Volume VI
Report No. 61
May, 1966

Laws Governing Hospitalization of the Mentally Ill

Formulated by the Committee on Psychiatry and the Law

Group for the Advancement of Psychiatry
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This report is the second in a series of Reports and Symposiums that will comprise Volume VI. For a list of other GAP publications on topics related to the subject of this report, please see page 162.
STATEMENT OF PURPOSE

The Group for the Advancement of Psychiatry has a membership of approximately 185 psychiatrists, organized in the form of a number of working committees which direct their efforts toward the study of various aspects of psychiatry and toward the application of this knowledge to the fields of mental health and human relations.

Collaboration with specialists in other disciplines has been and is one of GAP's working principles. Since the formation of GAP in 1945 its members have worked closely with such other specialists as anthropologists, biologists, economists, statisticians, educators, lawyers, nurses, psychologists, sociologists, social workers, and experts in mass communication, philosophy, and semantics. GAP envisions a continuing program of work according to the following aims:

1. To collect and appraise significant data in the field of psychiatry, mental health, and human relations;
2. To re-evaluate old concepts and to develop and test new ones;
3. To apply the knowledge thus obtained for the promotion of mental health in good human relations.

GAP is an independent group and its reports represent the composite findings and opinions of its members only, guided by its many consultants.

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In 1947 the Committee on Psychiatry and the Law (then known as the Committee on Forensic Psychiatry) selected the subject of this report for its first effort. Published in 1948 as a four-page folder under the title COMMITMENT PROCEDURES (GAP Report No. 4), over 14,000 copies of that brief but useful report were distributed.

In reviewing the 1948 report we were impressed by the progress that has been made during the eighteen intervening years. We refer not only to progress in the form of new and improved legislation but also to progress in the form of new and improved ways in which psychiatrists and lawyers have been viewing this age-old problem.

The authors of GAP Report No. 4 expressed the hope that it would "receive the attention of lawmakers, interested groups of citizens concerned with the improvement of their own state law, as well as of psychiatrists..." To some extent their hope has been realized. In fact, there has been such a ferment of activity in this area that we can mention here only a few of the major achievements.

In 1949, one year after publication of that report, the U.S. Public Health Service began work on A DRAFT ACT GOVERNING HOSPITALIZATION OF THE MENTALLY ILL. After long consultation with numerous experts in the field of psychiatry and the law, this document was finally published in 1952. In 1961 the American Bar Foundation published a comprehensive volume, THE MENTALLY DISABLED AND THE LAW, which was the culmination of six years of concerted effort. In New York State, a thorough revision of the statutes governing the admission of patients to mental hospitals was completed in 1964. This act promises to eradicate many of the evils of preexisting statutes and makes many laudable innovations. The State of Illinois adopted a new MENTAL HEALTH CODE with similar provisions, which became effective on July 1, 1964. The Subcommittee on Constitutional Rights of the Committee on the Judiciary of the U.S. Senate began work in 1961 on a bill (S935) "to protect the Constitutional rights of certain individuals who are mentally ill, to provide for their care, treatment and hospitalization and for other purposes." After extensive testimony and several revisions, this bill, which incorporates many of the best features of the Draft Act and the American Bar Foundation's recommendations, was finally enacted into law in 1964. This law (PL 88-597) applies only to citizens of the District of Columbia but will hopefully serve as a model for other states.

Although this report draws its inspiration from GAP Report No. 4, it represents a complete reworking of the original material based on new developments in psychiatry and law that have taken place during the intervening years. In this new version, as in the 1948 report, we have tried to present the basic issues in brief and succinct form. It is hoped that this report will be of use to psychiatrists and other professionals who seek a progressive orientation to the problems involved in the hospitalization of psychiatric patients.

INTRODUCTION

Every physician, as well as every psychiatrist, should be informed about and concerned with the laws and procedures that govern hospitalization of the mentally ill in his jurisdiction. Sooner or later, and regardless of his personal inclinations, situations inevitably arise that will require his knowledge of such laws. To claim ignorance of these matters or to bow out at such times is to shirk his professional responsibility to his patient. Ignorance may also lead to the selection of inappropriate procedures for hospitalizing patients that can impede or prolong treatment. When this occurs, it is particularly regrettable because the treating physician is often in the most strategic position to recommend hospitalization and to have his recommendations accepted.

The statutes governing hospitalization of the mentally ill have been generally designated as “commitment” laws. Although GAP Report No. 4 recommended that the word commitment be deleted in statutes, this term, curiously enough, was retained in both the title and the body of that report. Psychiatrists have long considered the term commitment an undesirable one. We are fully in accord with this sentiment. Hereafter the term commitment will not be used in this report except in the historical context. It is both ironic and encouraging that it remained for the lawyers to give this obsolete term a vigorous body blow. In their chapter, “Voluntary Hospitalization,” the authors of the American Bar Foundation report have this to say: “Since this term connotes an order employed in criminal proceedings, as well as in the confinement

of noncriminal mentally disabled persons, it has been replaced in more recent statutes by the less offensive term ‘hospitalization.’” Although change in terminology alone will not automatically correct the attitudes of the past, emphasis on hospitalization and treatment can only have a salutary effect.

Despite some progress, many undesirable features of hospitalization procedure still prevail in many states. Because each state has its own statutes governing the mentally ill and because these vary widely from state to state, the mere collection of data is a formidable task. This report will not present the laws or even the main provisions of the laws in each of the 50 states, since they are available elsewhere.* Nor will this report address itself to the admission of patients on the basis of court orders involving criminal charges. Instead, we shall make some general and specific recommendations for changes that should be included in any future legislation governing hospitalization of the mentally ill.

From the historical standpoint, “commitment” in the early statutes was limited primarily to the dangerously insane. The procedures of the criminal trial were followed in dealing with these persons. This tended to attach to them the stigma of criminality. As Flaschner has pointed out, “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.”†

The use of the jury in commitment procedures developed in the United States during the latter half of the 19th Century. This was

in part due to the notorious Packard case, tried 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, Mrs. Packard maintained that she had been railroaded into the institution. She obtained the right to a jury trial for every patient already committed in the State of Illinois. This ruling gave impetus to the use of the jury in commitment procedures and helped create an atmosphere of public fear and distrust of mental hospitals that has persisted to this day.

The basic components of enlightened and humanitarian laws governing the involuntary hospitalization of the mentally ill were eloquently stated almost a hundred years ago by Dr. Isaac Ray, one of the truly great American psychiatrists of the 19th Century. He stated them as follows:

In the first place the law should put no hindrance in the way to the prompt use of those instrumentalities which are regarded as most effective in promoting the comfort and restoration of the patient. Secondly, it should spare all unnecessary exposure of private trouble, and all unnecessary conflict with popular prejudices. Thirdly, it should protect individuals from wrongful imprisonment. It would be objection enough to any legal provision that it failed to secure these objects in the closest possible manner.  

It is a noteworthy commentary on human resistance to change that after a hundred years, Dr. Ray's laudable objectives have yet to be realized. It is encouraging to note, however, that recent efforts to achieve these goals are gaining momentum.

In their struggles to modernize and humanize the laws governing hospitalization of the mentally ill, psychiatrists are beginning to get strategic help from the legal profession. For example, Curran had this to say on the subject:

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THE GENERAL HOSPITAL MODEL

Many of the laws governing the admission of patients to mental hospitals have been heavily influenced by criminal law, a singularly inappropriate model in the light of contemporary thinking. A more appropriate and more desirable model, and one which works well in medical practice, is the procedure for admission of patients to the community general hospital.

At present there are approximately 500 psychiatric units in general hospitals in the United States. Most of them admit psychiatric patients on precisely the same basis as that which obtains in medical and surgical cases. Under such circumstances the ordinary doctor-patient relationship applies, with freedom on the part of the patient to enter and freedom to leave even against medical advice. It must be emphasized that the general hospital model can operate only when the patient is adequately prepared for admission and good medical care is available.

We strongly urge the widest possible adoption of this model, not only for psychiatric units of general hospitals but for all types of psychiatric hospitals. If this model were extended to mental hospitals, with acceptance by the community, the legal profession, and the medical profession, particularly psychiatrists, it is estimated that 90 per cent of all patients could be admitted on the basis of medical decisions alone. The remaining 10 per cent might still require hospitalization on a nonvoluntary basis. It is the latter group, however, which raises legal considerations of major importance.

There should be a variety of admission procedures available to permit a choice of the best one for any given situation. These procedures must be graduated in complexity, depending on the nature of the illness. A principal error of the past was that a stereotyped approach was applied to the hospitalization of persons with all types of mental illness. As a result, hospitalization under formal legal procedures was imposed on a large number of patients who did not require such legal restraint(patients who could have received treatment on an informal, voluntary, or nonprotesting basis had the laws permitted."

* For example, St. Elizabeth's Hospital in Washington, D.C. did not provide for the admission of voluntary patients until 1946. Prior to that time all patients had to be committed by law. By 1964, 18 per cent of patients were admitted on a voluntary basis. In September 1964, Public Law 88-597 took effect, which liberalized and modernized admission procedures. By January 1965, only 52 per cent of admissions were committed, while voluntary and nonprotesting patients accounted for 48 per cent of all civil admissions.
PROPOSED PROCEDURES FOR ADMISSION

I. Informal Admission
II. Voluntary Admission
III. Temporary Admission (Variously called Emergency Admission, Nonprotesting Admission, Admission on Certificate of One Physician)
Under optimal conditions it is estimated that approximately 90 per cent of all cases could be admitted under Procedures I, II, and III.

IV. Involuntary Admission (Admission on Certificate of Two Physicians)
Under optimal conditions it is estimated that the remaining 10 per cent of all cases would require Procedure IV.

I. Informal Admission

Many patients can be admitted to a psychiatric facility on precisely the same basis by which they are admitted to a general medical hospital, that is, *without formal or written application*. This is called the informal admission. As in the general hospital, such patients are completely free to leave at any time after admission. In certain circumstances, patients may be requested to sign themselves out “against medical advice.” Even this is not mandatory.

We urge that all states make provision for informal admission of suitable patients who request treatment.*

II. Voluntary Admission

Under this procedure any person may apply for admission to any public or private psychiatric facility for treatment. The application is made *in writing* at the time of admission. The person applying for this type of admission may come to the hospital on the advice of his physician, or he may seek help on the basis of his own decision. In either case the patient is admitted if examination by the admitting physician reveals the need for inpatient treatment.

Statutes governing the voluntary admission of patients to psychiatric facilities should specify the maximum number of days such patients may be detained after giving written notice of intention to leave. This would prevent the impulsive return of sick patients to the community and would give the hospital staff sufficient time to take action where appropriate.

The merits of voluntary admission are self-evident, yet only 15 to 20 per cent of patients in U. S. mental hospitals were admitted on this basis between 1955 and 1955. Although the percentage had grown to 29.9 per cent by 1963, † this is still in striking contrast to the situation in England, where over 80 per cent of mental patients enter on a voluntary basis. The reasons for this great discrepancy appear to be largely administrative, economic, and cultural.

When informal admission is not available or applicable, voluntary admission is the next most desirable procedure. In these circumstances we urge maximum utilization of voluntary admission. ‡

* At present, informal admission is provided *for by statute in a number of states*, e.g., Connecticut, Illinois and New York.
† Special Survey, Office of Biometry, National Institute of Mental Health, U. S. Public Health Service.
‡ At present, all states with the exception of Alabama provide for voluntary admission.
III. Temporary Admission

Many jurisdictions have procedures for admission variously called "nonprotesting admission," "emergency admission," and the like. These categories are used for patients who are (1) so senile or confused that they require hospitalization but are not able to make decisions of their own; or (2) so acutely disturbed that they must be immediately admitted to a psychiatric facility on an emergency basis. Thus, the decision to hospitalize must be made by a person other than the patient. In addition, established procedures must be available for protection of the patient's rights.

To meet these requirements we recommend a procedure for temporary admission. Under this procedure a person may be admitted to the hospital for a stipulated period on the written recommendation of one physician that sets forth a need for such hospitalization. This procedure may apply with equal validity to resisting and nonresisting patients, to confused and disoriented patients, or to unconscious and stuporous patients who are unable to respond. The admission of such a patient must be approved by the hospital staff and will be classed as a Temporary Admission.

Temporary admission should be for a stipulated number of days (for example, 15). Experience has shown that too short a period results in an excessive number of involuntary hospitalizations. This is due to the fact that psychiatric treatment may be required for some time before the patient is well enough for transfer to informal or voluntary admission status.

Within the stipulated period following admission, one of four possible developments must occur:

a. The patient may be discharged,
b. The patient may be transferred to informal admission status,
c. The patient may be transferred to voluntary admission status,

or

d. Procedures for involuntary admission must be initiated.

The four courses listed permit physicians to meet the multitude of variable and ambiguous circumstances in which it is impossible to make immediate and accurate decisions. At the same time it protects the patient's rights without undue legal complexity.

In summary, Temporary Admission should provide for:

1. Admission on the basis of the certificate of one physician, valid for a stipulated number of days of observation in a psychiatric facility.
2. Approval of the admission by the medical director of the hospital.
3. Prompt assistance by trained hospital personnel for protection and transportation by ambulance. When deemed necessary, prompt assistance by the police for protection, control, and transportation.
4. Opportunity for the patient to obtain the services of a physician of his own choice.
5. Prompt discharge of the patient following recovery from the acute symptoms, and when further hospitalization is not desired by the patient or deemed necessary by the medical staff.
6. Opportunity for transfer to informal or voluntary status as soon as medically indicated.
7. Legal protection for the physician who executes a certificate in good faith.

IV. Involuntary Admission

Involuntary hospitalization involves not only the question of mental illness but also the question of dangerousness to self, dangerousness to others, and need for treatment. Determination of these matters is largely a societal function and only in part psychiatric. Traditionally, the societal function has been performed by the courts. We now propose that this function be delegated in part to a Review Board (vide infra). After some experience with such a board it will become clear what role the courts would play in the hospitalization of involuntary patients.
Certification by two physicians is the ideal procedure in cases where involuntary admission for an indefinite period of time is necessary. The decision to use this procedure may be made prior to admission or after the patient has been admitted on another basis. Notarization of the physicians' certificates or their certification by a judge or magistrate should not be required. While ideally this function would be best performed by psychiatrists, any licensed physician should be permitted to make out the certificate.

Certification should be used only when all other methods fail and when there is a clear and present need for indefinite hospitalization. Depriving a person, even temporarily, of his freedom is a serious matter. The certifying physician should therefore record his observations as to the patient's illness and behavior in sufficient detail to justify his recommendation for involuntary hospitalization. Such statements should specify how the patient is dangerous to himself or others and/or why he is in need of treatment. In the event of court review, the sufficiency of the data on the certificate is the sole basis for the judicial determination of the legality of the action taken. Therefore conclusory statements in themselves are not enough. Moreover, specific data are essential to the admitting physician in carrying out his responsibilities.

It goes without saying that there should be an established procedure for written notification to the patient and next of kin whenever involuntary hospitalization is involved. Furthermore, the patient should have free access to legal counsel at any time.

This Committee (like its predecessor in 1948) is opposed to adjudication by a court in cases of involuntary hospitalization except when the patient petitions for a writ of habeas corpus. Such petitions may be filed with the Court only after hospitalization has been effected. If the writ is granted, the patient will be discharged; if not, hospitalization will continue. As a further protection, statutes should also provide for periodic review of cases for all involuntary patients by the independent Review Board.

**OTHER RECOMMENDATIONS AND OBSERVATIONS**

**Provision for Review of Cases**

Anyone who has ever worked on the staff of a large mental hospital, with its overworked personnel and overcrowding, knows that the dominant theme is to get the patient well and discharge him as soon as possible. The idea that innocent people are being "railroaded" into mental hospitals by scheming relatives and then kept there by conniving, power-hungry psychiatrists is a myth that exists largely in the minds of the ignorant, the fearful, and the disturbed.

While there have been instances of patients who have been needlessly hospitalized for long periods of time, such instances have been largely due to inadequate staffing, lack of proper facilities, and public apathy. For this reason it is advisable that all psychiatric facilities, particularly those specializing in long-term treatment, be subject to periodic review of all cases. Such a process might be carried out by a Review Board consisting of psychiatrists, physicians, lawyers, and other citizens not connected with the institution. The mere existence of such a Review Board would do much to provide the patients and the community greater assurance that no person was being forgotten.*

**Transportation of Mentally Ill Patients**

When practicable, transportation to the hospital should be the responsibility of the patient's family, under the guidance of the

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attending physician or psychiatrist. In most cases the private family car is adequate. Use of the police for the transportation of mental patients should be reserved for those instances where the safety of the patient and the public requires it, and specially trained hospital or clinic personnel should be employed for this purpose whenever possible.

When police officers are required, plainclothesmen should be assigned to the task except in emergencies. The standard police wagon (paddy wagon or Black Maria) as a conveyance for mentally ill patients is inexcusable and should not be tolerated. An ambulance or an unmarked car is preferable.

Retention of Mentally Ill Patients in Jails

The practice of retaining mentally ill persons in jail is still relatively widespread. Slovenko and Super\(^\dagger\) estimate that “nearly half of all patients are reaching mental hospitals by way of the police station.” In all but 13 states, laws provide for emergency detention of the mentally ill in hospitals.\(^\ddagger\) However, this provision has been relatively little used.

We condemn the practice of using jails for the retention of the mentally ill and urge legislation to provide psychiatric facilities that would make such a practice unnecessary.

Financial Status of Hospital Patients

In state, municipal, or other public hospitals, the ability of the patient or his family to pay should not be determined at the time of admission. This determination should be made only after admission of the patient, and then only by personnel specially trained in such matters.


\(^\ddagger\) States not providing for emergency detention are: Alabama, Delaware, Georgia, Idaho, Iowa, Kansas, Maryland, Mississippi, Nebraska, Nevada, New Hampshire, Vermont, and Virginia.

Terminology

The term *commitment* should be deleted from all statutes dealing with the mentally ill and the term *hospitalization* substituted. *Insanity* and *lunacy* should be replaced by *mental illness*. The terms *feeble-minded* and *weak-minded* should be abandoned. Similarly the designation *inmate* should be replaced by *patient*. The term *parole* should be deleted in favor of *convalescent status* or *extended visit*. Equally objectionable is the use of words such as *eloped* or *escaped*.

Major Defects in Some Laws Governing Hospitalization of the Mentally Ill

1. Overconcern with trial by jury. In a few states trial by jury is still mandatory; in other states patients are permitted to elect it.
2. Retention of procedures drawn from the criminal trial, which make the mentally ill feel like criminals.
3. Mandatory appearance of the patient in court, his exposure as a public spectacle, and making a public record of the hearing.
4. Combining the need for hospitalization with a finding of legal incompetence.
5. Insistence on determining the patient’s financial status prior to his admission to public psychiatric facilities.
6. Use of anachronistic terminology chiefly derived from criminal law.

Patients’ Rights

All psychiatric patients hospitalized in either public or private institutions should retain the following fundamental rights:

1. The right of communication with persons outside the hospital.
2. The right of visitation by appropriate persons.
3. All civil and political rights guaranteed by law unless specifically revoked by individual incompetency proceedings.
4. The right to good medical and psychiatric treatment.
5. The right to periodic review of status.
6. The right to discharge as soon as medically advisable.

Essential Elements in Laws Governing Hospitalization of the Mentally Ill

All laws governing hospitalization of the mentally ill should embody the following general features:
3. Provisions for Temporary Admission on the basis of certification by one physician.
5. Provisions for safeguarding the constitutional rights of the patient.
7. Minimal legal formalism.
8. Minimal psychic trauma to the patient.
10. Separation of the procedures that determine the need for hospitalization from those required to determine incompetency.
11. Provisions that safeguard the patient's right to good treatment as opposed to simple custody.

The successful achievement of the reforms necessary in mental health legislation can be insured only by the concerted efforts of an enlightened citizenry, the medical profession, and the legal profession. Physicians functioning through their local medical or psychiatric societies can do much to spearhead the movement for reform through constructive collaboration with members of the local Bar, community leaders, and key legislators.
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Mental Health Code, State of Illinois, Department of Mental Health, effective July 1, 1964. (Copies available from: Administrative Services, Department of Mental Health, State of Illinois, 401 Spring Street, Springfield, Illinois.)

Acknowledgments

The program of the Group for the Advancement of Psychiatry, a non-profit tax exempt organization, is made possible largely through the voluntary contributions and efforts of its members. For their financial assistance during the past fiscal year, in helping it to fulfill its aims, GAP is grateful to the following foundations and organizations:

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<td><strong>CHANGING DEMANDS—Oct. 1964</strong></td>
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<td><strong>URBAN AMERICA AND THE PLANNING OF MENTAL</strong></td>
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<td><strong>HEALTH SERVICES (symposium)—Nov. 1964</strong></td>
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<td>59</td>
<td><strong>PSYCHIATRY AND THE AGED: AN INTRODUCTORY APPROACH—Sept. 1965</strong></td>
<td>$1.00</td>
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A complete listing of publications of the Group for the Advancement of Psychiatry may be obtained upon request from the Publications Office.

Bound volumes of Reports and Symposia published since 1947 are also available. They include reports that are now out of print and unavailable in any other form.