# THE WAIVABILITY OF RECOMMITMENT HEARINGS

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Problems regarding the recommitment process are only now beginning to surface.[1] Previously, recommitment was relatively unknown, for civil commitment was typically of indefinite duration.[2] Patient release ordinarily occurred only if and when hospital authorities believed it warranted.[3] In particularly rare instances,[4] knowledgeable and persistent patients triggered judicial review of the propriety of their continued confinement. Once in court, those persistent petitioners were often expected to carry the burden of persuasion regarding their readiness for release.[5]

Release patterns in mental health law are now, however, in the midst of a radical revision. The revision is attributable to a rapidly emerging conviction that, as a matter of sound social policy[6] and quite probably as a matter of constitutional law,[7] durational limits should be clamped on civil commitments. After all, the Supreme Court has already recognized that due process requires that the "duration of commitment bear some reasonable relation to the purpose for which the individual is committed."[8] And in a recent civil commitment case, the Court has emphasized that "even if [a patient's] involuntary confinement was initially permissible, it could not constitutionally continue

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1. Wexler, *Comments and Questions about Mental Health Law in Hawaii*, 13 HAWAII B.J. 3, 7 (Winter 1978) [hereinafter cited as *Comments*]; Wexler, *Current Currents in Institutionalization*, 14 SAN DIEGO L. REV. 979, 987-1000 (1977).

2. *Developments in the Law—Civil Commitment of the Mentally Ill*, 87 HARV. L. REV. 1190, 1197 (1974) [hereinafter cited as *Developments in the Law*].

3. *Id.* at 1377, 1384.

4. *Special Project—The Administration of Psychiatric Justice: Theory and Practice in Arizona*, 13 ARIZ. L. REV. 1, 155 n.49 (1971) [hereinafter cited as *Special Project*].

5. *Developments in the Law, supra* note 2, at 1382.

6. *Id.* at 1391-93.

7. *Id.* at 1391-94.

8. Jackson v. Indiana, 406 U.S. 715, 738 (1972); *see* McNeil v. Director, Patuxent Inst., 407 U.S. 245, 249-50 (1972).

after that basis no longer existed."[9]

From those Supreme Court pronouncements, it is but a short and perhaps logically required step to the proposition recently recognized by the Connecticut court in *Fasulo v. Arafeh*:[10]

> [S]ince the state's power to confine is premised on the individual's present mental status, the original involuntary commitment proceeding can only establish that the state may confine the individual at the time of the hearing and for the foreseeable period during which that status is unlikely to change. Upon the expiration of that period, the state's power to deprive the patient of his liberty lapses and any further confinement must be justified anew.[11]

The proper procedure for the state to employ to justify anew its basis for continued confinement, according to the *Fasulo* court, would be a state-initiated recommitment hearing. At that proceeding, the patient would be given the full panoply of protections associated with commitment hearings generally, and the state would carry the burden of persuasion regarding the need for further confinement.[12]

*Fasulo* is fully representative of the trend of case law and statutes[13] requiring release or recommitment after the passage of a specified period.[14] The trend is to be applauded. After a reasonable period of time, it is wise to authorize judicial review of a committed patient's status, and the patient ought not to bear the onus of initiating that review.

The problems of patient-initiated review were clearly noted in *Fasulo*. Though purporting to avoid ruling on the merits of an amended statute that was technically not before it, the *Fasulo* court nonetheless addressed the statute's patient-initiated review requirement without much hesitation or equivocation:

> Unfortunately, though the statute provides for annual notice to patients of their right to a hearing, the burden of requesting and, therefore, initiating review remains with the patient. The state seeks to justify this procedure by arguing that allowing the patient to choose whether to have a hearing will avoid unnecessary judicial proceed-

9. O'Connor v. Donaldson, 422 U.S. 563, 575 (1975); *see id.* at 580 ("confinement must cease when those reasons no longer exist.") (Burger, C.J., concurring).

10. 173 Conn. 473, 378 A.2d 553 (1977).

11. *Id.* at 480, 378 A.2d at 556-57. Although the *Fasulo* court rested its conclusion on a construction of the Connecticut constitution's due process clause, its line of reasoning—based almost exclusively on citation to opinions of the United States Supreme Court—seems fully applicable to fourteenth amendment due process considerations.

12. *Id.*

13. *See, e.g.*, Suzuki v. Quisenberry, 411 F. Supp. 1113 (D. Hawaii 1976); ARIZ. REV. STAT. ANN. § 36-540 (1974); WIS. STAT. ANN. § 51.20(14)(g) (West Supp. 1977).

14. The problem of specifying the confinement period for various cases or categories of cases will clearly consume for some time the energy of many mental health law scholars, practitioners, and policymakers. See text & note 57 *infra*.

> ings. We doubt whether this rationale is adequate since it ignores the practical difficulties of requiring a mental patient to overcome the effects of his confinement, his closed environment, his possible incompetence and the debilitating effects of drugs or other treatment on his ability to make a decision which may amount to the waiver of his constitutional right to a review of his status.[15]

That language surely—and rightly—rejects a scheme where review is available only to those patients who affirmatively request it. The problem with the language, however, resides in its clear-cut potential for overkill.

*Fasulo* was concerned with environmental and clinical conditions which may impair a patient's "ability to make a decision which may amount to a waiver of his constitutional right to a review of his status."[16] That concern, therefore, may be interpreted as invalidating not only the requirement of *patient-initiation*, but as invalidating also the possibility of a patient *waiving* a state-initiated judicial review of the patient's status.[17]

The broad interpretation of the *Fasulo* language—the suggestion that *nonwaivable* recommitment hearings may be constitutionally compelled—is strongly reinforced by the court's heavy reliance on a law review project which, for reasons identical to those noted in *Fasulo*, apparently concluded that waiver of recommitment hearings should be ruled impermissible.[18] Fortunately, however, the interpretation is

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15. 173 Conn. at 482, 378 A.2d at 557.

16. *Id.*

17. The *Fasulo* quote in the text accompanying note 15 *supra* suggests that the court would view as inadequate a procedure where the state periodically notifies a patient of the right to a hearing, but conducts a hearing only if the patient indicates a desire for one. Surely, if a procedure is inadequate when the state periodically provides a patient with a notification form and the patient places a check in a box marked "yes," it seems only a short step for a court also to find inadequate a waiver procedure where a patient is notified that a hearing will occur unless the patient checks a box marked "no." *But cf.* Suzuki v. Quisenberry, 411 F. Supp. 1113 (D. Hawaii 1976) (permissible to require patient to trigger rehearing).

18. *See* 173 Conn. at 478, 378 A.2d at 555-56 (citing *Developments in the Law, supra* note 2, at 1398). The institutional pressures and medical factors deemed by *Fasulo* to impair patient decision-making ability, *see* 173 Conn. at 478, 481-82, 378 A.2d at 555-57, are derived from the discussion in *Developments in the Law, supra*. As part of its general discussion of those factors in the context of recommitment, *Developments in the Law* asserts that "courts have generally concluded that mentally ill or deficient persons are incapable of waiving important rights. This suggests that certain rights such as counsel and hearing should be nonwaivable." *Id.* at 1397. For suggestions seemingly inconsistent with that conclusion, however, see *id.* at 1315-16, 1398 n.124.

In some states, the constitutional propriety of authorizing a patient to waive a recommitment hearing may not arise unless and until the statutes themselves are rewritten to permit a hearing waiver. Often, apart from authorizing voluntary admission, which is typically left to the discretion of the hospital or the court, *see* WIS. STAT. ANN. § 51-10(1)(a), (b), (f) (West Supp. 1977), commitment statutes do not speak of waiver of initial hearings or recommitment hearings. *See id.* § 51-20 (procedures for involuntary commitment). *See also* ARIZ. REV. STAT. ANN. § 36-539 (1974) (conduct of hearing) (no mention of waiver; hearing must include testimony of two physicians and of two witnesses; patient shall be present at the hearing unless the court finds by clear and convincing evidence that the patient is unable to attend).

In Arizona, the state hospital, rather than requiring recommitment, follows a generous policy of allowing a patient to convert to voluntary status if the patient is "willing" to accept treatment

merely derived from inference and is dicta at that. The waivability of recommitment hearings is an emerging issue clouded by conceptual confusion, pragmatic considerations, and empirical uncertainties that need to be analyzed from many perspectives before closure is reached on the question. The present Commentary is a brief and initial step in that analysis. Perhaps the benefit of dictum—even (perhaps particularly) of "inferential" or "derivative" dictum—is its potential for prompting early analysis and debate on nascent legal issues.

## CONSIDERATIONS FAVORING WAIVABILITY

Clearly, if mechanisms could be devised to eliminate the need for those, and only those, recommitment hearings that are truly unnecessary and truly unwanted by the patients, a host of considerations would favor a rule of waivability. A number of such considerations come quickly to mind.

There is, of course, the sheer economic consideration involving the depletion of judicial, mental health, and related resources. Courts sitting in the vicinity of state hospitals have terribly heavy commitment calendars. They assuredly would wish to be spared the time and expense[19] of conducting unnecessary and unwanted recommitment hearings.

The judicial time-and-cost saving interest would be particularly evident, of course, if an appreciable number of patients wished to waive such hearings. At the moment, the percent of patients desiring waiver is an empirical unknown.[20] It would not be at all surprising,

voluntarily and is "capable" of accepting such treatment. Interview with Mary K. Wisdom, Esq., Legal Analyst, Division of Behavioral Health Services, Arizona Department of Health Services, in Phoenix via telephone (April 17, 1978). Some patients, however, though unopposed to recommitment, are deemed "unwilling" to be voluntary patients because they are unwilling to sign an admission form—or perhaps to sign their names to anything al all. *Id.* Further, despite their technical legal competence, some are deemed "incapable" of accepting treatment voluntarily because of a past history of signing out against medical advice. *Id.* In spite of their lack of opposition to continued confinement, patients falling in the above categories will be deemed inappropriate cases for conversion to voluntary status and will be subject to recommitment. *Id.* Waiver of the hearing is not permitted. Live testimony is required and, except in extraordinary instances, the patient must attend. *Id.*

The arguments advanced in this Commentary against constitutional rules of nonwaivability will be relevant also to lifting statutory bars to waiver.

19. Although initial commitment hearings are typically conducted in, and at the expense of, the patient's county of residence, recommitment hearings are conducted in the county of current confinement. That county must either shoulder the expense of those hearings or enter into elaborate bureaucratic "bill-back" arrangements with the patient's county of residence.

The most wasteful recommitment hearings of all are those initiated by the state with the expectation (and hope) of *losing*. Such hearings are initiated to secure a court order mandating release of the patient, thereby insulating the hospital and staff from liability in the event the patient later proves dangerous to himself or others.

20. That problem presents an important and timely research inquiry. Such research could probably best be conducted in a jurisdiction that permits waiver. Even in a jurisdiction that does not, however, functionaries engaged in the process could calculate the number of patients likely to choose the waiver option if it were available.

however, for a rather large number of patients to desire waiver. The depressed and suicidal might well constitute one such patient category. So too, many elderly, "gravely disabled"[21] patients might opt for waiver, were it available, rather than attend hearings only to learn what they already know: that their clinical and family situation is unchanged or has worsened, and that no facilities less restrictive than full-time hospitalization can yet be found for their placement.[22]

Needless to say, physicians, nurses, and ward attendants would also prefer to treat than to testify. To the extent that they are called upon to testify in unnecessary and unwanted hearings, the patients and the public would be best served by those mental health witnesses playing instead a therapeutic role.

Moreover, mental health personnel have an additional reason to avoid testifying in recommitment hearings if at all possible. Unlike the mental health personnel in the patient's home community who testify at the initial commitment hearing in favor of the patient's need for hospitalization, the mental health personnel who testify at recommitment hearings in favor of continued involuntary hospitalization are hospital-affiliated professionals charged with treating committed patients on a daily basis. Many hospital therapists believe such testimony serves to strain their therapeutic relationship with patients.[23] The problem is most acute in jurisdictions that are under judicial or legislative mandate to exclude hearsay evidence in commitment cases.[24] In such jurisdictions, there is lively debate over whether medical records revealing mental disorder and dangerousness fall properly within a hearsay exception.[25] If the records are ruled inadmissible, recommitment hearings will require from physicians, nurses, and attendants *in vivo* testimony regarding bizarre and dangerous ward behavior of their patients.

If the assumption about strained therapeutic relations is correct, live mental health testimony at recommitment hearings should be viewed as a necessary evil to protect the rights of patients who desire to challenge their continued confinement. But such testimony may con-

21. *See* ARIZ. REV. STAT. ANN. § 36-501(11) (1974) (defining "gravely disabled").

22. Indeed, after a patient—particularly a gravely disabled patient—has been confined in a mental hospital for a stated period and has become acclimated to his surroundings, placement in a so-called "less restrictive alternative," such as a nursing home, may no longer be his desire and may no longer satisfy the "best interest" test. *See Developments in the Law, supra* note 2, at 1387 n.71.

23. This belief was a central concern at the Conference on Commitment sponsored by the Mental Health Division, Hawaii Department of Health, held in Honolulu, December 14-16, 1977.

24. *See* Suzuki v. Quisenberry, 411 F. Supp. 1113, 1130 (D. Hawaii 1976).

25. *Cf.* Note, *Hearsay Bases of Psychiatric Opinion Testimony: A Critique of Federal Rule of Evidence 703*, 51 So. Cal. L. Rev. 129 (1977) (discussion of bases of psychiatric opinion testimony). *See generally* Orland, *Evidence in Psychiatric Settings*, 11 GONZ. L. REV. 665 (1976).

stitute an unnecessary evil—a gratuitous set-back and slap in the face—for patients recognizing the need for additional hospitalization and opposed to having testimony of their aberrant behavior broadcast before a tribunal.

The interests of psychotherapists and of certain patients converge in their concern over the possible traumatic and anti-therapeutic effects of recommitment hearings. Unlike initial hearings, where the possible trauma to the patient is probably outweighed by the feedback to him of the impropriety of his behavior and by the presentation of convincing evidence that commitment is called for,[26] the interests deserve to be balanced differently in the framework of recommitment.

By the time of recommitment, a patient may well be quite aware of what is objectionable about his behavior or of why alternative placement seems unsuitable. Moreover, whether hearing adverse testimony will prove traumatic or anti-therapeutic is no longer a matter of enormous abstract speculation: the patient will have already experienced one commitment hearing and may now be in a fairly good position to assess the relative costs and benefits of contesting recommitment.[27] If recommitment is in any event likely, a number of patients may wish to avoid hearings at which testimony will be given regarding, for example, the persistence of their depressed and suicidal state, or the continuing unwillingness of families or of nursing homes to accept patients who act out conflicts or who are sometimes assaultive.[28]

## AVOIDING NONWAIVABLE HEARINGS

If recommitment hearings are ruled constitutionally nonwaivable, a patient facing a recommitment hearing will, in theory at least, be appointed counsel sufficiently in advance of the scheduled rehearing to permit adequate preparation.[29] Presumably, that preparation will entail a conference with the client.[30] If the attorney's investigation leads him to conclude that the probability of recommitment is overwhelming, and if the client, for apparently plausible reasons, wishes to the extent legally possible to avoid being subjected to the rehearing proceeding, the lawyer might consider certain options likely to maximize the client's satisfaction.

If statutorily available, such options would include stipulating to

26. *See Special Project, supra* note 4, at 69-76.

27. *Cf. Developments in the Law, supra* note 2, at 1395 (comparative trauma at initial and subsequent commitment hearings).

28. For a discussion of the possible trauma of hearings, see Davidson, *Mental Hospitals and the Civil Liberties Dilemma*, 51 MENTAL HYGIENE 371 (1967); *Special Project, supra* note 4, at 69-71.

29. *See* ARIZ. REV. STAT. ANN. § 36-536 (1974).

30. *See id.*, § 36-537(B) (1).

the absence of live medical testimony at the hearing,[31] dispensing with the patient's presence at the hearing,[32] or, with the hospital's approval, seeking to convert the patient's status from involuntary to voluntary.[33] By dispensing with expert testimony, the patient may be spared the perceived agony of hearing others recount unfavorable behavioral incidents. The patient is of course similarly spared if he absents himself from the hearing. And, if a conversion to voluntary status is arranged, the hearing itself will be dispensed with.

In a jurisdiction flatly holding recommitment hearings nonwaivable, however, these avoidance devices would themselves be constitutionally suspect. In the overwhelming majority of cases, foregoing the opportunity to hear and cross-examine medical experts will be viewed as a psychiatric plea of *nolo contendere*. Failing even to attend the hearing will amount to a full-fledged psychiatric guilty plea. Since such maneuvers would constitute the *de facto* equivalent of waiving a nonwaivable hearing, they may well be disallowed.

The legal situation with respect to conversion to voluntary status is somewhat more complicated, but that course of action too is arguably impaired by a rigid rule of nonwaivability. First of all, if a "nonwaivability" jurisdiction were also to accept and embellish the equal protection principles established by the New York Court of Appeals in *In re Buttonow*,[34] the jurisdiction would largely limit the effects that would normally flow from a patient's conversion from involuntary to voluntary status.

*Buttonow* held that equal protection demands that the protections available to involuntary patients be accorded also to patients who con-

31. *See* CONN. GEN. STAT. ANN. § 17-178(c) (West Supp. 1978) where, in fact, the respondent must act affirmatively to trigger the live testimony of medical experts: "[T]he court shall require the sworn certificates of at least two physicians . . . . If such respondent notifies the court not less than three days before the hearing that he or she wishes to cross-examine the examining physicians, the court shall order such physicians to appear."

32. *See* Lynch v. Baxley, 386 F. Supp. 378, 388-89 (M.D. Ala. 1974) (competent waiver of presence permitted). For a looser waiver standard, *see* Greene v. State, 537 S.W.2d 100, 102 (Tex. Ct. App. 1976) (waiver of presence permitted if "the right has been knowingly and intelligently waived by such person or by adversary counsel acting in her behalf and for good cause shown"). *But see* State *ex rel.* Hawks v. Lazaro, — W. Va. —, —, 292 S.E.2d 109, 125 (1974) ("the subject individual, just as a criminal defendant, must be present in person and cannot waive that right."); CONN. GEN. STAT. ANN. § 17-178(f) (West Supp. 1978): "The respondent shall be present at any hearing for his or her commitment hereunder."

33. For one version of such a provision, see CONN. GEN. STAT. ANN. § 17-178(e) (West Supp. 1978): "At the beginning of any hearing . . . the respondent shall be given the opportunity by the court to indicate whether or not he or she is willing to enter the hospital on a voluntary basis . . . ."

The availability of conversion may, of course, rest very much within the control of the hospital. Voluntary admission generally requires the approval of the hospital. *See* ARIZ. REV. STAT. ANN. § 36-518(A), (C) (1974). Attempts by committed patients to convert to voluntary status may often meet with resistance. Hospitals may fear losing control over patients, or may fear that the status conversion is merely a strategic attempt to preclude recommitment. See discussion note 54 *infra*.

34. 23 N.Y.2d 385, 244 N.E.2d 677, 297 N.Y.S.2d 97 (1968).

vert from involuntary to voluntary status.[35] At issue in *Buttonow* was the right to be assisted by an advisory and advocacy unit known as the Mental Health Information Service, and the *right* to be accorded a periodic judicial review regarding continued retention. Both of those rights, according to the *Buttonow* court, had to be furnished the committed patient who converted to voluntary status.[36]

If *Buttonow* is applied not only in a jurisdiction where the protections afforded involuntary patients include a right to a periodic judicial review, but also in a jurisdiction which views the protection to include a *nonwaivable* right to such periodic judicial review, the so-called conversion to voluntary status will be rendered meaningless[37]—at least as respects the possibility of converting status in order to avoid recommitment hearings. Moreover, a jurisdiction so concerned with judicial review of status (and with the capacity of patients to waive such review) as to rule the review process nonwaivable is presumably also a jurisdiction that would be likely to accept *Buttonow* and a broad interpretation of it.[38]

Even if a *Buttonow* equal protection rationale is not invoked to preclude conversion to voluntary status in a jurisdiction that considers recommitment hearings to be constitutionally nonwaivable, the status conversion may nonetheless be deemed impermissible on due process grounds. Conversion of a committed patient to voluntary status may arguably be disallowed for the very reasons given for denying committed patients the right to waive recommitment hearings. Thus, the adverse impact on decision-making ability of the so-called "*Fasulo* factors"—institutionalization, staff pressure, mental disability, and drugs[39]—might be viewed as sufficient to preclude committed patients from converting to voluntary status, a status where their protections

35. *Buttonow* addressed only the equal protection rights of a patient who converted to voluntary status, not the rights of a patient originally admitted as voluntary. *Id.* at 392 n.5, 244 N.E.2d at 681 n.5, 297 N.Y.S.2d at 103 n.5.

36. *Id.* at 393, 244 N.E.2d at 682, 297 N.Y.S. 2d at 103-4.

37. *Cf. id.* at 397-98, 244 N.E.2d at 684, 297 N.Y.S.2d at 106-07 (Breitel, J., dissenting) (*Buttonow* itself goes a long way toward sapping the advantages of voluntary status).

38. It is of course possible, however, that *Buttonow* will not be generally accepted. It is possible, too, that *Buttonow* will be accepted, but only in the limited procedural context in which it was conceived (that is, the right to periodic judicial review as opposed to the right to nonwaivable periodic judicial review). In other words, the case itself may be followed, but it may not be read expansively to extend other sorts of involuntary patient rights to patients who have converted to voluntary status. In particular, a broad reading of *Buttonow* may be avoided where the supposed *benefits* to be afforded converted voluntary patients are perceived by such patients to be *burdens*. Thus, *Buttonow* might be invoked to accord converted voluntary patients a right to periodic judicial review without imposing upon those patients a nonwaivable obligation to submit to such review. Such an interpretation of *Buttonow* seems unlikely and unduly narrow, however, in a jurisdiction that views a nonwaivable hearing to be a benefit to committed patients even though such patients may regard the hearing as burdensome.

39. *See* 173 Conn. at 482, 378 A.2d at 557, *quoted at* text accompanying note 15 *supra*. *See also* Gilboy & Schmidt, *"Voluntary" Hospitalization of the Mentally Ill*, 66 NW. U.L. REV. 429 (1971) (pressures on voluntary patients).

will presumably be weak and where their vulnerabilities will be fair game for well-meaning and not-so-well-meaning hospital staff members. A jurisdiction so concerned with impermissible factors impinging upon a patient's decision to waive judicial review of his status may well be unwilling to permit a patient, possibly as a result of such impermissible factors, to convert to voluntary status and thereby to waive the important check of periodic judicial review.

With or perhaps even without *Buttonow*, then, a rule relating to the nonwaivability of recommitment hearings casts a constitutional cloud over the procedure of converting a committed patient's status to a voluntary status. That the common, well recognized, and rather well respected[40] conversion procedure arouses constitutional suspicion, however, is a consequence sufficiently dramatic to call for discussion over whether a legal structure can be designed to preserve the assumed benefits of conversion—and of waivers of recommitment hearings generally—without creating a situation where patients fall prey to the "*Fasulo* factors."

## THE FASULO FACTORS AND THE FUTURE

Some jurisdictions permit the waiver of even initial commitment hearings.[41] Intuitively, it seems evident that if one were permitted not only to enter a hospital voluntarily or informally, but were permitted also to waive an initial hearing and to actually consent to commitment,[42] then that person should a fortiori be permitted later to waive recommitment hearings. Arguments against permitting initial waiver seem in many respects to be stronger than do those against permitting subsequent waivers.[43] After all, the deprivation of liberty entailed in

40. *See In re* Buttonow, 23 N.Y.2d 385, 397-98, 244 N.E.2d 677, 684, 297 N.Y.S.2d 97, 106-07 (1968) (Breitel, J., dissenting).

41. *See* Greene v. State, 537 S.W.2d 100 (Tex. Ct. App. 1976); *Comments, supra* note 1, at 9; *cf.* Ellis, *Volunteering Children: Parental Commitment of Minors to Mental Institutions*, 62 CALIF. L. REV. 840, 905-06 (1974) (proposal for commitment of juveniles).

It is important to recognize that, technically, the waiver of a commitment hearing, as in *Greene*, is conceptually distinct from a voluntary admission and from an informal one. An informally admitted patient can sign himself out at will. A voluntarily admitted patient can sign himself out by giving the hospital a certain number of days advance notice (during which time the hospital may decide to initiate involuntary commitment proceedings if such are deemed necessary and proper). *See* CONN. GEN. STAT. ANN. § 17-187(a), (b) (West Supp. 1978) (distinguishing voluntary and informal admissions). Unless a statute specifies otherwise, however, a patient who waives a commitment hearing is technically consenting to remain hospitalized for up to the specified maximum commitment period. Release prior to that period would be available only in the hospital's discretion or by court order on habeas corpus, where the patient would bear the burden of persuasion. *Cf. Developments in the Law, supra* note 2, at 1392 n.98 (discussing various mechanisms for release or review). For a discussion of why a patient may be allowed to consent to commitment but not be allowed to be a voluntary patient, see notes 18, 33 *supra*.

42. See distinctions drawn in note 41 *supra*.

43. In terms of important but non-determinative economic considerations, it is perhaps noteworthy that the resource burden of nonwaivable recommitment hearings will fall disproportionately on the courts in the vicinity of state hospitals, but the resource burden of nonwaivable

the shift from community living to a period of total institutional confinement seems qualitatively different and comparatively more drastic than does the deprivation entailed in the continuation of hospitalization for an additional commitment period.[44] Further, at the outset of compulsory hospitalization, it may be therapeutic to demonstrate to a patient how and why others view his behavior as intolerably aberrant, and to demonstrate to him as convincingly as possible his need for hospitalization.[45] Repeat demonstrations may be considerably less necessary, however, after a patient has once received the "educational" benefits of a commitment proceeding.

Other factors being equal, therefore, it seems that, if anything, it should be legally more difficult for a patient to waive an initial commitment hearing than to waive a recommitment hearing. If the *Fasulo* factors alone were applicable, however, a contrary result would curiously follow. Since the effects of institutionalization, hospital personnel pressure, and chemotherapy are almost by definition far more applicable in the post-commitment setting than in the pre-commitment setting, the application of those factors to determine hearing waivability might well lead to a determination of waivability of the initial hearing but to nonwaivability of subsequent hearings. The counter-intuitive discrepancy can be somewhat reduced, however, when it is recognized that even a *Fasulo*-type jurisdiction need not, and should not, determine all hearing waivability decisions by application of the *Fasulo* factors alone. Those factors may well have bearing on the recommitment waiver decision, while other factors—such as the "educational" ones noted above—may bear strongly on the question of initial hearing waivers. A jurisdiction taking account of all the noted factors may, therefore, find both initial hearings and recommitment hearings to be nonwaivable.

Regardless of how a jurisdiction balances the interests in the initial waiver setting, however, it is possible, if and when an effective patient advocacy system is established,[46] for a jurisdiction, even in the recommitment context, to mitigate considerably the influence of the *Fasulo* factors. After a patient has been involuntarily confined for a specified time, the state must, under the laudable emerging body of law, release

initial commitment hearings would presumably be distributed proportionately along lines of population distribution. See discussion note 19 *supra*.

44. *Cf. Developments in the Law, supra* note 2, at 1395 (difference in trauma between initial confinement and recommitment).

45. *See* text & note 26 *supra*.

46. The need for effective advocacy in mental disability law is extensively discussed in *Mental Health and Human Rights: Report of the Task Panel on Legal and Ethical Issues*, 20 ARIZ. L. REV, —, —(1978).

the patient or initiate recommitment proceedings.[47] Once a recommitment petition is filed, the patient should be consulted by an appointed attorney.[48] If that attorney is performing properly, the interposition of counsel should counteract considerably the adverse influence of institutional factors on the client's decision-making ability.

Surely, counsel's advice can in most cases counter coercive influences of the institution or of its staff. And counsel's knowledge, coupled with a thorough investigation of the case, should overcome problems of client lack of knowledge. Counsel will be able to advise the patient of available options and of likely outcomes of contesting recommitment.

Counsel can, therefore, guard against coerced or uninformed decision-making. And although counsel's presence cannot itself overcome problems inherent in the patient's clinical condition and possible incompetence, we must, in discussing the waivability of recommitment hearings, be careful to insure that the competence question is kept in its proper perspective.

First of all, it is important to remember that some of the *Fasulo* factors (hospitalization, drugs) may actually improve the patient's competence. Further, the competence required to volunteer for admission to a mental hospital is ordinarily rather minimal.[49] And although the competence required for waiving a recommitment hearing is presumably somewhat distinct from that required for a voluntary admission,[50] the competence to waive standard should be rather easily satisfied. Presumably, a patient who has already undergone an initial commitment proceeding could often satisfy the recommitment waiver standard. He would seemingly satisfy it if he understood simply that there was to be another court hearing to decide whether he should be retained in the hospital. Perhaps it will also be required that he understand his lawyer's assessment of the case and its predicted outcome.

If the patient meets the minimal test of capacity, his autonomy should seemingly be respected regarding his desire to contest, or not to contest, recommitment.[51] Indeed, even if the patient's competence is in

47. See text accompanying notes 6-14 *supra*.

48. See text accompanying notes 29-30 *supra*.

49. *See In re* Buttonow, 23 N.Y.2d 385, 394, 244 N.E. 2d 677, 682, 297 N.Y.S.2d 97, 104 (1968) (applicant for voluntary admission need not possess legal capacity to contract). *See generally* Alexander & Szasz, *From Contract to Status Via Psychiatry*, 13 SANTA CLARA LAW. 537 (1973).

50. See discussion note 41 *supra*. Of course, to the extent that a statute authorizes a patient who has waived a recommitment hearing to revoke that waiver at will and, upon revocation, to force the state to prove its case for continued confinement, a consent to recommitment would very closely resemble (or perhaps constitute the equivalent of) a voluntary admission. In such a case, the capacity required for the two procedures ought to be virtually identical.

51. *Cf.* Lynch v. Baxley, 386 F. Supp. 378, 388-89 (M.D. Ala. 1974) (competent waiver of presence at hearing permitted).

question, a powerful argument can be made that his expressed intent should carry considerable weight. That is because showing respect for even an incompetent desire may promote autonomy and may in any event be consistent with the client's "best interest."[52] In any case, it is not unknown in mental health law for an attorney to be authorized to waive fundamental rights of a client so long as the client, with or without meeting the test of competence, "knowingly concurs" in the waiver.[53]

In short, the concerns (*Fasulo* factors) that prompt a nonwaivability rule in the recommitment context can seemingly be reduced by conscientious and effective counsel. Waivability—consent to recommitment for up to a specified period—should probably be authorized if a lawyer playing an adversary role certifies to the court that he has investigated the case and has consulted with his client, that he has explained to the client the options and the right to contest recommitment, and that he has concluded that the client desires to consent to recommitment.[54]

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52. *Cf.* Wexler, *Reflections on the Legal Regulation of Behavior Modification in Institutional Settings*, 17 ARIZ. L. REV. 132, 137 n.21 (1975):

> The client's antagonistic feeling toward the procedure, or perhaps his anxiety over it, may constitute a significant factor to be thrown into the hopper of considerations relevant to gauging whether, in a cost-benefit sense, the proposed procedure is in the best interest of the client. By the same token, the client's strong feelings in favor of the procedure may be relevant, though not determinative, in finding the procedure to be in his best interest.

As a factual matter, a client who fails to meet even the minimal test of competence set forth above is very likely to be recommitted whether or not he contests recommitment. At the very least, it surely could not be viewed as a travesty of justice if a lawyer, who believes the client will be recommitted, follows a course of action (for example, waiver of hearing) that corresponds to the client's incompetent but expressed desire. *Compare* Lynch v. Baxley, 386 F. Supp. 378, 396 & n.19 (waiving rights of incompetent patients sometimes permissible) *with* Suzuki v. Quisenberry, 411 F. Supp. 1113, 1129 n.14 (D. Hawaii 1976) (describing *Lynch* rule as "slippery ground").

53. *See Developments in the Law, supra* note 2, at 1315-16; *cf.* Ellis, *supra* note 41, at 905-06 (waiver of commitment hearing by juvenile). *See also* Quesnell v. State, 83 Wash. 2d 224, 240-42, 517 P.2d 568, 576-78 (1974). Of course, if the client desires a hearing, counsel should never waive it.

54. This recommended procedure parallels that developed by James Ellis regarding a juvenile's right to waive an initial commitment hearing. *See* Ellis, supra note 41, at 906.

A recommitment waivability rule would receive further fortification, of course, if appointed counsel consulted the client frequently, if the client were able to contact counsel with ease, and, perhaps most significant, if recommitment hearing waivers could be revoked at will. If consent to recommitment were revocable at will, the patient would be in a position virtually identical to a voluntary patient. See discussion notes 41 & 50 *supra*.

A statute which permits a recommitment hearing to be waived but which also permits later revocability of the waiver must be careful to guard against strategic use of the waiver-revocation duo to circumvent recommitment. For example, suppose a statute permits commitment or recommitment only if a patient has demonstrated his dangerousness by a recent overt act—perhaps defined as an act occurring within 15 days of the filing of a commitment petition. Suppose further that *P*, toward the end of his initial commitment period, acts out in a highly aggressive manner on January 10th. On January 20th, the state files a petition to trigger commitment for an additional period (180 days, et cetera). *P* "waives" the hearing, consents to recommitment, and then, on January 30th, revokes the waiver. If the state then seeks to recommit him, the overt act of January 10th, in the absence of a special statutory provision addressed to the situation, might now be deemed too remote to permit recommitment. A statutory provision could of course be designed to cover such situations by specifying that the recency of an overt act is to be determined

## CONCLUSION

The importance of the issue regarding the waivability of recommitment hearings cannot be seriously questioned. The vulnerability of institutionalized patients, to which the *Fasulo* court was so sensitive, may, however, be markedly reversed by effective advocacy systems.

If a substantial number of committed patients, such as elderly patients, patients suffering from depression, and the like, are willing to consent to recommitment, a rigid rule of nonwaivability may prove disadvantageous in many respects. Such a rule may prove disadvantageous not only to the judiciary, to testifying therapists, and to those patients willing to waive, but it may also prove disadvantageous to committed patients *in general*, including those eager to test the propriety of their continued confinement.

If a substantial number of patients undergo recommitment hearings merely because such hearings are nonwaivable, the recommitment process in general may degenerate to a very ritualistic one. Further, judicial time and energy may be diverted from those recommitment cases which are truly contested or which involve meritorious claims for release.[55] Most important, however, a desire by judges to avoid hearing many dull, uncontested cases may lead to the application of pressure on the legislature to maximize the length of time between recommitment hearings, or even to maximize the permissible length of confinement under initial orders of commitment.

For example, in light of empirical findings that attempted suicidal behavior is unlikely to recur even if the patient is confined for only a brief hospital stay, proposals are beginning to emerge which would limit dramatically the length of time suicidal patients could be involuntarily confined.[56] Suppose a legislature responded by limiting such commitments to thirty days. Suppose further the following hypothetical: From commitment courts throughout the state, one hundred suicidal patients are committed to the state hospital on a given day. Within thirty days, twenty-five of them have been released on the hospital's initiative. The hospital wishes to retain the remaining seventy-five for an additional thirty day period. Of those seventy-five, fifty are willing to stay and twenty-five are unwilling to. Of the twenty-five resisting patients, perhaps ten will be successful in court. But if the court in the vicinity of the state hospital is forced to hear all seventy-

by its proximity to the date on which the petition was filed, not to the date on which a petition is refiled following a hearing waiver and ultimate revocation.

55. *Cf.* Ellis, *supra* note 41, at 905 (initial juvenile hearings).

56. For a discussion of the empirical literature and of one legislative proposal, see Shuman, Hegland & Wexler, *Arizona's Mental Health Services Act: An Overview and an Analysis of Proposed Amendments*, 19 ARIZ. L. REV. 313, 339-40 (1977).

five cases, only ten of which lead to release, pressure may be exerted on the legislature to boost the initial confinement period for suicidal patients to sixty days. If the pressure proves successful, the patients who will be hurt are those who remain opposed to being hospitalized, who wish to contest their confinement in court, whose clinical condition may have improved, and who may be entitled to release.

A rule of nonwaivability of recommitment hearings, therefore, may well lead to legislative resistance to limiting compulsory confinement to "the shortest interval during which the condition of a significant number of patients is expected to change."[57] Ironically, therefore, if *Fasulo's* suggestion (or "derivative dictum") regarding nonwaivability is widely followed, legislatures may be reluctant to implement *Fasulo's major* message—that confinement be limited to "the foreseeable period during which [the patient's condition] is unlikely to change"![58]

57. *Developments in the Law, supra* note 2, at 1391 n.97. That confinement period is viewed as the permissible maximum because "if a longer period determined by the average rate of change were used, the standardized frequency for recommitment would allow the state to maintain custody over a number of patients for a duration not reasonably related to the purposes of their commitment." *Id.*

58. 173 Conn. at 480, 378 A.2d at 556.