Newer developments in community mental health have raised the question of commitment laws and procedures. We are now in a period when new legal enactments and procedures are being advocated. In the following presentation Professor Curran reviews the past and proposes a constructive approach to the future.

COMMUNITY MENTAL HEALTH AND THE COMMITMENT LAWS: A RADICAL NEW APPROACH IS NEEDED

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IT is now exactly 100 years since the publication of Mrs. E. P. W. Packard's first book attacking the commitment laws of the United States.[1] Its publication marked the beginning of Mrs. Packard's national campaign to reform the laws concerning hospitalization of the mentally ill.

Mrs. Packard was a very successful campaigner. She influenced legal changes throughout the United States. Today all of us in every state in the Union live under her legacy. Even though she did not visit every state to deliver her fiery speeches to spellbound legislators, the laws in every state are still basically designed to prevent the wrongs she crusaded against. We still operate under many of the legal procedures she imposed upon us in her efforts to protect against wrongful commitment to the huge, "snake-pit" mental hospitals of her day.

Mrs. Packard sought liberty and justice for persons accused of being mentally ill. Her legislation often bore such titles as "Personal Liberty Bill" or "Bill of Rights for the Mentally Ill." The basic principles of the Packard-influenced laws might be stated as follows:

1. All admissions to mental hospitals should be controlled by law.
2. Any person accused of being mentally ill should have a sworn complaint made against him and should have notice and an opportunity to protest in a court of justice against his confinement.
3. Notice of confinement should also be given to the accused's friends and relatives so that they may protest if the accused cannot.
4. The accused should have a jury trial regarding his sanity or lack of it.
5. It should be a serious criminal offense to engage in a conspiracy wrongfully to commit a person to a mental hospital.

It should be noted that none of these postulates is designed to aid persons actually mentally ill. They are designed to aid the healthy who are accused of being mentally ill or who are wrongfully hospitalized. Occasionally, some humane laws passed in aid of the actually mentally ill are attributed to Mrs. Packard. Most of these, however, were the result of the work of another crusader of the same period, a Massachusetts woman named Dorothea Lynde Dix.[2]

Criminal Law Analogies

It should be clear that the procedural model for these "Packard Laws" was the criminal law system. Here we find the sworn complaints, the jury trials, the open-court hearings, the reciting of charges, and the like. Soon after the enactment of Mrs. Packard's "Liberty Bills," the legislators, the hospital staffs, the courts, and the police got the idea: the nomenclature of the criminal law was adopted to describe the

insane. The "accused" person was "arrested" and brought to trial. He was "committed" and thereafter called an "inmate." If allowed out on a trial visit, it was called "parole." If he left the hospital against medical advice, he was an "escapee" and the police brought him back like any other escaped convict.

Legally, this period might be described as "the romance with the criminal law." The courts were supposed to protect innocent people against wrongful commitment by affording the accused the protection of criminal procedural safeguards. Under these laws, the walls around the mental hospitals were built very high. They were formidable obstacles to prevent healthy people from getting in. Little notice seemed to be taken that they kept people from getting *out* once they got in. All of the commitment laws provided for indefinite confinement. The assumption was that true mental illness is chronic and basically incurable, so why protect the patients legally once they are *legally* confined? Just to insure the fact that the inmates would not rebel, most of their civil rights were taken away from them during their confinement.

Under this legal regime, the state mental hospitals got bigger and bigger and more crowded than ever. It became more and more difficult to get patients into them voluntarily or to get professional staff to work in them under any conditions. Treatment methods declined over the next 50 years or so and the larger institutions became warehouses for the custodial care of the lower-class psychotics of America.

The next period in the legal history of the commitment laws began during or shortly after the Second World War, particularly with the writing of Henry Weihofen[3] who was much influenced in his work by two psychiatrists, Winfred Overholser and Manfred Guttmacher. The view was expressed that the criminal law-like commitment laws were hampering psychiatry in giving good care to the mentally ill. The laws were said to be stigmatizing the mentally ill with terms like "insane," "lunatic," "arrest," "parole," and the like. Jury trials were not helping the mentally ill; they were "traumatizing" them. So was legal notice and an opportunity to be heard. One of the three, Guttmacher, is quoted as late as 1959 as asserting that "there is current psychiatric opinion to the effect that it is possible in certain cases for *notice* to be more traumatic than *sudden confinement.*"[4]

There followed an excellent student note in the Yale Law Review[5] in 1947 which took a similar point of view and advocated removing the criminal law barriers to afford easier access to mental hospitals.

At about the same time, in 1948, another very influential psychiatric organization, the Group for the Advancement of Psychiatry, released a report which also attacked these same aspects of the commitment laws.[6] First on the list of the "worst features of contemporary commitment laws" was "legal service and notice to the patient."

The culmination of this movement was the publication in 1952 of the so-called Draft Act Governing Hospitalization of the Mentally Ill, prepared by the Federal Security Agency. It was a well-drafted legal document in that it was uncomplicated, clear, and simple in language. It removed criminalistic terminology and jury trials for the mentally ill. It advocated voluntary admissions. In place of enforced hospitalization it advocated adoption of what it called a "non-judicial procedure" whereby a person could be confined under medical certification without notice or an opportunity to protest before a court or other tribunal. The constitutionality of such deprivation of liberty was supposed to be afforded by giving the patient the right to protest *after* his confinement.

The rationale behind this movement of the late 1940's and early 1950's was that "railroading" or wrongful commit-

ments were a myth. The mental hospitals were said to be too crowded to want to take in people who were not mentally ill. The medical certification of outside doctors not on the staff of the hospital would protect the patient. Through these reforms easy access was to be provided to the mental hospitals. Doctors would decide who would get in just as they decide who would get out. It was to be a psychiatric decision for the good of all.

This period could be called "the romance with psychiatry." Various states adopted new laws characterized by such moves as substituting the term "mentally ill" for "insanity"; abolishing jury trials; adopting medical certification; and, in a few states, going all the way to adopting nonjudicial procedures such as that described above.

This period has not entirely ended and it has not been successful in its efforts in all states. We still have judicial commitment procedures in most states, at least on the statute books. Jury trials are still allowed in a number of states, though the majority have discarded them. The most radical procedural reform, the "nonjudicial" commitment procedure recommended by the Draft Act, was specifically declared unconstitutional in Missouri, the first state to adopt it.[7]

New Legislation

However, we are now in a new third period which tends to overlap the second period described above. It can be found in the new hospitalization laws adopted in New York State and Illinois in 1964 and even more so in the law adopted in the same year by the National Congress for the District of Columbia. I call this new period "the disenchantment." It is a disenchantment with both restrictive and punitive legal barriers and excessive reliance on psychiatric judgment. This period has finally recognized the great weakness in the law which was overlooked in both of the earlier periods: the great difficulty of getting *out* of the mental hospitals. It has been discovered that many patients languish in large institutions forgotten by their families and friends, the community, *and* by the meager hospital staffs. This was found particularly true in the treatment and care accorded the poor, and the larger the hospital, the worse the conditions. Furthermore, one group of patients had been totally overlooked in most of the early legal studies and they seemed particularly in need of legal attention. These were the mentally retarded.

In the new laws in New York, Illinois, and the District of Columbia, five particular types of reform are noteworthy. They can be listed as follows:

1. Requiring periodic review of all inpatients. (Adopted in all three jurisdictions, though differing somewhat in each.)
2. Emphasizing voluntary or "informal" admission. (Characteristic of all three.)
3. Repealing earlier laws which deprived mental patients of certain civil rights. (Adopted in various forms in all three.)
4. Installing a special legal aid system for mental patients. (Adopted only in New York.)
5. Enacting a statutory "right to treatment" for committed patients. (Adopted only in the District of Columbia.)

These new laws are an important step forward in each of these jurisdictions. Each was at a different stage of development, however, and their progress must be measured against where they were before the laws were amended. The District of Columbia law was by far the most backward and most closely allied to criminal law and the use of "lunacy commission" procedures. The new District of Columbia Code still displays much of its past. The reforms in Illinois and New York achieve a much healthier balance between legal protections and reasonable access to care and treatment.

Despite the progress accomplished in these laws, however, I do not believe that any of them, or any other changes in other states in recent years, make a radical break with the past or with the

basic structure of the Packard Laws of the 1860's. By this I mean that all of these laws still set out full and complete procedures concerning mental hospitalization. Nothing is left to professional determination or administrative regulation. Flexibility and an opportunity to experiment with new methods are sacrificed to the detailed spelling out of exact methods of handling all types of patients. There is a "law" for all methods of getting into a mental hospital. All hospitals must use the same methods, without deviation. "Mental illness" is defined by law for all categories and all purposes.

It seems to me that all of these laws, even the most advanced and most therapeutically oriented, are still addressed to coping with last year's problems, the conditions of public psychiatric care of the last 25 years. They are concerned almost exclusively with regulating admissions and discharges from the very large state hospitals caring for chronically ill psychotics. We are entitled to ask how these laws are to deal with the problems of today and tomorrow, the revolution in the care of the mentally ill, the development of community mental health programs.

Need for Change

I submit that these laws do not deal with these matters at all. The so-called commitment laws in every state in this country are, to my knowledge, totally unresponsive to this revolution in the methods of caring for the mentally ill.

This "lag" in the law is perhaps understandable. The community mental health movement has just begun in many parts of the country. However, it has been developing in some states for as long as ten years. Yet, in these same states, the book of commitment laws is still thick, complicated, and forbidding. These laws work to keep community care and state-hospital care quite separate, not a part of one continuous system in both directions. They work to keep community care of a simple, outpatient variety with an emphasis on short-term crisis intervention. The state hospital systems remain controlled and inflexible as chronic care institutions with strong ties to the courts and patients classified by admission status.

If the law is to change to accommodate the community mental health movement, to facilitate it and to help speed the day when there will be less need for prolonged, inpatient care in large, overcrowded state hospitals, then a more *radical* departure from the past is needed.

We need greater flexibility in the use to which we put mental health facilities. We need to abolish laws which require admission procedures to be the same for all facilities and all types of patients. These laws limit flexibility and tend to make all facilities the same. We should allow for experimentation in different methods for different purposes.

To accomplish this, I propose we abolish the commitment laws as we know them today. I would remove from the statute books all "admission laws." I would leave it to the hospitals and the Departments of Mental Health to determine their own procedures as adaptable to their own conditions. On a statewide basis, I would give legal authority to the Department of Mental Health to enact regulations setting standards in regard to admission, discharge, outpatient care, day care, night care, and so forth. The hospitalization system, if it were called that, would be very largely voluntary in all facilities, similar to conditions in Great Britain since the passage of their very fine Mental Health Act in 1959. I would leave to the law only those matters necessary to safeguard the rights and dignity of the patients and to protect the patients and the public from harmful actions by mentally ill persons.

The two primary areas where legal protection would still be necessary under a largely voluntary care system would be: (1) the requirement of a periodic,

comprehensive (clinical, social, and legal) review of all patients; and (2) a means of temporary, emergency hospitalization of a mentally ill person who is potentially dangerous to himself or to others and who will not himself seek or accept care and treatment. Of course, where any prolonged hospitalization is to be imposed, adequate notice and a legally effective hearing on the commitment would be constitutionally required. At such a hearing, the patient should be represented by legal counsel and should have an opportunity to present psychiatric evidence and any other evidence on his own behalf.

In other than unusual situations of dangerous conduct or potentially dangerous situations, all patients would be handled on what is now called a voluntary status. This would include "informal" procedures as they are now called and would cover what are called "nonprotesting" patients, concerning whom the initiative for seeking care comes from someone else. The commitment laws in many of our states make too many unnecessary classifications of admission on matters such as these in an often futile effort to achieve some flexibility in their otherwise rigid systems. They allow major differences in legal protections to patients, including the right to a hearing on commitment, to depend on such distinctions as these and on whether or not the patient is "certified" for hospitalization by one physician or two. In practice, I have never seen a patient's rights more adequately protected or his diagnosis more positively determined by a two-doctor certification than by one. It merely takes longer to hospitalize the patient because the attending physician must find a colleague to sign his papers. The culture of medical practice is not adversary; it is cooperative, or perhaps one might say it is mutually self-protective. Lawyers and judges seem to think that, having selected *two* physicians to examine a patient, they have provided a check-and-balance system like their own adversary court system. This just is not the case. The two doctors have basically the same interests. Even lawyers will be mutually protective under similar conditions.

The opening up of the state hospital system to flexible, voluntary methods and the expansion of community facilities to care for a wider range of cases can be accomplished without sacrifice of either quality of care, the rights of the patients, or the protection of the public.

In Massachusetts, we are seeking to put into law just such an approach as has been outlined here. A Special Commission appointed by the state legislature has been working diligently over the past few years and has now presented a complete recodification[8] of the state's mental hospitalization laws to accompany our new Community Mental Health and Retardation Services Act[9] passed in the final days of 1966. The Special Commission is composed of members of the legislature and three public representatives appointed by the governor.

The keynote provision of the new law which effectively replaces all the old commitment laws of the state, some 20 different procedures collected in over 100 sections, is as follows:

> The department [of Mental Health] shall adopt regulations establishing appropriate procedures for the reception, examination, admission, hospitalization, treatment, care, transfer and discharge of mental patients in facilities of the department. Such procedures shall be consistent with the highest practicable professional standards and may include provisions for in-patient care, day or night care, halfway-house services, family care, after-care, home treatment and such other provisions as the department requires. The department shall by regulation in accord with established professional standards define the categories of mental illness and mental disability for purposes of this section. Different procedures may be established by the department for specific types of patients or for particular facilities but shall be nondis-

criminatory in regard to race, creed, national origin or length of residence in a particular community. Such procedures shall be flexible and adaptable to changing conditions and advances in the methods of care and treatment and in the delivery of services. In making such regulations the department shall concern itself with the welfare of the patients under its care, the preservation of the rights and dignity of each such patient, and the protection and welfare of the community in general. Such regulations shall be in as simple and non-technical language as practicable and copies of such regulations shall be available to patients and their families. The department shall furnish the forms which may be required to be used in the procedures which it shall establish under the authority of this section, and shall keep records concerning admissions and other such procedures.[10]

A similar section to the above follows it in the new code making similar provision for the mentally retarded, but emphasizing training, habilitation, and evaluation procedures and long- and short-term residential services.

The new laws recommended by the Special Commission also propose a quite detailed and comprehensive periodic review for inpatients and residents in mental health and retardation facilities. It would include clinical, social, and legal considerations. The procedure for the review is spelled out in detail, since it is entirely new to the state. The procedure, particularly in requiring social and legal components, is much more comprehensive than the patient reviews provided in the new laws in New York, Illinois, and the District of Columbia.

The Special Commission also recommends that Massachusetts install a legal aid system for mental patients and retarded persons similar to that now operating in New York. The new law places specific responsibilities on these legal advisers, such as participation in the periodic reviews, and it is clear that the providing of this new service is one of the most important features of the recodification. The new law would also provide extensive reforms in criminal law and practice in regard to mental competence to stand trial, observational hospitalization of criminal defendants, and the care and treatment of mentally ill offenders.

Adoption of this recodification would remove the legal encrustations which have grown up for over a century around the mental hospitalization procedures. It would not only permit but would actively encourage the development of community mental health and retardation services directly interrelated with the state hospitals and state schools of Massachusetts.

Justice Holmes said that the states should be legislative laboratories of social experimentation. Today this is perhaps one of the major justifications for our 50 different legal systems within a federated union. We in Massachusetts hope that our new code is adopted and can provide a testing ground for this new approach to the mental hospitalization laws in the United States.

REFERENCES

1. Packard, E. P. W. Mrs. Packard's Prison Life, 1867.
2. See generally: Deutsch, A. The Mentally Ill in America (2nd ed.). New York: Columbia University Press, 1949.
3. See particularly: Weihofen, Henry and Overholser, Winfred. Commitment of the Mentally Ill. Texas Law Rev. 24:309, 1946; Guttmacher, Manfred, and Weihofen, Henry. Psychiatry and the Law. New York: W. W. Norton, 1952.
4. See Lindeman and McIntyre. The Mentally Disabled and the Law. Chicago, Ill.: University of Chicago, 1961, p. 36.
5. Analysis of Legal and Medical Considerations in Commitment of the Mentally Ill. Note in Yale Law Review 61:1178, 1947.
6. Report No. 4, Commitment Procedures. Group for the Advancement of Psychiatry, New York, 1947.
7. State ex rel. Fuller v. Mullinax. 364 Mo. 858, 269 S.W. (2d) 72 (1954).
8. Report of the Special Commission on Mental Health, Senate No. 1129 (1967).
9. Acts of 1966, Chapter 735, Commonwealth of Massachusetts.
10. Section 50, Chapter 123, General Laws of Massachusetts, as proposed in the Report, p. 16.

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