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CIVIL AND CRIMINAL COMMITMENT OF THE MENTALLY ILL IN MARYLAND†

By HOWARD S. CHASANOW*

INTRODUCTION

The problem of hospitalization of the mentally ill is one that is ever growing in scope, and because of its magnitude, should be of vital interest to doctors and lawyers as well as the general public. Today, one-half of all hospital beds in the nation are occupied by mental patients, and it is estimated that one out of twelve persons will spend some portion of his life in a mental institution. The direct cost of mental illness to taxpayers is over a billion dollars a year.¹

In colonial times only the "furiously mad" or violently and dangerously insane could be confined. Since there were no hospitals for the mentally ill, they were treated as criminals or paupers and incarcerated in jails, poorhouses, private cages or strong-rooms.

The first general hospital in the United States, The Pennsylvania Hospital, was established in 1756. This hospital received mental patients as well as those who were physically ill. The first hospital exclusively for mental patients was opened in 1773 in Williamsburg, Virginia.²

These early hospitals cared for the mentally ill in a deplorable manner; accepted procedures were whipping,

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¹ Hearings on H.R. 3458, House Committee on Interstate and Foreign Commerce, 84th Cong., 1st Sess. 1 (1955).

² Weihofen and Overholser, *Commitment of the Mentally Ill*, 24 Texas L. Rev. 307, 310 (1946).

chaining patients to the wall and "mad-shirts." No effort was made to discover and treat the disorder, the purpose of the institution being to guard the inmates and prevent their escape.

Improvement of the conditions in institutions came largely through the efforts of a few reformers such as Dorothy Lynde Dix in the 1840's, and Mrs. E. W. P. Packard, the latter writing several exposés in 1860 after spending three years in the State Insane Asylum at Jackson, Illinois.³

³At present there are six mental hospitals in Maryland which treat 80% of the state's mental patients. They are as follows:

Rosewood State Training School, located at Owings Mills, Maryland. This institution was incorporated under the name of "Visitors of the Asylum and Training School for the Feeble Minded of the State of Maryland" by Md. Laws 1888, ch. 183. It received its present name by Md. Laws 1912, ch. 187. Rosewood receives all mentally deficient and epileptic children from Baltimore City and the twenty-three counties of the State.

Crownsville State Hospital, located at Crownsville, Maryland. This institution was established under the name of "Hospital for the Negro Insane of Maryland" by Art. 58A, Md. Laws 1910, ch. 250 receiving its present name by Md. Laws 1912, ch. 187. Crownsville receives Negro patients from Baltimore City and the twenty three counties of the State, including the tubercular and the epileptic.

Eastern Shore State Hospital, located at Cambridge, Maryland. This institution was established by Md. Laws 1912, ch. 187 under its present name. The hospital receives white patients, except the tubercular and epileptic, from the nine counties on the Eastern Shore.

Springfield State Hospital, located at Sykesville, Maryland. This institution was established by Md. Laws 1894, ch. 231 under the name of the "Second Hospital for the Insane of the State of Maryland," and received its present name by Md. Laws 1900, ch. 70. Springfield receives mental patients from the following counties: Allegany, Baltimore County, east of York Road, Carroll, Frederick, Garrett, Howard, Montgomery, Washington and from Baltimore City - zones 1, 2, 5, 6, 11, 12, 13, 14, 18, 24, and 31. In addition Springfield admits all white tubercular and adult epileptic patients from Baltimore City and the twenty three counties. These patients are cared for in separate divisions of the hospital.

Spring Grove State Hospital, located at Catonsville, Maryland. This institution was established by Md. Laws 1797, ch. 102 and received its present name by Md. Laws 1912, ch. 187. Spring Grove receives its patients from the following counties: Anne Arundel, Baltimore County - west of York Road, Calvert, Charles, Harford, Prince George's, St. Mary's and Baltimore City - zones 7, 9, 10, 15, 16, 17, 23, 25, 26, 29, and 30.

Maximum Security Hospital, located at Jessup, Maryland. This institution was established under its present name by Md. Laws 1959, ch. 814. It admits male mental patients, both Negro and white, requiring maximum security hospitalization as well as male mentally ill prisoners transferred from penal institutions, and male defendants committed by the criminal courts.

In addition to the state mental hospitals, people suffering from mental disorders are also treated at the Veteran's Administration Hospital at Perry Point, the several private psychiatric hospitals and the general hospitals which accept patients for psychiatric treatment. Patuxent Institution for defective delinquents (See 3 MD. CODE (1957) Art. 318.) presents a specialized problem of classification and commitment and is outside the scope of this article.

CIVIL COMMITMENTS⁴

Today in Maryland there are three main procedures,⁵ unconnected with criminal proceedings, under which a person may be admitted to a mental hospital. Although these will be analyzed in detail later in the article, briefly they are as follows: commitment by County Commissioners on certification of two qualified physicians;⁶ commitment at the request of a member of the "insane's" family, relative, friend, etc., accompanied by two doctors' certificates;⁷ and voluntary admission.⁸

An analysis of any commitment procedure will show two often conflicting factors exerting varying degrees of influence. The first is the medical factor which bases commitment solely on the necessity for treatment of the individual, and has as its objective speedy commitment with a minimum of "red tape" so that treatment can be begun at the earliest possible stage of the illness. The second factor is the legal factor which bases commitment, in main, on the necessity to protect the individual and/or society. The legal factor helps safeguard the individual's personal and property rights as well as prevent "railroading". The varying degrees of influence asserted by the legal and medical factors in any commitment procedure would seem to explain the lack of uniformity in commitment procedure from state to state.

There are two general classifications of commitment procedure used in the United States. The first, judicial commitment, used in the majority of the states, requires a formal court proceeding to determine a person's mental condition in order to commit him to a mental institution. The second classification of commitment procedure is the *ex parte* commitment, used by thirteen states and Maryland,⁹ which permits an indeterminate commitment without a judicial hearing. The commitment order is issued by a physician, public official, public health officer, relative etc., and a judicial hearing is held only if the patient

⁴ The term "commitment" seems rather a bad choice of terms because of the definite connotation of criminality. However, since the Maryland statute continues to use the term and since it is still in vogue in other medico-legal writings the author will continue to use the term.

⁵ 2 MD. CODE (1957) Art. 16, § 144, under which an equity court may confine a person previously adjudicated "*non compos mentis*" upon the application of a court appointed trustee, will not be discussed in detail.

⁶ 5 MD. CODE (1957) Art. 59, § 1.

⁷ 5 MD. CODE (1957) Art. 59, § 32.

⁸ 5 MD. CODE (1957) Art. 59, § 37.

⁹ Ross, *Commitment of the Mentally Ill: Problems of Law and Policy*, 57 Mich. L. Rev. 945, 967 (1959).

appeals the order. It is to be noted that in the judicial commitment procedure the person's civil and property rights are amply protected since he has a full judicial hearing prior to commitment. In most states where it is used, formal adjudication of insanity accompanies a judicial commitment. However in most of the states using the *ex parte* procedure, including Maryland, the patient is not considered legally incompetent as a result of this commitment.

A great deal of criticism has been leveled at both the judicial and the *ex parte* commitment procedure. Among the criticisms of the judicial commitment are:

- 1) The traumatic effects of a judicial trial, where the patient hears friends or relatives testifying as to why he should be "put away."
- 2) The delays and loss of time involved in judicial proceedings.
- 3) The public record of the commitment proceeding.
- 4) The reluctance of the patient and relatives to expose to a jury the "public shame" of insanity.

Because of these factors it is felt by many writers that the judicial commitment has the effect of inducing public reluctance to seek psychiatric advice at the early stages of mental illness when the possibilities of effective treatment are the greatest.¹⁰ The proponents¹¹ of the judicial commitment procedure claim that the judicial proceeding is the only way to adequately safeguard the rights of mental patients.

The two main criticisms of the *ex parte* commitment procedure as used in Maryland and thirteen other states are that they are conducive to "railroading," and that they are unconstitutional as violative of the Due Process clause of the Fourteenth Amendment. The former criticism loses some of its impact when it is recalled that most mental institutions are seriously overcrowded and are most reluctant to take a patient unless he is clearly in need of treatment.

¹⁰ See Comment, *Analysis of Legal and Medical Considerations in Commitment of the Mentally Ill*, 56 Yale L.J. 1178, 1182 (1947); Weihofen, *Commitment of Mental Patients — Proposals to Eliminate Some Unhappy Features of Our Legal Procedure*, 13 Rocky Mt. L. Rev. 99, 105 (1941).

¹¹ Hugh Alan Ross, one of the leading writers in the field of mental commitments states, "My own conclusion is that the best results can be achieved by improving the judicial hearing rather than discarding it." 57 Mich. L. Rev. 945, 974 (1959).

The constitutional validity of *ex parte* commitments has been questioned in a number of state and lower federal courts, but has never been passed upon by the Supreme Court. Probably the leading case holding *ex parte* commitment procedures unconstitutional is *State v. Mullinax*.¹² In that case, a writ of mandamus was sought to compel the superintendent of a mental institution to admit a mentally ill person as a patient. The superintendent had refused admission on the grounds that the act whereunder the patient was sought to be committed was unconstitutional and void. The Act, Missouri Statutes Annotated, Section 202.797 (Vernon Supp. 1960) was similar to Maryland's commitment procedure and provided for commitment on application of a relative or friend and certification by two doctors that the person was mentally ill. The act also provided that if the patient or someone on his behalf requested his release he must be released within 48 hours or be granted a full judicial hearing. The Supreme Court of Missouri, in holding the procedure violative of the Due Process clause of the Fourteenth Amendment, stated that:

"[F]or the statute . . . to thus deprive a person of his liberty without an opportunity to be heard in advance of commitment, if he or those acting for him desire it, would constitute a denial of due process, and accordingly render the statute, in its present form, unconstitutional."¹³

It is to be noted that the constitutional objections to the *ex parte* procedures do not mean that a state may not temporarily restrain a person who is dangerous to himself or others pending judicial hearing; the objection is that a person is being committed, and thus deprived of his liberty for an indefinite period (until there is some change in his mental condition), without benefit of judicial hearing.

Courts reaching the opposite result, upholding its constitutionality,¹⁴ reason that commitment is based on protection, not punishment, and as long as adequate oppor-

¹² 364 Mo. 858, 269 S.W. 2d 72 (1954).

¹³ *Id.*, 77. See also *Barry v. Hall*, 98 F. 2d 222 (D.C. Cir. 1938); and *In re Maddox*, 351 Mich. 358, 88 N.W. 2d 470 (1958).

¹⁴ See *In re Bryant*, 214 La. 573, 38 So. 2d 245 (1948); *In re Crosswell*, 28 R.I. 137, 66 A. 55 (1907); and *cf. In re Cornell*, 111 Vt. 454, 18 A. 2d 304 (1941) which held that permanent commitments can be made only by a court, but where the issue of mental illness is subsequently determined by a court on post commitment request, due process is satisfied. See also Note, *Constitutionality of Nonjudicial Confinement*, 3 Stan. L. Rev. 109 (1950-51).

tunity to obtain judicial review is left open to the person committed or someone on his behalf then due process is satisfied. This is the view reached by the majority of cases.¹⁵

Even though the majority of courts uphold the constitutionality of *ex parte* commitment procedures, such procedures could be made the basis for a great deal of abuse. Hugh Alan Ross has suggested that if *ex parte* procedures be used, four additional safeguards should be provided.

- “1) The procedure should be used only for the state hospitals, and preferably only after an initial period of short-term observation commitment;
- 2) The patient should not be considered as legally incompetent;
- 3) The patient should be informed of his right to appeal, both by the examining physicians and by the hospital;
- 4) The statute which establishes the appeal process should be essentially the same as a well-drawn statute which governs initial judicial commitment.”¹⁶

To this list might also be added a clause stating that the patient should be examined by hospital physicians as soon after commitment as possible in order to protect against mistakes in judgment by certifying physicians.

Commitment of the Indigent or Partially Indigent

5 Maryland Code (1957) Article 59, Section 1 provides:

“When any person is alleged to be a lunatic or insane and without sufficient means to pay for his or her maintenance at any asylum, and who has no relative or relatives or others legally chargeable with his or her support, the county commissioners of the county in which such person may reside, or the department of welfare of the City of Baltimore (if such person resides in the City of Baltimore) shall, upon the written certificates of two qualified physicians made in accordance with the provisions of Section 31, cause

¹⁵ *Supra*, n. 9, 978.

¹⁶ *Supra*, n. 9, 975.

such person to be sent to a hospital or some other place better suited to his or her condition, there to be confined at the expense or partial expense of the county or city . . . until he or she shall have recovered and be discharged in due course of law * * *."

The section further provides for methods of obtaining a judicial hearing if requested by the alleged lunatic, his relatives or friends or the county commissioners.

The application of the county commissioner commitment procedure has gone through a stormy stage of transition. As late as 1954 this method was the "Basic Commitment Provision,"¹⁷ and was used for commitment of indigents as well as those patients able to pay for their own maintenance at an institution. In 1954 the Circuit Court for Prince George's County,¹⁸ ruled that the county commissioner commitment procedure was "clearly intended to apply to lunatic or insane paupers," and without proof that a person was a pauper and unable to defray his own expenses a person could not be committed under Section 1 of Article 59. This ruling, although it seems to have been ignored for a number of years, appears to be codified in 5 Maryland Code (Cum. Supp. 1960) Article 59, Section 4 which provides that Section 1 is not applicable to persons with sufficient income to pay their support or who have others legally chargeable with their support.

One other recent development will probably decrease the use of the Section 1 commitment. In June, 1960, the Commissioner of Mental Hygiene announced that this method will no longer be the preferred method of commitment, and questions of financial responsibility are to be treated as separate questions which can be settled after the patient has been admitted. Thus, although as late as 1959 the county commissioner commitment was used for 54% of the patients in state mental hospitals,¹⁹ it is expected that in future years the use made of this method of commitment will sharply decrease.

¹⁷ Maryland Department of Mental Hygiene, *Current Procedure in Compliance With Commitment Laws to a Mental Institution in the State of Maryland*, (1954) p. 12.

¹⁸ In the Matter of the Habeas Corpus of Carston Charles Harms, Circuit Court for Prince George's County, Daily Record, February 25, 1944 (Md. 1944).

¹⁹ Statistics in commitment to mental hospitals in 1959 (the latest compilations at the date of this writing) were obtained through the cooperation of Kurt Gorwitz, Director of Statistics for the Department of Mental Hygiene.

Family Request Commitments

5 Maryland Code (1957) Article 59, Section 32 provides:

“Whenever any person is shown to be a lunatic or insane by the certificates of two qualified physicians, as provided in § 31 of this article, the superintendent, . . . [of any mental institution in the state] . . . may receive and retain such person as a patient upon the written request of any member of his family, or near relative or friend, or the person with whom he resides, or an officer of any charitable institution or agency; . . .”

This section goes on to provide for methods of obtaining judicial review, and further states that the provisions relating to “the payment of the expenses of maintaining persons in state institutions shall be applicable to persons entering such institutions under the provisions hereof.”

The family request commitment is a relatively new procedure and seems to have come into existence as the result of the previously mentioned Circuit Court ruling that the county commissioner commitment was applicable only to indigents, thus leaving the old sheriff’s jury procedure (now abolished) as the only method of committing non-indigents.²⁰ The bill was passed in 1944 and, in the Legislative Summary published March 11, 1944, the explanation was simply that the bill was enacted in order to clarify the law governing commitment of insane persons to institutions in accordance with a recent court decision.²¹

When it was first enacted, despite the above-mentioned lower court ruling, the family request admission was used only as an “emergency commitment” where, because of a holiday or other contingency, a county commissioner commitment order could not be obtained. In 1954, the Department of Mental Hygiene stated that Section 32 “makes it possible for the hospital to legally hold and treat a patient, in the event of an emergency, until such time as the requirements of the basic commitment law, Section 1, Article 59, can be complied with.”²²

Fortunately this position has been abandoned and in June of 1960 the Commissioner of Mental Hygiene announced that the family request procedure is the preferred

²⁰ *Supra*, n. 18.

²¹ See Health and Welfare Council of the Baltimore Area, Inc., *Access to the Mental Hospital*, (1960) p. 26.

²² *Supra*, n. 17, 19.

procedure and the county commissioner support order will no longer be required before a patient is admitted. The basis of this ruling as stated by Commissioner Tuerk is that:

“hospitalization is always stressful for the patient and family and it should not be made more so by police custody, financial investigation prior to hospitalization, and other procedures not always necessary . . . modern concepts of psychiatric treatment place more emphasis on the cooperation and participation of the family.”

Since Section 32 is relatively clear and presents little difficulty in its application, its construction has not been passed upon by the Court of Appeals. The main question as to its interpretation, concerning who should sign the petition under the alternatives, seems to be adequately answered by the Department of Mental Hygiene, in its compilation of “Current Procedure” which states:

“These possible signers are listed in preferential order, i.e. if a relative is available, a friend should not sign the request. A policeman is not an officer of a charitable institution or agency. An agent of a welfare agency does comply with the requirements of this law, as does an officer of any hospital which has any charity beds.”²³

In 1959 only 17% of the patients in state mental hospitals were admitted under the Section 32 procedure;²⁴ however, in the light of the new announcement by the Commissioner of Mental Hygiene it is expected that this procedure will in the future be used for the great majority of admissions.

The Doctor's Certificate

5 Maryland Code Article 59, Section 31 provides:

“No person shall be committed to or confined as a patient in any institution . . . for the care and custody of the insane or idiotic except upon the written certificates of two qualified physicians²⁵ of the State of Mary-

²³ *Supra*, n. 17, 19.

²⁴ *Supra*, n. 19.

²⁵ A licensed osteopath is not a “qualified physician” as defined in the Mental Health Act, although a general practitioner clearly would be. *Palmer v. O'Hara*, 359 Pa. 213, 58 A. 2d 574 (1948).

land made within one week after separate examination by them of said alleged lunatic and setting forth the insanity or idiocy of such person and the reason for such opinion. No certificate shall be of force which shall be presented for the commitment of any patient more than thirty days after date of examination."

The statutory form of the certificate further requires that the signing physician have practiced for more than five years, and not be connected in any way with the hospital in which it is proposed to place the person examined. The examining physician must state that he is of the opinion that the person examined is "insane, and that the disease is of a character which . . . requires that the person shall be placed in a hospital. . . ." There is a further provision that "this section shall not apply to the cases of voluntary commitments. . . ."

This section probably presents more difficulties than any other part of the commitment procedure. The first area of difficulty, and one which perhaps can never be completely clarified to everyone's satisfaction, centers around the meaning of "insanity" as used in the certificate. The legal test contemplated by the use of the word would logically seem to be the same test used by a court in determining whether a person is well enough to leave an institution once committed, viz., would the person because of his illness if unconfined be a danger to himself or to the safety or property of others. In a fairly recent case, the Maryland Court of Appeals, although not directly dealing with the legal test for commitment, stated the general rule:

"Most jurisdictions have statutes authorizing the commitment and detention of the insane in institutions. Under the statutes, as generally interpreted (whether explicit in this regard or not) the right to confine or keep confined an insane individual depends upon whether or not the person, if free, will probably imperil his own safety or the safety and property of others."²⁸

Thus the legal test in commitment seems to be the common law test of danger to self or others; however, like many legal tests its application in specific situations is often very difficult. Since the physician is the person who must make the initial determination of sanity under our

²⁸ *Salinger v. Superintendent*, 206 Md. 623, 630, 112 A. 2d 907, (1955).

ex parte procedures the author has made a survey of a number of general practitioners in order to find out how the certification works out in actual practice. One of the interesting facts uncovered is that about twenty five to thirty percent of the general practitioners refuse to sign commitment certificates (of this percentage a few indicated that they might be willing to sign if the other certifying physician was a qualified psychiatrist). As to the actual tests used by doctors in forming their opinions, the individual's environment and type of care he could receive at home plays a very important part in the decision as to whether the certificate as to insanity will be signed. If a test could be stated, it would seem to be: all factors considered (including the illness, home environment, and treatment needed) would *this* individual be better off in an institution. Thus the doctor is looking primarily toward what is best for this individual, whereas the legal test also looks at safety and protection of others.²⁷ If any line can be drawn between the "committable" mentally disordered person and the person who is merely maladjusted, it would seem to be between the psychotic (the individual who has had a break or withdrawal from reality) and the neurotic (the individual who has had no break from reality but is the victim of inner conflicts which might be evidenced by anxiety, obsessions, compulsions or hysterical symptoms). Most doctors interviewed would consider committing the psychotic but would not consider committing the neurotic since a neurotic is not usually classed as "insane". Even with severe neurotic disorders such as *anorexia nervosa* (a loss of appetite so severe it threatens life) most doctors indicate that they would not certify the patient as insane but would instead have him treated at a general hospital.

Another question which arises with reference to the doctor's certificate is who is the actual committing agent. Under the county commissioner commitments previously discussed, the requisites are two doctors' certificates and an order of the county commissioner or the Department of Welfare of Baltimore City, and under the family request

²⁷ One psychiatrist has indicated that the doctor is therapy oriented and as such his prime motivation is to benefit the patient. However, when he signs a commitment certificate he is in effect deciding what is best for the community knowing that the patient's welfare may only be a secondary consideration. This conflict of roles may be part of the cause of the widespread hesitancy among the medical profession to commit mental patients. Szasz, *Commitment of the Mentally Ill, Treatment or Social Restraint*, 125 Jour. Nervous and Mental Diseases, 293, 305 (1957).

procedure the requisites are two doctors' certificates and a petition by a relative, friend, etc. There seems a split of authority on the question of who is the actual committing agent. There is some indication from the language used by the Court of Appeals that perhaps the doctor is the committing agent;²⁸ however, it was merely a choice of language to describe commitment and not the question before the Court. It would seem that under the procedure in Maryland the physician acts as a mere witness giving his opinion, not as the committing agent. The physician does not institute the procedure, he is merely asked by someone else to make an examination. The county commissioners, friends, relatives, etc. are not bound to commit merely because two doctors have certified that the person is insane. Further, if one or more doctors are of the opinion that the person is sane, the relative, etc., is allowed to "shop around" for two doctors having different opinions. The Committee on Hospitalization of the Mentally Ill of the Health and Welfare Council of the Baltimore Area, Inc., in an excellent publication entitled *Access to the Mental Hospital*, determined from their study of Maryland procedure that the doctor was not the committing agent and further stated:

"The clarification stated in this report as to the legal responsibility incurred by the physician when he signs a certificate — that this is an advisory act, not an act of commitment — is expected to remove one of the barriers to a fuller participation by the family physician in helping the family to find a solution to their problem."²⁹

There are several reasons why it is important to clarify the fact that the physician is not the actual committing agent. First, a patient is not very likely to respond to treatment by physicians when he knows that two physicians were legally responsible for his commitment, since a deranged person might well construe this as a conspiracy

²⁸ In *Lutz v. Superintendent*, 203 Md. 675, 100 A. 2d 732 (1953) the court said petitioner was committed "on the medical certificates of two doctors" under then Art. 59, §§ 1, 20, 30 of the 1951 Code. Also in *Ramberg v. Superintendent*, 217 Md. 652, 141 A. 2d 752 (1958) the court in describing petitioner's commitment said "he was committed on certificate of two doctors, and is now being detained under Code (1957) Art. 59, § 31." See also 14 Ops. Att'y. Gen. (Md. 1929) 180, 181 where the Attorney General said "It [the doctor's certificate] is in effect an adjudicative certification of the necessity of confining the patient which serves as the legal warrant to the institution to detain him."

²⁹ *Supra*, n. 21, 45. See also Szasz, *Civil Liberties and the Mentally Ill*, 9 Clev. Mar. L. Rev. 399, 402 (1960).

by physicians against him. Secondly, if physicians are aware that they are not the actual committing agents they might be more willing to sign a commitment certificate which they would otherwise refuse because of moral compunctions against becoming legally responsible for depriving another person of his liberty.

However, the mere fact that a doctor is not the committing agent will not absolve him from responsibility for a wrongful or false certification. Physicians in signing a commitment certificate are not acting as quasi judicial officers, and hence they are not accorded judicial immunity for their wrongful acts. Nor are physicians in signing the certificate acting as witnesses in a judicial proceeding and thus they are not immune from liability on that ground.³⁰ Liability would seem to be predicated on the fact that the physician knows that his certificate will be an instrument used in causing another to be deprived of his liberty.

Where a person committed to a mental institution brings a false imprisonment action against a certifying physician because of failure to comply with proper commitment procedures, the doctor usually tries to justify detention on the basis of the common law rule that any person can detain a mentally ill person who constitutes a danger to himself or others. There is some conflict among the decisions as to whether statutory commitment procedures replace or merely supplement the common law rule. In *Orvis v. Brickman*,³¹ the court held that the common law rule was a good defense to a false imprisonment action even though proper commitment procedures were not followed.

Maryland has never specifically passed on the question of whether the common law rule is replaced by our commitment statutes; however, the case of *Miller v. West*³² seems to indicate that the common law rule is still in force in Maryland and therefore the only time a certifying physician could be liable is when the committed patient was in fact sane and the doctor was negligent or did not make an examination. In the *West* case, a patient released after nine months confinement brought suit against the two certifying physicians on the grounds that their certifications as to his insanity were improperly and falsely made without proper examination. The court indicated

³⁰ *Rice v. Gray*, 225 Mo. App. 890, 34 S.W. 2d 567 (1930).

³¹ 196 F. 2d 762 (D.C. Cir. 1952). See also *Warner v. State*, 297 N.Y. 395, 79 N.E. 2d 459 (1948).

³² 165 Md. 245, 167 A. 696 (1933).

that a cause of action might exist by one who, by reason of the physicians' improper certification of insanity, was wrongfully confined in a mental hospital; however, the court sustained the defendants' demurrers on the grounds that mere allegations of falsity in the certificate and wrong in the confinement were too general and ambiguous. The court further stated:

"But the action, if it lies, can be resorted to only for redress of injury from the physicians' having contributed to bring about confinement of one who should not have been confined. If the patient was in fact insane, and in need of the confinement, there would be no actionable injury from wrongful procedure in confining him."³³

Voluntary Admissions

Voluntary admissions are probably the least controversial and most uniform method of gaining access to a mental hospital. However, it is to be noted that only a relatively small percentage of the mentally ill are capable of the volition required for a voluntary admission. In addition, few of these recognize their condition.³⁴ Only two states exclude voluntary patients unless formally committed.³⁵ One state has held its voluntary commitment law unconstitutional as a violation of due process on the ground that a mental patient could not have the capacity to make application for hospitalization.³⁶ However, this result has been severely criticized.³⁷

The Maryland statute³⁸ provides that the superintendent of a mental hospital may accept a patient for care and treatment whenever the individual applies for such treatment in writing. No person voluntarily admitted can be held longer than three days after his request to leave unless in the meantime he has been legally committed by one of the previously discussed methods. Further assurance that the admission is truly voluntary is provided by the act in that no person is to be committed whose

³³ *Id.*, 248.

³⁴ Curran, *Hospitalization of the Mentally Ill*, 31 N.C. L. Rev. 274, 278 (1953).

³⁵ 9 ALA. CODE (1940) Title 45, § 204, and 14A FLA. STAT. ANN. (1943) Title 27, § 394.25. Editor's note: See LINDMAN & MCINTYRE (EDS.), *THE MENTALLY DISABLED AND THE LAW* (1961), published after this article was written.

³⁶ *Ex parte Romero*, 51 N.M. 201, 181 P. 2d 811 (1947).

³⁷ Ross, *Hospitalization of the Voluntary Mental Patient*, 53 Mich. L. Rev. 353, 354 (1955). See also Overholser, *The Psychiatrist and the Law*, p. 81 (1953). See LINDMAN & MCINTYRE, *supra*, n. 35.

³⁸ 5 MD. CODE (1957) Art. 59, § 37.

mental condition is such that he does not understand the significance of his action and his rights in requesting discharge, and no commitment is to be continued under the provisions of the act when the mental condition of the patient becomes such that he is not competent to give continuous assent to his detention. Finally there is a provision that the act must be read or exhibited to every person requesting admission to any institution as a voluntary mental patient.³⁹

In 1959 voluntary patients accounted for ten percent of the population of Maryland's state mental hospitals.⁴⁰ With the growing realization by the general public of the modern concept of mental sickness as a disease similar to physical illness and the growing willingness of the average citizen to undergo psychiatric treatment, an increase in voluntary admissions may be expected.

One other factor in voluntary admissions deserves mention. Although the act does not require a doctor's certificate to accompany a voluntary patient, the Department of Mental Hygiene usually requires an endorsement by one physician that the person "is in need of treatment at an institution for mental disorders."⁴¹ This administrative requirement seems reasonable in the light of the overcrowded conditions in mental hospitals, and any voluntary patient truly in need of treatment should have no difficulty obtaining the required endorsement.

CRIMINAL COMMITMENTS⁴²

In this section no attempt will be made to analyze in detail all the statutory sections relating to the insane defendant; rather, the analysis will deal in main with the procedure and tests used for insanity at the different stages

³⁹ This last provision is an important safeguard in the light of a Connecticut holding that a voluntary mental patient does not have to be told by the hospital authorities of his right to obtain release by written request even though they are aware of his desire to leave. *Roberts v. Paine*, 124 Conn. 170, 199 A. 112 (1938). See editor's note: LINDMAN & McINTYRE, *supra*, n. 35.

⁴⁰ Statistics in commitment to mental hospitals in 1959 (the latest compilations at the date of this writing) were obtained through the cooperation of Kurt Gorwitz, Director of Statistics for the Department of Mental Hygiene.

⁴¹ Maryland Department of Mental Hygiene, *Current Procedure in Compliance with Commitment Laws to a Mental Institution in the State of Maryland*, (1954) p. 55.

⁴² The term criminal commitments is actually a misnomer but it is used by the author for brevity and means any court commitment to a mental institution arising from the fact that the patient was formally accused of a crime.

of criminal proceedings. Today in Maryland there are three separate legal tests of insanity to be applied to a criminal defendant. The first of these is whether the accused is "sane" enough to stand trial, the second is whether or not the accused was "insane" at the time of the criminal act and therefore not responsible for his actions, and the third test is whether, the accused, having been found to have been "insane" at the time of the alleged act, is still "insane".

*Is The Accused Sane Enough To Stand Trial?—
A Determination Of Insanity For The Trial Court*

At common law an insane person unable to conduct or advise in his defense could not be subjected to a trial in a criminal case.⁴³ The issue of insanity at the time of trial was to be determined before another step was taken, whenever inability to stand trial became apparent from observation or whenever the issue was raised.⁴⁴ Whether or not the accused was "sane" at the time of trial was decided by the trial court in its discretion.⁴⁵ The rationale behind this rule has been aptly stated by the Maryland court in *Price v. State*:

"If, however, the party be found insane at the time of the trial so as to incapacitate him, the law, out of a just and compassionate consideration for his condition, will not try him of the crime charged . . . , but will stay the charge and await such time when his reason shall be sufficiently restored, so as not to prevent him from properly conducting or advising as to the conduct of his defence, although he may have been of sound mind at the time the alleged crime was committed. The reason for this rests upon weighty considerations, for who knows better than the party charged the facts and the witnesses that may establish his innocence, and these may be his solitary and incommunicable possession by force of his mental condition."⁴⁶

The test and procedures used for determining whether the accused is sane enough to stand trial are set out in the Maryland statute which provides that:

⁴³ 3 A.L.R. 94 (1919); *Ashley v. Pescor*, 147 F. 2d 318, 319 (8th Cir. 1945).

⁴⁴ 23 C.J.S. 232, Criminal Law, § 940.

⁴⁵ *Slough and Wilson, Mental Capacity to Stand Trial*, 21 U. of Pitts. L. Rev. 593 (1960).

⁴⁶ 159 Md. 491, 499, 151 A. 409, (1930).

"Whenever any person charged with the commission of any crime, offense, or misdemeanor shall appear to the court or be alleged to be a lunatic or insane or if the court shall have any reason to suspect that such person may be a lunatic or insane the court may cause the Department of Mental Hygiene to inquire whether such person is at the time of such inquiry insane or lunatic, or of such mental incapacity as to prevent such person from properly conducting his or her defense or advising as to the conduct of his or her defense; and if the Department of Mental Hygiene shall find that such person is at the time of such inquiry insane or lunatic or of such mental incapacity as to prevent such person from properly conducting his or her defense or advising as to the conduct of his or her defense, the court shall in its discretion direct such person to be confined . . . [in a mental institution] . . . until he or she shall have recovered and shall stay the proceedings against such person until that time, and upon recovery the court shall proceed with the trial of the charge pending against such person."⁴⁷

Thus, the common law rule is codified with some modification. Although the court still makes the final determination as to whether or not the accused is sane enough to stand trial, the Department of Mental Hygiene acts as an advisory body. Seemingly this determination is also made at any stage of the proceeding where the accused's incapacity to stand trial is questioned or suspected by the trial court. There seems, however, to be some question as to whether the determination of insanity by the Department of Mental Hygiene, although admittedly only advisory, is necessary in order for the judge to commit the defendant to an institution under this section. In *In the Matter of the Habeas Corpus of Carston Charles Harms*,⁴⁸ the Circuit Court for Prince George's County, held invalid a commitment by the court under Maryland Code (1939) Article 59, Section 8 (now 5 Maryland Code (1957) Article 59, Section 9) after examination and certification by two physicians not members of the Department of Mental

⁴⁷ 5 MD. CODE (1957) Art. 59, § 9. Emphasis added. Section 11 of the same articles provides for observation and treatment of a prisoner who has been committed to jail in default of bail to await further proceedings and can result in a commitment in accordance with § 9.

⁴⁸ Circuit Court for Prince George's County, Daily Record, February 23, 1944 (Md. 1944).

Hygiene. The Court was of the opinion that in order for a commitment to be valid under this section there had to be an "inquisition" and some deliberative finding by the Department of Mental Hygiene upon which the Court should take action. It is important to note that although the determination of insanity by the Department of Mental Hygiene may be necessary in order to commit the accused under the statute, the judge is not required to request a finding by the Department of Mental Hygiene in order to rule the defendant sane enough to proceed with the trial even though incapacity to stand trial is pleaded.⁴⁹

The Maryland test of incapacity to stand trial, viz., whether the defendant is "of such mental incapacity as to prevent [him] from properly conducting his . . . defense or advising as to the conduct of his . . . defense,"⁵⁰ is an extremely strict test of mental disease,⁵¹ as are most of the tests for incapacity to stand trial. To be so "insane" as to be unable to stand trial the defendant would probably have to be clearly psychotic. The psychopathic defendant is capable of standing trial.⁵² Thus it would appear that a defendant could be "insane" under one or more tests for insanity yet still be sane enough to be able to assist in the conduct of his defense. Further, since the finding of incapacity to stand trial is one to be made by the trial court in its sound discretion the chances of reversal appear to be unlikely.

*Is The Defendant Not Guilty By Reason Of
Insanity And Insane Now?—*

Determinations Of Sanity For The Trier Of Fact

The first issue of sanity for the jury is whether the defendant was insane at the time of commission of the criminal act and therefore not guilty by reason of insanity. Even though the defense of insanity is specially pleaded, if there is no specific reference to sanity in the verdict of the trier of fact it is conclusively presumed that the finding

⁴⁹ *Hamilton v. State*, 225 Md. 302, 170 A. 2d 192 (1961); *State v. Hazel*, Criminal Court of Baltimore City, Daily Record, December 6, 1960 (Md. 1960). See also *Hereden v. U.S.* 286 F. 2d 526 (10th Cir. 1961).

⁵⁰ 5 MD. CODE (1957) Art. 59, § 9.

⁵¹ It seems to be a harsher test of mental disease than that applied by the federal courts viz., whether he has sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding — and whether he has a rational as well as factual understanding of the proceedings against him. See *Dusky v. United States*, 271 F. 2d 385 (1959), rev'd 362 U.S. 402 (1959).

⁵² *U.S. v. Jones*, 147 F. Supp. 265 (D.C. Md. 1956).

was made that the defendant was sane at the time of the commission of the act. In Maryland the test used to determine insanity sufficient to relieve the defendant of criminal responsibility is the M'Naughten rule,⁵³ as stated in *Spencer v. State* (referred to locally as the Spencer Test):

"if at the time of the commission of the alleged offense, he had capacity and reason sufficient to enable him to distinguish between right and wrong, and understand the nature and consequences of his act, as applied to himself, he is a responsible agent."⁵⁴

This test of insanity used in determining whether a person is responsible for his otherwise criminal acts is probably the strictest of all tests for insanity. A person could conceivably be insane under the civil test (danger to self or others), be too insane to stand trial (unable to conduct or assist in the conduct of his defense) and yet be able to distinguish between right and wrong and know the nature and consequences of his acts under the Spencer test. It is to be noted that the Spencer test, although used to determine sanity at the time of commission of the offense, cannot really be called a test of insanity. It is simply a test of responsibility for a given act. Insanity is a condition, almost a status at law. The Spencer test does not determine a patient's over-all mental condition; instead, it looks at a person's mental condition over a very short period (time of the act) and only in relation to specific acts, the person's over-all mental history and mental condition being important only in drawing inferences as to his mental condition at the time of the act.

If the accused was, in fact, "insane" at the time of the act, the trier of fact must now make a determination as to his sanity at the time of the trial. If the defendant is found by the trier of fact to be insane at the time of commission of the act but sane at the time of trial he leaves the court room a free man. If, however, he is found insane at the time of commission of the act and insane at the time of

⁵³ 10 Cl. & F. 200, 210, 8 Eng. Rep. 718 (1843).

"[T]o establish a defense . . . of insanity, it must be clearly proved that, at the time of the committing of the act, the party accused was labouring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing; or if he did not know it, that he did not know that he was doing what was wrong."

⁵⁴ 69 Md. 28, 37, 13 A. 809 (1888). For a discussion of the burden of proof of insanity at the time of the act see 15 Md. L. Rev. 157 (1955).

trial, the court is required to commit the defendant to a mental institution until he recovers his sanity.⁵⁵

There seems to be some question as to the result of a verdict of "sane" at the time of commission of the act but "insane" at the time of trial. Under Section 8,⁵⁶ the judge is empowered to commit a defendant found not guilty by reason of insanity and "insane" at trial. There is no authority given under this section to commit to a mental institution a defendant found guilty of the crime. Nor would this seem to be a determination of incapacity to stand trial, for that is a question for the trial court made upon the advice of the Department of Mental Hygiene. It would seem that when a verdict of guilty but "insane" at time of trial is brought in by the jury, the judge would have two alternatives: either to grant a new trial and if he thinks it necessary to compel an examination of the defendant by the Department of Mental Hygiene and, upon its recommendation, commit the defendant until he becomes sane enough to stand trial, or, if the judge is still of the opinion that the defendant was sane enough to stand trial, he seemingly could sentence the defendant upon the jury's verdict of guilty and leave it to the Board of Correction to hospitalize the defendant under its power to commit insane convicts to mental institutions.⁵⁷

Once the jury has determined that the defendant was "insane" at the time of the act, it then has to determine whether or not he is "insane" at the time of trial, and therefore whether he should be committed to a mental institution. The test for this "insanity now" is not specified in the Code (nor is the test for criminal responsibility) and the Court of Appeals has never specifically stated the test for the jury determination of insanity at the time of trial (or "insanity now").

Probably the best way to determine the test for "insanity now" is by a process of elimination — by first determining what the test cannot be. As was previously noted, the test for the jury's verdict of "insane now" does not seem to be that the accused lacks sufficient mental capacity to conduct or assist in conducting his own defense, since this is a collateral determination to be made by the judge upon the recommendation of the Department of Mental Hygiene. Also, it would seem both unjust and

⁵⁵ 5 MD. CODE (1957) Art. 59, § 8.

⁵⁶ *Ibid.*

⁵⁷ 5 MD. CODE (1957) Art. 59, § 43. See also 3 MD. CODE (1957) Art. 27, § 711.

illogical to submit to the jury along with the questions of guilt the further question of whether the defendant can legally be tried after he has in fact been tried. At least one state has ruled that submitting to the jury the question of a person's competency to stand trial, along with the question of his guilt or innocence, constitutes reversible error.⁵⁸ Thus, since the jury question of "insanity now" does not seem to be capacity to stand trial, the next possibility is that the test for "insanity now" is the same as the Spencer test for criminal responsibility viz., that the defendant cannot distinguish between right and wrong and does not know the nature and consequences of his acts.⁵⁹ It is doubtful whether this is the test used for "insanity now". As was indicated previously, the Spencer test is not a medical test for insanity, it is a test for criminal responsibility for a given act or acts. Efforts to rework the Spencer test into a test for continuing insanity would be extremely difficult and would present the jury with an almost impossible yardstick for insanity. Would the defendant have to have no present conception of right and wrong, or would a hazy conception of right or wrong still render him insane? Would appreciation of the nature and consequences of just some but not all of his actions render him insane, and if so which ones, or does the defendant have to be totally oblivious of the nature and consequences of all of his actions in order to be found "insane now", a result which would make a finding of "insanity now" a rare phenomenon since a person so severely mentally ill would probably never be tried. Thus, the one remaining test for "insanity now" would be the same test as that used for civil commitments viz., whether the person by virtue of his mental condition would, if a free agent, constitute a danger to himself and/or the safety or property of others. This test seems to be the test for "insanity now" not only by a process of elimination but also for logical and practical reasons.

In *Wagner v. M. & C.C. of Baltimore*⁶⁰ Wagner was found by the jury not guilty by reason of insanity and "insane now." He was committed to a state hospital for the insane and a trustee was appointed by the court. It was ordered that the trustee pay out of Wagner's estate, a specified sum for Wagner's support and maintenance at the hospital under what is now 5 Maryland Code (1957)

⁵⁸ State v. Charles, 124 La. 744, 50 So. 699 (1909).

⁵⁹ *Supra*, n. 54, 37.

⁶⁰ 134 Md. 305, 106 A. 753 (1919).

Article 59, Section 13. The trustee objected to the payment on the ground that a person confined because of a criminal offense should not have to pay for his own support. The Court of Appeals in affirming the support order stated:

“When his insanity was established by the verdict of the jury, he was no more a criminal than if he had never been charged with a crime, and he was in precisely the same situation as one who had, upon his own application or upon the application of others been adjudged insane.”⁶¹

Thus it would appear that if a person committed upon a jury verdict of “insane now” is in the same situation, and is to be treated the same as a person committed by civil procedures, the test for the two types of commitments should also be the same.

The case of *Salinger v. Superintendent*⁶² also might be an indication that danger to self or others is the test for “insane now”, although the court made no determination on this point. In the *Salinger* case the petitioner was found by a jury to be not guilty by reason of insanity and “insane now,” and was committed to Spring Grove. Four years after his commitment petitioner brought a proceeding to obtain his release on the ground that he had regained his sanity. In the second proceeding a jury found petitioner still insane under an instruction to the effect that even if petitioner could distinguish right from wrong and knew the nature and consequences of his acts he was still insane if, he would be a danger to himself or the safety or property of others. The Court of Appeals upheld the instruction and held that the test for release of a person found not guilty by reason of insanity and “insane now” is the same test used for release of a person committed by civil procedures, viz., danger to self or others. The court in the *Salinger* case stated:

“One found to have been and to be insane in a criminal proceeding, is committed not because he did the act which caused him to be brought into court, but because it is *not safe for him or the community for him to be at large*. The confinement is not punishment, it is custodial. The acts which preceded it merely served

⁶¹ *Id.*, 309.

⁶² 206 Md. 623, 112 A. 2d 907 (1955), noted in 15 Md. L. Rev. 255 (1955).

to bring about a judicial determination in a particular form of the need for custodial confinement."⁶³

In an address given before the Judicial Conference of the Maryland Judiciary on January 22, 1960, it was stated that:

"Where the issue is release from or commitment to a mental institution, the *Salinger Case*⁶⁴ tells us that 'insanity' means that the individual, if he becomes a free agent, will be a danger to himself and/or others. It is this same meaning, I believe, that the jury should have in mind, and it should be so instructed by the court as the test of 'insane now', when a plea of not guilty by reason of insanity is introduced under section 7⁶⁵ of the code."⁶⁶

The question then arises as to the validity of having one test for criminal responsibility and another still broader test to determine whether the person, found not guilty by reason of insanity, should be committed to a mental institution. The validity of this procedure is now certain. Many states have statutes providing for compulsory commitment to mental hospitals for varying periods where there has been a finding of not guilty by reason of insanity, and such statutes have been held constitutional even though the defendant is committed, regardless of his present mental condition.⁶⁷ In Michigan and Massachusetts, persons acquitted of murder (or of manslaughter in Massachusetts) by reason of insanity are automatically committed to mental institutions for life, subject to discharge by the governor on a finding that such discharge would not be dangerous.⁶⁸ In North Carolina persons acquitted of capital crimes because of insanity at the time of the act are committed for life and can only be released by a special act of the legislature; those acquitted of a lesser crime can be released only by the governor.⁶⁹ Thus

⁶³ *Id.*, 628. Emphasis added.

⁶⁴ *Supra*, n. 62.

⁶⁵ 5 MD. CODE (1957) Art. 59, § 7.

⁶⁶ Address by Prof. L. Whiting Farinholt, Jr. of University of Maryland School of Law.

⁶⁷ *Ex parte Boyd*, 108 Cal. App. 541, 291 P. 845 (1930); *People v. Dubina*, 304 Mich. 363, 8 N.W. 2d 99 (1943). Editor's note: See also LINDMAN & MCINTYRE, *supra*, n. 35.

⁶⁸ MICH. COMP. LAWS, § 766.15(c) (1948); 4 MASS. LAWS ANN. ch. 123, § 101 (1957).

⁶⁹ 3B N.C. GEN. STAT. ch. 22, § 122-86 (1952). For a discussion of these procedures see Weihofen, *Institutional Treatment of Persons Acquitted by Reason of Insanity*, 38 Texas L. Rev. 849 (1960).

it would seem that a more general and more inclusive standard than that provided in the Spencer "right-wrong" test should be applied in finding a person "insane now," and, if the author's interpretation is correct, an individual found not guilty by reason of insanity will not leave the court room a free man unless the jury is convinced that his mental condition will not make him a menace to himself or to the safety and/or property of others.

RELEASE

The procedures for obtaining release, or for obtaining a judicial determination of the necessity for continued commitment, are fully set out in the Code; therefore, only a brief outline of these procedures need be presented in this section. The test used in deciding whether a person should be released from a mental institution, regardless of the procedure used to commit him, is whether if a free agent he would constitute a danger to himself and/or the safety and property of others.⁷⁰ The voluntary mental patient has an absolute right to release within 3 days after he gives notice of his desire or intention to leave, unless in the meantime he is committed under some other procedure. Further, where the friends or relatives of any patient are maintaining him at private expenses in any mental institution they have an absolute right to remove him under 5 Maryland Code (Cum. Supp. 1960) Section 42 regardless of his mental condition.

A person committed under Section 32⁷¹ (by petition of a relative, friend, etc., and two doctors' certificates), or anyone on his behalf, may request release and the request must be complied with unless the superintendent feels that the patient's mental condition requires further detention, in which event the superintendent will petition the court for a sanity hearing. Section 21 of Article 59 further provides:

"Any person confined in a State or licensed private institution . . . or anyone in his behalf, . . . may file a petition in the law courts . . . requesting that the person so confined be brought before said court for the purpose of having the sanity of such person determined If the court or jury . . . shall determine that such person is insane or is suffering from a men-

⁷⁰ *Supra*, n. 62.

⁷¹ 5 MD. CODE (1957) Art. 59, § 32.

tal disease, the court shall order said person committed . . . otherwise he shall be discharged. After a person has had one hearing under the provisions of this section, any further petition filed by him within a period of one year from the date of the previous hearing shall be accompanied by one or more affidavits of a person or persons, other than himself or another person confined in an institution or hospital, as aforesaid, showing the mental condition of the petitioner at that time as compared with such condition at the time of the last previous hearing. If, in the opinion of the court, the affidavit(s) indicate a substantial improvement in the petitioner's mental condition, the case shall be heard . . . ; otherwise the petition shall be dismissed."⁷²

If the court, in a proceeding under this section, finds that the petitioner is still insane and orders the petitioner returned to the institution, this is a final determination of a court of law in a civil suit from which an appeal may be taken.⁷³ In a proceeding under this section the court may appoint counsel for the allegedly insane person and should have the testimony reported by a court stenographer.⁷⁴

The Code also provides that the hospital may discharge any patient, not under criminal charge, who appears "quiet and harmless" and would not be dangerous to himself or others.⁷⁵ Since most mental hospitals are overcrowded the hospital would probably be very lenient in its discharges, thus avoiding the necessity of a petition to the courts in most cases, if the patient has in fact recovered.

The provisions for release of persons committed as the result of criminal prosecutions are somewhat more complex. The use of the writ of habeas corpus is almost abolished as a method for redetermination of mental condition. Where a person accused of a crime is committed to a mental hospital "for observation and treatment before trial," the method for getting a redetermination of his mental condition is by petition to the law courts under Article 59, Section 21, and not by habeas corpus.⁷⁶ There

⁷² 5 MD. CODE (1957) Art. 59, § 21.

⁷³ *Adams v. May*, 196 Md. 152, 75 A. 2d 839 (1950).

⁷⁴ *Ibid.*

⁷⁵ 5 MD. CODE (Cum. Supp. 1960) Art. 59, § 42.

⁷⁶ *Robertson v. Superintendent*, 198 Md. 666, 80 A. 2d 900 (1951).

is, however, a provision in Article 59, Section 8 that where a person found not guilty by reason of insanity and "insane now" is committed to a mental institution, any judge of the Circuit Court for the county (or Supreme Bench of Baltimore City) where such person is detained "may upon habeas corpus proceedings, make any order, absolute or conditional, for the permanent or temporary discharge of the person upon satisfactory proof of permanent or temporary recovery."⁷⁷ However, it is doubtful whether an appeal is available for refusal to issue the writ.⁷⁸ A person committed under a finding of not guilty by reason of insanity but "insane now" is not "detained or confined as a result of a prosecution for a criminal offense." He was found "not guilty" and his confinement was ordered because, if free, he would constitute a danger to himself or others. Therefore it would seem that the requirements for appellate jurisdiction over a denial of the writ of habeas corpus are not met.⁷⁹ Thus the best procedure for obtaining a redetermination of sanity for criminal defendants committed by court order is Section 21 of Article 59, previously discussed.⁸⁰ There is one additional requirement for criminal releases. No matter what procedure is used, approval must be obtained from "a judge of the court in which such person's case was pending at the time of the commitment, or in which such person was acquitted by reason of insanity."⁸¹

CONCLUSION

In general, the author feels that the Maryland commitment and release procedures are adequate to fully safeguard the rights of the mental patient as well as provide

⁷⁷ 5 MD. CODE (1957) Art. 59, § 8.

⁷⁸ See *Miller v. Superintendent*, 190 Md. 741, 60 A. 2d 189 (1947). However, it is important to note that according to the court in this case Miller was committed under (then) MD. CODE (1939) Art. 59, § 7 which is the commitment procedure where a defendant is found not guilty by reason of insanity and "insane now." This allows habeas corpus in a later petition involving the same defendant, *Miller v. Superintendent*, 198 Md. 659, 80 A. 2d 898. The court intimates that Miller was actually committed prior to verdict and not under the above cited section. Therefore, although there seems to be no clear cut holding on this point, all indications are that a denial of habeas corpus under this section is not reviewable on appeal.

⁷⁹ 4 MD. CODE (1957) Art. 42, § 7 provides for appellate review of habeas corpus only where "the petitioner is detained or confined as the result of a criminal offense or has been confined as a defective delinquent."

⁸⁰ *Supra*, circa n. 72.

⁸¹ 5 MD. CODE (1957) Art. 59, § 14.

swift medical treatment. The two main areas where improvement might be made would be some type of emergency commitment procedure for those in need of immediate treatment but who do not submit to examination at the request of near relatives or friends,⁸² and possibly a compulsory commitment for observation of all persons found not guilty by reason of insanity.

⁸² In such cases, the practice has been to secure examination after such person has been arrested on a criminal charge (usually breach of peace), detained and examined while held at the police station or in jail. It is felt that this experience is sometimes harmful to the person's treatment, and that the procedure would be improved if provisions for arrest, detention, and examination at a mental hospital could be substituted for the procedure of arrest on criminal charge, detention, and examination at the police station or in jail.