of situation by providing for a trained staff to be attached to the judicial agency handling mental commitments. The most detailed statutory provision is that of California,[104] which authorizes each county to create a position for one or two "counselors in mental health," to be appointed by the judge and to hold office at his pleasure.[105]

As practice under this provision has developed in some areas, one applying for a judicial inquiry is first required to make a "pre-petition application" to the counselor, who then conducts his own investigation to determine whether there is sufficient cause for a medical examination and a full judicial inquiry. If he determines that there is, he contacts the prospective patient and gives him an opportunity to have a mental examination conducted on a voluntary basis by a psychiatrist of his own choice. In most cases, the prospective patient is not detained before the hearing but is merely issued an "order to appear."[106]

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[104] CAL. WEL. AND INST. CODE §5025-50. For descriptions of the implementation of these provisions, see Comment, *Commitment of the Mentally Ill—Superior Court of Los Angeles County*, 36 So. CAL. L. REV. 109 (1962) and Nix, *Recent Procedural Revisions in the Psychiatric Department, Superior Court of Los Angeles County*, 34 LOS ANGELES BAR BULLETIN 291 (1959). See also Blackley, *Judicial Intervention as a Psychiatric Therapy Tool*, 15 CLEV. MARSH. L. REV. 506 (1966) for a description of the Cuyhoga County (Ohio) Probate Court Psychiatric Unit developed pusuant to the general authority in OHIO STAT. §5522.13: "At the direction of the probate court, a pre-hearing . . . investigation may be made by . . . a competent social worker or other investigator appointed by the probate court."

[105] CAL. WEL. AND INST. CODE §5025.

[106] Comment, *supra* note 104, at 113-17.

Before the judicial hearing, the counselor makes an investigation of "the antecedents, character, family history, environment and superinducing cause of the mental disorder."[107] A report is made available to the court before or at the time of hearing.

If, at the hearing, the court determines that full-time hospitalization is not necessary but that the prospective patient is "mentally disoriented and bordering on mental illness but not dangerously ill," it may commit him to the custody of the counselor.[108] In such cases, the patient remains at home, usually receiving care on an out-patient basis, subject to return to the court (and full-time hospitalization) should the arrangement not work satisfactorily.

At least two Wisconsin counties have programs almost identical to those developed under the California statute, and both report extremely satisfying results from their experiments. It might be wise to recognize the potential value of such agencies by making express provision for them in the statutes; perhaps local communities could be assisted in establishing them by the provision of state financial assistance as is presently done for community mental health clinics.[109] In fact, the agency (especially in counties with relatively small populations) could be combined with some other facility such as a community mental health center or the county hospital.

While the precise function of such an agency would depend on the local needs and conditions as well as the inclinations of the county judge, the potential value of the agencies is evident from a list of the functions they might perform. First, by conducting a screening of all applications for judicial inquiries, the agency could weed out those with little or no merit and those where measures short of commitment would meet the need; this would also help disclose at the earliest possible point those few cases where the application is an attempt to "railroad" an individual into a mental hospital. Second, the agency could help minimize the use of pre-hearing detention by arranging for voluntary psychiatric examinations and voluntary attendance at the hearings.[110] Third, the agency could at all points of the proceeding encourage a prospective

[107] CAL. WEL. AND INST. CODE §5029.
[108] CAL. WEL. AND INST. CODE §5568.
[109] WIS. STAT. §51.36 (1965). The wisest course, it would seem, would be merely to authorize such agencies and offer financial assistance to those counties establishing them. In some areas, the small volume of cases would make the services of a full-time worker unnecessary; the community may also be so closely-knit that all relevant information is readily available to the judge through informal channels. But most important, the successful operation of such an agency depends on a close working relationship between the judge and the worker; any attempt to force such an agency upon an unsympathetic judge could not produce desirable results.
[110] Provision of such an agency would not automatically eliminate pre-hearing detention. Of the two Wisconsin counties already utilizing such agencies, one routinely uses pre-hearing detention while the other has effectively minimized its use. Available facilities, community attitude and the position taken by the county judge all exert influence on the extent of use of pre-hearing detention.

patient (if he, in fact, needs hospitalization) to admit himself as a voluntary patient, thereby minimizing the need for involuntary commitments. Fourth, the agency could prepare histories of the prospective patients for submission to the court to help it determine the justification for hospitalization; in light of the numerous non-medical factors that in practice affect the decision to hospitalize, such an investigation may prove as valuable as the medical examination. Fifth, the agency could carefully explain to prospective patients and those already hospitalized their legal status and their legal rights and disabilities. Such careful explanations by one trained in work with the mentally ill would probably be more effective in bringing about an awareness of the rights than an explanation by the court or the guardian *ad litem*. Finally, by working with the patient's family as well as with the patient himself, the agency would be able to assist the family to understand and accept the afflicted person's condition, thereby paving the way for the successful (and early) return of the patient to the family or community.[111] In some cases, it is reasonable to assume that hospitalization might be avoided altogether by making arrangements through the family for non-institutional care for the individual.[112]

IV. CONCLUSION

No attempt has been made here to evaluate the extent of non-compliance with the present statutory provisions. The objective has been to simply point out the areas in which such non-compliance does occur and various changes which might be made in response to this. Any reliable conclusions regarding the extent of the questionable practices described above will have to await a more intensive study.

The discussion here does, however, permit the formulation of the

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Information Service. The authorization, section 8 of the New York Mental Information Service. The authorization, section 88 of the New York Mental Hygiene Law, was enacted pursuant to the recommendation of the Special Committee of the New York City Bar, *Mental Illness and Due Process* 21-22 (1962). The Service, under the supervision of the presiding justices of the judicial departments, has the duties of reviewing the admission and retention of patients, informing them of their legal rights, assembling information for judicial consideration and counseling and advising patients. For a thorough description and evaluation of the Service after two years of operation, see Note, *The New York Mental Health Service: A New Approach to Hospitalization of the Mentally Ill,* 67 COL. L. REV. 672 (1967). Similar systems have been recommended for other states. See, e.g., Kenefick, *et. al., The Massachusetts Commitment and Hospitalization Laws for the Mentally Ill; An Analysis and Proposal for Change,* 2 PORTIA L. REV. 19, 27-29 (1967).

[112] The problem of readjusting a patient who has undergone full-time hospitalization to community life is recognized as a serious therapeutic problem. See Kasser and Cohen, *Follow-Up: Aftercare of Discharged Chronic Mental Patients,* 40 PSYCHIATRIC QUARTERLY 723 (1966); Hotchkiss and Prout, *Use of the Community in the Re-habilitation of Patients,* 39 PSYCHIATRIC QUARTERLY SUPPLEMENT 288 (1965). The coordination of community services might be of value to the ex-patient who has been described as an "endlessly complicated and frustrating problem." Coleman, *A Community Project in Behalf of the Hospitalized Mentally Ill Patient: The Cooperative Care Project,* 124 AM. J. PSYCHIATRY 76, 79 (1967).

basic features which, in light of present knowledge and attitudes, should be contained in realistic statutory provisions for the hospitalization of the mentally ill.

First, the provisions should recognize that voluntary rather than involuntary hospitalization should be used whenever possible; non-coercive admissions should be made attractive and readily available and those working with the mentally ill should encourage the use of these procedures wherever feasible.

Second, the legislature should assume its responsibility for establishing the criteria for involuntary hospitalization. Rather than the present ambiguous provision which permits—in fact, requires—local courts and physicians to read their own criteria into the statute, the statutory provision should expressly indicate the degree of need for treatment, dangerousness or irrationality that will justify the use of coercion to compel a mentally ill individual to undergo treatment.

Third, local conditions should be thoroughly examined to determine why the statutory scheme is not being routinely followed. Where the deviations represent necessary accommodations to local conditions, they should be "legitimized."[113] (For example, perhaps the routine use of pre-hearing detention for diagnostic purposes should be expressly authorized in some geographical areas.) But the statute should also indicate the most desirable procedure and contain sufficient flexibility to enable a given community to change to the preferred procedure when local conditions permit.

Fourth, the statutes should recognize that where a patient does not affirmatively raise any objection to his hospitalization, a full judicial proceeding will perform no valuable function and may be detrimental to the patient; but where the patient may have an objection, the opportunity to obtain a thorough judicial investigation of this complaint is an extremely valuable right. Somewhat summary procedures such as the Illinois provision should probably be made available, but emphasis should be placed on encouraging the patient to raise any objections he may have to his hospitalization. This requires making him effectively aware of his status and legal rights as well as making available an adequate opportunity to assert these rights.

Fifth, it should be recognized that in a large number of cases indefinite commitment is unnecessary. Provision should be made for

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[113] A principal benefit anticipated from the New York Mental Health Information Service was the development of a procedure for involuntary hospitalization which did not require judicial intervention prior to hospitalization but nevertheless realistically assured patients of their legal rights. *Mental Illness and Due Process* 21-22 (1962). It would not be unreasonable—and would perhaps be wise—to establish a certification procedure not involving early judicial participation (such as the Illinois procedure) only if a social service agency is made available to oversee its administration and to assure procedural regularity.

short-term intensive treatment on an involuntary basis without indeterminate commitment.[114]

Finally, it must be recognized that the implementation of an effective and fair statutory procedure is only partially a legal problem. It demands, in addition to well thought out and skillfully drafted statutes the full-time attention of a professional staff, trained in dealing with the mentally ill. Where feasible, a full-time social service agency devoted to the provision of public care and treatment of the mentally ill should be established.

No claim can be made that implementation of these objectives will "solve" the problems posed by the admission and retention of patients to mental health facilities. It will, however, provide a statutory framework for the development of a system in which an increasingly knowledgable medical profession in cooperation with a sympathetic and informed bar and community can provide help to the mentally ill without an unreasonable sacrifice of individual liberty.

APPENDIX

Admissions to Wisconsin Mental Hospitals: 1960-1965*

The following table is designed to compare the means by which patients were admitted to state and county mental institutions over a five-year period.

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[114] A principal problem in the formulation and enforcement of rules in the area of commitment is the ineffectiveness of supervision by appellate courts. Because of the non-adversary nature of the usual proceeding, appeals are seldom taken from actions of trial courts. This has been even more true in Wisconsin than in many other jurisdictions. But even where such matters have reached appellate courts, the nature of the underlying problem has encouraged the courts to hesitate to exercise their powers of reversal as a means of enforcing compliance with the statutory procedures. For a refreshingly frank recognition of this attitude see *In re* Leary's Appeal, 272 Minn. 34, 46, 136 N.W.2d 552, 560 (1965):

> [E]ven though there are many irregularities in this proceeding which we do not condone, the evidence does sustain the court's finding that appellant was mentally ill and that she was in need of hospital care and treatment. To hold otherwise may lead to appellant's being deprived of hospital care which she needs. We can hardly believe that all of these doctors were seeking the commitment of a person who was not mentally ill and in need of hospital treatment. We cannot see that any good would come from a reversal because of the technical errors that have been committed. . . . [T]he sole objective of a proceeding of this kind is to ascertain as best we can whether the person involved is so mentally ill as to need hospital care. If that fact is established, the decision should stand unless the patient has been deprived of a right to be adequately heard.

As a result, it is necessary to rely largely on voluntary compliance with proscribed procedures and substantive rules by trial courts and hospital personnel. This makes it of even more importance that the procedures and rules realistically reflect the problems of the work-a-day world.

* Source: Wisconsin Department of Public Welfare, Basis for Admission of Patients Admitted to Wisconsin State and County Mental Institutions for the years covered. All figures are for years ending June 30th of the year indicated.

Type of admission	*1960*	*1961*	*1962*	*1963*	*1964*	*1965*
1) temporary detention without court order						
MSH	3	.	3	10	5	5
WSH	.	.	10	9	21	20
County hospitals						
Milwaukee	325	370	311	298	488	483
all others	56	42	34	49	86	137
2) temporary detention with court order						
MSH	317	325	355	314	275	167
WSH	76	100	73	111	114	104
County hospitals						
Milwaukee	1,167	1,227	1,234	1,364	1,365	1,318
all others	378	439	418	409	353	388
3) voluntary admissions						
MSH	529	592	632	646	621	644
WSH	379	384	353	372	372	397
County hospitals						
Milwaukee	789	769	949	1,088	1,220	1,278
all others	53	61	91	155	208	352
4) temporary observational commitments (with court order)						
MSH	160	147	138	141	137	112
WSH	100	109	97	96	94	97
County hospitals						
Milwaukee	460	552	534	442	405	465
all others	37	50	33	88	92	71
5) indeterminate commitments						
MSH	228	182	173	139	163	152
WSH	466	423	386	389	386	376
County hospitals						
Milwaukee	5	.	.	1	1	1
all others	436	418	427	416	392	329
6) transfers from—						
(a) juvenile correctional institutions to						
MSH	12	28	16	21	14	12
WSH	..	1	..	2	2	2
County hospitals	..	..	..	..	..	..

7) (b) adult correctional institutions to						
MSH	..	..	1	..	..	1
WSH	5	13	6	4	6	13
County hospitals						
Milwaukee	..	..	..	6	42	6
all others	..	..	..	..	..	..