

RIGHTS IN FACILITIES

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[8.0] I. INTRODUCTION

In 2010 there were over 142,000 legal status admissions in New York State, of which approximately 88,000 were involuntary. Even allowing for the many patients who have multiple admissions, it is obvious that every year a large number of citizens will lose their liberty for reasons of treatment of a mental disability and protection of self or others.

It is well recognized that involuntary civil commitment (*admission and retention* in New York statutory parlance) constitutes a “massive curtailment of liberty,” which is constitutionally permissible only if stringent substantive and procedural due process standards are met.¹ Even the “willing patients” (voluntary and informal in New York) are not immune from such loss of liberty, as there is always the potential for these individuals to become involuntary patients (e.g., by improperly classifying as voluntary those patients who are unable to understand or exercise their rights or by applying to the court for involuntary retention). They, too, are entitled to constitutional protections.²

Attorneys practicing in the mental health field should understand that, in general, New York subscribes to a medical model for inpatient admission rather than a strictly legal or judicial model—that is, involuntary admission for a period of up to 60 days is accomplished solely on the certifications of examining physicians, without mandatory judicial review. During this initial admission period, judicial review is elective, and a challenge to involuntary hospitalization must be affirmatively exercised by the patient or others. Mandatory judicial review comes into play only for long-term retention. The statutory provisions governing admission and retention are set forth in N.Y. Mental Hygiene Law articles 9 (hospitalization of mentally ill individuals) and 15 (admission of developmentally disabled individuals to schools) (MHL).

A new civil commitment statute for the confinement and treatment of sex offenders has also been codified at article 10 of the MHL. Article 10 does not employ a medical model and has entirely different procedures designed to permit the indefinite civil commitment of sex offenders who are nearing anticipated release from criminal confinement while safeguarding their due process rights. Experience has demonstrated that many candidates for civil confinement are suffering from mental illness or have cognitive limitations due to developmental disabilities or brain injuries. Those committed to secure treatment facilities pursuant to article 10 of the MHL will find their rights severely restricted.

In contrast, there exists no statutory framework that mandates the extension of the protective legal framework for admission and retention to persons in community-based mental hygiene facilities, yet thousands of individuals are served in these facilities where their rights may be severely impacted. Thus, the practitioner who represents individuals receiving care and treatment in mental hygiene facilities (whether inpatient or in the community) will encounter multiple and compelling issues which affect the personal autonomy of individuals, including but not limited to the right to treatment and the right to refuse treatment, the use of restraint and seclusion, transfer between facilities, privacy, competency, communications and visitation, work activities and surrogate health care decision making.

This chapter outlines admission and retention procedures and the rights of people receiving care and treatment in both inpatient hospitals and schools and community residential settings licensed or operated by the Office of Mental Health (OMH) and the Office for People With Developmental Disabilities (OPWDD).

1 *Humphrey v. Cady*, 405 U.S. 504 (1972).

2 *In re Buttonow*, 23 N.Y.2d 385, 297 N.Y.S.2d 97 (1968).

[8.1] II. DEFINITIONS

Because of its specialized subject matter, the MHL employs numerous terms of art, which are defined below and throughout this chapter.

Department means the Department of Mental Hygiene of the State of New York. Except as used in article 5, the term *department* refers to an Office of the Department of Mental Hygiene—the Office of Mental Health (OMH), the Office for People with Developmental Disabilities (OPWDD) or the Office of Alcoholism and Substance Abuse.

Commissioner means the Commissioner of Mental Health, the Commissioner of Developmental Disabilities and the Commissioner of Alcoholism and Substance Abuse Services.

Mental disability means mental illness, mental retardation, developmental disability, alcoholism, substance dependence or chemical dependence. A mentally disabled person is one who has a mental disability.

Mental abnormality means a congenital or acquired condition, disease or disorder that affects the emotional, cognitive or volitional capacity of a person in a manner that predisposes him or her to the commission of conduct constituting a sex offense and that results in the person having serious difficulty in controlling such conduct.

Facility means any place in which services for the mentally disabled are provided. It includes, but is not limited to, a psychiatric center, developmental center, institute, clinic, ward, institution or building, except that in the case of a hospital, as defined in article 28 of the N.Y. Public Health Law (PHL), it means only a ward, wing, unit or part thereof that is operated for the purpose of providing services for the mentally disabled. *Facility* does not include a place where the services rendered consist solely of nonresidential services for the mentally disabled, which are exempt from the requirement for an operating certificate pursuant to articles 16, 31 or 32 of the MHL, nor does it include domestic care and comfort provided to a person in the home.

Department facility means a facility within one of the offices of the department; i.e., a state-operated psychiatric center or developmental center.

Examining physician means a physician licensed to practice medicine in the state of New York.

Certified psychologist means a person who has been certified and registered to practice psychology in the state of New York, pursuant to the N.Y. Education Law.

Hospital means the inpatient services of a psychiatric center under the jurisdiction of OMH or other psychiatric inpatient facility in the department; a psychiatric inpatient facility maintained by a political subdivision of the state for the care or treatment of the mentally ill; a ward, wing, unit or other part of a hospital, as defined in PHL article 28, operated as a part of such hospital for the purpose of providing services for the mentally ill, pursuant to an operating certificate issued by OMH; a comprehensive psychiatric emergency program, which has been issued an operating certificate by OMH; or other facility providing inpatient care or treatment of the mentally ill, which has been issued an operating certificate by OMH.

School means the inpatient service of a developmental center or other residential facility for individuals with developmental disabilities under the jurisdiction of the OPWDD or a facility for the residential care, treatment, training or education of individuals with developmental disabilities, which has been issued an operating certificate by OPWDD.

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Mental illness means affliction with a mental disease or mental condition that is manifested by a disorder or disturbance in behavior, feeling, thinking or judgment to such an extent that the person afflicted requires care, treatment and rehabilitation.

Patient means a person receiving services for the mentally disabled at a facility. It includes a resident at a school.

Infant or minor means a person who has not attained the age of 18 years.

Release means the termination of a patient's inpatient care at a school, hospital or alcoholism facility.

Conditional release means release subject to the right of the school, hospital or alcoholism facility to return the patient to inpatient care, pursuant to the conditions set forth in MHL § 29.15.

Discharge means the release and termination of any right to retain or treat the patient on an inpatient basis. The discharge of such a patient shall not preclude the patient from receiving necessary services on other than an inpatient basis nor shall it preclude subsequent readmission as an inpatient if made in accordance with MHL article 9, 15 or 22.

In need of care and treatment means that a person has a mental illness for which inpatient care and treatment in a hospital is appropriate or is developmentally disabled and would benefit from care and treatment as a resident in a school.

In need of involuntary care and treatment means that a person has a mental illness for which care and treatment as a patient in a hospital is essential to such person's welfare or is in need of inpatient care and treatment as a resident in a school, and such care and treatment is essential to such person's welfare, and that his or her judgment is so impaired that he or she is unable to understand the need for such care and treatment.

Need for retention means that a person who has been admitted to a hospital or school is in need of involuntary care and treatment for a further period.

Record of a patient shall consist of admission, transfer or retention papers and orders, and accompanying data required by the MHL and by the regulations of the commissioner.

Sex offender requiring civil management means a detained sex offender who suffers from a mental abnormality. A sex offender requiring civil management can, as determined by procedures set forth in article 10, be either (1) a dangerous sex offender requiring confinement or (2) a sex offender requiring strict and intensive supervision.

[8.2] III. ADMISSION AND RETENTION—ARTICLES 9 AND 15 OF THE MHL

A person may be civilly admitted to a hospital or school pursuant only to articles 9 and 15 of the MHL, which are largely parallel in their provisions.³ There are far more admissions to hospitals than to schools, however. The statutory scheme, in effect since 1965, establishes a two-tiered or two-stage process for admission and retention of patients in hospitals and schools.

3 MHL §§ 9.03, 15.03. Criminal defendants may also be admitted to hospitals and schools pursuant to Criminal Procedure Law art. 730 or § 330.20 (CPL).

The first stage employs the aforementioned medical model, allowing up to 60 days' confinement without mandatory judicial review. For patients in need of continued involuntary inpatient confinement beyond 60 days, the second stage provides for periodic court orders of retention, as outlined, *infra*, in III.E.

Some would argue that the medical model is constitutionally impermissible, or at least suspect; and indeed, most states do afford every involuntary patient a probable-cause hearing within five to 15 days of admission. However, both the N.Y. Court of Appeals and the U.S. Court of Appeals for the Second Circuit have held that New York's statutory scheme is constitutional due to its built-in due process protections, which include the Mental Hygiene Legal Service (MHLS).⁴

[8.3] A. Mental Hygiene Legal Service

The MHLS (formerly the Mental Health Information Service), operating pursuant to article 47 of the MHL, is an agency of the N.Y. Supreme Court, Appellate Division. The Service has several functions which are defined by statute and uniform regulations of the Appellate Divisions.⁵ These duties include, among other things, providing protective legal services, advice and assistance to mentally or developmentally disabled persons who are residents of facilities as defined in § 1.03 of the MHL or any other place which is required to have an operating certificate pursuant to articles 16 or 31 of the MHL and to persons alleged to be in need of care and treatment in such facilities.

The MHLS is responsible for the protection of the legal rights of persons confined, voluntarily or involuntarily, to state, municipal, veterans' and private hospitals on legal status and pursuant to article 9 of the MHL; or in state developmental centers and private schools on legal status and pursuant to article 15 of the MHL; or residing in community residences on legal status under such institutions' supervision. The jurisdiction of the MHLS also extends to mentally disabled persons residing in community-based facilities, such as community residences, group homes, intermediate care facilities, supportive apartments and family care homes, who typically are on no legal status.⁶

The objectives of the MHLS are to ensure that persons with mental and/or developmental disabilities are afforded due process and equal protection under the law; to provide legal counsel for its clients in judicial proceedings concerning admission, retention, transfer, care and treatment; to study and review the admission and retention of all patients; to investigate and take legal action relative to cases of abuse or mistreatment; and to make appropriate referrals for other needed legal services. The MHLS concentrates primarily on individual case advocacy. It also handles appeals and impact litigation.

A main departmental office of the MHLS is located in each of the four judicial departments of the state. Services to clients are provided from field offices strategically located throughout the state at or near all major mental hygiene facilities.

[8.4] B. Notice of Status and Rights

Adequate notice is a cornerstone of due process. Immediately upon admission or upon conversion to another legal status, each patient must receive a written notice, prescribed by the commissioner, setting forth the patient's rights under the MHL and the availability of the MHLS. Additionally, notices must be

4 *Project Release v. Prevost*, 551 F. Supp. 1298 (E.D.N.Y. 1982), *aff'd*, 722 F.2d 960 (2d Cir. 1983); *Flagen v. Miller*, 29 N.Y.2d 348, 328 N.Y.S.2d 393 (1972).

5 See N.Y. Comp. Codes R. & Regs. tit. 22, pts. 622 (1st Dep't), 694 (2d Dep't), 823 (3d Dep't), 1023 (4th Dep't) (N.Y.C.R.R.).

6 1993 N.Y. Laws ch. 330; see also *In re Alexis H.*, 174 A.D.2d 1030, 572 N.Y.S.2d 194 (4th Dep't 1991).

conspicuously posted throughout the facility, stating the availability of MHLS and the rights of patients in general.⁷ There must also be periodic notice of rights given to voluntary patients.⁸

[8.5] C. Voluntary (Willing) Admissions

Mentally ill persons may be admitted as *voluntary* or *informal* patients. Developmentally disabled persons may be *voluntary* or *non-objecting* residents.⁹

[8.6] 1. Suitability

To be suitable for admission on, or conversion to, voluntary or informal status, a person must understand the nature of the facility, that he or she is making an application for admission, and the nature of the status and the provisions governing release or conversion to involuntary status. Patients need not have legal capacity to contract.¹⁰

[8.7] 2. Informal Admissions

Formal written application is not required, and the patient shall be free to leave the hospital at any time.¹¹ There is no time limit on hospitalization and no provision for conversion to involuntary status, if release has been requested.

[8.8] 3. Voluntary Admissions

Any person in need of care and treatment who voluntarily makes written application therefor may be admitted as a voluntary patient. If a developmentally disabled person is under 18, or a mentally ill person is under 16, written application must be made by such person's parent, legal guardian, next of kin or certain public officials having custody. If the mentally ill person is over 16 but under 18, the facility director may, in his or her discretion, admit the minor on the minor's own application. There is no time limit on the admission.¹²

[8.9] a. Preference for Voluntary Status

Voluntary rather than involuntary admissions are encouraged by mental health officials. A person requesting voluntary admission, who is suitable therefor, shall be admitted only on voluntary status—or informal status, if the person is mentally ill. A mentally ill person specifically requesting informal status shall be so admitted.¹³ Any involuntary patient suitable for and willing to become voluntary shall be converted thereto; but to guard against inappropriate placement on voluntary status, a patient converted thereto is entitled to a court hearing.¹⁴

7 MHL §§ 9.07, 15.07.

8 MHL §§ 9.19, 15.17 (Also see notice requirements of each admission section in MHL arts. 9 and 15.).

9 MHL §§ 9.13, 9.15, 15.13, 15.25.

10 MHL §§ 9.17, 9.21, 15.15, 15.19.

11 MHL § 9.15. *Paradies v. Benedictine Hosp.*, 77 A.D.2d 757, 431 N.Y.S.2d 175 (3d Dep't 1980).

12 MHL §§ 9.13, 15.13.

13 MHL §§ 9.21, 15.19.

14 MHL §§ 9.23, 15.21.

[8.10] b. Review of Voluntary Status

A voluntary or informal patient who has not sought release but who is either unwilling or unsuitable for voluntary or informal status must either be released or converted to involuntary status pursuant to the provisions for involuntary admission or medical certification. The suitability and willingness of a voluntary (or informal) patient to remain in such status shall be reviewed annually. If the MHLS finds grounds to doubt suitability or willingness, it shall make application for a court order determining those questions.¹⁵

[8.11] 4. Non-Objecting Admissions

A developmentally disabled person in need of care and treatment who does not object thereto and who is so profoundly or severely developmentally disabled as to be unsuitable for voluntary admission, may be admitted on the application of a relative, friend or other person with standing,¹⁶ accompanied by the certificate of an examining physician or certified psychologist. There is no time limit on this status, and there must be annual review by the MHLS.¹⁷

[8.12] 5. Request for Release

Written request for release may be made by a voluntary or non-objecting patient of any age, by the MHLS, by the family or applicant for a minor voluntary patient or by anyone on behalf of a non-objecting patient.¹⁸

When a written request for release is made, the patient must be released immediately; however, if there are reasonable grounds to believe that the patient may be “in need of involuntary care and treatment,”¹⁹ the facility director may retain the patient for a period not to exceed 72 hours. Before the expiration of the 72-hour period, the director shall either release the patient or apply to the supreme court or county court for a judicial order of retention pursuant to MHL article 9 or 15. As discussed below, the patient is entitled to a hearing on the application within three days of demand. If the court determines the patient is in need of retention, it shall order the patient retained for a period not to exceed 60 days.²⁰

[8.13] D. Involuntary Admissions

There are several means of involuntary admission under New York’s medical model. The practitioner should note that these sections of the MHL are procedurally and substantively intricate. To the extent that such stringent, detailed requirements make involuntary admission less than easy, they reflect the gravity of the liberty interests at stake. Full compliance with statutory requirements is expected.

[8.14] 1. Involuntary Admission on Medical Certification

A hospital or school may receive as an involuntary patient or resident any person alleged to be mentally ill or developmentally disabled and in need of involuntary care and treatment upon the certification of two examining physicians, accompanied by an application for admission. (For the developmentally disabled patient or resident, one examiner may be a psychologist.) The application must be written and contain

15 MHL §§ 9.17(b), 15.15(b), 9.25, 15.23. *In re Harold F.*, 147 Misc. 2d 593, 558 N.Y.S.2d 474 (Sup. Ct., Albany Co. 1990).

16 MHL § 15.27.

17 MHL § 15.25.

18 MHL §§ 9.13, 15.13, 15.25.

19 *See supra* II.

20 *See supra* II. Subsequent retention is discussed in III.E.

facts supporting allegations of the need for admission; it must be executed under penalty of perjury and be signed *only* by one of the parties enumerated in the statute within 10 days prior to admission.²¹ The examination may be conducted jointly, but each examiner must execute a separate certificate (known as the two-physician certificate, or 2 PC). The examiners must consider less restrictive alternatives to admission and, if possible, consult with those who provided prior treatment.

Prior to admission on or conversion to an involuntary status, the need for involuntary care and treatment must be confirmed by a third physician on the staff of the hospital or school.²² Involuntary admission on medical certification is valid for up to 60 days from the date of admission.

At any time during those 60 days, the patient, MHLS or any relative or friend may, on behalf of the patient, make a written request for a court hearing. The facility director must forward forthwith a copy of the request to the supreme or county court.²³ The court must calendar the hearing for a date not later than five days after the date the court receives the request.²⁴ If the court denies the patient's release, the patient may be retained for a period not to exceed 60 days from the date of admission or 30 days from the date of the court's order denying release, whichever is greater.²⁵

[8.15] 2. Emergency Admission for Immediate Observation, Care and Treatment

For a period of up to 15 days, a hospital approved by OMH²⁶ may admit any person who, upon the examination of a staff physician, is alleged to have a mental illness (note that developmental disability is not covered) for which immediate observation, care and treatment in a hospital is appropriate, and which likely would result in serious harm to that person or others. *Likelihood to result in serious harm* is defined as

a substantial risk of physical harm to himself as manifested by threats of or attempts at suicide or serious bodily harm or other conduct demonstrating that he is dangerous to himself; or

a substantial risk of physical harm to other persons as manifested by homicidal or other violent behavior by which others are placed in reasonable fear of serious physical harm.²⁷

While the emergency admission is valid for 15 days, the patient may not be retained for more than 48 hours, unless a staff psychiatrist confirms the need for hospitalization.

At any time after admission, the patient, a relative or friend, or the MHLS may demand a hearing, which shall be held as soon as practicable, but no more than five days after the court receives the request. The court must determine the matter in accordance with the foregoing standard for admission.

Involuntary hospitalization beyond 15 days may be continued by the execution of a two-physician certificate, but if a hearing was previously requested pursuant to MHL § 9.39, it should be conducted under

21 MHL §§ 9.27, 15.27; see *Reuda v. Charmaine D.*, 17 N.Y.3d 522, 934 N.Y.S.2d 72 (2011).

22 MHL §§ 9.27(e), 15.27(e). See also *In re Pilgrim Psychiatric Ctr.*, 197 A.D.2d 204, 610 N.Y.S.2d 962 (2d Dep't 1994).

23 MHL § 9.31(b).

24 MHL §§ 9.31(c), 15.31(c).

25 MHL §§ 9.33, 15.33. The hearing process is discussed in III.F.

26 MHL § 9.39(a).

27 MHL § 9.39(a)(1), (2).

that section. In practice, most hospitals will attempt to merge the emergency admission and the 2 PC hearing. Since MHL § 9.39 has a higher substantive standard than § 9.27, such a merger should be contested.²⁸

An additional class of facility called a comprehensive psychiatric emergency program (CPEP)²⁹ was created to deal with the large number of patients, particularly in the downstate region, who were held in hospital emergency rooms for extended periods of time while awaiting the availability of regular hospital admission. The first such program began in 1990. Section 9.40 of the MHL provides for the admission of patients who are dangerous to self or others, as defined above. The initial examination must be made within six hours, and it may result in 24 hours' admission, with an extension to 72 hours based on a confirming examination by a second physician. Notice and hearing provisions are in accordance with MHL § 9.39. Continued hospitalization is permitted by means of MHL §§ 9.39 or 9.27.

[8.16] 3. Involuntary Admission on Certificate of Director of Community Services³⁰

The director of community services (DCS) is the chief mental health official in each county (in New York City, it is the city commissioner of mental health). A hospital, upon application by the DCS or an examining physician designated by the DCS and approved by the commissioner, may admit and retain a person who, in the opinion of the DCS or the director's designee, has a mental illness that is likely to result in serious harm to himself or others, and for which immediate inpatient care treatment in a hospital is appropriate. In rural counties, a non-medical DCS may admit a patient.³¹ The application must be based on a personal examination.

The need for immediate hospitalization shall be confirmed by a hospital staff physician prior to admission and again within 24 hours when the applicant is a non-medical DCS. Involuntary retention of the patient beyond 72 hours is accomplished by having another psychiatrist on the staff of the hospital file a certificate of examination, thereby extending the admission to 60 days. The patient's retention is subject to all the requirements of notice and hearing applicable to other involuntarily confined (2 PC) patients.

[8.17] 4. Other Emergency Admission Procedures

A mentally ill and dangerous patient (as previously defined) may be brought to a hospital approved by the commissioner for emergency admission³² for purposes of evaluation and, if appropriate, for involuntary admission under MHL § 9.39, as follows:

1. By peace officers and police officers³³
2. By order of courts of inferior or general jurisdiction³⁴
3. By order of the DCS³⁵

28 MHL § 9.39(b).

29 MHL §§ 1.03(37), 9.40, 31.27.

30 MHL § 9.37.

31 MHL § 9.37(c).

32 MHL § 9.39.

33 MHL § 9.41; *see also Rivera v. Russi*, 243 A.D.2d 161, 674 N.Y.S.2d 42 (1st Dep't 1998).

34 MHL § 9.43.

35 MHL § 9.45; *see also Ruhlmann v. Ulster Cnty. DSS*, 234 F. Supp. 2d 140 (N.D.N.Y. 2002).

4. By direction of a qualified psychiatrist who is treating or supervising the treatment of the patient at an outpatient mental health clinic or program³⁶
5. By the director of a general hospital, as defined in article 28 of the PHL, that does not have a psychiatric unit³⁷

[8.18] 5. Admissions to Residential Treatment Facilities for Children and Youth³⁸

A residential treatment facility for children and youth (RTFCY) is a specialized psychiatric facility that provides long-term treatment for persons who are under the age of 21. All rights and provisions of MHL article 9 apply to RTFCYs. In addition, admission is subject to prior review and approval by regional certification committees established by OMH.³⁹

[8.19] E. Court Authorization to Retain an Involuntary Patient

While persons held involuntarily on medical certification or emergency admission status have elective judicial review, retention beyond the 2 PC maximum of 60 days requires prior judicial approval. The facility director must apply to the court for retention before the medical certification expires.⁴⁰

Notice of application must be given to the patient or resident, who then has five days to request a hearing on the application. If no hearing is requested by or on behalf of the patient, and the court is satisfied that the patient meets the retention standard, entry of an order of retention is permitted. If a hearing is demanded, it is calendared in five days from when the notice of demand is received and conducted in accordance with MHL §§ 9.31 and 15.31.

Retention is time limited, with mandatory periodic judicial review for continued retention. For the mentally ill patient, the first period of retention is six months. Continued retention is for one year, followed by consecutive two-year orders of retention. For the mentally retarded resident, the first order authorizes retention up to one year, with continued retention for consecutive two-year periods. The court may authorize shorter periods. The facility may discharge the patient whenever release is clinically appropriate.

[8.20] F. Judicial Review of Involuntary Admission and Retention

Whether mentally ill or mentally retarded, newly admitted on a 2 PC or retained long-term on a two-year order, the patient or resident is entitled to a court hearing governed by the principles enumerated below.

[8.21] 1. Legal Representation

A patient has a right to counsel in civil hospitalization proceedings.⁴¹ The MHLS has a standing statutory appointment to serve as counsel for patients/residents in all proceedings concerning admission, retention, transfer, care and treatment.⁴²

36 MHL § 9.55.

37 MHL § 9.57.

38 MHL § 9.51.

39 14 N.Y.C.R.R. pt. 584.

40 MHL §§ 9.33, 15.33.

[8.22] 2. Burden of Proof

Although the MHL is silent as to burden of proof, the U.S. Supreme Court has held that due process requires that the hospital prove the need for commitment by clear and convincing evidence.⁴³ The New York courts have also adopted this standard.⁴⁴

[8.23] 3. Res Judicata

Following the court-ordered release of a patient, the principle of res judicata may apply in a successive commitment hearing, where no evidence that shows a change in the patient's condition is introduced.⁴⁵

[8.24] 4. Findings by the Court

[8.25] a. Substantive Criteria

In order to authorize the involuntary retention or to deny the release of a patient/resident, the court must find that the patient/resident is in need of retention—to wit, that he or she (1) suffers from a mental illness or has a developmental disability, (2) that care and treatment for such condition as an inpatient in a hospital/school is essential to his or her welfare, and (3) that the patient/resident's judgment is so impaired that he or she is unable to understand the need for such care and treatment.⁴⁶

The Mental Hygiene Law treats mental illness, developmental disabilities, and alcohol and substance abuse as separate and distinct disorders; substance abuse alone is not a mental illness for which an individual can be involuntarily psychiatrically hospitalized.⁴⁷

In addition to the foregoing statutory requirements, in *In re Scopes*,⁴⁸ the court ruled that in order to satisfy substantive due process requirements, “the continued confinement of an individual must be based upon a finding that the person to be committed poses a real and present threat of substantial harm to himself or others”; such a finding does not require proof of a recent overtly dangerous act.⁴⁹ The *Scopes* requirement has expressly been extended to involuntarily retained developmentally disabled individuals.⁵⁰

41 *People ex rel. Woodall v. Bigelow*, 20 N.Y.2d 852, 285 N.Y.S.2d 85 (1967); see also *People ex rel. Rogers v. Stanley*, 17 N.Y.2d 256, 270 N.Y.S.2d 573 (1966); N.Y. Judiciary Law § 35.

42 MHL art. 47; 22 N.Y.C.R.R. pts. 622, 694, 823, 1023.

43 *Addington v. Texas*, 441 U.S. 418 (1979).

44 *In re Harry M.*, 96 A.D.2d 201, 468 N.Y.S.2d 359 (2d Dep't 1983); *In re Scopes*, 59 A.D.2d 203, 398 N.Y.S.2d 911 (3d Dep't 1977); *In re Carter*, 102 Misc. 2d 867, 424 N.Y.S.2d 833 (Sup. Ct., Suffolk Co. 1980); see *In re Bethune M.*, 12 A.D.3d 605, 785 N.Y.S.2d 478 (2d Dep't 2004); *In re Richard E.*, 12 A.D.3d 1019, 785 N.Y.S.2d 580 (3d Dep't 2004); *In re Jill A.B.*, 9 A.D.3d 428, 779 N.Y.S.2d 790 (2d Dep't 2004); *In re Luis A.*, 13 A.D.3d 441, 786 N.Y.S.2d 560 (2d Dep't 2004); *N.Y. City Health & Hosps. Corp. v. Brian H.*, 51 A.D.3d 412, 857 N.Y.S.2d 530 (1st Dep't 2008).

45 *People ex rel. Leonard HH v. Nixon*, 148 A.D.2d 75, 543 N.Y.S.2d 998 (3d Dep't 1989).

46 MHL §§ 9.01, 15.01; the MHL was amended in 2011 to substitute “has a developmental disability” for “is mentally retarded” (2011 N.Y. Laws, ch. 37).

47 MHL § 1.03(3), (16), (20), (22), (40); *Lawlor v. Lenox Hill Hosp.*, 74 A.D.3d 695, 90 N.Y.S.2d 60 (1st Dep't 2010); *In re Michael S.*, 166 Misc. 2d 875, 636 N.Y.S.2d 261 (Sup. Ct., Westchester Co. 1995); see also MHL § 9.27(h).

48 59 A.D.2d 203, 398 N.Y.S.2d 911 (3d Dep't 1977).

49 *Id.* at 205; see also *In re Francine T.*, 302 A.D.2d 533, 755 N.Y.S.2d 276 (2d Dep't 2003).

50 *In re Harry M.*, 96 A.D.2d 201, 468 N.Y.S.2d 359 (2d Dep't 1983).

Cases following *Scopes* have refined the concept of dangerousness to self or others. An inability to meet one's need for food, clothing and shelter is sufficient to establish dangerousness to oneself.⁵¹ However, the fact that a patient can be stabilized in a hospital setting with medication and continuous supervision and care does not necessarily lead to the conclusion that the patient can function safely in an outpatient setting, especially where evidence exists to the contrary.⁵² To supply a basis for commitment, the dangerousness must be linked to the patient's mental illness—that is, there must be clear and convincing evidence that the dangerousness results from the mental illness.⁵³ Thus, refusing to accept treatment for a medical condition is, in and of itself, insufficient.⁵⁴

[8.26] b. Least Restrictive Alternative

The court must also determine whether there are any less restrictive alternatives to hospitalization—such as halfway houses, community residences, health-related facilities or outpatient clinics—that would adequately meet the patient's needs. The right to the least restrictive alternative has been recognized by the N.Y. Court of Appeals.⁵⁵ The right to live in the most integrated setting is also guaranteed by the federal Americans With Disabilities Act (ADA),⁵⁶ and patients released after court hearings have sued to vindicate their rights to community placement under both the MHL and the ADA.

[8.27] c. Procedural Issues

The court must determine certain procedural issues, including the facial adequacy of the admission papers and court applications and the timeliness of applications to the court. An application for retention filed untimely, or an application that is improperly or incompletely executed, may be dismissed and the patient released.⁵⁷ Where a patient retained in a state hospital is ordered immediately released following a hearing, the order is self-executing and not subject to an automatic stay upon the filing of a notice of appeal.⁵⁸ Also, a person released by court order has the right to adequate discharge planning, which includes the preparation of a written service plan.⁵⁹

51 *Id.* at 204; *In re Carl C.*, 126 A.D.2d 640, 511 N.Y.S.2d 144 (2d Dep't 1987); *Boggs v. N.Y. City Health & Hosps. Corp.*, 132 A.D.2d 340, 523 N.Y.S.2d 71 (1st Dep't 1987), *appeal dismissed*, 70 N.Y.2d 972, 525 N.Y.S.2d 796, *reconsideration denied sub nom. Anonymous v. N.Y. City Health & Hosp. Corp.*, 71 N.Y.2d 994, 529 N.Y.S.2d 278, *motion dismissed*, 70 N.Y.2d 981, 526 N.Y.S.2d 429 (1988).

52 *Boggs*, 132 A.D.2d at 341; *Ford v. Daniel R.*, 215 A.D.2d 294, 626 N.Y.S.2d 784 (1st Dep't 1995); *Donaldson v. Daley*, 206 A.D.2d 298, 614 N.Y.S.2d 525 (1st Dep't 1994); *Seltzer v. Hogue*, 187 A.D.2d 230, 594 N.Y.S.2d 781 (2d Dep't 1993); *Robinson v. Sanchez*, 168 Misc. 2d 546, 639 N.Y.S.2d 897 (Sup. Ct., Bronx Co. 1996); *see Anthony M. v. Sanchez*, 229 A.D.2d 322, 645 N.Y.S.2d 23 (1st Dep't 1996); *Arnold v. Donaldson*, 215 A.D.2d 302, 627 N.Y.S.2d 10 (1st Dep't 1995); *In re Yvette S.*, 163 Misc. 2d 902, 622 N.Y.S.2d 879 (Sup. Ct., Queens Co. 1995).

53 *Charles T. v. Sanchez*, 215 A.D.2d 235, 626 N.Y.S.2d 492 (1st Dep't 1995).

54 *Gilliard v. Sanchez*, 219 A.D.2d 500, 631 N.Y.S.2d 330 (1st Dep't 1995).

55 *Kesselbrenner v. Anonymous*, 39 A.D.2d 410, 334 N.Y.S.2d 738 (2d Dep't 1972), *rev'd*, 33 N.Y.2d 161, 350 N.Y.S.2d 889 (1973); *see also Jackson v. Indiana*, 406 U.S. 715 (1972); *Humphrey v. Cady*, 405 U.S. 504 (1972); *Project Release v. Prevost*, 551 F. Supp. 1298 (E.D.N.Y. 1982), *aff'd*, 722 F.2d 960 (2d Cir. 1983).

56 *Olmstead v. L.C.*, 527 U.S. 581 (1999).

57 N.Y. Civil Practice Law & Rules 201 (CPLR). *See In re Nancy H.*, 177 Misc. 2d 30, 675 N.Y.S.2d 774 (Sup. Ct., Rockland Co. 1998); *In re Gladstone*, 143 Misc. 2d 646, 540 N.Y.S.2d 960 (Sup. Ct., Bronx Co. 1989); *In re Sherman*, 98 Misc. 2d 431, 414 N.Y.S.2d 78 (Sup. Ct., N.Y. Co. 1979); *but see People ex rel. Noel B. v. Jones*, 230 A.D.2d 809, 646 N.Y.S.2d 820 (2d Dep't), *lv. to appeal dismissed without opinion*, 88 N.Y.2d 1065, 651 N.Y.S.2d 408 (1996); *Rebecca Y. v. Brunswick Hall Psychiatric Ctr.*, 76 A.D.3d 1028, 908 N.Y.S.2d 101 (2d Dep't 2010).

58 *In re Nile W.*, 64 A.D.3d 717, 882 N.Y.S.2d 690 (2d Dep't 2009).

59 *Dix ex rel. Craig AA v. Maul*, 38 A.D.3d 972, 831 N.Y.S.2d 564 (3d Dep't 2007).

[8.28] 5. Independent Medical Opinion

Expert medical (i.e., psychiatric) opinion is obviously critical to the outcome of MHL hearings. However, the Second Circuit has held that the federal due process clause does not require the state to provide indigent patients with a consulting or advocate psychiatrist in retention proceedings.⁶⁰ Patients may, of course, bring into court their own independently retained witnesses, but few have the financial or practical means to do so. Therefore, the patient may seek appointment by the court of up to two psychiatrists, certified psychologists or physicians at the state's expense.⁶¹ Some caveats: such appointment is discretionary with the court, the independent witness may oppose the patient's release, the independent physician is the court's witness (the patient may be unable to bar testimony he or she feels is unfavorable) and the limited compensation allowed often makes it difficult to secure independent medical opinion.

[8.29] 6. Rehearing and Review

A patient/resident (or others on such person's behalf) may obtain as a matter of right a rehearing and review of a court order denying release or authorizing retention within 30 days after such order.⁶² A jury trial may be demanded at this stage of the proceeding.⁶³ A rehearing should be conducted as a trial de novo; it is governed by the same principles as the original hearing.⁶⁴

[8.30] 7. Writ of Habeas Corpus

An individual may question the cause and legality of his or her detention in a psychiatric facility by means of a writ of habeas corpus.⁶⁵ Writs are especially appropriate when statutory hearings are unavailable (e.g., in the middle of a two-year retention order), or where the hospital breaches required admission procedures.

Although the foregoing principles apply to judicial review by means of a writ, the hospital may assert that the burden of proof is on the patient as petitioner. Nevertheless, it may be argued that where detention is based on the patient's mental condition, the burden of proof remains with the hospital seeking to retain the patient.⁶⁶

[8.31] 8. Sealing of Court Records and Papers

Court papers under MHL articles 9 and 15 are filed with the county clerk and shall be sealed. Court papers shall be exhibited, upon an order of the court, only to the parties to the proceeding or to someone properly interested.⁶⁷

60 *Goetz v. Crosson*, 967 F.2d 29 (2d Cir. 1992), *on remand*, 838 F. Supp. 136 (S.D.N.Y. 1993), *aff'd*, 41 F.3d 800 (2d Cir. 1994); *cf. In re Marvin B.*, 167 Misc. 2d 904, 639 N.Y.S.2d 656 (Sup. Ct., Queens Co. 1996).

61 Judiciary Law § 35(4).

62 MHL §§ 9.35, 15.35.

63 *Sporza v. German Sav. Bank*, 192 N.Y. 8 (1908).

64 *Arnold A. v. Sanchez*, 166 Misc. 2d 493, 634 N.Y.S.2d 343 (Sup. Ct., Bronx Co. 1995); *Maureen A. v. Wack*, 153 Misc. 2d 600, 582 N.Y.S.2d 333 (Sup. Ct., N.Y. Co. 1991); *see Launcelot T. v. Mullen*, 264 A.D.2d 697, 701 N.Y.S.2d 57 (2d Dep't 1999).

65 MHL § 33.15.

66 *See Winslow v. O'Neill*, 153 A.D.2d 563, 544 N.Y.S.2d 220 (2d Dep't 1989).

67 MHL §§ 9.31(f), 15.31(f).

[8.32] 9. Presumption of Competency

No form of involuntary admission or retention shall be a determination that a patient is incompetent or is unable to adequately conduct personal or business affairs.⁶⁸ “Absent a judgment of incompetency, an involuntarily committed patient retains the right to marry, draft a will, sue in his own name, and generally manage his affairs.”⁶⁹

[8.33] IV. ADMISSION AND RETENTION—ARTICLE 10 OF THE MHL

New York’s Sex Offender Management Treatment Act (SOMTA) was signed into law on March 14, 2007.⁷⁰ The act lengthens sentences for certain sex offenses and also provides for the civil commitment of some sex offenders to inpatient or outpatient supervision, pursuant to article 10 of the MHL.

Article 10 reaches “detained sex offenders” who are approaching their release dates, principally sentence-serving inmates convicted of sex offenses or sexually motivated felonies. Candidates for civil confinement include insanity acquittees, defendants found not fit to proceed, as well as persons under regular parole supervision. Candidates for civil confinement may have a range of mental disabilities. A federal lawsuit is pending challenging certain provisions of article 10. State courts have also had to reach the question of whether the law can be constitutionally applied to defendants found not fit to proceed and to those defendants found to have committed “designated felonies” alleged to be sexually motivated before the effective date of SOMTA.⁷¹

[8.34] A. Findings by the Court

To qualify for inpatient or outpatient commitment via the new MHL article 10, the detained sex offender must have a mental abnormality. The term “mental abnormality” is defined in MHL § 10.03(i) as

a congenital or acquired condition, disease or disorder that affects the emotional, cognitive or volitional capacity of a person in a manner that predisposes him or her to the commission of conduct constituting a sex offense and that results in that person having serious difficulty in controlling such conduct.

If the detained sex offender has a mental abnormality, the person is considered to be a “sex offender requiring civil management.” The person will either be committed to a secure inpatient facility or to intensive outpatient supervision. A “secure treatment facility” is a facility within the meaning of MHL 1.03, but it is not a “hospital.”⁷²

The person will be committed to a secure inpatient facility if he or she is a “dangerous sex offender requiring confinement.” The term “dangerous sex offender requiring confinement” is defined in MHL § 10.03(e) as follows:

68 MHL § 29.03.

69 *Winters v. Miller*, 446 F.2d 65 (2d Cir. 1971); *see also In re Buttonow*, 23 N.Y.2d 385, 297 N.Y.S.2d 97 (1968).

70 2007 N.Y. Laws ch. 7.

71 *See Mental Hygiene Legal Serv. v. Spitzer*, No. 07 CIV. 2935 (GEL), 2007 WL 4115936, (S.D.N.Y. 2007), *aff’d sub nom. Mental Hygiene Legal Servs. v. Paterson*, 2009 WL 579445 (2d Cir. 2009); *Mental Hygiene Legal Serv. v. Cuomo*, 785 F. Supp. 2d 205 (S.D.N.Y. 2011); *State v. Daniel OO*, 88 A.D.3d 212, 928 N.Y.S.2d 787 (3d Dep’t 2011), *State v. Farnsworth*, 75 A.D.3d 14, 900 N.Y.S.2d 548 (4th Dep’t 2010).

72 MHL § 7.18(b).

A person who is a detained sex offender suffering from a mental abnormality involving such a strong predisposition to commit sex offenses, and such an inability to control behavior, that the person is likely to be a danger to others and to commit sex offenses if not confined to a secure treatment facility.

[8.35] B. Procedural Issues

The statute provides for a probable cause hearing and a jury trial with respect to each article 10 commitment application. If the jury unanimously determines (or the judge determines, in the event a jury trial is waived) that the person is a detained sex offender who suffers from a mental abnormality, then MHL § 10.07(f) provides that the court (rather than the jury) must then decide whether the person qualifies for inpatient commitment to a secure facility, or shall be committed to intensive outpatient supervision under the supervision of the Division of Parole.⁷³ The constitutionality of MHL § 10.07(f) was upheld after a constitutional challenge, with the Court of Appeals holding that respondents are not entitled to a jury trial at the second phase of the proceeding.⁷⁴

[8.36] C. Independent Medical Opinion

At any time after the filing of a sex offender civil management petition, and prior to trial, the respondent may request the court in which the petition is pending to order that he or she be evaluated by a psychiatric examiner. Upon such a request, the court shall order an evaluation by a psychiatric examiner. If the respondent is financially unable to obtain an examiner, the court shall appoint an examiner of the respondent's choice to be paid within the limits prescribed by law. Following the evaluation, such psychiatric examiner shall report his or her findings in writing to the respondent or counsel for the respondent, to the attorney general, and to the court.⁷⁵

[8.37] D. Legal Representation

The court shall appoint the MHLS as counsel for article 10 respondents who are indigent. In the event that the court determines that the service cannot accept the appointment, the court shall appoint an attorney eligible for appointment pursuant to article 18-B of the County Law. The expense of counsel is a state rather than a county charge, however.⁷⁶

[8.38] E. Judicial Review of the Need for Confinement

Article 10 provides that persons who have been committed to a secure inpatient confinement may petition annually for judicial review. Persons who are committed to intensive outpatient supervision may petition bi-annually.⁷⁷

[8.39] F. Post-Commitment Remedies

The State may also file post-commitment applications to release a person confined in a secure facility to intensive outpatient supervision, to modify the conditions of intensive outpatient supervision, or to re-

73 The Division of Parole has now merged with the Department of Correctional Services, and the consolidated agency is called the Department of Corrections and Community Supervision – 2011 N.Y. Laws ch. 62.

74 *State v. Myron P.*, 20 N.Y.3d 206, 958 N.Y.S.2d 71 (2012).

75 MHL § 10.06(e).

76 MHL §§ 10.06(c), 10.15.

77 MHL §§ 10.09, 10.11(f).

move a person from intensive outpatient supervision to inpatient confinement.⁷⁸ Appellate remedies are provided for at MHL § 10.13.

[8.40] V. ALTERNATIVES TO INPATIENT TREATMENT

There are two statutory remedies designed to provide community-based treatment and supervision of mentally ill and developmentally disabled individuals who may otherwise require inpatient retention under articles 9 or 15 of the MHL. The first and long-standing remedy is conditional release as provided for by MHL § 29.15. Persons who are mentally ill or developmentally disabled can be candidates for conditional release. The other alternative to inpatient care and treatment is “assisted outpatient treatment,” codified at MHL § 9.60, which is designed to address the needs of persons with severe and persistent mental illness.⁷⁹

[8.41] A. Conditional Release

A patient may be discharged or conditionally released to the community by the director of a state-operated hospital or school, if, in the opinion of staff familiar with the patient’s case history, such patient does not require active inpatient care and treatment.⁸⁰

[8.42] 1. Legal Status

A person who is conditionally released remains on a legal status; either voluntary or involuntary. An involuntary patient may be conditionally released only for the remainder of the authorized retention period. A voluntary patient may be conditionally released only for a 12-month period. The conditional release for a voluntary patient may be continued beyond 12 months, however, if the suitability and willingness of the person to remain on conditional release is reviewed.⁸¹

[8.43] 2. Termination of Involuntary Status Conditional Release

For involuntary patients on conditional release, the statute provides that the director may terminate the conditional release and order the patient to return to the facility at any time during the period for which retention was authorized if, in the director’s judgment, the patient needs inpatient care and treatment and the conditional release is no longer appropriate; provided, however, that in any such case, the director shall cause written notice of such patient’s return to be given to MHLS.

The director shall cause the patient to be retained for observation, care and treatment, and further examination in a hospital for up to 72 hours if a physician on the staff of the hospital determines that such person may have a mental illness and may be in need of involuntary care and treatment in a hospital pursuant to the provisions of article 9 of the MHL.

Any continued retention in such hospital beyond the initial 72-hour period shall be in accordance with the provisions of article 9 of the MHL. If at any time during the 72-hour period the person is determined not to meet the involuntary admission and retention provisions of this chapter and does not agree to stay

78 MHL § 10.11.

79 There is also an outpatient treatment alternative for sex offenders determined to be in need of civil management which is codified at MHL § 10.11.

80 MHL § 29.15(a).

81 MHL § 29.15(b)(1), (2).

in the hospital as a voluntary or informal patient, he or she must be released, either conditionally or unconditionally.⁸²

While a person may be conditionally released from a hospital or a school, the statute only contemplates return to a hospital, and not a school, in the event the person's condition decompensates. Presumably, this was a legislative oversight.

[8.44] 3. Termination of Voluntary Conditional Release

In the case of a voluntary patient on conditional release, the director may terminate the conditional release and order the patient to return to the facility at any time, if, in the judgment of the director, the patient needs inpatient care and treatment and the conditional release is no longer appropriate, provided, however, that if such patient does not consent to return to the facility, he shall not be returned to the facility, except in accordance with the provisions of article 9 or 15 of the MHL.⁸³

[8.45] 4. Provision of a Written Service Plan

A person is conditionally released with a written service plan which shall include, but not be limited to, a statement of the person's need, if any, for supervision, medication, aftercare services, and assistance in finding employment; a specific recommendation of the type of residence in which the person is to live and a listing of the services available to the person in such residence; a listing of organizations, facilities and individuals who are available to provide services in accordance with the identified needs of the person; and an evaluation of the patient's need and potential eligibility for public benefits following conditional release, including public assistance, Medicaid, and supplemental security income. The facility director is required to implement and monitor the person's written service plan.⁸⁴

[8.46] B. Assisted Outpatient Treatment (AOT)

Mental Hygiene Law § 9.60 was adopted in 1999, and at that time New York became the 41st state to provide for a system of assisted outpatient treatment. The law is designed to reach persons with mental illness who are unlikely to survive safely in the community without supervision and court-ordered mental health treatment.⁸⁵

[8.47] 1. Findings by the Court

Before a court may issue an order for assisted outpatient treatment, the statute requires that a hearing be held at which a number of criteria must be established, each by clear and convincing evidence.

The court must find that

1. the patient is at least 18 years of age;
2. the patient suffers from a mental illness;
3. the patient is unlikely to survive safely in the community without supervision, based on a clinical determination;

82 MHL § 29.15(e)(1).

83 MHL § 29.15(e)(2).

84 MHL § 29.15(f), (g), (h).

85 1999 N.Y. Laws ch. 408, § 6 (Kendra's Law).

4. the patient has a history of lack of compliance with treatment for mental illness that has either (a) at least twice within the last 36 months been a significant factor in necessitating hospitalization, or receipt of services in a forensic or other mental health unit of a correctional facility or a local correctional facility, not including any period during which the person was hospitalized or incarcerated immediately preceding the filing of the petition, or (b) resulted in one or more acts of serious violent behavior toward self or others or threats of, or attempts at, serious physical harm to self or others within the last 48 months, not including any period in which the person was hospitalized or incarcerated immediately preceding the filing of the petition;
5. the patient is, as a result of his or her mental illness, unlikely to voluntarily participate in the recommended treatment pursuant to the treatment plan;
6. in view of the patient's treatment history and current behavior, the patient is in need of assisted outpatient treatment in order to prevent a relapse or deterioration which would be likely to result in serious harm to the patient or others; and
7. it is likely that the patient will benefit from assisted outpatient treatment.⁸⁶

An AOT petitioner is *not* required to demonstrate that the respondent lacks capacity as a prerequisite to securing relief from the court.

In *In re K.L.*,⁸⁷ the Court of Appeals held that since MHL § 9.60 does not permit forced medical treatment (see post-adjudication remedies, below), a showing of incapacity is not required, and the statute otherwise meets due process *minima* so that even people capable of making decisions about their own treatment may be constitutionally subject to an AOT order.

[8.48] 2. Legal Representation

A person who is subject to an AOT petition shall have the right to be represented by MHLS or privately retained counsel at all stages of the proceeding.⁸⁸ In actual practice, this has included the pre-petition and investigatory stages of the proceeding.

[8.49] 3. Least Restrictive Alternative

The court must also find by clear and convincing evidence that the assisted outpatient treatment sought is the least restrictive treatment appropriate and feasible for the patient.⁸⁹

[8.50] 4. Categories of Service

The categories of assisted outpatient treatment which may be ordered by a court include case management services, medication, periodic blood tests or urinalysis, individual or group therapy, day or partial day programming activities, educational and vocational training or activities, alcohol or substance treatment and counseling, and supervision of living arrangements.⁹⁰

⁸⁶ MHL § 9.60(c).

⁸⁷ 1 N.Y.3d 362, 774 N.Y.S 472 (2004).

⁸⁸ MHL § 9.60(g).

⁸⁹ MHL § 9.60(j)(2).

⁹⁰ MHL § 9.60(a)(1).

[8.51] 5. Post-Adjudication Remedies

If a person subject to an AOT order as an outpatient later fails or refuses to comply with treatment as ordered by the court; if efforts to solicit voluntary compliance are made without success; and if in the clinical judgment of a physician, the patient may be in need of either involuntary admission to a hospital or immediate observation, care and treatment pursuant to standards set forth in the MHL, then the physician can seek the person's temporary removal to a hospital for examination to determine whether hospitalization is required.⁹¹

The failure to comply with an order of assisted outpatient treatment shall not be grounds for involuntary civil commitment or a finding of contempt of court.⁹²

[8.52] VI. RIGHTS OF PERSONS RECEIVING SERVICES AS INPATIENTS AND IN COMMUNITY-BASED FACILITIES⁹³

Notwithstanding any other provision of law, no person shall be deprived of any civil right, if he or she is in all other respects qualified and eligible, solely by reason of receipt of services for a mental disability, nor shall the receipt of such services modify or vary any civil service ranking and appointment, the right to register for and vote at elections, or rights relating to the granting, forfeiture or denial of a license, permit, privilege or benefit pursuant to any law.⁹⁴

[8.53] A. Notice of Rights

To ensure that patients and residents of facilities or programs operated or licensed by OMH and OPWDD are treated consistently under the laws and regulations assuring quality care, the commissioners have promulgated regulations informing patients of their rights under law, including but not limited to the basic rights enumerated in MHL § 33.02.⁹⁵ These rights include the right to “a safe and sanitary environment”; “a balanced and nutritious diet”; appropriate clothing; observation of religious practices; “freedom from abuse and mistreatment”; “adequate grooming and personal hygiene supplies”; “safe storage space for clothing and other personal property”; “privacy in sleeping, bathing and toileting areas”; visitation with open communication; “appropriate medical and dental care”; and an “individualized plan of treatment.”⁹⁶

In addition to the rights enumerated at MHL § 33.02, § 41.41 of the MHL sets forth a bill of rights for developmentally disabled persons in community residences. Mental Hygiene Law § 41.41 expands upon the rights specifically enumerated in § 33.02 in that it expressly recognizes the right of a person in a community residence to request an alternative residential setting or change in roommate; to be free from physical or psychological restraints or pressure; to engage in appropriate activities though some risk may be involved; to choose a physician or dentist; to use personal money or property and be informed of fi-

91 MHL § 9.60(n).

92 *Id.*

93 The rights of sex offenders in secure treatment facilities differ from those of persons civilly confined, but the law is evolving in this area, and litigation in both federal and state courts may ultimately determine the conditions of confinement which meet due process *minima*.

94 MHL § 33.01.

95 MHL § 33.02; 14 N.Y.C.R.R. §§ 527.5(b), 633.4.

96 MHL § 33.02(a).

nancial status; and to participate in the establishment of house rules.⁹⁷ Additional rights, both procedural and substantive, may be found in OMH and OPWDD regulations.⁹⁸

In addition to the statutorily enumerated rights, persons who reside in intermediate care facilities for the mentally retarded (ICFs), which include all state-operated developmental centers, enjoy the client protections promulgated in federal Medicaid regulations.⁹⁹ Also, all persons, residing in mental hygiene facilities shall have the right to bring complaints to the facility director, the board of visitors, the MHLS and the Justice Center for the Protection of People with Special Needs.¹⁰⁰ Enumerated rights may not be limited as a punishment or for the convenience of staff. Any limitations must be ordered by a physician (in hospitals or schools) or by the facility director (in other licensed or operated programs) and be clinically justified.¹⁰¹

[8.54] B. Right to Adequate Care and Treatment

[8.55] 1. Statutory Right

Mental Hygiene Law §§ 31.19(a) and 33.03 require that facilities provide persons receiving services for the mentally disabled with care and treatment suited to their needs, which is skillfully, safely and humanely administered with full respect for dignity and personal integrity. Under MHL §§ 7.07 and 13.07, the state OMH and OPWDD must ensure that the care and treatment provided to mentally disabled individuals within the state is “of high quality and effectiveness, and that the personal and civil rights of persons receiving care, treatment and rehabilitation are adequately protected.”¹⁰²

New York State has acknowledged that the MHL establishes a statutory right of treatment for individuals with mental disabilities.¹⁰³ Therefore, a facility’s failure to provide a safe and humane environment and/or adequate treatment constitutes a violation of statutory rights, which may be enforced by CPLR article 78, habeas corpus and actions for damages.¹⁰⁴ The failure to render adequate care may also be a defense in an action brought by a facility to collect fees for a patient’s hospitalization.¹⁰⁵ Because OMH and OPWDD are required to license and oversee the operation of all mental health facilities within the state, the state itself might even be called upon to remedy a non-state-operated institution’s failure to provide a patient with adequate treatment.¹⁰⁶

97 MHL § 41.41(2).

98 See, e.g., 14 N.Y.C.R.R. §§ 527.5, 595.10, 633.4.

99 42 C.F.R. § 483.20.

100 MHL § 33.02(a)(12); the Justice Center was created in legislation known as the Protection of People with Special Needs Act (2012 N.Y. Laws ch. 501).

101 MHL § 33.02(b).

102 MHL § 7.07(c); see MHL § 13.07(c).

103 *Woe v. Mathews*, 408 F. Supp. 419 (E.D.N.Y. 1976), *aff’d sub nom. Woe v. Weinberger*, 562 F.2d 40 (2d Cir. 1977), *cert. denied sub nom. Woe v. Califano*, 434 U.S. 1048 (1978). See also *Project Release v. Prevost*, 551 F. Supp. 1298 (E.D.N.Y. 1982), *aff’d*, 722 F.2d 960 (2d Cir. 1983).

104 *Woe*, 408 F. Supp. 419; *Brown v. State*, 84 A.D.2d 644, 444 N.Y.S.2d 304 (3d Dep’t 1981); *Rennelli v. State Comm’r Mental Hygiene*, 73 Misc. 2d 261, 340 N.Y.S.2d 498 (Sup. Ct., Richmond Co. 1973).

105 *State v. Stavola*, 135 A.D.2d 1038, 523 N.Y.S.2d 189 (3d Dep’t 1987).

106 *Flowers v. Webb*, 575 F. Supp. 1450 (E.D.N.Y. 1983).

[8.56] 2. Constitutional Rights

[8.57] a. Right to Treatment

Although a number of federal courts have found that a constitutional right to treatment exists,¹⁰⁷ this question has never been squarely resolved by the U.S. Supreme Court. In New York, the federal courts have not squarely addressed the issue, choosing instead to rely upon the statutory right to treatment contained in the state Mental Hygiene Law.¹⁰⁸

If a constitutional right to treatment does exist, it most likely arises as a matter of due process. Due process requires that the nature and duration of commitment bear some reasonable relation to the purpose for which the individual is committed.¹⁰⁹ If a person is detained because of mental illness, some planned treatment must be afforded to such person.¹¹⁰

Once it is determined that a right to treatment exists, then the question becomes whether the treatment is adequate. A patient is not constitutionally entitled to the best or ideal treatment but, rather, to minimally adequate treatment. The question of whether adequate treatment was rendered may, in mental health cases, turn on whether professional judgment was exercised.¹¹¹

[8.58] b. Right to Protection From Harm

Although a constitutional right to treatment is not as yet firmly established in New York State, there is no question that institutionalized patients have constitutional rights to protection from harm and a safe environment.¹¹²

[8.59] C. Informed Consent and Surrogate Decision Making

With increasing frequency, advocates for mentally disabled individuals devote substantial resources toward ensuring that patients and residents receive quality health care, in addition to care, treatment and habilitation for mental disabilities. The threshold issue to confront is whether the person has the capacity to make his or her own medical decisions. New York State law and regulations codify the general principles of informed consent and the presumption that patients retain all residual decision-making capacity unless a judicial or clinical determination of incapacity is made.¹¹³

The recently enacted Family Health Care Decisions Act (FHCDCA),¹¹⁴ applicable in general hospitals, nursing homes and hospice settings, creates a statutory surrogate consent process for routine, major medical and life-sustaining treatment decisions to be applied when patients lack decision-making capacity.

107 See, e.g., *Welsch v. Likins*, 373 F. Supp. 487 (D. Minn. 1974), *aff'd*, 525 F.2d 987 (8th Cir. 1975); *Wyatt v. Stickney*, 344 F. Supp. 387 (M.D. Ala. 1972), *aff'd in part and rev'd in part sub nom. Wyatt v. Aderholt*, 503 F.2d 1305 (5th Cir. 1974).

108 See, e.g., *Project Release*, 551 F. Supp. 1298.

109 *Jackson v. Indiana*, 406 U.S. 715 (1972).

110 *Bartlett v. State*, 52 A.D.2d 318, 383 N.Y.S.2d 763 (4th Dep't 1976).

111 See, e.g., *Youngberg v. Romeo*, 457 U.S. 307 (1982).

112 *Id.*; *N.Y. State Ass'n for Retarded Children v. Rockefeller*, 357 F. Supp. 752 (E.D.N.Y. 1973).

113 14 N.Y.C.R.R. §§ 27.9 (OMH), 633.11–13 (OPWDD).

114 2010 N.Y. Laws ch. 8; PHL art. 29-CC.

The law was intended to fill gaps in the existing statutory and regulatory framework so surrogate consent procedures which preceded FHCDA survive and continue to be applied.¹¹⁵

Thus, if a patient who resides in or was transferred to a hospital from a mental hygiene facility is in need of medical care and lacks decision-making capacity, consent may be provided by a surrogate in accordance with OMH or OPWDD regulations, or alternatively, pursuant to article 80 of the MHL for those individuals without surrogates.

[8.60] 1. Surrogate Decision-Making Program

An MHL article 80 surrogate decision-making (SDM) panel is statutorily authorized to provide consent for treatment for a person who is currently receiving or in the past has received services from OMH and OPWDD operated or licensed facilities.¹¹⁶

The SDM program is an administrative alternative to the judicial process for securing surrogate consent, and SDM panels may entertain jurisdiction where major medical, dental and life-sustaining treatment is at issue.

SDM panels are composed of volunteers from different disciplines, including licensed health care professionals, attorneys, family members and advocates for persons with mental disabilities.¹¹⁷ The SDM program is administered by The Justice Center for the Protection of People with Special Needs. Regulations amplify the MHL and govern the conduct of panels and proceedings.¹¹⁸

When presented with a declaration for surrogate decision-making, the panel must consider (1) whether the person has the capacity to make the health care decision being proposed; (2) whether there is another surrogate decision maker available and willing to make the decision; and (3) if not, whether the medical procedure is in the best interests of the person. There are more stringent procedural and substantive requirements which apply when a panel entertains jurisdiction in a case involving life-sustaining treatment.¹¹⁹

[8.61] 2. OMH Surrogate Consent Regulations¹²⁰

OMH regulations provide that electroconvulsive therapy, surgery, major medical treatment or the use of experimental drugs or procedures¹²¹ may be administered to any patient only upon the informed consent of the patient or of a person authorized to act on his or her behalf after a full and comprehensive disclosure of potential benefits and the potential of harm. Patients are presumed to have sufficient mental capacity to give consent unless there are facts and substantial reasons to the contrary.¹²²

115 PHL 2994-b(3)(c).

116 MHL § 80.03(b) (“Once a person is eligible for surrogate decision-making, such person may continue to receive surrogate decision-making . . . regardless of a change in residential status.”).

117 MHL § 80.05(c).

118 14 N.Y.C.R.R. pt. 710.

119 14 N.Y.C.R.R. §§ 710.3, 710.4(d), (e).

120 14 N.Y.C.R.R. § 27.9.

121 OMH must comply with federal law or have the permission of the New York State Department of Health for human subject research. *See T.D. v. N.Y. Office of Mental Health*, 228 A.D.2d 95, 650 N.Y.S.2d 173 (1st Dep’t 1996), *appeal dismissed*, 91 N.Y.2d 860, 558 N.Y.S.2d 153 (1997).

122 14 N.Y.C.R.R. § 27.9.

[8.62] a. Decisions for Minors

If a patient is under 18 years of age, consent shall be obtained from the parents or legal guardian. If no parent or legal guardian is available or if such a patient having mental capacity to understand the procedure objects or one of the parents objects to the proposed procedure, the director may not initiate the procedure without a court order authorizing it, except in the case where surgery is indicated by significant danger to life or limb of the patient if the procedure is delayed.¹²³

[8.63] b. Decisions for Adults Who Lack Capacity

If a patient is 18 years of age or older but, in the opinion of the chief of the service, does not have sufficient mental capacity to give consent, authorization for the procedure in question must be obtained from (1) the spouse, (2) a parent, (3) an adult child, or (4) a court of competent jurisdiction. OMH regulations provide, however, that nothing in the regulations regarding surrogate consent shall be deemed to prevent the director from giving consent to a surgical procedure under emergency conditions where there appears to be significant danger to life or limb of the patient if the procedure is delayed.¹²⁴

[8.64] c. Decisions for Adults With Capacity

If a patient is 18 years of age or older and has sufficient mental capacity to give consent, the procedures may be initiated only with the patient's consent. The patient shall have the right, upon his or her request, to have a person of her or his choice present when consent is sought. In cases where a patient withholds consent to a procedure necessary for protection of life or limb, the facility director shall notify MHLS and may apply for court authorization.¹²⁵

[8.65] d. Independent Opinion

If it is not clear that the patient has sufficient mental capacity to give consent, an independent opinion about the patient's mental capacity must be obtained from a qualified consultant who is not an employee of the facility. After considering the opinion of the consultant, the facility director will decide whether the patient does or does not have the capacity to give consent, and the director may then proceed in accordance with the other provisions of this section. The director shall enter in the patient's clinical record the reasons for this decision.¹²⁶

Each facility director shall develop standard procedures to evaluate the decisions made on the mental capacity of individual patients to give consent. A qualified consultant who is not an employee of the facility shall be a member of the review process.¹²⁷

[8.66] 3. OPWDD Surrogate Consent Regulations¹²⁸

OPWDD regulations regarding informed consent are applicable to all state-operated and state-licensed facilities.

123 14 N.Y.C.R.R. § 27.9(a).

124 14 N.Y.C.R.R. § 27.9(b).

125 14 N.Y.C.R.R. § 27.9(c).

126 14 N.Y.C.R.R. § 27.9(d).

127 14 N.Y.C.R.R. § 27.9(e).

128 14 N.Y.C.R.R. § 633.11.

In any case where treatment is proposed to be rendered to a person for which informed consent would be required by law, the facility director is to ensure assistance in obtaining such informed consent by or on behalf of such person.¹²⁹

[8.67] a. Decisions for Minors

If a person is less than 18 years of age, consent shall be obtained from one of the following surrogates listed, in the order stated: (1) a legal guardian empowered to provide consent; (2) an actively involved spouse; (3) a parent; (4) an actively involved adult sibling; (5) an actively involved adult family member; (6) a local commissioner of social services with custody over the person pursuant to Social Services Law or the Family Court Act (if applicable); or (7) an MHL article 80 surrogate decision-making committee (SDMC) or a court of competent jurisdiction.¹³⁰

[8.68] b. Decisions for Adults Who Lack Capacity

If a person is 18 years of age or older but lacks decision-making capacity, informed consent shall be obtained from one of the surrogates listed, in the order stated: (1) a guardian lawfully empowered to give such consent or the person's duly appointed health care agent or alternative agent; (2) an actively involved spouse; (3) an actively involved parent; (4) an actively involved adult child; (5) an actively involved adult sibling; (6) an actively involved adult family member; (7) the Consumer Advisory Board for Willowbrook Class Members; (8) an MHL article 80 surrogate decision-making committee or a court of competent jurisdiction.¹³¹

[8.69] c. Decisions for Adults With Capacity

If a person is 18 years of age or older and has capacity to understand appropriate disclosures regarding proposed medical treatment, such treatment shall be initiated only upon the person's informed consent.¹³²

[8.70] d. Independent Opinion

If it is not clear whether a person has capacity to understand appropriate disclosures regarding proposed medical treatment, the facility director shall, in each instance, either (1) prepare and file a declaration with an MHL article 80 surrogate decision-making committee or (2) obtain an independent written opinion and analysis of the individual's capacity to understand appropriate disclosures regarding proposed professional medical treatment and to give or withhold informed consent thereto.¹³³

[8.71] 4. Special Consideration for Life-Sustaining Treatment

The Health Care Decisions Act (HCDA), which became effective in 2003, made explicit the authority of guardians appointed for mentally retarded individuals pursuant to article 17-A of the Surrogate's Court Procedure Act (SCPA) to make health care decisions, including decisions to withhold or withdraw life-sustaining treatment. The law is codified at SCPA 1750-b. The Court of Appeals later determined that

129 14 N.Y.C.R.R. § 633.11(a)(1).

130 14 N.Y.C.R.R. § 633.11(a)(1)(a).

131 14 N.Y.C.R.R. § 633.11(a)(1)(b).

132 14 N.Y.C.R.R. § 633.11(a)(1)(f).

133 14 N.Y.C.R.R. § 633.11(a)(1)(g).

the provisions of the HCDA were retroactive and applicable to 17-A guardians regardless of when they were appointed.¹³⁴

Subsequent amendments to the law made it applicable to corporate guardians and guardians of individuals with developmental disabilities.¹³⁵ The most recent amendments to the statutory and regulatory framework have expanded the list of surrogates capable of making end-of-life elections to actively involved family members, the Consumer Advisory Board for Willowbrook Class Members and MHL article 80 surrogate decision-making committees.¹³⁶

[8.72] a. Substantive Standards

Surrogate's Court Procedure Act 1750-b contains detailed procedural and substantive protections which should be reviewed in any case where a surrogate will make an end-of-life election on behalf of a patient who lacks decision-making capacity. This chapter merely summarizes major provisions of the law.

Before an end-of-life election may be made on behalf of a mentally retarded or developmentally disabled person who lacks capacity, an attending physician and a consulting physician must determine to a reasonable degree of medical certainty and note in the person's medical record that the person (a) has a terminal condition (which means an illness or injury from which there is no recovery, and which reasonably can be expected to cause death within one year); (b) is permanently unconscious; or (c) has a medical condition, other than such person's mental retardation, which requires life-sustaining treatment, is irreversible and which will continue indefinitely.¹³⁷

In addition, the physicians must opine and concur that the proposed life-sustaining treatment would impose an extraordinary burden on such person, in light of the person's medical condition (other than such person's mental retardation) and the expected outcome of the life-sustaining treatment, notwithstanding such person's mental retardation.¹³⁸

In the case of a decision to withdraw or withhold artificially provided nutrition or hydration, additional findings must be made that either there is no reasonable hope of maintaining life, or that the artificially provided nutrition or hydration poses an extraordinary burden to the person.¹³⁹

[8.73] b. Notice

A legally authorized surrogate does not have the unilateral authority to make an end-of-life election on behalf of a mentally retarded or developmentally disabled individual. Rather, the statute provides for notice to the patient and others before the election may be implemented.

At least 48 hours prior to the implementation of a decision to withdraw life-sustaining treatment, or at the earliest possible time prior to the implementation of a decision to withhold life-sustaining treatment, the attending physician shall notify

134 See *In re M.B.*, 6 N.Y.3d 437, 813 N.Y.S.2d 349 (2006).

135 2003 N.Y. Laws ch. 232; 2005 N.Y. Laws ch. 744, see SCPA 1750-a(2).

136 SCPA 1750-b(1)(a); 14 N.Y.C.R.R. § 633.10.

137 SCPA 1750-b(4)(b)(i).

138 SCPA 1750-b(4)(b)(ii).

139 SCPA 1750-b(4)(b)(iii).

(a) the mentally retarded person, except if the attending physician determines, in writing and in consultation with another physician or a licensed psychologist, that, to a reasonable degree of medical certainty, the person would suffer immediate and severe injury from such notification;

(b) the chief executive officer of the agency or organization operating such facility and MHLS, if the person is in or was transferred from a residential facility operated, licensed or authorized by the OPWDD, and

(c) the OPWDD commissioner or his or her designee, if the person is not in and was not transferred from such a facility or program.¹⁴⁰

[8.74] c. Objections

An end-of-life election shall be suspended, pending judicial review, when there is an objection at any time by

(a) the person on whose behalf such decision was made;

(b) a parent or adult sibling who either resides with or has maintained substantial and continuous contact with the person;

(c) the attending physician;

(d) any other health care practitioners providing services to the mentally retarded person, among them, physicians, dentists, physician's assistants, chiropractors, nurses, psychologists, social workers, occupational therapists, speech and language pathologists, respiratory therapists, and physical therapists;

(e) the chief executive officer of the mental hygiene facility;

(f) MHLS (if the person is in or was transferred from a residential facility or program operated, approved or licensed by OPWDD); or

(g) the OPWDD commissioner or designee if the person is not in and was not transferred from a mental hygiene facility.¹⁴¹

An objection by any party with standing suspends the end-of-life election.¹⁴²

[8.75] d. Dispute Mediation/Special Proceedings Authorized

At the request of the objecting party or a person or entity authorized to act as a guardian under SCPA 1750-b (except an MHL article 80 surrogate decision-making committee), the case may be referred for non-binding dispute mediation. In the event that such dispute cannot be resolved within 72 hours, or no

140 SCPA 1750-b(4)(e). The OPWDD commissioner has delegated to the directors of the various Developmental Disabilities State Operations Offices the responsibility to receive and respond to 1750-b notices for patients within their jurisdiction.

141 SCPA 1750-b(5)(a).

142 *Id.*

such mediation entity exists or is reasonably available for mediation of a dispute, the objection shall proceed to judicial review.¹⁴³

The guardian, the attending physician, the mental hygiene facility director, MHLS or the OPWDD commissioner or a designee all have standing to commence a special proceeding in a court of competent jurisdiction with respect to any dispute arising under this section, including objecting to the withdrawal or withholding of life-sustaining treatment because such withdrawal or withholding is not in accord with the criteria set forth in the law.

[8.76] D. Right to Object to Treatment

[8.77] 1. Existence of Right

It is well established that in New York, adults have a fundamental right to refuse treatment. This right arises under New York common law,¹⁴⁴ the due process clause of the New York State Constitution¹⁴⁵ and the state statutory framework.¹⁴⁶ Because the right to refuse treatment is fundamental, a compelling state interest must exist before involuntary treatment may be provided.¹⁴⁷ The following state interests have been identified as compelling by the courts in the various cases cited herein: prevention of a health threat to the community, prevention of suicides and self-inflicted injuries, protection of third persons and provision of care to incompetent persons.

[8.78] 2. Scope of the Right to Refuse Treatment

The right to refuse treatment encompasses many, if not all, forms of treatment, including psychotropic medications,¹⁴⁸ hip surgery,¹⁴⁹ transfusions/life support,¹⁵⁰ electric shock treatments¹⁵¹ and nutrition.¹⁵²

[8.79] 3. Application of Rights to Adults in Institutions for the Mentally Disabled

Regulations governing the involuntary treatment of inpatients are generally set out in 14 N.Y.C.R.R. §§ 27, 527 and 633. Due process and regulations require that a patient's counsel be permitted to participate in the final administrative review leading to the determination of the need for forced treatment.¹⁵³

143 SCPA 1750-b(5)(d).

144 *Schloendorff v. Soc'y of N.Y. Hosp.*, 211 N.Y. 125 (1914).

145 *Rivers v. Katz*, 67 N.Y.2d 485, 504 N.Y.S.2d 74 (1986).

146 PHL §§ 2504, 2805-d.

147 *Rivers*, 67 N.Y.2d 485.

148 *Id.*

149 *Hanes v. Ambrose*, 80 A.D.2d 963, 437 N.Y.S.2d 784 (3d Dep't 1981).

150 *In re Storar*, 52 N.Y.2d 363, 438 N.Y.S.2d 266 (1981).

151 *In re Gertrude K.*, 177 Misc. 2d 25, 675 N.Y.S.2d 790 (Sup. Ct., Rockland Co. 1998); *In re Rosa M.*, 155 Misc. 2d 103, 597 N.Y.S.2d 544 (Sup. Ct., N.Y. Co. 1991); *N.Y. City Health & Hosps. Corp. v. Stein*, 70 Misc. 2d 944, 335 N.Y.S.2d 461 (Sup. Ct., N.Y. Co. 1972); *In re Gladstone R.*, 44 A.D.3d 777, 843 N.Y.S.2d 404 (2d Dep't 2007).

152 *Delio v. Westchester Cnty. Med. Ctr.*, 129 A.D.2d 1, 516 N.Y.S.2d 677 (2d Dep't 1987); *In re O'Connor*, 72 N.Y.2d 517, 534 N.Y.S.2d 886 (1988); see also *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261 (1990).

153 *In re Lesser*, 144 Misc. 2d 359, 544 N.Y.S.2d 902 (Sup. Ct., Queens Co. 1989); *In re Bronx Psychiatric Ctr.*, 283 A.D.2d 73, 728 N.Y.S.2d 10 (1st Dep't 2001).

[8.80] a. Emergency Treatment

Where a person presents an immediate danger to self or others, the state's police power justifies forced and immediate treatment without a court order. Such treatment, however, may continue only as long as the emergency persists.¹⁵⁴

[8.81] b. Non-Emergency Treatment

Where involuntary treatment is sought based upon the state's compelling interest under its *parens patriae* power to provide treatment to its incompetent citizens, the state must establish that the patient is incapable of making a competent decision concerning such treatment.

There is a legal presumption that every adult is mentally competent to decline treatment, and this presumption exists even with respect to patients involuntarily committed to institutions for the mentally disabled.¹⁵⁵ *The determination of incapacity is a uniquely judicial function,*¹⁵⁶ and the state must establish incapacity by clear and convincing evidence.¹⁵⁷

The absence of a time limit or mandatory review relative to court-ordered forced medication does not render the order invalid, although many courts, upon the request of counsel, will limit the application of an involuntary treatment order to the authorized period of retention.¹⁵⁸

[8.82] c. Substituted Consent

Once a court determines that a patient is incompetent, it must determine on behalf of the patient what treatment decision the patient would make were he or she competent. In making such a determination, the court will rely on the following criteria:

1. *Prior competent choice:* The court must give effect to an incompetent patient's prior competent choice with respect to treatment. The burden is on the party asserting an incompetent patient's prior competent choice to establish the choice by clear and convincing evidence.¹⁵⁹
2. *Necessity of treatment:* In the absence of proof of a prior competent choice, the court must determine what the patient would choose to do, based upon all the objective factors, including but not limited to the risks and benefits of the treatment, the religious views of the patient, the desires of the patient's family and the availability of less intrusive forms of treatment.¹⁶⁰
3. *Surrogate decision makers:* In cases involving objections to treatment, a court generally will not delegate to conservators, committees guardians and families the authority to execute consent to treat-

154 *Rivers v. Katz*, 67 N.Y.2d 485, 504 N.Y.S.2d 74 (1986); 14 N.Y.C.R.R. §§ 527.8(c)(1), 633.11(a)(1)(ii).

155 *Hanes v. Ambrose*, 80 A.D.2d 963, 437 N.Y.S.2d 784 (3d Dep't 1981); MHL § 29.03.

156 *Rivers*, 67 N.Y.2d at 496. *But see* 14 N.Y.C.R.R. §§ 27.9, 633.11(a)(1)(iii)(b).

157 *Rivers*, 67 N.Y.2d at 497.

158 *In re McConnell*, 147 A.D.2d 881, 538 N.Y.S.2d 101 (3d Dep't 1989); *In re Mary Ann D.*, 179 A.D.2d 724, 578 N.Y.S.2d 622 (2d Dep't 1992).

159 *In re O'Connor*, 72 N.Y.2d 517, 534 N.Y.S.2d 886 (1988); *Delio v. Westchester Cnty. Med. Ctr.*, 129 A.D.2d 1, 516 N.Y.S.2d 677 (2d Dep't 1987); *In re Rosa M.*, 155 Misc. 2d 103, 597 N.Y.S.2d 544 (Sup. Ct., N.Y. Co. 1991).

160 *Rivers*, 67 N.Y.2d 485, 504 N.Y.S.2d 74 (1986); *In re Storar*, 52 N.Y.2d 363, 438 N.Y.S.2d 266 (1981); *Strunk v. Strunk*, 445 S.W.2d 145 (Ky. 1969) (mentally retarded patient as kidney donor); *Rockland Psychiatric Ctr. v. Virginia G.*, 166 Misc. 2d 659, 634 N.Y.S.2d 648 (Sup. Ct., Rockland Co. 1995).

ment without first determining for itself the question of the patient's competence and whether involuntary treatment is warranted.¹⁶¹ Some rights are so personal to an incompetent person that only the court may exercise them on the person's behalf.

Relevant case law includes *Rivers v. Katz*,¹⁶² which held that due process requires the court to balance a patient's liberty interests against the state's asserted compelling need, based on the facts of each medication case;¹⁶³ *In re Storar*,¹⁶⁴ in which the mother/guardian's desire to terminate blood transfusions was not binding upon the facility or the court; *In re Detzel*,¹⁶⁵ which held that the conservator lacked authority to place the conservatee in a health-related facility and thus was required to seek approval from the court; and *In re Baby Boy K.*,¹⁶⁶ where the court held that the committee could not consent to adoption of an incompetent mother's child without prior court approval, even where the mother had consented.

[8.83] 4. Minors

In general, children are incompetent as a matter of law. A parent or guardian has the plenary right to consent to treatment on the minor's behalf,¹⁶⁷ and it is improper for the courts to intervene where parents have chosen among reasonable treatment alternatives.¹⁶⁸ Courts may, however, override a parent's decision to deprive a child of all necessary treatment.¹⁶⁹

Minors who are patients in state-operated psychiatric centers may object to treatment, including the administration of psychotropic drugs, for which a parent or legal guardian has otherwise provided consent. Treatment may not be administered over the minor's objection absent compliance with an administrative review process and a potential judicial review via an Article 78 proceeding. It has also been held that a hospital may not involuntarily administer psychotropic medications over the objection of the minor and her parents where no neglect proceeding has been filed against the parents, there was no evidence that the patient was suffering from a life-threatening condition, and the recommended course of treatment had potential adverse side effects.¹⁷⁰

[8.84] E. Transfers of Patients¹⁷¹

[8.85] 1. Generally

A voluntary or informal patient may be transferred only with his or her consent. A voluntary patient under age 18 may be transferred only on consent of the family, unless the patient signed his or her own ap-

161 *In re Gertrude K.*, 177 Misc. 2d 25, 675 N.Y.S.2d 790 (Sup. Ct., Rockland Co. 1998); *In re Gordon*, 162 Misc. 2d 697, 619 N.Y.S.2d 235 (Sup. Ct., Rockland Co. 1994); *Superintendent of Belchertown State Sch. v. Saikewicz*, 373 Mass. 728 (1977).

162 67 N.Y.2d 485.

163 *Id.* at 498.

164 52 N.Y.2d 363; *but see In re Matthews*, 225 A.D.2d 142, 650 N.Y.S.2d 373 (3d Dep't 1996), *lv. to appeal denied*, 89 N.Y.2d 808, 655 N.Y.S.2d 888 (1997).

165 134 A.D.2d 205, 521 N.Y.S.2d 6 (1st Dep't 1987).

166 99 Misc. 2d 129, 415 N.Y.S.2d 602 (Fam. Ct., N.Y. Co. 1979).

167 PHL § 2504(2); 14 N.Y.C.R.R. §§ 27.9, 527.8(c)(2), 633.11(a)(1)(iii)(a); *Parham v. J.R.*, 442 U.S. 584 (1979).

168 *In re Hofbauer*, 47 N.Y.2d 648, 419 N.Y.S.2d 936 (1979).

169 *In re Sampson*, 29 N.Y.2d 900, 328 N.Y.S.2d 686 (1972).

170 *Sombrotto v. Christiana W.*, 50 A.D.3d 63, 852 N.Y.S.2d 57 (1st Dep't 2008).

171 MHL § 29.11.

plication for admission. No person admitted to one facility may be sent to another, by any form of involuntary admission, unless the MHLS is given prior notice of the proposed transfer.¹⁷²

Personal belongings shall go with a person transferred from one facility to another.¹⁷³ Female patients being transported to or from a facility “shall be accompanied by another female, unless accompanied by her father, brother, husband, or son.”¹⁷⁴

OMH and OPWDD have promulgated regulations that govern transfers between facilities.¹⁷⁵ In addition to regulations, OPWDD has special “client movement procedures,” which are policies governing client movement from developmental centers into the community and between community placements. The client movement procedures contain detailed notice procedures and the opportunity to object by the resident, correspondents, MHLS and others to proposed movement.¹⁷⁶

[8.86] 2. Right to Transfer

Under the regulations, any person may request transfer. Although there is no statutory right to treatment in one’s home community¹⁷⁷ or placement in a particular facility,¹⁷⁸ this right might be asserted as a matter of constitutional law under the doctrine of least restrictive alternative.

[8.87] 3. Involuntary Transfers

The notice provisions notwithstanding, an involuntary patient may be transferred from one facility to another by administrative order of the commissioner.¹⁷⁹ If at the time of the administrative order of transfer a commitment hearing is pending, the commissioner may either stay the transfer order until completion of the hearing, or direct the transfer to take place, substituting the director of the receiving facility in the legal proceeding. The period of retention at the receiving facility is determined from the patient’s legal status at the sending facility.¹⁸⁰ Furthermore, where a commitment hearing is pending, the court has statutory authority to determine the question of transfer, except where the hearing involves retention of a voluntary patient who has requested his discharge in writing. The statute, however, does not authorize the court to designate the particular facility to which the patient may be transferred.¹⁸¹

The constitutionality of the provisions of the law and regulations that permit the administrative transfer of an involuntary patient from an acute care facility to a department facility, over the patient’s objection and without a prior judicial hearing, has been sustained by the New York Court of Appeals.¹⁸² Addition-

172 MHL §§ 9.27(f), 15.27(f).

173 MHL § 33.07(a).

174 MHL § 33.17.

175 14 N.Y.C.R.R. pts. 17, 517.

176 See OPWDD Community Placement Procedures accessed online at www.opwdd.ny.gov/opwdd_resources/willowbrook_class/community_placement_procedures.

177 *Hagan v. Nixon*, 109 A.D.2d 380, 492 N.Y.S.2d 149 (3d Dep’t 1985).

178 *Savastano v. Prevost*, 66 N.Y.2d 47, 495 N.Y.S.2d 6 (1985).

179 MHL § 29.11(i), (j). See 14 N.Y.C.R.R. pts. 17 and 517 for details of administrative transfer process.

180 MHL § 29.11(i), (j).

181 MHL §§ 9.31(c), 9.33(b), 15.33(b). See also *In re Jerome G.*, 201 A.D.2d 562, 607 N.Y.S.2d 709 (2d Dep’t 1994); *In re Lesley B.*, 183 A.D.2d 509, 586 N.Y.S.2d 211 (1st Dep’t 1992).

182 *Savastano v. Nurnberg*, 77 N.Y.2d 300, 567 N.Y.S.2d 618 (1990).

ally, the Court of Appeals has held that a judicial hearing is not necessary when a patient is transferred from a non-secure facility to a secure one.¹⁸³

[8.88] F. Restraint and Seclusion—Inpatient Facilities

[8.89] 1. Restraint¹⁸⁴

Restraint means the use of an apparatus that prevents the free movement of both arms or both legs or totally immobilizes the patient, and which the patient is unable to remove easily.¹⁸⁵ Mental Hygiene Law § 33.04(c) provides that permissible forms of restraint include a “camisole,” “full or partial restraining sheet” and other less restrictive means authorized by the commissioner.¹⁸⁶ OMH phased out the use of the camisole and the full or partial restraining sheet through a policy directive.¹⁸⁷ The OMH policy now provides that the standard forms of mechanical restraint are the four-point restraint, five-point restraint, wrist-to-belt restraint, mitts, helmets and calming blanket. In choosing among the permissible forms of intervention, staff shall utilize the least restrictive type which is appropriate and effective under the circumstances. Mechanical supports, such as a cast, are not permissible restraints.

Restraint may be used only to prevent a patient from seriously injuring himself or herself or others and only if less restrictive techniques are insufficient; restraint may never be used for punishment or staff convenience.

Pursuant to MHL § 33.04(d), the use of restraint requires a physician’s order based on personal examination. The order must set forth the reasons for the restraint and the time of expiration; a maximum of four hours is permissible except from 9 p.m. to 9 a.m. In an emergency, senior staff may apply restraint without an order, subject to prompt personal examination by a physician. The statute provides that a restrained patient must be monitored closely, and a written assessment of the patient’s condition made every 30 minutes. The patient must be released every two hours except when asleep.¹⁸⁸ A full record of restraint must be kept.¹⁸⁹ OMH policies (PC-701) now provide additional safeguards for the monitoring of patients in restraint, including one-to-one constant observation.

[8.90] 2. Seclusion

Seclusion means the presence of a patient in a room or area alone with a closed door that the patient cannot open from the inside. Seclusion is applied only when absolutely necessary to protect the patient from injuring himself or herself or others.¹⁹⁰

183 *Mental Hygiene Legal Servs. v. Ford*, 242 A.D.2d 417, 663 N.Y.S.2d 1 (1st Dep’t 1997), *rev’d sub nom. Mental Hygiene Legal Servs. ex rel. Aliza K. v. Ford*, 92 N.Y.2d 500, 683 N.Y.S.2d 150 (1998); *In re Consilvio*, 307 A.D.2d 852, 764 N.Y.S.2d 12 (1st Dep’t), *lv. to appeal dismissed sub nom. Consilvio v. Michael B.*, 1 N.Y.3d 545, 775 N.Y.S.2d 241 (2003), *lv. to appeal denied*, 2 N.Y.3d 701, 778 N.Y.S.2d 459 (2004).

184 MHL § 33.04.

185 MHL § 33.04(a).

186 MHL § 33.04(c).

187 Office of Mental Health Official Policy Manual § PC-701 (Mar. 6, 2002).

188 MHL § 33.04(f).

189 MHL § 33.04(g).

190 14 N.Y.C.R.R. § 27.2(e).

In OPWDD facilities, seclusion is considered a form of client abuse and is prohibited.¹⁹¹ However, a time-out, which is isolation with staff in attendance or with an unlocked door, is practiced. The absolute prohibition against the seclusion of mentally retarded patients in OPWDD facilities¹⁹² is not retained or incorporated in the OMH regulations governing restraint and seclusion of dually diagnosed individuals in OMH facilities.¹⁹³

Pursuant to the commissioner's regulation, seclusion must be by physician's order (renewed daily), based on personal examination. It is limited to two hours, except when the patient is asleep.¹⁹⁴ As noted above, OMH policies (PC-701) now provide additional safeguards for monitoring patients in seclusion, including one-to-one constant observation.

[8.91] G. Clinical Records¹⁹⁵

[8.92] 1. Confidentiality

A complete clinical record for each patient shall be maintained at each mental health facility.¹⁹⁶ It shall contain information on all matters relating to admission, legal status, care and treatment.¹⁹⁷

Information about patients that is reported to the department, and clinical records that are maintained at department facilities and all other facilities, shall not be public record and shall not be released to any person or agency outside the department, except as expressly provided in MHL § 33.13. The list of exceptions is extensive, but carefully prescribed.

Information may be released to an endangered individual and a law enforcement agency when a treating psychiatrist or psychologist has determined that a patient is a danger to that individual. There is no statutory obligation to release such information.¹⁹⁸

Any disclosure made pursuant to MHL § 33.13 shall be limited to that information necessary in light of the reason for disclosure. Information so disclosed shall be kept confidential by the party receiving such information.

[8.93] 2. Access to Clinical Records¹⁹⁹

Patients and other qualified persons authorized by MHL § 33.16 may inspect a patient's clinical record maintained by a facility. The right of inspection is subject to limitations designed to protect the patient or

191 14 N.Y.C.R.R. § 624.3(9)(ii)(a).

192 *See id.*

193 *See* 14 N.Y.C.R.R. § 526.4(b); *see also Mental Hygiene Legal Serv. ex rel. DeAngelo v. Cuomo*, 195 A.D.2d 189, 607 N.Y.S.2d 179 (3d Dep't 1994).

194 14 N.Y.C.R.R. § 526.4(c).

195 MHL § 33.13.

196 MHL § 33.13(a).

197 In *Smith v. State*, 181 A.D.2d 227, 585 N.Y.S.2d 838 (3d Dep't 1992), it was held that the clinical record of a patient would properly include incident reports. *But see, Carol NN v. Stone*, 307 A.D.2d 455, 761 N.Y.S.2d 410 (3d Dep't 2003), *lv. to appeal denied*, 100 N.Y.2d 516, 769 N.Y.S.2d 202 (2003), where it was held that a quality assurance record which is not directly related to the patient's specific treatment is not a clinical record.

198 *But see Tarasoff v. Regents of Univ. of Cal.*, 17 Cal. 3d 425, 131 Cal. Rptr. 14 (1976) (therapist liable for failure to warn).

199 MHL § 33.16.

others from substantial and identifiable harm. Note, however, that a subpoena to compel production of a patient's clinical record must be accompanied by a court order.²⁰⁰

[8.94] 3. Sealing of Clinical Records²⁰¹

Any person who has been admitted to receive inpatient or outpatient services for mental illness (mental retardation is excluded) may commence a proceeding in state supreme court for an order directing the sealing of his or her records.²⁰² Grounds for sealing include illegal detention by reason of fraud, error or falsified documents, or a showing by competent medical evidence that the patient is not currently suffering from a mental illness and has not received inpatient service for three years, and that the interests of the patient and society would best be served by sealing the records.²⁰³ (Where a patient is younger than 16, best interests are presumed.)

Upon the issuance of such order, the admission is treated as a nullity. Once sealed, records may be unsealed upon request of the patient, by court order when unsealing is essential to the interests of justice, when the patient brings litigation in which his or her admission or treatment is at issue, and 75 years after the records have been sealed.²⁰⁴

[8.95] H. Communications and Visits

"Patient[s] . . . have the right to communicate freely and privately with persons outside the facility as frequently as [they wish], subject to regulations of the commissioner designed to assure the safety and welfare of patients and to avoid serious harassment to others."²⁰⁵ Correspondence with public officials, attorneys, clergy and the MHLS may not be restricted or censored. The commissioner shall promulgate regulations to assure patients a full opportunity to correspond, reasonable access to telephones, and frequent and convenient opportunities to meet with visitors.²⁰⁶

Communication and visitation may be restricted only in exceptional instances. Limitations must be discussed with the patient, and reasons therefor must be entered in the record.²⁰⁷ Patients whose rights have been restricted may pursue administrative remedies.²⁰⁸ Patients have the right to refuse visitors.

[8.96] I. Personal Property of Patients

A patient's right to retain his or her personal belongings upon admission to a facility shall be respected; however, the facility director may take temporary custody of personal property for health and safety reasons or if the patient is unable to care for such property.²⁰⁹ The director may not receive or obtain funds or other personal property belonging to a patient which exceeds \$25,000. Such funds so received shall be

200 CPLR 2302(a).

201 MHL § 33.14.

202 MHL § 33.14(a)(1).

203 MHL § 33.14(a)(1)(a), (b).

204 *Smith v. Butler Hosp.*, 144 Misc. 2d 554, 544 N.Y.S.2d 711 (Sup. Ct., N.Y. Co. 1989); *see* MHL § 33.14(b)(1)–(4).

205 MHL § 33.05(a).

206 MHL §§ 9.07, 15.07, 33.05; *see also* 14 N.Y.C.R.R. §§ 527.5, 527.10, 527.11, 633.4.

207 14 N.Y.C.R.R. § 527.12.

208 14 N.Y.C.R.R. §§ 527.12, 633.12.

209 MHL §§ 33.07, 33.02(a)(7); 14 N.Y.C.R.R. §§ 15.2, 27.1(e).

placed to the credit of the person for whom received and dispersed in the first instance to provide for luxuries, comforts and necessities for the patient. The facility director shall also be authorized to seek to place excess funds in a Medicaid qualifying special needs trust or similar device.²¹⁰

[8.97] J. Work Activities of Patients

The department shall encourage employment of patients as part of therapeutic, community care or release programs and shall promote training for gainful employment. Patients shall be compensated for services in accordance with applicable state and federal labor laws.²¹¹ No patient may be required to perform work except what is required to maintain personal space and possessions.²¹²

[8.98] K. Service of Legal Process and Execution of Instruments

The director of a facility shall not permit service upon any patient except upon an order of a New York or federal court, which order shows the court had notice that the person served is a patient. Exceptions are surrogate's court citations and notices in guardianship proceedings. Service must be documented in the patient's record, and copies must be distributed to specified persons.²¹³ No patient is permitted to sign a legal instrument until the director of the facility has determined that the patient has the mental capacity to do so. The circumstances of the transaction must be recorded in the patient's record. Endorsement of checks for deposit in the patient's account is excluded.²¹⁴

210 MHL § 29.23.

211 MHL § 33.09(b).

212 *See Arahovitis v. State*, 120 Misc. 2d 917, 466 N.Y.S.2d 928 (Ct. Cl. 1983) (court-committed patient entitled to damages for coerced employment in state hospital barbershop).

213 14 N.Y.C.R.R. § 22.2(b); *Mental Health Info. Servs. v. Schenectady Cnty. Dep't of Soc. Servs.*, 128 Misc. 2d 282, 488 N.Y.S.2d 335 (Sup. Ct., Albany Co. 1985).

214 14 N.Y.C.R.R. § 22.3.