December 1957

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PSYCHOLOGY, MENTAL ILLNESS, AND THE LAW

Lee Silverstein*

A number of recent developments both inside and outside West Virginia makes it timely to consider the relationship between psychology, mental illness, and the law. For instance, in both 1955 and 1957 our legislature enacted substantial and important changes in the statutes relating to commitment of the mentally ill and supervision of state and mental institutions. In the courts a recent case at Wheeling involved a fourteen-year-old boy who was convicted of murder despite a defense of insanity, while in a case at Weston a defendant indicted for robbery and murder was given a preliminary jury trial on the question of sanity alone. These cases draw attention to the need for re-examination of both procedural and substantive law as to insanity in criminal cases. Public concern with the problem of juvenile delinquency and youthful crime is at a high point. In this state a forestry camp was established for youthful offenders in 1955 and there is talk of a second such camp. Citizens' groups, led by the West Virginia Association for Mental Health, Inc., have taken an increasing interest in the serious plight of the state mental hospitals, which lost their accreditation in 1955.

Significant events have likewise occurred outside West Virginia. In the District of Columbia the Court of Appeals in 1954 laid down a new test of insanity in criminal cases, overruling the McNaghten and irresistible impulse tests. In England in 1953 the Royal Commission on Capital Punishment recommended a similar change in the British law. On the other hand the American Law Institute in the draft of its Model Criminal Code makes a more moderate recommendation on this subject. In the last few years legal and medical scholars have produced a large number of books and articles on insanity and the law. Several law reviews have carried symposia on the subject.2

*Member of the Kanawha County Bar. The author wishes to express his thanks to Russell L. Heinlein, M.D., a psychiatrist of Charleston, West Virginia, for reading and criticizing the manuscript of this article.

The purpose of this article is to review and comment on these and related developments, especially from the point of view of the West Virginia lawyer. After some introductory material, commitment of the mentally ill and related topics will be presented, to be followed by discussion of insanity and the criminal law and of juvenile delinquency.

I. LAW AS A SOCIAL SCIENCE

Today the view is widely accepted that law is one of the social sciences rather than a distinct study. Of the various philosophies of law which have been expounded in the past, the theory of sociological jurisprudence is now the most generally accepted in the United States. It is becoming increasingly evident—even to lawyers—that the public is not satisfied with a slow-moving, unimaginative legal system which fails to keep pace with the changing needs of society. One need not take the course in “Law, Science, and Policy” at Yale to sense that the legal system is not immune to changing times. Long has the relevance of economics to the law been recognized. The Brandeis brief is fifty years old. Today the social psychologist and the public opinion expert take the stand as expert witnesses along with the doctor and engineer. In balancing the various social interests competing for recognition before it, the wise court, legislative body, or administrative agency seeks help not only from traditional legal sources but from any learned discipline which can shed light on the problems. For a generation the law schools have been reorganizing their curricula to better meet the recognized needs of the profession and of the public. The modern casebook reflects these changes. And in the law reviews one finds much material drawn from political science, sociology, and economics.

It is in this context that the reader should view the law’s increasing acceptance of psychology—and of such related fields as psychiatry, criminology, social psychology, and even anthropology.


7 It is possible to look upon the use of psychology in law as the grounding
The trend in the law toward greater reliance on these fields of knowledge is unmistakable. The most important points of contact are probably in the criminal law, especially in the increasing use of pre-sentence investigations, probation, and parole. Another field of ferment is family law, including the juvenile court movement. It is significant that the Supreme Court relied heavily on the views of social psychologists in the public school segregation cases. McCarty urges the practicing lawyer to use psychology in his everyday contacts with office personnel and clients.

II. SOME HORNBOOK PSYCHOLOGY

Whether one agrees that the characteristic knowledge of our century is psychological, it is useful to know something of basic psychology. With some people the word psychology evokes a smile of derision or a frown of annoyance. To the lawyer, trained as he is to exactness in terminology and concepts, psychology is suspect on grounds of vagueness of expression and shadowy definitions. Moreover the psychologist's or social worker's concept of relevant facts is apt to be much broader than the lawyer's concept, especially in family problems. While the science of psychology is far from perfection, its present stage of development does afford some useful explanations of human behavior. Whether the lawyers like it or not, the basic postulates of Freud, Jung, and their disciples are being generally accepted not only by the psychiatrists and their ilk but by more and more of the general public. (Just notice the number of psychologically oriented articles appearing in the popular magazines, especially the women's magazines.) For instance, it is widely agreed that although heredity sets the outer limits of the individual's growth and development, his very early environment is crucially important in the formation of personality and character. The seeds

of legal precepts upon the insights of science rather than as the integration of the law and social sciences. Cady, Legal Relations of the Mentally Ill: A Functional Approach, 14 Ohio St. L.J. 154 (1953). This is the view of many psychiatrists. A sociologist writes that the law is gradually accepting determinism as the principle explaining human behavior. Kaplan, Criminal Responsibility, 45 Ky. L.J. 236 (1957).

9 McCarty, Law Office Management c. 3 (3d ed. 1955); McCarty, Psychology for the Lawyer (1929).
11 See generally Guttman and Weinber, Psychiatry and the Law c. 2 (1952); Lugar, Book Review, 55 W. Va. L. Rev. 78 (1952); Overholser, The Psychiatrist and the Law c. 1 (1953); Overstreet, The"
of mental illness or criminal behavior are often sown in early childhood as poor rearing or a broken home makes the child overly submissive, aggressive, or self-centered. The child's early relationship to his parents sets the pattern of his later adjustment to marriage—or lack of it. Not only must a child's (or adult's) physical needs be satisfied, but also his emotional needs—the needs for a sense of security and for a feeling of personal worth.12

Closely related to the theory that personality is formed in early childhood is the concept of the subconscious or unconscious mind. Psychologists hold that when a child has difficult or painful experiences he sometimes represses them into the subconscious mind in an effort to forget them. These repressed memories may predispose him to emotional difficulty in later life, when emotional strain or added responsibility may suddenly cause reactions which apparently are all out of proportion to the problem. Such is the explanation not only of many of the cases of mental illness and criminal behavior, but also of such lesser abnormalities as claustrophobia, excessive irritability, alcoholism, or desertion of wife and children.

Because of such repressed memories, unsatisfactory relations with parents, and other factors, some individuals mature physically but remain at a childish, even infantile, stage of emotional development. Overstreet declares that people grow from emotional immaturity to emotional maturity rather than from ignorance to knowledge or from evil to good.13

In stressing the importance of the unconscious mind and of basic drives, such as the sex drive, psychologists have not intended to discount completely the element of free will in determining behavior, as some critics have concluded. Some psychoanalysts recognize the factor of free will, e.g., as shown in the need for the patient to desire recovery.14 Rabbi Liebman has attempted to reconcile psychiatry and religion in his best seller, Peace of Mind (1946), and such books as those of Norman Vincent Peale also draw on the insights of psychology. From the viewpoint of the social psychologist it is said that man not only is the product of history

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12 Katz and Thorpe, Understanding People in Distress 8-17 (1955).
13 Overstreet, The Mature Mind c. 3.
but also that he plays an important role in molding the social process. 15 On the other hand it is recognized that some mental illnesses like many physical illnesses, will yield to treatment by drugs, especially the new tranquillizing drugs. 16

Under the heading of abnormal psychology or medical psychology the protean forms of mental and emotional disorders have been described and classified. It is generally recognized that persons in mental or emotional distress differ only in degree from the general run of people. Experience in World War II showed, moreover, that every man had his breaking point: under severe enough physical or emotional strain or hardship the strongest went to pieces. According to Guttmacher and Weihofen, the various kinds of mental illness may be classified into four broad groups. 17 These kinds of mental illness are to be distinguished from congenital intellectual deficiency, a fifth category which comprises those persons who have substandard mentality as the result of heredity, intra-uterine injury, or glandular malfunction. The first class of mental illnesses is the class of psychoneuroses or neuroses. Usually a neurosis does not involve a change in the whole personality, as does a psychosis, nor does the neurotic patient lose touch with reality, as does the psychotic. All of us have neurotic symptoms; 18 the person with a neurosis is the same as other people, but more so, in fact too much so. Among the neuroses are such legally significant forms of behavior as kleptomania, pyromania, exhibitionism (indecent exposure), accident proneness, traumatic neurosis brought on by being in or witnessing an accident, and the sudden homicide committed by the law-abiding citizen under unusual emotional pressures. (Not all instances of such behavior are necessarily caused by neuroses.) The second class of mental illnesses is the class of psychoses. Generally a psychosis is more serious than a neurosis, but a mild psychosis is less incapacitating than a serious neurosis. One of the major types of psychosis is the manic-depressive type: the patient typically has unusually wide variations of mood ranging from elation and overconfi-

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15 Fromm, Escape From Freedom 13-14 (1941).
16 See text at note 19 infra.
17 Guttmacher and Weihofen, Psychiatry and the Law c. 3-8. Other authorities have different systems of classification, but the terminology is similar.
18 "For if one has a mind at all, his mental processes are subject to some of the faults and failings that characterize the human mind." Menninger, The Human Mind xii (3d ed. 1945); see also Weihofen, The Urge To Punish 19 (1956).
dence to hopeless despair. During a period of despair the patient may attempt suicide. The most common type of psychosis is schizophrenia, formerly called dementia praecox. Schizophrenia, literally meaning division of the mind, is characterized by hallucinations, illusions and other behavior evincing lack of contact with reality. Paranoia, which is sometimes classified as a variety of schizophrenia and sometimes as a separate kind of psychosis, is characterized by a feeling of persecution and sometimes by litigiousness. The latest adjunct to the treatment of schizophrenia and other major psychotic reactions is the use of tranquilizing drugs; in some instances this treatment seems to shorten the number and frequency of electro-shock treatments. Indeed there is evidence that much mental disorder and criminal behavior can be explained at least in part by the body chemistry of the patient or offender, i.e., by the relative amounts of various body secretions and fluids which he has. Studies now being made may point the way toward new methods of treatment of the criminal as well as the mental patient. The third group of persons with mental disorders are the psychopaths or sociopaths. These are persons who are not neurotic, psychotic, or mentally deficient, yet who fail to adjust to the demands of society. Probably their very early environment is crucial in causing this defect. Most psychopaths are suffering from neurotic character disorders, e.g., swindlers and aggressive types of criminals such as burglars and robbers. The fourth group of mental disorders are those caused by accident, illness, or old age affecting the brain itself. Such maladies as cerebral syphilis, senile dementia, encephalitis, and epilepsy may result in criminal or other deviant behavior. Guttmacher and Weihofen give special attention to sex offenders, as this is an area of ferment in legal psychiatry. These authors assert that sex offenders are not a distinct group of abnormal persons, but that on the contrary all the other kinds of mental disorders can cause sexual deviations which violate the law. The subject of sex offenses will be further discussed below.

Traditionally, legal doctrine has taken little account of the emotions and of the unconscious mind as affecting behavior, short of patent insanity. Freedom of the will and complete accounta-


bility are the jural postulates of the law of criminal law and domestic relations, although certain exceptions are recognized such as homicide committed with provocation or in the heat of passion. Comparable concepts were developed in the law of contract, property, and related fields, reaching a high point in the late nineteenth century. Thus the development of the common law, as Maine said, was the development of the legal rights of the individual from feudal status to contract, paralleling the growth of modern liberal democracies on both sides of the Atlantic. Freedom of contract and equality of civil rights, however, carried with them the freedom to make a grossly disadvantageous bargain despite inequality of information and economic power as between the parties. In the present century the law of contract has gradually been modified, with such developments as implied warranties, workmen’s compensation, wage and hour laws, and legislation to protect consumers and investors. Turning back to the fields of criminal law, torts and domestic relations, we may well inquire whether traditional thinking in these fields of law is likewise ripe for change. Just as economics and sociology have influenced legal thinking in the law of contract, property, and related fields (e.g., the Brandeis brief), so there are indications that psychology and related studies are influencing legal thinking about criminal law, torts, family law, and related fields. This new development is the principal line of inquiry of this paper.

III. THE MENTAL HEALTH MOVEMENT; THE MENTAL INSTITUTIONS OF WEST VIRGINIA

In order to provide a better perspective for the “law” material which follows, a brief account of the mental health movement seems appropriate here. (The term “mental health” is now preferred over “mental hygiene”.) Developments in West Virginia will be recounted.

Mental illness is without much doubt the greatest public health problem in the United States. As Dr. Winfred Overholser of St. Elizabeth’s Hospital in Washington, D. C., has said:

“The problem of mental illness has been with us ever since the dawn of history. The challenge of it, however, is a new one in the sense that it is only recently being recognized by the public and by responsible officials as one of the most pressing problems in the whole field of human welfare. There are in the mental hospitals of this country about 725,000 patients occupying nearly one-half of all the hospitals beds. 98% of
these beds are supported by public funds at a total cost of at least $635,000,000 a year. Furthermore, these facilities are inadequate in number and in quality, and there is still a serious shortage of personnel. Over the years, however, there has been substantial progress in treatment, notably in the fields of psychological therapy, both individual and group, in the physiological treatments such as electro-shock, and still more recently with the innovation of so-called tranquilizing drugs. But, even though there has been an increase in our knowledge, we do not yet apply all we know. There is great need for further development of our institutions, for the relief of crowding and of understaffing. The need of research is tremendous, both as to the causes of mental disorder, their treatment, and most important of all, their prevention.  

Mental health is not only a public health problem; it is also important to national defense. During World War II a surprising number of draftees were rejected because of mental illness. General Hershey, Director of Selective Service, stated before a congressional committee in August, 1945, that of 4,800,000 men aged 18 to 37 who had been rejected for military service, of about 15,000,000 examined, no less than 1,091,000 had been rejected because of neuropsychiatric disorders. Another 676,000 were rejected because of mental and educational deficiencies. Still others of those rejected had some neuropsychiatric disorder, although this was not listed as the principal reason for rejection. Of those who served in the armed forces 460,000 were given medical discharges because of mental illness; this amounted to 36 per cent of all medical discharges. Another 250,000 were given administrative discharges because of other neuropsychiatric disorder. Of the 91,200 patients in Veterans Administration hospitals on June 30, 1947, 51,900 were neuropsychiatric cases.

The incidence of mental illness is considerably higher than one might suppose. The National Association for Mental Health estimates there are about 1,500,000 people in the United States suffering from mental illness and another 7,500,000 who have some other personality disturbance. In addition there are about 1,500,000 mentally deficient people. Based on figures from New York State, it is

21 BULL. OF TOWN MEETING OF AIR, June 12, 1955, p. 3.
23 NATIONAL ASS'N FOR MENTAL HEALTH, FACTS AND FIGURES 4 (1952) (pamphlet).
24 DEUTSCH, THE MENTALLY ILL IN AMERICA 476.
estimated that one of every twelve children born currently will at some time in his life suffer a mental illness severe enough to require hospitalization. Each year about 1,000,000 persons receive treatment in mental hospitals, including 250,000 new patients and 100,000 readmissions. It is estimated that the new patients admitted each year lose during their illness $1,750,000,000 in potential earnings. The average length of stay in state hospitals is still eight years, despite recent increases in the number of patients released after treatment with new drugs. Other equally striking figures could be cited.

The National Association for Mental Health takes the lead in coordinating and directing the mental health movement. The Association is an outgrowth of the National Committee on Mental Health, which was established in 1908 by Clifford Beers of Connecticut (1876-1908), who had himself been a mental patient. His great service in helping the mentally ill may be compared with that of Dorothea Dix of Massachusetts (1802-1887), the tireless crusader for humane treatment of the mentally ill. The National Association for Mental Health has worked closely with the proponents of such projects as social work, child guidance, and prison psychiatric clinics. By 1936 there were national societies for mental health in thirty countries. In 1948 these groups and others formed the World Federation for Mental Health, which works closely with agencies of the United Nations.

The West Virginia Association for Mental Health was first organized in 1954, although there were local citizens' mental health groups prior to that. The association now has several hundred members, with chapters in Cabell, Kanawha, Logan, Mason, McDowell, Mercer, and Raleigh counties; new chapters are being organized in other counties. The West Virginia association joined the national association in September, 1956. Lawyers would do well to join this progressive and humane organization.

There are six state mental institutions in West Virginia, including five mental hospitals and one training school for mentally retarded children and youths. (Note that the old terms "insane

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25 NATIONAL ASS'N FOR MENTAL HEALTH, FACTS AND FIGURES 3, 9 (1952).
26 N.Y. TIMES, April 28, 1957, § 1, p. 82.
27 BEERS, A MIND THAT FOUND ITSELF (1908).
28 This paragraph is based on DEUTSCH, THE MENTALLY ILL IN AMERICA c. 9, 15. See TWENTIETH CENTURY MENTAL HYGIENE (Shore ed. 1950). Part 5 describes developments in Great Britain, Switzerland, and Latin America.
29 See WEST VIRGINIA BLUE BOOK (1957) for history of and current information about these institutions.
asylum” and “feebleminded” are no longer used.) They house some 6,000 patients, although the facilities were originally intended for a much smaller number. Nevertheless the number of beds available in the state for the mentally ill is considerably below the national average of 4.4 beds for each thousand of population.30 Yet it would probably be unwise to build a new state mental hospital at this time, because of the difficulty in staffing it properly and because the trend in treatment of the mentally ill is toward development of local hospital facilities and the greater use of outpatient clinics.31 In addition to the state mental institutions the state supervises four outpatient “guidance clinics” which are jointly financed by federal, state, and local funds.32 West Virginia is a participating and contributing member of two interstate organizations, which inter alia help the member states improve their mental health programs. These organizations are the Council of State Governments and the Southern Regional Educational Board.33

In 1954 the Central Inspection Board of the American Psychiatric Association made a thorough inspection of the five state mental hospitals.34 As a result of this inspection the association withdrew its certification of all of the hospitals. This is all the more serious in the light of the association’s policy of granting certification if the hospital meets as much as 70% of the minimum standards developed by the association.35 The Central Inspection Board reported such conditions as extreme overcrowding, inadequate medi-

30 Address by Dr. Daniel Blaine, Medical Director of American Psychiatric Association, at West Virginia Association for Mental Health Meeting, Charleston, Sept. 22, 1956.
31 Ibid.
32 They are located at Charleston, Parkersburg, Martinsburg, and Morgantown.
33 COUNCIL OF STATE GOVERNMENTS, THE MENTAL HEALTH PROGRAM OF THE FORTY-EIGHT STATES (1950). This group has headquarters in Chicago near the American Bar Center. The Southern Regional Educational Board has headquarters in Atlanta; it is made up of sixteen southern states.
34 See the 300-page Report of this board, published in two paper-bound volumes (1955). Copies may be obtained from the Department of Mental Health as successor to the West Virginia Board of Control. Compare BUREAU OF MENTAL HEALTH OF DEP’T OF HEALTH, AUDIT OF MENTAL HEALTH TRAINING AND RESEARCH IN WEST VIRGINIA (1954), described in W. Va. Medical Journal, Oct. 1954, p. 1. This audit was prepared in cooperation with the Southern Regional Education Board for the Southern Governors’ Conference.
35 The hospitals were originally certified in 1946-48. Lakin State Hospital, under Dr. Simon Johnson, won a national achievement award in 1952. Address by Dr. Hiram Davis, Superintendent of Huntington State Hospital, at Charleston chapter, W. Va. Ass’n for Mental Health, Oct. 25, 1956.
cal and nursing staff and lack of in-service training for doctors and nurses, and too great a use of restraint and seclusion.36

Recognizing the serious plight of the hospitals, Governor William C. Marland and members of the legislature during the 1956 session traveled en masse to Lakin State Hospital to inspect conditions there and to hear addresses and recommendations by various experts. In accord with the recommendation of the Central Inspection Board and the platforms of both political parties the legislature in 1957 created a Department of Mental Health, transferring to it from the Board of Control the management and control of the six state mental institutions.37 The department is to be headed by a psychiatrist, removable only for cause. He is given very broad authority to supervise and regulate the mental hospitals and other phases of the mental health program of the state. It is to be hoped that the efforts of the new department will soon result in the reaccreditation of the state mental hospitals. The 1957 session of the legislature also passed a bill authorizing the state to join the Interstate Compact on Mental Health, a reciprocal arrangement wherein each member state agrees to the care of a nonresident mentally ill person if he is a legal resident of another member state.38 This legislation was sponsored by the Council of State Governments. West Virginia was one of the first states outside the northeast to join the compact.

IV. CIVIL COMMITMENT OF THE MENTALLY ILL

Just as present conditions in the mental institutions of West Virginia are not what they should be, so also revision is needed of the state's laws on hospitalization of the mentally ill. The most constructive line of current thinking about hospitalization of mental patients is that the law should make it easy for a person to go to the hospital voluntarily if he wishes; and if commitment is to be involuntary, then the procedure should be simple and should spare him embarrassment and discomfort, at the same time preserving his right to a fair hearing.

In some respects present practice in West Virginia falls short, despite the important changes made in the statute in 1955.39 A

36 Report, supra note 34, passim.
hearing before the county mental hygiene commission, and the procedures leading up to and following such a hearing, are still entirely too much like a criminal proceeding. The whole process apparently reflects the outdated belief that mental disorder is a wrong against society and that "lunatics" ought to be confined in jails or workhouses along with paupers, vagrants, and criminals. Remark the West Virginia statutory language. The complainant makes a sworn statement before the county clerk, who issues a warrant requiring the suspected person to be brought before the mental hygiene commission at a designated time.\textsuperscript{40} The warrant is addressed to the sheriff or a constable, who is directed to take the suspected person into custody. The respondent is likely to be lodged in the county jail pending the hearing, since most counties have no other facilities available, despite the amendment adopted in 1955 to discourage this long-standing practice.\textsuperscript{41} The commission itself includes a member of the county court, the prosecuting attorney or an assistant or both, and the county clerk or a deputy or both.\textsuperscript{42} If the commission decides on commitment, the respondent is usually returned to jail until a bed is available for him at a state hospital. Veterans whose mental illness results from military service may be sent to veterans' hospitals, which are usually less crowded and better staffed than the state hospitals.\textsuperscript{43} Then he will be taken there by the sheriff, unless the family arranges other transportation. And the term commitment itself suggests a form of punishment, as with commitment to jail for contempt of court. (By contrast a person charged with or convicted of a crime may be sent to a mental hospital upon a mere court order, without the mental hygiene hearing; thus the commitment procedure may be more humane for the person who commits a crime than for the person who does not. But if there is no vacancy in the mental hospital, it is mandatory that the "criminal" mental patient be kept in the county jail.)\textsuperscript{44} There are two kinds of civil commitment in West Virginia. A person may be hospitalized either for a temporary observation period not exceeding six months, or for an indeterminate period. The latter form of commitment relieves the patient of legal capacity,\textsuperscript{45} regardless of the nature and severity of his illness.

\textsuperscript{40} W. Va. Code c. 27, art. 5, § 1 (Michie 1955).
\textsuperscript{41} Id. art. 5, § 5.
\textsuperscript{42} Id. art. 3, § 1.
\textsuperscript{43} Id. c. 44, art. 15, § 14.
\textsuperscript{44} Id. art. 6, § 2.
\textsuperscript{45} Id. art. 5, §§ 4.
Such a proceeding is hardly conducive to the respondent’s mental health. The proceeding is a gross indignity if he is mentally well, and it is likely to make matters worse if he is not. The paranoid psychosis is characterized by a delusion of persecution, such as the feeling that “everybody is against me.” Serious harm may be done to a paranoid by a degrading, criminal-like proceeding, and when he finally arrives at the mental hospital he may feel that his confinement there is a continuation of his punishment rather than the beginning of his treatment. Of course the staff finds it hard to gain the confidence of such a patient, and his recovery is impeded accordingly.

It is questionable whether a hearing before the mental hygiene commission is the best way to determine the issue of whether a person should be committed. Rarely is a doctor a member of the commission, and the two doctors who assist the commission are usually not psychiatrists. The present procedure does not utilize the services of psychiatric social workers at all, although a few of them are available in the state. Although the statute requires that the two doctors shall make a mental examination of the respondent, “preferably before the hearing,” the practice in many instances is to conduct the examination as a part of the hearing itself. A mental examination, like a physical examination, ought to be conducted in an atmosphere of privacy, not at a hearing before an assemblage comprising the three or more members of the commission, the two doctors, a guardian ad litem, a reporter, the complaining witness, and maybe other witnesses, the sheriff, and persons waiting for the next case. How can the commission discriminate the borderline case of mental illness in such a setting and reach a wise decision?

How many persons are committed involuntarily each year in West Virginia? Figures for Kanawha county are available. They show that 165 persons appeared before the commission in 1955 and 127 were committed (figures include mentally deficient persons but not inebriates). There were more men than women committed, and more persons in the 30-39 age bracket than any other year bracket. Since Kanawha county has about one-ninth of the

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46 Address of Dr. Davis, supra note 35. At least one mentally ill person confined in the Kanawha county jail attempted suicide.

47 W. Va. CODE c. 27, art. 5, § 3 (Michie 1955).

48 In 1954, 155 persons appeared before the commission and 105 were committed. In 1955, the figures were 144 and 108 respectively. These data were gathered and tabulated by the Kanawha Welfare Council.
population of the state one may estimate very roughly that 1400 persons are brought before mental hygiene commissions each year and that 1100 of them are committed. Voluntary commitments are apparently much fewer.49

The same procedure that is used for commitment of the mentally ill is used for commitment of the inebriate and of the mentally retarded.50 Again it is questionable whether the mental hygiene commission as presently constituted is a tribunal properly qualified to decide these matters. (The problem of inebriacy is discussed in the next section.)

It is interesting to know that the mental hygiene commission in West Virginia was first created in 1915 under the name lunacy commission.51 Prior to that time the method of commitment was to obtain a lunacy warrant from a justice of the peace, who with the aid of a physician and other witnesses would decide the question of whether the respondent should be committed.52 Other states have various methods of commitment ranging from a hearing before a single judge to jury trial.53 Among the recommendations of the Central Inspection Board of the American Psychiatric Association is that West Virginia provide for commitment upon the certification of two qualified physicians, without the necessity of a hearing before the mental hygiene commission.54 The recommendation omits, apparently by mistake, to include the usual correlative provision that the person committed in this manner may object to the commitment and have a hearing at a later date.55 In states with similar provisions experience has shown that there are extremely few cases of unjustified commitment.56

A few years ago at the request of the National Advisory Mental Health Council, the United States Public Health Service developed

49 Dr. Davis states, supra note 35, that at Huntington State Hospital there were 145 voluntary patients of a total of 1300 patients.
50 W. Va. Code c. 27, art. 6, § 1, and art. 10, § 2 (Michie 1957).
54 1 Report, supra note 34, at 15.
55 See note 53 supra.
56 Ibid.
a model act on hospitalization of the mentally ill, which is the source of some of the 1955 amendments to the West Virginia law. Among the provisions not adopted are the following ones concerning civil rights:

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

"Mechanical restraints.—Mechanical restraints shall not be applied to a patient unless it is determined by the head of the hospital or his designee to be required by the medical needs of the patient. Every use of a mechanical restraint and the reasons therefor shall be made a part of the clinical record of the patient under the signature of the head of the hospital or his designee.

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

"(1) to communicate by sealed mail or otherwise with persons, including official agencies, inside or outside the hospital;

"(2) to receive visitors; and

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

"(b) Notwithstanding any limitations authorized under this section on the right of communication, every patient shall be entitled to communicate by sealed mail with the [committing agency] and with the court, if any, which ordered his hospitalization.

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

In this connection it is significant that the American Bar Association has established a committee on rights of the mentally ill, which is

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57 FEDERAL SECURITY AGENCY, PUBLIC HEALTH SERVICE PUBLICATION 51 (1951); Whitmore, Comments on a Draft Act for the Hospitalization of the Mentally Ill, 19 GEO. WASH. L. REV. 512 (1951).
undertaking a comprehensive study of this subject. The trend of modern psychiatric thinking is in accord with the draft act.

The writer recommends that the commitment law of West Virginia be further revised in the light of modern medical knowledge and with the guidance of the model act referred to above. The mental hygiene commission should be given a more modern name such as mental health board and should be reconstituted to include persons who by training know about mental illness and related matters. It is a paradox that our legal system recognizes that insanity should excuse a crime, yet in civil commitment proceedings treats the respondent as though he were a criminal. The terms “commit” and “commitment” should be replaced by the terms “hospitalize” and “hospitalization” since the latter terms connote treatment rather than punishment. All the language in the statute which smacks of a criminal proceeding should be changed. It is hoped that the new director of mental health will provide expert advice and leadership in the process of revision.

Alongside the need for enlightened revision of the law there is a need for enlightened administration. While attorneys who serve in the legislature can help in revision, attorneys who serve as members of mental hygiene commissions, as guardians ad litem, and as counsel for petitioners can help greatly in improving administration. The use of voluntary commitment should be encouraged. Provision should be made for better local or regional facilities for the care and custody of the mentally ill before the hearing or while awaiting transportation to the hospital, so that they may be spared the humiliation and shock of confinement in jail. Persons charged with or convicted of crime who are found to be mentally ill should also be kept in such facilities, for the crime itself may have been caused by the illness.

(TO BE CONTINUED)

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59 See note 53 supra; DAVIDSON, FORENSIC PSYCHIATRY c. 12 (1952).
60 See section VI infra.