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In 1980, the author of this article noted that Wyoming's involuntary civil commitment laws, which had been in effect since 1963, contained a number of constitutionally suspect provisions (see Volume XV, Land & Water Law Review). The Wyoming legislature substantially revised the laws in 1981. Here, the author examines the 1981 amendments and, while generally concluding that the new law is a vast improvement over the previous statutory scheme, he identifies several potential problems with the new procedures.

A PRELIMINARY REVIEW OF WYOMING'S REVISED CIVIL COMMITMENT PROCEDURES

*Robert B. Keiter**

The forty-sixth legislature substantially revised the existing statutory provisions governing the commitment and treatment of mentally ill persons in Wyoming. Effective May 20, 1981, the amendments changed the standard and procedures governing civil commitment, emergency detention, and transfer and release of patients from the state hospital. The revisions are basically consistent with national trends regarding the care and treatment of the mentally ill. They are designed to facilitate local treatment of patients and to encourage voluntary rather than involuntary hospitalization. They also are intended to assure procedural regularity to individuals facing detention or commitment. The revised statute represents a significant improvement over the pre-existing one which had governed

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these matters since its original adoption in 1963. Some problems, nevertheless, are apparent on the face of the new law, and others have surfaced with its initial application. Therefore, it seems appropriate to take a critical preliminary look at the statute.

While the article will note problems with the new scheme, it is recognized that the law has been in effect for little more than a year. Although this hardly provides an adequate opportunity for the courts, attorneys and others faced with implementing the statute to adapt to the new procedures and to clarify many of them, it is not too early to highlight particular problems with the hope that they can be resolved through judicial or administrative interpretation[1] or prompt legislative revision. Moreover, since the Public Defender's Office is not handling commitment cases under the new statute,[2] an examination of the provisions will hopefully prove helpful to the private attorneys who will receive court appointments in this area.

This article will first examine the involuntary hospitalization process, focusing particularly on the revised commitment standard and procedures.[3] Next, the article

1. The statute requires the Board of Charities and Reform to adopt standards governing the state hospital. WYO. STAT. § 25-3-105(a)(i) (1981). It likewise requires the Department of Health and Social Services to adopt standards for designating hospitals authorized to provide treatment to persons falling within the statute. *Id.* § 25-3-104(a)(i) to (ii). Also, the statute seems to provide the state hospital with the authority to promulgate rules and regulations governing its operation. *Id.* §§ 25-3-103, -124(a). Neither the Board of Charities and Reform nor the State Hospital have yet promulgated any regulations; the Department of Health and Social Services has drafted but not yet finalized standards for the designation of local hospitals. Careful and deliberate use of this rulemaking authority by these bodies can be expected to supplement the statutory mandates and, in many cases, may prove adequate to obviate apparent problems. Additionally, Wyoming statutes authorize the Attorney General's Office to issue written opinions on legal questions submitted to him by state officials. *Id.* § 9-2-505. The Attorney General's Office has prepared and disseminated a Procedures Manual outlining and explaining the revised civil commitment statute. *See* PROCEDURES MANUAL, EMERGENCY DETENTION & INVOLUNTARY HOSPITALIZATION (1981) [hereinafter cited as PROCEDURES MANUAL].
2. The statute requires the counties to assume the costs for the detention and legal proceedings attendant to commitment of a Wyoming resident to the state hospital. WYO. STAT. § 25-3-116(b) (1981). Consequently, the state public defender, who previously had handled most civil commitment matters in counties where established offices existed, no longer handles these cases.
3. In discussing the revised statute, it frequently will be necessary to refer to the pre-existing statute to clarify the changes which have been mandated. Since the 1963 statute was outlined thoroughly in a previous article, this article will rely upon and refer to the prior article in lieu of reciting

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will evaluate the revised emergency detention provisions. Finally, it will examine the changes mandated in handling the review, release and transfer of patients from the state hospital.[4]

I. INVOLUNTARY HOSPITALIZATION

The revised statute eliminates most of the constitutional problems concerning involuntary commitment procedures evident in the 1963 statute.[5] Section 112 of the statute redefines the standard governing civil commitment in a manner that is constitutionally acceptable and it incorporates the concept of the least restrictive alternative into the commitment process. For practical purposes, however, the new standard may not represent a significant improvement over the pre-existing one, and it is unclear whether the least restrictive alternative provision has any real meaning. The statute also clarifies involuntary hospitalization procedural requirements and it extends various procedural rights to individuals facing commitment hearings. But the procedural protections specified in Section 112 are not always consistent with other protections specified elsewhere in the statute. Furthermore, Section 112 may not adequately address all of the potential procedural issues that can be expected to arise during commitment proceedings.

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the various earlier provisions in detail. *See* Keiter, *A Constitutional Analysis of Involuntary Civil Commitment in Wyoming*, 15 LAND & WATER L. REV. 141 (1980) [hereinafter cited as *Civil Commitment in Wyoming*]. It is hoped that these shorthand references will avoid unnecessary duplication of the 1980 article, yet provide sufficient clarity to evaluate the revised statute.

4. *Civil Commitment in Wyoming, supra* note 3, cited numerous cases bearing upon the major topics to be investigated in this article. Rather than rehash these cases in detail, this article will refer to the prior decisions when appropriate, but it will focus most of its attention upon case law developments subsequent to publication of the earlier article. For the most part the two articles have been subdivided similarly for ease of comparison and for cross reference purposes.

5. *See Civil Commitment in Wyoming, supra* note 3, at 180-94. During the 1981 fiscal year, 228 patients were admitted to the Wyoming State Hospital as involuntarily committed patients. 1981 ANNUAL REPORT OF THE BOARD OF CHARITIES & REFORM 79 [hereinafter cited as 1981 ANNUAL REPORT].

A. *Commitment Standard*

The standard for involuntary commitment is a judicial finding that an individual is a "mentally ill person."[6] A "mentally ill person" is defined as:

> a person who presents an imminent threat of physical harm to himself or others as a result of a physical, emotional, mental or behavioral disorder which grossly impairs his ability to function socially, vocationally or interpersonally *and* who needs treatment *and* who cannot comprehend the need for or purposes of treatment *and* with respect to whom the potential risk and benefits are such that a reasonable person would consent to treatment.[7]

The statute requires that the finding of mental illness be based upon "clear and convincing evidence of recent overt acts, attempts or threats."[8] By incorporating the evidentiary standard of "clear and convincing" proof found constitutionally adequate by the Supreme Court in *Addington v. Texas*,[9] the statute cannot be faulted on procedural due process grounds. Otherwise, the constitutional validity of the commitment standard must be assessed under substantive due process doctrine.

Applicable substantive due process principles indicate that where an individual's liberty is at stake, as in the case of involuntary commitment, the legislation must be within the state's inherent authority and must utilize narrowly tailored means to accomplish its objective.[10] The Supreme Court has endorsed the state's police power and its *parens patriae* authority as viable bases for civil commitment legislation.[11] The Wyoming commitment standard seemingly rests upon both grounds since hospitalization is

6. WYO. STAT. § 25-3-112(k) (1981) (standard for civil commitment); *Id.* § 25-3-101(a)(ix) (definition of mentally ill person).
7. *Id.* § 25-3-101(a)(ix) (emphasis added).
8. *Id.* § 25-3-112(k).
9. 441 U.S. 418 (1979).
10. Humphrey v. Cady, 405 U.S. 504, 509 (1972). *Cf.* Roe v. Wade, 410 U.S. 113, 155 (1973) (right of privacy involved in abortion decision).
11. Addington v. Texas, *supra* note 9, at 426; O'Connor v. Donaldson, 422 U.S. 563, 575 (1975).

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sanctioned if, among other things, the individual is imminently dangerous and requires treatment. Whereas the old statute established dangerousness and treatment considerations as separate grounds for commitment,[12] the revised statute is framed conjunctively and incorporates both elements into one commitment standard. Since the dangerousness and treatment criteria are joined, the statute sets forth a standard under which *parens patriae* commitment considerations are related to the individual's potential for harm to himself or others.[13] By limiting commitment to those cases when an individual presents an imminent threat of harm to himself or others, the legislature clearly has acted within the constitutional bounds of its police power or its *parens patriae* authority.

Applicable constitutional principles also require that the statute must be drafted narrowly to assure that the state not exceed its limited police power and *parens patriae* objectives.[14] In addition, constitutional vagueness requirements mandate carefully constructed legislation where individual liberty interests are at stake.[15] In both regards the revised statute represents an improvement over the broad provisions of the old statute. Rather than treat mental illness as a separate component of the commitment standard,[16] the statute employs mental illness as the standard and attempts to define it in objective and functional terms. The statute contemplates that commitment decisions will be predicated upon factual evidence of a type which courts customarily handle. The dangerousness criteria requires the showing of an "imminent threat of physical harm to self or others" based upon "recent overt acts,

12. *See Civil Commitment in Wyoming*, *supra* note 3, at 152.
13. *See* Lynch v. Baxley, 386 F. Supp. 378 (M.D. Ala. 1974); Doremus v. Farrell, 407 F. Supp. 509 (D. Neb. 1975); Colyar v. Third Judicial Dist. Court for Salt Lake County, 469 F. Supp. 424 (D. Utah 1979). These decisions limited state statutory commitment standards predicated exclusively upon the state's *parens patriae* authority to those cases where the individual posed a threat of harm to himself. *See generally Civil Commitment in Wyoming*, *supra* note 3, at 156-57.
14. Humphrey v. Cady, *supra* note 10, at 509; Roe v. Wade, *supra* note 10, at 155.
15. Bell v. Wayne County General Hosp., 384 F. Supp. 1085 (E.D. Mich, 1974); Kendall v. True, 391 F. Supp. 413 (W.D. Ky. 1975); Stamus v. Leonhardt, 414 F. Supp. 439 (S.D. Iowa 1976).
16. *See Civil Commitment in Wyoming*, *supra* note 3, at 159.

attempts or threats."[17] The requirement that the threat of dangerous behavior must be "imminent" substantially narrows the commitment criteria so that it can be regarded as consistent with the state's police power interests.[18] The "recent overt act, attempt or threat" requirement envisions the factual testimony of persons familiar with the individual and his recent actions.[19] While a psychiatric prediction of dangerousness may be useful in individual cases, it probably cannot be regarded as adequate, standing alone, to justify commitment.[20] The statute also requires that dangerousness must arise from an underlying "physical, emotional, mental or behavioral disorder" and the disorder must impair the individual's "ability to function socially, vocationally or interpersonally."[21] By modifying the dis-

17. WYO. STAT. § 25-3-112(k) (1981). *See* Lessard v. Schmidt, 349 F. Supp. 1078, 1093 (E.D. Wis. 1972), *vacated and remanded,* 414 U.S. 473 (1973); 379 F. Supp. 1376 (E.D. Wis. 1974), *vacated and remanded,* 421 U.S. 957 (1975); 413 F. Supp. 1318 (E.D. Wis. 1976); Lynch v. Baxley, *supra* note 13, at 391.

18. *See* Suzuki v. Yuen, 617 F.2d 173, 178 (9th Cir. 1980) (overturning the Hawaii civil commitment standard because the statute did not require a showing of "imminent danger to self or others"); *But see* Hatcher v. Wachtel, 269 S.E.2d 849, 852 (W. Va. 1980) (imminent danger not required to justify commitment); In re Prime, 424 A.2d 804 (N.H. 1980) (period of seventy five days between dangerous act and commitment meets recent act of dangerousness requirement); In re Interest of Blythman, 302 N.W.2d 666 (N.W. 1981) (five year old act sufficient to show recent dangerous act justifying commitment under all facts of the case).

19. *See Civil Commitment in Wyoming, supra* note 3, at 162; Haber v. People, 78 Ill. App.3d 1120, 398 N.E.2d 121 (1979). *Cf.* People v. Taylor, 618 P.2d 1127, 1133 (Colo. 1980) (judge or jury role in civil commitment proceedings is to supplement professional medical opinion regarding connection between individual's mental illness and his potential for harm to himself or others); State v. Ladd, 433 A.2d 294, 295 (Vt. 1981) (court must state facts not medical conclusions in its commitment order).

20. Psychiatric predictions of dangerousness are highly unreliable. Ennis & Litwack, *Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom,* 62 CALIF. L. REV. 693 (1974). However, if the professional can testify from first hand knowledge about an individual's recent act, attempt or threat which was potentially dangerous to himself or others, then commitment might be based solely on his testimony. It is likely that the physician's knowledge would come from his conversations with the proposed patient which raises the possibility that the doctor-patient evidentiary privilege may preclude introduction of this type of evidence into the proceedings. *See infra* text accompanying notes 66-69. *But cf.* Matter of N.B., 620 P.2d 1228 (Mort. 1980) (testimony of "professional person" required to establish existence of serious mental disorder).

21. WYO. STAT. § 25-3-101(a)(ix) (1981). This aspect of the Wyoming statute apparently was based upon the Colorado statutory definition of mental illness, COLO. REV. STAT. § 27-9-102(5) (1973), which was repealed by the Colorado legislature on July 1, 1975. Instead Colorado presently defines a mentally ill person as one "who is of such mental condition that he is in need of medical supervision, treatment, care, or restraint." *Id.* § 27-10-102 (7) (1975). Colorado sanctions commitment only upon a finding that the individual is "mentally ill and, as a result of such mental illness, a danger to others or to himself or gravely disabled." *Id.* § 27-10-109(1)(a).

order requirement in such a manner the statute seems to contemplate additional factual type evidence regarding the individual's behavior. This further emphasizes the objective nature of the commitment inquiry and should render the proceedings more meaningful to courts and attorneys. In addition, the statute incorporates a reasonable person standard into the treatment criteria which represents another concept with which courts are familiar.[22]

Given the problems inherent in any attempt to define mental illness, the Wyoming standard represents a reasoned effort to confine the concept and, thus the basis for civil commitment, within relatively narrow grounds through the use of objective criteria. Based upon the decisions of lower courts faced with constitutional challenges to other state commitment standards, the revised Wyoming statute should withstand any such attack.[23] The statute, however, is not functionally as sound as it might be. Not all of the component parts of the commitment standard are necessary to shield the statute from constitutional objection. Courts might find the standard unwieldly to apply because it is framed conjunctively. Furthermore, courts are required to engage in a difficult inquiry to asses the reasonableness of treatment in particular cases.

As originally conceived the statute was designed to sanction commitment based upon an individual's potential dangerousness arising from an underlying disorder.[24] Amendment on the floor of the Senate added the treatment criteria.[25] While this further narrows the basis for commitment, it cannot be regarded as essential to the statute's validity. Courts which have passed upon other commitment standards have consistently upheld the police power based

22. WYO. STAT. § 25-3-101(a)(ix) (1981) ("with respect to whom the potential risk and benefits are such that a reasonable person would consent to treatment").
23. *See Civil Commitment in Wyoming*, *supra* note 3, at 151-67; *see* also People v. Taylor, *supra* note 19.
24. *See* House Bill No. 003 sponsored by the Joint Judiciary Interim Committee (1981) (81LSO-008.C3); WYO. STAT. § 25-3-101(a)(ix) (1981).
25. Letter from State Representative Ellen Crowley, Chairperson of the Joint Judiciary Interim Committee on Involuntary Commitment Procedures, to the author (March 13, 1981) (copy on file in the office of the *Land and Water Law Review*).

criteria of dangerousness without inclusion of a treatment determination.[26] States which recently have revised commitment statutes have tended to predicate commitment upon a standard of dangerousness to self or others, and to eliminate the treatment rationale from their statutes.[27] Some statutes have supplemented the dangerousness criteria with a grave disability standard in an effort to provide courts with an additional objective basis for decision-making.[28] This usually requires courts to determine whether an individual lacks the ability to provide himself with the basic necessities of food, shelter and clothing. Although such a standard is appealing in its simplicity, it may not add significantly to the existing harmfulness grounds in the Wyoming statute since they already encompass the notion of dangerousness to self.

The treatment criteria in the statute may unnecessarily alter the nature of commitment proceedings and engage courts in a quixotic inquiry. To establish the treatment criteria it is reasonable to assume that medical testimony is required which, at least partially, shifts the focus of the proceeding from a factual to a medical inquiry.[29] The treatment standard also requires the court to engage in the dubious undertaking of balancing the benefits and risks of treatment[30]—a task that can be expected to generate considerable disagreement among reasonable people. For instance, how would a reasonable person suffering from paranoid schizophrenic episodes resolve the question of whether he should submit to a chemotherapy regimen of

26. *See* cases cited *supra* note 13.
27. *See* NATIONAL INST. OF MENTAL HEALTH, CIVIL COMMITMENT AND SOCIAL POLICY: AN EVALUATION OF THE MASSACHUSETTS MENTAL HEALTH REFORM ACT OF 1970 53-54 (1981) [hereinafter cited as CIVIL COMMITMENT & SOCIAL POLICY].
28. *See, e.g.*, CAL. WELF. & INST. CODE §§ 5008(h), 5350-5368 (West 1972); COLO. REV. STAT. § 27-10-111(1) (Supp. 1980); WASH. REV. CODE ANN. § 71.05.010-.930 (Supp. 1980). *See* CIVIL COMMITMENT & SOCIAL POLICY, *supra* note 27, at 52 (31 states use grave disability criteria).
29. An additional problem which might arise stems from the fact that the pre-existing commitment standard was framed disjunctively (rather than conjunctively) in terms of dangerousness *or* need for treatment. The possibility exists that courts familiar with the old statute might read and apply the new statute in an identical fashion with it because of the similarity in terminology between the two statutes.
30. WYO. STAT. § 25-3-101(a)(ix) (1981) ("with respect to whom the potential risk and benefits [of treatment] are such that a reasonable person would consent to treatment").

prolixin? The treatment might temporarily stabilize his mental condition but the short term side effects of the drug include stiffness, shakiness, restlessness and dizziness; and the long term effects include tardive dyskinesia, a condition which involves involuntary muscle movement and possible permanent disability.[31] In other medical situations a competent individual does not face the risk of compelled medical treatment because a court would weigh the risk-benefit factors differently than he would.[32]

It is true that the revised Wyoming standard restricts commitment by requiring that both dangerousness and treatment determinations be made and, thus, protects individuals against possible judicial overreaching. However, an extensive recent study of the Massachusetts mental health legislative reforms concludes that the statutory commitment standard, regardless of its phrasing, may ultimately have little effect on the outcome of commitment hearings.[33] Nevertheless, elimination of the treatment criteria from the Wyoming statute would not jeopardize its constitutional soundness. Under such a revised statute courts could focus on the factual aspects of the commitment inquiry and avoid the medical-ethical judgments inherent in the risk-benefit equation.

One further problem regarding application of the revised commitment standard deserves mention. It is not clear that the statute provides for the involuntary hospitalization of alcoholics. The statute does not speak in terms of alcoholism, addiction or substance abuse as some state commitment statutes do.[34] However, the statutory definition of "mentally ill person" includes those suffering from a mental disorder,[35] and the American Psychiatric

31. *See* Goedecke v. State Dep't of Insts., 198 Colo. 407, 603 P.2d 123, 124 (1979); *In re* K.K.B., 609 P.2d 747, 748 n.3 (Okla. 1980).
32. WYO. STAT. § 25-3-125 (1981) (commitment does not constitute a determination of incompetency).
33. CIVIL COMMITMENT & SOCIAL POLICY, *supra* note 27, at 141.
34. *See, e.g.*, HAWAII REV. STAT. § 334-60(b)(1)(A) (Supp. 1981) (substance abuse); W. VA. CODE § 27-5-4 (Supp. 1981) (addiction); IND. CODE ANN. § 16-13-6.1-21 (Burns Supp. 1981) (alcoholic); COLO. REV. STAT. § 25-1-311 (Supp. 1981) (alcoholic).
35. WYO. STAT. § 25-3-101(a)(ix) (1981). The Attorney General's Office also has concluded that the statutory definition of "mental illness" includes substance and alcohol abuse. PROCEDURES MANUAL, *supra* note 1, at 2.

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Association recognizes alcoholism as a mental disorder.[36] The statute, thus, seems broad enough to cover the case of an alcoholic whose alcoholism posed a serious risk of harm to himself or others. Furthermore, an unrevised portion of Title 25, which was originally enacted in 1890, sanctions the involuntary hospitalization of persons for "habitual drunkenness," although it provides virtually no guidance in the handling of such cases.[37]

Neither of these statutes seems particularly well-suited to solve the problems involved in providing treatment for alcoholics. Wyoming has committed considerable resources to the problem of alcoholism,[38] yet the legislature has not clearly addressed the matter. Several states have recently adopted the Uniform Alcoholism and Intoxication Treatment Act as a viable approach to the problem.[39] Among other things the uniform statute provides a legal framework for judicial oversight in involuntary treatment proceedings.[40] Certainly a statute which specifically addressed the legal issues surrounding the treatment of alcoholics would represent an improvement over the prevailing situation in Wyoming.

B. *Least Restrictive Alternative*

The commitment statute requires the court to consider the "least restrictive and most therapeutic alternatives"

36. AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC & STATISTICAL MANUAL OF MENTAL DISORDERS 169 (3d ed. 1980).
37. WYO. STAT. § 25-1-101 (1977). The statute provides for the court to proceed as though the case involved "an idiot, lunatic, or person of unsound mind," but the involuntary hospitalization statutes no longer are framed in these terms. Presumably, however, the involuntary commitment procedures would still apply.
38. For fiscal year 1980-81, the Wyoming legislature appropriated $2,618,235 to the Department of Health & Social Services for operation of its Substance Abuse Division which provides services for alcoholism problems. In addition substantial federal funds were received by the state to support the Department's alcoholism programs. The Department has requested a legislative appropriation in excess of three million dollars for maintenance of its substance abuse programs for fiscal year 1982-83. Telephone conversation between the author and Mr. Guy Noe, Administrator, Division of Community Services, Department of Health & Social Services (Feb. 2, 1982). During fiscal year 1980-81, the Wyoming State Hospital expended $1,096,696 for maintenance of its alcohol and drug treatment unit. 1981 ANNUAL REPORT, *supra* note 5, at 90.
39. 9 U.L.A. 6 (Supp. 1981) (13 states had adopted the statute by 1981).
40. *See, e.g.*, COLO. REV. STAT. § 25-1-311 (Supp. 1981); *see also* OR. REV. STAT. § 426.460 (1981); IND. CODE ANN. § 16-13-6.1-21 (Burns Supp. 1981).

before it orders involuntary hospitalization.[41] The emergency detention statute also seems to contemplate the use of alternatives less onerous than involuntary hospitalization since it mandates dismissal of the proceedings where an individual has applied for voluntary hospitalization.[42] This represents a significant change from the previous statute which made no provision for judicial consideration of alternatives less restrictive than institutionalization at the state hospital. The incorporation of the least restrictive alternative doctrine into the statute strengthens the constitutional soundness of the statute.[43] It also reflects a statutory policy to encourage voluntary, community-based treatment.

The effect of the least restrictive alternative requirement on the actual outcome of commitment proceedings may, however, be more illusory than real. Although the statute directs courts to consider the "least restrictive and most therapeutic alternative," it also mandates that the court must commit the individual to a hospital, regardless of the appropriateness of an alternative placement.[44] While Section 112(k) apparently provides only for commitment to the state hospital presently, the term "hospital" is more broadly defined in the statute to include all hospitals which have been designated as qualified to provide treatment for mentally ill persons.[45] Presumably, once additional hospitals throughout the state have been designated as appropriate facilities, then local courts will have realistic alternatives available to them other than commitment to the state hospital. At present, no hospital has been designated under Section 104 other than the state hospital.[46] And, unless the

41. WYO. STAT. § 25-3-112(k) (1981).
42. *Id.* § 25-3-110(k)(ii). *See also id.* § 25-3-110(d) (providing that emergency detention is restricted to a "hospital or other suitable facility").
43. *See Civil Commitment in Wyoming, supra* note 3, at 167-71.
44. *Compare* WYO. STAT. § 9-6-661(e) (1981) (commitment to the State Training School shall be denied if the individual can be treated or served in an alternative setting), *with id.* § 25-3-112(k) (commitment to hospital required if individual is found to be mentally ill person).
45. *Id.* §§ 25-3-101(a)(vi),-104. The Department of Health and Social Services has drafted but not yet finalized standards for the designation of local hospitals. A copy of the proposed standards is on file at the *Land and Water Law Review* office.
46. Telephone conversation between Nadine Kuhns, Division of Health & Medical Services of the Department of Health & Social Services, and the author (Feb. 2, 1982).

state provides funding to enable local hospitals to establish adequate facilities for treatment of the mentally ill, it is doubtful that hospitals will seek designation as originally contemplated in the statute.[47]

Assuming, however, that other hospitals will be designated under the statute, then courts will be faced with the question of who bears the burden of producing evidence concerning the availability, or lack thereof, of an alternative treatment facility. Other jurisdictions which have addressed this question generally have placed the burden upon the state as part of the evidentiary load it must carry to justify commitment.[48] This seems appropriate since the state is most likely to have the resources available to canvass alternative placements. This should not, however, preclude the proposed patient's counsel from presenting alternatives as a component of his defense.

C. *Hearing Procedures*

The revised statute significantly tightens the procedural requirements surrounding involuntary hospitalization proceedings and eliminates many of the problems found in the old statute. These changes may represent the most important contribution of the legislature to protecting individual rights in this area. The Massachusetts study suggests that careful adherence to statutory procedural safeguards in commitment proceedings are more likely to influence the outcome than any other aspect of the proceedings.[49] Strict compliance with the statutory requirements in civil commitment matters is required since liberty interests are at

47. The state has not yet provided any funding for implementation of the revised statute—either for local hospitals or community mental health centers—despite the significant role which they are expected to play in the treatment of the mentally ill with the statutory emphasis upon community based treatment. The Department of Health & Social Services requested an appropriation of $1,000,000 for implementation of the state's local hospitalization provisions, but the Governor has reduced the request to $250,000 and the Joint Appropriations Committee has agreed with the Governor's recommendation. Telephone conversation between the author and Fred Kellow, Deputy Administrator, Division of Health & Medical Services of the Department of Health & Social Services (Feb. 8, 1982).

48. *See* TENN. CODE ANN. § 33-604(d)(3) (Supp. 1981); VA. CODE § 37.1-67.3 (Supp. 1981); W. VA. CODE § 27-5-4(j)(2) (Supp. 1981); Markey v. Wachtel, 264 S.E.2d 437, 447 (W. Va. 1979).

49. CIVIL COMMITMENT & SOCIAL POLICY, *supra* note 27, at 141.

stake.[50] So long as Wyoming courts adhere closely to the statutory procedures governing the hearing, the rights of individuals facing commitment should be adequately protected. Some ambiguity exists, however, within the statute which should be clarified.

The revised statute provides that an individual facing civil commitment must receive notice of the proceedings, whereas the old statute allowed for waiver of notice.[51] The notice must include, among other things, the statutory requirements for involuntary hospitalization and a detailed statement of the facts supporting the proposed hospitalization.[52] Thus, an individual facing commitment proceedings can expect to receive notice which will fully advise him of his rights and of the pending proceedings.

The revised statute requires the prompt appointment of counsel.[53] Representation by counsel is assured during involuntary hospitalization proceedings and emergency detention proceedings.[54] The statute does not detail the role which counsel is expected to play, but it does eliminate reference to the non-adversarial nature of the proceedings and to counsel's responsibility to advise the individual or his spouse regarding guardianship proceedings.[55] The statute appropriately envisions the attorney's role as limited to representation of his client's interests. Therefore, when his client objects to hospitalization, counsel is under a clear duty to defend him against the allegations.[56] The extent to

50. Sisneros v. District Court in and for Tenth Judicial Dist., 606 P.2d 55, 57 (Colo. 1980). *Cf.* Addington v. Texas, *supra* note 9 (holding that clear and convincing evidentiary standard applies to civil commitment proceedings); Holm v. State, 404 P.2d 740 (Wyo. 1965) (holding that rules of evidence apply to civil commitment proceedings).
51. WYO. STAT. § 25-3-112(e),(g) (1981). *See Civil Commitment in Wyoming*, *supra* note 3, at 150 & n.65.
52. WYO. STAT. § 25-3-112(e)(iv) to (v) (1981). Additionally the statute specifies that the notice must advise the proposed patient of the purpose of proceeding, the identity of the appointed examiner, and his right to counsel. *Id.* § 25-3-112(e)(i) to (iii).
53. *Id.* § 25-3-112(e)(iii).
54. *Id.* § 25-3-110(g),(h).
55. *See Civil Commitment in Wyoming*, *supra* note 3, at 185-86.
56. *See id.* at 185; CIVIL COMMITMENT & SOCIAL POLICY, *supra* note 27, at 122-23. *Cf. Ex parte* Ullmann, 616 S.W.2d 278 (Tex. Civ. App. 1981) (statutory right to effective assistance of counsel violated where single lawyer was appointed to represent 23 persons facing commitment with only four days notice).

which counsel vigorously undertakes this role most likely will influence the outcome of the proceedings.[57] Thus, counsel, whether appointed or retained, may be the single most important procedural protection available to the proposed patient.

The revised statute requires the individual's presence at the proceedings unless he waives this right.[58] The preexisting statute had provided that his presence was not required and it had not established any standard for determining when he might be excused.[59] Although the proceeding is to be conducted "in as informal a manner as is consistent with orderly procedure,"[60] it is clear that the individual has the right to confront and cross-examine adverse witnesses.[61] The statute further assures some degree of procedural regularity throughout the proceedings by incorporating the rules of civil procedure at various stages during the commitment process.[62] The revised statute retains the provision for a jury trial upon request.[63] It also provides that the court is authorized to appoint a Commissioner to hear these matters.[64] No provision is made for appointment of an independent examiner upon request by the proposed patient.[65] By retaining several of the safeguards provided by the old statute and clarifying the application of certain other protections which had been mentioned but were not assured under the old statute, the revised statute provides significant procedural protections without imposing undue administrative burdens.

57. CIVIL COMMITMENT & SOCIAL POLICY, *supra* note 27, at 114-24.
58. WYO. STAT. § 25-3-112(j) (1981).
59. *See Civil Commitment in Wyoming, supra* note 3, at 186-87.
60. WYO. STAT. § 25-3-112(j) (1981).
61. Holm v. State, *supra* note 50.
62. WYO. STAT. § 25-3-112(e),(h) (1981).
63. *Id.* § 25-3-112(h). *See Civil Commitment in Wyoming, supra* note 3, at 189-90.
64. WYO. STAT. § 25-3-112(m) (1981). *See Civil Commitment in Wyoming, supra* note 3, at 190.
65. *See Civil Commitment in Wyoming, supra* note 3, at 192, *see also* WYO. STAT. § 9-6-659 (1981) (providing for an independent examiner upon request before commitment to the State Training School); CIVIL COMMITMENT & SOCIAL POLICY, *supra* note 27, at 124 (recommending revision of the Massachusetts statute to include provision for an independent examiner to balance the testimony of hospital experts and to counteract the possibility of ineffective assistance of counsel).

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Section 112 makes no provision for application of the privilege against self-incrimination during involuntary commitment proceedings. Standing alone this statutory omission is unremarkable since most courts have concluded that the privilege is inapplicable in the involuntary hospitalization context.[66] Elsewhere, however, the statute explicitly recognizes the privilege by requiring that an individual who has been detained on an emergency basis must be advised of "his right to remain silent and that his statements may be used as a basis for involuntary hospitalization."[67] This provision clearly contemplates invocation of the privilege relating to matters underlying the hospitalization request as well as potential criminal conduct. While this might frustrate a physician's efforts to interview a potential patient and to apply his medical judgment to the commitment request, it will not preclude hospitalization in appropriate cases since the commitment decision should be based principally upon factual evidence.[68] Recognition of the privilege apparently reflects the legislature's judgment that it constitutes an important procedural safeguard. If so, it makes little sense not to incorporate the safeguard into the involuntary commitment procedures outlined in Section 112 since some individuals facing involuntary hospitalization will not have been detained originally under the emergency procedures.[69]

Section 112 provides that the Wyoming Rules of Civil Procedure govern the service of notice requirements[70] and the proceedings where a jury is convened.[71] The statute

66. *See, e.g., In re* Field, 120 N.H. 206, 412 A.2d 1032 (1980); Suzuki x. Yuen, 617 F.2d 173 (9th Cir. 1980); People v. Taylor, *supra* note 19; *see also Civil Commitment in Wyoming, supra* note 3, at 191-92. *Cf.* Estelle v. Smith, 101 S.Ct. 18866 (1981) (fifth amendment privilege attaches in psychiatric examination of criminal defendant where information obtained will be used in capitol sentencing phase of the proceedings).
67. WYO. STAT. § 25-3-110(g) (1981).
68. *See supra* text accompanying notes 14-23.
69. Under Wyoming statutes the physician-patient evidentiary privilege might be invoked by a patient confronted with testimony by his treating physician at a commitment hearing. WYO. STAT. § 1-12-101 (1977). Courts in other jurisdictions have sustained invocation of the physician-patient privilege in civil commitment proceedings. *See* Salas v. State, 592 S.W.2d 653, 656-57. (Tex. Civ. App. 1979); People v. Taylor, *supra* note 19, at 1140.
70. WYO. STAT. § 25-3-112(e) (1981).
71. *Id.* § 25-3-112(h).

does not explicitly provide that the rules otherwise apply to the proceedings. Since most hearings are conducted by a judge without a jury this is a significant oversight. One problem which can be expected to arise is whether the subpoena power provided in Rule 45 of the Wyoming Rules of Civil Procedure is available in judge-tried commitment cases. The statute makes no specific reference to the power of the court to compel the attendance of witnesses, yet it is hard to imagine that an individual facing loss of his liberty would be denied the right to subpoena witnesses to testify in his behalf.[72] The problem could be solved simply by amending Section 112 to recognize that the Rules of Civil Procedure apply to commitment proceedings except to the extent that they are displaced by specific statutory provisions.

II. EMERGENCY DETENTION

The most notable statutory changes are reflected in the revisions to the emergency detention process. The previous statute was seriously flawed since it apparently contemplated police power and *parens patriae*-based commitments on an emergency basis with limited judicial participation and virtually no specification of procedural safeguards.[73] Section 110 of the revised statute limits emergency detention to those cases where an individual is mentally ill and presents " an immediate risk of substantial physical injury to himself or others."[74] Under the statute either a law enforcement officer or an examiner may initiate detention upon determining that reasonable cause based upon the person's "recent overt acts, attempts or threats" exists.[75]

72. *See* Lynch v. Baxley, *supra* note 13, at 394.
73. *See Civil Commitment in Wyoming, supra* note 3, at 148-49, 171-80.
74. WYO. STAT. § 25-3-110(a) to (b). The present standard seems to be based upon the state's police power (danger to others) and its *parens patriae* authority (danger to self). Lynch v. Baxley, *supra* note 13, at 390. Regardless of the underlying basis for emergency detention, the revised statute significantly narrows the grounds for detention by requiring that the individual pose "an *immediate* risk of *substantial* physical injury." *Id.* § 25-3-110(a). By so limiting emergency detention the statutory standards is clearly within constitutional boundaries. *See* State *ex rel.* Doe v. Madonna, 295 N.W.2d 356, 362 (Minn. 1980). *See also Civil Commitment in Wyoming, supra* note 3, at 173.
75. WYO. STAT. § 25-3-110(a) (1981). The Attorney General's Office has interpreted "recent" as meaning within the past twelve hours. PROCEDURES MANUAL, *supra* note 1. at 9.

The statute requires that a professional conduct an initial examination within fifteen hours after the individual is detained to determine whether the conditions justifying detention are met.[76] If he concludes that detention is required, then the individual must be brought before a court within thirty-six hours of the initial detention to establish whether continued detention is necessary pending initiation of involuntary hospitalization proceedings.[77] Continued detention is sanctioned if the court determines upon a preponderance of the evidence that the conditions underlying the emergency situation persist[78] and if the individual has not applied for voluntary admission to the hospital.[79] This assures prompt medical evaluation of the individual's condition and judicial review of the detention decision which should eliminate any risk of improper prolonged confinement. In addition, by providing for dismissal of the proceedings if the individual applies for voluntary admission, the statute reflects a legislative preference for voluntary, rather than coerced, treatment whenever possible.[80]

Section 110 also specifies several procedural safeguards which are applicable to emergency detention proceedings. Notice must be provided to the detained person of the basis for his detention[81] and of the pending preliminary hearing.[82] He also must be advised of his right to be represented

76. WYO. STAT. § 25-3-110(b) (1981).
77. *Id.* § 25-3-110(b) (iii),(c),(h). The statute recognizes that this thirty-six hour probable cause hearing may be delayed upon request of the individual or his attorney. *Id.* § 25-3-110(h). Also the thirty-six hour time frame excludes Saturdays, Sundays and holidays. *Id.*
78. *Id.* § 25-3-110(k).
79. *Id.* § 25-3-110(k) (ii). This provision appears to represent a legislative conclusion that treatment can more effectively be provided to patients who voluntarily seek hospitalization than to those who are hospitalized involuntarily. However, it is not clear that individuals who seek hospitalization when they face continued detention and involuntary hospitalization proceedings do so voluntarily. *See* Gilboy & Schmidt, *"Voluntary" Hospitalization of the Mentally Ill*, 66 NW. U.L. REV. 429, 440 (1971). It is noteworthy that the statute requires application for voluntary admission as a precondition to dismissal of the proceedings, but it does not require actual acceptance as a voluntary patient.
80. *Cf.* Sisneros v. District Court in and for the Tenth Judicial Dist., *supra* note 50 (in view of legislative policy encouraging voluntary treatment, strict compliance with the procedural requirements governing emergency detention and utilization of voluntary hospitalization as an alternative is required). *But see supra* note 78.
81. WYO. STAT. § 25-3-110(e) (1981) (copy of statement of officer who detained individual must be provided); *id* § 25-3-110(j) (oral notification by the court of the basis for detention and the emergency proceedings).
82. *Id.* § 25-3-110(h).

by counsel and of the availability of appointed counsel.[83] At the outset of his detention, the individual must be advised of his privilege against self-incrimination and that his statements may be used as a basis for his involuntary hospitalization.[84] Upon completion of the probable cause hearing the individual may only be detained for an additional ten days before involuntary hospitalization proceedings are brought before the court.[85] Throughout this period detention is limited to a hospital or other suitable facility.[86] Treatment can only be given to the individual upon his voluntary consent unless treatment is necessary to prevent serious harm to himself or others.[87]

The revised statute brings the Wyoming emergency commitment procedures into conformity with constitutional standards in all but one respect. The statute authorizes short term detention based upon a preponderance of the evidence.[88] The preponderance requirement differs from the higher standard of clear and convincing evidence which applies to involuntary hospitalization proceedings.[89] The rationale of the Supreme Court in *Addington v. Texas*,[90] where the Court held that the clear and convincing evidentiary standard applied to long term commitment proceedings, would also seem to apply to short term, emergency commitments. Both proceedings portend a loss of liberty and accompanying stigmatization, as well as the prospect

83. *Id.* § 25-3-110(g),(h).
84. *Id.* § 25-3-110(g).
85. *Id.* § 25-3-110(k) (iii).
86. *Id.* § 25-3-110(d). *See Civil Commitment in Wyoming, supra* note 3, at 177-78.
87. WYO. STAT. § 25-3-110(f) (1981). The statute effectively recognizes that a competent individual has the right to refuse treatment prior to a determination that he requires involuntary hospitalization. *See Civil Commitment in Wyoming, supra* note 3, at 187 n.276. The statute does provide that a minor or incompetent may be treated upon consent of his parents or guardian. The statute is thus consistent with WYO. STAT. § 25-3-125 (1981) which provides that commitment to a hospital does not create any presumption concerning an individual's legal competency. In addition the statute provides immunity for a physician who acts in good faith to provide treatment so long as he does not act negligently or engage in deliberate misconduct.
88. WYO. STAT. § 25-3-110(k) (1981).
89. *Compare id.* § 25-3-110(k) *with id.* § 25-3-112(k). *See* Addington v. Texas, *supra* note 9; People v. Taylor, 618 P.2d at 1134.
90. 441 U.S. 418 (1979).

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of coerced treatment.[91] In *Suzuki v. Yuen*,[92] the Court of Appeals relied upon *Addington* and interpreted the Hawaii statute to require clear and convincing evidence before a five day temporary commitment could be ordered. Similarly, in *State ex rel Doe v. Madonna*,[93] the Minnesota Supreme Court indicated that the *Addington* standard applied to emergency detention proceedings.[94] Although the Wyoming statute simply envisions a probable cause hearing at this stage of the proceedings, application of the heightened evidentiary standard is appropriate since the judicial decision could lead to continued confinement.[95]

The statute suggests that the individual facing emergency detention is entitled to be present at the probable cause hearing,[96] but it does not address the question of whether he is entitled to confront and cross-examine adverse witnesses. With the individual present, the court is provided an opportunity to observe his condition first hand which should facilitate its resolution of the ultimate issues. The court also can be expected to rely upon the medical report from the preliminary examination,[97] particularly concerning the question of whether the individual's dangerousness is related to an underlying mental disorder. But it is often difficult to arrange for physicians or other professionals to attend these proceedings within the mandated

91. *Id.* at 425-26. *See also* Roth, Dayley & Lerner, *Into the Abyss: Psychiatric Reliability & Emergency Commitment Statutes*, 13 SANTA CLARA LAW. 400, 418 (1973).
92. *Supra* note 18, at 178, *aff'g in part*, 438 F. Supp. 1106 (D. Hawaii 1977).
93. *Supra* note 74, at 363 n.11.
94. *See also* People v. Taylor, *supra* note 19, at 1134-35; *but cf.* B.J.B. v. District Court of Okla. County *ex rel.* Wallace, 611 P.2d 249, 250 (Okla. 1980) (precluding joinder of a preliminary detention hearing with an involuntary hospitalization hearing because different evidentiary standards govern the two proceedings).
95. The statute does not direct the district court to base its probable cause determination upon "recent overt acts, attempts or threats." *See* WYO. STAT. § 25-3-110(k) (1981). This is somewhat surprising since the initial detention decision must be based upon this type of objective evidence, *id.* § 25-3-110(a), and the final involuntary hospitalization decision also must be based upon this. *Id.* § 25-3-112(k). Certainly this type of evidence could prove particularly useful to the court during the probable cause hearing since medical evidence will probably consist of submitted reports rather than direct testimony. *See infra* text accompanying note 98. Statutory symmetry could be easily achieved by amending the statute to incorporate the "recent overt act, attempt or threat" language into Section 110(k).
96. WYO. STAT. § 25-3-110 (h) (1981) (notice of probable cause hearing must be given to the detained person); *id.* § 25-3-110(j) (additional information must be given to him at the hearing).
97. *Id.* § 25-3-110(b).

thirty-six hour time period. When this is the case, their reports might be utilized on a hearsay basis[98] despite the fact that this practice effectively nullifies the individual's right of cross-examination. If the court relies upon such a report along with other evidence and if no evidence contradicting the report is presented, this should be sufficient to meet either the preponderance or clear and convincing evidentiary standard.

The revised statute establishes very clear time guidelines throughout the emergency detention process. Section 110 now requires that any individual who is detained on an emergency basis must be examined, usually through the local mental health center, within fifteen hours after he has been taken into custody.[99] Further detention is only justified if the examiner determines that he is mentally ill and poses an imminent threat of substantial danger to himself or others.[100] The statute limits the period of detention to thirty-six hours unless the individual is afforded a probable cause hearing before a court.[101]

These time limits have been criticized as unduly burdensome in view of the paperwork involved in detention decisions, tight judicial schedules, and the necessity that appointed attorneys be provided adequate time to familiarize themselves with the case.[102] Some courts have concluded that forty-eight hours is the maximum allowable period of detention without a preliminary hearing;[103] al-

98. State *ex rel.* Doe v. Madonna, *supra* note 74, at 366. It has been suggested that where the proposed patient's counsel wishes to challenge the factual accuracy of the medical report, then the examining professional must be present at the hearing. *In re* Barnard, 455 F.2d 1370, 1375 (D.C. Cir. 1971); *see Civil Commitment in Wyoming, supra* note 3, at 175.
99. WYO. STAT. § 25-3-110(b) (1981). Involvement of the local mental health center during this preliminary examination stage usually will provide the staff with the opportunity to treat the individual promptly, assuming that he consents to such treatment. *Id.* § 25-3-110(f). If local treatment proves adequate, hospitalization can most likely be avoided.
100. *Id.* § 25-3-110(b)(iii).
101. *Id.* § 25-3-110(h). The statute excludes Saturdays, Sundays and holidays from this thirty-six hour time calculation.
102. Conversation between the author and the Honorable Robert A. Hill, District Judge, Second Judicial District, Carbon County, Rawlins, Wyoming (Dec. 1981); telephone conversation between the author and Dr. Ray Muhr, Director of Southeast Wyoming Mental Health Center, Cheyenne, Wyoming (Jan. 18, 1982).
103. *See* Lessard v. Schmidt, *supra* note 17, at 1091; *In re* Barnard, *supra* note 98, at 1375.

though others have sanctioned considerably longer periods.[104] Mental health professionals report that many individuals who experience a crisis situation necessitating emergency detention often can be stabilized and released within a relatively short period of time.[105] Mental health centers, however, usually must promptly prepare the necessary paperwork for the emergency detention hearing since thirty-six hours generally does not provide them with sufficient time to ascertain whether they can successfully treat the patient locally.[106] This can divert valuable staff time from treatment of the detained individual which, to some extent, undermines the intent of the statute.[107]

Since virtually all of the statutory requirements encompassed within Section 110 have been reduced to forms prepared by the Board of Charities and Reform, it can be expected that the paperwork problems will diminish as those responsible gain familiarity with the use of these forms. Courts which continually find themselves facing time deadline difficulties should consider use of an appointed commissioner.[108] Since medical testimony can probably be received through written reports, this also should lessen scheduling problems.[109] Attorneys who find themselves in a dilemma because of inadequate preparation time can take

104. State *ex rel.* Doe v. Madonna, *supra* note 74, at 365 (three days); Bell v. Wayne County General Hosp., *supra* note 15, at 1098 (five days); Lynch v. Baxley, *supra* note 13, at 388 (seven days).

105. *See* Rennie v. Klein, 462 F. Supp. 1131, 1137 (D.N.J. 1978), *modified,* 653 F.2d 836 (3d Cir. 1981) (en banc); Hoffman & Foust, *Least Restrictive Treatment of the Mentally Ill: A Doctrine in Search of Its Senses,* 14 SAN DIEGO L. REV. 1100, 1146, 1150 (1977); Comment, *Madness & Medicine: The Forcible Administration of Psychotropic Drugs,* 1980 WIS. L. REV. 497, 540.

106. Telephone conversation between the author and Dr. Ray Muhr, Director of Southeast Wyoming Mental Health Center, Cheyenne, Wyoming (Jan 18, 1982). Dr. Muhr suggested that a seventy-two hour detention period would provide mental health centers with a greater opportunity to render careful clinical judgments on the patient's illness and to stabilize the patient's condition.

107. However, the statute does not preclude continued local treatment of the patient following the emergency detention decision. The statute provides the court with the authority to order emergency detention for ten days pending involuntary hospitalization proceedings and to extend the detention upon request of the patient or his attorney. WYO. STAT. § 25-3-110(k)(iii) (1981). Presumably, mental health centers will continue to treat patients during this emergency detention and, if successful, will be able to avoid involuntary hospitalization.

108. *Id.* § 25-3-112(m). Laramie and Natrona Counties utilize a Commissioner for these proceedings and they do not report serious difficulties.

109. *See supra* text accompanying note 98.

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advantage of the statutory provision authorizing a delay in the hearing, if this is consistent with the interests of their client.[110] However, it is clearly improper to combine the probable cause hearing and the involuntary commitment hearing since different standards govern the court's decision in each case and different standards of proof are required.[111]

The statute provides for dismissal of emergency detention proceedings if the proposed patient has applied for voluntary hospitalization.[112] This provision reflects an apparent legislative preference for voluntary rather than coerced treatment whenever possible. Recently in *Sisneros v. District Court in and for Tenth Judicial District*, the Colorado Supreme Court concluded that courts must strictly comply with the terms of the Colorado emergency detention statute in order to effectuate the legislative preference for voluntary treatment.[113] Since the Wyoming statute mandates dismissal of detention proceedings once a patient voluntarily applies for admission to the State Hospital, courts apparently have no discretion in the matter. The statute, however, makes no provision for the patient's transportation to the state hospital nor does it require the state hospital to accept the patient. The statute does authorize the state hospital to accept voluntary patients if they have symptoms of mental illness and sufficient capacity to apply for hospitalization.[114] The statute also requires the state hospital to discharge voluntary patients within twenty-four hours after they request their release.[115] Certainly, however, the state hospital can utilize the emergency detention procedures to prevent the release of voluntary patients, including those who might have applied under Section 110(k) (ii), if they present an imminent threat of harm to themselves or others.

110. WYO. STAT. § 25-3-110(h) (1981).
111. B.J.B. v. District Court of Okla. County *ex rel.* Wallace, *supra* note 94, at 250. *But cf.* State *ex rel.* Doe v. Madonna, *supra* note 74, at 366 (can combine probable cause hearing and involuntary hospitalization hearing since same standards apply to both).
112. WYO. STAT. § 25-3-110(k) (ii) (1981).
113. *Supra* note 50, at 57.
114. WYO. STAT. § 25-3-106(a) (1981). This provision also authorizes the state hospital to accept children and incompetents who have symptoms of mental illness as patients upon the application of their parents or guardians. *Id.* § 25-3-106(b). *See* Parham v. J.R., 442 U.S. 584 (1979).
115. WYO. STAT. § 25-3-109(a) (1981).

The revised statute also narrowly defines the circumstances under which an individual may be involuntarily treated while he is held in emergency detention. Unless the detained individual consents to treatment during this period he can only be treated if "treatment is necessary to prevent serious physical harm to the person or others."[116] Since detention contemplates placement of the individual in a hospital or other suitable facility,[117] it can fairly be concluded that treatment without consent can occur only in exceptional circumstances when the individual is physically unmanageable or suicidal. This restriction on treatment is consistent with recent court decisions limiting the non consensual treatment of mental patients who have not been adjudicated incompetent.[118] The courts have found that even the use of chemotherapy, a common method of treatment for stabilizing patients in a crisis situation, represents a significant intrusion into the patient's bodily integrity and, thus, constitutes an invasion of his liberty interests.[119] The statute does provide limited immunity for professionals who act in good faith to provide treatment for individuals detained under this section so long as they have not acted negligently.[120] In addition, the statute requires the treating professional to advise the patient prior to treatment and to file a report with the court if involuntary hospitalization proceedings are commenced.[121] This seems to represent a reasonable and constitutionally acceptable compromise which provides a detained individual with substantial protection against coerced treatment while enabling doctors and other professionals to act in appropriate, harm threatening situations.

116. *Id.* § 25-3-110(f).
117. *Id.* § 25-3-110(d). *See infra* text accompanying notes 122-27.
118. *See, e.g.*, Rennie v. Klein, 653 F.2d 836 (3d Cir. 1981) (en banc); Okin v. Rogers, 634 F.2d 650 (1st Cir. 1980), *cert. granted*, 101 S. Ct. 1972 (1980); *In re* K.K.B., *supra* note 31; Goedecke v. State Dep't of Insts., *supra* note 31.
119. *See, e.g.*, Rennie v. Klein, *supra* note 118, at 843; Okin v. Rogers, *supra* note 118, at 653.
120. WYO. STAT. § 25-3-110(f) (1981). The statute also precludes immunity in cases where a physician might have engaged in "deliberate misconduct" in administering treatment. *Id.*
121. *Id.* The requirement of judicial notification in those cases where a patient facing involuntary hospitalization has been treated involuntarily assures some limited judicial oversight of the treatment decision. It also alerts the court to the fact that the individual's present courtroom demeanor might be affected by the drugs or other treatment which he has received.

The revised statute provides that detained persons may be held in a hospital or other "suitable facility which is appropriate under the circumstances."[122] This represents a change from the old statute which had explicitly authorized detention in a county jail.[123] Nevertheless, some Wyoming counties do not have inpatient hospital facilities available for detention purposes[124] and, even among those which do have the facilities, they are unable to handle extremely unruly patients.[125] Thus, in some cases confinement in the county jail presents the only viable alternative for detention notwithstanding the countertherapeutic effects which this will most likely cause. While this might pass constitutional muster in certain limited circumstances,[126] it is clearly inconsistent with the legislative purpose of community based treatment which pervades the revised statute.[127] Ultimately successful implementation of the emergency detention provision of the revised statute is dependent upon the establishment of adequate local treatment facilities. This probably will require the legislative appropriation of substantial funds to underwrite the state's community mental health system. Without this, it will be difficult for those responsible under the statute to implement it successfully at a local level. Rather, many cases which might be handled locally will probably lead to involuntary hospitalization and its attendant expenses.

III. REVIEW, RELEASE & TRANSFER

The revised statute has substantially amended the provisions of the old statute governing the review, release and

122. *Id.* § 25-3-110(d). The statute does not define "suitable facility." The procedural manual prepared by the Attorney General's Office for implementation of the revised statute notes that "a jail may be used as a detention facility, but it is *only* to be used as a last resort and after all other possible remedies have been exhausted." PROCEDURES MANUAL, *supra* note 1, at 11 (emphasis in original).

123. *See Civil Commitment in Wyoming, supra* note 3, at 177-78.

124. *Id.* at 178. Uinta County, for instance, utilizes the State hospital as an emergency facility. Telephone conversation between the author and Dr. William Karn, Superintendent of Wyoming State Hospital (Jan. 20, 1982). *See also supra* text accompanying notes 44-47.

125. Telephone conversation between the author and Dr. Ray Muhr, Director of Southeast Wyoming Mental Health Center, and Greg Long, social worker at Southeast Wyoming Mental Health Center (Jan. 18, 1982); telephone conversation between the author and Jerry Statkus, Deputy County Attorney, Cheyenne, Wyoming (Jan. 15, 1982).

126. *See Civil Commitment in Wyoming, supra* note 3, at 178.

127. *See supra* notes 45-48 and accompanying text.

transfer of patients. Serious due process problems were evident in the old statute since it vested hospital officials with the authority to reach release and transfer decisions concerning an individual patient without providing the patient wtih a corresponding opportunity to challenge of the decisions.[128] The new statute extends a plethora of procedural due process protections to a patient who wishes to contest an administrative decision which affects his release from the hospital or his transfer to another institution. Under the standards established by the Supreme Court in *Vitek v. Jones*,[129] the revised statute clearly meets or exceeds minimum constitutional requirements. Some ambiguities and inconsistencies, however, are evident in the statute and some administrative problems can be anticipated.

The amended statute provides that within fifteen days after a patient is admitted to the hospital, the head of the hospital must review his record, examine him and develop a treatment plan for him.[130] The hospital may transfer a patient to another hospital if transfer is believed to be in the patient's best interests.[131] Also the hospital may accept transfer patients from a penal institution if the inmate is mentally ill and cannot be adequately treated at the penitentiary.[132] The head of the hospital is required to re-examine each involuntarily committed patient at six month intervals[133] and, if the conditions justifying hospitalization no longer exist, then he is required to discharge the patient.[134] Before discharge is permitted, however, the hospital is required to provide the court, law enforcement agencies, family members and the mental health center involved in the commitment with three days' notice of its intention to

128. *See Civil Commitment in Wyoming*, *supra* note 3, at 194-202.
129. 445 U.S. 480 (1980).
130. WYO. STAT. § 25-3-117(a) (1981).
131. *Id.* § 25-3-119(a). Sixty-one patients were transferred from the State Hospital to other institutions during the 1981 fiscal year. 1981 ANNUAL REPORT, *supra* note 5, at 80.
132. WYO. STAT. § 25-3-118(a) (1981). The statute further provides that admission to the state hospital is dependent upon the hospital's admission rules. Forty-six patients were transferred to the State Hospital from penal institutions during the 1981 fiscal year. 1981 ANNUAL REPORT, *supra* note 5, at 79.
133. WYO. STAT. § 25-3-120(a) (1981).
134. *Id.* § 25-3-120(b). Five hundred and twenty-eight patients were discharged directly from the State Hospital during the 1981 fiscal year. 1981 ANNUAL REPORT, *supra* note 5, at 80.

discharge the patient.[135] The court has the authority to schedule a hearing to review the hospital's release decision.[136] Also the head of the hospital has the authority to release patients on convalescent leave status[137] and to readmit them during the ensuing six months.[138]

Whenever a patient is dissatisfied with the hospital decision denying his release or ordering his transfer or readmitting him from convalescent leave status, then he is entitled to request a hearing before the district court to review the administrative decision.[139] In each case he is entitled to receive prior notification of the proposed action, and the notice must advise him of his right to contest the decision, his right to a hearing and his right to counsel.[140] To preserve his hearing right the patient must file an objection with the court within five days of receipt of the notice, and the court is obligated to schedule the hearing within fourteen days.[141] The hearing is to be held before the court without a jury and the decision must be supported by clear and convincing evidence.[142]

Since a decision concerning the release, transfer or readmission of a patient impacts significant liberty inter-

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135. WYO. STAT. § 25-3-120(b) (1981). Presumably notice to family members and the mental health center is required to enable them to prepare follow up care for the released patient. Apparently notice to law enforcement agencies is mandated to alert them that the patient, who was determined to be potentially dangerous at the time of his original commitment, is likely to be returning to the community. However, this rationale for notice to law enforcement agencies proves ultimately unsatisfactory since the released patient is presumptively no longer dangerous.
136. *Id.*
137. *Id.* § 25-3-121(a). The hospital must provide a convalescent leave patient with a plan for outpatient treatment to facilitate his readjustment to community living. Two hundred and sixteen patients were released from the State Hospital on convalescent leave status during the 1981 fiscal year. 1981 ANNUAL REPORT, *supra* note 5, at 80.
138. A convalescent leave patient may be readmitted to the hospital if an examiner finds that he is mentally ill and that hospitalization represents the least restrictive treatment available. WYO. STAT. § 25-3-121(b) (1981). However, once a patient has remained on convalescent leave status for six months he must be discharged. *Id.* § 25-3-121(c). *See infra* text accompanying notes 170-78.
139. WYO. STAT. §§ 25-3-118(b), -119(b), -120(c), -121(b) (1981).
140. *Id.* Additionally, where he faces an interinstitutional transfer the patient is entitled to notice setting forth the grounds for the transfer. *Id.* § 25-3-118(b)(1) (transfer from penitentiary to hospital); *id.* § 25-3-119(b)(1) (transfer from one hospital to another).
141. *Id.* § 25-3-122(b).
142. *Id.* § 25-3-122(c).

ests,[143] it is clear that some minimal due process protections must be available to guard against administrative errors. Recently, in *Vitek v. Jones*, the Supreme Court ruled that prisoners facing transfer to a mental hospital were entitled to a prior hearing if they wanted to contest the decision.[144] The framework established by the Court in *Vitek* provides for prior written notice of the transfer decision and of the inmate's rights, a hearing before an independent decisionmaker where the inmate is entitled to be present and to introduce evidence and to cross-examine adverse witnesses, and a written statement by the decisionmaker of the grounds for his decision.[145] Significantly, the Supreme Court concluded that someone other than a judge could serve as the independent decisionmaker[146] and that the state was not obligated to furnish an attorney for every inmate who sought to contest a transfer decision.[147] Although *Vitek* involved a prison to hospital transfer decision, the Court's rationale might fairly extend to analogous administrative decisions involving the transfer, release or readmission of state mental hospital patients. These decisions affect the individual interests of patients in much the same way that the interests of the inmates were affected in *Vitek*.[148] Since

143. Vitek v. Jones, *supra* note 129, at 491-92; Fasulo v. Arafeh, 173 Conn. 473, 378 A.2d 553, 555 (1977). *See Civil Commitment in Wyoming, supra* note 3, at 198, 201.

144. *Supra* note 129, at 494-96.

145. *Id.* The Court noted that the inmate might be denied the right to call witnesses and to cross-examine adverse witnesses upon a showing of good cause. *See* Morrissey v. Brewer, 408 U.S. 471, 489 (1972); Wolff v. McDonnell, 418 U.S. 539, 566 (1974).

146. Vitek v. Jones, *supra* note 129, at 496. The Court also held that the independent decisionmaker need not come from outside the prison or hospital. *Id.*

147. *Id.* at 496-97. Four justices felt that the inmate facing transfer to a mental hospital was entitled to the assistance of counsel because of the complexity of the issues facing him and the likelihood that he would have difficulty understanding the proceedings in view of his diminished mental capacity. However, Justice Powell, the crucial fifth vote, separately concurred and held that counsel need not be provided. Although Justice Powell recognized the difficulties confronting an inmate in these circumstances, he felt that it was adequate if he was provided with qualified and independent assistance. *Id.* at 499-500. Four justices dissented from the *Vitek* holding on the grounds that the case was moot. *Id.* at 500.

148. *Vitek* recognized that an individual committed to a mental hospital faced the loss of freedom, probable stigmatization, and possible intrusion into his personal security through compelled treatment programs. *Id.* at 491-92. Likewise patients denied discharge from the hospital or transferred to another institution or readmitted from convalescent leave status face the same disabilities. *See, e.g.*, Fasulo v. Arafeh, *supra* note 143; *Civil Commitment in Wyoming, supra* note 3, at 198.

the revised Wyoming statute provides patients with the safeguards recognized in *Vitek*, as well as the right to review before a court and the right to counsel, it should meet or exceed minimum constitutional requirements.

Nevertheless, in certain respects the revised statute does not clearly specify applicable hearing procedures. The statute does not provide for the patient's presence at the hearing—a requirement that *Vitek* seemingly mandates—but the statutory notice and counsel requirements certainly imply that the patient's attendance is anticipated.[149] Judicial interpretation of the statute which recognizes that the patient's presence is required should save the statute from objection on this basis. The statute also provides that the clear and convincing evidentiary standard is applicable to these proceedings,[150] but it does not specify whether state hospital officials or the patient must carry this burden of proof. Since it is the patient who faces loss of his liberty and since this factor has traditionally triggered application of a heightened evidentiary standard,[151] the state should be required to carry the evidentiary burden in these proceedings.[152] Additionally, the statute does not specify the method for service of notice to patients. Service which complies with the Rules of Civil Procedure should suffice to assure that those interested in the proceedings are advised of them.[153] However, since the Supreme Court has recognized that procedural due process is a flexible concept adaptable to

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149. *Compare* WYO. STAT. § 25-3-112(j) (1981) (individual shall be present at commitment hearing unless he waives this right) *with id.* § 25-3-122 (no provision for individual's presence).
150. *Id.* § 25-3-122(c).
151. *See* Addington v. Texas, *supra* note 9, at 427. *Cf.* D.S. v. Department of Public Assistance and Social Services, 607 P.2d 911, 919 (Wyo. 1980) (clear and convincing evidentiary standard applies to state termination of parental rights proceedings).
152. *See* Fasulo v. Arafeh, *supra* note 143, at 557; State v. Fields, 77 N.J. 282, 390 A.2d 574, 582 (1978).
153. *See* WYO. STAT. § 25-3-112(e) (1981) (notice in commitment proceedings must be served in accordance with the Wyoming Rules of Civil Procedure). However, WYO. STAT. § 25-3-120(b) (1981) provides that the court may schedule a hearing to review the hospital's favorable discharge decision so long as the hearing is scheduled within three days after the notice of the decision is sent. It is not clear that three days will provide adequate time if the notice is served in accordance with the Rules of Civil Procedure. Perhaps the alternative of telephone notification supplemented by written notification might be considered in these cases.

the nature of the proceedings,[154] alternative forms of notification other than personal service probably are adequate in view of the administrative nature of these proceedings.

Some potential administrative problems are presented by the statutory provisions authorizing district courts to review release, transfer or readmission decisions.[155] Although the *Vitek* decision holds that judicial involvement in this aspect of commitment is not required under federal constitutional standards, some state courts have mandated judicial or administrative review of release or readmission decisions.[156] These cases, however, have provided for judicial review in cases where individuals faced continued hospitalization and not in cases where the hospital has decided to discharge a patient. The Section 120(b) review provision authorizes a district court to review the hospital's discharge decision.[157] Apparently the court is empowered to reverse the hospital decision and order continued hospitalization, notwithstanding the hospital's determination that treatment is no longer necessary. This is inconsistent with the general discretion granted the hospital in providing for the treatment and discharge of patients. It creates administrative problems for the hospital which must notify courts of discharge decisions and for the court which must schedule hearings within three days after the notice is sent.[158] The provision is not necessary to assure the statute's constitutionality. The statutory schemes governing civil commit-

154. *See, e.g.*, Mathews v. Eldridge, 424 U.S. 319, 334 (1976); Morrissey v. Brewer, *supra* note 145, at 481. *See also* Mullane v. Central Hanover Trust Co., 339 U.S. 306, 314 (1950) ("An elementary and fundamental requirement of due process in any proceeding which is to be accorded finality is notice reasonably calculated, under all of the circumstances, to apprise interested parties of the pendency of the action and afford them an opportunity to present their objections.").

155. During the first six months that the revised statute has applied to these matters, very few patients have requested judicial review of a release, transfer or readmission decision. Only one patient has requested review of a hospital decision denying discharge and no patients have yet contested a transfer decision. Author's telephone conversation with Dr. William Karn, Superintendent of Wyoming State Hospital (Jan. 20, 1982).

156. *See, e.g.*, Fasulo v. Arafeh, *supra* note 143, at 556 (release decision); *In re* Anderson, 73 Cal. App. 3d 38, 140 Cal. Rptr. 546 (1977) (readmission decision).

157. WYO. STAT. § 25-3-120(b) (1981). Dr. William Karn, Superintendent of the Wyoming State Hospital, reports that no courts have yet scheduled a review hearing under Section 120(b) Telephone conversation between the author and Dr. Karn (Jan. 20, 1982).

158. WYO. STAT. § 25-3-120(b) (1981). *See supra* note 134.

ment in other states do not provide for similar judicial review of a hospital release decision.[159]

The statute also provides that patients who disagree with the hospital decision not to discharge them may initiate a hearing request.[160] The Connecticut Supreme Court in *Fasulo v. Arafeh* relied upon its state constitution to rule that a similar statutory provision was inadequate to meet due process standards because mental patients could not be generally expected to initiate judicial proceedings.[161] The court ruled that the state must provide a judicial review hearing periodically for all committed patients. It is doubtful, however, that the Supreme Court would adopt a similar position since it has consistently refused to impose a requirement of judicial review over administrative decisions in this area.[162] Moreover, the Wyoming statute assures patients that their commitment status will be reviewed by hospital officials at six month intervals.[163]

The revised statute does not clearly specify which court should review hospital release, transfer or readmission decisions. The statute defines the term "court" as meaning the district court which committed or detained the individual, or the district court where the individual resides, is found or is hospitalized.[164] In some cases venue might logically be found in any one of several courts. For instance, in the case of a patient who contests a decision ordering his readmission from convalescent leave status,[165] venue might be proper in the original committing court, the court located in the county where he presently resides or the court located where he

159. *See Developments in the Law—Civil Commitment of the Mentally Ill*, 87 HARV. L. REV. 1190, 1378 (1975) [hereinafter cited as *Developments*].
160. WYO. STAT. § 25-3-120(c) (1981).
161. *Supra* note 143, at 555-57. The Connecticut Supreme Court noted that mental patients typically find themselves in an isolated environment, and that they often suffer from mental incapacities which might limit their knowledge of available legal procedures and resources. The court also noted that patients frequently are incapacitated because of drug or other treatments which they might be receiving. *Cf.* State v. Fields, *supra* note 152, at 580 (not guilty by reason of insanity acquittees entitled to same judicial periodic review of their commitment as is enjoyed by civil committees).
162. *See, e.g.*, Parham v. J.R., *supra* note 114; Vitek v. Jones, *supra* note 129.
163. WYO. STAT. § 25-3-120(a) (1981).
164. *Id.* § 25-3-101(a)(ii).
165. *Id.* § 25-3-121(b).

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has been found—all of which might be located in different counties. While the statute might be amended to limit venue, the problem also could be eliminated through judicial or administrative interpretation narrowing venue to the forum where evidence is readily available and where the individual's presence can be secured without undue expense. In fact, the flexibility inherent in the broad definition of the term "court" in the statute might prove beneficial since it usually will permit proceedings to be scheduled in the most convenient forum.[166] Proper utilization of this scheduling authority might significantly expedite these matters, and minimize their expense in terms of judicial time or actual costs.

Another logistical problem can be anticipated with the Section 120(c) provision which seemingly allows a patient to request judicial review of his hospitalization shortly after his arrival at the hospital. Under Section 120(c) a patient who wishes to contest the decision to continue hospitalization after he has received his initial fifteen day examination is entitled to a hearing on the matter.[167] Due process principles certainly do not mandate a hearing in this situation since the committed patient will have just received full judicial review on the matter of his mental condition.[168] Further proceedings at this juncture can only be regarded as unnecessary, wasteful and costly. Moreover, the committed patient is assured judicial review of his commitment within six months of his admission which should adequately protect him against unnecessary prolonged hospitalization.[169] The provision sanctioning review of a Section 117 decision,

166. In the one case where a hospitalized patient requested judicial review of the hospital's decision not to discharge her, the matter was transferred from the Carbon County district court which originally committed the patient to the district court in Uinta County where the patient presently resided. Author's telephone conversation with Nick Deegan, Assistant County Attorney, Rawlins, Wyoming (Jan. 22, 1982).

167. WYO. STAT. § 25-3-120(c) (1981); *id.* § 25-3-117(a)(ii) (patients must be examined by the hospital within fifteen days after they are admitted).

168. The patient is entitled to a full hearing before he is committed to the state hospital. *Id.* § 25-3-112. *See also Developments, supra* note 159, at 1393.

169. WYO. STAT. § 25-3-120 (1981). Again, it should be noted that judicial review is available if the patient requests it. *See supra* text accompanying notes 160-63. Furthermore, the patient is entitled to seek his release through habeas corpus proceedings at anytime. WYO. STAT. §§ 1-27-101 to -134 (1977).

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therefore, could be eliminated from the statute without jeopardizing the constitutionality of the statute or its rigorous protection of patient interests.

The revised convalescent leave statutory provisions provide the head of the hospital with considerable discretionary authority to arrange for the trial release of patients. The head of the hospital has the authority to release patients on convalescent leave status if he determines that release would be appropriate and if he establishes an outpatient treatment plan for them.[170] Presumably patients who are released on convalescent leave status still meet the criteria for hospitalization; otherwise they should be discharged pursuant to Section 120. This raises the question of whether patients who are mentally ill as defined by the statute should be released from the hospital even on a trial basis. Typically convalescent leaves are arranged to enable patients to experiment with community living while the hospital, or another mental health agency, oversees their adjustment and retains the authority to rehospitalize them if the release proves premature. Such an arrangement is consistent with the underlying statutory philosophy of community based treatment and it provides the hospital with considerable flexibility in meeting the treatment needs of individual patients.[171] Many other state statutory commitment schemes similarly recognize and utilize convalescent leave.[172]

The statute authorizes the hospital to readmit the convalescent leave patient if he is mentally ill and hospitalization represents the least restrictive means for treating

170. WYO. STAT. § 25-3-121(a) (1981).
171. *See Civil Commitment in Wyoming, supra* note 3, at 198. The statute should not be faulted because it does not provide a standard for granting convalescent leave status. Because Section 121 makes no provision for judicial review of the hospital's convalescent leave decision, there is little necessity to establish a standard to govern the decision. Moreover, judicial review is not necessary at this juncture. *See supra* text accompanying notes 155-59.
172. *See, e.g.*, N.Y. MENTAL HYG. LAW § 29.15 (McKinney 1978); IND. CODE ANN. § 16-14-16-2 (Burns 1973); W. VA. CODE § 27-7-2 (1980).
173. Because Section 121 makes no provision for judicial review of the hospital's convalescent leave decision, there is little necessity to establish a standard to govern the decision. Moreover, judicial review is not necessary at this juncture. *See supra* text accompanying notes 155-59.

him.[173] Otherwise, the statute directs the hospital to discharge a convalescent leave patient who has remained on that status for six months.[174] Both of these provisions are inconsistent with related provisions governing the admission and discharge of patients. Patients may be originally hospitalized upon a finding that they are mentally ill without regard to whether hospitalization represents the least restrictive treatment available.[175] Thus, the standard governing initial commitment to the hospital is less rigorous than the standard governing readmission from convalescent leave status despite the fact that the convalescent leave patient is already under the disability of a commitment order.[176] Symmetry between the two provisions could be accomplished by amending the original commitment standard to require a least restrictive treatment finding before hospitalization was authorized. This would further effectuate the statutory policy to encourage community based treatment whenever possible. The six month discharge provision for convalescent leave patients does not provide for judicial review of the discharge decision; however, under Section 120(b) a hospital decision to discharge a hospitalized patient is subject to judicial review. It certainly makes little sense for a court to review the discharge of a convalescent leave patient who has managed satisfactorily on his own during his six month trial release; but it likewise makes little sense for a court to review hospital decisions to release other patients. The inconsistency could be easily remedied by deletion of the Section 120(b) judicial review provision.[177] Therefore, although these convalescent leave statutory provisions conflict with other provisions they should not be altered since they are consistent with the policies embodied in the revised statute. Rather the other inconsistent provisions should be amended to conform to the convalescent leave statute.

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173. WYO. STAT. § 25-3-121(b) (1981).
174. *Id.* § 25-3-121(c).
175. *Id.* § 25-3-112(k). *See supra* text accompanying notes 41-48.
176. One possible explanation for this inconsistency is the fact that a convalescent leave patient is a "mentally ill person" by definition since he remains under his original commitment. Therefore, he should not be returned to the hospital unless this represents the only viable treatment available.
177. *See supra* text accompanying notes 155-59.

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The statutory provisions governing readmission of a convalescent leave patient also do not address the problem of whether a convalescent leave patient who poses an imminent threat to himself or others can be detained pending a hearing on the revocation decision. The statute does not authorize detention preceding the Section 122 convalescent leave revocation hearing, but frequently detention will be necessary if the patient is unmanageable and presents a threat to himself or others. However, in view of the Supreme Court's *Morrissey v. Brewer* decision, it is clear that the state cannot detain a convalescent leave patient without affording him rudimentary due process protection.[178] In *Morrissey* the Court held that a parolee, by virtue of his conditional liberty status, was entitled to a probable cause hearing on the question of his detention pending a parole revocation hearing.[179] Similarly, a convalescent leave patient enjoys a conditional liberty interest in his status and, thus, he also should be entitled to a probable cause hearing before he is detained. In this situation, the Section 110 emergency detention procedures provide an efficient method for affording a patient a probable cause hearing pending the revocation hearing.[180] Since Section 110 authorizes detention for 10 days upon a finding of probable cause,[181] this should provide the state with sufficient time to schedule the Section 122 revocation hearing. Utilization of the Section 110 emergency procedure in this fashion assures that due process requirements are satisfied and it avoids the necessity of amendment to handle this situation.

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178. *Civil Commitment in Wyoming*, *supra* note 3, at 199-200.
179. Morrissey v. Brewer, *supra* note 145, at 485.
180. The Attorney General likewise recommends utilization of the Section 110 emergency detention procedures to meet this situation. *See* PROCEDURES MANUAL, *supra* note 1, at 4. Alternatively, the same result might be accomplished if the Section 122 hearing was promptly scheduled and held within 36 hours after the patient was detained following the hospital's revocation decision. This assumes that neither the patient nor his counsel object to the expedited scheduling of the Section 122 hearing. If they do, however, the state must afford some opportunity for a probable cause hearing. Because officials are unlikely to know in advance whether the patient will object to a prompt Section 122 hearing, the conservative course of action would be simultaneous initiation of the emergency detention and revocation hearing procedures.
181. WYO. STAT. § 25-3-110(k)(iii) (1981).

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CONCLUSION

The revised civil commitment statute represents a significant improvement over its 1963 predecessor. With one possible exception—inclusion of the preponderance evidentiary standard in the emergency detention proceedings—the statute appears constitutionally sound. The statute increases the role of the courts in the commitment and review process and it implements a detailed system of procedural safeguards. Despite the added burden this places upon the courts, it assures individual patients that their rights will be protected through the legal system. It also establishes that those responsible for administering the mental health system will ultimately be accountable for their actions in a judicial forum. Although potential administrative difficulties have surfaced with implementation of the statute, most of these problems can be solved through judicial or administrative interpretation of the statute. In those cases where the revised provisions appear unnecessary or inconsistent, the legislature should clarify the statute through amendment. However, any proposed amendments should be drafted carefully to insure that they are consistent with the underlying statutory philosophy.

The revised statute substantially redirects the state's efforts in its provision of treatment for the mentally ill. The statute encourages voluntary treatment at local mental health centers rather than involuntary commitment to the State Hospital. This is consistent with nationwide trends in the provision of mental health care and it comports with judicial rulings in other jurisdictions circumscribing the state's authority to treat involuntarily the mentally ill. Nevertheless, without adequate state support for a community mental health system, the statute's promise may not be fully realized. Inadequate local treatment facilities may necessitate involuntary hospitalization of patients in many cases. Recognizing this, the revised statute does not implement the least restrictive alternative doctrine since it does not require judicial findings on this point during the commitment process. Further, no local hospitals have

yet been designated as alternative placement facilities. The problem, however, could be solved if the state committed sufficient financial resources to establish a comprehensive community mental health system. If the revised statute is implemented in this fashion, then it should serve Wyoming well in the future and meet the needs of the state's mentally ill citizens.