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Social Implications of the Commitment Laws Governing the Mentally Ill

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SOCIAL IMPLICATIONS OF THE COMMITMENT LAWS
GOVERNING THE MENTALLY ILL

by

Annie Louise Scruggs

A Thesis Submitted to the Faculty of the School of Social Work of Loyola University in Partial Fulfillment of the Requirement for the Degree of Master of Social Work

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CHAPTER I

INTRODUCTION

This is a study of the social implications in the statutes governing the commitment of the mentally ill to state hospitals. Taking five states, it proposes to examine the expressed or implied social attitudes toward the mentally ill. Do these laws make adequate provision for the basic human rights of individuals, in conformity with the common good of society, or to what degree are they deficient? A comparison of these laws with The Draft Act Governing Hospitalization of the Mentally Ill, will also be made.

The commitment statutes in their entirety deal with several aspects of the commitment problem, such as, custody, maintenance and discharge. Discharge includes parole and after care. The discussion will be limited to commitment, but some attention will be given to parole or trial visit since this is an area in which social work is active. Maintenance will be mentioned briefly. Custody and discharge will not be discussed, since it would tend to take us beyond the scope of this subject.

The legal status of the mentally ill is a complicated technical subject, but one well worth the attention of the student of social work, because it involves basic social values. In addi-
tion, "since the mind and character of a people are more exactly and adequately expressed in and through its laws," an understanding of general attitudes and popular assumptions regarding mental disorders will no doubt be reflected in the statutes of these states. In determining this trend of thought, the proposed model commitment law or Draft Act as released by the federal security agency in 1950 will be used as a criterion.

Although much has been written regarding state commitment laws, most of the literature has dealt with the need for the states in general to modify their laws because of their anti-therapeutic nature. There has been nothing written regarding the major revisions, similarities, and trends in a group of states.

The five states chosen for the study are Illinois, Indiana, Michigan, Wisconsin, and Iowa. They are not being used because of any special contribution they have made in this important aspect of social welfare, but because it is felt that their size and location might reflect similar trends in the country as a whole.

This study will be based on material collected from literary sources, the statutes of the five states and the model commitment law hereafter referred to as the Draft Act.

II

Social Implications:

Public interest in the care and treatment of the mentally ill is at a new high. This interest stems from the emergence of psychiatry as a science. During World Wars one and two, many persons were rejected from the service because of some type of emotional disorder. This brought to the public the awareness of the prevalence of the illness. "Neuropsychiatric disorder was the largest single cause of draft rejections and the cause of forty-one percent of all army medical discharges."2

Dr. George S. Stevenson has noted that some 300,000 citizens are admitted to our mental hospitals each year. In addition to about 600,000 institutionalized cases, it is estimated that at least 8,000,000 of our population suffer from some sort of mental disease. Total loss in earning power amounts to over a billion dollars a year.3

These figures reveal that mental illness is one of the leading factors which adversely affect the social order. It is a prolonged illness, which not only shortens life, but reduces to a minimum the earning capacity of the individual. It gives rise to other social problems, in that it causes dissension in the home,

and general maladjustment in interpersonal relationships.

For the above mentioned reasons the care of the mentally ill has long been a great problem, and created a large burden for society in the event that the patient is hospitalized. And, if the patient becomes a menace, he must be given hospital care or otherwise restrained. What is the responsibility then of the family? What is the responsibility of the state?

The family in hospitalizing the patient does not give up responsibility for him. The hospital is merely a community resource for the use of the family, when the problem can no longer be handled by them.

Mental health administration is primarily a state responsibility, and the legal procedures involved in the commitment of mental patients is, therefore, a subject of state legislation. This factor makes for a lack of uniformity in the commitment statutes. Many of the states fail to resolve the conflict between the rights of the community to protection from the acts of the mentally ill person, and his right to be given suitable treatment and to be protected against wrongful and improper commitment procedures.

Commitment Problems:

The problems with which commitment laws have to deal are due to the nature of the disease itself. The Physically sick

patient is usually amenable to professional advice, since his orientation and understanding have not been principally affected. In addition he also has symptoms which are recognized by himself and others. The opposite is true with the mentally ill. He usually has no physical symptoms. If he realizes he is ill, he is unable to make decisions necessary for treatment. Therefore state statutes provide that the patient may have to be detained against his will. It would seem therefore that medical personnel would handle the procedure.

The commitment procedures have been handled traditionally by the courts with proceedings similar to criminal cases. The practice of arresting the patient, detaining him in jail and trying him in court, is rightly criticized because of the adverse effect it has on the patient.

In addition, this practice causes many patients to put off treatment until they are beyond help. The patient's family also suffers from the stigma attached to mental illness, which may be heightened when affairs are aired in court.

At this point it may be well to ask what the purpose of legal requirements for admission to a mental hospital is. "The total reaction may be summed up in the guarantee in the constitution that no person shall be deprived of life, liberty, or prosperity without due process of law." Along with this is public sentiment.

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5 Kempf, Laws Pertaining to the Admission of Patients, 2.
regarding the possibility of a well person being committed, and the public feeling that only the court can deprive a person of his liberty.

Progress has been slow in the general public's understanding of the problems of the mentally ill. While this understanding was lacking these individuals have been kept in work houses, almshouses and dungeons. The first public insane asylum in the United States came into existence during the eighteenth century. The nineteenth century brought the enactment of statutory procedure for the admission of mental patients.

History and Background:

There have always been persons who have suffered from some sort of mental illness. The highest incidence of mental breakdown is occurring now due to the impact of modern social living.

The right to restrain a mentally ill person against his will is based on common-law, and was practiced among the American Colonies, whenever confinement was necessary to protect the community. The principle consideration was that the patient was dangerous to be at large. The well to do patient was, for the most part, cared for in his own home. Since the patients were considered to be under evil influences the families did much to keep them from being seen in the community. If the families were unable to care for them the harmless roamed around the country. The dangerous were kept in the local jails chained in pens, locked in strong rooms or any secure place. Statutes were enacted only with refer-
ence to the estate of the insane with property. There was no concern for the well-being of these individuals.

As was the common-law, early state statutes were concerned with the violent and dangerously insane. They were not thought of as ill people, but rather as criminals and were treated as such.

One of the first signs of public interest in mental illness as a disease was in 1827. New York State enacted a statute forbidding the detention of the mentally ill in jail. Therapeutic reasons for restraint were more specifically spelled out in 1845 when Chief Justice Shaw interpreted the common law more broadly. He held that:

"The right to restrain an insane person of his liberty is found in that great law of humanity which makes it necessary to confine those who going at large would be dangerous to themselves or others -- - The question must then arise in each particular case whether a patient's own safety or that of others requires that he should be restrained for a certain period, and whether restraint is necessary for his restoration or will be conducive thereto--"6

Existing commitment legislation is in a state of flux at the present time. Many lawmakers are interested in the problems of the mentally ill, which is an indication of the public's awareness as a whole. Recently psychiatrists have been asked to advise legislators about proposed changes in commitment laws. In this connection the Federal Security Agency in 1950 released the proposed draft of a model certification law. "The Draft Act seeks to provide maximum

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opportunity for prompt medical care, protection against emotionally harmful experiences, protection against unwarranted confinement. In short, the act emphasizes the fact that hospitalization is a medical matter, to be obtained promptly and easily when needed, and the role of the court is to insure against unwarranted deprivation of personal liberty."

To learn what happens in the relationship between the committing authorities and the persons responsible for securing action in the care of the mental patients, the statutes of the five states and the draft act have been summarized under two broad headings, judicial and non-judicial commitment. Material in relation to these headings have been extracted, and will include the following: 1. The petition and who can initiate it; 2. the nature of the hearing; 3. the notice; 4. jury trial; 5. detention; 6. right of appeal; 7. temporary observational commitment; 8. voluntary commitment; 9. transfer of the patient to the hospital; 10. maintenance; 11. terminology and trial visit.

7 American Journal of Psychiatry: Commitment of the Mentally Ill, 712.
CHAPTER II.

JUDICIAL COMMITMENT

Formal involuntary commitment is the original and basic proceeding of the commitment process. It had its origin in antiquity where there was a lack of recognition that mental disease was an illness. Thus, the state statutes provide a picture of social attitudes toward mental disorders that reflects earlier periods as well as the present day.

Progress has been slow in the general public's understanding of the problems of the mentally ill, but indeed there has been progress. As over against the past, current procedures for commitment have for their purposes the detention of the patient in an institution; for the purpose of protecting the community from harmful conduct, and to protect the patient from his own conduct.

The state statutes involving this aspect of hospitalization of the mentally ill vary greatly. In their entirety however, the statutes deal with two types of commitment; judicial or involuntary formal commitment, and non-judicial or voluntary commitment.

Involuntary commitment which all five of these states have developed in one form or the other is defined as "a final order of commitment to a hospital for the mentally ill for an indefinite
period of time."¹

Since the patient's civil rights must be protected, and since this is an act of the court, the procedure includes certain legal elements. These elements are petition, notice, an opportunity to be heard and to defend in the proceedings. The law also provides a right to appeal. The following discussion will deal with these elements as they are used in the states selected for study.

**Petition**

In Illinois the petition may be initiated by any reputable citizen of the state in the county where the patient is found.² Indiana statutes also make this provision³ but a statement by a reputable physician must accompany the petition. In Michigan the complaint must be made by some one of intimate relationship to the patient, such as father, mother, wife, husband or siblings.⁴ Wisconsin holds that application must be made by at least three adult residents of the state, one of whom must be a person with whom the patient resides.⁵ In Iowa an application for commitment may be made on behalf of a person by his attending physician, experienced in the treatment of mental diseases.⁶ The draft act recommends

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¹ The Mental Health Programs of the 48 States, 5.
² Illinois Revised Statutes 1953 Sec. 91 1/2.
³ Burns, Indiana Annotated Statutes V Sec. 22-1203, 775.
⁴ Laws of Michigan Sec. 649.
⁵ Wisconsin Sec. 5101, 799.
⁶ Code of Iowa 1950 Sec. 271-56, 229.
that applications be filed by a friend, relative, spouse or guardian. 7

It will be noted that the draft act as well as the state statutes specify who can file the application. It is significant that most of the states stipulate that someone of intimate relationship file the application, and therefore one can assume that the law has taken into consideration the welfare of the patient. Inherent in this concept is the meaning of the family to the patient, that they are concerned about him and commitment is possibly a last resort.

Indiana and Illinois which provide that any one can file are reflecting the legal viewpoint, that protection of the community is of primary importance. The practical aspect of this ruling cannot be overlooked however, as it takes into consideration the fact that the patient may not have relatives, the social and economic status in which he is found, as well as the degree of his emotional imbalance.

Certification

The states also make provisions for certification of the medical examiners of the mentally ill. In all of the five states the qualifications of the physicians or the members of the board of commissioners are spelled out in the law. The statutes differ naturally from state to state, which might indicate the availability

7 A Draft Act Governing Hospitalization of the Mentally Ill, 8.
of psychiatric resources in these states. In three of these states the physicians are characterized by the term "reputable."

Wisconsin requires that the judge appoint two duly licensed reputable physicians to personally examine the patient. One of whom if available must have had two years of practice in his profession, or one year of practice in a hospital for the mentally ill. Neither of these physicians may be related to the patient by blood or marriage or have interest in his property.8

In Iowa the physician must be a reputable practicing physician, and a member of the Lunacy board, which is composed of the clerk of the district, the physician and an attorney.9 The state of Michigan requires that the two physicians be reputable.10 And Illinois merely requires that the physician be licensed, and unrelated to the patient.11

In Indiana the law stipulates that the judge shall appoint two medical examiners, who are in no way related to the patient. The physician who examines the patient for purposes of the petition cannot be one of these physicians. Indiana law also states that the physicians make their examinations separately, and send in the forms separately.12 The draft act states that the physician be

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8 Conway, Wisconsin Statutes 1951, Sec. 51.01, 799.
9 Iowa Code Annotated Sec. 229 Vol. II.
10 Laws of Michigan 1949, Sec. 646.
11 Illinois Revised Statutes Chap. 91½ Sec. 5-6, 112.
12 Burns Annotated Indiana Statutes 1950 V part 2 Sec 22-
licensed only. The act further recommends that the examination of
the patient himself be held at a place not likely to have harmful
effects on the patient's condition. The examination should be held
in the individual's home or in a medical facility. Since this
section is not spelled out in the laws of the five states, it is
felt that they follow this general procedure. Illinois has the
Cook County Psychopathic Hospital at its disposal for this purpose.

Certification of physicians by the states is required in
order to reduce the possibility of frivolous or malicious appli-
cations. This idea is further carried out by the stipulation that
the physician may not be related to the patient, or have an interest
in his property. Indiana goes a step further in its attempt to
protect the patient, in that it attempts to guard against collabora-
tion on the part of the physicians.

Hearing

The hearing represents the patient's constitutional right
to present his defense. According to Davidson this is the point
where the patient is definitely declared committable to a mental
hospital. All five of the states expressly recognize the right of
the patient to a hearing. In Illinois, Iowa, and Michigan

13 A Draft Act, 27.
14 Illinois Revised Statutes Sec 53, 226.
The patient's presence is required at the hearing. The statutes provide however, that the patient need not appear if there is a possibility of harming him. The danger to the patient must be verified by one or more physicians. Indiana also has this provision but elaborates with reference to the purpose of it. The act is not to create a court procedure in the matter of determining whether a person should be sent to a hospital for treatment, but to create a special hearing to determine the necessity of such treatment.17

In Wisconsin the presence of the patient at the hearing might be dispensed with if the judge or court is satisfied as to his illness.18 The Draft Act provides that the patient shall not be required to be present at the hearing, and all persons not necessary for the conduct of the proceedings shall be excluded.19

Much of this portion of the commitment statute fails to protect and guarantee the patient's constitutional rights, and has been tested in court on several occasions. In Iowa the patient has the right of appeal to the district court if he is found to be insane without his presence.

The states being studied generally carry the recommendations of the draft act in this portion of the commitment proceedings. The act stipulates that "this section have provisions to

17 In Re Mast, 217 Indiana 28; 25 N.E. (20) 1003.
18 Wisconsin Statutes 1951, Sec. 51.03.
19 A Draft Act, 9.
assure full and fair considerations of all relevant data so that the question of the proposed patient's hospitalization may be considered in the light of his total situation."20 Basic in this consideration is the patient's right to participate in the hearing, and if he chooses to exercise it, the court is under a legal obligation to give him the opportunity to do so. In an instance where the patient is too ill to appear, his basic constitutional right of an opportunity to appear and be heard is provided for.

**Notice**

The notice is a part of the commitment procedure having to do with due process of law. The purpose of the notice is to enable the mentally ill person to appear at the hearing prepared to protect such of his interests, as might be affected by the proceedings. As this is generally looked upon as a protection of civil rights all five of the states serve notice on the patient. The draft act provides that if it is injurious to the individual to be notified that an application has been filed, then, it may be omitted.21

In Illinois reasonable notice of the time and place where the hearing will be held must be served upon the patient. The law does not expressly state what constitutes reasonable notice, but it must exceed one day, as indicated by judicial opinion.22

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20 *A Draft Act*, 27.
gan's statutes provide that the patient be personally served at least twenty-four hours before the hearing. An attorney may receive the notice if it will be harmful to the patient. Wisconsin will not serve notice if it will be injurious to the patient or without advantage. Indiana does not have as lenient a procedure as this. It is rather threatening in that it states that the judge shall order and direct the sheriff of the county or some other suitable person to notify the person who is alleged to be insane. Iowa also makes this provision by court decision that the patient will not be served due to the harmful implications in this procedure.

It is felt by some that this feature of the commitment statute should be omitted, as it can have a very adverse effect on the patient. There is always the danger that a notice might be served on a very depressed patient, which might result in an attempted suicide. In addition, the patient could come to considerable harm trying to escape the unpleasant situation. As previously pointed out, the notice is an effort on the part of the states to protect the civil rights of the patient. However, due process does not provide that the individual be personally served. Therefore,

24 Wisconsin Statutes 1951, Sec. 51.02.
25 Burns Annotated Indiana Statutes Sec. 22-1205, 775.
26 Hiatt v. Soucek 1949, 240 Iowa 300.
in recognition of medical rights as well as legal rights the actual serving of notice on the patient should be done away with.

Trial by Jury

Medical personnel is very critical of jury trials in the commitment of the mentally ill. The jury trial is a formal proceeding held in an open court, and the patient is confronted by witnesses. Because of the stigma attached to mental illness, patients as well as their families are reluctant to air the condition in open court, which results in postponement of hospitalization.

The five states have given some recognition to this problem, and no longer have jury trials as a mandatory procedure. Illinois used jury trials in every commitment procedure for twenty-five years, and then abandoned them, because it was found that jury trials were no safeguard against "railroading."

In Illinois, Wisconsin, and Michigan the statutes require a jury trial when demanded by the allegedly mentally ill person, a relative or friend. A jury trial may also be had if the judge believes this to be necessary. In Iowa the judge commits or refuses on the recommendation of a commission or the commission decides. In the Indiana statutes as well as the draft act, there

27 Illinois Revised Statutes 1953 Sec 91 1/2 Ch. 5-4, 227.
28 Conway Wisconsin Statutes 1951 Sec. 91.03, 800.
30 Iowa Annotated Code Ch. 229, 267.
is no mention of jury trials.

The trial by jury of a mentally ill person is an outgrowth of the personal liberty bill, which originated in Illinois to safeguard the individual from unjust confinement. But the law did not serve the purpose it was designed to meet. It had more harmful effects than good. Reports from institutions found that more persons were wrongfully hospitalized under this system than the previous one. "Moreover the effect upon the patient was frequently detrimental arousing in his mind the idea that the court proceedings were for the purpose of substantiating some charge against him, and when found insane he believed himself innocently condemned." 31

It can be seen that this is a particularly hazardous and undesirable feature of the commitment process. However, the jury trial is no longer in vogue. In the states where it is employed, it is assumed that this is the lawmaker's attempt to individualize the patients by granting a trial only upon their request. These states seek further to protect the patient by permitting a jury trial at the discretion of the judge.

Detention

Frequently there is a period between the time of the filing of the original petition, and the determination of the patient's condition. If the patient is in custody, care must be

31 Deutsch, Albert The Mentally Ill in America, 426.
provided, sometimes for a considerable length of time. In three of
the states patients may be detained in jail, but only under certain
circumstances. Iowa, Michigan, and Wisconsin provide that
the patient may not be kept in jail unless he is extremely violent.
The draft act allows this only in extreme emergencies. Further,
Indiana provides that the patient be made comfortable at the expense
of the state if it cannot be provided otherwise. A patient may
be detained in jail in Illinois under any circumstances.

There is strong evidence of criminal procedure connected
with the detention of the mentally ill, prior to the determining
of his status. Iowa justifies this on the basis that the right to
restrain an insane person is not governed by the law which provides
that no one shall be deprived of life, liberty or property without
due process of law. Restraint under such conditions does not offend
against the constitutional inhibition.

The states, in setting up the criterion that the dangerous
nature of the patient's behavior only warrants detention in
jail, have shown progress. They reject the early thinking, wherein

32 Iowa Annotated Code Sec. 229.1, 2517.
33 Michigan Annotated Statutes, Ch. 127, Sec. 14.811, 291.
34 Wisconsin Statutes, Sec. 51.05, 801
35 A Draft Act, 11.
36 Indiana Annotated Statutes 1950, Sec. 22.1211, 778.
37 Maxwell v. Maxwell, 192 189 Iowa 7, 177 N.W.
it was held, that the criterion for commitment was the dangerous nature of his disease alone. Iowa, on the other hand, continue to reflect the thinking of the common law doctrine, and infers that as a class the mentally ill do not have the same rights as others. It is this type of attitude which tends to perpetuate the brand of criminality attached to mental illness, and permits the detention of these sick people in jail. Much unnecessary suffering is created for the patient in this practice, and it should be abandoned in favor of more humane treatment.

Right of Appeal

It is said that the right of appeal is an essential feature of due process of law. However, three of the states as well as the draft act make no mention of this. Iowa has spelled out that the individual has a right of appeal to the district court.\textsuperscript{38} Illinois also expressly grants this right.\textsuperscript{39}

This procedure is concerned necessarily with the fact that the patient might not have been provided with the opportunity to appear and defend himself. If this is not done in the first place - that is, if the patient is committed without the notice and hearing - according to some, this does not make the commitment valid. If the state statutes provide for a writ of habeas corpus, or the right of appeal, the patient may petition to be heard within a

\textsuperscript{38} Iowa Code Annotated Sec. 229.17, 275.

\textsuperscript{39} Illinois Revised Statutes, Sec. 5-3, 112.
reasonable time after commitment. With this provision it is claimed that the patient's rights have not been violated. Court action and legal interpretation have apparently made this practice valid. Many individuals share the opinion that less formalized commitment proceedings than those which embrace the right of appeal would do away with this questionable aspect of the commitment laws.

Temporary Observational Commitment

Because of the possibility of error involved, and the threat to the individual's freedom, it is found necessary to have an investigation prior to the hearing, which in three of these states takes the form of a placement for observation. This is a device for the diagnostic screening of the mentally ill persons. It is a court procedure, with the proceedings conducted exactly like the involuntary commitment. The difference being, that the judge specifies a limited period of time. The time varies from ten to ninety days.

In Illinois the patient may be held for observation for not more than ten days. In Michigan the period is thirty days. This is also true in Wisconsin. There is no provision for temporary observational commitment in Iowa or Indiana. The draft act

40 The Mental Health Programs of the 48 States, 52.
41 Illinois Revised Statutes, Sec. 5-3, 112.
43 Wisconsin Statutes, Sec. 51.04, 801.
makes no reference to this procedure as such.

Illinois will effect such a placement with or without a court order. While in Wisconsin and Michigan a court order is required.

Temporary observational commitment is regarded as therapeutic, because it is not concerned with an emergency commitment making confinement necessary for the protection of the community. It also does away with the stigma of a long indefinite confinement. Cooperation by the patient and his family tends to be elicited, thus making for early diagnosis and treatment. Therefore, under temporary observational commitment, a large number of patients can be sufficiently improved to recommend their release in a short period of time.

Summary

The introduction of the temporary commitment statutes added an important advance in the care and treatment of the mentally ill. Such laws provide that in certain cases where prompt treatment is necessary, the patient may be admitted for a limited period, without going through the complete legal procedures ordinarily required. Today in many instances persons thought to be mentally ill are sent to hospitals for observation. This period is usually limited to thirty days to determine their mental condition before final commitment is made. In this way temporary observational commitment tends to express in legal form the modern conceptions of mental illness, without endangering the liberty of the patient.
They also point up the patient's cause as a patient. This procedure has saved large numbers of mentally ill persons from the stigma of being declared legally insane. It helps to avoid the need for confining the patients in jails while waiting for the court to act.
CHAPTER III

NON-JUDICIAL COMMITMENT

Formalized commitment procedures entail much delay in getting the patient in the hospital. This delay can be instrumental in aggravating the patient's illness, and, as mentioned elsewhere, cause humiliation to the patient's family.

"One of the most perplexing problems in the historical development of the care and treatment of the mentally ill has been to find ways and means of reducing to a minimum the judicial process of commitment without infringing on the constitutional safeguard against deprivation of personal liberty without due process of law."1

The past few years have seen the rise of several features of the commitment laws in an effort to solve this problem. While groping for a solution, it is interesting to note the manner in which the commitment laws have swung back and forth. When the commitment laws were first enacted, the patient could be institutionalized with ease. There was little legal formality, and in many cases none at all. Then because of propaganda regarding improper commitment, the laws took a turn in the opposite direction. It became very difficult to commit an individual to a mental institution.

In the latter part of the nineteenth century, the states

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1 Deutsch, The Mentally Ill in America, 430.
took a more middle-of-the-road stand. They continued their fight against improper commitment, but amended laws which made it less difficult to enter the hospital which in turn, served to encourage prompt care and treatment. These amendments set a non-judicial procedure for entering the hospital.

The non-judicial procedure contains two features, namely, voluntary commitment, and emergency commitment. These two processes will be discussed in order of importance. The discussion will be in terms of who initiates the proceedings, what are the requirements, what are the merits of this type of hospitalization and what problems if any are introduced in this feature of the commitment laws.

Voluntary Admission

Provisions for voluntary self-commitment is a recent feature of state legislatures. It is defined as the "admission of a patient to a mental hospital upon his written request to the hospital superintendent, who may accept or reject the patient after examination."² It is a method which provides for an admission rather than a commitment. The voluntary admission code gives recognition of a more modern conception of mental illness, taking into consideration the right to self determination of the patient. It realizes that there are ill persons in the community, who are able to recognize that they are ill and in need of treatment. Voluntary hospitalization affords an opportunity for treatment on

² The Mental Health Program of the 48 States, 38.
on the same basis as other types of illnesses.

The draft act as well as the five states provide for voluntary admission in their statutes. The act requires that an adult be admitted upon his own application to the head of the hospital.\textsuperscript{3}

Iowa stipulates that any citizen of the state may make application for diagnostic observation, examination and treatment. The applicant must agree to give a three day notice in writing before demanding discharge.\textsuperscript{4}

Indiana's statutes provide that the application shall be accompanied by a statement of two reputable practicing physicians, residents of the applicant's county, containing a full history of the symptoms of his disease.\textsuperscript{5}

Illinois specifies that an individual can be admitted to the hospital if in the judgment of the superintendent such a person is a proper subject for admission. He must agree to give the hospital a notice fifteen days prior to his intention to leave.\textsuperscript{6}

Michigan states that the superintendent must receive any resident of the state desirous of entering an institution, whose mental condition renders him competent to make this decision. Three

\textsuperscript{3} A Draft Act, 20.

\textsuperscript{4} Code of Iowa 1950 Sec. 229.41.

\textsuperscript{5} Indiana Annotated Statute Ch. 13 Sec. 22-1301.

\textsuperscript{6} Illinois Annotated Statutes.
days notice must be given by the patient of his intention to leave the hospital.

Wisconsin provides that any adult resident can make application submitting along with it a doctor's certificate. He must give five days written notice before leaving.

An important feature of the practice of voluntary admission is the provision that a patient may not be held against his will, more than the period of time specified in the statute. If the superintendent of the hospital, however, is of the opinion that the patient should remain for further treatment, some form of involuntary proceedings must be instituted.

Voluntary commitment is seen as a forward movement in the care of the mentally ill. The patient's worth and dignity as an individual is maintained in that he has freedom to make a choice. In this way the family respect is also maintained. The patient's self respect is therapeutic in itself. He feels that he was ill, he went into the hospital on his own; and that he did not need to be put into an institution by society.

Deutsch lists other beneficial results of voluntary commitment; as follows: (1) They emphasize the patient's cause as a patient; (2) They afford protection to the family and community against the acts of the patient; (3) They obviate in a large number

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7 Laws of Michigan.

8 Wisconsin Statutes Sec. 51.10, 805.
of cases the delays; legal exactions, and semi-publicity having been declared insane; (4) And finally, they remove the hospitals from the isolation they have suffered in the community and make it possible for them to take their places as a more integral part of the social fabric.\textsuperscript{9}

In this type of commitment certain legal snags are encountered. The patient's competence to sign his own application is questionable. In order to offset this Illinois statutes provide that all committed persons be designated either as mentally ill or in need of mental treatment.\textsuperscript{10} The former classification carries with it a deprivation of civil rights, the latter does not.

"This represents the only statutory attempt to force a separate decision on every patient's legal status at the commitment proceedings, and the excellence of the procedure is reflected only by the confusing use of the terms mentally ill, and in need of mental treatment to convey incompetency.\textsuperscript{11}

The statutes also deal with the question of the patient's ability to pay for the cost of his institutional care and support his natural dependents.

Emergency Commitment

Distinct from the regular formal commitment is the emergency or temporary commitment. It has been observed that involuntary commitment is instituted by strict requirements set up in the

\textsuperscript{9} Deutsch, \textit{The Mentally Ill in America}, 432.

\textsuperscript{10} Smith-Hurd, \textit{Illinois Annotated Statutes}, Ch. 91\textsuperscript{1/2}, Sec. 4-1.

\textsuperscript{11} Smith-Hurd, \textit{Illinois Annotated Statutes}. 
statutes. Yet there are times when the illness is sudden and a need for hospitalization is urgent. The emergency commitment is a sort of streamlined procedure. It provides that mentally ill persons may be admitted to hospitals for a limited period without going through the complete legal procedure.

Emergency commitment like voluntary commitment is a new movement. The draft act and only three of the states being studied have this type of commitment. It is a procedure which may be put in operation by (1) the certificate of a health officer or, (2) by the certificate of one physician without a court order.

The health officer or police officer upon taking the patient into custody, must give the circumstances under which the person was taken into custody, and submit evidence that because of his illness was likely to injure himself and others if allowed to remain at liberty. The draft act states "that the patient's admission solely on the application of a police or health officer is on a strictly provisional basis. It is authorized purely as a safety measure where circumstances make it impossible to delay action."\(^{12}\)

In the second procedure the basic element is the written application for admission and the medical certification by two trained "designated" examiners. The application can be made by a friend, relative, spouse, or guardian of the individual. This provision is readily available if the patient is not able to apply for voluntary admission himself. A medical certification under this act will be effective as authority for the admission to the hospital, if the patient certified is presented within fifteen

\(^{12}\) A Draft Act, 25.
days after the date of the examination. Nevertheless, the hospitalization cannot be legally compelled unless the doctors state that there is an element of danger present. The basic consideration here is that the "important medical judgment at the root of a hospitalization procedure should be made by persons who have acquired a certain expertness in the diagnosis of mental illness."13

In case of critical situations the third type of commitment can be put into effect. A licensed physician states in the certificate that the individual is mentally ill and because of his illness is likely to injure himself and others, if not immediately restrained. This procedure is used when it is impossible to meet the requirements of the previously mentioned types of commitment.

The draft act specifically recommends emergency commitment as a more humane means of meeting the needs of the dangerously ill. It is significant to observe that only two of the states have emergency commitment as part of their statutes.

In Illinois emergency commitment may be effected upon the filing of a petition, and the certificate of a duly qualified physician. The patient may not be held more than fifteen days.

Michigan provides that a person believed to be insane, against whom no commitment proceedings have been instituted, may be hospitalized on the authorization of a judge, justice of the peace, or police justice based upon the certificate of two physi-

clans. Detention cannot exceed five days.

The remarkable feature of emergency commitment is that medical certification is sufficient to commit the patient for a short period of time. This is done primarily for the protection of the patient and the community. Emergency commitment does not depend on whether the patient should be confined and given treatment; but on the basis of the urgency of the situation.

Transfer to the Hospital

Under either type of commitment the moment eventually arrives when the patient is transferred to the hospital. He or she remains in therapeutic confinement for the specified period of time. This aspect of the proceeding also differs from state to state.

The draft act states that whenever an individual is about to be hospitalized under the provisions of section 6, 7, 8, or 9 the local health authority, shall, upon the request of a person having a proper interest in the individual's hospitalization, arrange for the individual's transportation to the hospital with suitable medical or nursing attendants and by such means as may be suitable for his medical condition. Whenever practicable, the individual to be hospitalized shall be permitted to be accompanied by one or more of his friends or relatives.14

In Illinois and Indiana the patient is accompanied by the sheriff or some other local official. Often preference of transporting the patient to the hospital is given to the relatives or friends.

In Michigan the judge or the administrative officials of

14 A Draft Act, 11.
the county are to make provision for the transfer, but no definite person is named as the responsible companion for the patient.

With reference to female patients Indiana law states that she must be accompanied by a female attendant. If a male attendant is designated by the judge, some suitable female shall go along.

Illinois goes a step further and states that in no case shall a female be transported without husband, father, brother, son or by some woman of mature judgment and character.

Though the other states do not mention this as a part of the law per se, it is assumed that the above procedure is generally followed.

Maintenance

Another facet of the statutes is the recognition of family responsibility in the maintenance of the mentally ill. Because of the court's activity in committing the patient, because of the location of the hospital, many families prefer to forget the patient. Yet the patients must be cared for, and maintenance of them is expensive. As a result, all of the states require a contribution from the patient or legally responsible relatives. The amount is determined by the resources available to the patient or his family. This cost varies from five dollars to actual cost.

Until recently Illinois was the only state that did not require a contribution from relatives. The Draft Act does not take up this subject.
Terminology

Apparently the legislators agree that a change in terms when referring to the mentally ill is desirable. In order to do away with legal technicalities which might arise in regard to those already committed, the draft act recommends a definition of terms when referring to those who are to be committed under current statutes.

Illinois, Wisconsin and Michigan follow through on this recommendation and define their terms also. In this connection it was especially observed that the Wisconsin statute refers to the individual as the patient.

The draft act makes mention of the hospitalization of the mentally ill rather than the commitment of the mentally ill. Illinois and Wisconsin refer in their statutes "to committing the mentally ill," while Iowa, Indiana and Michigan refer in their statutes to "the commitment of insane person."

It would be reasonable to assume that the states which have changed the wording of their laws to that which is more in keeping with the trend of the times, have recognized the true nature of mental disease. In addition they are willing to strip the mentally ill of the stigma attached to insanity. With the draft act as a model it is hoped that the modernization of terminology will increase.

Trial Visit

Parole, sometimes referred to as trial visit, is of
special interest to the social worker, for herein lies her great contribution to these patients. It was noted that Michigan, Wisconsin and Indiana were the only states to expressly mention this in their statutes. However, one author states that boarding out patients is in practice throughout the United States. In the care of the mentally ill the trial visit is not used to threaten the patient into good behavior, but is rather a means of helping the patient leave the hospital environs. It is a gradual return to the community. Trial visit takes the form of a placement in the patient's own home, or in a boarding home under the supervision of a social worker. The worker follows up the patient who ordinarily has difficulty in facing the realities of the community and the future. The help by the social worker is related to the patient's total situation. He gives guidance with reference to jobs and financial aid. The family also needs assistance with reality planning, instructions about the patient's illness, and guidance in the use of community resources.

The social worker's greatest resource in helping the patient is the Mental Hygiene Clinics. These clinics are a part of the state's program for providing services to the mentally ill. The clinics are designed to provide out-patient treatment for these individuals, in order to maintain them on the outside of the hospital. The social worker is an established staff member in these clinics. The meaning of the clinic to the patient was well pointed out by Deutsch. He said that many patients find it difficult and
unpleasant to return to the state hospitals at regular intervals, for advice and treatment. It is far more convenient and less irritating to attend a nearby clinic, where they may receive the aid and counsel of a psychiatrist and social workers.

The states have recognized this need to the extent that they now appropriate funds for this purpose. Illinois incorporated in its 1953 bill an appropriation for the training of psychiatric personnel for work in state hospitals and elsewhere. Indiana has this interesting provision: there is to be maintained a free clinic for persons of the district, where examination, advice, and treatment may be given by the hospital medical staff. They are to employ and utilize one or more field workers and visiting nurses in the interest of the prevention of mental diseases, and the after care of patients absent from the hospital.

Trial visit is a way of returning the patient to a self sustaining life in society. It is seen as the only way of his bridging the gap between hospital care and self direction in the community.

Summary

The entrance of the social worker into the scope of state hospital work greatly facilitated the practice of trial visit. At the time of the patient's discharge the social worker helps the family to make the readjustments necessary for the patient's return to the home. He also assists the patient in his planning for discharge and return to the community. If it is impossible for the
patient to return home, care in a foster home may be arranged. The social worker is in constant contact with the patient through visits at his home or his place of employment, to observe the degree of his rehabilitation in a community setting, and helps him with advice and with social services such as financial aid and job placement. In many hospitals, the social worker is the key person in the trial visit program. He mobilizes both individual and community resources to assist the patient in his rehabilitation and maintains a continued contact with the patient after his return to the community.
CONCLUSION

In this concluding chapter, the following points will be discussed: 1. The factors in the law which may be considered as being either positive or negative in their effect upon the patient; 2. the purpose of the law and its recognition of the importance of the family; 3. the implications of the terminology in the statutes; and 4. the use of social service and how the states measure up to the draft act.

It would seem that the states which considered more of the problems of the patient, and attempted through legislation to give the patient as nearly as possible the same status as other ill persons have the more positive purpose. Indiana is the most progressive of the states in this area, since it spelled out in the statutes the methods of meeting the small but real needs of the patient.

The states had many positive elements in common. The practice of individualizing the patient, especially in the provisions regarding the hearing and notice is good. It is part of the American tradition to give the individual the right to notice and to be heard in legal action. In this consideration Iowa reflects the view of medieval times, rather than the present day interpretations of mental illness.
Another positive feature of the law is the patient's right to self determination. It is seen in the patient's right to choose a jury trial.

The state's ability to recognize the importance of the family in matters of filing the petition, and transporting the patient to the hospital, was also good. In addition the states required that families assume some of the financial responsibility for these individuals.

This requirement is practical in that the states should not be required to perform the duties of the family.

An overall view of the state statutes tends to show that they are not as therapeutic as they should be. It would seem that the law continues to be more concerned with the protection of the community than with the patient. They have therefore been unable to resolve the conflict between the rights of the individual and those of the community. One might argue that the law exists for the promotion of the common good, but as an aspect of the common good; society has an obligation to utilize its forces to protect these individuals, who occupy such a disadvantageous position. The states fail to do this when they permit the patients to be served with warrants, arrested by the police and detained in jail. In short, much of the procedure for committing is outdated, and has all the features of criminal proceedings. This is evident in such terminology as, "commitment", "parole," "petition" and "insane."

These terms have serious implications for one who is ill. Since
Mental illness is an illness the terms for institutionalizing the patient should be changed. Terms such as admission, trial visit and application would be more appropriate. Further, the process of committing a patient is handled entirely by the judge. It would seem that the major portion of this procedure should be the responsibility of the medical profession. Of course, the matter of civil rights, such as, incompetency, property rights and the protection of the community should be left to the courts.

The use of social services in state hospitals greatly facilitates the practice of trial visits. In many instances where these services are not utilized, the patient fails to adjust to the community and has to be returned to the hospital.

By incorporating the use of social services into their statutes, Michigan, Wisconsin and Indiana are far ahead of the other states. Through the laws of these states, a large percentage of the patients in state hospitals comes to the attention of the social service department. The department, in turn, makes available a great deal of help. This help is directed toward enabling the patient and family to meet and handle their total situation as adequately and as smoothly as possible.

In making statutory provisions for the use of social services the three states also recognized the fact that the mentally ill person has more problems adjusting to the community than persons having other types of illnesses. They often have many fears, and are generally misunderstood by those who constitute
their environment.

It is said that trial visit is a practice throughout the United States, but is not a part of the statutes. Illinois and Iowa would do well to make social service a part of their statutes, since what is written is enforceable.

The Draft Act was proposed in order to effect a degree of uniformity in commitment laws throughout the forty-eight states. It was found that the states which revised their statutes at all, merely adopted part of the recommendations. While it is true that a complete adoption of the act might raise a question of the legality of persons already committed, it is a job that can be and should be done. We know that the law is said to be conservative and is said to be based on experience not logic. "But no matter how justified we are in depriving a person of a freedom that we consider basic in a democracy, society, in committing a patient, takes on a clear obligation to make that deprivation an act of good faith." 1

In many instances it was observed that this statement did not apply to the statutes. However, it seems safe to assume that the laws are more humane in their application than in theory, since on a whole human nature tends toward growth. Though the states have fallen short, it would appear that good was intended, and that the present statutes represent the legislator's efforts

1 A Draft Act, 5.
to be fair in dealing with human rights.

This study points up sharply the entirely different attitude the statutes of the five states takes toward mental illness as compared to other types of illnesses. In addition it can be seen that the statutes in part reflect the thinking of a century ago rather than contemporary scientific thinking. But progress was also apparent in the laws. This was evidenced in the recent revisions of some of them. Much remains to be done. Mental disease is increasing at an alarming rate. The rate of incidence will decrease only when the principles of mental hygiene are more widely adopted, and form part of the statutes.
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