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MEMORANDUM  
STATE OF MINNESOTA  
DEPARTMENT OF PUBLIC WELFARE  
CENTENNIAL OFFICE BUILDING  
SE. PAUL, MINNESOTA

DATE: January 13, 1970

TO: DPW Cabinet

All Medical Services Division Institutions  
ATTENTION: Medical Director  
ATTENTION: Administrator

Community Programs  
ATTENTION: Board Chairman  
ATTENTION: Program Director

Daytime Activity Centers  
ATTENTION: Board Chairman  
ATTENTION: Program Director

Medical Services Division Staff

Mental Health Medical Policy Committee

Members of the Minnesota State Legislature

Professional Colleagues

United States Public Health Service  
Region VI Office

FROM: David J. Vail, M.D., Director  
Medical Services Division

SUBJECT: Repeal of Involuntary Confinement

As you may know, I appeared on the television show, The Advocates, on November 23, 1969. My role there was "the man in the middle", to hear both sides of the question whether involuntary confinement of mentally ill persons should be abolished.

I have decided that we should repeal the involuntary confinement provisions of the Minnesota Hospitalization and Commitment Act. The processes leading to my decision and the reasons for it are set forth in my letter to Mr. Roger Fisher, the Executive Editor of The Advocates, a copy of which is attached.

I would appreciate your comments on this interesting and controversial issue.

DJV:mhv



STATE OF MINNESOTA  
DEPARTMENT OF PUBLIC WELFARE  
CENTENNIAL OFFICE BUILDING  
ST. PAUL, MINNESOTA 55101

January 6, 1970

Mr. Roger Fisher  
Executive Editor  
C/O The Advocates  
WGBH  
125 Western Avenue  
Boston, Massachusetts 02134

Dear Mr. Fisher:

I am writing to let you know that I have decided against the involuntary confinement of mentally ill persons, and I will proceed to try here in Minnesota and elsewhere to do what I can to obtain repeal of the present mental illness commitment laws.

A. Background

This decision has been forming itself in my mind for some time, and it would be difficult for me to recount the process in detail. Many individuals have influenced my thinking. I would say that the arguments of Thomas Szasz have carried more weight with me than those of any other single person.

The influence of the November 23, 1969, program of The Advocates might interest you. I was unable to make much of my experience on the program until a month later. The reason for this was the excitement of the situation and the fact that I missed a good deal of what was going on at the time. It happened that one of our people here had sense enough to make a video tape of the show, and I had the opportunity to see this on December 24, together with members of my staff. At that time, our small group explored the issues at great depth and with much feeling, and this discussion was very helpful to me.

As to the November 23, show itself, I was much influenced by the arguments of Mr. Baker and Professor Dershowitz and the excerpt from John Stuart Mill. I was already familiar with Szasz' ideas but his statements on the show were illuminating and helpful. I have read some of Dershowitz' work since the show, and that has influenced me also.

B. Reason for my Decision

I think we can bypass entirely the controversies surrounding the issues of "illness" and "treatment", and proceed directly to the three major problems that keep recurring in these discussions: (1) the helpless person, (2) the suicidal person, and (3) the person likely to injure others.

1. The helpless Person

I noticed that this seemed to be the prototype problem of greatest concern to Mr. Oteri in his cross examination of Dr. Szasz. Surely we have an obligation to the helpless person who is not capable of taking care of himself and will die unless we intervene to protect him. It may or may not be relevant to observe that such persons usually are not mentally ill in the generally accepted sense of that term. Rather they are as a rule senile or mentally retarded or otherwise suffering from gross neurological damage. In these cases I think it is fair to treat the individual as an infant in the eyes of the law provided that we prove in a court of law beyond any question of doubt that he is mentally incompetent in the sense of helplessness. He should then be committed to the guardianship of someone, hopefully a friend or relative, who could then contract for the best possible arrangements on his behalf. I think it is vital that such guardian be furnished adequate funds to provide the care and that he not be either a public official nor the superintendent or administrator of the hospital or facility to which the ward would be admitted. Safeguards would have to be provided to prevent abuse or peculation by the guardian, and some review process established, for guardianship has its own hazards. But I think such an arrangement would be preferable to existing ones.

2. The suicidal Person

This is an extremely difficult moral problem for most of us, but in the end it is just that, a moral problem not a legal one. The existence of emergency hold laws makes it too easy to deal with the suicidal problem by invoking the police power of the state, and reduces our incentive to employ other strategies for coping with the situation. To what extent, for example, have we tried to develop the use of volunteers to see the suicidal person through his crisis? What have we really done on a national scale to establish and pay for agencies that will provide crisis intervention around the clock? No, it is much easier to capture the person and get him into a hospital; once this is accomplished little may be done about the basic problem. The other way would be possibly harder until we got used to it, but it would be better in the long run.

3. The person likely to injure Others

This is the most difficult question of all, for it gets into all the complicated and delicate issues of prediction of behavior and preventive detention that Dershowitz and others have written about.

If there are to be commitments for mental illness that produces dangerous behavior, there are several important conditions. The "mental illness" must be confined to psychosis and not "psychiatric or other disorders" or "character disorders", which could include any of us; psychosis has a relatively more narrow and agreed-upon definition than "psychiatric disorder". The likelihood of the danger would have to be very clear and obvious. The danger would have to be defined in terms of bodily harm to other persons (not, for example, as in the usage of "There is a 'danger' that he will peek through the window.") Unfortunately all of the foregoing terms, in

particular likelihood, are impossible to define with clarity. Dershowitz makes a good case, I believe, that likelihood will never be definable so long as we gather in all the low-likelihood suspects, or "false positives" as he calls them. I agree with him that we must build a bank of true experience on which predictions can be based, and this is impossible under present laws.

In this context the problem of reversal of cardinal principles should be mentioned. In regard to jurisprudence per se Dershowitz points out that the old concept "better ten guilty men should go free than one innocent man be convicted" is turned around in the mental commitment procedures, where it is the general rule "When in doubt, commit." Scheff, in Being Mentally Ill, furthermore shows how the medical approach entirely reverses the common-law processes of criminal conviction. In criminal law one is innocent until proven guilty. But in the practice of medicine the applicant for examination is automatically "a patient" until found to be healthy and the process of review of the body systems is aimed at "ruling out" diseases. Thus, it is natural in medical practice that the minimal criteria rather than the maximal criteria will suffice to render a "diagnosis" of "pathology", the judgment that an actionable disease exists. This is a virtually inevitable outcome of the medical model of disease as it applies to deviant behavior.

All of these forces produce overdiagnosis of mental illness and overprediction of danger, and this is a basic fault of the existing system.

#### C. Comment

There are two further general points I would like to make.

1. People often overlook the fact that ominous and threatening behavior is itself legally offensive, under the general heading of assault or more specific headings. Thus it is not necessary to wait until a person does something extreme before taking action.
2. Commitment to the "treatment" system is often posited as a form of higher good than "punishment" under sentence and thus it is seen as an act of kindness or mercy on behalf of the person who commits an act while apparently not under entire self-control. A basic resolution of this dualism can be begun not by refining the contrasts between "punishment" and "treatment" --or "badness" vs. "illness"--but by radically questioning the entire ethos and effectiveness of the punishment system as we now know it.

#### D. A Compromise

The question remains whether one should allow emergency or temporary "hold" provisions concerning the above situations of incompetent, suicidal, or injurious persons. My experience leads me to suggest that special provisions of this kind produce escalating complexities of definition that are not only intrinsically confusing but will differ in application from jurisdiction to jurisdiction. On these grounds I would say that if we are going to abolish involuntary confinement for mental illness, let's really do it; and not leave behind a complex lattice-work of qualifications.

Page 4  
Mr. Roger Fisher  
January 6, 1970

Parenthetically I might point out that Iceland, with a body of extremely complex law of a millenium in duration, has managed to survive without any mental illness commitment statute as such; though they do reckon with the problem of incompetency.

E. A Note on Reform

The question of reform comes up. Reform in the law, in the way it is administered, and in the way the mental treatment facilities are run is certainly possible. But it is too slow. I have come to believe that a radical re-shaping of the entire treatment system is called for. And I think this cannot take place until compulsion is entirely removed.

F. Conclusion

Abolition of involuntary confinement for mental illness will be a large undertaking, and I expect that it will take many years. But I intend to begin working on it right away, in Minnesota at any rate.

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I appreciate the opportunity to appear on The Advocates. What I learned as a result will be very helpful to me.

I trust you will not object if I have copies of this letter made and distributed among staff and colleagues here and elsewhere.

Many thanks for your kindness and interest, and best wishes.

Yours sincerely,

David J. Vail, M.D., Director  
Medical Services Division

DJV:mhv

CC: Dr. Thomas Szasz

Professor Alan Dershowitz