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The Growing Concept of Social Responsibility Illustrated by a Study of the State's Care of the Insane in Indiana

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The placing of responsibility for the care of the insane has presented many difficulties to the State of Indiana. Successful placement of responsibilities is one of the major problems of statecraft, and, although not a new question, the structural relationship of philanthropic and political institutions is a matter of current interest.

This study which is primarily concerned with the development of state care of the insane in Indiana, will attempt to trace the present state service through legal and administrative procedures available in record form. Laws enacted by the General Assembly will be regarded as an index of public opinion as well as an indication of the degree of political advancement which the state has reached.

The care of the insane has been chosen as the problem because of the explicitness of laws relating to it and the existence of records in available form. The State of Indiana has been chosen as the political area, because of its location near the center of population of the United States, and because of its favorable status in wealth and industrial progress.[1]

[1] *The World Almanac.* 1935, 643. Indiana ranks as the thirty-seventh state in area, and for six decades the center of population of the United States has been within its boundaries. The state was eleventh in population in 1930, and in 1929, its wealth averaged $3000.00 per capita. Its agriculture and industry are well-developed. Only one and seven-tenths per cent. of the population was illiterate by the census of 1930.

Source material for this study has been obtained by personal visits to, or correspondence with (1) members of the erstwhile Board of State Charities, (2) the state hospitals for the insane, and (3) the present Board of Public Welfare. Documentary information has been found in statutes, annual reports, bulletins of voluntary and semi-official organizations, and in the Indiana Senate, House and Documentary Journals. Secondary sources of information consisted of studies in related fields, articles in scientific journals and professional literature.

This study was begun at the University of Chicago, where its progress was limited to the compilation of Indiana Statutes concerning the insane. In the summer of 1933, Dr. Henry N. Sherwood, then of the University of Louisville, Kentucky, read a skeleton draft of the material under consideration and referred it to Prof. William O. Lynch, editor of the Indiana Magazine of History, who encouraged its completion.

Indiana, located as it is near the center of population of the United States, is not only one of the most progressive states in the Union, but it is also one of the oldest. In its unusual course of political development it has been governed by France, England and the United States and by the State of Virginia. Its recorded history dates from 1682, when La Salle explored the Mississippi River. Statehood was conferred in 1816.

The development of the state care of the insane in Indiana illustrates the growing social responsibility of a state in which the change is brought about through social legislation in popular assemblage. The explicitness of Indiana laws and their availability in record form aid materially in following the gradual growth in this particular modification of state service from the Statutes of the Northwest Territory in 1792 to the Reorganization Act of 1933.

Briefly the state care of the insane in Indiana at the present time is provided for by seven institutions over which the state exercises supervision.[2] The seven institutions are maintained by funds appropriated by the General Assembly at each biennial session. There are two minor exceptions to full state maintenance of the hospitals for the insane. Patients, who have adequate income are required to pay a weekly fee of five dollars for treatment and maintenance[3] while clothing and transportation are provided by the county of the patient's residence or by township trustees.[4]

Private institutions for the insane are not supervised by the state but are controlled by certain legal restrictions. The Marion County Asylum for the Incurable Insane, located at Julietta, near Indianapolis, is an anomaly regulated by laws pertaining to county poor asylums.

There is no discrimination with reference to age, color, or sex in the admission of patients to state hospitals for the insane in Indiana. Legal residence may not be required as a qualification of admission to state institutions for the insane, provided the approval of the Department of Public Welfare is submitted, based upon a satisfactory investigation.

Prior to 1846, the insane in Indiana were cared for by

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[2] State hospitals for the insane are located in Indianapolis, Logansport, Evansville, Richmond and Madison. The Village for Epileptics is located in Newcastle and the Indiana Hospital for Insane Criminals, in Michigan City.

[3] Burns' *Annotated Indiana Statutes*, 1933-1935, chap. 22, Sec. 401.

[4] *Indiana Bulletin of Charities and Corrections*, Dec. 1934, 278.

legal guardianship, individual supervision, or custodial care in a county poor asylum, with the type of care depending upon the patient's economic status. Legal guardianship provided protection for the person and property of the insane and for the persons and properties exposed to the insane person's destructive tendencies. There was a difference between the care extended to the insane property-owner and the insane pauper.

The Marion County Asylum for Incurable Insane, at Julietta near Indianapolis, is not under state supervision, but is controlled by laws relating to the management of county poor asylums and the care of their inmates. Nor do private institutions for the insane come under state supervision. Nevertheless, they have certain legal restrictions. The foregoing brief review of the present status of the care of the insane in Indiana indicates the results of a somewhat steady growth in the field of philanthropy, under state supervision.

The earliest provisions for the insane in Indiana were solely of a legal character. These provisions were of a strategic nature and came out of the necessity of protecting both the person and property of the insane person himself and persons and property within the radius of his destructive tendencies. There was, as stated above, a difference between the care extended to the insane person with property and the insane pauper. The former was placed in charge of a suitable person appointed as his guardian, while the latter was placed in a county asylum or farmed out. A statutory provision in the Northwest Territory in 1792 empowered the judge of the probate court to assign some suitable person as guardian to take care of the insane person and estate, both real and personal, and to make perfect inventory of the said estate to be filed in the probate office.[5]

Indiana was not unlike other pioneer sections in classifying insane paupers with other paupers. It was customary to farm out both classes to the lowest bidder. A notation is made in the record from the Orphans Court of St. Clair in March, 1808, that "the insane boy Lemay was cried down to Francois Turcotte, for sixty-nine dollars for one year from that date."[6]

The same distinction in care between the insane property

[5] Salmon P. Chase, *The Statutes of Ohio and of the Northwestern Territory*, I, 127.
[6] Francis L. Philbrick, *Laws of Indiana Territory, 1801-1809*, cxxx.

owner and the insane pauper was clearly defined in the last year of the territory's existence, when the General Assembly enacted a law by which "twelve men should inspect the insane," call for testimony and appoint three persons as guardians to care for the person and property of the insane, and that other persons insane "who have not property for their support shall be entitled to benefits for the relief of paupers."[7] Similar provisions were incorporated into laws when Indiana became a state.[8] Although county poor asylums, which were established in 1821, were open to the insane also, the policy of farming-out did not cease, but alternated with custodial care made available in the county institutions.[9]

The only provision of a medical nature appearing in the laws during this period, recommended in 1815, that a physician be included among the twelve men chosen by the sheriff "to inspect the insane." The medical service was limited to testimony and did not apply to professional service in the way of treatment. Simplicity of pioneer life, neighborly interest and closely knit communities with a common concern for the sick were the only guarantees against neglect of the mentally disturbed.

The first act toward planning for the state care of the insane was in 1825, when Indianapolis, superseding Corydon as the state capital, was founded in the wilderness on land granted by Congress, and square No. 22 was set aside in the city-to-be as the site of a state hospital for the insane. A log cabin constructed on the square, accommodated inmates until the first buildings of what is now the Central State Hospital for the Insane were ready for occupancy.[10] Funds for a building were provided when the General Assembly of 1831 made legal provision for the use of one section of government land, or from the proceeds of that sale, in the erection of an asylum for the care of the insane from the whole state.[11]

Despite the fact that legislative measures had been adopted to provide both a site and adequate funds for a building to be used as a hospital for the insane, there was inordinate delay in carrying out the program. In the meantime the

[7] *Acts of Indiana Territory*, 1815, 66-68.

[8] *Laws of Indiana*, 1818, 331-332.

[9] William A. Rawles, *Centralizing Tendencies in the Administration of Indiana* (New York, 1903), 145.

[10] Alexander Johnson, "A State Aged One Hundred Years," in *Survey* (April 29, 1916), XXXVI, 117.

[11] Rawles, *op. cit.*, 148. Refers to *Special Laws*, 1830-1831, 188-189.

little cabin on square No. 22 no longer served adequately. Inertia produced reactionary legislation in a protective measure approved February 12, 1840,[12] making it "the duty of the justice of the peace, after a hearing before the jury, to appoint a suitable person to take charge of any dangerously insane person" for which service he was to be compensated from the county funds. The reversion to the use of county funds was an emergency measure passed to meet the exigency of the situation.

An active campaign to hasten the construction of the hospital was carried on by Governor Samuel Bigger, who, in his message in 1841, declared that "in all the legislation respecting the insane, they had only been regarded as incapable of self-government,"[13] at the following session of the Legislature, governor Bigger announced that he had complied with the request of the previous session in collecting information and in obtaining plans and specifications for the proposed structure.[14]

The work of Dorothea L. Dix., social reformer of international recognition, who addressed the General Assembly in 1844, was influential in moulding public opinion and hastening favorable legislation in Indiana as well as in many other states.[15]

A stirring appeal was made by Governor James Whitcomb in 1844.[16] It met with favorable legislative action that produced $12,000 for a hospital building. An Act in 1845 provided for a hospital site. Square No. 22 had become not only inadequate in size, but the location was now unsuitable. Consequently, authorization was given for the sale of the "Hospital Block," as it was called, and the proceeds were to be applied toward the new building.[17] On August 28, 1845, the farm of N. Bolton, consisting of one hundred and sixty acres, and situated two miles from Indianapolis on the macadamized National Road, was bought at $53.12½ per

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[12] *Laws of Indiana*, 1839, 72.

[13] *Documentary Journal* (Indiana), 1841-1842, 85. Governor's message.

[14] *House Journal* (Indiana), 1843-1844, 18.

[15] James V. May, *Mental Diseases*, 47. Dr. May is of the opinion that more than any other one person, Miss Dorothea L. Dix, was undoubtedly directly responsible for the inauguration of the state care of mental diseases in this country. She is credited with having memorialized twenty-two different state legislatures on this subject. See also Alexander Johnson, "A State Aged One Hundred Years," *op. cit.*, 117.

[16] *Senate Journal* (Indiana), 1844, 24.

[17] *Laws of Indiana*, 1846, 220-222.

acre, and the property passed to the state of Indiana the following day.[18]

Previously, the problem of caring for the insane had been solved by legal guardianship, alone, or by individual supervision of insane persons and custodial care in county poor asylums, depending upon the economic status of the insane person. Curability of the insane with timely care and treatment had been the theme of the campaign which, resulted in 1846 in providing a suitable site and building for a state hospital. This achievement marked the beginning of state responsibility which made possible medical care for the insane.

State Responsibility for the Insane

The completion of the first state hospital in 1846 inaugurated formal state responsibility and medical care for the insane. Patients were to be admitted under the supervision of a well educated physician. First preference was given to acute cases; second preference, to chronic cases with symptoms favorable to recovery, while discrimination was shown against the long standing chronic group.[19] The new Constitution of Indiana, which was adopted in 1851, specifies that "it shall be the duty of the General Assembly to provide by law . . . for the treatment of the insane."

The substitution of treatment and attempted cure of patients for custodial care without treatment, continued until 1865, when the state recognized the need of assuming responsibility for both curable and incurable insane. The large number of hopelessly incurable cases, added to the knowledge that these wards could be cared for more economically and more satisfactorily in state institutions than elsewhere, were major influences in bringing about the change in policy, which did not take place until 1875 when the hospital's physical capacity was doubled.[20]

The difficulties confronting the hospital in Indianapolis, the only hospital of its kind in the state from 1848 to 1888, serve as an index to the indifference as well as to the active opposition shown toward state care of the insane during that period. The legislature of 1857 failed to provide means for

[18] Henry Mills Hurd, *The Institutional Care of the Insane in the United States and Canada* (Dayton, 1922), II, 822.

[19] *Laws of Indiana*, 1847-1848, 83-86.

[20] Rawles, *op. cit.*, 155-156.

the maintenance of the patients in the hospital, and they were sent back to their respective counties, where they were lodged in poor-houses, jails and isolated cabins erected for the purpose. Some of the patients were in such an acute condition that they were returned to the hospital to be maintained at the expense of their counties. It should be noted that the closing of the hospital was not due to the poverty of the state, since "Indiana prospered between 1850 and 1860. Over three million acres of land were cleared and planted while farms more than doubled in value."[21]

Adequate financial provision was made to re-open the hospital in October, six months after its closing. The difficulties arising from the return of patients to their respective counties became eventually a constructive experience, with such good effect that when no appropriation was made for the hospital during the Civil War, not one patient was sent back to his county. The hospital was maintained by a general fund until adequate provision could be made by the General Assembly.[22]

Partisan politics, in aggravated form, with the spoils system of office-holding, tended to nullify the humanitarian aspects underlying the policy of state care for a helpless group. This problem was most clearly accentuated during the seventies and eighties. The official records from 1870 to 1879, of the state hospital are not even in existence. At the legislative session of 1887, the Civil Service Reform Association uncovered graft, cruelty and abuses. The local political campaign of that year stressed administrative reform, which meant that both political parties were aware of the need for a constructive shift in the government. Open discussion and clarification of the issues resulted in the beginning of a new era in the care of the insane in 1887.[23]

Social legislation dating from 1883[24] shows a tendency toward a degree of permanence in state philanthropy, which must be attributed, in some measure, to the economic development of the state. The financial phase of the problem was becoming less difficult. Political maneuvering, in connection with the construction of three additional state hospitals for

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[21] Logan Esarey, *History of Indiana* (Indianapolis, 1919), II, 585.
[22] Hurd, *op. cit.*, 324.
[23] Johnson, "A State Aged One Hundred Years," *op. cit.*, 119.
[24] *Laws of Indiana*, 1883, 164-168.

the insane was prompted partly by regional interests within the state. When funds for a second state hospital for the insane, were blocked in 1883, a third hospital was proposed as a solution of the blocking. With the continuance of the deadlock, a fourth hospital received approval. Thus, three new hospitals emerged to relieve the hospital in Indianapolis, which had been the sole accommodation for the insane in the state for forty years. The fifth state hospital for the insane which is located near Madison was authorized in 1905,[25] and opened in 1910.[26]

Permanence of state responsibility in the field of philanthropy now seemed assured. During the next two decades, inadequate facilities were the most obvious problem. As a result of overcrowding in the state hospitals, three institutions, differentiated in type, were established, as follows:

1. The Marion County Asylum for the Incompetent Insame was opened at Julietta in June, 1910.
2. The Village for Epileptics was opened at Newcastle, in September, 1907.
3. The Indiana Hospital for Insane Criminals was opened at Michigan City, in October, 1912.

The Marion County asylum for the Incompetent Insane was established in 1901[27] to relieve the overcrowded condition of the Marion County Poor Asylum. Incurably insane paupers and incurably insane wards are admitted "upon such compensation as may be agreed upon" with their guardians. The institution is controlled by the board of county commissioners and maintained by county appropriations in the same manner as other county institutions. This deviation is a throw-back to county responsibility and the acceptance of custodial care in lieu of medical care, but it is the only instance of its kind in the state.

An Act providing for the Indiana Village for Epileptics, was passed March 6, 1905.[28] A site containing 1,245 acres was purchased near Newcastle and the institution was opened

[25] *Ibid.*, 1905, 26.

[26] The annual reports of the several state hospitals for the insane furnish the following data:

	Authorized	Opened
Central State Hospital (Indianapolis)	1844	Nov. 21, 1848
Logansport State Hospital	1883	July 1, 1888
Richmond State Hospital	1883	Aug. 4, 1809
Evansville State Hospital	1883	Oct. 30, 1890
Madison State Hospital	1905	July 23, 1910

[27] *Laws of Indiana*, 1901, 430-433.

[28] *Ibid.*, 1905, 483-489.

with two small cottages on September 16, 1907. No incurable or violent insane patient may be admitted to this institution.

An appropriation for $65,000.00 was made in 1909,[29] for the Indiana Hospital for Insane Criminals, as a part of the Indiana State Prison at Michigan City, under the management of the trustees and warden. The building was constructed almost entirely by prison labor and was opened to receive patients October 12, 1912.

Indiana's records show that the first criminal was imprisoned in Jeffersonville in 1822; the first insane patient was admitted to a state hospital in 1848, and the first criminal-insane patient was segregated for treatment in 1912, a period ten years short of a century after the first commitment of a criminal to the prison at Jeffersonville.[30]

The achievements of this period may be measured by permanence in state responsibility expressed in a centralized program of medical care for the insane and the provision of specialized institutions for particular groups of mental cases in need of special kinds of care and treatment. The provision for adequate institutional care of the insane by the state made the poor asylums less a general dumping ground for helpless inmates, and at the same time provided more suitable care for them. Partisan political strategy and gross neglect of the insane had to be counter-acted before the centralized service for the care of the insane could be permanently established.

Administration of State Hospitals for the Insane

The state hospital presented a twofold problem; namely, the efficient administration of funds appropriated for its maintenance and the need of unremitting interest in the humanitarian goal which had prompted its creation. Benevolent institutions in Indiana have always been controlled by boards. This policy dates from the era of local responsibility when supervision and reports were adopted as measures to prevent careless treatment of public wards. In 1799, overseers of the poor were required to see that paupers, bound out to service, were properly cared for and they reported the results of their visits to the boards transacting the county business. Directors of poor asylums and private contractors for indigent individuals were required to report to the county

[29] *Ibid.*, 1909, 202-208.
[30] Hurd, *op. cit.*, 379.

board.[81] In 1843, county commissioners were required to visit the county asylums "to inspect them with regard to their fitness, in all respects, for the objects of their establishment."[82]

At the present time, the policy of legal checks expressed in the control of boards is somewhat more intricate. Each hospital for the insane is supervised individually by its own Board of Trustees and its Superintendent. The supervision of fiscal affairs, large in volume and a fertile source of problems, is now vested jointly in the State Board of Accounts, established in 1909, and the State Budget Committee, established in 1925. The Governor was authorized by an Act in 1833, to appoint a State Purchasing Agent, with part of the duties of the office designated as securing bids and making advantageous purchases of supplies, materials and equipment for state benevolent institutions. General supervision over all state institutions is vested in the Department of Public Welfare, which superseded the Board of State Charities in 1933. Briefly, there is individual supervision plus specialized supervision of fiscal affairs and the purchasing of supplies, and, finally, there is centralized general supervision of state benevolent institutions.

The Village for Epileptics and the five state hospitals for the insane are under homogeneous supervision. The Indiana Hospital for Insane Criminals comes under the management of the state prison, which does not emphasize medical treatment, while the Marion County Asylum for Incompetent Insane is controlled by the board of county commissioners.

When the Indiana Hospital for the Insane was opened in 1848, it was placed under the management of a board of six commissioners, created by law. A staggered service period was adopted to preserve continuity in administration. The term of office of one commissioner was to expire annually. The board had power to appoint the superintendent and major officials, to prescribe their duties, tenure of office and salaries and to remove them from office. Visits of inspection were made at specified intervals, reports were exacted of officers of the Hospital and, in turn, the board of commissioners submitted a full annual report to the General Assembly.

The superintendent was to be "a person of knowledge,

[81] Rawles, *op. cit.*, 175.
[82] *Indiana Revised Statutes*, 1843, 361.

skill and ability" in the medical profession. His duties consisted in the employment of attendants and servants, the admission of patients and their discharge, when cured, but, in all instances, he was subject to the control of the commissioners.[83] The treasurer of the state served as the treasurer of the hospital and collected its debts.[84]

The tendency toward centralization was shown in the creation of the first board of trustees, by an act of legislature March 5, 1859.[85] The Board of Trustees consisted of two representatives for each of the three benevolent institutions maintained by the state, namely, the schools for the deaf and blind and the state hospital for the insane. One added trustee as a common member served as the president. This greatly desired appointment was always given to a faithful party henchman who was obliged to discharge his political obligations in the selection of officials. The superintendent was now deprived of the appointive power which heretofore had been allotted to him, and the Board of Trustees in his stead exercised full authority in filling all vacancies. The Board of Trustees also directed and controlled all expenditures of the hospital and the state had no other medium of obtaining information with reference to the financial condition of the public usefulness of the hospital. Despite the fact that the board enjoyed enlarged power, no particular qualifications were required of its members.[86]

A definite change did not come until 1879, although there had been criticism against the high-handed policy of the Board for a number of years. Governor Thomas A. Hendricks, Democrat, expressed the following criticism in his biennial message in 1876:

> The boards of trustees in charge of the benevolent institutions do not give that protection to the State which was intended. They make stated visits, hastily examine the vouchers and accounts, and look through the wards and rooms, but generally receive their views and opinions from the superintendents. There is not that thorough investigation and rigid control which should prevail.[87]

Later during his administration, the Governor was em-

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[83] *Ibid.*, 1852, 322-331.
[84] *Ibid.*, 323.
[85] *Laws of Indiana*, 1859, 41-42.
[86] *Ibid.*
[87] *Documentary Journal*, 1876-1877, 12. Message of the Governor.

powered to reorganize the Board. A salary of $900.00 per year was allowed the chairman, and $600.00 per year was allowed the other members. The duties remained unchanged, but the Governor had authority to dismiss members who failed to assume their responsibilities properly. Itemized bills were required before any moneys should be paid out. The reports were to be made to the Governor, who submitted them to the General Assembly. Pecuniary interest in any contract on the part of any member of the Board of Trustees was made punishable by imprisonment or fine or both.[38]

The reform lasted until 1883, when the General Assembly resumed the power to appoint the members of the board.[39] It was during this period that sectional strife brought about the construction of three additional hospitals for the insane instead of one. The act providing for the location and construction of the three hospitals "went into force March 7, 1883, by lapse of time without the governor's approval."[40] Governor Albert G. Porter, elected by the Republican party, held office from 1881 to 1885.

General Benjamin Harrison, in 1887, declared that state institutions were "managed as houses of patronage."[41] Investigation followed accusation. The charges that the board had appointed unqualified officials, and that the inmates of the institutions had not been given adequate food and had not been treated well were answered satisfactorily and it was recorded that the chairman of the Board of Trustees, who had been made the victim of the "most infamous outrages ever perpetrated upon a public official," was exonerated.[42]

Interest was now centered in the reorganization of the administrative machinery, and particular attention was directed to the elimination of partisan control. In 1893 the Governor, instead of the General Assembly, was empowered to appoint the members of the Board.[43] Two years later, legislation was passed requiring that not more than nine of the eighteen trustees (three trustees for each of the six state institutions) should be from the same political party, and for the first time, they were "to be of known fitness, probity and

[38] *Laws of Indiana*, 1879, 5-11.
[39] *Ibid.*, 1883, 15-16.
[40] *Ibid.*, 1883, 164-168.
[41] Rawles, *op. cit.*, 180.
[42] *Senate Journal*, 1887, 946-947.
[43] *Laws of Indiana*, 1893, 137.

high character."[44] At the next session of the Legislature, a law was passed providing that twelve of the eighteen trustees might belong to the same political party,[45] and a protective balance against partisan political control was effected in 1907, when the individual boards of trustees were increased from three to four members, with the requirement that two be chosen from each political party.[46]

Each state benevolent institution, at present, is managed by a board of four trustees, chosen "for fitness and probity," who serve a term of four years, and not more than two of whom shall be affiliated with the same political party. Each trustee shall give bond with surety for $10,000, and the treasurer shall give bond for $25,000. Three hundred dollars yearly plus reasonable expenses, not to exceed $125.00 per year is the annual compensation for each member of a board. Each board has power to appoint the superintendent, fix his salary and determine the number of officials and employees, with their duties and compensation. No person may be appointed superintendent of a hospital for the insane who has not had previous professional experience in such an institution. The superintendent appoints all other employees in the hospital. Any person who is a contractor with the institution, or who is interested in any contract or in furnishing any of the supplies for such an institution is ineligible for appointment as a trustee.[47]

Governor Paul V. McNutt urged in 1935, that the local boards of state institutions be continued and that their appointment be made by the State Board of Public Welfare with the approval of the Governor.[48] The boards of trustees have changed in form and functions many times in becoming more efficient units in administrative machinery.

The Board of State Charities was established by law in 1889,[49] and its duties were taken over by the State Department of Public Welfare in 1933. In 1889, there was dire need for general non-partisan supervision of state benevolent institutions and the Board of State Charities was successful in meet-

[44] *Ibid.*, 1895, 300-301.

[45] *Ibid.*, 1897, 157.

[46] *Ibid.*, 1907, 138-143. The individual institutions of the state at the present time are under the supervision of boards of trustees governed by the law of 1907 as amended in 1913, 1929, and 1933.

[47] Burns' *Annotated Statutes of Indiana*, 1933, chap. 22, sections 101-104.

[48] *Indiana Bulletin of Charities and Corrections*, March, 1935, 403.

[49] *Laws of Indiana*, 1889, 51-52.

ing the situation. The six members of the Board appointed by the Governor, served without salary but were allowed traveling expenses. The Governor was *ex-officio* member and president of the Board and the person appointed as secretary received a salary and clerical assistance with offices in the capitol building. The duties were of a supervisory nature rather than administrative or controlling in the immediate sense, although certain duties took on an administrative character.[50]

In answer to the criticism that the Board would be ineffectual because it had no executive power, the annual report of 1891 explained that its duties were new to the state, were little understood, that there were no precedents for guidance, and that its usefulness must be effected by methods of convincing and conciliating and not of commanding.[51]

The measure of the Board's achievement was set forth in 1904 in two contrasted sets of conditions.[52] Later on separate boards, with full administrative authority, took over some of the functions of the Board of State Charities. It might be said that this Board was a citizens' committee with emphasis on general supervision of state benevolent institutions and that it was established before the existence of professional training in public welfare. It can also be said that the work of the Board contributed richly to the movement which created professional training in social service and public welfare. During its existence of nearly a half century the Board of State Charities was a major factor in moulding public opinion and in developing constructive measures adopted by the state in its welfare program.

[50] The *Annual Report of the Board of State Charities*, 1931, 255-261, presents a list of duties prescribed by law, among which the following involve the care of the insane:

> To investigate the whole system of public charities and correctional institutions of the state.
> To examine into the condition and management of prisons, jails, infirmaries, public hospitals and asylums.
> To report its findings to the Governor and to print an annual report, for the use of the legislature, with such suggestions as it deems necessary and pertinent.
> To secure accurate, uniform and complete statistics.
> To receive reports of the transfers to the Indiana Hospital for Insane Criminals.
> To certify to the Auditor of State the average daily population of certain state institutions.
> To approve plans for out-patient clinics maintained by state hospitals for the insane.
> To administer the law providing for the deportation of . . . epileptic, insane and pauper non-residents.

[51] *Ibid.*, 1891, 14.

[52] Board of State Charities, *Development of Public Charities and Corrections in the State of Indiana*, 1892-1910 (prepared for the Louisiana Purchase Exposition, St. Louis, 1904), 5. In this report the greatly improved conditions were set over against the bad conditions which had earlier prevailed.

The administration of fiscal affairs presented a complex problem to the state. A non-partisan Legislative Committee, which existed from 1897[53] to 1921, whose duty it was to ascertain the needs of state institutions, was made up of three members-elect of the Legislature who were to be "of known probity and business ability." Their services were not to exceed thirty days in the aggregate of the forty-five days preceding the convening of the Legislature. Their compensation was three dollars per day and traveling expenses.

Prior to 1897, the Legislature had attempted to ascertain the needs of state institutions by means of "junketing" committees, which necessitated the absence of members from sessions, interfered with legislative business and furnished little reliable information. Such inadequate service is presumed to have ended with the successful functioning of the Legislative Committee.[54]

The Legislative Committee was modified and superseded by the conjoint functioning of the State Board of Accounts and the State Budget Committee. The State Board of Accounts was created by legislation in 1909, for the purpose of carrying on centralized inspection and supervision of the sources of income and total expenditure of benevolent institutions.[55] The State Budget Committee is composed of the State Examiner of the State Board of Accounts, *ex-officio*, and four members of the General Assembly, appointed by the Governor, only two of whom may be from one political party, and whose duty it is to make a budget for all departments and institutions.[56]

An Act of 1933,[57] directed the Governor to appoint a State Purchasing Agent with such assistants as may be necessary in the purchase of supplies, equipment and material for state benevolent institutions and other specified organizations as well as exceptions. The duties are such as are authorized by the law governing boards of trustees of institutions concerning the purchasing of supplies and include the securing of advantageous bids. Thus fiscal affairs are centralized and

[53] *Laws of Indiana*, 1897, 16.
[54] Rawles, *op. cit.*, 199-200.
[55] *Laws of Indiana*, 1909, 136-137.
[56] *Ibid.*, 1925, 71.
[57] *Ibid.*, 1933, 728.

placed in the hands of persons with business qualifications, who are held strictly responsible to the state.

The State Executive-Administrative Act passed in 1933[58] gave to the Governor authority to reorganize the former Board of State Charities, which is now the Department of Public Welfare. The Department is assigned to the executive division which is composed of the Governor alone, and it takes over the duties assigned by law to the former Board of State Charities.[59] The State Board of Public Welfare is a non-partisan board of citizens who are appointed by the Governor and who serve without compensation. The Director of Public Welfare is appointed by the Governor and is selected because of experience in welfare administration. His tenure of office continues "during good behavior and faithful performance of duties." The Director is the only salaried member of the Board.

The Indiana Society for Mental Hygiene which was organized in 1917 during the World War "to work for the conservation of mental health" is a voluntary organization with membership conferred upon the payment of stipulated dues. There are annual meetings for which well-known speakers are engaged. Records of discussions are kept and distribution of information is a part of the Society's educational program.[60]

Four factors are noted in the foregoing account of the administration of state institutions for the insane. The gradual change in form and function of the boards, which are the mediating agencies between the institutions and the state, resulted in: (1) a more satisfactory form of legal checks in inspection and reports; (2) more desirable qualifications both of board members and of professional personnel; (3) a more efficient service in the introduction of scientific business methods; and (4) a more effective degree of centralization in state service for the care of the insane.

Administrative Policies Within State Hospitals for the Insane

Legal regulations and diagnostic classification of patients control the intake of the hospitals, while inadequate facilities

[58] *Ibid.*, 1933, 7.
[59] *Indiana Bulletin of Charities and Corrections*, Sept., 1933, 202-204.
[60] *Ibid.*, March and April, 1931, 203-204.

act as a mechanical control of the hospital population. Institutional care is legally available to any person who can be shown to have legal residence in Indiana, which is defined as "one unbroken year's residence in the state."[61] Non-residents are entitled to institutional care upon two conditions, namely; inability to ascertain the legal residence and upon the authorization of the Department of Public Welfare based upon a satisfactory investigation.[62] Legal regulations define the procedure of admission. Right to commitment depends upon the findings at the inquest of the patient.

The procedural development of the inquest, diagnostic classification of patients and procedure of terminating hospital residence indicate, in some measure, the growth and significance of medical control. The important change in the procedure of the inquest, which is required for commitment, is the gradual introduction of medical evidence based upon the assumption that insanity is of a pathological nature. The first reference to testimony of a medical nature, is in the Territorial Laws of 1815, which specify that a medical man would be desirable as one of the twelve men summoned "to inspect" the insane person.[63] The inspection in nowise involved treatment.

Acceptability of a physician as a witness is again referred to in the Revised Statutes of 1843, in which it is stated that "the opinion of a witness not being a medical man, as to a person's insanity, is not admissible evidence, unless the facts upon which it is based, have come under his own observation.[64] A law of 1843[65] required that "at least one of the witnesses present at the examination shall be a physician." He was required to submit a social and medical history and an account of any treatment rendered the person.[66]

The slow acceptance of the policy of depending on medical evidence is shown by the requirement in 1881[67] of the testimony of one physician in addition to the attending physician, by whom a social and medical history was submitted

[61] *Laws of Indiana*, 1901, 324.

[62] Burns' *Revised Statutes of Indiana*, 1933, chap. 22, sec. 1501.

[63] *Acts of Indiana Territory*, 1815, 66-68.

[64] *Indiana Revised Statutes*, 1843, 858. See Yeates *v.* Reed, 4 Blackford 463; Doe *v.* Reagan, 5 Blackford 217.

[65] *Laws of Indiana*, 1848, 87.

[66] Admission to state hospitals for the insane was denied to any person having an infectious disease until 1921, when a law was passed providing for laboratory tests after which admission was determined by scientific methods. *Laws of Indiana*, 1921, 106.

[67] *Ibid.*, 1881, 545-555.

in a sworn statement. In 1901[68] two physicians were required by statute to report conjointly, in addition to the full statement of the attending physician. Since 1927, three physicians have been required to testify in the proceedings for a person's admission to a state hospital for the insane.[69] Thus it is seen, that over a period of eighty years medical evidence introduced into the inquest increased from the required testimony of one physician to that of three physicians.

A guardian was appointed by jury action until 1895.[70] Since that time, like all civil actions under probate jurisdiction, the guardianship is determined by court procedure, or by a jury impaneled by court, if necessary.

Diagnostic classification of patients as a control of admissions begins with the first hospital for the insane in 1848 which was opened only to curable cases. Twenty years later, the large number of hopelessly incurable cases, added to the fact that these patients could be cared for more economically and more satisfactorily in state institutions, opened the doors of the state hospitals to the incurable insane. The policy was not carried over effectively into administrative measures until 1875.[71] The three differentiated types of institutions established for the insane was the direct outcome of diagnostic classification, in an attempt to relieve overcrowding.

The importance of diagnostic classification as a control of the population of state hospitals is shown in the annual reports. The Central State Hospital, Indianapolis, reported in 1930, that quite a number of applications for admission "presented no more than a simple mental condition common to old age, and could be taken care of elsewhere, under proper supervision, and would be far happier in other surroundings . . . their care in fact, is only custodial and demands no specific treatment, except looking after their physical well-being." The annual report shows that thirty-six cases were rejected and seventy-three cases were suspended.[72]

The Madison State Hospital reported in 1931, that "the thirteen patients rejected, lacked merit, or could not be admitted under the law, and that the twenty-nine patients, who

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[68] *Ibid.*, 1901, 529.
[69] *Ibid.*, 1927, 180.
[70] *Ibid.*, 1895, 206.
[71] Rawles, *op. cit.*, 155-156.
[72] *Annual Report of the Central State Hospital*, 1930, 22-23.

were suspended were senile, almost without exception, and could be cared for at home."[73]

The Richmond State Hospital observed in 1933, that "the number of admissions had declined for three reasons, namely: (1) the difficulty of persuading relatives to take home convalescent patients to make room for other patients; (2) as only the most urgent cases had been admitted during the last two years, the number of convalescent patients had been smaller than usual and; (3) the very low death rate during the year had created fewer vacancies than usual."[74]

The termination of hospital residence is marked by transfer or discharge of the patient. The Governor has the power to recommend the transfer of any inmate of a benevolent institution, at any time, in his discretion, if the superintendent of the institution deems it advantageous and if the transfer does not lengthen the time of residence of the person so transferred. The latter reservation refers to insane criminals.[75]

A patient may be discharged upon two conditions, first, upon sufficient recovery. A statement to that effect supplemented by social and medical data, is submitted to the court by the superintendent, and the court in turn, declares the patient sane and free from guardianship. Second, incurable and harmless patients may be discharged to make room for recent acute cases. Such patients are returned to their guardians or are transferred to county institutions.[76]

Overcrowded conditions act constantly as a mechanical control of hospital population, and modify the policies within the institutions. The overcrowding of state benevolent institutions often sounded a note of emergency and extended state service from necessity.

Many states require an inquest for reädmission. Indiana is one of the most advanced states in requiring only one inquest. A former patient who has been discharged may be readmitted to a hospital when a physician states that hospital care is needed. The clerk of the circuit court completes the

[73] *Annual Report of the Madison State Hospital*, 1931, 52.

[74] *Annual Report of the Richmond State Hospital*, 1933, 11. This and the two preceding references uniformly express the policy of preference in the admission of curable and acute cases, which was the policy of the first hospital in 1848.

[75] *Indiana Bulletin of Charities and Corrections*, Dec. 1934, 279; *Acts of 1917*, 559.

[76] *Laws of Indiana*, 1933, 1167.

legal formalities. A second inquest is never necessary for recommitment in Indiana.[77]

In addition to committed patients, voluntary patients are entitled legally to admission. The law authorizes the superintendent to receive as "a boarder or as a patient, any person suitable for care or treatment who voluntarily makes written application therefor. He must agree to abide by the established rules and regulations and to give ten days' notice in writing, of his desire to leave the institution." The application for admission must be endorsed by two reputable practising physicians.[78]

Although the policy of admitting voluntary patients, is legal, it does not appear that the practice of admitting them has been extensive. The Central State Hospital and the Richmond State Hospital consider the conditions under which voluntary patients may leave the institution a distinct disadvantage and base their opinion on the fact that the termination of residence may have nothing to do with improvement in the mental illness for treatment of which admission had been requested.

Clinics for the treatment of persons resident in the respective areas of jurisdiction of the state hospitals vary, and on the whole, have not developed sufficiently to become an effective part of the state care of the insane.

In summary, legal regulations and diagnostic classification control the intake of state hospitals for the insane while medical prognoses and overcrowding control the discharge of patients. Few voluntary admissions are reported and the development of clinics for convalescents and out-patients has been relatively ineffective. Emphasis remains upon the institutional care of the insane.

SUMMARY

The development of state responsibility for the care of the insane has been slow. A century and a half has elapsed since the first legislation protected the insane person by a locally appointed guardian. Custodial care in poor asylums followed and curable cases only were admitted to the first state hospital which made medical care possible in 1846. In

[77] Hurd, *op. cit.*, 320-321.
[78] *Laws of Indiana*, 1919, 734-735.

time institutions offering specialized treatment for particular types of mental disorders appeared.

Neglect of the insane and partisan political strategy needed to be counteracted before a state service could be permanently established. Investigations and reports were made and public opinion aroused. Persevering citizens, voluntary organizations, thoughtful philanthropists, officials and legislators worked diligently and intelligently to meet specific immediate aims, such as, the increase of appropriations and physical facilities, the introduction of legal checks and efficient business methods in administration, the improvement of personnel, and a higher degree of centralized state service. The translation of higher ideals of social service into statutory enactment marked each step in the gradual development of the present state care of mental patients.

The growth of the service has been correlated in a measure with state and national crises. Entrance upon statehood brought county asylums into existence; the founding of the present state capital is coincident with the allotting of a hospital site; and world-wide economic slowing-down necessitated stock-taking in terms of costs, purposes and results, under the guidance of specialists, in an attempt to redefine the social responsibilities of the state.

The growth of the state service has been comprehensive from the legal point of view and centralization in administration has been well developed. But the supervision of state hospitals for the insane is regional since it is in the hands of individual boards and a superintendent. The regional supervision of hospitals tends to emphasize institutional treatment with its definite limitations and hinders a more scientific and comprehensive program for the treatment of the insane, which could more probably be developed under a state psychiatrist with state wide jurisdiction.

When Governor Paul V. McNutt was given authority to reorganize the state government in 1933, he recognized government as a basis of the welfare and prosperity of human society and defined the reorganization as "an effort toward the improvement of the social structure of our people." The Governor in referring to the goal of reorganization said that "the end must be sought in the integration of our welfare ac-

tivities; when we reach that end, we will be able to perform the duties imposed upon us by law and likewise by society, in serving the needs of our people."[79]

[79] Gov. Paul V. McNutt (President State Board of Public Welfare), "The Integration of Welfare Activities," in *Indiana Bulletin of Charities and Corrections*, Nov., 1935, 402.