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COMMITMENT OF THE MENTALLY ILL IN MAINE:

A HISTORY OF PUBLIC POLICY

By

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This paper traces the historical development in the State of Maine of the procedures by which persons found to be mentally unsound can be committed to institutional care against their will. Beginning in 1820 and continuing to the present, specific changes in the statutes governing this area are noted. Both the criminal and civil commitment procedures are dealt with. Following the historical trace, pending legislation relating to the criminal commitment process is examined in detail. Finally, consideration is given to the need for a complete reexamination of the practice of involuntary commitment involving ethical and constitutional issues.
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In ancient times there were no written laws which governed the mentally disturbed. Taboos and tribal customs however, prescribed what in many cases were brutal physical measures designed to make the disturbed person normal according to the ideology of the time (12, p.1). At different times in history mental disturbance has been viewed as caused by demons, celestial bodies, and supernatural powers. In the past one hundred and fifty years, the prevalent view has been that mental disturbance is essentially a medical problem, a view which actually originated in the fourth century with Hippocrates (12, p. 1). This ideology is reflected in the term "insane" which literally means "unhealthy". The first legal reference to the mentally disturbed with respect to their incarceration occurred in 1676 when Massachusetts enacted a statute ordering the officers of a town to restrain disturbed persons so that they would not harm others (30, p. 80). The first hospital to which the insane could be sent for treatment in the United States was established in 1773 at Williamsburg, Virginia (12, p. 5). At the time that Maine became a state in 1820, the Williamsburg hospital was the only facility of its kind in the United States.

This paper traces the statutory history in Maine of the commitment of the mentally disturbed, the process by which such people are incarcerated by society. The historical treatment of this subject is important for a thorough under-
standing of the commitment process today. The actions of the legislature reflect a great deal about the attitudes of the populace of the time, for it is their will which the legislature must act upon. As the legislative process continues into the future, reflection on the past can shed light on decisions which must be made. The reasons for and purposes of commitment have been developed over a long period of time, and consideration of future changes should not be made without an evaluation of the entire process including the historical aspects.

The first legislators of the State of Maine wasted no time in making sure that the statutes dealt with the problem of insane persons in the state. The first issue covered involved the children of the insane. It was provided that the Judge of Probate could appoint a guardian to care for the children of the insane "in the same manner as though their parents were dead" (25, p. 177). The Judge of Probate could also upon recommendation from the selectmen, appoint a guardian to administer the estate of the person (25, p. 177). Thus for the purposes of the care of their children and the administration of their estates, the insane had no more rights than a dead man. Here also can be seen the first qualification of the insane as "lunatics, idiots, non compos, or distracted persons" (25, p. 177). So far there is only a
provision for his estate and children, but what became of the insane person himself? A method for their commitment was provided in chapter CXI, section 6. When it was shown to two justices (apparently any justice of any court although this was not detailed) that any person was so insane "as to render it dangerous to the peace or the safety of the good people for such person to go at large", they could commit the person to the house of corrections "till he be restored of his right mind" (25, p. 363). The status of the insane person as a convict is reinforced by the provision that although debtors and minors had to be confined separate from other criminals, the insane did not have to be confined separately. Unlike the criminal however, the insane person had to pay for the expenses of his confinement and in addition had to be put to work during the period (25, p. 363). Whether the reason to put the insane to work was considered therapeutic or punitive is unclear, although there probably was an element of both.

The first legislature also provided for the disposition of the "insane criminal", those acquitted by the courts or those not indicted by the Grand Jury because of insanity. They too were to be committed to prison at their own expense until they were "restored of right mind" (25, p. 207). The only differences between the person convicted of a crime and sentenced to prison and the person acquitted of a crime
by reason of insanity seem to be that the convicted crim-
inal did not pay for his incarceration and in addition,
recieved a definite period of confinement; things not so 
for the "acquitted" insane person.

These were the first set of statutes dealing with the 
insane in Maine. By way of summary, civil commitment could 
be ordered when two justices found a person to be: either 
an idiot, lunatic, non compos, or distracted person and 
a danger to the peace and safety of the community. Crimin-
al commitment was automatic upon acquittal after a defense 
of insanity. In both cases, commitment was to prison for 
an indefinite period at the person's expense. It is inter-
esting to note that the statutes do not mention the pro-
cedures for release of a person so committed. Apparently 
it was up to the prison superintendent to decide whether 
the person was restored of his right mind or not since there 
were no provisions for a rehearing. Although not mentioned 
in the statutes, habeus corpus was of course available to 
those aware of its use. This writ requests a judicial deter-
mination of the legality of continued confinement (23, p. 226). 
Thus to be released on a writ of habeas corpus the committed 
person would have to prove that either the procedures by 
which he had been committed were not the correct ones, or 
that he had been restored to right mind and confinement was 
no longer justified
Another important facet of the commitment process that was not written into the statutes involves the defense of insanity. As indicated previously, the first statutes provided that those acquitted by this defense be committed; but there was no provision for the basis to be used to determine the issue of insanity. This was left to the courts to decide. It appears that the rule being applied at this time was the simple "right-wrong" or "good and evil" test originated in 1760 in the Ferrer decision (16, p. 142), although exactly when it was adopted in Maine or under what circumstances is not clear. It was a carry-over of the old Common Law rule in effect in Massachusetts before Maine became a separate state. The right-wrong test is extremely simple and states that an accused criminal is to be found not guilty by reason of insanity if he could not distinguish the difference between right and wrong, in a general sense (16, p. 142). But the wording of the test was very important in light of the statute providing automatic indefinite commitment upon acquittal.

The first major change in the commitment statutes in Maine was anticipated in 1834 with the filing of a report from the joint standing committee of the legislature concerning the establishment of an insane hospital. This report pointed out that formerly there had been no hope of recovery for the insane but that developments in medicine
and philosophy meant that "confinement of the insane need no longer be merely for maintaining order in society" (33, p. 657). Examples were cited of successes in curing the insane and it was estimated that there were over 550 insane persons in the state (33, p. 657). A few days after the filing of this report, the legislature authorized twenty thousand dollars for the erection of an insane hospital for "one hundred lunatic persons furiously mad..." (33, p. 661). The intention of the legislature in this undertaking is especially noteworthy since it represents a drastic policy change. Clearly the intention was not merely to provide a separate facility for punitive or custodial care but the very use of the word hospital emphasizes that this was to be a facility where the insane would receive treatment intended to cure them. Thus insanity was to be viewed as a medical problem and the role of the insane person switched from convict to patient, at least in theory.

In 1840 with the opening of the new Insane Hospital at Augusta some changes were made in the commitment laws as contained in the Revised Statutes of 1841. The procedure remained the same as before but commitment could now be ordered to either prison or the insane hospital under both the civil and criminal processes (34, p. 721, 740). Since the hospital had a limited capacity, the statutes provided that only those found to be dangerous could be committed
under the civil process (34, p. 740). Because of this, it is not hard to see how the insane hospital came to be viewed as not a hospital at all but a repository for dangerous "lunatics" and the commitment process as a means of getting the insane out of circulation rather than giving them treatment. The fact that there were no provisions for voluntary admission but that the only way one could be admitted was through the involuntary judicial process, reinforced this view. Thus the aims of the legislators in setting up the hospital were not met and the hospital acquired a stigma which has been attached to it ever since.

This seems to have been recognized by the superintendent of the hospital in his first annual report to the legislature. In it he states that the hospital "must receive the most wretched that breathes the vital air and restore them to reason... Then and only then will be fully and justly appreciated the beneficence of the enlightened Representatives of this state" (24, p. 21). Likewise the governor recognized the problem in his recommending action to admit others in need of care and treatment who were not deemed to be "so furiously mad as to be dangerous" (15, p. 21).

When the hospital first opened, the legislature took no action concerning its regulation or operation. This was handled through the office of the governor who appointed a board of trustees and a superintendent to supervise the oper-
ation of the hospital at the outset. In 1847 however, the legislature did take action and wrote into the statutes a system to govern the hospital and in addition made many changes in the commitment laws. Briefly, the hospital was to be governed by a board of trustees appointed by the governor and a superintendent appointed by the trustees (1, p. 28). The trustees were to examine the hospital annually and report on the "conditions, concerns and wants of the hospital" with particular attention to be placed on the examination and auditing of the accounts of the hospital (1, pp. 29-30). The superintendent's duty was to reside at the hospital at all times and to be sure that the patients were apportioned equally among the towns (1, p. 29). Clearly the legislature does not seem to have been overly concerned with what was going on inside the hospital other than in making sure that the books were in order and that money was being spent fairly. Any matters concerning the particular therapies or regulations within the hospital including the size and qualifications of the staff, were left to the trustees to decide. However, the legislature did not provide that the trustees or the superintendent have any expertise in the field of mental health care, although it did state that the superintendent was to be a physician (1, p. 28).

The changes made in the commitment statutes in 1847 were substantial. It became the duty of the parents or guard-
ian of an insane minor to send him or her to the hospital within thirty days after the onset of an attack of insanity, if they were of sufficient means to support the expenses of hospitalization (1, p. 30). No medical or legal review was necessary, so the parents or guardian could apparently decide for themselves whether their child was insane or not. For those not subject to this procedure a formal means of civil commitment was to be followed. The municipal officers (the mayor and aldermen) of a town constituted a board of examiners who after a complaint in writing were authorized to inquire into the condition of a person and to receive "all testimony necessary for a full understanding of the case" (1, p. 30). If they found as a result of this testimony that the person was insane and that either his or others' safety and comfort would be promoted by his commitment, they could direct the hospital to receive and detain him till he was restored of his right mind (1, p. 31). As previously was the case, the person or his guardian was liable for the expenses of the commitment; but if neither were able to pay, the town which authorized the commitment was liable (1, p. 31).

The non-medical and particularly the non-judicial quality of this procedure is striking when one remembers that the result is to deprive a person of his liberty for an indefinite period. There was however a judicial safeguard on
this process, in the form of a provision for appeal. The appeal consisted of a hearing before two justices of the peace who would hear any evidence presented to them and decide upon the person's sanity and either affirm or overturn the finding of the board of examiners (1, p. 31). This was however, as high as the appeal process could go. As is true of most legal processes, the poor were at a great disadvantage since many could not afford to pay the appeal expenses which amounted to two dollars a day and ten cents per mile for each justice (1, p. 31).

Another important aspect of the 1847 revision of the commitment laws was that for the first time a discharge procedure (although a limited one) was written into the statutes. A person liable for the support of a patient could apply to the municipal officers of the town from which he had been committed and ask for an inquiry to determine whether continued confinement was justified (1, p. 33). After hearing all witnesses and information relative to the subject the municipal officers could direct the hospital to release or continue to detain the person; but in either case their action was binding and could only be undertaken once every six months (1, p. 33).

Although civil commitment to prison was no longer an option after 1847, the statutes did permit it as an alternative in cases involving criminal commitment (1, p. 34). It was stated however, that commitment in such cases could
only be ordered to prison if there was no room available in the hospital (1, p. 34). A new way by which a person could be committed through the criminal process was written into the statutes at this time. When it became known to the judge of a court before which a person charged with a criminal offense was to be tried, that this person would plead insanity as a defense to the charge, the judge could order him detained in the insane hospital until further notice from the court (1, p. 34). Apparently the superintendent had no authority at all to release a person so committed but he was to report back to the court concerning the "truth or falsity of the plea" (1, p. 34). Under the English Common Law it was an established principle that those persons becoming insane before trial would not be tried (16, p. 126). This statute appears to be an attempt to formalize this Common Law principle, however loosely. The statute is unclear as to exactly what should be the effect of the hospital's finding when reported back to the court. More importantly however, it lumps together what should be two separate judicial determinations: the issue of competency to stand trial and the issue of criminal responsibility under the insanity defense.

The next major changes in the laws relating to the commitment of the insane did not occur until 1871. This revision dealt primarily with expanding the discharge pro-
cess but made no changes in any statutes relating to the actual commitment procedures themselves. The duties of the trustees on their annual inspection were further defined to include their making "a particular inspection into the condition of each patient" (35, p. 928). They were authorized to discharge any patient whom they felt was restored to the point that neither his nor the public's safety and comfort required his continued confinement (35, p. 928). This provision finally gave a standard for release that could be worked with and did not rely merely upon the judgment of one person, the hospital superintendent, with no guidance from the legislature. However, it will be remembered that this standard was being applied by those who need have no qualifications of expertise in the field of mental health to be appointed.

A check was provided at this time on possible abuses or injustices resulting from the commitment of insane "criminals" before trial. Those committed by the courts prior to trial for a determination of their sanity were to be released by the superintendent if they were not called for by the courts during the next term following confinement (35, p. 933). This sought to prevent the type of situation where a person could be confined for a long period of time without any judicial determination of his sanity. Thus the courts were forced to either permit the person to have his trial on
the criminal charge or to initiate civil commitment proceedings against him. This seems only reasonable, but until then it had not been the case.

There were two other areas covered in the 1871 revision which relate to the commitment process. For the first time the state began a trend towards absorbing the costs of institutionalization, although on a very limited scale. Towns with less than two hundred inhabitants did not have to support their insane—the state would (35, p. 932). The other area involved a provision for criminal penalties including a fine and imprisonment for those attendants at the hospital found mistreating patients in any way (35, 934).

This piece of legislation had come about as a result of an investigation which had been conducted three years earlier in 1868 into patient abuse (30), and marks for the first time an attempt by the legislature to control conduct inside the hospital.

During this time, while the legislature was writing and revising the statutes relating to commitment, the courts were hearing cases involving challenges to and interpretations of the statutes. Most of these cases had as a common denominator a controversy over who was to pay for a particular person's hospitalization expenses. The legality of having the selectmen of a town decide the issue of insanity was challenged but affirmed in the case of "Inhabitants of
Eastport v. Inhabitants of Machias" (21, p. 402). The selectmen were ruled to be the proper legal certifying officers and their findings to be fact (21, p. 402). In the case "Overseers of Fairfield v. Gullifer", an important ruling was made which excluded idiots (the mentally retarded) from the class of "insane persons" for the purposes of commitment (28, p. 360). It was ruled that the judge of a probate court could not appoint a guardian for such a person and he therefore could not be committed (28, p. 360). The principle of this ruling was followed up and written into statutory form in 1874 by an act which stated that the term "insane person" could include an idiot, non compos, lunatic, or distracted person but that in regard to their civil commitment, it would not include idiotic or non compos persons (2, p. 157).

In 1870 there was an important development in the case law which had a direct bearing on the criminal commitment statutes. In the case of "State v. Lawrence", Maine abandoned the old right-wrong test for criminal responsibility under a defense of insanity and adopted the revised or modified right-wrong rule. (45, p. 574). This new test, known as the M'Naghten rule, was developed in 1843 in England and had gained acceptance in the United States with Maine being one of the only states at the time which had not yet adopted it. The Maine version of the M'Naghten rule stated that to be found not guilty by reason of insanity the accused must show
"...that at the time of committing the act, he had not capacity and reason sufficient to enable him to distinguish between right and wrong as to the particular act he was doing" (45, p. 574). It is further added that a partial derangement of the mind would not excuse the person from criminal responsibility but a person must have profound deficits in memory and understanding the relation between himself and others (45 p. 574).

At first glance the M'Naghten rule as adopted in Maine may not at seem at all different from the previous simple right-wrong test; yet there is a very important difference between the two. Under the simple right-wrong test the requirement is that the accused must show that he does not know the difference between right and wrong or to put it another way, that he is (and presumably was) unable to distinguish between the two in a general sense. The modified right-wrong test asks whether the accused knew the difference between right and wrong at the time he was alleged to have committed the wrongful act and with particular reference to that act. In other words, did the accused know when he committed the act that it was wrong? Thus the change from the simple to the modified right-wrong test was a change from a general inquiry into the general mental condition of the accused to a specific inquiry into the specific mental state at a particular time.
The next important revisions to the commitment statutes were adopted in 1880. The trend continued towards the exclusion of the mentally retarded (idiotic) from the civil commitment process. The superintendent was to report to the trustees the names of any patients whom he felt were idiotic at the time of commitment (36, p. 986). The trustees were to release such persons if in their opinion there was no danger to the safety of either the person or the public (36, p. 986). There were now two statutory checks on the civil commitment of the idiotic. Apparently the legislature was not satisfied with the trustees' reporting and visitation process, because although the procedure itself was not altered, it was directed that the governor appoint a separate committee to visit the hospital regularly without notice and report on abuses or ill treatment of inmates (36, p. 991). For the first time the legislature saw fit to deal with the area of patients' rights, evidencing a further concern over activities within the hospital walls. Inmates were to be supplied with writing materials and free postage so they could write whomever they desired; and it was specifically provided than no officer of the hospital could read or tamper with the mail of any patient (36, p. 992).

That the legislature considered a special statute necessary to guarantee to mental patients one of the rights guaranteed to other persons (i.e. the right to read one's
own mail) is revealing about the drastic nature of the commitment process. The first part of the provision, to supply patients with writing materials and postage, is perhaps even more revealing. The committed person not only had no control over his possessions which were administered by a court appointed guardian; neither did he have any control over his person. Once committed unless he had the means to communicate with the outside world he could not contact a lawyer to initiate habeas corpus proceedings, to secure his own release. Thus without this provision the person was completely at the mercy of others and habeas corpus, as well as any statutory provision for self-initiated release, would have been meaningless.

Some minor changes were made at this time in statutes relating to the disposal of insane criminals. Those eligible for criminal commitment could now be ordered initially only to the hospital; but once there, if deemed by the superintendent to be incurable and a bad influence on the other hospital patients, they could be removed to the state prison (36, p. 955). There can be no claims that this was anything but preventive detention. A somewhat macabre provision was also made which stated that a person sentenced to death and then becoming insane could not be executed until restored to reason (36, p. 955).

The most important part of the 1880 revision involved
an evidentiary regulation on commitment proceedings. It was required that the testimony of at least two "respectable" physicians was necessary to establish the fact of insanity in all initial commitment proceedings (36, p. 991). Furthermore, their testimony had to be based upon a personal examination and they had to provide written certification to accompany the person when committed to the hospital (36, p. 991). Thus the legislature sought to insure that a commitment order was based upon "expert" medical evidence in order to insure against abuse of the commitment process by the certifying officers. Such an abuse would thereafter require the collaboration of at least two doctors.

One point should be clarified at this point. Between 1840 when the insane hospital first opened and 1880, its size had not remained constant. The capacity had, through additions, more than tripled from one hundred to 350 by this time and even this capacity was inadequate since there were 404 patients in the hospital (32, p. 2). Thus procedures such as the one above to require medical certification before commitment, were probably designed to keep the hospital from overcrowding as well as to prevent against injustices. An attempt to alleviate this overcrowding was made with the opening of the Bangor hospital for the insane in 1901.

After 1880 there followed a long period of inactivity with regard to changes in the commitment laws. The Revised
Statute of 1904 contained the same civil and criminal commitment procedures, and hospital regulations. One additional provision had been made during this period which seems to recognize hospitalization as a form of punishment. Previously, inmates of state prisons could be sent to the insane hospital if found to be insane but the period of time during which they were at the hospital would not count toward their prison sentence. It was provided at this time however, that those hospitalized in this manner had to be released at the expiration of their sentence whether still considered insane or not (37, p. 978). In other words the time spent in the hospital did count toward the prison sentence. However this did not preclude the superintendent of the hospital from initiating civil commitment proceedings which would, if finalized, authorize further detention.

In 1916, perhaps spurred by developments in the field of psychology such as the theoretical formulations of Freud, some revisions were made in the commitment statutes. In 1907 the legislature which had been excluding the mentally retarded from the insane hospitals, authorized the construction of a separate facility to care for these people at Pownal to be called the Maine School for the Feeble Minded (38, p. 1629). In 1909 the new facility opened and the statutes enabled the trustees to transfer a patient between the two insane hospitals or between a hospital and the school for the feeble minded,
once he was committed to any of them (38, p. 1619). It seems likely that those persons who were believed capable of being helped were sent to the hospital whereas those considered beyond help went to Pownal. The purpose of the school for the feeble minded was to provide care and education to idiotic males between the ages of six and forty and females between the ages of six and forty-five except that "paupers" of either sex could be admitted after these ages (38, p. 1629). The power to commit original jurisdiction was given to the judge of probate. A hearing was to be held preceded by due notice to all the parties including the person in question (38, p. 1629). This was the first time in any commitment proceedings that specific provision was made to allow the person who was the subject of the proceedings to attend. Certification was required from two physicians, who had to be graduates of an organized medical college and residents of the state for three years, stating that the person was "a proper subject for said institution" (38, p. 1629). However before commitment could be ordered approval was necessary for admittance from the superintendent of the Pownal facility. The legislature established a set order for admittance with poor people who had already been in state institutions given first priority and those who could afford to pay for their own support were to be admitted only if there was room (38, p. 1629). The order for commitment was subject to appeal in
the normal judicial manner giving the person the privilege of taking the case to the highest levels on appeal if unsatisfied. Although not stated in detail, a provision was made for release giving the trustees or a justice of the Supreme Judicial Court the power to discharge a person "whenever a further detention in such school in their opinion is unnecessary" (38, p. 1629).

The procedures for civil commitment to the insane hospitals also changed at this time but they remained somewhat different from the procedures for commitment to the school for the feeble minded. The municipal officers of the town wherein the person resided still had original jurisdiction over the process of commitment to the insane hospitals according to the same procedures as before. However the judge of probate was also given the power to commit. Upon complaint from a relative together with a certificate from one physician stating the person was insane a hearing would be held, due notice of which had to be given to the person subject to the order of commitment (38, p. 1622). However this procedure could be undertaken only after the municipal officers of the town had specifically refused to act on the case and thus it was not an appeal process. Appeals from decisions of the municipal officers in regard to commitment were still to be directed to two justices of the peace according to the previous procedure. The legislature continued to regard the
process of civil commitment to the insane hospital as essentially a non-judicial matter to be decided upon by the people of a town through their municipal officers. However judicial remedies were available if a party was unsatisfied. A new procedure for temporary release was also introduced at this time. The superintendent could permit an inmate to leave the hospital for up to six months, receiving him back any time during this period without a further order for commitment (38, p. 1625). No guidelines were given for the superintendent to follow, leaving implementation of this statute at his discretion. Nevertheless he was indirectly cautioned against too much use by the provision that the state was liable for the actions of those temporarily released in this manner in the same way as if they had remained continuously in the hospital (38, p. 1625).

With regard to the criminally insane, the statutes of 1916 provided that an insane criminal in a prison could no longer be transferred to the insane hospital at the discretion of the warden. An examination by a doctor was required and a specific order for commitment was required from a judge of a local municipal court after a hearing on the matter (38, p. 1579). Authorization was given for a separate facility at the Augusta hospital to house the criminally insane (38, p. 1581). The superintendent of the hospital could however move patients between the building for the
23.

An important and extensive revision of the statutes relating to commitment occurred in 1930. Many of the new statutes reflect a desire to open up the commitment process allowing admittance without the need to go through the lengthy procedures which necessitate hearings before judicial or municipal bodies. A provision was made for the emergency hospitalization of those in need of immediate "detention or restraint for his safety or comfort" (39, p. 1723). Pending the determination of the issue of insanity in the normal manner by the municipal officers, the superintendent of the hospital was authorized to detain such people if accompanied by the original complaint (to the municipal officers) and a physician's certificate (39, p. 1723). Commitment in this manner was valid for only ten days and detention was to cease if the municipal officers did not formalize the commitment within this time period (39, p. 1723). For the first time a provision was made in the statutes for voluntary admission to the insane hospital. The superintendent could accept applications for admission from those desiring it if in his judgement the person making application was sufficiently competent to make it (39, p. 1731). Although it may seem paradoxical to say that a person would only be criminally insane and the regular hospital as the safety of the patients required it in his judgement (38, p. 1581).
admitted upon application if he was sufficiently sane to make a competent application, there is a reason for this. Those admitted voluntarily were permitted to leave the hospital when they chose to (39, p. 1731). Thus the desire was to assure that the most deranged people be committed in the normal manner so that they could be detained and unable to leave at will.

The standard procedure for commitment to the insane hospital was modified at this time also. In lieu of certification by two physicians as a prerequisite for a formal commitment order, a person could be committed to the hospital by a judge or municipal officer under such limitations as the officer might direct for the purpose of a determination of his insanity (39, p. 1731). Thus under this statute a person could be detained to determine whether he should be committed. Power to commit for short periods was also extended to physicians, members of the board of health, and police officers (30, p. 1732). It was the responsibility of the superintendent, in cases referred in this manner, to cause these people to be either committed according to the standard procedure, to become voluntary patients, or to be released within fifteen days (39, p. 1732). As a check against this extension of the power to commit it was provided that if a person referred in this manner was deemed by the superintendent of the hospital to be not a suitable subject
for hospitalization, the person referring commitment would be liable for all reasonable expenses which had been incurred in the process (39, p. 1731).

The revision of 1930 for the first time dealt with the regulation of private mental hospitals and authorized commitment thereto. A system of licensing was instituted and these hospitals had to be visited at least once a year by an officer of the board of health who was to inspect the cleanliness and sanitary conditions of the premises (39, p. 1733). A person could be committed to a licensed hospital for a thirty day period by two physicians if they found that his proper care warranted it and providing that his relatives agreed to pay for his support (39, p. 1733). If the superintendent felt that detention after the thirty day period was needed, he could apply to the judge of a local municipal court requesting a hearing after which the judge could order the person to be detained until restored of right mind or until release was requested by those who were paying for his support (39, p. 1734).

An extremely important provision allowing sterilization of those committed to public insane hospitals was introduced in the 1930 revision. If a physician in charge of a patient at an insane hospital found that sterilization was needed "for the prevention or reproduction of feeble-mindedness or for the therapeutic treatment of some forms of mental dis-
ease", he was to notify the nearest relative of this person about his opinion (39, p. 1732-3). If the person in question was capable of giving consent, his consent was necessary for the operation to occur; but if he was not capable of giving consent, the consent of the nearest relative would be sufficient to authorize the operation (39, p. 1733). The question of the ability to give consent was to be determined by a council composed of two physicians each of whom had to have practiced in the State of Maine for five years (39, p. 1733). This provision for sterilization is important because it further shows the effect of an order for commitment and the precarious legal status of the mental patient.

In 1944 a review of the statutes of the State of Maine was made but very few changes were made in the statutes relating to the commitment of the insane. A reorganization of the statutes placed the commitment provisions under chapter 23 entitled "The Department of Institutional Services". The only new provisions gave the department authority to discharge anyone from the state hospitals who they felt it best for and in addition mandated that records kept by the department not be open for public inspection (40, p. 501). The procedures for commitment remained exactly the same as in 1930 except that chapter 155 section 55 of R.S. 1930, which gave police officers, physicians and members of the board of health the power to commit, was repealed (3, p. 114-5).
In 1951 a complete rewriting and revision of the mental health statutes occurred, repealing all former statutes in an attempt at consolidation and simplification. All the places where the word "insane" had been used in the past were now changed to read "mentally ill" except in relation to criminal statutes where the word "insane" continued to be used (4, pp. 426-435). The standard civil commitment procedure could be initiated by a justice of the peace, police officer or relative of the person to be committed. A petition was to be addressed to the superintendent of the hospital together with certification by one physician claiming that the person was mentally ill and required confinement and treatment. The petition was then sent to a municipal officer of the town where the person resided, who would inquire into the matter and then sign the petition if he felt that confinement and treatment were needed. His signature would authorize commitment (4, p. 426). The period of this initial commitment was for thirty-five days but a method was provided to extend this to an indefinite period (4, p. 426). The superintendent, any justice of the peace or any notary public could apply during the first twenty-five days of the initial period to the judge of probate requesting that the person be confined for continued care and treatment (4, p. 427). A hearing was held (although the person in question did not have to be notified of the hearing) and the judge
after hearing all relevant testimony could order indefinite commitment if "his safety or that of the public will thereby be promoted" (4, p. 427-8). The judge of probate could likewise decide to commit indefinitely in the same manner as above on a direct petition in the first instance from a blood relative of the person to be committed (4, p. 428). In this case however, the person had to be properly notified of the hearing to take place (4, p. 428).

The intention of these new procedures seems to be to keep simple cases involving short periods of commitment out of the courts. However there was a realization at the same time that the permanent, or at least indefinite commitment period, was something more serious in nature which required a judicial determination. Criminal penalties were to be imposed on anyone who gave false testimony at one of the hearings or who conspired to have someone not mentally ill committed (4, p. 429). Again a provision for voluntary patients to be admitted to the hospital was instituted, although these persons were there voluntarily in name only. A person would be admitted to the hospital on his own application, however he had to give ten days notice in writing before he would be allowed to leave (4, p. 429). In addition the superintendent was authorized to detain the person beyond the ten day notice period if he felt that the person could not be freed with safety to himself and others, while
civil commitment proceedings were initiated (4, p. 429). Thus voluntary patients were not much better off in terms of their freedom than were civilly committed patients.

The statutes in the area of criminal commitment were also rewritten and revised at this time. The courts were no longer required to automatically commit those found not guilty after raising the defense of insanity, but they could order such persons either committed indefinitely or released (4, p. 31). Once a person had been so committed however, the superintendent could not release him (as he was specifically authorized to do in all other cases) without a court order "after satisfactory proof that his discharge would not endanger the peace and safety of the community" (4, p. 431). Once again a person could be committed for thirty days to determine his sanity when the court found that the person would plead insanity as a criminal defense. If found by the hospital to be not insane the person would be ordered back to jail to await trial; but, if found by the hospital to be insane, he would remain detained therein for continued observation (4, p. 430). No time limit was placed on the duration of such commitment, and indeed persons confined in such manner would have never had the issue of their insanity and need for confinement judicially determined in one way or the other. Thus in theory they could remain in the hospital for the rest of their lives merely for "observation" to determine
their competence to stand trial.

In 1952 in the case of "Appeal of Sleeper in Re Commitment of Ralph S. Small to Augusta State Hospital", the Supreme Court of Probate handed down an extremely important decision in regard to the statutory history of commitment in the State of Maine. This was apparently the first at this level to raise questions about the legality of the commitment process that did not have financial considerations as its ulterior motive. In addition, this case was important because it reviewed the statutes on the books and provided guidelines for commitment procedures to be followed by legislatures in the future. The decision struck down the entire section of the 1951 revision discussed above, ruling that adequate safeguards to protect the constitutional rights of the person to be committed were not provided for (11, p. 315). The court reasoned that the regular commitment procedures, as established in the 1951 revision, applied indiscriminately to all persons alleged to be mentally ill whether or not they actually required detention for their own safety or the safety of others, and whether or not they had sufficient capacity to understand the meaning of a notice of commitment proceedings even if one were served upon them (11, p. 307). The court stated:

Under this act a person may be committed for observation and treatment for a preliminary period of not exceeding thirty-five days without hearing, without notice, without any opportunity to be heard and without any provision being made in the act allowing him within said period
to institute any proceedings to test the necessity of his commitment for observation and treatment. (11, p. 307)

It was recognized by the court however, that there were instances where emergency hospitalization of a person pending a determination of his ultimate commitment to a hospital for the mentally ill, was needed. Thus the court ruled that the emergency hospitalization statute as written in 1930 and left virtually unchanged in the 1944 revision, adequately provided detainment ancillary to a proceeding to determine final commitment (11, p. 305). Although the emergency hospitalization provision was only a part of the 1951 law, the court struck down the entire law because it saw the emergency hospitalization provision to be the major thrust of the entire law. In addition the court apparently wanted the legislature to reconsider the entire area and come up with some better solutions than were posed in the 1951 revision. But for the time being, commitment proceedings would be governed by the statutes written thirty years earlier. The conclusion of the court in this case was a far reaching one, which extended to its extreme, is used by many today as an argument to abolish the act of involuntary commitment entirely: "The confinement of one who is mentally ill in a mental hospital is a deprivation of his liberty within the meaning of the fourteenth amendment to the Constitution unless accomplished and continued with his voluntary consent" (11, p. 313). This argument will be dealt with in more detail later.
In 1949 the National Institute of Mental Health together with the Federal Security Agency began work on a project whose purpose was to study the commitment statutes of the various states and to formulate a standard set of procedures to govern the hospitalization of the mentally ill (9, p. 455). It was hoped that a commission of this nature could study all aspects of the problem in more detail and could thus come up with an act which would be acceptable to all states giving one standard in the country instead of the vastly different procedures from state to state then in effect.

In 1952 as a result of this effort, the "Draft Act Governing Hospitalization of the Mentally Ill" was published (see appendix). The Draft Act was slow to gain acceptance at first but in 1961 the Maine legislature considered it in an effort to find a more up to date acceptable set of statutes in this area than the voided 1951 attempt. Although Maine made many changes in the Act (as had other states, defeating one of the purposes of the Act), the 1961 revision of the commitment procedures was based heavily both in language and substance on the original version of the Draft Act. Since the 1961 adoption of this revised version forms the basis of the commitment procedures in effect today, it will be dealt with in considerable detail.

The first issue dealt with in the 1961 revision involved a definition of terms to be used in the act, the most
important of which defined a mentally ill individual as some-
one "having a psychiatric or other disease which substan-
tially impairs his mental health" (5, p. 345). Voluntary
admission to a public mental hospital was to be granted by
the superintendent to anyone applying therefor who showed
symptoms of mental illness, except for persons with crimin-
al actions pending (5, p. 345). A voluntary patient was to
be released immediately upon request except that release
could be postponed for up to ten days while civil commitment
proceedings were instituted if the release would be unsafe
for the patient of others, in the judgement of the superin-
tendent (5, p. 346). Thus again voluntary patients are
subject to detention with no judicial order or hearing. That
judicial proceedings could not be instituted against volun-
tary patients unless release had been requested, may have
made some patients reluctant to ask for release. They might
fear that they would be detained and then committed indefin-
itely if they were not completely well at the time of asking
for release (48, p. 277).

There were three procedures for involuntary commitment
provided for under the Maine version of the Draft Act. The
procedures were: 1) medical certification, standard non-
judicial procedure; 2) medical certification, emergency pro-
cedure; and 3) court order. (5, p. 346). The medical certi-
Fication procedure could be initiated by a friend, relative
or guardian of a person. The person would be committed to
the hospital if two licensed physicians certified that they
had examined the individual and found him to be mentally
ill and either likely to injure others if not detained or
in need of care and treatment and unable to make application
for voluntary commitment (⁵, p. 347). The emergency procedure
could be initiated by any police or health officer and re­
quired certification from one physician that the person was
mentally ill and likely to injure himself or others if not
immediately detained for commitment to occur (⁵, p. 347).
People committed in either of the two above ways had to be
examined within three days after being admitted by a physician
on the hospital staff; and if he was not examined or if the
physician could not certify that the person was likely to
cause injury if released, he would be immediately discharged
(⁵, p. 350). In addition any person so committed would be
released within ten days after a request in writing to the
superintendent (⁵, p. 351). Notice however that these
persons could be detained against their will in some cases,
with only a finding by a physician that they need care and
treatment and without a hearing. (This would seem to be
contrary to the dictates of the court in the Appeal of Sleeper;
but as will be shown later, the Supreme Judicial Court up­
held these provisions.)

The third means of commitment in the 1961 act as indicated
above was the standard judicial procedure by court order. The procedure as specified by the legislature is extremely detailed as had never before been the case. The proceedings commenced, like many others, with a written application to the probate court from a friend, relative, spouse or guardian together with certification from one physician that the person has refused to be examined (5, p. 348). Notice was then to be given to the person in question as well as his parents, spouse and closest other relative or friend. However notice to the proposed patient could be omitted if the court believed that it would be injurious to him (5, p. 348). The court would then appoint two licensed physicians to examine the person at his home or other suitable place and to report back to the court about his or her mental condition and suitability for hospitalization (5, p. 348). Depending upon the findings of the physicians, the judge could either order the hearing to take place or terminate any further action in the case. The hearing was to take place in an informal manner and could be held in public at the request of the proposed patient (5, p. 348). The court would hear any testimony at its discretion and witnesses could be cross examined. An important provision gave the proposed patient an opportunity to be represented by legal counsel at the hearing and if he did not have one of his own, the court would provide one for him (5, p. 348). If after the hearing
of all evidence, the court found that the person was mentally ill and was likely to injure himself or others if not detained, or needed care and treatment but could not make responsible application therefor; it could order his hospitalization for an indefinite period (5, p. 348). Any patient committed in this manner could apply to the probate court for a re-hearing which would be conducted in the same manner as above. However he had to wait six months for the first re-hearing and one year for each subsequent one (5, p. 351). There was no provision for appeal of the commitment order to a higher court or to any other body.

The 1961 revision, again based on the Draft Act, did not stop at providing procedures for commitment but went into detail on post admission provisions as had never before been done. The superintendent was directed to inquire into the case of each patient at least once a year to determine whether continued detention was necessary and if it was not, to discharge the patient (5, p. 351). In addition he could release a patient on convalescent status subject to conditions such as a plan of treatment on an outpatient basis if this was indicated. Patients on convalescent status could be ordered readmitted at any time by the superintendent without further judicial order, and endorsement of such an order by a municipal judge, would authorize the use of police officers to take the person into custody and convey him to the hospital
Patients were given a number of rights which had not previously been guaranteed by statute. The benefits of the writ of habeas corpus were to be afforded to all patients guaranteeing its availability in addition to statutory release procedure (5, p. 352). Patients were given the right to humane care and treatment according to the "highest standards" and no mechanical restraint could be used on any patient unless required by his medical needs (5, p. 352). He was given the right to communicate by sealed envelope with whomever he chose and could be visited by his lawyer or clergyman at any time (5, p. 352). It is unclear what other rights mental patients may have had under this act, but the specification of these particular rights seems to imply that others could be taken away.

Before this 1961 revision was passed by the legislature, questions were put to Justices of the Supreme Judicial Court of the State of Maine concerning the constitutionality of certain provisions of the act. Basically the legislature wished to know whether the objections that had been raised to the 1951 laws could be raised under the new provisions. The court answered affirmatively to questions raised as to whether the provisions for involuntary commitment adequately protected the constitutional rights of the proposed patient (27, p. 209). Thus the state's highest court specifically approved of the act and affirmed the legality of the commit-
In 1961 changes were also made in the statutes relating to the area of criminal commitment. A judge was still able to commit a person who he learned would plead insanity to a criminal charge before him, but there was no longer any provision for the period of detention. Neither was there even any provision that the hospital need report back to the judge on the condition of the person. Presumably, however, the Superintendent would inquire into the case of such persons as was his annual duty for all patients. But since the person was merely there for observation at the request of the court, the Superintendent could not release such a person without a specific order to that effect from the court. Another change made at this time such that once again commitment became automatic after an acquittal under the defense of insanity in criminal trials (5, p. 364). Commitment in this instance could be ordered to either of the institutions for the mentally ill or to the Pineland hospital (as the Maine School for the Feeble Minded had been earlier renamed) but again discharge could result only from a court order upon satisfactory proof that release would not endanger the peace and safety of the public.

The most important change in the criminal commitment statutes made in 1961 and indeed one of the most interesting and far-reaching statutory changes ever, came with the adoption
of a new test to be used to determine the question of criminal responsibility under an insanity defense. With the adoption of this new test Maine abandoned the old M'Naghten rule which had been in effect for over ninety years. The writing of this new test in the statutes was in itself a major change because in most jurisdictions and up till then in Maine, the formulation of such tests was left to the courts and not prescribed by statute. The wording of the new test, was based upon a controversial decision by the United States third District Court in the case of "Durham vs. The United States", which has come to be known as the Durham Rule (16, p. 862). The Maine version of the Durham rule states "An accused is not criminally responsible if his unlawful act was the product of mental disease or defect. The terms 'mental disease' or 'mental defect' do not include an abnormality manifested only by repeated criminal conduct or excessive use of drugs or alcohol"(5, p. 364).

Maine was only the fourth jurisdiction (along with the District of Columbia, the Virgin Islands, and New Hampshire) to adopt a Durham type formulation, but was also the last. Basically this test was designed to open the defense of insanity to more people than did the cognitively oriented M'Naghten rule. Since anyone whose criminal act was the product of any mental disease, would be acquitted under the Durham rule, it is easy to see why the legislature made sure that all those
so acquitted would be automatically incarcerated. The courts accepted the use of the Durham rule as the basis to determine criminal responsibility in 1963 in the case of State vs. Parks (46, p. 328). Some of the implications of the Durham rule will be discussed later.

In 1963 the procedures for commitment to the Pineland Hospital and Training Center were revised to bring them into line with the civil commitment procedures, but there are some noticeable differences between the two. Voluntary admission procedures could be initiated by a parent, relative, spouse or guardian but they could not be initiated by someone on his own behalf (6, p. 454). Thus it was voluntary only to the person making the application, not to the person to be committed. Emergency commitment was provided for upon request from a licensed physician with approval from a relative or guardian, for a period of fifteen days. If continued confinement was indicated, procedures for voluntary commitment without certification were to be initiated (6, p. 456). A person admitted under either of the two above procedures would be released within ten days after it was requested by the person's parent or guardian, but again the person could not request his own release (6, p. 456). The procedures for court ordered commitment to the Pineland hospital were identical to the procedures for commitment to state hospitals for the mentally ill outlined above. However in order to
commit the court need not find that the person was dangerous in any way but that he was "mentally retarded...and because of his retardation...is in need of education, training, treatment, or care at the Pineland Hospital" (6, p. 455). There was no detailing of patients' rights as was done for patients in hospitals for the mentally ill, with the sole exception of the right to Habeas Corpus being guaranteed to all patients.

Between 1963 and the present there have not been many substantial changes made in the commitment statutes. In 1965 a procedure for informal admission to the hospitals for the mentally ill was added, repealing the voluntary admission procedures. Any person applying for admission would be granted it if the superintendent felt such a person was a suitable subject for hospitalization (7, p. 123). Importantly, the person was free to leave at any time without notice and it became the responsibility of the superintendent to inform the patient of that right (7, p. 123). The "prisoner" status of a person committed through acquittal after a defense of insanity was reinforced. It was provided that those so committed could be released by the superintendent but their actions were to be governed by the State Probation and Parole Board (7, p. 638).

In 1973 the standard to be applied to determine whether commitment would be needed was changed. The old formulation
it will be remembered, asked whether the person was likely to injure himself or others if not detained or was in need of care or treatment and could not make responsible application therefor. The new standard provided that the person could be committed if the court found by a preponderance of the evidence that the person "poses a likelihood of serious harm" (8, p. 969). It should be kept in mind that only this standard was changed, but the procedures remained basically intact. Likelihood of serious harm was defined to mean:

A. risk of physical harm to other persons as manifested by evidence of homicidal or other violent behavior or evidence that others are placed in reasonable fear of violent behavior and serious physical harm to them; or

B. risk of physical harm to the person himself as manifested by evidence of attempts at or threats of suicide or serious bodily harm; or

C. reasonable certainty that serious impairment or injury will result to the person alleged to be mentally ill as manifested by his inability to avoid or protect himself from such impairment or injury and suitable community resources for his care are unavailable (8, p. 969).

Also in 1973 an important restriction was made upon the length of time for which commitment could be ordered by the court in civil cases. First of all the court was to consider all alternatives to commitment including outpatient care or anything else suitable. If commitment was indicated as a last resort the order in the first instance would only be good for four months (8, p. 971). Each subsequent rehearing could be followed by a commitment order good for one year.
The final change of subsistance in the commitment process that has been made to date occurred in 1974. In all instances where certification was needed from a licensed physician, certification could also be made by a psychologist licensed to practice clinical psychology (29, p. 94).

At the present time there is a major piece of legislation before the Maine legislature dealing with the area of criminal commitment in the form of a new test to determine criminal responsibility under the insanity defense. This proposal, a part of the new Maine Criminal Code, seeks the adoption of the Model Penal Code or American Law Institute (ALI) rule. The rule states:

1. A person is not responsible for criminal conduct if at the time of such conduct as a result of mental disease or defect he lacks substantial capacity either to appreciate the criminality of his conduct or to conform his conduct to the requirements of law.

2. As used in this section "mental disease or defect" means any abnormal condition of the mind regardless of its medical label, which substantially affects mental or emotional processes and substantially impairs the processes and capacity of a person to control his actions.

3. The defendant shall have the burden of proving by a preponderance of the evidence that he lacks criminal responsibility as described in subsection I. (10, p. A-20).

This rule was originally written in 1955 by the American Law Institute in an effort to provide a uniform standard across the country in much the same way that the National Institute of Mental Health did in its Draft
Act for civil commitment. It has aroused a good deal of controversy but, although slowly at first, it has gained wide acceptance in the courts. In 1972, the Court of Appeals for the District of Columbia which had originally devised the Durham rule, abandoned it and adopted the ALI rule (49, p. 969). This fact is used by the proponents of the rule’s adoption in Maine as evidence on its behalf. Maine thus faces the problem of whether to keep the Durham rule or adopt the ALI rule; a problem that shall be examined in detail since it sheds light on the criminal commitment area.

The purpose behind the formulation of the Durham rule, as mentioned earlier, was to open the defense of insanity up to more defendants than were able to use it under the M’Naghten rule. All that is necessary under the Durham rule for the jury to find a defendant who has pleaded insanity “not guilty” is for them to find that the person’s wrongful act was the product of a mental disease or defect. Any evidence as to the person’s mental state at the time of committing the crime may be introduced and thus the issue of criminal responsibility is not left to rest upon any particular (cognitive or emotional) symptom. But it is precisely this broad nature of the Durham rule that has accounted for its criticism. Originally it was felt that many defendants would use the insanity defense as an escape from criminal responsibility but this criticism has not proved valid since no evidence has been found of an increase
in the number of persons invoking the defense in jurisdictions under the Durham rule. Another criticism is the use of the word "product" without clarification. It is somewhat ambiguous and difficult to prove whether an act occurred as a product of the mental disease or merely occurred in addition to it. It must be clearly shown that the act was a direct result of the mental disease or there is criminal liability. At the very time that the Durham rule was being introduced in Maine the concept of "mental disease", upon which the rule so heavily relied, was coming under attack. Led by Thomas Szasz, critics claim that "mental disease...has outlived whatever cognitive usefulness it might have had and it now functions as a myth" (47, p. 12).

A major criticism of the Durham rule is that it has shifted the burden of determining criminal responsibility from the legal to the medical establishment. The jury does not have the latitude under the Durham rule to determine the issue of responsibility that it has under other tests. Testimony by medical experts as to a person's mental state is no longer merely evidentiary but it is conclusive. If for example a psychiatrist testifies that a defendant is suffering from "schizophrenia" the inquiry becomes nothing more than a battle between experts to determine whether the person was indeed suffering from this disease. The jury need make no conclusions about the person's mental state other than which expert was
correct. Thus the verdict of the jury is not a judgement by "peers" but is instead a judgement made by medical experts and reiterated by the jury. The problem in this regard is dramatically highlighted by the "weekend flip-flop case" (22, p. 18). The petitioner was described as a sociopath, and a psychiatrist from St. Elizabeth's Hospital in Washington stated that a person with a sociopathic personality was not suffering from a mental disease. That was Friday afternoon. On Monday morning through a policy change at St. Elizabeth's Hospital it was determined as an administrative matter that the state of a sociopathic personality did constitute a mental disease (22, p. 18).

Perhaps the most valid criticism of the Durham rule is that it does not adequately deal with the question of criminal intent. The logic behind the laws' acceptance of mental incapacity as a defense to crime is based on the fact that a crime consists of both a wrongful act and a wrongful intent (44, p. 107). Thus a person who is acquitted of a crime under a defense of insanity, is considered to have not had the requisite criminal intent or mens rea because of his mental condition. But the Durham rule could be interpreted to infer that any person with any mental disease or defect could not be capable of intending to commit a crime. It seems clear that some persons who are suffering from a mental disease or defect could intend to do wrong in some situations
and if they did intend to do wrong there is no reason why
they should not be held responsible for their actions.

The ALI rule eliminated many of the problems that have
arisen under the Durham rule. It is not as general as the
Durham rule and it gives to the jury some latitude to consider
medical testimony while at the same time imposing its own
judgements based on that testimony. The wording of the ALI
rule, although based on a synthesis of the M'Naghten rule
and the Irresistible Impulse rule, is modernized and does
not generate many of the criticisms either of these rules did.
It substitutes "appreciate" for "know" bringing in the emotional
as well as cognitive aspects of criminal intent. It uses
the word "conform" instead of "control" in bringing in the
voluntary component while staying away from the misleading
words "irresistible impulse". However the ALI rule continues
to cling to the mental disease concept which as has been
pointed out, causes some problem.

It appears uncertain at this time whether this provision
of the proposed Criminal Code will pass or not. The opposi-
tion comes largely from the Maine Psychiatric Association.
This is understandable since under the Durham rule psychi-
atrists have a greater voice in the determination of criminal
liability. Opposition to this change has also come from civil
liberties groups. They apparently feel that the ALI rule
is too restrictive and will result in many people going to
jail who should go to a hospital. (In this instance they forget their own argument used in other instances that there is not much difference between the two.) Clearly it will be difficult to adopt the ALI rule for criminal responsibility in Maine over the objections of the psychiatric "experts" and the civil libertarians.

There is another change proposed in the new criminal code effecting the criminal commitment area. This involves the court procedure to be followed when a person enters a plea of not guilty together with a plea of not guilty by reason of insanity. Basically this would involve a two part trial with the issue of guilt and the issue of insanity being separated and determined in different phases of the trial (10, p. 20). The first phase would determine only the factual issue of guilt with evidence of mental disease or defect inadmissible. If the jury finds the defendant not guilty the proceedings would terminate at that point; however if they find him guilty the second phase of the trial would commence (10, p. 20). During the second phase the jury would hear only evidence of his mental condition and would apply the prevailing test to find the defendant either responsible or not guilty by reason of insanity (10, p. 21).

The purpose for having a trial of this kind, as expressed by the writers of the code, is to give the defendant "the opportunity to make an insanity defense without thereby
making the implied admission to the jury that he committed the act charged against him" (10, p. 21). This was the case under the standard trial procedure in which the defendant pleading insanity usually conceded the fact that he committed the act and concentrated on proving his insanity. However the defendant does not have to concede committing the act. He could at the same time provide evidence to show that both: the act was not committed by him and that by reason of mental incapacity he could not have the requisite intent. It is important to remember however that a crime is composed of two elements, a wrongful act and a wrongful intent. Each element is necessary but neither is sufficient for there to be criminal responsibility. In the two part trial formulation however, a crime is in effect treated as being composed of only one element, the wrongful act. After it is determined whether the defendant is guilty or not, then the issue of his insanity is decided. By separating these two issues, insanity no longer is a defense to crime but is instead an excuse. The verdict of not guilty by reason of insanity is, after a verdict of guilty in the first phase of the trial, more like the Scotch verdict of "guilty but insane" (20, p. 540). Thus insanity becomes a defense in name only.

Although I know of no serious objections that have been raised to this part of the proposed Criminal Code by any groups, careful study by the legislature should result in its
rejection. Should it pass however, it probably could not stand up in the courts. A similar provision for a two part trial was struck down in Arizona, although one was upheld in Wisconsin. In making a proposal for a two part trial of this kind, the legislature seems to be tackling (although unintentionally) a much larger problem of whether to abolish the insanity defense altogether. This should not be undertaken without very careful study; and even if it were decided to do away with the defense, at least two courts have ruled that this would be unconstitutional on "due process" grounds (10, p. 20). It appears that the insanity defense is "so integral a part of the criminal process that a person may not be convicted without invoking its benefits" (10, p. 20).

Probably the most important aspect of the criminal commitment area is not dealt with in either the proposed Criminal Code or in other pending legislation. This is the provision for automatic commitment after a person is acquitted under the defense of insanity. There will have to be a review of this provision and subsequent release procedures in the near future because different tests for insanity are relatively meaningless compared to it. In practice, the particular test that is applied may not make much difference to a jury of twelve average people who most probably have an idea of whether the person is insane or not irregardless of the instructions given to them (18, p. 1448). However the provision for
mandatory commitment is important because it dictates whether a person acquitted under the insanity defense will be incarcerated or set free. Indeed if the jury is aware of such a provision their decision of guilty or not guilty by reason of insanity becomes a choice of "whether to send the poor devil to the jug or the loony bin" (26, p. 211). If the jury is unaware of such a provision they may be reluctant to acquit for fear of turning loose a "dangerous criminal".

The practice of summary commitment after acquittal under a defense of insanity seems to be a violation of the "due process" clause of the fourteenth amendment to the Constitution of the United States. Section one of the fourteenth amendment states in part:

No state shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any state deprive any person of life, liberty or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the law.

When a defendant pleads insanity to a criminal charge he is alleging that at the time the wrongful act was committed he could or did not have the requisite criminal intent. With the present backlog in criminal cases before most courts, the trial may very well take place years after the act took place. Thus the determination of insanity in a criminal trial relates to a specific act that may have occurred years before. In addition, in order to stand trial the defendant has to be found competent to understand the charges against him and to
participate in his defense. Thus he is "sane" enough to stand trial. In no way is the verdict not guilty by reason of insanity a statement on the mental condition of the defendant at the time the verdict is given, yet automatic commitment follows such a verdict. To commit someone in this manner without a hearing to determine his mental condition at the time of commitment may be a deprivation of liberty without due process of law. This is not to suggest that the person might not be severely disturbed and in need of treatment, but to summarily commit such a person without a hearing is serious indeed. In rebuttal to this argument, however, it has been suggested by a noted expert in this area that "since commitment via the criminal process is initiated by the defendant, it is more akin to voluntary than involuntary civil commitment" (19, p. 230).

A serious problem arises, when a person summarily committed in this manner, is to be released from incarceration. Since there is no hearing solely to determine the issue of commitment, its purposes are not clear. Is the person committed because he needs treatment or is he committed because he poses a potential danger to the community? In Maine it appears that the person is committed because of his potential danger since the standard for release specifies that the person no longer "pose a likelihood of serious harm" as discussed previously. Again, however, no determination was ever made
in the first place that the person did pose a likelihood of serious harm. The power to determine whether a person committed via the criminal route is not potentially dangerous and hence can be released, is left to the courts with psychiatrists as expert witnesses. Most hospital administrators are probably happy to leave this determination to the courts since releasing someone from the hospital whom the courts have ordered detained places a heavy burden of responsibility on the releasing officer. However one body of opinion regards courts as peculiarly ill-suited to judge the readiness for release from a hospital of persons committed under the criminal process (19, p. 227). The leading exponent of this position, Dr Thomas Szasz, states the argument in the following manner:

If a psychiatrist in charge of a patient—who is not a convicted criminal!—regards him in his own best judgement as ready to leave a hospital, how can he in his professional conscience let a court tell him that this he can not do?.....While the court has the right to order commitment, once a patient has been committed he comes under the jurisdiction of the hospital authorities. Hospital psychiatrists should be able to release the patient should they wish to do so (19, p. 227).

This emphasizes the peculiar legal position of the criminally committed mental hospital inmate. On the one hand he has been acquitted of criminal liability to be treated as a patient not a prisoner. But on the other hand he is not in all respects a patient since he is subject to special release procedures not applicable to other patients. This ambiguous
position of the patient committed through the criminal process, certainly can lead to frustration as he wonders about his peculiar status. Such frustration can only be described as anti-therapeutic making the entire criminal commitment process worthless.

It should become clear from this discussion of the criminal commitment process that a complete re-evaluation is needed. Changing the particular test of criminal responsibility while important in itself does not improve the overall situation when there is a provision for mandatory commitment upon acquittal. In addition, clarification of the meaning of the insanity defense and the legal status of the defendant acquitted under the defense is needed for any changes made in the statutes to be truly effective. These are questions which must be considered by the legislature in the future although it is likely that they will be studied only after the courts have intervened.

In contrast to the proposed changes in the criminal commitment statutes that are before the legislature, there are no substantive changes proposed in the civil commitment statutes at the present time. The civil commitment statutes have come a long way especially with the adoption of the revised Draft Act and subsequent changes. The end of civil commitment for an indefinite period was particularly important in safeguarding persons against unjust confinement.
However as with the criminal commitment statutes, there are some fundamental issues underlying the civil commitment process which need to be examined preferably before the courts mandate examination. Civil commitment is taken for granted, but the time has come for a complete evaluation of the ethics and constitutionality of involuntarily confining someone because of his mental condition.

In Maine, the present standard for civil commitment states that to be committed a person must "pose a likelihood of serious harm" as discussed previously. Thus commitment is justified as being for the protection of the person and the community. Although the phrase "likelihood of serious harm" is defined and clarified in great detail, it still is based on propositions which are scientifically tenuous. Psychiatrists and psychologists are asked to make predictions about the future behavior of a person which they have no expertise in doing with any degree of certainty. "The assessment of dangerousness involves sociological rather than primarily medical and psychiatric judgements"(20, p. 542). In addition, underlying all this is the belief that people with some form of mental illness are more dangerous than normal people when the evidence suggests that this is not the case. In a study of 684 patients released from mental hospitals in England, there were no reports of violence over a five year period (20, p. 540). Another study showed that the crime
rate of a sample of mental patients both before and after commitment is about one fourth of that for the general population (51, p. 1289). Other studies in this area have led to the inescapable conclusion that mental illness is an especially poor indication of future dangerous conduct (51, p. 1295).

Even if potential dangerousness could be shown with a high degree of accuracy, the notion of confining a person against his will because of such a finding is contrary to the American notion of liberty as expressed in the law. If a sociologist predicted that a person not alleged to be mentally ill was eighty per cent likely to commit a felony, no law would permit his confinement (13, p. 1290). To allow that a mentally ill person about whom such a prediction has been made may be confined, seems to be a violation of the equal protection clause of the fourteenth amendment.

If the interest which justifies making only the mentally ill liable to confinement is the need to protect society, then the classification is both overinclusive (most mentally ill persons are not dangerous) and underinclusive (many non-mentally ill persons are potentially dangerous). This is a combination of defects to which courts have been especially hostile (51, p. 1294).

The United States Court of Appeals in ordering the release of a mental patient from St. Elizabeth's Hospital on a habeas corpus petition ruled that "the courts have no legal basis of ordering...continued confinement on mere apprehension of future unlawful acts" (19, p. 237). It is precisely such
apprehension which permits the commitment of the mentally ill under the present statutes in Maine.

Committing mentally ill persons because they are dangerous to others is constitutionally suspect for another reason also. The Supreme Court held in Robinson vs. California that a law declaring narcotics addiction to be a criminal offense was unconstitutional because confinement for a condition was cruel and unusual punishment within the meaning of the eighth amendment of the United States Constitution (42, p. 1417). The court inferred that civil commitment of the mentally ill would be constitutional if the purpose was to provide treatment. But commitment of dangerous persons is a harder case because the chief purpose of such a measure is to afford protection for society, not treatment for the patient. There can be no question but that the deprivation of a person's liberty against his will is a form of punishment. "Incarceration may not seem like punishment to the jailers but it is punishment to the jailed" (14, p. 1101). The Utah Supreme Court has ruled in relation to a voluntary mental patient that "a patient at the hospital is as much confined and has as little freedom as a mentally alert trustee in a jail or prison" (48, p. 277). It thus seems possible that the courts could rule that commitment under the "likelihood of serious harm" basis of Maine's commitment statutes, without a provision for treatment, is cruel and unusual punishment.
It may very well be that the courts would not consider civil commitment in and of itself to be either a violation of the equal protection clause of the fourteenth amendment or cruel and unusual punishment under the eighth amendment. However even if the concept of commitment of the mentally ill is not unconstitutional, there certainly is no reason why the procedures leading to commitment can not be carefully scrutinized and opened to constitutional attack. In the Maine version of the Draft Act with subsequent amendments, the judicial hospitalization procedure is particularly vulnerable. The pre-hearing procedures are elaborated in great detail but the procedures the court is to follow for the conduct of the hearing are not so detailed. It is provided that the hearing be held in an informal manner and the rules of evidence need not be applied (5, p. 348). To be deprived of his liberty after committing a crime, an accused must be tried according to strict procedures designed to safeguard against his being unfairly confined. This is to insure that the accused is not deprived of his liberty without the "due process of law" spoken of in the fourteenth amendment. However these procedural safeguards in the form of evidentiary rules such as the "hearsay rules", are not provided for persons being deprived of their liberty in civil commitment hearings. This informal manner in which the hearings to determine commitment are held is justified by the framers of the Draft
Act as insuring that no "important matter be barred on technical grounds" (12, p. 468). Their intention to "assure full and fair consideration of all relevant data" (12, p. 467) is laudable; but the serious nature of the proceedings seems to have been overlooked. "Due process" demands that the same procedural safeguards given to accused criminals before their liberty be denied them, be extended to proposed mental patients.

The lack of procedural safeguards along with the other lapses in constitutional guarantees outlined above are often justified by the benevolent reason that treatment is being provided to those who need it and are unable to afford themselves of it (13, p. 1288). This argument clouds the issue by stating a purpose for commitment (the need for treatment) that was specifically repealed and replaced with the "likelihood of serious harm" standard in Maine. Recently the courts have begun to look into this area and have recognized the right to treatment as a key issue in attacks on the commitment process, regardless of the statutory purpose for commitment.

Early cases to recognize the right to treatment were based upon statutory interpretations. These cases were brought when a person was detained under a statutory provision that commitment be for the purpose of care and treatment; and the courts held that such a patient must be confined in a
setting somewhat more therapeutic than a jail (51, p. 1285). In Rouse vs Cameron, although again based on a statutory provision, the court ruled that "when society confines a man on the asserted ground that he needs treatment, its lofty purpose can not be forgotten--treatment must be provided" (41, p. 89). In Wyatt vs. Stickney the District Court of Alabama ruled that all civilly committed patients were entitled to treatment (50, p. 781). But the important point of this decision was that it was not based upon a statutory provision. All patients regardless of why they were committed had a constitutional right to receive adequate treatment. In addition, a finding of treatability was necessary at the time the commitment is ordered (51, p. 1291). The reasoning behind the court's decision takes into account the lack of procedural and substantive safeguards in the commitment process. The court's conclusion seems to be that these possible constitutional violations are allowable if commitment can be justified by showing that those committed needed and were receiving treatment for their disorder. The effect of this decision is to make the states stop playing the "pea-and-shell game with the individual's rights" (51, p. 1289) by assuring that the benevolent justification, that people are committed for their own good, is carried out.

A problem area of the Wyatt decision is in defining and establishing standards as to exactly what constitutes adequate
treatment. There is some question as to whether this is a proper judicial matter since the evaluation of treatment is essentially an area of medical or psychiatric expertise. It has been pointed out however that the courts in, for example malpractice suits, are often called on to resolve conflicts that result from disagreeing experts (51, p. 1297). Since the legislature is the authority which establishes the means and standards of the commitment process, it seems proper that they should also establish the standards for adequate treatment to be enforced by the courts. What are needed are not specific therapeutic programs to be decided on by the legislature, but standards. In the Wyatt case the court mandated staff to patient ratios for physicians, psychologists, nurses, social workers, and aides (50, p. 383-384). It is these type of guidelines that the legislature should establish. It would be a mistake for the legislature to try to determine best or better treatments but they should not accept the "assertion that simple custody of the mental patient, away from society and its stresses and free from day to day responsibility is treatment" (41, p. 106). Milieu therapy would thus be unacceptable by itself. Judge Bazelon has proposed as a standard for treatment "that adequate in light of present knowledge"; although this is fairly vague (41, p. 104). However it has been warned that "if too high a standard of treatment is imposed, less conscientious states may abandon
all pretense of providing public treatment" (41, p. 112).
Clearly this can be avoided if it is required that each patient receive an individual program of treatment, and that continued detention be justified by substantial progress.

It should be evident from this discussion that the practice of involuntarily committing the mentally disordered raises some important questions which challenge both the ethics of commitment itself and the procedures through which commitment is accomplished. Some minimal limitations are suggested from what has been said, which future legislatures must consider in drawing up legislation in this area. First where commitment of the mentally ill is authorized to protect society from harm, rigid procedures are needed similar to the safeguards of the criminal process (41, p. 102). Second where commitment is justified as being for the person's own good and constitutional rights might otherwise be violated, adequate treatment must be provided (41, p. 102). But beyond these minimums there should be an evaluation of whether there really is a need to detain these people against their will. Are mentally disturbed people committed because they are truly potentially harmful or truly in need of treatment; or is it because society does not like them and is uncomfortable by their presence? Perhaps a society has the right to ostracize those members whom it feels that way about. But if that is the case, society should admit it, and not hide behind a
a more ego-syntonic benevolent facade. It is a decision which should not be made indirectly. Thorough consideration might lead the legislature to conclude, as did the board of directors of the New York Civil Liberties Union, that:

Mental illness can never...be a justifiable reason for depriving a person of his liberty against his objections. Even when such deprivations are accompanied by fair procedures, they are unjustified except on a basis...that would be equally applicable in the absence of mental illness (43, p. 126).
APPENDIX

The NIMH Draft Act
AN ACT GOVERNING HOSPITALIZATION OF
THE MENTALLY ILL

Part I--Definitions

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

(a) Mentally ill individual.--An individual having a psychiatric or other disease which substantially impairs his mental health.

(b) Patient.--An individual under observation, care, or treatment on a hospital pursuant to this Act.

(c) Licensed physician.--An individual licensed under the laws of this State to practice medicine and a medical officer of the Government of the United States while in this State in the performance of his official duties.

(d) Designated examiner.--A licensed physician registered by the (central administration) as specially qualified, under standards established by it, in the diagnosis of mental or related illness.

(e) Hospital.--A public or private hospital or institution, or part thereof, equipped to provide in-patient care and treatment for the mentally ill.

(f) Head of hospital.--The individual in charge of a hospital, or his designee.

(g) (Central administration).--The (State) (Department of Health) (Mental Health Commission) (Department of Mental Hygiene).

Part II--Voluntary Hospitalization

Sec. 2. Authority to receive voluntary patients.--The head of a private hospital may and, the head of a public hospital, subject (except in case of medical emergency) to the availability of suitable accommodations, shall admit for observation, diagnosis, care, and treatment any individual who is mentally ill or has symptoms of mental illness and who, being 16 years of age or over, applies therefore, and any individual under 16 years of age who is mentally ill or has symptoms of mental illness, if his parent or legal guardian applies therefore in his behalf.

Sec. 3. Discharge of voluntary patients.--The head of the hospital shall discharge any voluntary patient who has recovered or whose hospitalization he determines to be no longer advisable. He may also discharge any voluntary patient if to do so would, in the judgment of the head of the hospital, contribute to the most effective use of the hospital in the care and treatment of the mentally ill.

Sec. 4. Right to release on application.--(a) A voluntary patient who requests his release or whose release is requested, in writing, by his legal guardian, parent, spouse, or adult next of kin shall be released forthwith except that
(1) if the patient was admitted on his own application and the request for release is made by a person other than the patient, release may be conditioned upon the agreement of the patient thereto, and

(2) if the patient, by reason of his age, was admitted on the application of another person, his release prior to becoming 16 years of age may be conditioned upon the consent of his parent or guardian, and

(3) if the head of the hospital, within 48 hours from the receipt of the request, files with the (probate) court or a judge thereof, whether in session or in vacation, a certification that in his opinion the release of the patient would be unsafe for the patient or others, release may be postponed on application for as long as the court or a judge thereof determines to be necessary for the commencement of proceedings for judicial hospitalization, but in no event for more than 5 days.

(b) Notwithstanding any other provision of this Act, judicial proceedings for hospitalization shall not be commenced with respect to a voluntary patient unless release of the patient has been requested by himself of the individual who applied for his admission.

Part III--Involuntary Hospitalization

Subpart A--Admission Provisions

Sec. 5. Authority to receive involuntary patients.--The head of a private hospital may and the head of a public hospital, subject (except in case of medical emergency) to the availability
of suitable accommodations, shall receive therein for observa-
tion, diagnosis, care, and treatment any individual whose
admission is applied for under any of the following procedures:

(a) Hospitalization on medical certification; standard nonjudicial procedure.

(b) Hospitalization on medical certification; emergency procedure.

(c) Hospitalization without endorsement or medical certifica-
tion; emergency procedure.

(d) Hospitalization on court order; judicial procedure.

Sec. 6. Hospitalization on medical certification; standard nonjudicial procedure.--(a) Any individual may be admitted to a hospital upon

(1) written application to the hospital by a friend, relative, spouse, or guardian of the individual, a health officer, or the head of any institution which such individual may be, and

(2) certification by two designated examiners that they have examined the individual and that they are of the opinion that

(A) he is mentally ill, and

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

(C) 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 therefor.

The certification by the designated examiners may be made jointly or separately, and may be based on examination conducted jointly or separately, as the regulations of the (central
administration) may prescribe. An individual with respect to whom such certification has been issued may not be admitted on the basis thereof at any time after the expiration of 15 days after the date of examination, exclusive of any period of temporary detention authorized under section 11. The head of the hospital admitting the individual shall forthwith make a report thereof to the (central administration).

(b) Such certification, if it states a belief that the individual is likely to injure himself or others if allowed to remain at liberty, shall, upon endorsement for such purpose by the head of the (local health authority) or by a judge of any court of record of the county in which the individual is resident or present, authorize any health or police officer to take the individual into custody and transport him to a hospital designated in the application.

Sec. 7. Hospitalization on medical certification; emergency procedure.--(a) Any individual may be admitted to a hospital upon

(1) written application to the hospital by any health or police officer or any other person stating his belief that the individual is likely to cause injury to himself or others if not immediately restrained, and the grounds for such belief, and

(2) a certification by at least one licensed physician that he has examined the individual and is of the opinion that the individual is mentally ill and, because of his illness, is likely to injure himself or others if
An individual with respect to whom such a certificate has been issued may not be admitted on the basis thereof at any time after the expiration of 3 days after the date of examination. The head of the hospital admitting the individual shall forthwith make a report thereof to the (central administration).

(b) Such a certificate, upon endorsement for such purpose by the head of the (local health authority) or a judge of any court of record of the county in which the individual is present, shall authorize any health or police officer to take the individual into custody and transport him to a hospital as designated in the application.

Sec. 8. Hospitalization without endorsement or medical certification; emergency procedure.--Any health or police officer who has reason to believe that

(a) an individual is mentally ill and, because of his illness, is likely to injure himself or others if allowed to remain at liberty pending examination and certification by a licensed physician, or

(b) an individual who has been certified under section 6 or 7 as likely to injure himself or others and therefore cannot be allowed to remain at liberty pending the endorsement of the certificate as provided in those sections, may take the individual into custody, apply to a hospital for his admission, and transport him thereto. The application for admission shall state the circumstances under which the individual was taken into custody and the reasons for the officer's belief. The
head of the hospital admitting the individual shall forthwith
make a report thereof to the (central administration).

Sec. 9. Hospitalization upon court order; judicial procedure.
(a) Proceedings for the involuntary hospitalization of an
individual may be commenced by the filing of a written applica-
tion with the (probate) court by a friend, relative, spouse, or
guardian of the individual, or by a licensed physician, a
health or public welfare officer, or the head of any public or
private institution in which such individual may be. Any such
application shall be accompanied by a certificate of a licensed
physician stating that he has examined the individual and is
of the opinion that he is mentally ill and should be hospitalized,
or a written statement by the applicant that the individual has
refused to submit to examination by a licensed physician.

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

(c) The examination shall be held at a hospital or other
medical facility, at the home of the proposed patient, or at
any other suitable place not likely to have a harmful effect
on his health. A proposed patient to whom notice of the com-
mencement of proceedings has been omitted, the court shall
appoint two designated examiners to examine the proposed patient
and report to the court their findings as to the mental condition
of the proposed patient and his need for custody, care, or treatment in a mental hospital.

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

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

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

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

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

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

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

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

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

Sec. 10. Hospitalization by an agency of the United States.

(a) If an individual ordered to be hospitalized pursuant to the previous section is eligible for hospital care or treatment by an agency of the United States, the court, upon receipt of a certificate from such agency showing that facilities are available and that the individual is eligible for care or treatment therein, may order him to be placed in the custody of such agency for hospitalization. When any such individual is admitted pursuant to the order of such court to any hospital or institution operated by any agency of the United States within or without the State, he shall be subject to the rules and regulations of such agency. The chief officer of any
hospital or institution operated by such agency and in which the individual is so hospitalized, shall with respect to such individual be vested with the same powers as the heads of hospitals or the (central administration) within this State with respect to detention, custody, transfer, conditional release, or discharge of patients. Jurisdiction is retained in the appropriate courts of this State at any time to inquire into the mental condition of an individual so hospitalized, and to determine the necessity for continuance of this hospitalization, and every order of hospitalization issued pursuant to this section is so conditioned.

(b) An order of a court of competent jurisdiction of another State, or of the District of Columbia, authorizing hospitalization of an individual by any agency of the United States shall have the same force and effect as to the individual while in this State or District issuing the order shall be deemed to have retained jurisdiction of the individual so hospitalized for the purpose of inquiring into his mental condition and of determining the necessity for continuance of his hospitalization, as is provided in subsection (a) of this section with respect to individuals ordered hospitalized by the courts of this State. Consent is hereby given to the application of the law of the State or District in which is located the court issuing the order for hospitalization with respect to the authority of the chief officer of any hospital or institution operated in this State by any agency of the United States to retain custody, transfer, conditional release, or discharge the individual hospitalized.
Sec. 11. Transportation; temporary detention.--(a) Whenever an individual is about to be hospitalized under the provisions of section 6, 7, 8, or 9, the (local health authority) shall, upon the request of a person having a proper interest in the individual's hospitalization, arrange for the individual's transportation to the hospital with suitable medical or nursing attendants and by such means as may be suitable for his medical condition. Whenever practicable, the individual to be hospitalized shall be permitted to be accompanied by one or more of his friends or relatives.

(b) Pending his removal to a hospital, a patient taken into custody or ordered to be hospitalized pursuant to this Act may be detained in his home, a licensed foster home, or any other suitable facility under such reasonable conditions as the (local health authority) may fix, but he shall not, except because of and during an extreme emergency, be detained in a nonmedical facility used for the detention of individuals charged with or convicted of penal offenses. The (local health authority) shall take such reasonable measures, including provision of medical care, as may be necessary to assure proper care of an individual temporarily detained pursuant to this section.

Subpart B--Post-Admission Provisions

Sec. 12. Notice of hospitalization.--Whenever a patient has been admitted to a hospital pursuant to section 6, 7, or 8 on the application of any person other than the patient's legal guardian, spouse, or next of kin, the head of the
hospital shall immediately notify the patient's legal guardian, spouse, or next of kin, if known.

Sec. 13. Medical examination of newly admitted patients.—(a) Every patient admitted pursuant to the provisions of section 6, 7, 8, or 9 shall be examined by the staff of the hospital as soon as practicable after his admission.

(b) The head of the hospital shall arrange for examination by a designated examiner of every patient hospitalized pursuant to the provisions of section 7 or 8. If such an examination is not held within 5 days after the day of admission, or if a designated examiner fails or refuses after such examination to certify that in his opinion the patient is mentally ill and is likely to injure himself or others if allowed to remain at liberty, the patient shall be immediately discharged.

Sec. 14. Transfer of patients.—(a) The (central administration) may transfer, or authorize the transfer of, an involuntary patient from one hospital to another if the (central administration) determines that it would be consistent with the medical needs of the patient to do so. Whenever a patient is transferred, written notice thereof shall be given to his legal guardian, parents, and spouse, or, if none be known, his nearest known relative or friend. In all such transfers, due consideration shall be given to the relationship of the patient to his family, legal guardian or friends, so as to maintain relationships and encourage visits beneficial to the patient.

(b) Upon receipt of a certificate of an agency of the United States that facilities are available for the care or
treatment of any individual heretofore ordered hospitalized pursuant to law or hereafter pursuant to section 9 of this Act in any hospital for care or treatment of the mentally ill and that such individual is eligible for care or treatment in a hospital or institution of such agency, the (central administration) may cause his transfer to such agency of the United States for hospitalization. Upon effecting any such transfer, the court ordering hospitalization, the legal guardian, spouse, and parents, or if none be known, his nearest known relative or friend shall be notified thereof immediately by the (central administration). No person shall be transferred to an agency of the United States if he be confined pursuant to conviction of any felony or misdemeanor or if he has been acquitted of the charge solely on the ground of mental illness unless prior to transfer the court originally ordering confinement of such person shall enter an order for such transfer after appropriate motion and hearing. Any person transferred as provided in this section to an agency of the United States shall be deemed to be hospitalized by such agency pursuant to the original order of hospitalization.

Sec. 15. Discharge.—The head of a hospital shall as frequently as practicable, but not less often than every 6 months, examine or cause to be examined every patient and whenever he determines that the conditions justifying involuntary hospitalization no longer obtain, discharge the patient and immediately make a report thereof to the (central administration).
Sec. 16. Convalescent status; rehospitalization.--(a) The head of a hospital may release an improved patient on convalescent status when he believes that such release is in the best interests of the patient. Release on convalescent status shall include provisions for continuing responsibility to and by the hospital, including a plan of treatment on an out-patient or nonhospital patient basis. Prior to the end of a year on convalescent status and, if he determines that in view of the condition of the patient hospitalization is no longer necessary, he shall discharge the patient and make a report thereof to the (central administration).

(b) Prior to such discharge, the head of the hospital from which the patient is given convalescent status may at any time readmit the patient. If there is reason to believe that it is to the best interests of the patient to be rehospitalized, the (central administration) or the head of the hospital may issue an order for the immediate rehospitalization of the patient. Such an order, if not voluntarily complied with, shall, upon the endorsement by a judge of a court of record of the county in which the patient is resident or present, authorize any health or police officer to take the patient into custody and transport him to the hospital, or if the order is issued by the (central administration) to a hospital designated by it.

Sec. 17. Right to release; application for judicial determination.--(a) Any patient hospitalized under the provisions of section 6, 7, or 8 of this Act who requests to be released or whose release is requested, in writing, by his legal guardian,
spouse, or adult next of kin shall be released within 48 hours after receipt of the request except that, upon application to the court or a judge thereof, whether in session or in vacation, supported by a certification by the head of the hospital that in his opinion such release would be unsafe for the patient or for others, release may be postponed for such period not to exceed 5 days as the court or a judge thereof may determine to be necessary for the commencement of proceedings for a judicial determination pursuant to section 9.

(b) The head of the hospital shall provide reasonable means and arrangements for informing involuntary patients of their right to release as provided in this section and for assisting them in making and presenting requests for release.

Sec. 18. Petition for re-examination of order or hospitalization. Any patient hospitalized pursuant to section 9 shall be entitled to a re-examination of the order for his hospitalization on his own petition, or that of his legal guardian, parent, spouse, relative, or friend, to the (probate) court of the county in which he resides or is detained. Upon receipt of the petition, the court shall conduct or cause to be conducted by a special commissioner proceedings in accordance with such section 9, except that such proceedings shall not be required to be conducted if the petition is filed sooner than 6 months after the issuance of the order of hospitalization or sooner than 1 year after the filing of a previous petition under this section.
Part IV--Provisions Applicable to Patients Generally

Sec. 19. 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.

Sec. 20. 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.

Sec. 21 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 (central administration) and with the court, if any, which ordered his hospitalization.

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

Sec. 22. Writ of habeas corpus.—Any individual detained pursuant to this Act shall be entitled to the writ of habeas corpus upon proper petition by himself or a friend to any court generally empowered to issue the writ of habeas corpus in the county in which he is detained.

Sec. 23. Disclosure of information.—(a) All certificates, applications, records, and reports made for the purpose of this Act and directly or indirectly identifying a patient or former patient or an individual whose hospitalization has been sought under this Act shall be kept confidential and shall not be disclosed by any person except insofar

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

(2) as disclosure may be necessary to carry out any of the provisions of this Act, or
(3) as a court may direct upon its determination that disclosure is necessary for the conduct of proceedings before it and that failure to make such disclosure would be contrary to the public interest.

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

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

Sec. 24. Detention pending judicial determination.—Notwithstanding any other provision of this Act, no patient with respect to whom proceedings for judicial hospitalization have been commenced shall be released or discharged during the pendency of such proceedings unless ordered by the court or a judge thereof upon the application of the patient, or his legal guardian, parent, spouse, or next of kin, or upon the report of the head of the hospital that the patient may be discharged with safety.

Sec. 25. Additional powers of (central administration).—In addition to the specific authority granted by other provisions of this Act, the (central administration) shall have authority to prescribe the form of applications, records, reports, and medical certificates provided for under this Act and the information required to be contained therein; to require reports from the head of any hospital relating to the
admission, examination, diagnosis, release, or discharge of any patient; to visit each hospital regularly to review the commitment procedures of all new patients admitted between visits; to investigate by personal visit complaints made by any patient or by any person on behalf of a patient; and to adopt such rules and regulations not inconsistent with the provisions of this Act as it may find to be reasonably necessary for proper and efficient hospitalization of the mentally ill.

Sec. 26. Unwarranted hospitalization or denial of rights; penalties.—Any person who wilfully causes, or conspires with or assists another to cause, (1) the unwarranted hospitalization of any individual under the provisions of this Act, or (2) the denial to any individual of any of the rights accorded to him under the provisions of this Act, shall be punished by a fine not exceeding $..... or imprisonment not exceeding .........., or both.
REFERENCES

11. Appeal of Sleeper in Re Commitment of Ralph S. Small. 147 Me. 302 (1952).


21. Inhabitants of Eastport vs. Inhabitants of Machias. 35 Me. 402 (1854).


28. Overseers of Fairfield vs. Gullifer. 49 Me. 360 (1864).


32. Reports of the Maine Insane Hospital. Augusta, 1872.


34. Revised Statutes of the State of Maine. Hallowell, 1841.


42. Robinson vs. State of California. 82 S. Ct. 1417 (1962).
44. Smoot, George A. The Laws of Insanity. Kansas City, 1929.
45. State vs. Lawrence. 57 Me. 574 (1870).