

Summer 1975

Administrative Discharge Procedures for Involuntary Civilly-Committed Mental Patients: An Alternative

Barbara Woodall Kragie
Indiana University School of Law

Follow this and additional works at: <http://www.repository.law.indiana.edu/ilj>

 Part of the [Administrative Law Commons](#), and the [Law and Psychology Commons](#)

Recommended Citation

Kragie, Barbara Woodall (1975) "Administrative Discharge Procedures for Involuntary Civilly-Committed Mental Patients: An Alternative," *Indiana Law Journal*: Vol. 50: Iss. 4, Article 11.

Available at: <http://www.repository.law.indiana.edu/ilj/vol50/iss4/11>

This Note is brought to you for free and open access by the Law School Journals at Digital Repository @ Maurer Law. It has been accepted for inclusion in Indiana Law Journal by an authorized administrator of Digital Repository @ Maurer Law. For more information, please contact wattn@indiana.edu.



JEROME HALL LAW LIBRARY

INDIANA UNIVERSITY
Maurer School of Law
Bloomington

Administrative Discharge Procedures for Involuntary Civilly-Committed Mental Patients: An Alternative

Historically, state practices governing institutionalization of mental patients have escaped serious challenge. Sparked, however, by a rising societal concern for individual rights¹ and an increasing recognition of the pervasiveness of mental illness,² litigators and commentators are now demanding a more critical examination of the treatment of mental patients. In accord with these realizations, this note will focus on involuntary, civilly-committed patients in state mental hospitals and will examine both highly protective systems recently enacted by some states as well as failures of discharge procedures in others. An alternative system, providing a second level of administrative review, with some improvements on judicial review, will be recommended for those states which currently maintain inadequate procedures and which realistically cannot or will not bear the cost of more protective systems.

IMPORTANCE OF ADEQUATE DISCHARGE PROCEDURES

Most litigation involving the rights of involuntary civil patients focuses on the lack of due process in commitment procedures and on deprivations and abuses occurring within institutions.³ Discharge procedures are largely ignored because it is assumed discharges were relatively easy to obtain. Inadequate funding and understaffing often make speedy discharges the only realistic goal of mental institutions.⁴ Moreover, judicial relief is available in some states when an administrative discharge is refused. In addition, with a result completely inapposite to the state's avowed goal of protecting society, a patient can sometimes

¹ *Developments in the Law: Civil Commitment of the Mentally Ill*, 87 HARV. L. REV. 1190 (1974) [hereinafter cited as *Developments*].

² Psychiatrists predict that one in ten persons will be afflicted with a serious mental illness. R. ROCK, M. JACOBSON & R. JANOPOL, HOSPITALIZATION AND DISCHARGE OF THE MENTALLY ILL 1 (1968) [hereinafter cited as ROCK].

³ See generally *O'Connor v. Donaldson*, 95 S. Ct. 2486 (1975); *Jackson v. Indiana*, 406 U.S. 715 (1972); *Humphrey v. Cady*, 405 U.S. 504 (1972); *In re Winship*, 397 U.S. 358 (1970); *Rouse v. Cameron*, 373 F.2d 451 (D.C. Cir. 1966); *Wyatt v. Stickney*, 344 F. Supp. 373 (M.D. Ala. 1972), *aff'd sub nom. Wyatt v. Aderholt*, 503 F.2d 1305 (5th Cir. 1974).

⁴ ROCK, *supra* note 2, at 216; AMERICAN BAR FOUNDATION, THE MENTALLY DISABLED AND THE LAW 137 (rev. ed. S. Brakel & R. Rock 1971) [hereinafter cited as BRAKEL].

obtain administrative discharge merely by threatening to sue.⁵ Institutions often lack staff time to devote to courtroom adjudication as well as motivation to appear. Similarly, they seek to avoid potential adverse publicity. Thus, unless a patient is truly dangerous, the institution usually will not contest the suit.⁶ These factors combined with a high rate of discharge⁷ might make proposed changes in discharge statutes appear unnecessary. The following considerations, however, demonstrate a compelling need for revision.

Proper discharge procedures could provide a valuable check on inadequate commitment protections, or they might serve to remedy a judgmental error.⁸ In addition, within institutions tragically inadequate funding⁹ and non-compliance with standards of the American Psychiatric Association¹⁰ have produced a situation which cannot be remedied by stricter commitment standards. For example, due to understaffing in one Texas hospital, 45 people on a ward of 134 had never been diagnosed.¹¹ Individual discharges do not always occur as fast as national statistics indicate.¹² In some instances, patients were even found to have been purposely retained because they were good, low-cost workers.¹³

The possibility of a patient obtaining a "too easy" discharge, such as by merely threatening suit, is itself troubling. The discharge is

⁵ ROCK, *supra* note 2, at 241.

⁶ *Id.* at 235.

⁷ BRAKEL, *supra* note 4, at 136. Statistics show that in one year there were 495,077 admissions and 525,584 discharges. U.S. DEP'T OF HEALTH, EDUCATION, & WELFARE, MENTAL HEALTH STATISTICS, CURRENT FACILITY REPORTS: PROVISIONAL PATIENT MOVEMENT AND ADMINISTRATIVE DATA, STATE AND COUNTY MENTAL HOSPITALS, UNITED STATES, JULY 1, 1968-JUNE 30, 1969, at 5.

⁸ ROCK, *supra* note 2, at 214.

⁹ In a brief filed in the *Wyatt* case, the lawyer for the plaintiffs stated that Alabama had allocated more funds for a sports hall of fame, a junior-miss pageant, a swine and cattle show, and maintenance of the White House of the Confederacy than for mental health programs. Offir, *Revolution in Bedlam*, PSYCHOLOGY TODAY, Oct. 1974, at 64.

¹⁰ Birnbaum, *Some Remarks on "The Right to Treatment,"* 23 ALA. L. REV. 623, 631-35 (1971).

The seven suggested standards are: 1. Hospitals should be accredited by the Joint Commission of Accreditation of Hospitals; 2. Hospitals should be accredited by the Social Security Administration; 3. Hospitals should be accredited by the American Psychiatric Association; 4. There should be a minimum staff-patient ratio; 5. Medical and psychiatric professionals should be state-licensed; 6. There should be required progress reports; 7. Intermediate facilities should be provided. In many institutions visited, doctor-patient ratios of 1/600 were common, ROCK, *supra* note 2, at 225. Cf. Wyatt v. Stickney, 344 F. Supp. 387, 395-407 (M.D. Ala. 1972) (Appendix A).

¹¹ Gainfort, *How Texas is Reforming its Mental Hospitals*, THE REPORTER, Nov. 29, 1956, at 20.

¹² For example, in West Virginia in 1972-73 commitments averaged 15.91 years. State *ex rel.* Hawks v. Lazaro, — W. Va. —, 202 S.E.2d 109, 121 (1974).

¹³ ROCK, *supra* note 2, at 228; Goldman and Ross, *The Patients Who Shouldn't Be In*, PARADE, Nov. 11, 1956, pt. I, at 11, 17.

granted "against medical advice," a designation which might prevent future voluntary commitment.¹⁴ On the other hand, if a dangerous patient is released without medical approval, the public is inadequately protected.

Equally troubling is the phenomenon of institutionalization: a psychological reaction involving an increased dependence on the security and routine of the institution. While the patient remains in the hospital, community and family connections disappear and unused skills deteriorate.¹⁵ In other words, chances for release decrease as the length of commitment increases.¹⁶ The resulting passivity may help to explain the lack of discharge litigation, as patients must generally initiate their own suits.

STATE DISCHARGE PROCEDURES

Limited commitment, a model adopted in at least ten states,¹⁷ best protects a patient's right to liberty. Under such a scheme, the original commitment is statutorily limited to a period believed sufficient to effect improvement (usually six months). If, at the end of that period, the staff believes further commitment necessary, there must be a judicial hearing in which the state bears the burden of justifying extended hospitalization. Recommitment is usually limited to a year.

Less protective are periodic examinations required in more than thirty states.¹⁸ Although under this system patients are committed and released through judicial and administrative procedures, the hospital is also required to conduct periodic examinations (from every six months¹⁹ to "as frequently as practicable"²⁰) to determine if the patient meets statutory standards for release. Even though some type of examina-

¹⁴ ROCK, *supra* note 2, at 236.

¹⁵ Note, *Remedies for Individuals Wrongly Detained in State Mental Institutions Because of their Incompetency to Stand Trial: Implementing Jackson v. Indiana*, 7 VAL. L. REV. 203, 217 (1973).

¹⁶ ROCK, *supra* note 2, at 228.

¹⁷ CAL. WELF. & INST'NS CODE § 5304 (West 1972); FLA. STAT. ANN. § 394.467 (Supp. 1975); GA. CODE ANN. §§ 88.506.4-6 (1971); ME. REV. STAT. ANN. tit. 34, §§ 2334, 2374 (Supp. Pamphlet 1973); MASS. GEN. LAWS ANN. ch. 123 §§ 4, 8 (Supp. 1974); N.H. REV. STAT. ANN. § 135-B:38 (Supp. 1973); N.Y. MENTAL HYGIENE LAW § 31.33 (McKinney Supp. 1974); N.C. GEN. STAT. § 122-58.7 (1974); WASH. REV. CODE ANN. § 71.05.320 (Supp. 1975).

¹⁸ Twenty jurisdictions provide only for periodic medical review. See *Developments*, *supra* note 1, at 1382 n.30.

¹⁹ *E.g.*, DEL. CODE ANN. tit. 16, § 5131 (Rev. 1974); KY. REV. STAT. ANN. § 202.239 (1972).

²⁰ *E.g.*, ALA. CODE tit. 45, § 252(a15) (Cum. Supp. 1973); MO. ANN. STAT. § 202.827 (1972).

tion is guaranteed, making it less likely that patients will be "lost,"²¹ opportunities to contest the institutional decision remain inadequate. Moreover, periodic examination requirements are sometimes simply ignored.²²

Many states do not provide either alternative. Instead, administrative release procedures must be initiated by a doctor or someone working with the patient.²³ Most statutes leave the initial release decision to the discretion of the hospital superintendent or his designated representatives.²⁴ If an administrative discharge is denied or never sought, several judicial remedies are available. All states grant review of original commitments and the right to petition for habeas corpus.²⁵ Additionally, 37 states and the District of Columbia²⁶ provide a judicial hearing to contest continuing detention. Procedural requirements and guarantees range from requiring the patient to secure a physician's certification of sanity²⁷ to guaranteeing a free, independent psychiatric examination.²⁸

This note is addressed to states²⁹ without a statutory right to a judicial hearing as well as to those with an inadequate review of denials of administrative discharge. Despite the availability of judicial review and habeas corpus, such a hearing is constitutionally required under the due process clauses of the fifth and fourteenth amendments.³⁰ Arguably, a second-level administrative review may more satisfactorily protect all interests than the judicial hearings presently utilized by many states.

²¹ ROCK, *supra* note 2, at 225.

²² *Id.* at 218-19.

²³ BRAKEL, *supra* note 4, at 136; ROCK, *supra* note 2, at 52, 232. Some provide this in addition to the schemes discussed above. See *Developments, supra* note 1, at 1379 n.11.

²⁴ *E.g.*, KAN. STAT. ANN. § 59-2924 (Cum. Supp. 1973); MICH. COMP. LAWS ANN. § 330.1476 (1975).

²⁵ Review is a natural part of the judicial procedure. Habeas corpus is available either at common law or by statute. BRAKEL, *supra* note 4, at 139. For habeas corpus provisions, see *Developments, supra* note 1, at 1381 n.22.

²⁶ See *Developments, supra* note 1, at 1379-80 n.15.

²⁷ See *Developments, supra* note 1, at 1380 n.21.

The patient or a relative may request that the patient be examined by a physician from the hospital. If the superintendent believes the patient should remain hospitalized and the doctor who examined the patient agrees, the patient cannot obtain court review. A patient is permitted to employ an outside physician at his own expense and an indigent patient may request the state to provide an outside physician. . . . [But] [e]ven if the patient is able to find a doctor to support him, the court may, under the statutes, simply dismiss the petition without a hearing.

Id.

²⁸ See MICH. COMP. LAWS ANN. § 330.1476 (1975); MINN. STAT. ANN. § 253.19(3) (1971).

²⁹ Alabama, Arkansas, Montana, Nebraska, New Jersey, Oregon, Pennsylvania, Virginia, and Wyoming (New York and North Carolina also do not permit patients to request a hearing but there patients are committed under the more protective limited commitment system).

³⁰ U.S. CONST. amends. V & XIV.

Such an administrative system should be considered because it would protect both patients denied administrative discharges and those too passive to initiate any action on their own behalf. This administrative procedure would also be less costly and time-consuming than theoretically more protective schemes such as limited commitment and periodic examination.

CONSTITUTIONAL RIGHT TO A HEARING

Analogous Right-to-Hearing Decisions

Recent Supreme Court decisions require an administrative or judicial hearing whenever a government agency, federal or state, makes any determination that inflicts a "grievous loss"³¹ upon an individual.³² Since public mental hospitals are units of a state agency (the department of mental health),³³ the requisite state action is easily found in a superintendent's determinations.

Upon first glance the "losses" involved in previous right-to-hearing cases differ conceptually from the loss resulting from an incorrect discharge determination. The parolee whose "conditional liberty"³⁴ is revoked, and the welfare recipient whose benefits are terminated experience an immediate deprivation. Because the patient remains in the same situation when the state's justification for detention no longer exists, his loss appears less severe. Upon closer examination, however, the analogy strengthens. The right to liberty attaches when the justification for confinement, such as the need for treatment,³⁵ no longer exists.³⁶ Therefore, if the superintendent erroneously retains a patient in an institution when he actually meets the statutory criteria for release, the patient is being deprived of liberty beginning with the incorrect determination.

At least one court has implicitly relied on similar reasoning. The district court in *Ackies v. Purdy*,³⁷ citing prior right-to-hearing cases,³⁸

³¹ *Goldberg v. Kelly*, 397 U.S. 254, 263 (1970).

³² Note, *The Parole-Release Decision—Due Process and Discretion*, 33 LA. L. REV. 708, 710 (1973) [hereinafter cited as *The Parole Release Decision*]; *Goss v. Lopez*, 419 U.S. 565 (1975) (suspension from high school); *Morrissey v. Brewer*, 408 U.S. 471 (1972) (parole revocation); *Goldberg v. Kelly*, 397 U.S. 254 (1970) (termination of welfare benefits); *Joint Anti-Fascist Refugee Committee v. McGrath*, 341 U.S. 123 (1951) (designation of organizations as Communist).

³³ *E.g.*, IND. ANN. STAT. § 16-13-1-4 (Code ed. 1973).

³⁴ *Morrissey v. Brewer*, 408 U.S. 471, 484 (1972).

³⁵ *O'Connor v. Donaldson*, 95 S. Ct. 2486 (1975).

³⁶ *Developments, supra* note 1, at 1386.

³⁷ 322 F. Supp. 38 (S.D. Fla. 1970). *Cf.* *United States v. Thornton*, 344 F. Supp. 249, 251 (D.C. Del. 1972) (A judicial hearing, although less than full-scale, is constitu-

granted a bail hearing to a defendant detained prior to trial despite the lack of change in physical circumstances. The distinction between remaining in custody and losing welfare benefits was either ignored or deemed unimportant. The stakes are higher and a hearing even more important for a mental patient facing a potentially indeterminate stay than for a defendant who will eventually have a trial.

Distinguishing Rights Accorded Detained Prisoners

Although the right to a parole hearing has not been accorded to detained persons most similarly situated to institutionalized mental patients, prisoners eligible for parole,³⁹ several important distinctions may be drawn between the two groups. An initial parole board determination affects only a privilege accorded by the state.⁴⁰ In contrast, a superintendent's determination might abridge a patient's right to liberty,⁴¹ which, under *Goldberg v. Kelly*,⁴² requires greater protection.

The potential parolee already enjoys a more advantageous situation because his application is considered by several board members.⁴³ Although some commentators lament the qualifications and potential social biases of parole boards,⁴⁴ a decision is reached by combining the qualities and opinions of several board members. A mental patient, on the other hand, is subject to the judgment and prejudices of a single individual.⁴⁵ Parole decisions are also more closely regulated by statute.⁴⁶ The possibility of an indeterminate stay increases the importance of a correct determination for a mental patient. Thus, the denial of parole hearings is not a barrier to the right to a hearing for mental patients.

tionally required before termination of civil commitment for drug rehabilitation. The patient, prompted by threat of criminal charges upon termination, desired to remain in the program).

³⁸ *E.g.*, *Goldberg v. Kelly*, 397 U.S. 254 (1970).

³⁹ See 1 PLI, PRISONERS' RIGHTS 203 (1972) [hereinafter cited as PRISONERS' RIGHTS]; *Menechino v. Oswald*, 430 F.2d 403 (2d Cir. 1970), *cert. denied*, 400 U.S. 1023 (1971).

⁴⁰ PRISONERS' RIGHTS, *supra* note 39, at 271; *The Parole-Release Decision*, *supra* note 32, at 714.

Under *Goldberg*, the right to a hearing depends on the degree of loss rather than on the distinction between a right and a privilege. Nevertheless, the deprivation of a right remains more likely to satisfy the "grievous loss" standard.

⁴¹ *The Parole-Release Decision*, *supra* note 32, at 714.

⁴² 397 U.S. 254 (1970).

⁴³ D. DRESSLER, PRACTICE AND THEORY OF PROBATION AND PAROLE 86 (1969).

⁴⁴ PRISONERS' RIGHTS, *supra* note 39, at 292.

⁴⁵ The doctor, often the real decisionmaker, is not always as qualified as may be supposed. Some doctors may suffer from an "institutional myopia," basing their judgments solely on the patient's adaptation to the hospital.

⁴⁶ See *Scarpa v. United States Bd. of Parole*, 477 F.2d 278 (5th Cir. 1973).

Standards Mandating the Right to a Hearing

Some courts require a hearing when an individual might be injured by a governmental body⁴⁷ or when an agency determination directly affects the legal rights of an individual.⁴⁸ If a discharge determination were examined under such standards, a hearing would be required.⁴⁹

In other cases, the individual interest is balanced against the burden imposed on the government.⁵⁰ Under such scrutiny, the patient's right to liberty would rank high as a protected interest while the government interest in discharge determinations, consisting of three conflicting goals, is more complex than in previous right-to-hearing cases. The government must limit costs while fulfilling its responsibilities: first, to a non-criminal who has merely deviated from a vaguely defined norm; and second, to the public who should be protected. Satisfactory resolution demands that commitment and discharge standards be narrowly drawn (a mandate also required by soaring hospital costs) while standards and procedures also must accurately identify dangerous persons. For such a complex decision, a hearing should be a minimal requirement.

In addition to the balancing test, courts also consider the impact of the determination. For example, in *Hannah v. Larche*,⁵¹ a citizen demanded a chance to appear before a presidential commission created to report violations of the Civil Rights Act of 1957 and recommend program changes to the President and Congress. A hearing was not required because the Commission's "function [was] purely investigative and fact-finding It [did] not make determinations depriving anyone of his life, liberty, or property."⁵² A due process hearing was required in *Jenkins v. McKeithen*⁵³ involving a labor commission charged with investigating criminal activities, "exercis[ing] a function very much akin to making an official adjudication of criminal culpability."⁵⁴ This "purpose" standard, when applied to a discharge determination which might result in unconstitutional detention,⁵⁵ also strongly mandates a

⁴⁷ *Dixon v. Alabama State Bd. of Educ.*, 294 F.2d 150, 155 (5th Cir.), *cert. denied*, 368 U.S. 930 (1961).

⁴⁸ *Hannah v. Larche*, 363 U.S. 420, 442 (1960).

⁴⁹ See note 18 *supra* & text accompanying.

⁵⁰ See cases cited note 32 *supra*. *Cafeteria & Restaurant Workers Union v. McElroy*, 367 U.S. 886, 895 (1961) (hearing refused because the government's right to exclude aliens was "absolute" while the individual interest was "small").

⁵¹ 363 U.S. 420 (1960).

⁵² *Id.* at 441.

⁵³ 395 U.S. 411 (1969).

⁵⁴ *Id.* at 427.

⁵⁵ If the patient is no longer in need of hospitalization, but he is detained because of an incorrect adjudication, his detention is unconstitutional under *O'Connor*.

hearing.

Inadequacies of Judicial Review and Habeas Corpus

Appeal of the original commitment, a right granted by all states,⁵⁶ does not satisfy the hearing requirement.⁵⁷ In some states, the trial judge's decision is conclusive,⁵⁸ and the validity of continuing detention may not be challenged.⁵⁹

Under some statutes, a habeas corpus hearing might supply adequate protection while in other states, an additional hearing would be required. Early statutes provided only for a review of the original commitment,⁶⁰ but most states now grant a right to contest continuing detention.⁶¹ The writ, however, is an extraordinary remedy, sometimes available only after all state remedies have been exhausted and other statutory requirements satisfied.⁶² Unless a maximum waiting period is specified,⁶³ such petitions are also subject to the delay characteristic of the judicial system. Even if a petition is granted, the ensuing hearing may not incorporate many of the protections guaranteed in a criminal trial. Moreover, the only remedy may be the reopening of sanity proceed-

⁵⁶ See note 25 *supra*.

⁵⁷ In some states, the appellate court may choose not to review even the trial judge's discretion. See *Dixon v. Jacobs*, 427 F.2d 589 (D.C. Cir. 1970); *Clendening v. McCall*, 145 Ohio St. 82, 60 N.E.2d 676 (1945). *Contra Covington v. Harris*, 419 F.2d 617 (D.C. Cir. 1969) (review available).

⁵⁸ *E.g.*, IND. ANN. STAT. § 4-22-1-14 (Code ed. 1974).

⁵⁹ The review on appeal is limited to the normal determination of questions of law.

⁶⁰ *Rock*, *supra* note 2, at 52; *Graham v. Squier*, 132 F.2d 681 (9th Cir. 1942), *cert. denied*, 318 U.S. 777 (1943).

⁶¹ R. SOKOL, FEDERAL HABEAS CORPUS § 4.1 (1969) [hereinafter cited as SOKOL]. See also *Malone v. Overholzer*, 93 F. Supp. 647 (D.D.C. 1950); *Hiatt v. Soucek*, 240 Iowa 300, 36 N.W.2d 432 (1949).

⁶² Comment, *The Expanding Role of the Lawyer and the Court in Securing Psychiatric Treatment for Patients Confined Pursuant to Civil Commitment Procedures*, 6 Hous. L. Rev. 519, 528 (1969) [hereinafter cited as *The Expanding Role*]; see *In re Tew*, 280 N.C. 612, 187 S.E.2d 13 (1972). *Contra*, *Overholzer v. Boddie*, 184 F.2d 240 (D.D.C. 1950); *Byers v. Solier*, 16 Wyo. 232, 93 P. 59 (1907).

For example, in Pennsylvania a patient must include a physician's certificate of sanity before his application will even be considered, PA. STAT. ANN. tit. 50, § 4426 (1969); Commonwealth *ex rel. Swann v. Shoulin*, 423 Pa. 26, 223 A.2d 1 (1966). Some commentators have argued that such statutes unconstitutionally burden access to the courts. 10 DUQ. L. REV. 674, 682 (1972); Comment, *Release Procedures Under the Pennsylvania Mental Health and Mental Retardation Act of 1966*, 5 DUQ. L. REV. 496, 501 (1967).

In *Ex parte Clarke*, 86 Kan. 539, 121 P. 492 (1912), a provision requiring a superintendent's certificate was upheld because the legislature had a valid goal in allowing the superintendent to determine who was going to court. See Comment, *Release Procedures Under the Pennsylvania Mental Health and Mental Retardation Act of 1966*, 5 DUQ. L. REV. 496, 499 (1967).

⁶³ *E.g.*, CAL. WELF. & INST'NS CODE § 5276 (West Supp. 1972) (within two judicial days of petition); DEL. CODE ANN. tit. 16, § 5126(b) (1975) (within five days after petition).

ings,⁶⁴ requiring the patient to undergo a second hearing.

Prior decisions also suggest that review and habeas corpus alone supply less protection than is constitutionally required for they can only free a patient after an erroneous administrative determination resulting in a period of unconstitutional detention. Despite the availability of a post-termination review, welfare recipients are entitled to a prior hearing so they will not be erroneously deprived of their benefits.⁶⁵ Similarly, revocation hearings are required even though, after reincarceration, the prisoner has a right to review and to petition for a writ of habeas corpus.⁶⁶ Detained defendants also have a right to a bail hearing.⁶⁷

PROBLEMS INHERENT IN THE JUDICIAL SYSTEM

Assuming that a discharge hearing is required, a procedure should be designed to adequately protect the patient's rights while minimizing the burden on the state. In reality, a balanced program may more likely be implemented than limited commitment, which provides greater protection but at a higher cost because of the judicial procedures required.

Under previous right-to-hearing decisions a judicial hearing is not required.⁶⁸ Although a judicial hearing is usually presumed to offer the best protection of individual rights,⁶⁹ the lack of judicial expertise in understanding mental illness and deficiencies in present judicial discharge procedures⁷⁰ suggest an administrative system may better serve both the patient and the state.

Personal Barriers

Mental patients seldom resort to the courts for a variety of reasons. Because of lack of education or the debilitating effects of drugs,⁷¹ a patient may be incapable of understanding possible court remedies. The cost might also be prohibitive.⁷² Moreover, courtroom formality, de-

⁶⁴ *The Expanding Role*, *supra* note 62, at 528.

⁶⁵ *Goldberg v. Kelly*, 397 U.S. 254, 263 (1970).

⁶⁶ *Morrissey v. Brewer*, 408 U.S. 471 (1972).

⁶⁷ *Ackies v. Purdy*, 322 F. Supp. 38 (S.D. Fla. 1970).

⁶⁸ *See Morrissey v. Brewer*, 408 U.S. 471, 489 (1972); *Goldberg v. Kelly*, 397 U.S. 254, 266 (1970). *Contra*, *United States v. Thornton*, 344 F. Supp. 249, 251-52 (D. Del. 1972).

⁶⁹ *Goldberg v. Kelly*, 397 U.S. 254, 267 (1970).

⁷⁰ Note, *supra* note 15, at 219.

The low number of judicial discharges (1-2 percent of all discharges, Rock, *supra* note 2, at 234) provides some indication of the failure of the system. The low number may be caused by easy administrative discharges, but also by patients' initial reluctance to go to the courts, administrative relief if the suit is threatened, and judges' refusal to either hear the case or grant a discharge.

⁷¹ *Developments*, *supra* note 1, at 1398.

⁷² *Id.*

signed to heighten respect, may, for a person who has lost self respect and confidence, evoke fear.⁷³ Institutionalization may compound this fear and rob a patient of the initiative required to begin court proceedings.⁷⁴ Finally, patients may be reluctant to agitate within the institutional community because of possible hostility or even punishment from the staff.⁷⁵ These problems are presently partially solved only by those states which require automatic judicial review.

Statutory Barriers

In addition to internal inhibition, statutory requirements often impede the vindication of a patient's rights. Jurisdiction is sometimes limited to the committing court.⁷⁶ When the institution is not located near that court, a patient with little money (or without personal control over his estate) may face severe logistical problems. Furthermore, complications arise once a patient reaches the courthouse. Some judges burdened by overcrowded dockets may be inclined to dismiss mental patients' petitions as frivolous.⁷⁷ Even if a hearing is granted, crowded dockets may force patients to wait several months in the institution. There are, of course, no special provisions for release pending trial because the patient is still under his original commitment order.⁷⁸

Procedural rules further complicate the discharge process. In most states, the patient bears the burden of proving his own sanity.⁷⁹ With "clear and convincing evidence"⁸⁰ he must overcome two presumptions: that the adjudicated insanity continues to the present time⁸¹ and that the hospital staff is correct in its refusal to discharge.⁸² Additionally, patients may have trouble obtaining evidence⁸³ as even the right to talk

⁷³ *But see* Deposition of Dr. Israel Zwerling, *Wyatt v. Stickney*, 344 F. Supp. 373 (M.D. Ala. 1972), reprinted in 1 *LEGAL RIGHTS OF THE MENTALLY HANDICAPPED* 522 (B. Ennis & P. Friedman eds. 1973) (presence at a formal hearing might be therapeutic).

⁷⁴ See text accompanying note 15 *supra*.

⁷⁵ Landever, *Regional Commissions to Monitor Confinement Institutions: A Proposal*, 22 CLEV. ST. L. REV. 450, 469 (1973).

⁷⁶ *E.g.*, MINN. STAT. ANN. § 253A.19(1) (1971); MO. ANN. STAT. § 202.8037 (1972).

⁷⁷ B. ENNIS & L. SIEGEL, *RIGHTS OF MENTAL PATIENTS* 46 (1973) [hereinafter cited as ENNIS & SIEGEL].

⁷⁸ Landever, *supra* note 75, at 469.

⁷⁹ *Developments, supra* note 1, at 1382; *Overholser v. O'Beirne*, 302 F.2d 852 (D.C. Cir. 1962).

⁸⁰ Comment, *The New Mental Health Codes: Safeguards in Compulsory Commitment and Release*, 61 NW. U.L. REV. 977, 978 (1967).

⁸¹ *E.g.*, *Rosario v. State*, 42 Misc.2d 699, 248 N.Y.S.2d 734 (Ct. Cl. 1964).

⁸² Comment, *supra* note 80, at 279.

⁸³ Note, *Due Process for All—Constitutional Standards for Involuntary Civil Commitment and Release*, 34 U. CHI. L. REV. 633, 655 (1967).

to "outside people" is sometimes severely limited by hospital rules.⁸⁴

Patients must also contend with such vague standards as "mental illness,"⁸⁵ a term courts have struggled with for years in the context of the insanity plea. Statutes requiring a demonstration of restoration to sanity⁸⁶ are also unrealistic in light of the present state of legal psychiatry. Indeed, even a "normal person" would be hard-pressed to affirmatively show that he was legally sane.⁸⁷ Discharge decisions are also based on "unwritten standards" extraneous to the patient's mental health, such as availability of work and willingness of friends and family to care for him.⁸⁸ Even if the patient fulfilled the criteria required in the state statute, his release might be withheld if he could not show someone or something was waiting for him.⁸⁹

INADEQUATE SAFEGUARDS

With a paternalistic desire to minimize the trauma and publicity of a formal trial,⁹⁰ legislators denied mental patients many of the safeguards guaranteed in a criminal trial. For example, although the patient has notice since he or a friend must initiate the judicial procedure,⁹¹ the patient is sometimes denied an opportunity to be heard.⁹²

Very few states grant a right to counsel in discharge proceedings.⁹³ Even if counsel is guaranteed, patients may have trouble finding a lawyer willing to represent them.⁹⁴ Lawyers often believe that the determination of sanity is solely a medical question,⁹⁵ or they may refuse to accept a case from a mental patient believing that it is probably frivolous or futile.⁹⁶

At least as important as the right to counsel is the right to an

⁸⁴ *Id.* at 655.

⁸⁵ *E.g.*, HAWAII REV. STAT. § 334-76 (1968).

⁸⁶ *E.g.*, OHIO REV. CODE ANN. § 5122.25 (1970); OKLA. STAT. 43A, § 75 (Supp. 1974).

⁸⁷ Note, *supra* note 83, at 655-56.

⁸⁸ Rock, *supra* note 2, at 217-18.

⁸⁹ *Developments, supra* note 1, at 1385.

In light of *O'Connor v. Donaldson*, 95 S. Ct. 2486 (1975), it is clear that such standards are no longer constitutionally acceptable. If a patient is not dangerous (the placement of the burden of proof is not specified), the hospital cannot retain him without treatment. The Court left undecided the question whether treatment justified the commitment and involuntary detention of a non-dangerous person.

⁹⁰ Comment, *supra* note 80, at 1003.

⁹¹ *E.g.*, ARIZ. REV. STAT. ANN. § 36-546 (Supp. 1974); D.C. CODE ANN. & 21-546 (Supp. 1970).

⁹² *E.g.*, KY. REV. STAT. ANN. § 202.360 (1969).

⁹³ Comment, *supra* note 80, at 1003.

⁹⁴ BRAKEL, *supra* note 4, at 140.

⁹⁵ ROCK, *supra* note 2, at 238.

⁹⁶ BRAKEL, *supra* note 4, at 139.

independent psychiatric examination.⁹⁷ At present, however, few states provide a free examination.⁹⁸ Advocates of this right claim that patients examined by an institutional psychiatrist are subject to biases which hinder a fair evaluation.⁹⁹ The staff psychiatrist will have originally refused to release the patient or may have worked closely with the psychiatrist who made the original discharge decision. Furthermore, an institutional psychiatrist's judgment may be based on the patient's behavior within the institution rather than his mental condition demonstrated by psychological tests.¹⁰⁰

ADMINISTRATIVE DISCHARGE MODEL

Defects in Present Administrative Discharge Procedures

Although most statutes require the superintendent of the hospital to make discharge determinations, in reality this task is usually delegated to a doctor.¹⁰¹ Advocates of this system stress the importance of the familiarity that staff members have with both the patient and his treatment program.¹⁰² However, such familiarity, even if shown to exist, may not be wholly advantageous.¹⁰³ Because staff physicians may see patients individually as infrequently as twice a year,¹⁰⁴ their decisions are often based on reports by nurses or aides with little or no psychiatric training.¹⁰⁵ Moreover, the doctor often places undue emphasis on the patient's adjustment to the institution.

The power to deny release may also be used as a threat to force

⁹⁷ See text accompanying note 18 *supra*.

⁹⁸ BRAKEL, *supra* note 4, at 149-52 (tables).

⁹⁹ See note 45 *supra*.

¹⁰⁰ Although behavior seems to be a logical factor in determining mental health, judging a patient by his reaction to the mental hospital may be very misleading. Some commentators assert it may be a sign of mental health to react with hostility toward the institution instead of accepting its routines passively. C. NEWMAN, SOURCEBOOK OF PROBATION, PAROLE AND PARDONS 335 (3d ed. 1968) [hereinafter cited as NEWMAN].

¹⁰¹ ROCK, *supra* note 2, at 230.

¹⁰² BRAKEL, *supra* note 4, at 136; NEWMAN, *supra* note 100, at 335.

¹⁰³ See text accompanying note 100 *supra*. Most right-to-hearing cases have specified the decisionmaker should not be directly involved in the case. *Morrissey v. Brewer*, 408 U.S. 471, 489 (1972); *Goldberg v. Kelly*, 397 U.S. 254, 259-60 (1970).

In addition, empirical studies have not supported the accuracy of institutional decisions. One Veterans Administration study showed that patients judicially discharged contrary to the institutional judgment demonstrated a better rate of adjustment to the community than those administratively discharged. Shawver & Boquet, *A Survey of Patients Discharged by Court Order*, 33 INFORMATION BULLETIN 29 (U.S. Veterans Administration, Department of Medicine and Surgery, Psychiatry and Neurology Service, Sept. 21, 1956). These statistics do not mean courts are the best place for discharge determinations; instead they merely indicate that the institutional judgment is not infallible. ROCK, *supra* note 2, at 241.

¹⁰⁴ See sources cited in note 4 *supra*.

¹⁰⁵ *Id.*

compliance with hospital regulations.¹⁰⁶ Such mistakes and abuses are not easily checked because of the low visibility of the institutional process.¹⁰⁷ Further, the dispersal of authority results in a lack of uniformity in discharge standards even within a particular hospital.¹⁰⁸

Another deficiency in the present administrative discharge system is the lack of patient-initiated procedures. Although a patient may persuade his doctor to recommend a discharge, there is no formal provision for a patient himself to file a discharge application. Since there is no way to ensure consideration of a patient's condition in those states where periodic review is not required, the tragedy of a "lost" patient is an ever present danger.¹⁰⁹

Although defects in present administrative discharge processes are obvious, a strong argument can be made for their retention as a first level if supplemented by subsequent review. Since most patients are quickly and efficiently discharged,¹¹⁰ supplemental proceedings on behalf of the relatively few disappointed patients might feasibly be initiated by an official intermediary.¹¹¹ Such a system, however, would be lacking in two respects. Under existing structures, the only possible decisionmakers would be the superintendent or a judge, both incorporating above-mentioned defects. In addition, society would still be endangered by premature releases granted patients threatening suit.

The proposed second level administrative proceeding could provide a convenient and relaxed forum at a relatively low cost due to the small number of cases requiring extended review. Similarly, the state would have an opportunity to justify continued detention without the time, cost, and publicity of a judicial hearing.¹¹²

Second Level Administrative Review

Because of defects in both the judicial and administrative systems, a second level of administrative review might be more protective of

¹⁰⁶ NEWMAN, *supra* note 100, at 335.

¹⁰⁷ *Id.*

¹⁰⁸ Usually the decision rests totally on the doctor's discretion, but on one ward in a midwestern hospital, the patients vote on discharges at a group meeting. ROCK, *supra* note 2, at 230.

¹⁰⁹ ROCK, *supra* note 2, at 225.

¹¹⁰ See text accompanying note 7 *supra*.

¹¹¹ Landever, *supra* note 75, at 497; Kihss, Book Review, *New York Times*, Mar. 30, 1975, at 22, col. 1 (for medical hospital patients); *Developments*, *supra* note 1, at 1356-58 (ombudsman to keep the patient informed of treatment and release alternatives).

¹¹² The decreased visibility might be similar to the situation in which a doctor makes his discharge decision. See text accompanying note 101 *supra*. The use of a panel, however, should reduce the possibility of arbitrariness.

patient's rights.

Working from office space within the institution, an ombudsman could initiate discharge proceedings, monitor and publicize substandard living conditions, and investigate patient grievances. Moreover, if a patient's first request for discharge were refused, the ombudsman could then begin proceedings for the second level of review.¹¹³

Some statutes seek to involve lawyers, psychiatrists, and social workers, to assist courts with discharge determinations.¹¹⁴ Because courts normally defer to the expert panel's decision,¹¹⁵ it would serve efficiency to eliminate judicial participation by allowing a panel to bring its informed judgment to bear on the crucial determination.

Because relatively few patients will require a second level administrative hearing, strict procedures could be adopted to protect their rights without unduly burdening the state.

In order to reduce fear and create familiar surroundings, the hearing might be held in the hospital rather than in a courtroom.¹¹⁶ The resulting convenience as well as the reduction in time, cost, and publicity would also encourage hospital authorities to press more vigorously their view in contested cases. Before the hearing, the review panel should consider the hospital records as well as the superintendent's justification for continued hospitalization and social worker's reports on the patient's family, community, and availability of work.¹¹⁷ Since institutional doctors could no longer be considered neutral,¹¹⁸ the patient should also be afforded an independent psychiatric examination.¹¹⁹ The waiting period between the application and the hearing

¹¹³ An ombudsman should have legal training and at least some experience in social work. Although attracting such a person might prove costly for the state, the burden could be reduced by staffing the office with students in law or social science. Landever, *supra* note 75, at 496. The role would demand conscientious people who could work within the institution while monitoring its inadequacies. In order to escape staff identification with the institution, the independence of the role should be stressed.

¹¹⁴ *The Expanding Role*, *supra* note 62, at 533.

¹¹⁵ SPECIAL COMMITTEE TO STUDY COMMITMENT PROCEDURES OF THE ASSOCIATION OF THE BAR OF THE CITY OF NEW YORK, MENTAL ILLNESS AND DUE PROCESS 122-23 (1962).

In Great Britain, which established regional Mental Health Review Tribunals under the Mental Health Act of 1959, each panel has at least three members: a lawyer, usually as president; a doctor; and a lay member with experience in public affairs or social service. C. GREENLAND, MENTAL ILLNESS AND CIVIL LIBERTY 22 (1970).

¹¹⁶ The required interval following an unsuccessful hearing should be reasonably related to the time in which the patient is expected to improve. *Developments*, *supra* note 1, at 1392.

¹¹⁷ Such reports are utilized by the Mental Health Review Tribunals. Wood, *Mental Health Review Tribunals*, 10 MEDICINE, SCIENCE, AND THE LAW 86, 88 (1970).

¹¹⁸ *Sarzen v. Gaughen*, 489 F.2d 1076, 1086 (1st Cir. 1973).

¹¹⁹ *Dale v. Hahn*, 440 F.2d 633, 638 n.10 (2d Cir. 1971).

should be limited to two weeks or less.¹²⁰ During this time, the degree of formality should be chosen by the patient after reviewing his case with the ombudsman.¹²¹

At the hearing, protective safeguards should be applied. Counsel¹²² should screen information presented to the panel and assist the patient with the presentation of his case.¹²³ Because strict judicial rules are inapplicable, counsel need not be an attorney but rather a friend or member of the ombudsman's staff. In accordance with the constitutional right to be present at such proceedings,¹²⁴ a patient would have a right to appear and be heard. Before the patient could be excluded¹²⁵ or evidence withheld from him,¹²⁶ there should be a showing of serious potential harm. Even though a jury is not required, the panel itself would supply community judgment in a situation where standards are less definite than those in a criminal statute.¹²⁷

Because commitment is based on the assumption that hospitalization will cure mental illness or will restrain dangerous people from harming themselves or society, the state should bear the burden of affirmatively proving the necessity of continued treatment or retention.¹²⁸ If, however, the patient bears the burden of proof, the standard should be reduced from requiring an exhibition of total recovery¹²⁹ to demonstrating that "conditions justifying [the original] hospitalization no longer exist."¹³⁰ In order to obtain the appropriate balance of burdens, the presumption of continuing mental illness should disappear

¹²⁰ This constraint will not overburden the panel because it will handle few applications in a geographically limited area.

¹²¹ Most right-to-hearing cases have held the proceedings need not be quasi-judicial. *E.g.*, *Goldberg v. Kelly*, 397 U.S. 254 (1970).

¹²² Most commentators agree there is a right to counsel. *Sokol*, *supra* note 61, at 118-20; *Landever*, *supra* note 75, at 466; *Lessard v. Schmidt*, 349 F. Supp. 1078, 1092 (E.D. Wis. 1972), *vacated and remanded on other grounds*, 414 U.S. 473 (1974); *Heryford v. Parker*, 396 F.2d 393, 396 (10th Cir. 1968).

¹²³ *ENNIS & SIEGEL*, *supra* note 77, at 11.

¹²⁴ *E.g.*, *Goldberg v. Kelly*, 397 U.S. 254 (1970); *State ex rel Hawks v. Lazaro*, — W. Va. —, 202 S.E.2d 109 (1974).

¹²⁵ Such a requirement, however, requires special policing. Exclusion in discharge proceedings could be other than physical. For example, if the patient has been drugged in the institution, he might not have recovered from the effects of the drugs. *Lessard v. Schmidt*, 349 F. Supp. 1078 (E.D. Wis. 1972), *vacated and remanded on other grounds*, 414 U.S. 473 (1974).

¹²⁶ The panel may gain insight into the patient's possible reaction by studying his reaction to evidence at the commitment hearing. *Developments*, *supra* note 1, at 1395.

¹²⁷ *Humphrey v. Cady*, 405 U.S. 504, 509 (1972). There is no right to a jury in commitment proceedings. *McKeiver v. Pennsylvania*, 403 U.S. 528 (1971).

¹²⁸ *Developments*, *supra* note 1, at 1391-92.

¹²⁹ *E.g.*, OHIO REV. CODE ANN. § 5122.25 (1970).

¹³⁰ *BRAKEL*, *supra* note 4, at 461.

After *O'Connor v. Donaldson*, 95 S. Ct. 2986 (1975), "mental illness without more" will not justify continued retention.

after a reasonable period of hospitalization. In addition, the state should provide evidence in its possession otherwise unobtainable by the patient.¹⁸¹

Finally, the panel, with its combined experience and knowledge of the community, can deal creatively with a patient who no longer needs hospitalization, but does require some attention, as well as with someone who simply has nowhere to go.¹⁸² Thus, a patient would be fairly judged, without many of the problems inherent in the judicial system. As a result, the ultimate resolution of cases will be more satisfactory for both patients and hospital authorities.

CONCLUSION

Discharge procedures vary considerably among states. A few have adopted the highly protective limited confinement system. Many, however, retain paternalistic statutes for the disposition of the "insane," which deny even rudimentary due process. This note prescribes for such states, as a minimal and perhaps temporary measure, an administrative review system which will meet constitutional requirements while imposing less of a burden than judicial review of each patient's case. Constructive legislative action is urged in this unsettled area of the law which is so susceptible to neglect.

BARBARA WOODALL KRAGIE

¹⁸¹ Note, *supra* note 83, at 658.

¹⁸² As the abuses existing within institutions and the lack of after-care is brought to light, groups are strongly advocating community mental health programs. See Schumach, *Localization of Mental Aid Urged by Carey Study Unit*, New York Times, Jan. 26, 1975, at 1, col. 4. See generally Chambers, *Alternatives to Civil Commitment of the Mentally Ill: Practical Guides and Constitutional Imperatives*, 70 MICH. L. REV. 1108 (1972).