COMMITMENT PROCEDURES

Every psychiatrist has concern for the procedure of committing psychiatric patients to hospitals and often is involved in this. All of us in psychiatry are aware that many undesirable features of the commitment procedure exist in many of our states. Because each state has its own commitment law, these vary widely and few practicing psychiatrists have opportunity to evaluate or compare the many different laws.

In this Report the Committee on Forensic Psychiatry of the Group for the Advancement of Psychiatry has collected the data about the laws of each state and pointed out the undesirable features. Recommendations are made regarding the features of an ideal "certification" law. The work of this Committee has been reviewed by the entire membership of 150 psychiatrists of the Group for the Advancement of Psychiatry who have given this report their full endorsement. It is hoped that this Report may receive the attention of lawmakers, interested groups of citizens concerned with the improvement of their own state law, as well as of psychiatrists, in order that the improvement of our certification laws may be speeded up.

FACTUAL DATA AND CONCLUSIONS

1. The Essential Varieties of Commitment Laws.
   a. By jury (21 states)
      1. Mandatory—Texas—Mississippi
      2. Optional (19 states), Alabama, Colorado,
         Delaware, Georgia, Illinois, Iowa, Kansas,
         Kentucky, Maryland, Massachusetts,
         Michigan, Minnesota, Montana, Oklahoma,
         Tennessee, Vermont, Washington,
         Wisconsin, Wyoming.

   b. By certification of two physicians (6 states),
      Louisiana, Vermont, Rhode Island, Pennsylvania,
      Maryland, New Hampshire.
      (NOTE) in Pennsylvania and New Hampshire
      the physicians' certificate requires certification
      by law judge or magistrate.

   c. By standing Commissions (appointees for term
      designated by Court)—(6 states),
      Iowa, Nebraska, North Dakota, South Dakota,
      Virginia, West Virginia.

   d. Non-judicial authority with 2 physicians (3 states),
      Connecticut, Maine, North Carolina.

   e. Judge and Commission (3 man usually including
      a physician and lawyer) (6 states),

   f. By Judge and 1 physician (8 states), Alabama,
      Arkansas, Idaho, Kansas, Missouri, New Mexico, Ohio, Oregon.

   g. By Judge and 2 physicians (23 states), Arizona, California, Connecticut, Illinois, Indiana,

2. The Essentials of a Satisfactory Commitment Law.
   a. Minimum legal formalism.
   b. Devices which aim to get maximum patient
      participation in treatment which includes
      intramural detention.
   c. Minimal psychic traumatization in admission
      procedures.
   d. Removal of stigmata, resulting from archaic
      legal phraseology.

3. The Most Common Aspects of Bad Commitment Laws.

Historically the commitment in early statutes was limited to the dangerously insane. This has tended to perpetuate the stigma of criminality upon mental illness. "The mentally ill person may be arrested by a sheriff with a warrant, charged with insanity by a judge, detained in a jail pending a hearing, tried in open court before a jury, remanded to jail pending a vacancy in a mental hospital and finally transported to a hospital by a sheriff. While this procedure in each detail may not be followed by any jurisdiction, it represents a pattern of existing practices which are especially objectionable."2

The use of the jury in commitment procedures developed during the latter half of the 19th Century. This was in part due to a notorious case which oc-


2Flaschner, Loc. Cit.
curred in Illinois in 1860. Mrs. E. P. W. Packard, the wife of a Calvinist minister who differed violently with her husband on religious matters had been committed involuntarily. On her release, she maintained that she had been railroaded into the institution. In Illinois she obtained the right to a jury trial for every patient already committed. This gave impetus to the use of the jury in commitment procedures.

The worst features of contemporary commitment laws are:

a. Legal service and notice to the patient.

b. Insistence of personal appearance in court.

c. Exposure of patient as public spectacle and the public record of such.

d. Emphasis of lay judgment as in trial by jury. Identification of mental illness and criminality by similarity of procedure.

e. The common acceptance of certification of mental illness as tantamount to legal incompetence rather than a clear separation of these as different issues affecting the rights of the person.

f. Use of anachronistic terminology.

g. Inquiry into patient's financial status at time of commitment.

4. The states that seem to have the most satisfactory commitment laws are those states empowering commitment by certificate of 2 physicians: Louisiana, Vermont, Rhode Island, Pennsylvania, Maryland, New Hampshire.

5. The states which have the most unsatisfactory laws are Texas and Mississippi which require trial by jury and to an extent less obnoxious are those states which utilize the permissive trial by jury on petition of patients.

6. States Which Provide for Voluntary Admissions:

At present all states except Alabama, Florida, Mississippi, Missouri, North Dakota, Georgia. Since 1939 the following ten states have adopted voluntary admissions:—Arizona, Arkansas, Idaho, Louisiana, Montana, Nebraska, Nevada, New Mexico, Tennessee, Wyoming.

The merits of voluntary admission are self evident. The Committee is not sufficiently informed regarding legislative development to assert categorically the reason why such admissions are still not used in some states. It is, however, our impression that the factor is largely economic. This is suggested by the fact that three states now provide for the voluntary admission of only the patients who pay.


The extent to which this practice is used is unknown statistically. The Committee made inquiries from the National Jail Association and the Federal Bureau of Prisons and from these collateral sources it would seem that the practice of retaining mentally ill persons in jail is widespread.

8. The Trend toward Reform of Terminology.

Pennsylvania was the first state (1923) to substitute “Mental illness” for the term insanity. Nine other states followed:—Connecticut, Illinois, Iowa, Nebraska, Nevada, New York, North Carolina, Ohio, Oregon.

The term “parole” is still in wide use throughout the country.

RECOMMENDATIONS BY THE FORENSIC COMMITTEE ON COMMITMENT PROCEDURES IN GENERAL:

1. Transportation of Mentally Ill Patients

The Committee believes that the use of regular peace officers should be eliminated as much as possible and suggests the possibility of delegating or deputizing state hospital or clinic personnel especially trained for this purpose.

2. Commitment and Release Procedures:

The Committee recommends the complete repeal of all types of commitment and release procedures which retain the pattern of criminal procedures.

3. Financial Status of Hospital Patients

In keeping with the principle that the treatment of mental illness is a state obligation, the Committee believes that the status of indigence and the ability to pay should not be determined initially by court procedure but only after commitment and by fiscal agents employed by the state hospital system.

4. Control of Property

Commitment procedures should be completely divorced from incompetency procedures.

5. Involuntary Formal Commitments

The Committee believes that the certification by 2 physicians now employed in 6 states is the ideal method of procedure. The Committee is unable to see any particular purpose in requiring the physicians to have certificates certified by a law judge or magistrate as required in Pennsylvania and New Hampshire. The Committee believes that they should not advocate that all certificates be made by psychiatrists, except in such areas where psychiatric talent is practically available.

The Committee believes that there is no need for the protection of the patient by the use of legal devices beyond the scope of habeas corpus and the provisions exemplified in the Maryland Law of 1944. The Committee is opposed to the practice of a jury adjudicating any phase of commitment or discharge and is also opposed to any procedure whereby the patient is served personal notice or required to appear in open

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8See addendum, Law of Maryland, March 1944, page 63, 34A.
hearings. The Committee does realize the need and usefulness of legal notice to kin and the practice of representation of the patient by proxy.

6. Emergency Commitments

Twenty-two states have emergency commitment laws. The period of detention ranges from 2 to 30 days. In the period from 1936 to 1946 eight states revised their commitment laws. At present 25 states have temporary observational commitments with detention ranging from 10 to 90 days. Four of these states permit renewals and in 5 all patients are on temporary detention by certification and not formal commitment. The Committee believes that there is no realistic therapeutic or legal value in temporary commitments. More legal formality in commitments (temporary commitments) may create even greater impediments to curing the patient. Any legal artifice setting conditions of time and of treatment tend to prevent the doctor from orienting the patient to his internal psychic problem. Temporary commitments or similar legal devices in practice tend to be reduced in time to routine circumventions and token compromises. Given enough time they deteriorate to the level of meaningless rituals. Our Committee subscribes to the belief that indeterminate commitment serves the best interest of the patient.

No acutely disturbed patient should be delivered to or retained in a jail but should be admitted on an emergency basis to the nearest psychopathic or state hospital. When certifying physicians are not available the admission to the psychopathic or state hospital should be left to the decision of the admitting psychiatrist of such hospital. The usual machinery for certification should be implemented within 72 hours after the admission thereto. In the absence of a welfare worker, a relative or health officer, it should be the duty of the local peace officer to initiate this emergency admission.

7. Voluntary Admissions

The Committee would encourage all measures permitting the more extensive use of voluntary admissions and recommends that the period to which the applicant pledges should be not less than 15 days.

At present, provisions for voluntary admission do not exist in the following states: Alabama, Florida, Mississippi, North Dakota, Georgia, Missouri. It is noted that the tendency in the direction of voluntary admissions has been progressively developed. Ten states have enacted laws for the same since 1939. Voluntary admissions should not be limited to patients who pay.

The application of a voluntary patient implies a contract between the patient and the superintendent and on occasions in which the applicant is regarded as incompetent, the legal guardian or close relative should be permitted to arrange for the admission. Such procedure is provided for in four states: Illinois, Arkansas, Ohio and Utah.

It is clear that voluntary admission should not be denied a patient even when insight is dubious. "A person who is a fit subject for mental treatment should not be denied the easy method for admission merely because he may be too indecisive, weak-minded or incompetent to sign his own papers." (Flaschner) Loc. Cit.

8. Uniform Commitment Law

The Committee recommends a uniform law embodying the following general features:

a. Certification by 2 qualified physicians.
b. Safeguard of patients' rights to petition for release by court hearing as exemplified by the present Maryland law.
c. Emergency admissions.
d. Voluntary admissions.

9. Private Sanitarium

The Forensic Committee has learned that only 17 states require licensing regulation and inspection of private hospitals. Such measures should be a universal practice and the enactment of laws pertaining to the licensing of private institutions should be sponsored by G. A. P.

10. Terminology

The Committee believes that all statutes should delete the term "commitment" in place of which should be substituted the term "certification"; "insanity" and "lunacy" should be replaced by the term "mental illness," and the terms "feeble-minded" or "weak-minded" should be abandoned.

The Committee believes that the term "parole" should be abandoned and in its place the term "convalescent status" or "convalescent leave" should be substituted.

11. Patients' Rights

The Committee believes that all mental patients detained in either public or private institutions should be granted the following fundamental rights:

a. Communication with persons outside.
b. Periodic physical and psychiatric examination.
c. Discharge as soon as possible.
d. Civil rights guaranteed by law unless revoked by the same.
e. Use of the very best existing medical techniques of therapy.

12. State Departments of Mental Hygiene

The Committee believes that for the successful implementation of the reforms necessary in mental health and in the laws relating to mental illness it is essential to promote improvements in the adminis-
tration in the various states. We would advocate that because of the scope of the problem and the social importance of mental disease there be created in every state a separate department of Mental Hygiene and that there be created an administrative head of such a department who is a recognized leader in psychiatry. His appointment and tenure of office must be stabilized by statute and maintained free of political influence.

LAW OF MARYLAND—MARCH, 1944

34A. In addition to the methods provided by law for the commitment of lunatic or insane persons, such persons may be committed to institutions in accordance with the provisions of this section.

Whenever any person is shown to be a lunatic or insane by the certificate of two qualified physicians, as provided by Section 34 of this Article, the Superintendent or physician in charge of any State or licensed private institution for the care, custody or treatment of insane persons may receive and retain such person as a patient upon the written request of any member of his family, or near relative or friend, or the person with whom he resides, or an officer of any charitable institution or agency; provided, however, that such person, or anyone in his behalf, may make a request in writing to said Superintendent or physician for the discharge of such person and such request shall be complied with unless said Superintendent or physician shall be of the opinion that the mental condition of such person requires his further detention, in which event said Superintendent or physician shall retain the custody of such person and shall forthwith file a petition for his furtherance with Section 22 of this Article, for the purpose of having the decision of such person determined, and if the Court shall commit such person to that or some other suitable institution, as provided by said section, he shall be confined thereafter until he shall have recovered, or shall be discharged in due course of law. The provisions of this Article relating to the discharge of recovered patients and to the payment of the expenses of maintaining persons in State institutions shall be applicable to persons entering such institutions under the provisions hereof.

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