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NOTES AND COMMENTS

NOTE: MENTAL HYGIENE LAW—AN ANALYSIS OF NON-COMPULSORY ADMISSION PROCEDURE

Mental illness is a serious medical problem despite the attitude of those states which treat it as a crime.¹ When mental illness results in either an inability of the individual to care for his needs or in antisocial conduct directed at others, the problem takes on social and legal significance;² but it does not lose its character as being essentially a medical problem.³ The function of mental health laws is, therefore, to protect society's interests while the patient is being cured.

The mental health problem is significant

¹ *Barry v. Hall*, 98 F.2d 222, 225 (D.C. Cir. 1938).

² *Ross, Commitment Of the Mentally Ill: Problems of Law and Policy*, 57 MICH. L. REV. 945, 954 (1959).

³ *OVERHOLSER, THE PSYCHIATRIST AND THE LAW* 102 (1953).

because it affects so many people. In 1959, it was estimated that eight million Americans were suffering from mental illness,⁴ and that half of the hospital beds in the United States were occupied by mental patients.⁵ Because of these figures and because of the recent advances in the medical approach to mental hygiene, such as the introduction of tranquilizers in 1955,⁶ and the current emphasis on patient cooperation,⁷ it would appear that a re-evaluation of our mental health laws is appropriate. In

⁴ *Melaney, Commitment of the Mentally Ill*, 12 U. PITT. L. REV. 52, 71 (1960).

⁵ *Ibid.*; *Willcox & Roemer, Hospitalization Under the British Mental Health Act, 1959*, 9 AM. J. COMP. L. 606 (1960); NATIONAL COMMITTEE AGAINST MENTAL ILLNESS, WHAT ARE THE FACTS ABOUT MENTAL ILLNESS 2 (1959).

⁶ SPECIAL COMMITTEE TO STUDY COMMITMENT PROCEDURES OF THE ASSOCIATION OF THE BAR OF THE CITY OF NEW YORK, MENTAL ILLNESS AND DUE PROCESS I (1962) [hereinafter cited as N.Y.C.B.A., MENTAL ILLNESS AND DUE PROCESS].

⁷ *Id.* at 56.

1960, a Special Committee of the New York City Bar Association [hereinafter referred to as the New York Committee], undertook such a re-evaluation of the New York Mental Hygiene Law. It issued thirty-four recommendations as a result of its two year study.⁸ It is the purpose of this note to evaluate these recommendations, not only in terms of the New York law with which the Committee was concerned, but also of mental health laws in general. The object of this evaluation is to determine whether there are workable solutions to the mental health problem. Though the New York Committee's recommendations dealt with the non-compulsory, compulsory and criminal admissions of patients into mental hospitals, this discussion will be limited to the *non-compulsory admissions*.

Before discussing those laws which are applicable to non-compulsory admission, it is necessary to set forth the objectives of those laws. The goal of mental hygiene laws is twofold: first, to treat the disease medically in order to effect a cure; and second, to view the disease *as a disease* rather than a crime, in order to remove the social stigma which attaches to mental illness.⁹ While it is unquestionable that considerations such as public safety and due process must be manifested in such laws,

⁸ The Committee, composed of judges, doctors, and lawyers working in cooperation with the New York State Department of Mental Hygiene, completed its study in January 1962 but incorporated judicial and legislative developments until May 31, 1962 into its report. N.Y.C.B.A., *op. cit. supra* note 6, at V-IX.

⁹ See Hoch, *Commitment of Senile Aged to Mental Hospitals*, 139 N.Y.L.J. 4 (1958). Doctor Hoch, Commissioner of Mental Hygiene of the State of New York, said that "the stigma of the mental hospital will never be removed, however, if admission procedures continue to suggest criminal procedures."

they should not be permitted to overshadow the primary goal, that is, to treat the problem as being basically medical. In spite of the nature of the problem, one statute provides that an alleged incompetent should be arrested and given an immediate hearing on the question of his competency. Pursuant to this statute a sheriff arrested an alleged incompetent and placed him in a jail, prior to a hearing scheduled for the following morning. By such compliance with the statute, his legal right to personal freedom was preserved, but the prisoner hanged himself during the night.¹⁰ The statute was inadequate, not on legal considerations, but because it attempted to treat what is essentially a disease as a crime rather than *as a disease*.¹¹

Non-compulsory admissions fall into two basic categories: voluntary and informal. The procedures for voluntary admission are controlled by statute. In general, these statutes establish requirements for the patient's consent to a minimum period of confinement in the hospital,¹² prescribe procedures for admission¹³ and create standards for the patient's release.¹⁴ The

¹⁰ Ross, *supra* note 2, at 959.

¹¹ "The defects in the ordinary forms of judicial procedure when applied to the determination of mental illness are more widely recognized." Ross, *supra* note 2, at 966.

¹² See, e.g., N.Y. MENTAL HYGIENE LAW § 71 (fifteen days).

¹³ ALA. CODE tit. 43, § 207 (1915) (requiring certification of commitment by a probate judge); ALASKA COMP. LAWS. ANN. § 41-4-20C (Supp. 1958) (requiring application accompanied by physician's certificate); ARIZ. REV. STAT. ANN. § 36-502 (Supp. 1963) (requiring written petition).

¹⁴ See, e.g., CONN. GEN. STAT. ANN. § 17-187 (1960) (requiring written notice and ten day maximum detention after receipt of notice); FLA.

informal admission, on the other hand, is non-statutory. It is simply an open ward policy, allowing for the free admittance of patients who seek treatment and the immediate release of those who wish to leave.¹⁵

A voluntary admission is essentially a contract between the patient and the hospital (or the patient and the state) whereby the patient agrees to accept treatment.¹⁶ A problem arises in those states which require a minimum period of detention in the hospital after a request to leave has been made by the patient.¹⁷ In this connection it must be recognized that, though detention in a mental institution is curative rather than penal, it is no less an effective restraint on personal liberty than a criminal imprisonment.¹⁸ Thus, while the primary goal of cure is important, the requirements of due process should not be forgotten. In *Ex parte Romero*,¹⁹ the Supreme Court of New Mexico held that a voluntary admission statute, allowing the hospital to detain the patient ten days after the receipt of a request to leave, contravened the due process clause of the fourteenth amendment.²⁰ The rationale of this decision was that if the patient

were so ill as to require treatment in a mental institution, his "contract" with the hospital would be unenforceable. On the other hand, if the patient were not so ill as to disqualify his contract, there would appear to be no reason for compelling him to remain in the institution.

The New York statute provides for both a "minimum stay" before a request will be received and a ten day detention after its receipt.²¹ The most important New York authority which has considered the constitutionality of its statute is an Opinion of the Attorney General which advises that a patient's rights are not invaded by compliance with the statute. However, the opinion did concede that the detention period was based on a contractual relationship.²²

This apparent conflict between New Mexico and New York is resolved to some extent by the fact that although the court in *Romero* declared a ten day statutory detention period to be unconstitutional it also indicated that a reasonable detention period would be acceptable. The court defined reasonable detention as the holding of a person temporarily until legal proceedings could be commenced to determine whether the patient is dangerous to himself or to others.²³ The *Romero* approach seems to have been adopted in many other jurisdictions whose more recent statutes provide for

STAT. ANN. § 394.20 (1960) (immediate release); MICH. STAT. ANN. § 14.809(1) (1956) (written notice and five day maximum detention after receipt of notice).

¹⁵ Willcox & Roemer, *Hospitalization Under the British Mental Health Act, 1959*, 9 AM. J. COMP. L. 606, 609-10 (1960); see, e.g., National Mental Health Act, 1959, 7 & 8 Eliz. 2, c. 72 § 5.

¹⁶ N.Y. OPS. ATT'Y GEN. 332, 334 (1923).

¹⁷ See, e.g., N.Y. MENTAL HYGIENE LAW § 71 (ten days); CONN. GEN. STAT. ANN. § 17-187 (1960) (ten days); MICH. STAT. ANN. § 14.809(1) (1956) (five days).

¹⁸ *Barry v. Hall*, *supra* note 1, at 225.

¹⁹ 51 N.M. 201, 181 P.2d 811 (1947).

²⁰ *Id.* at 205, 181 P.2d at 815; see also *Ex parte Keddy*, 105 Cal. App. 2d 215, 233 P.2d 159 (2d Dist. 1951).

²¹ "In the discretion of the director of the hospital, facility or institution, such person may be detained for a period not exceeding fifteen days for the purpose of such care and treatment and thereafter until ten days after receipt of notice in writing from such person of his intention or desire to leave. . . ." N.Y. MENTAL HYGIENE LAW § 71.

²² N.Y. OPS. ATT'Y GEN., *op. cit. supra* note 16.

²³ The court indicated that in this particular case two days would not be an unreasonable period in which to institute commitment procedures. *Ex parte Romero*, *supra* note 19, at 206, 181 P.2d at 815.

a short detention period.²⁴ These detention periods are qualified by the fact that the patient may only be detained for the purpose of instituting commitment proceedings.²⁵

The contractual detention period found in the New York statute appears to be contrary to the majority approach in that the detention is unqualified.²⁶ Although the New York Committee made no recommendations in this area, the statute of that state would appear to have two defects. The first defect, as already indicated, lies in the fact that the statute may be assailable on constitutional grounds. The second defect involves the fact that patients may be deterred from applying for voluntary admission if they know they must surrender their freedom for a given length of time.²⁷ Thus, a "voluntary admissions" statute, designed mainly to encourage voluntary admissions, would appear to be self-defeating because of this deterrent.

Statutes providing for a "minimum stay" should not be dismissed, however, as providing no benefits. While a statute allowing release at any time has the advantage of encouraging participation, it also may have the disadvantage of allowing the patient to leave before a cure can be effected and perhaps even before his illness can be fully

diagnosed.²⁸ This disadvantage can be mitigated to some extent by a provision in the applicable statute allowing for the institution of commitment proceedings, but it cannot be completely eliminated. Although such a "minimum stay" provision can guarantee no greater possibility of cure, it may enable diagnosis to be completed.²⁹ Nevertheless, it would appear that the *Romero* approach is superior since it provides greater protection for the mentally incompetent by encouraging more extensive participation in the voluntary programs.

Although the voluntary admission process is beneficial in theory, it cannot function without carefully drafted entrance procedures. In this regard, the New York Committee has advocated simplicity.³⁰ The procedure now approved by the Committee, requires only that the patient sign the necessary admission forms with an awareness and appreciation of what he is doing. This simple procedure is in sharp contrast to the Alabama procedure which requires that "no patient shall be received...who is not presented with a certificate from a proper court committing him to the institution."³¹ The involved requirements of this statute, in effect since 1915, would represent a substantial deterrent to the mentally ill person who might desire to seek treatment. The less complicated procedure recommended

²⁴ See, e.g., COLO. REV. STAT. ANN. § 71-1-2 (Supp. 1957) (five days); FLA. STAT. ANN. § 394.20 (1960) (hours); MICH. STAT. ANN. § 14.809 (1) (1956) (five days); MO. ANN. STAT. § 202.790 (1959) (48 hours).

²⁵ See, e.g., FLA. STAT. ANN. § 394.20(3) (1960); MO. ANN. STAT. § 202.790 (1959); N.D. CENT. CODE § 25-03-06 (1960); UTAH CODE ANN. § 64-7-31 (1953).

²⁶ N.Y. MENTAL HYGIENE LAW § 71.

²⁷ Willcox & Roemer, *Hospitalization Under the British Health Act, 1959*, 9 AM. J. COMP. L. 606, 609-10 (1960); Ross, *Hospitalization of the Voluntary Mental Patient*, 53 MICH. L. REV. 353, 374 (1955).

²⁸ Ross, *supra* note 27, at 374 (1955); cf. Note, *Analysis of Legal and Medical Considerations in the Commitment of the Mentally Ill*, 56 YALE L.J. 1178, 1201 (1947).

²⁹ "Either the period is too short for effective treatment, or it is so long that it discourages use of voluntary admission." Ross, *supra* note 27, at 380.

³⁰ N.Y.C.B.A., MENTAL ILLNESS AND DUE PROCESS 23 (1962).

³¹ ALA. CODE tit. 45, § 207 (1959) (This statute was originally enacted September 25, 1915).

by the Committee would appear to be more in keeping with the primary goal of treating the disease. Statutes such as Alabama's, which have the added defect of socially stigmatizing the patient as having been "committed to the institution by a court," should be revised to encourage the mentally ill to seek help.³²

The discharge provisions under voluntary admissions are generally the same in all jurisdictions, at least with regard to one aspect. They provide that when the doctor in charge of the hospital is of the opinion that the patient has sufficiently recovered, the patient is to be discharged from the hospital.³³ The statutes, however, differ in their methods of release after the patient submits a request to leave.³⁴

The form of the request itself presents difficulties. Some states require that the request be in writing,³⁵ while others would accept an oral request.³⁶ The dangers inherent in a "written request" procedure are best illustrated in the Connecticut approach. The

pertinent statute of that state provides for no minimum detention period; there is however, a maximum ten day detention subsequent to the patient's written request to leave.³⁷ In *Roberts v. Paine*,³⁸ a voluntary patient in a Connecticut institution orally requested his release. The request was denied but the hospital did not disclose to the patient that the only ground for the denial was his failure to submit the request in writing. Later, on the advice of counsel, the patient submitted his request in writing and was duly released. The former patient subsequently brought an action for false imprisonment but the highest court of the state rejected the plaintiff's claim. The court held that there was no duty on the part of the hospital to disclose a fact which was ascertainable by both parties.³⁹

The inequity of this case is quite evident. The mental patient under a voluntary admission system has only two means of securing his release: (1) he may comply with the statute and submit a written request,⁴⁰ or (2) he may petition for a writ of habeas corpus on the ground that the detention statute is unconstitutional.⁴¹ However, either of the aforementioned means would require the mentally ill person to recognize that there existed some legal solution to his problem.⁴² It has been pointed out that the

³² N.Y.C.B.A., MENTAL ILLNESS AND DUE PROCESS 24 (1962); Melaney, *Commitment of the Mentally Ill*, 12 U. PITT. L. REV. 52, 60 (1960).

³³ See, e.g., MO. ANN. STAT. § 202.787 (1959); N.D. CENT. CODE § 64-7-30 (1953).

³⁴ See, e.g., CONN. GEN. STAT. ANN. § 17-187 (1960) (written notice with ten day detention period thereafter); ILL. ANN. STAT. ch. 91½, § 4-2 (Supp. 1960) (detention for 30 days after written notice in a first or second voluntary admission, after third or fourth admission, patient can't give 30 day notice until committed for 90 days, after fifth or later admission not until after 6 months); MD. ANN. CODE art. 59, § 37 (1957) (detention for 3 days after written notice). Some states have no release provisions. Ross, *supra* note 27, at 381.

³⁵ See, e.g., N.Y. MENTAL HYGIENE LAW § 71; ARIZ. REV. STAT. ANN. § 36-504(b) (Supp. 1963); MICH. STAT. ANN. § 14.809(1) (1956).

³⁶ See, e.g., FLA. STAT. ANN. § 394.20 (1960); MO. STAT. § 202.790 (1959); UTAH CODE ANN. § 64-7-31 (1953).

³⁷ CONN. GEN. STAT. ANN. § 17-187 (1960).

³⁸ 124 Conn. 170, 199 Atl. 112 (1938).

³⁹ *Id.* at 175-76, 199 Atl. at 115.

⁴⁰ *Roberts v. Paine*, 124 Conn. 170, 199 Atl. 112 (1938).

⁴¹ *Ex parte Romero*, 51 N.M. 201, 181 P.2d 811 (1947).

⁴² "One of the findings of the committee's staff is that some voluntary patients are not aware of their right to ask for discharge. This is understandable, considering the atmosphere of compulsion that has surrounded hospitalization of the mentally ill for many decades." N.Y.C.B.A., MENTAL ILLNESS AND DUE PROCESS 29 (1962).

disadvantage of such a requirement is the possibility that a patient might suffer traumatic effects from the prolonged incarceration before discovering that such a remedy existed.⁴³ The only other protection afforded such a patient is his right to redress his injuries by bringing an action for false imprisonment. However, such a decision, as that rendered in the *Roberts* case, would appear to eliminate that protection from unreasonable restraint by the hospital.

To remedy the wrongs created by such situations, the New York Committee has advanced the following two recommendations. First, a patient would be given notice of his status and rights as a voluntary patient.⁴⁴ This notice would be given to a patient when he entered the hospital and periodically thereafter.⁴⁵ It would provide the requisite knowledge to one who would otherwise be unaware of his legal rights and would also help one who had forgotten his status or rights after undergoing electric shock therapy.⁴⁶ Second, the Committee

⁴³ "Administrative procedures should be so organized as to have minimum psychic traumatization." Recommendation of the Group for Advancement of Psychiatry cited in Melaney, *supra* note 32, at 60.

⁴⁴ N.Y.C.B.A., MENTAL ILLNESS AND DUE PROCESS 29-30 (1962): "[U]nless the patient is informed of his right to request release and is assisted in making his request, the right of release on notice may have no real meaning." Ross, *Hospitalization of the Voluntary Patient*, 53 MICH. L. REV. 353, 377 (1955).

⁴⁵ Ross, *Hospitalization of the Voluntary Patient*, *supra* note 44.

⁴⁶ N.Y.C.B.A., MENTAL ILLNESS AND DUE PROCESS 29 (1962); A similar problem may be created by the use of tranquilizers. "[T]ranquilizers may reach the very source of the will to resist. Since a patient who has been admitted to a mental hospital may not be in a position to object to his continued detention because of the nature of his illness or the initial steps in its treatment, his rights must be protected as fully as those of the patient who voices his protest." *Id.* at 26.

recommended the establishment of a "Mental Health Review Service" which, as an independent organization under state auspices, would insure that the periodic notice would be given to the voluntary patient.⁴⁷ Such a proposal for an independent organization appears to be modeled after the British "Mental Health Tribunals."⁴⁸ Both are to be staffed by persons generally labeled as "qualified,"⁴⁹ and both are designed to protect the legal rights of the mentally ill. There can be little doubt that such an organization would be of great assistance in protecting the patient's legal interests; it might also prove effective in encouraging participation in a voluntary program.⁵⁰

Not all jurisdictions require a voluntary patient to request his own release. Some statutes permit a patient to be released on the request of another, but only if the patient consents to such release.⁵¹ When a patient

⁴⁷ Recommendation No. 1. *Id.* at 29-30.

⁴⁸ See, e.g., Willcox & Roemer, *Hospitalization Under the British Mental Health Act, 1959*, 9 AM. J. COMP. L. 606, 622-23 (1960).

⁴⁹ Neither the recommendations nor the British system establish the qualifications of the members with certitude. Under the New York Committee's recommendations the Service would be "staffed by those trained for this work." N.Y.C.B.A., MENTAL ILLNESS AND DUE PROCESS 21 (1962). Under the British system the tribunal is composed "of 'legal members' (one of whom is chairman), of doctors, and of persons specially qualified in administrative or social service or otherwise." Willcox & Roemer, *supra* note 48, at 623.

⁵⁰ One possible problem concerning hospital administration has been raised, however. Thus, it has been pointed out: "While in principle the enumeration of patient's rights may be objectionable as impinging upon the executive authority of the hospital administration, in practice they probably do not disrupt administration and in the main reflect the present standards of care in our better run mental hospitals." Ross, *Hospitalization of the Voluntary Mental Patient*, 53 MICH. L. REV. 353, 361 (1955).

⁵¹ See, e.g., MO. ANN. STAT. § 202.790 (1962); UTAH CODE ANN. § 64-7-31 (1953).

is under the legal age the request for his release must be made by a parent or guardian.⁵²

The second type of non-compulsory admissions, the informal admission, is designed to encourage maximum patient participation by permitting him to freely enter and leave the hospital. Experience demonstrates that such a program is highly effective in practice. For example, St. Lawrence State Hospital, the only New York hospital to have all of its patients on an open ward system, had the highest percentage of non-compulsory patient population in the state.⁵³ England, in a complete revision of its mental health laws in 1959,⁵⁴ rejected the use of any voluntary or statutory non-compulsory admissions.⁵⁵ In its place England substituted the informal admissions.⁵⁶ This system provides an atmosphere which is most conducive to caring for the patient by inducing full patient cooperation.⁵⁷ It has the added virtue of eliminating all formalism which in

turn reduces the social stigma attached to "commitment." The result of the British innovation has been dramatic. In England, seventy-five per cent of all admissions are now non-compulsory, and in Wales, also governed by the new statute, ninety per cent of all admissions are informal.⁵⁸

There are three reasons why the Royal Commission rejected voluntary admission statutes. First, there would be no contractual relationship in the informal system, hence no need to determine the patient's capacity to contract.⁵⁹ Second, as previously indicated, the informal system eliminates the technicalities of voluntary admissions;⁶⁰ and finally, experience indicated that the informal system encourages the greatest patient participation.⁶¹

The New York Committee has endorsed the use of informal admissions⁶² and this procedure has since been adopted.⁶³ However, it has also continued its endorsement of the voluntary system.⁶⁴ While the two systems are not mutually exclusive, it seems unnecessary to have both. Perhaps the New York Committee should have chosen the informal system, and recommended its use exclusively, since it has proven to be the better system.

⁵² See, e.g., FLA. STAT. ANN. § 394.20 (1960); MO. ANN. STAT. § 202.790 (1959).

⁵³ That hospital with 100% open wards had 56.3% of its patients on a voluntary status, whereas New York state hospitals in general, with 63.4% open wards had only 21.3% of their patients on a voluntary status. N.Y.C.B.A., MENTAL ILLNESS AND DUE PROCESS 262 (1962).

⁵⁴ National Mental Health Act, 1959, 7 & 8 Eliz. 2, c. 72.

⁵⁵ Willcox & Roemer, *supra* note 48, at 611 (citing the Royal Commission's Report).

⁵⁶ Melaney, *supra* note 32.

⁵⁷ WORLD HEALTH ORGANIZATION, HOSPITALIZATION OF MENTAL PATIENTS, A SURVEY OF EXISTING LEGISLATION 15 (1955); NATIONAL INSTITUTE OF MENTAL HEALTH, FEDERAL SECURITY AGENCY, A DRAFT ACT GOVERNING HOSPITALIZATION OF THE MENTALLY ILL (Public Health Service Pub. No. 51, rev. ed. 1952). "A fully operating program of voluntary admissions will reduce materially the harmful experiences often associated with compulsory hospitalization and at the same time encourage the mentally ill and their families

to obtain care at an early stage, when the promise of recovery is greatest." part III, 19.

⁵⁸ Willcox & Roemer, *Hospitalization Under the British Mental Health Act, 1959*, 9 AM. J. COMP. L. 606, 609-10 (1960).

⁵⁹ *Id.* at 611.

⁶⁰ Melaney, *Commitment of the Mentally Ill*, 21 U. PITT. L. REV. 52-60 (1960) (recommendations 1-3).

⁶¹ N.Y.C.B.A., MENTAL ILLNESS AND DUE PROCESS 278 (1962).

⁶² *Id.* at 30 (recommendation 11).

⁶³ N.Y. MENTAL HYGIENE LAW § 71 (Supp. 1963).

⁶⁴ See, e.g., Recommendations 9-10, 12, N.Y.C. B.A., MENTAL ILLNESS AND DUE PROCESS 28-31; textual treatment at 54-82.

The British system would seem to eliminate all of the previously discussed objections to voluntary programs. It encourages the earliest⁶⁵ and greatest patient participation, and the treatment of the disease *as a disease* by eliminating the formalism accompanying voluntary admissions. It eliminates the *Romero* problem since there is no contractual relationship, no "minimum stay" requirement, and no maximum unqualified detention period after a release request. It also obviates the problems of notice such as the *Roberts* situation since the patient may leave at any time.⁶⁶

The only problem not eliminated by the informal admission itself, namely that posed by a patient who was unaware that he could leave or a patient who lost this awareness through shock therapy, would be alleviated by other facets of the British system. That system applies the same solution which was suggested by the New York Committee — namely, a review service or tribunal to protect the rights of the patients and to ensure adequate notice to the patient.⁶⁷

Both the informal admission⁶⁸ and the voluntary admission⁶⁹ generally have a conversion feature, that is, a statutory provision which would allow the chief medical officer or doctor in charge of the hospital to petition a court to convert the non-compulsory status of a patient to a compulsory status. Such conversion is authorized only when a patient is dangerous to himself or to others,⁷⁰ and then only after a patient has

requested his release.⁷¹ The states have varying requirements as to the time during which the hospital may detain the patient pending the institution of proceedings to convert his status.⁷² The cases generally hold that a patient may be detained for a reasonable time in such circumstances.⁷³ These conversion features would probably not deter any patient from availing himself of the non-compulsory admission, since the patient would either believe that he is not dangerous and therefore not apt to have his status converted, or recognize that he is dangerous and, desiring treatment, not request release.

Although this conversion feature is necessary, there is at least one deterrent to a patient's voluntary submission to treatment. Some statutes provide for the sterilization of patients if in the opinion of the hospital such sterilization would be for the benefit of society.⁷⁴ The "benefit" sought is the prevention of the spread of inheritable mental disease.⁷⁵ The Supreme Court of the United States, in 1927, held that this practice was not unconstitutional.⁷⁶ Although such a decision may be questioned in the light of

MO. STAT. ANN. § 202.790 (1959); N.D. CENT. CODE § 25-03-06 (1960); UTAH CODE ANN. § 64-7-31 (1953).

⁷¹ See, e.g., FLA. STAT. ANN. § 394.20 (1960); MO. STAT. ANN. § 202.790 (1959).

⁷² See, e.g., FLA. STAT. ANN. § 394.20 (1960) (hours); COLO. GEN. STAT. ANN. § 71-1-2 (Supp. 1957) (five days); MICH. STAT. ANN. § 14.809(1) (1956) (five days); MO. ANN. STAT. § 202.790 (1959) (48 hours).

⁷³ See, e.g., *Ex parte Keddy*, 105 Cal. App. 2d 215, 233 P.2d 159 (1951); *Ex parte Romero*, 51 N.M. 201, 181 P.2d 811 (1947).

⁷⁴ See, e.g., MICH. STAT. ANN. c. 115 (1956); UTAH CODE ANN. § 64-10-1 (1953).

⁷⁵ See, e.g., ARIZ. REV. STAT. ANN. § 36-531 (1956); VA. CODE ANN. tit. 37, § 231 (1950).

⁷⁶ *Buck v. Bell* 274 U.S. 200 (1927).

⁶⁵ Willcox & Roemer, *supra* note 58 at 610.

⁶⁶ *Id.* at 609.

⁶⁷ *Id.* at 620-23.

⁶⁸ National Mental Health Act, 1959, 7 & 8 Eliz. 2, c.72 § 30.

⁶⁹ See, e.g., ARIZ. REV. STAT. ANN. § 36-504(b) (Supp. 1963); FLA. STAT. ANN. § 394.20 (1960).

⁷⁰ See, e.g., FLA. STAT. ANN. § 394.20 (1960);

modern medical advances⁷⁷ and natural law norms,⁷⁸ a more detailed analysis is beyond the scope of this note.

While initially it would seem that a patient would be reluctant to submit to a commitment program which might subject him to such drastic measures, statistical facts do not necessarily bear this out. Although some states having sterilization statutes have the lowest admissions per capita (on a percentage basis) in the United States,⁷⁹ Delaware, which also has a sterilization statute,⁸⁰ has one of the highest admission rates.⁸¹ The Delaware anomaly may be explained in a number of ways: (1) the statute may not be widely known, (2) the statute may not be widely used or (3) most admissions may be on a compulsory basis.⁸²

⁷⁷ See generally OVERHOLSER, *THE PSYCHIATRIST AND THE LAW* 102 (1953).

⁷⁸ FAGOTHEY, *RIGHT AND REASON* 302-05 (2d ed. 1959); AQUINAS, *SUMMA THEOLOGICA* II-II, q. 65, art. 1.

⁷⁹ The following chart delineates the lowest and the highest admissions in the country, measured by the number of patients per hundred thousand civilian persons in each state.

State	Rate per 100,000
Mich.	36.8
Utah.	45.3
Mo.	47.9
Fla.	48.2
Mass.	140.5
Del.	141.5
N.D.	149.7

U.S. Statistical Abstract 26 (1963). Michigan and Utah, the two states having the lowest admissions both have sterilization statutes. *MICH. STAT. ANN.* c. 115 (1956); *UTAH CODE ANN.* § 64-10-1 (1953).

⁸⁰ *DEL. CODE ANN.* tit. 16 §§ 5701-05 (1953).

⁸¹ See chart, *supra* note 79.

⁸² These figures in note 79 *supra*, are not broken down into voluntary, informal or compulsory admissions.

It would appear, however, that the existence of such a statute would present a deterrent to a potential patient who knows of its existence.

Under a voluntary admissions statute the patient has no greater rights than the compulsory patient.⁸³ Though the informally admitted patient does have greater rights, in the following three areas he does not.

First, the patient's mail is frequently subject to censorship,⁸⁴ but statutes normally provide a class of persons to whom the mental patient may send uncensored mail.⁸⁵ In New York, however, the statute did not include the patient's attorney as a person to whom mail might be freely directed. In spite of this omission, the Court of Appeals, in *Hoff v. State*,⁸⁶ found New York liable for damages to a patient whose letter containing a petition for habeas corpus was never forwarded to his attorney. It would appear that the main purpose of the censorship statutes is to protect the public from indiscriminate mailings by the mentally ill rather than to limit the rights of the patient.

⁸³ "The New York statute . . . implies . . . that hospitalization does result in incompetency." Ross, *Hospitalization of the Voluntary Mental Patient*, 53 *MICH. L. REV.* 353, 367 (1955). Professor Wigmore suggests that commitment should only be of evidentiary value in determining incompetency. 5. WIGMORE, *EVIDENCE* §1671 (3d ed. 1940).

⁸⁴ See generally Ross, *supra* note 83, at 362.

⁸⁵ See, e.g., General Order 26, Correspondence of Patients, N.Y. Mental Hygiene Dep't, an administrative regulation, which provides that "the hospital director [may] . . . prevent the transmission of outgoing mail that is obscene, profane, illegible, incoherent, or otherwise objectionable. All letters addressed to the Governor, certain public officials, judges, lawyers, and certain officers of the Department of Mental Hygiene must be forwarded at once and without examination, and all mail in reply must be delivered to the patient."

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

Also, the courts have demonstrated a willingness to protect the patient's right of free speech in matters concerning his status as a patient.⁸⁷

The Committee makes no specific recommendation in regard to censorship but presumably a patient's rights would further be protected by including the Mental Health Service Review in the list of privileged addressees.⁸⁸ This is an area where the public interest should be balanced against the private interest, and there is unfortunately no definite solution provided by either the voluntary or the informal system.

Second, the New York Committee specifically discusses the right to drive and the right to vote. Naturally, the former could be exercised only during a period of out-patient care. The New York Motor Vehicle Bureau would look to the nature of the illness, so that if a patient's mental illness would not interfere with his ability to drive, no restrictions would be placed upon him.⁸⁹ The New

York Committee approves of this procedure since it is a practical approach to the problem.⁹⁰ However, the nature of the disease has no bearing on the patient's right to vote under current New York law. Voluntary and informal patients may exercise this right; compulsory patients may not.⁹¹ Although it may be argued that a procedure which would look to the nature of the illness protects the interests of society, it has been stated that a procedure which would look to the nature of the admission would encourage patient participation in the voluntary admissions program. Again the problem is one of balancing public and private interests.

It seems more reasonable to base voting and driving rights on the nature of the illness rather than on the type of admission since society is entitled to equal protection in both areas. Of course it could be argued that under such a system doctors would be given the power to decide who may vote and who may not and that such a power might easily be abused. On the other hand, is the voluntary patient necessarily more competent than the compulsory patient?⁹² Finally, if the incompetent can relinquish some of his liberties by contract, he should be able to do the same as far as his voting rights are concerned. Both sections of such a contract should be equally binding.⁹³

⁸⁷ *Ibid.* See also, *Jacobs v. Worthington*, 167 Misc. 702, 4 N.Y.S.2d 630 (Sup. Ct. 1938). For the opinion that patients should have free access to communication facilities see the testimony of Dr. Ewalt for the American Psychiatric Association. *Hearings Before a Subcommittee of the Senate Committee on the Judiciary*, 87th Cong., 1st Sess., pt. 1, at 75 (1961).

⁸⁸ "[T]he Service . . . will be available to aid voluntary patients who ask for its help." N.Y.C.B.A., *MENTAL ILLNESS AND DUE PROCESS* 21 (1961) (recommendation 1).

⁸⁹ "The Department of Motor Vehicles has never suspended or revoked a license merely because of the certification of the holder to a mental hospital. Under an informal agreement between the Commissioner of Motor Vehicles and the Department of Mental Hygiene, the director of a state hospital notifies the Commissioner in writing at the time of the patient's release if the hospital believes the patient not fit to drive. The license is then suspended, and the person is entitled to a hearing on the suspension. He may obtain a court review of

the decision to revoke his license." The department takes the position despite the provision of the N.Y. VEHICLE AND TRAFFIC LAW § 510(3) (b) to the effect that a license may be suspended or revoked because of the "court commitment of the holder. . . ." N.Y.C.B.A., *MENTAL ILLNESS AND DUE PROCESS* 80 n.35 (1962).

⁹⁰ *Ibid.*

⁹¹ N.Y. ELECTIONS LAW § 152(6).

⁹² N.Y.C.B.A., *MENTAL ILLNESS AND DUE PROCESS* 81 (1962).

⁹³ Although the validity of contract would appear

The third and final problem concerns a patient's right of privacy. Withholding the hospital record of a mental patient would go far toward encouraging participation in a non-compulsory program,⁹⁴ but complete privacy appears impossible. First, the patient's name must be registered with the hospital and with certain state health agencies.⁹⁵ If the New York Committee's Mental Health Review Service were put into operation it would likewise be necessary to register the patient with the Service in order to further protect his interests. In addition, a statement of the patient's name and mental condition would have to be submitted to the proper state authorities in connection with his driving and voting privileges. Finally, transactions in land must be made secure from attacks in the chain of title based on mental incompetency. This might well require an open list of persons incompetent to enter into commercial transactions

to be open to question, a state holding that a patient may contract away his right of personal freedom should have no difficulty in holding that same person may contract away his right to vote.
⁹⁴ Ross, *Hospitalization of the Voluntary Mental Patient*, 53 MICH. L. REV. 353, 363-64 (1955).

⁹⁵ See, e.g., N.Y. MENTAL HYGIENE LAW § 71, which requires notification to be given the Department of Mental Hygiene within two days of the patient's admission.

or dealings in real property.⁹⁶ The New York Committee makes no recommendations in this area.

Innovations such as the highly successful British system will do much to eliminate the problems which surround voluntary admissions. Limiting detention periods in conversion statutes, eliminating sterilization statutes, employing a "capacity test" in both driving and voting restrictions, while developing safeguards for the patient's privacy, all will encourage the mentally ill to seek aid while protecting their legal rights. By applying the recommendations of the New York City Bar Committee considerable progress will have been made in improving the mental health laws.

Perhaps, in the future, society will see no difference between a patient entering a mental hospital for treatment of mental illness and another patient entering a general hospital for cancer or tuberculosis. Perhaps, too, society will view the mental patient's need for isolation as analogous to the need to isolate the person who has a contagious disease.

By adopting a program of informal admission in conjunction with some of the Committee's recommendations the law will be better adjusted to the interests of society by treating mental illness *as a disease* rather than a crime.

⁹⁶ Ross, *supra* note 94, at 364.

