The Origins of Commitment for Substance Abuse in the United States

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Policymakers in the United States have long been perplexed by how to deal with substance abuse. As attitudes shifted in the 19th century toward viewing substance abuse as a medical problem akin to insanity rather than as a moral failing, greater emphasis was given to the potential for treatment. Thus, by the middle of the 19th century, states began developing substance abuse commitment codes and institutions to which substance abusers could be committed. Public ambivalence over whether substance abusers should be seen as having an illness or a weakness of will, however, was reflected in the lack of sustained support for these efforts, in contrast to support accorded systems for commitment of the mentally ill. Contemporary policymakers are faced with the same ambivalence, as they struggle with the extent to which substance abusers ought to be subjected to involuntary treatment. The legacy of the early years of substance abuse commitment lives on.

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Substance abuse has captured the concern of physicians, social reformers, the legal community, and policymakers in the United States for two centuries. In the face of perennial debates over when society should intervene, how best to do so, and how to fund these interventions, legal mechanisms for substance abuse intervention took several forms in the United States in the 19th century. Habitual drunkards, dipsomaniacs, opium addicts, and cocaine inebriates were incarcerated, placed in workhouses, committed to almshouses, subjected to inquisitions leading to guardianship, and committed for treatment to inebriety asylums and related facilities. This article records one aspect of substance abuse intervention history: the evolution of the first identifiable substance abuse commitment codes.

Social Underpinnings

The post-Revolution United States was a hard-drinking place. Alcohol, the "good creature of God,"[1] was the universal remedy. Americans drank at almost three times the present rate, with per capita consumption of ethanol reaching 7.1 gallons annually by 1830. In the face of this prodigious intake, problems related to the use of alcohol became a serious concern for civic leaders, law enforcement officers, and physicians.[1–3] *Status ebrietas* accounted for the majority of arrests and incarcerations, overwhelming courts, jails, and houses of industry.[3,4–8] In a perpetual circuit between the streets, jail, and other public facilities, recidivist habitual drunkards became known as "police court rounders."[9] Common drunkards were moral offenders whom the police could arrest without warrant in public places; even private drunkenness was criminalized in Massachusetts.[7,10]

Efforts to counter substance abuse originated with the temperance movement in the late 18th century. Temperance advocates collectively opposed the abuse, and eventually use, of alcohol. With ardent speeches and religious fervor, they sought to educate the public, reform the drunkard, and sway legislatures. Even with vigorous medical leadership, both punitive and reformative threads were found within the temperance movement, and temperance writers characterized intemperance sufferers as victims.[7,11–14] It is also in the temperance literature that

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the suggestion that alcohol is irresistable first occurs, ushering in the controversy surrounding the role of volition that shapes discourse on interventions to this day.[15–17]

Despite medical involvement in the formative years of the temperance movement, reformation as envisioned by temperance advocates typically involved mutual-aid fellowships of individuals devoted to abstinence, such as the Washingtonians and subsequent fraternal temperance societies.[3] Later in the century, the increasingly moralistic focus had shifted to prohibition, for "only evil-disposed persons and fools fall victims to the alcoholic excesses."[18] Temperance advocates succeeded in enacting a wave of prohibition statutes, starting with Maine in 1851. Fifteen states soon followed suit. Prohibition statutes were short-lived, however; some were ruled unconstitutional[19] and the remainder, declared the U.S. Brewer's Association, were "not sustained by the will of the people."[20]

Despite prohibition's failures and the decline of the short-lived Washingtonian movement, mounting intolerance of public drunkenness fomented social and religious pressures to aid, treat, and contain the dependent and deviant. Embraced by the great social welfare and public health movements of the 19th century, efforts to correct or reform drunkards preoccupied authorities and reformers. Public health officials warned that intemperance was an enormous evil, and the cause of a vast amount of suffering, endangering the public and the offspring of intemperate parents.[15,21–23]

The Medical Community Responds

For centuries, physicians had warned of dangers to health and mind from excessive consumption of alcohol. Although such influential physicians as Thomas Trotter, Samuel Woodward, and Benjamin Rush characterized habitual drunkenness as a disease of the mind, they represented a minority viewpoint at the dawn of the 19th century. Temperance-movement physicians were responsible not only for developing and advancing the disease concept of alcoholism among physicians, temperance advocates, and the general public, but were among the earliest advocates for medical treatment of drunkards.[2,24–28] They were not entirely successful: Early temperance literature referred to intemperance, variously, as a disease, or productive of a disease, or an evil.[5,29] Perhaps Boorstin got it right, arguing that when evil was encountered, Jeffersonian ideas led to naturalization into a disease.[15] This was a time of conspicuous intemperance among physicians, who faced declining public confidence, censure, and admonishment for prescribing alcohol as a remedy.[2,27,30,31] In any case, the abundant dangers, or evils, were often lethal. They included suicide, delirium tremens, lunacy, congenital idiocy, and incurable maladies stemming from the habit of drunkenness.[20,23,26,33–39] Dipsomania, declared inebriety pioneer J. Edward Turner, was America's "national disease."[40]

No nomenclature for substance abuse existed before the 19th century.[41] The newly proposed disease, however, was accompanied by an enthusiastic nomenclature, and diagnostic, descriptive, and etiologic categories abounded. Among the many diagnoses used were methyskomania, mania à potú, oinomania, mania ebriosa, narcomania, absinthe imbecility, and dipsomania. Dipsomania, a morbidly uncontrollable propensity for paroxysmal bouts of drunkenness, was one of the most commonly used diagnoses, and physicians engaged in ill-fated efforts to distinguish it from habitual drunkenness. Medical causation theories included J. E. D. Esquirol's partial insanity or monomania, Thomas Crothers' physical disease, George Beard's theories of social evolution leading to nervous exhaustion and neuroasthenia, James Prichard's concepts of moral insanity, Charles Palmer's moral typology of inebriates, phrenologic explanations, and Benedict Morel's theory of cumulative hereditary degeneration.[34,42–47]

Despite these medical theories of a generally biological basis for inebriety, the disease theory remained controversial in the medical community.[48,49] Even insane asylum superintendents were unable to agree on whether inebriety was a disease or a vice. Physicians agreed, however, that for those "deprived of volition," involuntary institutional care was a necessary intervention, declaring that inebriates should be restrained on grounds of moral depravity, detained as diseased requiring treatment, or committed as *non compos mentis*.[50]

Throughout the 19th century, physicians urged medical alternatives to incarceration of inebriates.[40,51] Blaming incarceration practices for increased crime, the Connecticut Medical Society in 1830 characterized penal discipline as degrading and injurious, impolitic and cruel.[52] Thomas Crothers declared that prosecution of the inebriate as wicked was analogous to prosecution of the insane as devil-

possessed.[51] Mason warned of medical dangers when a seriously intoxicated person was taken to jail, stating, “The average policeman is not a good diagnostician.”[8]

While temperance advocates became preoccupied with moral arguments, punitive measures, and restrictive approaches such as prohibition, physicians devoted to the medical treatment of inebriety were increasingly occupied with “rational” and “scientific” methods and discounted the role of volition.[44] Enfield declared, “The science of medicine has commenced a new war against an old but recently discovered disease.”[53] In 1870, the American Association for the Cure of Inebriety (AACI) was founded. Composed primarily of physicians affiliated with institutions for the treatment of inebriety, the AACI ranks included such highly regarded medical leaders as the founder of the American Medical Association. The AACI held annual scientific meetings, founded a journal, encouraged legislative advocacy, and endeavored to reach a consensus regarding the etiology and treatment of inebriety. Albeit with some dissension, the AACI promoted the concept that inebriety was a true medical disorder and thus most appropriately treated in special hospitals. Promoting involuntary treatment and strict public regulation of treatment institutions, AACI physicians strove to avoid moralistic approaches. They also advocated for the absence of volitional control in substance abuse insanity defenses,[54–56] arguing that mentally diseased inebriates were “moral paralytics.”[44] Even Isaac Ray, the father of American forensic psychiatry, characterized alcoholic craving as an “unutterable agony of spirit, the resistless impulse by which he is driven.”[42] Why, wondered physicians such as Louise Thomas, did the temperance movement no longer call on medical science?[57]

Remedies Proposed

Decades before the emergence of identifiable substance abuse commitment codes, many states developed civil mechanisms to intervene with habitual drunkards. These mechanisms included guardianship and commitments to almshouses and workhouses. Thus emerged civil mechanisms to confine or reform the habitual drunkard, who could be sent for treatment by order of his or her committee.[58,59] Case law clarified that guardianship proceedings could be instituted against a habitual drunkard who had no estate, and a therapeutic agenda was added to the guardian’s custodial responsibilities. The court affirmed that power over the person was complete and should be used to effect a reformation by kind and humane treatment.[60] The court reasoned, “The protection of property is of but little consequence in comparison with the salvation of its deluded owners, who may properly be considered as morally deranged. . . .”[61]

Physicians, who were more familiar with involuntary treatment of the mentally ill, actively sought legislation that would permit commitment of substance abusers for institutional treatment. The models to which they looked were developed in the second quarter of the 19th century, as states began to construct public facilities for the care of persons with mental illness. Before that time, most hospitalization of the mentally ill occurred on an informal basis, with family members and physicians deciding when admission and discharge were indicated. With the development of the state asylums (only two existed before 1830), enabling legislation generally preserved this approach. Thus, patients could be hospitalized at the initiative of their families or, if they were paupers, by the overseers of the poor, when they required care and treatment. The hospital superintendent’s concurrence was necessary, but there was no judicial review of the admission decision. Patients retained the right to trigger a court hearing by invoking a writ of *habeas corpus*, although this was an infrequent event.[62,63]

Physicians’ recommendations for commitment laws for substance abusers reflected a similar paternalistic ethos. As early as 1812, Benjamin Rush had proposed that intemperate persons be examined by a physician and magistrate for court commitment to a sober house hospital.[25] Other measures to date had been inadequate, physicians argued, and involuntary treatment was needful and merciful.[13,17,23,25,26,28,34–36,64,65] Commitment would permit the environment change, medical supervision, and vigilance required for treatment, for inebriates in the throes of uncontrollable craving were thought to use extreme deception and cunning. Furthermore, treatment was the salvation of the morally dead inebriate, who became a morally responsible being.[40] Protection of the inebriate demanded involuntary treatment due to the risks of self-ruin, squandering property, medical complications, and suicide. Inebriates were also considered a contaminating influence, thus dangerous to others.[66,67]

Invoking "preventive justice"[37] and social preservation, physicians reasoned that prevention of crimes, cost-savings to be gained by treatment, and prevention of the hereditary transmission of the "inebriate diathesis" would be served by commitment.[66] Inebriates were also a crucial disposition issue for superintendents of asylums for the insane, who supported substance abuse commitment when paired with recommendations for inebriety asylums.[68] Because the state had created the disease by permitting legal sales of alcohol, the state was responsible to pay for treatment, opined one asylum proprietor.[40]

Amid the therapeutic and paternalistic rationales for involuntary treatment, an occasional physician acknowledged a role for the inebriate in his or her own recovery process. For example, in 1855, Wilson reminded physicians that part of the cure depends solely on the drunkard himself.[17] Most, however, viewed treatment as a medical procedure. Some medical advocates of involuntary treatment even declared that claims of self-cure were fraudulent,[69] resorting to circular arguments such as that by Enfield: "Because it is a disease, it is therefore curable. . . . Being a disease, its cure rests with the physician."[53]

Benjamin Rush's 1812 response to liberty concerns set the tone for the remainder of the century:

> Let it not be said, that confining such persons in a hospital would be an infringement upon personal liberty, incompatible with the freedom of our governments. We do not use this argument when we confine a thief in jail, and yet, taking the aggregate evil of the greater number of drunkards than thieves into consideration, and the greater evils which the influence of their immoral example and conduct introduce into society than stealing, it must be obvious, that the safety and prosperity of a community will be more promoted by confining them, than a common thief (Ref. 25, pp 267–8).

Subsequent physician advocates of involuntary treatment similarly dismissed legal concerns with individual liberties as both dangerous[11,70] and "merest nonsense."[71] A committee of the Massachusetts legislature formed to evaluate the need for commitment of inebriates held a similar view.[72] Physicians viewed such abstractions as of little significance when compared with the realities of inebriety: "There is one liberty which the humane would desire to see denied to every class of people: the liberty of making themselves slaves."[17] However the matter of detaining inebriates for treatment past their initial "paroxysm" represented a conflict of duties for some physicians.[64] Isaac Ray said, "I do not see how we can help compromising either the happiness of families or the rights of the individual."[3]

How did the physicians who advocated commitment of inebriates propose to treat them? With patience, compassion, and what corrections physician Lucy Hall described as "absolute and unremitting control and protection."[12] The principles of therapeutic intervention were first outlined by Thomas Trotter and consisted of managing withdrawal, a controlled environment, physical restoration, and education.[26] Later physicians, styling the treatment as rational and scientific, emphasized remedying the preinebriate condition, manual labor, probation, and time.[18,51,73,74] Reformation was a matter of growth and development, not a "presto-chango" affair.[75]

Physicians who urged legislative mechanisms for commitment of substance-abusing patients also advised development of institutions for the treatment of inebriates. American proposals for institutional care began with Benjamin Rush's proposal for a sober-house hospital in 1812. Soon thereafter Samuel Woodward[28] and the Connecticut Medical Society (1830) called for the founding of medical asylums to treat inebriates. Woodward frankly referred to this proposal as "an experiment in treating inebriety."[13] Jailers and state hospital superintendents joined in.[50,76] Thomas Crothers, proprietor of the Walnut Lodge in Hartford, Connecticut, went so far as to state that some individuals were sane "only when confined in an asylum."[11] Treatment with chemical restraints such as chloral, bromides, and opium at home was excessively dangerous, he warned, and prolonged the duration of the disease. The structure and discipline of the institutional setting were crucial, for recovery required alternation of restraint and freedom applied with "military exactness."[77]

The first "embryo asylum" was Boston's Washingtonian Hall, founded in 1845. By 1893, the AACI reported that more than 50 U.S. inebriety hospitals and medical facilities for treatment of inebriates were in operation, including homes, "faith cure" halls, and lodging houses; another account for the same year counted 118 proprietary cure institutes affiliated with the Keeley Foundation (see Case Study 3, to follow).[1,76,77] Inebriety hospitals or asylums often provided involuntary treatment to committed inebriates. Eventually, smaller institutions formed by temperance fellowships devoted to voluntary reformation such as the Washingtonian Home in Chicago

and the San Francisco Home shifted toward coerced treatment and enforced abstinence. Police court diversions to these otherwise voluntary facilities became commonplace.[78,79]

Debate about commitment procedures reflected the class concerns that simmered among those who treated inebriates. Inebriety physicians distanced themselves from "vicious drunks" of the "criminal classes," arguing that persons should be of "good character" to be eligible for the commitment process.[3] Generally, American physicians who worked at public facilities were prone to favor broader definitions of inebriety. Those at private institutions styled dipsomania and the neurasthenic inebriate affliction of upper-class and "refined" professions as the true diseases in need of medical treatment, whereas "vicious drunks" were characterized as ignorant, degraded, and of the criminal classes.[14,46,55,76,80] U.S. physicians collaborated with British efforts to enact substance abuse commitment; the resultant Habitual Drunkards Act was heavily class oriented. The exasperated physician John Bucknill responded, "I anticipate with some repugnance the duty of carrying out its provisions for treating the rich drunkard as if his conduct were the uncontrollable result of disease, while upon the poor and ignorant wretch I must still impose the penalty of vicious excess."[81]

Opponents of commitment statutes argued that the proposed treatments were costly, ineffective, and applied to conditions about which the medical community disagreed. More precisely, they pointed out that compulsory abstinence was not cure.[49] Moralists, noting disinterest by the temperance community, criticized the abdication of voluntary treatment approaches that fostered individual responsibility and moral heroism.[48,55,78,82] Pragmatists expressed skepticism regarding superintendents who wanted to take only those inebriates who desired treatment and concerns about facilities where only brief treatment was provided. Furthermore, it would be impossible to provide such a large group with industrial employment, an important aspect of rehabilitation recommendations.[73]

The legal community expressed doubt about a dubious certification process and concerns about wrongful detention and contended that morality could not be legislated. Doctors and family were suspected of sinister motives; examiners were suspected of pecuniary interests.[83] Although the medical community paid little heed, attorneys on both sides of the Atlantic took notice when a New York statute was ruled unconstitutional (discussed later, in Case Study 1). After all, if they were truly suffering from a mental disease, why not treat dipsomaniacs under insanity laws? And what possible rationale could justify detention during periods of sobriety? Furthermore, English common law had long held drunkards to be *voluntarius daemon*, thus affording no excuse for crimes committed when intoxicated. If inebriety was a disease requiring commitment, the English practice of holding a drunkard responsible could be eroded.[40,48,82–90]

Hard-line social reformers favored prison sentences because they were shorter, cheaper, and more severe.[73,55] The disease approach represented a "fundamental challenge to the rising organizational effectiveness of the social reform of the latter part of the 19th century."[55] Commitment, opponents implied, was an extreme response to a widespread problem.[79] Declared British opponents: "Here is the project of an Act for making us all sober with a vengeance. . . . Imprisonment may come from a picnic."[38]

Statutes Are Enacted

Despite this opposition, at least 14 U.S. states as well as many other countries succeeded in enacting substance abuse commitment codes during the last half of the 19th century. American, Canadian, British, and European advocates exchanged testimony and efficacy figures; opponents did likewise. U.S. statutes covered commitments to public facilities (e.g., Refs. 91–95) and a variety of private facilities (e.g., Refs. 96–100). Many of the earliest statutes hybridized guardianship and commitment (e.g., Refs. 92,101–107). Some incorporated criminal diversion procedures and mechanisms for voluntary commitment. Other jurisdictions enacting similar substance abuse commitment codes included Australia, Austria, Belgium, most Canadian provinces, England, Germany, Ireland, New Zealand, Norway, Russia, and Switzerland. In France, a guardianship-based procedure permitted involuntary treatment for inebriates and the mentally ill.[8,37,43,71,108–110] Closely tracking U.S. legislative activities, efforts to enact a substance abuse commitment code in England began early in the 19th century, although limitation in knowledge about the disease of inebriety and the difficulty in knowing the appropriate duration for detention were the primary difficulties with enacting legislation when Laycock wrote in

1855.[35,36] Legal commentators, shrewdly observing that temperance activists and medical entrepreneurs were the primary proponents of substance abuse commitment, declared that although involuntary treatment of substance abusers was not in conflict with the moral sense of the nation, it must involve support from more than teetotalers to enact.[111] England's Habitual Drunkards Act of 1879 consisted of a much-maligned voluntary commitment procedure, although an 1898 revision finally permitted involuntary treatment.[38,112–114]

Although the medical community urged the development of commitment procedures for decades before the first facilities were founded,[13,115] as with commitment for "lunacy," substance abuse commitment codes generally accompanied the founding charter of an institution. Their evolution tracked the course of the facilities they served, beset by social pressures, medical debates, and financial woes. The facilities involved included hospitals, asylums, reformatories, charitable institutions, and even a workhouse.[40,116] Some commitment statutes reflected the rejection of small, voluntary programs that were so reluctant to use coercion that they failed to protect patients, their families, and the public or to impose discipline when they received court-ordered inebriates.[79,97,98] In the transformation and demise of the San Francisco Home, for example, Baumohl noted "a failing faith in moral suasion and a growing conviction that those who repeatedly failed the test of the pledge needed prolonged and enforced separation from alcohol, whether in jail or in an asylum under medical management."[82]

With a petition or complaint alleging habitual intemperance, most statutes permitted any inebriate, dipsomaniac, or habitual drunkard to be committed. Some required the inebriate to have lost the power of self-control—a volitional standard that emphasized the person's need for treatment. Although the AACI's model legislation proposed dangerousness to self or others as a basis for commitment in 1872, only two New York statutes used this standard.[117,118] Legal theorists such as Christopher Tiedeman[119] argued that forcibly subjecting the inebriate to medical treatment could only be justified when individuals were insane or dangerous. British law reviewers opined:

> As a cause of forfeiture of the right to bodily freedom, drunkenness probably stands on much the same footing at common law as madness. It is probable that any person may justify at common law such restraint of a drunken man as may be necessary for preventing him from doing an injury to himself or to others if there is reasonable cause to believe that such injury will be done (Ref. 90, p 691).

Due process provisions were noticeably absent from most of the earliest statutes,[94,96–98,104] although litigation changed this picture. Some specified, vaguely, "due inquiry" by the court.[120] The court also adopted due process principles from insanity commitment litigation (e.g., *In re Wellman*) regarding the need to provide notice to the alleged inebriate of the impending proceedings. Excepting Maryland, most states avoided jury trials, despite their basis in common law.[92,121]

How long to treat an inebriate was a matter of considerable debate. Most physicians advised commitment for six months to three years or until patients were able to resist temptation and thus were cured.[8,13,77,112,122] As they gained experience committing inebriates, however, physicians revised their recommendation for discharge, first to restoration of sound mind and sober habits, and finally to "medical readiness."[14,123] Those physicians who supported shorter stays argued that delirium—the feature that most closely resembled temporary insanity—resolved within days.[82,124,125] Furthermore, abstinence due to enforced restraint was entirely different from "eradicating the morbid tendency."[18] Release, if terms were specified, was typically by court order or when the committed individual was no longer "subject to dipsomania or habitual drunkenness."[95]

The history of these statutes can be illustrated by exploring their courses in three states: New York, a colorful piecemeal; Massachusetts, a public sector story; and Minnesota, a tale of jittery taxpayers at the public-private interface.

Case Study 1: The New York Story

The nation's first identifiable substance abuse commitment code accompanied the granting of the charter of the New York State Inebriate Asylum. Billed as the world's first hospital dedicated to the treatment of substance abusers, the impressive Binghamton facility opened its doors in 1864 after decades of promotional efforts by inebriety pioneer and entrepreneur J. Edward Turner. The private facility was funded by shareholders, among whom numbered ex-presidents, former supreme court justices, and other political luminaries. Turner's grand designs refer to a "castellated gothic" structure with a

chapel seating 500, a winter garden, bowling rooms, and Russian baths. Despite concerns that commitment could become "an instrument of oppression by confining persons not drunkards in the true meaning of that word without power of redress,"[40] the legislature empowered the superintendent to accept and retain all inebriates who entered the asylum, initially both voluntary patients and those who entered by "orders of the committee" of any habitual drunkard, and later by judicial commitment. Commitment required evidence in the form of *ex parte* affidavits that the drunkard was lost to self-control or unable, because of inebriation, to attend to business or was dangerous to remain at large. Despite legal challenges and vigorous opposition by liquor proprietors, Turner succeeded in getting further legislative refinements, making it a misdemeanor to sell or give alcoholic stimulants, tobacco, or opium to asylum patients, and in adding police force protection to the facility.[117] Predictably, detainees filed writs of *habeas corpus*. The courts held that the legislature had failed to pass a law that conferred authority to detain voluntary patients.[126] Furthermore, the law depriving persons of their liberty for a considerable period of time without being heard, or having the opportunity to be heard, was repugnant to the state and U.S. constitutions, and the use of *ex parte* affidavits violated due process principles.[119,127] Although the empowering statute was voided, the facility continued to receive voluntary patients. Turner was ousted within a few years by trustees who objected to his coercive measures and questioned his financial management. In 1878, the inebriate asylum was taken over by the state and turned into an asylum for the insane.[77]

Brooklyn's Kings County Inebriates Home was founded in 1867, and a second series of facility-specific New York commitment codes ensued. Responding to pressures of law enforcement, corrections, and the medical community, New York became one of several states in the post-Civil War era to permit inebriates in police custody and prison inmates confined for substance abuse-related charges to be transferred to treatment in lieu of incarceration.[93,97–99,120,127] At a time when the prevalence of addiction had risen to an estimated two to four percent of the population,[129] the 1875 King's County statute led the nation by recognizing the increasingly troubling problem of narcotic addiction.[118]

In 1882, the third series of New York substance abuse commitment statutes originated, improbably, from criminal diversion efforts with prostitutes.[99,100,130] Women with intemperate habits could be detained in charitable institutions such as the Magdalen Female Benevolent Asylum, the Home of Fallen Women, and St. Saviour's Sanitarium. Like the overturned New York Inebriate Asylum statute, the St. Saviour's statute permitted the forcible retention of voluntary inebriates. Yet again, the court held that proceedings under the act lacked due process and were invalid, in that they depended on the discretion of those who detained the patients, and that although the object of the act appeared protective rather than penal, the deprivation of liberty produced by the act was penal in effect. Furthermore, New York's effort to evade due process shortcomings by expressly permitting application for writs of *habeas corpus* was unsuccessful because this was a right detainees already possessed in common with every other citizen of New York.[131] Although not unwilling to permit involuntary hospitalization for substance abuse treatment, the New York courts were vigilant in insisting on strict procedural safeguards.

Case Study 2: The Massachusetts Story

The Massachusetts story began when state insane asylum superintendents implored the legislature to found an inebriety hospital. They, along with their colleagues in the American Association of Medical Superintendents of Asylums for the Insane, viewed inebriety asylums as the best possible way of relieving overcrowded insane asylums of the burden of caring for inebriates. Instead, Massachusetts enacted a statute in 1885 permitting just what the superintendents had "always earnestly protested against"[132]: the commitment and treatment of dipsomaniacs and inebriates at state insane asylums. The Massachusetts experience was discouraging. The dipsomaniac was to be held until no longer subject to dipsomania or habitual drunkenness or until confinement was no longer necessary for public safety or the patient's welfare. State hospitals were already overflowing with cases of ordinary insanity.[68] With the influx of inebriates, the superintendent's position degenerated into that of a policeman trying to maintain order in a crowd of inebriates and the mentally ill.[132] Judges disregarded the requirement that satisfactory evidence be furnished that the person was not of bad repute or bad character. Although committing magistrates con-

strued the statute as also applying to private asylums for the insane, the state hospitals were quickly overrun.[95]

State officials eventually responded to these concerns by opening the Massachusetts Hospital for Dipsomaniacs and Inebriates in 1893; a special inebriety hospital did not solve the management problems, however. From the outset, trustees reported ongoing difficulties managing committed inebriates, handling escapees, and excluding incorrigible patients. And then there were the disgruntled patients, who believed they had been misled about the duration of their two-year commitments. Punitive commitments by family members who relented once the inebriate had been "punished enough" further compromised efforts to maintain a therapeutic program. Trustees also reported indiscriminate or inappropriate commitments of confirmed drunkards, medically ill individuals, inebriates who were past the age of possible cure, and "vicious inebriate" criminals of bad character.[14,123] Eventually, a procedure for early release was enacted whereby trustees were required to certify that the patients would no longer be subject to dipsomania or inebriety or would not be benefited by further treatment, thus permitting problematic patients to be culled.[133]

Massachusetts detainees were a litigious lot. As early as 1834, Samuel Woodward, superintendent of the state's insane asylum in Worcester, had anticipated that individuals detained in inebriety asylums might seek redress for false imprisonment, and he recommended a hold-harmless arrangement with family, friends, and guardians. Congruent with the disease model that underpinned these statutes and in parallel with procedures for committing the insane, Massachusetts was one of several states that required a physician's examination and certificate.[95,100,103,117,120,134,135] Theodore Fisher, superintendent of the Boston Lunatic Asylum, gained experience in defending an action for improper certification and was of the opinion that ambiguity in the 1885 statute could lead physicians to certify inebriates who were actually of sound mind. In *Niven v. Boland*, a tort case against two physicians alleged to have negligently certified a patient for commitment to the Massachusetts Hospital for Dipsomaniacs, the appeals court affirmed the importance of the examining physicians. Characterizing their role as quasi-judicial, the court indicated that the privilege that attaches to parties and witnesses in other judicial proceedings should attach to examining physicians.[136]

In Fisher's address to the Massachusetts Medical Society, "Insane Drunkards," he further characterized the difficulty of retaining a committed insane drunkard, whose prominent symptoms were transient. "In a surprisingly short time he is on his feet, under perfect control, looking around for a lawyer to help him swear that his confused recollection of the circumstances of his commitment is the true version."[137] When the statute was revised, adding procedural due process protections, the burden of proof was placed on the patient, who was required to show cause why he or she should not be committed.[123,138] Massachusetts' experience highlights the tendency for statutes originally developed for therapeutic purposes to be turned into overt mechanisms for social control, with the apparent acquiescence of the judiciary.

Case Study 3: The Minnesota Story

The Minnesota story is one of concern for financial outlays. Admission into the Minnesota Inebriate Asylum in 1875 required a judicial certificate of inability to defray expenses (thus limiting public expenditures to care for the indigent), a finding of incompetence, and guardianship on account of excessive drinking. The Inebriety Asylum was subsumed by Rochester State Hospital, and before the century was over, Minnesotans prohibited treatment of inebriates at their state hospitals. With proprietary facilities booming, Minnesota county governments were then required to take on financial responsibility for the court-enforced "voluntary" treatment of inebriates. These commitments required habitual drunkards to petition for their own commitment and demonstrate a desire to be cured.[94,103,139,140] The Minnesota statute even specified, briefly, that inebriates could be committed by the counties to Keeley Cure "reputable double chloride of gold institutes."[1] The most popular of these were the franchised facilities founded by Dr. Leslie Keeley, where his patent remedy for inebriety was administered. Keeley facilities, and the supportive "Keeley Leagues" of cured or recovering individuals, were powerful enough to enact similar voluntary commitment laws in Colorado, Louisiana, Maryland, North Dakota, and the Oklahoma Territory.[1,141–145] The counties, however, were loathe to pay for such treatment, and the court held that "so-called commitments under this statute

were unconstitutional, assigning judges powers beyond their constitutional jurisdiction."[146] A subsequent revision applied only to residents of populous counties and was also found unconstitutional, because the provisions of the act thus discriminated between urban and rural drunkenness.[147] Minnesota's courts, in contrast to New York's, had concerns about commitment for substance abuse treatment that extended beyond the procedural to encompass the substantive basis for deprivation of liberty.

Impact

Inebriety physicians generally retained a hopeful outlook for the institutional (and often involuntary) treatment of inebriates. They based their opinions of efficacy on long-term follow-up surveys of thousands of patients. The published results were positive enough to generate some skepticism: Thirty-five percent of 3,000 patients from Boston's Washingtonian Home were reported temperate and well 8 to 12 years after treatment; 42 percent of inebriates treated at the Massachusetts Hospital for Dipsomaniacs and Inebriates were doing well 2 to 14 months later; and 61 percent of 1,100 patients treated at the New York State Inebriate Asylum were deemed by relatives to be temperate and well after 5 years. Other asylum proprietors quoted similarly promising results, although in none of these reports are the outcomes classified according to whether the patient was voluntary or involuntary.[68,123,148]

The evangelical tone of physicians promoting institutional treatment of inebriates became tempered as the decades passed, for their central problem was never resolved: how to treat the accumulation of refractory inebriates, the same incorrigibles who clogged courts, jails, and workhouses. As physicians endeavored to confront this issue, their tone became increasingly strident. They recommended state guardianship. They proposed long-term and even life-long detention in industrial hospitals, or emigration to a temperance island.[54,67,75,122] Dr. Clark, a police surgeon, proposed trying the Scottish system "of sending inebriates to certain islands in the Frith of Clyde and would deport to the Pacific Islands our growing and hereditary class of inebriates."[113]

Statutes serving both public and private facilities were enacted throughout the last half of the century. Although intolerance of public drunkenness provided the constituency that permitted their enactment, skeptical legislators were loathe to fund inebriety treatment. Not until the 1890s did public funding for inebriety treatment become routine in statutory language—and this only in the wave of voluntary commitment statutes requiring county funding. Their formula took advantage of societal ambivalence by removing patient language and by reintroducing voluntarism, requiring evidence that the habitual drunkard was willing to obtain treatment. This time, advocates were not medical scientists but medical entrepreneurs of the 1890s.

Commitment statutes were rarely problem-free. Physicians succeeded in influencing the revision process not only by requiring physicians' certificates but by developing admission screening criteria such as "fit subject for treatment," a determination made by physicians. They sequestered inebriates away from insane asylums (except in Maryland), asserted physician discretion over discharge or conditional discharge procedures, developed transfer procedures between facilities, and modified duration.

Physicians who promoted commitment for institutional treatment of inebriates had a significant impact in fostering the scientific study of substance abuse and developing concepts of addiction as a form of psychological or neurologic disease. Limiting this impact, however, were the incongruities of inebriety as an inheritable yet treatable condition and a disease theory that never satisfactorily addressed the matter of volition. Furthermore, a treatment philosophy focusing solely on intervention meant a failure to develop a philosophy of prevention. Thus, inebriety physicians failed to ally with the public health movements or to develop an environmental approach or a social theory of the disease.[38] Public policy interests in social control ultimately prevailed over medical interests in scientific treatment measures, even when treatment was provided in the context of legal mandates.[149]

Nineteenth-century substance abuse commitment practices faded from use with closure of inebriety asylums in the wake of prohibition of alcohol and criminalization of narcotics. Not until the 1960s did the states again enact substance abuse commitment statutes. International and federal initiatives spurred this process, as did a series of U.S. Supreme Court decisions that decriminalized alcoholism and addiction.[150–153] The majority of states now have a mechanism for involuntary civil commitment of substance abusers, and involuntary treatment mechanisms in the criminal justice system (e.g., "drug courts") have

proliferated in the past decade.[154–156] Does the history of substance abuse commitment in the 19th century hold any lessons for contemporary policy?

With all the caution that must be taken in extrapolating across disparate historical epochs, we suggest that the early years of U.S. experience with involuntary treatment of substance abuse appears to point to three conclusions. First, unless a societal consensus can be achieved regarding the desirability and legitimacy of involuntary treatment, such programs as are established will be undercut by judicially imposed restrictions, the reluctance of the public—acting through their legislators—to provide adequate funding, and the unwillingness of family members or doctors to commit patients to these programs. Attempts to achieve broad social support before implementation of involuntary programs are crucial for their success and probably require some resolution of societal ambivalence over whether substance abuse should be viewed as willful misconduct or the consequence of an unwilled affliction. Second, in the absence of effective models of treatment, support for coercive interventions with substance abusers will wane. Substance abusers will be left on their own to bear the burdens of their behavior or will be relegated to the mercies of the criminal justice system. Thus, research that demonstrates efficacy has critical importance for public policy, as well as clinical, purposes. Finally, the temptation to use systems of involuntary treatment for purposes other than those for which they were created will always be substantial. Carefully crafted eligibility criteria and due process protections are needed to minimize the risk that involuntary treatment mechanisms will be used to serve other than therapeutic ends related to social control.

Conclusions

The story of substance abuse commitment codes is that of using law to solve complex human problems. Substance abuse commitment in the 19th century did not live up to the restorative or curative potential promised by its medical advocates, who failed to solve the problem of the chronic recidivist patients that ultimately overwhelmed treatment facilities. Nineteenth-century debates over the role of coercion, the nature of the underlying disease, and the efficacy of treatment are stunningly similar to present-day policy arguments, and the dilemmas faced by our medical forebears are decidedly familiar. Nevertheless, hope is to be found in this story of the enduring nature of the medical community's ethical and scientific motivation to intervene.

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