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David W. Mernitz
United States Department of Justice

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PRIVATE RESPONSIBILITY FOR THE COSTS OF CARE IN
PUBLIC MENTAL INSTITUTIONS†

DAVID W. MERNITZ‡‡

Witch-burning is everywhere discountenanced. No one now believes that mentally ill persons are insensitive to heat and cold. The exorcism of demons has been replaced by the therapy of drugs. These are past chapters in the treatment of the mentally ill.

Yet—despite the considerable progress made in the past two centuries in attitudes toward and treatment of the mentally ill—in the important area of allocating the costs of public institutional care, vestiges of ideas which antedate the burning of witches remain. Of course, the village idiot is no longer auctioned to the bidder undertaking to support him at the least expense to the community; and to suggest that the minor children of a mentally ill person be indentured to help offset the cost of his care is unthinkable. But in many states, the determination and enforcement of private responsibility for the costs of care in public mental institutions is grounded upon concepts of morality and family responsibility reaching back to the Elizabethan Poor Law of 1601 and its analogues in the American colonies. Reimbursement practices are steeped in the tradition of paupers and almshouses.

A re-examination of the role of private responsibility in the light of new knowledge of mental illness and new ideas about mental health is long overdue. Even though concepts of social responsibility may be expanding, the private obligation for the costs of care in public mental institutions is not an outworn and useless anachronism. A well-grounded and fair state reimbursement program can make a genuine contribution to the costly battle against mental illness. It is clear, however, that the rationale for the imposition of private responsibility must be sought not in the context of colonial American views of social responsibility but in light of the present real requirements and best interests of the state, the patient and the family.

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‡‡ Attorney, Criminal Division, United States Department of Justice.
The problem of institutional costs, like most other matters which touch upon questions of state finance and state services, is an immediate one. More than ninety-five percent of all hospitalized mental patients in the United States are in state mental hospitals.\(^1\) The total state outlays for maintaining and operating these hospital facilities have more than tripled since 1948, while the average daily per patient expenditure has risen approximately 150 percent.\(^2\) It is not surprising that mental hospital expenses have become one of the several largest categories of state expenditures.\(^3\)

Proponents of intensive treatment centers, research projects, "halfway houses" to bridge the gap between hospital and home, and other recent mental health developments must face the question which the state fiscal planner is sure to ask: Where is the money to come from? With traditional sources of tax revenue now wholly inadequate to meet the budgetary needs of the states, they must exercise their ingenuity to find funds elsewhere. The burgeoning popularity of unclaimed property statutes testifies to the attempts of many states to tap other non-tax sources of revenue.\(^4\)

It should be recognized that a state mental health program can never become a self-sustaining enterprise. Each day discloses a further need for new facilities, additional personnel, and greater research. Modern mental health care, with its emphasis on treatment rather than custody,\(^5\) will become more expensive, not less so. Nevertheless, up-to-date procedures for the determination and enforcement of private responsibility can greatly enhance attempts to secure substantial revenues from institutionalized persons or their families. Furthermore, modernization of these reimbursement procedures can minimize their often negative influence on establishment of a therapeutic milieu for the patient's recovery.

Not only, then, must the basic hypothesis of private responsibility be evaluated in terms of today's knowledge of mental illness, but the pro-

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1. Average daily resident-patient population, 1956: private hospitals, 14,505; public hospitals, 554,157. BIOMETRICS BRANCH, NATIONAL INSTITUTE OF MENTAL HEALTH, U.S. DEPARTMENT OF HEALTH, EDUCATION AND WELFARE, PATIENTS IN MENTAL INSTITUTIONS 1956, Part II (Public Hospitals for the Mentally Ill) Table 20, and Part I (Private Hospitals for the Mentally Ill) Table 6 (Public Health Service Pub. No. 623, 1959) [Hereafter cited as PATIENTS IN MENTAL INSTITUTIONS (1956)].

2. INTERSTATE CLEARINGHOUSE ON MENTAL HEALTH, COUNCIL OF STATE GOVERNMENTS, STATE ACTION IN MENTAL HEALTH, 2 (1956-57).

3. In most states, the expenditures for the state hospital system are surpassed only by those for schools, social welfare, and highways. See, COUNCIL OF STATE GOVERNMENTS, BOOK OF THE STATES, SECTION VII (1960-61).


5. See THE PATIENT AND THE MENTAL HOSPITAL, passim (Greenblatt et al., eds., 1957).
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procedures which determine and impose this responsibility must also be re-oriented so that they conform to an underlying philosophy. When this is done, the imposition and enforcement of private responsibility for the costs of care in public mental institutions can stand as an integral part of a program which positively contributes to the mental health of the community.

I. THE HISTORICAL HERITAGE

VII. And be it further enacted, That the father and grandfather, and the mother and grandmother, and the children of every poor, old, blind, lame, or impotent person, or other poor person not able to work, being of sufficient ability, shall, at their own charges, relieve and maintain every such poor person in that manner, and according to that rate, as by the justices of peace of that county where such sufficient persons dwell, or the greater number of them, at their general quarter sessions shall be assessed; upon pain that every one of them shall forfeit twenty shillings for every month which they shall fail therein.

—43 Eliz. c. 2 (1601)

Perhaps the most prominent characteristic of the earliest provisions for organized community aid to the indigent was that it was a last resort. In England indiscriminate almsgiving by the monasteries and wealthy overlords had not ameliorated poverty but encouraged it. Confronted by the large number of paupers who sustained themselves in idleness by wandering in search of alms, the English Parliament in the sixteenth century enacted a series of statutes which, by imposing severe penalties on the roving apprentice, servant or laborer, were intended to curtail this vagrancy. In 1601 the Elizabethan Poor Law levied an annual exaction for the support of the poor in each community. Eligibility for community aid, however, was contingent upon the complete exhaustion of other possible means of support. The family of "sufficient ability" was obliged to meet the needs of its indigent members upon penalty of a fine for failure to do so.6

Whether the need arose from mental incapacity, physical handicap, or mere indolence, the feeling that community support of the poor was an extreme measure was, if anything, intensified by its transplant to

6. The development of the English poor law during this period is traced in 7 Webb, English Local Government (1927); Leonard, Early History of English Poor Relief 67-94 (1900).
The hardships of the new world were sufficient without the burden of wilful poverty. Mere survival required the utmost in mutual co-operation and effort. Each man benefited to the extent of the common ability, and each had to toil in assistance of this common benefit.

A necessary corollary of this organization for survival was the grouping of the whole community into family units. The child without parents had to have a sponsor pledged to support him in case of need; the servant was bound to his master by the rigorous terms of his indenture, guaranteeing the servant's faithfulness in his duties and the master's fidelity in supporting the servant.

The fruits of family misfortune were in the first instance viewed as a family responsibility. The incapacity of the family's chief provider meant only that the children and wife had to carry a greater burden. Although the lunacy of a wife or the birth of a defective child was recognized as a matter of grave concern to the family, still community relief was not to be expected; in an age which believed widely in demoniacal possession, such embarrassments were best handled as unobtrusively as possible. Rigid colonial religious orthodoxy preached that sympathy toward those afflicted with mental illness or similar disabling handicaps was not only unwarranted, but perhaps sinful. Burdens of handicapped members of the community were viewed as the natural consequence of judgment decreed by a stern God upon the wicked and innately inferior. Mental illness was therefore keenly felt as a family disgrace.

As has already been suggested, little distinction was drawn between the mentally ill and other socially dependent persons. When a family could no longer care for a mentally ill member, he was cared for (or neglected) like any other member of that amorphous group called "paupers." One persisting effect of this agglomeration has been that, despite the subsequent separation of the mentally ill from other dependent classes,

7. The most convenient brief history of the American development is Deutsch, The Mentally Ill in America (2d ed. 1952) [Hereafter cited as Deutsch]; another useful history is One Hundred Years of American Psychiatry (Hall et al., eds., 1944) [Hereafter cited as One Hundred Years]. Older works are Grimes, Institutional Care of Mental Patients in the United States (1934); Hurd, The Institutional Care of the Insane in the United States and Canada (4 vols. 1916-17). In addition, there are a number of studies of the development of public assistance and poor relief in individual states. See, e.g., Kelso, The History of Public Poor Relief in Massachusetts 1620-1920 (1922); Cafen, Historical Development of the Poor Law of Connecticut (1905); Schneider, The History of Public Welfare in New York State 1609-1866 (1938). Benton, Warning Out in New England 1656-1817 (1911) is a fascinating little book on one aspect of early American poor law. I have drawn freely from these and other sources in outlining the development of the idea of private responsibility.


9. See Shryock, The Beginnings: From Colonial Days to the Foundation of the American Psychiatric Association, in One Hundred Years, at 5.
the belief persists in many quarters that mentally ill persons cared for outside the family are per se economically destitute. As will be seen, this notion, among others, has had a crippling effect upon the reimbursement programs of a number of states.

As population and urbanization increased, makeshift methods of fulfilling primitive social welfare obligations were found wanting. They began to give way in the face of a recognized need for greater centralization and uniformity in the administration of social welfare. Of primary significance was the rise of the almshouse or poorhouse as a focal point for the gathering and maintenance of paupers. While the care these institutions afforded was probably only a scant improvement over that formerly supplied, the building of such institutions represented a substantial step forward from the previously predominant attitudes of neglect and indifference. Furthermore, upon payment of the very nominal costs of care, the almshouse would accept those persons whose care customarily had been a family responsibility. Thus, except for those mentally ill persons whose families could afford care in the few existing private institutions, the responsibility for providing places of custody for the mentally ill was largely assumed by local governments.

The almshouse was a combined penal institution, workhouse, and hospital. The criminal and imbecile, prostitute and cripple, aged and infant—all of society’s outcasts—were mingled within its walls.

Gradually, however, the idea grew that perhaps poverty was not itself the illness, but only a symptom which many maladies shared. If this were true, then indiscriminately to collect these pariahs in one place might be wrong. Mental illness, for example, this awakening sophistication said, was perhaps an ailment which could be treated and cured rather than the divine judgment of a just God.

This novel idea gained further acceptance around the beginning of the seventeenth century, largely because of the success of the so-called “moral treatment” of the mentally ill in France and England. Prior to that time the belief prevailed that none, or very few, of the mentally ill actually could be cured. Moral treatment contradicted this belief, resting as it did on the premise that mentally ill persons were nonetheless persons and might improve if they were treated as such.

10. DEUTSCH, 186-87.
11. The basic tenets of moral treatment, according to a contemporary view, were these:
A system of humane vigilance is adopted. Coercion by blows, stripes and chains is now justly laid aside. The rules most proper to be observed are the following: Convince the lunatics that the power of the physician and keeper is absolute; have humane attendants, who shall act as servants to them; never threaten but execute; offer no indignities to them, as they have a high sense of honour; punish
To facilitate this treatment, its advocates prevailed upon the legislatures in a number of states to appropriate funds for the erection of separate institutions for the mentally ill. Between 1824 and 1844, Georgia, Kentucky, Maine, Maryland, Massachusetts, New Hampshire, New York, Ohio, South Carolina, and Tennessee had opened separate mental hospitals and Virginia its second.¹²

Not only was the former pessimism regarding the treatment of the mentally ill discarded, but in its wake came a "curability craze." The new mental institutions, each trying to surpass the others, made competing claims for the efficacy of their respective "cures."¹³ More significantly, they instilled in the public a belief in curability which gave even greater impetus to the expanding movement for erection of hospitals for the insane with state funds.

Unfortunately, the building of these institutions did little to alleviate the plight of the dependent insane, who for the most part remained in almshouses. Since the costs of maintenance in these asylums, when not paid by the incompetent's family, continued to be borne by the local community, the attitude of local officials was dictated by financial considerations. Even though provision was made for admission of the indigent insane to the new mental institutions at very low rates, economy-minded local poor-law officials were disinclined to increase expenses—in some community almshouses as low as twenty-five cents per person per week—by sending their dependent insane to the mental hospitals. Nor was this parsimony confined to the poor-law officials. An 1827 New York law¹⁴ required relatives of sufficient ability to reimburse the overseer of the poor for support costs of persons maintained in an asylum; however, if these relatives themselves provided "a suitable place of custody" and there maintained the lunatic, he could not be removed from their care. Some persons took advantage of this latter provision by confining their disobedience peremptorily in the presence of the other maniacs; if unruly, forbid them the company of others, use the strait waistcoat, confine them in a dark and quiet room, order spare diet . . . ; tolerate noisy ejaculations; . . . let their fears and resentments be soothed without unnecessary opposition; adopt a system of regularity; make them rise, take exercise and food at stated times.


¹² The first separate institution for the mentally ill was opened in 1773 in Williamsburg, Virginia. Hamilton, The History of American Mental Hospitals in One Hundred Years at 73.

¹³ These claims offer an interesting example of the manipulation of statistics to the best possible advantage. For example, the percentage of cures was based on the total number of patients discharged during the year and new admissions were completely ignored. Moreover, it appears that in a number of instances, patients were reported as cured a number of times. The most flagrant example is that of a woman who was reported "cured" forty-six times before her death—in the asylum. Deutch, 149-56.

unfortunate kindred in attics, pens or cages to save the costs of maintenance in a public institution.\textsuperscript{15}

The expansion, both geographically and numerically, of industrial and commercial society during the mid-nineteenth century rendered local communities more and more inadequate to cope with advancing welfare needs. Local treasuries were extended to the limit. The supposition that public welfare services could be founded upon the cornerstone of local responsibility was no longer supportable. To an ever greater extent, the state became involved in the financing of charitable institutions.

The states' grudging assumption of responsibility for public welfare services, especially provision for the mentally ill, was transformed into an accepted duty largely through the efforts of a single dedicated crusader, Dorothea Dix. Appalled by the treatment of the mentally ill in local almshouses and asylums, Miss Dix devoted herself to urging acceptance of her belief that persons afflicted with mental illness were entitled to care and treatment in mental hospitals financed and administered by the state. Glowing with the righteousness of her cause, Miss Dix was extremely persuasive. To her influence may be directly attributed the erection of new mental institutions in a number of states, and countless improvements in already existing ones. Most importantly, however, she convinced a number of states that the local obligation theory of support for the indigent insane was obsolete.\textsuperscript{16}

The New York State Care Act of 1890\textsuperscript{17} was perhaps the first state law unequivocally to adopt the principles which Miss Dix had been urging. It declared that as soon as they could be accommodated, all the insane then in almshouses and asylums should be transferred to state asylums and thereafter be supported wholly by the state. During the late nineteenth century other states had enacted into law the principle of state care in varying degrees; and with the New York act as a prime example, more states

\textsuperscript{15} Deutsch, 421.

\textsuperscript{16} Miss Dix was not unaware that the assumption of this responsibility by the states would place a heavy burden upon their treasuries. She therefore urged Congress to pass a bill giving federal lands to the states, who in turn were to use the proceeds from their sale to improve the condition of the mentally ill. Her original proposal involved only five million acres. When it was defeated, she modified the proposal upward and returned to do battle anew. When her "12,225,000 Acre Bill" finally passed both houses of Congress in 1854, it was vetoed by President Franklin Pierce, who maintained that under the Constitution the federal government had no right to dispense charity. Deutsch, 158. For a more charitable view of Pierce's veto—that his real fear was land speculation—see Nichols, Franklin Pierce 349 (1931). In spite of this setback, the effectiveness of Miss Dix's crusade can be measured by the fact that by 1880, at about the time of her retirement, the United States boasted some seventy-odd public mental institutions as well as many private ones. Hamilton, op. cit. supra note 12 at 153-159.

\textsuperscript{17} New York Laws 1890 ch. 126 at 303.
soon followed the lead. Thus, shortly after the turn of the century, the principle that the state should provide facilities and funds for the care of the mentally ill was widely accepted.\textsuperscript{18}

Notwithstanding this radical shift of the obligation to support the indigent insane from the local government to the state, the responsibility of families of sufficient ability to pay the costs of care of their institutionalized kin remained unchanged.\textsuperscript{19} The old poor-law provisions imposing the obligation to support the needy upon relatives of sufficient means were broadened where necessary to make them specifically applicable to the institutional support obligation. This transmutation was made without any apparent recognition that new factors existing in the area of mental illness and the mental institution might dictate different patterns of private responsibility and different agencies for its enforcement. As with their poor-law counterparts, these statutes were either ignored or nullified by lax enforcement. Apparently it was assumed that the small revenues which might be realized through their enforcement would be more than offset by the costs of collection. With some exceptions, this is the prevailing situation in the United States today.

II. STATE PROCEDURES FOR THE DETERMINATION AND ENFORCEMENT OF PRIVATE RESPONSIBILITY

A. Persons Liable

Currently, liability for at least a portion of the costs of care in state mental institutions is imposed upon the patient and members of his family unit, variously defined, in virtually every one of the United States. In five states—Arizona,\textsuperscript{20} New Mexico,\textsuperscript{21} South Carolina,\textsuperscript{22} South Dakota,\textsuperscript{23} and Georgia—statutory liability is limited to the estate of the patient. Prior to 1959 Georgia uniquely extended free institutional care to those committed to its single state mental hospital; and despite the new liability imposed on the patient’s estate by a 1959 law, difficulties in its enforcement were more than offset by the costs of collection. With some exceptions, this is the prevailing situation in the United States today.

\textsuperscript{18} A few states, it should be noted, adopted what has been called the Wisconsin or county-care system. Under this plan, whose chief advocate was Wisconsin, each county provides its own institutional facilities for mental patients, with the state sometimes contributing toward the support of indigent patients. It has been suggested that the county-care system was not adopted by conscious choice, but rather was forced upon some states by overcrowding in the few state facilities that were originally provided. DEUTSCH, 261-69. Wisconsin, Iowa, Nebraska, and New Jersey still adhere to some form of the county-care system.

\textsuperscript{19} The responsibility of families of sufficient ability likewise remained the same when the county rather than the state, provided the institutional facilities.

\textsuperscript{20} ARIZ. REV. STAT. ANN. §§ 36-503, -520 (Supp. 1960).

\textsuperscript{21} N. MEX. STAT. ANN. § 34-2-21 (1953).


\textsuperscript{24} GA. CODE ANN. § 35-1106 (Supp. 1959).
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interpretation have so far precluded enforcement. Each of the forty-five remaining states, either by specific statutory provisions governing the institutional support obligation or by reference to other general statutory support provisions imposes additional liability upon various other family members. This liability is joint and several in some states, while in others varying sequences have been established for its imposition. Typically, the obligation is extended to spouses, parents and children. However, at least nine states place the duty to contribute toward institutional support on less closely related members of the family, including grandparents, grandchildren, brothers and sisters.

25. Letters to author from the Chairman of the House Sub-committee on Elenemony Institutions of the Georgia Legislature, June 20, 1959; and the Assistant Business Administrator of the Milleville State Hospital, June 1959.


In the absence of any statutory provisions providing for reimbursement for support expenditures, the state's right to claim it has been denied, on the ground that support was intended and understood as an act of charity. Wiseman v. State, 94 S.W.2d 265 (Tex. Civ. App. 1936).

27. E.g., CAL. WELFARE AND INST'NS CODE § 6650; NEV. REV. STAT. § 433.370 (1957); MICH. STAT. ANN. § 14.811 (Supp. 1959); N.Y. MENTAL HYGIENE LAW § 24(2); ORE. REV. STAT. §§ 179.620(2), .630, .690 (1959).


It is not surprising that the statutory language employed in those states which extend liability to more remote relatives often amounts to little more than a paraphrase of early American private responsibility laws and the Elizabethan Poor Law upon which they were patterned. Although the old language remains intact, enforcement practices recognize the changes the past century has brought in the cohesiveness of the family and the economic interdependence of its members. Regardless of the scope of statutory liability, primary enforcement activity is characteristically directed against the estate of the patient, his spouse, parents and children, normally in that sequence. Any extension of liability beyond this area multiplies the difficulties of enforcement to a degree where the return to be expected does not warrant the effort involved. Thus, enforcement against grandparents, grandchildren, brothers and sisters is the very infrequent exception to the general rule.

B. Amount and Duration of Liability

1. The Maximum Charge. With several exceptions, the maximum statutory charge—assessed against those responsible for the costs of supporting a state mental patient to the extent they can pay—is based upon and limited to the per capita cost—what some states somewhat mis-


30. A state which carries on only moderately active collection efforts may confine its attempts to secure reimbursement to claims against the estate of the patient, either living or deceased, and against the decedents’ estates of others who are secondarily liable. See Rushfeldt, Liability for Support of Patients in State Hospitals, 26 Kan. State B.A.J. 409, 420 (1958).

31. The author has not found a single reported case involving attempts to enforce the institutional support obligation against these more distantly related persons. While this does not demonstrate that informal attempts to enforce liability are not undertaken, it does indicate that this enforcement stops short of formal legal action.
leadingly call "actual cost."\textsuperscript{32} This statutory maximum, however, applies only to \textit{private} responsibility. When the county is initially liable for the costs of care of its residents, the county's maximum cost is far below the private per capita figure and ranges from five to twelve dollars per month.\textsuperscript{33}

It should be noted that while some statutes set the reimbursement rate in terms of "actual cost," they do not mean the cost to the hospital of caring for a particular patient. Rather, the term "actual cost" in these statutes, like the more common "per capita" formulation, means the aggregate cost to the hospital of caring for all patients, divided equally among them; in other words, the average per patient cost.\textsuperscript{34} Thus, a patient receiving expensive drug therapy, shock treatments and psychiatric interviews can be charged no more than a chronic patient requiring nothing more than custodial care.

This equalization of the costs of care in state mental hospitals is indicative of an attitude which is in sharp contrast with that prevailing toward general hospitals. Both general hospitals and the public-at-large

\textsuperscript{32} In New Jersey and New York, the statutory language permits the maximum charge to be set at a rate higher than per capita cost. N.J. \textsc{Stat. Ann.} § 30:4-67 (1940); N.Y. \textsc{Mental Hygiene Law} § 24(1). In Minnesota, while the patient himself can be charged the per capita maximum, the liability of relatives is limited to ten percent of this amount. \textsc{Minn. Stat. Ann.} § 246.51 (Supp. 1960).

In a few other states, a dollar maximum—which, if recently revised, probably reflects per capita cost—is specified by statute or regulation. \textsc{Ind. Ann. Stat.} § 22-401a (Burns Supp. 1960) (ten dollars per week); \textsc{Neb. Rev. Stat.} § 83-352 (Supp. 1959) (four dollars per day); \textsc{Va. Code Ann.} § 37.125-15 (Supp. 1960) (sixty-five dollars per month); \textsc{Ill. Mental Health Reg. No. 53}, authorized by \textsc{Ill. Stat. Ann. ch. 91½, § 9-21} (Smith-Hurd 1956) (eighty-one dollars per month); \textsc{Ga. Code Ann.} § 35-1106 (Supp. 1959) (three dollars per day).

The average per patient per diem cost in public hospitals for the mentally ill in 1958-59 was $4.32. \textsc{Council of State Governments, Book of the States 1960-61}, 351.

\textsuperscript{33} \textsc{Mo. Ann. Stat.} § 202.863(5) (Supp. 1959) (six dollars per month); \textsc{Minn. Stat. Ann.} § 246.54 (Supp. 1960); \textsc{N.D. Cent. Code Ann.} § 25-02-08 (1960) (forty-five dollars per month); \textsc{Tenn. Code Ann.} § 33-614 (1955) (two hundred dollars per year).

This discrepancy makes it theoretically possible for counties in some states to make a profit on patients they send to the state mental institution, since they may be able to seek reimbursement from liable persons at the private rate. Compare \textsc{N.D. Cent. Code Ann.} § 25-02-08 (1960) with \textsc{Minn. Stat. Ann.} §§ 246.53, 246.54 (Supp. 1960).

The fact that many of the statutes which speak in terms of "actual cost" require these costs to be computed on the basis of expenditures for the previous year clearly indicates that in these cases actual cost is intended to be synonymous with per capita cost. \textit{E.g.}, \textsc{Alaska Comp. Stat. Ann.} § 51-4-20bb (Supp. 1958); \textsc{Mass. Ann. Laws ch. 123, § 96} (Supp. 1960); \textsc{Wash. Rev. Code} § 71.02.410 (1951); \textsc{N.C. Gen. Stat.} § 143-118 (1958). Compare the language of \textsc{Del. Code Ann. tit. 16, § 5127(b)}:

The State Board of Trustees of the Hospital shall keep an account of the cost of the care, maintenance and support furnished each patient while in the Hospital and shall credit against the account all monies received from the patient or from any other person on behalf of the patient.

It is somewhat difficult to see how this statute can be interpreted as establishing or authorizing a per capita rate.
anticipate that each patient will pay for the care which he is given; and to
a large degree this expectation is well-grounded. The many varieties of
hospitalization and group insurance now available have made it possible
even for those at lower income levels to bear a large proportion of the
costs of their necessary hospital care.\textsuperscript{35} On the other hand, the apparent
hypothesis of state mental hospital care, another legacy of its historical
development, is that the patient will be unable to pay more than a nominal
charge. Since most of the funds will come from the state, it has never
been thought necessary to develop the more sophisticated per-patient ac-
counting found in the general hospital. Indeed, in some states the equali-
zation of mental hospital costs is carried even further by fixing the maxi-
mum charge at the average per capita cost of all state institutions of a
similar kind.\textsuperscript{36}

The obvious difference, in these circumstances, between a maximum
charge derived from institutional per capita cost and one based upon an
average of institutional per capita costs will be especially marked when
the more costly of the specialized institutions, such as those maintained
for the training and education of retarded children, are concerned.\textsuperscript{37}

2. The Means Test. The significance of these variations in the
maximum charge, and of the statutory maximum itself, is diminished by
the fact that only a small proportion of the patients in state mental insti-
tutions are able to pay the maximum amount chargeable.\textsuperscript{38} Far more
important than the ceiling placed upon private responsibility is the floor.
Without exception, this minimum is determined through application of

\textsuperscript{35} In 1958, sixty per cent of the costs of hospital care was paid for by health
insurance. Williams, Developing Role of Health Insurance, 13 J. Am. Soc. CLU 212,
216 (1959).

\textsuperscript{36} Thus, the per capita cost computation may be an average of the costs at state
custodial institutions, intensive treatment centers, institutions for the mentally deficient,
and institutions for alcoholics, among others. Cf. CAL. WELFARE AND INST'NS CODE
§ 6651; OHIO REV. CODE ANN. § 5121.03 (Page Supp. 1960); ILL. STAT. ANN. ch. 91½,

\textsuperscript{37} In Connecticut, for example, the per capita cost for children at certain of the
state training centers for retarded children is four or five times as much as the per
capita cost at the state mental institutions. Interview with Assistant to the Commissioner
of Mental Health, Connecticut Department of Mental Health, December 29, 1959.

The Ohio statute minimizes the cost differentials arising from the kind of care an
institution gives by classifying mental institutions into four groups—receiving hospitals
for the mentally ill, state hospitals for the mentally ill, state schools and institutes for the
mentally deficient, and state institutions of psychiatry—and providing for averaging
only within each group. OHIO REV. CODE ANN. § 5121.03 (Page Supp. 1960).

\textsuperscript{38} Illinois, which carries on a vigorous reimbursement program, during fiscal
1958 billed at the maximum rate only about nine per cent of the total patient population.
Department of Public Welfare, State of Illinois, Statistical Information Relating to the
Reimbursement Service (4-22-59). While other states, whose ability-to-pay formulae
are less sophisticated than Illinois', may bill a larger percentage of their patient popu-
lations at maximum, this fact does not indicate that more than nine or ten per cent of
the total patient population is, in fact, able to pay the maximum rate.
the means test, which involves simply an ascertainment of ability to pay.\textsuperscript{29} Under the general formula that the patient and his family should pay no more of the statutory maximum than they can afford, the maximum charge is adjusted to a figure which those responsible can reasonably be expected to provide. Provision is usually made for a redetermination of the amount of liability on the basis of altered circumstances.\textsuperscript{40}

Because of its elusive character, application of the ability-to-pay standard is subject to considerable manipulation, not infrequently resulting in unfairness and favoritism. Most statutes imposing private responsibility lack any standard of determination at all other than the bare direction that charges be assessed in accordance with ability to pay. If this determination is left to a centralized administrative agency, then of necessity that agency will develop some uniform criteria. When, however, a state gives the committing court or a local board the responsibility for determining ability to pay, cases tend to be handled on an \textit{ad hoc} basis, with the locality's social philosophy often as important to decision as the responsible family's finances.

The relatively few statutory formulae for arriving at ability to pay vary from simple tests considering only assets, current income, and a few current obligations\textsuperscript{41} to Connecticut's more complex formulation:

\ldots in determining ability to pay, in each case the welfare commissioner shall consider, among other items, the following expenses and obligations: Special employment expenses; education expenses of the children of the patient or relative; medical and hospital obligations, if being liquidated; shelter expenses in excess of one-fourth of the gross income of the liable person, minus federal income tax and any mandatory retirement deductions; accrued and unpaid obligations under a court order; debts currently being liquidated if contracted prior to the date of admission of the patient or contracted involuntarily subsequent to such date; and the number and condition of others

\textsuperscript{39} In at least one state, no provision is made for adjustment of the maximum charge. \textit{Iowa Code Ann.} \textsection 230.15 (Supp. 1960):

Mentally ill persons and persons legally liable for their support shall remain liable for the support of such mentally ill. \ldots The county auditor \ldots shall enforce the obligation herein created as to all sums advanced by the county.

(Emphasis added.)


\textsuperscript{41} \textit{E.g.,} \textit{Ariz. Rev. Stat. Ann.} \textsection 36-520(A) (Supp. 1960) (assets); \textit{Ore. Rev. Stat.} \textsection 179.610(3) (1959 Repl.) (current living expenses and other reasonable necessary obligations); \textit{Vt. Stat. Ann.} tit. 18, \textsection 2651 (1959) (income of the person committed and earnings of the husband or wife and minor children.)
dependent upon him, and shall also consider any payments which may become due and payable to the patient or the patient’s estate by reason of any social security, workmen’s compensation, Veteran’s Administration or other like benefits or from any policy of insurance covering such patient.42

Besides directing consideration of such factors as these, a few states also make explicit the necessity of preserving a cushion of assets against the patient’s eventual release to avoid his becoming a charge upon the state.43

3. Accrual of Charges. Though application of the means test generally allows responsible parties to pay for the patient’s support at a rate less than the statutory maximum, a number of states provide that the difference between this adjusted rate and the maximum charge shall accrue as a debt collectible from the estate of the patient and, in some cases, from the estate of any liable relative.44 If the patient leaves no dependents, there is no injustice in allowing a claim against his estate; reimbursement of the institution which cares for the patient during his life should be preferred over the claims of legatees or intestate successors, to whom any distribution is likely to be a windfall. On the other hand, when a patient leaves dependents or when the claim for accrued charges is asserted against a deceased relative’s estate, the choice is not so clear. Depriving a dependent of an inheritance may shift his dependency to the state, costing the state more in the long run than any amount it may realize by pressing collection; and the imposition of the institutional sup-

42. CONN. GEN. STAT. § 17-295 (1960).
43. This protective cushion is specified in some states and ranges from $300 in Vermont to $500 in Massachusetts. VT. STAT. ANN. tit. 18, § 2661 (1959); MASS. ANN. LAWS ch. 123, § 96 (Supp. 1960). Compare Wyo. STAT. ANN. § 25-14 (1959). If committed person is single, widow or widower without dependents, cushion of $3,000 is allowed; if married, or a widow or widower with dependents, the cushion is $5,000. Elsewhere, the amount of the cushion is left to the discretion of the enforcement agency or enforcing court. The Illinois regulations relating to this problem quite sensibly tie determination of the cushion to the age of the patient and the amount of his income from social security and retirement benefits. See note 105 infra. Of course, if no hope exists for the patient’s eventual release, the necessity for a cushion vanishes. California, for example, provides that a medical certificate stating that the patient is suffering from a “chronic form of insanity” and that, in the opinion of the certifying physician, “will, in all probability, continue to be a charge in a State hospital until death,” will release the cushion and allow its application to maintenance costs. CAL. WELFARE AND INST’NS CODE § 6655.
44. CAL. WELFARE AND INST’NS CODE § 5077 (county has a claim for all funds expended for institutional care of a mentally deficient person); Colo. REV. STAT. § 71-1-16 (1953) (estate of patient liable for full per capita cost); ILL. STAT. ANN. ch. 91/2, § 9-24 (Smith-Hurd Supp. 1960); IOWA CODE ANN. § 230.30 (1949); Md. ANN. CODE art. 59, § 5(c) (Supp. 1960); MINN. STAT. ANN. § 246.53 (Supp. 1960); Nev. REV. STAT. §§ 433.410(3), 480 (1957); N.Y. MENTAL HYGIENE LAW § 24(1); Ore. REV. STAT. §§ 179.620(3), 740(4) (1959 Repl.); VT. STAT. ANN. tit. 18, § 2680 (1959). These accrued claims against the estate may also be given priority over certain other debts of the estate. See statutes cited in note 79 infra.
port obligation on others than the immediate family no longer comports with present social realities. The considerable discretion normally vested in the official empowered to make such claims probably softens the absolute statutory language in these circumstances. It is likely that those charged with enforcing the statute err more on the side of foreswearing just claims than in pressing claims which would result in hardship. Furthermore, the size of accrued claims is often reduced by statutes of limitation, although it should be noted that in some states these statutes are made specifically inapplicable to claims for institutional support costs.

4. The Duration of Liability. In prescribing the charge for institutional care, a few states, besides taking into account personal resources through the means test, consider the period of time for which the family’s liability for support will continue. In many cases of mental illness, a family may reasonably expect that its institutionalized member will shortly return to productive economic activity, and further progress in the treatment of mental illness makes the expectation of early release increasingly stronger. In some tragic cases, however, as with a seriously defective infant, hope for anything but life-long institutionalization is probably unwarranted. The protection and care afforded such a person in an institution often results in an almost normal life span. When this is the case, to require the family to contribute perpetually to the patient’s support may result in a financial drain interfering with the lives of the family’s normal members. Lack of financial resources may prevent a brother of the defective from obtaining an adequate education; it may discourage from marriage a sister who feels an obligation to aid her aging parents.

45. While no specific authority can be cited in support of this conclusion, in light of the general disfavor with which many state officials view the institutional support obligation it seems a reasonable inference.

46. E.g., CAL. CODE CIV. PROC. § 345 (4 years); CONN. GEN. STAT. § 17-295 (1960) incorporating CONN. GEN. STAT. § 52-576 (1960) (6 years); NEV. REV. STAT. § 433.480 (1958) (estate of patient discovered within five years of his death liable for maintenance charges); N.Y. MENTAL HYGIENE LAW § 24(6) (6 years); cause of action does not accrue until patient for whose care action is brought has died or been discharged); OKLA. STAT. ANN. tit. 43A, § 115 (1954) (suit must be instituted if charges are not paid within ninety days of due date); S.C. CODE LAWS § 32-950.25 (Supp. 1960) (no action to enforce lien of assistance may be brought more than one year after patient’s death; but compare S.C. Mental Hosp. v. May, 226 S.C. 108, 83 S.E.2d 713 (1954) (where it was held that the 6 year statute of limitations did not apply to actions for maintenance.) VA. CODE ANN. § 37-125.1 (Supp. 1960) (no recovery of amounts more than five years past due); WIS. STAT. ANN. § 46.10(11) (1957).

47. E.g., MICH. STAT. ANN. § 27.605 (6) (Supp. 1960); N.C. GEN. STAT. ANN. §§ 143-122, -125 (1958); VT. STAT. ANN. tit. 18, § 2681 (1959); WASH. REV. CODE ANN. § 71.02.360 (1951); KY. REV. STAT. § 203.110 (1953) (statute of limitations does not run against recovery until after acquisition of an estate.)
To avoid, or at least to mitigate, such socially undesirable results, Connecticut, Maryland, and Montana have limited the duration of the statutory support obligation.\(^4\)

C. Patterns of Organization and Procedure for Determination and Enforcement

Any determination of the amount and incidence of liability or any decision to enforce liability is, of course, a matter of individual judgment. Even when the most complex and exact statutory formula guides the imposition of private responsibility, the effectiveness of the reimbursement program ultimately depends upon the capabilities of its administrators and the character and scope of the limitations placed upon them by the organizational setting in which they operate. Where coordination and control are poor or entirely lacking, administrative decisions often exhibit wide variations. For these reasons, the functional structure of the states' reimbursement programs is at least as significant as the substantive rules which the programs seek to effectuate.

Generally speaking, existing patterns of administrative organization fall into three categories—local, institutional and central—according to the level at which the primary activity leading to collection of institutional support costs takes place. These classifications, however, are not necessarily exclusive. Occasionally the structure of a state program may combine the characteristics of one or more categories.

1. **Local responsibility.** In consonance with the early tradition of local community concern for the mentally ill, slightly less than one-half of the states provide that the determination of the support obligation, as well as its enforcement, should take place at the local level.\(^4\) The agency

48. The Connecticut statute, the most recent pronouncement by a state, wholly relieves liable relatives of the costs of support after sixteen years or upon the patient's majority, whichever occurs later. **Conn. Gen. Stat.** § 17-295 (1960). The Maryland and Montana statutes reduce the maximum rate chargeable to the family of an institutionalized person after a specified period. **Md. Ann. Code** art. 59, § 5(a) (Supp. 1960) (after thirty months the rate chargeable to the family of the patient not to exceed twenty-five per cent of the per capita cost); **Mont. Rev. Code Ann.** §§ 38-214, 411 (Supp. 1959) (three dollars per day for first ninety days, two dollars per day thereafter).

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which carries the greatest responsibility in this type of organization is the local probate court or county baseline court. In the usual situation the court determines ability to pay in conjunction with its duties as the committing agency, and it retains jurisdiction to enforce its decision. In a few instances, especially when the county itself is primarily liable for support of residents in state institutions, the county welfare board or a similar agency may make the initial determination, relying on the court in contested cases or if enforcement by formal action becomes necessary.50

The judicial inquiry into the financial status of the patient and responsible relatives formerly often took place in the very hearing to determine sanity. This practice was almost universally condemned by both lawyers and psychiatrists.51 At best, application of the means test is an enforced inquiry into personal affairs which the individual would keep to himself if he were free to do so; when it is incorporated into a procedure often resembling a criminal jury trial, it becomes all the more distasteful.52 Today, with some exceptions,53 a committing court given the duty of making the means-determination conducts separate proceedings for that purpose.

In the typical situation, as soon as the mentally ill person has been admitted to the institution, the court designates some person or agency, usually the county welfare department or county attorney, to conduct an investigation into the financial status of the patient and, if it appears likely that he will be unable to pay in full, to determine whether there are any relatives who may be liable for his support costs.54 The investigating agency may require a guardian and any responsible relative to furnish full financial information.55 This information is then reported to the


52. See generally, Ross, Commitments of the Mentally Ill, 57 Mich. L. Rev. 945 (1959). For a comparison with commitment procedures in other countries, see Patterson, Hospitalization Procedures for the Mentally Ill in the U.S.S.R. and Other European Countries, 21 Ohio St. L.J. 111 (1960).


court, which may either issue an order to those named by the investigators to show cause why a support decree should not be entered against them or may make its decision on the basis of the report alone.\textsuperscript{56} If the former course is followed, or if a timely request is made by some interested party, a full hearing will ensue, with the introduction of evidence, including the investigative report, on the issue of the respondents' ability to pay.\textsuperscript{57} In either case the normal avenues of judicial review are open to any person aggrieved by the support order.\textsuperscript{58} A copy of the final order is sent to the institution, which bills the patient or responsible relatives at the ordered rate.\textsuperscript{59} A default in payment is treated as a violation of the court's decree and subjects the violator to punishment for contempt.

2. Institutional responsibility. As previously indicated, in many instances in which the institution is nominally responsible for deciding upon whom and to what extent the support obligation is to be imposed, it must rely upon information supplied by a committing court or some other local investigating agency.\textsuperscript{60} Sometimes, however, the full responsibility for making the investigation is left with the institutional business manager or department of collections.\textsuperscript{61} In these cases considerable reliance must be placed upon the data which is obtained through admission interviews and questionnaires sent to the patient's guardian or family. Although it may be possible to verify the information supplied in these questionnaires through a check of local property tax rolls and state income tax returns, if the existence or whereabouts of children or other responsible persons is not disclosed by the questionnaire, the likelihood that any obligation will ever be imposed upon these absent persons is indeed remote.

When responsible persons found by the business manager to be able to pay at a certain rate refuse to contribute, the institution must seek the


\textsuperscript{58} E.g., Ore. Rev. Stat. § 179.640(5) (1959 Repl.).

\textsuperscript{59} In a common variation of this pattern, the financial information collected by the court or local investigating agency is forwarded to the institution, which attempts to use this information as the basis of a voluntary agreement with responsible persons. Only when this effort fails is a judicial declaration of the obligation necessary. See note 49, supra.

\textsuperscript{60} See note 59, supra.

assistance of the state legal officer or one of his local assistants to enforce the obligation. Even when the reluctance of these officials to institute suits of this kind can be overcome, the court may refuse to grant judgment for the accrued charges without proof that the institutional determination as to the amount of the assessment is in fact in accord with the responsible person's ability to pay; and on this question the views of the court and the institution may diverge.

3. Centralized responsibility. The states' increasing assumption of responsibility for providing facilities for the care of the mentally ill in their expanding populations has prompted the recognition, as it did at an earlier time in our history, that centralized agencies are necessary to maintain adequate and efficient control over total state programs. Those states which are the largest from the standpoint both of population and of number of public institutions have generally led the way in establishing centralized departments of control within which are located the reimbursement agencies.62

The common facts of centralization and state-wide responsibility, however, do not eliminate the diversities arising from the kind of central department in which reimbursement and collection activities are placed.Centralized reimbursement agencies are variously situated within a department charged with the oversight of all public institutions, as, for example, a department of institutions,63 within a state department of revenue;64 and within a department of mental health or department of welfare.65

62. California, New York, Illinois and Ohio, for example.
Again, the basic attitude of the state toward mental illness and the mentally ill is often betrayed by which of these schemes of centralization it has chosen. The tradition of custodial care for the insane, rather than of intensive treatment for the mentally ill, probably explains why many states have placed the control of mental institutions, and of corresponding reimbursement activities, within a department of institutions and not in a department of health. The state mental hospital has long been viewed as the place where "crazy people are kept"; under this view the mental hospital deserves no different treatment from the state penitentiary, in which other aberrant individuals are confined. Thus, despite the fact that the treatment function of a mental hospital is today more significant than its role as a place of custody, the states conferring authority on an agency generally supervising all institutions have entrusted the planning and execution of enforcement policies to a board lacking sufficient, if any, psychiatric or medical expertise. 66

Similarly, states viewing contributions made for the support of institutionalized persons as nothing more than a matter for the department of revenue completely ignore the context of mental illness which gave rise to the obligation. Family-hospital-patient interrelationships have been recognized as having fundamental therapeutic importance in the treatment of the mentally ill. 67 From this perspective, it becomes obvious that the imposing of private responsibility from a primarily fiscal standpoint can seriously hamper effective treatment. While any centralized agency is perhaps a step forward in the administration of private responsibility programs, only agencies operating within the state's department of health or within a separate department of mental health are properly situated for preparing and executing a well-integrated reimbursement effort.

Beyond these diversities inherent in departmental location, many other differences can be found in the duties and powers of the central agencies. Some states have purposely employed general language in their responsibility statutes and have invested the governing agency with extensive rule-making power to define more precisely applicable criteria. 68

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66. One recent writer has argued that, in providing nothing more than custodial care for institutionalized mental patients, states are in effect depriving these persons of their liberty without due process of law, in violation of the Fourteenth Amendment. He argues that the concept of due process should include the right of an institutionalized person to have adequate medical and psychiatric treatment of his mental illness. Birnbaum, The Right to Treatment, 46 A.B.A.J. 499 (1960); Compare Comment, 56 Yale L.J. 1178 at 1203 (1947).

67. See Lidz et al., Patient-Family-Hospital Interrelationships in The Patient and the Mental Hospital 535 (Greenblatt et al. eds. 1957); Preston, The New Public Psychiatry, 51 Mental Hygiene 177 (1947).

The Department [of Public Welfare] is authorized . . . to make determina-
To gather the financial information which is the raw material of the means test determination, some central agencies employ field workers who secure necessary information by interviews in the homes of liable persons. Others, lacking sufficient funds or personnel to make independent investigations of financial standing, rely more heavily upon data secured through questionnaires, which they may verify through comparison with state income tax returns or through the use of private credit investigating firms.

In some states, while the central agency makes the necessary investigations and determinations, the actual billing of responsible persons is handled by each institution. Other central state agencies are responsible for both initial determinations and subsequent billing and collection.

Very few agencies have been given legal staffs authorized to carry enforcement to the ultimate conclusion of court proceedings. Usually

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69. This is the practice of the Connecticut Department of Public Welfare, for example, as well as that of the Bureau of Support of the Ohio Department of Mental Hygiene and Correction. Letters to author from assistant to the Commissioner of Mental Health, Connecticut Department of Mental Health, December 29, 1959; and from Chief of Division of Administration, Ohio Department of Mental Hygiene and Correction, June 19, 1959.

70. Virtually all the centralized agencies have a standard form for tabulation of relevant facts relating to financial ability. The interviews by field workers only supplement this information.

71. Indiana, for example, uses a private credit investigating agency to verify financial reports submitted by relatives. Letter to author from Indiana Commissioner of Mental Health, June 15, 1959. The legal division of the Kansas Board of Social Welfare employs attorneys on a part-time basis to gather and verify financial information. Rushfelt, Liability for Support of Patients in State Hospitals, 26 KAN. St. B.A.J. 409, 418 n.61 (1958).

72. Ohio, for one, presently follows this arrangement. Letter to author from Chief of Division of Business Administration, Ohio Department of Mental Hygiene and Correction, June 19, 1959.

73. The Illinois Reimbursement Service, for one, handles both. Letter to author from Deputy Director, Reimbursement Service, Illinois Department of Public Welfare, June 16, 1959. A central agency is also occasionally given other duties not strictly related to its reimbursement functions. For example, both the Wisconsin Bureau of Collections and Deportations and the Illinois Department of Public Welfare, Reimbursement Service are responsible for making arrangements for deporting to their home states mentally ill residents requiring hospitalization.

74. The Legal Division of the Board for Texas State Hospitals and Special Schools is the only one of which the author is aware.
the agencies must rely upon action by either the state attorney-general or one of his local district attorneys. To a degree this dependence subjects the centralized form of administration to the same sort of difficulties which attend local enforcement of locally or institutionally determined obligations. However, the continuing out-of-court pressure which a central agency with continuity of concern can put upon a responsible guardian or relative makes the need for enforcement by legal action comparatively infrequent. By the same token, when such action does become necessary, a central agency can often bring effective pressure on a local official reluctant to perform his duty.

4. Enforcement sanctions. Irrespective of the level at which reimbursement activity occurs, special procedures are often available to aid the enforcement of private responsibility. The prime weapon of the enforcement arsenal is, of course, court action—usually in the probate or baseline court of the county where the patient or responsible person resides. Enforcement may take the form of a simple action to enforce the statutory support obligation or, if the court has made the initial determination of liability, of a proceeding for contempt of the court's order. But an action predicated directly on the obligation set forth in the statute is not always the sole method of enforcing private contribution. In some instances, before receiving a voluntary patient, a state mental institution may require the execution of a bond or a contract binding a relative or guardian for payment of the costs of support. Besides having the salutary effect (for the enforcing agency) of concluding the necessity of a financial investigation, obtaining a contract or bond may help to overcome the reluctance of local officials to bring enforcement proceedings, since in cases of default suit may be brought on an instrument which, on its face at least, suggests an obligation voluntarily incurred. Furthermore, such a contractual arrangement may avoid the often difficult problem of proving to an enforcing court that a charge assessed against a patient or liable relative comports with his ability to pay; it may also circumvent the force of some case law which requires that ability to pay be shown for each period in which a charge is made, when statutory

75. The Arkansas arrangement is unique in that the Arkansas Hospital Board is given specific statutory authorization to employ a private collection agency under a contingent fee arrangement. Ark. Stat. Ann. § 59-230.1 (Supp. 1959).

actions are brought encompassing long periods of delinquency.\textsuperscript{77}

Because of the unpleasantness often associated with inquiries into personal finances, reimbursement agencies are perhaps warranted in encouraging the making of voluntary contracts. Care must be exercised, however, to insure that the obligation assumed by the liable party is not out of proportion to his real ability to pay. Under the stress of the situation it is entirely possible that a responsible relative can be induced to sign a burdensome contract. In such circumstances, enforcement of the contract tends to engender the same difficulties as enforcement of statutory responsibility and the advantages to be gained by the voluntary arrangement are lost.\textsuperscript{78}

Of course, once a judgment for charges is obtained, the usual methods of enforcing judgments are available. In addition to those remedies normally associated with a suit for debt, however, the enforcing agency often commands several supplementary procedures in aid of collection. An agency may be authorized to seek a court order requiring the patient’s guardian to liquidate some or all of the property in his charge so that arrearages can be satisfied and future installments can be paid as they fall due.\textsuperscript{79} A Michigan statute renders voidable as against the state certain transfers without consideration made by persons liable for institutional support costs, in a provision not unlike the fraudulent transfer provisions of the Federal Bankruptcy Act.\textsuperscript{80} And a common


\textsuperscript{78} It is not inconceivable that a court would refuse to enforce such a contract on grounds of duress or public policy, much in the same way that some courts have rejected certain onerous terms in mass standardized contracts, as for example, insurance policies. See Kessler, \textit{Contracts of Adhesion—Some Thoughts About Freedom of Contract}, 43 COLUM. L. REV. 629 (1943).

\textsuperscript{79} CAL. WELFARE AND INST’NS CODE § 6655; IDAHO CODE ANN. § 66-355 (Supp. 1959); MD. ANN. CODE art. 59, § 5(d) (Supp. 1960); MICH. STAT. ANN. § 14.817 (1956); NEV. REV. STAT. § 433.400(2) (1957); TENN. CODE ANN. § 33-627 (1955); VT. STAT. ANN. tit. 18, § 2657 (1959). Such statutory authorizations allowing institutional or state creditors to seek a court order subjecting a patient’s property to the payment of support costs should be distinguished from other statutory provisions which \textit{ex proprio vigore} give the state a lien on a patient’s property for payments in arrears. E.g., IOWA CODE ANN. § 230.25 (Supp. 1960) (giving a lien of assistance on real estate owned by the committed person or his spouse); N.J. STAT. ANN. § 30:4-80.1 (Supp. 1960) (lien against property of inmates or persons chargeable with support); S.C. CODE ANN. § 32-950.25 (Supp. 1960) (lien on real and personal property of any person receiving treatment).

While a court may properly refuse a petition for liquidation brought under the former provisions, especially if the property in question has a potential value far in excess of its present value, when a lien for arrears is sought to be foreclosed, under normal circumstances the court has no discretion to refuse liquidation, except insofar as the amount of the “cushion” may be left to the court’s discretion.

D. The Success of Collection Activities

On a nationwide basis, collections from all persons liable for institutional support costs probably do not exceed ten percent of the total costs of providing such support. While the proportion is as much as twenty-five percent or better in a few states, this return is more than balanced by the experience in other states, which, despite very similar statutory maxima, realize as little as one percent on their outlay. That the efficacy of reimbursement activities is largely responsible for these disappointing figures is beyond question. Probably less than thirty percent of the total charges billed against patients or liable relatives is ultimately collected; and, it must be remembered, in a large number of cases the first step, ascertainment of liable relatives, is never undertaken. Even on the assumption that an active and effective reimbursement program in every state would raise the nation-wide collection average only ten percent, the additional revenues available to the states for their mental health programs would amount to an estimated sixty-five million dollars.

Although the percentage of over-all costs recovered by the states is roughly comparable whether determination and enforcement procedures are local or central in character, the proportion of paying patients is by far greater in those states which have a centralized reimbursement program. The general non-success of the centralized states, despite more


82. These estimates are based upon data found in SUMMARY OF COLLECTION ACTIVITIES IN THE 48 STATES FOR CARE GIVEN MENTAL PATIENTS, compiled in 1955 by the Bureau of Collections and Deportations of the Wisconsin Department of Public Welfare. The difficulty in obtaining complete information on collection activity should be noted. The Biometrics Branch of the National Institute of Mental Health, United States Department of Health, Education and Welfare discontinued in 1955 the publishing of data on the number of paying patients and the amount paid in full or in part for their care in state mental hospitals, because of the inadequacy of the reporting of these items. Letter to author from Chief of Hospitals Studies Section, Biometrics Branch, January 14, 1960.

83. The total maintenance expenditures in public mental hospitals in the United States in 1956 were approximately $656 millions. PATIENTS IN MENTAL INSTITUTIONS 1956, Part II, Public Hospitals for the Mentally Ill, Table 19, p. 69. An increase in collection success from the present estimated ten per cent of total costs to twenty percent would raise revenues from an estimated $65.5 million to $131 million.

84. HOSPITAL STUDIES SECTION, BIOMETRICS BRANCH, NATIONAL INSTITUTE OF MENTAL HEALTH, U.S. DEPT. OF HEALTH, EDUCATION AND WELFARE, PATIENTS IN MENTAL INSTITUTIONS 1954, Part II, Public Hospitals for the Mentally Ill, Table 21,
active programs, to offset a higher proportion of their total costs suggests that collections in these states tend to be regular and small, while those in the local enforcement states are sporadic and occur primarily when the amounts involved are considerable, warranting the effort and expenditure necessary to enforce the claim. But the apparent anomaly also may be partially attributed to variations from state to state in the general economic level of families sending members to state institutions.

Despite the increasing costs of hospital care, a number of states have retained the maximum charges set when costs were much lower, apparently in the belief that comparatively low charges make collections easier and result in greater returns than if the full cost of institutional care were charged. But a 1950 study found that those states having moderate maximum rates of reimbursement (under thirty dollars per month) tended to be less successful in their collection activities than those states which set higher maximums (above sixty dollars).

It is questionable whether the level of the maximum charge has any real effect upon the success of collection activity. The greater success of states with higher maximums may be explained, at least in part, by the fact that an upward adjustment of the maximum rate has often coincided with a state's re-examination of the role of private responsibility—a review which has usually led to more effective and vigorous reimbursement machinery. On the other hand, a low maximum charge may have a significant adverse effect upon the total amount of a state's collections. As has already been noted, when the maximum charge is pegged at actual cost, this figure has very little limiting effect upon the amount of contributions, since application of the ability to pay formula usually requires a downward adjustment of individual reimbursement rates. When, however, the maximum rate is considerably less than actual cost, this figure does limit the amount of collections from those whose ability to pay is at a rate above the low maximum but not equal to actual cost. Since a low maximum rate probably does not facilitate collections, the fact that several states retain such maximums can be explained either by their adoption of a conscious policy of assuming almost all the costs of caring for

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85. See, e.g., Directors of Insane Asylum v. Boyd, 37 N. Mex. 36, 17 P.2d 358 (1932) (claim for nearly $4,000 after person admitted to asylum as an indigent had received a large inheritance).

86. See Hollingshead and Redlich, Social Class and Mental Illness (1958).

87. See note 32, supra.

the institutionalized mentally ill or, what is more likely, their continuing belief that most mentally ill persons and their families will be able to pay nothing more than a nominal charge anyway. Whether or not this latter notion is openly expressed, its continuing influence upon both the substance and operation of state reimbursement programs cannot be ignored.

E. The Disposition of Collected Funds

Because of budgeting difficulties resulting from the uncertainties of collection, monies collected from patients and other liable persons are usually returned to the general fund of the state, the legislature appropriating the full amount required for institutional operation. Thus, payments in discharge of the private support obligation normally lose all identification with the institution caring for the patient or even with mental health in general.

Recently, a few states have enacted legislation dedicating some or all of the revenues derived from this source to the state mental health program, particularly for use in the areas of training and research. Not only is the special character of these monies preserved in this way, but through knowledge and skills gained from the additional training and research the state can more effectively care for its mentally ill—an aspect of the plan which may well make it less expensive to the state in the long run than if all revenues were applied to offset operating expenses.

Moreover, legislation specially dedicating these funds presents a potentially effective political approach for the advocates of expanded mental health research and training. The building of mental hospitals, where the bricks and mortar evidence the legislature's interest in mental health, will always appeal more to legislative sensibilities than a program of training and research, the results of which are generally less tangible. Lawmakers may be much more willing to embark upon the latter type of program when they are presented with a means whereby such a program can be financed with little or no appropriation from the general tax revenues for that purpose.


90. See Training and Research, op. cit. supra note 89 at 204.

91. Compare Ginsberg, A Pattern for Hospital Care, Final Report of the New York State Hospital Study 233 (1949).
III. TOWARD A MODERN STATE REIMBURSEMENT PROGRAM

A. Can Private Responsibility Be Justified?

Present-day social theory has progressed somewhat beyond the Spencerian viewpoint of C. R. Henderson, a prominent sociologist, who wrote in 1893 that "state aid [for dependent classes] interferes with the wholesome efforts of nature to weed out the inferior and incompetent in the struggle for existence." The principle that caring for the mentally ill is a common obligation is today too firmly established to be questioned.

The extent of society's obligation in this respect, however, is a matter of some controversy still. Those espousing widely divergent political philosophies will agree that one prominent aspect of American political and social development has been the increasing devolution upon government of the responsibility for providing facilities and services whose provision was formerly wholly a matter of private concern. Education is an early example; recreational facilities, unemployment insurance, and social security are more recent ones. These state services and facilities are open for the most part, not only to those who cannot afford to provide the same things for themselves privately, but also to those who can. And, through the medium of taxation, all citizens support these services roughly in accordance with ability to pay, irrespective of the extent of their individual use. The proponents of complete governmental responsibility for mental hospital costs would carry this principle of broadbased support over to the area of mental health.

To consider the implications of this position from the point of view of a political philosopher or social theorist is not the purpose of this examination. Certainly, its worth or ill-logic is not illuminated by such epithets as "socialism" or "welfare state." The objections to the principle of private responsibility are in many instances intensely practical ones and can be profitably examined as such.

The major criticisms made by those who favor complete government subsidization are three: first, that collections made through enforcement procedures do not warrant the expenditures for that purpose; second, that enforcement of the institutional support obligation scarcely ever results in a rich relative supporting his poor kin, but rather requires those who have very little to contribute to the support of others who have even less; and finally, that enforcement of the support obligation against

92. HENDERSON, AN INTRODUCTION TO THE STUDY OF DEPENDENT, DEFECTIVE, AND DELINQUENT CLASSES 36 (1893).

93. For a statement recognizing the trend toward shifting responsibility for mental health care from the family and local communities to "larger units of society," see TRAINING AND RESEARCH, op. cit. supra note 89 at 204.
an unwilling relative often creates a breach in family relationships at a time when it is most important to draw the family closer together.\textsuperscript{94}

The most significant fact to be noted is that none of these objections is really directed against the basic principle of reimbursement; rather, each is a criticism of the way in which the reimbursement machinery operates.

While those who favor continuation and even expansion of private responsibility raise a number of philosophical and theoretical arguments to buttress their position, the most compelling reason for private support is simply that most states cannot afford to neglect a possible source of non-tax revenue. The state suffers a double loss during the period in which a mentally ill person is institutionalized: the cost of his care falls heavily upon the state, and his loss of earning capacity not only affects tax revenues, but may also require governmental support for his dependents.\textsuperscript{95} To say that this financial burden can be offset by increasing general tax rates overlooks the fact that most states have reached, or at least believe they have reached, the saturation point in raising revenues by this means. Whether or not private responsibility laws reinforce community judgments as to the desirability of intra-family responsibility, then, it is abundantly clear that without additional sources of revenue many states will be unable to continue existing mental health programs and certainly will be unable to institute new ones. Until and unless some radical revolution occurs in state financing, the continuation of the principle of private responsibility can be justified on the same basis as the special tax on gasoline, used for highway construction and maintenance, that those who receive the primary benefits from the facilities should bear the primary burden of paying for them.

Moreover, it is demonstrable that the increased administrative costs which may result from the establishment of an effective reimbursement program are more than offset by the additional revenues realized. In Illinois, for example, support collections increased from approximately $1,500,000 in 1952 to $7,100,000 in 1958, while the administrative costs remained constant at between six and seven percent of collections.\textsuperscript{96}


\textsuperscript{95} For a full analysis of the costs of mental illness, see Fein, Economics of Mental Illness (1958).

\textsuperscript{96} Illinois Department of Public Welfare, Statistical Information Pertaining to the Reimbursement Service (April 22, 1959).
The justification of the private support obligation reaches beyond the question of financial necessity. Enlightened application of the principle of private responsibility may constitute a potentially effective instrument in achieving the difficult goal of reshaping community attitudes toward the mentally ill. The earlier belief that mental illness was a manifestation of divine punishment brought about by moral defects is not altogether rejected today. Even where more progressive thinking prevails, obloquy still is frequently directed toward families in which mental disorders occur; and the patient's relatives themselves often experience a sense of guilt arising from concern over their possible responsibility in the patient's illness. Indeed, underlying the beliefs of those who advocate the abolition of private responsibility may well be a general charitable intent to attenuate the family's identification with its mentally ill member by interposing the impersonal agency of a benevolent government. When group responsibility is substituted for individual responsibility in this way, the likelihood of critical re-examination of individual attitudes considerably diminishes.

Conversely, the operation of private responsibility programs necessarily requires that some individuals face squarely the problem of mental illness as it affects them. Even as the principle of private responsibility is presently formulated in the statutes, in the rough terms of "per capita cost," the theoretical premise is that payment is required for the actual care and treatment received by the one who is ill. This approach tends to undercut popular stigmatization of mental illness by viewing the care of mental patients as not very different from the treatment of, say, persons suffering from appendicitis. Further modernization of the statutes to make the basic support charge better conform to the theoretical premise of actual cost should fortify this view. The extent to which this and other considerations should be taken into account in shaping the private responsibility principle is the subject of succeeding sections.

B. The Scope of Liability

1. Upon whom should the support burden fall? Legal liability for institutional support costs ought to be limited to the patient, his spouse, parents and children. As has already been suggested, limiting legal liability to the patient, his spouse, and his first degree lineals merely puts the statutory language in line with generally existing enforcement practices and thereby explicitly acknowledges the changes that have occurred

98. See text at notes 30, 31 supra.
in family interrelationships.  

The omission of more remote relatives from the scope of legal liability ought not, however, to suggest that voluntary contributions should not be sought from them. When those legally liable are unable to pay, the reimbursement agency should provide routine procedures to encourage and facilitate voluntary contributions by brothers and sisters, grandparents, and any other relatives or friends who may have the ability and the desire to contribute in some way to the patient’s support.

Clearly, the patient’s liability for the costs of his care should be prior to that of anyone else. It may also be that reimbursement agencies should be required to look to the estate of the spouse before seeking to impose responsibility on parents or children. But from an administrative standpoint, it is necessary that obligors other than the patient or his spouse be held collectively and individually liable for support costs, so that the reimbursement agency is free to collect the full amount due from any one of them. Of course, it is preferable that each of these persons bear his proportionate share of the costs according to his ability to pay; and, if for no other reason than the preservation of family harmony, the agency should attempt to make arrangements for collection on this basis. But if, for example, one of the joint obligors is able to pay the entire obligation and is within the state, while the other both refuses to pay his proportionate share and lives beyond the reach of state process, the agency should not be put to the necessity of entering another state’s courts in order to collect the full amount.

2. How much should responsible persons pay? At the very heart of a reimbursement program lies the method of formulating the amount to be charged responsible persons. The unsatisfactory status of most present-day state programs is the direct result of a failure to develop statutory charges in line with some consistent, informed policy of private responsibility.

   a. Maximum liability. No compelling reason appears why the starting point for setting the amount of private responsibility should not be the actual cost to the state of caring for the individual patient rather than the average per capita rate. Indeed, to the degree that any scheme


100. The *Uniform Reciprocal Enforcement of Support Act* provides a comparatively simple means for enforcement of support obligations against non-residents and it should be utilized whenever possible. Nevertheless, out-of-state enforcement of support obligations should be left to the agency’s discretion, and it should not be required to undertake such action even though it cannot secure full reimbursement from a liable person within the home state.
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dearts from this approach, it deviates from what has always been considered an underlying principle of private responsibility programs, namely, reimbursement. A public mental hospital is not like a general charity hospital, which admits only a very limited segment of the population at the lowest income levels. To the contrary, state mental hospitals serve persons from almost all economic groups and in this respect are more like private general hospitals. If a patient in a public mental hospital or his family can afford to pay the full costs of his care, it is anomalous that they should instead be charged a lesser amount based on the average cost of caring for all patients in that hospital or in state mental institutions generally.

The most obvious method of determining the cost of individual care would be for the mental institution to adopt a system of per-patient accounting like that used in most general hospitals. A basic charge would be made for routine items, such as room, board and customary nursing care, and a surcharge would be added for any special care. This system would require some categorization of non-routine services, and a cost-analysis of each service to reflect the time spent by professional staff members, maintenance costs of special facilities, use of special drugs, and any other expense directly related to the service.

An alternative method, involving somewhat less bookkeeping, would be to classify patients within an institution according to the type of treat-
ment they receive and to set a separate maximum rate for each classification. Such a system would be compatible with the goal of an actual cost maximum, however, only if the classifications were defined so as to minimize cost variations among patients in the same category. A group or class rate could be established by adding to the basic charge for routine services provided for all classes a charge based upon the average cost of additional facilities and services offered to patients within the particular class. When an altered prognosis brought about a change in a patient’s treatment, reclassification would follow for purposes of determining a new maximum charge.

Although few states are apt to plan their institutional facilities around the comparatively large number of classes that might be necessary to insure cost-uniformity within categories, many states will have one or two specialized institutions which provide roughly comparable treatment for all their patients. In such cases, there would be no objection to setting the maximum rate for these patients at the institutional per capita cost of operation.

b. Ability to pay. To establish full reimbursement as the measure of the fundamental private support obligation only partially disposes of the question of how much responsible persons should be required to pay. It is perfectly clear that many obligors simply will be unable to reimburse the state for full maintenance costs. Even the most outspoken advocates of the principle of private responsibility do not venture to suggest that in these circumstances the patient should be deprived of public institutional care; such a suggestion is neither politically nor socially acceptable. Nor can the private reimbursement obligation be viewed simply as another debt, whose satisfaction the state should demand without regard to hardship. The likely consequence of such a view would be not to lighten the state’s burden but to increase it. Moreover, this approach would effectively destroy the possibility of establishing a proper sanatory relationship among the patient, family and hospital. For families of limited financial resources, the ability to pay formula should continue to operate as the practical determinant of the amount of liability.

Among the several problems which attend formulation of an ability-to-pay standard is the question of statutory definition. When inadequate

102. This might be true, for example, in a state which maintained a separate custodial institution.
103. See note 39, supra.
104. The statutes of a few states provide, however, that the failure of those responsible for costs—either relatives or the county—to pay support installments as they become due is grounds for expelling the patient from the institution. E.g., Mo. ANN. STAT. § 31.050(1) (Supp. 1960); Tenn. Code Ann. § 33-631 (1955).
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criteria guide determinations of private responsibility, uniformity of application usually suffers, and the reimbursement system loses public confidence and respect. On the other hand, the rigidity which results from too detailed specification presents at least as great a danger as the disuniformity stemming from oversimplification. Therefore, although the statutory formulation of the ability-to-pay standard may, and perhaps should, detail to some degree the factors to be considered in making ability-to-pay determinations, it should not circumscribe agency discretion in weighing these various factors, nor should it exclude consideration of other factors. The desired balance could best be achieved by leaving the detailed mechanics of ability-to-pay determinations to the reimbursement agency under a general rule-making power.

Among the relevant considerations toward which the statute might direct the reimbursement agency's attention are not only the contributor's income, but also the number of the contributor's dependents; reasonable living expenses; job expenses; taxes; previously incurred liabilities; educational expenses; medical expenses; and the contributor's age. In addition to these factors which would affect the contributor's ability to pay out of current income, the statute should also direct consideration of the value of the contributor's assets.

Even with intelligible statutory guidelines, translating these abstractions into a dollars and cents determination of ability to pay is a most difficult task. From the standpoint of administrative convenience, the simplest approach is probably to set up a table similar to that provided for computing federal incomes taxes, the basic support charge thus depending upon the liable person's income and number of dependents. While the task of establishing such a table appears deceptively simple, its preparation must be preceded by the gathering and interpretation of considerable data concerning the cost of living of family units of various sizes. Moreover, since current income is not the sole indicator of ability to pay, provision must be made for appropriate adjustments in the indicated assessment to account for other relevant factors.105

105. Illinois Department of Public Welfare Mental Health Regulations Nos. 53 and 54, set out in part below, indicate some of the difficulties encountered in promulgating regulations which provide explicit guidelines for determining ability to pay without unduly restricting the administrator's discretion when unusual circumstances are involved. Although the basic procedure for determining the amount of the assessment outlined by these regulations approximates that suggested in the text, it should be noted that the maximum contribution contemplated by these regulations is set at an arbitrary level rather than at a true actual cost. The schedule of charges, omitted below, establishes a $3 monthly contribution for a family of two persons, excluding the patient, with a gross monthly income between $310-$319. For each $10 increase in the gross monthly income above this amount, the monthly contribution is increased by $3, up to the maximum monthly assessment of $81 at an income above $520 per month. For each additional de-
Ideally, the weight to be given these factors should be dictated by a consideration of the reasonable economic expectations of the family. For example, a liable person might claim a reduction in his indicated assessment because his business required that he acquire and maintain a reliable motor vehicle, and he was presently making payments on such a vehicle, which investigation disclosed to be a $6,000 automobile. As-

pendent an additional $50 is allowed before the charges are assessed. For example, a family of three is not required to make a contribution until its monthly income reaches $360.

MENTAL HEALTH STANDARDS FOR ABILITY AND LIABILITY
REGULATION No. 53: TO PAY MAINTENANCE CHARGES

Determination of the ability and the amount of the liability of the spouse, parents, or children to pay for the costs of the care, treatment, detention, and training of a patient in a state hospital shall be made in accordance with the schedule of gross monthly income and number of dependents set forth in this regulation. Monthly income shall be defined to include the income of the responsible relative and his family unit. Dependent persons shall be those persons legally dependent upon the liable relative for more than one half of their support.

Voluntary payments will be accepted from persons whose incomes are below the minimum base amounts shown on this schedule. Voluntary payments in excess of required amounts will be accepted from liable persons as well as from non-liable persons.

In those cases in which a liable relative is not able to pay all of the costs of care and treatment on the basis of current income but has real and/or personal property having a current market value in excess of $10,000, the amount of such property over $10,000, in conjunction with income in excess of that amount needed to maintain a reasonable standard of living for the liable relative for the remainder of his life and for his dependents for the anticipated periods of their dependency, may be used as a measure of the ability to pay. A reasonable standard of living shall be considered to be equal to the monthly amount of income set forth in the gross income schedule before charges are made for the costs of maintenance on the basis of current income. The total amount of capital to provide a reasonable standard of living shall be computed by multiplying the anticipated number of years of life expectancy of the liable relative according to the most recent table of ordinary life expectancy of the National Office of Vital Statistics and the anticipated number of years of dependency of dependents, if any, by the amount needed to provide the indicated standard of living for a one-year period less the regular income which can be expected from other sources.

The income and assets of a patient shall not be subject to charges for the costs of care and treatment until the needs of his dependents for a reasonable standard of living are provided. If the current income of the patient, or his estate, is sufficient to provide a reasonable standard of living in accordance with the gross income schedule set forth herein, any remaining income and assets may be assessed for the costs of care and treatment. If current income is inadequate to provide a reasonable standard of living for the dependents for their anticipated periods of dependency, the amount of the assets necessary to provide such a standard of living for that period of dependency shall not be considered assessable for the payment of maintenance charges. The total amount needed to provide a reasonable standard of living shall be computed by multiplying the anticipated number of years of a dependency by the amount needed to provide such reasonable standard of living for a one-year period less the amount of annual income of the patient and his dependents. For these purposes a reasonable standard of living shall be considered to be equal to the monthly amounts of gross income set forth in the schedule included herein.
assuming that the claim for a reduction has some merit, the reimbursement agency might determine that a person in his circumstances and income class could reasonably expect to purchase and maintain a vehicle costing only $2,500. On this basis the agency would allow a proportionate reduction in the assessment based not upon the liable person’s actual expenditures for the acquisition and maintenance of the car, but upon that part of these expenditures justified by reasonable economic expectations.

Of course “reasonable economic expectations” is almost as slippery a concept as “ability to pay”; and many of the questions which arise will be much more perplexing than the example. As a guide to the administrator’s exercise of discretion, however, the criterion of reasonable economic expectations is far more explicit than any general exhortation simply to “consider” various factors.

The “economic expectation” approach to determination of ability to pay would eliminate the necessity for limitations on the duration of liability. Such limitations have stemmed from a feeling that a long-continued support burden too often results in hardship on other members

MENTAL HEALTH
REGULATION No. 54:
ALLOWANCES FOR UNUSUAL EXPENSES OR CIRCUMSTANCES IN DETERMINING ABILITY TO PAY MAINTENANCE CHARGES

If examination reveals unusual expenses or other circumstances which indicate that gross income is not an adequate measure of ability to pay maintenance charges for a patient in a state hospital, allowances for the unusual expenses and circumstances listed below shall be made by decreasing the gross income and by using the resultant amount as income in applying the schedule for the purpose of determining the monthly charge.

Proof of payment of the unusual expenses, or proof of circumstances, must be furnished upon request.
1. Expense of medical and related costs in excess of 4% of the gross income.
2. Expense of maintaining dependents outside the home in excess of $50 per month per dependent.
3. Expense of contributing toward support of relatives other than dependents outside the home.
4. Expense of housekeeper or baby sitter when the spouse is the patient.
5. Expense of cleaning and laundry when the spouse is the patient.
6. Expense of education of dependents in excess of $50 per month per dependent.
7. Expense of educational courses for employed liable relative.
8. Expense of travel of the liable relative only when required for the job and if not reimbursed by the employer.
9. Expense of rent of liable relative in excess of 25% of gross income.
10. Expense of maintaining two homes when liable relative’s family cannot be moved to place of employment.
11. Expense of alimony or court ordered support paid by the liable relative.
12. One additional dependency when liable relative is blind.
13. One additional dependency when liable relative is 65 years of age or over.
14. One additional dependency for the liable relative when more than one-half of the patient’s support is provided by the liable outside the hospital during period of assessment of charges.
of the family. If, however, ability to pay were determined in accordance with the family's reasonable economic expectations, the obligation of support would moderate at just those times when funds were needed for other legitimate purposes. As parents grew older, for example, their reasonable need to provide for retirement would decrease their obligation to pay for an institutionalized dependent. Similarly, normal children approaching college age would furnish the occasion for a reduction of the family support burden provided, of course, the family could realistically expect to contribute toward the expenses of higher education.

This approach would also obviate any need for providing for a cushion of assets in some arbitrary amount against the patient's eventual release, since the computation of ability to pay would take into account the possibility that the family would have to support the patient at home during his convalescence and the obligors would be permitted to accumulate or preserve a fund for that purpose.

C. The Implementation of Policy

Clearly, it is both impossible and undesirable to eliminate the judgment of the administrator in the process of determining liability. Nevertheless, if a state is to achieve a unified approach to the question of private responsibility, it must provide an effective method of disseminating uniform procedures and policies to these administrators and of controlling their individual efforts to apply them. The advantages of a centralized administration for this purpose far outweigh any of the possible or putative merits of a locally or institutionally controlled reimbursement effort.

It is said that a system of local responsibility, under which a local court and local welfare agencies cooperate in determining and enforcing private responsibility, places reimbursement in the hands of those whose understanding and appreciation of the problems of persons in their community is much greater than that of "outsiders." This localization, the argument goes, simplifies the process of investigation and provides persons responsible for support costs with a convenient and familiar forum for determinations of their ability to pay. No fundamental inconsistency exists, however, between the concept of centralized administration and some degree of localization in providing facilities and personnel for determinations and enforcement of the support obligation. A successful central reimbursement agency, in any but the smallest states, would of necessity have to provide for some kind of local administrative contact.
The critical difference between existing systems of local control over reimbursement and a centralized system is that local control suffers from an absence of effective coordination in both policy and procedure. Inevitably, the fact that each community court must independently develop its means test criteria leads to disuniformity throughout a state. Some judges are strict, others lenient. The amount that a family is required to contribute more often depends upon the accident of residence than upon any state-wide policy of private responsibility. Furthermore, to place the final responsibility for administration of the means test with locally elected or appointed officials is not only to leave uncontrolled the variations arising from the diverse temperaments of different judges but also to invite actual manipulation as a means of currying political favor. It is extremely difficult, as a practical matter, to detect an understatement or omission of assets or income in a report on financial status; and the pressures on government officials in this area are as significant as they are in other areas which intimately involve the monetary interests of private citizens.

Besides presenting problems of uniformity and control, local organization lacks the breadth of operation and the flexibility necessary to achieve an effective reimbursement program. The mobility of present-day state populations, coupled with the limited resources of independent, local systems, make it extremely unlikely that a county court or its designated investigative agent can make a thorough canvass of a family's financial situation or, indeed, even succeed in locating all persons statutorily liable. On the other hand, a central agency with the sole and continuing responsibility for administering a reimbursement program can develop techniques of routine investigation and verification and achieve a state and even interstate co-ordination that will make its operations much more efficient and more thorough than those of an independent local agency.

Since an institutionally administered reimbursement system must often rely upon local officials for information and enforcement activities, its deficiencies are in many respects similar to those of a local system. The chief claim of merit of the institutional system is that it allows the institution to consider the effect of the support burden on the relationship among the patient, his family, and the hospital. This is not an unmixed blessing, however, since it has been noted that a close connection between the financial and psychiatric elements of administration within a hospital has occasionally fostered a staff attitude toward patients' relatives "strikingly like traditional attitudes toward a patron: ambivalence and out-
Moreover, because the business manager of a mental institution usually has neither the time nor the training to weigh the complex factors of an adequate means test, the potential advantage disappears in a mechanical application of insufficient criteria. Enforcement, too, is ordinarily compromised under an institutional system. The needed persistence for the collection of difficult claims is usually lacking, not only because other immediate administrative tasks seem more important, but also because motivation is lacking: in most states the funds which may be collected do not accrue to the direct benefit of the institution. A central agency whose specialized and immediate concern is reimbursement alone can be far more effective than an institutional division of collections.

While a centralized reimbursement program offers the advantages of co-ordinated policy, adequate investigation, a uniform collection effort, and freedom from local political pressures, centralization alone is not sufficient. The primary goal of institutionalization for mental illness is to effect the patient's recovery. Administration of the reimbursement program must be harmonized with this therapeutic end. The needed liaison between state medical officers and personnel charged with the revenue aspects of the state mental health program is made difficult, if not impossible, when the reimbursement agency is administratively separate from the state's over-all program of mental health care. For this reason, the central reimbursement agency should be comprehended within that state department which is also responsible for the institutional care for which support charges are assessed.

The agency should be made responsible not only for the determination of private responsibility, but also for the process of billing and collections. Such a system would free institutional administrators to concentrate on other tasks.

The central reimbursement agency should be vested with adequate rule-making power and sufficient powers of general investigation so that the ability-to-pay criteria which it formulates will be based upon concrete information furnishing a sound basis for judgment. The agency should be authorized to enter into voluntary contractual arrangements for payment for the costs of care. Its contested determinations, like those of most other administrative agencies, should be subject to limited judicial review confined to an examination of the agency's exercise of discretion.

To aid in its enforcement activities, a legal staff should be provided for the agency, authorized not only to advise but also to prosecute col-

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lection actions on its behalf. This staff would minimize the agency's dependence upon local officials and insure the elimination of local favoritism or bias. It would also be well situated to utilize reciprocal state laws for the enforcement of support and, conversely, to handle out-of-state requests for enforcement of institutional support obligations against state residents. In light of the presumptive correctness of the agency's determination and to avoid delays, it might be desirable to provide summary court procedures for agency enforcement of actions for support.

In short, the centralized reimbursement agency would be fully effective only if given broad powers and wide discretion, with the freedom to shape its special operation within the broad confines of legislative policy.

IV. CONCLUSION

The improvement of existing state procedures for the determination and enforcement of private responsibility is only a fragment of the larger program of providing the best possible care for the mentally ill. By themselves, any changes in state reimbursement programs will have only the most indirect effect upon such other problems as inadequacy of facilities, of treatment, and of staff. Furthermore, the practical problems involved in a major revision of a state reimbursement program should not be underestimated.

Nevertheless, it is clear that many of the problems of mental health care stem from a single source: a prevailing public attitude toward mental illness combining apathy, hopelessness and shame. There is no magic formula for transforming such attitudes overnight. A number of organizations, both local and national, have long labored in this subtle task. A reimbursement program which itself views mental illness like other illnesses and assesses charges on that basis is geared to and may be helpful in fostering a more enlightened attitude toward mental illness.

Indeed, the effect of charging patients or their relatives for treatment received instead of on an average per diem basis is of considerable potential practical importance. While health insurance plans have been expanding in the past decade, they have generally not covered treatment for mental illness. Since mental institutions have been viewed largely as places of custody, and health insurance is intended to be an interim benefit to bring about recovery, it has not been thought appropriate to extend insurance to cover the costs of mere custodial care. If, however, mental institutions fulfill their obligation of treatment, and charges are assessed individually for that treatment, there is no logical reason why insurance benefits could not easily be expanded. Not only would such insurance
coverage make support contributions a much more significant source of state revenue, but it would in turn be a factor in reshaping public attitudes.

Finally, a centrally operated reimbursement program based on actual cost provides a sound framework for adjusting the private support obligation to advancing methods of administering treatment to mental patients. Foremost on the horizon, for example, is the concept of outpatient care—supportive treatment administered by local health agencies and social workers after the patient has been discharged from the hospital. Such post-hospital care offers an effective and comparatively economical method of maintaining certain types of patients in the community and curtailing the periodic readmissions which otherwise are necessary. The cost of this supportive care given outside the hospital could easily be integrated into the private support obligation and its reimbursement administered without alteration of the basic reimbursement program.

Mental illness, we have been told, is America’s number one health problem. We cannot, therefore, afford to neglect a single possibility which may contribute to its eventual solution. Along with other pressing needs in this field, the reformulation of state reimbursement programs is a necessary task for today.