Mental Health Services for the Poor

*Henry Weihofen**

MENTAL ILLNESS RANKS with heart disease and cancer as one of the nation's three greatest health menaces. It is clearly the costliest.[1] More hospital beds are occupied by mental patients than are required for all other diseases combined.

Experts are convinced that mental illness is vastly more prevalent than the statistics reveal, and that perhaps one person in ten in the United States suffers from some form of mental illness.[2] Probably no more than ten to twenty per cent of those needing treatment receive it.[3] The ones not getting it are primarily the poor—because they cannot afford it and because they are skeptical and even hostile toward psychiatry and social agencies generally.

One alarming circumstance is the extent of such illness and related handicaps among our children and young people. The Department of Health, Education, and Welfare estimates that some five million handicapped children and young people,[4] at least ten per cent of our school age population, need special educational opportunities, of which there are few. Three out of four retarded children today receive no special instruction

---

* Ph.B., 1926, J.D., 1928, J.S.D., 1930, University of Chicago. Professor of Law, University of New Mexico Law School.

[1] The noneconomic costs cannot be measured; the economic costs alone add up to some 3.5 billion dollars a year. *New Directions Toward Community Health*, Blue Cross Rep., July-Sept. 1964, pp. 10-13. See also FEIN, ECONOMICS OF MENTAL ILLNESS x-xii (Monograph Series No. 2, 1958) (report to the Staff Director, Joint Commission on Mental Illness and Health); JOINT COMM'N ON MENTAL ILLNESS AND HEALTH, ACTION FOR MENTAL HEALTH, FINAL REPORT 9-10 (1961); LINDMAN & MCINTYRE, THE MENTALLY DISABLED AND THE LAW 1 (1961).

[2] This is the estimate made from facts compiled in 1961. NATIONAL COMM. AGAINST MENTAL ILLNESS, WHAT ARE THE FACTS ABOUT MENTAL ILLNESS IN THE UNITED STATES? 1 (1961). Difficulties of getting agreement on a definition of mental illness and of finding untreated cases have made for wide variations in estimates of prevalence. A recent study conducted by the National Institute of Mental Health together with Group Health Association of Washington, D.C., based on a sample of more than 6,000 patients, concluded that one in seven adults seen by a physician has a psychiatric ailment. Others have estimated that as high a proportion as one-half of the patients treated by general practitioners have predominantly psychiatric complaints or suffer from physical ills with psychiatric complications. See statement of Dr. S. Bernard Wortis in *Hearings Before House Committee on Interstate and Foreign Commerce*, 83d Cong., 1st Sess., pt. 4, 1,034-35 (1953) (Causes, Control and Remedies of the Principal Diseases of Mankind).

[3] NATIONAL COMM. AGAINST MENTAL ILLNESS, *op. cit. supra* note 2, at 1. Even this estimate may be too high. See Scheff, *The Role of the Mentally Ill and the Dynamics of Mental Disorder: A Research Framework*, 26 SOCIOMETRY 436, 440-41 (1963).

[4] Address by Wilbur J. Coben, *A Day for Brighter Beginnings*, before the 16th Annual Convention of the National Ass'n for Retarded Children, Sept. 29, 1965.

whatever.[5] They are left to shift for themselves in classrooms where they cannot compete. They are tomorrow's dropouts.

Half a million children of school age suffer from serious forms of mental illness, childhood schizophrenia, and other psychoses. Yet less than one per cent of these half million are getting adequate care.[6] Especially alarming is the high proportion of children and young people in the mentally-ill population. Of the 750,000 persons who in 1964 were served in out-patient psychiatric clinics, 300,000—or forty per cent—were under the age of twenty. Probably equally as many were placed on waiting lists of a year or more.[7] Delay in providing care for these young people may have tragic consequences for the nation that will never be set right later.

The incidence of mental illness is highest among low-income groups; and they receive the least attention.[8] Three-fourths of the mentally ill cannot afford treatment. One study indicated that of the children of families on welfare, thirty per cent have health problems, and nineteen per cent have emotional or behavior problems.[9] Wilbur J. Cohen, Under-Secretary of Health, Education, and Welfare, has estimated "that 50% or more of children with I.Q. scores between 70 and 80 come from disadvantaged homes."[10]

About eighty to ninety per cent of all mental retardates appear quite normal in the physical sense, but they function as mentally retarded. "These persons invariably derive from and have been reared in socially and economically disadvantaged environments. They are heavily represented in the slums of the metropolitan centers of the country and in depressed rural areas. Their greatest concentration is among minority groups residing in city slums."[11] Roots of this type of retardation are almost certainly to be found among the concomitants of deprived social and eco-

---

[5] *Ibid.*

[6] NATIONAL ASS'N FOR MENTAL HEALTH, THE NAMH PROGRAM: HOW WE SERVE 12 (1965).

[7] Estimate based on data for 1961-62 collected by the National Institute of Mental Health. U.S. DEP'T OF HEALTH, EDUC. & WELFARE, PILOT PROJECT IN TRIANING MENTAL HEALTH COUNSELORS 1 (1965).

[8] "At least in the United States, mental illness is more prevalent in the lower classes than in the upper; more severe there; less likely to be treated; and when treated, more likely to receive custodial or organic therapy than psychotherapy." BERELSON & STEINER, HUMAN BEHAVIOR: AN INVENTORY OF SCIENTIFIC FINDINGS 639 (1964).

[9] Westchester County Studies of Basic Causes of Poverty, Bull. of N.Y. State District Branches of the American Psychiatric Ass'n (Mar. 1965).

[10] Address by Wilbur J. Cohen, *A Day for Brighter Beginnings*, before the 16th Annual Convention of the National Ass'n for Retarded Children, Sept. 29, 1965.

[11] U.S. DEP'T OF HEALTH, EDUC. & WELFARE, PROCEEDINGS OF A CONFERENCE ON SPECIAL PROBLEMS IN VOCATIONAL REHABILITATION OF THE MENTALLY RETARDED, MADISON, WISCONSIN 16-17 (Rehabilitation Service Series No. 65, 1963).

nomic circumstances—poor or nonexistent pre-natal care, high rates of prematurity, and inadequate infant health supervision.[12]

In addition, this major group of the mentally retarded is exposed to all the influences that make for crime and delinquency, broken family relations, alcoholism, drug addiction, mental illness, and prostitution.[13] One misfortune reduces capacity to fend off others, so we have the hard-core, multi-problem families, in which we find mental illness, *and* crime, *and* alcoholism, and other ills. Any community mental health program is thus likely to become a poverty program, enmeshed in the problems of economic deprivation, unemployment or unemployability, and social disorganization.[14]

I

PROGRAM FOR THE FUTURE

A. Safeguards for Children

A large part of our school drop-out problem stems from mental retardation and mental illness. A study of 503 reported drop-outs from the Gary, Indiana school system in the year 1963-64 revealed that 59.7 per cent were retarded.[15] Another study showed that many drop-outs have definite internalized personality problems.[16]

Paradoxically, as school systems try to do more for retarded children, the drop-out rate rises. This is understandable. In the past, many school systems excluded children with a tested IQ of less than seventy. Such children therefore did not figure in the drop-out statistics. But even when given the help of special programs, low-IQ children are the most likely to drop out: Difficulty in learning to read and adjusting to the social patterns of the schoolroom may result in symptoms of withdrawal, schoolphobia, and rebellion, particularly in a school offering little or no individual counseling or special teaching. The strain of trying to keep up and the recognition of failure almost inevitably leads these unhappy children to adopt psychological and adaptive behavior to protect their egos. One such protective device is refusing schooling. Dropping out of school may literally preserve what mental health they have. But by doing so, they condemn themselves to the poverty and the feeling of worthlessness of the uneducated and untrained person. The vast size of the drop-out problem requires

---

[12] *Ibid.*

[13] PRESIDENT'S PANEL ON MENTAL RETARDATION, REPORT OF THE TASK FORCE ON LAW 10 (1963).

[14] Pasamanick, Scarpitti, Lefton, Dinitz, Wernert & McPheeters, *Home vs Hospital Care for Schizophrenics*, 187 A.M.A.J. 177, 179 (1964).

[15] Roser, *On Reducing Dropouts*, Fed. Probation, Dec. 1965, p. 49, at 51.

[16] LICHTER, RAPIEN, SEIBERT & SKLANSKY, THE DROPOUTS (1962).

a heroic effort to stem the widening circle of this social blight. Needed are more pupil personnel services, work programs, family services, teachers with specialized skills, and more child guidance centers in the schools, with psychiatrists, psychologists, and social workers on the school staff.[17]

We cannot solve the heart-breaking problem of retardation and physical defects and handicaps by building bigger and better institutions. We must also improve the quality of human reproduction. No special training school, no braces or hearing aids or speech therapy can match nine safe months in the uterus of a healthy mother. Especially in some areas—the South and the charity hospitals of our cities—rates of premature births, fetal deaths, and neo-natal deaths are high and are rising, mainly among the indigent and nonwhite population. In Georgia from 1947 to 1960, although white premature births remained relatively level, nonwhite premature births rose from 68 per 1,000 live births to 130.[18]

Of 4.5 million live births expected in the United States this year, about 7.8 per cent are likely to be premature. About fifteen per cent of these "preemees" do not survive. Of those that do, about ten per cent will be so retarded mentally that they will need institutional care. At an average cost of two thousand dollars per year for each of these thirty thousand infants who will need institutional care, the *direct* cost of care for *this* year's class over their expected life span (fifty years) will be three billion dollars.[19] This amount does not include the costs of constructing the facilities or training the needed personnel.

This is the cost only for retardation due to prematurity. But prematurity is one cause of retardation for which we know ways to reduce the incidence—by better nutrition, prenatal care, and management of complicated pregnancies. Women who receive adequate pre-natal care are one-third as likely to give birth to premature babies as women who don't have such care. Very small premature babies are about ten times more likely to be mentally retarded than are children of normal birth. And a Johns Hopkins study showed that premature infants have two to three times as many physical defects and fifty per cent more illnesses than full-term infants.[20] Yet approximately thirty per cent of expectant mothers in the United States receive no prenatal care whatever.[21]

---

[17] See Roser, *supra* note 15, at 55.

[18] GA. DEP'T OF PUBLIC HEALTH, GA. VITAL STATISTICS, xvi (1961).

[19] A paper by Robert A. Aldrich, M.D., The Liquidation of the Problem Through Research and Training, read before the White House Conference on Mental Retardation, Sept. 18-20, 1963. See WHITE HOUSE CONFERENCE ON MENTAL RETARDATION, PROCEEDINGS 81, 82-83 (1963).

[20] PRESIDENT'S PANEL ON MENTAL RETARDATION, A PROPOSED PROGRAM FOR NATIONAL ACTION TO COMBAT MENTAL RETARDATION 51 (1962).

[21] NATIONAL ASS'N FOR RETARDED CHILDREN, THE MENTALLY RETARDED (undated).

Social-cultural factors adversely influencing the quality of births are prevalent among the indigent. A high percentage of them are functionally illiterate, and an even higher percentage are illegitimately pregnant.[22] All this points up the enormous sociological problem involved in giving indigent expectant mothers adequate ante-partum care.

We are in a vicious circle of indigency, unplanned parenthood, and poor reproductive quality. And the situation is getting worse. Dr. John D. Thompson of Emory University believes that within a decade it will deteriorate into utter chaos.[23] We know what the expected sharp increase in births will mean in terms of more schools, teachers, water, roads, and recreational facilities. But we haven't given much thought to the task of caring for the expectant mothers and trying to improve the quality of their infants.

Every American child should have the opportunity to be "created equal." We cannot, of course, assure every child good genes or loving, competent parents. "But it does not lie beyond the reach of justice to insist that no child be negligently born (without elementary pre and post-natal care) or negligently exposed after birth to surroundings, physical or social, that alter his chances for a rewarding maturity."[24]

B. The Need for New Techniques

The needs of the high-risk indigent group require special maternity-care programs and mental therapy techniques based on an adequate understanding of socio-cultural as well as medical factors. The poor live in a sub-culture. They typically do not understand mental troubles; they think of them as physical, as caused by such things as "bad blood," "a bump on the head," or "too much booze." They are disappointed if they don't get practical advice on how to solve their problems and run their lives. They expect pills and needles plus perhaps a little sympathy. They have no confidence in a "talking treatment." Hollingshead and Redlich in their classic study, *Social Class and Mental Illness*, found that less than two per cent of the lowest-class patients understood the aims or techniques of psychotherapy.[25] Freudian self-analysis is much too sophisticated. If

---

[22] An Emory University Hospital study of 250 expectant mothers found 17% functionally illiterate and 34% illegitimately pregnant. Thompson, *The Quality of Human Reproduction*, in WHITE HOUSE CONFERENCE ON MENTAL RETARDATION, PROCEEDINGS 85, 87 (1963).

[23] *Id.* at 88.

[24] PRESIDENT'S PANEL, *op. cit. supra* note 13, at 16.

[25] HOLLINGSHEAD & REDLICH, SOCIAL CLASS AND MENTAL ILLNESS: A COMMUNITY STUDY 339-41 (1958). See also Brill & Starrow, *Social Class and Psychiatric Treatment*, in MENTAL HEALTH OF THE POOR 74 (Riessman, Cohen & Pearl eds. 1964); Ruesch, *Social Factors in Therapy*, in PSYCHIATRIC TREATMENT 59 (1953).

treatment begins with the assumption that the indigent patient should gain "insight" into his own emotional psychological processes, his reaction is likely to be, "Don't give me a lot of talk; just tell me what to do to get well."

Lower class families often fail to recognize even serious mental disorder in a relative. He may have a lifelong history of hostility, suspicion, violence, and even bizarre behavior without his family's ever thinking of him as a "psychiatric case." To some extent this is true of people in all social classes but it is particularly true among the poor. They will attribute his conduct to meanness, laziness, or physical illness rather than to factors of psychogenic origin. This attitude is due not only to ignorance, but to a conscious or unconscious refusal to face an unpleasant fact. Just about the worst thing that can happen to a poor person is to be labelled "crazy," for such a label is all too likely to mean a life sentence in the state hospital. Psychiatry is a status symbol in Hollywood, but it means calamity and disgrace in Watts.

Even in communities where treatment is financially feasible, those members of the working class who need help may avoid it because of skepticism or hostility.[26] This, however, is becoming less true as a result of the spread of information about mental health programs and especially about the success of the new drugs and more intensive therapy that often enable patients to avoid long periods of hospitalization or even to remain in the community without hospitalization.

The patient who is involuntarily subjected to treatment is likely to resent and resist treatment, or at best passively to expect to be cured or cared for. Even the resentful patient, however, more often than not comes to recognize and admit that his stay in the hospital helped him; and he does cooperate by reporting to the after-care clinic and taking his drugs as prescribed. This is of course more likely if the treatment was humane and the physical facilities decently comfortable.

Because the illness so often comes to the attention of the authorities only through some crisis, commonly expressed in some anti-social way, the police are likely to be the first public representatives called. It is therefore important that they understand the nature of the person's behavior. If they do, he has a chance of being turned over to a psychiatric facility; if not, he is likely to be put through the penal mill.[27]

If the poor have not been eager to get psychiatric help, psychiatrists have not been eager to have them as patients.[28] Many of those who do try to work with low income patients fail, largely because they don't under-

[26] Gorman, *Psychiatry and Public Policy*, 122 AMERICAN J. OF PSYCHIATRY 55, 58 (1965).
[27] HOLLINGSHEAD & REDLICH, *op. cit. supra* note 25, at 184.
[28] *Id.* at 344.

stand the working class behavior style. Today, however, an appreciable number of psychiatrists are expanding from an exclusively private practice into "community psychiatry," devoted not so much to working with patients themselves as with other agencies, by educating, advising, and consulting with social workers, police, school counselors, probation officers, and others.

Because low income people often view mental illness in physical terms, they may be more willing to accept treatment from a general practitioner than from a psychiatrist. Special training should be designed to equip the G.P. with a practical therapy for the common man; this practical therapy would have to blur the distinction between mental and physical illness, be directive rather than nondirective, supportive, using tranquilizers, sedatives, stimulants, hormones, and vitamins—in the hope they will be helpful, either in fact or as placebos.

The treatment base should be near the client and should avoid the labyrinth of bureaucratic red tape—innumerable forms and many interviews. His first contact should be with someone with whom he can relate and talk. Perhaps the key is a neighborhood service center using nonprofessional people from the low income neighborhoods. In the South Bronx of New York City, Lincoln Hospital has set up three such centers, two of them in street-level store fronts. Each center is staffed with one or two mental health professionals, plus five to ten nonprofessionals picked from the neighborhood and given short intensive pre-employment training.[29]

If general community services such as schools, churches, and health facilities are good, there will be less need for specialized services. What the schools do, for example, affects the burden on specialized services for retarded or disturbed children.[30] The extent of community services, general and special, will affect admission and release policies of the residential institutions. If the schools have special classes for the retarded, if the community has sheltered workshops, training facilities, home-maker services, a day-care center, and special recreational programs, many persons can be kept at home and in the community instead of being committed to state institutions. Also, the institutions will be able to release more inmates than when there are no such supportive services.

What happens to institutionalized patients depends also on a number of other things. If the institution is supported in such a niggardly way that

[29] Riessman, *Strategy for Mental Health Centers*, in REPORT ON EXPANDING COMMUNITY MENTAL HEALTH SERVICES THROUGH COOPERATION WITH ORGANIZED LABOR, THE WORKER AND MENTAL HEALTH 26, 27 (1964). A grant to evaluate the impact and effectiveness of these centers was awarded by the National Institute of Mental Health in January 1966.

[30] PRESIDENT'S PANEL, *op. cit. supra* note 13, at 11; MENTAL HEALTH OF THE POOR viii (Riessman, Cohen & Pearl eds. 1964).

patients are used to do a substantial part of the work, the release rate is likely to be lower than if able-bodied patients did not do the hospital work. At one eastern state hospital, the use of state prisoners instead of hospital patients to do the hospital laundry work resulted in a remarkable rise in releases of patients.[31]

Whether the state can be sued in tort may also affect the kind of care provided in state institutions. The New York Court of Claims, in a recent decision[32] breaking new ground, upheld against demurrer a suit brought on behalf of an illegitimate infant born to a mentally deficient mother as the result of a rape by a fellow patient in a state mental institution. Liability of the state was rested on alleged negligent care and supervision of the mother.

Hollingshead and Redlich found that the kinds of care provided in psychiatric facilities vary directly with the socio-economic level of the patients. The private psychiatrist is most likely to be treating the more prosperous citizens. The state mental hospital is the major resource for the working class.[33] And it isn't primarily a matter of money. The poor are not prone to apply for out-patient treatment even in free psychiatric clinics. And when they do apply or become patients, they are treated differently, even in public clinics that purport to make no distinctions between paying and nonpaying patients. A recent study revealed that "not only were patients from upper social classes accepted for treatment more often, but their treatment was more apt to be given by a more senior or more experienced member of the staff than was the case with patients from lower social classes."[34]

Those who work with low income groups tell us that their psychological inaccessibility is not caused by any ingrained characteristic, but is due to suspicion and acculturated bias. Dr. Philip S. Wager, Chief of the Department of Psychiatry at the Southern California Permanente Medical Group in Los Angeles, said that with a proper approach, "within an hour or two the average working man is frank, far more frank than the middle class patient we see in Los Angeles, less intellectually defensive and able

---

[31] Observations by the author made in connection with a study conducted at George Washington University under a grant from the National Institute of Mental Health. The study was completed in 1965. To date, no report has been published.

[32] Williams v. State, 46 Misc. 2d 824, 260 N.Y.S.2d 953 (Ct. Cl. 1965), noted in 66 COLUM. L. REV. 127 (1966); *cf.* Zepeda v. Zepeda, 41 Ill. App. 2d 240, 190 N.E.2d 849 (1963), *cert. denied*, 379 U.S. 945 (1964).

[33] HOLLINGSHEAD & REDLICH, *op. cit. supra* note 25, at 276-78.

[34] Brill & Starrow, *supra* note 25, at 68. See also HOLLINGSHEAD & REDLICH, *op. cit. supra* note 25, at 192 (Psychiatrists "try to select what they call a good patient. We are not sure what attributes a good patient must have, but they include sensitivity, intelligence, social and intellectual standards similar to the psychiatrist's, a will to do one's best, a desire to improve one's personality and status in life, youth, attractiveness, and charm.").

to confide with direct expression of sincere emotion." And the authors of *Mental Health of the Poor* question the notion that psychotherapy is not suitable for blue-collar people: "The failure of psychotherapy with low income groups may be in large measure due to the insistence on a particular model of treatment, namely the psychodynamic, insight and reconstructive oriented approach."[35]

C. *The Community Mental Health Movement*

It is generally agreed that we should avoid as much as possible committing people to large state institutions. Isolating patients from family and friends is traumatizing and makes treatment more difficult. Treating patients in their community and preferably in their homes through the use of out-patient clinics and other local facilities is generally more effective: Treatment begins earlier and is more intensive.

If we had adequate local facilities, such as community centers and half-way houses, rehabilitation counselors, and vocational training, it has been estimated that one-third to one-half of all mental retardates could be released from institutions, made relatively self-sufficient, and the burden of their care removed from the taxpayers.[36] In a carefully controlled experiment in Louisville, Kentucky, a number of mentally ill patients who normally would have been hospitalized have been maintained in the local community more or less successfully.[37] The building of such community mental health centers has, during the past decade, become the goal of a nationwide movement to which the entire mental health field is committed, and Congress has appropriated funds to help the states establish such centers.[38] And they *are* being established. From 1955 to 1962, the number of patients served in out-patient clinics doubled—from 379,000 to

[35] MENTAL HEALTH OF THE POOR, *op. cit. supra* note 25, at vii.

[36] Shriver, *Mental Retardation: A 20th Century Challenge*, in WHITE HOUSE CONFERENCE ON MENTAL RETARDATION, PROCEEDINGS 21, 25 (1963).

[37] Pasamanick, Scarpitti, Lefton, Dinitz, Wernert & McPheeters, *supra* note 14, at 187. A survey of the population of St. Elizabeths Hospital, Washington, D.C., conducted in 1961 determined that one-half the patients were releasable, if alternative facilities were available. Only 7% of these, however, were considered eligible for release to their own homes. Classification of Patients at Saint Elizabeths Hospital by Hypothetical Eligibility for Release (unpublished report 1963).

[38] In the Community Mental Health Centers Act of 1963, 77 Stat. 290 (1963), 42 U.S.C. §§ 2681-87 (1964), as amended, 42 U.S.C. §§ 2682-87 (Supp. I, 1965), Congress authorized $150 million in federal aid to the states for construction of comprehensive community mental health centers over three years, 1965-67. The federal share can range from one-third to two-thirds of the total cost. In 1965, Congress amended the act to authorize federal financial aid toward meeting the cost of technical and professional personnel serving such centers during the first 51 months any such center is in operation or during which new services are offered in existing centers. Grants can amount to 75% of eligible staff costs for the first 15 months, 60% in the first subsequent year, 45% of the next and 30% of the third and final year.

741,000. Few of these clinics thus far provide all the "five essential elements" of a center as defined by the Department of Health, Education, and Welfare (in-patient and out-patient services, part-time hospitalization, emergency services, and consultation and education services). But as projected, the program should within the next decade reduce the present mental hospital population of 530,000 by half.

General hospitals have also been adding psychiatric screening and treatment services. Today, more than one thousand general hospitals admit psychiatric patients.

San Mateo County, California, a suburban community in the San Francisco Bay Area, offers comprehensive mental health services in its Public Health Department. Nearly eight thousand patients get service each year through the adult clinic, child guidance clinic, in-patient therapeutic community (a thirty-bed open service in the general hospital), day hospital, rehabilitation service, nursery school for disturbed children, delinquent and offenders treatment, alcoholic rehabilitation unit, research and evaluation service, and the consultation service. The staff comprises seventy-four professional mental health workers plus twenty volunteer psychiatrists and psychologists in private practice. Needless to say, these services cost a lot of money—1.25 million dollars, or 2.50 dollars per capita, the highest in the nation. But the treatment cost per patient is far less than that in the state hospital, where the average is 6.00 dollars per day for three months, or about six hundred dollars per patient. The average total cost per patient treated in the San Mateo County General Hospital unit is only 216 dollars, even though the daily cost is twenty-seven dollars, because the average stay is but eight days. Out-patient care is even less. And because of this comprehensive mental health service, the county's state hospital admissions have remained static while admissions from four other Bay Area counties rose sixty-one per cent.

Other communities are also finding that a program of prevention through early detection and treatment in the home community makes long years in custodial hospitals unnecessary. Georgia, for example, found that of 1,800 mental patients treated in the psychiatric units of four general hospitals, only 126, or seven per cent, had to be sent to the state hospital. At the time of commitment it was estimated that sixty per cent would need long-term hospitalization.

Beginning with the Kennedy Administration, the federal government has undertaken a massive effort to encourage expansion of our mental health services. Under Medicare,[39] persons aged sixty-five get

[39] Health Insurance for the Aged Act, P.L. 89-97, 79 Stat. 290 (codified in scattered sections of 26, 42, and 45 U.S.C. (Supp. I, 1965), but see particularly 42 U.S.C. §§ 1395-96d (Supp. I, 1965)).

hospital benefits for up to ninety days for each spell of illness,[40] with the patient responsible for payment of an initial deductible of forty dollars[41] plus ten dollars a day for each day after sixty days.[42] In-patient services in a qualifying psychiatric hospital are included, but there is a lifetime limit of 190 days of covered services in psychiatric hospitals.[43] Psychiatric care received in a general hospital, however, does not count toward the 190-day lifetime limit.[44]

A 1965 amendment to the Social Security Act[45] authorizes federal aid of up to seventy-five per cent of the costs of comprehensive projects for diagnosing and treating children, particularly those of low income families. This amendment also authorizes federal funds to the states for needy aged residents of mental institutions.[46] These patients have long been excluded from receiving public assistance payments.

The Elementary and Secondary Education Act of 1965[47] will give a tremendous impetus to efforts at developing educational services for the retarded. Title I authorizes a three-year effort to encourage and support the creation, establishment, or improvement of special programs. This may include the construction of facilities to meet the needs of culturally deprived children from low income families, many of whom are diagnosed as mentally retarded but who actually only lack education.

Other amendments provide for expansion of vocational rehabilitation services,[48] a form of therapy more acceptable to the poor than Freudian analysis. With this encouragement, states are extending and improving rehabilitation services, especially for the severely disabled and other hard-to-rehabilitate cases. The 1965 amendments increased the federal participation from seventy-five to ninety per cent of cost during the first three years and seventy-five per cent for the next two years.[49] State vocational rehabilitation agencies are also encouraged to work with the more disabled public assistance cases and people in other hard-core dependency groups, such as young people rejected for the draft or the Job Corps, thus helping to return more people to self-help and employment. It is highly probable that the mental illness treatment program will have to become a part of a

---

40 79 Stat. 291, 42 U.S.C. § 1395d(a)(1) (Supp. I, 1965).
41 79 Stat. 293, 42 U.S.C. § 1395e(b)(1) (Supp. I, 1965).
42 79 Stat. 292, 42 U.S.C. § 1395e(a)(1) (Supp. I, 1965).
43 79 Stat. 292, 42 U.S.C. § 1395d(b)(3) (Supp. I, 1965).
44 See 79 Stat. 314, 42 U.S.C. § 1395x(c) (Supp. I, 1965).
45 79 Stat. 354, 42 U.S.C. § 729-1 (Supp. I, 1965).
46 79 Stat. 356, 360, 42 U.S.C. § 306(a) (Supp. I, 1965).
47 P.L. 89-10, 79 Stat. 27 (codified in scattered sections of 42 U.S.C. (Supp. I, 1965)).
48 79 Stat. 1282, 29 U.S.C. §§ 31-42 (Supp. I, 1965).
49 79 Stat. 1283, 42 U.S.C. § 33 (Supp. I, 1965).

nationwide group-practice medical care program; the economics of the situation demands it.[50] We have already moved in that direction. Medical and hospitalization benefits of group insurance policies and union contracts to cover mental illnesses are bringing psychiatric services to millions who never had them.[51] In the automobile and agricultural implements industry, recent agreements with the UAW provided mental illness insurance programs for nearly 2.5 million workers and dependents.[52] The program will pay for treatment by a private physician, clinic, or day-care program, and for forty-five days of continuous care in a hospital. The California Physicians' Service now provides psychiatric coverage for nearly 400,000 of its more than a million members.[53]

But even with facilities and services available, a community mental health program encounters special obstacles in servicing the poor. The Louisville experiment found that about ten per cent of the families refused to accept a patient back home, and an additional number would have preferred that the patient remain in the hospital until he was really better. Many of these families are economically deprived, and the patient represents an unwelcome burden. The home-care mental health program thus ties in directly to and needs the support of a program to alleviate poverty.

A demoralized and disorganized home environment imperils any home-care program. Returning a patient to such a home is like sending someone with a communicable physical disease into a home and neighborhood rife with the same disease. Home care can provide strengths and support to a patient that an institutional environment lacks, but home care in unfavorable conditions is probably worse than living alone or in a night hospital. To successfully reintegrate patients into an unfavorable family setting requires family counseling, an enriched program of homemaking services, job training, sheltered work shops, and frequent access to direct psychiatric services.

---

[50] Perlis, *Social Class in Mental Illness*, in REPORT ON EXPANDING COMMUNITY MENTAL HEALTH SERVICES THROUGH COOPERATION WITH ORGANIZED LABOR, THE WORKER AND MENTAL HEALTH 11, 13 (1964). Mr. Perlis is National Director of Community Services for the AFL-CIO.

[51] Most of the membership of Blue Cross Association is now covered at least to some extent for hospitalization for mental illness. *New Directions toward Community Mental Health*, Blue Cross Rep., July-Sept. 1964, pp. 14-18.

[52] Shoemaker, *Problems of Financing*, in THE WORKER AND MENTAL HEALTH, *op. cit. supra* note 50, at 40, 41-42.

Dr. Daniel Blain, past president of the American Psychiatric Association, is now heading a study of the impact of such pre-payment plans on mental health programs. The study is being financed by the National Institute of Mental Health and is being carried out jointly with the Research Institute of UAW.

[53] California State Dep't of Mental Hygiene, California Mental Health Progress, Oct. 1965.

D. The Need for Personnel

It takes no crystal ball to foresee that to provide all the needed psychiatric and related services, we shall need a vastly larger number of psychiatrists and other mental health professionals than we now have. Congress hopes that the Health Professional Educational Assistance Act of 1963[54] and the Nurse Training Act of 1964[55] will give us the necessary physicians and nurses from which mental health specialists can be had. Estimates are that the number of psychiatrists will increase from 18,593 in 1965 to 23,735 in 1970. Nurses will increase from 20,554 in 1965 to 25,690 in 1970.

But even such increases are not going to provide enough psychiatrists to do the job, especially since we are starting with a deficiency. New positions for psychiatrists are mushrooming in schools, colleges, churches, social agencies, courts, prisons, hospitals, and clinics. We face a tremendous increase in demands for intensive treatment for old people. The gap between demand and supply is rapidly widening.

As our mental hospitals develop better treatment methods, more patients will be released earlier. Many hospitals today discharge patients as soon as possible. But one out of three so released relapses[56] and has to be readmitted. One reason is the lack of follow-up medical care and social and vocational rehabilitation services after the patient is sent home. Such service costs only one-tenth of hospital care.[57] But we need the personnel to do it. We shall have to train nurses to follow patients into the community after discharge from the hospital. Psychiatric nursing personnel will be needed in a number of new areas, including day and night hospitals, out-patient clinics, mental health clinics, half-way houses, and follow-up visits in the home; and these psychiatric nurses will need new knowledge and skills, including some public health nursing skills and better knowledge of the community. We also need some 300,000 special education teachers for handicapped children.[58] We have perhaps 70,000, and many of these have minimal special training.[59]

New discoveries and new techniques can help combat certain forms of disorder, but they also require increased professional services. Thus the

---

[54] 77 Stat. 164 (1963), 42 U.S.C. §§ 292-92b, 292d-94e (1964), as amended, 42 U.S.C. §§ 292c-95g (Supp. I, 1965).

[55] 78 Stat. 908 (1964) (codified in scattered sections of 42 U.S.C., primarily at §§ 296-298b), as amended, 42 U.S.C. §§ 297b, 298b (Supp. I, 1965).

[56] NATIONAL ASS'N FOR MENTAL HEALTH, THE NAMH PROGRAM: HOW WE SERVE 16 (1965).

[57] *Ibid.*

[58] Address by Wilbur J. Cohen, *A Day for Brighter Beginnings*, before the 16th Annual Convention of the National Ass'n for Retarded Children, Sept. 29, 1965.

[59] *Ibid.*

best hope for combating phenylketonuria is early detection. But early detection of inborn errors of metabolism is difficult because the victims look normal. Legislation that would require testing for all such inborn errors might be a solution. But testing all new-born infants would require medical manpower.

We cannot begin to meet the demands for psychological and social help from all who need it.[60] We must find new sources of manpower, new ways to effectively use the professionally trained specialists we now have, and patterns of functioning that make the fullest use of the resources we have. For example, general practitioners may have to take over a bigger share of the job. Some hospitals are operating a post-graduate training course to teach GP's to recognize and diagnose early symptoms of mental illness.[61]

Dr. Lawrence S. Kubie, Director of Training at Sheppard and Enoch Pratt Hospital, has for years been crusading for a school of psychological medicine. It would grant a degree of Doctor of Psychological Medicine after six to eight years of college. The curriculum would include basic human biology, physiological and psychological growth processes, medical and psychiatric social work, sociology, education and learning theory, linguistics and communication theory, psychopharmacology, genetics, dynamic psychopathology, psychodiaguosis, and all forms of psychotherapy. "In one-half to two-thirds the time it takes to train a board-approved psychiatrist fully," Dr. Kubie has pointed out, "the same facilities could produce about twice as many well qualified diagnosticians and therapists. Each would finish earlier, and would have more years of useful professional life ahead of him. But we need a preliminary ten-year period for the special training of a cadre of new teachers."[62]

But even with heroic efforts to develop more efficient patterns of professional functioning, there aren't going to be enough professionals in any of the healing or behavioral professions. We are going to have to turn to nonprofessionals. Some experiments along this line are now going on. The National Institute of Mental Health began an experiment in 1960 to see whether educated housewives could be trained within two years to do limited psychotherapy. It was felt that women in their forties, with their children grown, could be trained to work therapeutically with patients. Such women, after managing their homes and raising their children, have

---

60 Gorman, *Psychiatry and Public Policy*, 122 AMERICAN J. OF PSYCHIATRY 55, 59 (1965).

61 Some of these programs are described in six papers. *Education of the Nonpsychiatrist Physician*, 122 AMERICAN J. OF PSYCHIATRY 485-508 (1965).

62 SK & F Psychiatric Reporter, Sept.-Oct. 1965, pp. 4-5. See also Kubie, *A School of Psychological Medicine Within the Framework of a Medical School and University*, 39 J. MEDICAL EDUCATION 476 (1964).

had more life experience than the ordinary beginning professional worker. The experiment has been gratifyingly successful.[63]

In North Carolina and Tennessee, elementary school teachers are working with emotionally disturbed children in residential schools. The apparent success of the project suggests similar programs for other groups, such as the mentally retarded, the aged and senile, and even chronic psychotics.[64] Other such experiments are going on all over the country.

College students constitute another resource for personnel. The college Work-Study program has been a valuable source of mental health personnel.[65] VISTA (Volunteers in Service to America) workers in Georgia, North Carolina, and West Virginia, are working full time in slum areas, hospitals, schools, and institutions for the mentally ill and the mentally retarded.[66] Other mental health groups are recruiting and screening applicants for the Job Corps' Urban Centers for Women and other centers, to train unemployed young people to serve as mental hospital attendants and as laboratory technicians.[67]

Even if we had all the facilities and services needed, we would still face a special problem: how to get those who need these services to come and get them. In the old days, ward heelers took care of their people. Today we need a new kind of intervenor. Labor unions and veterans' organizations have recognized this, and have set up counselors and service representatives. A similar device being tried in several places is the "indigenous nonprofessional"—not the college-educated, middle-class housewife or the volunteer college student, but someone from the same neighborhood as the people he serves, often a member of the same minority group, sharing a common language, style, and interests. Thus a young man working with a recreation program for delinquents may be a former youthful offender.

The job of the indigenous nonprofessional is to be a link between the

[63] Dr. Lawrence S. Kubie, Director of Training at the Sheppard and Enoch Pratt Hospital, who participated in the experiment said, "It has been a heartening and exciting experience to see how a group of mature women, who have gone through the stresses and turmoils of bringing up their own families, with diverse college backgrounds but no prior technical training in psychological disciplines, could, in so short a time, become thoughtful, studious, perceptive, sensitive, and patient psychotherapeutic counselors. If anyone needed it, there would be no better proof that this opens up an important new way to attack the bottleneck caused by the shortage of trained workers in this field." Rioch, Elkes & Flint, *Pilot Project*, in U.S. DEP'T OF HEALTH, EDUC. & WELFARE, TRAINING MENTAL HEALTH COUNSELORS iv (1965).

[64] PROJECT RE-ED, A DEMONSTRATION PROJECT FOR THE REEDUCATION OF EMOTIONALLY DISTURBED CHILDREN (1963).

[65] Address by Senator Javits, *Mental Health and the War on Poverty*, at the annual meeting of the National Ass'n for Mental Health, New York, Nov. 18, 1965.

[66] *Ibid.*

[67] *Ibid.*

client and the community agencies, to serve as negotiator, investigator, expediter. He can also act as interpreter, explaining behavior that may puzzle or irritate agency staff or professional personnel, and explaining to clients agency procedures that may seem pointless and nnsympathetic. He can thus help break the vicious cycle of misunderstanding, nnstrust, and rejection that can so easily develop between the overworked staff and the desperate client.[68] The Neighborhood Youth Corps, through which high school dropouts are trained on the job with public institutions in their home towns, could be used for this purpose. Although this has been one of the more successful of the antipoverty programs, little has been done with the Corps in the field of mental illness.

E. Guardianship

A significant number of persons now sent to mental hospitals could remain home if provided with guardians and perhaps out-patient care. Some would not even need a guardian if they were given a little help in managing their affairs—perhaps nothing more than help in planning a budget plus a periodic check to see if they were following it. Others may need someone to accompany them when they cash their income checks and pay their rent, or to arrange for a near-by restaurant to help choose well-balanced and inexpensive meals, or to get a reliable contractor to make necessary repairs to the house. Possibly "indigenous non-professionals" could be used for such services. Others are incapable of making any important decisions or arrangements for themselves. For these, a more directive supervision is necessary if they are to be kept in the community rather than institutionalized.

In the modern welfare state, almost everyone has some income from social security benefits, public assistance payments, or pensions. The incompetent may need someone to manage this income, although he may be unable to pay court costs and fees for formal guardianship. Certain other changes have occurred in our society during this century that further suggest the need for a tax-supported device such as the public guardianship pioneered by Minnesota[69] and adopted to some extent in a few other states. People now live longer. But age tends to diminish one's capacity, physical and mental. Because our society is less rural and static than it was, families are less cohesive and there is less feeling of responsibility for the incompetent grandparent or other relative. The impersonality

---

[68] PEARL & RIESSMAN, NEW CAREERS FOR THE POOR (1965); REIFF & RIESSMAN, THE INDIGENOUS NON-PROFESSIONAL (1965), originally published as a monograph, third in a series of reports by the National Institute of Labor Education (1964).

[69] Levy, *Protecting the Mentally Retarded: An Empirical Survey and Evaluation of the Establishment of State Guardianship in Minnesota*, 49 MINN. L. REV. 821 (1965).

of modern life makes it difficult to find not only volunteer guardians, but also personal bondsmen. The individual man of substance who knew both the incompetent and the guardian and was willing to go on the guardian's bond has all but disappeared. Today, bonding is performed almost exclusively by commercial companies—who must charge for their service.

A few years ago Kentucky found that although its state hospitals had intensified their home and community placement programs, many patients could not be released because they had no relatives or friends interested in helping them. Most of them could be placed if they could qualify for public assistance; but they needed someone to act as guardian or committee. In a few counties public committees were available, but they charged five per cent for expenses. Operators of nursing homes or boarding homes into which patients could have been placed might have been appointed as guardians, but this would have created a conflict of interest. To meet the dilemma, the legislature in 1960 authorized the Department of Mental Health to be declared guardian for patients having no one else willing to serve.[70] The Director of the Guardianship Section is thus able to receive public assistance payments for patients after they leave the hospital, make payments to the home operators or to the patients themselves, and account to the court as required by law—all free of charge.

California, like a few other states, provides county Public Guardians.[71] The services are free, but are limited to patients in certain public institutions and recipients of public assistance. Although it does not solicit guardianship, the Los Angeles Public Guardian in 1962 served approximately 1,700 persons.[72] Most cases come either from the superior court after adjudication under Welfare and Institutions Code section 5076 or from the Bureau of Public Assistance.

Here, too, those in need of help may not seek it, nor even be aware that they need help, nor know where to find it. They may come to agency attention only as a result of some collateral crisis, such as physical illness, stroke, or an accident such as a broken hip. The immediate physical difficulty will often have mental complications. The protective service has a special responsibiilty to reach out to such persons, that is, to publicize its existence. "If persons are to seek help for themselves or others, they need to be assured of a place where the older person will receive the required attention. Persons who seek help for another need assurance that they will

---

[70] KY. REV. STAT. § 210.290 (Baldwin 1963).

[71] CAL. WELFARE & INST'NS CODE § 5076.

[72] Data collected by Professor William Cohen, U.C.L.A., for a study conducted at George Washington University under a grant from the National Institute of Mental Health. The study was completed in 1965. To date no report has been published.

not be expected to assume more responsibility than is commensurate with their relationship to him."[73]

Whether the appointed guardian is a relative, a commercial fiduciary, or a public guardian, a social caseworker should be available to advise the guardian and the court about available resources and to help in budgeting those resources. Often the condition that makes appointment of a guardian necessary entails a reduction in income or an increase in expense. Budgeting therefore may take on an importance it never had before, even when the person was mentally competent. Protective service might be more effectively rendered through an administrative agency than through a court. The agency could appoint, supervise, and terminate fiduciaryships for those requiring assistance in financial management. Such a venture would not be wholly novel. The Veterans Administration, the Bureau of Old Age, Survivors, and Disability Insurance of the Social Security Administration, and the Railroad Retirement Board have for years exercised judicial functions in designating recipients of benefits for incompetent beneficiaries. Their procedures and the experience under them could suggest ways to proceed. The VA, for example, tries to avoid the expense of judicial proceedings by designating someone as recipient for a veteran rated incompetent by the VA, rather than having a formal guardian appointed. The wife is the preferred person provided she is "qualified to administer the benefits payable and will agree to use the amounts paid for that purpose."[74]

Guardianship is a valuable device that has not been given much attention by the law or by social workers, and is probably not adequately appreciated. Resort to it will become urgent in the near future, especially for elderly incompetent persons.

II

LEGAL ASPECTS

A. Hospitalization and Incompetency Proceedings

When a poor person becomes mentally ill, he is more likely to be committed to a state hospital than to receive treatment in a local clinic or by a private psychiatrist. And the commitment procedure is almost certain to be summary and short. The same is true of incompetency proceedings. In New York, a fairly expensive incompetency proceeding called the sheriff's panel, carrying extensive procedural safeguards, is available for those who can afford it;[75] for others a much more summary proceeding is used.[76] In

[73] LEHMANN & MATHIASEN, GUARDIANSHIP AND PROTECTIVE SERVICES FOR OLDER PEOPLE 124 (1963).

[74] 38 C.F.R. §§ 13.55, 13.57 (Supp. 1965).

[75] N.Y. MENTAL HYGIENE LAW § 78.

[76] N.Y. MENTAL HYGIENE LAW § 76.

all states, commitment and incompetency cases are run through the courts in a minimum of time, on a minimum of evidence, and with essentially no hearing at all.[77]

Let me describe, for example, the Texas procedure. Texas has one of the most recent and most carefully drafted statutes in the country, the product of painstaking research financed by the Hogg Foundation and as carefully designed as any to preserve personal rights. It has, for example, a novel provision that no person may be indefinitely committed to a mental hospital without first having been sent there for a temporary stay of sixty days. At the hearing determining whether the person should be indefinitely hospitalized, the issue of incompetency may also be decided.

The Texas Mental Health Code[78] provides for a hearing and requires the appointment of an attorney *ad litem* to represent the person at the hearing. The statute, however, imposes no particular duties on the attorney. In at least one Texas city, these duties seem to consist of seeing that the papers are in order and that the notices were sent. Rarely does the attorney actively represent his client at the trial. The attorney receives ten dollars per case. The position is filled by rotation from a list of younger members of the bar—in this city the list is comprised of those who helped the judge in his campaign for office. At one hearing forty-one cases were heard in an hour and five minutes, an average of sixty-six seconds per case. All but one of the proposed patients were apparently temporary patients in the state hospital. All had signed waivers of jury trial. At the hearing, two doctors reported the weight, height, and color of hair and eyes of the patient (this for the form sent to the Department of Public Safety for action concerning drivers' licenses). The judge read the patient's name and the date of medical examination, and asked the doctors, "Is it your opinion and both of you that he is a mentally ill person and needs medical care and treatment for his own welfare and protection or the protection of others and is mentally incompetent?" The doctors answered, "Yes," and the next case was called. Only two of the forty patients actually appeared at the hearing.

The attorney *ad litem* earned four hundred dollars for sixty minutes of work plus travel time. He had no contact with his clients and had never seen nor heard from most of them. The Code contemplates that the issue

---

[77] Observations based on a study of nine communities throughout the United States. The study was conducted at George Washington University under a grant from the National Institute of Mental Health, and was completed in 1965. To date no report has been published.

[78] TEX. REV. CIV. STAT. art. 5547-1 to 104 (Vernon's 1958), as amended, art. 5547-4 to 204 (Vernon's Supp. 1965), especially art. 5547-41 to 51, as amended, art .5547-47 to 49 (Vernon's Supp. 1965).

of incompetency be regarded as distinct from that of commitability,[79] but, as seen above, both are covered in one question and one answer.

In other states also, court-appointed counsel often play a passive role.[80] Privately retained lawyers are more likely to show diligence in learning the facts before the hearing. Though they may not take a belligerently opposing stance at the hearing, they will probably have taken pains to assure themselves that hospitalization is called for and that the client is being given fair treatment.

In most cases the need for guardianship or hospitalization is obvious. But in one case out of perhaps a hundred a summary procedure may work an injustice.[81] The problem is, of course, how to find that one case in a hundred without wasting time on unnecessary elaboration in the other ninety-nine. Most persons brought into court in hospitalization proceedings are without counsel. Most of them probably do not even see the necessity of counsel. They often do not have the financial resources to fight a governmental agency that may be recommending hospitalization. Corporations sometimes find it prudent to knuckle under rather than fight administrative orders. The poor, and particularly the mentally disabled poor, are even more easily regulated. Yet a lawyer, plus perhaps a psychiatrist, might not only successfully defend the case in court, but might see it dropped without getting to court.

In most states members of the family of a patient are legally obligated to pay all or part of the cost of hospital care if they have the financial means. The extent of means and the cost that the family is to bear is typically determined administratively. Many poor families do not protest this determination, even though the payments assessed may be very burdensome. In 1964 the California Supreme Court held that a statute imposing liability for the care of a mentally ill parent committed to a state hospital violated California's state constitutional guarantees of equal protection.[82] The court based its reasoning in part on "the social revolution which has been developing during the past half century," and which has "brought expanded recognition of the *parens patriae* principle . . . and other social responsibilities, including . . . public welfare programs to

79 TEX. REV. CIV. STAT. art. 5547-51 (Vernon's 1958).

80 See, *e.g.*, Cohen, *The Function of the Attorney and the Commitment of the Mentally Ill*, 44 TEXAS L. REV. 424, 448 n.108 (1966).

81 SPECIAL COMM. TO STUDY COMMITMENT PROCEDURES OF THE ASS'N OF THE BAR OF THE CITY OF NEW YORK, MENTAL ILLNESS AND DUE PROCESS 189, 272 (1962).

82 Department of Mental Hygiene v. Kirchner, 62 Cal. 2d 586, 400 P.2d 321, 43 Cal. Rptr. 329 (1965). A prior decision of the same court in this case, 60 Cal. 2d 716, 388 P.2d 720, 36 Cal. Rptr. 488 (1964), had on certiorari to the United States Supreme Court been remanded because the California court had not stated whether its holding was based on the equal protection clause of the fourteenth amendment or the California constitution, article I, §§ 11, 21, or both. 380 U.S. 194 (1960).

which all citizens are contributing through presumptively duly apportioned taxes."[83] The court concluded that "a statute obviously violates the equal protection clause if it selects one particular class of persons for a species of taxation and no rational basis supports such classification."[84]

In what promises to be a landmark decision, the Court of Appeals for the District of Columbia has held[85] that an aging person unable to care adequately for herself but not dangerous to others cannot be involuntarily kept in a mental hospital without full exploration of all possible alternatives available for her care in the community. A staff psychiatrist had testified that in his opinion she would not be a source of potential danger either to herself or others if released; the problem was only that she would be exposed to difficulties if left unattended. There would be no objection to release if she could have adequate attention under appropriate supervision, as in a nursing home. Her family, however, was not able to pay for such care or supervision. Her counsel therefore, on application for release on habeas corpus, argued that she was being deprived of her liberty not because of her mental condition but because of her poverty. The District statute provided for hospitalization or "any other alternative course of treatment which the court believes will be in the best interests of the person or of the public." The court's duty, it was said, is to consider whether the person and the public would be sufficiently protected if she were required to carry an identification card, so that she could be taken home if she wandered, or whether she should be required to accept public health nursing care, community mental health services or foster care, or whether welfare payments might finance private care. The burden, said the court, was not on the petitioner to show the availability of alternatives, but on the courts with the aid of community agencies to explore the possibilities.

---

[83] 60 Cal. 2d at 722, 388 P.2d at 723, 36 Cal. Rptr. at 491.

[84] *Id.* at 722, 388 P.2d at 724, 36 Cal. Rptr. at 492. Professor tenBroek has called the case "a landmark decision in the law of the poor," and one whose importance cannot be overestimated. tenBroek, *California's Dual System of Family Law: Its Origin, Development, and Present Status*, 17 STAN. L. REV. 614, 638-39 (1965).

An Arizona case has held that no right to appeal exists from an order of a juvenile court requiring parents to pay a specified amount for maintenance of their delinquent child in a state industrial school. The court did not reach the constitutional question of the validity of the statute subjecting parents to liability for such maintenance costs. Ginn v. Superior Court, 1 Ariz. App. 455, 404 P.2d 721 (1965).

Such portions of veterans' benefits as have been converted into permanent investments have been held subject to claims for reimbursement for amounts expended in institutional care of the veteran. District of Columbia v. Phillips, 347 F.2d 795 (D.C. Cir. 1965). The decision creates a problem for the committee or guardian of a mentally incompetent person: whether to spend all veterans' benefits received for the ward, or save and invest for emergencies with the result of subjecting such invested amounts to claims for maintenance.

[85] Lake v. Cameron, —— F.2d —— (1966).

Four members of the court dissented, saying that the majority's decision orders the court to perform functions which it is not equipped to carry out and which are normally reserved to social agencies. It is certainly true that it calls for major reforms in traditional methods of caring for the aged.

A related but narrower contention being argued with increasing frequency is that persons compulsorily institutionalized because they need treatment have the right to insist that they get the treatment which is the justification for their confinement. If the institution is not providing such treatment, the confinement is unjust and arguably unconstitutional.[86]

Little investigation seems to have been made of the extent to which state mental institutions are required to comply and do comply with standards applicable to similar operations conducted outside the institution. Thus, all states have industrial codes calling for certain safeguards for persons working in shops, mills, or manufacturing plants. Does the laundry at the state institution, for example, have to meet the same standards of safety and comfort that other laundries are required to maintain for their workers? Are the laundries and workshops in the institution subject to the general sanitary codes? What of laws concerning the dispensing of drugs? Certain drugs, such as the tranquilizers and barbiturates, are generally not allowed to be dispensed except by a registered nurse. In some (we do not know how many) state hospitals they are dispensed in great quantities without such restrictions. Is the medical service of the hospital accredited? The residents of a community can be counted on to show concern that their hospitals are accredited. But no one is likely to be equally concerned over the state hospital. The same is true of the staff. Are the hospital's physical therapists registered as such? Are they required to have the same qualifications as those practicing physical therapy outside the hospital?

Although institutions for the retarded are generally called schools, the

---

[86] Birnbaum, *The Right to Treatment*, 46 A.B.A.J. 499 (1960). Congress in enacting the present District of Columbia commitment law recognized a "moral obligation to afford adequate treatment to those hospitalized for mental illness." H.R. REP. No. 1833, 88th Cong., 2d Sess. 6 (1964). The act itself unequivocally provides that any person hospitalized in a public mental hospital shall "be entitled to medical and psychiatric care and treatment." D.C. CODE § 21-562 (Supp. 1966).

A New York court refused to order commitment of geriatric patients who were not actively psychotic or overtly mentally disturbed. Application for Certification, 20 Misc. 2d 866, 195 N.Y.S.2d 131 (Sup. Ct. 1959). The same court also refused to transfer to a mental hospital an elderly woman described as "confused, disoriented," with a very poor mental grasp and a diagnosis of chronic brain syndrome with senile brain disease. Application of Anonymous No. 13, 6 Misc. 2d 596, 159 N.Y.S.2d 842 (Sup. Ct. 1957). See also Brenner, *Denial of Due Process and Civil Rights to Aged Seniles Without Major Medical Impairment*, 34 N.Y. STATE B.J. 19, 21 (1962).

children in such institutions may, in comparison with normal children, receive inferior educational services. For example, the teachers may not meet the standards of qualification required for other teachers. Teacher-pupil ratios may be much more unfavorable. Are social security benefits to which institutionalized children are legally entitled being made available for their benefit? Are they getting equal benefits under the state's compulsory education laws, vocational rehabilitation acts, and federal and state provisions for aid to crippled children?

B. Protections in Criminal Cases

Any confession of a mentally retarded person obtained by police interrogation is likely to be nonvoluntary. Slight pressure—perhaps only suggestive questioning—may be frightening and coercive to a retarded person. Such a person is less likely than most to know his constitutional rights to remain silent and to consult an attorney. Even if told of these rights, he may not appreciate their significance. The retarded are vulnerable not only to threats and coercion but also to a show of friendliness. Some desire to please authority; if a confession will please, or will keep people from being angry with him, such a person may gladly confess, not appreciating the implications or consequences of his statements. Certainly, silence in the face of an accusation should not be taken as evidence of guilt: Lack of intelligence may make him unable to understand what is being asked or unable to understand quickly enough to formulate answers.

The President's Panel on Mental Retardation suggested that the police work out self-imposed standards for questioning the retarded; for example, a person suspected of being retarded would not be questioned unless his attorney, parent, or guardian was present.[87] But the courts also ought to review such confessions. Mental retardation might not have been apparent at the time of the police interrogation, and all too frequently unfair procedures have been used. The Supreme Court in recent years has recognized that mental retardation may diminish the ability to resist police pressure; it has held certain confessions involuntary and inadmissible in evidence.[88]

The test of competence to stand criminal trial is usually stated to be the ability to tell one's side of the story and to assist counsel. But competence to relate a story may not be the same as competence to withstand cross-examination. A mentally retarded witness, although telling the truth, may fail to give the impression of doing so, because he is easily confused

---

[87] PRESIDENT'S PANEL ON MENTAL RETARDATION, REPORT OF THE TASK FORCE ON LAW 34 (1963).

[88] Reck v. Pate, 367 U.S. 433 (1961); Culombe v. Connecticut, 367 U.S. 568 (1961); Fikes v. Alabama, 352 U.S. 191 (1957).

under pressure of effective cross-examination, with the result that he may be discredited in the eyes of the jury or even induced to testify untruthfully.

To help eliminate the inequality that lack of money creates, it has been proposed that in prosecutions in which mental condition is an issue, a defendant be furnished the assistance of a psychiatric expert. One federal court has held that due process of law requires that such assistance be provided in a felony prosecution.[89] Professor Larry A. Bear has said that "it is absolutely monstrous to allow the availability of a psychiatrist to assist the defense to depend upon the personal wealth of the defendant or his family. It is no answer to say that where the state provides an 'impartial' psychiatrist the defendant doesn't need one of his own. He is entitled to present any respectable psychiatric theory at his trial which might assist him in prevailing upon his plea, even though the 'impartial' expert may be prejudiced against it."[90] The Criminal Justice Act of 1964[91] now provides investigative, expert, and other services as well as the assistance of counsel, to indigent defendants in federal courts.[92] Little attention thus far seems to have been given to providing psychiatric expert services.[93] Mr. Justice Brennan has suggested that local branches of the American Psychiatric Association might be asked to provide free

---

[89] Bush v. McCollum, 231 F. Supp. 560 (N.D. Tex. 1964), *aff'd*, 344 F.2d 672 (5th Cir. 1965). See also United States *ex rel.* Smith v. Baldi, 192 F.2d 540 (3d Cir. 1951), in which three of the judges took the position that where there are grave indicia of mental disease and where it appears that counsel cannot properly prepare his client's case without the aid of a psychiatrist, refusal to provide psychiatric assistance in effect deprives the accused of benefit of counsel. The majority of the court, however, refused to accept the proposition that a defendant is constitutionally entitled to receive at public expense all the collateral assistance needed to make his defense.

[90] Bear, *Reflections on the Problem of Formulating Pre-Trial Mental Examination Legislation in Criminal Cases*, 34 REV. JUR. U.P.R. 307, 351 n.131 (1965). That "impartial" court-appointed experts may not in fact be impartial has been argued by other writers. Diamond, *The Fallacy of the Impartial Witness*, 1959 ARCHIVES OF CRIMINAL PSYCHODYNAMICS 221; Goldstein, *The Psychiatrist and the Legal Process: The Proposals for an Impartial Expert and for Preventive Detention*, 33 AMERICAN J. OF ORTHOPSYCHIATRY 123 (1963); Goldstein & Fine, *The Indigent Accused, the Psychiatrist, and the Insanity Defense*, 110 U. PA. L. REV. 1061 (1962); Hess & Thomas, *Incompetency to Stand Trial: Procedures, Results, and Problems*, 119 AMERICAN J. OF PSYCHIATRY 713 (1963); Koskoff, *Unconscious Bias Sways Some Medical Experts*, Va. Law Weekly Dicta, Feb. 19, 1959.

[91] 78 Stat. 552, 18 U.S.C. § 3006A (1964).

[92] Scotland also has since 1964 provided criminal legal aid to indigents, including payment not only of solicitors and couusel but also of necessary expert and other witnesses. Forensic Science Society Bull. No. 4, 1964, p. 4.

[93] See Report of the Judicial Conference of the United States on the Criminal Justice Act, Minutes of Meeting of Oct. 17, 1964, of the Committee to Implement the Criminal Justice Act of 1964, 36 F.R.D. 277, 374 (1965); Kutak, *The Criminal Justice Act of 1964*, 44 NEB. L. REV. 703, 737-40 (1965).

or low-cost psychiatric help to indigent defendants.[94] Such help might be crucial not only at the trial, but also when the court is considering what sentence to impose.

The people who land in prison are not generally the most dangerous criminals. They are the failures in crime. They fail for the same reasons they fail in noncriminal efforts; they are not bright, or they are too impulsive and lack foresight. Poverty may or may not have led them to commit crime, but once in prison, poverty will certainly work to keep them there. The man with no job or other assets justifying hope for success on parole is likely to serve the maximum sentence.

The statutory procedures of some states may discriminate against the criminal who has become insane while in prison. The New York procedure has recently been held by the United States Supreme Court to deny equal protection in that (1) it permits civil commitment at the expiration of a penal sentence without the jury review available to all other persons so committed, and (2) it permits commitment to a state hospital maintained by the Department of Correction and used primarily to house persons found insane while serving sentence, persons charged with crime but found mentally incompetent to stand trial, and persons acquitted of crime by reason of insanity, whereas other persons are committed to that institution only if after a judicial hearing they are found to be dangerously mentally ill.[95] The invidious discrimination here is against those convicted of crime, rather than against the poor as such. But convicts are generally poor.

The New York procedure also failed to provide for appointment of counsel, and the petitioner in the case had appeared at the hearing alone; but the Supreme Court did not discuss the issue.[96] The Supreme Court of Illinois, however, has held that even though commitment proceedings are civil in nature, a person sought to be committed at the expiration of sentence is entitled to have counsel appointed for him, unless he intelligently waives such right.[97]

---

[94] Brennan, *Law and Psychiatry Must Join in Defending Mentally Ill Criminals*, 49 A.B.A.J. 238, 242-43 (1963).

[95] Baxstrom v. Herold, 383 U.S. 107 (1966).

[96] In 1965, New York, under its Mental Hygiene Law, § 88, created a review commission. The presiding justice of each appellate division appoints a staff consisting of lawyers and civil service personnel to review admissions. The commission conducts a full investigation and makes a formal report to the judge holding the sanity hearing, who has discretion to appoint counsel if needed.

California added a provision to its Penal Code in 1961, providing that at any time after expiration of sentence the prisoner if retained in a mental hospital may petition for a hearing on the issue of his mental illness, in the manner provided for civil commitment. CAL. PEN. CODE § 2964. The judge may appoint an attorney or the public defender; if the prisoner is financially unable to employ counsel, counsel shall be appointed at his request. CAL. WELFARE & INST'NS CODE § 5565.

[97] People v. Breese, 34 Ill. 2d 61, 213 N.E.2d 500 (1966).

CONCLUSION

The poor need vastly expanded mental health services, especially local community health centers. To raise the money to build needed facilities and to find the personnel to staff them will be prodigious tasks, but even if we accomplish them, we shall still face the baffling problem of inducing the poor to use those services. The poor often do not recognize that they need help; even when they do, they may not know that services exist or how to obtain them. They are apathetic about finding out, or cynical, or hostile. That this attitude of defeat, bitterness, and despair has become so widespread throughout our nation is a damning indictment of our sins of the past. It should shame and goad us to more heroic efforts now.