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INVOLUNTARY CIVIL COMMITMENT
IN THE FIRST JUDICIAL DEPARTMENT,
NEW YORK CITY

W. Lawrence Fitch
Bradley D. McGraw
Janice Hendryx
Thomas B. Marvell

Institute on Mental Disability and the Law

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TABLE OF CONTENTS

	<u>Page</u>
PREFACE	v
ACKNOWLEDGEMENTS	vii
CHAPTER I. INTRODUCTION	1
Overview of the Report	1
Summary of Involuntary Civil Commitment in the First Judicial Department, New York City	4
Summary of Recommendations	6
CHAPTER II. STUDY METHODS	11
CHAPTER III. PREHEARING	15
Initiating Mental Health Treatment	15
Screening and Initial Examination	19
Notifying Respondents of Rights	20
Opportunity for Informal or Voluntary Admission	21
Prehearing Examination	21
Prehearing Treatment	23
Prehearing Dismissal and Discharge	23
Conclusions and Recommendations	24
CHAPTER IV. COUNSEL FOR THE RESPONDENT	31
The Mental Health Information Service	31
Appointment of Counsel	32
Role of Counsel	33
Conclusions and Recommendations	34
CHAPTER V. THE HEARING: DETERMINING COMMITTABILITY	37
When Hearings are Held	37
Characteristics of the Hearing	38
Criteria for Commitment	40
Counsel for the Hospital	41
Assignment of Judges	41
Witnesses at the Hearing	43
Rules of Evidence and Procedure	44
Conclusions and Recommendations	44

	<u>Page</u>
CHAPTER VI.. THE HEARING: DETERMINING TREATMENT	53
Respondent's Capacity to Make Treatment Decisions:	53
Considering Less Restrictive Alternatives	53
Presenting a Treatment Plan	54
Judicial Treatment Options	55
Conclusions and Recommendations	55
CHAPTER VII. POSTHEARING CONCERNS	59
Right of Appeal	59
Institutional Practices	59
Transfers	60
Patients' Civil and Personal Rights	61
Retention Proceedings	63
Conclusions and Recommendations	63
APPENDIX A. FORMS USED IN THE INVOLUNTARY CIVIL COMMITMENT PROCESS IN THE FIRST JUDICIAL DEPARTMENT, NEW YORK CITY	67
APPENDIX B. DATA COLLECTION INSTRUMENTS USED IN THE FIRST JUDICIAL DEPARTMENT OF NEW YORK STUDY	97

PREFACE

This report describes involuntary civil commitment in the First Judicial Department (Manhattan and the Bronx) of New York City. The study upon which this report is based was part of a larger project undertaken by the Institute on Mental Disability and the Law, National Center for State Courts. Phase 1 of the project began on January 1, 1981, and lasted for eighteen months. Funding was provided by a coalition of private foundations. The major funding was provided by a grant from the John D. and Catherine T. MacArthur Foundation of Chicago. Additional grants were made by the New York Community Trust, the Della Martin Foundation of Los Angeles, the Chicago Community Trust, the Columbus Foundation, and the Winston-Salem Foundation.

This first phase has resulted in two major products. The first is a set of five site-specific volumes containing recommendations for improvement of involuntary civil commitment systems in five metropolitan areas throughout the United States: Chicago, Columbus (Ohio), New York City, Los Angeles, and Winston-Salem (North Carolina). The second product of Phase 1 is Provisional Substantive and Procedural Guidelines for Involuntary Civil Commitment, published in July 1982. This document has a national perspective, but builds upon the field work and analyses undertaken in New York and the other metropolitan areas mentioned above. Together these two products comprise in excess of 800 pages of text and contain over 240 guidelines and recommendations for the improvement of involuntary civil commitment throughout the United States.

These two products are intended to be pragmatic and utilitarian. Site-specific reports, such as this document, focus primarily on the manner in which a local involuntary civil commitment system functions or should function. Each site-specific report contains observations of how statutory provisions are currently implemented, where and why practice deviates from statute, and what practices go beyond the current scope of the law. Strengths and weaknesses are identified and recommendations are made for change and improvement. Provisional Guidelines contains nationally oriented guidelines aimed at judges, court personnel, and mental health professionals in agencies allied with the courts, who work with the involuntary civil commitment process on a daily basis. The principal goal of that volume is to facilitate more efficient management of resources available to these individuals, and to facilitate the development and use of fair, simplified, and streamlined procedures for involuntary civil commitment. Great emphasis is given to practical considerations, that is, to making the implementation of existing laws workable.

Phase 2 of this project has been planned and will commence this fall, contingent upon receipt of adequate funding. During the second phase, the Institute on Mental Disability and the Law intends to put the site-specific recommendations and the provisional guidelines into the hands of those who can use them. The Phase 2 work will entail six major

elements: (1) the review, revision, publication, and dissemination of the recommendations and provisional guidelines developed in Phase 1; (2) the development of an information clearinghouse for the improvement of involuntary civil commitment; (3) education and training of court and mental health personnel; (4) technical assistance to the courts and allied agencies; (5) demonstrations of model systems; and (6) maintaining of liaison with user groups.

ACKNOWLEDGEMENTS

This report owes its existence to many people and organizations. We hope here to acknowledge that debt and credit the contributions that have been made to the overall effort.

Two foundations provided the funds to support this work. The New York Community Trust was the major contributor to the research in New York City. A significant supplement was provided by the John D. and Catherine T. MacArthur Foundation of Chicago. The MacArthur Foundation also supplemented the project's work in Columbus, Ohio; Winston-Salem, North Carolina; Chicago, Illinois; and Los Angeles, California.

The management, staff, and Board of Directors of the National Center for State Courts must be acknowledged for their contributions in making this project possible. Edward B. McConnell, Executive Director of the National Center, is responsible for the project's conception. Professor Anthony L. Guenther of the College of William and Mary, working as a consultant to the National Center, refined the concept and developed the idea for a field research project. Members of the National Center's Board of Directors reviewed the project idea and commented on it from the perspective of judges. National Center library staff provided enormous aid in locating and acquiring reference materials throughout the project period.

In the early phases of the project, we received substantive guidance from a remarkably informed group of people known collectively as the National Advisory Board. The individuals in this group helped define the critical research questions, sharpen the project goals, and develop research methods:

Paul Appelbaum
Professor
Law and Psychiatry Program
University of Pittsburgh
Pittsburgh, Pennsylvania

Paul Friedman
Attorney
Ennis, Friedman, Bersoff, and Ewing
Washington, D.C.

B. James George, Jr.
Professor
New York Law School
New York, New York

Richard P. Lynch
Attorney and Project Director
American Bar Association
Washington, D.C.

Floyd E. Propst
Probate Court Judge
Fulton County Courthouse
Atlanta, Georgia

Loren H. Roth
Professor and Director
Law and Psychiatry Program
University of Pittsburgh
Pittsburgh, Pennsylvania

Joseph Schneider (Chairman)
Circuit Court Judge
Chicago, Illinois

David B. Wexler
Professor
University of Arizona
Tucson, Arizona

Helen Wright
Past President
National Association for Mental Health
Washington, D.C.

A special advisory group was assembled in New York City. These advisors provided detailed information about the city's legal and mental health systems and identified people of central importance to the functioning of their systems. The New York advisory group was composed of the following individuals (the titles and affiliations given were current as of the time of the research for this project):

Ronald N. Gottlieb
Director
Mental Health Information Service
First Judicial Department
New York City

Naomi Goldstein
Psychiatrist in private practice
New York City

Edward J. Greenfield (Chairman)
Supreme Court Judge
First Judicial District
New York City

Carol Horn
Executive Director
Mental Health Association of New York
and Bronx Counties

Fannie J. Klein
Senior Consultant
Institute of Judicial Administration

Robert Levy
Attorney
New York Civil Liberties Union

Peter J. McQuillan
Supreme Court Justice
First Judicial District
New York City

James Payne
Assistant District Attorney
New York County District
Attorney's Office

Simon Rosenzweig
Special Committee on
Commitment Procedures
New York Bar Association

Allan Sullivan
Assistant District Attorney
New York County District
Attorney's Office

During the field work in the First Judicial Department, many individuals helped explain and demonstrate the workings of the system. Some of these people must go unnamed -- the patients, secretaries, clerks, family members, and others who simply acted naturally and allowed us to observe as they played their parts in the system. Individuals who generously gave of their time for personal and group interviews include (the titles and affiliations given were current as of the time of the research for this project):

Sidney Asch
Supreme Court Justice
First Judicial District
New York City

Marvin Bernstein
Attorney
Mental Health Information
Service

Roger Biron
Medical Administrator
Manhattan Psychiatric Center

Ronna Blau
Attorney
Mental Health Information
Service

Martin Geller
Unit Chief
Bellevue Psychiatric Hospital

Adila S. Goldman
Director
Metropolitan Hospital

Merrill Goldstein
Attorney
Mental Health Information
Service

Sharon Goodstine
Social Worker
Mental Health Information
Service

Ronald N. Gottlieb
Director
Mental Health Information
Service

Kenneth J. Greene
Attorney
North Tarrytown, New York

Edward J. Greenfield
Supreme Court Justice
First Judicial District
New York City

Stephen Harkavy
Attorney
Mental Health Information
Service

Janet Heiser
Senior Attorney
Mental Health Information Service

Michael Ippolito
Sergeant
New York City Police

Clifford S. Karr
Associate Attorney
Mental Health Information Service

Steven Katz
Medical Director
Bellevue Psychiatric Hospital

Irving Kirschenbaum
Supreme Court Justice
First Judicial District
New York City

Alvin Kline
Supreme Court Justice
First Judicial District
New York City

Robert Levy
Director
New York Civil Liberties Union

Frank Lipton
Unit Chief, Psychiatric
Emergency Admitting Service
Bellevue Hospital

Mr. Fred Masten
Patient Advocate
Project Release

John McLaughlin
General Counsel
New York City Health and
Hospitals Corporation

Salvatore Napoli
Lieutenant
New York Police Department

Allan Sullivan
Assistant District Attorney
New York County District
Attorney's Office

Charles G. Tierney
Supreme Court Justice
First Judicial District
New York City

Mark McDougal
Head Administrator
Bellevue Psychiatric Hospital

Maureen McLeod
Attorney
Health and Hospitals
Corporation

Simon Rosenzweig
Chairman
Special Committee on Commitment
Procedures
New York Bar Association

Martin Stecher
Supreme Court Justice
First Judicial District
New York City

Stephen Zarkin
First Judicial Department
New York City

We apologize to any individuals whom we may have inadvertantly neglected to acknowledge -- your contributions are much appreciated.

Last but not least, it is fitting to acknowledge the contributions made by the project staff: Ingo Keilitz, Lisa Russell, and Joel Zimmerman shared with the authors the tasks of examining the statutes, reviewing the literature, conducting the interviews, observing the practices, and analyzing and reporting the results. Valuable assistance was provided by Paul Barnett, Beth Holmstrup, and Doug Schoppert, law students at the Marshall-Wythe School of Law, College of William and Mary. Robert F. Roach, Assistant Professor of Law at Marshall-Wythe, also contributed to the project.

Points of view and opinions expressed in this report are those of the project staff only. They do not represent official policies or positions of the National Center for State Courts; any of the agencies that helped fund this research; the court system in the First Judicial Department in New York City; the Mental Health Information Service; the New York City or State Departments of Mental Health; the New York City Advisory Board; or any of the individuals who participated in this research or the organizations with which they are affiliated.

CHAPTER I

INTRODUCTION

OVERVIEW OF THE REPORT

This report focuses on the system of involuntary civil commitment in the First Judicial Department of New York City. This brief introduction explains how the research was conducted, what its limitations are, and how certain terms are used in the report.

The Nature of the Study

This document is a descriptive and qualitative analysis of the laws and procedures relating to the involuntary civil commitment of adults in New York City. The bases for the analysis are the New York statute and relevant case law, professional literature in law and mental health, interviews with people who work in the New York system, and observations of the system at work.

Although the report contains many references to the New York statutes, it is not intended as either a definitive legal analysis of those statutes or an exhaustive descriptive analysis. Reference is made to the statutes to help explain why and how the system works as it does in New York. Statutory interpretations presented in this report should not be taken as authoritative, whether presented as the interpretations of these researchers or of people in the field.

Neither is this report to be taken as a scholarly analysis of issues. It contains no citations to professional literature, although an enormous body of relevant literature exists. Scholarly works abound on mental health law and civil commitment, including some produced by the staff of this project. To cite professional literature as it relates to the manifold aspects of this report would have been an enormous task and would have increased the bulk of this report significantly. We thus chose to not cite these works, leaving scholarly analyses to other reports. Our obvious debt to the scholarly work of others in this field is readily acknowledged, however, and will be easy to identify in the pages that follow. We make no pretense that the philosophical and technical ideas raised in this volume are original thoughts, and we apologize in advance to the numerous authors whom we fail to credit.

This report describes how informed people who are involved with commitment cases in New York perceive their system to work. It is a report of what these people do, what they feel about what they do, and what they have suggested about other ways their work might be done. While we do not claim to present an authoritative treatise on either the law or current scholarly thinking in this area, we do hope to present an accurate and representative report of the opinions and practices of the people who are central to the New York City civil commitment system.

All that we know about the system is what we have been told by the people in New York, supplemented by the statutes, the professional literature, and a limited number of personal observations. When it is reported that certain events occur in New York, it should be understood that this means we were told that those events occur or that we observed them occur. If specific sources of information are not cited, it can be assumed that this information was reported to these researchers by virtually everyone who was interviewed. If information came only from a particular source, or if it differed from information coming from other sources, then the specific source of the information is identified. All information sources are reported as generic categories of people, such as judges, attorneys, physicians, mental health professionals, and so on. Specific names of people are not used. We have attempted to maintain confidentiality of the information that was provided to us. We promised that names would be removed from all data materials so that particular persons could not be associated unambiguously with particular bits of information provided to us.

Appendix B contains copies of the data collection guides that were used by researchers in New York. The appendix also contains a statement of research ethics and confidentiality that directed this work.

The analysis is organized roughly chronologically, proceeding from prehearing events, through the hearing, to posthearing concerns. A separate section is included regarding the respondent's counsel, who usually comes into the picture after a person has been taken into custody but before a hearing, and whose involvement may last through the posthearing period. While another means of organizing these materials might arguably have been more effective, this general organization scheme was used in order to provide maximum comparability between these materials and those that the project staff prepare for other sites and for general use.

Limitations and Focus of this Report

Every research effort has its limitations. These need to be acknowledged so that the conclusions in the report are not generalized to situations to which they do not apply.

This report applies only to the process of civil commitment in the the First Judicial Department of New York City. It is not meant to apply to any other parts of the State of New York, or even to the City's other judicial departments. Some of the information presented certainly will generalize beyond the First Judicial Department; but generalizations to other areas must be made by the reader as fortuitous and serendipitous offshoots of this work, and not as the intention of these researchers. Other products coming from this research project will establish some general lessons that might be applied nationwide, but that will not be the intent of this report.

This report relates only to mentally ill adults in the civil justice system in the First Judicial Department. The report is not meant to be accurate with reference to prisoners, juveniles, or the mentally

retarded or developmentally disabled, except where noted. Neither is this report intended to apply to criminal commitments. A reviewer of an earlier draft of this report correctly stressed that although this report is not intended to directly address criminal commitment procedures, implementation of many of the included recommendations would necessarily affect criminal procedures. Two classes of patients in particular might be affected. The first includes patients, previously charged with serious crimes, who are found not responsible by reason of mental disease or defect (P.L. 30.05) and are subsequently committed pursuant to C.P.L. 330.20. The second class includes patients who are found not competent to assist counsel with respect to pending criminal charges and thus are committed pursuant to C.P.L. Article 730. Readers should recognize the focus of the study upon which this report is based and should consider its ramifications toward patients committed pursuant to criminal procedures.

The data for this report were gathered during October 1981. The final report was released in June 1982. The report is accurate as of that time. In performing policy analysis and making recommendations for change, one implicitly hopes that the report soon will be out of date. The longer a situation remains unchanged, the longer the report contents remain accurate and the greater the evidence that the report had no impact.

Terminology

Some terms used throughout this report deserve special comment. Particularly troublesome is the word "commitment," and its various forms and derivatives. The current vogue is not to use this word because of its strong negative connotations. In its place, many people are using the term "hospitalization." We have chosen, though, to use "commitment" in this report for two reasons. First, it is a term that is commonly used in speech, readily recognized, and well understood. Second, in several states, commitment and hospitalization are not synonymous. Where hospitalization is merely one form that an order of commitment may take, commitment is more nearly synonymous with "court-ordered treatment." Although the term "court-ordered" might in one state be a good substitute for the word "committed", statutes in other states, including New York, make it possible for people to be committed without the involvement of a court. Thus, the search for a synonym is frustrated and "commitment" is used despite the stigma that has been associated with it. Perhaps the ultimate solution to this dilemma will be the reform of civil commitment law and practice, and subsequent re-education of the public, so that the stigma, and not the word, eventually disappears.

Two other words appearing throughout this report are "respondent" and "patient." These words are essentially synonymous for the purposes of this report. Technically, a patient is a person who has been admitted for mental health treatment, with or without court involvement, as either an inpatient or an outpatient. (Outpatients are more frequently referred to as "clients" by mental health professionals, but they will be called "patients" in this report.) A respondent is a person who is the subject of an involuntary commitment proceeding.

Generally, the report refers to the person as "respondent" with regard to legal concerns and before a commitment has been ordered. The person is referred to as a "patient" with regard to treatment concerns and following a commitment or voluntary admission to treatment.

Another term frequently used in this report is "these researchers." Associated terms are "we," "project staff," "our," and so on. These terms refer to staff of the National Center for State Courts who participated in this research project. They are listed by name in the Acknowledgements. The project benefited immensely from the staff's sharing of observations, ideas, and opinions. As a result of the sharing process, however, it is impossible to place responsibility for any of the report's contents with any single individual. W. Lawrence Fitch, Bradley D. McGraw, Janice Hendryx, and Thomas B. Marvell, served as authors of this report, however, and it is they who bear responsibility for the accurate chronicling of this material.

Throughout this report, reference is made to "the New York statutes," or simply "the statutes." These statutes are contained in the New York Mental Hygiene Law (McKinney 1978).

SUMMARY OF INVOLUNTARY CIVIL COMMITMENT IN THE FIRST JUDICIAL DEPARTMENT, NEW YORK CITY

The New York Mental Hygiene Law prescribes four basic procedures for the initiation of involuntary civil commitment proceedings: emergency admission; admission upon the application of statutorily designated lay individuals accompanied by the certificates of two examining physicians; admission upon the application of the Director of Community Services or his or her designee; and admission upon the order of a court.

In practice, most involuntary commitments in the First Judicial Department of New York City begin as emergency admissions. A reviewer of an earlier draft of this report said that in the Bronx, although admissions at the three city hospitals are generally emergency admissions, the three private hospitals with psychiatric units generally admit patients by one of the other three procedures. The reviewer suggested that this variance between public and private hospitals is probably also true in Manhattan. The statutory criterion for a fifteen-day emergency admission is "a mental illness for which immediate observation, care, and treatment in a hospital is appropriate and which is likely to result in serious harm to himself or others." (9.39) "Likelihood to result in serious harm" is defined as "(1) 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 (2) 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." (9.39)

The police are authorized by statute to take into custody anyone meeting the emergency admissions criterion. Further, courts of general jurisdiction are empowered to order the removal of a person to a mental health facility for possible emergency admission. This court-ordered admissions procedure, while statutorily authorized, reportedly is very rarely used in New York City. Police initiation of the emergency admissions procedure is the norm.

Before a person may be admitted to a hospital pursuant to the emergency admissions procedure, a hospital physician must examine the person and determine that he or she meets the criterion for emergency admission. If, within forty-eight hours of admission, a member of the hospital's psychiatric staff conducts an examination which confirms the pre-admission examination findings, the person may be detained for up to fifteen days.

Upon admission, the patient is informed of his or her status and legal rights and of the availability of the legal services of the Mental Health Information Service (MHIS). A judicial hearing is held only if requested by the patient, a relative or friend of the patient, or MHIS. A hearing must be held within five days of a request, unless a continuance is granted.

In order for a patient to be involuntarily hospitalized beyond the fifteen-day emergency period, an application and two physician's certificates must be received by the director of the hospital. At any time within sixty days from the date of a patient's initial emergency admission a patient, a relative or friend, or the MHIS, may challenge the director's decision to commit by giving to the director written notice requesting a hearing. The director, in turn, must forward to the court a copy of the notice and of the patient's record. The court must set a hearing for not later than five days after it receives the notice and record. If the court determines, based upon a review of these materials, that the patient is mentally ill and in need of involuntary care and treatment, it may order continued involuntary hospitalization for up to sixty days. A person is deemed "in need of involuntary care and treatment" if he or she has a mental illness for which hospitalization is essential to the person's welfare, and has an impairment of judgment that renders him or her unable to understand the need for such hospitalization.

At the expiration of the sixty-day treatment period, the court may order continued involuntary hospitalization for up to six months upon a showing that the patient remains in need of involuntary care and treatment. At the end of this period, the court may order treatment for up to an additional year. Subsequent treatment periods of up to two years each may be ordered.

Any person who has been involuntarily hospitalized following a court hearing may, within thirty days of the court's order, obtain a rehearing and review of the order. Orders resulting from review hearings may be appealed. The MHIS continues to provide legal services to patients during their periods of commitment.

SUMMARY OF RECOMMENDATIONS

This report is intended to be of practical use to the courts and agencies in New York City that provide services to the mentally ill. In addition to describing the First Judicial Department's civil commitment system, the report presents practical recommendations for improvement in the system. The recommendations were derived from several sources. Many were taken from suggestions made by people working in the New York City system. Others are variations of suggestions made by professionals in the other project sites to accommodate their systems' problems. Some recommendations spring primarily from the research staff's observations of civil commitment practices in New York and from the staff's review of the professional literature on this topic.

Each of the chapters of this report contains a number of recommendations. After studying this report, or simply from being familiar with commitment procedures in New York, the reader may be surprised that some recommendations have not been made. Many issues can be identified on which recommendations might have been offered but were not. The absence of recommendations addressing particular issues can be accounted for in two ways. First, if the New York system is administering a certain procedure in a manner that appears impossible to improve upon, no recommendation is made. Thus, to some extent, the lack of a recommendation may be taken as implicit approval of the status quo. Second, situations are identified in the report in which the countervailing factors are so nearly weighted that any recommendation would be hard to justify. In these situations, the preference was to make no recommendation rather than to present a recommendation with a weak foundation. It should be apparent after reading the report why particular recommendations were not made, as well as why others were.

Recommendations are made throughout the report as they arise from the textual discussions. The text is organized in an approximately chronological fashion, as events ordinarily unfold during a commitment proceeding. Here, the recommendations are reproduced according to the chapter in which they appear in the text. Thus, one can quickly turn to the chapter from which the recommendation was taken and locate the textual discussion accompanying the recommendation. In this section, the recommendations are presented in summary form only, without discussion. The full report must be reviewed for a complete understanding of each recommendation.

Recommendations

Prehearing

RECOMMENDATION: A PROCEDURE SHOULD BE DEVELOPED TO PERMIT POLICE OFFICERS TRANSPORTING RESPONDENTS TO HOSPITALS PURSUANT TO THE EMERGENCY ADMISSIONS PROCEDURE TO LEAVE RESPONDENTS IN THE CUSTODY OF THE HOSPITAL WHETHER OR NOT AN EXAMINATION HAS BEGUN. HOSPITAL STAFF SHOULD DEVELOP A STANDARD SET OF QUESTIONS DESIGNED TO ELICIT FROM POLICE

OFFICERS INFORMATION ABOUT THE RESPONDENT'S BEHAVIOR DURING THE CUSTODY-TAKING THAT MIGHT BE HELPFUL TO THE PHYSICIAN IN CONDUCTING THE EVALUATION. THESE QUESTIONS SHOULD BE MADE AVAILABLE TO POLICE OFFICERS IN ADVANCE SO THAT RESPONSES MAY BE PRESENTED IN WRITING TO EMERGENCY ROOM STAFF UPON PRESENTATION OF THE RESPONDENT.

RECOMMENDATION: STAFF OF THE HOSPITAL'S ADMISSIONS DEPARTMENT, IN COOPERATION WITH THE HOSPITAL'S PSYCHIATRIC EMERGENCY ROOM STAFF, SHOULD BE RESPONSIBLE FOR OBTAINING FROM RESPONDENTS THE NAMES OF PERSONS TO BE NOTIFIED, IF ANY, AND SHOULD PROVIDE SUCH NOTIFICATIONS AS ARE REQUIRED BY STATUTE.

RECOMMENDATION: PHYSICIANS CONDUCTING INITIAL EXAMINATIONS OF RESPONDENTS UPON PRESENTATION FOR ADMISSION SHOULD CAREFULLY EXPLAIN TO RESPONDENTS THEIR STATUS IN THE HOSPITAL AND THEIR RIGHTS AS PATIENTS. MHIS STAFF SHOULD MEET PERSONALLY WITH EVERY RESPONDENT SOON AFTER EMERGENCY ADMISSION TO EXPLAIN CLEARLY HIS OR HER LEGAL RIGHTS AND PROTECTIONS.

RECOMMENDATION: HOSPITAL STAFF AND MHIS ATTORNEYS SHOULD PLACE MORE EMPHASIS ON EXPLORING THE SUITABILITY OF INFORMAL OR VOLUNTARY STATUS AND SHOULD EXPLAIN FULLY TO RESPONDENTS THEIR OPTION OF ACCEPTING INFORMAL OR VOLUNTARY STATUS UPON ADMISSION AND THE PRACTICAL AND LEGAL CONSEQUENCES OF ACCEPTING INFORMAL OR VOLUNTARY STATUS.

RECOMMENDATION: EXAMINING PHYSICIANS SHOULD EXPLAIN TO RESPONDENTS THE NATURE AND PURPOSE OF THE EXAMINATION AND HOW THE INFORMATION GENERATED BY THE EXAMINATION MIGHT BE USED BY STAFF OF THE HOSPITAL AND BY THE COURTS.

RECOMMENDATION: EXAMINING PHYSICIANS SHOULD BE REQUIRED TO HAVE SIGNIFICANT FLUENCY IN ORAL AND WRITTEN ENGLISH.

RECOMMENDATION: IF ANY MEDICATION IS ADMINISTERED TO THE RESPONDENT DURING THE PREHEARING PERIOD AND THE RESPONDENT'S TREATING PHYSICIAN HAS ANY REASON TO BELIEVE THAT THE RESPONDENT'S BEHAVIOR IN COURT WILL BE AFFECTED BY SUCH MEDICATION, THE PHYSICIAN SHOULD INDICATE TO THE COURT, THE RESPONDENT'S ATTORNEY, AND THE ATTORNEY REPRESENTING THE HOSPITAL OR THE STATE WHAT MEDICATIONS WERE ADMINISTERED AND WHAT CONSEQUENCES THESE MEDICATIONS ARE LIKELY TO HAVE ON RESPONDENT'S BEHAVIOR DURING THE HEARING AND ON RESPONDENT'S ABILITY TO ASSIST COUNSEL.

Counsel for the Respondent

RECOMMENDATION: EVERY PATIENT SHOULD BE VISITED SOON AFTER ADMISSION BY A MEMBER OF THE MHIS STAFF. THE MHIS STAFF MEMBER SHOULD INFORM THE PATIENT ABOUT PROCEDURES FOR

ADMISSION AND RETENTION AND ABOUT THE PATIENT'S RIGHTS TO CHALLENGE COMMITMENT IN COURT, TO BE REPRESENTED BY COUNSEL, AND TO SEEK INDEPENDENT MEDICAL OPINION. THE MHIS STAFF MEMBER SHOULD TAKE CARE TO ENSURE THAT FAILURE OF PATIENTS TO AVAIL THEMSELVES OF THESE RIGHTS IS DONE KNOWINGLY. THE SIZE OF THE MHIS STAFF SHOULD BE INCREASED SUFFICIENTLY TO ACCOMPLISH ITS STATUTORY GOALS.

RECOMMENDATION: THE NEW YORK STATUTES (29.09) SHOULD BE AMENDED TO PERMIT MHIS ATTORNEYS TO WITHHOLD FROM THE COURT INFORMATION THAT IS PRIVILEGED OR IS ADVERSE TO THE CASE FOR THE DEFENSE.

The Hearing: Determining Committability

RECOMMENDATION: A STATUTORY AMENDMENT SHOULD BE SOUGHT REQUIRING A JUDICIAL HEARING IN EVERY INVOLUNTARY COMMITMENT CASE, TO BE HELD WITHIN 5 DAYS OF THE PATIENT'S ADMISSION TO THE HOSPITAL.

RECOMMENDATION: THE SUPERIOR COURT IN EACH NEW YORK COUNTY SHOULD MONITOR CAREFULLY THE SERVICES PROVIDED BY THE MHIS ATTORNEYS IN ADVISING AND REPRESENTING PERSONS INVOLUNTARILY COMMITTED; WHENEVER THE COURT FINDS THAT THESE SERVICES ARE NOT BEING PROVIDED PROMPTLY AND SUFFICIENTLY, IT SHOULD ORDER THAT A HEARING BE HELD WITHIN 7 DAYS OF ADMISSION.

RECOMMENDATION: REPRESENTATIVES OF THE SUPREME COURT, THE MHIS, AND THE CITY HOSPITALS SHOULD EXPLORE WAYS IN WHICH HEARINGS COULD BE HELD AT LOCATIONS MORE CONVENIENT FOR HOSPITAL PERSONNEL WHO ARE REQUIRED TO ATTEND.

RECOMMENDATION: JUDGES SHOULD STRICTLY ENFORCE PROPER COURTROOM ORDER AND DECORUM.

RECOMMENDATION: JUDGES SHOULD INSIST THAT ALL HEARING PARTICIPANTS BE PRESENT AND PREPARED TO GO FORWARD AT THE TIME SCHEDULED FOR HEARINGS. ATTORNEYS FOR THE HOSPITALS SHOULD ENSURE THAT ALL NECESSARY PAPERS AND WITNESSES ARE AVAILABLE FOR PRESENTATION TO THE COURT.

RECOMMENDATION: WHEN CONTINUANCES ARE NECESSARY, THEY SHOULD BE FOR NO LONGER A PERIOD OF TIME THAN IS NECESSARY TO ACCOMMODATE THE DIFFICULTY REQUIRING A CONTINUANCE. RATHER THAN CONTINUE CASES FOR AN ENTIRE WEEK (UNTIL THE DAY REGULARLY SCHEDULED FOR HEARINGS IN THE PARTICULAR HOSPITAL), JUDGES SHOULD BE PREPARED TO RETURN TO THE HOSPITAL ON ANOTHER DAY DURING THE WEEK IN ORDER TO HEAR CASES REQUIRING CONTINUANCE. ALTERNATIVELY, CASES REQUIRING CONTINUANCE SHOULD BE RESCHEDULED FOR THE HEARING DAY IN THE OTHER HOSPITAL IN WHICH HEARINGS REGULARLY ARE HELD.

RECOMMENDATION: A STATUTORY AMENDMENT SHOULD BE SOUGHT LIMITING TO FIVE DAYS THE TIME FOR WHICH A CONTINUANCE MIGHT BE GRANTED, UNLESS REQUESTED BY THE PATIENT..

RECOMMENDATION: THE STATUTORY PROVISION PROHIBITING CONTINUANCES IN EMERGENCY ADMISSION CASES, UNLESS REQUESTED BY THE PATIENT, SHOULD BE STRICTLY APPLIED..

RECOMMENDATION: JUDGES SHOULD NOT LOOK PRIMARILY TO EXAMINERS FOR INFORMATION ABOUT DANGEROUSNESS; RATHER, DANGEROUSNESS SHOULD BE INFERRED FROM SPECIFIC THREATS OR VIOLENT ACTS OF RESPONDENT, REPORTED IN TESTIMONY GIVEN BY COMPETENT WITNESSES..

RECOMMENDATION: THE PROCEDURE FOR ASSIGNING JUDGES TO COMMITMENT CASES SHOULD BE CHANGED TO INSURE THAT JUDICIAL ASSIGNMENTS ARE LENGTHY ENOUGH TO ALLOW THE JUDGE TO BECOME WELL ACQUAINTED WITH THE UNIQUE SUBJECT MATTER OF CIVIL COMMITMENT.

RECOMMENDATION: EVERY JUDGE ASSIGNED TO HEAR COMMITMENT CASES SHOULD BE REQUIRED TO PARTICIPATE IN AN ORIENTATION/EDUCATION PROGRAM PRESENTED PERIODICALLY AS A JOINT EFFORT OF THE MHIS AND THE PSYCHIATRIC HOSPITALS IN NEW YORK CITY. STAFF OF THE MHIS AND PERSONNEL OF THE CITY PSYCHIATRIC HOSPITALS, AS ADVISED BY THEIR COUNSEL, IMMEDIATELY SHOULD ASSUME RESPONSIBILITY FOR DEVELOPING AND IMPLEMENTING SUCH AN EDUCATIONAL PROGRAM.

RECOMMENDATION: TESTIFYING EXAMINING PHYSICIANS SHOULD PRESENT THEIR TESTIMONY IN AN IMPARTIAL MANNER.

RECOMMENDATION: MHIS STAFF, IN COOPERATION WITH COUNSEL FOR THE PSYCHIATRIC HOSPITALS IN NEW YORK CITY, SHOULD DEVELOP AND CONDUCT ORIENTATION/EDUCATION PROGRAMS FOR MENTAL HEALTH PROFESSIONALS WORKING IN THE CITY HOSPITALS. ALTERNATIVELY, BEFORE EACH COMMITMENT HEARING, COUNSEL FOR THE HOSPITAL SHOULD EXPLAIN TO THE TESTIFYING PHYSICIAN WHAT WILL BE EXPECTED OF HIM OR HER DURING THE HEARING.

RECOMMENDATION: COUNSEL SHOULD STRIVE TO PREVENT THE INTRODUCTION OF EVIDENCE THAT IS IN VIOLATION OF THE FORMAL RULES OF EVIDENCE. WHEN TESTIMONY THAT IS HIGHLY OBJECTIONABLE IS GIVEN OVER NO OBJECTION, THE COURT SHOULD ALERT COUNSEL THAT RULES OF EVIDENCE SHOULD BE BETTER FOLLOWED.

RECOMMENDATION: INFORMATION ON PREVIOUS PSYCHIATRIC TREATMENT SHOULD BE ADMISSIBLE INTO EVIDENCE AT THE COMMITMENT HEARING FOR PURPOSES OF DIAGNOSIS AND TREATMENT PLANNING, BUT SHOULD NOT BE ACCEPTED AS SUFFICIENT EVIDENCE THAT RESPONDENT MEETS THE CRITERIA FOR COMMITMENT.

The Hearing: Determining Treatment

RECOMMENDATION: A STATUTORY AMENDMENT SHOULD BE SOUGHT AUTHORIZING JUDGES IN COMMITMENT PROCEEDINGS TO ORDER RESPONDENTS INTO INVOLUNTARY TREATMENT IN PROGRAMS OF CARE LESS RESTRICTIVE THAN HOSPITALIZATION.

RECOMMENDATION: BEFORE ORDERING INVOLUNTARY HOSPITALIZATION, THE COURT SHOULD CONSIDER WHETHER ANY LESS RESTRICTIVE ALTERNATIVE WOULD BE APPROPRIATE AND AVAILABLE TO ACCOMMODATE THE RESPONDENT'S DISORDER AND SHOULD MAKE A FINDING THAT LESS RESTRICTIVE ALTERNATIVES WERE CONSIDERED AND NONE WAS FOUND TO BE APPROPRIATE..

Posthearing Concerns

RECOMMENDATION: AS REQUIRED BY STATUTE, ANY JUDGE WHO RECEIVES A PETITION FOR A REHEARING SHOULD CAUSE A JURY TO BE SUMMONED UNLESS THE PATIENT OR OTHER PERSON APPLYING FOR THE REHEARING ON THE PATIENT'S BEHALF WAIVES A TRIAL BY JURY AND CONSENTS IN WRITING TO TRIAL BY THE COURT.

RECOMMENDATION: THE APPELLATE DIVISION OF THE SUPREME COURT SHOULD MAINTAIN AN EXPEDITED CALENDAR FOR COMMITMENT APPEALS, WHICH SHOULD ALLOW SUCH APPEALS TO BE HEARD WITHIN FIFTEEN DAYS OF FILING.

RECOMMENDATION: AS REQUIRED BY STATUTE, RESTRAINTS SHOULD BE EMPLOYED ONLY WHEN NECESSARY TO PREVENT A PATIENT FROM SERIOUSLY INJURING SELF OR OTHERS. RESTRAINTS MUST NEVER BE USED AS A PATIENT MANAGEMENT DEVICE. BEFORE ORDERING THE USE OF RESTRAINTS, THE PHYSICIAN SHOULD DOCUMENT IN THE PATIENT'S RECORD THE FACT THAT LESS RESTRICTIVE TECHNIQUES WERE CONSIDERED AND WERE CLINICALLY CONSIDERED TO BE INAPPROPRIATE OR INSUFFICIENT TO AVOID INJURY.

RECOMMENDATION: PATIENTS REFUSING TREATMENT AND APPEALING THE PHYSICIAN'S TREATMENT DECISION, USING THE PROCEDURES OUTLINED IN THE REGULATIONS OF THE OFFICE OF MENTAL HEALTH, SHOULD NOT BE TREATED DURING THE APPEAL PROCESS UNLESS, AS REQUIRED BY REGULATION §27.8, "THE TREATMENT APPEARS NECESSARY TO AVOID SERIOUS HARM TO LIFE OR LIMB OF THE PATIENTS THEMSELVES." THE COURTS AND THE MHIS ARE ENCOURAGED TO ENSURE COMPLIANCE WITH THE INTENT OF THIS REGULATION.

CHAPTER II

STUDY METHODS

This chapter presents a discussion of the project methodology. It considers methods for the first phase of the national project as well as for the project work specific to New York City.

Literature Review

In January 1981, the project staff began collecting and reviewing professional literature in the psycho-legal area. Source materials were collected from books and journals in the disciplines of law, psychiatry, psychology, social work, sociology, and public administration. Professors and mental health practitioners throughout the country were contacted and asked to provide copies of unpublished papers and other hard-to-find writings pertaining to involuntary civil commitment. Members of the project's National Advisory Board were particularly helpful in steering project staff to valuable reading materials.

Just prior to a meeting of the National Advisory Board in April, staff prepared an "Issues Paper" summarizing the relevant literature and defining important contemporary issues of civil commitment with which this project was to be concerned. The substantive portion of the "Issues Paper" has been altered slightly and published as "Involuntary Civil Commitment: The Discerning Eye of the Law" (State Court Journal, 1981, 5(4), 5 ff.), copies of which are available from the National Center for State Courts Publication Department. At their meeting, members of the National Advisory Board helped staff decide what research questions should be explored during site visits and gave advice on field research methods.

Statutory Review

By identifying the important questions that might be addressed in a commitment statute and then ordering them roughly as they might become relevant in a typical commitment proceeding, a scheme was devised for analyzing statutes governing civil commitment. A complete statutory analysis was performed for 20 states, including the states in which the National Center's project had received funding to conduct site-specific research and states having statutes that were particularly interesting, innovative, or modern. Using this analytical scheme, staff compiled all the variations of statutory provisions relating to each analytical category and determined how commitment statutes and procedures differed from state to state. These points of difference became the focus for the field data collection.

Preliminary Site Visits

A preliminary visit was made to each of the five project sites. Three project staff visited New York City in April 1981, meeting with

judges, court personnel, attorneys, and mental health professionals. This visit served several purposes. First, the participants in the New York civil commitment system shared with staff their perceptions of how the New York system worked. They noted problems with the system and peculiarities that set it apart from most others. Most importantly, individuals with whom we met identified the agencies and institutions in New York that are involved in civil commitment cases. Key people within these organizations were named, as were other people unrelated to major institutions but important or knowledgeable in the commitment area.

Site Visits

After completing the comparative statutory analysis, staff made intensive data-collection trips to each of the five project sites. Four staff members traveled to New York City for one week in September 1981.

During the two weeks prior to the site visit, intensive preparations were made. Individuals who had been identified during the preliminary site visit as important or knowledgeable in the commitment area were contacted by telephone and interview appointments were scheduled. Staff thoroughly reviewed the New York statute and case law and identified questions of particular concern for the First Judicial District, New York City system. Interview guides including these areas of concern were mailed in advance to people who were to be interviewed so that they could prepare for the interviews if they so wished.

Most site participants were interviewed individually, although some were interviewed in groups. With very few exceptions, all interviews were conducted by two or three staff researchers. Before each interview, one researcher was assigned the role of "scribe." The scribe's duty was to record the interviewee's responses, while another researcher led the interview and attended carefully to substance.

Staff observed all court hearings conducted during the time of the site visit. An observation guide was prepared and studied in advance of the hearings. (The observation guide for New York is included in Appendix B.) Notes taken during interviews and court hearings were in rough form. Each staff researcher rewrote his or her notes during the week following the site visit.

While in New York, staff met at the end of each day to compare notes and impressions about the city's commitment system. Key concerns were whether information received from various sources and whether information in particular substantive areas was complete. Based on these discussions, interview assignments for the next day were made. When staff members were confident of the information they had received on a particular topic, no further questions were asked concerning that topic.

The names of people interviewed in New York are listed at the beginning of this report. Those individuals were chosen on the basis of their involvement in commitment proceedings in the city. An effort was made to interview at least one representative from each facility and agency having contact with commitment respondents. These individuals

were not intended to constitute a statistically representative sample. Furthermore, the research was not intended to establish the typical person's view of commitment system in New York. Rather, it was to gain insight into how the system works and how it might be improved, from the perspectives of people with extraordinary abilities to understand and comment on the system.

The Form of the Data

The ultimate goal of this research project was to generate information that could be used to improve civil commitment procedures in jurisdictions throughout the country. The purpose of the data collection was to obtain practitioners' opinions, advice, and suggestions about the civil commitment process, particularly as it operates in their own localities. Accordingly, it was appropriate that the research be qualitative rather than quantitative. Our main purpose was not to ask how many, or even how; rather it was to ask why, how well, and how else. Basically, we sought information about what works best and why.

The questions in the data collection guide were open-ended. Multiple-choice types of question were avoided so that interviewees would be free to formulate their own opinions rather than have their thoughts slotted into predetermined categories by the researchers.

The data collection guide (in Appendix B) is a complete set of all the questions that were asked. The interview guide covers many topics and flows, more-or-less, in chronological order, as events occur during a typical commitment proceeding. The questions unavoidably overlap to some degree, but repetition was minimized as much as possible. It should be easy to see that the interview questionnaire was organized in the same basic scheme that was used for the statutory analysis.

Because of the length of the data collection guide, every question was not asked of every interviewee. A subset of questions was presented in each interview to optimize the match of the interviewee's special area of knowledge with the questions asked. Everyone, however, was invited to discuss any aspect of the commitment process with which he or she was familiar or about which he or she had particular opinions or suggestions. Interviewers were able to (and frequently did) stray from the planned path of questions when it seemed useful and appropriate.

The questionnaire was considered only a data collection guide, not a dictum. Neither the precise language of the questions, nor the order in which questions were asked was considered to be important. The guide was simply a reminder of important issues and ideas that needed to be discussed. More concern was given to understanding the responses than to recording them thoroughly or verbatim.

A complete set of field notes, with all names and personal identifiers removed, is available from the National Center for State Courts. For the cost of duplication and mailing it will be provided upon request.

Analysis, Report, and Review

A qualitative content analysis was performed on the data collected. Interview and observation notes were first reviewed and cross-referenced. Note was made of topics of significance, points of agreement among interviewees, and points of disagreement. For each topic of concern, the analysis covered the statutory provisions, the practices at the site, and commentary about the statute and practices.

Three major criteria are used in this report to evaluate the civil commitment system in New York: legal protections, provision for treatment, and social benefits. That is, each procedure is analyzed in terms of how well it protects the legal (e.g., liberty) interests of respondents, how well it provides for respondents' treatment needs, and how well it accommodates the interests of society (e.g., safety, public health, minimum cost). The judgments of how to apply these criteria to elements of law and practice fell to the project team, based upon their knowledge of the literature, observations, discussions with practitioners, and (as our sociologist colleagues are quick to point out) their sociohistorical biographies. The reader is free, of course, to disagree with this analysis and may choose to view the system's strengths and weaknesses differently. As will be discussed, a system characteristic may be simultaneously a strength and a weakness, when viewed from different perspectives.

The results of the analysis assume the form of recommendations for improvement in the First Judicial Department's civil commitment system. The recommendations should not be taken as research conclusions or empirically proven statements of fact. Rather, they are the suggestions of these researchers, based upon their studies and points of view. The recommendations derive from a variety of sources: suggestions made by people in New York; suggestions made by people in other cities; conclusions from the professional literature; and ideas generated by the researchers during the course of the project. It is impossible to sort out the influence of these various sources in any recommendation, or to report accurately how extensive any person's or group's agreement would be with any particular recommendation.

The purpose of presenting recommendations is to highlight certain problems and alert people in New York to possible solutions. Although it is easy for us to identify a problem, we are too far removed from the system to be expected to have "The Answer." A more realistic objective is to present "an answer," however modest and tentative, as a stimulus and starting point for thoughtful consideration by those in a better position to know New York's system and make appropriate changes.

CHAPTER III

PREHEARING

This chapter describes procedures and events that occur before a judicial hearing in the First Judicial Department of New York City involuntary civil commitment process. For many respondents, these initial procedures and events constitute the entire extent of their involvement in the involuntary civil commitment process. That is, many will be screened and diverted from compulsory hospitalization, many will elect to enter a hospital voluntarily once an affidavit for involuntary hospitalization has been filed with the court, any many will be involuntarily committed and subsequently discharged without having a hearing.

INITIATING MENTAL HEALTH TREATMENT

The New York statutes describe procedures for informal admissions, voluntary admissions, and involuntary admissions into inpatient hospital treatment for the mentally ill. Under informal admissions, a person requesting inpatient treatment may be admitted by the director of the hospital without making formal or written application. The patient is classified as an informal patient and is free to leave at any time (9.15). A voluntary admission occurs when a person makes a written application for admission to a hospital. Voluntary patients ordinarily must be promptly released upon request. The director of the hospital, however, may retain the patient for a period of up to 72 hours if there are "reasonable grounds for belief that the patient may be in need of involuntary care and treatment." At the expiration of the 72-hour period, the director must either release the patient or apply to court for involuntary commitment of the patient (9.13).

As a practical matter, most involuntary admissions in New York City are initiated as emergency admissions. The New York emergency admissions statute provides that a person may be involuntarily hospitalized for up to 15 days if he or she is alleged to have "a mental illness for which immediate observation, care, and treatment in a hospital is appropriate and which is likely to result in serious harm to himself or others" (9.39). "Likelihood to result in serious harm" is defined as "(1) 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 (2) 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" (9.39). The statute provides that emergency admissions may be taken by any hospital that maintains the appropriate staff and facilities and is approved by the Commissioner of the Department of Mental Hygiene. The approved hospitals are listed in the Department's Regulations, section 15.9(e). In the First Judicial Department, they number about 14.

Police Procedure in Emergency Admissions.

The vast majority of involuntary commitments in New York City begin as emergency commitments initiated by the police. The police are authorized by statute to take into custody anyone meeting the emergency admissions criterion (9.41), and the New York City police department has established specific procedures for such admissions, contained in a manual that accompanies police officers in their patrol cars.

Many police procedures are new and are designed to reduce the time required by officers to process emergency commitments. They reflect a deep concern in the department about the resources required to handle these cases. The size of the City's police department has been reduced by about a third in recent years because of the city's fiscal difficulty; the volume of commitments has greatly increased. According to police department statistics, the number of people transported to hospitals for mental health examinations increased from 1,084 in 1976 to 7,785 in 1980, thus almost doubling every year. It is widely believed that this trend probably is caused by the deinstitutionalization policy in New York, accompanied by inadequate housing for and treatment of those released from mental hospitals serving the City. The average time required by a police officer to process an emergency commitment, according to informed sources, is about three hours. Hence, emergency commitments consume a substantial amount of the police department's manpower.

The police procedures are contained in the department's "Patrol Guide," which was substantially revised in August 1981 (see Appendix A). The procedures apply when an officer "believes that a person, who is apparently mentally ill or temporarily deranged, must be taken into protective custody because the person is conducting himself in a manner likely to result in serious injury to himself or others," or, in other words, when the officer believes the person falls under the statutory requirements for emergency commitment. The guidelines do not provide specific criteria for determining when a person is mentally ill and dangerous; reportedly, the individual police officers learn to make such judgments through their experiences.

It is the policy of the New York City police department to become involved in these cases only if the person's behavior presents a threat of serious harm at the moment. The police generally will not take someone into custody based solely on the allegations of relatives or other persons. Police will respond to a call only if the likelihood of serious harm is imminent; and they will take into custody only those persons whose behavior in the officer's presence indicates a likelihood of serious harm.

The Patrol Guide states that police are to use physical force only to the extent necessary to restrain the person until sent to the hospital or to prevent serious physical injury to the person or others. Before taking the person into custody, the officer is directed to isolate and contain him or her and to call the patrol supervisor and the Emergency Service Unit to the scene. The officer also must establish police lines and request an ambulance.

The patrol supervisor, according to the Patrol Guide, upon arriving at the scene must caution the officers present to not use firearms unless there is a threat to life. The supervisor may cancel the request for Emergency Service, if it is not needed, and may request the help of other services or individuals, such as an interpreter, a hostage negotiating team, or a clergyman.

Police department guidelines state that persons should be transported to the hospital by ambulance, although a patrol car can be used if an ambulance is not available and if the removal can be made with responsible constraint. Also patrol cars should be used if needed to remove a person quickly to relieve a potentially explosive situation. As a practical matter, most transportation is now by patrol car, although until last year ambulances were generally used.

The Patrol Guide requires that the police officer accompany the person to the hospital; two officers are required if there are two or more potential patients. The officer may use handcuffs or other restraining equipment if the person resists or is violent or if the examining physician requests such restraints. When possible, females are to be accompanied by another female or by an immediate relative. At the hospital, the officer must accompany the person until he or she is examined and must inform the examining physician about the events leading to the custody-taking.

The police department is concerned about the amount of time that officers must wait at the hospital while the examination is completed. It is negotiating with at least one hospital to reduce this time by having officers write down the information, rather than being required to wait until the physician is available for an oral report.

After completing the admission, the officer must submit an "aided report" at the station house. This report is presented on a card used in all situations in which the police come to the aid of people; mental illness, one of several categories on the card, may be checked. The card contains information about the person aided, details of the incident and the actions taken by the officer, and the names and addresses of people to notify about the incident. The police department keeps these cards for 10 years. Among other things, the cards are used to notify the person's relatives, a service that the police department frequently performs, even though the hospital ordinarily is responsible for providing notice.

The New York statutes provide that the director of the hospital to which a person is admitted must, not later than five days following the admission, "cause written notice" of the admission to be given personally or by mail to the nearest relative of the person, other than the applicant, if known to the director, and to as many as three additional persons if so designated in writing by the respondent (9.39). Many people interviewed commented that staff of the hospitals in New York City do not always provide these notifications. Indeed, staff of the hospitals seemed generally unsure about who was responsible for providing

such notice. A common reason for not sending notifications was that the staff believed that the patients did not wish them sent.

Other Involuntary Commitment Procedures

Although most involuntary commitments in the First Judicial Department of New York are police initiated, several other procedures are available. Two emergency procedures may be initiated by a court or by the Director of Community Services for the Mentally Disabled. Two non-emergency procedures may follow examinations by physicians. None is used with any frequency.

In two situations, any court may order someone sent to a hospital authorized to take emergency commitments (9.43). The first situation occurs when 1) someone files a "verified statement" that the respondent is apparently mentally ill and is acting in a manner that either constitutes disorderly conduct or evidences dangerousness to self or others, and 2) the court holds a hearing on the matter and finds that the respondent "has or may have a mental illness which is likely to result in serious harm to himself or others" (9.43). The second occurs when the court finds that a defendant in a criminal proceeding is not guilty but "appears to have a mental illness which is likely to result in serious harm to himself or others" (9.43).

There are two statutory procedures for commitments based on referrals from the Director of Community Services for the Mentally Disabled. The first, an emergency procedure, provides that if one of several statutorily specified individuals (including a relative, a physician, or a police officer) reports that the person is mentally ill and dangerous to self or others, the Director, or his or her designee, may remove any person within his or her jurisdiction to a hospital authorized to take emergency commitments (9.45). The second, a non-emergency procedure, provides that the Director, or an examining physician designated by him or her, may refer to a hospital anyone who, upon examination, is found to be mentally ill and dangerous to self or others (9.37). A staff physician at the hospital must confirm the need for hospitalization, and the certificate of an additional physician is required to keep the respondent against his or her will for more than 72 hours. Thereafter, the regular involuntary admission procedures must be followed. It was estimated that the Director of Community Services refers no more than a dozen persons per year.

The final procedure for involuntary commitment, which we will call the standard non-emergency procedure, provides that any person allegedly mentally ill and in need of care and treatment may be involuntarily hospitalized upon the application by one of several statutorily designated individuals (including anyone residing with the respondent, a member of the respondent's immediate family, or the director of a hospital where the respondent resides), and accompanying written certification by two examining physicians (9.27). This procedure is commonly referred to as the two-physician certificate, or the "two P.C." The application must contain a statement of the facts supporting the allegations of mental illness and need for care and treatment

(9.27). The certifying physicians may not be related to respondent or the person applying for the admission, and they may not be directly connected with the hospital. The physicians' certificates must be based on examinations conducted within 10 days of the admission.

As a practical matter, the "two P.C." procedure rarely is used for initial involuntary admission. Rather, as discussed earlier, involuntary admissions are almost always initiated by the emergency admissions procedures. (Of course, many mentally ill persons come to New York hospitals accompanied by people other than the police, such as family members; the basis for their admission, however, generally is voluntary admission, rather than the two P.C. procedure.) The most frequent use of the two P.C. procedure in New York City is to extend the hospitalization of someone admitted pursuant to the emergency admissions procedures. Here, the "sponser" is the hospital director, and the certificate must be filed within 15 days of the initial commitment (9.39). This procedure is described in more detail below.

SCREENING AND INITIAL EXAMINATION

Several stages of screening must precede an individual's involuntary commitment. As discussed earlier, the first screening is performed by the police. The police initiate the vast majority of involuntary commitments. It was commonly stated by those interviewed that the police do an excellent job of diverting cases for which involuntary hospitalization is inappropriate. Following the initial police screening are several stages of screening at the emergency psychiatric units of the hospitals. In at least one city hospital, nurses review prospective patients (respondents) and may refuse acceptance in two circumstances. First, if the respondent has a serious medical problem, he or she is sent to a general hospital unit for treatment. The respondent may be returned to the psychiatric unit after clearing medically. Second, the nurses determine whether the respondent evidences sufficient symptoms of mental illness to merit attention by the psychiatric unit; if not, the respondent may be referred elsewhere.

The major review in the emergency unit is the physician's evaluation, required by statute in emergency proceedings (9.39). These are performed by psychiatrists (often residents) in the emergency room soon after the police bring in the respondent. The officer's account of the respondent's behavior is an important element of the examination. Reportedly, about 50 or 60 percent of the police referrals are accepted for emergency admission. In general, the hospitals are said to strictly apply the criterion for emergency admission. When a respondent is to be admitted for emergency care and treatment, some four to six hours is spent in the emergency unit before transfer to the inpatient unit.

If the emergency room does not admit a respondent, the staff may refer him or her to other sources of help, such as drug or vocational rehabilitation programs. Police officers frequently provide respondents with transportation if admission is refused. The officer may take the respondent to the police station and charge him or her with a crime, if

so warranted by the acts that initially led the officer to pursue involuntary hospitalization.

The emergency admissions statute states that the respondent may not be retained for more than forty-eight hours unless a second examination, by a staff physician at the hospital, confirms the finding of mental illness and dangerousness (9.39). It is not clear whether this examination must be performed within 48 hours of the initial detention by the police, the respondent's arrival at the hospital, or the formal admission by the examining physician.

Generally, the courts do not screen a person prior to admission (except in court-initiated commitments under the seldom used Section 9.43 of the Mental Hygiene Law). In many other jurisdictions, the usual practice is to require a court order before a person may be involuntarily hospitalized, with infrequent resort to emergency procedures permitting admission without judicial involvement.

NOTIFYING RESPONDENTS OF RIGHTS

The New York law requires that immediately upon the respondent's admission to a hospital or conversion to a different status (e.g., from voluntary to involuntary status), the hospital director must inform the respondent in writing of his or her status, of his or her rights under the law, and of the availability of the Mental Health Information Service (9.07). Further, hospitals must post notices of rights at conspicuous places visible to all patients.

In the First Judicial Department, respondents in commitment proceedings are verbally informed of their rights at several stages. The doctors in the emergency room try to talk to patients about their rights at the time of the initial examination, although this communication is not always successful. After admission, the Mental Health Information Service (MHIS) attorneys, and often MHIS social workers as well, meet with and explain legal rights to some patients. While the MHIS staff is able to advise all those who specifically request their services, they reportedly do not contact all patients involuntarily committed. The police ordinarily do not inform respondents of their legal rights during the custody-taking (unless, of course, a criminal charge is placed).

While it appears that patients ordinarily are provided with information about their legal rights, many people interviewed questioned whether this information always was provided in an effective manner. Some hospital personnel reportedly consider communications about rights to be a waste of time because respondents at the time of admission often are too ill, anxious, and confused to comprehend the information about rights. They suggest that overwhelming these people with confusing papers and "verbal gibberish" merely exacerbates an already strained situation. Others, concerned about the patient's right to meaningful notification, point out that, for whatever reasons, few respondents truly understand their legal rights or how to exercise these rights. They

suggest that more individual and thoughtful counseling with each patient should be provided.

OPPORTUNITY FOR INFORMAL OR VOLUNTARY ADMISSION

The law requires officials with responsibilities concerning the mentally ill "to encourage any person suitable therefore and in need of care and treatment for mental illness to apply for admission as a voluntary or informal patient" (9.21). The law also encourages conversion from involuntary to voluntary status. A section of the Mental Hygiene law states that "nothing in this article shall be construed to prohibit any director from converting, and it shall be his duty to convert, the admission of any involuntary patient suitable and willing to apply therefore to a voluntary status" (9.23).

Hospital personnel report that patients seldom are converted from involuntary to voluntary status. Hospital personnel believe that the MHIS attorneys would like to see more such conversions because the hospital has less control over voluntary patients. MHIS staff, on the other hand, suggest that the hospital personnel prefer the conversion of involuntary patients to voluntary status because voluntary patients require less paperwork, fewer hearings, and generally less administrative attention. In any event, it appears that hospital personnel are reluctant to convert patients to voluntary status unless they believe that the patients are sincerely motivated to accept treatment. It is generally acknowledged in New York that involuntary patients sometimes convert to voluntary status so they can sign themselves out. Voluntary patients may sign themselves out unless the facility director successfully seeks a court order of detention.

PREHEARING EXAMINATION

As discussed earlier, persons presented for involuntary hospitalization pursuant to the emergency admissions procedure are examined prior to admission, and again within 48 hours. The second examination is to confirm the first examiner's findings. The examiner conducting the second examination must be a member of the psychiatric staff of the hospital (9.39).

In order for a patient to be retained involuntarily beyond the 15-day emergency hospitalization period, the two-physician certificate (2 P.C.) procedure must be initiated. The two examinations required by this procedure may be conducted jointly, but each examining physician must execute a separate certificate (9.27). The examinations must have been completed within 10 days of the date of admission on the medical certificate. The examining physicians must consider alternative forms of care and treatment that might be adequate to provide for the person's needs without requiring involuntary hospitalization. If an examining physician knows that the respondent was treated for mental illness in the past, he must try to consult with those who provided such treatment. The examining physician may not be a relative of the respondent; may not be a

manager, trustee, visitor, proprietor, officer, director, or stockholder of the hospital in which the respondent is or is to be hospitalized; may not have any pecuniary interests in such hospital; and may not be on the staff of "a proprietary facility to which it is proposed to admit such person" (9.05).

In the New York public hospitals studied for this report, the examining physicians are the attending physicians in the patient's ward. According to the hospital staff, the two physicians only occasionally disagree concerning the diagnosis.

Several people interviewed complained that the information in the applications and certificates often is very general and contains unsubstantiated opinions. Further, some complain, these documents frequently do not meet the technical requirements of the law; for example, some are filed late, after the 15 days required by the emergency commitment statute. When such a case goes to hearing, the judge may dismiss it because of the technical deficiency. Typically, however, a judge merely overlooks such problems and considers the case on the merits.

Language problems with some foreign-born physicians are an important consideration in certification examinations. Many people in New York City complain that the poor language fluency of some physicians makes communication between physicians and patients difficult. It has been suggested that these physicians' incomplete understanding of English, particularly its idiomatic uses, can lead to important misunderstandings and misinterpretations of statements made by respondents. Some people in New York report that, in addition to possibly leading to inaccurate medical observations and diagnoses, the poor level of communication frequently causes respondents to become anxious and uncooperative.

The New York statutes provide respondents with the right to "seek independent medical opinion" (29.09). In New York City, the request for an independent examination is made to the judge, who has discretion to appoint a physician to examine the respondent. The examiner, who cannot be on the staff of the hospital where the patient is committed, is selected from a pool of examiners maintained by the court. In practice, independent examinations seldom are requested, reportedly because such an examination may delay the hearing for one to two weeks. The MHIS attorneys generally recommend independent examinations only when they consider that a reasonable likelihood exists that the resulting testimony would strengthen the patient's case. According to one MHIS attorney, independent psychiatric testimony would either weaken or be unhelpful to some cases. According to hospital staff, independent examinations do not often result in conclusions different from those of the hospital examiners. Because of the infrequency of independent examinations, reliable information concerning the proportion of instances in which disagreement would result may be unavailable. One attorney suggested that usually the central issue is not the diagnosis of the patient's condition, but rather the availability of suitable alternatives to hospitalization.

The statutes in New York do not address the question of whether respondents in involuntary hospitalization proceedings have a right to refuse to speak to the public hospital's examining physician. As a practical matter, physicians in New York reportedly do not recognize such a right and do not advise respondents concerning how the information generated by the examination might be used.

PREHEARING TREATMENT

The New York statutes do not indicate whether and to what extent involuntary patients may be treated prior to hearing. Because hearings are not mandatory in New York, it probably is fair to presume that patients need be treated no differently whether a hearing is pending or not. In practice, most respondents are treated (usually with medication) shortly after they are admitted to a hospital, and this treatment typically is continued for the duration of the commitment period, regardless of whether a hearing is requested. (Questions relating to the patient's right to refuse treatment and the requirement that the hospital secure the patient's consent for extraordinary treatment are discussed in Chapter VII, "Posthearing Concerns".)

Controversy exists over whether patients should be permitted to be under the influence of medication during hearings. A patient who is medicated effectively may make a better appearance in court because he or she has greater self-control and displays fewer symptoms of psychosis, factors that frequently influence judges to order commitment. On the other hand, medication (primarily a problem of overmedication) may cloud the patient's thinking and diminish his or her ability to testify effectively. Additionally, some medications have undesirable side effects that create the appearance of mental illness regardless of the patient's true condition.

PREHEARING DISMISSAL AND DISCHARGE

As discussed earlier, the New York statutes provide that no one presented for involuntary hospitalization under the emergency admissions procedure may be admitted unless a hospital physician examines the person and determines that he or she meets the criterion for commitment. No one admitted by this procedure may be retained for longer than 48 hours unless the admitting physician's finding is confirmed after examination by another physician who must be a member of the psychiatric staff of the hospital (9.39). These statutory requirements reportedly are met in the hospitals serving New York City's First Judicial Department. It is estimated that almost half of all persons presented for emergency involuntary admission at Bellevue Hospital are screened out and discharged under this examining procedure. Reportedly, the majority of involuntary patients are discharged within 15 days of admission, regardless of whether a hearing is held. Many people in New York believe that the hospitals are quicker to release patients if they request hearings.

Some observers suggest that patients who are discharged prior to a requested judicial hearing might want their "day in court." Yet, in New York (as in other cities across the country), it is reported that almost all respondents, if discharged from the hospital, want their cases summarily dismissed and show no inclination to go to court in order to clear their names, set the records straight, or make philosophical or legal points.

CONCLUSIONS AND RECOMMENDATIONS

Initiating Mental Health Commitment

Although apparently not the subject of great concern in the First Judicial Department, a weakness in the commitment system may be the absence of an effective and accessible procedure for the hospitalization of someone who actually meets the commitment criterion, but refuses to be examined by a physician and does not manifest a threat of harm serious enough to warrant police custody. In many states, procedures permit relatives or other persons close to an allegedly mentally ill person to apply to a court for involuntary hospitalization of the person. Without the availability of such procedures, many believe, it may be unreasonably difficult to effect the hospitalization of someone who may be seriously in need of care and treatment but who has never committed a violent or self-destructive act in the presence of a police officer. Theoretically, a relative or other person may petition a New York court or the Director of Social Services to initiate emergency commitment procedures (9.43, 9.45), but in practice these procedures almost never are used. Moreover, it is clear that neither the courts nor the police department wishes to encourage the use of these procedures.

The procedures followed by the police in initiating emergency admissions are to be commended. The practice of requiring the police officer to wait at the hospital while the respondent is being examined, however, may be an inefficient use of the police officer's time. It was reported that negotiations are underway to have hospital security personnel in at least some of the city facilities assume responsibility for security of the respondent when he or she is presented for emergency admission. Reportedly, the Health and Hospitals Corporation is attempting to implement a procedure which would entail the police officer turning over custody of a detained individual to a Health and Hospitals Corporation special officer (security guard). Because it may be important for the examining physician to have the opportunity to speak with the officer, some people in New York believe that the officer should be required to remain with the respondent until the examining physician is prepared to begin the evaluation. However, if a standard set of questions could be developed to which police officers could present answers in writing upon delivery of the respondent, this concern may become less pressing.

RECOMMENDATION: A PROCEDURE SHOULD BE DEVELOPED TO PERMIT
POLICE OFFICERS TRANSPORTING RESPONDENTS TO HOSPITALS
PURSUANT TO THE EMERGENCY ADMISSIONS PROCEDURE TO LEAVE

RESPONDENTS IN THE CUSTODY OF THE HOSPITAL WHETHER OR NOT AN EXAMINATION HAS BEGUN. HOSPITAL STAFF SHOULD DEVELOP A STANDARD SET OF QUESTIONS DESIGNED TO ELICIT FROM POLICE OFFICERS INFORMATION ABOUT THE RESPONDENT'S BEHAVIOR DURING THE CUSTODY-TAKING THAT MIGHT BE HELPFUL TO THE PHYSICIAN IN CONDUCTING THE EVALUATION. THESE QUESTIONS SHOULD BE MADE AVAILABLE TO POLICE OFFICERS IN ADVANCE SO THAT RESPONSES MAY BE PRESENTED IN WRITING TO EMERGENCY ROOM STAFF UPON PRESENTATION OF THE RESPONDENT.

There was some concern among those interviewed that the hospital staff made insufficient effort to contact relatives or others designated by a patient to be notified about the patient's commitment. The police notification procedure somewhat mitigates this problem; still, the hospitals have the statutory responsibility for notification (9.39).

RECOMMENDATION: STAFF OF THE HOSPITAL'S ADMISSIONS DEPARTMENT, IN COOPERATION WITH THE HOSPITAL'S PSYCHIATRIC EMERGENCY ROOM STAFF, SHOULD BE RESPONSIBLE FOR OBTAINING FROM RESPONDENTS THE NAMES OF PERSONS TO BE NOTIFIED, IF ANY, AND SHOULD PROVIDE SUCH NOTIFICATIONS AS ARE REQUIRED BY STATUTE.

Screening Mechanisms

The screening provided by officers of the police department is highly regarded by most people interviewed on the topic. Although some people complain that the police do not respond to any but the most serious incidents involving allegedly mentally disordered persons, given the limited resources of the city's police department and the great demand for its services, little more can be expected. Further, the city hospitals admit only about 50 percent of those people brought in by the police. This suggests that relaxing the criteria for police transport would not result in many more emergency admissions.

The statutory requirement that persons presented for emergency hospitalization not be admitted until examined by a staff physician of the hospital is an exemplary screening provision. The requirement that this examiner's opinion be confirmed after examination by another physician on the hospital's psychiatric staff within 48 hours of the respondent's admission also is a strong feature. Because of these mental health screenings, many people avoid the intrusion of prolonged hospitalization and society saves the cost of treating persons able to care for themselves.

Notification of Rights

Although the New York statutes provide numerous legal rights and protections, many people interviewed were concerned that written statements of rights are too complex for some respondents to understand. Reportedly, hospital staff rarely take the time that is required for effective communication of these rights. Further, MHIS staff reportedly do not meet personally with every respondent and explain clearly the

respondent's legal rights and protections. Although it may require increased staff, the MHIS should meet with every respondent. Some of those interviewed contend that time spent explaining rights to respondents is usually time wasted because most respondents are unable to understand their rights, regardless of how these rights are explained to them. However, it is important that every effort be made to communicate rights effectively, especially since hearings are not mandatory in New York involuntary commitment proceedings.

RECOMMENDATION: PHYSICIANS CONDUCTING INITIAL EXAMINATIONS OF RESPONDENTS UPON PRESENTATION FOR ADMISSION SHOULD CAREFULLY EXPLAIN TO RESPONDENTS THEIR STATUS IN THE HOSPITAL AND THEIR RIGHTS AS PATIENTS. MHIS STAFF SHOULD MEET PERSONALLY WITH EVERY RESPONDENT SOON AFTER EMERGENCY ADMISSION TO EXPLAIN CLEARLY HIS OR HER LEGAL RIGHTS AND PROTECTIONS.

Opportunity for Informal or Voluntary Admission

Apparently, neither the staff of the hospitals in New York nor the MHIS staff encourage involuntary patients to convert to informal or voluntary status. Many people feel this is appropriate, noting that such encouragement easily takes the form of coercion. The New York statutes, however, require all state and local officers having duties to perform relating to the mentally ill to encourage informal and voluntary admissions. Furthermore, treatment as an informal or voluntary patient frequently is in the respondent's best interests (from a legal standpoint as well as from a treatment standpoint). In keeping with the principle of the least restrictive alternative, discussed in Chapter VI, the following recommendation encourages the use of informal and voluntary status.

RECOMMENDATION: HOSPITAL STAFF AND MHIS ATTORNEYS SHOULD PLACE MORE EMPHASIS ON EXPLORING THE SUITABILITY OF INFORMAL OR VOLUNTARY STATUS AND SHOULD EXPLAIN FULLY TO RESPONDENTS THEIR OPTION OF ACCEPTING INFORMAL OR VOLUNTARY STATUS UPON ADMISSION AND THE PRACTICAL AND LEGAL CONSEQUENCES OF ACCEPTING INFORMAL OR VOLUNTARY STATUS.

The statutory right provided to respondents to challenge in court their conversion to voluntary is a strong feature of the commitment law in New York. People in other cities suggest that too frequently involuntary patients sign voluntary admission papers without realizing the consequences of a voluntary admission. Allowing a patient to contest his or her conversion to voluntary status enables the patient who makes an uninformed conversion to correct his or her mistake.

Prehearing Examinations

In several states, respondents in involuntary civil commitment proceedings are accorded a right to remain silent during a mental health evaluation. Several federal courts have held that the privilege against

self-incrimination applies to commitment proceedings. Because this is a controversial issue on which there is no clear consensus of opinion in New York, we will refrain from recommending that the privilege against self-incrimination be made applicable in New York City.

Regardless of whether the privilege should attach, however, many people in New York City believe that examining physicians should inform respondents about how information generated by the examination will be used. Former involuntary patients interviewed in New York and in other cities speak of a sense of bewilderment and confusion during the initial stages of a commitment process. They say that the "silent treatment" often given respondents by staff of the detaining facility fosters resentment and may hinder cooperation with the staff. Furthermore, it has been suggested that if examining physicians do inform involuntary patients concerning how information from the initial interview may be used, that patient communication will be discouraged and treatment thereby impeded. During the project, however, many examiners who do give frank disclosure and explanation have informed Institute staff that respondents are pleased that an examiner had leveled with them. The result is an enhanced atmosphere of trust and cooperation. Ironically, the effects of an open, honest explanation are not the negative ones which might be expected.

A similar issue is whether the respondent's communications to the examiner fall under the doctor-patient privilege. Most scholars agree that little or no such privilege attaches during a court-ordered evaluation. However, if the examining physician is also the treating physician (e.g., when examinations are conducted during hospitalization), the matter is not so clear. A few state laws provide that the physician who evaluates the respondent for the purposes of a commitment proceeding cannot be the respondent's treating physician. In Columbus, Ohio, for instance, each respondent is examined by a "court doctor" and by an "independent doctor". The independent doctor is bound by the doctor-patient privilege; the court doctor is not. One New York attorney suggested that because most hearings are patient-initiated and the patient is placing his or her medical or psychiatric condition in issue, the doctor-patient privileged has been waived. In any event, several scholars have suggested that, so long as the patient is informed that the results of an examination might be used by a court in a commitment proceeding, it is acceptable for a treating physician to reveal his or her findings; absent a notification of purpose, however, the treating physician is in violation of ethical standards if he or she reveals examination findings.

RECOMMENDATION: EXAMINING PHYSICIANS SHOULD EXPLAIN TO RESPONDENTS THE NATURE AND PURPOSE OF THE EXAMINATION AND HOW THE INFORMATION GENERATED BY THE EXAMINATION MIGHT BE USED BY STAFF OF THE HOSPITAL AND BY THE COURTS.

One reviewer of the above recommendation stated that requiring examining physicians to explain the nature, purpose, and consequences of the examination improperly casts physicians in the role of patient counsel. The reviewer suggested that this function would be more

properly, and probably more effectively, handled by the MHIS. It is important to note that the reviewer did not take exception to the recommended explanation, but rather to who is required to give the explanation. If the MHIS can give each respondent an accurate and clear explanation of the nature, purpose, and consequences of the examination, that would be sufficient. The important point is that each respondent receive such an explanation. The recommendation specifies the examining physician in recognition that the logistics of the initial interview may place the physician in a better position to provide an adequate explanation.

The emphasis in the New York statutes on multiple examinations (e.g., admissions examinations, psychiatric confirmation examinations, and two P.C.'s) is a strength of the New York commitment system. The right to seek independent medical opinion also is a strong feature. The professional literature suggests that multiple and independent examinations are important for two reasons: they provide additional opinion in an area in which unreliable assessment is not uncommon, and they provide some incentive for the state's examiners to be thorough. Furthermore, given that commitment decisions often turn upon the medical testimony, the respondent has little to draw on in developing a defense without the opportunity to generate independent medical evidence.

The complaints voiced in New York (as well as in other large cities throughout the country) that many foreign-born examining physicians speak English poorly is cause for concern. Although foreign-born physicians may be sufficiently trained in medicine, it is vitally important to the success of the commitment process that they be capable of communicating fluently in English as well. Respondents must be able to understand questions posed by examining physicians if they are to provide valid information in response. Physicians must have a sufficient understanding of the English language if they are to interpret patient's responses accurately. Finally, medical evidence must be communicated in a manner that makes the information meaningful to attorneys and judges.

RECOMMENDATION: EXAMINING PHYSICIANS SHOULD BE REQUIRED TO HAVE SIGNIFICANT FLUENCY IN ORAL AND WRITTEN ENGLISH.

One reviewer of this recommendation suggested that requiring examining physicians to have significant fluency in English only partially solves the communication problem mentioned above. He observed that in New York City many respondents either do not speak English or do not speak English fluently. To have a meaningful interview, such respondents need an interpreter or a physician who speaks their native language. The reviewer suggested that the above recommendation be amended to require the use of stand-by interpreters and the hiring of bilingual physicians. We agree that requiring physicians to have significant fluency in English does not facilitate interviews with respondents who do not speak English. The recommendation, however, is designed to address a more prevalent problem which Institute staff observed in New York: that many foreign-born examining physicians do not speak English fluently. The use of stand-by interpreters and the hiring

of bilingual physicians may be effective ways of facilitating interviews with nonEnglish-speaking respondents. Requiring these remedial measures, however, might cause fiscal and administrative burdens which outweigh the benefit of the measures. Resource burdens might be minimized if, for example, the MHIS maintained a list of volunteer interpreters who might be available to assist with nonEnglish-speaking respondents. The need for such services, however, would probably be infrequent. It is the ultimate responsibility of the examining physician and treatment facility to ensure an effective interview. If an interpreter is necessary, the physician or facility should secure one.

Prehearing Treatment

As discussed earlier, the question of whether patients should be under the influence of medication during commitment hearings is a controversial one. The respondent's appearance and behavior in court as well as his or her ability to assist counsel are important factors affecting the outcome of the commitment hearing. In order to assist the judge in arriving at an appropriate disposition, the following recommendation is offered:

RECOMMENDATION: IF ANY MEDICATION IS ADMINISTERED TO THE RESPONDENT DURING THE PREHEARING PERIOD AND THE RESPONDENT'S TREATING PHYSICIAN HAS ANY REASON TO BELIEVE THAT THE RESPONDENT'S BEHAVIOR IN COURT WILL BE AFFECTED BY SUCH MEDICATION, THE PHYSICIAN SHOULD INDICATE TO THE COURT, THE RESPONDENT'S ATTORNEY, AND THE ATTORNEY REPRESENTING THE HOSPITAL OR THE STATE WHAT MEDICATIONS WERE ADMINISTERED AND WHAT CONSEQUENCES THESE MEDICATIONS ARE LIKELY TO HAVE ON RESPONDENT'S BEHAVIOR DURING THE HEARING AND ON RESPONDENT'S ABILITY TO ASSIST COUNSEL.

A reviewer of the above recommendation suggested that it be modified to prohibit the prehearing administration of medication absent "dangerous conduct" by the respondent. We reemphasize that New York statute fails to address whether and to what extent involuntary patients may be treated prior to hearing. The intent of the recommendation is not to fill in this statutory gap. The recommendation addresses a more limited issue: if the respondent is under the influence of medication, what should be done to ensure that the effects on the respondent do not affect the outcome of the commitment hearing? The broader issue addressed by the reviewer is a controversial one. It involves a balancing of the respondent's liberty interest (in being free from unwanted medication) and the state's interest as parens patriae (in protecting the mental health of its citizens). In general, Institute staff have found that formulations such as "dangerous conduct" are not adequate in protecting either pole of this balance. Such standards are elastic and provide little direction. A more effective way of achieving this balance may be not to define the conduct or condition of the respondent, but rather to define the types of medication which may be administered pending hearing. Although we make no attempt here to precisely define such types of medication, a precise definition should limit these types to relatively mild medications administered only to the extent necessary to

stabilize the respondent's condition. As mentioned earlier in this chapter, however, because hearings are not mandatory in New York, no requirement seems to exist that patients be treated differently whether a hearing is pending or not. We, thus, make no specific recommendation in this area.

Prehearing Dismissal and Discharge

The statutory provisions and hospital procedures concerning the discharge of patients who are determined upon examination to not meet the criteria for commitment are exemplary. Although it appears that, upon discharge, patients lose the opportunity to challenge the validity of the commitment in court, this does not seem to be an issue of significant concern to those interviewed in New York.

CHAPTER IV

COUNSEL FOR THE RESPONDENT

This chapter considers the function of the involuntary patient's attorney. Legal issues for which respondents may be entitled to the assistance of counsel arise during many phases of the commitment process. Prior to the hearing, an attorney sometimes is called on to explain legal rights and options to patients. During the hearing, counsel is primarily responsible for presenting the respondent's case. During a period of hospitalization, attorneys may become involved in protecting patient's rights and exploring avenues for discharge. An attorney's help may be needed again if a patient is held for the full period of commitment and the hospital wishes to retain the patient for further treatment.

THE MENTAL HEALTH INFORMATION SERVICE

An important feature of the New York civil commitment laws is the Mental Health Information Service (MHIS). The MHIS, which is under the judicial branch of government, is directed to perform several functions (29.09):

- study the admission and retention of all patients.
- inform patients of their rights,
- in any court case, provide the court with all relevant information about the patient,
- provide services and assistance to patients and their families,
- investigate cases of alleged patient mistreatment and take legal action to protect patients from mistreatment.

Also, although not specified in the statute, MHIS attorneys generally represent patients in commitment hearings.

The MHIS, thus, has a comprehensive function in aiding patients who have been involuntarily committed to hospitals in New York. This function includes providing legal advice prior to any hearing, handling negotiations with hospital staff about the length of a patient's commitment and about treatment in the hospital, and representing patients in commitment hearings. Also, MHIS attorneys represent patients in controversies concerning medication requirements and they review all transfers of patients from one hospital to another.

In addition to supplying counsel for involuntary patients, MHIS employs social workers who investigate alternative treatment programs for some patients. The social workers work with MHIS attorneys to bring about the release of patients for whom alternative treatment programs are appropriate and available.

Whenever a hearing is requested and whenever the hospital recommends a six-month retention, the MHIS prepares a memorandum for the court. This memorandum contains a brief history of the patient, reasons why the doctors think the patient should stay in the hospital, and arguments that might be advanced in support of the patient's release. The hospital's clinical summary is attached to the memorandum. The purpose of the memorandum is to advise the court about the case. It is, therefore, expected to include all relevant information. The MHIS attorneys claim to adhere to this purpose. They also claim that as advocates for their clients' interests, they must prepare the memorandum in the manner most favorable to their clients, but without leaving out any relevant facts relied upon by the hospital.

The New York statutes provide that upon admission (or conversion to a different status) every patient must be informed of the availability of MHIS. "At any time thereafter, upon request of the patient or of anyone on the patient's behalf, the patient shall be permitted to communicate with a Mental Health Information Service and avail himself of the facilities thereof" (9.07). The statutes further require that every involuntary patient's record must be sent to the MHIS within five days of admission (9.11). By way of these notifications, the MHIS becomes responsible for the legal representation of involuntary patients.

One of the responsibilities of MHIS is to inform patients about procedures for admission and retention, and about the patients' rights to have judicial hearing and review, to be represented by legal counsel and to seek independent medical opinion (29.09). Reportedly, MHIS staff make an effort to speak with every involuntary patient; however, because of limited resources, not every patient receives a personal visit. It is generally agreed, however, that any patient requesting assistance from MHIS is visited promptly.

APPOINTMENT OF COUNSEL

Indigency is not a prerequisite for MHIS representation. Rather, MHIS attorneys represent all patients, irrespective of their ability to pay for legal assistance. If a patient so desires, however, he or she may retain private counsel. According to one MHIS attorney, the MHIS has had a uniform policy since 1965 of carefully refraining from competing with the private bar. Although MHIS attorneys generally have greater knowledge of mental health law than do private attorneys, if a patient has the desire and the resources to retain a private lawyer, the MHIS will assist the patient in contacting a lawyer of his or her choice or a bar association referral committee. Furthermore, the MHIS will remain available to the private lawyer if their services are desired. Even when

a private attorney is retained, the court sometimes requests that the MHIS attorney continue with the case in an advisory role.

ROLE OF COUNSEL

Because the MHIS is charged with various responsibilities, several issues arise concerning the role of MHIS attorneys and possible conflicts of interest. Some observers contend that the dual responsibility of MHIS to represent patients and to provide the court with all relevant information regarding the patient's case creates a conflict of interest. As a practical matter, however, most people agree that MHIS attorneys are able to provide the court with the information it needs without compromising the patient's right to a fair hearing. One MHIS staff member suggested that the responsibility to provide information to the court in fact may be viewed as an opportunity to present information about the case in the light most favorable to the patient's expressed desires.

For the most part, MHIS attorneys reportedly act as advocates for their clients' expressed desires. Although some people (primarily mental health professionals) believe that attorneys should assume the role of guardian ad litem, acting in what they perceive to be the best interests of patients, most agree that attorneys are ethically bound to advise clients regarding available options and then zealously pursue the course of action desired by the client.

The attorneys generally do not view their role as being solely to bring about their clients' release or to follow their clients' every suggestion. They also advise clients concerning what they consider to be in the clients' best interests. One attorney, for example, said that if he thought a patient was "really sick," he would try to persuade the patient to remain in the hospital; but if the patient insisted, the attorney would take the case to court. Nevertheless, some people in New York are concerned that because most MHIS attorneys are relatively young and inexperienced, they may not be sufficiently sensitive to the subtle consequences of different legal approaches and may supply inadequate advice about how best to proceed. Occasionally, the adversary stance of the MHIS lawyers leads to friction between them and the psychiatric staff at the hospitals. This is commonly considered to be a natural result of the functions of the two professions, although exacerbated in some cases by the personalities of particular lawyers and psychiatrists. Some critics charge that MHIS attorneys fight for the release of their patients, regardless of the medical, legal, and social consequences of a court-ordered hospitalization (e.g., rather than encourage voluntary admission, an MHIS attorney might fight for release and lose, only to cause the client an increased legal and social disability upon discharge). In general, however, most people interviewed were very pleased with the service provided by MHIS.

CONCLUSIONS AND RECOMMENDATIONS

Appointment of Counsel

The manner in which legal representation is provided for patients in New York is exemplary. There are a number of different systems in different states for providing counsel in commitment proceedings, including the use of a public defender, the assignment of private attorneys available locally, and the use of special advocates responsible exclusively or primarily for commitment cases. The experience of the authors, and of others who have researched this topic, suggests that attorneys whose sole responsibility is to provide legal services for mental patients provide much better representation than attorneys appointed to such cases on an occasional basis. Another especially beneficial feature of MHIS representation is that patients typically receive representation well before the court hearing (and, of course, even if there is no court hearing), permitting sufficient time to advise patients about possible courses of legal action and providing the lawyers with an opportunity to learn about their clients and, thus, to prepare well in advance of a court hearing.

MHIS attorneys appear remarkably knowledgeable about mental health law and practice and, most agree, provide excellent service to their clients and to the court. On the other hand, some of those interviewed feared that, because of the large number of admissions and the relatively small size of the MHIS staff, not every patient receives sufficient attention from MHIS. Given the confused mental condition of many patients at the time of admission, it is understandable that some patients do not have the wherewithall to request the assistance of an MHIS attorney. Because it is important that every patient truly be provided with the opportunity to employ the services of the MHIS, it is imperative that every patient be visited by an MHIS representative soon after admission.

RECOMMENDATION: EVERY PATIENT SHOULD BE VISITED SOON AFTER ADMISSION BY A MEMBER OF THE MHIS STAFF. THE MHIS STAFF MEMBER SHOULD INFORM THE PATIENT ABOUT PROCEDURES FOR ADMISSION AND RETENTION AND ABOUT THE PATIENT'S RIGHTS TO CHALLENGE COMMITMENT IN COURT, TO BE REPRESENTED BY COUNSEL, AND TO SEEK INDEPENDENT MEDICAL OPINION. THE MHIS STAFF MEMBER SHOULD TAKE CARE TO ENSURE THAT FAILURE OF PATIENTS TO AVAIL THEMSELVES OF THESE RIGHTS IS DONE KNOWINGLY. THE SIZE OF THE MHIS STAFF SHOULD BE INCREASED SUFFICIENTLY TO ACCOMPLISH ITS STATUTORY GOALS.

The automatic provision of legal counsel in every case regardless of the patient's financial ability to employ private counsel, although seemingly wasteful, is to be commended. The financially able patient who fails to contact an attorney should not be presumed to have made a competent decision not to pursue his or her legal rights. The automatic provision of counsel protects those patients who are mentally incapable of deciding whether to employ an attorney.

Some people interviewed in New York believe that if legal services are provided to a patient who subsequently is shown to be financially capable of retaining private counsel the patient should be billed for the services rendered. However, most agree that the cost of recovering these monies usually would be greater than the amount recovered.

The Role of Counsel

The role assumed by most MHIS attorneys (to counsel patients and represent their expressed wishes) is to be commended. Although in many areas of the country, attorneys in involuntary hospitalization proceedings assume the role of guardian ad litem, in most large cities, in the statutes and case law of many other states, and throughout the professional literature, it is clear that counsel are being directed to assume a strong advocacy role. The diagnosis of mental illness is widely regarded as an imprecise endeavor. Further, recent studies have shown quite convincingly that psychiatric predictions of future dangerous behavior are terribly unreliable--that predictions of dangerousness much more frequently are wrong than they are right. Given the difficulties psychiatrists have in assessing patients' suitability for commitment, it is unrealistic to suggest that patients' attorneys can know what is in their clients' best interests.

The statutorily prescribed responsibilities of MHIS are generally good. It is not clear, however, if MHIS attorneys are required to represent the patient's interests at hearings. Because as a practical matter such representation is provided, however, failure of the statute to specify this probably is unimportant.

The statutory requirement that MHIS provide the court with all relevant information about the patient's case presently is implemented in New York City in such a way as to avoid conflict of interest problems. However, because of the potential for conflict presented by this statutory language, thought should be given to amending the statutes to permit MHIS attorneys to withhold from the court information that the attorneys believe is privileged or is adverse to the case for the defense.

RECOMMENDATION: THE NEW YORK STATUTES (29.09) SHOULD BE AMENDED TO PERMIT MHIS ATTORNEYS TO WITHHOLD FROM THE COURT INFORMATION THAT IS PRIVILEGED OR IS ADVERSE TO THE CASE FOR THE DEFENSE.

The function of the MHIS social workers to investigate alternative treatment programs is particularly praiseworthy. The doctrine of the least restrictive alternative, which has been heartily endorsed by courts and legislatures throughout the country, is applied in practice in very few jurisdictions. One reason is that no one involved in the commitment process assumes the responsibility for investigating the availability of alternative treatment programs. Reportedly, because of the efforts of the MHIS social workers, some patients are diverted from involuntary hospitalization into treatment programs in less restrictive settings.

CHAPTER V

THE HEARING: DETERMINING COMMITTABILITY

This chapter discusses the aspects of judicial hearings that pertain to the determination of a patient's need for involuntary care and treatment. The chapter will consider the characteristics of hearings, the various people involved in hearings, and the criteria that must be met for involuntary hospitalization. The following chapter also considers hearing procedures but concentrates on the aspects of hearings that pertain to the determination of treatment questions. This distinction, between determining whether or not treatment is needed and determining the nature of treatment, is made primarily for the analytical purposes of this study. Within the judicial hearing, consideration frequently is given to both matters simultaneously. The two are separated here only for clarity of thought and should not lead the reader to believe that these issues are necessarily bifurcated in their consideration at hearing.

WHEN HEARINGS ARE HELD

The New York statutes do not provide for the automatic conduct of judicial hearings in involuntary hospitalization cases. Rather, hearings are held only upon request. Hearings may be requested by the patient, any relative or friend, or the Mental Health Information Service (9.31, 9.39). Hearings to challenge emergency admission may be requested anytime after admission; hearings to challenge admission on a "two P.C." may be requested anytime within sixty days of admission. Habeas corpus petitions may be filed at any time.

As a practical matter in the First Judicial Department, few involuntary hospitalizations entail a hearing. This is either because no hearing is requested or because the case is settled (i.e., the patient either is discharged or converts to voluntary status) before a hearing takes place. (Six month retention orders are always signed by a judge. When the hearing is waived, however, the signing is a mere formality.) When held, the hearings are usually requested by the patient; relatives and MHIS attorneys rarely request hearings without specific demands by the client. According to the MHIS attorneys, the hearings that are held typically are requested by first-time patients. MHIS attorneys are in disagreement concerning the frequency with which repeat patients request a hearing. Some say repeat patients rarely press for a hearing. One MHIS attorney stated that at Manhattan Psychiatric Center, repeat patients frequently request hearings.

The attorneys give several reasons why so few commitment cases go to hearing. First, many patients prefer to avoid discussion of their case in court. (Some, apparently, do not wish the facts of their cases aired, even though the hearings are confidential and the record closed.) Second, the MHIS attorney may persuade the patient that hospitalization

is the best course. Third, many cases are settled before the hearing stage is reached. Settlements frequently involve the placement of the patient in a less restrictive treatment program. The MHIS social workers play a key role in locating alternatives to hospitalization, and, thus, in effecting release. Reportedly, settlements often are accomplished under the threat of a hearing. That is, the MHIS attorney may advise the hospital staff that the patient will demand a hearing unless a less restrictive alternative to hospitalization is offered. Alternatively, the attorney might actually file for a hearing in order to prompt settlement. These tactics reportedly are effective, from the respondent's viewpoint, because many physicians dislike appearing in court, particularly if the hearing must be held in another hospital.

Unlike in most other jurisdictions, no court hearing ordinarily is held before or immediately following emergency commitment. Although some disagreed, persons interviewed generally suggested that this was justified on the grounds that the police and the hospital staff strictly apply the standards for commitment. Also, by holding hearings later, it was contended, lawyers would have more of an opportunity to prepare the case and hospital staff would learn more about their patients. Thus, the police and hospital staff would provide improved information to the court and the adversary process would function more effectively. Finally, the longer prehearing period provides time for the negotiation of settlements. This obliterates the need for hearings in many cases.

CHARACTERISTICS OF THE HEARINGS

The request for hearing must be given in writing to the hospital director, who must forward "forthwith" to the court a copy of the request, together with a copy of the patient's record. A copy of the request and the record must also be provided to the Mental Health Information Service. The court must schedule a hearing within five days from the date that it receives the request for a hearing (9.31, 9.39). As a practical matter, because hearings are held in each facility only every seven days and because continuances are common, this five-day limit is regularly exceeded.

Commitment hearings are held every Tuesday morning at Bellevue Hospital and every Thursday morning at Manhattan Psychiatric Center. Because Bellevue is primarily an acute care (short-term) facility, hearings there usually are to determine whether an initial admission was appropriate. Hearings at Manhattan Psychiatric Center, a long-term care hospital, usually are to determine whether hospitalization should be ordered for an additional treatment period.

Hearings ordinarily are not held in the other hospitals in Manhattan. Patients in these hospitals generally must be transported to Bellevue or Manhattan Psychiatric Center. Testifying physicians, hospital security guards, and MHIS staff also must make the trip. On rare occasions, however, the court will hear cases in these other hospitals, when warranted by special circumstances (such as unusual problems in transporting the patient). Reportedly, unlike in Manhattan,

hearings in the Bronx are held at each hospital as cases arise. The court personnel, rather than the hospital staff, do the necessary traveling.

Hospital staff in Manhattan generally dislike traveling to different hospitals for hearings. According to several physicians and attorneys working in hospitals where hearings ordinarily are not held, patients who request hearings and are only marginally committable often are released so that the inconvenience of a hearing might be avoided. As a result, the proportion of patients going to hearings from Bellevue and Manhattan Psychiatric Center reportedly is higher than the proportion from other hospitals.

Commitment hearings are conducted by justices of the New York Supreme Court on a rotating basis. The hearings typically are closed to the public, and it is only by the expressed permission of the court (or the court administrator) that nonparticipants are admitted. A court stenographer makes a permanent, confidential record of proceedings. With few exceptions, patients are present at their hearings. At both Bellevue and Manhattan Psychiatric Center, hearings are conducted in a special room set aside for that purpose.

Hearings observed by these researchers at Bellevue Hospital were generally informal and disorderly. A sizeable group typically is present, including five or six attorneys, four or five psychiatrists, several police and security officers, and several court personnel. The clamor created by the group is exacerbated by poor acoustics in the Bellevue courtroom. In several cases, the court was not provided with the proper certificates and other papers. In an effort to locate these papers, many of the hearing participants addressed the court simultaneously; a mood of confusion prevailed. Also, because necessary papers or witnesses could not be located, cases frequently were called and then adjourned until later in the day (or sometimes for another week). Hearings proceeded in a more orderly fashion at Manhattan Psychiatric Center, although much of what transpired there appeared to confuse patients and other participants as well.

On a typical hearing day, about 20 cases are on the court calendar, but only about four are heard. Some are dismissed because the patient and the hospital have reached an agreement. Many others, however, are continued and must be argued later.

The New York statutes indicate that hearings may be adjourned (9.31, 9.39) but do not specify limits on the length of adjournment. Hearings concerning emergency admissions may be adjourned only upon request of the patient; hearings concerning "two P.C." admissions apparently may be requested by either the patient or the hospital. Requests for adjournment are common in New York City. MHIS attorneys frequently request adjournments in order to settle cases by arranging placement in community treatment programs. Hospital attorneys request adjournments less frequently but on occasion request adjournments because the required paperwork is incomplete or because medical witnesses are unavailable. According to participating lawyers, judges almost always

grant adjournments requested by patients' attorneys but approve hospital requests only upon a showing of good cause. It also was reported that judges sometimes adjourn cases simply because they are not able to remain at the hospital long enough to hear all the cases on the docket.

CRITERIA FOR COMMITMENT

The New York statutes provide that the criterion for emergency admission is mental illness for which immediate inpatient care and treatment in a hospital is appropriate and which is likely to result in serious harm to self or others (9.39). "Likelihood of serious harm" is defined as "1. 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 2. 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 or serious physical harm" (9.39). "In need of care and treatment" means that a person has a mental illness for which inpatient care and treatment in a hospital are appropriate (9.01).

The criteria for involuntary admission on a "two P.C." are that the respondent is mentally ill and in need of involuntary care and treatment (9.27). "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 the person's welfare and whose judgment is so impaired that he or she is unable to understand the need for such care and treatment (9.01). Although dangerousness is not specified as a requirement for involuntary commitment on a "two P.C.", the appellate division of the Supreme Court has ruled that

... substantive due process requires that 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 criteria would authorize the continued confinement of an individual whose mental illness manifests itself in neglect or refusal to care for himself, where such neglect or refusal presents a threat of substantial harm to his own well-being.

Scopes v. Shah, 398 N.Y.S. 2d 911, 913 (1977) (emphasis added). The burden of proof is on the hospital (or the state). The standard of proof in emergency admissions hearings is "reasonable cause to believe" that the criteria are satisfied (9.39). The standard of proof in medical certification hearings is clear and convincing evidence. Scopes v. Shah.

Those interviewed generally believe that the Supreme Court justices in New York City reliably apply the above criteria when making commitment decisions. When questioned about the criteria, however, some judges were unsure which applied in which proceedings. One MHIS attorney said that although a judge may be unsure which criteria apply in an abstract discussion, when the judge is hearing an actual case the judge

has before him or her the MHIS trial memorandum which sets forth the precise standard and the questions presented. In hearings observed by staff of the National Center for State Courts, however, the judges did not always clearly address the criteria requiring proof. Whether respondents in "two P.C." proceedings were able to understand the need for care and treatment was particularly overlooked.

Although no overt act need be shown for continued involuntary hospitalization on a "two P.C." (Scopes v. Shah), evidence of acts demonstrating dangerousness is considered especially persuasive.

COUNSEL FOR THE HOSPITAL

Until mid-1981, municipal and private hospitals were not always represented by attorneys in commitment hearings. Attorneys from the Attorney General's Office have always prosecuted cases involving state hospital patients. The court recently has begun to require that cases involving patients in private hospitals be prosecuted by attorneys for the hospitals. Attorneys from the Office of General Counsel of the Health and Hospitals Corporation now prosecute commitment cases involving patients in city hospitals.

The New York statutes do not require that the hospital be represented. Reportedly, the practice of attorney representation has developed because of a concern that when only the patient is represented by counsel, the psychiatrist or the judge must assume the role of "prosecutor". Because of the resulting conflict of roles, many MHIS attorneys prefer that hospitals be represented.

Hospital attorneys and representatives of the Attorney General's Office typically do little preparation in most cases. One attorney stated that the role of the prosecuting attorney is simply to ask questions of the witnesses designed to elicit evidence demonstrating that the commitment criteria are met. Because the same questions are applicable in most commitment cases, little prehearing preparation is necessary. One judge opined that the hospitals' attorneys generally are competent professionals who seem to have a fairly broad interest in both helping patients and representing the interests of their employers. Another judge reported that occasionally hospital attorneys will take a position against involuntary hospitalization if they believe such a position is appropriate.

ASSIGNMENT OF JUDGES

Commitment cases are heard by justices of the civil division of the Supreme Court on a rotating basis. Judges in Manhattan ordinarily hear commitment cases for one week and then move on to other assignments. It is the general consensus of people interviewed in New York and in other cities that this rotation system fosters an uninformed judiciary. Unless judges are involved in commitment cases with some frequency, it is often said, they do not become sensitive to the unique

questions in this area. Reportedly, in the Bronx, judges are assigned to hear commitment cases for two months. This assignment typically is repeated at least once each year. An annual, two-month assignment may permit judges to acquire the necessary expertise.

There is general agreement that the quality and knowledge of the justices who preside over commitment proceedings in Manhattan varies greatly. Attorneys and mental health professionals alike were critical of many judges for knowing little of the applicable law. Others were concerned that judges are generally ignorant of concepts of mental illness and psychiatric treatment. Reportedly, judges assigned to the mental health rotation are provided with a book containing information on mental health and the law. Additionally, lunchtime seminars are held occasionally to educate judges. Still, many observers in New York contend that improved judicial education in this area is essential.

Another problem with the Manhattan rotation system is the lack of coordination among the judges who sit from week to week. If a case is continued from one week to the next, the "sense" of the case is lost and, essentially, the proceeding must begin anew.

The MHIS attorneys, however, favor the rotation system, because they are afraid that a permanent judge might, by chance, be a "wrong judge" and some patients would never be released. At present, if a judge is generally unsympathetic to the patient's position, he or she probably will be followed by a more favorable colleague. Although, the situation seems ripe for judge-shopping (a tactic whereby cases are continued to a day when a more favorable judge is sitting), the MHIS attorneys said it rarely occurred. The reasons given were that most judges are unpredictable, that the attorneys do not know which judge will be sitting from week to week, and that even if the patient is advised that the judge sitting that week is particularly "bad," the patient often prefers not to delay the proceedings.

One consequence of the rotation system is that it enhances the role of the MHIS attorneys. Judges generally rely on the MHIS pre-hearing memoranda for an articulation of the law as well as for a presentation of the facts. The MHIS attorneys generally prepare very well for cases and ordinarily are the best informed individuals participating in the hearings.

Another consequence of the rotation system is that the court clerk, who is permanently assigned to mental health hearings, often assumes a key role in the court proceedings. Some observers believe that the clerk exercises too much authority. He or she schedules the cases, monitors their progress, and advises judges about continuances and other case-management activities. More importantly, the clerk sometimes advises the judge about substantive matters, such as points of mental health law, evidentiary matters, and possible treatment orders. The judges who are typically unfamiliar with these matters reportedly rely substantially on this advice. The MHIS and hospital attorneys, it should be added, are present to contest the clerk's advice when it is counter to their clients' interests. A reviewer of the draft version of this report

stated that since July 1982, there has been a new court clerk who assumes no role in the hearings at Manhattan Psychiatric Center and Bellevue Psychiatric Center.

WITNESSES AT THE HEARING

The New York statutes do not explicitly require the presence of medical experts at commitment hearings. In practice, however, an examining or treating psychiatrist is present to testify in virtually every case. As discussed earlier, virtually all involuntary patients are examined by a staff psychiatrist at the hospital. This psychiatrist typically is the chief psychiatrist of the patient's unit and often is the psychiatrist who presents the expert testimony. In addition, the court receives the certificates of physicians whose examinations are required by law.

Although most people who were interviewed in New York agree that the proper role of the testifying psychiatrist is to present medical evidence in a neutral manner, many believe that psychiatrists usually feel obligated to support the case for commitment and direct their testimony accordingly. It was suggested that many psychiatrists simply do not seem to understand very well how the adversary system works or why their expertise as doctors is being questioned.

There seemed to be a consensus among judges that the psychiatrists who present neutral testimony generally are the most persuasive. One judge suggested that the examiner's testimony should be the key factor influencing the court. He admitted that at times the quality of testimony presented by psychiatrists was not very high. He stated, however, that he did not believe he had the authority to try to fill in the lack of medical evidence with his own reading or experience. Other judges suggested that medical evidence should not be overly influential. The judges and attorneys interviewed indicated that it was particularly important that the examiners present sufficient factual support for any contention of dangerousness or other behavioral criteria for commitment.

Some psychiatrists admitted that examining physicians frequently prefer to discharge patients rather than go to court because of the intimidation associated with testifying. Although psychiatrists in New York and in other cities generally resent the authority of the court to interfere with their treatment decisions concerning patients, many admit that they appreciate being relieved of what they consider the social responsibility of ordering involuntary hospitalization or release.

In addition to the psychiatrist, witnesses often include the respondent, relatives and friends of the respondent, and social workers. Because police and hospital records generally are considered admissible evidence, police officers and other hospital personnel rarely attend hearings.

The witnesses' testimony is directed primarily by the lawyers for the two sides; the MHIS lawyers, especially, conduct considerable cross-examination. Many judges also take an active role in questioning witnesses--apparently much more so than in ordinary trials--although their questions usually are intended only to clarify testimony elicited by the attorneys. The introduction of attorneys for the hospital, we were told, has noticeably reduced the amount of questioning from the bench.

RULES OF EVIDENCE AND PROCEDURE

Because of the relatively informal manner in which hearings are conducted, judges to varying degrees admit evidence that would be declared inadmissible in more formal trials. One judge reported that the rules of evidence and procedure simply are not applied in civil commitment cases. In his words, "everything goes in order to get all the information out that is relevant and of interest." Other judges indicated that they attempt to apply the rules, particularly when objections are made, but will make exceptions for hearsay evidence and evidence of prior psychiatric treatment.

Most observers agree that civil commitment proceedings are not entirely exempt from the rules of evidence and procedure applicable in other civil court cases. Because involuntary commitment is designed to serve the best interests of the mentally ill, however, many judges and attorneys are reluctant to apply these rules strictly. Most observers acknowledge that information about previous psychiatric treatment is almost always considered, although MHIS attorneys often object to the introduction of this evidence. One psychiatrist reported that he considered information about previous psychiatric treatment as relevant to the court in understanding a patient's diagnosis, prognosis, and treatment plan. He suggested that it was inescapable that previous psychiatric involvement would be discussed because mental illness is a chronic condition that simply goes through cyclic phases. Judges rule on objections when they are made by counsel but typically do not find, sua sponte, that evidence is inadmissible. (Of course, the judge is free to disregard evidence that he or she feels is not admissible.)

CONCLUSIONS AND RECOMMENDATIONS

When Hearings are Held

The most unusual, and probably the most important, feature of the New York involuntary civil commitment procedure is the lack of a court hearing in the great majority of cases. Almost all other states require a court hearing before commitment or, in the case of emergency commitments, within a few days of hospitalization. While the popular range extends from two to ten days, most states with progressive statutes require that hearings be held within 5 days of hospitalization. While not conclusive, the fact that other states take this extra precaution to preserve the patients' rights suggests that the New York procedure may be

inadequate. Moreover, federal courts in other parts of the country have ruled that due process requires judicial review before a patient is involuntarily detained for more than a few days. A mental patient, it should be stressed, may well not be capable of making an intelligent or informed decision concerning whether to request a hearing.

RECOMMENDATION: A STATUTORY AMENDMENT SHOULD BE SOUGHT REQUIRING A JUDICIAL HEARING IN EVERY INVOLUNTARY COMMITMENT CASE, TO BE HELD WITHIN 5 DAYS OF THE PATIENT'S ADMISSION TO THE HOSPITAL.

The recommendation requires a judicial hearing within five days of admission but does not specify whether the hearing is a "probable cause" or "full" hearing. This omission is intended. A hearing within five days serves the functions that a two-hearing system serves in many other jurisdictions, but eliminates the often needless repetition and expending of resources caused by requiring two hearings. A typical two-hearing formulation requires a probable cause hearing within 48 to 72 hours and a full hearing within 10 to 14 days. Requiring only one hearing is not an attempt to place economy, efficiency, and expediency above liberty. Compensating factors justifying only one hearing within five days include a strengthening of prehearing screening and review, allowing a more rapid release in cases of improper detention. The one-hearing procedure would also serve the respondent's liberty interest by resolving the commitment issue rapidly while allowing the respondent's counsel time to better prepare for the case.

The arguments given in support of the New York procedure are noted elsewhere in this report. The advocacy provided by the MHIS attorneys probably is considered the most important justification for the procedure. It is suggested that in representing the patient, the attorney is, in part, assuming the role that the judge plays in other jurisdictions. If the attorney believes that a patient does not meet the criteria for commitment, he or she may insist that the court consider the case.

Admittedly, mandatory hearings in and of themselves do not make the commitment process fairer or better; indeed, in many jurisdictions, mandatory hearings are pro forma exercises. Furthermore, a full, adversarial hearing in every commitment case is a costly endeavor. One reviewer of the above recommendation stated that a court hearing in every involuntary civil commitment case would severely burden the courts, the hospitals, and the MHIS, and might result in pro forma hearings. Because of the loss of liberty and potential for stigma that results from involuntary commitment, however, the vast majority of observers are adamant that no one should be involuntarily hospitalized without court review soon after commitment. Nevertheless, to the extent that the MHIS attorneys carefully consider each case and insist on a hearing for every case in which the patient's committability is questionable, the practical utility of the New York procedure may outweigh the danger posed by the lack of automatic hearings.

This conclusion, however, is reached primarily on the basis of the practices in the courts and hospitals in New York studied for this report. The MHIS attorneys and social workers in the First Judicial Department are, we believe, as capable of protecting the patients' rights as the court would be in a preliminary hearing. We cannot say, however, that the MHIS in other parts of New York acts with the high level of professional competence and with the adversarial stance required to bear this responsibility. Nor can we be sure that the First Judicial Department MHIS will continue to perform as it does now--indeed, it presently does not have sufficient resources to enable a thorough review of all emergency admissions at the hospitals studied. It is suggested, therefore, that the MHIS staff be enlarged so that every admission might be promptly reviewed. The recommendation which follows may be viewed as an alternative to the immediately foregoing recommendation, or as an interim measure to be employed while legislation requiring a hearing is pending.

RECOMMENDATION: THE SUPERIOR COURT IN EACH NEW YORK COUNTY SHOULD MONITOR CAREFULLY THE SERVICES PROVIDED BY THE MHIS ATTORNEYS IN ADVISING AND REPRESENTING PERSONS INVOLUNTARILY COMMITTED; WHENEVER THE COURT FINDS THAT THESE SERVICES ARE NOT BEING PROVIDED PROMPTLY AND SUFFICIENTLY, IT SHOULD ORDER THAT A HEARING BE HELD WITHIN 7 DAYS OF ADMISSION.

Characteristics of Hearings

As noted earlier, staff in Manhattan hospitals other than Bellevue and Manhattan Psychiatric Center dislike traveling to these two hospitals for hearings and frequently discharge patients in order to avoid hearings. The staff of Metropolitan Hospital, in particular, claim that the involuntary patient population there is sufficient to justify in-house hearings.

RECOMMENDATION: REPRESENTATIVES OF THE SUPREME COURT, THE MHIS, AND THE CITY HOSPITALS SHOULD EXPLORE WAYS IN WHICH HEARINGS COULD BE HELD AT LOCATIONS MORE CONVENIENT FOR HOSPITAL PERSONNEL WHO ARE REQUIRED TO ATTEND.

After reviewing this recommendation, one MHIS attorney said its implementation would be costly and burdensome on court personnel. He suggested that the current procedure already has judges riding the circuit and that hospital personnel should share the inconvenience. Selecting a hearing site requires a balancing of conflicting interests. The recommendation does not mandate that hearings be held in every hospital within the First Judicial Department. Rather, it encourages the participants in the hearing process to consider alternative locations for hearings. Selection of hearing sites involves not merely a balancing of the interests of court and hospital personnel, but also of the interests of the patients themselves. Holding hearings within additional treatment facilities not only reduces the logistical problems of transporting patients to another facility, but spares patients the indignities and

discomfort of supervised transportation. Because hospital staff often do not attend hearings held at other hospitals, a patient may lose his or her opportunity to confront and cross-examine key witnesses. On the other hand, some facilities tend to discharge patients who are marginally committable to avoid sending staff and patients to other facilities.

Although the professional literature suggests that holding commitment hearings in a hospital puts the defense at a disadvantage, the practical utility of this arrangement in New York City is compelling. It is widely believed in New York as well as in other cities, however, that, regardless of where hearings are held, courtroom order and decorum must be maintained. Because of the emotional climate of commitment proceedings and the special sensitivity of respondents and other witnesses (particularly members of the respondent's family), it is particularly important that hearing participants be treated respectfully and that the appearance of justice be maintained.

RECOMMENDATION: JUDGES SHOULD STRICTLY ENFORCE PROPER COURTROOM ORDER AND DECORUM.

In many cases observed by researchers from the National Center for State Courts, physicians' certificates were not available in court, hearing participants were not prepared to go forward when cases were called, and, in some cases, respondents were not present in court. As a result, valuable court time was wasted and general confusion prevailed. Furthermore, it was reported that hearings seldom begin promptly at the scheduled time; consequently, psychiatrists, attorneys, social workers, and witnesses typically spend from twenty minutes to one hour waiting outside of the courtroom for the proceedings to begin.

RECOMMENDATION: JUDGES SHOULD INSIST THAT ALL HEARING PARTICIPANTS BE PRESENT AND PREPARED TO GO FORWARD AT THE TIME SCHEDULED FOR HEARINGS. ATTORNEYS FOR THE HOSPITALS SHOULD ENSURE THAT ALL NECESSARY PAPERS AND WITNESSES ARE AVAILABLE FOR PRESENTATION TO THE COURT.

Given the extraordinary liberty infringement that results from involuntary hospitalization, it is important that, unless requested by the patient, judges grant continuances only when absolutely essential to the conduct of a fair proceeding.

RECOMMENDATION: WHEN CONTINUANCES ARE NECESSARY, THEY SHOULD BE FOR NO LONGER A PERIOD OF TIME THAN IS NECESSARY TO ACCOMMODATE THE DIFFICULTY REQUIRING A CONTINUANCE. RATHER THAN CONTINUE CASES FOR AN ENTIRE WEEK (UNTIL THE DAY REGULARLY SCHEDULED FOR HEARINGS IN THE PARTICULAR HOSPITAL), JUDGES SHOULD BE PREPARED TO RETURN TO THE HOSPITAL ON ANOTHER DAY DURING THE WEEK IN ORDER TO HEAR CASES REQUIRING CONTINUANCE. ALTERNATIVELY, CASES REQUIRING CONTINUANCE SHOULD BE RESCHEDULED FOR THE HEARING DAY IN THE OTHER HOSPITAL IN WHICH HEARINGS REGULARLY ARE HELD.

Statutes relating to continuances in most states specify a maximum period of time for which a continuance is permissible. Maximum continuance periods generally range from three to five days. Most observers agree that few difficulties of the sort necessitating continuance persist beyond 5 days.

RECOMMENDATION: A STATUTORY AMENDMENT SHOULD BE SOUGHT LIMITING TO FIVE DAYS THE TIME FOR WHICH A CONTINUANCE MIGHT BE GRANTED, UNLESS REQUESTED BY THE PATIENT.

Although one reviewer of this recommendation stated that a five-day limit would unduely burden the court system and counsel, the respondent's interest in a rapid resolution of the commitment issue requires that the granting of continuances not be unlimited. The recommendation allows flexibility, without infringing upon the respondent's liberty interest, by permitting the respondent to request a longer continuance.

The statutory provision prohibiting continuances of hearings in emergency admission cases unless requested by the patient is commendable. That this provision is overlooked by some judges is a serious weakness in the New York commitment system.

RECOMMENDATION: THE STATUTORY PROVISION PROHIBITING CONTINUANCES IN EMERGENCY ADMISSION CASES, UNLESS REQUESTED BY THE PATIENT, SHOULD BE STRICTLY APPLIED.

Criteria for Commitment

The criteria for emergency admission applied in the First Judicial Department are consistent with criteria for emergency commitment in other states. The "reasonable cause" standard of proof, however, is used in other states only in probable cause hearings to determine whether a patient should be detained (but not committed for the purposes of treatment) pending a hearing on the question of commitment. The standard of proof typically applied, and required as the constitutional minimum in emergency admission cases, is clear and convincing evidence (Addington v. Texas, 441, U.S. 418 (1979)). This standard is not specified by statute in New York, however. The statutory criteria for involuntary admission on a two P.C. fail to meet the requirements of Scopes v. Shah, 398 N.Y.S. 2d 911 (i.e., real and present threat of substantial harm to himself or others). A statutory amendment incorporating the requirements of Scopes v. Shah and Addington v. Texas, however, probably would result in no appreciable changes in the standard and burden of proof currently applied in First Judicial Department involuntary civil commitment hearings.

Although overt acts need not be proved for involuntary commitment in New York, judges should be aware that predictions of dangerousness are notoriously unreliable (studies have shown that such predictions are wrong far more often than they are right) and should require evidence for dangerousness that is based on threats or specific behaviors of the respondent.

RECOMMENDATION: JUDGES SHOULD NOT LOOK PRIMARILY TO EXAMINERS FOR INFORMATION ABOUT DANGEROUSNESS; RATHER, DANGEROUSNESS SHOULD BE INFERRED FROM SPECIFIC THREATS OR VIOLENT ACTS OF RESPONDENT, REPORTED IN TESTIMONY GIVEN BY COMPETENT WITNESSES.

Counsel for the Hospital

Most observers agree that the participation of an attorney on behalf of the hospital or the state is important, especially to enhance the objectivity of the testifying physician and the court. The experience of these researchers in courts where the hospital is not represented suggests that the psychiatrist, and often the court, assumes the role of prosecutor. The practice of judges in the First Judicial Department to require that the hospitals be represented in every case is to be commended.

Assignment of Judges

As discussed earlier, many people in New York (as well as in other cities throughout the country) believe that assignment of judges to commitment proceedings on a rotating basis is ill advised, unless each assignment is lengthy enough for the judge to become well acquainted with the legal and medical aspects of involuntary commitment. Judicial continuity also reduces the disruption in cases caused by adjournments. The danger that a failure to rotate judges may result in a poor judge receiving a lengthy assignment should be minimized by the increased awareness that judges should experience in a lengthy rotation.

RECOMMENDATION: THE PROCEDURE FOR ASSIGNING JUDGES TO COMMITMENT CASES SHOULD BE CHANGED TO INSURE THAT JUDICIAL ASSIGNMENTS ARE LENGTHY ENOUGH TO ALLOW THE JUDGE TO BECOME WELL ACQUAINTED WITH THE UNIQUE SUBJECT MATTER OF CIVIL COMMITMENT.

As reported earlier, many people in New York complain that the judges do not understand commitment law and practice as well as they should. Although some judicial orientation/education is offered concerning involuntary commitment, an enhanced program of judicial education should be provided. Because of the MHIS staff's special knowledge of the commitment process, it seems reasonable to suggest that they be involved in providing this education. This would be consistent with their statutory mandate to inform the court. Further, as a number of people in New York suggested, every judge newly assigned to hear commitment cases should be provided an orientation to the local mental health facilities.

RECOMMENDATION: EVERY JUDGE ASSIGNED TO HEAR COMMITMENT CASES SHOULD BE REQUIRED TO PARTICIPATE IN AN ORIENTATION/EDUCATION PROGRAM PRESENTED PERIODICALLY AS A JOINT EFFORT OF THE MHIS AND THE

PSYCHIATRIC HOSPITALS IN NEW YORK CITY. STAFF OF THE MHIS AND PERSONNEL OF THE CITY PSYCHIATRIC HOSPITALS, AS ADVISED BY THEIR COUNSEL, IMMEDIATELY SHOULD ASSUME RESPONSIBILITY FOR DEVELOPING AND IMPLEMENTING SUCH AN EDUCATIONAL PROGRAM.

As indicated earlier, many observers considered the influence of the court clerk in civil commitment proceedings to be excessive. Judges in New York City should be sensitive to this and should act more independently in the hearing of commitment cases.

Witnesses at the Hearing

It is important that examining physicians present neutral testimony. Whether or not appropriate, the medical evidence unquestionably is the most influential evidence in commitment hearings. Given that "independent" medical opinion rarely is presented, testimony of examining physicians must be impartial.

RECOMMENDATION: TESTIFYING EXAMINING PHYSICIANS SHOULD PRESENT THEIR TESTIMONY IN AN IMPARTIAL MANNER.

Testifying in court is a highly distasteful experience for many mental health professionals. Physicians, who are unaccustomed to having their opinions challenged by persons having no medical expertise, resent being forced to explain and justify their conclusions. Mental health professionals who testify in commitment cases frequently have had no formal training about legal procedures and do not understand what is expected of them in the commitment hearing. The presentation of orientation/education programs for hospital personnel in the psycho-legal area may enable testifying physicians to feel more comfortable in court and provide higher quality information.

RECOMMENDATION: MHIS STAFF, IN COOPERATION WITH COUNSEL FOR THE PSYCHIATRIC HOSPITALS IN NEW YORK CITY, SHOULD DEVELOP AND CONDUCT ORIENTATION/EDUCATION PROGRAMS FOR MENTAL HEALTH PROFESSIONALS WORKING IN THE CITY HOSPITALS. ALTERNATIVELY, BEFORE EACH COMMITMENT HEARING, COUNSEL FOR THE HOSPITAL SHOULD EXPLAIN TO THE TESTIFYING PHYSICIAN WHAT WILL BE EXPECTED OF HIM OR HER DURING THE HEARING.

Reportedly, the Health and Hospitals Corporation has conducted seminars in several of its facilities in order to familiarize hospital staff with legal issues surrounding involuntary commitment and to prepare psychiatrists to testify in commitment hearings. We commend this practice and urge that it be continued.

Rules of Evidence and Procedure

Commitment cases frequently are based on allegations made by family members or other acquaintances of the patient and often grow out of ongoing personal disputes. As a result, these allegations and the

testimony provided by lay witnesses may not always be entirely objective. Because of this and because the emotional state of respondents at the time of hearing may hinder their capacity to refute testimony that may not be trustworthy, it is important the proceedings be conducted so as to ensure that only credible testimony is admitted into evidence. To the extent that judges conduct commitment proceedings according to rules of procedure and rule on objections according to rules of evidence, it may be argued that these concerns are academic; however, to the extent that counsel fail to make objections, these concerns are significant.

RECOMMENDATION: COUNSEL SHOULD STRIVE TO PREVENT THE INTRODUCTION OF EVIDENCE THAT IS IN VIOLATION OF THE FORMAL RULES OF EVIDENCE. WHEN TESTIMONY THAT IS HIGHLY OBJECTIONABLE IS GIVEN OVER NO OBJECTION, THE COURT SHOULD ALERT COUNSEL THAT RULES OF EVIDENCE SHOULD BE BETTER FOLLOWED.

It is common sense, as well as empirically established fact, that knowledge of a respondent's previous psychiatric commitment makes a decisionmaker more inclined to order another commitment. Most observers agree, however, that the statutorily required determination of mental illness rarely requires information from previous psychiatric hospitalizations. On the other hand, it is acknowledged that information about previous psychiatric treatment serves a valid function in the hearing. This information is important to an accurate diagnosis of the exact nature of the mental disturbance and to the formulation of an effective treatment plan. For these reasons, this information should be admissible at the hearing, but must be used correctly. A respondent should not be committed substantially on the basis of psychiatric history, because this makes it virtually impossible for the respondent to avoid being committed again, once previous behaviors and events have become sufficient to satisfy the commitment criteria. The respondent should be committed only because his or her current condition warrants it. But a complete diagnosis and plan for respondent's treatment must be made on the basis of psychiatric history as well as the respondent's present condition.

RECOMMENDATION: INFORMATION ON PREVIOUS PSYCHIATRIC TREATMENT SHOULD BE ADMISSIBLE INTO EVIDENCE AT THE COMMITMENT HEARING FOR PURPOSES OF DIAGNOSIS AND TREATMENT PLANNING, BUT SHOULD NOT BE ACCEPTED AS SUFFICIENT EVIDENCE THAT RESPONDENT MEETS THE CRITERIA FOR COMMITMENT.

CHAPTER VI

THE HEARING: DETERMINING TREATMENT

This chapter considers matters raised during hearings that are relevant to the type of treatment to which a respondent might be ordered. For the most part, these matters are important only if a person is determined to have met the commitment criteria. As a practical matter, however, these matters typically are considered concurrently with evidence bearing on the question of whether to commit.

RESPONDENT'S CAPACITY TO MAKE TREATMENT DECISIONS

Involuntary hospitalization on a two P.C. requires a showing that the respondent's judgment is so impaired that he or she is unable to understand the need for care and treatment. (9.01) The respondent's competency or capacity to make treatment decisions once hospitalized, however, is not adjudicated at the commitment hearing.

A patient may appeal the physician's treatment order through an administrative appeals route if during a period of hospitalization, the patient refuses routine treatment. The question of the patient's right to refuse treatment is discussed further in the Posthearing section of this report. In the case of extraordinary treatment (i.e., electroshock therapy or surgery), if the competency of the patient to consent to such treatment is in doubt, a court determination may be made of the patient's competency to consent. If the psychiatric staff of an Health and Hospitals Corporation facility questions a patient's capacity to give or withhold consent, staff contact the Office of General Counsel which, in turn, seeks to obtain court authorization for the procedure.

CONSIDERING LESS RESTRICTIVE ALTERNATIVES

The New York statutes provide that the examining physician must consider treatment alternatives before endorsing hospitalization (9.27). The statutes, however, impose no duty on the court to consider less restrictive alternatives during the hearing. The statutes do provide that if it appears that a relative of the patient or a committee of the patient's person is willing and able properly to take care of the patient at some place other than a hospital, then, upon their written consent, the court may order the transfer of the patient to the care and custody of such relative or committee (9.31).

Hospital representatives report that less restrictive alternatives are considered when a proposed patient enters the emergency room. It was estimated that 95 percent of those not admitted to Bellevue are referred elsewhere for help. The hospital employs two social workers to investigate referral sources and arrange for alternative placements.

The requirement that physicians completing certificates for two P.C. admissions consider alternative forms of care and treatment is, reportedly, largely ignored. One psychiatrist complained that conducting a meaningful investigation of less restrictive alternatives would unduly delay the person's admission.

MHIS attorneys note that the question of less restrictive alternatives may be brought to a court's attention in a number of different ways. Frequently, MHIS staff investigate treatment options and raise the question of less restrictive alternatives during the hearing. In other cases, they prefer to question the testifying physician concerning the extent to which he or she investigated less restrictive alternatives for the respondent. Occasionally, an MHIS attorney calls a patient to testify about alternative treatment programs that are available in his or hers community.

Reportedly, the biggest problem MHIS attorneys face is arranging for respondents to be accepted into community treatment programs prior to hearing. Understandably, many judges are reluctant to refrain from committing someone simply because a community program exists that might be appropriate for the person. Most judges require some assurance that the patient will be accepted by and enter the program before they will discharge the patient. One judge stated that he requires a representative from the alternative program to indicate that the patient would be accepted if discharged from the hospital. Similarly, this judge indicated that before releasing a patient to a family member, he evaluates the family member's sincerity in promising to care for the patient. Another judge stated that if evidence is presented showing that an appropriate less restrictive alternative is available, the case will be dismissed on the condition that the alternative program be utilized. This judge admitted, however, that there is no effective mechanism for ensuring that the alternative program is used.

A major problem faced by the city hospitals is to identify and arrange for community placements for patients. Reportedly, Bellevue Hospital and some other local facilities operate day care programs that can be useful for some patients. Vocational services and out-patient clinics also are used when they are appropriate and available. The single room occupancy (SRO) hotels are another alternative. Approximately 40 percent of the SRO's are occupied by former mental patients. Bellevue has a team of physicians and social workers who visit the SRO hotels to treat and work with former patients. It was reported that many of the SRO's have been converted to apartments in recent years and rent for more than most former patients can afford to pay. As a result, many former patients literally are forced to live on the streets of the city. Reportedly, a significant percentage return to the hospitals as either voluntary or involuntary patients.

PRESENTING A TREATMENT PLAN

The New York statutes require hospitals to develop and maintain treatment plans for all patients. There is no requirement, however, that these plans be presented at commitment hearings.

As a matter of practice, treatment plans reportedly are prepared for all patients, but these plans rarely are presented formally at hearings. Although most testifying physicians are prepared to discuss their plans for patients if and when the court requests this information, it is not standard procedure for the courts to ask for this information. One judge, however, stated that he always inquires concerning the kind of treatment which would be provided to the patient and how long the treatment would require to be completed.

JUDICIAL TREATMENT OPTIONS

Judicial orders of commitment may do no more than bind a patient to the care of an institution (or person). Although judges sometimes order commitment for a time period shorter than the maximum authorized by statute, they have no authority to issue orders specifying mandatory minimum treatment periods or particular treatment modalities. Rather, the institutions retain full control over the manner in which patients are treated. While this practice is generally considered appropriate--essentially leaving the commitment decision to the judge and the treatment decisions to the doctors--some observers have suggested that judges should inquire more actively into whether the hospital plans to treat the respondent in the least restrictive setting within the hospital.

CONCLUSIONS AND RECOMMENDATIONS

Respondent's Capacity to Make Treatment Decisions

In some states, the court makes a finding during the commitment hearing as to the respondent's competency to make treatment decisions (i.e., refuse treatment) once committed. In states where involuntary patients are accorded the right to refuse treatment once committed, a determination at the commitment hearing regarding respondent's competency is quite useful. Although present law in New York does not provide for an adjudication of competency at the commitment hearing, neither does it rule out the possibility that this question could be heard and disposed of during the hearing (so long as the requirements of the judicial procedure for determining incompetency were followed during the hearing, or course). Procedures for judicial determination of a patient's competency to consent to extraordinary treatment are generally applauded by New Yorkers.

Considering Less Restrictive Alternatives

Conceptually, less restrictive alternatives may be viewed as a threshold question of committability (i.e., if a less restrictive program of care is appropriate, involuntary treatment may not be ordered) or as a placement concern of the commitment order (i.e., respondent's commitment must be to the least restrictive program that is appropriate). Although the statutes in New York do not require judges to consider less restrictive alternatives at all, as a practical matter, most judges view less restrictive alternatives as a threshold concern of

the question of committability. This position is consistent with the holdings in several federal court cases to the effect that a court may not commit to involuntary treatment anyone for whom a less restrictive alternative is appropriate.

However, the practice of allowing judges to commit patients to programs of care less restrictive than hospitalization has much to recommend it. Some observers suggest that, realistically, most judges will refuse to refrain from committing someone simply because a program exists that the patient may or may not enter if released from the hospital. However, if the judge is empowered to order the person into the less restrictive program, the alternative becomes more attractive.

RECOMMENDATION: A STATUTORY AMENDMENT SHOULD BE SOUGHT AUTHORIZING JUDGES IN COMMITMENT PROCEEDINGS TO ORDER RESPONDENTS INTO INVOLUNTARY TREATMENT IN PROGRAMS OF CARE LESS RESTRICTIVE THAN HOSPITALIZATION.

This recommendation is not to suggest that judges should be authorized to order respondents into treatment programs less restrictive than hospitalization when the respondent does not meet the commitment criteria. On the contrary, before ordering a respondent into any treatment program the judge must first be satisfied that the commitment criteria are met. Institute staff recognize that in most commitment hearings, consideration of the questions of committability and disposition are intertwined. Judges should recognize, however, that each question requires an independent answer.

One reviewer of the above recommendation suggested that its implementation would be impracticable. He suggested that it would be impossible for a court to compel patient participation in a treatment program less restrictive than hospitalization. This argument is frequently asserted against application of the least restrictive alternative principle to civil commitment proceedings. The success of many outpatient services suggests, however, that more people can be treated in the community than have been in practice. Nevertheless, a respondent's willingness to comply with outpatient treatment is a major factor in determining whether noninstitutional treatment is appropriate.

The practice of the MHIS staff to investigate and bring to the court's attention less restrictive alternatives for commitment respondents is to be commended. The experience of these researchers is that such an investigation rarely is undertaken in most cities, despite being statutorily required in many jurisdictions.

The failure of the statutes in New York and the local procedures in the First Judicial Department of New York City specifically to require that the court make commitment decisions in accordance with the least restrictive alternative principle is a weakness of the city's commitment system. Neither the interests of respondents nor those of society are satisfied when respondents receive treatment that is more intrusive and more expensive than is necessary to accommodate their disorders. Certainly most of the judges in New York City in fact give some degree of

consideration to the question of less restrictive alternatives when hearing commitment cases. The question of less restrictive alternatives, however, may be too easily disregarded unless the court is required, before ordering commitment, to make a finding that less restrictive alternatives were considered and that none was appropriate.

RECOMMENDATION: BEFORE ORDERING INVOLUNTARY HOSPITALIZATION, THE COURT SHOULD CONSIDER WHETHER ANY LESS RESTRICTIVE ALTERNATIVE WOULD BE APPROPRIATE AND AVAILABLE TO ACCOMMODATE THE RESPONDENT'S DISORDER AND SHOULD MAKE A FINDING THAT LESS RESTRICTIVE ALTERNATIVES WERE CONSIDERED AND NONE WAS FOUND TO BE APPROPRIATE.

Presenting a Treatment Plan

The criteria for involuntary commitment in a number of states require a showing that respondent's debilitating condition is one for which appropriate treatment is available. The U.S. Supreme Court has held unconstitutional, at least with respect to persons committed on the basis of dangerousness to self, the involuntary commitment of a person without the administration of appropriate treatment designed to address the person's disorder (O'Connor v. Donaldson, 422 U.S. 563 (1975)). It is largely because of this right to treatment that procedures in many states require the submission of a treatment plan at the commitment hearing. The plan is intended to provide a basis upon which the judge or other decisionmaker may determine the appropriateness of the treatment proposed and the likelihood that such treatment will bring about the desired change in respondent's condition. As pointed out to the research staff in all of the cities in which we studied commitment procedures, however, it is optimistic to think that a meaningful treatment plan can be constructed during a short prehearing hospitalization period. Because of this difficulty, because the involuntary commitment criteria in New York do not require a showing that respondent is treatable, and because the local hospitals as a matter of practice regularly update their patient's treatment plans during the period of hospitalization, that treatment plans are not often presented at hearings in New York probably is of no profound significance. At retention hearings, however, it may be useful for the court to consider treatment plans developed during the course of the hospitalization period so that it might evaluate how well the treatment provided addressed the patient's disorders. If the court determines that the treatment provided resulted in no improvement in the patient's condition, it may discharge the patient under the O'Connor v. Donaldson rationale.

Judicial Treatment Options

A few people in New York suggest that the court should have the discretion to commit patients for mandatory minimum periods of treatment. The clear majority of people, however, feel strongly that the courts should have no such discretion. Moreover, no one seriously suggests that the courts should have the authority to specify particular treatment modalities or other medical conditions of commitment (except,

perhaps, to the extent that a court might be authorized to order treatment in the least restrictive setting). The law in New York and the practice in New York City--to leave postcommitment treatment decisions in the hands of mental health professionals--are in line with procedures in other states and seem to be entirely satisfactory.

CHAPTER VII

POSTHEARING CONCERNS

RIGHT OF APPEAL

The New York statutes provide that any person (or any relative or friend on the person's behalf) who has been denied release or whose retention, continued retention, or transfer and continued retention, has been ordered by the court may obtain, within thirty days of such court order, a rehearing and review of the proceedings (9.35). This review is initiated by petitioning a supreme court justice other than the one presiding over the court which made the original order (9.35).

Review hearings are to be heard by juries unless the patient or other person applying for review consents in writing to trial by the court (9.35). Attorneys from both the MHIS and the Health and Hospitals Corporation disagree concerning whether the granting of a review hearing is within the judge's discretion, based on some error in the original proceeding, or is a matter of right. A Health and Hospitals Corporation attorney, and an MHIS attorney, stated that rehearings are de novo and no error need be shown. An MHIS attorney agreed that rehearings are de novo but indicated that petitions for rehearing are granted only upon a showing of error in the original proceeding or upon the discovery of new information that would make a new hearing appropriate. A reviewer of the draft version of this report stated that §9.35 of the Mental Hygiene Law provides for a rehearing as a matter of right. As a practical matter, when such hearings are held, juries never are summoned. Reportedly, this is because juries are less inclined to release respondents and because they cause delay. Orders resulting from review hearings may be appealed (9.35), presumably in the same manner that other civil cases may be appealed.

Reportedly, rehearings are rarely requested, and appeals are extremely rare. It was suggested that, because the appellate process takes so long (reportedly one year for an appeal to the appellate division), appeals rarely are taken for the purpose of pursuing a patient's interest in release. Rather, appeals, when they are taken, are for the purpose of settling points of law.

In addition to rehearings and appeals, involuntary patients and relatives or friends of such patients are entitled upon proper application to a writ of habeas corpus to question the cause and legality of detention. Reportedly, habeas corpus relief is not often sought.

INSTITUTIONAL PRACTICES

For the most part, the court's involvement with the institution ends with the commitment order. Treatment facilities retain the right to

refuse patients into their programs and, once patients are admitted, to select and manage their treatment programs. Reportedly, private hospitals in New York City, preferring to work with voluntary patients, generally do not accept patients whose hospitalization is court ordered. State hospitals receiving patients committed initially in city hospitals exercise discretion in deciding whether to admit these patients (see "Transfers," below).

The MHIS continues to provide legal services to patients during their periods of commitment. MHIS responsibilities include representing patients in matters involving transfer, objection to treatment, and appointment of conservators and guardians. MHIS staff investigate cases of patient abuse and annually review the status of all patients. In the past, MHIS attorneys have instituted litigation to assure adequacy of care and treatment.

The New York statutes require that hospitals develop written treatment plans to assure adequate care and treatment for each patient (29.13). Treatment plans must include a statement of treatment goals, an indication of treatment or therapies to be undertaken to meet such goals, and a specific timetable for assessment of patient programs as well as for periodic mental and physical reexaminations. Patients (or their authorized representatives) must be interviewed and provided an opportunity to actively participate in the preparation and revision of treatment plans (29.13). Reportedly, treatment plans are developed and maintained in the city facilities essentially as required by statute.

As discussed earlier in this report, patients may object to the physician's treatment decision by appealing using an administrative procedure outlined later in this chapter (see below, "Patients' Civil and Personal Rights"). Extraordinary treatment such as electroshock therapy and surgery may be performed only after the patient has given informed consent.

Restraints may be employed only when necessary to prevent a patient from serious injury to self or others. Restraints may be used only if less restrictive techniques have been clinically determined to be inappropriate or insufficient to avoid such injury. Restraints may not be used as punishment, for the convenience of staff, or as a substitute for treatment (33.04). Despite this, some people in New York charge that seclusion and restraint frequently are used in the public hospitals as patient management devices. Whether these allegations are based in fact would require additional investigation.

TRANSFERS

The transfer of patients from one hospital to another is the source of much anxiety for hospital personnel and patients in New York. Hospitals in New York serve particular areas of the city. If someone is brought to a hospital that is outside his or her area, the hospital may refuse to evaluate the person for admission. If the police present such a person for admission to Bellevue Hospital, Bellevue personnel may

transfer the person to a hospital that is within that person's area. Bellevue physicians, however, question whether they have the authority to order such transfers given that at the time of the transfer the individual has no patient status at Bellevue.

Transfer problems more frequently arise when a patient is initially admitted to an acute care facility and later is found to require treatment in a long-term facility. Hospitals in New York are under no obligation to accept all patients presented for admission. As a practical matter, however, the primary long-term public facility serving the First Judicial Department, Manhattan Psychiatric Center, admits all involuntary transferees unless the transfer papers are not properly completed. Voluntary transferres who indicate to admitting staff at Manhattan Psychiatric Center that they do not wish to be admitted will not be accepted at Manhattan Psychiatric Center. Typically, in this situation, Manhattan Psychiatric Center personnel will telephone the sending institution and inquire whether it wishes for the patient to be returned. Frequently, such patients are discharged. Reportedly, some patients are aware of this practice and convert to voluntary status prior to transfer with the intention of refusing admission upon transfer to Manhattan Psychiatric Center. Of course, many such patients are returned to the sending facility, where proceedings may be instituted to convert the patient's status to involuntary (by way of the two P.C. involuntary admissions procedure discussed earlier). Reportedly, staff at Metropolitan Hospital, in an effort to prevent voluntary patients from refusing admission at a facility to which they are transferred, frequently will convert voluntary patients to involuntary status prior to transfer.

MHIS receives copies of all transfer notices and makes an effort to meet with all patients who are to be transferred. The New York statutes provide that no patient may be transferred to another hospital by any form of involuntary admission unless the MHIS is given notice thereof (9.27). Personnel of some city hospitals believe that involuntary patients may contest a transfer in court. Although several MHIS attorneys suggested that respondents have merely an implied right to a judicial challenge of transfer, statute mandates notice of transfer and an opportunity to be heard (9.31(c)).

Transferring institutions reportedly provide receiving institutions with a copy of the patient's discharge summary. If the receiving institution wishes to obtain a copy of the patient's full record, however, a request must be submitted in writing. Upon receipt of such a request, the transferring institution ordinarily will forward the patient's full record only if the patient so consents.

PATIENTS' CIVIL AND PERSONAL RIGHTS

The New York statutes provide that each patient must receive "care and treatment that is suited to his needs and skillfully, safely, and humanely administered with full respect for his dignity and personal

integrity" (33.03). The following are additional statutory requirements (33.03):

- careful reexamination and evaluation of each patient not less frequently than once per year;
- medical and dental evaluations and evaluations of mental disabilities of inpatients by qualified professionals no less frequently than once per year;
- the order of a staff member operating within the scope of a professional license for any treatment or therapy, based on appropriate examination;
- consent for surgery, shock treatment, major medical treatment in the nature of surgery, or the use of experimental drugs or procedures; and
- inclusion in the patient's clinical record of all written treatment plans and notation of examinations, individualized treatment programs, evaluations and reexaminations, orders for treatment, and specific therapies, signed by the personnel involved.

The statutes also protect the personal and civil rights of patients, including the rights to vote and to conduct personal and business affairs (33.01 and 29.030).

The following procedures, which appear in Mental Hygiene Department regulations (27.8), are used when an involuntary patient objects to treatment other than extraordinary treatment:

- (1) The refusal and request by the doctor to treat will be reviewed by the head of the service. That decision is sent to the patient, the patient's representative, and the MHIS.
- (2) The patient or his or her representative may appeal to the director of the facility. The director will make a decision and will inform MHIS and the patient of that decision.
- (3) The patient can appeal again to the Regional Director of Mental Hygiene. The regional director's decision will be final.

Although most people in New York agree that patients should not be treated during the appeals process, unless such treatment is necessary to preserve the safety of the patient or others, many admit that some physicians treat anyway. Once the appeals process has been exhausted and permission to treat has been granted, many physicians believe they may treat the patient for the duration of his or her stay. Most legal scholars suggest, however, that such permission should expire after a reasonable period of time.

People in New York City are in disagreement regarding the extent to which the civil and personal rights of patients are protected in the local hospitals. Some observers contend that conditions are often not sanitary, heating in the winter time frequently is inadequate, basic medical care often is not provided, and the personal safety of patients is not well protected. As was indicated earlier, some people charge that seclusion and restraints are improperly used as patient management devices. Much of the blame for this inadequate treatment is placed on the ward nurses, who tend to be underpaid and too few in number. Some blame the psychiatric staff, who allegedly prefer not to become involved in questions concerning conditions of care. Other persons in New York state that the civil and personal rights of patients are well protected. They suggest that the MHIS is very effective in ensuring this protection. It must be noted that these researchers have no significant first-hand knowledge of conditions in the local hospitals.

RETENTION PROCEEDINGS.

Involuntary patients admitted pursuant to the emergency admissions procedure must be discharged within fifteen days of admission unless they agree to remain as voluntary or informal patients or they are admitted pursuant to the conditions governing involuntary admission on applications supported by medical certification and subject to the provisions for notice, hearing, and review (9.39). Patients admitted upon an application supported by medical certification must be released within sixty days from the date of involuntary admission supported by medical certification or thirty days from the date of an order denying an application for the patient's release, whichever is later, unless the patient agrees to remain as a voluntary patient or the director of the hospital applies to the supreme court for an order authorizing continued retention (9.33). The patient has a right to contest the continued retention at a hearing, if the hearing is requested within five days from the date the patient receives notice of the application for continued retention (MHIS may request a hearing on the patient's behalf). Retention hearings are reported to be essentially identical to initial commitment hearings, which are described earlier in this report. On the basis of this application, or on evidence presented at a hearing if one is requested, the court may order continued retention for a period not to exceed six months from the date of the order. At the expiration of this six month period, similar retention proceedings may be initiated. Based on these proceedings, the court may order continued retention for a period not to exceed one year. Following this retention period, the court, pursuant to retention proceedings as outlined above, may order continued retention periods of two years each (9.33).

CONCLUSIONS AND RECOMMENDATIONS

Right of Appeal

The rehearing procedure in New York is to be commended. It allows for the prompt correction of mistakes made at the initial hearing. The MHIS is encouraged to exercise discretion in advising

patients whether to pursue rehearings, given the potential for court congestion that this procedure presents. Given the statutory requirement that juries be summoned for rehearings (unless waived), the failure of judges to summon juries may be serious weakness in commitment practice in New York.

RECOMMENDATION: AS REQUIRED BY STATUTE, ANY JUDGE WHO RECEIVES A PETITION FOR A REHEARING SHOULD CAUSE A JURY TO BE SUMMONED UNLESS THE PATIENT OR OTHER PERSON APPLYING FOR THE REHEARING ON THE PATIENT'S BEHALF WAIVES A TRIAL BY JURY AND CONSENTS IN WRITING TO TRIAL BY THE COURT.

It is important that appeals be available to persons committed to involuntary treatment, not only to allow for the settling of points of law interpreted differently by different judges, but, more importantly, to allow for the review of particular cases. The practical impediment to the effective use of the appellate procedure in New York--the slowness of the appellate process--is a serious weakness in the city's commitment system.

RECOMMENDATION: THE APPELLATE DIVISION OF THE SUPREME COURT SHOULD MAINTAIN AN EXPEDITED CALENDAR FOR COMMITMENT APPEALS, WHICH SHOULD ALLOW SUCH APPEALS TO BE HEARD WITHIN FIFTEEN DAYS OF FILING.

Institutional Practices

The statutory recognition of an involuntary patient's right to legal representation during the commitment period is a strong feature of the commitment law in New York. The ordinary affairs of life that sometimes require the assistance of an attorney (e.g., marriage, divorce, bankruptcy), do not cease during commitment; rather, a host of new legal problems may arise. The MHIS attorneys' practice of assisting patients during the commitment period, reportedly, is an excellent compliance with New York statute and serves to give meaning to the numerous rights accorded patients by statute.

Although the laws and procedures relating to the provision of treatment and the development and maintenance of a meaningful treatment plan are commendable, the alleged misuse of seclusion and restraint, if this occurs, is a weakness in the hospitalization process.

RECOMMENDATION: AS REQUIRED BY STATUTE, RESTRAINTS SHOULD BE EMPLOYED ONLY WHEN NECESSARY TO PREVENT A PATIENT FROM SERIOUSLY INJURING SELF OR OTHERS. RESTRAINTS MUST NEVER BE USED AS A PATIENT MANAGEMENT DEVICE. BEFORE ORDERING THE USE OF RESTRAINTS, THE PHYSICIAN SHOULD DOCUMENT IN THE PATIENT'S RECORD THE FACT THAT LESS RESTRICTIVE TECHNIQUES WERE CONSIDERED AND WERE CLINICALLY CONSIDERED TO BE INAPPROPRIATE OR INSUFFICIENT TO AVOID INJURY.

Transfers

Although many people in New York City complain that procedures for transferring patients from one hospital to another are cumbersome and inconvenient, no one proposed to these researchers procedural reforms that would improve the transfer process. Hospital personnel should be aware that the New York statutes do not require that MHIS approve all transfers. The requirement that MHIS be informed of the proposed transfer of any involuntary patient is, however, important: a transfer typically entails the movement of a patient to a facility that, because its population consists of generally sicker patients, may represent a more restrictive setting. The opportunity generally provided to request a hearing to contest the transfer is to be commended.

Patients' Civil and Personal Rights

The New York statutes provide in great detail for the protection of the human rights of committed persons. Given that mental institutions through the years have acquired poor reputations in this regard, the thorough statutory concern for patient's rights in New York is praiseworthy. Whether all of these rights are respected for every patient is a matter of controversy in New York. Apparently, at least in some of the city's hospitals, the conditions of life for involuntary patients fall short of those contemplated by statute. Without further study, however, it would be inappropriate for these researchers to present recommendations addressing these problems.

The administrative procedures available to patient's objecting to treatment and wishing to appeal treatment decisions are generally consistent with the requirements of recent appellate court cases and seem to be respected by people in New York. The reported failure of some physicians, however, to refrain from treating patients pending administrative appeals subverts the procedure.

RECOMMENDATION: PATIENTS REFUSING TREATMENT AND APPEALING THE PHYSICIAN'S TREATMENT DECISION, USING THE PROCEDURES OUTLINED IN THE REGULATIONS OF THE OFFICE OF MENTAL HEALTH, SHOULD NOT BE TREATED DURING THE APPEAL PROCESS UNLESS, AS REQUIRED BY REGULATION §27.8, "THE TREATMENT APPEARS NECESSARY TO AVOID SERIOUS HARM TO LIFE OR LIMB OF THE PATIENTS THEMSELVES." THE COURTS AND THE MHIS ARE ENCOURAGED TO ENSURE COMPLIANCE WITH THE INTENT OF THIS REGULATION.

Although under scrutiny the standard provided in §27.8 for determining when involuntary treatment should be permitted while an appeal is pending appears vague, the intent of the regulation is clear: to hold in abeyance all but emergency treatment. Given the specificity of the regulation, which is unique among states, the courts and the MHIS are encouraged to facilitate its implementation. The regulation protects patients from the intrusive treatment they are contesting yet does not simply prohibit all challenged treatment. Allowing treatment under

emergency circumstances may prevent the necessity of merely placing patients in back wards or restraints. The regulation also enables the court to presume the competence of mental health professionals in making treatment decisions. Such a presumption is consistent with recent federal court decisions (e.g., Youngberg v. Romeo, 50 U.S.L.W. 476, 4685 (1982)).

Retention Proceedings

Generally, the procedures specified for retention proceedings seem adequate. Because retention hearings are essentially identical to initial commitment hearings, discussion and recommendations applicable to initial commitment hearings apply here as well.

APPENDIX A

FORM USED IN THE INVOLUNTARY CIVIL COMMITMENT
PROCESS IN THE FIRST JUDICIAL DEPARTMENT,
NEW YORK CITY

Index

	<u>Page</u>
Instructions for Handling Mentally Ill or Temporarily	
Deranged Persons	69
Patrol Guide: Aided Report	70
Procedure	71
Revision Notice	73
Memorandum to the Court	75
Record of Emergency Admission	79
Examination for 48-hour Confirmation of Need for Emergency	
Admission	80
Notice of Status and Rights--	
Emergency Admission	81
Admission de Emergencia	82
Involuntary Status	83
Voluntary or Minor Voluntary Admission	84
Notice of Right to Appeal	85
Application for Admission as Patient: Two P.C.	86
Certificate of Examining Physician	90
Voluntary Request for Hospitalization	92
Patient Grievance Form	94



INSTRUCTIONS FOR HANDLING MENTALLY ILL OR TEMPORARILY DERANGED PERSONS PD 104-110 (2-81)

Department Policy - In these cases the Department's policy is one of isolation and containment. Handling an emotionally disturbed person (EDP) can be a sensitive and dangerous job.

The safety of all concerned is the paramount issue in the removal of an EDP to a hospital. If the EDP is imminently threatening his life or others, necessary force can be used at that time to prevent serious physical injury and save life. If however, the EDP is not imminently life threatening to himself or others, he should be contained until help arrives. In this situation where there is time to negotiate and/or contain the individual, we will use all the time that is necessary for a safe resolution of the situation. In accordance with that policy, physical force is used only to the extent necessary to restrain the subject until delivered to hospital authorities or detention facility. Deadly physical force is used by a member of the service only as a last resort to protect the life of himself/herself or another present.

Procedure - When police action is required, including restraining or taking into protective custody an apparently mentally ill or deranged person who is acting in a manner likely to result in serious physical harm to self, the police officer or others present, and immediate physical force is not required, the following shall be strictly adhered to:

MEMBER(S) FIRST ON SCENE

1. Summon assistance, including the supervisor of patrol and Emergency Service Unit.
2. Attempt to isolate and contain the mentally ill or deranged person until the arrival of the patrol supervisor and the Emergency Service Unit.
 - a) If the patrol supervisor determines that the Emergency Service Unit is no longer necessary, he shall cancel the request for the Emergency Service Unit.
3. Request ambulance.
4. Establish police lines.

PATROL SUPERVISOR

5. Establish firearms control.
 - a) Direct members not to use their firearms or use any other deadly physical force unless their lives or the life of another is in imminent danger
 - b) Comply with Patrol Guide 104-1—"Use of Firearms."
6. Request assistance of:
 - a) Emergency Service Unit, if not already requested
 - b) Hostage Negotiating Team, if necessary

- c) Interpreter, if language barrier
- d) Subject's family or friends
- e) Local Clergyman
- f) Prominent local citizen
- g) Any public or private agency deemed appropriate for possible assistance.

7. Notify station house officer of facts.
 - a) Request Precinct Commander/Duty Captain to respond.
8. Establish police lines if not already done.

S.H. OFFICER

9. Notify Precinct Commander/Duty Captain to respond.
10. Notify Operations Unit and Patrol Borough Command of facts.

RANKING SUPERVISORY OFFICER AT SCENE

11. Assume Command of firearms control
12. Direct whatever action is necessary, including use of negotiators, to restrain subject with minimum use of physical force consistent with circumstances.
13. Direct use of alternate means of force, if appropriate, according to circumstances (mace, tear gas, baton, restraining equipment).
14. Be guided by provisions of Patrol Guide procedures 106-11, Aided Cases, Mentally Ill Persons.



PATROL GUIDE

FD-147 (Rev. 7-78)

1063

AIDED REPORT

DATE ISSUED	DATE EFFECTIVE	REVISION NUMBER	PAGE
11-24-78	12-1-78	78-12	1 of 1

FRONT

Mo./Day/Yr.

ENTER R.M.A. IF
AIDED REFUSES
MEDICAL AID

Date of Occur.	Surname	First Name and Initial	Sex	Color	Age	Pct.
10/20/78	CRANSTON,	LAMONT S.	M	W	39	21
Time of Occur.	Address		Apt. Flr.	Aided No.		
1635	77 HENRY STREET, BROOKLYN, N.Y.		3C	482		
Place of Occurrence						
IND Subway - Church and Chambers St., NW corner Stairway No. 1693						
Check One	<input type="checkbox"/> Abandoned <input type="checkbox"/> Dead <input type="checkbox"/> Sick <input type="checkbox"/> Abused Child <input type="checkbox"/> Neglected <input checked="" type="checkbox"/> Injured <input type="checkbox"/> Lost <input type="checkbox"/> Mentally Ill	Nature of Illness or Injury				
		Head Injury				
Removed To	Admission No.	Responding Attendant	Treated by (Name)			
<input type="checkbox"/> Home <input checked="" type="checkbox"/> Beekman	<input type="checkbox"/> Hospital <input type="checkbox"/> Morgue	Fiori	Dr. Cass			
Children or Dependent Adults Uncared For	If Yes, indicate their disposition on reverse side under "Details"		Log Entries	Pct.	Complaint No.	M.P.S. No.
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
NOTIFICATIONS: (Enter name, address and relationship of friend or relative notified. If aided is unidentified, list who at M.P.S. was notified. In either case, list date and time of notification.)						
Wife - Margo S/A notified by P.O. Ryan, Sh. No. 426, 21 Pct. at 1710 hrs.						
Comm Div Notified	Time	Date	Received By	Sent By		
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
City Involved	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, prepare form Accident Report (Inv. PD 301-155)	To Dept or Agency	Arrest	Summons	
			NYC Transit Authority			
DUPLICATE REPORTS FORWARDED TO: <input type="checkbox"/> Harbor Unit <input type="checkbox"/> Emer. Svc. Unit <input type="checkbox"/> Youth Authority						

REPORTING OFFICER
MAKES THIS ENTRY IN
HIS OWN WORDSREQUIRED ONLY IF
AIDED IS UNIDENTIFIED
AND HOSPITALIZED.

AIDED REPORT

BACK

DETAILS (include descriptions of lost, abandoned, abused, neglected, destitute child, unidentified person. When CPR is administered, include length of time CPR performed and results obtained.)

Aided tripped and fell down five (5) steps of stairway 1693 at time and place of occurrence.

Diagnosis - laceration over right eye and concussion. Treated and released.

ENTER DIAGNOSIS, IF
AVAILABLE, IN CITY
INVOLVED CASES.

ADDITIONAL REPORTS

PREPARED BY: PD 301-155

NAME AND ADDRESS OF WITNESSES (if none, so state)

Clark Kent - 37 Chambers Street, N.Y.C.

REPORTED BY	Rank	Name (Print or Type)	Shield No.	City	Signature
	P.O.	Noel Deignan	23140	21	Noel Deignan
REVIEWED BY	Rank	Signature of Reviewing Officer	Pct.	Aided No.	
	Sgt.	Thomas X. McCormack	21	482	

ENTER AIDED NO. EVEN
THOUGH ALREADY IN-
DICATED ON FRONT SIDE.

ACTUAL SIZE 4 X 6

AIDED CASES **MENTALLY ILL OR TEMPORARILY DERANGED PERSONS**

8-28-81

9-4-81

81-7

1 of 2

PURPOSE

To safeguard a mentally ill person who does not voluntarily seek medical assistance.

**LEGAL
REFERENCES**

Section 33.17 Mental Hygiene Law
 Section 29.19 Mental Hygiene Law
 Section 9.21 Mental Hygiene Law
 Section 9.37d Mental Hygiene Law
 Section 9.41 Mental Hygiene Law
 Section 9.43 Mental Hygiene Law
 Section 9.45 Mental Hygiene Law
 Section 35.10, subdivisions 4, 5 & 6, Penal Law

PROCEDURE

When a uniformed member of the service believes that a person, who is apparently mentally ill or temporarily deranged, must be taken into protective custody because the person is conducting himself in a manner likely to result in serious physical injury to himself or others, and immediate physical force is not required:

PRIOR TO TAKING PERSON INTO CUSTODY**UNIFORMED
MEMBER OF
THE SERVICE**

1. Request patrol supervisor and Emergency Service Unit to respond to scene.
 - a. If patrol supervisor is unavailable for any reason, request Communications Division to direct any available supervisor to respond.
2. Attempt to isolate and contain the mentally ill or deranged person until the arrival of the patrol supervisor and the Emergency Service Unit.
3. Request ambulance.
4. Establish police lines.

**PATROL
SUPERVISOR**

5. Cancel request for Emergency Service if services not required.
6. Establish firearms control.
 - a. Direct members concerned not to use their firearms or use any other deadly physical force unless their lives or the life of another is in imminent danger.
7. Request assistance of:
 - a. Emergency Service Unit if not already requested.
 - b. Hostage Negotiating Team, if necessary.
 - c. Interpreter, if language barrier.
 - d. Subject's family or friends.
 - e. Local clergyman.
 - f. Prominent local citizen.
 - g. Any public or private agency deemed appropriate for possible assistance.
8. Notify station house officer of facts and request that Precinct Commander/Duty Captain respond, if necessary.
9. Establish police lines if not already done.

S.H. OFFICER

10. Notify Precinct Commander/Duty Captain to respond.
11. Notify personnel assigned to Operations Unit and patrol borough command of facts.

**RANKING
SUPERVISORY
OFFICER AT
SCENE**

12. Assume command of firearms control.
13. Direct whatever action is necessary, including use of negotiators, to restrain subject with minimum use of physical force consistent with circumstances.

AIDED CASES **MENTALLY ILL OR TEMPORARILY DERANGED PERSONS**

8-28-81

9-4-81

81-7

2 of 2

NOTE

The safety of ALL persons is paramount in a case involving an emotionally disturbed person. If such person is dangerous to himself or others, necessary force may be used to prevent serious physical injury or death. Physical force will be used ONLY to the extent necessary to restrain the subject until delivered to a hospital or detention facility. Deadly physical force will be used ONLY as a last resort to protect the life of the uniformed member of the service assigned or any other person present. If an emotionally disturbed person is not dangerous, the person should be contained until assistance arrives. In any case, when there is time to negotiate, all the time necessary to insure the safety of all individuals concerned will be used.

14. Direct use of alternate means of force, if appropriate, according to circumstances (Mace, tear gas, baton, restraining equipment).

WHEN PERSON HAS BEEN RESTRAINED**UNIFORMED
MEMBER OF
THE SERVICE**

15. Have person removed to hospital in ambulance.
- a. Restraining equipment, may include handcuffs, if patient is violent, resists, or upon direction of a physician examiner.
 - b. If unable to transport with reasonable restraint, ambulance attendant or doctor will request special ambulance.
 - c. When possible, a female patient being transported should be accompanied by another female or by an adult member of her immediate family.
 - d. Remove property that is dangerous to life or will aid escape.
16. Ride in body of ambulance with patient.
- a. Two (2) police officers will safeguard if more than one (1) patient is being transported.

NOTE

If an ambulance IS NOT available and the situation warrants, transport the emotionally disturbed person to the hospital by RMP if able to do so with reasonable restraint.

17. Safeguard patient at hospital until examined by psychiatrist.
- a. When entering psychiatric ward of hospital, unload revolver.
18. Inform psychiatrist of circumstances which brought patient into police custody:
- a. Inform relieving police officer of circumstances if safeguarding extends beyond expiration of tour. Relieving police officer will inform psychiatrist of details.
19. Enter details in ACTIVITY LOG (PD112-145) and prepare AIDED REPORT (PD304-152).
- a. Indicate on AIDED REPORT name of psychiatrist.
20. Deliver AIDED REPORT to station house officer.

**ADDITIONAL
DATA**

Prior to interviewing a patient confined to a facility of the Department of Hospitals, a uniformed member of the service must obtain permission from the hospital administrator who will ascertain if the patient is mentally competent to give statement.

Refer persons who voluntarily seek psychiatric treatment to proper facility.

A police officer will also comply with this procedure upon direction of the Commissioner of Mental Health, Mental Retardation and Alcoholism Services. It should be noted that the Commissioner HAS NOT authorized anyone to act as his designee.

REVISION NOTICE

GUIDE

PATROL

NUMBER

81-7

DATE

8-28-81

The following procedures have been added, amended or revoked.

1 of 2

HAND WRITTEN INK CHANGES REQUIRED BY THIS DIRECTIVE ARE EFFECTIVE
SEPTEMBER 4, 1981.

1. Uniformed members of the service performing patrol duty may, with the approval of the patrol supervisor, remove an emotionally disturbed/mentally ill person who requires hospitalization to a medical facility in a radio motor patrol car, IF an ambulance is not available and IF removal can be made with reasonable restraint. Such person may also be removed to a hospital immediately by radio motor patrol car to relieve a potentially explosive situation. In any case, police officers have a great deal of discretion, depending upon existing conditions, to remove such persons immediately by a radio motor patrol car to a medical facility.

The officer assigned to the case should realize that handling a mentally ill/emotionally disturbed person is sensitive and potentially dangerous. If the person is threatening his own or the life of another, necessary force may be used to protect life and/or prevent serious physical injury. However, if there is no imminent threat to life or serious physical injury and the decision has been made to await the arrival of an ambulance, the member shall isolate the disturbed person until additional assistance arrives.

In all incidents involving an emotionally disturbed/mentally ill person, the member on the scene shall request that the patrol supervisor and emergency service personnel be dispatched. If the precinct patrol supervisor is unavailable, the radio dispatcher shall assign a supervisor from an adjoining precinct to respond.

The Mental Hygiene Law no longer requires a uniformed member of the service to take an emotionally disturbed person into custody solely on the basis of two written statements from two physicians. In addition, the section of the additional data statement in the present procedure that requires a uniformed member to comply with this procedure upon receipt of a court order has been removed. However, a uniformed member must comply when a court warrant is received directing that an alleged emotionally disturbed person be brought before the court.

The Patrol Guide is amended. Therefore, remove and replace procedure 106-11 (2 pages). In addition make the following change in ink in the Index.

INDEX PAGE

9

CHANGE

After caption EMERGENCY SERVICE UNIT - WORK UNIFORM,
add the following caption:
EMOTIONALLY DISTURBED PERSON 106-11

2. A new procedure has been prepared that standardizes the manner in which injuries to Auxiliary Police Officers who are performing duty are processed. Therefore, add new procedure 106-25 (1 page). In addition make the following addition in ink in the Index:

INDEX PAGE

4

CHANGE

Add the following new caption immediately above
AVIATION UNIT to read:

AUXILIARY POLICE OFFICER

Injury on duty 106-25

11

Add the following new sub-caption immediately below
INJURY, LINE OF DUTY to read:

Auxiliary police officer 106-25

12

Add the following new sub-caption immediately below
LINE OF DUTY, INJURY to read:

Auxiliary police officer 106-25

REVISION NOTICE

GUIDE	NUMBER	DATE
PATROL	81-7	8-28-81

The following procedures have been added, amended or revoked.

2 of 2

3. A uniformed member of the service who buys, acquires, sells or disposes of a pistol or revolver must prepare ACQUISITION OR DISPOSITION OF FIREARMS BY POLICE OFFICERS - REPORT TO NEW YORK STATE POLICE (PD424-150). This form and a copy of the bill of sale or a copy of a report to the commanding officer, License Division, as appropriate, will be submitted to the station house officer of the member's assigned command. Procedures 120-22, 120-23 and 120-24 have been rewritten to include the processing of this form. The Patrol Guide is amended. Therefore, remove and replace procedures 120-22, 120-23 and 120-24 (1 page each procedure).

Interim Orders No. 13 and 13-1, c.s., are REVOKED.

4. Uniformed members of the service below the rank of captain who perform permanent clerical or administrative duties, and members required to prepare an INVESTIGATOR'S DAILY ACTIVITY REPORT are required to carry and maintain an ACTIVITY LOG (PD112-145) when such members are assigned to a detail, e.g., strike duty, parade, etc. The Patrol Guide is amended. Therefore, make the following change in ink on the existing procedure page:

PROCEDURE

116-32, page 1

CHANGE

SCOPE, at the end of the statement add the following sentence to read:

"However, when any uniformed member below the rank of captain is assigned to a detail, e.g., parade, election duty, etc., the member concerned will maintain and make required entries in an ACTIVITY LOG (PD112-145).

5. The City of New York is entitled to reimbursement for damages to city property resulting from vehicular accidents. The POLICE ACCIDENT REPORT (MV 104AN) prepared for this type accident should indicate that a duplicated copy of the report will be forwarded to the Bureau of Highways. The Patrol Guide is amended. Therefore, make the following changes in ink on the existing procedure page:

PROCEDURE

107-5, page 2

CHANGE

Change third condition down to read:

"Damage to parkway, through park road, highway, stone wall, curb, fence, guide rail, post, media barrier".

Change third agency down to read:

"Department of Transportation Bureau of Highways Legal Department".

6. Patrol Guide revision 81-3 indicated that an ACCIDENT REPORT-CITY INVOLVED (PD301-155) is no longer prepared when a uniformed member of the service is injured in the line of duty. Procedure 120-3 is amended to reflect this change. Therefore, make the following change in ink on the existing procedure page:

PROCEDURE

120-3, page 1

120-3, page 2

CHANGE

Step #12, delete subdivision b.

Step #18, delete the words:

"and ACCIDENT REPORT - CITY INVOLVED".

MEMORANDUM TO THE COURT

SUPREME COURT
 NEW YORK COUNTY
 FROM: MENTAL HEALTH
 INFORMATION SERVICE
 First Department
 Address:
 41 Madison Avenue
 New York, N. Y. 10010

PATIENT'S NAME

INSTIT. IDENT. NO.

INSTITUTION

DATE OF ADMISSION

1/5/79

Manhattan Psychiatric Center

CURRENT ADMISS. STATUS DATE

Two Physician Certifi- EXPIR.
 cate Appl. Signed 6/26/81 8/26

NAME AND ADDRESS OF PATIENT'S COUNSEL, IF ANY

Mental Health Information Service

NAME AND ADDRESS OF PATIENT'S PSYCHIATRIST, IF ANY

MEMORANDUM

SIX MONTH ORDER OF RETENTIONNATURE OF THE PROCEEDING:

Manhattan Psychiatric Center makes application to the Supreme Court for an order to retain [redacted] for a period not to exceed six months pursuant to §9.33 of the Mental Hygiene Law. [redacted] objects to his continued hospitalization and has requested a court hearing to determine the need for his involuntary hospitalization.

Section 9.01 of the Mental Hygiene Law states that "need for retention" means that a person is in need of involuntary care and treatment in a hospital for a further period. "In need of involuntary care and treatment" means that "a person has a mental illness for which care and treatment in a hospital is essential to such person's welfare and whose judgment is so impaired that he is unable to understand the need for such care and treatment". §1.03(20) of the Mental Hygiene Law defines mental illness as "...an affliction with a mental disease or mental condition which is manifested by a disorder or disturbance in behavior, feeling, thinking or judgment to such an extent that the person so afflicted requires care, treatment and rehabilitation".

Article 9 of the Mental Hygiene Law does not state what the standard of proof should be in civil commitment hearings. However, the United States Supreme Court, in the case of Addington v. Texas 441 U.S. 418, 99 S. Ct. 1804 (1979), has held that in order to satisfy the due process clause of the Fourteenth Amendment in civil commitment proceedings the hospital has the burden of proving the need for commitment by clear and convincing evidence rather than by a mere preponderance of the evidence.

/continued

MHIS
MEMORANDUM TO THE COURT - CONTINUED

PAGE 2

PATIENT'S NAME

INSTIT.

IDENT. NO.

Prior to the Addington decision, the only New York case that dealt with the issue also adopted a clear and convincing standard. Matter of Scopes 59 App. Div. 2d 203, 398 N.Y.S. 2d 911(1977). Recently the standard of clear and convincing evidence has been specifically applied to a situation where a hospital had applied for an order of retention pursuant to §9.33 of the Mental Hygiene Law. Matter of Carter 424 N.Y.S. 2d 833, [Sup. Ct. Suffolk County, January 1980].

Therefore in considering the hospital's application for retention the court must decide whether the hospital has proven by clear and convincing evidence rather than by a mere preponderance of the evidence that:

1. is mentally ill;
2. Care and treatment in a hospital is essential to his welfare;
3. His judgment is so impaired that he is unable to understand the need for such care and treatment.

Should the court determine that any one of these three criteria is absent the hospital's application for retention must be denied.

REQUIREMENTS FOR TREATMENT IN THE
LEAST RESTRICTIVE ENVIRONMENT:

The Mental Hygiene Law and regulations promulgated pursuant to that law presently mandate that care and treatment of the mentally disabled be provided in the least restrictive setting possible. The basis of this requirement is set out in 14 NYCRR 36.1 as follows:

The long-term rehabilitation of mentally disabled persons is promoted by maintenance of relationships with other persons and agencies in the community, avoidance of institutionalization, and minimization of disruption in life rhythms. The civil rights of mentally disabled persons require that such persons be treated and served in the least restrictive setting possible in which treatment or service goals can be met. (emphasis added.)

/continued

PATIENT'S NAME

INSTIT.

IDENT. NO.

COUNSEL:

The Mental Health Information Service has advised _____ of his legal rights, including his right to a court hearing, his right to privately retained counsel, or if he does not secure private counsel, his right to be represented by the Mental Health Information Service in this proceeding. _____ is represented by the Mental Health Information Service.

EVENTS LEADING TO HOSPITALIZATION:

According to his hospital record, _____ was admitted to Manhattan Psychiatric Center as a voluntary patient on January 5, 1979 due to suicidal ideation and depression. While at Manhattan Psychiatric Center _____ remained on a voluntary status until June 26, 1981, when the hospital completed a two physician certificate application thus converting _____ to an involuntary patient status.

On August 21, 1981, Manhattan Psychiatric Center made timely application to the Supreme Court for an order to retain _____ for an additional six month period.

FAMILY, EDUCATION AND BACKGROUND:

The following information was obtained from _____ and / or his hospital record.

_____ was born in Puerto Rico on November 3, 1935. _____ was educated through the 12th grade while living with his parents in Puerto Rico.

Prior to his hospitalization _____ resided with his wife, _____ and his son, _____, at _____ in New York City.

_____ has been employed as a watch repairman and a shipping clerk. He worked for La Salle Lettering Company from 1970-1977. _____ is currently a recipient of Social Security benefits. In addition, _____ is entitled to a pension from District 65, United Auto Workers Union.

INTERVIEWS:

With: _____ Patient

_____ was interviewed by the Mental Health Information Service on several occasions. _____ stated that he is no longer in need of hospitalization and therefore wishes to be discharged. _____ also stated that he had never tried to kill himself during his hospitalization and has no desire to hurt himself or any one else.

[continued]

MHIS
REPORT TO THE COURT - CONTINUED

PAGE 4

PATIENT'S NAME

INSTIT.

IDENT. NO.

Furthermore, _____ stated that he would be willing to attend an aftercare clinic if it were so prescribed. Upon discharge, _____ intends to find his own apartment and support himself with his pension and social security benefits.

With: _____ Attending Psychiatrist

Dr. _____ stated to the Mental Health Information Service that, in his opinion, _____ is in need of continued treatment and observation because _____ remains irrational, delusional, paranoid and very talkative.

MENTAL HEALTH INFORMATION SERVICE SUMMARY:

Manhattan Psychiatric Center makes application to the Supreme Court for an order to retain _____ for a period not to exceed six months pursuant to §9.33 of the Mental Hygiene Law. _____ is opposed to his continued hospitalization and has requested a court hearing to determine the need for his continued involuntary hospitalization.

DATED: September 10, 1981

Respectfully submitted by,

By _____

NM/sb

STATE OF NEW YORK
OFFICE OF MENTAL HEALTH

RECORD OF EMERGENCY ADMISSION

Use this form *ONLY* for Emergency Admissions under Section 9.39 of the Mental Hygiene Law.

Use Form OMH 471 to request admission of patients on certificates of examining physicians (Section 9.27) or on the certificate of a Director of Community Services or his Designee (Section 9.37).

PROVISIONS GOVERNING EMERGENCY ADMISSIONS

Section 9.39 of the Mental Hygiene Law provides for emergency admission to a hospital, for a period of 15 days, of any person alleged to have a mental illness for which immediate observation, care and treatment in a hospital is appropriate and which is likely to result in serious harm to himself or others.

"Likelihood to result in serious harm" is defined as:

- (1) 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

- (2) 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.

Only hospitals approved by the Commissioner of Mental Health and maintaining adequate staff and facilities for the observation, examination, care and treatment of persons alleged to be mentally ill may receive and retain patients pursuant to this section of the law.

PROCEDURE

- A. Upon admission the admitting physician shall examine the person alleged to be in need of emergency admission to the hospital, and shall certify below his finding that such person qualifies for admission under the provisions outlined above.
- B. He shall also record in the space below the name of the person or persons, if any, who brought the patient to the hospital, and the details of the circumstances leading to the hospitalization of the patient. As soon as possible after admission, further identifying data about the patient should be obtained and recorded on Form OMH 459, Identifying Data Sheet, and attached to this form.
- C. Within 48 hours of the time of admission of the patient, he must be examined by another physician who must be a member of the psychiatric staff of the hospital. The findings of this psychiatric examiner shall be recorded on the reverse side of this form.
- D. If the psychiatric examiner confirms the finding of the admitting physician, that the patient qualifies for admission under the provisions outlined above, the patient may then be retained for a period up to fifteen days from the date of his admission to the hospital.
- E. The patient may be retained beyond 15 days only by a new admission on an application supported by two new examining physicians' certificates, unless he agrees to remain as a voluntary or informal patient. In either case, the date of admission shall be deemed to be the date when the patient was first received as an Emergency Admission.

RECORD OF ADMISSION

PATIENT NAME _____ AGE _____

ADDRESS _____

The patient was brought to this hospital at _____ on _____ by:
TIME DATE

NAME RELATION TO PATIENT

OFFICIAL TITLE, OR BADGE NUMBER, IF ANY

ADDRESS PHONE

The circumstances which lead to the hospitalization of this patient were as follows:

I have examined the patient named above and confirm his need for immediate observation, care and treatment for a mental illness which is likely to result in serious harm to himself or others.

EXAMINATION FOR 48-HOUR CONFIRMATION
OF NEED FOR EMERGENCY ADMISSION

PATIENT NAME		(Last)	(First)	(Middle)
NAME OF HOSPITAL				
DATE OF ADMISSION		TIME OF ADMISSION		
"C" NO.				

1. Pertinent and Significant Factors in Patient's Medical and Psychiatric History:

2. Physical Condition (Including any special test reports)

3. Mental Condition: The conduct of the patient (Including statements made to me by others) has been:

4. The patient showed the following psychiatric signs and symptoms:

5. Does the patient show a tendency to injure himself? _____; to injure others? _____

Explain _____

6. Mental diagnosis (if determined) _____

7. a. I, _____, M.D., am a member of the psychiatric staff of _____ Hospital.

b. I have with care and diligence personally observed and examined _____
(INSERT NAME OF PATIENT)
at _____, on _____, 19_____, and as a result of such examination I find
(TIME)

and hereby certify to the fact that he has a mental illness for which immediate care and treatment in a hospital is appropriate and which is likely to result in serious harm to himself or others.

c. I have formed this opinion from the history of the case and my examination of the patient as given above.

d. I hereby certify that the facts stated and information contained in this certificate are true to the best of my knowledge and belief.

State of New York
OFFICE OF MENTAL HEALTH**NOTICE OF STATUS AND RIGHTS — EMERGENCY ADMISSION**
(to be given to an emergency patient at the time of his admission)

TO: _____, 19____

Copies of this Notice of Status and Rights are also being sent to the Mental Health Information Service and others designated by you to be informed of your admission.

State and Federal Laws prohibit discrimination based on race, color, creed, national origin, age, sex, or disability.

HOSPITAL	
ADMISSION DATE	"C" NUMBER
<input type="checkbox"/> EMERGENCY ADMISSION (Sec. 9.39 M.H. Law)	

YOU HAVE BEEN ADMITTED TO THIS HOSPITAL FOR THE MENTALLY ILL ON AN EMERGENCY BASIS FOR IMMEDIATE OBSERVATION, CARE AND TREATMENT. WITHIN 48 HOURS OF THE TIME OF YOUR ADMISSION, YOU WILL BE EXAMINED BY ANOTHER MEMBER OF THE PSYCHIATRIC STAFF. IF HIS FINDING CONFIRMS THE INITIAL FINDING OF THE ADMITTING PHYSICIAN, YOU MAY THEN BE RETAINED FOR A PERIOD UP TO FIFTEEN DAYS FROM THE DATE OF YOUR ADMISSION TO THIS HOSPITAL. DURING THIS FIFTEEN DAY PERIOD YOU MAY BE RELEASED, ASKED TO REMAIN AS AN INFORMAL OR VOLUNTARY PATIENT, OR BE ADMITTED AS AN INVOLUNTARY PATIENT.

YOU, YOUR RELATIVES, AND YOUR FRIENDS SHOULD FEEL FREE TO ASK MEMBERS OF THE HOSPITAL STAFF ABOUT YOUR CONDITION, YOUR STATUS AND RIGHTS, AND THE RULES AND REGULATIONS OF THE HOSPITAL.

IF YOU, YOUR RELATIVES, OR YOUR FRIENDS FEEL THAT YOU DO NOT NEED IMMEDIATE OBSERVATION, CARE AND TREATMENT, YOU OR THEY MAY REQUEST A COURT HEARING. COPIES OF ANY WRITTEN REQUEST FOR A COURT HEARING WILL BE FORWARDED BY THE HOSPITAL DIRECTOR TO THE APPROPRIATE COURT AND THE MENTAL HEALTH INFORMATION SERVICE.

MENTAL HEALTH INFORMATION SERVICE

THE MENTAL HEALTH INFORMATION SERVICE, A COURT AGENCY INDEPENDENT OF THIS FACILITY, CAN PROVIDE YOU, AND OTHERS ACTING IN YOUR BEHALF, WITH PROTECTIVE SERVICE ASSISTANCE AND INFORMATION WITH REGARD TO THEIR HOSPITALIZATION. YOU HAVE A RIGHT TO A COURT HEARING AND A RIGHT TO BE REPRESENTED BY A LAWYER.

YOU, OR SOMEONE ACTING IN YOUR BEHALF, MAY CALL OR WRITE DIRECTLY TO THE MENTAL HEALTH INFORMATION SERVICE, OR REQUEST THAT A MEMBER OF THE HOSPITAL STAFF CONTACT THE SERVICE FOR YOU.

THE ADDRESS AND PHONE NUMBER OF THE MENTAL HEALTH INFORMATION SERVICE FOR THIS HOSPITAL IS:

*Metropolitan Hospital Center
Psychiatric Pavilion
Mental Health Information Service
Room 9M51
Tele: 360-6006*

THE ABOVE PATIENT HAS BEEN GIVEN A COPY OF THIS NOTICE.

Date_____
Staff Physician

COPIES TO: Persons designated by patient to be informed of admission (If None type in "NONE").

NOTIFICACION DE ESTADO Y DERECHOS - ADMISION DE EMERGENCIA
(para entrega al paciente de emergencia cuando se le admite)

A: _____ de _____ de 19 _____

Copias de esta Notificación de Estado y Derechos también se están transmitiendo al Servicio de Información de Higiene Mental y a los otros que Ud. ha pedido sean informados de su admisión.

Las leyes estatales y federales prohíben la discriminación basada en la raza, color de piel, creencia religiosa, nacionalidad, edad, sexo, o incapacidad.

HOSPITAL	
Fecha de admisión	Núm. "C"
<input type="checkbox"/> Admisión de emergencia (Secciones 9.39, Ley de H.M.)	

Ud. ha sido admitido a este hospital para enfermos mentales en circunstancias de emergencia para observación, atención médica y tratamiento inmediatos. Dentro de 48 horas del momento de su admisión otro psiquiatra del hospital le examinará. Si los fallos de éste concuerdan con los del médico que le admitió a Ud., Ud. será retenido por un plazo de hasta 15 días de la fecha de su admisión a este hospital. Durante este plazo de 15 días, le pueden dejar irse, pedirle que se quede como paciente no-formal o voluntario, o admitirle como paciente involuntario.

Ud., sus parientes, y sus amigos tienen plena libertad de consultarse con los miembros del personal del hospital sobre su propia condición física y mental, su estado y sus derechos, y las reglas y reglamentos del hospital.

Si Ud., sus parientes, o sus amigos creen que Ud. no necesita observación, atención médica y tratamiento inmediatos, Ud. o ellos pueden solicitar una audiencia judicial. El director del hospital transmitirá copias de toda petición por escrito para una audiencia judicial a la corte apropiada y al Servicio de Información Sobre la Salud Mental.

SERVICIO DE INFORMACION SOBRE LA SALUD MENTAL

El Servicio de Información Sobre la Salud Mental, un agente de la corte independiente de este hospital, les puede proporcionar, y a sus representantes, servicios de protección, asistencia e información con respecto a su hospitalización. Usted tiene derecho a una audiencia judicial y a ser representados por un abogado.

Ud., o su representante, puede llamar o escribir directamente al Servicio de Información Sobre la Salud Mental, o puede solicitar que un miembro del personal del hospital se comunice con el Servicio en nombre suyo.

La dirección y el número de teléfono del Servicio de Información Sobre la Salud Mental para este hospital es:

A: paciente arriba nombrado se le ha dado una copia de esta notificación.

Fecha

(Médico del Hospital)

COPIAS A: Las personal que el paciente ha pedido sean informadas de su admisión. (Si Ninguna escriba a máquina "NINGUNA.")

NOTICE OF STATUS AND RIGHTS - INVOLUNTARY STATUS
(to be given to a patient at the time of admission or conversion to involuntary status)

TO: _____, 19 _____

Copies of this Notice of Status and Rights are also being sent to the Mental Health Information Service, the original applicant, your nearest relative and others designated by you to be informed of your admission.

State and Federal Laws prohibit discrimination based on race, color, creed, national origin, age, sex, or disability.

HOSPITAL

ADMISSION DATE

CASE NO.

YOU HAVE BEEN:

- (check one (1)) ☐ ADMITTED TO THIS HOSPITAL FOR THE MENTALLY ILL AS AN INVOLUNTARY PATIENT;
☐ CONVERTED TO INVOLUNTARY STATUS AT THIS HOSPITAL FOR THE MENTALLY ILL.

YOU HAVE BEEN HOSPITALIZED ON INVOLUNTARY STATUS IN ACCORDANCE WITH THE PROVISIONS OF:

- (check one (1)) ☐ SECTION 9.27 OF THE MENTAL HYGIENE LAW - INVOLUNTARY ADMISSION ON MEDICAL CERTIFICATION;
☐ SECTION 9.37 OF THE MENTAL HYGIENE LAW - INVOLUNTARY ADMISSION ON CERTIFICATE OF A DIRECTOR OF COMMUNITY SERVICES.

YOU, YOUR RELATIVES, AND YOUR FRIENDS SHOULD FEEL FREE TO ASK MEMBERS OF THE HOSPITAL STAFF ABOUT YOUR CONDITION, YOUR STATUS AND RIGHTS, AND THE RULES AND REGULATIONS OF THIS HOSPITAL.

IF YOU, YOUR RELATIVES, OR YOUR FRIENDS FEEL THAT YOU DO NOT NEED INVOLUNTARY CARE AND TREATMENT, YOU OR THEY MAY REQUEST A COURT HEARING. COPIES OF ANY WRITTEN REQUEST FOR A COURT HEARING WILL BE FORWARDED BY THE HOSPITAL DIRECTOR TO THE APPROPRIATE COURT AND THE MENTAL HEALTH INFORMATION SERVICE.

MENTAL HEALTH INFORMATION SERVICE

THE MENTAL HEALTH INFORMATION SERVICE, A COURT AGENCY INDEPENDENT OF THIS FACILITY, CAN PROVIDE YOU, AND OTHERS ACTING IN YOUR BEHALF, WITH PROTECTIVE SERVICE, ASSISTANCE AND INFORMATION WITH REGARD TO YOUR HOSPITALIZATION. YOU HAVE A RIGHT TO A COURT HEARING AND A RIGHT TO BE REPRESENTED BY A LAWYER.

YOU, OR SOMEONE ACTING IN YOUR BEHALF, MAY CALL OR WRITE DIRECTLY TO THE MENTAL HEALTH INFORMATION SERVICE, OR REQUEST THAT A MEMBER OF THE HOSPITAL STAFF CONTACT THE SERVICE FOR YOU.

THE ADDRESS AND PHONE NUMBER OF THE MENTAL HEALTH INFORMATION SERVICE FOR THIS HOSPITAL IS:

Metropolitan Police Center
 Psychiatric Services
 Mental Health Information Service
 Room 5A51 Tel: 505-6100

THE ABOVE PATIENT HAS BEEN GIVEN A COPY OF THIS NOTICE.

Date _____

Staff Physician _____

COPIES TO:
 (Original Applicant)

COPIES TO: Persons designated by patient to be informed of admission (if None type in "NONE")

(Nearest Relative)

NOTICE OF STATUS AND RIGHTS - VOLUNTARY OR MINOR VOLUNTARY ADMISSION

(to be given to a voluntary or minor voluntary patient at the time of his admission)

TO: _____, 19 _____

A copy of this Notice of Status and Rights is also being sent to the Mental Health Information Service.

State and Federal Laws prohibit discrimination based on race, color, creed, national origin, age, sex, or disability.

HOSPITAL BELLEVUE PSYCHIATRIC HOSPITAL	
ADMISSION DATE	CONSECUTIVE NO.
<input type="checkbox"/> MINOR VOLUNTARY ADMISSION (Sec. 9.13, M.H. Law)	<input type="checkbox"/> VOLUNTARY ADMISSION (Sec. 9.13, M.H. Law)

YOU HAVE BEEN ADMITTED TO THIS HOSPITAL FOR THE MENTALLY ILL AS A VOLUNTARY OR MINOR VOLUNTARY PATIENT.

AT ANY TIME, YOU MAY TELL THE DIRECTOR OR OTHER STAFF MEMBERS THAT YOU WANT TO LEAVE. HOWEVER, YOU MAY NOT LEAVE FOR THREE DAYS UNLESS THE DIRECTOR LETS YOU. IF THE DIRECTOR THINKS THAT YOU NEED TO STAY, HE MAY ASK A COURT FOR AN ORDER TO KEEP YOU HERE.

YOU, YOUR RELATIVES, AND YOUR FRIENDS SHOULD FEEL FREE TO ASK MEMBERS OF THE HOSPITAL STAFF ABOUT YOUR CONDITION, YOUR STATUS AND RIGHTS, AND THE RULES AND REGULATIONS OF THE HOSPITAL.

MENTAL HEALTH INFORMATION SERVICE

THE MENTAL HEALTH INFORMATION SERVICE, A COURT AGENCY INDEPENDENT OF THIS FACILITY, PROVIDES PATIENTS, AND OTHERS ACTING IN THEIR BEHALF, WITH PROTECTIVE SERVICE, ASSISTANCE AND INFORMATION WITH REGARD TO THEIR HOSPITALIZATION. PATIENTS HAVE A RIGHT TO A COURT HEARING AND A RIGHT TO BE REPRESENTED BY A LAWYER.

YOU, OR SOMEONE ACTING IN YOUR BEHALF, MAY CALL OR WRITE DIRECTLY TO THE MENTAL HEALTH INFORMATION SERVICE, OR REQUEST THAT A MEMBER OF THE HOSPITAL STAFF CONTACT THE SERVICE FOR YOU.

THE ADDRESS AND PHONE NUMBER OF THE MENTAL HEALTH INFORMATION SERVICE FOR THIS HOSPITAL IS:

**MENTAL INFORMATION SERVICE
BELLEVUE PSYCHIATRIC HOSPITAL
TEL: 561-4961, 2, 3, 4**

I HAVE READ, OR HAD READ TO ME, AND UNDERSTAND THE CONTENTS OF THE ABOVE NOTICE.

Date

Patient's Signature or Mark

THE ABOVE PATIENT HAS BEEN GIVEN A COPY OF THIS NOTICE.

Date

Staff Physician

Bellevue Hospital Center
Psychiatric Division

NOTICE OF RIGHT TO APPEAL

(to be given to all patients at the time of his admission)

To: _____ 19 _____

You have been admitted to this hospital for the mentally ill as a voluntary, informal, emergency, or involuntary patient.

At any time, you may tell your doctor that you wish to Appeal decisions relating to your treatment or rehabilitation or conditions with which you are dissatisfied. You will be given a "grievance form" to fill out and give to your attending physician. If you are dissatisfied with your physician's decision, you may appeal to the physician in charge of the ward. If continued dissatisfaction with the decision at the ward level persist, you may now appeal to the Director of the Psychiatric Division.

A response or decision will be given to you verbally and in writing on your "grievance form" at each level. However, the right to appeal does not preclude your right to use the Judicial System at any time.

I have read, or had read to me, and understand the contents of the above notice.

Date

Patient's Signature or Mark

The above patient has been given a copy of this notice, and copy placed in his chart.

Date

Staff Physician's Signature

APPLICATION FOR
ADMISSION OF PATIENT

Admission on medical certification to a hospital for treatment of mental illness requires the completion of this form and the appropriate examination certificates. Please read the instructions on page 2 carefully before completing this form. Errors or omissions may delay admission.

State and Federal Laws prohibit discrimination based on race, color, creed, national origin, age, sex, or disability.

Do not Use This Form for Voluntary, or Informal Admissions. Use Form OMH 472 for Voluntary and Minor Voluntary Admissions. There is no formal Application for Informal Admission; instead, only provide Notice of Status and Rights - Informal Status (Form OMH 473).

GENERAL INFORMATION

1. WHO MAY MAKE APPLICATION

An application for admission of a patient to a hospital for the care and treatment of mental illness may be made by any person with whom the person alleged to be mentally ill resides, the father or mother, husband or wife, brother or sister, or the child of any such person or the nearest available relative, the committee of such a person, an officer of any public or well recognized charitable institution or agency or home in whose institution the person alleged to be mentally ill resides, the director of community services or social services official, as defined in the social service law, of the city or county in which any such person may be, the director of the hospital in which the patient is hospitalized, the director or person in charge of a facility providing care to alcoholics or drug dependent persons, or the Director of the Division For Youth.

2. QUALIFICATIONS OF EXAMINING PHYSICIANS

- a. For involuntary admission to a hospital of a person alleged to be mentally ill and in need of involuntary care and treatment, applications made by any of the persons listed above must be supported by two Certificates of Examination (Form OMH 471A) completed by two examining physicians. An "examining physician" for this purpose means a physician licensed to practice medicine in the State of New York.
- b. An application for immediate inpatient care and treatment in a hospital for a mental illness which is likely to result in serious harm to the patient or to others, submitted by the Director of Community Services for the mentally disabled or by an examining physician duly designated by him, must be supported by a "Certificate of Examination by Director of Community Services or His Designee" (Form OMH 471B). For the purpose of conducting this Examination, the Director of Community Services must be a psychiatrist. If the Director of Community Services is not a psychiatrist, the Examining Physician designated and empowered to conduct such examinations on behalf of the Director of Community Services must be a qualified psychiatrist.
- c. An examining physician must not be a relative of the person applying for the admission, or of the person to be admitted.
- d. An examining physician must not be a manager, trustee, visitor, proprietor, officer, director, or stockholder of the hospital in which the patient is hospitalized or to which it is proposed to admit the patient, or have any financial interest in such hospital other than receipt of fees, privileges or compensation for treating or examining patients in such hospital.
- e. A physician on the staff of the hospital to which admission is sought may act as an examining physician, if he is not disqualified by the provisions stated in paragraphs c and d above, except that if the hospital is a proprietary facility, neither examining physician may be on the staff of that hospital.

3. DATE OF APPLICATION AND EXAMINATION CERTIFICATES

The date of this application and of the required examinations may not be more than 10 days prior to the date of the patient's admission to the hospital. The date of each Certificate of Examination shall be the date the examination took place.

4. MENTAL HEALTH INFORMATION SERVICE

A Mental Health Information Service exists in New York State. This Service provides patients, and others interested in the patients' welfare, with assistance and information about admission, retention, and the patients' rights to have judicial hearing and review, to be represented by legal counsel, and to seek independent medical opinion.

A patient, or someone acting on the patient's behalf, may communicate directly with the Mental Health Information Service, or request that a member of the hospital staff contact the Service for him. The address of the Mental Health Information Service can be obtained from any member of the hospital staff.

5. REIMBURSEMENT

The patient is legally responsible for payment for the cost of care. Additionally responsible, if of sufficient ability, are the patient's spouse and the parents of a patient under the age of 21. Also legally responsible are the committee, guardian or trustee of a trust fund established for the support of the patient, or any fiduciary or payee of funds for the patient.

In order to assist in determining the ability of legally responsible relatives to pay for the cost of care, the applicant should be careful to provide the information requested as to names, addresses and ages of those relatives.

INSTRUCTIONS FOR COMPLETION OF APPLICATION

Read the requirements for the appropriate type of admission and complete the corresponding paragraph in Part A, on Page 3. Complete Part B and Part C regardless of type of admission.

**ADMISSION ON
CERTIFICATE OF
TWO PHYSICIANS**

(Section 9.27 of
Mental Hygiene Law)

- a. The patient may be admitted on an application from any of the persons listed in Section 1 on page 1 of this form, if such person or persons feel he is mentally ill and in need of involuntary care and treatment.
- b. The applicant completes Paragraph 1 in PART A, and PARTS B and C, on pages 3 and 4 of this form. PART A must be signed by the applicant - NOT by the examining physicians.
- c. A "Certificate of Examination" (Form OMH 471A) must be completed by each of two examining physicians. The examination may be conducted jointly, but each examining physician must execute a separate certificate.
- d. If no request for a court hearing is made, the hospital may retain the patient for up to 60 days without taking other action.
- e. If the hospital director determines that the condition of the patient requires continued hospitalization beyond 60 days, the patient may agree to remain as a voluntary or informal patient, and complete Form OMH 472, "Voluntary Request for Hospitalization" or Form OMH 473 "Acceptance of Informal Admission".
- f. If the patient does not agree to remain as a voluntary or informal patient, before the 60 day period ends the director must apply for a court order authorizing continued retention. He must also inform the patient and others interested in the patient's welfare that he is applying for a court order, to give them the opportunity to request a hearing before the court if they so desire.

**ADMISSION ON
CERTIFICATE OF A
DIRECTOR OF
COMMUNITY SERVICES
FOR THE
MENTALLY DISABLED**

(Section 9.37 of
Mental Hygiene Law)

- a. The patient may be admitted on an application from the local Director of Community Services or his designee, if in their opinion the patient has a mental illness for which immediate inpatient care and treatment in a hospital is appropriate, and which is likely to result in serious harm to himself or others.
- b. Paragraph 2 in PART A, and PARTS B and C are completed by the Director of Community Services or his Designee.
- c. Form OMH 471B, "Certificate of Examination by Director of Community Services or his Designee", is completed and submitted with the application.
- d. If the patient is to be retained beyond 72 hours (excluding Sunday and holidays), he must agree to remain as a voluntary or informal patient, or else the certificate of an examining physician ("Examination for 72 hour Conversion", Form OMH 471C), supporting the application, must be filed with the hospital.
- e. After filing of the examining physician's certificate, the patient is subject to the same provisions as though it were a two physicians' certificate admission, with the date of admission being the date the patient was first received.

PART C - IDENTIFYING DATA (Must be typed or printed clearly in ink).

NAME OF PATIENT (Last Name) (First Name) (Middle Name)			Male 1 <input type="checkbox"/> Female 2 <input type="checkbox"/>	"MEDICARE" CLAIM NO.	
STREET ADDRESS		CITY	COUNTY	STATE	ZIP CODE
DATE OF BIRTH	PLACE OF BIRTH	U.S. CITIZEN 1 <input type="checkbox"/> YES 3 <input type="checkbox"/> NO	HOW LONG IN U. S.	HOW LONG IN N. Y. STATE	
NAMES OF LIVING RELATIVES OF PATIENT (If No Relatives, Nearest Known Friend)		RELATION	AGE	STREET ADDRESS	CITY AND STATE
					PHONE NO.

PREVIOUS PSYCHIATRIC TREATMENT

NAME OF FACILITY	TYPE	LOCATION (City & State)	DATE OF ADMISSION	LENGTH OF STAY

PREVIOUS NON-PSYCHIATRIC HOSPITALIZATIONS

NAME OF HOSPITAL	LOCATION (City & State)	DATE OF ADMISSION	LENGTH OF STAY	REASON

DO NOT WRITE
IN THIS SPACE

PART D - TO BE COMPLETED BY HOSPITAL

☐ ADMISSION

☐ CHANGE IN STATUS

I have examined the above named patient and confirm the need for immediate care and treatment in an institution or facility for the mentally ill because

1 ☐ ALTERNATIVE CARE WOULD NOT BE ADEQUATE

OR

The following adequate alternative(s) (is) (are) not available

2 ☐ PSYCHIATRIC DAY CARE

4 ☐ NURSING HOME OR EXTENDED CARE FACILITY

6 ☐ TREATMENT IN GENERAL HOSPITAL PSYCHIATRIC UNIT

7 ☐ OTHER

3 ☐ TREATMENT IN THE HOME BY VISITING THERAPIST

5 ☐ OUTPATIENT TREATMENT

Hospital admission is medically necessary for

☐ TREATMENT WHICH COULD REASONABLY BE EXPECTED TO IMPROVE THE PATIENT'S CONDITION

☐ DIAGNOSTIC STUDY

SIGNATURE OF ADMITTING PHYSICIAN

HOSPITAL		DATE OF ADMISSION OR CHANGE		SERVICE-WARD	
NUMBER		SOCIAL SECURITY NO.		SOURCE OF REFERRAL	
VETERAN - WAR SERVICE		ETHNIC GROUP		RELIGION	
OCCUPATION		MARITAL STATUS		LEGAL STATUS 20 <input type="checkbox"/> Two Physicians	
23 <input type="checkbox"/> Director of Community Services or his designee					

ADDRESS

CERTIFICATE OF EXAMINING PHYSICIAN
(MENTAL ILLNESS)

CERTIFICATION

I, _____, do certify as follows:
(name of physician)

a. I am a physician licensed to practice medicine in New York State.

b. On this date I have with care and diligence personally observed and examined

_____, at _____,
(name of person examined) (place where examined)_____
(address)

c. I find this person:

1. has a mental illness;
2. requires, as essential to his welfare, care and treatment as a patient in a hospital; and
3. is so impaired in his judgment that he is unable to understand the need for such care and treatment.

d. I have considered alternative forms of care and treatment but believe that they are inadequate to provide for the needs of this person, or are not available.

e. I have formed my opinion on the basis of facts and information I have obtained (described below and on reverse side) and my examination of this person.

f. To the best of my knowledge and belief, the facts stated and information contained in this certificate are true.

(date)_____
(signature)_____
(address)_____
(print name signed)

(telephone number)

VOLUNTARY REQUEST FOR HOSPITALIZATION

Before completing, read the instructions on the preceding pages.

Check Off Appropriate Box and Complete Corresponding Paragraph.

PART A:

Application for
Voluntary
Admission

Section 9.13

☐

THIS SECTION MUST
BE SIGNED BY THE
PROSPECTIVE
PATIENT

I, Bellevue Hospital, hereby apply for voluntary admission

to _____, a hospital for the mentally ill.

My reasons for requesting care and treatment are stated in Part C below.

I have been notified and understand the nature of the voluntary status and the provisions governing release or conversion to involuntary status.

Date: _____ Signature of Patient

PART B

Application for
Minor Voluntary
Admission

Section 9.13

☐

THIS SECTION MUST
BE SIGNED BY THE
PARENT,
LEGAL GUARDIAN
OR NEXT-OF-KIN OF
THE PROSPECTIVE
PATIENT

I, _____, acting for my _____, (Relationship)

_____, hereby apply for his (Name) (Age) admission to _____, a hospital for the mentally ill.

My reasons for requesting his care and treatment are stated in Part C below.

I have been notified and understand the nature of the voluntary status and the provisions governing release or conversion to involuntary status.

The Mental Health Information Service
Bellevue Psychiatric Hospital
400 East 30th Street, New York, NY 10016
Telephone #561-4961, 2, 3, 4

Date: _____ Signature of minor patient's parent, guardian, or next of kin

PART C - Statement of reasons for requesting hospitalization. (To be completed by patient or by parent, guardian or next of kin).

PART D - IDENTIFYING DATA (Must be typed or printed clearly in ink.)

[illegible]

PREVIOUS PSYCHIATRIC TREATMENT

[illegible]

PREVIOUS NON-PSYCHIATRIC HOSPITALIZATIONS

NAME OF HOSPITAL	LOCATION (City & State)	DATE OF ADMISSION	LENGTH OF STAY	REASON

DO NOT WRITE
IN THIS SPACE

PART E - TO BE COMPLETED BY STAFF PHYSICIAN

ADMISSION

☐ CHANGE IN STATUS

I have examined the above named patient, and confirm the need for immediate care and treatment for mental illness. Hospital admission is medically necessary for

TREATMENT WHICH COULD REASONABLY BE EXPECTED TO IMPROVE THE PATIENT'S CONDITION

DIAGNOSTIC STUDY

I certify that the patient is suitable for the type of admission requested.

SIGNATURE OF ADMITTING PHYSICIAN

HOSPITAL		DATE OF ADMISSION OR CHANGE		SERVICE-WARD	
"C" NO.		SOCIAL SECURITY NO.		SOURCE OF REFERRAL	
				VETERAN-WAR SERVICE	
ETHNIC GROUP		RELIGION		OCCUPATION	
				MARITAL STATUS	
				LEGAL STATUS	
				32 <input type="checkbox"/> Voluntary 33 <input type="checkbox"/> Minor Vols	

Bellevue Hospital Center
Psychiatric Division

Patient Grievance Form

Date

I, _____ wish to appeal the following:

Patient's Signature

Attending Psychiatrist's Reply: _____
Date

Attending Psychiatrist's Signature

Unit Chief's Reply: _____
Date

Unit Chief's Signature

Associate Medical Director's Reply: _____
Date

Associate Medical Director's
Signature

APPENDIX B

DATA COLLECTION INSTRUMENTS USED IN THE
FIRST JUDICIAL DEPARTMENT OF NEW YORK STUDY

Index

	<u>Page</u>
Data Collection Guide	99
Statement of Confidentiality and Project Ethics	103
Master Data Guide	107
Observation Guide	129

INVOLUNTARY CIVIL COMMITMENT PROJECT

DATA COLLECTION GUIDE

PURPOSE

The ultimate goal for this research project is to generate information by which the civil commitment process can be made to function as well as possible. The purpose of this data collection is to obtain practitioners' opinions, advice, and suggestions about the civil commitment process, particularly about the process as it operates in their own localities. Our staff has become familiar with each state's statute and basic commitment process. We know, however, that systems do not always operate exactly as statutes prescribe. Situations occasionally arise that are not explicitly provided for in statute. People who work with a system on a day-to-day basis can explain why things are done as they are and can offer insights into how a system might be made to operate most smoothly.

This research is entirely qualitative, not quantitative. Our main purpose is not to ask how many, or even how. Our purpose is to ask why, how well, and how else. Assuming that we are aware of the basic statutes and procedures, questions do not call for descriptions of legal requirements or commitment process events, per se. Descriptions of law and process are requested only to help explain advantages, disadvantages, and possible modifications of a system. We seek information about what works best and why.

APPROACH

This is not a typical research survey. The people with whom we are speaking have been chosen because they are well informed about the civil commitment process. Thus, our sample of interviewees is not a statistically representative sample; we therefore have no reason to count what percent of interviewees feel one way or the other. Our job in this research is to report on the unique and authoritative insights that these key people can impart. Because we are looking for what works best, the research has not been designed to show validly what is average or typical.

The questions in this data collection guide are open-ended. Multiple choice types of questions have been avoided so that interviewees will be free to formulate their own opinions rather than having their thoughts slotted into predetermined categories by the researchers. The only exceptions to this are the few background questions about each interviewee. Using these questions, we hope to group the interviewees into a small number of predetermined categories to help us understand how different types of people view different issues.

ORGANIZATION

This data collection guide is a complete set of all the questions that are to be investigated. People will be interviewed individually and in homogeneous groups. Some of the questions also will be answered by project staff on the basis of their own empirical observations. Project staff have a separate observation guide to help them note important events and to key the observation information to appropriate questions in this data guide.

The interview covers many topics. The complete data collection flows in a more-or-less chronological order, as events occur during a typical commitment process. The questions unavoidably overlap each other to some degree, but repetition was minimized as much as possible.

All the questions are coded according to the types of people whom we expect will be able to give us the desired information. The codes and their meanings are these:

- J Judges, magistrates, special justices, and so on;
- C Clerks and other court personnel;
- L Law enforcement officers, probation officers, and so on;
- A Attorneys and patients' rights advocates;
- P Psychiatrists, psychologists, social workers, and so on;
- R Respondent, petitioner, family members and other lay individuals;
- O Direct observation.

Because of the length of the data collection guide, every question will not be asked of every interviewee. We will select a subset of questions to present in each interview, trying to optimize the match of peoples' areas of knowledge with the questions asked. Everyone will be invited, however, to discuss any aspect of the commitment process with which they are familiar or about which they have particular opinions or suggestions.

ADMINISTRATION

Whenever possible, the data collection guide will be sent to interviewees prior to the actual interview. This will give people a chance to consider the issues that are to be raised, collect their thoughts, and prepare their answers in advance, if they wish.

Questions in the data collection guide are in normal type. Text printed entirely in capitals, LIKE THIS, is meant as instruction to interviewers.

Remember that this is only a data collection guide, not a dictum. Precise language in the questions is not important, and neither is the order in which questions are covered. The guide is simply a reminder to important issues and ideas that need to be discussed. More concern is to be given to understanding the answers than to writing them down thoroughly or verbatim. Immediately following an interview, interviewers will go back through their notes to write answers fully and in proper sentences and to be sure that there are no "loose ends." If necessary, telephone calls will be made to review particular comments or to check the exact meaning of unclear answers.

In this vein, the data guide is written in conversational style. We expect the interviews to be conducted as free-flowing discussions. The information will be condensed and cast into the "King's English" during the analysis phase.

Finally, we do not necessarily expect answers to every question that is asked. We recognize that people have concerns and expertise in some areas and not in others. If interviewees do not wish to answer a particular question, the question can be skipped and the interview can progress to the next topic.

CONFIDENTIALITY

A complete statement regarding confidentiality accompanies each data collection form and is to be reviewed prior to every interview. The most important point of that statement is repeated briefly here. That is, responses to this data collection effort (or staff observations) never will be reported with reference by name to any particular individual. Anonymity of private individuals will be maintained absolutely. The anonymity of public officials will be maintained to the extent that is possible; it is acknowledged that because of their positions and special information, it may not always be possible to present information reported by public officials in a manner that would make it impossible for knowledgeable people to determine that these officials were the source of the information.

INVOLUNTARY CIVIL COMMITMENT PROJECT

Statement of Confidentiality and Project Ethics August 28, 1981

Protecting Confidentiality

The reports that result from the information collected by interviews and observations will not identify individuals by name. Any information that reasonably could be expected to identify a private person will be deleted or disguised.

A list of public persons interviewed and the organization each represented will be included in the final report. In the report, where it is appropriate or necessary to identify comments or suggestions with an organization or person, generic descriptions will be used -- e.g., out-patient treatment personnel, attorneys, advocates, in-patient treatment personnel.

It is possible that persons knowledgeable about the mental health or legal communities could identify organizations and public persons representing them as sources of certain reported statements. We will make every reasonable effort to use multiple sources of information in order to reduce the probability of revealing the identity of particular public persons.

Information in our files will generally be deidentified. Personal identifiers will be attached to file materials only when necessary for some valid and important research purpose. We will keep all personally identifiable information in locked file cabinets. All remaining personal identifiers will be deleted or the papers destroyed at the conclusion of the project. Any requests for information that might identify an individual will be refused, unless needed for a valid and important research purpose, and then will be transmitted only after completion of a formal, written information transfer agreement, which will bind the receiver of the information, at the least, to the principles of this Statement of Confidentiality and Project Ethics.

To summarize, we will ensure the complete anonymity of private persons (patients, ex-patients, and families of same). The confidentiality of public persons and institutions will be protected to the maximum extent possible.

Research Ethics

Our staff is guided by three principles of ethical obligations:

1. We are obliged to participants in protecting their privacy and accurately representing their responses;

2. We have a duty to society, in that we do not waste funds on unnecessary research and that we make public our findings and recommendations; and
3. We are obligated to science and future researchers in conducting reliable and valid research, and documenting our methods and findings.

Informed Consent

Prior to beginning any interview or observing any non-public event for purposes of this research, one of the following statements will be read. Data collection will not occur without the expressed consent of all interview and observation subjects of this research (or of their guardians or responsible spokespersons).

This statement will be read prior to beginning any interview.

We are from the National Center for State Courts. We are performing a project to help judges and mental health professionals understand and improve the process of ordering involuntary treatment for the mentally ill. We would like to ask you some questions. We greatly appreciate your help with this project. But, please understand that you may refuse to answer any questions that you wish and you may decide to stop this interview at any time. Also, you may interrupt us to ask about the project at any time, and we will answer your questions as fully as we can. Our project is being done according to a written statement of confidentiality and ethics. Your interview statements will be kept entirely confidential (FOR A PUBLIC OFFICIAL ADD: to the best of our ability). Copies of information about this project and of our statement of confidentiality and ethics are available for you to read if you wish. Do you have any questions to ask before we begin the interview?

Prior to observing hearing or prehearing activities, the following statement will be read to the senior court official in the jurisdiction. If he or she so directs, it will be read to any other persons as necessary or appropriate.

We are from the National Center for State Courts. We are performing a project to help judges and mental health professionals understand and improve the process of ordering involuntary treatment for the mentally ill. We would like the court's permission to observe hearings and other prehearing

events. We will do this with the understanding that anonymity of persons will be maintained according to the project's statement of confidentiality and ethics. At any such time as any subjects of our observations object to our presence, we agree to stop such observations immediately unless we receive your specific permission to continue them. Copies of information about the project and of the statement of confidentiality and ethics will be available for you and any other persons to read at any time. We also will read this statement to all other persons whom you shall designate, if any. We greatly appreciate your help with this project. But, please understand that you may stop our observations at any time. Also, you and any other persons may ask questions about the project at any time, and we will answer your questions as fully as we can. Do you have any questions before we begin our observations?

Prior to any observations in or at a treatment facility, the following statement will be read to the facility director or other person with authority to consent to our project activities. If he or she so directs, it will be read to any other persons as necessary and appropriate.

We are from the National Center for State Courts. We are performing a project to help judges and mental health professionals understand and improve the process of ordering treatment for the mentally ill. We would like your permission to observe this facility and any examinations or treatment activities that are occurring, which are relevant to our work. We will do this with the understanding that anonymity of persons will be maintained according to the project's statement of confidentiality and ethics. At any such time as any subjects of our observations object to our presence, we agree to stop such observations immediately unless we receive your specific permission to continue them. Copies of information about the project and of the statement of confidentiality and ethics will be available for you and any other persons to read at any time. We also will read this statement to all other persons whom you shall designate, if any. We greatly appreciate your help with this project. But, please understand that you may stop our observations at any time. Also, you and any other persons may ask questions about the project at any time, and we will answer your questions as fully as we can. Do you have any questions before we begin our observations?

Involuntary Civil Commitment
Master Data Guide

CHECK ONE

_____ Interviewer

_____ Observer _____

Date _____ City _____

Place _____

Subject of data collection. FILL APPLICABLE BLANKS

Individual interview:

Name _____

Title or Position _____

Observation:

Re Case _____

Event _____

Group interview: LIST NAME/TITLE OR POSITION

_____ / _____	_____ / _____
_____ / _____	_____ / _____
_____ / _____	_____ / _____
_____ / _____	_____ / _____
_____ / _____	_____ / _____
_____ / _____	_____ / _____

PROVIDE THIS INFORMATION FOR ALL SINGLE-PERSON INTERVIEWS. OTHERWISE,
SKIP TO PAGE 4.

Before talking with you about specific issues, I would like to get some information about your familiarity with the commitment process and your general feelings about it.

I-1 How many years of experience have you had working in any capacity with the civil commitment of the mentally ill? _____

I-2 How would you describe your familiarity with the civil commitment statutes in this state? READ LIST OF ALTERNATIVES AND CHECK ONE BELOW.

I-3 How would you describe your familiarity with the civil commitment system and procedures in this state? READ LIST AND CHECK ONE

	I-2 Statutes	I-3 Procedures
Not at all familiar	_____	_____
Have partial or slight familiarity	_____	_____
Know well or know most	_____	_____
Know thoroughly or are expert	_____	_____

NOW DO THE INTERVIEW, BUT RETURN TO THE FOLLOWING TWO QUESTIONS AT THE VERY END.

For my final few minutes with you, I'm going to ask a couple of questions to help me summarize the way you perceive the civil commitment system in general.

I-4 I am going to read three statements about this state's present civil commitment system. Please indicate which statement you would most closely agree with. READ ALL AND CHECK ONE

_____ This state's system makes it too hard to get a person in for mental health treatment or to protect other people from the dangerous mentally ill.

_____ This state's system makes it too easy to get a person into treatment who may not really need it.

_____ This system strikes a good balance between the interests of committing a person to treatment and protecting the person's wish not to be treated involuntarily.

I-5 Similarly, I am going to read three statements about trends in your state's laws and procedures. Which one most closely reflects your feelings? READ ALL AND CHECK ONE

_____ This system seems to be changing to make it harder to get people committed to treatment.

_____ This system seems to be changing to make it easier to get people committed to treatment.

_____ This system seems to be pretty stable in this regard.

Prehearing Section

- JCL II-1
R I would like to begin by discussing the way commitment proceedings get started. Considering the people who can initiate the process, the actions they must take to bring their complaint to the attention of the authorities, and any prepetition screening that is done....
- a.. What do you think are the advantages of this system?
 - b. What are the disadvantages?
 - c. What changes would you suggest, and why?
- JC II-2
A a.. Do petitions and certifications usually contain all the
O information required in them by statute?
- b. IF NO: Why not? What is lacking?
 - c. ALL: What other information ought to be provided, and why?
- J II-3
AP As we understand the statute in your state, in order to
O initiate commitment, it is necessary to assert that respondent is mentally ill, _____ and/or _____.
- a. Is this correct?
 - b. What else is required?
 - c. Are these requirements typically met in initiating commitments?
 - d. IF NOT: Why not?
- J II-4
AP a. In your opinion, how should these requirements be altered?
- JCL II-5
APR In some places, people have worked out ways to get help for respondents before any formal hearing takes place. This can be a method for getting help without a formal commitment to treatment, or a way of avoiding the need to take the case through a formal hearing.
- a. Are there any ways to do this type of prehearing diversion here?
 - b. IF YES: What are they, and how well do they work?
 - c. ALL: Can you suggest some prehearing diversions or screening procedures that are not used here now, but could be?

J L II-6 a. Once a commitment process is begun, what circumstances
AP or conditions must exist to justify taking a respondent into custody?

b. What changes, if any, would you suggest in this regard, and why?

J L II-7 a. Is there any way to avoid holding a respondent in custody
A prior to an examination or prior to a hearing?

b. IF NO: Is there any reason why this can't be done?

c. IF YES: How and when does this occur?

J L II-8 a. How, exactly, is a respondent picked up or taken into
AP custody when a commitment is initiated against him or her?

b. What are the strong points of this process?

c. What are the weak points?

J II-9 We know that states differ in their practices with regard
AP to where they hold respondents prior to an examination or hearing. As examples, some states use hospitals or local clinics exclusively, while other states allow people to be held in jails or to remain at liberty in their homes.

a. What facilities are used here to hold respondents most frequently?

b. What are the advantages to using these?

c. What are the disadvantages?

d. What other facilities might be used, and what advantages would they offer?

J II-10 a. How long are respondents typically held in custody prior
AP to receiving a hearing? PROBE FOR ANY COMMENTS ON TIME.

J E II-11 a. ASK THIS QUESTION ONLY IF ANSWER IS NOT ALREADY OBVIOUS FROM
APR EARLIER QUESTIONS. Do you feel that prehearing detention
practices in this system unnecessarily restrict respondent's
right to liberty? Why?

b. Do you feel these practices adequately protect society from
dangerous mentally ill people? Why?

c. Do you feel these practices are adequate to protect people
who might be dangerous to themselves? Why?

d. Do you feel that the prehearing detention practices
adequately meet the immediate treatment needs of the
hospitalized person?

e. What changes or procedures can you suggest to improve these
practices?

J II-12 Let's talk a bit about mental health examinations.
AP

a. How many examinations do respondents typically receive prior
to a commitment for treatment, and when do they occur?

b. Who does the examinations?

c. What information does an examiner usually have about the
respondent prior to the examination?

J II-13 a. Does the examination process present any special
APR considerations in this jurisdiction with respect to the
examiner and the respondent in their relationships as a
doctor and patient?

b. IF YES: How are these considerations dealt with and
what are the effects?

c. ALL: Is this a particular problem at time of
recertification?

J II-14 a. Do examination reports usually contain all the information
AP required by law?
O

b. What, if any, information is not contained in examination
reports that you think should be included? Why would it
be helpful to include this information?

- J II-15 a. How frequently does a respondent assert or pursue a right
AP to remain silent during an examination?
O
- b. Is every patient informed of the likely consequences of the examination, and of the right to remain silent, if there is one?
- c. IF YES: How and when is this done?
- d. ALL: What effect does this have on the examination?
- J II-16 a. How frequently do respondents request an independent
AP examination?
- b. IF EVER: When an independent examination is requested, does it seem to make a significant difference to the proceedings?
IF YES: How?
- c. IF NEVER: Do you feel that independent examinations should be done? IF YES: Why?
- JC II-17 The next few questions will be addressed to the matter of
A respondent's attorney. These questions will be related to
O the entire commitment process, not just the prehearing stage.
- a. Are all respondents represented by counsel?
- b. IF NOT: Why are some not represented?
- c. ALL: How is indigency determined?
- d. What method is used for the appointment of counsel?
- e. What qualifications are required for appointed attorneys?
- J II-18 a. What do you see as the proper role of counsel for the
AP respondent?
O
- b. Do attorneys tend to advocate strongly for the respondent's liberty interests in all cases, or is this true only when the attorney feels this is in the respondent's best interests?
- c. Do you think this should be changed, and why?

JC II-19 a. Do you feel that most attorneys are sufficiently prepared
APR in their roles as counsel for respondent?
O

- b. IF NOT: What more should they be doing?
- c. ALL: What kinds of incentives or disincentives exist for counsel to be thorough?
- d. ALL: Do you think this should be changed, and why?

JC II-20 a. Do respondents frequently reject the assistance of
AP appointed counsel?
O

- b. IF YES: How is this handled by the court?
- c. Are there ways in which this can be handled better?

J II-21 a. How frequently will attorneys challenge an examiner's
AP credentials or conclusions?
O

- b. How frequently will attorneys object to testimony or admissibility of evidence at hearing?
- c. Do attorneys ever insist on psychiatrists using lay language?
- d. What is the effect whenever any of these actions is done?

JC II-22 a. Do attorneys have prompt and sufficient access to all
A information they need for respondent's case?

- b. IF NOT: What more do they need, and how can it be provided to them?
- c. ALL: Do attorneys make use of all the necessary information relating to the respondent that they have access to?
- d. IF NO: What important information might counsel be missing, and what can be done to correct this?

JC II-23 The next questions have to do with prehearing treatment.

AP

O

- a. Under what circumstances, if any, do respondents receive treatment prior to a formal disposition hearing?
- b. What types of treatment usually are given?
- c. Are respondents ever medicated when they are brought to the hearing? IF YES, ASK: Is this communicated to the court?
- d. IF YES: What problems or advantages does this create?
- e. ALL: What changes would you suggest?

J II-24 a. Do respondents ever assert a right to refuse treatment prior to disposition?

AP

- b. IF YES: What happens when respondent does so?
- c. ALL: What changes would you suggest in your system with regard to respondent's right to refuse prehearing treatment and why?

JC II-25 a. Under what circumstances might a case be dismissed or a respondent be discharged prior to a hearing?

AP

- b. If a respondent is discharged from the custody of a mental health facility prior to a hearing, is the case automatically dismissed, or might a hearing be held anyway?
- c. Do you feel that a hearing should be held, even after a person has been discharged by a mental health facility?
- d. IF YES: Why and in what manner?

JCL II-26 a. When and how is respondent notified of his or her rights, such as the right to counsel, to an independent examination, and to see copies of the petition and certification?

APR

O

- b. What more should be done, if anything, to inform respondents of their rights?
- c. Are there formal procedures for waiver of rights?

CL II-27 a. Who is notified when a respondent is first taken
AP into custody?

- b. What notifications are made if respondent is discharged or the case is dismissed?
- c. What procedure is used for giving notices?
- d. What other notifications ought to be made?
- e. Are notifications given that are unnecessary?
- f. What are your practices if a respondent requests that certain people not be notified?

JC II-28 a. We are interested in the payment of the costs of prehearing
AP procedures. Could you tell me who is responsible for these costs, who usually pays them, and whether the regulations regarding payment have any important effects on the way the following are done:

- 1. Picking up the respondent
- 2. Detention
- 3. Examination
- 4. Treatment
- 5. Emergency hearings

- b. Who is responsible for administration and collection of payments?

JCL II-29 Before going on to some questions about the hearing itself,
APR I'd like to find out whether you have any comments to make
0 about the early part of the process, in addition to the things we already have discussed.

- a. What aspects of initiating an emergency commitment procedure in your system are especially helpful or problematic, and what comments or recommendations would you make about them?
- b. What comments or recommendations would you care to make relating to initiating a commitment by the usual judicial hearing procedure in which no emergency is involved?
- c. IF APPROPRIATE TO STATE: Would you care to make any comments about your state's procedures for initiating a commitment that does not require judicial review?
- d. What strengths or weaknesses can you comment on regarding your system's ability to use conservatorships or guardianships to get help and treatment for the mentally ill?

- e. Do you care to comment on this system's procedures for initiating a commitment proceeding against a person who is currently a voluntary patient and who is seeking release?
- f. What particular strengths or weaknesses, if any, does your system have for initiating a commitment for treatment for prisoners?

The Hearing: Adjudicating Commitment

- JC III-1 a. The questions in this part of the interview will focus on
A the hearing, per se. But first, let me ask some questions about how treatment might occur without a hearing. Excluding voluntary admission and treatment in emergency situations, is it possible for a person in this system to be committed for treatment without going through a formal hearing?
- b. IF YES: How does this happen?
- c. ALL: Do you see any reason why this might be advantageous?
- d. ALL: Would you suggest any changes in this regard?
- JC III-2 a. Does respondent ever have trouble obtaining a prompt
A hearing?
- b. IF YES: What is the difficulty and how might it be overcome?
- c. ALL: What period of time do you feel is needed between the filing of a petition and holding a hearing?
- d. ALL: What difficulties would arise in holding the hearing prior to this time?
- JC III-3 a. Where are commitment hearings typically held?
AP
O
- b. What are the advantages and disadvantages of holding hearings there?
- c. Would you suggest having the hearings somewhere else?
- d. IF YES: Under what circumstances, and where?
- JC III-4 a. Is the respondent given an opportunity to elect voluntary
APR admission prior to or during a hearing?
O
- b. IF YES: Do you favor giving respondent this opportunity? Why?
- c. Before permitting a respondent to choose voluntary admission, does the court consider whether the respondent has the capacity to make treatment decisions?
- d. What changes would you suggest, if any, in the process of allowing for election of voluntary admission?

- J III-5 a. Our understanding of your civil commitment code is that
AP a person must be found to be _____,
O _____ and/or _____ in order to support
a commitment. Is this correct? Is it interpreted this
way in practice?
- b. Are these requirements typically met?
- c. What other factors appear to influence the court's
decision?
- d. What specific facts typically are presented to the court to
support these criteria and the existence of other factors?
- e. What changes do you think are called for in the legal
criteria supporting a commitment for treatment?

- J III-6 a. Does your system have a problem with chronically disturbed
APR people who seem to be regularly in and out of treatment
facilities? IF NO, GO TO III-7.
- b. IF YES: What exactly are the nature and cause of the
problem?
- c. Can you suggest a solution?

- JC III-7 a. How, if at all, does a consideration of less restrictive
AP alternatives enter into the hearing? That is, how, if at
O all, does the topic get raised and who presents testimony
in this regard?
- b. (ASK ONLY IF NOT OBVIOUS FROM LAST ANSWER) Does the court
dismiss the case if a less restrictive alternative is
identified?
- c. ALL: Do you feel that adequate attention is given to less
restrictive treatment alternatives in the hearing?
- d. IF NOT: What more, specifically, should be done?

- JC III-8 a. Do hearings typically include a state's attorney or district
attorney?
- b. What is the best role for state's attorney in a commitment
hearing?

- JC III-9 a. How frequently does a hearing include an attorney for the
A petitioner?
- b. What advantage or disadvantage is there in having petitioner represented by counsel?
- JC III-10a. Under what circumstances are commitment hearings held before
A a jury?
- b. What are your feelings about jury hearings in such cases?
- JC III-11a. Is respondent always present at the hearing?
AP
O
- b. IF NO: Under what circumstances would respondent not be there?
- c. ALL: What recommendations would you make about holding the hearing without respondent being present?
- J III-12a. How frequently is a person who examined respondent present
O to testify at a hearing?
- b. IF NOT ALWAYS: How is examination evidence presented if the examiner is not present?
- c. ALL: What recommendations would you make about having examiners present at hearings?
- JC III-13a. In practice, how strongly does the examiner's testimony
AP or evidence influence the court and, in effect, determine
O the outcome of the hearing?
- b. Should this be different?
- c. IF YES: What can you suggest to change this?
- J III-14a. How frequently do psychiatrists and other examiners present
AP a neutral assessment of respondent's condition, or how
O frequently do they act as advocates either for or against respondent's commitment?
- b. What is the effect of this?
- c. How, if at all, should this be changed?

J III-15a. What other witnesses (such as petitioner) typically are at
AP the hearings?
O

- b. How do you feel about the effects or importance of having such witnesses at the hearings? BE SURE TO EXPLORE THIS QUESTION FOR EACH WITNESS MENTIONED IN III-15 a.

J III-16a. Who actually conducts the hearings, a judge or somebody
A else?
O

- b. During a hearing, does the judge [OR OTHER OFFICIAL ACTING IN THIS CAPACITY] typically take an active part in directing questions to respondent and witnesses, or does the judge usually just listen as the case is presented by counsel?
- c. Does this seem to be a good way to conduct the hearing? Why?
- d. IF ANSWER IS NOT ALREADY OBVIOUS, ASK: What would you recommend as the best role for a judge in a commitment hearing?

JC III-17a. Are hearings typically open or closed to the public?
AP
O

- b. What are the problems or advantages to the way your court system handles this?

JC III-18a. Does the court make a permanent record of commitment
hearings? IF YES: How?

- b. Is a permanent record useful or necessary? Why?
- c. What additional costs are created by making a permanent record, and are the costs justified by the need?
- d. What policies would you recommend for retaining or destroying civil commitment records? Why?
- e. What policies ought to be followed in sealing the records and in allowing various parties to have access to these records? Why?

J III-19a. Under what circumstances are continuances granted?
A
O

- b. What useful or harmful effects have you noticed as a result of granting continuances?

J III-20a. Does the court apply formal rules of procedure and rules
A of evidence to the commitment hearing?
O Procedure _____ Evidence _____

b. What is your opinion about allowing hearsay testimony?

c. What is your feeling about allowing information about previous commitments as evidence?

d. Do you care to comment further about your system's practices regarding procedure, evidence, and testimony?

JC III-21 I have some further questions about notification.
A
O

a. Who is given notification of commitment hearings and at what time?

b. When, if at all, is respondent notified of the right to elect voluntary admission?

c. When, if at all, is respondent notified of the right to a jury?

d. What recommendations do you have regarding these or other notifications?

JC III-22a. What provisions are made for paying costs associated with a
A hearing?

b. Who is responsible?

c. Who usually pays?

d. Do the regulations governing payments have any important effects on the way hearings are conducted?

e. What changes should be made in this regard?

f. Who is responsible for the administration and collection of payments?

Hearing: Determining Treatment

- J
AP
O
- IV-1
- a. During commitment hearings, is the question ever raised of respondent's capacity to make treatment decisions?
 - b. IF YES: Under what circumstances?
 - c. ALL: Is this question ever raised at a separate hearing?
 - d. IF YES: Under what circumstances?
 - e. ALL: Would you suggest any changes in practices with regard to raising this question?
 - f. IF YES: Why and what change?
- AP
- IV-2
- a. Is a ruling on capacity to make treatment decisions required if a person is to be committed for treatment?
 - b. Is such a ruling required before treatment can be administered involuntarily after a person has been committed?
 - c. What recommendations would you make about the need to rule on this question prior to commitment and treatment? BE CAREFUL TO GET ANSWERS TO BOTH ASPECTS OF THIS QUESTION, IF YOU CAN.
- J
APR
O
- IV-3
- a. How customary is it for treatment plans to be presented at hearings? IF NEVER, GO TO LAST PART OF THIS QUESTION
 - b. Who presents the plan?
 - c. Are treatment plans ever challenged in the hearing?
 - d. IF YES: With what effect?
 - e. What recommendations would you care to make about the presentation of treatment plans during commitment hearings?
- J
AP
O
- IV-4
- a. Who, if anyone, investigates and reports to the court about treatment alternatives?
 - b. What people or other resources does the judge usually rely on for information about commitment options?
 - c. What are the advantages or disadvantages of this?
 - d. What changes, if any, would you suggest?

- J IV-5 a. What hospitalization alternatives are available to the
AP courts?
O
- b. In practice, which of these alternatives are utilized?
- c. In ordering hospital treatment, to what extent does the court consider hospital resources and conditions?
- d. Are other alternatives needed?
- e. IF YES: Why, and what do you recommend?
- J IV-6 a. Does the court ever commit a respondent to a nonhospital
AP treatment alternative (such as an outpatient program
O or into another person's care and custody)?
- b. IF NO: Why not?
- c. IF YES: What specific alternatives are used?
- d. ALL: What recommendations would you make regarding commitment for treatment in a less restrictive, nonhospital setting?
- J IV-7 a. How does a judge decide which hospital or less restrictive
AP alternative should be chosen in a particular case?
O
- J IV-8 a. Does the court ever issue an order requiring a respondent
AP to get a particular type of treatment, or requiring that
O treatment must be given for a specified minimum or maximum time?
- b. What are your feelings about the court issuing such orders?
- JC IV-9 a. Is a determination made of liability for payment of
P services when treatment is ordered? IF YES, ASK: How?
O
- b. Does this determination affect the types of services made available or the procedures for obtaining services?
- c. What changes need to be made in this regard?

Posthearing

- JC V-1 These questions will concern several issues that become
A important after the hearing is completed.
- a. What notifications, if any, are given if a respondent is committed? IF ANY, ASK: How are notices given?
 - b. What notifications are given if a respondent's case is dismissed? IF ANY, ASK: How are notices given?
 - c. Are these notifications sufficient and useful?
 - d. IF NO: What changes would you suggest?
- J V-2 a. How often does an appeal take place?
A
- b. Who usually begins this process?
 - c. Are respondents adequately informed about their right to appeal?
 - d. What assistance is available to respondents in bringing appeals?
 - e. Is the appeal process easy enough to understand and use?
 - f. IF NO TO c OR e, ASK: What changes would you suggest?
- J V-3 a. If an appeal is brought, how soon is it usually heard?
A
- b. If an appeal is brought, how does this affect what happens to the respondent at the treatment facility?
 - c. Under what circumstances, if any, can a respondent remain at liberty following a commitment order and pending appeal?
 - c. Should this be changed?
- J V-4 a. After a person is ordered for treatment, what options do
P hospitals or alternative treatment facilities use in deciding whether or not to examine or admit for treatment?
- b. Does this create any problems?
 - c. What benefit comes from their having those options?
 - d. What changes would you suggest?

- J V-5
AP
- a. If a facility admits a patient pursuant to a court order, is it under any restrictions regarding the type or extent of treatment it may administer.
 - b. IF YES: What are the limitations?
 - c. ALL: Do you feel it is wise to place treatment constraints on a facility? Why?
 - d. ALL: What treatment-constraining powers should be exercised by the court (or by statute) in your opinion, and at what point in the process?

- J V-6
AP
- a. What information, if any, does the treatment facility provide to the court to inform the court of the patient's progress?
 - b. IF ANY: What is the reason that this information is provided; that is, is it sent because it is required by statute, it was ordered by the court, or is it provided for some other reason?
 - c. What additional information does the court need, in your opinion?
 - d. When should such information be provided?
 - e. What does the court do with this information?

- J V-7
APR
- a. In your opinion, is the court's oversight of what happens to a committed patient adequate, too much for the facility, or not demanding enough? Why?
 - b. What would you recommend?

- J V-8
A
- a. What, if any, judicial sanctions are available for ensuring compliance by facilities or respondents with court orders regarding treatment?
 - b. How frequently are such sanctions used, and with what effect?
 - c. What recommendations do you have in this regard?

- J V-9 a. What difficulties arise regarding the transfer of patients?
APR b. IF ANY: How could these problems be overcome?
- J V-10 a. What difficulties arise regarding patient discharge?
APR b. IF ANY: How could these be overcome?
- A V-11 a. How far after the hearing is court-appointed counsel responsible to the client? That is, does the client-attorney relationship continue during appeal and treatment?
b. What continuing role do you feel counsel should play following a commitment order?
- AP V-12 a. Following commitment, does a patient have the right to refuse treatment? IF YES, ASK: How is the patient notified of this right?
b. Do you feel a patient should have this right?
c. IF YES TO a, ASK: What difficulties does this cause, if any, and how can they be overcome?
- AP V-13 a. Under what circumstances does a treatment facility obtain informed consent prior to administering treatment to an involuntarily committed patient?
b. How does this differ for voluntary patients?
- AP V-14 a. Excluding those who refuse it, are all patients who are admitted given some form of treatment?
b. IF NO: Why not, and what should be done about this?
- AP V-15 a. In your opinion, are the civil and personal rights and safety of committed patients adequately protected?
b. IF NO: Why not, and what should be done about this?

- J V-16
APR
- a. Do patients have access to and use a patient advocacy system to represent their interests?
 - b. IF NO: Why not?
 - c. IF YES: What makes the system useful to patients?
 - d. ALL: Would you recommend any changes in making an advocacy system available? (IF YES) What?
- J V-17
AP
- a. How long are most commitment periods ordered for?
 - b. To the best of your knowledge, how long does the average patient actually remain in treatment?
 - c. To the best of your knowledge, are patients typically treated for a correct amount of time, given the help that they require?
 - d. Should treatment periods be longer or shorter, in your opinion, and why?
- J V-18
AP
- a. In what ways can a patient seek a change in or release from treatment?
 - b. What is the most effective way?
 - c. Do you feel that patient's options for seeking change or release are too easy or too hard? Why?
 - d. How often is a writ of habeas corpus used to seek release?
 - e. What suggestions would you make concerning these avenues for treatment modification and patient release?
- J V-19
APR
- a. Are the review hearings effective and useful? Why is this?
 - b. Do they differ in procedure from original commitment hearings, and how?
- J V-20
AP
- a. Are patients' commitment periods typically extended or recertified?
 - b. What changes do you feel are necessary in the process for recertifying a commitment?

INVOLUNTARY CIVIL COMMITMENT PROJECT

Observation Guide

Observer _____ Date _____
City _____ Place _____
Event _____ Re Case _____

What to observe during PREHEARING EXAMINATION or TREATMENT

1. Where is the action taking place? (II-7, II-9)
2. What information is given to the examiner? (II-12)
3. What are the examiner's (treater's) qualifications? (II-12)
4. Is respondent informed of his/her rights? (II-15, II-23)
5. Does respondent refuse to cooperate with any part of the process?
(II-15, II-23)
6. What information is generated about respondent? (II-14)
7. How is the report to the court formulated? (II-14)
8. What type of treatment is being given? (II-22)
9. Have statutory criteria been met to justify examination or treatment?
(II-12, II-22)
10. Is respondent held or discharged? (II-24)

Observer _____ Date _____
City _____ Place _____
Event _____ Re Case _____

What to observe during PREHEARING PROCESSING

1. Who initiated the action? (II-1)
2. Where is the action taking place? (II-1)
3. What is being asserted about respondent? (II-3)
4. What documents and other evidence have been filed? (II-3)
5. Have all the necessary papers been filed? (II-2)
6. Do all filed papers contain all the required information? (II-2, II-3, II-14)
7. Is respondent informed of his/her rights? (II-15, II-23, II-25)
8. What options are considered and used for diversion, release, treatment? (II-5, II-7, II-9, II-22)
9. How and when is counsel appointed? (II-17, II-19, II-21)
10. Is treatment being administered? (II-22, II-23)
11. What notifications are given? (II-25, II-26)
12. Is respondent held or discharged? (II-24)

Observer _____ Date _____
City _____ Place _____
Event _____ Re Case _____

What to observe during HEARINGS

1. Where is the action taking place? (III-3)
2. Are proper petitions and certificates available to the court? (II-2, IV-3)
3. Do all filed papers have all required information on them? (II-2, II-14)
4. Are examiners' reports available to the court? (II-2, II-14)
5. Do examiners' reports have sufficient and required information (II-2, II-14, III-7, III-12)
6. Who is conducting the hearing? (III-16)
7. What is the role of the person conducting the hearing?
 - a. Does he/she direct questions? (III-16)
8. Is respondent's attorney retained or assigned? (II-17)
9. What are attorney-for-respondent's behaviors?
 - a. Does he/she appear to know the facts of the case well? (II-9, II-21)
 - b. Does he/she actively challenge examiners' qualifications evidence against respondent? (II-18, II-20)
 - c. Does he/she seem to have all the necessary information about LRAs? (II-21, IV-4)
10. Is respondent present? (III-11)
11. Is respondent medicated? (II-22)
12. How does the respondent behave? Does his or her behavior seem to influence the judge's decision?
13. What witnesses (including examiners) testify? (II-14, II-16)

What to observe during HEARINGS

14. Is respondent informed of his/her rights? (III-4, III-21)
15. Is respondent given opportunity to elect voluntary admission? (III-4)
16. Are necessary criteria met for commitment? (III-5)
17. What rules of evidence and procedure are applied? (III-20)
18. What is examiners' influence at hearing? (III-12, III-13, III-14)
19. Is a treatment plan presented? (IV-3)
20. Are alternative treatment possibilities discussed? (IV-4, IV-5, IV-6, IV-7)
21. Who presents information on alternative treatment options? (IV-3, IV-4)
22. Is question raised of capacity to make treatment decisions? (III-4, IV-2)
23. What are the roles of attorney for petitioner and state's attorney? (III-8, III-9)
24. Is there a jury? (III-10)
25. Is the public present? (III-17)
26. Are continuances granted? (III-19)
27. Are notifications given? (III-21)
28. Are provisions made for payment? (III-22)